EMERGENCY NURSES ASSOCIATION
SAFE PRACTICE, SAFE CARE

Position Statement

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Emergency Nursing Interface with Mobile Integrated Health (MIH) and Community Paramedicine (CP) Programs

Description

Emergency departments (ED) provide a substantial proportion of the healthcare delivered in the United States.[1] Increased ED utilization is a reflection of not only increasing community healthcare needs, but also the lack of access to available care.[1,2] Indeed, a recent literature review found that on average, 37% (range 8–62%) of patients seeking emergency care were triaged with the lowest rating of non-urgent.[3] With ever-increasing numbers of patients, emergency departments face significant barriers to the delivery of acute care and essential healthcare services.[2,4] Inappropriate use of emergency services, crowding, frequent "bounce-back" visits, barriers to access of care, and fragmentation in care all strain emergency departments, which serve as the safety net of the US healthcare system.[4] These inefficiencies are more than an economic problem: they have a human toll and lead to suffering and unnecessary deaths.[4]

The Institute for Healthcare Improvement has proposed a three-pronged approach to:

- Improve the experience of care
- Improve the health of populations, and
- Reduce the per capita costs of healthcare[5]

Achieving these aims would require communitywide partnerships to bring together clinicians, social service providers, behavioral health professionals, and educational leaders to provide an effective approach. In 2013, citing wasteful spending, unnecessary services, and inefficiently delivered services, as well as missed prevention opportunities, the Institute of Medicine (IOM) recommended a "system wide transformation" to include engaging patients, embracing new technologies, increasing teamwork and transparency, and valuing outcomes of care.[4, pg. 320]

One innovative strategy, Mobile Integrated Healthcare (MIH), is being piloted or has been implemented across the United States. This population-based healthcare delivery approach uses out-of-hospital resources in the prehospital and community setting to provide services to a wide range of patients within a given population. Another program involves community paramedics (CP), working within their scope of practice in the field under the direction of a physician.[6,7] These programs were originally implemented to increase access to healthcare in underserved rural areas.[8] However, in 1996, the US Department of Transportation *Emergency Medical Services (EMS) Agenda for the Future* outlined a plan for EMS to integrate primary care services into the community.[9] Then, in 2012, there was a proposal for further expansion of the EMS role into non-rural areas.[8] In many cases, CPs are filling a gap in services that had been performed by public health nurses and visiting nurses.[7] This raises uncertainty related to overlapping responsibilities, education and training,[7] and underlines the necessity for interprofessional collaboration and role clarity.[10–14] Registered nurses currently play a key role in discharge planning, referrals for chronic disease management, post-discharge community follow-up, and continuing preventive care.[7]

The belief that "patient-centered care coordination is a core professional standard and competency for all registered nursing practice" is cited by the American Nurses Association as a major reason to establish interprofessional collaboration.[7,pg.1]

The intended role of the CP may be in conflict with emergency nursing education and training. The competencies for Standard number 4 (Planning) in the *ENA Scope and Standards of Practice* include statements that the emergency registered nurse:

- "Develops ... an individualized (care) plan ..."
- "Provides for continuity within the plan of care" and

- "Utilizes the plan to provide direction to other members of the healthcare team"[15]

Thus, teams with members having clearly defined roles will be essential as multiple disciplines work to provide specific needs-based resources, social services, and healthcare within the framework of MIH and CP programs.[8,10–14]

ENA Position

It is the position of the Emergency Nurses Association that:

1. Emergency nurses promote and support public health services that provide safe, patient-centered, quality care
2. Emergency nurses support all members of the healthcare team to function fully and collaboratively, consistent with their education, training, and scope of practice
3. Patient-centered care coordination is a core professional standard and competency for all registered nursing practice
4. Interprofessional teams with members having clearly defined roles are essential to provide patient care within the framework of MIH and CP programs
5. Emergency nurses collaborate with a variety of other professionals in improving the health of populations served, reducing healthcare costs, and improving the individual patient experience
6. Emergency nurses advocate for additional research to measure the performance efficacy of these community programs
7. Emergency nurses support formalized programs that provide advanced education for EMS providers

Background

Pioneering programs such as the MIH and CP have launched a movement for more cost-effective healthcare spending using a patient-centered approach integrated with a team-based, interprofessional collaborative structure.[10–13] A successful program will conduct a community assessment to determine population healthcare needs and gaps in access.[8] The services offered by MIH and CP programs include telephone triage, chronic disease management, follow-up home visits, post-discharge education, and preventive care, all under medical direction or oversight.[16–20] There are some data showing that use of these programs may help prevent hospital readmissions for congestive heart failure patients and reduce ED visits by decreasing the number of frequent-user transports.[8] Some programs call for advanced paramedical training while others use EMS at all levels without additional training.[8] Education may include diagnostic and triage skills, expanded psychomotor skills, and pathophysiology of chronic disease.[8] The role of the community paramedic is subject to state and certification regulations.[6,7,10–14, 20] Many states require every patient be transported, thus presenting regulatory barriers.[8] Many states have well-established MIH or CP programs, whereas others have only recently amended their EMS laws legalizing and supporting these programs.[10] To date, not all states have enacted legislation to authorize MIH or CP programs. Further, several states have no legislation in place at this time regarding MIH and CP programs, creating regulatory challenges and barriers including uncertainty over funding and reimbursement.[21]

Emergency nurses may have an opportunity to collaborate with their EMS colleagues and play a key role in facilitating the transition of patients from the ED into these community programs. When discharging patients back into communities with formalized MIH and CP programs, emergency nurses complete an assessment to identify patients at risk who might benefit from these community resources and link them to these programs by providing education, contact information, and community referrals.

MIH and CP programs may present an opportunity to increase the proportion of individuals who have access to care. However, there are currently few studies to support the efficacy, safety, and economic benefit of MIH and CP programs.[8] Additional studies are necessary to validate preliminary findings and provide evidence-based performance measures.[8]

Resources

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