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Canada

# CP@clinic: Université Laval

Fall 2025



Paramédic  
communautaire



dessercom  
département clinique

CONSORTIUM  
FOR RESEARCH  
& INNOVATION  
IN ACUTE CARE  
TEAM CESNA



CONSORTIUM  
DE RECHERCHE  
ET INNOVATIONS  
EN SOINS AIGUS  
ÉQUIPE CESNA



Healthcare Excellence Canada would like to formally acknowledge Université Laval's generosity in sharing their skills, knowledge, expertise and experiences to inform this promising practice.

## About Healthcare Excellence Canada

Healthcare Excellence Canada (HEC) works with partners across the country to shape a future where everyone in Canada has safe and high-quality healthcare. We bring together people, evidence and action to move Care Forward - spreading and scaling quality and safety improvements, strengthening capacity and collective leadership and catalyzing change in policy and practice.

At HEC, healthcare excellence means improving safety, quality and value for everyone. It means care grounded in what matters most to patients, caregivers, communities and people in the workforce. It also means care that respects and responds to First Nations, Inuit and Métis priorities and is culturally safe, equitable and supported by the appropriate use of technology. Together with our partners, we embed these foundations across the health system.

Our work also focuses on expanding access to safe, connected, high-quality care closer to home and community. This includes supporting people with primary health care needs and older adults with health and social needs.

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150 Kent Street, Suite 200  
Ottawa, Ontario, K1P 0E4, Canada  
1-866-421-6933 | [info@hec-esc.ca](mailto:info@hec-esc.ca)

[LinkedIn](#) | [Bluesky](#) | [Instagram](#) | [Facebook](#)

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## Enabling Aging in Place collaborative

The Enabling Aging in Place collaborative brought together health and social service organizations from across the healthcare continuum to implement promising practices that can delay people's entry into long-term care. The collaborative aimed to improve safety, health and quality-of-life outcomes, while also reducing emergency department visits, lessening demands on care partners and making better use of health and social care resources.

Teams from communities across the country participated in the Enabling Aging in Place collaborative.

# CP@clinic

The [CP@clinic](#) model was initially developed by a research team at McMaster University in Ontario, the implementation in Quebec is coordinated by Université Laval's Consortium for Research & Innovation in Acute Care (CESNA team). The initiative is a collaboration with community paramedics from [Dessercom](#), a paramedicine organization, as well as the [Office municipal d'habitation du Québec](#) (OMHQ) and the [Office municipal d'habitation du Grand Portneuf](#) (OMHGP).

The Quebec CP@clinic model preserves the essential characteristics of the Ontario model, including providing services to low-income older adults.

The CP@clinic program is hosted at four Office municipal d'habitation (OMH) buildings in the Capitale-Nationale region. Community paramedics provide structured health assessments at these buildings for residents who are interested in attending.

The clinics focus on chronic disease prevention, management and health promotion, as well as improving the health and quality of life of older adults. The program also aims to reduce social isolation, facilitate connections with primary care and community resources and reduce the economic burden of avoidable 911 calls by older adults.

## Key Features

### Objectives

The primary objective of this work is to evaluate the feasibility of the CP@clinic community paramedicine model in Quebec, specifically in the Capitale-Nationale region.

Secondary objectives include:

- exploring the impact of community paramedicine on a range of health outcomes
- exploring the impact of community paramedicine on the use of pre-hospital emergency services and emergency departments
- exploring the impact on delayed entry to long-term care

### Population served

The CP@clinic program is currently implemented in four OMH buildings. Two clinics are located in rural areas of the regional county municipality (RCM) of Portneuf, and two in urban areas of the Capitale-Nationale region. Depending on the building the clinics are either held once a week or once every two weeks.

Participants of the CP@clinic programs often have limited access to medical and other services, especially in rural areas. This model helps improve equity of services.

### Program team

The research team is made up of a clinical research coordinator and a principal clinician investigator, with expertise focusing on research in pre-hospital care and acute care for older adults. This team is responsible for organizing the collaborators involved in CP@clinic and ensures that the required information and resources for the program's operations are available. The team also ensures that compliance standards and ethical requirements are upheld.

The community paramedics implement the program, conducting visits with CP@clinic participants. They complete health assessments and refer participants to

appropriate health and community services, based on their specific needs identified.

