



Community Paramedics

City of Kawartha Lakes



Autumn Campbell

Superintendent
Community Paramedic Program

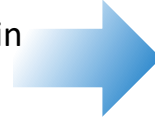


SUCCESS STORY



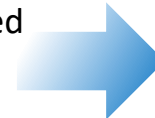
- **23 year old female** presents at the ED, receives **bloodwork**, **leaves without treatment**

23 year old female presents in the ED, receives bloodwork and testing, leaves without treatment



Female tests positive for syphilis
Leaves ED without treatment

Female is precariously housed
Lives 45 minutes away from the ED



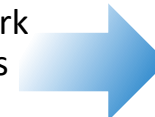
Resource nurse from hospital reached out to CP team to see if we could help

CP drives north to administer medication



Repeats as required until treatment is completed

Pt required further bloodwork and treatment for other STI's and substance use



CP met at hospital for support
All staff made comment on recovery and overall health and transformation

Individual feels less stigma and more support



Patient states the support has helped her never want to feel "dope sick again" and will endeavor to continue with success

BACKGROUND



February 2023 Meeting:

- Mental Health from local hospital
- Harm reduction
- John Howard Society
- Community Paramedics

Goal - ***to address needs of highly vulnerable individuals***



ROSS MEMORIAL
HOSPITAL
Kawartha Lakes

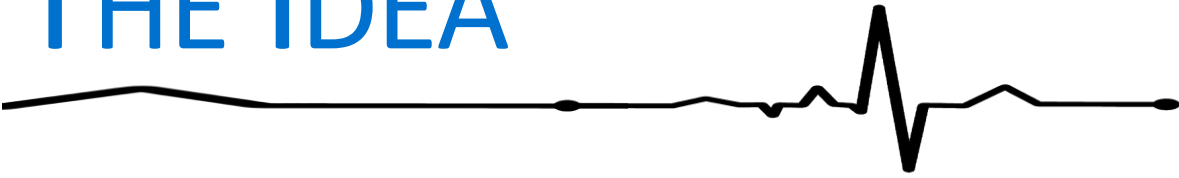


HALIBURTON, KAWARTHA,
PINE RIDGE DISTRICT
HEALTH UNIT

john howard society

Kawartha Lakes & Haliburton

THE IDEA



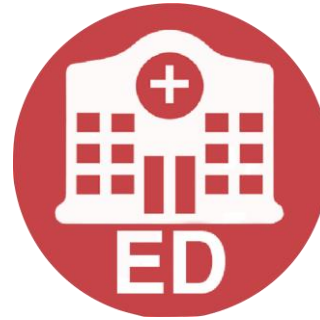
- Low barrier support and access
- 2 hours twice a week



Highly
Utilized
Buildings



High
Users of
9-1-1



High
Users of
ED



POPULATION

- Highly stigmatized individuals
- Users/interactions with all emergency service providers
- Substance users
- Unhoused, marginally or precariously housed
- Those with little to no supports or access to primary care



WHAT WE KNEW



- This population can experience stigma from multiple levels of health care and other service providers
- Can be hesitant to trust and or seek care
- Apprehension further needs and exacerbation can develop
- Potential to grow and develop to suit local needs
- Does not typically trust very easily so consistency and trust building was going to be needed



NEEDS ASSESSMENT COMPLETED



- ✓ Feelings of hopelessness
- ✓ Lack of affordable housing
- ✓ Low-barrier, pet-friendly spaces and emergency space(s) to rest
- ✓ Basic needs – public washrooms, food
- ✓ Accessible mental health services including substance use
- ✓ Wandering
- ✓ Reducing stigma, and discrimination
- ✓ Outreach services that are consistent, long-term and individualized
- ✓ Need for integrated wellness
- ✓ Desire for drop-in centre



PARTNERS



- **Ross Memorial Hospital** – Mental Health Crisis Outreach Supports
- **John Howard Society** – Harm Reductions and other Addiction Support Services
- **Community Health Centre** – Registered Nursing and Nurse Practitioner Services
- **City of Kawartha Lakes Paramedic Services** – Community Paramedicine Program
- **City of Kawartha Lakes** – Outreach Services and Life Stabilization Supports
- **Community Counselling Resource Centre** – General Counselling, as contracted by the City of Kawartha Lakes
- **Elizabeth Fry** – Bail and Court Support Services
- **Health Unit** – Sexual Health Services
- **PARN** – Harm Reduction Services
- **Ontario Disability Support Program** – Case Management

SUCCESS STORY



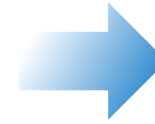
- **Female** experiencing **homelessness** and is **pregnant**.
- **Food Security** is a concern as well as **distrust** of many providers.

