Building a Better Community Medic

by John Erich On Aug 21, 2014

Figure 1: California Community Paramedic Pilot Projects

LEAD AGENCY	LEAD EMS AGENCY	TYPE OF PROJECT	EMS AGENCIES PARTICIPATING
1. UCLA Center for Prehospital Care	Los Angeles	Alternative destination	Santa Monica, Glendale, Pasadena FDs
2. UCLA Center for Prehospital Care	Los Angeles	CHF follow-up	Burbank, Glendale FDs
3. Orange Co. Fire Chief's Assoc.	Orange Co.	Alternative destination	Fountain Valley, Huntington Beach, Newport Beach FDs
4. Butte County EMS	Sierra-Sac. Val.	EMS post-hospital follow-up	Butte County EMS
5. Ventura County EMS Agency	Ventura	Observed TB treatment	AMR Ventura, Gold Coast, LifeLine
6. Ventura County EMS Agency	Ventura, Sta. Barb.	Hospice support	AMR Ventura, Santa Barbara
7. Alameda County EMS Agency	Alameda County	Hospital follow-up, 9-1-1 users	Alameda City, Hayward FDs
8. San Bernardino County FD	San Bernardino Co.	Post-hospital follow-up	San Bernardino County FD
9. Carlsbad FD	San Diego	Alternative destination	Carlsbad FD
10. City of San Diego	San Diego	Frequent 9-1-1 users	San Diego City FD, Rural/Metro
11. San Joaquin Co. EMS Agency	San Joaquin Co.	Post-hospital follow-up	AMR San Joaquin County
12. Mountain Valley EMS	Stanislaus County	Alt. dest., mental health	AMR Stanislaus County
13. Medic Ambulance	Solano County	Post-hospital follow-up	Medic Ambulance

As a measure of the rapid recent growth of community paramedicine in the United States, consider this: Half a year or so ago, 145 educational institutions had sought copies of the standardized community paramedic educational curriculum developed by the Community Healthcare and Emergency Collaborative (CHEC). By this summer, when national leaders in CP education completed a survey of such institutions and how they use the curriculum, the number had risen to more than 200. That's an increase of 38% in six months.

"The momentum is really just exploding," says Anne Robinson-Montera, RN, BSN, who led the team behind the latest curriculum update (version 3) and was part of the group that polled its recipients. "Since the paper there have been more than 100 additional institutions that have said they want to teach the course. We're really thinking that within the next five years, we can have as many as 167 colleges and universities around the world teaching it. I think if anything, the paper demonstrates that this is becoming a standard of education."

As programs proliferate, such a standard is increasingly necessary. To institutionalize and advance the CP concept, an educational foundation that's common across systems, yet pliable enough to accommodate local circumstances and emphases, is an essential step.

Who's Using & How

The survey, the results of which were published in International Paramedic Practice,1 went to 223 post-secondary educators and government officials. More than 30% responded—a rate that's 2–3 times the average rate for external surveys.

Of those answering the direct question, roughly three-quarters said they'd already conducted, were conducting or planned to conduct a CP course in the next five years. Half of the rest just awaited state approval.

At the time of the survey, the authors concluded, many CP courses both domestic and international were still in planning stages, but the curriculum disseminated internationally "has been broadly accepted and will be widely utilized."

Among the most notable adoptions here at home has been that of of California, the first state to embrace the curriculum at the statewide level. The California EMS Authority has contracted with the UCLA Center for Prehospital Care to develop CP courses that will be taught at sites around California in advance of pilot projects being developed under the state's Health Workforce Pilot Projects (HWPP) program. That should all start in January.

"We have two courses we'll kind of be the 'mother ship' for at UCLA," says Robinson-Montera, "and then we'll have separate sites set up for students to come and receive content from subject-matter experts we're bringing in from all over the nation. There are a variety of programs being set up; for instance, there's one department helping people with asthma, and there's another that helps administer tuberculosis medications."

Leaders at the 12 pilot sites have spent the summer planning protocols, training and data collection. For a list of the planned projects, see Figure 1.

