Community Paramedicine Activities – COVID-19 Response and Health Promotion Update – December 2021

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Report Summary

This report provides information regarding the Community Paramedicine programs delivered by Greater Sudbury Paramedic Services.

Relationship to the Strategic Plan, Health Impact Assessment and Community Energy & Emissions Plan (CEEP)

This report refers to operational matters and has no direct connection to the Community Energy and Emissions Plan.

Financial Implications

There are no financial implications associated with this report.

Background

Greater Sudbury Paramedics Services Response to the COVID 19 Pandemic

Paramedics have been an essential resource amid the COVID-19 pandemic and this report has been prepared to highlight the essential roles Greater Sudbury Paramedics have filled in the City's response to the COVID-19 pandemic. Throughout this human health emergency, paramedics are providing COVID-19 testing, administering COVID-19 vaccines (both in clinics and in homes), providing services within Community Paramedicine programs, in addition to core emergency service delivery. Community Paramedicine has been a crucial support for individuals during the pandemic, especially for isolated seniors, vulnerable citizens, and those living in remote areas.

Community Paramedics Providing COVID 19 Vaccinations

Working collaboratively with Public Health Sudbury and Districts, Community Paramedics have been operating mobile vaccine to client (VTC) clinics, delivering vaccine to those within the City of Greater Sudbury who are unable to make it to a mass immunization clinic. To date, our Paramedics have completed over 775 first and second dose appointments to eligible clients in their homes.

Mobile COVID-19 Testing – Collaboration with Health Sciences North

Paramedics continue to support the Health Sciences North (HSN) COVID-19 Assessment Centre by providing mobile in-home COVID-19 testing for select individuals unable to attend the Assessment Centre in person either due to limited mobility or transportation challenges. Currently, Community Paramedics have assessed and tested over 8,624 residents in the community total, with 4,785 between January 1, 2021 and October 31, 2021 allowing equitable access to COVID-19 testing. In addition, we continue to collaborate with community partners, conducting surveillance and outbreak testing in settings of declared outbreaks and addressing specific needs of vulnerable populations within our community.

Care Transitions Community Paramedicine Program (CTCP)

The Care Transitions Community Paramedicine Program partners with Health Sciences North to utilize trained Community Paramedics (CP) to provide home visits and approved interventions under medical oversight to complex, high-risk patients to assist them in transitioning from acute care to community and/or self-supported in-home care.

The program's goal is to decrease emergency department visits and readmissions for identified high-risk patients with chronic disease (CHF, COPD, and diabetes) compared to their past utilization. Paramedics assigned to the CTCP continue to deliver services as outlined in the 2021 work plan during the pandemic.

From January 1, 2021 until October 15, 2021, there were 226 active patients enrolled within the program and only 27 patients reported the need to utilize our 911 service for the treatment of their chronic health condition in this eight-month period. Care Transitions Community Paramedics referred a total of 198 patients to community health and social services; 113 patients to primary care, 20 to Home and Community Care Support Services North East (previously known as NE LHIN / CCAC) and 65 to "other" community services, thus improving the quality of life for these patients.

In an effort to reduce in person contacts during COVID-19, the CTCP program contacts patients over the phone if preferred and appropriate for the situation. Home visits continue as preferred by patients / caregivers and are either scheduled or same day calls for Just in Time (JIT) visits. These JIT visits are for those situations of chronic illness exacerbation to allow CTCP paramedics to intervene prior to activation of 911 or an emergency department visit.

Visits Completed / JIT	1,487 / 180
Working Days	281
Active Patients	226
911 Calls Related to CTCP	35

Reporting date range is from January 1, 2021 – October 15, 2021

Health Promotion Community Paramedicine (HPCP)

The objective of this program is to maintain and expand health promotion, education, and injury prevention. This program will also assist citizens in chronic disease recognition and prevention, injury awareness/prevention strategies, referrals, and health system navigation assistance. The primary goals of this program are to mitigate emergency calls and hospital visits, keeping our "at-risk" aged population healthy and at home. This is an attempt to aid our vulnerable population and redirect them to more suitable community resources other than the emergency department.

During the pandemic, the HPCP program has collaborated with the various community agencies in our provision of COVID-19 mobile testing to ensure our patients are tested and may remain safely in their place of residence.

- HSN COVID-19 Assessment Centre is screening phone calls from citizens to evaluate if COVID-19 testing should be conducted, scheduling in-home testing by the Community Paramedic Mobile Testing service for those in our community who are unable to physically attend the HSN COVID-19 Assessment Centre and are members of the mobile testing group who provide the in-home COVID-19 testing.
- Community Paramedicine completes congregate setting outbreak testing aligned with Ontario Health North and under request from Public Health Sudbury and Districts.
- We have established a priority referral process to HPCP from Home and Community Care Support Services North East / Maison McCulloch Hospice for those in the community who require COVID-19 testing for admission to either a long-term care facility or hospice.
- A group of Primary Care Physicians function as CP medical oversight physicians. They offer guidance / follow-up if required for those patients the Community Paramedic's test, assess, and who require further intervention(s).
- Sudbury and District Nurse Practitioner Clinic (SDNPC) with Dr. Alex Anawati and the Canadian Mental Health Association (CMHA) have collaborated with HPCP where HPCPs provide on demand COVID-19 testing every morning at the HSN Withdrawal Management Clinic at 336 Pine Street.

