

2012

International Roundtable on Community Paramedicine

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Recommended Citation

Wingrove, G. (2011). International Roundtable on Community Paramedicine. *Australasian Journal of Paramedicine*, 9(1). Retrieved from <http://ro.ecu.edu.au/jephc/vol9/iss1/1>

This Editorial is posted at Research Online.
<http://ro.ecu.edu.au/jephc/vol9/iss1/1>

EDITORIAL

International Roundtable on Community Paramedicine

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In January 2005 a single phone call from Halifax to Lincoln changed the world history of Paramedicine. At the time, neither Mike McKeage (the call maker from Nova Scotia) nor Dennis Berens (the call receiver from Nebraska) knew they were doing anything special. That first call led to a conference call, which led to more conference calls involving more nations, which led to the first gathering in July 2005 and the creation an informal organization called the International Roundtable on Community Paramedicine and Rural Healthcare Delivery ([IRCP](#)).

IRCP will conduct its seventh annual meeting in Sydney in October 2011, linked to the Paramedics Australasia conference and combined with the Council of Ambulance Authorities Rural and Remote Symposium. What began as a gathering of delegates from Australia, Canada, Scotland and the United States has also seen in subsequent years delegates from England, Israel, New Zealand, Qatar and the United Arab Emirates, and this year will include delegates from Germany and Switzerland.

There have been many changes around the world since that 2005 phone call. The EMS Chiefs of Canada¹ has joined the United States (US)² and the United Kingdom (UK)³ in producing their vision of the future of EMS, a vision with Community Paramedics as a focal point. Community Paramedicine has expanded into the urban areas of many of the countries that had established its roots in rural and remote areas, which resulted in IRCP dropping “and Rural Healthcare Delivery” from its established name. Out of necessity IRCP has also adopted a naming convention for those formerly known as EMS workers so that we have a common language and understand each other when meeting over the internet, by phone or in person.¹

Contemporary Community Paramedic programs were established to fill identified healthcare gaps, primarily in rural areas. Paramedic Services are really good at filling gaps. What we’re not good at is recognizing that we’ve done something special, and then sharing our learning and experience with others. This is the particular niche that IRCP fills.

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- i. IRCP has established four levels of EMS providers, Primary Care Paramedics (PCP), Intermediate Care Paramedics (ICP), Advanced Care Paramedics (ACP) and Critical Care Paramedics (CCP). It also adopted Community Paramedic (CP) for those PCPs, ICPs, ACPs, and CCPs with specific CP training, and Paramedic Service as the term for agencies employing those providers.

IRCP is not incorporated; has no members or board of directors; has no telephone number, email address or postal address. IRCP does its work via those that choose to participate. That structure, while unfamiliar in the healthcare sector, has served IRCP very well. IRCP's mission and vision are to create a forum for the free exchange of information among participants and to foster the growth and collaboration of gap filling models.

Since the establishment of IRCP we have seen some really creative models for filling gaps emerge and we are starting to get some data about how these programs make a difference. The first Nova Scotia model of Community Paramedics was started nearly 10 years ago to meet the healthcare needs of a populated isolated island in the Atlantic Ocean. A five year review shows a reduction in ambulance transports to the closest hospital on the mainland of 40%. Early results of Nova Scotia's second program, targeted to the needs of long term care residents, shows the result of a decrease of ambulance transports for non-urgent patients of 68% (340 of the first 500 patients encountered). Nova Scotia's third model is slated to begin in July 2011 and involves paramedics staffing rural emergency rooms, supplemented by the oversight of an on-call physician.

Saskatchewan piloted a "health bus" staffed with a combination of nurse practitioners and paramedics that offers free clinic services throughout the city of Saskatoon. The pilot program, conducted in a make-shift motor home, was so successful that the Province is making it permanent and a brand new bus customized for this use is in production. We have a similar program in my home state of Minnesota.

A program in urban Texas was organized to address the specific needs of 21 patients who combined stressed the emergency care system 821 times in a one year period resulting in the consumption of 4,872 emergency room bed hours, 1, 218 ambulance unit hours and a \$3 million revenue loss. By working directly with these 21 individuals, the Med Star paramedic service reduced their calls to the emergency dispatch center by 50% the first month. Their Community Paramedics provide direct primary care assessment and treatment; or, divert these patients to clinics (including mental health); activate mobile crisis intervention teams; provide public transportation passes; or, engage the service of a para-transit provider. Over the first year of the program, the paramedic service is responsible for diverting nearly \$10 million in cost out of the emergency care system. A similar system, with specially trained paramedics working both ends of the care spectrum (high volume, low acuity and low volume high acuity) is in place in North Carolina. San Francisco has a similar program directed entirely to their homeless population.

In addition to these examples of great programs, IRCP has led to some related collaborations. Institutions in Nebraska, Minnesota, Nova Scotia and Australia have collaborated to create a Community Paramedic curriculum for free use by accredited colleges and universities worldwide. The curriculum is currently being revised from version 2.2 to 3.0 and the new version will be available this Fall. So far, the curriculum has been given to 42 colleges and universities in 5 countries, and to the US military. A six state pilot course of the new curriculum version is slated for this Fall in the US.

I look forward to interacting with you at the upcoming Paramedics Australasia (formerly Australian College of Ambulance Professionals) 2011 conference in Sydney. And, if you're interested in Community Paramedicine and want to mingle with an international group of likeminded paramedics and administrators from several countries, please plan to stay in Sydney for our meeting at the Menzies Hotel (near the Hilton), on October 10 and 11

(opening reception the evening of October 9th). Registration for IRCP is free and is available on the CAA website at <http://caa.net.au/index.php/events/open-conference/registration-form>.

References

1. EMS Chiefs of Canada; The Future of EMS in Canada: Defining the Road Ahead; EMSCC/DUSMCC; Calgary, Alberta, Canada; 2006.
2. McGinnis, KK; Rural and Frontier Emergency Medical Services Agenda for the Future; National Rural Health Association Press; Kansas City, MO; 2004
3. UK Department of Health; Taking Healthcare to the Patient: Transforming NHS Ambulance Service. COI Communications, 269299 1p 4k; 2005 (CWP)