APP Curriculum & Training Questions

1. Isn't the curriculum from Minnesota not only a national but international curriculum? Or, is that simply their goal?

   Dr. Myers: The Minnesota group has established an excellent initial curriculum that has been recognized internationally. There is not, however, an official accreditation body to establish a formal curriculum.
   Dr. Tan: There is no "official" curriculum as of yet, but the one promulgated by Minnesota is a good start and has been recognized both nationally and internationally.

2. Is it possible to have access to the APP curriculums? If so, where can we access them?

   Dr. Myers: The Wake County course was taught through the community college with broad goals. There is no official curriculum – we are working on a draft but it is not yet ready.
   Dr. Tan: There is no "official" curriculum, but if you email me, I'd be happy to give you my training schedule. David.Tan@amr.net

3. Without a unified curriculum why would a paramedic work to get additional education? It seems one would have to invest hundreds of hours to participate in these programs yet there is no clear advantage in terms of using that education elsewhere. Do you anticipate that the paramedic would have a career advancement pathway? Or would they just be extra capable in a single community and restart the training if they move to another community?

   Dr. Myers: The medics in the Wake system invested the hours to promote within our organization. This remains a very popular position with very little turnover, so it has been a good retention tool. At the moment, they are only capable of advancing in a single community – the ultimate goal is to have a more transferrable education.
   Dr. Tan: Our AMR paramedics have chosen to undergo this training for personal satisfaction, a new way of practicing medicine, and to simply understand focused disease processes more in-depth. At this time, we are also looking at the possibility of a higher pay structure as well.

4. How is the APP different from the Community Paramedic Idea? Are you working towards a college level training to create this type of Health Care provider?
   Dr. Myers: The APP includes response to critical emergencies as the experienced hand. During times not assigned to a high acuity call, they are conducting prevention and re-direction activities (the "community paramedicine" role). In other settings, the critical call volume may be either rare enough or handled by others that a medic may focus more exclusively on the Community Paramedic work. Some certified/accredited program is the goal, but may be a few years off.
   Dr. Tan: There is no "official" definitions yet of various terms to include "Advanced Practice Paramedic," "Community Paramedic," or "Mobile Healthcare Paramedic." The State of Missouri is attempting to catch up to this rapidly growing segment of EMS. As we discussed during the webinar, these types of initiatives are often outpacing government's ability to manage or "regulate" the programs. Thus, my

definition of an APP is very different from another's. In my model, the APP practices both CP and Mobile Healthcare. I have yet a different subset of Specialty Care Transport paramedics that undergo a different curriculum and selection process.

5. Is there any relationship between the Critical Care Paramedic training programs and the APP training?

   Dr. Myers: In the Wake EMS System, there is no relation. We are not adding skills or monitoring capabilities but rather advanced decision making that is not provided in the traditional Critical Care Paramedic education.
   Dr. Tan: In the AMR-St. Louis operation, there is no relationship between the two.

6. How much clinical education after the 200 didactic?

   Dr. Myers: 8 hours per site. Wake EMS has 3 emergency departments, 2 clinics, 2 alcohol treatment programs, and additional clinical time. Total was about 80 hours and is modified based on previous experience of the providers, etc.

7. What criteria do you use to select paramedics to become APP?

   Dr. Myers: Number of calls in the EMS System (minimum number to assure sufficient previous experience to make an informed decision about proceeding), performance in critical patient simulation exercise, performance in the didactic portion of the APP academy, clinical observations, performance during interview, and (after the first class graduated) performance during clinical ride-a-longs with existing APPs.
   Dr. Tan: Employee service record, Clinical Education Specialist (CES) review of patient care performance, Operations Manager recommendation, preceptor reviews during clinical training.

8. Do you have age limits (upper or lower) on who will respond?
   Dr. Myers: No, we do not.
   Dr. Tan: No.

9. Will any of you be presenting your curriculum at NAEMSP this year?
   Dr. Myers: Hope to have this ready for presentation in 2014.
   Dr. Tan: If invited to share our experience, yes.

APPs Relationship With/To Other Providers

10. Is there a role for telemedicine from the APP to the ED physician? Have Dr. Tan or Dr. Myers used any telemedicine equipment in either of their programs?
    Dr. Myers: We do not use telemedicine at this point.

