Community Paramedicine Education for Ohio

Adam D. Howard

University of Cincinnati

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Signed: ________________________________

Adam D. Howard
Abstract

The concepts of community paramedicine have been gaining momentum in the United States over the past few years. In 2013 the Ohio Emergency Medical, Fire, and Transportation Services (EMFTS) Board formed the Mobile Integrated Healthcare Ad Hoc Committee to explore the concepts of community paramedicine. Legislative changes are currently required in Ohio to allow EMS providers to expand their services to include functions of community paramedicine.

Once the Ohio Revised Code (ORC) is updated to allow EMS providers to engage in community paramedicine functions, the Ohio EMFTS Board will then predictably task the Mobile Integrated Healthcare Ad Hoc Committee with the development of the Ohio Administrative Code (OAC). The OAC for community paramedicine will likely define the education and training requirements, for the certified EMS providers, to allow them to serve in this expanded role. This research explores different methods of delivery for the education and training of Ohio’s future community paramedicine providers.

Research was conducted evaluating what other states are currently doing to meet the educational and training needs for community paramedicine. A model curriculum was also discovered and evaluated. Interviews were also conducted with influential members within the state.

Based upon the research conducted it is recommended that Ohio delegates the requirements of community paramedicine education to the local EMS agencies and medical directors. This will allow each program to be custom designed to meet the diverse needs of each independent community. All Ohio EMS providers can be utilized within their current scope of practice to perform in this new expanded role.
Introduction

The concepts of community paramedicine have been gaining momentum in the United States over the past few years. In fact, there are several EMS agencies that are already performing community paramedicine functions in several states including Arizona, California, Colorado, Georgia, Idaho, Indiana, Maine, Minnesota, Missouri, Nevada, North Carolina, Pennsylvania, Texas, and Washington. In 2013 the Ohio Emergency Medical, Fire, and Transportation Services (EMFTS) Board formed the Mobile Integrated Healthcare Ad Hoc Committee to explore the concepts of community paramedicine.

Mobile integrated healthcare is another phrase that is used synonymous with community paramedicine. There has been debate within the EMS industry about what to call this new collection of ideas (Goodwin, 2013). However, both terms are still in use and they represent the same general concepts. While the Ohio EMFTS Board prefers mobile integrated healthcare, the phrase community paramedicine will be used throughout this research, due to its increased prevalence and recognition at this point.

Legislative changes are currently required in Ohio to allow EMS providers to expand their services to include functions of community paramedicine. Ohio Revised Code (ORC) 4765, which regulates EMS, currently only allows EMS providers to perform emergency services (Ohio Emergency Medical, Fire, and Transportation Services Board, 2014).

**ORC 4765.37:** "An emergency medical technician-basic shall perform the emergency medical services described in this section in accordance with this chapter and any rules adopted under it by the state board of emergency medical, fire, and transportation services."

In addition, immunity from civil liability applies only if the certified EMS provider is administering “emergency” medical services (Ohio Emergency Medical, Fire, and Transportation Services Board, 2014).
ORC 4765.49: “A first responder, emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic is not liable in damages in a civil action for injury, death, or loss to person or property resulting from the individual's administration of emergency medical services, unless the services are administered in a manner that constitutes willful or wanton misconduct.”

In April of 2014, the Ohio EMFTS Board issued a notice to all EMS certificate holders that warned that without a statutory change they simply cannot provide non-emergency care.

According to Ohio State Senator Bill Seitz in October of 2014, during a community paramedicine seminar hosted by the University of Cincinnati, there are some positive indicators suggesting that the required legislative changes, allowing community paramedicine in Ohio, may come as early as 2015. Once the ORC is updated to allow EMS providers to engage in community paramedicine functions, the Ohio EMFTS Board will then predictably task the Mobile Integrated Healthcare Ad Hoc Committee with the development of the Ohio Administrative Code (OAC), which establishes the administrative rules that will govern community paramedicine within the state. The OAC for community paramedicine will likely define the education and training requirements, for the certified EMS providers, to allow them to serve in this expanded role. This research explores different methods of delivery for the education and training of Ohio’s future community paramedicine providers.

Background and Significance

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 took root (Goodwin, 2013). This lead up to March 23, 2010, when President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. The law was slated to be phased in over several years, requiring most Americans to have some form of health insurance by 2014. The PPACA as signed into law is a total of 906 pages, which lays out a plan to make health care more affordable, accessible and
of a higher quality, for families, seniors, businesses, and taxpayers’ alike (U.S. Department of Health & Human Services, 2014).

