Community Paramedicine Long-Term Care Program Update

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Report Summary

This report provides information regarding the first nine months of the launch of the Community Paramedicine for Long-Term Care Pilot.

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 with the Community Energy and Emissions Plan.

Financial Implications

There are no financial implications associated with this report.

Background

The Long Term Care (LTC) sector is faced with increasing capacity pressures and these pre-existing pressures have only been exacerbated by COVID-19. Currently in Greater Sudbury there are more than 650 seniors on the LTC wait list living in the community. Approximately 10% have been designated “priority/crisis”, or no longer able to cope at home, even with maximum community supports and services in place. The City of Greater Sudbury’s Community Paramedicine for Long-Term Care (CP-LTC) program is fully funded by the Ministry of Long-Term Care (MLTC). Funding is based on LTC waitlist volumes. Greater Sudbury Paramedic Services will receive $6.5 million over 3.25 years to deliver this program ($500,000 per quarter, January 1, 2021 to March 30, 2024).

The initial quarter funding was intended primarily for program start-up costs including vehicles, technology, training, equipment, and supplies. Community Paramedics were hired and trained through April 2021 and first patient visits began May 17, 2021.

Target Population and Goals

Target population for this program include seniors who are on the LTC waitlist, or are soon to be eligible for LTC, including frail seniors, those with inadequate supports, and those at high risk for failing at home. The following are this program's goals:

- Address health system capacity challenges by reducing 911 calls and avoidable emergency department visits/hospital admissions
- Stabilize the LTC wait list (including prevention of priority or "crisis" designation)
- Increased integration with primary care and home and community care
- Patient/family/caregiver peace of mind

Program Model

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.

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.

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 Paramedic Services and Home and Community Care/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.

The CP-LTC program is an episodic care model that is accessible, responsive, proactive, with a patient centered response to changing patient conditions. This program connects patients to appropriate providers, monitors and/or treats to prevent emergency incidents and exacerbation of existing conditions.

Clinical Services in the CP-LTC Program

Our highly trained Community Paramedics provide in home patient assessment and clinical management of acute illness exacerbation. The CP-LTC program offers remote clinical monitoring, mobility/falls assessment and management, hospital to home transition, point of care diagnostic testing, patient teaching, chronic disease management, community support referrals, first dose medication and monitoring, and caregiver peace of mind.

Program Rollout – A Phased Approach and Key Milestones

First Quarter – January 1, 2021 to March 31, 2021

- Initial program planning and development
- Hiring for program leadership positions
- Equipment and supply procurement

Second Quarter 2021 and Beyond

Human Resources and Training

Target staffing – ten dedicated full time community paramedics, one administrative support, one clinical lead, and eight relief paramedics.

Paramedics were onboarded and trained throughout the second quarter of 2021 to balance staffing demands throughout the Paramedic Service. As of June 30th, 80% of LTC Community Paramedic staff were trained and seeing patients with a target of 100% staffing by September 2021.

All LTC Community Paramedics, plus relief staff are enrolled and supported in initial Community Paramedic education courses, in addition to the partnership with North East Specialized Geriatric Services (NESGS), who will ensure ongoing education and mentorship opportunities targeting care of the elderly.

Medical Oversight and Directives

In the second quarter of 2021 we onboarded a Medical Director for CP-LTC, Dr. Joanne Clarke, geriatrician with Health Sciences North - North East Specialized Geriatric Centre (NESGC). Dr. Clarke and her team at NESGC provide 24/7 on call support from the NESGC physician team. Pathways and medical directives have been developed to support Paramedics in delivering prompt and appropriate care for the most common challenges in this patient population.

Equipment

Our program looks to maximize in home diagnostic capability for homebound patients with equipment that allows point of care testing (blood, urine), portable ultrasound technology (bladder scanning), remote patient monitoring (vital signs, weight, glucose), and assisted virtual care (i.e. virtual medical consults).

Additionally, our program supports a mobile and responsive model of care with technology. This technology keeps the CP-LTC team connected to each other, our patients, and our community partners with mobile communications, and an electronic medical record platform.

Patient Referrals and Community/Health Care Partnerships

Our program launched on May 9th, 2021 with an intentional and directed rollout in line with a staggered start staff onboarding which ensured capacity to meet program goals.

Our initial referral partners include Home and Community Care, NESGC, and Paramedic Services (911 calls).

For the purposes of this report, and as this is the first time CPLTC has reported to this Committee, the following patient statistics will include only the four months the program has been actively seeing patients May 17, 2021 to September 17, 2021. It is relevant to note that during these first 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. At the time of this report, CPLTC has 193 active patients, a number which increases by approximately 25 patients weekly. In the first four months CPLTC had 657 patient contacts 55% were home visits, the remainder were phone contacts. Of those 358 home visits, 83 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 83 JIT visits, 87% were able to remain home because of the interventions and follow up care provided by CP, resulting in 72 911/ED visits avoided.

Total patient contacts/home visits/JIT	657 / 358 / 83
Total patient referrals	242
Active patients at time of report	193
911/ED visits avoided	72
Referrals to other agencies (HCCSS, NESGC, primary care, etc.)	86

Reporting date range is from May 17, 2021 – Sept 17, 2021

Conclusion/Next Steps

This report provides an overview of the key milestones in the CP-LTC pilot development and implementation. Next steps for this program include developing stronger partnerships with Health Sciences North, Primary Care, and community health support services. Our focus will also be on widening our program visibility with local health care services and agencies in the Sudbury area.