PROMISING PRACTICES IN EMERGENCY MEDICAL RESPONSE AT FIRE RESCUE SERVICES: LESSONS FROM WINNIPEG

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As one case study in a cross-Canada search for promising practices in emergency medical response and employment equity at urban professional fire rescue services, Winnipeg Fire Paramedic Service provides an outstanding model of emergency medical response. Service is provided in an effective and efficient manner, helping to meet Winnipeg residents' health care and social care needs, particularly in life-threatening or precarious situations.

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THE RESEARCH CASE STUDY

This case study is part of a research project funded by the Social Sciences and Humanities Research Council of Canada. The project aims to analyze changes and continuities at urban professional fire services that reveal shifts in Canadian health care and social care provision. It focuses on fire services' increasing share of care to "vulnerable" populations as other welfare state services retreat and retrench. This shift is a gendered shift in caring labour, as most health care and social care is provided by women. This fact makes employment equity concerns at fire services, already a topic of debate across protective services, additionally pertinent.

As part of this research, case studies of urban, suburban and rural professional fire services have been conducted across Canada. At an early stage in the research, fire chiefs and union representatives asked for promising practices reports as one outcome of this research. Thus, this research project was partially re-aligned with this goal and aims to identify promising practices in emergency medical response work at urban fire services across Canada. This report reflects only findings from the Winnipeg case study.

This study employed four methods:

1) Background research on the history of Winnipeg's fire services involvement in emergency medical response and employment equity initiatives as well as the changing social welfare and health care issues facing Winnipeg residents.
2) Interviews with administrators, managers, dispatch and fire fighters at Winnipeg Fire Paramedic Service (WFPS) and the City of Winnipeg, as well as researchers in Winnipeg who have knowledge of social welfare, health care and employment equity issues in the Winnipeg area. In this study, thirteen formal recorded interviews and fifteen informal interviews (where hand written notes were made) were completed. Each interview lasted between 20 minutes and 2.5 hours, with the average length of 1.25 hours.
3) Work observation at four of Winnipeg's busiest fire/ paramedic stations, in which the researcher rode along on every possible call for the duration of full shifts, and in some cases, for two full shifts, as well as talking with groups of firefighters about their work. Detailed field notes were made on these observations.
4) Comparative data analysis in which the data from the Winnipeg study was compared to findings from seven other Canadian fire-rescue services that have been included in this study to date.

   The findings reflect the methods.

Limitations: The findings do not indicate that these practices are fully integrated across all aspects of the department or are uniformly successful or that they are the best way to meet community need. The findings

are evidence of innovation in service delivery that appears to meet community needs more effectively and efficiently than more traditional fire-rescue services. Further, the study has focused on emergency medical response as an aspect of fire rescue services delivery. Data collection with paramedic/ambulance services was limited.

SITUATING WINNIPEG'S INTEGRATED EMERGENCY MEDICAL RESPONSE: THE SOCIO-ECONOMIC CONTEXT

Winnipeg's 9-1-1 emergency medical calls are shaped by the particular health care and social care needs in the city, which in turn are shaped by the political, economic, social and environmental context.

Winnipeg has the largest urban population of Aboriginal peoples in Canada, who made up 11% of the population in 2011 (City of Winnipeg Trends Report 2013). Many recent arrivals have migrated to Winnipeg from reserves with horrendous living conditions, including environmental pollution and other immediate health risk factors. This population is also living with the scars of colonialism, including land issues, residential schools, child welfare, missing or murdered women and ongoing racism. The effects are clear in Winnipeg, where the homeless population is approximately 50% aboriginal (Social Planning Council 2012). Some of this population is transient and include a high proportion of youth.

Poverty rates in Winnipeg are high compared to other Canadian cities, but have been higher. Aboriginal peoples are over-represented, with 37% of Aboriginal people living in poverty in 2005. The overall poverty rate in the city was 11% in 2011 (World Vision Canada 2013).

Winnipeg has been the murder capital of Canada and the child poverty capital of Canada. Gang activity has been a persistent issue. In 2014-15, Winnipeg received press coverage that suggests significant structural racism in the city, particularly aimed at aboriginal peoples.

