Community Paramedicine Program Update – December 2024

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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)

The City of Greater Sudbury's Community Paramedic programs, support Council's strategic initiative to create a healthier community through integrated community programming to meet the needs of vulnerable populations and reduce emergency responses and hospital admissions.

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

Community Paramedicine (CP) models are continuously evolving across the province and our local CP program is no exception. Our CP team, including leadership, work closely with local service providers to build trust and establish relationships. This community engagement allows us to enhance the CP program by gaining a broader understanding of the unique needs of the population we serve, enabling us to tailor our services to better meet those needs.

CPs continue to fill critical gaps in access to care and establish important linkages with vulnerable populations. CP will also continue to build and sustain partnerships with others in the health system to improve care for the City's diverse community. CPs are seen as capacity enhancers and support many in need to help with more than just the ambulance service concerns, but those of the entire community.

CP programs include wellness clinics in low-income housing, visits to shelters, home visits, follow-up care and services for monitoring patients with complex needs, especially frail seniors living in isolation and individuals who are disconnected from the health system. CP models are intentionally implemented to

support local needs and provincial priorities.

CP continues to play a pivotal role in Ontario Health (OH) services delivery. Progress continues to be made in enhancing system capacity by addressing system pressures. The Ministry of Long-Term Care (MLTC) and Ministry of Health (MOH) continue to invest in CP programs provincially. Despite the nimbleness of CP program development, the current legislation governing paramedic services has gaps, therefore guidance is needed to support CP development and ensure the safety of patients. Ongoing work includes collaboration with the College of Physicians and Surgeons (CPSO) on medical delegation models, standardization of patient referral systems, and creation of a minimum data set to potentially aid with the reporting burden.

CGS Paramedic Services Community Paramedicine Program Overview

CP is an integral partner in our local health care system. The City's CP program has several program service models which are all fully funded:

Long Term Care CP Program (24 hours / 7 days)
- 4 CPs Advanced/Primary Care Paramedics (ACP/PCP during a 12-hour day shift)
- 1 CP (during a 12-hour night shift)

Care Transitions Program (12 hours / 7 days)
- 1 ACP CP

High Intensity Supports Program (12 hours / 7 days)
- 1 ACP CP

Health Promotion and neighbourhood model LTC in Sudbury Housing (12 hours / 7 days)
- 2 PCP CP

CP-LTC (Community Paramedicine for Long Term Care)

Since 2021, all land ambulance services in Ontario have been operating CP-LTC programs. These fully funded CP programs are a $426 million investment over six years made by the MLTC as an innovative solution to support seniors living in the community but on the Long-Term Care (LTC) Home waitlist. In 2020, Greater Sudbury Paramedic Services were granted the maximum funding of $6.5 million dollars over three years, with an extension of $2 million in annual funding until the end of the 2025-2026 fiscal year. We do anticipate base permanent funding for program continuation beyond 2026.

The MLTC program evaluation, which was released in spring of this year, summarizes the first two years of CP-LTC in Ontario. Throughout this program's duration, Greater Sudbury CPs have provided an enormous amount of patient-specific and aggregate data points to the MLTC, which has contributed to the outcomes reported in that evaluation.

Key findings from the program evaluation:

- The cost of CP-LTC is quoted as $8.40 per client / day.
- In a patient's first six months of being enrolled in the CP-LTC program, there is an average reduction of 24% in ED visits, and a 19% reduction in hospital admission from emergency department (ED) visits.
- Provincially, 911 calls decreased by 22-32% for patients enrolled in CP-LTC. Locally, CPLTC is expected to conduct close to 6,000 home visits in the 2024 calendar year. Of these visits, approximately 1,000 (or 18%) are unplanned same-day urgent requests that typically have been directed to 911 or the ED.
- In over 70% of those urgent requests, a visit by a CP that same day can provide assessment and/or treatment that allows the patient to stay home, avoiding 911 and ED/hospital use.
- Patients of CP-LTC who are on the LTCH (Long Term Care Homes) waitlist are less likely to be moved to the crisis category and are less likely to experience deterioration in their health condition.

- In patient and family survey responses collected by the MLTC, over 90% responded that CP-LTC helped maintain or improve the client's health and well-being, and helped the client feel safer in their living arrangement.

Health Promotion and Vulnerable Persons Initiatives

Sudbury Housing Wellness Clinics

The goal of Wellness Clinics are to help keep low-income older adults healthy at home and reduce avoidable 911 calls.

