2020 PROGRAMME
17th MEETING

March 18-19, 2020

Jurys Inn Hotel & Conference Centre

Hinckley Island Leicestershire,

United Kingdom

WEDNESDAY March 18 2020

15.00 **Arrival and Registration**
Conf Room 11

MEETING OPENING

16.00 *Welcome to England*
Steve Irving
Executive Officer AACE

16.10 *IRCP Welcome*
AACE: Martin Flaherty, Steve Irving [GBR]

Gary Wingrove FACPE CP-C, Mayo Clinic [USA]

Passing of the IRCP Gavel
Gary Wingrove, Chair, IRCP [USA]
Randy Mellow, President, PCC [CAN]
Steve Irving, AACE [GBR]

Proposal by The Paramedic Foundation to host the 18th IRCP

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.

16.30 17.A.1 *Prevention Program facilitated by the Paramedic Service: A novel idea of the BRK KV Regensburg*
Andreas Bauer ACP: Chief of the Department of Education
Bayrisches Rotes Kreuz Kreisverband Regensburg [GER]

The paramedic service is currently one of the last resorts in escalation within the health care system in Germany. Patients who do not reach their primary care physician or have been insufficiently cared for on an outpatient basis no longer know how to help themselves. Therefore, they use the Paramedic resources, due to the paramedic service being obliged to follow up on the request for assistance. Regardless, whether it is necessary or not, patients are transported to an emergency room. This being done despite a variety of outpatient care services and other healthcare providers; patients are discharged from the emergency room on the same day after care because in most cases there was no life-threatening condition.

This practice causes immense cost that the health insurance companies and the existing health system have to bear. The increased demand for paramedic services must be countered with an innovative concept in order to counteract the many unjustified hospital transports and admissions.

Our approach is to expand the paramedic service in the area of "prevention" and “being proactive” meaningfully. We want to actively support citizens to stay in their familiar environment – their home – for as long healthy, safely and secure as long as possible.

Prevention is not a new strategy in Germany. If you take a look at other public safety authorities, prevention is an important part of daily work and provides relief for the emergency services. The fire brigade invests countless hours in preventive fire protection in order to prevent a fire from breaking out. The Paramedic service in Germany traditionally have not implemented efforts or processes to counteract the increasing annual call volume with innovative programming

In my presentation I will introduce the possibilities and chances of a Paramedic service - preventive program. The rescue service area of Regensburg is used as an example.

17.15 17.A.2 *Research Outcomes in CP- Do they paint the full picture?*
Diane Flint, ACP CCP DPA: Assistant Professor and Program Director
University of Maryland, Baltimore County [USA]

This session will discuss current research outcomes in CP and facilitate discussion of the impact of research results versus overall program outcomes. Participants should come prepared to discuss current research, their own or other research currently published, to further expound on the implications to international CP program.

18.30 Time at Leisure & Networking
Hotel's Triumph Bar

08.00 **Arrival and Registration**

08.30 17.A.3 *Community Paramedics Tackle Mental Health Crisis*
Kevin Creek, CP-C ACP: Community Paramedic Supervisor
Eagle County Paramedic Services [USA]

Mental health calls are becoming more and more frequent for ambulance services around the world. Unfortunately, most of the time the emergency department is the only outlet emergency crews have in order to care for these patients. However, unless there has been some sort of ingestion or a physical attempt made, the emergency room is almost always the worst place they can be cared for. In Eagle County Colorado, Eagle County Paramedic Services has created a co-response model with Community Paramedics and mental health professionals to tackle this problem. In the event of a 911 call where mental health is the complaint, the patient will get a dual response from a Community Paramedic and a mental health crisis clinician. Once on scene, these providers will assess the patient from both the medical and mental health side and find the most appropriate course of action to take in order to deliver the best possible care. By doing so, most of the time it allows providers the ability to keep the patient out of the hospital and moved into a crisis stabilization program that looks at both mental and physical problems causing the crisis. In addition, following this sentinel event, both providers have the ability to follow the patient in the home over the coming weeks to work with them and assist them in the recovery process.

