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Making sense of the community paramedicine model: a conceptual guide to innovators

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Introduction

- Introduction
- Objectives and research methods
- Findings from Ontario, Canada
- RESPIGHT community paramedicine model
- Distinguishing features
- Issues for discussion
- Questions

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Objectives

1. Present a theoretical model for community paramedicine
2. Explain how community engagement and situated practice distinguish community paramedicine
3. Demonstrate that successful community paramedicine programs are integrated with local health systems
4. Argue that paramedic leadership is a key characteristic of the community paramedicine model

Study Setting

- County of Renfrew, Ontario, Canada
  - Sits along the boundary between the provinces of Ontario and Quebec and is largely defined by the Ottawa River.
  - 770,000 hectares, with a population of 100,000+
  - Five small to medium towns, along with many other small villages and settlements.
  - Socio-economic profile is patchy, with enclaves of high-income residents hiding considerable economic disadvantage throughout much of the County.

Elements of the Renfrew Program

- The Renfrew Community Paramedic program consists of four key elements:
  - Ageing at Home Program
  - Paramedic Wellness Clinics
  - Ad hoc Home Visiting Program
  - Paramedic Response Unit Program

Research Process

- Observational, ethnographic study, drawing on boundary theory
  - Interviewed 27 people and conducted three focus groups over two summers
  - Shadowed community paramedics and observed practice
  - Participants
    - Community members, including patients, family and carers
    - Paramedics and EMS managers from Renfrew County and Greater Ottawa area
    - Paramedic educators in Ontario
    - Physicians, nurse practitioners and other health care providers
    - Expert informants, such as health economists and health service managers
- An innovative component of this research was the use of boundary theory to identify and analyse how ambulance services and community paramedics create and maintain new role boundaries and identities.

A Community Paramedicine Model

- A CP model emerged from a synthesis of the Australian domains of paramedic practice and data from Ontario.
- The resulting model follows the pneumonic of RESPIGHT, combining the enabling factors that emerged from this work and modification of the previously presented *RESP model*

Emerging CP Model

- Two components
  1. Role and Place elements
     - Built on previous Australian study (RESP)
     - Modified slightly
  2. Enabling factors
     - Emerged from Canadian study
     - Need to be validated

Enabling Factors

- Integration with health system
- Patient/client pathways
- Governance
- Appropriate paramedic education

Integration with Health System

- Effective and deep integration of paramedic services within the local health system is a challenge in a Provincial scale health system

If we are going to talk about patient centered care then it is a team event and so we need to bring everybody in … from the Physician all the way to the Paramedic and everybody in-between. We all have to play together to make sure that this patient is dealt with in the most cost effective way, in the most appropriate way to get them in the hospital healthy enough to be discharged back home and make sure that that home support is there for them. Where does that home support come from, I think it comes from the Paramedic. (Participant 10)

Separation from Health

- Integration when paramedic services are outside the Ministry of Health are very challenging

Around twenty years ago there was downloading of Paramedic Services to the communities so there was a complete divorce between Healthcare the rest of Healthcare and Paramedics. So Paramedics belonged to a city, a Region … the rest of Healthcare belongs to the Ministry of Health …

… the major barriers as you can see are not the interest or prejudice or whatever, it's more the structure, the infrastructure that we are working with right now. (Focus Group B Participant)

Paramedic as Navigators

… they have to facilitate that link because often what happens is many of the patients even if they are aware of the Service, the actual physical act of making the connection is too complicated for them …

So people just resist doing that or just give up in frustration and so sometimes it actually takes someone else. i.e. the Paramedic actually picking up the phone in the patients house and making that initial link so that is done because that can be a tremendous barrier for a lot of people, they are intimidated by the System.

It's an obvious need in Canada I don't know about the Australia but the System Navigation idea where you know even people in the System can't navigate it. … so you can imagine how intimidating it can be for someone who is rural, who is isolated, who doesn't have a familiarity with the System. I think that facilitation for those linkages are really important. (Participant 7)

Governance

- The existing medical oversight model is focused on emergency medicine and seems to be unsuited for what is broadly speaking a primary healthcare model of service delivery that requires different knowledge and skills across a much broader domain of practice.
- Separation of governance, management and clinical delivery levels rather than being tied up into one role?

Higher Education

- The need for a broader education was identified, particularly in those areas related to health promotion and prevention.

I think your other barrier there to is also the education of the Paramedics. I don't know a lot about your [paramedic] *education, but if you are looking at health promotion and preventative medicine I think your focus for your education will also have to change and again that is also another huge barrier.* (Focus Group B Participant)

… there isn't any education on health determinants, social determinants, the actual structure of how the system works … what kind of skills do we need to be able to possess or what skills do we need or what knowledge do we need to be able to successfully integrate, collaborate with our partners. (Participant 3)

Challenges of Educational Reform

- Curricula of the current paramedic programs are already at full capacity with acute care topics and skills, they are "busting at the seams already" (Participant 10).
- Difficulty of convincing predominately young students that the role of future paramedics is more about community primary care practice than emergency calls.

