Community Paramedicine for Long-Term Care

Framework for Planning, Implementation and Evaluation

Ministry of Long-Term Care

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Background

Community paramedicine is a model of community-based health care where paramedics use their education and expertise in community based, non-emergency care roles, outside their emergency response and ambulance transport roles. Existing community paramedicine programs have reduced the number of costly 911 calls and avoidable emergency room hospital visits and provided additional supports and connections for high risk or vulnerable individuals.

The Ministry of Long-Term Care (the ministry) is funding a community paramedicine program to provide services to individuals who are waiting for placement in a long-term care (LTC) home or who are soon to be eligible for long-term care. This initiative is part of the province's modernization plan to address systemic barriers in long-term care bed development and the growing demand for long-term care.

Purpose

This framework provides guidance to participating communities for planning, implementing and evaluating a Community Paramedicine for Long-Term Care (CPLTC) program.

CPLTC will be delivered by selected municipalities and District Social Services Administration Boards (DSSABs) in partnership with Local Health Integration Networks (LHINs) and Ontario Health Teams, where applicable. The purpose of the program is to keep individuals who are on the long-term care wait list, or who are soon to be eligible for long-term care, stabilized in their illness trajectory and in their own homes for as long as possible. The program will do this through preventive and responsive care, such as home visits and remote patient monitoring.

Health system partners can also use this framework to understand how a CPLTC program will coordinate with existing health services, including residential long-term care, home and community care, emergency care, primary care, and other community and social services.

This framework builds upon the 2017 Community Paramedicine Framework for Planning, Implementation and Evaluation (Ministry of Health and Long-Term Care). The general requirements in the 2017 framework apply to CPLTC programs where appropriate. This CPLTC framework outlines the specific requirements and considerations for planning, implementing and evaluating CPLTC programs. It was

developed with support from the Ministry of Health, the Ontario Community Paramedicine Secretariat, paramedics, LHINs, and the municipal sector.

The framework forms part of the CPLTC service agreement between the selected municipalities and the ministry. The ministry recognizes that changes to the program's design may be necessary as a result of delivery partner feedback and consultations, as well as lessons learned from the early phases of the program and potential future expansion. As such, the guidelines may be updated as needed and any updates will be communicated to delivery partners.

Guiding Principles

The CPLTC program is based on four guiding principles:

- **Accessible**: 24/7 access to community paramedicine services for non-emergency procedures in their own home and health system navigation support
- **Responsive:** Prompt, flexible, proactive, and patient-centred response to changing circumstances or medical conditions and if necessary, connection to the right health care provider at the right time in order to avoid escalation and crisis
- **Proactive:** Systematic, routine-based remote or home monitoring to prevent emergency incidents or escalation in medical conditions
- **Safe:** Certain diagnostic procedures and treatments can be provided at home and if required, under appropriate medical oversight