Winnipeg is a growing city. While it experienced population decline in the past, the provincial nominee immigration program has led to substantial population growth, which is expected to continue (City of Winnipeg Trends Report 2013). The majority of immigrants come from the Philippines, then India and then China.

The proportion of older people in the population is growing, and in addition, absolute numbers of the over 65 age group are anticipated to increase by 68% by 2035 (City of Winnipeg 2014a).

Unemployment is low, at 5.3%, and wage rates are relatively low, compared to most provinces (Community Trends Report 2013). Relative income inequality is low, compared to most large Canadian cities.

Housing prices have experienced growth of 51% between 2007 and 2013, but appear to be moderating. However, housing demand is strong, and the average housing price remains lower than other major cities in Canada. Demand for rental accommodation is high, with an overall vacancy rate of 1.7%. Costs are relatively low, compared to other major cities. Winnipeg has one of the lowest rates of core housing need in urban centres in Canada, at 9.5% (AllAboard Annual Report 2013-14). This rate is almost twice as high for Aboriginal people. However, low income households have been struggling with rapidly increasing costs of rental properties and declining supply (policyfix.ca), spending a higher proportion of their total income on housing (World Vision Canada 2013). Further, most available rental housing is in the downtown core in older buildings that are increasingly in need of repair, and bachelor accommodation has a vacancy rate of .5% (Distasio, Sareen, & Isaak 2014).

The number of people using food banks in Winnipeg rose by more than 40% between March 2008 and March 2010. The number dropped back in 2011 but remained 37% higher than pre-recession levels, with over 45, 000 people in core food need (World Vision Canada 2013).

Winnipeg has a relatively strong economic outlook, due to a diversified economic structure and low relative costs for doing business (Community Trends 2013).

WINNIPEG'S HEALTH CARE AND SOCIAL WELFARE SERVICES CONTEXT:

Demand for emergency medical response is situated within the context of other health care and social welfare services. Winnipeg has a wide variety of services available, but many services are struggling to meet service demand.

Winnipeg health care is the responsibility of the local Winnipeg Regional Health Authority, which has a geographical catchment area or jurisdiction that almost matches the borders of the municipality. Health care in Winnipeg is relatively accessible, with 89% of residents reporting that they have a family physician (WRHA Annual Report 2014). There are both crisis and community mental health services available, but these services appear to operate at the edges of their capacity. Emergency rooms have been experiencing increased demand, and hospitals have been struggling with acute care patient flow. These issues have been high on the Authority's priorities. In order to organize other care facilities for those who have chronic or non-acute persistent care needs and housing issues, a Transitional Supportive Care program has been developed, to support up to 21 individuals through community services who might otherwise use emergency or in-patient services. They have produced a public awareness campaign, called MyRightCare, to discourage use of emergency services in favour of community services (WRHA Annual Report 2014). The WRHA also runs a quite well developed Home Care program. As in many other provinces, this service is delivered through sub-contracts with a wide variety of service providers.

Social Assistance is provided through the Employment and Income Assistance Program (EIA), which is an income support program that includes benefits for people with disabilities. There are a number of employment support and income supplement programs offered, including rent subsidies.

Manitoba Housing provides subsidies to households under various housing programs. Within the portfolio, Manitoba Housing owns and manages some housing units. It also funds some non- profit/cooperative sponsor groups or property management agencies. It provides subsidy and support to households (including personal care home beds).

Police services are also involved in responding to 9-1-1. Calls for "check well-being" are their second highest volume call category, with just over 10,000 calls in 2013. Their highest call volume was for "domestic disturbance" (Winnipeg Police Service 2013). Police services deploy both officers and cadets in responding to these calls.

The Main Street Project is a unique program designed to address the immediate and longer term needs of the downtown Winnipeg indigent and homeless populations. It includes a range of services that provide continuity of care, particularly to those with substance abuse issues. These include a 10 day detox program, an emergency shelter and Main Stay, a transitional housing program for those who have struggled to stay housed. Main Street Project is a sanctioned destination for ambulances, based on paramedic assessment. Costs to provide services are significantly less than hospital care and it offers services that more closely meet the needs of those it serves. It is a permanent program funded primarily by the Province of Manitoba, through the Winnipeg Regional Health Authority.

