# International Roundtable on Community Paramedicine 20th Roundtable Forum: Proceedings Document

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**Abstract**

This report summarizes the 20th-anniversary meeting of the International Roundtable on Community Paramedicine (IRCP) in Quebec City, Canada. Founded in 2005, the IRCP aims to enhance healthcare through community paramedicine (CP) models. Gary Wingrove, an IRCP founding member, inaugurated the conference, which featured presentations and discussions on CP advancements, challenges, and innovations.

Key topics included global paramedic colleges, with a focus on the UK's regulatory and educational frameworks, and the Community Paramedicine Needs Assessment Tool (CPNAT) for customizing CP programs to community requirements. Canadian healthcare delivery innovations were highlighted, showing successful CP programs that lowered emergency room visits and hospital admissions through patient-centered models like mental health response teams and discharge support programs. Cross-organizational collaboration for indigenous healthcare and community-led initiatives was stressed, particularly the Saskatchewan Health Authority's integration of CP with local public health via data-driven methods and community engagement.

Day two began with a study on dispatch priorities in Quebec City, uncovering discrepancies between documented and dispatched urgencies. Discussions contrasted traditional emergency response roles with patient-centered CP roles, noting CP's impact on reducing emergency room crowding in Ireland. Presentations covered diverse topics, including ambulance models in various economic contexts, Australian stroke ambulance technology, and a proposed international career structure for CPs, from primary care technician to CP consultant. The UK's independent prescribing by paramedics and the hospital-at-home program were also discussed, emphasizing immediate home interventions by CPs. The forum ended with addressing healthcare

barriers for vulnerable populations, highlighting collaborative efforts to aid under-resourced communities.

Throughout the conference, participants shared resources, engaged in discussions, and fostered collaborations, demonstrating IRCP's dedication to advancing CP globally. The meeting underscored the need to adapt CP models to diverse community needs and utilize data for healthcare innovations.

Keywords: community paramedicine, mobile integrated healthcare, proceedings, ircp, paramedicine, emergency medical services

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## Background

The International Roundtable on Community Paramedicine (IRCP) is an organization of motivated professionals from around the world who are dedicated to exploring the promotion and better delivery of healthcare through the utilization of community paramedicine (CP) models of care (IRCP, 2024). The IRCP began in 2005 after a few significant phone calls between Nova Scotia and Nebraska which led to the first IRCP roundtable in Halifax, Canada in July of that year. That first meeting was described as a “nice conversation” and while CP is doing things they could not have dreamed of back then, some of those original attendees report “we were right 20 years ago.” Twenty years later, IRCP has been meeting annually rotating between locations in Canada, United States, Australasia, New Zealand, and United Kingdom. The 20th anniversary

meeting was again in Canada in beautiful Quebec City. Attendance pins were given to returning attendees including ten people who received five-year pins, five who received ten-year pins, three who received 15-year pins, and one who received a 20-year ring.

Thank you to the IRCP advisory council for their contributions to make this roundtable a success: Gary Wingrove, Mary Ahlers, Nick Nudell, Peter O'Meara, J.D. Heffern, Scott Willits, and Debbie Gillquist. For more information about the IRCP, please visit https://ircp.info.

*Figure 1 - Group photo of IRCP 2024 attendees.*

**Day 1 Presentations**

Gary Wingrove, a founding member and President of The Paramedic Foundation gave the opening remarks stating the IRCP has one agenda: Promote CP across the globe. Conference documents, sample forms, and presentations can be downloaded from this location: https://linqapp.com/ghgkv2b09ct1

***What is a College of Paramedics: Differences Around the Globe***

Presented by Dr. Peter O'Meara (Monash University, AUS), Helen Beaumont-Waters (College of Paramedics, UK), Matthew Leyenaar (Government of Prince Edward Island & University of Prince Edward Island, CAN), and Chris Hood (Paramedic Assoc of New Brunswick, CAN). Colleges of Paramedics primarily focus on patients but also assist systems such as labor unions and employers.

In the UK, the College of Paramedics represents paramedics with the allied health regulator and represent all of the profession through a collaborative approach. The college pushes agendas to evolve paramedic regulations, publish education documents to increase consistency, and represent the four nations of the UK.

