

Community Paramedicine Program



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Why are we doing Community Paramedicine Projects?

Changing Patient Demographic:

- Ontario's older population expected to double over next 20 years, while its 85 and older population set to quadruple (*Sinha 2011*)
- *Presently 14.6%* of Ontario population is 65 and older and accounts for 50% of the Health and Social spending (*Census 2011*)
- Northeastern and Northwestern Ontario has the oldest population in Ontario and is projected to have the highest growth in seniors and has some of the highest ratios of Chronic Diseases (CIHI 201).

Impact on Paramedic Service:

- Seniors are the highest users of EMS resulting in higher service costs thus there is a need to transition the system from **Response (reactive)** to **Prevention (proactive)**
- *Living Longer, Living Well"* (*Sinha 2012*) recommends the development and expansion of Community Paramedicine Programs.
- In Sudbury 60% of our call volume are for patients 60 years and older, predicting a 33% increase in service demand for patients 65+ over the next 8 years

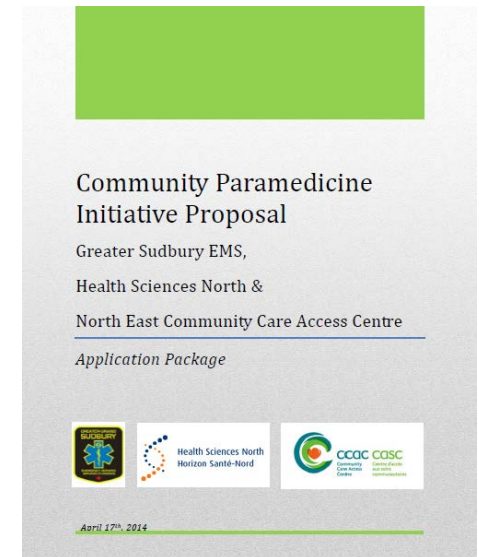


Expanding Community Paramedic Programs

Jan 2014 – MOHLTC announced \$6M funding to support the expansion and development of CPP in Ontario, and in total 30 submissions received funding

Sudbury submitted three proposals and received funding for two, they are:

1. Care Transitions Community Paramedic
Max. Funding Approved: \$300,000
2. Health Promotion Community Paramedic
Funding Approved: \$102,900



Why Paramedics?



Reconceptualising the Paramedic as a Mobile Health Provider



- Paramedic System infrastructure designed to support mobile health care, going into the community and patient's homes which is a natural fit for supporting seniors in their homes.
- Paramedics Experienced in delivering medical interventions using medical directives with physician oversight.
- Alternative model of community care that does not exist.

Care Transition Community Paramedic Pilot

HSN



Patient Diagnosed with COPD, CHF, Diabetes, Dementia identified as high risk for readmission

Discharge



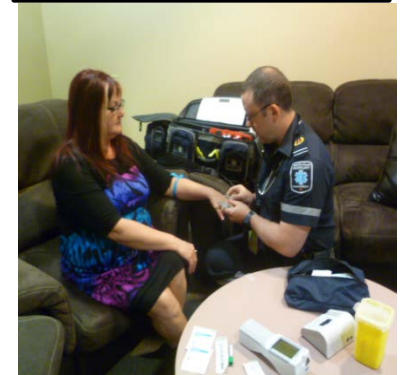
On discharge Patient enrolled in the Care Transitions program

At Home



CCAC - Rapid Response Nurse follow-up with patients within the immediate discharge period (1 – 30 Days)

At Home



Community Paramedic visits patients within the immediate discharge period and beyond. (1 - 90 Days)



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North East
CCAC CASC
Community Care Access Centre
Centre d'accès aux soins communautaires du Nord-Est



What does community paramedic “*post hospital care*” look like?

- Physician oversight – if required, the CP may consult directly with one of the on-call program Physician’s or with HSN chronic disease clinics
- Point of care testing – laboratory blood analysis, 12-Lead ECG analysis
- Medical interventions – such as medication administration and dosage adjustments
- Just-in-time and Scheduled Visits – Patient can call CP directly anytime to request a visit to manage a worsening condition
- Education on disease management and as required medication reconciliation



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Care Transition Community Paramedic Program



- Schedule: 1 CTCP -12 hrs per day/365
- Staff: 3 ACPs (min 7 yrs exp)
2 Fulltime and 1 Part-time
- Trained Centennial College
- Medical Director & “Doc in the Box” program



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Goal and Outcomes

Goal:

Decrease ED visits and readmissions for identified high-risk patients discharged from HSN compared to their past utilization

Program Facts: (as of July 31th)

- Average patient age 77
- One or more of three chronic diseases (Diabetes, CHF, COPD)
- Complex medical patients, averaging more than 10 medications per patient
- **186** patients contacted, **119** have been enrolled in the pilot
- **539** home visits, averaging 3 visits per patient
- **49** “Just-in-time” Visits



Project 2: Health Promotion Community Paramedic

Goal:

Develop standardized Programs, to assist citizens in chronic disease recognition, prevention and health system navigation.

Health Promotion Program components include:

- Wellness Clinics & Health Education
- Community Referrals by Paramedics
- Medical Research Studies
- Public CPR and AED Training



Health Promotion Community Paramedic

Regular Shelter Wellness Clinics

- Wellness clinics promoting healthy lifestyles.
- Refer to appropriate Community services.
- Assist patients to reconnect with the health care system.
- Commenced May 12th- clinics every Thursday

Partnership with local emergency Shelters

- Cedar Place Women's and family
- Salvation Army Men's
- Foyer Notre Dame Youth



Health Promotion Community Paramedic

Electronic Paramedic Referral process to NE-CCAC:

- Paramedics send electronic referrals to NE-CCAC for consenting patients with unmet needs.
- Paramedics will use the PERIL Tool = Paramedics assessing Elders at Risk of Independence Loss Tool
- April 30 – July 31: **66 referrals** to NECCAC

CPR Blitzes:

- Free “Hands Only CPR”/ AED familiarization in partnership with Heart & Stroke
- Fall 2014: 8 sessions **192** people trained
- Blitz - May 29, 2015: **49** people trained



Research – HP Community Paramedic

Community Health Assessment Program through EMS w/ McMaster University (CHAP-EMS)

- Target = Older adults in subsidized housing
- Health Risk Assessment to identify modifiable risk factors that contribute to Cardiovascular Disease
- Participant indicates area(s) of desired lifestyle change(s)
- Weekly wellness clinics & vital sign checks
- Links to community health promotion programs & family physician
- Goal = Early identification, management & prevention of chronic disease



The CHAP-EMS study is supported by the Canadian Institutes of Health Research (CIHR) www.cihr-irsc.gc.ca (Grant MOP-133563).



Community Paramedic Programs

Additional initiatives:

- Paramedic Health Concern Forms
- Community Mobilization Sudbury: RMT
- Emergency Department Diversion for Mental Health and Substance Misuse Patients.



Community Mobilization Sudbury
Mobilisation Communautaire Sudbury
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Questions

