2024 PROGRAMME

20th ROUNDTABLE FORUM

June 7-8, 2024
Delta Hotels Quebec
Quebec City, Quebec, Canada, G1R 5A8

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Back to the Future: 20th Anniversary IRCP Returns to Canada!

In January 2005, a pivotal phone call from Nova Scotia to Nebraska forever changed paramedicine. This call led to a historic meeting in Halifax in July 2005, where representatives from four countries laid the foundation for the International Roundtable on Community Paramedicine (IRCP). We extend our gratitude to the Canadian leaders who initiated this call and the US National Rural Health Association for their influential publication.

When IRCP first convened at Dalhousie University, the integration we see today between paramedic services, primary care, and public health was unimaginable. As paramedics, we excel in decision-making and problem-solving within our communities, often unaware of the global impact of our innovations.

IRCP has been instrumental in sharing these local solutions on a global stage.

The Saskatchewan Health Bus stands as an early exemplar of integration, inspiring others to collaborate beyond their organizations, adapting the health bus model in diverse ways.

IRCP's collaborative efforts have spurred further global cooperation. The core countries of IRCP also established the Global Paramedic Leadership Alliance, which fosters the exchange of innovations beyond community paramedicine, produces multi-national position statements, and champions paramedic safety and mental health.

As you engage with the latest innovations at this year's meeting, remember that the true essence of IRCP is found in the informal interactions during breaks and evening gatherings. The full experience of IRCP is best realized through in-person participation. We acknowledge the challenges in securing travel funding as budgets tighten, but rest assured, IRCP will continue to adapt alongside the agencies we serve.

Welcome once again to IRCP 2024! Let's continue to share, innovate, and grow together.

Gary Wingrove, FACPE, CP-C
Chair, International Roundtable on Community Paramedicine

FRIDAY, JUNE 7, 2024

07.00	**24.A.0**	**Arrival and Registration – All IRCP sessions will be held in the Jonquiere/Lauzon Room.**
08.00		**Honor Guard**
08.05		**Land Acknowledgement**
08.10	**24.A.1**	***Welcome to Quebec City, Quebec, Canada*** **Kevin Smith;** President, Paramedic Chiefs of Canada [CAN]
08.15		***IRCP Welcome*** **Gary Wingrove**, Chair, IRCP [USA]
08.20		**Opening Ceremony**
		The passing of the IRCP Gavel **Gary Wingrove**, Chair, IRCP [USA]
		Kirsty Lowery-Richardson, Head of Education, College of Paramedics of the UK [UK]
		Kevin Smith; President, Paramedic Chiefs of Canada [CAN]
		Proposal by the Council of Ambulance Authorities of Australasia to host the 20th IRCP in Australia

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 and their program names may be different from those listed in this programme.

Please join our appreciation and gratitude for the Advisory Council, with whom IRCP and the 20th Roundtable Forum would not be possible.

ADVISORY COUNCIL


Gary Wingrove


Mary Ahlers


Nick Nudell


Peter O'Meara


J.D. Heffern


Scott Willits


Debbie Gillquist

08.50 24.B.1 What is a College of Paramedics: Differences Around the Globe

Dr Peter O'Meara, BHA, GradCertAgHlthMed, MPP, PhD, RP, FACPara; Adjunct Professor of Paramedicine, Monash University [AUS]

Helen Beaumont-Waters, BSc (Hons), PGDip (Elderly Care), PGDip (Medical Education), MSc (Advanced Clinical Practice), MCPara, MInstChP; Head of Clinical Development for Primary and Urgent Care, College of Paramedics of the UK [UK]

Matthew Leyenaar, PHD; EHS Director with the Department of Health & Wellness, Government of Prince Edward Island; Adjunct Faculty, University of Prince Edward Island [CAN]

Chris Hood; Executive Director and Registrar, Paramedic Association of New Brunswick [CAN]

Around the globe Colleges of Paramedics serve varied functions. In some cases they are paramedic associations, in others they are regulators, and in others they are both an association and a regulator. In this session you'll learn about these variations.

09.55 Sponsor Presentation & Refreshment Break

10.30 24.B.2 The Community Paramedicine Needs Assessment Tool

Alan Batt, PhD; Queen's University [CAN]

The needs of communities in different contexts and settings will differ, highlighting the importance of a detailed community assessment to ensure community paramedicine programs are designed to meet community health and social needs. Using a literature review and a document analysis, we identified items to include in a community paramedicine program needs assessment tool. The CPNAT tool guides the assessment of community health and social needs, as well as resource and workforce capacity. In this presentation we will outline the development of the tool, and lead into a facilitated feedback session to inform the final version of the tool.

