



# Northumberland Community Paramedicine Community Paramedicine Program Description

- ▶ SUSAN BROWN - CHIEF
- ▶ GORD NEVILS - DEPUTY CHIEF PROFESSIONAL STANDARDS
- ▶ KIM WILKINSON - CP COORDINATOR





# Goals for the CP Program

- ▶ To improve one's confidence and independence regarding their health and create an environment that is safe to stay at home. Ultimately this is seen when Patients use 911 less and have longer periods of time spent at home.
- ▶ The scope of the CP program is flexible and scalable. Additional skills, treatments and diagnostic assessments can be added upon determination of need.



# General Information

- ▶ Referrals through hospitals, PHTs, Paramedics, others
- ▶ The program operates out of two locations 7 days a week to provide coverage across the County:
  - ▶ **Cobourg:** 4 Paramedics / day
  - ▶ **Campbellford:** 2 Paramedics / day
- ▶ 24 hr / 7 days access



# CP - Funding Streams

**Three separate funding streams provide the resources for the Community Paramedicine program**

1) **Ministry of Long-Term Care**

**Goals:** to provide in community health supports to;

- Those waiting for admission to long term care
- Those that have been assessed for admission to long term care
- Those that could soon be eligible for admission to long term care
- Reduce the reliance on Emergency (911) services for assistance in these groups



