Community Paramedicine Activities – COVID-19 Response and Health Promotion Update – February 2022

Presented To:	Emergency Services Committee
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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 Paramedic Services Roles in COVID-19 Response in the Community

Paramedic Services have been essential amid the COVID-19 pandemic. COVID-19 response has included providing COVID-19 testing, administering COVID-19 vaccines both in clinics and in homes, transporting individuals to testing centres, providing services within Community Paramedicine programs, in addition to their regular emergency service responsibilities. 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 (PHSD), 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 delivered over 800 first and second dose appointments to eligible clients in their home and have commenced the third dose campaign the week of January 17th with a goal of supporting PHSD for the months of January to March.

Mobile COVID-19 Testing – Collaboration with Health Sciences North

Paramedic Services continue to provide support in the community to address the changing demands created by this pandemic. Paramedics continue to support the Health Sciences North (HSN) COVID-19 Assessment Centre by conducting 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, paramedics have assessed and tested over 9,877 (since inception) symptomatic residents in the community, 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. This clinic home visit program is staffed with one Community Paramedic 7:00 a.m. to 7:00 p.m. seven days per week.

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 December 31, 2021, there were 325 active patients enrolled within the program and only 67 patients reported the need to utilize our 911 service for the treatment of their chronic health condition in this 12 month period. Care Transitions Community Paramedics referred a total of 273 patients to community health and social services; 138 patients to primary care, 23 to Home and Community Care Support Services North East (previously known as NE LHIN / CCAC) and 112 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 patient contacts 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	1,799 / 229
Working Days	365
Active Patients	325
911 Calls Related to CTCP	67

Reporting date range is from January 1, 2021 – December 31, 2021

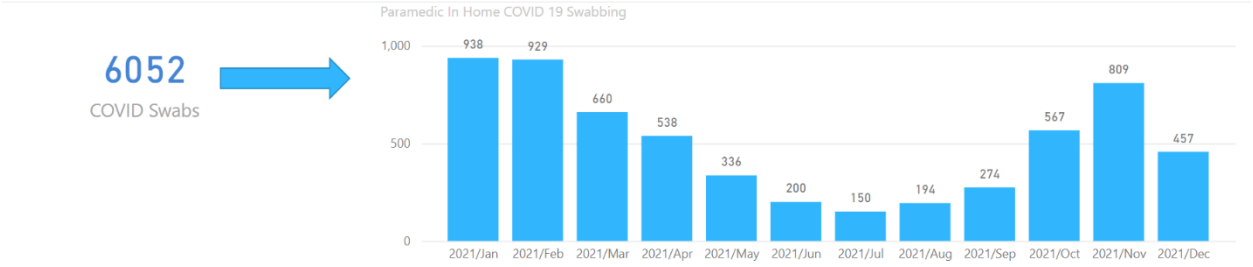
Health Promotion Community Paramedicine (HPCP)

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, keep our "at-risk" aged population healthy and at home. This is an attempt to aid our vulnerable populations and redirect them to more suitable community resources other than the emergency department.

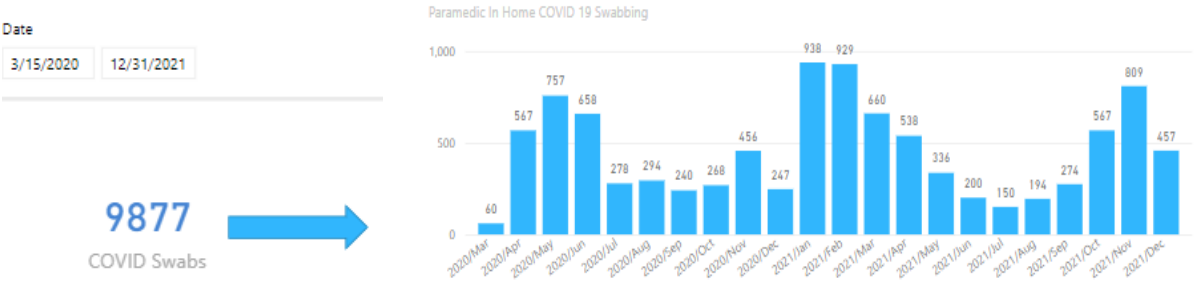
During the pandemic, the HPCP program has collaborated with various community agencies in our provision of COVID-19 mobile testing to ensure our patients are tested and may remain safely in their place of residence.

- HSN COVID-19 Assessment Centre is screening phone calls from citizens to evaluate if COVID-19 testing should be conducted. In addition they schedule in clinic appointments or refer to Paramedic Services for in home testing.
- 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. They offer guidance / follow-up if required for those patients the CPs test and assess and require further intervention(s).

From **January 1 to December 31, 2021** a total of 6,052 in-home COVID-19 tests have been performed by paramedics.



Since paramedics began performing in home COVID-19 tests on March 15, 2020, paramedics have completed **9,877** tests.



HPCP: Paramedic Referrals and RMT Engagement

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

Currently Shelter Clinics are on hold but anticipate restarting these clinics once it is safe to do so.

HPCP Paramedic Referrals and RMT engagement between January 1 to December 31, 2021:

Paramedic Referrals (PR): Number of PRs reviewed, processed and actioned by HPCPs	765
Rapid Mobilization Table (RMT): HPCP as RMT originating agency	38
Rapid Mobilization Table (RMT): HPCP as RMT presentation lead agency	19
Rapid Mobilization Table (RMT): HPCP as RMT presentation assisting agency	112

Health Promotion Community Paramedic program has been requested as a supporting agency in a total of 122 other RMT presentations originating from other community agencies out of 173 overall total of RMT presentations between January 1 to December 31, 2021, or 70.5% of all RMT presentations to date (122/173).