In Canada, some of the provinces have Colleges of Paramedics who both regulates practice and service delivery. Practice regulation in the UK includes education, licensure maintenance, and reciprocity. Service delivery regulation in the UK includes responding to emergencies and transporting to the hospital. Service delivery was described as a congested one-way street that is restrictive for CPs and has a lot of challenges.

In Canada, the New Brunswick model is both the regulator and the association for paramedics. Paramedics are no longer accredited by the same accreditor as other allied health programs. Investigations and hearings make up 50% of the College of Paramedics budget.

Reciprocity was discussed as merit badge medical training has gone away and there is less focus on entry exams. Member services are secondary to public protection activities.

***Community Paramedicine Needs Assessment Tool (CPNAT)***

Presented by Alan Batt (Queen's University, CAN). The needs assessment tool presented and discussed can be found here:
https://drive.google.com/drive/folders/1dHI5k7UDQoCWM7CwxhVExCbzRavnYn09

The CPNAT was developed because CP programs should be tailored to community needs but there are few system-level needs assessment tools available. The IRCP attendees were broken into teams to review the tool and provide feedback. Some comments included the following. The tool provides a formal process, but agencies are not limited to the tool. The tool recognizes needs but also community strengths. The tool should include assessments of community health changes, not just a snapshot.

Some of the best and most often heard comments during the review process were people telling their peers, "I'll send you our tool" and "Can you send me that?"

***Innovating Healthcare Delivery Across Canada: Mobilizing Community Partnerships and Workforce Solutions***

Presented by Donald MacLellan (Medavie Health Services, CAN), Angela Sereda (Medavie Health Services West, CAN), Jason Helpard (EHS Nova Scotia, CAN), and Grant Atkinson-Hardy (Island EMS, CAN).

There is a revolution away from brick-and-mortar institutions towards patient- and family-centered healthcare where patients design their own healthcare. CPs are the center of successful CP programs. Some examples of success include a one-month program with one CP

servicing over 800 clients focusing on withdrawal, detox, and access to psychiatry which resulted in over 1100 less emergency room visits. Another program discussed included a mental health response team of an RN, social services worker, and paramedic that reduced ambulance responses by 75%, reduced hospital admissions by 10%, and resulted in 80% of the patients contacted being connected to a permanent resource. Finally, a discharge support team example was discussed that focused on over 400 patients discharged from an emergency room through over 800 in-person CP visits and over 200 virtual visits which resulted in more than 19,000 hospital bed hours saved. The discussion was summed up by a statement that quantitative data is important, but qualitative data such as testimonials is also important with one presenter saying CP is the "most meaningful work of my career."

Q&A: How do you adapt to problems without just chasing the new thing? Focus on the patient.

Q&A: How do you prepare CPs for mental health? 20-hour self-paced program, use new resources, and provide in-house training from partners.

Q&A: How do you get partners to understand the value of CP? Timing is important and getting a physician champion.

Q&A: How did the 9-1-1 alternative number get rolled out? Public announcements with simultaneous service roll-out.

***Unveiling Synergies: How IRCP Catalyzed Cross-Organizational Collaboration for Indigenous Healthcare Advancements***

Presented by Amy Poll (Provincial Health Services Authority, CAN) and JD Heffern (Government of Canada, CAN).

The largest class-action lawsuit in Canadian history resulted in 94 calls to action to improve the rights of indigenous peoples. Seven of those calls to action were healthcare related. While paramedics are the Swiss Army knives of healthcare, CP success is due to people skills and collaboration. CP programs in indigenous communities are working to move healthcare towards indigenous people led and run by supporting first responders and empowering communities. However, they must work at the speed of trust. Some examples of success include indigenous people artwork on response vehicles and CP given special tokens to allow them to participate in ceremonies.

Q&A: Does locally run EMS cause fractionalized healthcare benefits? Do nothing for us without us is important. For example, a multiple-choice exam is colonial, not indigenous-friendly.

***Saskatchewan Health Authority Community Paramedicine and First Nation Communities Working Together***

Presented by Erika Stebbings (Saskatchewan Health Authority, CAN), Sherri Jule (Saskatchewan Health Authority, CAN), Jenna Mujer (Saskatchewan Health Authority, CAN), and Kelly Prime Medavie Health Services, CAN).