While the PPACA doesn’t directly mention EMS, it sets up opportunities for EMS (Nicol, 2014). Changing the way doctors and hospitals are paid will require changing how care is delivered, and in the process, restructuring nearly one-fifth of the U.S. economy (Boulton, 2014). The Institute for Healthcare Improvement exposes the three primary dimensions required for successful healthcare reform, under the PPACA, into what they call the Triple Aim. The Triple Aim focuses on improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care (Institute for Healthcare Improvement, 2014).

In 2012 alone, the Centers for Medicare & Medicaid Services (CMS) announced it would award up to $1 billion in Healthcare Innovation Grants to applicants with the most compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and the Children’s Health Insurance Program (McCallion, 2012). These federal policies and trends appear to support the development of community paramedic programs (National Conference of State Legislators, 2014). Therefore, in the Spring of 2012, CMS awarded more than $13 million in grants to launch community paramedicine programs across several states (Goodwin, 2013). EMS providers can play a critical role in the shift away from episodic emergency care, to regular and consistent care (National Conference of State Legislators, 2014). Every EMS provider knows all too well the futility of transporting a patient to the hospital when they really just need a prescription filled, a check-up by a primary care physician, mental health, or social services. Community paramedicine programs would enable EMS providers to take on a broader role in the healthcare system by filling gaps in services, such
as these. With its 24/7 mobile workforce, EMS is in a great position to deliver the needed healthcare to the community it serves (Goodwin, 2013). The transition to the concepts of community paramedicine really reframes the role of EMS within the nation’s healthcare system. EMS will no longer be just an extension of the emergency department, but rather a networked part of the overall healthcare system (Erich, 2014). Therefore, EMS will be required to articulate its value to its healthcare partners in terms of cost-saving, provider and patient satisfaction, and clinical outcomes. Initial outcomes data, from pilot community paramedicine programs, are promising and suggesting that such programs have the potential to reduce emergency department visits and related costs (National Conference of State Legislators, 2014). However, healthcare partners need to see that EMS providers are appropriately credentialed to perform in this new expanded role (McCallion, MIH Summit Ponders Payer and Policy Issues, 2014).

**Literature Review**

Research was conducted by reviewing several documents and internet sources on the topic of community paramedicine education. The primary focus was to evaluate what other states are currently doing to meet the educational and training needs for community paramedicine. Model curriculum was discovered and evaluated for both content and length. Finally it was realized that education is essential to combating the political opposition from groups such as home health nursing associations.

In January of 2009, Wake County EMS in North Carolina began a new Advanced Practice Paramedic (APP) program under the direction of medical director Dr. Brent Myers (Wake County Government, 2014). The APP program is a model that was developed internally to meet specific objectives based on the needs of the community and is not a state recognized EMS certification level (Mazurek, 2010). The APP program has three main objectives that focus
on the three R’s: response, reduction and redirection (Berry, 2012). The APP providers attend a specialized in-house education program that consists of more than 200 hours of didactic training, as well as an additional 128 hours of clinical training (Wake County Government, 2014).

Following the lead established by Wake County, MedStar EMS in Ft. Worth, Texas also launched an Advanced Practice Paramedic (APP) program, in July of 2009, under the direction of medical director Dr. Jeff Beeson (Berry, 2012). More recently MedStar EMS changed its name to MedStar Mobile Healthcare to better convey the services it provides to the public (Cravens, 2013). The organization has also changed the name of its APP providers to Mobile Healthcare Practitioners (MedStar Mobile Healthcare, 2014). Similar to the Wake County APP program, the Mobile Healthcare Practitioner program is a model that was developed internally to meet specific objectives based on the needs of the community and is not a state recognized EMS certification level. The training requirements of the Mobile Healthcare Practitioners includes only 80 hours of classroom training and 48 hours of clinical rotation (MedStar Mobile Healthcare, 2014). MedStar has already experienced some significant success with its newly developed program. As a result, the volume of 9-1-1 calls from 186 enrollees, from July 2009 to August 2011, dropped by 58 percent. The annual EMS transport costs for enrolled patients fell by more than $900,000 and other charges fell by more than $2.8 million. The regions emergency departments estimated an even larger reduction in charges and costs, including a $9 million reduction in emergency department charges. The decline in ambulance transports also freed-up emergency department capacity by as much as 14,000 additional bed hours, as a result of MedStar’s CHP program.

