County of Renfrew Paramedic Service
Community Paramedic Programs

-Achieving the Triple Aim-

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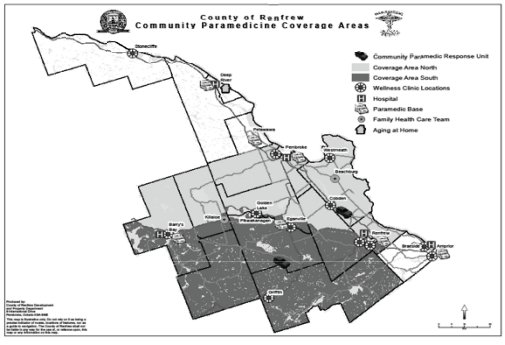
Community Paramedicine Objectives

1. Overview of community paramedic initiatives in Renfrew.
2. A design built, practitioner led program.
3. Improved patient experience by utilizing alternate pathways.
4. Improved health of population with ideas that make sense.
5. Improved health care capacity with a new approach.

County of Renfrew



County of Renfrew Paramedic Service

County of Renfrew Paramedic Service Vision

Our vision is to improve the quality of life of the residents and visitors of the County of Renfrew.

Corporate Goals

- Healthy Supportive Communities
- Positive Change in Our Communities
- Consistent & Shared Communication
- Collaborative Partnerships

County of Renfrew Paramedic Service Goals

✓To improve the quality of life of our seniors in our community.

✓To allow seniors to stay at home.

✓To decrease unnecessary 911 calls.

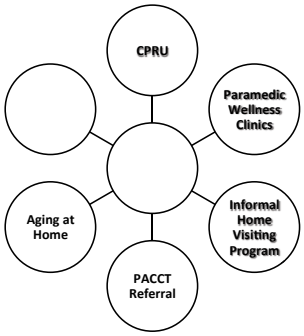
✓To decrease Emergency visits and hospital off- load delay.

✓To relieve stress for the family and caregivers.

County of Renfrew Current Reality

- Community needs vary widely
- Multilingual areas in the county
- Wide coverage with rural pockets
- Aging population
- 50% of population is overweight or obese
- 47% are physically inactive
- 25% are smokers
- 18% have high blood pressure
- 59% do not eat recommended +5 vegetables / fruits per day
- high % unemployment
- low education levels – post secondary education (54%)
- high poverty rates & low resource communities
- inadequate affordable housing

Community Paramedic Programs



1. Aging at Home

To allow seniors to live with dignity and independence in their own homes.

Partnered with North Renfrew Long Term Care

Aging at Home

The Deep River Community Challenge:

- 87% of senior population is waiting placement to Long Term Care, rehabilitation or in home clinical support.
- 5 year wait for institutional Long Term Care
- Proportionately older population than County average.

Setting

Aging at Home

Program Components:

- Paramedic
- Housekeeping
- Maintenance
- Personal Support Worker
- Alerting system
- 24 hour support line

Intervention

- Program activation system
  - Call bell system- closed loop
- Program hours of operations
  - 24 hours
- Response
  - Non-emergency SUV
- Skill Set
  - Wound care, diabetic education
  - Vitals, Medication compliance. Nutrition education
  - Urinalysis, fall prevention

Impact

• 55 clients in total over 5 years
• Approximately 600 visits completed a year
• Emergency Department return visits on average have dropped by 8%
•Saves the Healthcare system an average of $150 per day, per client.

2. Informal Home Visiting Program

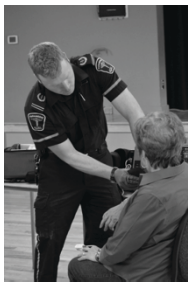
•Approx 5 Paramedics
•Approx 60 clients
•Currently do 911 follow ups and referrals from the Geriatric Emergency Management nurse.

A Typical Day

- Poor hygiene
- Poor med compliance
- A large drop in weight
- Arranged to have meals on wheels
- Involved CACC.
- Increased job satisfaction.

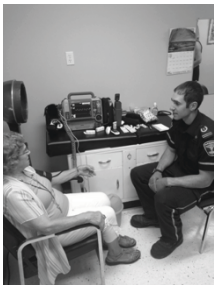
3. Wellness Clinics

- 600+ clients a month.
- 12 clinics total



Wellness Clinics

- BP checks
- Heart Rate
- Oxygen Saturation
- Blood Glucose
- Temperature
- ECG if necessary