The first job of the presented program was reported to be linking CPs with local public health. The second job was to get out of their way. CPs need to be present in the community at social and health events even if there are no requests. A robust data dashboard for CP activities was presented along with a marketing video that was for first nation peoples by first nation peoples.

Q&A: Can you share your data monitoring tools? It is a manual process right now. There are datasets for prevalence of care for long term care, but not for EMS.

Q&A: Is there a data-sharing agreement with first nations? No, we used our own EMS and CP data.

Q&A: What is an early success? Nothing for us without us.

Q&A: How do you overcome mistakes? Own them and rely on your friends.

***Scalability of the Community Paramedicine at Clinic Program using an Implementation Science Approach: Replicability of Program Impact on British Columbia, Canada, and Victoria Australia***

Presented by Dr. Evelien Speltin (La Trobe Rural Health School, AUS), Dr. Gina Agarwal (McMaster University, AUS), D. Louise Reynolds (Safer Care Victoria, AUS), and Monica Morgan (Provincial Health Services Authority, CAN).

The CP@clinic program was described as family practice visits at community centers by CPs which resulted in 19-25% reduction in EMS calls. The program saw $257,000 worth of benefits at a cost of $128,000. The program was replicated at another location where a CP and pharmacist held a clinic at a high-call-volume building one day per week which saw a reduction in the number of 911 calls at that building after program implementation. A third location was discussed where an excess of paramedics needed opportunities and the results of that study showed improvements in paramedics working at the top of their scope. A fourth location discussed showed a 38% reduction in 911 calls and $99,000 worth of benefits while costing $74,000 along with improved patient outcomes (reduced blood pressure, improved nutrition, and reduced obesity).

***Enhancing Community Health through the Integration of Community Paramedics and Innovative Programs in Renfrew County***

Presented by Mathieu Grenier (County of Renfrew, CAN), Matt Cruchet (Monash University, CAN), and Michael Nolan (County of Renfrew, CAN).

This CP program was reported to have been started due to seniors were waiting for placement in long term care facilities and needed help at home. One success was attributed to CPs transition from running "calls" to caring for "people." Their program changed the focus for both operations and CP to categorize 911 calls as level one if seconds matter, level two if minutes matter, and everything else might have other solutions besides traditional ambulance transport. Their 14 full-time CPs have about a 150-client case lead each with one visit per 30 days. Their system also includes triage phone calls, virtual visits, a mental health response, and an addiction response, which have resulted in about 1,000 fewer ER visits. An additional benefit of the addiction response is it serves as a pipeline of information about new drugs on the street to the 911 system. They described a categorization of clients into "active" where the system comes to the client and "inactive" where the client must make a specific request to be seen again. "Active" clients are those that are working to improve their condition and have no alternative to CPs. "Inactive" clients are those that have either met their goals or are not going to meet their goals.

Q&A: How was the phone number adopted? It was started in COVID, so people did not want to come in to facilities.

Q&A: With 150 clients per FTE, how many visits per shift? Twelve-hour shifts during the daytime results in about seven clients per shift plus supporting 9-1-1 calls.

***Collaborative Pathways to Enhanced Healthcare in the Canadian North: The Journey of Advanced Medical Solutions***

Presented by Brian Carrier (Advanced Medical Solutions, CAN) and Hussein Lockhat (CAN).

This program was described as being born from clinics having staffing shortages and a request for paramedic help. Community health nurse training was applied to paramedics. They also found that paramedics needed to learn detailed assessment skills to transition to CPs. Additionally, street paramedics feel they have to be good at everything and they need to be taught that it is OK to ask for assistance for specialty needs.

***American College of Paramedics and Global College of Paramedics***

Presented by Nick Nudell (IRCP Advisory Council) and Gary Wingrove (IRCP).

A short discussion was held describing the need for an American College of Paramedics and the efforts of the American Paramedic Association. Additionally, discussions were made concerning the need for a global college of paramedics similar to IRCP to facilitate a forum for international collaboration.

***Group Dinner and Social Activities***

Throughout the conference, people met in small and medium-sized groups. Overheard conversations included stories of individual careers and why attendees chose paramedicine and CP. A few stories were shared of attendees meeting famous people and some funny ambulance events. Sharing contact information and the promise of keeping in touch to collaborate and share resources were also a common activity.

