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TO: Susquehanna Region EMS Agencies, Providers, and Hospitals

FROM: Ann Teng, D.O., REMAC Chair and Regional EMS Medical Director

DATE: December 20, 2018

SUBJECT: Implementation of the Advanced EMT (AEMT) Level of Practice in Our Regional EMS System

INTRODUCTION

In February 2007, the United States Department of Transportation, National Highway Traffic Safety Administration (NHTSA - the lead Federal agency for Emergency Medical Services) published the *National EMS Scope of Practice Model* (Publication DOT HS 810 657), which, in turn, was based on the *EMS Agenda for the Future* (1996), and *The EMS Education Agenda for the Future: A Systems Approach* (2000). The *Scope of Practice Model* describes four levels of EMS providers, including detailed descriptions of the levels, and of the psychomotor skills they each encompass:

- Emergency Medical Responder
- Emergency Medical Technician
- Advanced Emergency Medical Technician
- Paramedic

In January 2009, NHTSA published the *National Emergency Medical Services Education Standards* (Publication DOT HS 811 077A), upon which all educational curricula for the training and retraining of EMS providers, throughout the nation, is to be based. In April 2012, the New York State Department of Health, Bureau of Emergency Medical Services and Trauma Systems (BEMST) announced plans to transition all NYS EMS original, refresher, and CME-based recertification courses to the new national standards, with the transition process to be completed by May 23, 2013. This transition included the elimination of the old Advanced EMT-Intermediate (AEMT-I) provider level, and the introduction of the new national standard Advanced EMT (AEMT) level. However, despite this transition, the Advanced EMT-Critical Care (AEMT-CC) level, unique to New York State, was to remain in place until a time then uncertain.

While the AEMT-CC provider level remained available, and provided for a relatively "comprehensive" scope of prehospital advanced life support (at least for adult patients), ALS course sponsors in our region continued to devote their resources to providing courses at that level, to the exclusion of the new AEMT level. In August 2017, however, BEMST announced that it, in consultation with and with the consent of the State EMS Council, had decided to "sunset" the non-national-standard AEMT-CC level, with no new original AEMT-CC courses permitted to begin after 1/1/2017, and all "traditional" AEMT-CC refresher courses completing final written certification testing by 8/15/2019. Currently-certified AEMT-CCs would be allowed to maintain their certification, and thereby continue practicing at that level, indefinitely via the continuing medical education ("CME-based") recertification process, as long as they continued to qualify for participation in that program. Also, more recently announced is an on-line education program, approved by BEMST, through which currently-certified and experienced AEMT-CCs will be able to "bridge" their certifications to the New York State Paramedic level, thus assuring their continued ability to function as "full" ALS providers in perpetuity.

In December 2018, the Broome County Office of Emergency Services completed the first AEMT (new national standard level) original certification course in our Region, with 12 students. If successful in their written certification exams, these students will receive their AEMT certificates in mid-January 2019.

Q & A: INTEGRATING AEMTs INTO OUR REGIONAL EMS SYSTEM

Although this Region participates in the Collaborative New York multi-regional protocols, which support the AEMT level of practice, we have never before had AEMTs who actually practice here, and multiple questions have arisen with respect to their role. In response to these, I assembled a workgroup of EMS educators and administrators, well-familiar with AEMT education and scope-of-practice, to advise me. The following are a list of these "FAQs", and my answers to them, as Regional Medical Director:

Q: Are AEMTs considered "ALS Providers" for the purpose of dispatching ALS to "Charlie", "Delta", and "Echo" priority calls in our Region?

A: No. AEMT-level care is considered "enhanced BLS" for this purpose, and ALS care at the Critical Care or Paramedic level will still need to be dispatched/provided for such calls, even if the "first-due" ambulance responding to the call is staffed to the AEMT level. For this same reason, EMS units staffed at the AEMT level should not place themselves on-duty, or otherwise represent themselves to their dispatch center, as being "ALS" or "advanced" units.

Q: Are AEMT-level units adequate for providing "advanced life support" for the purpose of complying with any policy or protocol indicating that ALS should be summoned, if available?

