Ontario Community Paramedicine Reporting Guidelines

Performance Measures & Evaluation Working Group
Ontario Community Paramedicine Secretariat

Table of Contents

1 – Data Set Definitions

The Community Paramedicine (CP) programs are required to have processes in place to collect a minimum set of data for the measurement of processes, services and outcomes to understand and evaluate program functioning and impacts. The following is the Ontario CP Minimum Data Set list of variables for individual level and program level aggregate data including their definitions, data type and variable source. It is expected that each of the data points in the Minimum Data Set are to be collected by community paramedics at least once a year per patient and must be collected at program intake if the patient is new to Community Paramedicine.

Individual Level Data Variables:

	Variable	Definition/Description of Variable	Data Type	Variable Source
First Visit Data Variable (Collected Once)	**Identifiers**			
	Patient ID	A de-identified number created by your CP program assigned to one individual patients (ID stays the same throughout repeat interactions or across different CP programs)	CP Program ID#	Patient Medical Record
	Case Opened Date	Date the client is assigned a de-identified Patient ID	Date	Patient Medical Record
	Patient Intake Date	Date of patient enrollment/onboarding. Case Opened Date may be the same as or precede Patient Intake Date, but Patient Intake Date cannot precede Case Opened Date	Date	Patient Medical Record
	Case Closed/Discharge Date	Date when patient is discharged from program. Leave blank until status known.	Date	Patient Medical Record
	Patient Status	Indicate whether patient is actively receiving care and/or services from a community paramedicine program: ○ Active ○ Inactive	Binary	Patient Medical Record
	Case Closed/Discharge Reason	List reason for Case Closed/Patient Discharge: • patient moved out of catchment or unknown location, • deceased, • new or appropriate services in place (including assisted living, long-term care, etc.), • improved patient condition, • patient refused continued services, • patient admitted to hospital, • other	List/Text	Patient Medical Record

	Type of Program Enrollment	Classification of program where intake occurred: • Referral during 9-1-1 call (including new models of care), • Hospital discharge, • Primary Care Home Visit, • Home & Community Care Home Visit, • Wellness Clinic, • 9-1-1 call follow-up (including repeated callers OR new models of care), • Emergency/Disaster situation (including State of Emergency or hosting evacuees), • Community Event (including special events and outreach events), • Other, Clinic Setting, • Other, Health Care Provider Referral, • Other, Home Visit Program, • Other	List/Text	Patient Medical Record
	Referral Source	Indicate which organization/provider submitted the referral: • Paramedic, • Primary Care Provider, • ED Staff • Home & Community Care Staff, • Specialist Physician, • Discharge Planner, • Police, • Other, Health Care Provider, • Other, Community Agency, • Other	List/Text	Patient Medical Record
	Reason for Referral	Describes the primary reason for the referral to the CP program by a community partner, hospital program/staff, primary care, 911 responding paramedic, other, etc.) • Chronic disease education/behavior change, • Chronic disease medical surveillance, • Influenza immunization, • Fall's risk program, • General Community Health Assessment, • Health system navigation, • Alternative level of care programs, • Facilitated D/C programs,	List/Text	Patient Medical Record

	• Treatment, • Emergency evacuation, • other		
Demographics			
Gender	How patient identifies	M/F/Other	patient/EMR
Age	Use DOB to create age. Use most current age, either age at day of discharge or age at day of reporting.	Date of Birth	patient/EMR
Housing Type	Identify type of housing at time of intake: • Private home / apartment / rented room, • Board and care, • Staff Assisted living or semi-independent living, • Mental health residence—e.g., psychiatric group home, • Group home for persons with physical disability, • Setting for persons with intellectual disability, • Psychiatric hospital or unit, • Homeless (with or without shelter), • Long-term care facility (nursing home), • Rehabilitation hospital / unit, • Hospice facility / palliative care unit, • Acute care hospital, • Correctional facility, • Other	List/Text	paramedic
Living Status	Identify living arrangement: • Alone, • With spouse / partner only, • With spouse / partner and other(s), • With child (not spouse / partner), • With parent(s) or guardian(s), • With sibling(s), • With other relative(s), • With non-relative(s)	List	patient/paramedic
Marital Status	At time of intake, based on most-current status: • Never married, • Married, • Partner / Significant other, • Widowed,	List	patient/family

