

## CP@home

CP@clinic



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

Adapted to be delivered in patients' homes

CP@home



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

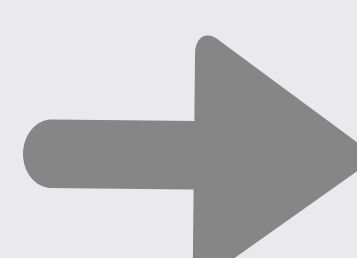
### Features of the out-of-the-box CP@home Program



- 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

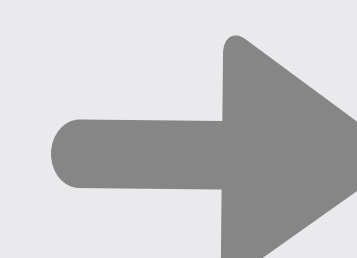
CP@home First Visit

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