

Ideas
Analysis
Insight

Best Practices

IN EMERGENCY SERVICES

Quick Look

Improving Continuity of Care in Kansas

Sedgwick County EMS in Kansas recently implemented a policy designed to discourage frequent 911 callers from going from hospital to hospital seeking care. According to the policy, patients transported to an ED who call 911 again within 72 hours must be transported to the same ED.

“We have a group of patients who would call us and say they didn’t like the staff at this hospital, or they didn’t get what they think they should have received ... so take me somewhere else,” says Scott Hadley, director of Sedgwick County EMS.

Some of the patients may have substance abuse issues and are seeking pain medications, while others have a multitude of chronic ailments, often coupled with mental health or social services needs. Not only do those patients take up an inordinate amount of EMS resources, but they cause hospitals to have to repeat tests and labwork that may have already been done elsewhere. “By taking them back to the same facility, that facility will have all of their pertinent medical information, their history, and may have talked with the primary care doctor,” Hadley adds.

The idea for the protocol came after Hadley and his team analyzed the habits of their top 50 911 callers. They noted that many frequent users would go to multiple hospitals, sometimes even on the same day. With the support of Sedgwick County EMS Medical Director Sabina Braithwaite, M.D., they got the OK from the Medical Society of Sedgwick County, which oversees EMS protocols and includes representatives from area hospitals, to

Continued on page 7

Finding a New Seat at the Healthcare Table

Will the emerging concept of mobile integrated healthcare practice transform EMS?

By Jenifer Goodwin

Editor’s note: Some of EMS’s most influential leaders believe the concept of mobile integrated healthcare practice has the potential to change not just what EMS calls itself, but how emergency care is delivered and reimbursed. It’s so important that we’re presenting a special in-depth report on the topic here. Next month we’ll hear more from Eric Beck, D.O., medical director for the City of Chicago EMS System and Chicago Fire Department and one of the leading advocates for this emerging concept. — Keith Griffiths

In Reno, with the help of a \$9.8 million federal Innovation Grant, the Regional Emergency Medical Services Authority (REMSA) is partnering with local health and social service agencies to take intoxicated patients directly to detox and psych patients to a mental health facility. They’re also finalizing plans to make house calls to recently discharged hospital patients with chronic illnesses to prevent readmissions. And they’re working to establish a seven-digit nurse triage line as an alternative to 911.

In Fort Worth, MedStar Mobile Healthcare, formerly known as MedStar Emergency Medical Services, has arrangements with local hospitals, doctors’ groups and hospice organizations to be paid to provide services to congestive heart failure and hospice patients at home, also with the goal of improving care while avoiding costly trips to the emergency department.

These efforts are part of a burgeoning movement that some of EMS’s most influential leaders are calling “mobile integrated healthcare practice.” From telemedicine to prevention campaigns, from community paramedicine to nurse triage lines, mobile integrated healthcare practice moves the EMS industry definitively out of the realm of public safety and positions it firmly into the realm of healthcare. “EMS needs to rethink its basic mission of being about transportation and instead be about providing care in the most effective way for the patient,” says Eric Beck, D.O., medical director for the City

Continued on page 8

Highlights from the issue

Special report: Does an emerging concept portend the future of EMS?.....	1
Justice Department improves PSOB program	2
Study shows paramedics often get STEMI wrong	3
Bill Brown on his legacy at the NREMT—and what retirement holds for him	4
LAFD increases ambulance staffing	7
Committee will integrate mobile integrated, community paramedicine groups... 11	
The need to resuscitate imagination	12

Publisher
Jacob Knight

Editor in Chief
Keith Griffiths

Editor
Carole Anderson Lucia

Associate Editor
Jenifer Goodwin

Contributing Writer
Aimee J. Frank

Art Director
Morgan Haines

Editorial Board of Advisers
Bonnie Drinkwater, Esq.
Drinkwater Law Offices

James N. Eastham Jr., SC.D.
CEO, CentreLearn Solutions, LLC

Jay Fitch, Ph.D.
President, Fitch & Associates

Stewart Gary
Principal, Fire & EMS Services
Citygate Associates, LLC

Kevin Klein
Director, Colorado Division of Fire Safety

William Koenig, M.D., FACEP
Medical Director, Los Angeles County EMS

Jon R. Krohmer, M.D., FACEP
U.S. Department of Homeland Security

Pete Lawrence
Battalion Chief
Oceanside, Calif., Fire Department

Todd J. LeDuc, MS, CFO, CEM
Deputy Fire Chief, Broward Sheriff's Office
Department of Fire Rescue & EMS

Lewis Marshall, M.D., J.D.
Chairman of Emergency Medicine
Wyckoff Heights Medical Center
Brooklyn, N.Y.

Patrick Smith
President, REMSA

Gary L. Wingrove
Mayo Clinic, North Central EMS Alliance

Best Practices In Emergency Services (ISSN 1540-9015)
is published monthly by
The National Emergency Services Institute
679 Encinitas Blvd., Suite 211
Encinitas, CA 92024 • Tel. 760-632-7375 • Fax 866-448-1436

emergencybestpractices.com

© 2013 by The National Emergency Services Institute
All rights reserved
Subscription rates: USA: one year: \$279; two years: \$450 (save \$108);
outside the USA: Please add \$10 per year.

Best Practices is a membership benefit of the
National EMS Management Association.

Justice Department Improves PSOB Program

Several important improvements to the Public Safety Officers' Benefits (PSOB) program were announced by Attorney General Eric Holder in May following a comprehensive review of the program by his office during the past year.

Holder discussed some of the changes his office has made to ease and expedite the process and additional changes that he anticipated would be in place in the months to come. He announced the changes during his speech at the 25th Annual National Law Enforcement Officers Memorial Candlelight Vigil in Washington, D.C., where he pledged last year to reform the system that pays a federal financial benefit to eligible survivors of law enforcement officers and other first responders killed in the line of duty.

The application process was reorganized to reduce the burden on claimants by eliminating paperwork to require only the documents truly necessary to support a claim. Holder plans to streamline the process further by bringing PSOB functions, including legal, under one roof, all in an effort to improve efficiency to ensure that fallen or injured officers and their families receive benefits in a timely manner. Unnecessary outside legal review has been criticized for prolonging the review process and delaying the delivery of benefits. A new electronic case management system was implemented so claims can be expedited and families can check the status of their claims online at their convenience.

Holder's speech is at tinyurl.com/l9gv63a.

NHTSA Sees EMS Use for Crash Notification Data

The National Highway Traffic Safety Administration (NHTSA) is assessing the ways in which advanced automatic crash notification (AACN) telematics systems can be used to develop dispatch and triage protocols by providing important information before emergency responders are on scene. AACN provides real-time motor-vehicle crash data from information produced live from such automobile features as OnStar and Safety Connect.

NHTSA is assessing the potential utility of these data in reducing death and disability by optimizing dispatch of appropriate EMS resources to the scene, improving triage of crash victims and arranging transport to the appropriate level of trauma care. NHTSA is also examining the current use of AACN data in EMS response and medical direction, where it exists, in developing EMS and 911 protocols by incorporating real-time information.

