



2019 PROGRAMME

16th MEETING

June 15-16, 2019

Delta Hotels Prince Edward

Charlottetown, PEI, Canada

Pope Ballroom

Prince Edward Island Convention Centre

FRIDAY June 14 2019

18.00 **Welcome Reception**
Local Pub
Location

SATURDAY June 15 2019

08.00 **Arrival and Registration**
Delta Hotels Prince Edward
Pope Ballroom

09.00 **MEETING OPENING (Pope Ballroom)**
Welcome to Prince Edward Island
Name
Position, Agency

First Nations Welcome
Chief, Local First Nation

09.10 *IRCP Welcome*
Randy Mellow, President, PCC [CAN]

Gary Wingrove, Mayo Clinic [USA]

Passing of the IRCP Gavel
Gary Wingrove, Chair, IRCP [USA]
David Waters, Chief Executive, CAA [AUS]
Randy Mellow, President, PCC [CAN]

Proposal by the Association of Ambulance Chief Executives to host IRCP 2020
Name, Position, AACE [GBR]

IMPORTANT NOTE: The IRCP uses a standardized nomenclature of professional titles and agency names in order to reduce audience confusion. The actual local titles of the presenters, their program names and their agency may be different than listed in this programme.

A sessions are planning related; B sessions are implementation related; and, C sessions are evaluation related.

09.20 *Keynote: Off the road less travelled: Primary Care Community Paramedicine within Indigenous Remote and Isolated Canadian communities*
J.D. Heffern, AEMCA ACP BSc MBA(c): Paramedic Portfolio Manager
Indigenous Services Canada, First Nation Inuit Health Branch [CAN]

09.40 **15.A.1** *Community Paramedicine in Developing Countries*
Duncan McConnell MBA(Exec), MCOM, GradCertAmbMgt, DipHlthSc(Amb) DipInfoTech, FIML, AFCHSM, CHM, MAP: Foundation Paramedicine Program Director / Senior Lecturer
Griffith University [AUS]

10.00 15.A.2 *Community Paramedicine: A Systematic Review of Program Descriptions and Training*
Gina Agarwal, MBBS PHD: Professor, Family Physician
McMaster University [CAN]

10.20 Refreshment Break (Pope Ballroom)

10.40 15.A.3 *The No One Brought In Patient: Strategies for limiting risk and providing patient centered care*
Jeremy Measham, ACP BSc: Coordinator, Quality and Projects
Island Paramedic Service [CAN]

11.00 15.A.4 *Sick Visits: Patient Safety the Key for Success*
Joseph Hughes, ACP CP-C: Manager, Community Paramedicine
EasCare Paramedic Service [USA]

11.20 15.A.5 *International trends on the developing role of the Community Paramedic Practitioner*
Mary Ahlers, MEd BSN ACP CP-C EMSI: Director/Chair
Paramedic Health Solutions [USA]

Peter O'Meara, PhD: President/CEO
Global Paramedic Higher Education Council [USA]

11.50 15.A.6 *Assessment practices in community paramedicine*
Matthew Leyenaar, PhD(c): PhD Candidate
McMaster University [CAN]

12.15 Lunch (Pope Ballroom)

POSTER AVAILABLE DURING LUNCH:

Hybrid High-Fidelity Simulation in Community Paramedic Training

Ryan Brown, MPH PCP FRSPH: Community Paramedic Programs Clinical Development Paramedic
Emergency Medical Care Inc [CAN]

13.00 15.A.7 *The Complex Care Hub & Community Paramedicine: A hospital at home model for patients with complex medical conditions*
Michele Smith, ACP BSc: Manager, Community Paramedicine
Alberta Health Services [CAN]

13.20 15.A.8 *Utilizing Improvement Science Methodology and Organizational Re-Design to Improve Community Paramedicine Performance?*
Joe Pedulla, PMP CHE MHSc ACP RRT: Superintendent - Community Paramedicine
Hamilton Paramedic Service [CAN]

13.40 15.A.9 *Education of Community Paramedics in Alberta, Canada*
Steven Amrhein, BTec, ACP: Manager, North Sector Operations, Community Paramedicine
Alberta Health Services [CAN]

14.20 15.B.1 *Cape Breton Integrated Health program*
Francine Butts, ACP: Supervisor
Emergency Health Services Nova Scotia [CAN]

Sandy Dewolf-Knight, BScN, RN: Clinical Resource Nurse, 811 TeleHealth
Emergency Health Services Nova Scotia [CAN]

- 14.40 15.B.2 *Cost-utility analysis of a Community Paramedicine Program for low-income seniors: the Community Paramedicine at Clinic Program (CP@clinic)*
Gina Agarwal, MBBS PHD: Professor, Family Physician
McMaster University [CAN]

15.00 Refreshment Break (Pope Ballroom)

- 15.20 15.C.1 *The Sense of Coherence, Health and Resilience Assessment (SCHARA) as part of a study of identified frequent users of the Canadian emergency services system: How well does the tool align to paramedic prescribed interventions to improve health resilience?*
Krista Cockrell, MHLthSc ACP: Research Officer
Western Sydney University [AUS]