A: Many protocols within the *New York State Statewide Pre-Hospital Treatment Protocols* direct that advanced life support should be requested, "if available". Similarly, most protocols that are part of the Collaborative New York multi-regional protocols direct care to be given at the Critical Care and/or Paramedic level, assuming that such care is available. The REMAC directive in this Region, which dates to the early 1990s, that ALS be dispatched to any calls for which there is a clear indication for it at the time of initial dispatch, has been successful in assuring that the vast majority of these patient receive prehospital ALS in a timely manner, and it is expected that this will continue to be the case. Therefore, any request from BLS providers for ALS assistance in compliance with applicable protocols, or simply based upon the BLS provider's impression that the patient requires ALS, should continue to be answered by units staffed at the Critical Care or Paramedic level. However, it is recognized that "full ALS" care is not universally available, especially in rural areas or during times of high EMS system demand, and that the nearest source of "full-ALS" care may, in these and other instances, be the hospital emergency department to which the patient is to be transported. In such cases, the appropriate, protocol-directed treatment should be provided by the highest-level EMS provider that *is* available, and the patient should be transported to the appropriate hospital destination without delay. If the patient continues to be unstable or potentially unstable, an ALS intercept from an agency that can meet the BLS unit along its route of travel to the hospital should be sought.

Q: What, then, is the value of an AEMT if she/he is not considered to be a "real" ALS provider?

A: The AEMT level is similar, in many ways, to the old AEMT-Intermediate level, which was also not considered to be "full ALS". These providers predominated in rural areas, and could bring a higher-level of care to patients in those areas *sooner* than ALS units from larger communities could arrive, or could intercept the transporting unit enroute to the hospital. This is known as "tiered care", and has been demonstrated to have real value for patients, especially those who are critical and/or unstable. AEMTs, like the former AEMT-Is, have also proven their value as "Paramedic assistants", who can aid higher-level providers in accomplishing their objectives much more quickly and efficiently. We feel strongly, therefore, that this provider level will be a genuine enhancement

to our EMS system and its patients, and will subtantially contribute to the professional development of those who achieve it.

Q: Can an AEMT who contacts a patient prior to the arrival of an ALS (CC or P) unit or provider cancel the ALS response if she/he feels that AEMT-level care is adequate to meet the patient's needs?

A: Just as in the case of a BLS provider who arrives prior to a responding ALS unit or provider, ALS that has been dispatched pursuant to criteria (such as "C", "D", or "E" EMD determinants) that do not turn out to be *substantially* mistaken, must not be cancelled prior to arrival, *unless* an on-line medical control physician is consulted and agrees that the patient may be transported under the lower level of care. The same is true if, after the arrival of ALS, the ALS provider seeks a BLS or AEMT "release" after assessing the patient. In all such cases, the transporting BLS or AEMT provider, as well as the "released" ALS provider, should thoroughly document the criteria for requesting the release, as well as the identity of the concurring physician, in their respective prehospital care reports. REMEMBER: If there is doubt about the stability of any patient, ALS providers should still accompany the patient to the hospital, even if they do not initiate ALS care due to an initial lack of clear indication for it.

Q: How does a BLS agency go about upgrading to the AEMT level, and how must an AEMT (as the highest level of care offered) unit be equipped?

A: BLS ambulance services based in our Region must make application to, and be approved by the REMAC to upgrade their level of care to the AEMT level. Such an application must have the support and active involvement of the agency's physician medical director. A BLS first response agency ("med team") would need to upgrade to the status of an ALS first response agency ("ALSFR"), which requires that the agency apply to the Regional EMS Council for a "certificate of need", while concurrently applying to the REMAC for approval to operate at the AEMT level.

The regional equipment standard for an AEMT (as the highest level of care) unit is attached. Please note that these requirements are *in addition to* the state requirements listed under 10NYCRR Part 800 for ambulances and emergency ambulance service vehicles (fly cars) operated by certified EMS agencies.

Please contact the SREMS Regional EMS Program Agency for more information, or with any additional questions you may have in this, or related matters.