By collecting vehicle crash data such as location and collision severity, AACN data can potentially decrease disability and death by:

- Predicting the likelihood of serious injury to the vehicle occupants
- Decreasing response times by all necessary levels of prehospital care providers
- Providing additional information for field triage destination and transport decisions
- Decreasing time to definitive trauma care

AACN could also save money by validating minor crashes that don't need a full EMS response. The strategy assessment is expected to be completed in late 2013.

"NHTSA Explores Automatic Crash Notification Use For EMS and 911" is available at ems.gov/newsletter/march2013/crash_notification.htm.

More Responders to Receive Health Benefits

Emergency responders who are or who could become ill from their work on Sept. 11, 2001, at the Pentagon or Shanksville, Pa., terrorist attack sites were made eligible for health care benefits under the Zadroga 9/11 Health and Compensation Act of 2010, effective May 1, under a rule of the Department of Health and Human Services (HHS) published in March.

The World Trade Center Health Program (WTCHP), ultimately run within HHS, provides the long-term medical care mandated by the Zadroga Act, such as free annual

Study Shows Paramedics Often Get STEMI Wrong

Paramedics' ability to identify STEMI (ST-elevation myocardial infarction) by interpreting prehospital ECGs is inconsistent, a new study finds.

More than 470 paramedics from 30 municipal EMS agencies in northeastern Ohio completed surveys that asked them to review ECGs from 10 prehospital patients. Three ECGs showed STEMI (inferior, anterior and lateral); two were normal; and five showed STEMI mimics, or abnormal electrical activity that can look like STEMI but has another cause. Of the respondents, 52 percent had 10 or more years of experience, 69 percent had received ECG training within the past year, and 74 percent reported they were confident in their ability to recognize STEMI.

All paramedics correctly identified the normal ECGs. Nearly all (96 percent) detected the inferior STEMI; 78 percent spotted the anterior STEMI, while half missed the lateral STEMI. Overall, only 39 percent correctly identified all three STEMI, while just 3 percent correctly identified all 10 ECGs as either STEMI or not STEMI.

There was no correlation between years of experience, recent training or confidence level and ability to interpret ECGs, according to the study, which was conducted by researchers from Summa Akron City Hospital in Akron, Ohio, and colleagues. "Given the overall low sensitivity and specificity of our paramedics' ability to recognize a STEMI, we cannot at this time rely solely on their interpretation to activate the cardiac catheterization laboratory," researchers concluded. Relying on paramedics to activate the cath lab could result in both missed activations and unnecessary activations, they added.

The study is in the April-June issue of *Prehospital Emergency Care*.

Prehospital ECG Computer Identification of STEMI Unreliable

Also in the April-June issue of *Prehospital Emergency Care*, a retrospective analysis of 200 prehospital ECGs found that computer interpretation of ECGs to identify STEMI isn't accurate enough to use as the sole source of information for cath lab activation decisions.

The analysis included 100 STEMI ECGs and 100 normal ECGs acquired using Lifepak 12 monitors and transmitted by one of 20 EMS agencies to Summa Akron City Hospital, a Level 1 trauma center. Although the computer correctly identified all 100 patients with normal ECGs, it picked up only 58 percent of STEMI. "This would have resulted in 42 missed cardiac catheterization laboratory activations, but zero inappropriate activations," the researchers wrote. The most common incorrect interpretation of STEMI ECGs by the computer were "data quality prohibits interpretation" and "abnormal ECG unconfirmed."

Google Flu Tracker Tripped Up This Season

Google Flu Trends, which estimates the prevalence of influenza based on flu-related internet searches, got tripped up this season, vastly overestimating the actual number of cases, according to a report in the Feb. 13 issue of *Nature*. In previous years, Google Flu Trends closely matched official data from the Centers for Disease Control and Prevention (CDC), which is based on actual reports from thousands of hospitals nationwide. But Google Flu Trends' estimate was twice that of the CDC's this year.

But don't count out the ability of social media to be used for epidemiological trend-spotting. "As flu-tracking techniques based on mining of web data and on social media proliferate, the episode is a reminder that they will complement, but not substitute for, traditional

epidemiological surveillance networks," wrote author Declan Butler. Experts told *Nature* it's possible that because this year's flu season was more severe than normal, media coverage prompted many more people to search for info about flu than actually had it.

Trauma Patients, Families Support 'Exception from Informed Consent' for Research

More than 300 trauma patients and their families surveyed by researchers from the University of Pennsylvania Perelman School of Medicine expressed a "high degree of support" for the Food and Drug Administration's Exception from Informed Consent policy. The policy was set in 1996 to allow researchers to conduct clinical trials on treatments for time-sensitive emergencies such as trauma, cardiac arrest and stroke when getting a patient's OK may be impossible.

Specifically, researchers asked trauma patients and their families about AVERT Shock, which will investigate the effect of using the hormone vasopressin during resuscitation of patients who have lost a lot of blood. More than 95 percent support the need for more trauma research and agree that the AVERT Shock Trial is an important study to perform. About 67 percent said it would be appropriate to enroll a patient without the consent of a family member; 77 percent said they themselves would agree to be enrolled, according to the study, which is in the January issue of the *Journal of Trauma and Acute Care Surgery*.

U.S. Drivers More Distracted than European Drivers

U.S. drivers aged 18 to 64 are three times more likely to say that they talked on their cell phone while driving in the past month than drivers in the United Kingdom (69 percent vs. 21 percent), according to a study using data collected in 2011 from the United States, the United Kingdom and six European nations (Belgium, France, Germany, the Netherlands, Portugal and Spain). About 31 percent of U.S. drivers reported reading or sending texts or e-mails while driving, higher than all other nations except for Portugal, also at 31 percent. On the low end was Spain: 15 percent of drivers admitted texting. The rest of the European nations fell somewhere in between.

U.S. men and women aged 25 to 44 years were more likely to talk on a cell phone while driving than those aged 55 to 64, while those aged 18 to 34 years were more likely to text or e-mail than older groups. The research is in the Centers for Disease Control and Prevention's March 15 *Morbidity and Mortality Weekly Report*. **Bp**

— Jenifer Goodwin

Join us at Pinnacle 2013

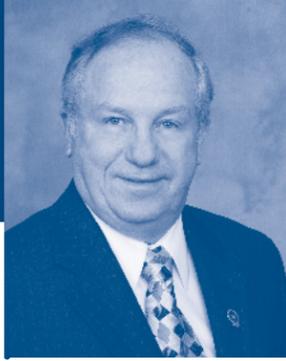
“The most insightful and network-friendly conference I have ever experienced—by far the best value for the money.”

— Pinnacle 2012 attendee

Best Practices is a proud supporter of the Pinnacle EMS Leadership Forum. Please join us at the Omni Plantation Amelia Island near Jacksonville, Fla., from Aug. 5–9, 2013.

pinnacle-ems.com

Continued on page 12



Q&A with William E. Brown Jr.