**Day 2 Presentations**

***MPDS Performance Study for BLS Dispatching in Quebec City***

Presented by PhD candidate Jessica Harrisson (CAN).

A short presentation was made discussing a retrospective study comparing dispatch priority and ePCR data in an urban Canadian city. While 81% of calls were documented as non-urgent, only 22% were dispatched as non-urgent. The following dispatch codes were identified as having more falsely elevated urgency: Abdominal problems, back pain, falls, and psychiatric.

Q&A: How were calls from ePCR classified as non-urgent? Subjective decision by the documenting paramedic.

Q&A: Was the human factor of dispatchers considered? No.

***Is Community Paramedicine a Unique Identity?***

Presented by Buck Reed (Charles Sturt University, AUS).

This presentation began with a request to come to next year's IRCP in Australia by describing next year's event as a "seven-day wine tour briefly interrupted by presentations."

A brief description of identity theory was presented using social identity versus situated identity. Social identity describes people that like to be part of a group and often include their profession (i.e. paramedicine) as a subset identity. Situated identity describes people identifying with their situation and often includes their environment (i.e. community practice) as a subset identity. Positive distinctiveness was described as the behaviors and self esteem based on those identities. Traditional versus CP identities were discussed:

| Traditional Paramedic Identity | CP Identity |
| --- | --- |

| Focus: Emergency response | Focus: Prevention |
|---|---|
| Event-centered | Patient-centered |
| Goals: Save lives | Goals: Quality of life |
| Work alone | Work in teams |

Q&A: How do we keep from getting lost in multiple identities? We need scope-focused naming and labeling and need to define paramedicine better (i.e. ambulance, emergency, nursing, uniform?).

Q&A: How does regulation affect identity? Agency definition of sub-roles.

Q&A: Good CPs are usually odd balls; how do we foster teamwork? Value, appreciate, and support people in the roles they are comfortable in.

***A Review of National Ambulance Service Community Paramedic Call Data in Ireland***

Presented by Charles Brand (National Ambulance Service College, IRL).

There are only seven CPs in Ireland and emergency room crowding and increasing turnaround times were the reason for CP development in 2019. Three programs were described: The Pathfinder Alternative program includes a team of a CP, an occupational therapist, and a physical therapist dispatched to low acuity falls of those over 65 years old. The Prehospital Alternative program includes a team of a CP and a physician dispatched to low acuity calls. The Clinical Hub Alternative program is a dispatch call center to improve call prioritization. In a four-month retrospective study of ePCR data, those seven CPs averaged 43 contacts per month seeing a total of 1,041 patients. The MPDS sick person classification was found to be the most overused and not specific enough. Additionally, 42% of charlie, delta, and echo calls where a CP responded were discharged at the scene by the CP. The conclusion of the study found that CPs

need to be involved in call triage using the example of a COPD patient with mild exacerbation needs a CP response, not emergent ambulance for difficulty breathing.

***Pragmatic Solutions for the Delivery of Prehospital Care: What is the Difference between High Income and Low-to-Middle Income Countries?***

Presented by Duncan McConnell (Griffith University, AUS).

The TV show MacGuyver was used as an example of the epitome of paramedicine. Two ambulance models were described: The Franco-German Ambulance Model (FGAM) includes a doctor and an RN. The Anglo-American Ambulance Model (AAAM) includes only paramedics. High-income countries use the AAAM model while low-income countries use the FGAM model.

***Stroke Ambulances in Australia***

A quick discussion was held describing a $44M grant in Australia to miniaturize brain scan imaging for stroke assessments. Three different technologies are being investigated:

- Miniature CT machine that requires an arm over the stretcher.
- Miniature MRI machine that requires an arm over the stretcher.
- Miniature PET machine that utilizes a helmet on the patient.

***An International Community Paramedic Career Structure: A Synthesis of the Literature, Regulatory Frameworks, and Community Paramedicine Expert Advice***

Presented by Dr. Peter O'Meara (Monash University, AUS).

CPs are poorly defined and are an evolving autonomous health discipline. CP was defined as being person-centered, meeting needs of the community, integrated, and focused on patient outcomes. A study using literature review, expert panel, online questionnaire, and a

testing panel was used to define a CP career structure. A five-step career structure with four themes and two pathways was developed. Listed from lowest to highest education level and most directive to most autonomous pathways:

- Primary Care Technician (certification)
- CP Clinician (associate’s degree)
- CP Practitioner (bachelor's degree)
- Advanced Paramedic Practitioner (master’s degree)
- CP Consultant (doctorate degree)

When asked if a financial aspect such as salaries were included, the discussion described only students in the U.S. will care because other healthcare systems are properly funded.

