THE HAPPY MEDIC
FIRE – RESCUE – PARAMEDICINE

Time to Upgrade Your System

An introduction to EMS 2.0

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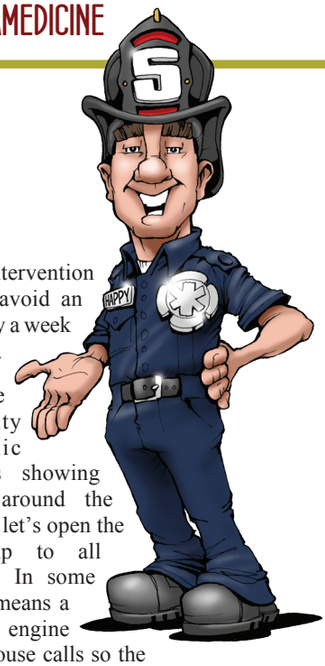

Remember the movie City Slickers when Curly the crusty old trail boss tells us the most important thing is this one thing, but that that one thing is different for everyone? Same here.

EMS 2.0 embraces a community approach to systems design that doesn't rely on previous methods of EMS delivery but builds a system unique to local challenges.

EMS 2.0 will also rely on new methods of deploying Paramedics, EMTs and transport resources to maximize the effectiveness and abilities of the fleet. This will likely include a fly/chase/car model that allows an experienced licensed Paramedic to assess, direct and, when appropriate, use their resource vehicle to transport persons to appropriate care when other modes of transport are not available.

This new way of thinking of a Paramedic as less of a person who comes in an ambulance and more of a rolling clinician will move the heavy workload of the ER onto one person in the field.

Changing the opinion of EMS will take time. EMS 2.0 recognizes there is no magic bullet to solve all the problems, but one of the easiest steps to take is re-assessing the concept of liability within emergency medicine and emergency medical services.

Why 2.0?

The term "2.0" brings to mind backing up all your desktop photos in anticipation of some new version of software you're using. It isn't the same, some buttons have moved, the background is different, but it still does the same things. EMS 2.0 does the opposite. We intend to completely change the way the program works while leaving all your favorite features in place, keeping it comfortable.

The term also brings to mind the invention of "Web 2.0" which signaled the introduction of user based content and the idea of community. Google, ebay, facebook, twitter, amazon, all these user driven sites thrived when everyone had a chance to put up a picture and leave a comment. Everyone had a part, felt like one of the community.

So I say take the best of both worlds.

Make EMS into what it needs to be while reaching out to the community for input and solutions. That is EMS 2.0.

The movement is service based, focusing on what can be provided by EMS staff and giving those providers more access to services other than an ER in a hospital as the only option for patients.

EMS 2.0 combines advanced practice paramedic services as well as a number of options for transport, transfer and relocation.

This new service revolves around a seamless network of emergent, non-emergent, clinic and community resources working together, not each service struggling to deal with each other's overload. Imagine an emergency room that only deals with emergencies. Imagine a clinic that only handles acute, non-emergent cases and a physicians office where people aren't threatened by large co-pays and 40 day waits to get an appointment.

Recent health care reform legislation has some concerned about long waits for service, but these uninsured folks are already in the system, the EMS system, draining resources that are locked into a 40 year old concept that corpsman or later, EMTs and Paramedics are the eyes and ears of the physician in the field. With the increase in training and education must come a realization that we can operate as stand alone clinical practitioners instead of a certification or license under the license of another.

Not every practitioner has a place in the future of EMS, you're going to have to want it. And it isn't going to be more down time, but instead being proactive in your community, being able to trend responses and conditions, anticipating when a person in your service area may need a minor intervention today to avoid an emergency a week from now.

The community Paramedic model is showing promise around the nation, so let's open the model up to all systems. In some places it means a fire engine making house calls so the paramedic on board can check a woman's blood sugar instead of waiting for her to call later. Proactive EMS providers may choose to break the paramedic resource way from the suppression unit to better serve the community. Some may not have the resources. Each community's population and resources are different so there is an EMS 2.0 for everyone.

EMS 2.0 will not be accepted by the masses of EMS supervisors, administrators and Chiefs who have built a 30 year career on the back of a 20 week course. Respect will not be issued from a central office. For this reboot to work, it will be the field providers who rise up not only in voice but in standards they hold themselves to. It will be we who run the calls and interact with the public that have the most to gain and the most to lose, so we need to get started as soon as possible, earning respect as we go.

This isn't a new idea, it comes up from time to time, but something is different, something that gives us the opportunity to succeed where others have failed.

But what does it really mean, this EMS 2.0. We've heard where the idea came from and how it got around, but what is it?