WFPS Paramedics work at the Main Street Project, providing assessment, monitoring, and addressing both emergent and primary care needs. They get to know those who use the facility, developing trust and a more therapeutic relationship. Not only has care improved to this vulnerable population, improving health outcomes, but ambulance transports from the facility have decreased significantly as a result – by 56% according to staff.

WINNIPEG FIRE PARAMEDIC SERVICE: HISTORY OF CHANGE

Innovation in emergency response is a Winnipeg hallmark. For example, Winnipeg was the first city in North America to introduce 9-1-1 as a community emergency response, commencing in 1959. Upholding this reputation, this fire paramedic service has made significant changes to its operations over the past thirty years. The most significant change was to integrate fire and Emergency Medical Services through a corporate amalgamation in 1997. This move resulted in ten years of labour strife, which was finally settled in 2007. The initial amalgamation proposal intended to reduce the number of unions involved. This "union-busting" approach was ultimately abandoned in favour of work-sharing agreements, leading to opportunities for service integration and an atypical public sector amalgamation.

This process did not yield the kinds of costs saving initially projected, but did save money by reducing management positions and the number of stations needed. No unionized jobs were lost in the process.

The WFPS has been led by a number of Chiefs since the amalgamation. The process was initiated under Barry Lough, and begun under the watch of Wes Shoemaker (1998-2007), who had background and training in fire and EMS. Jim Brennan, who also had this combined background, took over from 2007 – 2011, replaced by Reid Douglas, who was terminated in 2013. The Fire/Paramedic Chief is now John Lane, who has a background in both EMS and fire. He took over the role in 2014.

The firefighters are represented by the United Fire Fighters of Winnipeg, a local of the IAFF that has been led by Alex Forrest, President, since 1997. This consistent and strong leadership has been a significant factor in producing the kinds of changes experienced in Winnipeg.

The ambulance paramedics are represented by the Manitoba Government and General Employees Union, which is the largest union in the province. It has a wide mandate and is not a trade union. The relationship between MGEU and the Fire Paramedic Service is organized at the union local level, which has had changes in leadership over the period since amalgamation.

Firefighters' and paramedics' unions and other representative organizations across Canada have been engaged in a number of battles surrounding scope of practice and funding. Winnipeg has seen some of these battles.

There are three other bargaining units that represent workers at Winnipeg Fire Paramedic Service: Canadian Union of Public Employees (CUPE), Winnipeg Fire Paramedic Senior Officers' Association (WFPSOA), and Winnipeg Association of Public Service Officers (WAPSO).

Fire and EMS dispatchers were co-located in 2007 at a new call centre. Although working under two different collective agreements from two unions, a formal work sharing agreement was negotiated that means all workers share the same training and know each other's jobs. This work arrangement and co-location was organized in order to reduce processing time for emergency calls and enhance service coordination.

FIRE SERVICES BASIC DATA:

Winnipeg Fire Paramedic Service is a busy fire service relative to many urban services, although direct comparison is difficult due to Winnipeg's innovative service model. With 1,370.76 Full time equivalent positions, including 864 firefighter positions, (July 2015), it responded to 15, 083 fire-related incidents and 63,619 emergency medical responses in 2013 (Community Trends Sept. 2014, WFPS). These figures do not include inter-facility transfers or Community Paramedicine contacts. Winnipeg's firefighters (as of Dec. 2013) are overwhelmingly "white" men, as is typical of most fire services. However, 10.2% of firefighters were of Aboriginal descent and 5.1% were women. These figures are well above national averages for urban professional fire services. Employment equity goals appear to be intentions, rather than explicit targets or goals, due in part to debates about physical fitness for the job that continue to impede affirmative action at fire services across Canada. However, progress has been made.

