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

Presented To:	Emergency Services Committee
Meeting Date:	August 10, 2022
Type:	Correspondence for Information Only
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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 centers, 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. Throughout the pandemic Community Paramedics have maintained essential face to face contact with individuals while many other care providers shuttered services and conducted assessments virtually. There is no replacement for face-to-face interaction, especially while feeling the effects of social isolation. As this COVID-19 Pandemic hopefully comes to an end, Community Paramedics are dedicated to continuing care, increasing patient enrolments in our Community Paramedicine programs as well as introducing more care services aimed at keeping Sudbury residents out of hospital and in their homes.

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 13,970 (since inception) symptomatic residents or residents who require COVID-19 testing for medical treatment in the community, allowing equitable across the entire City. 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. Requests for testing continue for pre-medical procedure and for individuals that may require therapeutic interventions such as immunocompromised or unvaccinated individuals.

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 home visit program is staffed with one Community Paramedic from 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).

Currently there are 172 active patients enrolled within the program and 7 911 calls for service that are related to COPD, CHF or Diabetes during the period of April 1 to June 30, 2022. During that same period of time, second quarter of 2022, Care Transitions Community Paramedics referred a total of 216 times to community health and social services, thus improving the quality of life for these patients

Community Paramedics offer face to face contact by completing home visits and same day calls for Just in Time (JIT) visits. We maintained face to face visits throughout the pandemic. These JIT visits are for those situations of chronic illness exacerbation to allow Community Paramedics to intervene prior to activation of 911 or an emergency department visit.

Care Transitions	Q1 2022	Q2 2022
Visits Completed / JIT	338 / 44	342 / 46
Working Days	90	86
Active Patients	186	172
911 Calls Related to CTCP	24	7

911 calls with Code 3 or 4 return related to chronic conditions- new collection method

Health Promotion Community Paramedicine (HPCP)

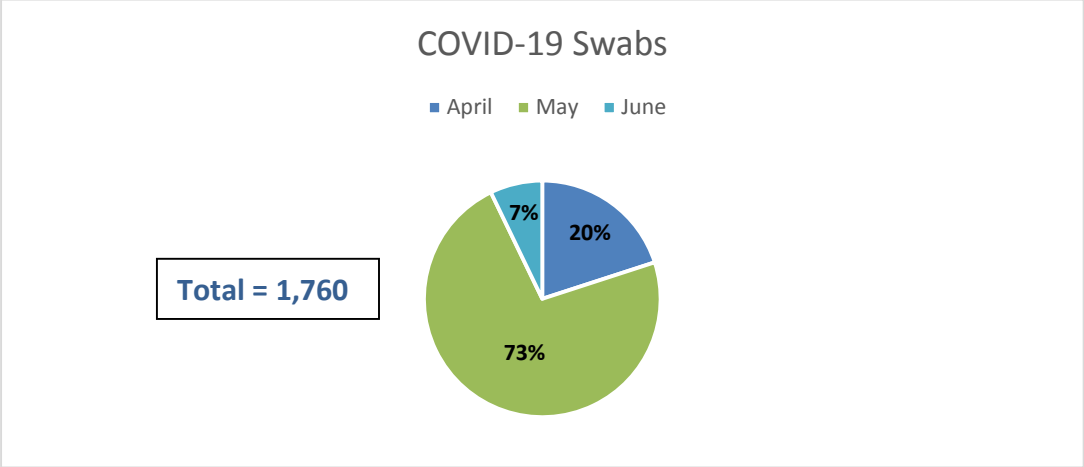
The objective of this program is to maintain and expand health promotion, education, and injury prevention. This program will also assist citizens in chronic disease recognition and prevention, injury awareness / prevention strategies, referrals, and health system navigation assistance. The primary goals 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 Community Paramedic program 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. In 2022 we have seen a shift from symptomatic COVID-19 testing to testing required before surgeries, in patient procedures, and day surgery.