12.10 Group Photo

12.30 Lunch Break

13.30 24.C.1 Innovating Healthcare Delivery across Canada: Mobilizing Community Partnerships and Workforce Solutions

Donald MacLellan, BSc; Medavie Health Services [CAN]

Angela Sereda; Senior Manager, Mobile Integrated Health, Medavie Health Services West [CAN]

Jason Helpard; Manager, Integrated Health Programs, EHS Nova Scotia [CAN]

Grant Atkinson-Hardy; Manager, Mobile Integrated Health, Island EMS [CAN]

Mobile Integrated Health (MIH) programs managed by Medavie Health Services have dedicated community paramedic teams providing mental health and addictions support to clients, facilitating safe and supportive Emergency Department (ED) discharges, and being part of multi-disciplinary teams to improve access to primary care and ED diversion. Success of these collaborative programs are dependent on the meaningful relationships developed with community partners and through these collaborative programs and partnerships, teams share resources and knowledge to enhance their efforts to ensure their clients receive the best care possible, while easing the strain on the health care system.

14.10 24.C.2 Unveiling Synergies: How IRCP Catalyzed Cross-Organizational Collaboration for Indigenous Healthcare Advancements

Amy Poll, Director, Community Paramedicine Program; Provincial Health Services Authority [CAN]

JD Heffern, AEMCA, ACP, BSc, MBA(c): Chief of Paramedicine; First Nations and Inuit Health Branch, Indigenous Services Canada, Government of Canada [CAN]

This presentation will delve into the transformative collaboration between Amy Poll and JD Heffern, both keen supporters of Community Paramedicine. Our narrative will focus on how the unique platform provided by IRCP served as a catalyst, facilitating a meeting that might not have occurred under typical circumstances.

Discussion Topic **Why are you attending the 20th IRCP Roundtable Forum?**

14.40 24.C.3 SHA Community Paramedicine and First Nation Communities Working Together

Erika Stebbings, RN, BSN; Manager/Deputy Chief of Community Paramedicine, Saskatchewan Health Authority [CAN]

Sherri Julé, RN, BSN; Director/Chief, EMS North & Community Paramedicine, Saskatchewan Health Authority [CAN]

Jenna Mujer, RN, BSN; Clinical Nurse Educator Community Paramedicine, Saskatchewan Health Authority [CAN]

Kelly Prime, MBA(HRMgt), ACP; General Manager/Chief of Paramedic Services Medavie Health Services (MHS) West-East Central [CAN]

Community Paramedicine (CP) is most successful when synergies are created by enhancing existing teams with CP supports. In 2023-24 the Saskatchewan Health Authority (SHA) CP Department sought to foster enhanced engagement with First Nations and Métis people in meaningful ways, and one of those ways was to begin a CP program with Day Star First Nation. Provincial standardized CP readiness assessments, sequencing metrics and data reporting pathways were implemented with the new program launch. The streamlined processes allow for predictable, measurable and methodical expansion of CP programming. Six months after implementation, Day Star First Nation stakeholders provided additional insights on how to best connect and communicate with their members, and other First Nation communities. That feedback has been incorporated into both the local and provincial CP processes. The CP Program, provided by Medavie Shamrock Division, with Day Star First Nation has since doubled their monthly number of care events, and received resoundingly positive feedback because we took the time to develop open communication pathways, build trust and invest in collaborative relationships.

Through collaboration with local communities and local health care teams, CP providers support available health care services and create dynamic inter-professional working relationships. This work has resulted in a provincial success rate of 96% of our CP patients receiving care closer to home. SHA CP programming is founded upon building relationships by offering patient-centred, trauma-informed and culturally respectful care.

15:15 Sponsor Presentation & Refreshment Break

15.50 24.C.4 Enhancing Community Health through the Integration of Community Paramedics and Innovative Programs in Renfrew County

Mathieu Grenier; Deputy Chief of Community program; County of Renfrew [CAN]

Matt Cruchet, BSc, HBOR, MSc(P), ACP; County of Renfrew; Adjunct Lecturer, Department of Paramedicine, Monash University[CAN]

Michael Nolan; Chief Paramedic of Emergency Services; County of Renfrew [CAN]

This presentation explores the impact of a comprehensive community program implemented by the County of Renfrew paramedic services, aimed at improving healthcare delivery and outcomes. The program integrates various components including Community Paramedics, Renfrew County Virtual Triage and Assessment Centre (RCVTAC), integrate virtual care (IVC), and the integration of paramedics within emergency department staff. These elements collectively form a protective layer that enhances paramedic response efficiency to 911 calls and supports the emergency department's operations. Provide equitable access to care to all resident of the County of Renfrew

Discussion Topic **What new questions or ideas has IRCP given you?**

16.25 24.C.5 Scalability of the Community Paramedicine at clinic (CP@clinic) Program using an implementation science approach: replicability of program impact in British Columbia, Canada and Victoria, Australia

Dr. Evelien Spelten; Professor, Director of Graduate Research; La Trobe Rural Health School [AUS]