- 15.40 15.C.2 *Paramedics and interprofessional practice: Balancing autonomy and collegiality*
Buck Reed, MIHM ACP: Associate Lecturer
Western Sydney University [AUS]

- 16.00 15.C.3 *Interprofessional tertiary education in the rural environment as a means to enhance multidisciplinary care in future practice: Breaking down silos in health education*
Krista Cockrell, MHLthSc ACP: Research Officer
Western Sydney University [AUS]

16.30 GROUP REFLECTION ON THE DAY



08.00 Arrival and Registration

- 09.00 15.B.3 *Paramedics and Palliative Emergencies*
Jennie Helmer, ACP Paramedic Specialist MEd: Project Coordinator
British Columbia Emergency Health Services [CAN]
- 09.20 15.B.4 *Innovating to Better Address the Current and Future Health Care Needs of Niagara*
Karen Lutz-Graul, BScCP ACP: Project Lead, System Transformation
Niagara Paramedic Service [CAN]
- 09.40 15.B.5 *Community Paramedicine: A Patient-centred approach to primary care in rural and remote communities*
Michelle Brittain: Project Manager, Strategy and Transformation
British Columbia Emergency Health Services [CAN]

10.00 Refreshment Break (Pope Ballroom)

- 10.30 15.B.6 *Paramedics Providing Palliative Care at Home in New Brunswick*
Susan Dugas, BSc PCP: Operations Manager
Ambulance New Brunswick [CAN]
- 10.50 15.B.7 *An Integrated Approach to Interstate Community Paramedicine: Case Studies*
TJ Popp, ACP CP: Team Leader/Community Paramedic
Sedgwick County Paramedic Service [USA]
- 11.10 15.B.8 *Community Hospice Collaborative stems from Community Paramedic engagement*
Malachi Winters, ACP CP-C FP-C: Program Manager
Sedgwick County OMD [USA]
- 11.50 15.C.4 *Using the Four Frames approach to clinical history taking in a community paramedicine education program.*
Dave Anderson, RN ACP: Paramedic Lecturer
Auckland University of Technology [NZL]

12.10 Lunch (Pope Ballroom)

- 12.40 15.C.5 *An evidenced based approach to constructing a post graduate remote and community area paramedicine practitioner*
Dave Anderson, RN ACP: Paramedic Lecturer
Auckland University of Technology [NZL]
- Mel McAulay, RN ACP: Program Leader
Auckland University of Technology [NZL]
- 12.50 15.C.6 *Community Paramedicine Remote Patient Monitoring: An Evaluation*
Dustin Carter, PCP CMMIII EMS Professional: Superintendent, Community Paramedicine

Middlesex-London Paramedic Service [CAN]

Rick Whittaker, Credentials: CEO, CPRPM Project Lead
Future Health Services [CAN]

- 13.20 15.C.7 *Update on Rural Health in the United States ***DON'T PUT EARLY SATURDAY****
Tommy Barnhart: Past President
National Rural Health Association [USA]

Brock Slabach, MPH: Vice President Member Services
National Rural Health Association [USA]

- 13.50 15.C.8 *Frailty Screening & Assessment: Role(s) for Community Paramedics?*
Judah Goldstein, PCP PhD: Research Coordinator
Emergency Health Services Nova Scotia [CAN]

- 14.10 15.A.11 *Transitional Community Paramedic Education Framework*
Al Benney, AS ACP: Community Paramedicine Program Chair
Hennepin Technical College [USA]

Tristan Coomer, ACP, CP-C: Chief Operating Officer
Mobile CE [USA]

14.40 Refreshment Break (Pope Ballroom)

- 15.10 15.C.9 *Reporting & Evaluating CP in Ontario, Canada*
Matthew Leyenaar, PhD(c): Director
Ontario Community Paramedicine Secretariat [CAN]

- 15.30 15.C.10 *Perspectives from the frontline of two North American community paramedicine programs: an observational, ethnographic study*
Peter O'Meara, PhD: Professor
Monash University [AUS]

16.10 Closing Remarks



Presentation Abstracts



Keynote:

Keynote: Off the road less travelled: Primary Care Community Paramedicine within Indigenous Remote and Isolated Canadian communities

J.D. Heffern

Indigenous Services Canada, First Nation Inuit Health Branch [CAN]

We know that indigenous healthcare has its challenges and firmly believe that Community Paramedics can play an integral role in filling in gaps within the current healthcare system servicing indigenous communities.

Indigenous Services Canada and the First Nation Inuit Health Branch are in process of integrating Paramedics into the Primary Health care working in traditional roles while embracing newer roles of Community Paramedicine in rural, remote, and isolated indigenous communities.