PROMISING PRACTICES:

Winnipeg's leading promising practice is an integration of professional fire and paramedic/ambulance services in an urban environment. While these services have amalgamated, it is the ***service integration*** that this report commends, as amalgamation does not necessarily produce this result, nor is amalgamation strictly necessary to achieve this service integration. The Winnipeg approach to service integration appears to yield continually improving service and patient outcomes as well as service efficiencies for funders. It also appears to offer significant potential benefits to street level and other workers in terms of career opportunities and work satisfaction. The following promising practices were noted as significant to excellence in service delivery.

1. MUNICIPAL- PROVINCIAL ALIGNMENTS AND CO-OPERATION:

Service integration was supported by a jurisdictional alignment between the City of Winnipeg and the Winnipeg Regional Health Authority (WRHA). The Winnipeg fire services and the WRHA-funded ambulance services have almost the same jurisdictional boundaries.

Winnipeg Regional Health Authority entered into a cost-sharing agreement with Winnipeg Fire Paramedic Service that supports the integrated emergency medical response. This has been a model agreement, and a key indicator of significant and on-going cooperation between the city and the authority.

Throughout this report, various protocols, agreements and cost-sharing arrangements are highlighted. These have been developed between and among levels of government, unions and community organizations. These

agreements speak to relationships of negotiation and cooperation that have been developed, maintained and renewed among those involved in service delivery. Leadership is no doubt critical to these relationships, but was not the focus of this report.

2. WORK-SHARING AGREEMENTS WITH UNIONS:

Work sharing agreements have been the basis for the new service delivery model. Agreements with the firefighters' and paramedics' unions were finalized after 2007, resolving 10 years of labour dispute. These agreements make clear delineations between the work to be done – and not to be done – by firefighters, paramedics and by dispatchers for each service. These agreements addressed concerns from the various bargaining groups as well as developing relationships that could support systems improvements through shared service delivery.

Workers are **central** to quality service delivery. Respectful union-management relationships are necessary to maintain positive change, as are respectful relationships between unions and bargaining units. While there have been times when these relationships have not been in place in Winnipeg, it appeared that all concerned are committed to respectful relationships, while also negotiating tensions among their various interests.

3. PCP/FIREFIGHTER ON EVERY FIRE APPARATUS:

Efficiencies in the delivery model are due to having a cross-trained Firefighter/Primary Care Paramedic (PCP) on every fire apparatus. These workers are fully empowered to function as PCPs with full scope of practice, including assessment and treatment. Currently Winnipeg PCPs, whether on fire apparatus or ambulances, are not able to do 12 lead ECG acquisition or IV initiation, unlike PCPs in the rest of Manitoba. However, it is anticipated that this issue will be addressed shortly, expanding their scope of practice.

"Using fire units basically triples our response capacity."

This policy has been supported by a program that allows paramedics who want to cross- train for fire to do so. There were some indications that those who have done so have experienced some "chilly climate" from other paramedics, however.

4. MINIMIZE SERVICE DUPLICATION:

One continual criticism of 9-1-1 responses in most jurisdictions is that to send fire and ambulance is an unnecessary and expensive duplication in service delivery. Winnipeg Fire Paramedic data demonstrates that with a Fire/PCP on each vehicle, ambulance services are seldom sent out in cases that don't typically result in transport. This means that in 2013, over 10,000 medical calls were dealt with by Fire/PCPs only. This allows precious ambulance services and advanced paramedic skills to be distributed where most effective. Dispatch protocols appear to be working well to achieve these goals. This result was evident not only in the data but was confirmed by work observations.

> *"We've moved away from a whole culture of you're CUPE or you're, like, a fire dispatcher or ems."*

5. DISPATCH WORK ORGANIZATION AND PROTOCOLS THAT PREVENT DUPLICATION:

Dispatch operations are critical to ensuring that the right service arrives at the right time. Dispatch workers are also often the underappreciated team members in fire and EMS response. Cross-training and working side-by-side means that dispatchers from fire and EMS understand each other's work, appreciate each other's skills and decision-making, and experience similar working conditions if not identical union agreements.