HPCP: Paramedic Referrals and Community Mobilization Sudbury - Rapid Mobilization Table Engagement

HPCPs have continued with our paramedic referral programs and Community Mobilization Sudbury-Rapid Mobilization Table (CMS-RMT) presentations and in person responses to support those found at acutely elevated risk of harm with coordinated immediate multiple agency wrap around care.

Paramedic Referrals (PR): Number of PRs reviewed, processed, and actioned by HPCPs	481
Rapid Mobilization Table (RMT): HPCP as RMT originating agency	34
Rapid Mobilization Table (RMT): HPCP as RMT presentation lead agency	16
Rapid Mobilization Table (RMT): HPCP as RMT presentation assisting agency	112

HPCP Paramedic referrals and RMT engagement between January 1, 2021 to October 15, 2021

The Health Promotion Community Paramedic program has been requested as a supporting agency in a total of 112 other RMT presentations originating from other community agencies out of 140 overall totals of RMT presentations between January 1 to October 15, 2021, or 80% of all RMT presentations to date.

HPCP Wellness Clinics in Vulnerable / Older Adult Subsidized Housing Buildings

Health Promotion Community Paramedics have returned to offering CP clinics in partnership with McMaster University, CGS Housing, Ontario Health North and CGS Paramedic Services. HPCPs will continue to offer Health Clinics through virtual technology communication (when preferred) with Ontario Telemedicine Network (OTN) or phone consultations; and in-person clinics set to resume in early July 2021.

Between the dates of February 28, 2021 – October 15, 2021 the following virtual contacts and in person clinic contacts have been made:

Number of residents who attended in person clinics CP@Clinic (restarted July 2021)	59
Number of residents called by CP to book a virtual CP@Clinic appointment	210
Number of residents who booked a virtual CP@ Clinic appointment	48
Number of TOTAL videoconference CP@Clinic appointments completed	13
Number of UNIQUE videoconference CP@Clinic appointments completed	7
Number of TOTAL telephone CP@Clinic appointments completed because residents did not have technology/internet/know how	96
Number of UNIQUE telephone CP@Clinic appointments completed because residents did not have technology/internet/know how	46
Number of missed phone appointments by participants	8
Number of missed video conference appointments by participants	2
Number of referrals to community agencies, support services and primary care by CPs (Virtual clinics and in person clinics started in July 2021.)	4

New Community Paramedicine Programs

Ontario Health North - Remote Clinical Monitoring Pilot

In January 2021, Greater Sudbury Paramedic Services was awarded $142,000 from Ontario Health, approved as dedicated short-term funding to support provincial and regional initiatives that provide COVID-19 patients with remote clinical care and monitoring in the community. The objective of this funding was to ensure COVID-19 patients and other vulnerable patients receive appropriate clinical care and monitoring in the community, including escalation to a medical assessment or acute care where necessary. By supporting remote clinical care models, a goal of this funding was also to reduce the risk of infection among health care workers. Greater Sudbury Paramedic Services collaborated with three other paramedic services and health care agencies in the northeast and designed a program delivered as a regional model. Our program is staffed with one dedicated Community Paramedic operating twelve hours per day, seven days per week. Paramedic Services commenced a five-month pilot program in December 2020, which since has been extended at the request of Ontario Health North. A sustainability plan has been created and a new submission for funding, which could see us continue this service into 2022, has been submitted. The following chart outlines the various sources of patient referrals to the remote monitoring program.

Public Health Sudbury and Districts	123
Patient Self-Referral	40
Paramedic Services (front line 911 staff or other Community Paramedic Programs)	32
Primary Care Practitioners	23
Health Sciences North COVID-19 Assessment Centre	19
Health Sciences North ED or Floors at point of Discharge	14
Community Health Clinics	2
Other Community Sources	28

December 1, 2020 – October 15, 2021

The Remote Clinical Monitoring Program has provided clinical monitoring services and discharged a total of 261 patients since the commencement of the pilot program and currently has 23 active patients on service being monitored in their homes who are recovering from either COVID-19 or managing chronic health conditions. The strength of this program stems from a strong collaboration with various local health care partners and the regular or on demand paramedic contact to monitor a patients' wellbeing with phone consultations or daily visits.