Retired executive director, National Registry of Emergency Medical Technicians

When it comes to promoting the professionalism of EMS personnel, few EMS institutions are as important as the National Registry of Emergency Medical Technicians (NREMT). For 24 years, William "Bill" Brown was the Registry's executive director, working tirelessly to build support for standardized training and testing requirements for EMS providers until his retirement in May.

When Brown took the helm in 1988, 29 states used the Registry to certify EMS providers and 300,000 had been certified. During his tenure, that number grew to 46 states. Some 1.7 million have been certified by the Registry since its inception, including 270,000 currently.

Brown grew up in Youngstown, Ohio, the son of a firefighter and the oldest of four children. With the Vietnam War raging, he enlisted in the U.S. Air Force and became a pararescueman. From 1969 to 1972, he conducted rescues in Cambodia, North Vietnam and Laos. In 1971, he received the Distinguished Flying Cross for rescuing a pilot who had been shot down over Laos and spent nine hours dangling in his parachute which was tangled in a 200-foot tree.

Brown's wartime service was among his most formative experiences, he says, teaching him self-discipline and focus, but also about the fleeting nature of life. "For a young guy, you really learn the value of life and how precious it is," Brown says. "If you learn that

young, it becomes a part of your character ... I was not afraid like when you go to a scary movie. I was in fear for days at a time. Three or four times it was, I'm going to die."

After leaving the military, Brown enrolled at Youngstown State University. After Vietnam, term papers and studying didn't seem too daunting. "Holy smokes, it was pretty easy compared to special ops in Vietnam," he says. "There, you experienced every single emotion you could possibly feel."

After receiving undergraduate degrees in nursing and law enforcement administration, Brown worked as an emergency department nurse at Indianapolis' Wishard Hospital, a Level 1 trauma center. He went on to earn a master's in health and safety education, and then returned to Youngstown State as director of the paramedic education program. He joined the National Registry in 1985 and became executive director three years later. A mountain climber and long-distance bike rider, Brown has climbed to the summit of Mount Whitney in California and rode 3,195 miles from Disneyland in California to Disneyworld in Florida to celebrate his 50th birthday.

Brown spoke with Best Practices about the importance of the Registry and the long road to earning the industry's acceptance of the organization.

Q What is the toughest challenge you had to face during your time with the Registry in terms of earning acceptance?

It was getting people to understand that the Registry is really trying to protect the public. We're not the National Association of EMTs; we don't advocate or lobby for people. We can't just pass you because you're a good old guy, or because you really, really want to be an EMT—you need to have the knowledge, skills and abilities. We are a standard-setting organization. We got that message across one state at a time, one phone call at a time.

Q What do you consider your proudest moment as the executive director of the Registry?

It's a culmination of a lot of things, but good overall acceptance of the Registry is probably No. 1. I've received a lot of Lifetime Achievement Awards, and I'm certainly proud of those, along with some of the comments I've heard people say about the job I

did. But pride is not a very good characteristic to have. You're better off to be humble and stay focused on the mission. For me, it started out with pararescue. Their motto is "That others may live," and I've held onto that throughout my life.

Q Why wouldn't every state want to be a part of the Registry?

There are only four that aren't: Illinois, New York, North Carolina and Wyoming. In North Carolina, somewhere along the line in the development of EMS, in order to get it through the legislation, the state said that volunteers wouldn't have to pay for testing and licensure. But the Registry can't conduct its business for free.

But the Registry is used by certain EMS agencies in North Carolina. In the major metropolitan areas such as Wake County and Charlotte-Mecklenburg County, you have to be nationally registered to work there.

Illinois and Wyoming used the Registry at one time, then they dropped it. I do

believe Wyoming is making movements to come back into the national standard, but I don't know what is going on in Illinois.

I love those folks in New York. We've had leaders from Albany, Buffalo and Syracuse serve on National Registry committees, and they are scratching their heads about why New York isn't a part of the national standard.

The National Registry is willing to work with the remaining states to become part of the national standard. But it takes such energy to keep the 46 states that are part of the national standard happy. At some point, it's, *Never mind the four that aren't. Our concentration of energy has to be on the 46 that are.*

Q What are the most significant changes you've seen in the Registry since you started?

We increased the number of people taking the exam from 29,000 to 142,000 annually, and we went all paperless for certification and recertification. We use the premier testing methodology and science to determine

the pass-fail score for our exam, called computerized adaptive testing. It's fair, precise, secure and efficient.

There is a lot more that goes into developing these test questions than people realize. It takes a year of developmental time before questions can show up on the test. You have to have people from all over the United States weigh in. You have to quality-assure the items. Then you have to put them on the live test as pilot items that don't count. From there you have to calibrate them on the difficulty scale. Then you have to present them to candidates so that they receive questions matched to their ability level. When they have shown that they have met the standard, the very sophisticated computer switches off and the test is over.

We also went from having 29 states using the National Registry to 46. All Army and Air Force medics must be nationally registered. We went from a staff of nine to 32.

Acceptance of the Registry is huge. The National Registry can be viewed as the boogeyman by people who fail. But it is our job to assure the public that when an EMT or a paramedic walks into their home, they know enough to have the skills to do the job at the entry level. When a person fails, it's a heart-breaking situation for them, but our customer is the public.

Q What percentage of people who take the test fail?

For first-time test takers, 35 percent fail. I believe that transitioning from selling pizza or parking cars or working as a waiter in a restaurant to working in the back of an ambulance and having to manage patients with all sorts of diseases and injuries after a 10-week course is one of the most challenging academic endeavors that one can undertake. There are so many age groups, so many diseases and so many ways people can injure themselves, it's a pretty big mass of knowledge that people have to gain rapidly.

Q What are the limitations of the Registry?

The National Registry's mission is to make sure EMTs and paramedics know the minimum amount they need to know to get into the back of that ambulance. It's up to their employers and their peers to make them a really excellent EMT, and it's obviously up to the individual, too. No one, no certifying body—not the American Board of Emergency Medicine, or the American Board of Nursing Specialties, or the NREMT—would say this person is going to be an excellent physician, nurse or EMT. The standard is entry level. Excellence, you must develop yourself.

“The National Registry can be viewed as the boogeyman by people who fail. But it is our job to assure the public that when an EMT or a paramedic walks into their home, they know enough to have the skills to do the job at the entry level. When a person fails, it's a heart-breaking situation for them, but our customer is the public.”

— Bill Brown

Q The Registry website says the NREMT increased fees in 2002 for the first time since 1973. What are the costs to take the exam, and how have you kept the price reasonable?

The fee to take the National Registry exam is \$70. About \$50 goes to the test administrator; the National Registry gets around \$20. We started out getting \$10 in 1971, and we're getting \$20 in 2013, 42 years later.

If you look at the Consumer Price Index, we should be charging \$150 right now. But we are a nonprofit corporation and we take that seriously. We don't believe we should be charging money if we don't need it. Our volume is so huge, and we are highly efficient, so we don't need to.

Q You've described EMS as a 'sleeping giant.' What do you mean by that?