Saturday Lunch Poster

Hybrid High-Fidelity Simulation in Community Paramedic Training

Ryan Brown

Emergency Medical Care Inc [CAN]

The sub-specialty of Community Paramedicine (CP) is an ever-expanding discipline, meeting diverse needs in the health care systems and communities which these programs serve. While literature exists as it pertains to program design and Community Paramedic competencies, a paucity of literature is available on the training of Community Paramedics. Recently, a Community-Based Paramedicine program was launched in a populous region of a provincial Emergency Medical Services system. The focus of this program is supportive discharge from the emergency department and medical/surgical floors of a community hospital as well as a regional center. Training was a mix of classroom-based lectures, skills stations, self-directed learning and simulation. Some literature reporting on CP education is available, however, there is no mention of simulation as an educational modality. A total of seven hybrid, high-fidelity simulations utilizing standardized patients and high-fidelity simulators were delivered to learners focusing on chronic disease assessment/management, frailty scoring, cognitive testing, medication compliance, socioeconomic status and care planning. Skills pertaining to the patient population were integrated as were clinical consults and documentation. Debriefing of the simulations was conducted using a mix of Plus/Delta and Advocacy and Inquiry methodology. Feedback from the learners was overwhelmingly positive. The Community Paramedics felt the simulations allowed them adequate practice of slow medicine and a more in-depth assessment of both physical health as well as psychosocial issues.



15.A.1 *Community Paramedicine in Developing Countries*

Duncan McConnell

Griffith University [AUS]

Prehospital care in developing countries is often viewed upon as limited or scarce at best. But what if we could take lessons learned from years of prehospital care development in developed countries and work with the Ministries of Health within developing countries to establish a sustainable and internationally recognised prehospital delivery model based on the needs of their health care system? Duncan is currently engaged in this development with the Ministry of Health in Mongolia, which is supported by the World Health Organisation (WHO) and with the Ministry of Health the Republic of the Maldives. Two very different countries, but both with very similar challenges and priorities. The use of community paramedicine within Maldives new National Ambulance Service (NAS), provides a holistic use of the response matrix, that will enable them to bridge the gap of acute and non-acute services, as well as relieve current strains on the already struggling Atoll Health Services. The use of community paramedicine within Mongolia presents a very different challenge to that of the Maldives. The ambulance response here is physician run, however this is becoming unsustainable due to training and higher paying opportunities within the medical profession. Although these developments are very new in their application and implementation, applying the needs required for each specific developing country's health system, has already started to provide improvements in patient care delivery and outcomes across both countries.



15.A.2 *Community Paramedicine: A Systematic Review of Program Descriptions and Training*

Gina Agarwal

McMaster University [CAN]

Community Paramedicine (CP) is an emerging health services delivery system utilizing paramedics. It has potential to reduce inappropriate health care use and increase appropriate health care visits, such as visits to primary care physicians. This study will identify the different types of CP programs and the training required or described for each using a robust Systematic review methodology.



15.A.3 The No One Brought In Patient: Strategies for limiting risk and providing patient centered care.

*Jeremy Measham
Island Paramedic Service [CAN]*

All paramedic services are presented with a high-risk call type that is increasingly becoming more common; clients that phone 911, receive ambulance services but then refuse transport to hospital. No One Brought In (NOBI) patients pose a particular challenge to both the patient and the EMS agency that serves them. In Prince Edward Island, Island EMS (IEMS) conducts approximately 3000 NOBI episodes of care per year and each NOBI has both risk management and quality management implications. In May 2018, IEMS launched a program to cycle back to these clients within 8-35 hours after the initial 911 call. Clients are re-assessed for continued or worsening illness and offered transport to hospital if needed or desired. NOBI clients were also offered a scheduled visit by paramedics if they did not already have healthcare at home services in place. The IEMS NOBI Follow UP program has conducted 5000 episodes of care to date and has fielded a patient survey to gauge client attitudes about the program and its effect on their general health. This presentation will outline the IEMS NOBI Follow Up program and explore its implications for patient health, satisfaction and the programs ability to prevent transport and admission to hospital for the clients it serves.



15.A.4 Sick Visits: Patient Safety the Key for Success

*Joseph Hughes
EasCare Paramedic Service [USA]*

EasCare's Mobile Integrated Health pilot program is in its 5th year. This program was started by EasCare Ambulance located in Boston Massachusetts with its partner Commonwealth Care Alliance (CCA) an ACO, to deliver an ED avoidance option to CCA members. CCA members in the greater Boston area suffer from complex medical conditions like Cerebral Palsy, spinal cord injuries, heart failure, diabetes and mental health issues. After normal clinic hours, members have no option but to seek the ED for their complaints if they feel like they cannot wait for the next day. EasCare has seen over 3,000 patients using one Community Paramedic in a dedicated vehicle for 8 hours each night. The patient population is seen for respiratory, urinary, wounds, and exacerbation of existing conditions. Being able to identify when a patient's acute condition makes them not suitable for a home visit is the key to safety. To ensure safety we looked retrospectively at our data and identified the patient's heart rate to be a key indicator of treatment failure. We also implemented stratifying other objective information including vital signs using the National Early Warning Score (NEWS). These two pieces of valuable information allow a rapid assessment of acuteness and predictability in patient's outcomes. This presentation will look at both of these components and examine their usefulness as it relates to patient outcomes. We have been successful in preventing greater than 80% of patients seen from ED visits and hospitalizations.