Female attended Mobile Outreach at 68 Lindsay



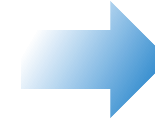
Female is pregnant and Spouse has Mental Health and Physical Challenges

Female convinced her spouse to attend Clinic



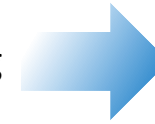
Female felt safe. No stigma felt

Spouse gained comfort and trust in providers



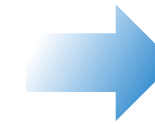
Engaged with the Mental Health team from RMH

Female stated that spouse was experiencing challenges



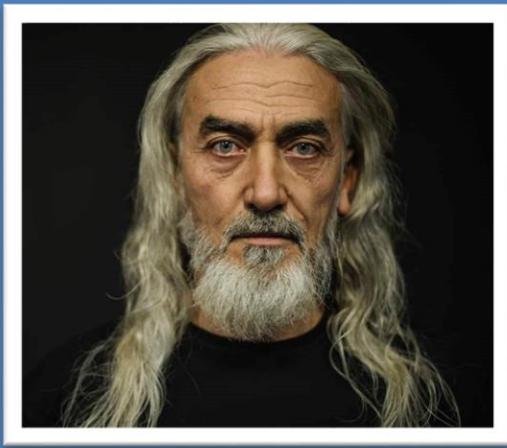
Engaged with team
Concerns were addressed as well as medical concerns for her

Collaboration done outside of clinic time



Due to nature of situation, Outreach assembled a team (outside of hub hours) Care ultimately received

SUCCESS STORY



- **56 year old under resourced** male
- **Thought** that he was **medically stable**, had not visited primary care in quite some time.
- Patient had **no previous knowledge** of underlying health conditions

Nutrition and a gathering space is offered



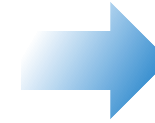
Comfort, familiarity and trust developed

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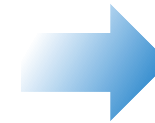
Allowed the Community Paramedics to preform vitals

CP's found concerns



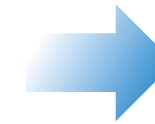
Pt had high blood pressure Irregular heart rate

Encouragement to contact primary care



Individual has not been diagnosed with high blood pressure and atrial fibrillation

Collaboration



Reduced health risks Increased trust.
Encouraged others to attend clinic

WAS IT WORKING?



From February to Present:

1,725

INTERACTIONS

4 HOURS

PER WEEK

In the past quarter there were **500**
additional interactions



111 WILLIAM CLINIC



Donated 2 bedroom apartment

- 1 "bedroom" for mental health assessment
- 1 "bedroom" for physical health assessment
- Living space – generalized use

SUCCESS STORY



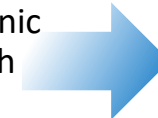
- **40 year old female** with lived experience, **currently housed** in social housing, experiencing **neurological symptoms** and **optic disturbances**

Female attended Outreach Clinic



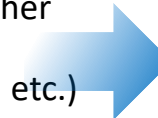
Female has felt significant stigma over the years
Trust building is required

Community Paramedic at clinic noticed “something off” with person’s eye



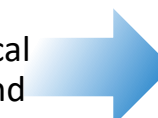
CP contacted individual’s primary care
CP and outreach worker attended ED with patient for support and validity in concern

Pt then required multiple other appointments (MRI, CT, ultrasound, ophthalmology, etc.)



Concern found on results – lesions on brain
Determined with history to be Neurosyphilis

Superintendent of CP immediately engaged Medical Director for development and implementation



Pt was having difficulty maintaining medication protocol
CP and outreach worked through method that would work for all involved

Pt received all medication. Pt states that the work and collaboration of the clinics literally changed her life



She admits she would not have attended all appointments if not for CP

LOCAL NEEDS MET



- ✓ Development of localized medical guidelines to continue to address needs
- ✓ Collaboration between Health Unit, Midwives, and CP
- ✓ Syphilis medical directive



COLLABORATIVE RESEARCH WORKS

- The organic nature of how these clinics came to be is what is needed to be recognized
- We have not reinvented the wheel
- Partnerships with like minded individuals who only wish to support those most vulnerable



KEY TAKEAWAYS



- **Consistency**
- **Teamwork**
- **Success looks different for all**
- **Respect**
- "Being unwanted, unloved, uncared for, forgotten by everyone. I think that is a much greater hunger, a much greater poverty than the person who has nothing to eat"
- Mother Teresa