Community Paramedicine Program

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Community Services Committee
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Why are we doing Community Paramedicine Projects?

<u>Changing Patient Demographic:</u>

- Ontario's older population expected to double over next 20 years, 85 and older population set to quadruple *(Sinha 2011)*
- Presently 14.6% of Ontario population is 65 and older accounts for 50% of Health and Social spending *(Census 2011)*
- <u>Northern Ontario</u> has the oldest population in Ontario and is projected to have the highest growth in seniors and has some of the highest ratios of Chronic Diseases (CIHI 2011).

<u>Impact on Paramedic Service:</u>

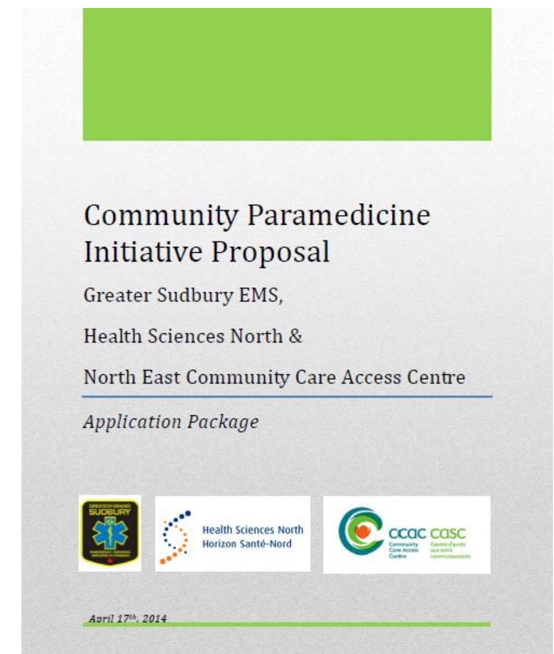
- In Sudbury 60% of our Paramedic call volume is for patients 60+ years, <u>predicting a 33% increase in service demand for patients 65+ over the next 8 years</u>
- Provincial report *"Living Longer, Living Well" (Sinha 2012)* recommends the development and expansion of Community Paramedicine Programs (CPP)
- Seniors are the highest users of EMS resulting in higher service costs, there is a need to transition the system from **Response (reactive) to Prevention (proactive)**

Expanding Community Paramedic Programs

Jan 2014 – MOHLTC announced $6M funding to support the expansion and development of CPP in Ontario (30 submissions received funding)

Sudbury submitted three proposals and received funding for two:

1. Care Transitions Community Paramedic
   Max. Funding Approved: $300,000
2. Health Promotion Community Paramedic
   Funding Approved: $102,900


Community Paramedicine Initiative Proposal

Greater Sudbury EMS,

Health Sciences North &

North East Community Care Access Centre

Application Package

Why Paramedics?

- Paramedic System infrastructure designed to support mobile health care, going into the community and patients' homes which is a natural fit for supporting seniors in their homes
- Paramedics Experienced in delivering medical interventions using medical directives with physician oversight
- Alternative model of community care that does not exist

Care Transition Community Paramedic Pilot

HSN

Patient Diagnosed with COPD, CHF, Diabetes, Dementia identified as high risk for readmission

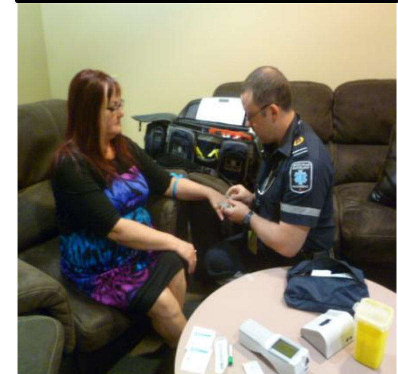
Discharge

On discharge Patient enrolled in Care Transitions program

At Home

CCAC – Rapid Response Nurse follow-up with patients within immediate discharge period (1 - 30 Days)

At Home



Community Paramedic (CP) visits patients within immediate discharge period and beyond (1 - 90 Days)

Health Sciences North
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What are the Care Transition Community Paramedics doing?