15.A.5 International trends on the developing role of the Community Paramedic Practitioner

*Mary Ahlers
Paramedic Health Solutions [USA]*

*Peter O'Meara
Global Paramedic Higher Education Council [USA]*



In developed countries around the world, paramedic roles and scopes are changing to meet the needs of population health today. The paramedic practitioner, now utilized in a number of countries, confirms the career pathway and position integration within health systems. Australia, New Zealand and the United Kingdom have moved toward the mandatory higher education models required for entry to paramedicine practice. Industry and community health demands of today and the corresponding necessary changes in paramedicine practice have offered the opportunity for specialty paramedicine practice, broadening required education. The Paramedic role and scope of practice is changing in response to both demographic and world health reform. Educational programs and accreditation process must focus on the future role of paramedics.



15.A.6 Assessment practices in community paramedicine

*Matthew Leyenaar
McMaster University [CAN]*

The Common Assessments in Repeated Paramedic Encounters (CARPE) Study was a prospective cohort study intended to evaluate a standardized assessment instrument in community paramedicine home visit programs by multiple Canadian paramedic services. As part of the study, researchers completed a search of published literature, investigated current assessment practices, consulted an international panel of experts about appropriate assessment content, and developed an implementation strategy to put findings into practice. This presentation will focus on the latter, how findings were consolidated to assist frontline community paramedics and their supervisors in using best practices in patient assessment. The presentation will address inconsistency in case-finding for "at-risk" older adults and the challenges associated with evaluating the effectiveness of interventions in community paramedicine without a clearly defined baseline assessment. A description of interoperability standards and how assessment data can seamlessly be used for secondary purposes will showcase the utility of third-generation assessment solutions. Identifying changes in patient condition through follow-up assessments and linkages with other health records will be illustrated. Assessment is an underlying assumption about the provision of patient care. Best practices in patient assessment direct appropriate care planning and can serve to inform quality improvement exercises, ensure patient safety, be used in program evaluation, assist in determining appropriate resource allocation, and provide structure and accountability to program development and implementation.



15.A.7 The Complex Care Hub & Community Paramedicine: A hospital at home model for patients with complex medical conditions

Michele Smith

Alberta Health Services [CAN]

Alberta is facing a health crisis with the increase in seniors over age 65 from 11% at present to a projected 20% in 2031. A recent survey of Homecare Case Managers in Calgary estimated 10% of homebound clients are only able to access healthcare by calling 911, and 16% regularly use Emergency Medical Services for symptom management. They estimated 65.3% of their clients would prefer to avoid hospitalization and receive care at home, including end-of-life care. Hospital care is not always safe. Hospital acquired infections, complications and adverse events are common, as outlined by the Institute of Medicine and other studies. For seniors, hospitals can be even more problematic. Issues such as delirium and falls are not only common, they are also associated with longer lengths of hospital stay, costs, morbidity, and increased mortality. With this in mind, there has been an interest in an alternate model of care that would utilize an integrated healthcare delivery system in Calgary, Alberta for patients with complex medical conditions. The Complex Care Hub program is based on the hospital at home concept. It combines General Internal Medicine expertise, Transition Services case management and the skills of Community Paramedics to deliver hospital level care to patients in their residence. Evaluation indicates that the program has improved the quality of care for vulnerable populations resulting in reduced demand on inpatient services, lower costs, fewer procedures, less family stress, higher patient satisfaction, and better functional outcomes than traditional acute hospital care.



15.A.8 Utilizing Improvement Science Methodology and Organizational Re-Design to Improve Community Paramedicine Performance?

Joe Pedulla

Hamilton Paramedic Service [CAN]

HPS has several community paramedic initiatives - home visits, health clinics, remote patient monitoring, palliative care support, and the social navigator program (police & paramedic). Faced with growing constraints on resources, a move towards integrated health teams, and a growing population of repeat users HPS undertook a complete redesign of our CP programs. Starting with stratifying callers into populations we moved to process and value stream mapping to streamline processes. We strengthened or established new partnerships with providers that have specific expertise to deal with our identified populations and enhanced our mobile technology capacity to enable seamless communication between our partners. At baseline, repeat 911 calls were reduced by 0.333 calls/patient (N= 33 patients, 98% CI -5.1 to 4.8, p = 0.566). After improvement activities repeat calls were reduced by 2.5 calls/ patient (N=67, 98% C.I. 5.7 to 2.7, p<0.01). In addition, the increased capacity allowed the CP program to process twice as many patients.