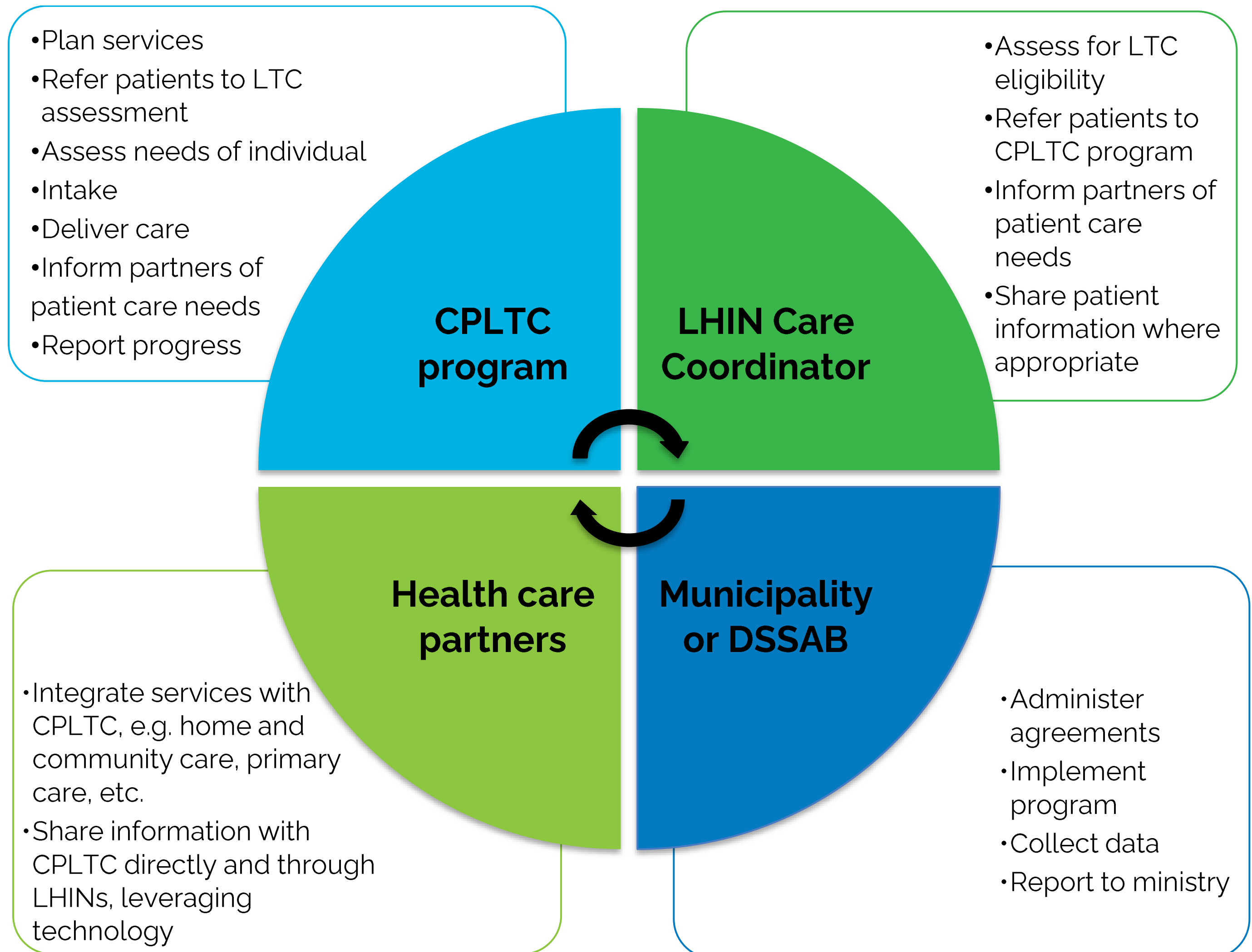
Partnerships and Collaboration

Collaboration with key health system partners is critical to support effective local-level planning, implementation, and evaluation of the CPLTC program.

The CPLTC program should consider regular meetings with health system partners to discuss system level issues, clinical decisions, service innovations, and discharge planning.

This diagram shows high-level roles that select partners will play in delivering the CPLTC program. Other local partners may also be engaged as required.

High-Level Roles of Program and Partners



Program Parameters

The Ministry of Health and Long-Term Care created a Community Paramedicine Framework in 2017 to guide municipalities and ambulance services in providing high-quality services while promoting patient safety and adopting operational best practices.

The CPLTC program parameters build upon the original Community Paramedicine Framework and provide guidelines specific to CPLTC. These parameters may evolve over time and are not in isolation from one another and may have substantial overlap.

The following parameters apply to the CPLTC program:

A. **Program Planning**
   - Program Eligibility
   - Program Objectives
   - Services
   - Roles and Responsibilities
   - Referral and Intake Process
   - Program Transition and Discharge

B. **Implementation**
   - Coordination and Service Alignment
   - Staffing and Medical Oversight

C. **Accountability and Evaluation**
   - Program Accountability
   - Program Analysis and Evaluation

A. Program Planning

Program Eligibility

There are three categories of people eligible for CPLTC:
- those on the wait list for long-term care
- those who have been assessed as eligible for long-term care by a LHIN Care Coordinator (but not yet on the wait list)
- those who are soon to be eligible for long-term care

The criteria for individuals being soon to be eligible for long-term care include:
- individual is identified as needing or waiting for a LHIN Care Coordinator to assess eligibility for long-term care
- individual has specific circumstances or conditions that would benefit from CPLTC services (e.g. conditions that benefit from remote monitoring) and help the individual avoid hospitalization or long-term care

Individuals deemed soon to be eligible for long-term care would not automatically become eligible for long-term care or placed on the waitlist because they are participating in the CPLTC program. Participants are still required to follow appropriate channels for assessment and application for placement by LHIN Care Coordinators in order to receive long-term care services.

The Method for Assigning Priority Levels (MAPLe) score or other assessment tools may be used as a reference to determine whether CPLTC services would be suitable for individuals.

Eligible individuals may also be assessed by a paramedic service provider to ensure that the services and programs provided through CPLTC match the individual's needs and requirements. CPLTC services may not meet the needs of all individuals on the long-term care waitlist.