About 1.7 million have been certified by the National Registry. In the earlier days, when states wrote their own licensing exam, we figure more than 1 million took those. So it would seem logical to me that if there are 1.7 million who have been certified and another million or more who were state licensed, it's not a stretch to say there are probably 3 million EMTs in the United States, either now or in the past. There are only 300 million Americans. That means 1 in every 100 citizens is now or was an EMT. That is a huge contribution EMS has made to the health and safety of the United States of America.

If all those people who were or are EMTs spoke with a unified voice about an issue, they could create some major change in the United States. There are about 600,000 physicians; there are 800,000 to 1 million EMS providers. We are the second largest health care occupation in the United States—only nursing is larger than EMS. Yet how much

influence do physicians have over the crafting of rules, regulations and laws compared to EMS? [He laughs.]

We spend more mental energy trying to determine if EMS should be delivered by paid, volunteer, fire or third service. Then throw in episodic issues like drug shortages and put low pay into the mix, and *oh my*. Nothing kills EMS worse than low pay. It results in high-turnover personnel and a failure to have the psychic energy to develop a unified voice.

Q Is there a particular mentor who stands out for you?

I have a bunch of them. Dr. Roger White was the first one. He's an anesthesiologist and resuscitation expert at the Mayo Clinic, and he was on the National Registry board for more than 20 years. He was a wise man and an adviser to me when I was a young executive director. He ingrained in me that right is the master of might, and as long as you do the right thing and you do it for the betterment of the patients, you're going to be OK regardless of who gets upset with you and why.

Drew Dawson is another one. We met in 1989 and have remained friends even today. Drew taught me about process, that things don't change overnight—it takes consensus, science and collective thought. A lot of people are better than one or two people, and it takes a long time to achieve buy-in. Even if it's a high-quality product, people are not going to endorse it without time to review it, to reflect on it and time to make it a part of their own belief system. A lot of times we think the product is the most important, but the process you went through to develop that product can be just as important.

My other mentor was my department chairman at Youngstown State who passed away, John Yemma. He taught me to hire

Continued on page 6

“Nothing kills EMS worse than low pay. It results in high-turnover personnel and a failure to have the psychic energy to develop a unified voice.”

— Bill Brown

great people and let them run. That's what I did at the National Registry. I'm proud of the team that we assembled in 1989 and kept right through 2005. Why was the Registry so successful? It was a team of very, very dedicated, bright people who were great communicators who sacrificed a huge amount for the organization to be successful.

Q How did the Registry come to host the LEADS (Longitudinal EMT Attitudes and Demographics Study) project? Why is it important?

LEADS is a longitudinal study hosted by the National Registry. It started in 1998. The impetus for LEADS are the rumors we hear in EMS—that we have the highest divorce rate, that EMTs are getting killed every day, that there is a high level of burn-out, that we are underpaid. But where were the facts on all of this? So we started this project and examined people entering and leaving the profession for a 10-year period so that we would have data on who we are and what has happened to us as a profession. The first survey involved 17,000 people from eight cohort groups: new EMTs, minority EMTs, experienced EMTs, experienced minority EMTs, and then the same four groups at the paramedic level.

There have been 35 peer-reviewed papers that have talked about what we found. Now we're trying to do one big overview of the project over the whole 10 years. The final report is being written up now.

LEADS is going to continue, allowing us to conduct more analyses. In 2008, we redesigned it. This year, we enrolled 1,000

paramedics and 1,000 EMTs, all new people in the profession who consented for a 10-year-period to be surveyed once a year about their work activities, working conditions and job satisfaction, including whether they are still in the profession.

Q Has anything emerged from the LEADS data that surprised you?

The satisfaction of people in EMS is unbelievable. So is the sleepiness. We perform the worst on the sleep scale of any profession, including truck drivers and airline pilots. That startled me.

What else startled me was the number of people who took an EMT course and never entered the occupation. Half of those who take a class never fill out a trip report within a year. We found there are a large number of people who take an EMT course as preparation to be in law enforcement, nursing, the military or an allied health profession. They want to see if they are interested in EMS. So they take the exam and the license but they never look for a job in EMS.

We've also found that EMS workers are highly dedicated to the job. They love the job. They love the mission. They love the tasks. But if somebody offered them a job for more money, they would leave in a minute. Satisfaction is very high, but their occupational commitment is very low because of the low pay.

Q Do you think the paramedic profession should eventually move toward requiring a four-year degree?

Do I believe that academic credentials should be a part of being a paramedic? Yes. If you go to the U.S. Department of Labor's job classifications, in the health sector, EMS is one of only three that require a minimum of a high school education. The others are home health aides and pharmacy techs. In order to scrape crud off your teeth, a dental hygienist has to have an associate's degree. To be an X-ray technician—"Excuse me, can you hold your breath? Click"—you have to have an associate's degree. But to save a life, you have to have a high school education.

Q What would you tell a new EMT or paramedic entering the profession?

I would tell them to always seek higher credentials. Life is over when you stop learning, so why not have it be in a formalized setting where you can get a degree? Nothing is better than a degree. If you

enjoyed getting an associate's, get a bachelor's. Don't stop there. Get a master's. Get a Ph.D. Learning is one of the most positive human endeavors. Continue your education.

Q What are your plans for retirement?

Right now I'm on terminal vacation, though I have plans to get involved in some books. I'm a Christian, so wherever God takes me and whatever doors he opens up, I will try to figure out if that's the one I want to pass through. It's been more than 40 years since Vietnam, and I'm still happy to be alive. Every day is a gift to me. My roommate was killed in Vietnam. The two guys in the room with me got Silver Stars for heroism. When I left, the guy who came in to occupy my bed, he was killed. Believe me, you learn the value of life.

Q You recently talked about your '10 Principles of Life' in a speech at the National Association of EMS Educators. What are they and how did you come up with them?

I was doing a farewell address at the meeting and I came up with Bill Brown's "Top 10 Pieces of Advice." Many people said they wanted me to do it again, but I said, "You only say goodbye once." These are things that are just ingrained in my character.

1. Love thy neighbor as thyself.
2. Never come to a meeting unprepared.
3. Success comes at the crossroads of preparation and opportunity.
4. The view from the summit is not as clear as it was during the ascent.
5. Establish realistic expectations and you'll always achieve them.
6. When the pressure is on, step back and think.
7. Live within your means.
8. Fitness is intellectual, physical and spiritual.
9. Don't do anything until your wife says it's OK.
10. This is what it is all about: "That Others May Live." BP

— Jenifer Goodwin

implement the policy last summer. Responders can tell from the electronic patient care report if the patient has been transported recently.

Initially, when EMS providers informed patients that they would have to return to the same hospital, some patients resisted. "Many of them weren't happy about it," Hadley says. If the patient couldn't be persuaded, medics would contact Braithwaite, who would explain the policy to the patient over the radio.

Braithwaite was called several times a month during the first few months. But a year after implementation, many patients seem to have accepted the policy and challenge it less often. "Crews are also more adept at explaining it," Hadley says.