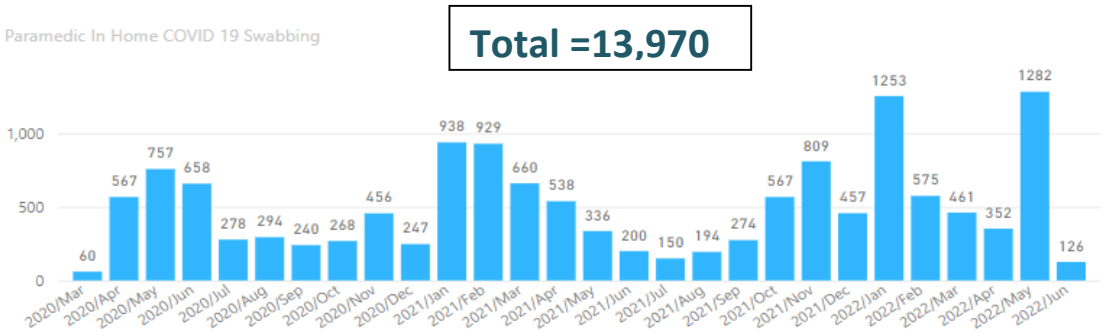
- HSN COVID-19 Assessment Centre is screening phone calls from citizens to evaluate if COVID-19 testing should be conducted. In addition, they schedule in clinic appointments or refer to Paramedic Services for in home testing.

- A group of Primary Care Physicians function as Community Paramedic medical oversight. They offer guidance / follow-up if required for those patients the Community Paramedic's test and assess and require further intervention(s).

From April 1 to June 30, 2022, a total of 1,760 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 13,970 tests.



Totals current to June 30, 2022

Health Promotions: Paramedic Referrals and Rapid Mobilization Table Engagement

Health Promotion Community Paramedic's (HPCP) 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 agencies wrap around care.

Paramedic Referrals (PR) and CMS-RMT Presentations	Q1 2022	Q2 2022
Paramedic Referrals (PR): Number of PRs reviewed, processed and actioned by HPCPs	185	278
Rapid Mobilization Table (RMT): HPCP as RMT originating agency	9	5
Rapid Mobilization Table (RMT): HPCP as RMT presentation lead agency	5	5
Rapid Mobilization Table (RMT): HPCP as RMT presentation assisting agency	38	17

In 2022, the Health Promotion Community Paramedic program has been requested 55 times as a supporting agency from other collaborating agencies at the Rapid Mobilization Table. Out of 77 overall RMT presentations, HPCP assisted in 71% of all presentations to date (55/77). It can be said that in 2022, we are seeing the impact the Community Paramedic and other programs are having in the community as we are seeing a decrease in RMT cases and escalations.

Health Promotions - Wellness Clinics in Vulnerable / Older Adult Subsidized Housing Buildings

Our Health Promotion program has re-commenced Community Paramedic led clinics in partnership with McMaster University, CGS Housing, Ontario Health North and CGS Paramedic Services. In July 2021, the Our Health Promotion Program resumed offering CP lead Clinics through virtual technology communication (when preferred) with Ontario Telemedicine Network (OTN) or phone consultations; and in-person clinics. Clinic operations ramped down in 2021 due to COVID-19 restrictions and efforts to protect the most vulnerable populations, however, we can conclude from the data in the following table that wellness clinics have resumed and are in full operations in 2022.

HPCP Wellness Clinics		Q1 2022	Q2 2022
Number of patients who attended one-to-one CP@Clinic education sessions	CP@Clinic + Virtual CP@Clinic (OTN or Phone)	320	189
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)	117	77
Number of patients ≥ 75 years	Patients who attended a CP Clinic education session	115	100
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)	119	83

High Intensity Supports at Home Community Paramedicine Program (HISH)

The HISH program is a collaboration between Home and Community Care Support Services (HCCSS) and Community Paramedics, funded by Ontario Health. The program was up and running January 17, 2022, with two Advanced Care Community Paramedics working 7 days a week, 7:00 am to 7:00 pm. This partnership began at the end of 2020 for 6 months and has been sustained with renewed funding for the 2022-2023 fiscal year. The patient population targeted for the HISH program are; alternate level of care (ALC) patients

in acute care hospital with a discharge destination of LTC, patients residing in the community who are awaiting placement in LTC with complex care needs often requiring daily visits, and those who are generally frail with multiple comorbidities and requiring more than visit-based care. The HISH Community Paramedics work closely with care coordinators from HCCSS accepting patients who are on the crisis list for LTC as well as accept patients with a goal of hospital avoidance. CP program medical oversight physicians are available for assistance if required for treatment orders and patient management.

Patients enrolled	56
Visits Completed/time spent	409 / 18222 min of work
Just in time (JIT) visits	10
*911 calls/physician consultations	11

January-June 30, 2022
911 calls with Code 3, 4 return-New collection method

NEW Neighborhood Model of Care for Older Adults living in Subsidized Housing Buildings

This quarter Community Paramedics from the Health Promotion program have expanded their scope and taken on a caseload which includes CPLTC patients living in CGS subsidized housing buildings. This Neighborhood Model of Care has many benefits for these at-risk patients as well as for the CP program capacity and sustainability. Health Promotion CPs are already familiar with many of these buildings through their CP@clinic work and know the communities, challenges and supports available to these patients. By grouping patients in a Neighborhood Model, CPs can see patients more often and spend less time on the road and more time with patients. A Neighborhood Model of Care also ensures the patient and CP become familiar with each other, leading to better continuity of care and improved ability to track and act on health changes. It also fosters a familiarity with the neighborhood itself leading to closer partnerships between care partners and better outcomes for patients.