CPs visit older adults in common rooms of geared-to-income multi-unit housing, addressing their unmet health needs. They use evidence-based assessments to evaluate health risks of these individuals. This program's objectives are to maintain and expand health promotion, education, injury prevention, and recognition, prevention and management of chronic diseases. CPs also assist with referrals for services and health system navigation. Currently CPs are conducting wellness clinics in eleven (11) different buildings monthly throughout the City. The buildings chosen are either seniors housing or residences with a large population of seniors. To date in 2024, CP has held 144 clinics.

Clinic locations include; 1920 Paris, 1960 Paris, 211 Caswell, 160 Leslie, 12 Elgin, 340 McLeod, 1052 Belfry, 111 Larch (separate apartment door knocks), 1699 St. Jean in Val Caron, 36/38 Coulson in Capreol, and 3553 Montpellier in Chelmsford.

Shelters

Along with collaborating agencies, CP identified a gap in primary care and wound care for citizens in marginalized and unhoused/underhoused circumstances. CP has collaborated with the Samaritan Centre, and most recently Safe Harbour House Shelter, operated by the Elizabeth Fry society, to provide a half day of weekly dedicated CP on-site care. The Ontario Aboriginal HIV and AIDS Strategy (OAHAS) is a biweekly clinic that occurs either at the drop in on Elm Street or mobile outreach, utilizing OAHAS' modified van.

The focus of this time is to meet the citizens who use these key community organizations for support where they are, and to provide assessments, treatment, and referrals. Most of the CP work with this vulnerable population includes assessment of minor/moderate ailments, burns, wounds, infections, and chronic disease as well as initial and follow up care for wounds and infections and connecting people to health and social services that they could not otherwise easily access without this support.

This approach to care has been successful in large part due to the collaboration that occurs between the CP and the staff and volunteers of OAHAS and the shelters. This population can be particularly difficult to reach due to the unpredictability of their movement throughout the downtown core and the challenges of unmet basic needs, often paired with addictions and substance misuse. By partnering with outreach workers and having a regular time and day each week for the three shelters has meant that staff will watch for patrons they know need a visit or track them down to ensure they are at the shelter at the designated time to have the opportunity to be assessed.

While the volume of individuals may not be impressive compared to our other programs, the impact certainly is. The following is just one of many examples:

The poisoned drug supply (laced with Xylazine) is leading to more frequent complex wounds that can lead to sepsis and death. A CP is able to provide earlier assessment and intervention and facilitate access to antibiotics and wound care for someone who is ED-resistant or hard for home care to find.

This past month, an outreach worker identified a client of OAHAS with a grossly infected wound that had penetrated the bone and was on the verge of a systemic infection. The outreach worker who was able to help the CP locate the client at various spots in the downtown core several days in a row, building a relationship of trust with the CP to the point where she allowed the CP to take her to the hospital. The CP

team coordinated with community partners and hospital staff to provide support, addressing both the patient's wound infection and addiction. This holistic approach enabled her to receive treatment successfully.

Rapid Mobilization Table (RMT)

Community Mobilization Sudbury (CMS) is a community partnership representing over 30 organizations from diverse sectors. Community Paramedicine has been a member of CMS for almost ten years. The group comes together around a common need and desire to build multi-sectoral and collaborative mechanisms for responding to situations of acutely elevated risk**.**

The CMS threshold of acutely elevated risk refers to:

- A situation affecting an individual, family, group, or place where there is a high probability of imminent and significant harm to self or others (i.e., offending or being victimized, experiencing an acute physical or mental health crisis, loss of housing).
- Circumstances require the support of multiple service providers and have accumulated to the point where a crisis is imminent if appropriate support is not put in place.

Representatives from CMS partner agencies meet twice each week at the Rapid Mobilization Table (RMT). The RMT is a focused, disciplined discussion where participants collaboratively identify situations involving those who are at high risk of harm.

Once a situation is identified, all necessary agency partners participate in a coordinated, joint response, ensuring that those at risk are connected to appropriate support. Community Paramedicine is identified as one of the top six assisting agencies at RMT with a 69% involvement in all responses. Please see data from the Community Mobilization RMT Data Report below.

Greater Sudbury Paramedic Services – Lead or Assisting Agency

Conclusion Reason	**# of Discussions**	**%**
Overall risk lowered - Connected to services	42	66%
Overall risk lowered - Through no action of the Situation Table	3	
Overall risk lowered – Connected to personal supports	1	
Overall risk lowered – Connected to services in other jurisdiction	1	
Still AER - Informed about services; not yet connected	7	32%
Still AER - Refused services/uncooperative	7	
Still AER - Systemic issue	9	
Other - Unable to locate	1	1%
Other - New information reveals AER did not exist to begin with		
Other – Deceased		
Other Relocated		
Rejected - Situation not deemed to be one of acutely elevated risk		
Rejected - Originator has not exhausted all options to address the issue		

