Advanced Practice Paramedic (APP): Community Para Medicine and Mobile Health Care

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Agenda

Welcome and Housekeeping
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Advanced Practice Paramedic (APP):
Community Paramedicine and Mobile Health Care
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Brent Myers, MD, MPH, FACEP

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All speakers and planners completed financial disclosure declarations. Upon disclosure, none of the speakers or planners had any relevant financial relationships to report.

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Advanced Practice Paramedic (APP): Community Para medicine and Mobile Health Care

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Learning Objectives

• Apply and discuss the Advanced Practice Paramedic (APP) concept.
• List the benefits that APPs can have in emergency departments.
What is an Advanced Practice Paramedic (APP)?
Advanced Practice Paramedic

- An “advanced practice paramedic” provides a significantly better match between patient acuity and paramedic experience
- Experienced paramedic with additional training
- Assigned a “district” to cover
  - Respond to critical calls
  - Deliver services to reduce the number of calls
  - Arrange alternative (not ED) health care where appropriate
- Non-transport vehicle
Advanced Practice Paramedic

• Advanced practice paramedic (APP) – limited number to ensure appropriate annual experience with high-risk patient encounters
• Response time goal of 14:59 at 90th percentile to supervise or perform high-risk, low frequency procedures
• Expanded role
  – Alternative transport decisions
  – Preventative measures
  – Advanced pharmacology

JEMS September 2007, p 62-68
What is its history and how did it evolve?
Historical Scope of Service

Respond to 911 Calls

Transport to Hospital E.D.

Treat in difficult environment
Why do we need APPs?

What is your ideal goal for their practice?
**Desired Scope of Service**

- **Reduce 911 calls** in Special Populations
  - Repeat users (frequent flyers)
  - Diabetes
  - Pediatric Asthma
  - CHF
  - Homeless

- **Respond to 911 Calls**
  - Treat in difficult environment
  - Transport to Hospital ED
  - Redirect
    - Treat/release from scene
    - Refer - get appointment
    - Transport elsewhere
The Three Rs

• **Respond:** Critical medical emergencies occur and require an experienced paramedic to mitigate

• **Redirect:** Not all patients need an emergency dept evaluation – experienced paramedics can help with destination decisions

• **Reduce:** Well-person checks for diabetic patients, CHF patients, etc.
Please describe the training, education and ability of APPs.
Is it possible to get reimbursement for APPs’ service, especially if they do not transport?
What effect will APPs have on ED usage?
Alternative Destination

- Ambulance is returned to service <10 minutes 78% of the time
- This returned 120 unit hours to the EMS system
- Of patients screened, 32% ultimately “alternatively destined”
- Safely increasing the proportion of alternative destinations is now a focus
How will APPs affect overcrowding?
Alternative Destination

- 204 patients in a 12 month period were placed
- Mental health patients consume 14 ED bed hours on average (2,448 hours)
- Chest pain patients consume 3 ED bed hours on average
- Thus, we opened beds for 816 chest pain patients in the 12 month period
- This also saved ~$350,000 in total healthcare costs for this population
Alternative Destination

• Most recent observational data indicate an average length of stay of 35 hours in the crisis and assessment unit

• The actual savings for the alternative destination is not only the emergency department bed hours saved but also the in-patient bed hours for mental health “holds”
Since many EMS departments rely on taxpayer support, how do you think APPs will do with the public’s expectations?
Many EMS transfers are from long term facilities; could the APP treat and not transport at these facilities to decrease the ED census?
Falls in Assisted Living Facilities

• IRB approval is in place to study all such transports for the past year:
  – Evaluate safety of a decision tree that would allow APPs to evaluate patients on-site and avoid unnecessary transports
  – Determine proportion of patients with any findings on evaluation that required intervention
  – Determine costs associated with the evaluation
Falls in Assisted Living Facilities

- 1 to 5 transports per day for our EMS system
- Majority are patients who are “found down” with no obvious injury or complaint
- Risk management strategy for the facility is to summon EMS for transport to the emergency department
Falls in Assisted Living Facilities

- 1500 such transports were made last year
- ~$2.5 million dollars in healthcare expense
- Evaluation of the first 150 of these patients, 81% did not require admission and were discharged from the emergency department
Falls in Assisted Living Facilities

- Prospective evaluation will begin soon (hopefully in next 6 months)
- Public/private partnership with Doctors Making Housecalls (DMH)
- No ambulance will be dispatched; rather, APP only to simple falls
- Common medical record with DMH
- On-going evaluation of safety and costs
How will this affect the work load and involvement of EMS directors?
Benefits

- Provides community health assistance (vaccines, well-being checks) in collaboration with Wake County Human Services
- Provide pre-planned disaster preparedness assistance (ventilator checks, O₂ delivery)
- Intervene with “hot spot” frequent consumers of EMS (blood glucose checks, alternate destinations)
- Provide meaningful step on career ladder
Community Health

• Substance abuse/mental health (SA/MH)
  – Direct transport to facility for mental health or substance abuse care
• Falls prevention/care
• Hypertension/CHF checks
• Diabetic checks
• Pre-plans (nursing homes, home health)
Summary

• Hot spots that are amenable to intervention in the EMS population exist
• The Advanced Practice Paramedic program is one method to improve care while reducing cost to the healthcare system
• Standardized measures to evaluate performance are the next challenge
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