Dispatch protocols at this service prevent duplication in dispatch. The benefits can be measured in part by what I did not observe. For example, unlike in other cities, where workers sometimes complain that "fire doesn't get dispatched until after EMS, yet EMS is slower", in Winnipeg, dispatch co-location means that dispatch protocols are transparent. Systemic problems with dispatch were not mentioned in interviews. Further, the "atmosphere" of the Winnipeg dispatch room was significantly less tense and less isolating for workers who are taking calls than other city dispatch fire and EMS operations that I have visited.

6. SMALL APPARATUS USE:

Winnipeg Fire-Paramedic Service uses "Squads" for many kinds of calls associated with emergency medical response. These smaller trucks have a small pump and hose load on a reel. They are roughly the size of a large pick-up truck. They have some fire capability that is particularly useful for wild land and for winter conditions. They also provide safer and more nimble transport than a large fire truck on downtown streets. To staff these squads, an engine crew of 4 was split in two to staff two 2-person squads. The squad is staffed by a lieutenant and a firefighter/PCP.

Squads attend to incidents such as motor vehicle accidents, man down, check well-being and similar sorts of calls. They also provide rapid response to high acuity calls with ambulance, as part of a tiered response.

7. SEAMLESS PATIENT RECORD AND SMART TECHNOLOGIES:

Patient information is captured on an electronic patient record that is seamlessly transferred between fire and ambulance. Implemented in 2007, many at WFPS and in the community recognize these Electronic Patient Care Reports (EPCR) are a key aspect of Winnipeg's success in emergency medical response.

Assessment information is recorded on an electronic tablet by one firefighter, while the cross-trained Firefighter/PCP assesses the patient and calls out information. This information is transferred to ambulance paramedics' tablets when they arrive, via a click of a button and blue tooth technology. These records are also transmitted to headquarters and to the receiving emergency department. Compared to other services included in this study, this use of smart technologies saves hours of worker time, enhances accuracy and completeness, facilitates service integration and many other service enhancements (see below). It also improves conditions of work, in that unlike many services, firefighters are not spending frustrating hours on computers after each call to enter call data by clicking through multiple screens that load slowly. This

technology also avoids the need for firefighters and paramedics to attempt completion of paper forms at emergency scenes, and ensures no data from any responders is lost or otherwise not provided to the emergency department.

This data collection is also collated and analyzed through subscription to a Computer Assisted Dispatch (CAD) compatible program called "First Watch". This program gives WFPS capacity to identify trends or triggers in the data. Like any tool, this program is only as useful as the questions posed and the attention to analysis. WFPS is making use of this program to initiate and promote innovation in service delivery.

Community paramedics (at the Main Street Project and EPIC see below) use the Electronic Medical Record, which gives access to E-Chart Manitoba, providing access to lab, diagnostic and dispensing information. Access to Home Care MDS electronic records will be possible in the foreseeable future. This access allows these paramedics unparalleled abilities to coordinate services and orchestrate case management.

8. CROSS-TRAINING AND CAREER OPPORTUNITIES FOR STREET LEVEL WORKERS:

Cross-training opportunities offer workers opportunities to improve their training and job satisfaction over a career. While there are issues, a new culture of public service delivery is also apparent, particularly among newer cadres of workers.

Firefighters' opportunities to cross-train, while mentioned by some of the firefighters as a job benefit, are somewhat undermined by cadre effects. For example, more experienced firefighters (with 15+ years of experience) often expressed derogatory remarks about emergency medical response, while less experienced firefighters, many who entered the field by first qualifying as paramedics, tended to express positive opinions about this aspect of their job. They clearly resented their more experienced colleagues' remarks. However, some new firefighters concurred with their more experienced peers. Others told me that they had witnessed new firefighters becoming influenced by the more experienced workers' views, adopting them in an effort to become more accepted team members.

Paramedics' opportunities to cross-train were also mentioned and also undermined by similar cadre effects. Some workers mentioned that some union executive members had not been supportive of cross-training. These factors had a chilling effect on people's motivations to cross-train. Some workers indicated that the attitudes of their co-workers were a factor in whether or not they intended to cross-train.