Over the last several years, Minnesota has become the epicenter of the community paramedicine movement. In 2011, the nation’s first training program opened at Hennepin
Technical College (Dayton Daily News, 2013). The same year, the Minnesota legislature enacted into law the new profession of community paramedic (EMT-CP). To obtain a community paramedic certificate the applicant must possess a current paramedic certification, have two years of full-time services as an EMT-P, and graduate from an accredited course (Minnesota Department of Human Services, 2014). Section 144E.28, subdivision 9, further states that the applicant must successfully complete a community paramedic education program from a college or university that has been approved by the board or accredited by a board-approved national accreditation organization. It continues by stating that the education program must include clinical experience that is provided under the supervision of an ambulance medical director, advanced practice nurse, physician assistant, or public health nurse operating under the direct authority of a local unit of government. This subdivision also establishes that a community paramedic must complete an additional 12 hours of continuing education in clinical topics approved by the ambulance service medical director every two years (Minnesota Statutes, 2014).

In 2013, it appears that Missouri followed Minnesota’s lead by signing a similar law into place, giving community paramedics the ability to function. To obtain a community paramedic certification in Missouri the applicant must be certified as a paramedic, successfully complete a community paramedic certification program from a college, university, or educational institution that has been approved by the department or accredited by a national accreditation organization approved by the department, and complete an application form (Missouri Revised Statutes, 2014). 19 CSR 30-40.800 further states that the education program must include a minimum of sixty hours of didactic training and practical and lab skills, as well as at least forty hours of clinical experience.
The Community Healthcare and Emergency Cooperative (CHEC) formed in July 2007 to address critical health care shortages in rural and remote areas, specifically by developing a new community health provider model. The CHEC benefits from several partners, which include:

- North Central EMS Institute, St. Cloud, Minnesota
- Australian Centre for Prehospital Research, Brisbane, Queensland, Australia
- Creighton University EMS Education, Nebraska
- Dalhousie University, Nova Scotia
- EMS Education, Offut Air Force Base
- Hennepin Technical College, Eden Prairie, Minnesota
- Mayo Clinic Medical Transport, Minnesota
- MnSCU Healthcare Education—Industry Partnership, Minnesota
- RURAL Centre, Halifax, Nova Scotia
- State Offices of Rural Health, Minnesota and Nebraska
- State Offices of EMS, Minnesota and Nebraska
- University of Nebraska Medical Center

The CHEC has developed a standardized community paramedicine training curriculum that is consistent internationally, yet can be modified and customized for each community, province and nation. The Community Paramedic Program is built on the Rural and Frontier EMS Agenda of the Future, a 2004 report that describes an optimal future for rural EMS, as well as the changes required to achieve that vision. It is also supported by the International Roundtable on Community Paramedicine (Community Paramedic, 2014). The first edition, known as version 3.0, of the CHEC community paramedic curriculum was estimated to require approximately 100 hours of core educational experience. Along with an additional 50 to 200 hours of clinical foundation, varying based upon previous experience. The curriculum was developed using a standardized multi-module delivery model, which allows it to be modified based upon local needs. The first edition curriculum included the following seven modules (Cooperative, n.d.):

- Module 1 – Role of the Community Paramedic in the Health Care System
- Module 2 – Social Determinants of Health
- Module 3 – Public Health and Primary Care Role of the Community Paramedic
- Module 4 – Developing Cultural Competence
• Module 5 – The Community Paramedic’s Role Within the Community
• Module 6 – The Community Paramedic’s Personal Safety & Wellness
• Module 7 – The Clinical Experience

Approximately 497 requests for information have been received from individuals and 111 colleges or universities in six countries have received the curriculum (North Central EMS Institute, 2014). Buck McAlpin of North Memorial Hospital announced in October of 2014, during a community paramedicine seminar hosted by the University of Cincinnati, a new edition of this curriculum is being prepared for release.