All RMT Discussions (n=103)

Conclusion Grouping	**# of Discussions**	**%**
Overall risk lowered	62	60%
Still AER	35	34%
Other	3	3%
Rejected	3	3%

HISH (High Intensity Supports at Home)

In September of 2023, the High Intensity Supports at Home (HISH) Community Paramedicine pilot at CGS received permanent base funding from Ontario Health. The HISH program is a collaboration between the former Home and Community Care Support Services, now referred to Ontario Health @ Home (OH@H), CPs, Behavioural Supports Ontario (BSO), the Alzheimer's Society, and several other community health agencies. Working collaboratively, this team strives to provide wrap around care on a short-term basis for frail older adults with complex medical, behavioural and/or social needs awaiting an urgent/crisis-level placement priority.

HISH aims to support the patient and family in their own home to prevent hospital admission and Alternate Level of Care (ALC) status while awaiting LTC Home. Many patients in this program have moderate to severe dementia, and the families are experiencing significant caregiver burnout.

The HISH CP program rosters only 20-30 patients at any time, by far the smallest CP program roster, but this allows the CPs to see the patients frequently, often multiple times a week, and to collaborate closely with partner agencies to relieve the burden of care from the patient and family. For this population, the transition from home to LTCH is often a particularly challenging one with many potential barriers and opportunities for failure. The alternative is long term hospitalization. This past fiscal year, Health Sciences North (HSN) was able to meet and exceed a provincial target of 10% reduction in ALC beds by March 31, 2024. The HISH program and CP involvement plays a pivotal role in keeping this number low, transitioning patients from home to LTC Home without adding to the ALC numbers. The collaboration between our High Intensity CPs, who are Advanced Care CPs, continues to collaborate and build the strength of this interdisciplinary team.

CTCP (Care Transitions) Program

The Care Transitions Community Paramedicine Program (CTCP) CPs provide home visits and interventions under medical oversight to patients with complex chronic disease to assist them in transitioning from acute care to community and/or self-supported in-home care. The program's primary goal is to decrease ED visits and readmissions to hospital for patients with chronic disease namely congestive heart failure, chronic obstructive pulmonary disease, and diabetes, who are at elevated risk of repeated admission to hospital. The program focus is on education and self-management. The CTCP program offers a combination of same-day visits for episodic management and patient education/monitoring to reduce frequency and severity of exacerbations of their chronic illness. Patients can be discharged once self-management goals are achieved. This enables the program to enroll new individuals into the service who have had recent hospital admissions.

Collaborations

The CTCP program was our first 7 day/12 hour CP program. This initiative began our partnership with HSN's outpatient pulmonary rehabilitation clinic, cardiac rehab as well as the diabetes education program. In 2023-2024 the collaborative initiative was dusted off, updated, and now CPs can easily send a referral to these programs without a physician signature.

CPs recently have begun a new direct referral process to St. Joseph's Complex Continuing Care. CP's can refer patients who meet program criteria directly from the community to Complex Continuing Care, a bedded rehabilitation program whose mandate to support citizens to live healthy longer at home closely aligns with CP goals. Offering short term bedded rehabilitation to those with risk factors prior to a catastrophic event such as a fall and fractured hip, goes a long way to promote an upstream preventative approach to care that will strengthen and support frail individuals and keep them out of hospital longer.

2024/2025 Statistics and Projections (April 1, 2024 - March 31, 2025)

Our numbers have decreased slightly from the last update report in May, 2024. This is not unexpected. The unsolicited favorable program feedback from community partners as well as patient family members, along

with operational changes by OH@H, we continue to see steady referrals being received for the different CP programs. As the number of patients goes up, our capacity limit becomes more possible. We have had to change our referral and discharge process to have a number of patients become “On Demand.” This means that the patient is lower in acuity, can still manage without many services or is very well supported by family, will call us when they require assistance or guidance, rather than CPs pre-booking the next visit. We also have Health Human Resources challenges that we continue to try to mitigate.

Program	Unique Individuals	Total Patient Interactions	Fiscal Year Projections
Long Term Care program	1,722	5,342	9,157
Care Transitions program	290	862	1,477
High Intensity program	77	553	948
Health Promotion program	111	527	903
All Programs Total	**2,191**	**7,284**	**12,485**

Conclusion

Community Paramedicine continues to be a developing model in healthcare. Analysis at both provincial and program-specific levels reveals that the CGS Community Paramedicine Program effectively assists individuals in maintaining safety and health at home. This initiative contributes to the sustainability of our healthcare system, which is striving to meet the challenges presented by an aging population. CP program agility will continue to bridge gaps, evolve and provide equitable, safe, timely and professional assistance to the citizens of our community.