15.A.9 *Education of Community Paramedics in Alberta, Canada*

Steven Amrhein

Alberta Health Services [CAN]

Significant work is being done to ensure that new community paramedics are adequately trained in Alberta. There has been three distinct but collaborative efforts to support the development of community paramedics in Alberta. A qualitative study was conducted interviewing experts to gain their perspective of education of community paramedics. This study identified areas of education for community paramedics. This information is used to inform the education that Alberta Health Services Emergency Medical Services provides to community paramedics as well as its ongoing education program. AHS provides three weeks in class training followed by a minimum of one-month mentorship. After each recruit class is concluded, the new community paramedics are surveyed. The feedback is used to determine gaps in the education program from the staff perspective. An ongoing education program for the community paramedics is provided with monthly education. The continuing education is selected based upon staff feedback, leadership direction and upcoming program development.

University: Mount Royal University's CP Extension Certificate is a new program developed in collaboration with Alberta Health Services for experienced Advanced Care Paramedics (ACP) to apply their knowledge and skills beyond the traditional emergency response role. This program is the first of its kind, focusing on primary health care strategies within inter-professional environments for urgent and specialized medical treatment. ACPs acquire in-depth theoretical knowledge and extensive practice experience in a variety of health care settings in the community that typically require an acute care setting.



15.A.10 *Transitional Community Paramedic Education Framework*

Al Benney

Hennepin Technical College [USA]

Tristan Coomer

Mobile CE [USA]



Emerging specialty roles and scopes of paramedicine practice are being driven by demographic change, technology innovation and evidence-based research. More visible are the links between emergency medicine, critical care, public and community health, necessitating the move from the paramedic technician model toward a practitioner clinician model. Migration has challenges as transition to new framework brings change. Offering a broader knowledge base, autonomous problem-solving and decision making will allow transition into this roll of greater flexibility.



15.B.1 *Cape Breton Integrated Health program*

Francine Butts

Emergency Health Services Nova Scotia [CAN]

Sandy Dewolf-Knight

Emergency Health Services Nova Scotia [CAN]



As part of the Connected Care for Cape Breton transformation, Emergency Health Services (EHS) launched a community-based Integrated Health Program (IHP) to serve the Cape Breton Regional Municipality (CBRM). This program sees patients referred to either a clinical support nurse virtual visit, a Community Paramedic (CP) home visit or a combination of both. Referrals are generated by health care providers within the hospitals with the goal of delivering supportive care to the patients that are identified for this type of service providing timely access to unique clinical services within the CBRM community.



15.B.2 *Cost-utility analysis of a Community Paramedicine Program for low-income seniors: the Community Paramedicine at Clinic Program (CP@clinic)*

Gina Agarwal, MBBS PHD: Professor, Family Physician

McMaster University [CAN]

Community Paramedicine at Clinic (CP@clinic) is an inexpensive community-based primary care strategy, targeting subsidized seniors, housing, utilizing trained community paramedics (CPs). The program has been shown to significantly decrease expensive emergency service (ES) use but overall cost-utility is unknown. This paper evaluates the cost-utility of CP@clinic compared to usual care in seniors residing in subsidized housing.



15.B.3 *Paramedics and Palliative Emergencies*

Jennie Helmer

British Columbia Emergency Health Services [CAN]

For individuals with life-limiting conditions, who would like to live and die at their location of choice, BC Emergency Health Services (BCEHS) is implementing a new approach to providing palliative and end-of-life care. This standard of practice aligns paramedics with the patient's goals and enhances existing communication pathways with the patient's care team. This shift is integral to the success of the BCEHS Community Paramedic (CP) program. Paramedics are often called upon in times of crisis to provide rapid response to medical emergencies, however traditional practices of assess, treat and transport to hospital emergency rooms are not appropriate for all. Most palliative patients prefer to be treated and remain in the home. BCEHS paramedics lack palliative and end-of-life education and training, and until recently, have been unable to treat patients in their location of choice. Additionally, access to and availability of, comprehensive palliative care teams can be difficult, particularly in remote and rural areas of the province. Recognizing that this project is still in its infancy, BCEHS has begun implementing change that could offer immediate support to 4,000 paramedics across 945,000 square kilometers of BC, who in 2016, transported 9,000 palliative patients to hospital. The BCEHS CliniCall desk, a paramedic-led secondary triage service with provincial clinical oversight, serves as an initial intervention for paramedics in the field who are caring for palliative patients. CliniCall provides paramedics with support and tools for palliative patients while also strengthening our reach and increasing capacity in BC's remote and rural communities.



15.B.4 *Innovating to Better Address the Current and Future Health Care Needs of Niagara*

Karen Lutz-Graul

Niagara Paramedic Service [CAN]

A brief overview of Niagara EMS will be shared including demographic, geographic and statistical information demonstrating the need for EMS system transformation. Current system sustainability is not possible or affordable within the traditional model of care and despite the success of the Community Paramedic program through scheduled visits to high users of the 911 system, call volumes continue to escalate. The presentation will move on to relate the current state of scheduled Community Paramedicine (CP) in Niagara and challenge the audience to begin to think of Mobile Integrated Health (MIH) Care as an evolution of Community Paramedicine that is more integrated with system providers and can be applied to real time 911 responses in the form of unscheduled Community Paramedic visits but in a multidisciplinary team designed for specific call types. (MIH) Teams are a key component of overall system transformation. The presentation will relate the formation of the committees to help guide and advise the work of MIH in addition to a description of each team's roles and responsibilities. An overview of Key Performance Indicators with preliminary results will be shared in addition to the measures used to ensure quality assurance and continuing quality improvement. The presentation will conclude with a brief overview of the new clinical response plan and the Emergency Communication Nurse System as secondary telephone triage and demonstrate the way Mobile Integrated Health Care is integrated into both.