A lot of people who come into my Program are looking for the lights and sirens and trauma and excitement, and when we start talking about something with a slower pace in Community Paramedicine, then we take them back. … a lot of students sort of walk in the door going, I want to drive fast, lights and sirens and car crashes and all that good stuff, and when you say, well in actual fact that's about five percent of your career, 95 percent of your career looks much more like Community Paramedicine … (Participant 10)

Patient/client pathways

- The idea is to keep patients and client at home and avoid inappropriate Emergency Department attendances.

  to make this sort of system work with Paramedics … there needs to be the pathways for patients and the information available to help them and then the Paramedic needs to go and assess the situation and then advise the patient, communicate and then make a connection, make the referrals to other Services? (Participant 7)

- These pathways need to be wider that traditional medical pathways and include social and cultural activities for isolated clients or patients.

Enhanced Community Paramedic Model

- RESPIGHT
  - Response to emergencies
  - Engagement with the community
  - Situated practice
  - Primary health care

  Role & Place

  - Integration with health system
  - Governance
  - Higher Education
  - Treatment and transport pathways

  Enablers

Figure 1: Community Paramedic Model

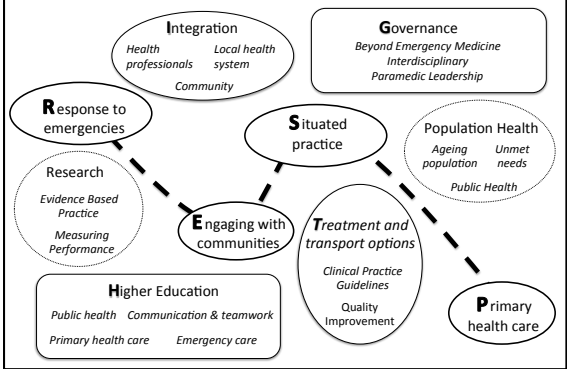

Table 1: RESPIGHT Community Paramedicine Model

Domains of Practice / Enabling Factors	Descriptions	Potential Performance Measures
Response to emergencies	Timely emergency responses remain the core business of paramedic services.	Continue to monitor conventional paramedic service measures. eg. cardiac arrest outcomes.
Engaging with communities	Encouraging and embracing co-production with patient groups and/or communities.	Audit and analysis of community input into policy and practice.
Situated practice	Key component of the model, giving it flexibility to respond to local needs and take account of existing resources.	Determine population access to appropriate health services.
Primary health care	Expansion of practice from acute incidents to interprofessional care.	Monitor responses to unmet need.
Integration into the health system	Both an enabler and a key benefit of the community paramedic model.	Network analysis of communication and collaboration with health partners.
Governance	Paramedic leadership and effective interprofessional clinical governance systems.	Survey stakeholders and undertake clinical risk audits. Measure adverse events.
Higher education	Access to degree-level education for entry-level practitioners, consistent with other health professionals.	Map paramedicine program curricula against other health professions and community health needs.
Treatment and transport options	Development of clear and transparent clinical and social pathways for patients in collaboration with other health professionals, families and social services.	Cost-utility analysis comparing community paramedicine programs against inappropriate emergency department presentations and hospital admissions.

Distinguishing Features

1. Based on real world or 'lived' experience:
   - Theory has been built, not imposed
2. Different from other related models of service:
   - adaptability to different settings
   - use of engagement strategies to integrate with local communities and health systems
   - Potential role for paramedic leadership in the development of effective governance structures and processes
3. Strong integration and collaboration with the health system

Paramedic services that implement CP programs are able to be a broker for 'at risk' population groups who may only engage with the health system during times of crisis.

Few other health professionals regularly make unscheduled contact with patients in their homes, workplaces or public places, placing community paramedics in an ideal position to observe and integrate the individual and social determinants of health into their models of practice.

This ability to engage communities through a bottom-up, community driven approach is the main strength of the CP model.

Issues for Consideration

1. Governance
   - The public health philosophy of CP programs may play themselves out in the types of governance systems that could emerge, with the model more likely to embrace an interprofessional approach to clinical governance if given the opportunity.
   - The CP model appears to have the potential for paramedics to take more responsibility for their own professional practice issues and to develop higher levels of professional autonomy.
   - Such as system could see a separation between governance, management and clinical delivery levels, rather than being part of one role in the form of a medical director.
   - This move toward a greater degree of paramedicine leadership is dependent and intertwined with higher levels of education and appropriate legislative frameworks being established.
2. Professional Boundaries
   - This professional transition may see the manifestation of challenges to established professional boundaries as the position of paramedics as 'sub-professional' and subservient health providers changes to paramedics taking leading roles in partnership with other health professionals.
3. Measuring Success
   - Other questions arise about how to measure determine the impact of CP programs on the health and welfare of specific population groups and communities.

Conclusions

- The aspiration is that community paramedics will become part of a health system that ensures:
  - People are as healthy as they can be
  - People are managing their own health better
  - People have the best health care service outcomes possible
  - Care is clinically and cost effective and delivered in the most clinically appropriate and cost effective settings
  - The health system is highly productive and sustainable (DoH, 2011)

Questions

Thank you

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