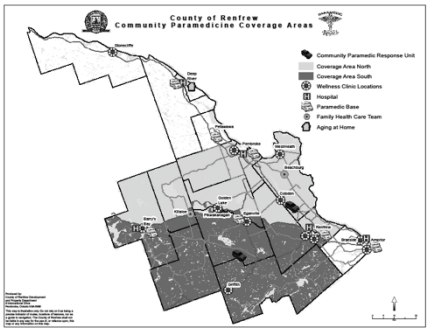


4. Community Paramedic Response Unit

Staffing

- ✓13 Advanced Care Paramedics
- ✓2x 12hr day/7 days a week
- ✓0700-1900 and 0900-2100
- ✓Stationed out of Whitewater Municipal Office in Cobden

Coverage Area

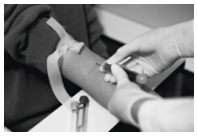


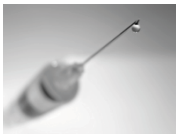
Design Built, Practitioner Led

- Town hall meetings
- Interested paramedics were welcome
- A smaller working group was developed and they worked on further shaping what the program was going to be.

Design Built, Practitioner Led

- Core group (7) had several meetings and brainstorming sessions
- A needs assessment was completed, that included visiting different stakeholders.
- Concentrated on not duplicating any services.
- Developed a Memorandum of Understanding.
- Enabled us to do Medically Delegated Acts (blood draw/ flu shots).





Community Stakeholders

- ✓ Whitewater-Bromley Community Health Centre
- ✓ Rainbow Valley Community Health Centre
- ✓ Geriatric Emergency Management Nurse out of Renfrew Victoria Hospital
- ✓ Community Care Access Centre
- ✓ Elder Abuse Team
- ✓ Mental Health Team
- ✓ Algonquins of Pikwàkanagàn Family Health Centre.

Training

- ✓University of Victoria – Falls Prevention course
- ✓Geriatric Emergency Management Training
- ✓Clinical Placement with Physiotherapist
- ✓Clinical placement with Geriatric Emergency Management nurse
- ✓Clinical Placement with Lab Technician (Phlebotomy)

Home Visits

- Wellness Checks
- Vital signs
- Medication compliance
- Fall risk factors
- Timed Up and Go
- (T.U.G)
- Blood draws
- ECG
- Postural BP
- Mini-mental state evaluation

What We Do

40%

Emergency Response

- 9-1-1
- Emergency Coverage
- Incident Standby

60%

Community Paramedicine

- Home visits
- Wellness Clinics
- Public speaking
- Community events
- Training events
- Community CPR and AED

Impact

- Reduced the overall number of visits to the CHC, and therefore helped increase the capacity for the WBCHC.
- Reduced the number and frequency of other healthcare services.
- Reduced time and services required during clinic appointments.
- An increase of the services available.
- Improved access to Primary Care in the community.

Impact

- 150 clients to date have been enrolled.
- In 2013, approximately 800 home visits were completed.
- 6.6 visits per client per year
- 30 Blood draws were completed
- Average duration of participation was 6 months.

Case Study One

- Age: 72
- Female
- Widow, lives alone, in a single story house.
- First referred to the program by a Physician at White -Water Bromley Community Health Centre.
- Referred for blood pressure monitoring.

Case Study One- Blood Pressure Records

January 19	BP-- 188/89
January 21	BP-- 197/90
January 23	BP-- 169/70
July 22	BP-- 178/81
July 24	BP-- 175/84
July 29	BP-- 168/99
August 1	BP --167/83
August 21	BP --142/83 (completed by Clinic)

Successfully increased health care capacity.

Case Study Two

- Age: 72
- Male
- Lives with wife in single family home.
- Client has no family physician.
- Home visits started as a follow-up to a Wellness Clinic visit.
- Client requested a home visit as he had surgery and was unable to attend.

Case Study Two - Assessment

- Vitals
  - HR:60,
  - BP:126/64,
  - Blood Glucose 5.6 mmol,
  - Temp 37.7C(99.8F)
- Left knee pain, increased edema to left leg, new blister on the back of the left leg.

Successfully utilized an alternate pathway and greatly improved the clients experience.

Case Study Three

- Age:87
- Male
- Lives alone in a two story house
- First referred to the program by a Physician at White-Water Bromley Community Health Centre.
- Referred for social reasons

Case Study Three

- Findings found during a Home Visit
- Made contact with his physician's office.
- Client seen by Primary Care – diagnosed with pneumonia and was started on treatment.
- Avoided a situation where the client may have ended up hospitalized.

Successfully utilized an alternate pathway

Case Study Four

- Age: 60
- Female
- Lives with her 94 yr old mother in a two story home.
- Referred to us by a Nurse Practitioner at Rainbow Valley Community Health Center
- Referred to us to have full assessment and INR weekly.

Improved health of population with ideas that make sense.

Case Study Five

- Age: 80
- Male
- Lives alone in single family home
- Visited the clinic 17 times in two months.
- 5 visits total since being put in program.

Successfully increased health care capacity.

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External Partners in Community Paramedic Programs

Questions?