HPCP Wellness Clinics in Vulnerable / Older Adult Subsidized Housing Buildings

Health Promotion CPs are planning a gradual return 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 resumed in July 2021 when public health measures eased in the region.

Between the dates of January 1, 2021 - December 31, 2021 the following contacts were made (virtual only until July 12, 2021):

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	12

2021						
HPCP Wellness Clinics		**Jan-Mar**	**Apr-Jun**	**Jul-Sept**	**Oct-Dec**	**Total**
Number of patients who attended one-to-one CP@Clinic education sessions	CP@Clinic + Virtual CP@Clinic (OTN or Phone)	28	31	288	321	668
Number of referrals originating from clinics not from 911 calls (for our CP@Clinic program run out of common rooms)	Referrals (for services through LHIN, Primary Care, Community Support Services, or other health social or community services providers)	N/A	N/A	78	78	156
Number of patients ≥ 75 years	Patients who attended a CP Clinic education session	7	4	142	166	319
Number of patients with 3 or more ambulatory care sensitive chronic health issues	Chronic conditions (COPD, asthma, epilepsy, diabetes, heart failure & pulmonary edema, hypertension, angina)	10	15	141	134	300

New Community Paramedicine Programs

Ontario Health North Remote Clinical Monitoring Pilot

Greater Sudbury Paramedic Services operates a remote monitoring program that provide COVID-19 patients with remote clinical care and monitoring in the community. The objective of this pilot is 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, this program is also intended to reduce the risk of infection among health care workers. Paramedic Services commenced a five-month pilot program in December 2020, which has been extended through the 2021-2022 fiscal year. This current program has been staffed with one Community Paramedic 12 hours per day.

The following data is representative of January 1, 2021 - December 31, 2021.

Community Paramedics receive referrals for Remote Patient Monitoring from various sources:

Public Health Sudbury and Districts	244
Patient Self-Referral	80
Paramedic Services (front line 911 staff or other Community Paramedic Programs)	63
Primary Care Practitioners	46
Health Sciences North COVID-19 Assessment Centre	68
Health Sciences North ED or Floors at Point of Discharge	45
Community Health Clinics	8
Other Community Sources	67

This program has helped to support 369 discharged patients in 2021 and continues to support 11 currently active patients in their homes who are recovering from either COVID-19 or managing chronic health conditions. The strengths of this program are the collaborative nature of our partnerships with local Medical Physicians who act as medical oversight, the comfort that comes with regular or on demand paramedic contact to monitor a patients' wellbeing with phone consultations / daily visits, and reduced exposures to communicable disease for both patients and the community.

Total number of patients who have utilized the CP RPM to date	369
Number of appropriate escalations to alternate levels of care as decided by Paramedics	262

Vivify Health App from TeleHomeCare

To better support patients referred with mild symptoms related to COVID-19 this year we have expanded our remote monitoring program to include Telehomecare's program Vivify. Vivify's Mobile App is designed for patients to use their own smart devices to easily navigate through patient-customized pathways, biometric measurements. Through daily patient self-reporting the Community Paramedic can maintain oversight for those stable individuals that require observation through their COVID-19 isolation periods. Enrollment for this service will commence by the end of January.

Diversion

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 to utilize 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 community.

Diversion Destinations January 1 to December 31, 2021:

Total number of times paramedics offered diversion as an alternative destination to the HSN ED	72
Total number of diversions COMPLETED as an alternative to HSN ED	38
Total number of diversions to Crisis Intervention Services	11
Total number of diversions to Mobile Crisis Intervention Services	7
Total number of diversions to Withdrawal Management Services	20

Universal Influenza Immunization Program: Community Paramedics Providing Community Influenza Vaccinations

This program was initiated on November 23, 2020, in partnership with Public Health Sudbury and Districts. Community Paramedics have continued to offer community influenza vaccinations for the 2021/22 influenza season as well to our own frontline Paramedic Services staff, ORNGE flight paramedics, residents in our Community Paramedic Wellness Clinics and all patients of our home visit Community Paramedic programs which include Care Transitions and Community Paramedic – LTC. In the 2021-2022 influenza season a total of 195 vaccines were administered.

Community Paramedicine for Long Term Care Program (CPLTC)

The Community Paramedicine for Long Term Care (CPLTC) 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 Long Term Care (LTC). 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 Health Sciences North - North East Specialized Geriatric Services for ongoing training, education and patient supports.

The CPLTC program goals include reducing 911/Emergency Department/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 Support Services (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 Advanced Care Paramedics and Primary Care Paramedics) support a model of four vehicles during the day (7:00 a.m.–7:00 p.m.) and one vehicle overnight (7:00 p.m.–7:00 a.m.).

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 CP's 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 December 31, 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 December 31st CPLTC had 368 active patients, a number which increases by approximately 25-45 patients bi-weekly. Since inception in May 2021 to December 31, 2021 CPLTC had 1,456 patient contacts - 65% home visits, the remainder phone contacts. Of those 940 home visits, 207 were just-in-time visits initiated by the patient/family or a health care partner (HCC, HSN-NESGC, etc.) and would previously have gone to 911. Of those 207 JIT visits, 93% were able to remain home because of the interventions and follow up care provided by the Community Paramedic, resulting in 193 911/Emergency Department visits avoided.

Total patient contacts/home visits/JIT	1,456 / 940 / 207
Total patient referrals	397
Active patients at time of report	368
911/ED visits avoided	193
Referrals to other agencies (HCCSS, NESGC, primary care, etc.)	394

Reporting date range is from May 17, 2021 – December 31, 2021