- Physician oversight – if required, the CP may consult directly with one of the on-call program Physician's or with HSN chronic disease clinics
- Point of care testing – laboratory blood analysis,12-Lead ECG analysis
- Medical interventions – such as medication administration and dosage adjustments
- Just-in-time and Scheduled Visits – Patient can call CP directly anytime to request a visit to manage a worsening condition
- Education on disease management and as required medication reconciliation

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Goal and Outcomes

Goal:

Decrease ED visits and readmissions for identified high-risk patients discharged from HSN compared to their past utilization

Program Facts:

- Average patient age 77
- One or more of three chronic diseases (Diabetes, CHF, COPD)
- Complex medical patients, averaging more than 10 medications per patient
- 148 patients contacted, 83 have been enrolled in the pilot
- 31 phone consults
- 304 home visits, averaging four visits per patient
- 35 “Just-in-time” Scheduled Visits

Goal and Outcomes

ED Visits - Community Paramedic Patients Registered in February

Mean ED Visits

	ED vists 30 days Pre-Registration	ED Visits 30 days Post-Registration	ED vists 60 days Pre-Registration	ED Visits 60 days Post-Registration
Community Paramedic	0.08	0.08	0.33	0.17
No Community Paramedic	0.33	0.60	0.87	1.07

Important to note *that at this point in time the outcome data does* *<u>not</u> include comparison of potential effects from other services.*

Project 2: Health Promotion Community Paramedic

Goal:

Develop standardized programs to assist citizens in chronic disease recognition, prevention and health system navigation

Health Promotion Program components include:

- Wellness Clinics & Health Education
- Community Referrals by Paramedics
- Medical Research Studies
- Public CPR and AED Training

Health Promotion Community Paramedic

Regular Shelter Wellness Clinics

- Wellness clinics promoting healthy lifestyles
- Refer to appropriate Community services
- Assist patients to reconnect with the health care system

Partnership with local emergency Shelters

- Cedar Place Women's and Family
- Salvation Army Men's
- Foyer Notre Dame Youth

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Health Promotion
Community Paramedic

Electronic Paramedic Referral process to NE-CCAC

- Paramedics send electronic referrals to NE-CCAC for consenting patients with unmet needs.
- Paramedics will use the PERIL Tool = Paramedics assessing Elders at Risk of Independence Loss Tool

CPR Blitzes

- Free "Hands Only CPR"/AED familiarization in partnership with Heart & Stroke
- Public CPR Blitz held May 29, 2015 at Churchill Public School

Research – HP Community Paramedic

Community Health Assessment Program with McMaster University (CHAP-EMS)

- Target = Older adults in subsidized housing
- Health Risk Assessment to identify modifiable risk factors that contribute to Cardiovascular Disease
- Participant indicates desired lifestyle change(s)
- Weekly wellness clinics & vital sign checks
- Links to community health promotion programs & family physician
- Goal = Early identification, management & prevention of chronic disease

Research – HP Community Paramedic

Remote Patient Monitoring Program with Queen's University (CPRPM)

- Target = High 911 callers or repeat ED users with history of congestive heart failure or chronic obstructive pulmonary disease
- Monitored via "blue tooth" vital sign taking equipment installed in their home
- Remote monitoring for readings that are outside of set parameters
- Follow-up & coach patient when an alert is received to avoid 911 activation or ED visit
- Goal = Patient learns to better manage their chronic disease with Paramedic guidance until they can manage independently

Community Paramedic Programs

Additional initiatives

- Paramedic Health Concern Forms
- Rapid Response Table
- Emergency Department Diversion for Mental Health and Substance Abuse Patients

Community **Mobilization** Sudbury
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Next Steps

- MOHLTC continues to monitor the 30 pilot programs and review pilot project progress
- Allow both Community Paramedic Programs operate to completion – est. Oct 31, 2015
- Complete Care Transition pilot project evaluation and report (June 2015 – Dec 2015)
- Report back to Community Services Committee in first quarter of 2016

Questions

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