All participating community paramedics successfully completed the “Programme des Soins Paramédicaux Communautaires à la Clinique” [In-clinic community paramedic care program] training developed by the McMaster team. This training covers the major issues that must be considered when assessing participants including health promotion and disease prevention; risk factors for cardiac disease, diabetes and falls; blood pressure and blood sugar readings; food and income security; social isolation and loneliness.

Participating OMH building teams supported clinic implementation by providing appropriate spaces in their buildings and facilitating awareness of the clinics with their residents.

## CP@clinic

In Quebec, CP@clinics take place in the communal spaces of participating OMH buildings. There, residents access free evidence-based health assessments as well as friendly visits with community paramedics.

## Referrals

Awareness of the clinics was promoted through an initial meeting to present the program to tenant committees of buildings selected for the CP@clinic program. Posters were also put up in each of the buildings to indicate the times and locations of the clinics so that residents could choose to attend.

## Enrollment and services

Participation in clinics is entirely voluntary and there is no limit to the number of visits, each visit is customized to the individual’s needs. To begin, community paramedics conduct an initial overall health assessment of the

participant. This preventive care approach aims to improve physical and mental health and quality of life in a population that often has multiple comorbidities. The program also supports referrals for participants to available community or health resources that are tailored to the needs identified in the assessment.

During a visit, the community paramedic first obtains written informed consent from the older adult, then proceeds with the following steps:

- conducts an overall health assessment using evidence-based standardized tools
- works with the participant to set personal health goals
- provides personalized health education
- engages the participant in healthy lifestyle discussions
- supports referrals and facilitates access to primary healthcare services and relevant community resources

For example, someone experiencing high blood pressure may receive information about diet and exercise and receive a referral for self-monitoring tools. The results from blood pressure readings are shared with their primary care provider when applicable to help them provide follow-up care for chronic diseases. Another individual who might benefit from having access to healthy eating options may be referred by the community paramedic to a low-cost meal delivery service to support them with this goal.

## Implementation context

The partnership between the CESNA team and [Dessercom](#) supported the effective delivery of services within the clinics and was critical in expanding the program to Quebec.

The partnerships section outlines another unique adaptation of the CP@clinic to the Quebec setting: its direct relationship with [211](#), a service that provides information about community, public and parapublic services. The partnership with this organization supported an effective referral pathway tailored to the individual needs of each participant.

## Outcomes<sup>1</sup>

### Improving prevention and early intervention

For many older adults in social housing, access to care is made more difficult by reduced mobility, limited financial resources or lack of a support system. Their access to care is improved through regular visits with community paramedics at the CP@clinics. The clinics provide simplified barrier-free access to primary care the older adults may otherwise not have access to.

As the clinic is in the housing building where participants live, community paramedics are able to easily monitor and conduct follow-ups with participants to identify changes in their health statuses. As the clinics are easily accessible to participants, action can be taken quickly when there are early signs of decline or illness, which helps prevent hospitalizations.

The community paramedic team has observed that more frequent visits have resulted in concerns being treated sooner and participants gaining a better understanding of the importance of their own active engagement in

managing their own health. The research team has also received feedback from families stating that, since the clinic opened, their loved ones seem to take their health more seriously and have made positive changes to their lifestyle.

### Increasing meaningful personal connections and reducing isolation

The older adults who visit the clinics are not just receiving advice about their care, they are also developing a trusted relationship with qualified providers who take the time to listen, show them respect and compassionately support them. Participants also feel like their concerns are taken into account and that they are not rushed during visits.

“There are so many participants who’ve made changes to their lifestyle after getting advice from the CP@clinic paramedics. For example, one participant who was grieving didn’t really feel comfortable speaking about it with her children, as they were also grieving. But she did trust the community paramedic enough to talk about it, and they helped her find some solace.”

- Member of the CP@clinic research team

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<sup>1</sup> The outcome and impact information shared reflects information available at the time of writing this promising practice. HEC would like to acknowledge that evaluation activities are an ongoing process for many promising practices and

the type of data collected is influenced by program goals, the length of time the program has been implemented and the level of resources available to support evaluation.

## Strengthening social ties and feelings of safety

Having the same team at the clinics on a regular basis fosters a local community of kindness and compassion. Participants feel safe and trust the teams at the clinic.

Many participants are reassured to know that they can easily get help every two weeks, especially clients who live alone or have little family or social support.

The OMH coordination teams have also observed a general reduction in anxiety in their residences.