Total number of patients who have utilized the CP remote patient monitoring to date	284
Number of appropriate escalations to alternate levels of care as decided by paramedics	221

Alternate Patient Destination – Mental Health and Addictions / Crisis Diversion Pilot

Paramedics responding to a 911 call may offer Mental Health and Addictions Diversion to suitable and consenting patients. This program offers a method for hospital emergency department aversion strategies and supports patient centered care; the right treatment to the right patient at the right time. These alternate destinations allow paramedics to transport patients to one of three community/hospital support services; HSN Crisis Intervention Services at 127 Cedar Street, initiation of HSN Mobile Crisis Intervention Services team to attend the residence, or HSN Withdrawal Management Services at 336 Pine Street. This program has been available to patients since 2015 and has proven to be a safe and effective alternative to the emergency department in supporting those in need of mental health and/or addictions supports in the community.

Total number of times paramedics offered diversion as an alternative destination to the HSN ED	55
Total number of diversions completed as an alternative to HSN ED	28
Total number of diversions to Crisis Intervention Services	7
Total number of diversions to Mobile Crisis Intervention Services	7
Total number of diversions to Withdrawal Management Services	14

Diversion January 1 to October 15, 2021

Naloxone Distribution / Harm Reduction

In December 2020, Sudbury Paramedic Services commenced participation in the Ontario Naloxone Program in collaboration with PHSD. This program has paramedics not only administering Naloxone as part of their standard paramedic care, but also distributing Naloxone kits to identified individuals where appropriate in the course of their duties or when requested from the public. This program permits 24/7 access to Naloxone in Sudbury, which was not previously available. This important initiative allows paramedics to promote harm reduction for those who misuse drugs with a goal of improving positive health outcomes in the community.

Since the implementation of this program on December 12, 2020, paramedics have distributed 332 Naloxone kits and continue to support those in need.

Community Paramedicine for Long Term Care Program (CPLTC)

The Community Paramedicine for Long Term Care Program targets seniors living in the community who are either on the Long-Term Care Home (LTCH) waitlist or are frail elderly at risk of failing in the community and becoming reliant on hospital admission or needing LTCH. The program utilizes trained Community Paramedics (CP) to provide 24/7 ongoing and/or episodic support to the geriatric population through a combination of planned and needs-based just-in-time (JIT) home visits. LTC CPs use approved interventions under medical oversight as well as clinical assessment and reasoning, and connections with other community health partners to mitigate 911/ED transfers and support patients at home whenever possible. This program is supported by geriatrician-led medical oversight, and partners closely with the North East Specialized Geriatric Services for ongoing training, education, and patient supports.

The CPLTC program goals include reducing 911/ED/ALC presentations, stabilizing the LTCH waitlist (which currently sits at 600+ for Greater Sudbury) by avoiding crisis states, delaying entry to LTCH through support at home, increased integration between PS and HCCSS/primary care, and patient/caregiver peace of mind. CPLTC is unique among CP programs in that it operates 24/7. Ten full time paramedics (mix of ACP and PCP) support a model of four vehicles during the day (7am-7pm) and one vehicle overnight.

CPLTC is 100% funded by the Ministry of Long-Term Care with a grant of $500,000 per quarter from January 1, 2021 until March 31, 2024. The initial quarter funding was intended primarily for program start-up costs including vehicles, technology, training, equipment and supplies. CPs were hired and trained through April 2021 and first patient visits began May 17, 2021.

This program was initiated during the COVID-19 pandemic and is quite reliant on in-home visits given the patient population. Fortunately, the CPs ability to safely provide in-person care to this group has been minimally impacted. Phone and video consults are available and utilized upon request, however home visits tend to be the client preference, and are in keeping with best practice for frail elderly for whom communication barriers can be significant.

For the purposes of this report, the following patient statistics will include only the five months the program has been actively seeing patients (May 17, 2021 to October 15, 2021). It is relevant to note that during the first four months, due to staffing constraints and challenges associated with new program roll out, CPLTC was operating at less than 50% of its capacity. As of September 15, CPLTC has ramped up to 100% staffing, expanding patient capacity accordingly. As of October 15th, CPLTC had 240 active patients, a number which increases by approximately 25-45 patients bi-weekly. In the first five months CPLTC had 751 patient contacts, 64% home visits and the remainder phone contacts. Of those 480 home visits, 115 were just-in-time visits initiated by the patient/family or a health care partner (HCC, NESGC, etc.) and would previously have gone to 911. Of those 115 JIT visits, 85% were able to remain home because of the interventions and follow up care provided by CP, resulting in 96 911/ED visits avoided.

Total patient contacts/home visits/JIT	751 / 480 / 115
Total patient referrals	310
Active Patients at time of report	240
911/ED visits avoided	96
Referrals to other agencies (HCCSS, NESGC, primary care, etc.)	153

May 17, 2021 to October 15, 2021