Program Objectives

The overall goals of the CPLTC program are to:

- safely keep eligible individuals in their own home for as long as possible, including reducing avoidable emergency department visits and hospital stays through preventive and responsive care, such as remote monitoring
- mitigate the illness or disease trajectory thereby supporting increased quality of life
- provide individuals, families and caregivers peace of mind while waiting for a long-term care bed or in choosing to delay the option for long-term care
- minimize waitlist growth and duration by providing alternative options for some individuals who wish to stay home longer with appropriate care

Services

Every community's CPLTC program must have a clear description of the types of services that the program will offer. These services should correspond with the specific needs of people on the waitlist and the overall program goals. The program should be accessible, responsive, proactive and safe.

The types of services funded by this program may include:

- 24/7 access to community paramedicine services for defined non-emergency procedures in people's own homes addressing urgent, episodic care needs. For example, diagnostic procedures, assessment and testing during routine home visits; at-home treatment under supervision of a physician, where required; or at-home treatment of minor conditions (e.g. falls, lacerations, bruises).
- Prompt, flexible and proactive response to an individual's changing circumstances or medical conditions, and if necessary, connecting them to the right health care provider and social services at the right time in order to avoid escalation and crisis.

- Routine-based remote monitoring to prevent emergency incidents or escalation in medical conditions. For example, monitoring of blood pressure, heart rate, oxygen saturation, blood glucose, weight and temperature alerts.
- Immunizations, vaccinations and other injections (e.g. tetanus).
- Certain other controlled medical procedures and treatments at home under appropriate medical oversight.

Roles and Responsibilities

Municipalities, DSSABs and the CPLTC program will collaborate with partners in the health system, such as home and community care and primary care, to provide high-quality integrated patient-centred care. The program will work with these partners to determine the appropriate services to meet the needs of the program's target population. Good information exchange will ensure the individual is provided with the right services and care when they need them, while also increasing efficiency and reducing duplication.

Roles and Responsibilities Guidelines

Partner	Planning	Implementation	Evaluation
Municipalities and DSSABs	• Administer funding relationship • Identify community needs for CPLTC services, working with paramedic service providers to understand what services are required to benefit those eligible or soon to be eligible for LTC • Collaborate with paramedic service providers to design services and local guidelines • Liaise with First Nations, Inuit, Métis communities	• Oversee program accountability to ensure services and program meet program guidelines and resources are maximized	• Report back to ministry regarding program accountability and evaluation

Partner	Planning	Implementation	Evaluation
	• Leverage and expand relationships with Social Services and Housing		
CPLTC Program	• Design services • Provide personnel, equipment and resources to operate programs	• Hire, educate and train paramedics to provide community paramedicine • Deliver care and services to patients • Assist LHINs with reviewing waitlist to determine suitability for CPLTC program depending on services currently available • Identify patients that may soon be eligible for long-term care • Work with LHINs and Ontario Health Teams (where applicable) on service integration and coordination with existing community paramedicine programs, home and community care services, and primary care • Provide information about interventions to LHIN Care Coordinator when appropriate • Refer orphaned patients to primary	• Collect data • Administer client and provider satisfaction surveys • Incorporate Patient & Family Advisors • Submit data to municipalities

Partner	Planning	Implementation	Evaluation
		care providers, home and community care services and other community supports	
LHIN Care Coordinators	• Share information about community needs with CPLTC program, where appropriate • Share information with CPLTC program about high-risk, crisis, or complex patients, and patients with caregivers experiencing compassion fatigue (e.g. through weekly or bi-weekly rounds)	• Refer eligible clients to the CPLTC program • Review LTC waitlist information and refer existing patients to CPLTC program who meet the eligibility requirements of the program • Enable integration with existing community paramedicine programs, home and community care services, and primary care • Enable patient information sharing with CPLTC program, where appropriate • Receive patients discharged from the program for other services (e.g. LTC)	• Not applicable
Ontario Health Teams (where applicable)	• Involved in supporting integration of CPLTC program (e.g. weekly or bi-weekly rounds on patients suitable for program)	• Refer suitable patients to CPLTC program through LHIN Care Coordinator • Support LHINs on service integration of CPLTC with primary care	• Not applicable

Partner	Planning	Implementation	Evaluation
Primary Care Providers	• Support identification of community needs and development of potential services	• Refer suitable patients to CPLTC program through LHIN Care Coordinator • Support service integration of CPLTC with other services • Provide services for orphaned patients	• Not applicable
Ontario Health (Ontario Health Shared Services)	• Enable data sharing capabilities by providing CPLTC program access to home and community databases (e.g. Client Health and Related Information System) and LTC waitlist information	• Support coordination and alignment among CPLTC, home and community care, and primary care • Support required communication pathways	• Provide data to the Ministry of Long-Term Care from home and community care databases
Ministry of Long-Term Care	• Provide funding to municipalities • Determine overarching goals and guidelines for the program • Draft Transfer Payment Agreements (TPAs) between ministry and municipalities	• Support municipalities in delivering on TPA requirements and patient safety guidelines • Support paramedic services' access to necessary data	• Overall program evaluation