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However, the thought of a paramedic serving as the eyes and ears of a Physician is no longer

an accurate portrayal of our roles in the pre-hospital arena.

In decades past, minimally trained paramedics operated from a base hospital where orders were given by radio or phone from nurses and physicians.

Now, with some EMS providers exceeding the training and requirements of some nurses, this system makes little if any sense.

For EMS to move forward the chains must be removed, not broken, making the Licensed Paramedic a stand alone practitioner operating under the protocols set forth by the agency they are responding under.

Many may say that is what is happening now, but with Physicians still required to be on staff to allow Paramedics access to the pharmacy supply, the chains remain firmly clamped.

Stand alone Paramedics within a system are trusted to use their advanced training and technology to effect an adequate, thorough assessment and then direct that client to the proper resource based on differential diagnosis.

These Paramedics are not diagnosing and treating in the field in all cases, but they need the flexibility to re-direct persons not suffering an emergent condition AWAY from the ER and to the care indicated for their condition.

This move alone reduces the heavy load on emergency rooms and the overwhelming costs associated with every cut and scrape waiting for an ER bed. Urgent Care and walk in centers are scarce and those that are open are also crowded, but crowded with appropriate persons. An opportune chance for additional urgent care centers to open to cater to the needs of the minor injuries now no longer being transported by ambulance.

EMS 2.0 will also rely on new methods of deploying Paramedics, EMTs and transport resources to maximize the effectiveness and abilities of the fleet. This will likely include a fly/chase/car model that allows an experienced licensed Paramedic to assess, direct and, when appropriate, use their resource vehicle to transport persons to appropriate care when other modes of transport are not available.

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It will not be an easy position, but those who seek it out will be those who will do it well, who consider EMS a passion, a profession.

The new vision of EMS allows highly trained and licensed Paramedics to not only redirect but, when appropriate, refuse transport to those who seek asylum from the elements, food or other non medical care from emergency departments. Instead of a gurney garage, or hallway of persons sleeping, those persons are redirected into local social programs or non-profit centers who can help rehabilitate the client.

Changing the opinion of EMS will take time. EMS 2.0 recognizes there is no magic bullet to solve all the problems, but one of the easiest steps to take is re-assessing the concept of liability within emergency medicine and emergency medical services.

I see two main types of liability, perceived and actual.

When a person demands a transport without a medical need, systems are weary not to refuse because of a perceived liability that the person will become irate and sue. So the system eliminates the perceived liability in exchange for opening up an actual liability.

Imagine the case mentioned earlier. When the ALS unit is taken out of service to transport the non-injury but that person's neighbor suffers a life threatening emergency, the response of the system is not optimal, opening up a liability issue should something bad happen. The thought of a law suit from something that can be medically defended in court weighs against something that can not be explained or blamed on the problem in court.

"Your honor, we had no ambulances because Mr Johnson's neighbor made us take her in for a sore throat." You lose. You lose big.

Shift the liability from where you think it is to where it actually is, the patients suffering from life threatening emergencies. Allowing a flexible transport system can address this issue by leaving the cot transport units for emergencies and sending other units for first response.

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EMS 2.0 recognizes the failure of the BLS before ALS concept. This model was adopted and remains because of the high cost of maintaining a large amount of paramedics in a system. The model also suffers from a false perception that more paramedics means less skill efficiency. Less paramedics means less patients receiving life saving interventions and, more commonly, advanced assessments to rule in or out the need for such treatments.

Putting 10 Paramedics in cars with 2 BLS ambulances is better than 10 EMTs and 2 ALS ambulances for dozens of reasons, the least of which should be cost.

But cost is one major hurdle of EMS 2.0. Training Paramedics to a higher standard costs a lot of money. Equipping them with the latest technology to capture an accurate and complete assessment is also not going to be cheap. Cost should not enter into it when life is on the line, but it always will, especially when many transport systems are based on a fee for service. The less people we encounter and transport, the less the agency can collect and therefore the less they can staff.

EMS 2.0, ideally, has no funding issues as it is a service to the citizens of the locality they respond to.However, with a higher trained and more trustworthy workforce, the costs are justified with the higher level of service to the community. You will pay me more because I know more, I see more and I have the ability to help the system in real time from the ground level. The costs of full implementation of an EMS 2.0 program can not be estimated, but the savings add up fast if the system can hit the ground running with adequate resources for assessment, alternate transport and trust from the Administration and Medical Staff.

In summary, EMS 2.0 requires practitioners to become patient advocates by addressing ways in which their services are misused, as well as how they can be better serving their particular community.

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