15.B.5 *Community Paramedicine: A Patient-centred approach to primary care in rural and remote communities*

Michelle Brittain

British Columbia Emergency Health Services [CAN]

The introduction of BC Emergency Health Services (BCEHS) Community Paramedicine (CP) program marks a significant transformation for the organization and paramedic practice. CP is an innovative model that delivers primary healthcare, prevention, and health promotion - directly where people live. The Community Paramedic role bridges healthcare gaps in rural and remote communities while stabilizing paramedic staffing. Community Paramedics provide scheduled home visits, support existing health clinics, and deliver health promotion services to fill knowledge and skill gaps. Through scheduled in-home wellness checks, Community Paramedics have the unique opportunity to see the whole patient; identifying needs and reporting back to the healthcare team. Further, they advocate for the patient, recommending and/or connecting them to appropriate community resources such as social workers, dietitians, or senior groups. Respondents to patient experience surveys indicate that the presence of CP in their community has removed barriers to accessing primary care. The program has enabled patients to better understand their health and wellness, feel more secure at home, reduce their anxiety and isolation, and help improve their overall wellbeing. Patient statements are supported through the results of the patient reported outcome measurement tool (EQ-5D-5L), which indicates improvement over time. Survey results show that after 6 weeks of care, 84% (or an increase of 5%) had either no or only slight difficulties with their ability to provide self-care, indicating an improvement over time. Overall, the EQ-5D-5L results indicate that 52% of patients had maintained or improved their health status.



15.B.6 Paramedics Providing Palliative Care at Home in New Brunswick

Susan Dugas

Ambulance New Brunswick [CAN]

This presentation will provide an in-depth look at an innovative model of community-based palliative care provision in New Brunswick that will see Ambulance New Brunswick (ANB) paramedics and Extra-Mural Program (EMP) healthcare professionals working collaboratively to provide palliative care to New Brunswick patients in their own homes. The Extra-Mural Program, known as the “hospital without walls” has recently transitioned to a new public organization along with Ambulance New Brunswick, creating an opportunity to develop inter-disciplinary synergy among a diverse group of health care providers. Topics covered in the presentation include the development, implementation and evaluation of this ground-breaking initiative aimed at improving patient and family experience and increasing system effectiveness, efficiency and thus the sustainability of the healthcare system for future generations.



15.B.7 An Integrated Approach to Interstate Community Paramedicine: Case Studies

TJ Popp

Sedgwick County Paramedic Service [USA]

Community Paramedicine programs are emerging all across the Country with each program being unique to its area it serves. As providers we care for these individuals in our area making sure that they are connected with the services that they are in need of. What happens when these individuals move away from our area? Who will be there to connect them with resources in their new community? What if the individual is unable to receive any benefits in the area that they are in? Is there a different area that has better services to offer the benefits that they need? At Sedgwick County EMS, our Community Paramedic program we have ran into both of these issues and finding solutions was challenging. We were able to collaborate with other Community Paramedic programs and even International agencies to keep our clients connected with services that they needed. We have 2 case studies that discuss the challenges we faced in finding services for these individuals that left our community and the solutions we were able to come up with.

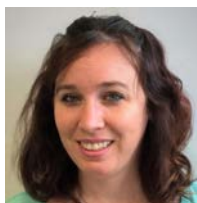


15.B.8 Community Hospice Collaborative stems from Community Paramedic engagement

Malachi Winters

Sedgwick County OMD [USA]

Paramedics have frequent interactions with patients on hospice or with advanced directive plans that are not in line with usual paramedic emergent protocols. Hospice agencies help manage patient and family issues surrounding end of life, but the hospice community can be competitive and fragmented, with significant barriers to shared information and protocols. Paramedic contacts with patients receiving in home hospice care often results in emergency department visits, admissions, and unfortunately, revocation of hospice coverage in some cases. What started as a few hospice agencies attempting to address this issue grew into an opportunity to create a shared community coalition. The Sedgwick County Hospice Coalition provides training on hospice and end of life issues to the public, other healthcare professionals, and EMS personnel. An EMS specific End of Life protocol enables paramedics to carry out hospice orders and bridge care back to the hospice provider that is caring for them.



15.C.1 The Sense of Coherence, Health and Resilience Assessment (SCHARA) as part of a study of identified frequent users of the Canadian emergency services system: How well does the tool align to paramedic prescribed interventions to improve health resilience?