Dr. Tan: We have considered using FaceTime or similar applications, but we do not currently use telemedicine at this time.

11. Have you looked into the PSiam/LowCode program from Priority Solutions which has Registered Nurses in the EMS Communication Center to process low acuity calls? They have the ability to schedule 9-1-1 callers directly with their PCP or get them to an Urgent Care Center, with transportation included.
    Dr. Myers: We have not utilized any re-routing of calls from the PSAP to a nurse line.
    Dr. Tan: No. The way our current APP program is set up, calls come in through a non-emergency line dedicated to either the Community Paramedic program or Mobile Healthcare program.

12. Is anyone utilizing Social Service networks for those "customers" that need other services, rather than 911?
    Dr. Myers: We refer patients to our Human Services department, which includes social services. This is bi-directional, in that the APPs get referrals from Human Services when it appears our services would be a better fit and vice versa.
    Dr. Tan: The Community Paramedic works directly with the hospital Case Coordinator since our main focus is the high-risk hospital discharge patient.

13. Has anyone had any back lash from their nurse association regarding their medics doing such practice?
    Dr. Myers: Not so far – we are working with nursing in all of the local hospitals to ensure we are filling a gap in current service rather than competing with nursing.
    Dr. Tan: No. We specifically worked with hospital administrators to fill needs not currently met by its home health nurse program. We do not want to compete with them.

14. What do you see as the difference between a APP and a PA in terms of scope of practice? Have you considered using a PA in this role?
    Dr. Myers: The APP role is more limited and focused – assuring established care plans are completed, following checklists, and they still must be outstanding paramedics for in-field critical emergencies. I do not see an immediately role for Pas in this setting.
    Dr. Tan: For what we are using the APP for now, I think a PA would be overkill. The APP is currently filling a very focused and defined role.

15. Was there any thought to utilizing emergency nurses to fulfill this role in the capacity of performing field triage?
    Dr. Myers: We have the triage nurses help educate the APPs, but we do not utilize them in any day-to-day fashion.
    Dr. Tan: No.

16. How did you get your Medical Command physicians to approve not transporting patients to the Emergency Department?
    Dr. Myers: We are the medical command physicians – we bought in all along. The key is to have the safety profile and the mechanism to follow patients transported to alternative destinations in place early in the program so facts can overcome anecdotal cases.
    Dr. Tan: The 3 largest EMS systems in our area all have Medical Control through our hospital (all in the same group), so it wasn't a problem.

17. Why EMS providers for these bounce back programs rather than established nursing based home health care? Is this not a duplication?
    Dr. Myers: We respond and evaluate the patients within 24 hours of discharge. In our community, home health typically evaluates the patients on day 7 to day 30 post-discharge – the APPs fill the gap rather than duplicating services.
    Dr. Tan: In our area, home health will often only see patients during normal business hours. Our APP's will see patients 24/7 and bridge a need that is currently unmet by home health practices. We specifically are avoiding "competition" with home health nurses.

18. Who is the medical direction overseeing the Medics providing the care?
    Dr. Myers: Same as the EMS Medical Director
    Dr. Tan: The EMS Medical Director oversees the APP since they are still paramedics first.

Financial Aspects

19. What are the various ways that this can be funded? Does the EMS service receive any reimbursement from insurance/Medicaid/Medicare? What is the cost per visit and targeted fee per visit?
    Dr. Myers: At the moment, there is limited reimbursement for APP activities. Given the success of some pilot programs with both private insurance as well as CMS, it appears likely additional funding may be forthcoming.
    Dr. Tan: The funding mechanisms are limited only by one's imagination. Currently, our hope is to charge a percentage of proven savings when comparing patients served by the APP vs. standard follow-up. I also believe that, once these programs do prove themselves, CMS and insurance reimbursement will eventually follow.

20. What is the average salary for a seasoned paramedic verses that of a APP?
    Dr. Myers: 10% pay increase compared with non-APP medics with similar years of experience.
    Dr. Tan: In our system, it will most likely be an hourly differential based on years of experience.

21. Does the hospital reimburse the EMS agency AAP's services for those follow ups for HF patients?
    Dr. Myers: After the pilot program, we hope the hospitals will provide reimbursement. There is none in Wake County at the current time.
    Dr. Tan: Not during our pilot study, but eventually this is the plan.

