Cape Breton Community-Based Paramedic Program

811 Peace of mind 24/7

EHS Emergency Health Services

nova scotia health authority

NOVA SCOTIA Health and Wellness

Health Care Redevelopment

As part of the Connected Care for

Cape Breton transformation project,

Emergency Health Services (EHS)

launched a community-based Integrated Health Program (IHP) on

December 17th 2018 as a way to provide in-home care to residents of the

Cape Breton Regional Municipality (CBRM).

Program Model

Health care provider referral based system;

- Providing 12-72 HRs post discharge support.
- Services include singular, combined or multi-day:
  - ❑ Telecare RN virtual visit
  - ❑ Community Paramedic (ACP) home visit

Implantation Approach

Soft launch, phased in approach;

- ED supportive discharge (phase one, December 2018)
- Medical unit supportive discharge (phase two, May 27, 2019)
- Long Term Care (TBD)
- Chronic disease support (TBD)
- Super users (TBD)

Operational Details

- Hours of operation: 0700HRS – 2100HRS daily
- Health care provider referral based system
- Referral form / orders are submitted via fax - to - secure file server
- Clinical Support RN (CSN) receives and clinically vets all referrals

Patient Types

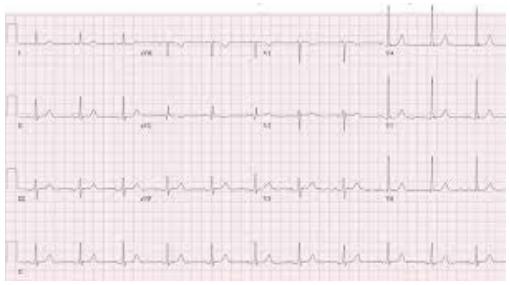
- At risk patients that could benefit from short term support as they transition back into their home environment (example: those that live alone or lack community supports).

- Patients that are clinically frail or have other risk factors and could benefit from an at home assessment (example: falls risk assessment, AMA, medication compliance and coaching etc.).

Patient Types

- Patients that require a next day intervention / diagnostic test that could be performed at home (example: IV antibiotic, ECG, blood collection /analysis).

- Patients with delayed access to community follow-up care (example: diabetic patient requiring follow-up with clinic).



Program Services

Clinical Support Nurse (CSN) Virtual Visit

- Medication adherence
- Education / health information
- NSHA: Discharge and/or Post-operative Instructions
- TeleHealth: Disease Specific, Medication or Health Promotion
- Community resources (self-referral options available within community)
- Chronic disease assessment: Diabetes, COPD, HF, CAD

Program Services

Community Paramedic (CP) Home Visit

- Comprehensive assessment
- Cardiac monitoring, 12 Lead ECG
- Vital sign assessment
- iSTAT, phlebotomy, urinalysis
- Medication compliance / coaching
- Chronic disease support (diabetes, COPD, HF, CAD)
- Antibiotic therapy (single dose)

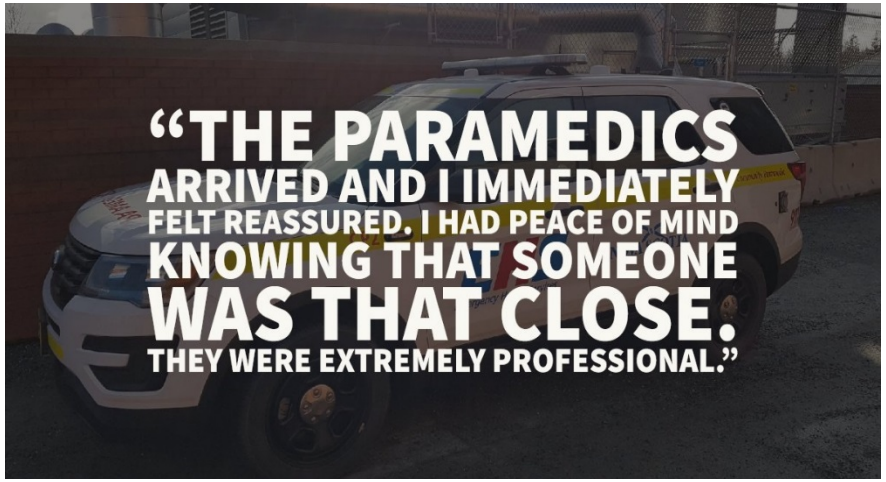
Post CP Home Visit Team Huddle

What Comes from the Clinical Huddle?

- Case close out
- Additional CP visit
- CSN virtual visit
- Additional CP and CSN visits
- Ambulance transport to hospital (rare)

Patient / Family Testimonials

Several calls/testimonials received from patients and families praising service!



- ☑ Patients and families very appreciative and pleased with service!
- ☑ Great collaboration amongst RN staff, Clinical Support Nurses and Community Paramedics
- ☑ Quality assurance and risk mitigation (recent patient taken back to ED)
- ☑ All referrals are 100% audited and are compliant to program standards