# CP - Funding

## 2) **Ontario Health Network – OHT-N**

**Goals:** to provide in community health supports to those experiencing;

- Homelessness
- Addictions
- Frail with comorbidities
- Mental Health

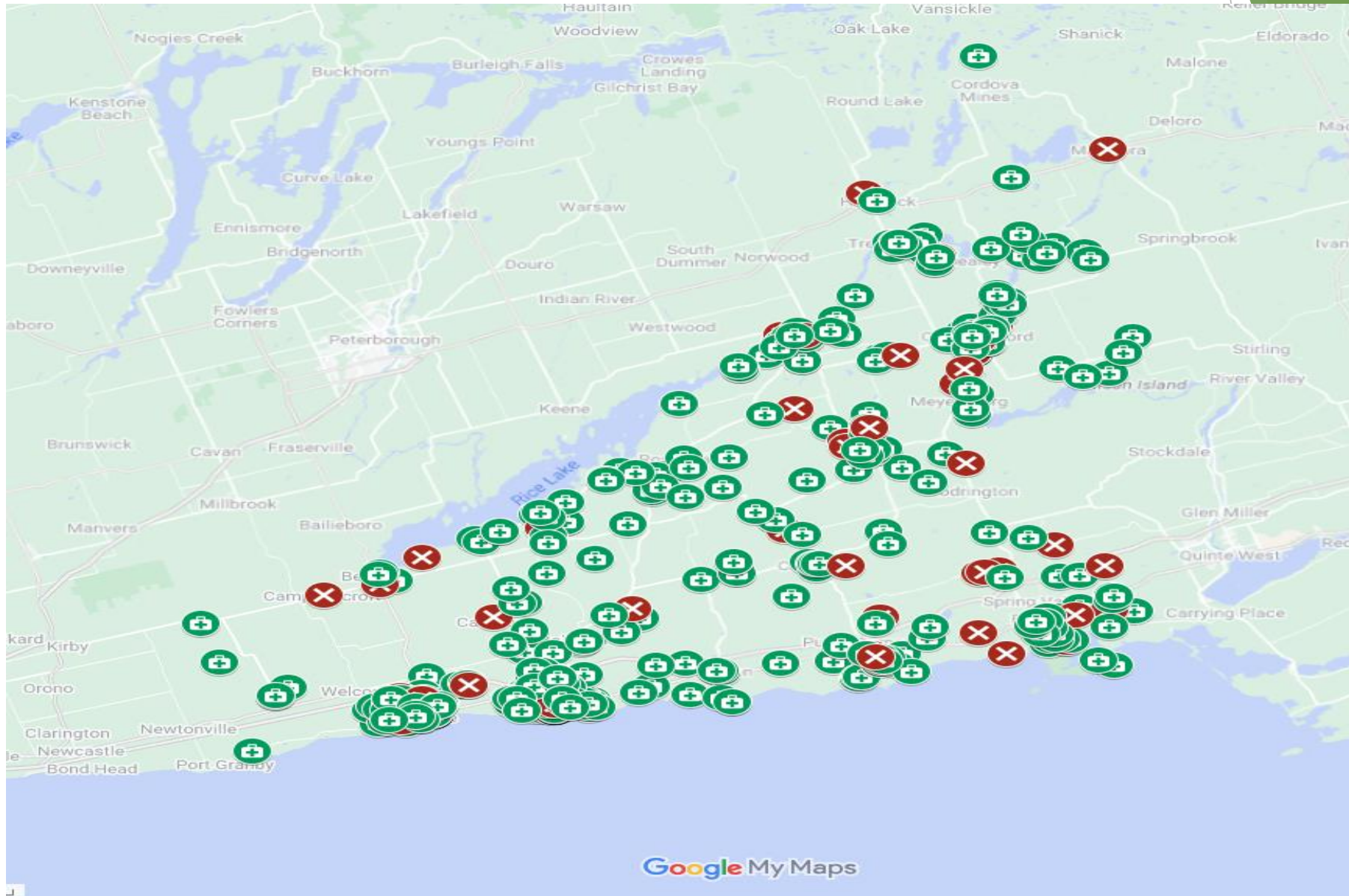
# CP - Funding

## 3) Ontario Health / LHIN

**Goals:** to provide in community health supports to those experiencing;

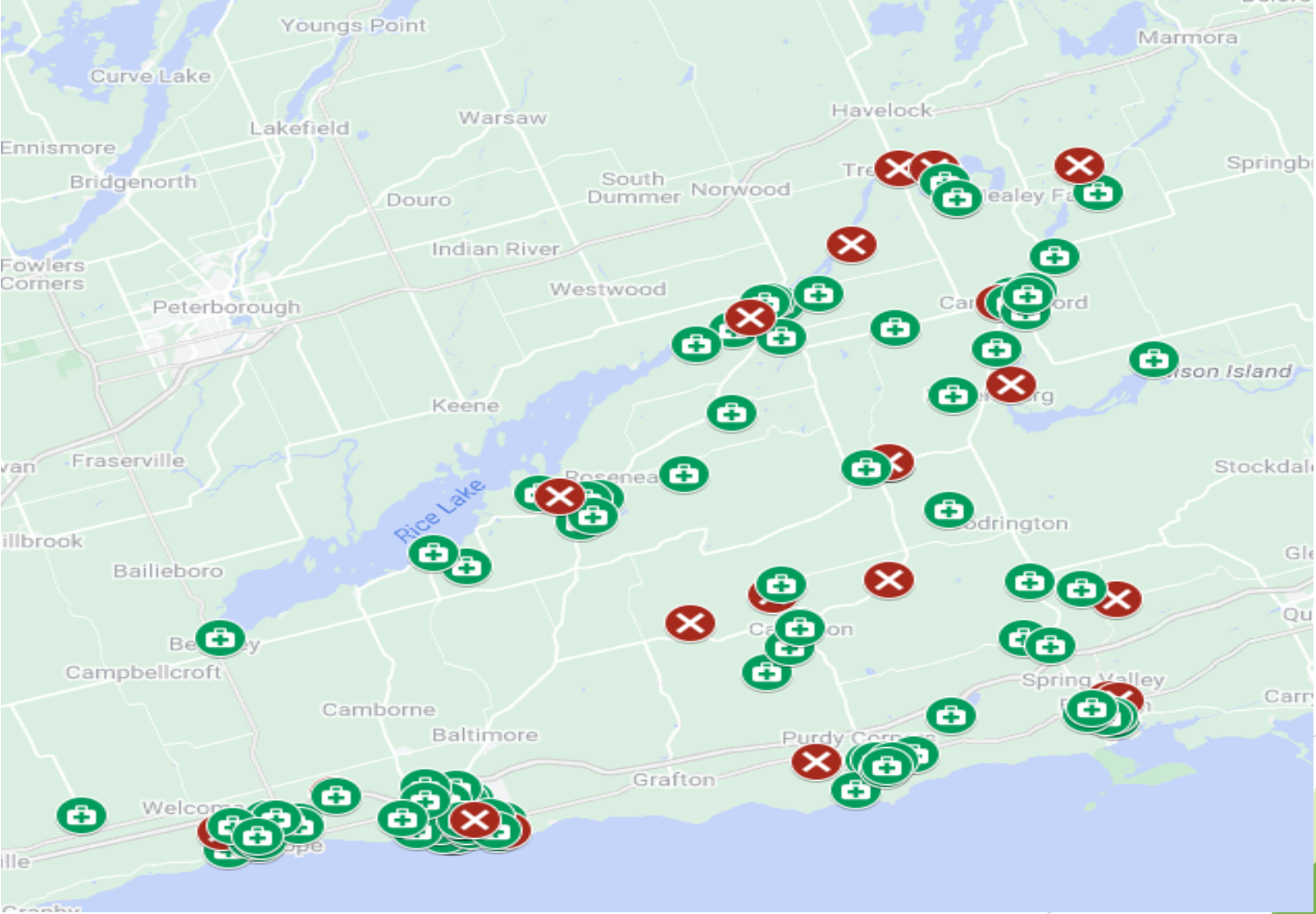
- Individuals requiring High Intensity Supports at Home (HISH)
- Individuals identified by Home and Community Care Services (HCCS)
- Reducing the reliance on Emergency (911) services for assistance in these groups