		• Separated, • Divorced		
	Baseline Assessment			
	Chronic Conditions	Identify every diagnosed disease: • Coronary heart disease, • Chronic obstructive pulmonary disease, • Congestive Heart Failure, • Other, Cardiac, • Other, Respiratory, • Alzheimer's disease, • Dementia other than Alzheimers, • Stroke/CVA/TIA, • Other, Neurological, • Hypertension, • Seizure, • Cancer, • Diabetes, • Anxiety, • Depression, • Schizophrenia, • Other, Mental Illness/Psychiatric, • Recent Infection (last 30 days pre-enrollment), • Renal Failure, • Other, Chronic Condition requiring ongoing disease management, care or treatment.	List (select all that apply)	patient / EMR
	Palliative Care	Patient in need of palliative care (regardless of receiving care or on wait list for care/hospice)	Y/N	patient/EMR
	History of Falls	Patient had a fall event, regardless of outcome (got up uninjured, lift assist and transport, fracture, surgery, etc.), within last 30 days	Y/N	patient/family/EMR
	Chronic Pain	Patient reports ongoing pain (mild, moderate, severe) for >3 months	Y/N	patient
	Medications	Number of prescribed medications (regardless of compliancy)	Number	patient/EMR
	Interventions			
Data	Referrals to Primary Care	Number of referrals made by Community Paramedicine to Primary Care	Count	CP files
	Referrals to Home/Community Care	Number of referrals made by Community Paramedicine to Home and Community Care	Count	CP files
	Health Care Provider	Number of consultations for patient care with any Health Care Provider, via	Count	CP files

Consultations	phone, OTN, email, fax, or in person		
Increased Services	Number of added supports for clients because of CP involvement (lab requisitions, social work, housing, rehabilitation, other)	Count	CP files
Patient Interactions	Number of client communication interactions (including over phone with client or family member)	Count	CP files
Home Visits	Number of client in-home visits	Count	CP files
Clinic Visits	Number of clinic visits	Count	CP files
Remote Patient Monitoring (RPM)	Number of clients registered and set up for RPM	Y/N	CP files
Remote Patient Monitoring Alerts	Number of abnormal (outside of parameters) events captured by Remote Patient Monitoring	Count	CP files
Health Teaching/Education	Number of events where education was provided on health conditions, medication administration, signs & symptoms, etc.	Count	CP files
Point of Care (POC) Tests	Number of POC tests (INR, BGL, blood, urine, influenza swab, other)	Count	CP files
Patient Care/Treatment	Number of treatments provided (wound care, vaccines, prescribed medications, protocol implementation)	Count	CP files
Outcomes			
CP initiated Request for 911 Services	List the number of individual 911 requests for service by enrolled patients (include all patient contacts, transports and non-transports)	List	CP files
911 Activations	Number of 911 activations by enrolled clients stratified by CTAS (CTAS – at first patient contact)	Count/CTAS score at patient contact	ACR Database
Hospital ED visits	Number of hospital ED visits (if obtainable) by enrolled clients stratified by CTAS (CTAS – at first patient contact)	Count	hospital EMR
CP System Utilization as First Contact	Number of occurrences where clients call CP program for a medical concern rather than activating 911 for emergency response	Count	CP files
Patient Satisfaction	Record each response (ensure same survey given to all clients) ○ Very Satisfied ○ Satisfied ○ Dissatisfied ○ Very dissatisfied ○ No response ○ Not surveyed	Scale/count	Survey
Evaluation			
911 Activations Pre-90 Day Enrollment	Number of 911 activations (both transports and 72s) by client in the 90 days prior to CP enrollment	Count	ACR Database

	911 Activations Post-90 Day Enrollment	Number of 911 activations (both transports and 72s) by client in the 90 days post CP enrollment	Count	ACR Database
	911 Activations Pre-365 Day Enrollment	Number of 911 activations (both transports and 72s) by client in the 365 days prior to CP enrollment	Count	ACR Database
	911 Activations Post-365 Day Enrollment	Number of 911 activations (both transports and 72s) by client in the 365 days post to CP enrollment	Count	ACR Database