Dr Gina Agarwal, MBBS, PHD, MRCGP, CCFP, FCFP: Professor in Family Medicine, Canada Research Chair; McMaster University [CAN]

Dr Louise Reynolds: Dr Louise Reynolds, PhD, Associate Professor in Paramedicine, Australian Catholic University and Chief Paramedic Officer, Safer Care Victoria [AUS]

Monica Morgan: Manager, Community Programs; Provincial Health Services Authority [CAN]

Background and objectives: The CP@clinic Program was developed to reduce the number of repeat 911 calls from social housing buildings and to improve the quality of life and well-being of vulnerable older adults. After a positive pragmatic cluster randomized control trial (RCT) in 5 Ontario regions, the program has been scaled-up in British Columbia (B.C.), Canada and scaled-out to Victoria, Australia. CP@clinic is a standardized out-of-the-box chronic disease prevention and management program that provides accredited CP@clinic paramedic training, evidence-based health risk assessments and a SMART database with built-in algorithms with decision support that analyzes the data input by paramedics, provides assessment results, and recommends actions based on these results and local available resources. This study examined the replicability of the impact of the original trial in the scale up/out locations. Results The CP@clinic RCT showed 19-25% reduced 911 calls with a net resource gain of $128,120 for the Emergency Care System. In BC, there was a relative reduction in 911 calls of 38% with estimated net resource gains of at least $99,368. Cardiometabolic risk factors and BP also demonstrated comparable improvement among participants across all sites. Qualitative interviews from all sites (Canada, Australia) revealed that participants experienced similar personal benefits, including timely access to health information and services, support in achieving health goals, and enhanced understanding of the healthcare system. Conclusion: These scale-up and scale-out projects implementing the CP@clinic program have demonstrated that it is adaptable and its outcomes are replicable to different Canadian and even International settings.

17.05 **24.C.6** **Collaborative Pathways to Enhanced Healthcare in the Canadian North: The Journey of Advanced Medical Solutions**

Brian Carriere; Advanced Medical Solutions [CAN]

Hussein Lockhat [CAN]

This presentation explores the transformative journey of Advanced Medical Solutions (AMS) in enhancing healthcare delivery within the underserved communities of the Canadian North. Focusing on collaboration and partnership, AMS has developed a model that highlights the crucial roles of community engagement, government cooperation, and the integration of Indigenous knowledge. These elements are pivotal in formulating and implementing culturally appropriate medical services and educational programs.

Key initiatives, such as the Tsiigehtchic Community-Based Emergency Care (CBEC) course and the Community Paramedic Program, will be examined to showcase the innovative strategies AMS employs to empower local communities. These strategies are geared towards increasing healthcare accessibility and ensuring the sustainability of health improvements in these remote regions. The initiatives illustrate how AMS has worked to equip local healthcare providers with the necessary skills and knowledge to deliver effective care, thereby enhancing community health resilience.

By detailing the efforts of AMS, the presentation aims to contribute to the broader discussion on addressing healthcare challenges in remote and underserved areas. It underscores the significant impact of partnerships and community involvement in developing resilient, responsive, and culturally competent healthcare systems, which are crucial for the long-term improvement of health outcomes in the Canadian North.

17.35 **Sponsor Presentation**

17.45 **24.A.3** **Closing Remarks**

Gary Wingrove, FACPE, CP-C; Chair, IRCP [USA]

Discussion Topic

What do you think are the next steps to advance the clinical practice, industry standards, and service area geography of Community Paramedicine?

SATURDAY, JUNE 8th, 2024

08.00 24.A.4 Opening Remarks

Gary Wingrove, FACPE, CP-C; Chair, IRCP [USA]

08.35 24.D.1 Is Community Paramedicine a Unique Identity?

Buck Reed, PhD; Lecturer in Paramedicine; Charles Sturt University [AUS]

Since the beginnings of community paramedicine, community paramedics often felt like they had a unique place in paramedicine. However, with the advent of advances in training and clinical governance, more elements of community paramedicine are being adopted into mainstream paramedicine as standard practice. This then questions whether community paramedics are a unite subset of paramedic and on what basis this is differentiation is made. Likewise, on what basis is someone "uniquely" a community paramedic and does that exclude them from identifying in other ways as a paramedic. Identity is a complex phenomenon which is rooted in a range of social elements. This many include the social context of identity, occupation and organisational affiliations, and elements of self-identification. Community paramedicine is in some ways a more complex identity framework as community paramedics operate in a range of communities of practice and the very nature of community paramedics is that they are not homogenous. While significant attempts have been made to define community paramedicine, it does not operate with clearly defined borders the way that other areas of paramedicine such as aeromedical paramedicine and critical care paramedicine often have. Likewise, many community paramedicine practitioners operate in a range of contexts and often share community paramedic practice with more traditional forms of practice. This paper explores the framework in which we can view community paramedic identity, examines professional identity from a social and occupational identity theory lens and considers the complex nature of community paramedic identity.