# CP Client Map (2022)





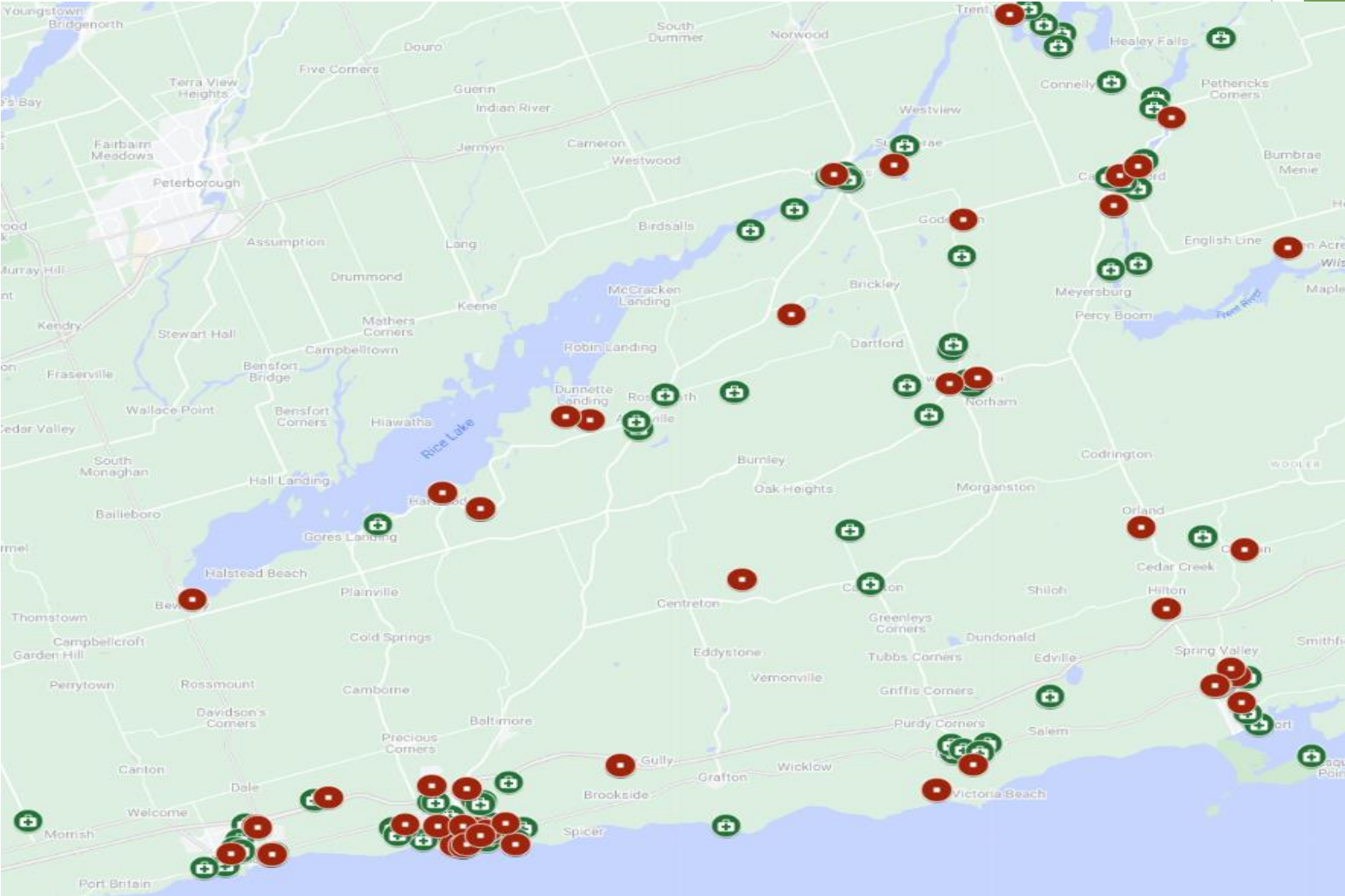
# RPM Client Map (2022)