Referral and Intake Processes

The CPLTC program will work with health systems partners to create a clear and transparent referral and intake process. Referrals can occur through:

- the CPLTC program identifying and referring participants during their routine community paramedicine services
- LHIN Care Coordinators identifying and referring participants during their routine assessments for home and community care or long-term care

The referral process should also include various health partners to ensure equitable access to care. These may include Family Health Teams and community agencies that can receive and send referrals to and from the program, through the LHIN Care Coordinator where appropriate.

Where possible, referrals and intake should utilize common and internet-based tools. Frequent communication about referrals and intake through existing channels is strongly recommended. For example, sharing information about new patients at weekly or biweekly discussions or rounds between the LHINs and the CPLTC program can help to avoid duplication of services. Consultation with home and community care providers should also assist in determining the proper care needs for the client and avoid duplication of services. Please refer to the Program Eligibility section for more information on how to assess eligibility.

The program should consider jointly reviewing the referrals with the LHINs to ensure that the appropriate people participate in the program. The process may also require the CPLTC program to undertake further assessment of eligible individuals to determine if a patient is a suitable candidate for CPLTC based on their individual needs and services available.

Municipalities and DSSABs should consider the needs of First Nations, Inuit, and Métis communities in their geographic area regarding referral, intake, and service coordination with the program.

The CPLTC program is responsible for the intake process. Features should include:

- utilizing the MAPLe Decision Support Tool and Frailty Scores for prioritizing patients and reporting purposes if applicable
- determining the services that will benefit the individual
- informing and familiarizing the individual and their caregivers with services they are eligible to receive
- communication with other services providers
- collecting information for accountability and evaluation purposes
- seeking voluntary patient consent to share data with the province for evaluation purposes

Each CPLTC program must develop clear and accessible documents describing referral and intake processes for public and health partner communication purposes.

Program Transition and Discharge

The CPLTC program will work with LHIN Care Coordinators and other relevant care providers to ensure patients receive the next appropriate care level, if they transition or choose to discontinue their enrolment in the program. The program will establish open communication and share all relevant information with health partners about the patient, such as documented health records and care plans, for seamless transition to the next required care level.

If the patient requires long-term care supports, the existing long-term care processes apply. If the patient is discharged to the hospital, the CPLTC program will continue to work with the hospital about their care and discuss next steps for the appropriate care level, such as continuing in the program or transitioning to another service.

B. Implementation

Coordination and Service Alignment

Local coordination is a key factor to the success of this program. The CPLTC program will build on existing community services and community paramedicine programs in order to add capacity and maximize resources rather than subsidize or offset existing programs. CPLTC does not replace current home and community care services. The program can complement these services and provide additional support and peace of mind to participants and their caregivers so that they can feel safe and supported in their own communities. A successful CPLTC program will need to work in close alignment and coordination with home and community care and primary care providers.

Focusing the recommended weekly or bi-weekly discussions or rounds on high-risk, crisis or complex patients can also help to ensure effective alignment of services and maintain service volumes and avoid duplication of services.

Municipalities and DSSABs should work with other health care providers to develop policies and processes, using formalized agreements or mutually accepted guidelines, in order to ensure strong coordination and service alignment at the local level.

The following parts of the program require coordination:

- **Patient care plans:** The CPLTC program should work with LHIN Care Coordinators, primary care providers and home and community care agencies to understand and contribute to the existing patient care plans in a manner that addresses the needs of the individuals and their caregivers.
- **Transition processes and hand-offs**: Health providers in the circle of care should establish timely, ongoing, and open communication with one another about the services provided to the patients in order to transition them to the next appropriate care level when required and avoid duplication, such as double dosing of immunizations or assigning multiple physicians to orphaned patients. CPLTC programs will work with the LHINs and other care providers to refer orphaned patients through existing processes to the appropriate services. CPLTC programs will have mechanisms in place to discuss assessment, follow-up, monitoring, and provide advice on emerging issues or needs.
- **Documentation and medical records**: The CPLTC program should work with partners to ensure there is easy and seamless access for all health providers in the patient's circle of care to read and record patient information and ongoing care, as appropriate. Documentation and record-keeping should be integrated into existing systems or electronic format. CPLTC programs, LHINs, and other health partners may consider working together to use a common platform to access and input information.