This project is still new but is currently carrying a caseload of approximately 62 seniors across about half of the City of Greater Sudbury's fifty plus subsidized housing buildings. Quantitative data on this new addition to Community Paramedicine programming will be provided in future reports. Wellness clinics are currently occurring at 1052 Belfry, 1960 Paris, 1920 Paris, 720 Bruce, 12 Elgin, 36 and 38 Coulson, and 27 Hanna.

NEW Diabetic Retinopathy Screening Pilot

Sudbury Paramedic Services has partnered with Vision Loss Rehabilitation Canada for the Diabetic Retinopathy Tele-Retinal Screening Program. The program is coordinated by Vision Loss Rehabilitation Canada with the goal of providing screenings for diabetic retinopathy closer to home and integrated in our own community. The program consists of three components: screenings, education on eye health and coordination of care.

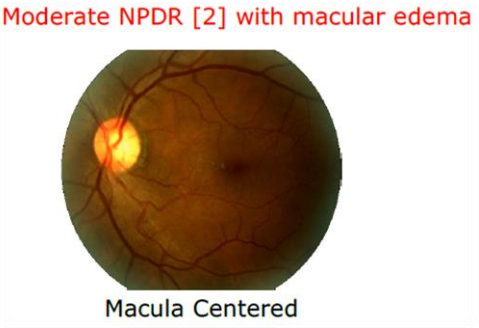
There are approximately 3.7 million Canadians with diabetes and diabetic retinopathy is seen in 20% of newly diagnosed diabetics. The overall risk of blindness is 25 times higher for someone with diabetes.

All people with type 1 or type 2 diabetes are at risk, whether their diabetes is controlled by diet, tablets, or insulin. Risk of diabetic retinopathy is increased by the length of time the person has had diabetes, poor control of blood sugar and high blood pressure. Once a definitive diagnosis of diabetes has been made, patients should be screened for diabetic retinopathy annually for life.

Health Promotion Paramedics will conduct eye screenings while attending various wellness clinics in Community Housing. Digital photographs are taken of both retinas using a portable hand-held camera. The images are uploaded into an automated diabetic retinopathy screening software, approved by Health Canada. The screening results are presented to you immediately and the Community Paramedic will discuss next steps. If needed, a referral is made to Vision Loss Rehabilitation Canada, who will coordinate required

follow-up with the patient's physician and/or the appropriate eye care professional.

Example of moderate Non-Proliferative Diabetic Retinopathy (NPDR) with macular edema:



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 – Northeast Specialized Geriatric Services (NESGC) 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 Community Paramedics deployed during the day (7:00 a.m.–7:00 p.m.) and one Community Paramedic 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 the second quarter of 2022 from April 1, 2022, to June 30, 2022. As of June 30, 2022, CPLTC had 654 active patients, a number which increases by approximately 30-45 patients bi-weekly. During this second quarter reporting period (91days),

CPLTC had 1,222 patient contacts - 75% home visits, the remainder phone contacts. Of those 920 home visits, 189 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 189 JIT visits, 87% were able to remain home because of the interventions and follow up care provided by the Community Paramedic. When combined with phone interventions that would otherwise have gone to 911/ED, more than 184 911/Emergency Department visits were avoided this reporting period.

Total patient contacts/home visits/JIT	1,222 / 920 / 189
New patient referrals	261
Active patients at time of report	654
911/ED visits avoided	184 = 2 per day
Referrals to other agencies (HCCSS, NESGC, primary care, etc.)	342

Ontario Health North Remote Clinical Monitoring Pilot

Greater Sudbury Paramedic Services operated a remote monitoring program that provided COVID-19 patients with remote clinical care and monitoring in the community. The objective of the pilot 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, this program was 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 program was staffed with one Community Paramedic 12 hours per day

We continue to work closely with HSN and our other clinical partners in preventing hospital admissions and supporting patients clinically in their homes post discharge with COVID-19 if enrolled in a Community Paramedic Program.

Strengths of the RPM 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	475
Number of appropriate escalations to alternate levels of care as decided by paramedics	262

Ontario Health is currently accepting proposals or continued remote monitoring funding for the 2022-2023 fiscal year and work is underway in completing a joint proposal with Health Sciences North.