Sedgwick County EMS hasn't yet studied whether the policy has led to a decrease in transports for frequent users, but Hadley says there have been individual successes. One man, for example, called 911 a dozen times in January and February, complaining of abdominal pain and other problems. He'd get mad at EMS crews and hospital staff and call Hadley's office daily to complain. "He would always want to go to a different hospital," Hadley says. "He didn't like what the other hospital was doing for him. He didn't believe they were taking his condition seriously. They weren't doing the right tests. He didn't think the hospital or our crews were being nice to him." Eventually, Hadley and the hospital got the man connected with mental health and social services. In March, EMS transported him only once.

Fostering partnerships between hospital EDs and EMS benefits both, Hadley says. "It's where EMS has a real opportunity to be an integral part of reducing overall health costs and, most importantly, getting patients the right resources they need at the time," he says. "For a long time, we were not looked at like a healthcare partner; we were paid to transport people to the hospital. But I believe there is an opportunity to improve communication with the hospitals, so that we can help them help us."

LAFD Increases Ambulance Staffing

The Los Angeles Fire Department is reassigning some firefighter-EMTs from fire apparatus to ambulances in order to boost their fleet of BLS ambulances.

The LAFD is made up of "task forces," which include 10 firefighters who staff three vehicles (a ladder truck, a pump and a fire engine), and "light forces" (a pump and a fire engine) staffed by six firefighters.

Starting in May, the LAFD began reassigning one firefighter per shift from task forces at stations with low call volumes to ambulances at stations with higher call volumes. The LAFD is also moving one firefighter per shift from light force fire trucks at stations with heavy call volumes to ambulances at the same station. The move will remove one firefighter from 22 trucks while boosting the department's fleet of non-paramedic ambulances by about one-third, to 45, says Capt. Jamie Moore, LAFD public information officer. Los Angeles Fire Chief Brian Cummings announced the staffing change at a Los Angeles City Council public safety committee meeting in May.

More than 80 percent of LAFD responses are medical, and many of those can be handled by a BLS team, the department says. "Moving these medically trained firefighters from the fire trucks to open these 11 Basic Life Support ambulances will increase the availability of LAFD's resources and increase the department's ability to properly serve the public," Cummings said in a statement.

The plan is opposed by the firefighters union. On its website, United Firefighters of Los Angeles City (International Association of Firefighters Local 112) calls the plan "dangerous and unacceptable."

The Los Angeles Times website has a link to the new staffing plan. Visit documents.latimes.com/draft-lafd-ambulance-plan/.

Free Guide to Preventing the Spread of Infections in EMS Available

The Association for Professionals in Infection Control and Epidemiology is offering a guide for EMS in preventing the spread of infectious diseases such as *Staphylococcus aureus* (MRSA).

"The major goal of this guide is to increase awareness, educate, and provide guidance to EMS system responders who are at risk for occupational exposure to blood, other potentially infectious materials, infectious diseases, and bioterrorism," write the authors, led by Janet Woodside, R.N., an EMS program manager for Portland Fire and Rescue. "Standard EMS training curriculum contains information on infection prevention. However, EMS needs more integration with other community IPs [infection preventionists, health care professionals who have special training in infection prevention] and more efficient communication networks for information sharing."

The 86-page "Guide to Infection Prevention in Emergency Medical Services" includes:

- Infection prevention standards, regulations and best practices in patient and EMS system responder safety
- Instructions, examples and tools to conduct surveillance and risk assessments
- Forms and templates for infection prevention education, training and compliance monitoring
- Emergency, disaster and bioterrorism preparedness information

The authors point out that proper hand-washing, proper use of personal protective equipment, and thoroughly disinfecting equipment and ambulances are key ways of preventing the spread of infections. But exposures happen. And when there is one, EMS agencies should have a written plan outlining work restriction guidelines, policies and procedures. Likewise, EMS agencies should ensure that all EMS responders are properly immunized.

The guide includes information on who should be immunized, along with contraindications. Download the guide at tinyurl.com/crkv7g6. BP

— Jenifer Goodwin

Information for Subscribers

- > **MEMBERSHIP PAYS.** Members of the National EMS Management Association receive *Best Practices* as a membership benefit. Visit nemsma.org for information.
- > **WANT TO VIEW PAST ISSUES?** All content is archived online at emergencybestpractices.com. Access is available to subscribers and NEMSMA members with a special login.
- > **NEED HELP?** For membership questions or assistance accessing the website and archives, contact Melissa Dalton at mdalton@redflashgroup.com or call 760-632-8280, ext. 230.
- > **SMALLER REALLY IS BETTER.** For your convenience, BP uses a service called "tinyURL," which creates short aliases for long or complicated website addresses. They take you to the same place—but with less typing! (And, as always, all links in all articles are active on our website; simply click on one and you'll be taken directly to the website in question.)

of Chicago EMS System and the Chicago Fire Department, and a leader in the mobile healthcare movement. “That could be community paramedicine. It could be by integrating nurse triage into dispatch, or using telemedicine to enable patients to be treated at home without having to transport.”

To its advocates, mobile healthcare is more than a tweaking of what EMS does, such as adding a new medication or proce-

what we are providing is mobile healthcare. The world is changing, and we have to change with it.”

Healthcare reform driving changes

Just how substantially is the world of healthcare changing? Over the past two decades, as healthcare costs soared and it became evident that the pace of the increase was unsustainable, a healthcare reform effort

While no one questions that EMS will continue to answer 911 calls or that emergency medical response will remain a key part of the mission, true emergencies represent a small percentage of call volume, and EMS’s identity needs to be expanded to reflect that.

ture. Rather, it’s a redefining of what EMS is, emphasizing measuring patient outcomes over processes like response times, and enabling paramedics and EMTs to take on a broader role in the healthcare system by filling gaps in services based on community need. While no one questions that EMS will continue to answer 911 calls or that emergency medical response will remain a key part of the mission, true emergencies represent a small percentage of call volume, and EMS’s identity needs to be expanded to reflect that, mobile healthcare supporters say.

Not only does the shift add value to what EMTs, paramedics and EMS systems have to offer a community, but there’s a compelling financial reason to do so. With the Centers for Medicare & Medicaid Services (CMS) and major insurers moving away from fee-for-service toward pay-for-performance reimbursement, EMS has to find a way—and soon—to make sure it’s not overly reliant on billing for transporting patients to the hospital, the most expensive place to receive care.

“For the last 27 years, we have been ‘MedStar Emergency Medical Services.’ In January, we transitioned to ‘MedStar Mobile Healthcare,’” says Matt Zavadsky, MedStar’s public affairs director. “The fastest growing component of what we deliver does not involve ambulance transport to provide emergency medical services. More and more,

took root. New models of care emerged, including patient-centered medical homes and accountable care organizations, which seek to put an end to incentivizing physicians for providing more services, and instead dole out rewards and penalties based on outcomes—that is, how patients fared, and whether the care they received was cost-effective.

The goals of all reform efforts are summed up by what the Institute for Healthcare Improvement calls the “Triple Aim”: lowered costs, improved patient experience and improved outcomes.