Staffing and Medical Oversight

A person who provides community paramedicine services must also be a paramedic within the meaning of the *Ambulance Act*. While a paramedic from any level of practice may be appropriate to take part in a community paramedicine program, per the 2017 framework, consideration should be given to the particular vulnerability of the target population for CPLTC.

Community paramedicine service providers are only permitted to perform controlled acts under the delegation of a regulated health professional with the authority to perform and to delegate those acts. Where a CPLTC program provides activities or services that may include a Controlled or Delegated Act, the program should document the process of how this work will be delegated by a responsible physician. This documentation should detail the level and nature of medical oversight required for services such as medical assessment, diagnosis, or treatment, particularity in rural communities that lack provider resources.

Protocols and guidelines will be developed in consultation with physicians, nurses and other health care professionals, compliant with applicable paramedicine practice, the requirements of applicable health professional colleges, and legislative or regulatory frameworks.

C. Accountability and Evaluation

Program Accountability

The ministry will establish the following accountability mechanisms with participating communities:

- **Formal agreements** (e.g. TPAs or Memoranda of Understanding)

  These documents will include terms, conditions, and provisions that:
  - Clarify resources and funds and how they will be used.
  - Define the governance, oversight, and reporting structure among the parties involved, including expectations of each partner.
  - Explain how the governance and accountability structures will ensure that all community paramedicine activities fall within current legislative, regulatory or program parameters.
  - Explain how the municipality or DSSAB is accountable for the program participants and their care plans.
  - Provide information on medical oversight mechanisms.
  - Define roles and responsibilities of program partners, including LHINs, etc.
  - Outline financial management and oversight processes.
  - Require the municipality or DSSAB to collect, use and share program participant health information with the province, with the consent of the participant.

- **Quality improvement reviews and reporting**
  - Participating communities need to demonstrate how community paramedicine programs contribute towards achieving the intended policy goals. The TPAs will include reporting requirements for outcome evaluation. The participating municipalities will use templates to provide regular and consistent reporting to the ministry.

- **Financial Reporting**
    - Participating communities need to demonstrate how the allocated funding was spent on various program components, including services provided, staffing, and new technology. Requirements will be laid out in the TPAs.

Program Analysis and Evaluation

Program evaluation will help the province, municipalities, and health partners understand the outcomes and impact of the CPLTC program, such as improved patient outcomes and cost effectiveness. The ministry will work together with participating communities to collect and analyse data on processes, services and outcomes, which will help inform future decision-making and program improvement.

Participating communities are required to report regularly to the ministry on a set of indicators linked to outputs and outcomes.

The indicators to be collected are identified in the table. These indicators may change over time.

Individual communities may choose to collect additional qualitative or quantitative measures depending on their needs for planning purposes.

Ontario

Table of Indicators

Client profiles

Indicator	Indicator details
Health Card Number (HCN)	HCN as an identifier to link community paramedicine data with other heath sector databases
Age of patients	Age of patients upon enrollment in the program
Chronic health conditions	Top 3 or more chronic conditions, such as chronic obstructive pulmonary disease (COPD), asthma, epilepsy, diabetes, heart failure & pulmonary edema, hypertension, angina
Long-term care home (LTCH) wait list	Whether the client is on the LTCH wait list
Number of clients who have transitioned from hospital, were on the LHIN's "crisis" list, or are receiving episodic care as part of the region's COVID-19 response	Whether the client receiving community paramedicine services has transitioned from hospital, were on the LHIN's "crisis" list, or are receiving episodic care as part of the region's COVID-19 response

Services provided

Indicator	Indicator details
Types of community paramedicine services provided (e.g. remote monitoring, home visits, and others; select up to 3 types of services)	Range of community paramedicine services available in the community
Length of client enrolment in the program	The date that the client enrolled in the program, and if applicable the date the client was discharged from the program
Number of in-person visits	Number of community paramedicine home or virtual visits completed per patient

Client and provider experience

Indicator	Indicator details
Patient, family, and caregiver experience, including client and caregiver perspectives on whether community paramedicine helped them stay at home	Satisfaction level of enrolled patients
Provider partner satisfaction with CPLTC services	A separate survey than the one for patients and caregivers that would reflect satisfaction or experience of other partners, including primary care providers, hospitals, community agencies, home and community care providers, and OHTs

Integration with other service domains

Indicator	Indicator details
Number of referrals	Number of referrals to other health and community services, such as primary care or community support services

Broader health system usage

Indicator	Indicator details
Impact on broader health system usage	The province will leverage health system data to analyse CPLTC's impact on broader health system usage (e.g. number of 911 calls, emergency department (ED) visits, hospital admissions or readmissions clients made or experienced)