09.15 17.A.4 *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]

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.

10.00 **Refreshment Break**

10.30 17.A.5 *Germanys first community paramedic system and the role of telemedicine*

Nils Jacobsen, ACP MD: Consultant Anesthesiologist, Deputy Chief of Telemedicine Service
University of Oldenburg [GER]

Germany's first nationwide project for community emergency paramedics is attracting great attention both nationally and internationally. It has now been in operation for over a year. Regular meetings of the project participants take place in order to subject the figures, data and facts to a precise analysis and to initiate corrective measures if necessary. The Joint Federal Committee has made 1.1 million euros available for a scientific study of the project. What are the tasks of the community emergency paramedic and which patients does he meet? What can already be seen from the deployment data.

11.15 17.A.6 *The contribution of paramedics in primary and urgent care: Realist Research*

Georgette Eaton, BSc (Hons) PGCert MSc ACP FHEA: Graduate Reading for a DPhil in Evidence Based Healthcare
University of Oxford [GBR]

Funded by the UK Department of Health, I am using realist approaches to explain and understand the contribution of paramedics in primary care within the UK. I have completed (and awaiting publication) of a systematic review of the UK literature, and am currently looking at the international literature – which I will talk about in March from a scoping perspective.

12.00 Buffet Lunch - Hotel Restaurant

12.45 17.A.7 *Not all Community Paramedics Are Created Equal*

John R Clark, JD MBA ACP FP-C CCP-C CMTE: Chief Operating Officer
International Board of Specialty Certification [USA]

The data for this presentation was drawn from a cross-sectional online survey designed to better understand the scope of practice between community paramedics practicing in a variety of countries, their own expectations regarding their ability to provide optimal patient care and their perception of their role compared to that of their traditional ambulance counterpart.

Community Paramedics were asked to respond to questions relating to their beliefs and expectations relating to paramedic scope of practice in community paramedicine environment using a four-point Likert scale for each. Descriptive statistics are used to describe responses to survey questions:

1. My current scope of practice is appropriate for the patients I transport.
2. I routinely perform assessments and critical thinking that is different than my ambulance counterparts.
3. My training requirements adequately address my scope of practice.
4. My counterparts recognizes the special skills and education I bring to the healthcare environment?
5. As a community paramedic, I believe that my scope of practice is broader than my paramedic counterparts working on a ground ambulance?
6. I am permitted to perform more skills than ambulance counterparts.
7. I am satisfied with my role in the community paramedic environment.

13.30 17.A.8 *Key intervention points for the efficient work-role transition to community paramedicine practice*

David Long, PhD: Academic/Lecturer
Queensland University of Technology, [AUS]

Objective: Paramedicine continues to evolve rapidly as evidenced by the introduction of specialist streams of paramedic practice. Community paramedicine is one such example. Its main aim is to provide patients with alternate pathways within the healthcare system, thus avoiding unnecessary presentations to emergency departments. This submission critiques existing work-role transition models and argues for the utilisation of discipline-specific knowledge that identifies the key intervention points required of qualified paramedics to navigate the transition to community paramedicine practice more efficiently. **Methods:** Based on doctoral studies involving Extended Care Paramedics (n=25) from two Australian jurisdictional ambulance services and Community Paramedics (n=11) from a Canadian provincial health service, a constructivist grounded theory approach was taken to develop a theoretical model of transition. **Results:** Transition to a specialist work-role in community paramedicine contrasts notably with extant work-role transition theories utilised in other health disciplines such as Benner's Model of Skills Acquisition. Transition to community paramedicine practice involved four core categories: Engaging in a Community of Practice, Adjusting to Organisational and Cultural Change, Developing Critical Thinking and Mastering Skills. Within this context, eight key intervention points were identified that may provide paramedics, educators and community paramedicine program managers with the knowledge to better navigate the transition experience. Suggested support strategies appropriate to different phases of transition are also described. **Conclusion:** The utilisation of discipline-specific knowledge and identification of key intervention points may benefit paramedics with targeted and on-going support to facilitate transition to community paramedicine practice.