The pace of change picked up with the passage of the Affordable Care Act, which includes both a carrot and a stick approach: large grant programs for healthcare providers that show they can achieve the Triple Aim, coupled with CMS fines for hospitals with excessive readmissions within a 30-day window. For hospitals, the stakes are high, says Ed Racht, M.D., medical director for American Medical Response, the nation’s largest private ambulance service. Hospital chief medical officers have confided, he notes, that the 2 percent readmissions penalty is of less concern than what a high readmission rate does to their reputation.

Rankings are easily accessible on the internet, he points out. “So if a hospital is one of the high re-admitters, the community might perceive that if you go to that

hospital, the chances of them not fixing you and getting readmitted is high, so why would you go there?” Racht says. “Insurers will look at that same list and say, ‘Wait a minute. Spending is higher on our patients there. Maybe we shouldn’t include them in our plan.’”

That certain people cost the system a lot of money, and that those people are often not best served in EDs, isn’t news to EMS. Every EMT and paramedic knows all too well the futility of transporting patients to the hospital when they really need a prescription filled, a check-up by a primary care physician, or mental health or social services. Likewise, EMS managers have been feeling the pinch of downward pressure on Medicaid and Medicare reimbursements as populations of the elderly, chronically ill, underinsured and uninsured have grown.

This turmoil prompted forward-thinking EMS leaders to look around and ask: How long would it be before pay-for-performance would reach EMS? How could EMS avoid becoming viewed as just another expense and instead become a part of the cost-containment solution? With its 24/7 mobile workforce, how could EMS do better at delivering an appropriate level of care, where and when people need it?

“Those of us who have been in EMS long enough have always seen the potential of the EMS system—its operational structure and the people who provide it—to do more than respond to 911 calls or move patients from point A to point B,” Racht says. “For decades we’ve come across situations where we’ve said, ‘Gosh, this lady doesn’t need to go to the ED. But I can’t just leave her here. I wish there was a better way.’ We felt the frustration with the current healthcare delivery system, and we saw the potential of the EMS structure to be a major contributor in helping to change how medicine is delivered.”

Community paramedicine gains steam

For some, the solution was community paramedicine. Innovators like Gary Wingrove, founder of the International Roundtable on Community Paramedicine and the North Central EMS Institute, promoted the concept of paramedics with expanded training who could fulfill a variety of community health needs and led the development of a national community paramedicine curriculum.

Other pioneers included Chris Montero, who as chief of Western Eagle County

Whatever the outcome of the mobile healthcare discussions, EMS leaders agree that it’s critical that the entire industry comes together, quickly, to figure out EMS’s place in the new healthcare order.

Ambulance District in Colorado launched a program in cooperation with public health to have medics help with medication compliance, blood sugar monitoring and immunizations for children in Eagle County, an underserved, rural population. Then there are the advanced practice paramedics who serve in Wake County, N.C., under the medical direction of Brent Myers, M.D.

With measurement of results a key part of reform efforts, others in EMS focused on research and quality improvement initiatives to prove that EMS can impact patient outcomes. In 2009, the National EMS Advisory Council produced the seminal document, “EMS Makes a Difference.” Other initiatives include AMR’s Caring for Maria, aimed at improving outcomes and patient experience in several key areas, including pain management, and the HeartRescue Project, a collaborative effort sponsored by Medtronic Philanthropy, the nonprofit arm of Medtronic Inc. Its goal is to improve sudden cardiac arrest survival by 50 percent within five years in six partner states and with AMR.

“With EMS, our traditional focus has been, *You call, we haul*. As a matter of fact, we’ve been reimbursed for ALS, BLS and mileage, not specific care we provide,” Racht says. “To make that cultural shift to accountable, performance-based care, we have to really, really focus on outcomes now. That doesn’t mean, *We get there in eight minutes, 59 seconds 90 percent of the time*. We have to

prove that we make a difference, such as improving pain and improving physiological conditions, which is something that is relatively new for EMS.”

Last spring, community paramedicine got a big boost when CMS announced more than \$13 million in grants to launch community paramedicine programs in Pagosa Springs, Colo.; Prosser, Wash.; and Reno/Sparks, Nev. In Reno, in addition to transporting mental health and intoxicated patients to alternative facilities, paramedics who have undergone four hours of additional training on conducting an advanced assessment can transport patients with low-acuity medical conditions such as a cold, cough, flu or minor laceration to one of four urgent care centers or clinics, says Brenda Staffan, REMSA project director. Under the grant, REMSA receives the same reimbursement for taking a patient to a non-ED facility as they would for an ED transport.

What’s in a name?

Yet even as they lauded community paramedicine’s progress, some in EMS wondered if the term “community paramedic” or “advanced practice paramedic” was too restrictive to describe what EMS was in the process of becoming.

“In Chicago in the ’90s, there was a pilot program that sent EMT-basics trained in the pediatric immunization schedule to housing projects. Those EMTs would identify the children, send them to a nurse, who would get the child immunized, and then connect them with a pediatrician for primary care follow-up,” Beck says. “What I like about this is it takes an EMT-basic, who hasn’t gotten a lot of attention in the community paramedicine sphere, doing an important primary prevention task in a defined, underserved population. They immunized more than 1,000 children, and they teamed up with other providers to close the loop.” (The vaccine program ended when the projects were demolished.)

Participants in the HeartRescue Project, including Racht and Beck, in between sharing notes on resuscitation best practices, had been informally discussing how community paramedicine was creating new opportunities for EMS. In December 2012, a group of them got together for a more formal meeting in Chicago to discuss their experiences and ideas. Underwritten by Medtronic Philanthropy, the meeting included Beck; Myers; Jeffrey Beeson, M.D., of MedStar; Joan Mellor, senior program manager for the HeartRescue Project; and

four representatives from AMR, including Racht; Scott Bourn, vice president of clinical affairs; Lynn White, national director of resuscitation and accountable care; and Alan Craig, vice president of clinical strategies.

The concepts of community paramedicine and mobile healthcare are of particular interest to Medtronic Philanthropy, Mellor notes, because an important goal of the organization is to support the development of programs that expand access to care for the underserved with chronic diseases, measuring their success and replicating the programs elsewhere.

“If you empower patients and engage the frontline healthcare workers, you will help people living with chronic diseases to be more successful in managing their condition,” she says. “In the United States, a big part of the frontline is EMS.”

While the original intent of the meeting was to explore a more cohesive approach to community paramedicine, the conversation evolved into the broader concept of mobile healthcare, Mellor reports.

One of the main questions that emerged was what to call this collection of ideas. While community paramedics would be important participants, not everyone had to be a community paramedic. Nor was some iteration of “prehospital” a good fit, since EMS would increasingly provide preventive or post-hospital care. What they were looking for were more inclusive words, ones that emphasized collaboration among health, mental health, social services and public safety disciplines, rather than identifying the concept solely with EMS. “We are talking about something larger than community paramedicine and larger than EMS,” Beck says. “This is about *How do we bring together all of the appropriate resources to have collective impact on a health need for a population?*”

Eventually, the group decided on “mobile integrated healthcare practice.” “We are of course *mobile*. We need to be *integrated* with every facet of the community—health, social services and the public safety community. We don’t always provide emergency services, but we always provide *healthcare*,” Zavadsky says. “And the term *practice* is important for two reasons: Everything we do is under the supervision or direction of a physician. This is their practice of medicine. And *practice* means we are learning as we go.”