The home healthcare industry has been especially anxious about community paramedic programs (McCallion, MIH Summit Ponders Payer and Policy Issues, 2014). The Missouri Nurses Association released a position statement warning about the concerns they had with the new community paramedicine law in their state. Their concerns were focused on the perceived lack of educational requirements, which only included 60 hours of classroom and 40 hours of clinical training. Acting as patient advocates, they are calling for a more standardized educational process for community paramedics. However, they also stated in the same positions statement that there is no question that community paramedicine will provide patients with access to care that they may not have previously had (Missouri Nurses Association, 2013). The American Nurses Association released a similar positions statement titled ANA’s Essential Principles for Utilization of Community Paramedics. Within this position statement the ANA states that they believe that every patient deserves access to safe, quality care from all healthcare providers. They go on to state that health care is ever-changing and is currently undergoing a significant transformation. ANA supports initiatives which allow all members of the healthcare team to fully function consistent with their education and training in a cooperative manner. However, they are calling for community paramedics to receive uniform education and clinical
training from an accredited program in the higher education setting, which should be required by state statute, rules, and regulations. The ANA states that community paramedics should be accountable for self, to the community, and to a regulatory agency. From these positions statements it is clear that standardized educational requirements for community paramedicine providers are essential in combating the political opposition of groups such as home health nursing associations.

Discussion

An interview was conducted with Fire Chief Paul Wright, President of the Ohio Fire Chief’s Association (OFCA). Chief Wright explained that he was unable to state when the ORC legislative changes would be introduced but did advised that the OFCA has already reached out to a few of the legislators to gain support. He felt that the most important discussion is going to center around the OAC development for community paramedicine. The OFCA’s position is that the state not mandate any specific education requirements for community paramedicine and that the control remains at the local level. He further explained that EMS systems and communities across the state vary greatly in both needs and capabilities; therefore, a standardized training requirement would not make sense. The local EMS agencies and medical directors are in the best position to determine the community paramedicine functions that would best meet the needs of their communities. The medical directors can implement and provided oversight of the custom designed training classes to meet those specific functions.

An interview was also conducted with Dr. Jason Pickett, an emergency room physician and medical director for multiple EMS agencies in the Greater Dayton, OH region. He stated that the process of defining and implementing community paramedicine is a marathon not a sprint.
He went on to state that what we are discussing and embarking upon is going to fundamentally change the EMS industry and how we do business. However, he also cautions against overreaching educations requirements. He used the comparison of the recent move by hospital employers to require existing register nurses (RNs) to obtain a Bachelor of Science in Nursing (BSN) to maintain employment. Some of the RNs have provided outstanding clinical care with years of experience but suddenly some hospital administrators think it’s necessary for them to go back to school. The education and knowledge associated with a BSN degree is great for someone in a management position but it’s just not necessary for everyone. Dr. Pickett feels that this movement is the result of the political forces coming from the business model of the higher education industry. He also supports the concept of delegating the education and training elements of community paramedicine to the local level, for similar reasons as presented by the OFCA.

Conclusion

Based upon the research conducted it is recommended that Ohio delegates the requirements of community paramedicine education to the local EMS agencies and medical directors. However, there are certainly benefits associated with a full standardized curriculum. Local communities should be able to determine what level of service they want to utilize to meet their specific needs. Universities and colleges can still offer and market the standardized community paramedic curriculums. Communities that want to achieve premier full spectrum community paramedic programs will utilize these educational programs. However, some communities may not be able to afford to train their personnel to this full level. This should not
prevent them from performing some of these beneficial non-emergency functions for the citizens of their community if they are capable.

Rather than creating a new EMS certification for community paramedicine, Ohio would be better served by simply allowing all EMS provider levels to perform community paramedicine functions as approved by their medical director. The Ohio EMFTS Board should identify which non-emergency functions are permissible by each level of EMS provider, similar to the current scope of practice chart; however, rather titled as an expanded roles (Appendix A). In addition, a requirement should be placed into the OAC that requires some additional education to be approved by the medical director and conducted before any EMS provider performs any non-emergency functions. This should ensure that the EMS providers are properly prepared to serve in their new expanded roles. It may also help to combat the political opposition of groups such as home health nursing associations.

The concepts of community paramedicine present a multitude of significant benefits, which meet the goals of current healthcare reform. Ohio must move forward by passing legislation to first allow EMS providers to engage in non-emergency healthcare. Then Ohio should delegate the education and training requirements to the local level, so that each program can be custom designed to meet the diverse needs of each independent community. Standardized community paramedicine curriculum should also be made available by university and colleges to meet the high level needs of some communities. There is no valid reason to restrict these non-emergency services to certified paramedics. All Ohio EMS providers can be utilized within their current scope of practice to perform in this new expanded role.
References


# Ohio EMS Expanded Role - Draft

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<td>2 Assist Compiling Med Info / Vial-of-Life Program</td>
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<td>3 Home Safety Assessment</td>
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<td>4 Fall Prevention</td>
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<td>5 Vaccinations</td>
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<td>6 Substance Abuse Referral</td>
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Appendix A