Krista Cockrell

Western Sydney University [AUS]

The Sense of Coherence, Health and Resilience Assessment (SCHARA) is a new tool emerging from literature about salutogenesis. It is designed to help guide healthcare planning and develop appropriate referral pathways, particularly amongst disadvantaged populations with poor access to healthcare. Community Paramedics have been previously identified as uniquely positioned to identify barriers and enablers to accessing care pathways or health resources. By assessing sense of coherence and resilience, paramedics may determine patients' capacity to cope with and manage health events. Paramedics may likewise implement strategies to improve resilience for current and future health events. The SCHARA was incorporated into the Community Paramedicine at Home Program (CP@Home) as a pragmatic randomized controlled trial, by the McMaster Community Paramedicine Research Team from early 2019. CP@home participation is offered to Identified frequent users of emergency medical systems. Participants are connected to a community paramedic providing home visits, conducting an array of risk assessments. Findings are used to implement referrals and other interventions through community resources and link results back to the participant's general practitioner. To date 58 unique participants have undergone assessments, the mean age was 72.4 (sd=15.7), 57.9% were females. Results will be presented describing the scoring of each sub-component of the SCHARA and their alignment with potential recommended community resources. This paper examines the potential of the SCHARA in the determination of predicted referral pathways, since its benefit is that it integrates a range of social and personal elements of health not traditionally found in more clinically-focused referral algorithms.



15.C.2 Paramedics and interprofessional practice: Balancing autonomy and collegiality

Buck Reed

Western Sydney University [AUS]

Globally paramedics are experiencing a rapid journey of professionalisation which results in increased autonomy, education and diversity of practice roles. Community paramedicine is an early example of situated practice and diversity of roles compared to traditional concepts of paramedic practice. As paramedicine expands, this creates an impetus for both increased autonomy and increased collaboration.

While autonomy of practice may seem the goal for paramedicine, with such autonomy comes a mandate to participate in communities of practice with other health professionals. Community paramedicine represents a form of paramedic practice which engages with other practitioners in shared care, non-traditional practice roles and permeable role boundaries. Such practice may be counter-intuitive to practitioners who have worked within rigid role boundaries and rigid constructs of professional identity. This may result in challenges and resistance when adopting new roles, boundaries, and ultimately identities.

Creating structures for interprofessional and collaborative practice need to address social and professional identity issues as part of their design to provide more effective models of practice.



15.C.3 Interprofessional tertiary education in the rural environment as a means to enhance multidisciplinary care in future practice: Breaking down silos in health education

Krista Cockrell

Western Sydney University [AUS]

Western Sydney University implemented an IPE program to promote a collaborative approach to improving care through interprofessional cooperation. Each IPE event consists of a variety of complex simulated health events in a range of environments with patient(s) and bystanders being treated collaboratively by Paramedicine, Nursing and Medical students. Participants are asked to provide feedback of the IPE event highlighting key 'take home' messages learnt, how their perceptions of other professionals and their roles changed as a result of participating and how the experience may influence their delivery of care in future practice.

Two IPE events have been held with 54 students participating. 34 students provided feedback as part evaluating the IPE program. Findings identified increased understanding of the contributions of other disciplines in enhancing patient care, team approaches and cross-discipline communication. indicating a need to engage in collaborate care in future practice.



15.C.4 Using the Four Frames approach to clinical history taking in a community paramedicine education program.

*Dave Anderson, RN ACP: Paramedic Lecturer
Auckland University of Technology [NZL]*

The four frames approach to clinical history taking – developed at the Warwick school of medicine in the United Kingdom – is used to shift our community paramedicine students from an emergency ambulance service paradigm into a community/clinic arena. This model includes the four frames of: presenting complaint; past medical history, allergies, drugs; social and family history; and, ideas, concerns and expectations of the patient.

Anecdotal evidence suggests this model greatly assists in both moving the community paramedic out of the EMS paradigm and improving students clinical history taking.



15.C.5 An evidenced based approach to constructing a post graduate remote and community area paramedicine practitioner

*Dave Anderson, RN ACP: Paramedic Lecturer
Auckland University of Technology [NZL]*

*Mel McAulay, RN ACP: Program Leader
Auckland University of Technology [NZL]*

We examined data on the top low acuity presentations to our national ambulance service.

This produced a list of our national top 30 see and treat presentations. In collaboration with our deputy medical director and urgent community care practitioners, we synthesised this information into a one-year course consisting of 3 x 3 to 4 day intensive block courses covering the assessment and treatment of the majority of these presentations.

Integrated into these block courses are also clinical history taking using the four frames approach and safety netting. We also include teaching and assessment of important clinical skills including NG insertion, suturing, otoscopy, dental blocks and vision testing.



15.C.6 Community Paramedicine Remote Patient Monitoring: An Evaluation

Dustin Carter

Middlesex-London Paramedic Service [CAN]

Rick Whittaker

Future Health Services [CAN]



The CPRPM program is an initiative of Community Paramedics across Ontario to keep patients with chronic illness, such as congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and diabetes mellitus (DM) safe at home and out of the hospital. The goal of CPRPM is to promote self-management and understanding of the disease process to improve overall health.