# CP Client Map (Jan - Mar 2023)

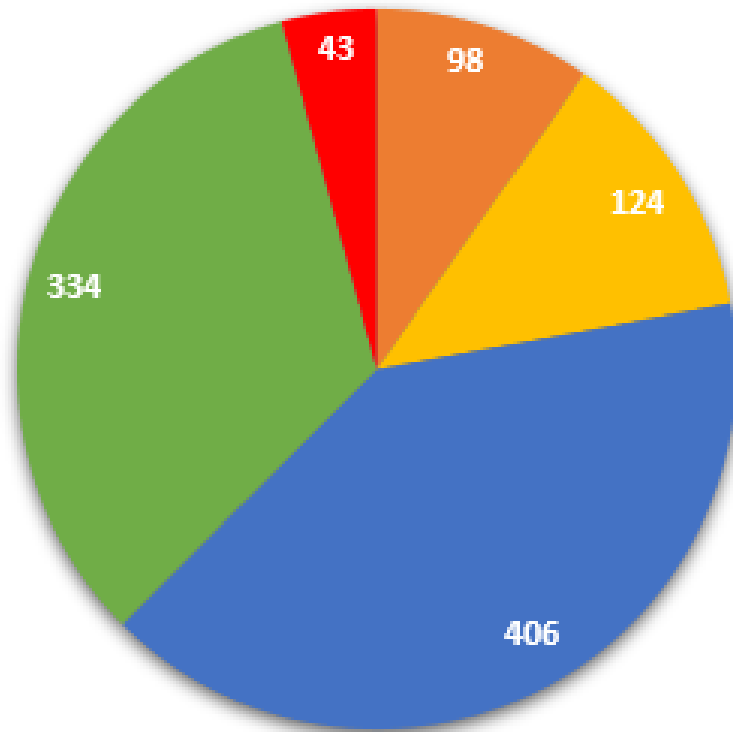


# RPM Client Map (Jan - Oct 2023)



# Total 2023 Referrals - Source Breakdown

Total Referrals: Jan-Sept 2023



- Self Referrals
- Paramedic Referrals
- Home and Community Care Referrals (LHIN)
- Primary Care Providers, Health Teams & Hospitals
- Other Community Services (i.e. Retirement Homes, Hospice, Shelters)



# Referral Process

- ▶ eReferral via website [Northumberland.ca/CP](http://Northumberland.ca/CP) or Oceans
- ▶ Needs to include:
  - ▶ Details of patient condition / circumstances
  - ▶ Urgency of visit



# Supports

- ▶ In person and telephone wellness checks
- ▶ Thorough patient assessments including cardiac, respiratory, neurological, GI, GU and other body systems
- ▶ Vital sign assessments; GCS, Temp., RR, BP, HR, Pupils, SPO2
- ▶ Chronic disease management, particularly for COPD, CHF and diabetes
- ▶ Cardiac monitoring; Lead II, 12/15 lead capabilities
- ▶ Blood Glucose testing
- ▶ Urinalysis (litmus dip)
- ▶ Point of care blood testing (TCO<sub>2</sub>, Na<sup>+</sup>, K<sup>+</sup>, iCa<sup>++</sup>, Cl<sup>-</sup>, Hct, Glu, Crea, BUN/Urea, Hb) - for homebound individuals with socioeconomic barriers to in home blood work
- ▶ Coagulation Testing (INR)