9. EFFECTIVENESS, JUDGMENT AND JOB SATISFACTION IN EMERGENCY MEDICAL RESPONSE:

Cross-trained Firefighter/PCPs were unanimous in their view that cross-training provided them the skills needed to adequately meet the demands of emergency medical calls. This response is in strong contrast to the opinions expressed by fire-trained firefighters in other cities. Winnipeg's firefighter/PCPs believed that their assessments led to different outcomes for patients and for greater service efficiency. These workers indicated that they see their involvement is making a difference.

Further, firefighters' abilities to make referrals to EPIC (see below), and to fire prevention were mentioned by members of all teams involved in the study as a significant improvement in service delivery that improved their job satisfaction.

10. MICRO-WORK COORDINATION BETWEEN FIRE AND PARAMEDICINE IN EMERGENCY MEDICAL RESPONSE:

In observations on emergency medical responses, it was noted that the work organization between fire/PCPs, fire-trained workers and advanced care paramedics was well coordinated and respectful. Firefighters assessed and secured the physical safety of the site, often spoke with and soothed bystanders and family members, asked for background information when appropriate, provided lifts, clean-up and physical support, and digitally recorded information in coordination with the firefighter/PCP.

Firefighter/PCPs focused on patient assessment and well-being. They were usually supported by a firefighter who recorded assessment information dictated by the firefighter/PCP on a tablet. These workers also took the lead on coordinating care with advanced care paramedics who arrived on the scene, briefly reviewing what they had assessed and any other relevant information, so that the patient and onlookers or family did not have to repeat their entire story.

Advanced care paramedics seldom redid the assessments (as I have witnessed elsewhere), thus not only respecting their colleagues' professionalism but also minimizing intrusiveness and eliminating unnecessary duplication. They listened to the assessment information, confirmed that they had received data transfer to their tablet, asked questions clearly and respectfully, asked for support from fire-based workers rather than directing and, on several occasions, consulted on patient concerns with their fire-based colleagues.

11. "ITS TREATING PATIENTS LIKE PEOPLE, NOT A TASK":

> *"We are a health care team. Yeah, we're {firefighters} not the one who's measuring the blood pressure or listening to the chest… but we have a vital role to play in that, in terms of observation and those kinds of things."*

Cross-trained firefighter/PCPs and paramedics gave accounts of their work in emergency medical response that reflected the view that their service delivery model allowed them to treat patients "like people, not tasks", as one worker expressed it. Firefighter/PCPs and paramedics told me that they liked having the skills to offer both medical aid and "care and comfort" when people needed it most. Many workers described that they were following a protocol that allowed for attention to people's unique circumstances, and gave them some discretion about how to best respond. (See New Challenges section for some additional information).

12. A PILOT PROGRAM TO ASSIST SERVICE USERS AND ACHIEVE EFFICIENCIES:

A pilot program, called Emergency Program in the Community (EPIC), has been in operation since April, 2013. This initiative aims to reduce 9-1-1 emergency services use through a program that uses community paramedics as primary care providers who assess and support highly vulnerable individuals and/or households, organizing as much as possible needed services. ***This program is worthy of a separate promising***

practices report, due to the high level of service it can provide and the significant efficiencies it produces. The EPIC program is discussed in some detail here. Note that this program is possible in any urban jurisdiction and is not dependent on amalgamations. It depends upon highly skilled staff who can broker and maintain relationships and promote a high level of service coordination. It also requires strong support from senior administrators across fire, paramedicine and health services.

The program began with a cadre of six Community Paramedics who work 12 hour shifts to provide coverage seven days a week. They have continual medical oversight, with a physician medical director always available.

EPIC Service Type 1: The program began by identifying the 40 most frequent 9-1-1 emergency service users. These persons typically do not have a family physician, are living in poverty, have multiple chronic health conditions and complex medical histories, are often disabled and have difficulty staying housed.
The paramedics support by managing very long term medical issues, sorting out safety issues and dealing with hazards, liaising with appropriate community services and "quarterbacking" home care provision. In other words, these paramedics provide a mix of medical assessment and health care, case management, patient monitoring and advocacy. Patients can call the EPIC service directly, instead of calling 9-1-1. Often, these patients develop relationships with the workers that facilitate care through the development of trust and knowledge over time.