09.05 24.D.2 A review of NAS Community Paramedic Call Data in Ireland

Charles Brand, PhD., MSc, BA(HONS); Research Officer, National Ambulance Service College [IRL]

The National Ambulance Service (NAS) in Ireland experiences an average annual increase in demand for services of 6.5% caused by declining availability of GPs, an ageing population and increase in comorbidities/mortality. Less Ambulance capacity in the community because of long turnaround time at hospitals leads to long waits and poor performance indicators for the ambulance service. Community Paramedicine is an Alternative Care Pathway option first introduced to the Irish National Ambulance Service (NAS) in 2018. The rationale for community paramedicine is based on the growing demand for healthcare services, a shortage of primary care providers in many areas and the need to reduce healthcare costs. Community paramedics (CPs) are provided directly through the National Emergency Operation Centre (NEOC) by NAS. CPs respond to all protocols of low acuity to find alternative pathways more appropriate to patient healthcare needs. This study sought to quantify the number and types of calls responded to by CPs in Ireland and reviewed all calls completed by seven CP,Äôs in four counties in Ireland over a four-month period from September to December 2022.

09.30 24.D.3 Pragmatic solutions for the delivery of prehospital care; what is the difference between high income and low-to-middle countries?

Duncan McConnell, MBA, MCom, MParaPrac, GradCertAMBMGT, FIML, AFCHSM, MPA, CHM, Paramedic (AHPRA), MACPP, I-CAPP Board Director; Senior Lecturer, Clinical Director; Griffith University, EMS Global [AUS]

Ambulance services around the globe struggle with all different kinds of approaches to operational delivery, patient care and education of staff. Examples include ambulance ramping, implementation of mobile integrated healthcare programs, funding requirements, meeting the needs of staff education and where does prehospital care delivery fit and look like now and into the future, in the overall delivery and recognition within the healthcare system. These are just some of the challenges you might think are unique to you, but in reality these same challenges and more, are faced by ambulance services globally.

How many quick fix solutions have come and gone, instead of trying to truly get to the source of the problem and make real change? How many change makers have tried to make these changes only to burn out or be chased out by the resisters to change?

Join me as I discuss pragmatic solutions for the delivery of prehospital care, as we take a look into how these solutions can affect both high income and low-to-middle income countries in their delivery of prehospital care services.

10.00 Sponsor Presentation & Refreshment Break

Discussion Topic

Will we see you in Australia in 2025 for the 21st IRCP Roundtable Forum?

10.40 24.D.4 An International Community Paramedic Career Structure: a synthesis of the literature, regulatory frameworks, and community paramedicine expert advice

Dr Peter O'Meara, BHA, GradCertAgHlthMed, MPP, PhD, RP, FACPara; Adjunct Professor of Paramedicine, Monash University [AUS]

It can be unclear where community paramedics fit within existing paramedicine career structures and their professional capabilities are sometimes ill-defined or misunderstood. This study aimed to develop a community paramedic career structure and descriptions of their professional capabilities. It was developed through the synthesis of the paramedicine literature, key regulatory frameworks, and advice from two panels of international community paramedicine experts. These purposively recruited panellists comprised practicing community paramedics, students and educators, professional leaders, and subject matter experts. Thematic analysis was undertaken of their open-text on-line questionnaire responses. After feedback from the first panel a paramedic system modernization continuum was used to fashion community paramedic career structures to meet the needs of paramedic systems at different stages of development. These structures were tested with members of the second panel. A five-step career structure was designed and conceptually separated into two distinct but related pathways to facilitate international comparability across paramedic systems in terms of professional autonomy and levels of education. The structural and cultural characteristics are represented through professional capability statements and indicative education levels that are incorporated into a conceptual paramedic system continuum ranging from directive to professionally autonomous paramedic systems. These finding raised questions about how attractive career structures could improve paramedic retention in general. Successful implementation of this career structure requires the support of key stakeholders in the face of strong structural and cultural barriers that continue to challenge innovations in paramedicine.

11.10 24.D.5 Independent Prescribing by Paramedics in the UK: The Reality and Impact on Patient Care.

Andy Collen, DipHE MSc FCPara DipUMC; Consultant Paramedic (Urgent & Emergency Care), South East Coast Ambulance Service NHS Foundation Trust; Medicines and Prescribing Projects Lead, College of Paramedics; Clinical Ambassador, Clinical Human Factors Group [UK]

The session will briefly review the journey to achieve independent prescribing for UK paramedics, including the political and practical aspects of changing legislation. This will include the approach to making a case for change, undertaking public consultation, and presenting findings and arguments to the committee responsible for making recommendations to Ministers on changes to medicines law.