# Supports cont'd

- ▶ Assessment of high utilization users of 911/ED services
- ▶ Remote patient monitoring equipment
- ▶ Vaccination administration (COVID, flu)
- ▶ Immunization administration (Tetanus, shingles)
- ▶ Some medication administration (eg B12 injections, Ozempic, etc)
- ▶ Libre and Dexcom sensor change (if assistance required)



# Additional Comprehensive Clinical Practice Guidelines

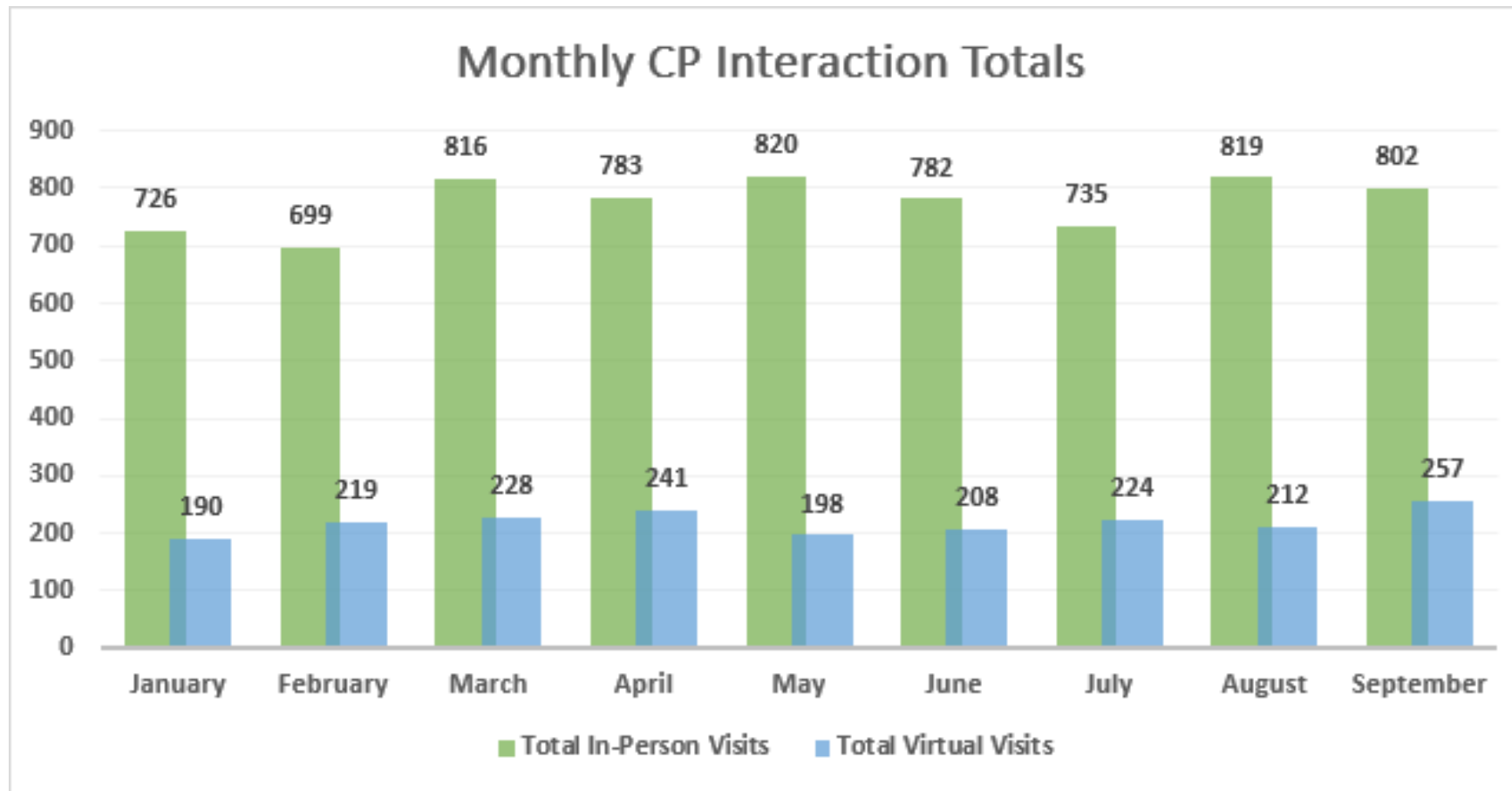
Directives/Referral pathways to be developed with assistance of Dr. Ketov include the following:

- ▶ Chronic disease management; CHF, COPD, Diabetes
- ▶ Dehydration
- ▶ Nausea/Vomiting
- ▶ Bronchoconstriction
- ▶ IV therapy
- ▶ Analgesia
- ▶ etc





# 2023 Client Interactions (Telephone, In-person)





# Remote Patient Monitoring Program

- ▶ Blood pressure; heart rate; oxygen saturation; weight; blood glucometry; temperature
- ▶ Sends alerts based on parameters requested by primary care practitioner
- ▶ Primary care providers and/or caregivers can be given access to monitor readings (with client permission)

## Monitored Person and Remote Monitoring Devices (in Home)



Bluetooth (2.1+ EDR) In-Home Communications (no PHI)



# RPM Alerts



Northumberland Paramedics

Tasks Plans Inventory Reports

Hi, Kim Wilkinson

User Name, Address or Device Id



Add User

## Reading Alerts

Group:

All

Branch:

All

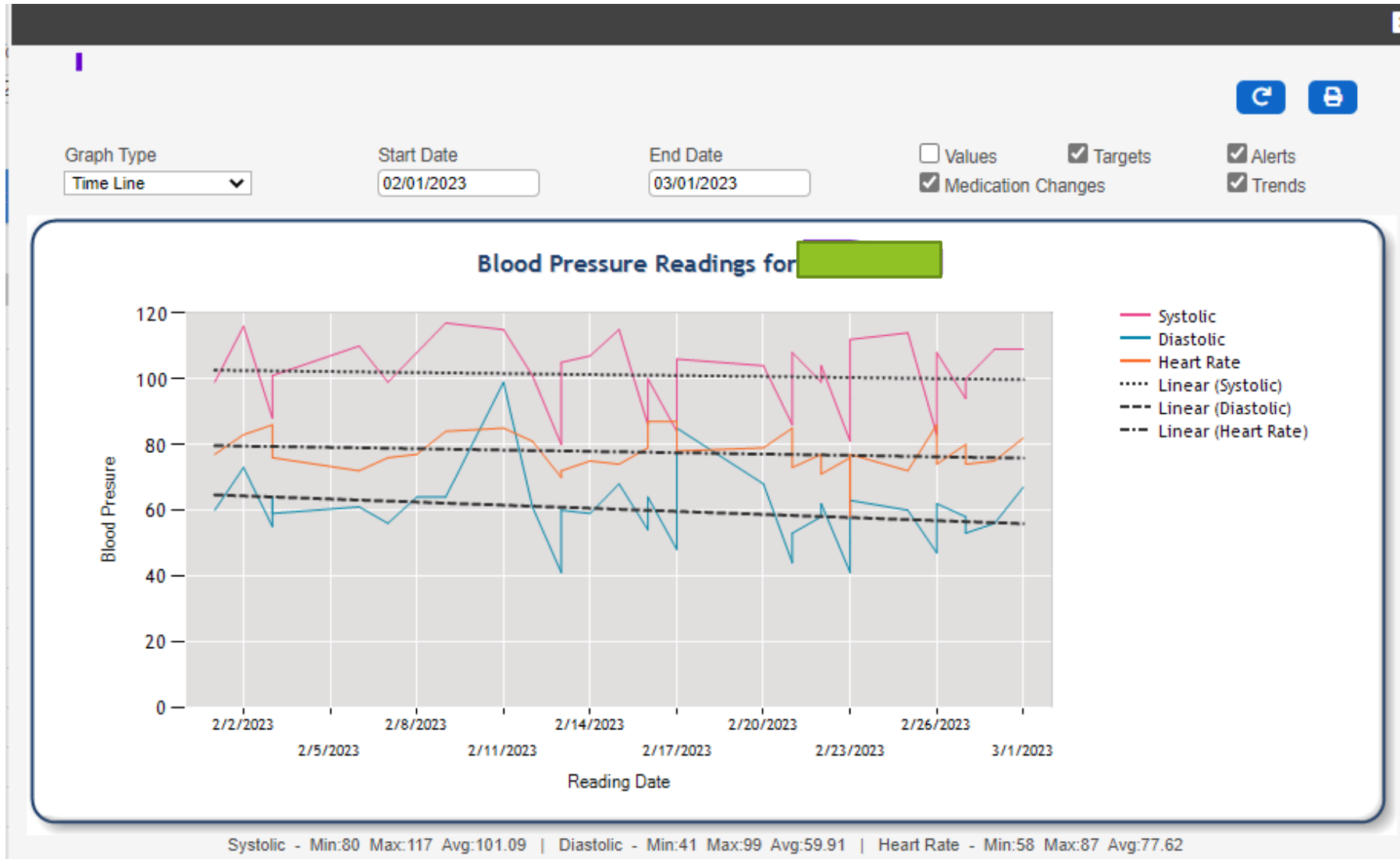
State/Province:

All

- = High
- = Medium
- = Low

Alert Priorities	User Name	Phone Number	Alert Count	Latest Readings	Score	Complete
● 4	[REDACTED]	[REDACTED]	> 4 Alerts	153/72♥72 98.96Kgs 87 SpO2, ♥75		[REDACTED]
● 1   ● 1	[REDACTED]	[REDACTED]	> 2 Alerts	137/81♥80 125.40Kgs 95 SpO2, ♥78		[REDACTED]
● 2	[REDACTED]	[REDACTED]	> 2 Alerts	141/55♥65 80 SpO2, ♥63		[REDACTED]
● 1	[REDACTED]	[REDACTED]	> 1 Alerts	128/78♥97 96 SpO2, ♥33		[REDACTED]

# Care Team Access



# Testimonials

- ▶ “This program increased my quality of life. I would normally go to hospital every month...since the Community Paramedics started seeing me, I have been able to stay out of hospital for six months at home. I am far more relieved and feel safe at home.” (client)
  
- ▶ “This program has helped; knowing that this service has impacted immensely, not only physically but on my mental health. A sincere thank you.” (client)

# Testimonials

- ▶ “At the age of 100, my mother was in very good health until the end but did not relish trips to the doctor for any reason. The visits from the paramedics kept us all feeling that she was being monitored and cared for. We particularly appreciated their calm and respectful manner with mom, and the time they took to answer her questions and our own. In the end it was the paramedics who correctly suggested/diagnosed the UTI that triggered her system failure and who kept in touch with us until we were connected with the palliative care team.... I am certain that without the support of the Northumberland Paramedic team we would have had to call 911 and my mom would have died in the hospital against her wishes and at public cost. I cannot fully express how appreciative we are of your team and the service you provide.” (caregiver)

# Testimonials

- ▶ “Both my mother and father are registered with your program. This program has brought peace of mind to me as well as my siblings, knowing someone is there for our parents. If not for the community paramedic program, I am positive that we would be taking more time away from work as our parents would be contacting us if they felt different or thought they needed to go to the Dr office or hospital. With the CPP they are more at ease with knowing if anything is wrong vitally, someone is monitoring this and will call or visit if needed.

I strongly believe that the CPP has prevented my parents from going to the hospital or Drs office so often. My parents just love the visits they receive from the medics as they are friendly, professional and take the time to answer all questions they have at that time” (caregiver)



# Testimonial

- ▶ “I referred a high-risk patient with multiple health issues including issues with multiple medical comorbidities, problems with mobility, and social isolation to the Northumberland Community Paramedicine Program during the COVID pandemic. The patient is thrilled with the level of support and monitoring that has been provided by the program and feels safer as a result. The program has enhanced my ability to provide care to this patient including monitoring labs, vital signs, and checking in on how they are feeling.” (primary care practitioner)

Northumberland Community  
Paramedicine

1-833-718-1942

Questions??