Racht agrees that the name fits and notes that a year ago, AMR began using “practice” with its local operations. “*Practice* has been

“The fastest-growing component of what we deliver does not involve ambulance transport to provide emergency medical services. More and more, what we are providing is mobile healthcare. The world is changing, and we have to change with it.”

—Matt Zavadsky,
MedStar Mobile
Healthcare

traditionally associated with medicine,” he says. “We believe that’s an important message for the community and helps them understand the role a little bit better.”

While most are supportive of the general concept of cooperation, integration and an expanded role for EMS, not everyone agrees with the name. It’s too soon to abandon “community paramedicine” as a way of describing an enhanced role for EMS in healthcare, says Sean Caffrey, EMS programs manager at the University of Colorado School of Medicine and a board member of the National EMS Management Association.

“In the case of the community paramedic movement, the terminology is only beginning to gain acceptance, especially outside of EMS,” Caffrey notes. “It would be unfortunate to have subgroups of our community developing new terms that may confuse the issue and distract from our unity of effort in this important and evolving area of EMS practice.”

And “mobile integrated healthcare practice” is overly broad, Caffrey adds. “The term could be reflective of any number of services provided by virtually anyone,” he says. “As

such, it does little to differentiate that we are talking about what EMS providers in particular are doing to impact the health of local communities.”

However the name unfolds, Beck suggests that getting hung up on terminology will distract from the bigger goal, which is EMS working together with other professions to solve problems and promoting that role for EMS to potential healthcare partners, private insurers and the government to ensure that EMS is paid for providing that service.

“No one owns this process,” he says. “It’s merely a discussion—an open, grassroots exploration of a concept.”

Moving ahead

With “mobile integrated healthcare practice” the working moniker, the group held a second meeting in March in Minneapolis that involved more stakeholders, including representatives from a variety of organizations, including the federal Centers for Disease Control and Prevention, the National Registry of EMTs, the National Association of State EMS Officials (NASEMSO) and the National Association of EMS Physicians, as well as community paramedicine pioneers and other interested parties.

Out of the meetings emerged broad industry collaboration in support of the concept and cohesion around five guiding principles:

1. Assess community needs, remain value-focused and feature a competency- and evidence-based practice that ensures continual education, 24-hour community access and ongoing performance improvement.
2. Ensure community partnership with active medical direction.
3. Deliver improved access to care and health equity for populations served through 24-hour care availability.
4. Focus on patient-centered navigation and offer community-centered care by integrating existing infrastructures and resources, bringing care to patients through technology, communications and health information exchange.
5. Use evidence-based practice, incorporating multidisciplinary and inter-professional teams through which providers utilize their full scope of practice.

The community needs assessment is one of the key elements of mobile healthcare, because it helps determine who is involved, which patients are included and what care is delivered, White says. “What we’re trying to do with mobile integrated healthcare practice is to have people take a good look at the community’s resources and match those resources with the community’s needs,” he says. “If you’ve got medics, great. But there could be others who could also provide that service. It’s about building a network so the gaps aren’t there.”

Racht puts it another way. “One size doesn’t fit all,” he says. “But one cultural approach has to be applied to all.”

Rural EMS in crisis

Nowhere is a culture of collaboration needed more than in rural America, says Jim DeTienne, president of NASEMSO. As EMS director for Montana’s Office of EMS and Trauma Systems, DeTienne has grown increasingly alarmed about the strain on his state’s volunteers. “In the last two to three years, more and more of my time is spent with services that can’t get staffed, can’t get people trained or aren’t able to fund [rural EMS],” DeTienne says. “In Montana, we have built an EMS system on the shoulders of volunteers. That system is just about broken.”

Finding people willing and able to volunteer is increasingly difficult, yet the tax base is too small and the call volume is too low to support a paid service. Taking care of the chronically ill in rural areas is especially difficult, he says. Too often, volunteers need to leave their jobs to take a patient to the hospital and end up waiting around for hours to transport them back home, only to get called again a few days later for that same patient, he says.

Perhaps paradoxically, by emphasizing the other things EMTs and paramedics can do besides 911 response, DeTienne believes EMS may be in a better position to secure the funding and resources needed for emergency response readiness. A mobile healthcare approach could shore up rural services in several ways. One could be by contracting with an urban or suburban service to “borrow” a paramedic to work a few days a week responding to 911 calls and providing other community health services in the rural community, while volunteers could handle responses at night and on weekends. Another method would be working with rural and regional hospitals to have EMTs in rural areas do outreach and follow-up with patients

to prevent readmissions, or via participation in telemedicine programs.

“In five to 10 years, we’re going to have a totally different EMS system, particularly in the rural areas,” DeTienne says. “Mobile integrated healthcare is so interesting because it represents a new idea about how to support a service in a rural area better than we have in the past, by integrating our rural providers into the healthcare system.”

A sense of urgency

Transforming EMTs and paramedics into mobile healthcare providers will likely require some additional education and training to support the shift from a largely protocol- and assessment-driven profession to one that requires more “complex decision-making,” Racht says.

That doesn’t necessarily mean changing EMTs’ or paramedics’ scope of practice, but instead reapplying skills they’re already licensed to perform to other purposes—managing chronic diseases, helping patients navigate the healthcare system, heading off emergencies through prevention campaigns and public education such as vaccination and elderly falls programs, and intervening with serial 911 users. “We consider it expanded role vs. expanded scope,” says Doug Hooten, MedStar’s executive director. “Our position is that we make 112,000 house visits a year. We assess patients, take blood pressure and so on. Everything we do today in our community health programs we also

do every day in our 911 system. It’s a little different focus, but there isn’t a real change in scope.”

Whatever the outcome of the mobile healthcare discussions, EMS leaders agree that it’s critical that the entire industry—fire-based, private, public and third service—comes together, quickly, to figure out EMS’s place in the new healthcare world order. “There is not a huge window of opportunity,” Hooten says. “It’s not 10 years. If we don’t do it, it’s 18 months to two years before the hospitals engage in sending nurses out into the field to do this very practice.”

As new partnerships are being formed, new models of care are becoming the norm. CMS announced in May that it’s making available another \$1 billion in Innovation Grants to find projects that test healthcare payment and delivery models to meet the Triple Aim. Other professions, from respiratory therapists to X-ray technicians, are competing to provide services in the out-of-hospital arena. “Everyone wants to be in this space, because the reimbursement dollars are shifting to it,” Racht says.

