Introducing the Community Paramedicine at Home Program

CP@home

The Community Paramedicine at Clinic (CP@clinic) Program is:
- innovative, evidence-based, and cost-effective
- a chronic disease prevention, management, and health promotion program
- held in common spaces in social housing buildings
- offered on a drop-in basis

The CP@clinic Program has been adapted to be delivered as an in-home visit, referred to as CP@home.

CP@home features all of the same assessments/tools that are familiar to CP@clinic community paramedics.

Populations that can benefit from CP@home:
- Vulnerable and frail older adults
- Populations prioritized by the Ontario Health Teams
- Individuals referred by paramedics (includes frequent callers)
- Individuals referred by hospital discharge planner (e.g. at-risk for readmission)
- Individuals with multiple chronic conditions
- Individuals with limited mobility
- Individuals on the Long-Term Care Waitlist
- Individuals receiving remote patient monitoring

Benefits of the CP@home Program
- Improved patient quality of life
- Identifying and managing chronic diseases
- Help patients stay healthy at home
- Educating and empowering patients to look after themselves
- Connecting back to primary care

Features of the out-of-the-box CP@home Program
- Evidence-based program grounded in 10 years of robust research
- Standardized online paramedic training
- Uses appropriate validated assessment tools/questionnaires
- Standardized electronic database with decision support
- Standardized reports for monitoring and quality assurance
- Customized impact reports for services needs

CP@home First Visit
Completion of patient intake assessments

CP@home Follow-up Visit
Patient check-ins with assessments as needed

CP@home Program Discharge
Definite end-point for in-home visits