EPIC Service Type 2: Community paramedics go out to visit "at-risk" individuals who have been identified during emergency or other responses by firefighters or paramedics as an at-risk individual. These workers use a computer program, called First Watch, which works with the Computer Assisted Dispatch System and EPCR to identify trends or triggers in data. The EPIC paramedic goes out to see these people to deal with issues in a proactive way.
An example of one of these reports is: "Patient has difficulty ambulating, lives alone, is very weak, has not been set up for any care services, patient home not cleaned. Feces on floor, mattress in closet, patient unable to open her medication. Lives alone, safety concerns."

"It's an 85 year old guy that lives by himself…we've been there a couple of times a week for falls and lift assists. We looked into it and his wife is recently deceased. We've now engaged the Geriatric Mental Health Assessment team to go out and see him, and homecare… he's afraid to reach out for himself but we've gone and talked to him and kinda said, you deserve this."

EPIC Service Type 3: The program has also identified frequent locations, or common addresses, that are accessing 9-1-1 services. The EPIC program provides a proactive response to these addresses, and look to address concerns before they require EMS transport to the Emergency Department. An example of such an address is often a rooming house in a depressed area of the city, or other address where people with many difficulties find refuge.

EPIC Service Type 4: Patients that have been seen at hospital Emergency Departments and have had diagnostic testing done, but have left before the results have come back, are now referred to the EPIC program. The community paramedic works with the Emergency Department to find these individuals and facilitate transport back to the site if required.

EPIC Service Type 5 (Proposed): It has been proposed that the program could be used to provide short-term support to relatively stable patients who need to be seen at hospital when there is a queue in the hospital emergency department. If available, an EPIC paramedic could be dispatched to monitor the patient as

needed, putting telemetry in place. The patient could enter the queue at the hospital virtually while staying safely at home until called, with the support of the Community Paramedic.

EPIC Coordination of Care Contributions:

a) The EPIC program ensures that each of their clients is assigned a social worker from one of a variety of community organizations, in order to adequately support their clients. For example, EPIC paramedics work with a dedicated social worker in the Emergency Room at the Health Science Centre who is mandated to work with "common callers". This social worker coordinates care for EPIC clients who use that hospital. EPIC paramedics also work with a Police Services social worker and two social workers from Emergency Social Services at the City of Winnipeg. The social workers do psycho-social assessments and link clients to appropriate community agencies, while also introducing EPIC workers to social welfare services that are beyond the usual knowledge of the more health-care oriented paramedics.
b) Physiotherapy, respiratory therapy and occupational therapy are facilitated by EPIC. EPIC paramedics go out to clients' homes with these service providers, who are Home Care providers, to introduce them and smooth a path for assessment at home to these usually very vulnerable people.

13. PROTOCOLS FOR "HAND OFF" OF INTOXICATED PATIENTS AMONG EMERGENCY SERVICES:

In Winnipeg, there are well-developed protocols that support emergency services workers to serve the public more efficiently and kindly. For example, in the case of emergency responses to people that meet the minimum criteria/health status markers of intoxication (as assessed by a PCP), there is a protocol that allows WFPS paramedics (both fire and ambulance) to call police. Police officers or cadets humanely apprehend these individuals and transport them to the Main Street Project, where there is a unit that allows people to sober up in a safe environment. This is an alternative to jail or other punitive measures.

WFPS Advanced Care Paramedics, located at the Main Street Project, are in positions fully funded by the Winnipeg Regional Health Authority. They address the immediate medical needs of these patients, such as responding to seizures, blood sugar issues and other common health concerns. These workers, called Community Paramedics, also do discharge assessments to ensure that these individuals are sufficiently competent and well at discharge.

As well, there is a protocol that allows a PCP to "hand off" care to a Community Paramedic when warranted. In these cases, patients are typically unresponsive, hypoglycemic, cold and/or may meet the criteria for involuntary psychiatric treatment.