Of any EMS agency in the nation, MedStar is the farthest along in transforming itself into a new type of practice. The number of patients treated using their alternative delivery strategy is growing. More hospitals and other healthcare providers are interested in participating. They’re also fine-tuning payment arrangements to align MedStar’s financial interests with those of their

partners, enabling MedStar to share in both cost-savings and risk. For example, local hospitals estimate the average cost of each CHF admission at \$17,500. If MedStar can prevent that readmission by working with the patient to manage the disease, MedStar is proposing that it will receive about 20 percent of the savings. If they’re unsuccessful at preventing the readmission, they don’t receive that money.

“The hospitals and the payers under our current health financing environment are very motivated to meet the Triple Aim,” Zavadsky says. “If no one brings to them a solution they haven’t thought of like mobile integrated healthcare practice, we will once again as a profession be standing on the outside saying, ‘We could have done that.’”

At AMR, Racht says his company has no plans of letting that happen. He and his team are talking with everyone from fire departments to hospitals to insurance companies to work out what these new arrangements will look like. “From AMR’s perspective, we think that the EMS profession has a new seat at the healthcare table,” he says. “And we want to help manage those patients not just in the 911 arena, but where they need it most.” 

New Committee Will Connect Mobile Integrated and Community Paramedicine Groups

In May, the National Association of State EMS Officials (NASEMSO) formed a new committee to bring together leaders in the so-called mobile integrated healthcare practice movement with those from the community paramedicine movement. Called the Mobile Integrated Health-Community Paramedicine Committee, the group will meet via conference call every other month to share information and ideas.

“As individual programs and EMS systems are moving into these areas, state-level EMS offices need to be better informed about what’s going on and what the best practices are so we do our due diligence in protecting the public, but not doing it in a way that creates barriers to the continued development and innovation that needs to happen,” says NASEMSO President Jim DeTienne.

In another sign that community paramedicine and mobile healthcare advocates view their efforts as complementary, leaders

of both are joining forces in applying for an Agency for Healthcare Research & Quality (AHRQ) grant to hold a summit covering both topics.

In 2012, NASEMSO and the North Central EMS Institute held the first national summit on community paramedicine in Atlanta with an AHRQ grant. Eric Beck, M.D., medical director for the City of Chicago EMS System and Chicago Fire Department, and other mobile healthcare advocates have since been invited to join the group’s Steering Committee on Community Paramedicine. The plan is to hold a series of smaller conferences to discuss specific elements of community paramedicine and mobile health, such as education needs, medical direction and reimbursement, and then apply for another AHRQ grant to hold a joint Mobile Health-Community Paramedicine Summit in 2014, DeTienne says. — J.G.

Capitol Report

Continued from page 2

medical exams and free treatment for any diagnosed 9/11-related health conditions. Prior to May 1, 2013, when the WTCHP was expanded, the program was open only to responders who worked or volunteered at the World Trade Center site.

For new responders to be eligible for the WTCHP, they must have been a member of a fire, emergency or police department, whether active or retired; worked for a recovery or cleanup contractor or were volunteers; or performed rescue, recovery, demolition, debris cleanup or other related activity at either the Pentagon or airplane crash site. Pentagon responders must have participated at the site for at least one day between Sept. 11 and Nov. 19. Shanksville responders must have worked for at least one day through Oct. 3.

HHS estimates that between 540 and 1,467 responders will enroll in the WTCHP in 2013. The total cost of initial medical exams, annual monitoring and treatment is expected to be at least \$988,300 and no more than \$3,203,400 annually through 2016. Due to the high-risk nature of the situation, the HHS secretary exercised the available rights to waive prior notice and comment procedures usually governing agency Rules and Interim Rules. These actions will enable responders to apply for enrollment in the WTCHP as soon as possible.

For the Interim Final Rule, which became effective May 1, see tinyurl.com/cvvzp2o. For more information about the program and a link to the application page, go to cdc.gov/wtc. 

— Aimee J. Frank

The Need to Resuscitate Imagination

By John Becknell

“I can’t imagine it being different,” an EMS chief declared at a recent session of the EMS Leadership Academy. He was talking about the ongoing cycle of budget cuts, internal morale issues and the perpetual feelings of frustration that surround leading a struggling ambulance service. The chief’s choice of words, “I can’t imagine,” invites some rumination.

Imagination is not a word or concept given much attention in emergency services. In working with more than 900 leaders from around the nation over the past five years in the Leadership Academy, we have observed that the EMS leader’s capacity to imagine, create and innovate is often limited. In a small group exercise, we ask leaders to imagine an ideal future EMS system, vehicle and frontline worker. Many struggle to imagine anything more than a variation of what already exists. Little out-of-the-box imagining shows up.

This isn’t surprising. Most EMS leaders come up through the ranks of a training and work paradigm that kills imagination. In the unstable environment of emergencies, field providers need to be creatures of protocol and direction—we don’t, after all, want them innovating in the field. The critical nature of the work demands that they follow algorithms, seek direction and implement established processes. We drill and skill the imagination out of them.

Imagination is simply the ability to conceive of something that does not exist and interestingly, EMS was birthed in wild imagination. “Imagine” is the first word of the 1996 video “Making a Difference,” narrated by Jim Page, about the history of modern EMS. Everything from citizen CPR to the idea of taking cardiac care to the streets emerged from people who dared to see what had yet to be created.

Yet following that brief period of early development, EMS has seen little imagination. One exception was the work of Jack Stout, who

was not an EMS provider but an economist. Stout imagined efficiencies through predicting demand and completely up-ended conventional thinking about resource use and deployment.

We need to resuscitate our imagination. If we are to break out of the confining boxes that inhibit recognition, adequate funding, cooperation, a fix to the broken reimbursement system, replacement of the volunteer subsidy and an appropriate valuation of the EMS workforce, we need to imagine how things might be different. Paraphrasing Albert Einstein, we can’t solve our problems using the same thinking that created them—and we need imagination more than we need more knowledge and research.

While we often talk about innovation, imagination is the critical first step in a continuum that also includes creativity and innovation. When a geeky young EMT dreams up a fantastic design for a tricorder-like assessment device, he is exercising imagination. If he actually sits down and makes a model or prototype of the tricorder, he is exercising creativity. If his tricorder actually advances the practice of assessment, we have innovation. But the whole process depends on the fertility of imagination to seed it all. Of course, not everything that is imagined—and perhaps very little—moves on to become innovation. But here is the important thing: There is no innovation without imagination. We need to imagine richly and wildly to solve our current problem.

Seeding and feeding imagination in a climate that kills imagination is not easy. However, following the work of experts and building on what we’ve seen, I’m convinced that imagination can be cultivated and nurtured. It is both an act and a practice that emerges when you slow down and feed it.

Here’s a suggestion. At a staff or leadership team meeting, make a list of current challenges facing your organization. Then stop and, as a group, watch the first hour of Tom Hanks’ 1998 HBO miniseries *From the Earth to the Moon*. After that, having primed the pump with the imagination that was needed to put a man on the moon, host a discussion about how to solve your challenges. Just watch what happens. 

John Becknell is the founding publisher of Best Practices and a consultant and partner at SafeTech Solutions (safetechsolutions.us).