22. How is payment of the MD being handled; by the community paramedic grant?
    Dr. Myers: There is no incremental payment for the MD – we are covering this as part of the routine EMS medical direction.
    Dr. Tan: Right now, it is just being piled on to current responsibilities. Nothing extra.

Regulations & APP Models

23. What State regulations have been adopted that support Redirection of Patients thereby reducing the liability for the providers?
    Dr. Myers: There have been no new regulations. The providers are covered in that they are following a medical control protocol, so the liability rests with the System/medical director, not with the provider.
    Dr. Tan: None in Missouri. Since the provider is following medical protocol, their practice coverage is no different than if they were answering a 9-1-1 call.

24. Do the APPs work for the hospitals or do they work for the EMS agencies? What oversight is given and what quality measures are utilized to evaluate their performance?
    Dr. Myers: APPs work for the EMS agency. They are evaluated on efficiency, as much as their work is self-generated. Thus, an APP who actively seeks patients in their zone with falls risk, CHF, or diabetes will have more time-on-task than one who simply makes one attempt at follow-up. Additionally, their work is directly observed by in-field supervisors who rank their activity and work.
    Dr. Tan: In my model, they work for our EMS agency with the usual medical director oversight and QA from the education department like the rest of the staff.

25. How would EMTLA affect a hospital based EMS service where a physician level evaluation is required, if you believe the EMS crew is an extension of the hospital? This is currently an issue in Massachusetts.
    Dr. Myers: EMTALA applies once the patient requests an evaluation. We are not attorneys, and this is not legal advice, but it is recommended that you check with your legal team and if the patient voluntarily seeks care elsewhere, they are not requesting service, and thus EMTALA need not apply.
    Dr. Tan: I oversee a private EMS service and honestly wouldn't be able to answer that question. Sorry!

26. How have you been able to transport a patient to a psychiatric facility prior to medical clearance process? Some state regulations do not permit paramedics to transport to a facility other than the ED, was this issue encountered by Dr. Tan or Dr. Myers?
    Dr. Myers: In North Carolina, everyone thought there was a state regulation that prohibited transport to any facility except an emergency department. It turned out this was urban myth – the apparent reference was to Medicare language that will not pay for such non-emergency department transports. Once we contacting the State Office of EMS, we were assured there was no prohibition about destination of ambulance transport and that our only concern should be with our billing vendor to assure we did not violate CMS rules by billing for transport to alternative destinations.
    Dr. Tan: Currently, our APP program does not address psychiatric patients.

27. Are you encountering problems or are you having to change state laws governing the scope of practice for paramedics to allow this advanced practice?
    Dr. Myers: As we are only adding decision making capabilities and not skills or procedures, we have not had to change our state laws.
    Dr. Tan: The State of Missouri has unofficially told us that, since everything we ask the paramedic to do is within their current scope of practice, we do not need any additional permissions to operate the program. We have not encountered any problems from a regulatory standpoint.

28. Is there model enabling legislation and regs, or good examples out there? In California, EMS legislation very restrictive as to scope and locations of practice.
    Dr. Myers: We would encourage you to review recent legislation in Minnesota that has covered these issues.
    Dr. Tan: I believe Minnesota is the only state to legislatively create the APP. Click on: https://www.revisor.mn.gov/bin/bldbill.php?bill=S0119.2.html&session=ls87

Identifying Patients to Divert

29. How do you identify the low acuity patients?
    Dr. Myers: Through the Emergency Severity Index (ESI) score that is used in many (if not most) emergency departments in the US – can be found on the cdc website.
    Dr. Tan: For our Mobile Healthcare clients, calls are first screened at intake to make sure the chief complaint does not meet criteria for an emergency response. We also educate our clients beforehand on when to use the MHC line and when to call 9-1-1 or the emergency line.

30. With regard to your APP model that focuses on APP responding and treating the highest acuity patients, isn't there a concern about eroding the experience and skill of general paramedics?
    Dr. Myers: There is this concern – we try to emulate the attending physician/resident model whereby the general paramedics provide most of the direct interventions and the APP supervises/intervenes as necessary. Not perfect, but seems to be working well, at least anecdotally.