14. A CULTURE THAT CAN PROMOTE AND SUPPORT NEW IDEAS:

WFPS appears to have been able to develop, support and promote new ideas – like EPIC. This ability should not be reduced to the contemporary fascination with "innovation" in services. It appears to be due to the exceptional commitment and interest among key personnel to push for service improvements, some strong abilities to "sell" these ideas both internally and among other stakeholders, and to develop the trust and relationships that support positive service improvements. This means that these personnel have sufficient time and autonomy in their day-to-day working conditions to allow them to plan, consult, organize, meet, test and

pilot promising practices. This work organization and culture must be recognized as promising practices that are promoted and maintained by staff at all levels.

> *"I work with great people who are very like-minded in terms of let's be progressive, let's not be afraid of change."*

15. TRAINING AND DEVELOPMENT OPPORTUNITIES THAT WORK:

While all the fire services that are included in this study tend to have strong training programs, Winnipeg offers some promising practices in this area.

1. Street level workers are oriented to dispatch through spending time at the communication centre.

2. Individualized development plans for training are in place for dispatch and some other workers. These plans offer an opportunity for significant personalization in the training, with extensive use of books and on-line resources for independent study. Course work may include technical, administrative, inter-personal, equity and other skills and orientations related to worker's short and long-term career development.

16. TRAINING TOWARD RESPECTFUL CARE FOR ABORIGINAL PEOPLES:

WFPS Training includes a three day aboriginal awareness program that includes historical background on residential schools, the role of women in aboriginal communities, colonization and inter-generational trauma. While some firefighters expressed concern that they see only the bleak side of aboriginal life and this tends to reinforce racism, there were also many who demonstrated more a complex understanding of the problems confronting aboriginal peoples.

NEW CHALLENGES NOTED:

In reviewing the data from this relatively brief but intensive research visit, I noted a few significant and inter-related findings related to emergency medical response. These findings suggest that success in fire-involvement in EMS response presents new challenges, particularly in the area of training needs and health and safety concerns.

1. "Over and over, man down. It eats your soul." Vicarious trauma and compassion fatigue due to emergency medical response appears to be a serious health and safety issue affecting fire/PCPs, EMS personnel and dispatchers.

   In my short visit, I interviewed and talked with many workers who told me, unprompted, that they were finding that continual exposure to people living in desperation, addiction and turmoil was affecting their own well-being, including feeling burnt out, feeling " my compassion bleed away", missing shifts because they needed a break, and even wondering if they were suffering from PTSD. When I

inquired about training to deal with vicarious trauma, no one had taken such training and didn't believe it was offered. This concern was expressed by fire/PCPs, Dispatchers and EMS. Some workers have left EMS roles or have not continued in community paramedic roles due to these issues, sometimes citing other reasons.

2. "Send the boys, the Chief says, but [the union officials] needs to stand up and say we're not going". There is a lot of confusion about why fire services need to attend certain kinds of emergencies among both fire and EMS personnel. The challenge appears to be that some workers do not understand or appreciate the changes to health care and social welfare problems and service delivery that are shaping reliance on 9-1-1, and so are blaming the organization, rather than seeing the broader picture. The success of Winnipeg's service model relies on workers' understanding of the importance of what they do, including those calls that seem to enable those with problems or which address no clear problem. Training could address this issue.

3. "Family members are my worst thing". Some firefighters complained of a lack of skills for the social care aspects of emergency medical response. They indicated that their training didn't do much to cover this, and that these so-called "soft skills" are not well articulated on the job. While I witnessed some firefighters use very strong interpersonal skills at responses, many workers, including those with good skills, told me that this was not an area of confidence. Room for improvement for these workers was noted in the relationships with family, where firefighters frequently appeared to have inadequate training to deal with emotional volatility, grief or shock. Further, they did not take advantage of opportunities to ask for or find medications, shoes, coats and eyeglasses for transport patients. Finally, they did not use their opportunities to share knowledge of protocols and procedures with family members in order to help them cooperate and understand the work conducted by emergency services workers.

CONCLUSION:

The Winnipeg Fire Paramedic Service offers many outstanding "promising practices" in service integration that could be applied by other municipalities. Press coverage in Manitoba and elsewhere has tended to focus on the problems of amalgamation rather than the very significant benefits of service integration. This has been achieved through the political will and dedicated collaboration of many stakeholders.

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