"For a state to really adopt this as its curriculum," adds Robinson-Montera, "I think speaks volumes about its content."

Basic Content

If you're familiar with version 2 of the CP curriculum, that content was reorganized and bolstered in version 3, with added goals and objectives. The current iteration has seven sections:

Role of the community paramedic in the healthcare system—The opening module covers the definition and practice scope of the CP as well as the relationships they'll need and locating organizations they can work with.

The social determinants of health – This section examines the social characteristics of those likely to benefit from CP services, and how they correlate with health behaviors.

Public health and the primary care role – This section describes a public health approach to areas like health promotion, injury prevention and chronic disease management, as well as risk mitigation and financial impact.

Cultural competency – Subjects include the cultural impact on health and the distinction between culture and individual identity. This section helps students develop "cultural competence" and avoid stereotyping.

Role within the community – This covers conducting a community needs assessment, developing profiles of patient candidates, and determining types and levels of care to be delivered.

Personal safety and wellness – This examines well-being among CP providers, including the warning signs of stress and strategies to manage it and avoid burnout.

Clinical experience – The clinical module requires students to compile histories on subacute, semichronic patients; perform physical exams and document their histories; utilize specialty equipment, including that of home healthcare; access and maintain ports, central lines, catheters and ostomies; obtain specimens and samples for lab testing; and interpret various results and reports.

The first six modules, basically core competencies, can be taught online. The clinical/lab portion is delivered in the community and tailored to the type of program being established. Expert reviewers vetted the curriculum once it was complete, then a pilot process in 2012 tested it across 23 agencies in 14 states.

“Version 2 had a lot of teaching material, and it was hard for one college or university to just pick it up and really know where to start,” says Robinson-Montera. “It had four modules, but some of them applied and some didn’t always, and there wasn’t much structure or framework for teaching it. So we just kind of stepped back and reorganized what was there. We added goals and objectives. Then what we’ve been doing is working with individual agencies and helping them further develop lesson plans and teaching materials.” Guidance for that is compiled in a resource manual that’s provided for instructors.

Establishing a Program

At ZOLL’s Summit 2014 in May, Robinson-Montera outlined steps for establishing and delivering a CP education program. Briefly those are:

1. Affiliate with an accredited college;
2. Request the curriculum (it’s free);
3. Gather champions for additional support (e.g., medical director, nurses, public health, hospital discharge planners, home health).
4. Assemble a multidisciplinary faculty; look to physicians, nurses, public health personnel, behaviorists, social workers, home health, hospice and others from related fields.
5. Establish clinical sites 6–8 months in advance, then develop a clinical guidebook. This should outline objectives and responsibilities and expectations of all participants.
6. Select appropriate learners. Not everyone in EMS is cut out to be a community paramedic. Look for experience, prerequisite knowledge and education, and an ability to devote the time and learn online.
7. Develop the course structure, including standards, grading criteria, etc.
8. Develop the course. Construct a syllabus for each module and provide a resource manual. Incorporate subject-matter experts.
9. Assess the learners: Are they getting what you’re trying to teach them?
10. Evaluate all aspects of the program as you progress and when you’re done. This should include student selection, system needs, technology, faculty, clinical sites and overall satisfaction.

A mistake some institutions have made is to keep their programs too EMS-centric. Successful efforts have to draw on a wider range of instructor expertise. “A program won’t be successful if it’s run just through an EMS type of faculty,” says Robinson-Montera. “You need to make sure the faculty is diverse, with backgrounds in areas like public health, social work and nursing. You can’t just have your typical paramedic instructors; the whole concept of community paramedicine is bringing together all these different healthcare stakeholders and having them work together.”

Efforts are underway to establish an accreditation process to verify the quality of CP educational programs. Once that's in place, its will provide a mechanism for funding and making further refinements to future versions of the curriculum.

For more on CHEC and its community paramedic curriculum, see http://communityparamedic.org/.

Reference

1. Raynovich W, Weber M, Wilcox M, Wingrove G, Robinson-Montera A, Long S. A survey of community paramedicine course offerings and planned offerings. International Paramedic Practice, 2014 Apr–Jun; 4(1): 19–24.