31. Isn't there a decent body of literature stating that paramedics are mediocre at best at determining whether a patient "needs" to go to the ED or not? Did you find research supporting this idea or have you found/published anything demonstrating this?
    Dr. Myers: The literature relied upon non-standard endpoints such as “patient required admission to hospital” which is a subjective endpoint at best. Some studies demonstrate >90% accuracy with recommendations, others much lower. Our plan utilizes a small group of APPs to make this decision who are also responsible for following the patient through the chain of care. We believe this is a better, but our formal evaluation is not yet complete. More to come – jury is still out.
    Dr. Tan: The results of the few studies evaluating U.S. paramedic determinations of medical necessity for ambulance transport vary considerably, and only two studies report complete data. The studies also did not take into consideration paramedics who are specially and specifically trained for more in-depth and focused evaluation of specific disease processes with very integrated medical control. Thus, I am not certain that the current body of literature is applicable to the APP model.

32. How do you work to change the mentality of patients who are used to going to the ED for non-emergent care?
    Dr. Myers: Not there yet – our alternative destination programs are completely voluntary and 1/3 or more refuse because of their expectations.
    Dr. Tan: Our high-risk hospital discharge patients are pre-selected for intervention by the APP program and advised of the follow-up plan prior to being sent home.

Safety

33. How do you ensure safety for your APPs responding to known "troubled" or "unsafe" areas, assuming they respond alone at times?
    Dr. Myers: Same as law enforcement – they never go without checking out on the call with the location (including GPS) with dispatch, they have a 20 minute timed check from the telecommunicator, and they have scene awareness/safety training as part of the APP academy.
    Dr. Tan: Our APPs will respond in pairs and follow the same “scene safety” rules as when they are running 9-1-1 calls.

34. Can you address the increased malpractice risk for the director?
    Dr. Myers: We are not aware of any increased costs, but we are self-insured, so we may not be the best model to evaluate this.
    Dr. Tan: I don’t think there is enough actuarial data to say how much of an increased risk there is. I am a fully covered employee of AMR who considers this part of my medical director duties.

Other Programs/Buy-In/Hand Offs/More Information

35. Have APPs been implemented or utilized in any high volume urban areas within the US? If so, how long what areas and what kind of results evolved?
    Dr. Myers: The Raleigh/Wake metro is ~1,000,000 citizens with over 80,000 9-1-1 EMS request per year. We are working to publish our results.
    Dr. Tan: I would consider Dr. Myers’ area to be a high-volume urban area and hope to see his results soon! The current model for AMR-St. Louis is limited to two hospitals and not necessarily the entire city.

36. Are you, in either program, considering assessment and referral to primary care or urgent care in 4 or 24 hours like is done in Orange County, NC?
    Dr. Myers: Not yet – we are working on a pilot project with a local physician group to do this for their patients in assisted living facilities. Should be up and running in the next 120 days – but obviously no experience yet.
    Dr. Tan: Yes. We work closely with the primary care clinic who has already agreed to see unscheduled patients should the need arise.

37. How difficult was it obtaining the "buy-in" from the alternative agencies (public and faith-based)?
    Dr. Myers: Not difficulty at all – so long as we remain true to the mutually agreed-upon protocol, all has been good.
    Dr. Tan: No other public or faith-based agency offers our service, so it has not been a problem.

38. How does the hand off at the alternative care center differ from the ED hand off? How many re-works/untriage to alternative care that secondarily goes to ED?
    Dr. Myers: Out of the first 204 encounters, only 4 went to the emergency department with no bad outcomes. Handoff is via a pre-arranged checklist with patient information from the APP (either in person or via electronic means) to the receiving facility staff.

39. Is there a venue for on-going communication and development of this project/program, especially for those of us in the process of developing a program like this?
    Dr. Myers: There is a community paramedic website – it appears to be non-functional today but has been in the past. Just do a Google search to find it.
    Dr. Tan: The National Fire Protection Association (NFPA) is considering creating a "Guide for the Development of Community Paramedicine Programs" due to the high demand for guidance in this area. If they move forward with it, opportunity for public comment will be given.
    Also, NAEMT has a nice compendium of currently available guides at:
    http://www.naemt.org/about_ems/CommunityParamedicine.aspx