Developing the case of need will be reviewed to highlight the issues that the proposal sought to resolve for patients, such as the need to apply patient-centred care using protocol-based approaches.

The discussion will then focus on the findings from the qualitative studies undertaken in the wake of the introduction of independent prescribing among UK paramedics, and how this reality impacts on patient care and healthcare services. The application of independent prescribing will be explored in the different modalities that have emerged across a range of practice settings.

11:40 24.D.6 No New Buildings: Prescribing the Home for Life with Hospital at Home

Scott Willits, CP-C, ACP; Mobile Health Innovations [USA]

A systematic review of integrating multidisciplinary teams to provide patient-centric care outside of a brick-and-mortar facility throughout the care continuum with various care models. From ED in Home, Hospital at Home, Recovery and Observation, Longitudinal, Palliative, and Primary Care models built around the community paramedic role from around the world.

12.00 24.D.7 Collaboration to address barriers to support vulnerable, under resourced, unhoused and marginalized populations in our community

Autumn Campbell; Superintendent of Community Paramedicine, City of Kawartha Lakes [CAN]

In February of 2023 a local multidisciplinary team of care providers collaborated to address barriers to support vulnerable, under resourced, unhoused and marginalized populations in our community. Each of these stakeholders brought together their skills, expertise and time to rethink old practices. Collectively from this arrived the idea of a Community Outreach Clinic. This Outreach Clinic brings the stakeholders together a couple times a week at different low-income housing facilities to help meet the needs of this population. These Clinics bring food, mental health, sexual health, social services and any other medical needs. In the first 9 months, the Community Clinic facilitated more than 1100 patient interactions. These interactions provided opportunities to gain trust, enhance relationships and only gained momentum. This momentum has only provided a platform to improve, grow and enhance the services for this population that traditionally either avoids health care or are utilizers of the 911 system. Additionally, the momentum has caught the attention of other stakeholders that now include Midwives, Nurse Practitioners and the local Health Unit. The collective efforts from all stakeholders are what have allowed this initiative to be successful and are allowing for expansion to new locations, new services allowing this group to rethink how we are providing resources to these vulnerable populations.

12.25 Special Presentation (Kniki Foundation)

12.35 Sponsor Presentation & Lunch Break

13.45 24.E.1 Changing the Mindset from 911 to CP

Kimberlyn Tihen, CP, BSN: Battalion Chief; St. Charles County Ambulance District [USA]

This is an interactive presentation going step by step through our initial patient encounter for a new CP. We will be utilizing our intake form as a reference. Topics covered are the reasoning behind the questions and looking at the patient through a new lens. By the end of the session, we will have a customized care plan you developed for this patient. This will be a 30 minute session.

Discussion Topic **Who will you invite and challenge to attend the**

21st IRCP Roundtable Forum?

14.15 24.E.2 Updates From the Laguna Community Care Team, a Multi-Disciplinary Frontier Indigenous Community Paramedicine Program in Laguna Pueblo, New Mexico, USA

Chelsea White, MD, ACP, FAEMS, FACEP: Associate Professor of Emergency Medicine; University of New Mexico Department of Emergency Medicine [USA]

Since 2015, Laguna Fire Rescue (LFR) and Laguna Community Health and Wellness Department have operated a unique form of Community Paramedicine on the Pueblo of Laguna Indian Reservation in New Mexico, USA. The program started as a collaboration between LFR and the Laguna Community Health Representatives (LCHRs) to address unmet and undermet medical needs in the community beyond the scope of practice of the LCHRs. As the COVID-19 pandemic receded, the team expanded to also include members from Laguna Behavioral Health, the Laguna Rainbow Elderly Center, and the new Laguna Community Health Center, as well as the LFR Deputy Medical Director, an EMS Nurse Practitioner-Paramedic. The team, now called the Laguna Community Care Team (CCT), meets regularly to discuss patients and distribute patient care tasks to team members based on patient needs and provider capabilities. This model takes advantage of the strengths of each provider and adapts quickly to changing patient needs.

14.45 24.E.3 Emergency Telemedicine and Community Paramedicine

Ryan Brown, CP-C: Captain; Ute Pass Regional Health [USA]

Analyzing the implementation of an emergency telemedicine program in a community hospital setting with community paramedics in the rural setting.