Identified candidates for CPRPM by paramedics or other health care professionals receive a combination of Bluetooth enabled devices based on specific health condition such as a weight scale, blood pressure monitor, heart rate monitor, glucometer, and a Pod that connects to Community Paramedics in real time. Using these devices daily allows for monitoring, trending, and reporting of biometric data. If the recording goes outside of the threshold set, an alert is generated prompting the Community Paramedic to review the patients' current health status.

Recognizing that there is no one size fits all solution when it comes to digital health monitoring, CPRPM complements other digital health monitoring programs by providing a different model of care, and the ability to support diverse patient cohorts.



15.C.7 Update on Rural Health in the United States

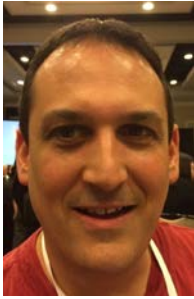
Tommy Barnhart

National Rural Health Association [USA]

Brock Slabach

National Rural Health Association [USA]

This presentation will provide attendees with: a brief update on the status of rural health in the United States; a glimpse of the potential future of rural health in the US; the possible role of EMS and Community Paramedicine in rural America; and, the outlook for the NRHA's involvement in international rural health.



15.C.8 *Frailty Screening & Assessment: Role(s) for Community Paramedics?*
Judah Goldstein
Emergency Health Services Nova Scotia [CAN]

This presentation will review the evidence on frailty screening, assessment, and outcomes in the context of Community Paramedicine. Current frailty screening and assessment measures will be discussed focusing on feasibility, clinical properties, and how they may be operationalized within Community Paramedic programs. Community paramedics should be aware of frailty given emerging “treat in place” and “treat and refer” pathways. Paramedic practice that includes knowledge of frailty may improve diagnosis and prognostication thereby improving patient outcomes. This knowledge can be used to inform goals of care discussion and care planning. Paramedics can use this knowledge to counsel patients and family about frailty and discuss mitigation strategies, highlighting preventative services and ultimately slowing its progression. Through a frailty lens, community paramedics can focus on patient mobility, quality of life, function while preventing further independence loss. The role(s) of Community Paramedics in identifying and managing frailty require further discussion and exploration.



15.C.9 *Reporting & Evaluating CP in Ontario, Canada*
Matthew Leyenaar
Ontario Community Paramedicine Secretariat [CAN]

The Ontario Community Paramedicine Secretariat (OCPS) was created to support the development of standards of program delivery and the monitoring, evaluation, and reporting efforts for CP programs to enhance accountability and inform decision-making across Ontario. The OCPS works with the existing Local Health Integration Networks (LHINs) and the Ontario Association of Paramedic Chiefs (OAPC) to insure broad representation in this endeavour. The goal of the OCPS is to support the strengthening of collaborations and partnerships, particularly with primary care, that can prevent hospitalizations and improve the patient experiences as they transition from acute care settings back to the community. The OCPS has continued building a CP Community of Practice to enable the creation and dissemination of standardized care processes as well as performance reporting and measurement activities. This presentation will provide information about how the OCPS will act as the principal advisor in Ontario for the implementation, evaluation and spread of CP across the province; including guidance on the standardization of processes, measurement and reporting for CP programs and information about building capacity and opportunities for knowledge transfer and exchange (KTE) across different CP programs to promote quality improvement.



15.C.10 Perspectives from the frontline of two North American community paramedicine programs: an observational, ethnographic study

Peter O'Meara

Monash University [AUS]

Community paramedicine can expand the reach of primary care and public health service provision in underserved communities through proactive engagement of paramedics in preventative care and chronic disease management. This study addressed the motivations, job satisfaction and challenges from the perspectives of community paramedics and their managers pioneering two independent programs in rural North America. An observational ethnographic approach was used to acquire qualitative data from participants, through informal discussions, semi-structured interviews, focus groups and direct observation of practice during two field trips. Thematic analysis was used to identify common themes. The findings highlighted that the innovative nature of the CP role can leave practitioners feeling misunderstood and unsupported by their peers. A major motivator is the growing use of ambulances for non-emergency calls and the need to develop strategies in response. Paramedics were motivated by a genuine desire to make a difference and attracted to the innovative nature of a role delivering preventative care options for patients. Transitional challenges included lack of self-regulation, navigating untraditional roles and managing role boundary tensions between disciplines. Experienced and highly motivated paramedics with excellent communication and interpersonal skills should be considered for CP roles. Practitioners who are proactive about community paramedicine and self-nominate for positions transition more easily into the role: they tend to see the bigger picture, have broader insight into public health issues and the benefits of integrative health care. Paramedic services and policymakers need to incentivize career pathways in community paramedicine.





2019 PROGRAMME

16th MEETING

Delta Hotel Prince Edward



Paramedic Chiefs of Canada
Leadership Summit 2019
June 12-14, 2019 Charlottetown PEI