***Independent Prescribing by Paramedics in the UK: The Reality and Impact on Patient Care***

Presented by Andy Collen (South East Coast Ambulance Service NHS Foundation Trust, College of Paramedics, & Clinical Human Factors Group, UK).

Patient populations are changing, and the paramedic profession needs to change. 2,000 of the 37,000 paramedics in the UK can now prescribe medications. Paramedics are now required to have a master’s degree. The public perception vs the lawmaker’s perception of paramedics was very different, including some senior healthcare regulators who did not know what a paramedic was. Paramedic prescriptions still rely on paper pads instead of electronic systems. Controlled substances are still a barrier for paramedic prescriptions. If patient care has to be handed off to someone else to prescribe, it is less safe, and the patient has less trust. Some data:

- 40% of prescriptions by paramedics are new medicines.
- 63% of visits include medication management.

- 42% of visits include prescribing medications.
- Most prescriptions are related to infections.

Q&A: What were the challenges in convincing paramedics? Non-degree holding paramedics are being offered a transition.

Q&A: Is autonomous paramedicine safer than directive paramedicine? Absolutely. Medical directors probably would not sleep at night if they knew what their paramedics who are following protocols are doing. Protocols direct care to the middle of the bell curve, not individual needs.

***No New Buildings: Prescribing the Home for Life with Hospital at Home***

Presented by Scott Willits (Mobile Health Innovations, USA).

The hospital at home program is substituting hospital stays with home stays in multiple countries. Primary advantages of CP at home vs nursing at hospital: Interventions can be immediate without the need for a physician order and CPs offer transportation assistance. Multiple studies and case presentations illustrated the advantages of hospital at home.

***Collaboration to Address Barriers to Support Vulnerable, Under Resourced, Unhoused, and Marginalized Populations in Our Community***

Presented by Autumn Campbell (City of Kawartha Lakes, CAN).

Five agencies originally collaborated to meet the needs of a marginalized community stigmatized by substance abuse and being unhoused. The collaboration grew to 15 agencies. A needs assessment was completed, and two success story case studies were presented. In the first five months of the program, 1,725 interactions were had only providing services four hours per week.

***Keneya Ni Kalan Institute Ambulance Project***

During a conference, a chance encounter on a bench outside the hotel revealed the need for ambulances in Mali. A foundation to bring medications to villages is in place and only two ambulances are covering more than 200,000 people. The program for sending educators to Mali to build EMR, emergency driving, and community health curriculums was discussed. Ambulances and equipment are still needed due to the cost of $3,500 just to send vehicles by boat.

***Changing the Mindset from 911 to CP***

Presented by Kimberlyn Tihen (St Charles County Ambulance District, USA). The initial intake visit report form discussed in this presentation can be found here: https://docs.google.com/document/d/1LzmbRyJ8h6spjqpgGiQsT0WCtILay-Kj3mmdCDII6Gg

An overview of a Missouri ambulance service providing care for 500,000 people with 52,000 calls for service was discussed. New CPs are trained using the intake visit report form to change their mindset from being a 9-1-1 paramedic to a CP. Going through this form provides the WHY and overview of nursing care plans.

Q&A: What sources do you get the info to complete the form? ePCR and Epic data.

Q&A: How often is completing the form a multi-visit process? All the time.

***Updates from the Laguna Community Care Team: A Multi-Disciplinary Frontier Indigenous Community Paramedicine Program in Laguna Pueblo, New Mexico, USA***

Presented by Chelsea White (University of New Mexico, USA).

An overview of a New Mexico ambulance service providing care for 4,000 people with 1,800 calls for traditional paramedics was discussed. The CP team includes a CP, public health,

and a physician. There is still a need to add CHW training for CPs to be able to get more funding.

***Emergency Telemedicine and Community Paramedicine***

Presented by Ryan Brown (Ute Pass Regional Health, USA).