15.10 Sponsor Presentation & Refreshment Break

15.45 24.E.4 Mercy Flights (MIH): Transforming Healthcare Across Southern Oregon's Diverse Landscapes

Sabrina Ballew, CP-C, CHW: Program Manager; Mercy Flights [USA]

Embark on a transformative journey with the Mercy Flights (MIH) team as they shatter healthcare barriers, extending equitable and compassionate care across diverse non-emergent and emergent scenarios where groundbreaking medical innovations redefine care across Southern Oregon,Äôs diverse landscapes. Serving nearly 2700 expansive square miles, this dynamic team conquers challenges, weaving success stories of improved patient outcomes, collaborative partnerships, and a lifeline to timely, impactful care in Southern Oregon. Discover how the MIH team goes beyond traditional boundaries by providing a variety of services to their community, such as guiding seamless hospital discharges to providing critical crisis de-escalation in mental health emergencies. Beyond standard medical narratives, this journey reveals a story of persistent innovation and community impact. The MIH team ensures precise patient care and connections to resources when patients need them most. Southern Oregon resonates with success stories and testimonials, echoing the transformative impact of the MIH Program. Join us on this riveting medical innovation journey, where the MIH Program stands not only as a healthcare initiative but as a beacon of positive medical change in the vibrant tapestry of Southern Oregon.

16.15 24.E.5 Community Paramedic Patient Case Studies

Sherri Hercules, CP-C: Captain - Mobile Integrated Health; St. Charles County Ambulance District [USA]

This presentation reflects the stories of 4 patients with complex needs. Working with complex patients presents a challenge for MIH paramedics in improving patient outcomes. You will see through the processes implemented, how relying on community partners and alternative care plans helps to bring positive outcomes to this challenging patient population. Each patient's story will have descriptions of needs, resources given and how MIH impacted their life.

16.45 24.A.5 Closing Remarks

Gary Wingrove, FACPE, CP-C, Chair; IRCP [USA]

Discussion Topic **What is one thing that you learned at IRCP this year?**

POSTER PRESENTATIONS

24.F.1 San Antonio's Experience with an MIH Program at a Local Homeless Shelter

Jeffrey Rollman, MPH, NRP (Assistant Professor/Clinical – UT Health San Antonio) [USA]

Haven for Hope (H4H) houses half of San Antonio's sheltered homeless population, with 1,700 available beds and 1,600 daily clients. H4H is San Antonio Fire Department's (SAFD) leading address for 9-1-1 calls, accounting for 1,800 EMS ambulance transports in a 12-month period prior to the MIH program. Most occurred at night, when on-site health clinics were closed. Recognizing that many H4H patients don't need an ambulance or emergency department (ED), SAFD's MIH division collaborated with UT Health and community partners to create an overnight Acute Care Station (ACS) clinic. UT Health trained paramedics in expanded scope and formulary, including multiple antibiotics, OTC medications, and advanced wound care. Starting in 2018, an SAFD MIH paramedic was staffed at the fully-equipped ACS from 1900-0700 daily. ACS paramedics assess, treat, and release most patients on-site, but can also refer patients to on-site primary care, arrange a taxi to the ER, or call a 9-1-1 ambulance if needed. Since inception, the percentage of overnight EMS encounters at H4H resulting in ambulance transport declined from 64% to 17%. This collaborative MIH program helps ensure that homeless patients can maintain a consistent medical home on campus, providing timely appropriate care for H4H residents.

24.F.2 The Value of Community Paramedicine in Maine: A Mixed-Methods Evaluation

Katie Rosingana, BA; Catherine Cutler Institute, University of Southern Maine [USA]

Karen Pearson, MLIS, MA; Catherine Cutler Institute, University of Southern Maine [USA]

Evelyn Ali, MPH; Catherine Cutler Institute, University of Southern Maine [USA]

Rachel Gallo, MPH; Catherine Cutler Institute, University of Southern Maine [USA]

Tyler Egeland, BA; Catherine Cutler Institute, University of Southern Maine [USA]

This is the first study using both qualitative and quantitative methods, specifically claims data, to evaluate a state-wide community paramedicine (CP) program, adding to the evidence base for the sustainability for CP and informing policy to assist in the development of a reimbursement model. Qualitative interviews with CP program personnel and stakeholders were conducted to provide a context for the evaluation. The cost-avoidance model used three sources of data: 1) emergency department (ED) visits and costs and hospital readmission costs for targeted conditions and selected hospitals; 2) de-identified records of all CP and 911 activations for patients receiving CP during the study period; 3) ambulance transport charges from EMS agencies providing CP services. Additional analyses on Medicaid claims data provided the basis to gain a better understanding of the MaineCare (Medicaid) patient profile for the CP program to help inform state reimbursement policy. Results of this study add to the literature and evidence base for a data-driven approach to understanding the value of community paramedicine programs. Additionally, the results of this study can be used by other state EMS offices and agencies looking to provide a business case for the implementation of a financially viable and sustainable CP program.