Ms. Strasbourg, age 78, also attends events organized by her OMH, which helps her feel like part of the community and helps her find balance in her life.

The clinic makes her feel much safer at home. She also says that her neighbours, who don't all have a family physician, see the clinic as a valuable resource that cares about how they feel. Especially important to her is how the paramedics take a comforting, reassuring approach to patient interactions that is based in professionalism and compassion.

## Enabling aging in place and reducing the number of avoidable 911 calls

Community paramedicine is still new in Quebec, and the CP@clinic is the first implementation of it to be offered in a clinic setting. The preliminary results indicate that local support services combined with rapid

referral to primary care helps older adults stay independent and safe for longer.

Additionally, initial data shows a reduction in the number of 911 calls, with more in-depth exploration of this in the future expected.

"We are temporarily unable to access 911 data on reductions in non-urgent calls due to ongoing strikes in front-line services in Quebec. That said, low-cost housing residents and managers involved in the project all agree that there has been a significant drop in 911 calls and ambulances used for low-priority issues."

- Member of the CP@clinic research team

## Improving health outcomes and faster access to primary care

In the fall of 2025, the Capitale-Nationale CP@clinic saw 95 participants, with an average age of 74 (64 percent of them women). According to the research team, "there is moderate participant turnover due to residents moving out and new residents moving in." Residents visited the clinic on average five times. Over 70 percent of participants made follow-up visits to the clinic, 86.8 percent of whom improved or stabilized their systolic blood pressure.

2/3 of participants with high systolic blood pressure had a family physician, so the information collected during CP@Clinic visits was sent to their physicians for follow-up.

“A gentleman who drank only liquor and smoked over 10 cigarettes a day has cut back his drinking and smoking. He now drinks at least one litre of water and smokes about five cigarettes each day. His goal is to gradually quit smoking. He is so very proud of his progress, and so am I! His blood sugar levels have always been very high, but recently, they’ve been within the normal range. This is fantastic news for him, given the awful outcomes diabetes can have.”

- Community paramedic

## Funding

Implementation of the CP@clinic in Quebec was made possible by support from Healthcare Excellence Canada and [VITAM](#)—the sustainable health research centre of CIUSSS de la Capitale-Nationale.

CP@clinic also receives community paramedic expertise from [Dessercom](#), an organization that is very well established in the province’s emergency pre-hospital care network. As part of this project, the Dessercom team received seed funding from McMaster University.

# Asset-Based Community Development Approach

**Asset-Based Community Development (ABCD)** is a strengths-based approach to solving challenges in communities that focuses on and develops the strengths of local assets (e.g. people, physical assets) that are key to ensuring a sustainable community.

Thanks to the ABCD approach training and the support received, the CESNA research team from Université Laval focused on the strengths, knowledge and resources available in the community, rather than just on needs or shortcomings. This approach has enabled the team to be more collaborative and inclusive as they seek to recognize and value participants’ skills, strengthen their sense of belonging and encourage them to get actively involved in initiatives.

More significantly, the ABCD approach has encouraged community members to become more active and involved participants, while fostering collaboration between community and institutional interest holders. The approach has made our services more relevant and sustainable because they are built on local assets and commitments from the community that go beyond the intervention itself.

In short, the CP@clinic has grown to be more than just healthcare support, it is a way to mobilize and leverage the collective strength of our communities and make an even greater impact locally.

# Partnerships

Through the ABCD approach, each clinic is assessed for locally available resources (health services or social support).

Each clinic also forges a number of community partnerships, including with health, housing and community services for older adults. These partnerships mean participants can be referred to resources that they may not be aware of. Additionally, the CP@clinic program demonstrated the importance and usefulness of community paramedicine in the Quebec landscape.

“This program helps us see what’s available at the community level... It’s easy to get in contact with community organizations, as they understand how complementary community paramedicine is to their work.

We are trying to break down the silos created by a lack of communication between primary healthcare services and community services.”

- Member of the CP@clinic research team

This promising practice was co-produced with the CESNA team from Université Laval and McMaster University. Information was compiled in fall 2025. To reflect the changing and evolving nature of care, information may change. We encourage you to reach out to this team for any information that could help you as you work to improve care for those you serve.

## How can I learn more?

CESNA team contact information

[ann-pier.gagnon.ciussscncn@ssss.gouv.qc.ca](mailto:ann-pier.gagnon.ciussscncn@ssss.gouv.qc.ca)