An overview of a Colorado ambulance service providing care over 3,000 square miles using three ambulances and two CPs providing 4,000 calls for ambulances and 1,000 calls for CPs was discussed. 20% of the requests for service are related to behavioral emergencies. CPs received 520 hours of college training for mental health. Their average scene time is 2.5 hours. Typically, after de-escalation of mental health emergencies, placement is not needed which results in better outcomes.

Q&A: How often is law enforcement needed? LE is only requested if there is a safety concern. Once LE makes the scene safe, the CP releases LE from the scene.

***Mercy Flights Mobile Integrated Healthcare: Transforming Healthcare Across Southern Oregon's Diverse Landscapes***

Presented by Sabrina Ballew (Mercy Flights, USA).

An overview of an Oregon ambulance service providing ground and flight transport plus CP in terrain from 900 to 9,000 ft elevation was discussed. The CP program was started in 2016, but COVID and two large wildfires in 2020 increased demand for a mental health response. The entire team was cross trained in CHW and use Subaru Foresters and provide resource bags to reduce readmissions.

Q&A: Where do you get your supplies such as cell phones to give out? We work with an Autism group.

Q&A: How do you overcome the fear of healthcare? CPs wear just a polo, not an ambulance uniform. We must be consistent and follow through on promises.

### ***Community Paramedic Patient Case Studies***

Presented by Sherri Hercules (St Charles County Ambulance District, USA).

Four case studies were presented with the overall takeaway being relationship building for CPs is critical.

Q&A: Why do paramedics like CP work? The complexity of patients provides a challenge. Also, the CP gets to see the results of their care.

Q&A: How do we create the next generation of CP leaders? This new generation of paramedics have more patient compassion as compared to older medics who gravitate towards CP as a way to get off the truck.

## **Wrap-Up**

The final roundtable was in the form of a pop quiz to generate conversations.

### ***Question 1: Why did you attend the 20th IRCP forum?***

- There is stuff to learn.
- Coming back to CP career.
- Came for JD's birthday party.
- Came to see the beautiful city of Quebec (x2).
- I am a new CP and wanted to learn more.
- I am supporting the team (x3).
- Creating a succession plan (x2).
- Peers fill my batteries for another year.
- Never experienced training on the international level (x2).
- Want to see people in person instead of on a screen.

- JD invited me.
- It was close to home (x2).
- This is a great group of people.
- See follow-up from previous presentations.
- Celebrate 20 years of IRCP.
- Learn from the O.G.s.
- I want to meet new peers.
- I wanted to give a program update.
- This is my favorite conference and group.
- I believe in what we do.

***Question 2: What is at least one thing you have learned at the 20th IRCP forum?***

- Mental health programs from around the world.
- Education solutions for CP staff.
- There are others that are both medics and RNs.
- I got more out of the last two days than the previous several months.

***Question 3: What new questions or ideas has IRCP given you?***

- Tools and metrics obtained here.
- CP programs research and data.

***Question 4: What do you think are the next steps to advance the clinical practice, industry standards, or service geography of CP?***

- American College of Paramedicine (x2).
- Autonomous CP model is needed.
- Metrics to measure CP performance.
- We need to keep working on legislation.

***Question 5: Will we see you in Australia in 2025 for the 21st IRCP forum?***

- Yes (x10):
  - Hell yeah.
  - Already booked an Air B&B.

  - Wife already looking for hotels.
  - Remote.
  - Probably.
  - Love to, but need to find funding.
  - Hopefully (x2).

- No:
  - Can't afford the travel, but maybe online.
- Maybe (x5):
  - Hope so (x2).
  - Don't know.
  - Will see (x2).
- Since there were seven from Australia that came to the Americas this year, to keep the same ratio, 70 from the Americas need to go to Australia next year.

***Question 6: Who will you invite and challenge to attend the 21st IRCP forum and why?***

- Everyone in this room.
- Colorado Springs.
- One of my team members (x3).
- My whole team (x3).
- Timothy Deans
- Ground medics.
- Local CP programs.
- A young paramedic mentee.
- Fellow colleagues.
- Physician decision makers.
- CEO of my service.
- Graduate student.
- My leadership team (hosted online).
- Students in CP.
- Neighboring services.
- Colleagues in Germany and Turkey.
- Union partners.

## References

IRCP. (2024). *About us*. Retrieved from International Roundtable on Community Paramedicine: https://ircp.info/About-Us