24.F.3 IT ALL STARTED IN OREGON: The Vital Need to Make POLST Forms Digitally Accessible by Fire & EMS Clinicians in the Field

Jonathon Feit; Co-Founder & Chief Executive of Beyond Lucid Technologies [USA]

Every state now recognizes some form of end-of-life medical order, and they carry at least sixteen (16) distinct names. Nationally, this form is known as a POLST and it has been cited for years as an essential tool for Mobile Medical professionals (including Fire, Emergency Medical Service, and Critical Care Paramedic teams) to honor a medically frail patient's health wishes during life-threatening distress. It is also considered a vital tool for hospice and palliative care clinicians, but it is often unavailable to crews in the field, at the patient's side during emergencies if the health crisis occurs outside of the home. This essentially renders the form moot; the patient's wishes that it represents end up unknown and therefore impossible to honor. Innovations like precision medicine and the increased availability of clinical trials and remote patient monitoring, patients have access to tools that let them live longer, more comfortably, and more independently -- even after receiving a serious diagnosis. But improved quality of life simultaneously means a higher risk of unanticipated healthcare emergencies occurring outside the home. Public health emergencies can disproportionately affect patients with chronic illnesses and medical complexity, making it more -- not less -- vital for one's wishes to be documented and current; and then, once the patient undertakes the effort to document those wishes, that crews have real-time access to them.

24.F.4 Trauma Teams Are "Trained to Operate in the Absence of Information." What If They Didn't Have To?

Arthur Groux; Administrative Officer and Head of Clinicals of Beyond Lucid Technologies [USA]

In 2013, an interventional radiologist said emergency clinicians are trained to save lives in the absence of information. He asked, why would they focus on data from emergency medical services (E.M.S.) that they do not know are accurate or complete? What are the clinical, operational and financial impacts of patient data reaching the receiving emergency department in EHR-consumable formats, in real-time? At a time of increasing financial accountability and operational constraints, the lack of awareness of patients' healthcare needs in context -- both in real-time and over time, both medical and social -- risks a huge unnecessary expenditure of resources that could be applied to patients who require the highest level of care. Others can be diverted to another facility further from the accident scene, or they may need no transport at all. Requiring that every activation generates a rapid response of hospital personnel awaiting E.M.S. arrival, with a typical data loss at handoff of 50% (and anecdotally as much as 80%) of patient data prior to arrival -- including medical history, medications, etc. -- slows down patient care and treatment while simultaneously increasing the potential for iatrogenic errors—such as administering medications contraindicated due to hospital staff being unaware of what medications a patient is currently taking.

24.F.5 Integrating community paramedicine topics into degree-level paramedic education programs

Dr Peter O'Meara, BHA, GradCertAgHlthMed, MPP, PhD, RP, FACPara; Adjunct Professor of Paramedicine, Monash University [AUS]

Irrespective of the paramedic system in place, community paramedics have adopted knowledge, skills, and behaviours characteristic of primary healthcare professionals. Paramedics often lack access to affordable higher education that would enable them to practice autonomously as clinicians and practitioners alongside other health professionals. This study aimed to develop an educational framework to support the integration of community paramedicine topics into degree-level education programs.

The overall role and capabilities expected of community paramedics as clinicians and practitioners guided this research. The curriculum framework was designed through an examination of existing curricula, community paramedicine literature and questionnaire responses from two panels of expert paramedicine professionals drawn from six countries where community paramedicine is established or emerging.

The education framework is focused on the knowledge, skills and behaviours that are relevant to community paramedicine that can be integrated into Paramedicine Associate's and Bachelor's Degrees. The topics will equip graduates with the capabilities to practice as interprofessional clinicians or practitioners in primary care settings. Community paramedicine is a concept that has existed for over two decades and it is ready to be integrated into mainstream paramedic education programs within the higher education system alongside other healthcare professionals.

24.F.6 Enhancing Patient Care Through Community Paramedic Follow-Up Calls Post-911 Discharge

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The Ottawa Safe Patient Transport Cancellation Program assesses low-acuity patients to determine if they can safely remain at home with a care plan, following consultation with a physician. A novel aspect of the program is a follow-up phone call within 24 hours by community paramedics to ensure patient safety, clarify care plans, and evaluate patient experiences.

From February 18, 2023, to January 25, 2024, Ottawa Paramedics assessed 310 patients for safe cancellation, leading to 220 patients remaining at home. Community paramedics conducted 269 follow-up calls to 207 unique patients, with 153 consenting to follow-up.

Of the follow-ups, 81.7% patients were better, 14.4% unchanged, and 3.9% worse, one patient required redirection to the ED after follow- up assessment. Paramedics provided additional advice on 21% of calls. 96.6% of patients felt sufficiently informed to manage symptoms, and 98% understood their care plan. 93.8% of patients were pleased with the option to stay at home. 53% of patients offered additional feedback, with 91% comments positive and 9% negative, highlighting paramedic response time issues and desiring more care options in the home by paramedics.