14.15 Break

14.45 17.A.9 *Learning how to integrate care: Setting up a rotational model of Advanced Paramedic Practice through the North Wales Pacesetter Collaboration.*

Duncan Robertson, ACP BSc(hons) MSc MClinRes: Consultant Paramedic
Welsh Ambulance Services NHS Trust [GBR]

Ambulance services are under pressure to retain paramedics as opportunities present across the NHS for this valuable group of staff. Rotational working is one means of providing multiple opportunities over a longer work-span. The team of Welsh Ambulance Services NHS Trust (WAST) Advanced Paramedic Practitioners (APP) in North Wales provided a focal point for the evaluation of an internal rotation.

Welsh Government Pacesetter funding enabled the formation of a collaborative team drawn from WAST, Betsi Cadwaladr University Health Board, Public Health Wales, NewMedEd and contributing Primary Care Clusters and Practices. Workforce planning provided the numbers of available APPs and a plan to recruit the back-fill. In each cluster, APPs would be deployed based on the requirements of their patient population (e.g. home visits, clinics) to work alongside the wider Primary Care Multi-Disciplinary team with the aim of providing safe care closer to home.

Funding secured time from GPs to act as clinical supervisors and an innovative education framework was commissioned from a team of GP Educators who deliver sessions every other week to the APP team to support them on their development.

With funding secured for year two, the team will ensure the project is learning from year one and developing the best model to meet the requirements of a modern APP, including the journey into non-medical prescribing. This presentation will outline the learning from the project so far, with the interim results of the evaluation from 1st June 2019 when the first APPs began their rotation into Primary Care.

15.30 17.A.10 *The Advanced Paramedic Practitioner Primary & Urgent Care Programme in London Ambulance Service.*

Georgette Eaton, BSc (Hons) PGCert MSc ACP FHEA: Clinical Practice Development Manager - Advanced Paramedic Practitioners (Urgent Care)
London Ambulance Service NHS Trust [GBR]

This is a rotational programme between the ambulance service, primary care and urgent care. I oversee the programme as the Clinical Practice Development Manager, and believe we offer a novel approach whereby
we recruit paramedics with 5 years clinical experience, and support them to undertake a Master's in Advanced Practice over three years - with the goal of being an 'Advanced Paramedic' at the end. We have a robust training plan and portfolio to support their development, and offer opportunities to explore other areas of interest (e.g., immigration and refugee health care; health inequalities etc.). It is no surprise that the programme is popular, and we are the only UK Trust working in this way.

16.15 17.A.11 *The evolution of community paramedicine programs: providing care in rural and remote communities*

Pierre Poirier, ACP BA MBA: Executive Director/directeur général
Paramedic Association of Canada/Association des paramédics du Canada [CAN]

CSA Z1630 *Community Paramedicine: Framework for program development* is a national standard that recognizes the rapidly expanding roles of community paramedics using their specialized skills and mobile presence to effectively provide patient-centred care through unique health delivery models beyond traditional emergency response. Since 2017, this Standard is widely used as a foundational document for community paramedicine program development, providing a robust framework for the development, implementation, monitoring, and evaluation of a community paramedicine program that is appropriate and responsive to community needs and the resources available.

To evaluate the reach and applicability of CSA Z1630 in different Canadian settings, research was conducted through a focused exploration of the health service needs and gaps in locations where paramedic services were less available or absent, and where the provision of care is made more challenging by the harsh climate and relative isolation of rural communities in Canada's north. Two CSA Group research projects inspired by the Standard were conducted in 2018 and 2019 looking at the current state of emergency response and community-care provision in relation to health needs. The results demonstrated a collective community desire to improve the health of residents through improved access to care and a recognition that community paramedicine could be a sustainable and implementable solution to build healthier communities. The findings validated that community paramedicine programs in remote areas require integration into a collaborative network and reiterated the importance of establishing ongoing engagement with the community, health care providers, and partners, as mentioned in the Standard.

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