The follow-up component of the Ottawa Safe Patient Transport Cancellation Program demonstrates a high level of patient safety and satisfaction. The data suggest that community paramedics play a pivotal role in providing continuity of care and ensuring the success of non-transport decisions. The program's design addresses critical gaps in patient care post-911 call, though the precise nature of negative feedback warrants further analysis to enhance service quality

~ NOTES ~

Discussion Topic **What is one thing that you learned at IRCP this year?**

~ NOTES ~

Discussion Topic **What new questions or ideas has IRCP given you?**

~ NOTES ~

Discussion Topic

What do you think are the next steps to advance the clinical practice, industry standards, and service area geography of Community Paramedicine?

~ NOTES ~

Discussion Topic

Will we see you in Australia in 2025 for the 21st IRCP Roundtable Forum?

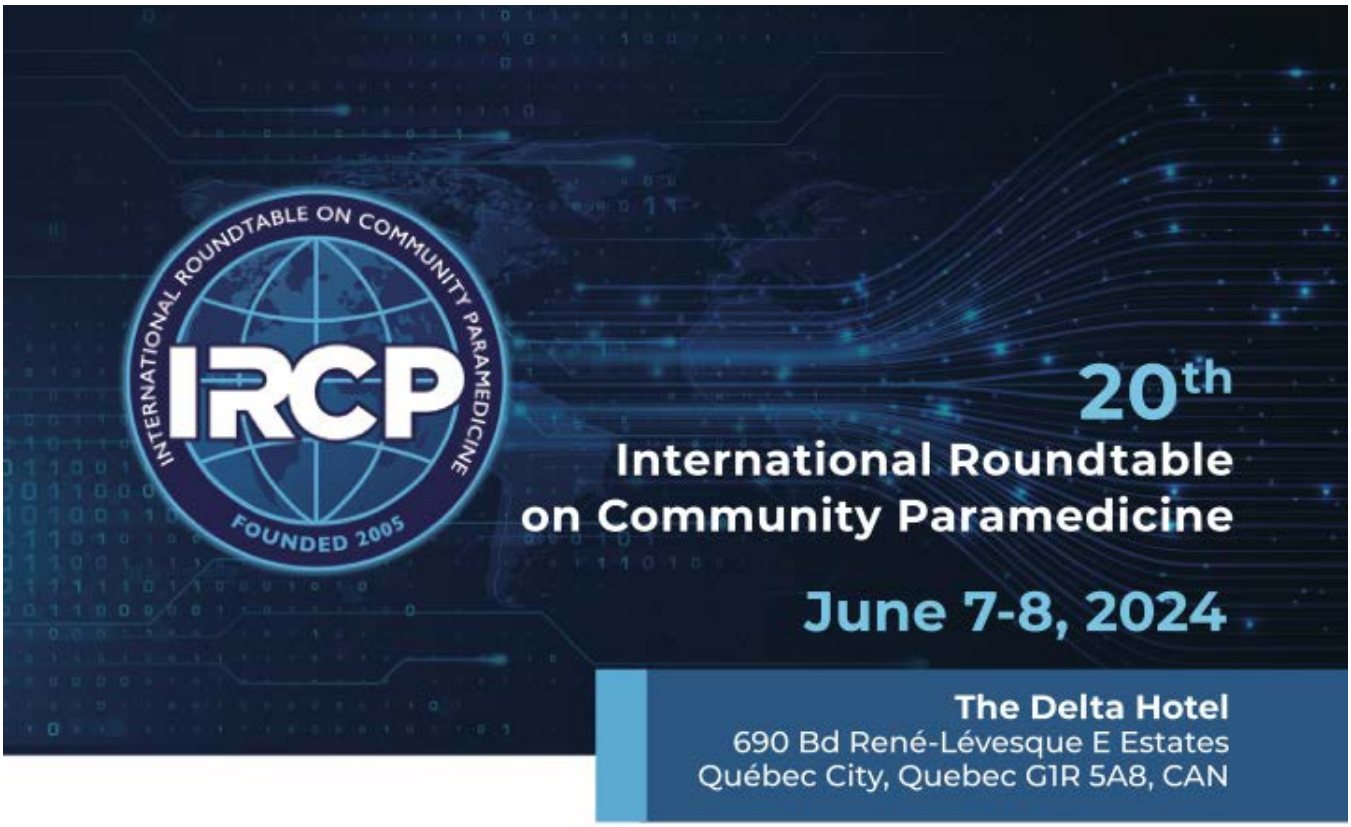
~ NOTES ~

Discussion Topic	**What clinical practice, operational model, academic research, or other topic would you present or like to attend?**

~ NOTES ~

Discussion Topic

Who will you invite and challenge to attend the 21st IRCP Roundtable Forum?



Continuing Professional Development Certificates

The **Paramedic Network** is delighted to offer continuing professional development certificates for the 20th **International Roundtable on Community Paramedicine**, June 7-8, 2024, Quebec City, Quebec, Canada.

Questions, contact: edu@paramedichs.org

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