Program Level Aggregate Data Variables:

PROGRAM LEVEL (AGGREGATE) REPORTING			
Variable	**Calculated by the combination of the collected individual level data elements over a specific period to reflects the program's overall activity in a defined period.**	**Data Type**	**Variable Source** (Individual Level Data Elements)
Identifiers			
Patient ID	Number of clients contacted or visited by CP program (can stratify between all methods of contact)	Count of CP Program Patient ID's	Patient ID
Patient Intake Date	Average length of time (days) between Case Opened Date and patient intake date	Count of Days	Case Opened Date & Patient Intake Date
Case Closed/Discharge Date	Average length of time (days) client remains active in program - *difference between enrollment and discharge dates*	Count of Days	Case Opened Date & Case Closed/Discharge Date
Case Closed/Discharge Reason	Count in each category populated by all reasons entered	Counts for each category and percentage	Case Closed/Discharge Reason
Type of Enrollment	Count in each category program stream	Counts for each category and percentage	Type of Enrollment
Referral Source	Count of each referral category (home and community care, hospital, primary care, law enforcement, etc.)	Counts for each category	Referral Source
Reason for Referral	Describe the reason for the referral to the CP program.	Counts for each category	Reason for Referral

Number of Referrals to CP	Sum of referrals received in reporting time frame per client.	Count for each category	Referral Source
Demographics			
Gender	Sum of clients who identified as female/male/other	Counts for each category	Gender
Age	Sum in each age category (<60, 60-64, 65-69, 70-74, 75-79, 80-84, =>85)	Counts for each category	Age
Housing Type	Sum in each housing category	Counts for each category	Housing
Living Status	Sum in each living category	Counts for each category	Living Status
Marital Status	Sum in each marital category	Counts for each category	Marital Status
Baseline Assessment			
Chronic Conditions	% of patients with each disease	Counts for each category	Chronic Conditions
Palliative Care	Sum of patients receiving palliative care	Count	Palliative Care
History of Falls	Sum of patients with history of falls	Count	History of Falls
Chronic Pain	Sum of patients with chronic pain	Count	Chronic Pain
Medications	average number of prescribed medications	Mean or average number	Medications
Interventions			
Referrals to Primary Care	Number of referrals made to primary care that were successful (client contact or intervention was completed)	Count	Referrals to Primary Care
Referrals to Home/Community Care	Number of referrals made to Home and Community Care that resulted in follow-up or other health care services	Count	Referrals to Home/Community Care
Provider Consultations	Number of consultations regarding patient care/assessment/medication change or prescription via any communication	Count	Provider Consultations
Increased Services	Number of implemented supports that were initiated and completed by CP medic/program	Count	Increased Services
Patient Interactions	Number of phone conversations that provided support, guidance, follow-up, etc.	Count	Patient Interactions
Home Visits	Number of scheduled or drop-in visits for clients where safety check, health	Count	Home Visits

	assessment, POC, blood work, etc. was done		
Clinic Visits	Number of visits to CP clinic (count each attendance by every client)	Count	Clinic Visits
Remote Patient Monitoring	Number of clients new to RPM	Count	Remote Patient Monitoring
Remote Patient Monitoring Alerts	Number of follow-ups or contact made to client because of RPM received data	Count	Remote Patient Monitoring Alerts
Health Teaching/Education	Number of education sessions provided to clients (count every event, not just client)	Count	Health Teaching/Education
Point of Care (POC) Tests	Number of Point of Care tests stratified by type	Counts for each category	Point of Care (POC) Tests
Patient Care/Treatment	Number of treatments provided with no adverse outcome	Count	Patient Care/Treatment
Outcomes			
911 Request for service	Total number of 911 activations by enrolled clients in this reporting period (stratified by CTAS – at first patient contact)	List	ACR Database
911 Activations	Total number of 911 activations by enrolled clients in this reporting period (stratified by CTAS – at first patient contact)	Count	ACR Database
Hospital ED visits	Total number of hospital ED visits by enrolled clients in this reporting period (stratified by CTAS – at first patient contact)	Count	hospital EMR
System Utilization	Total number of times clients resorted to using CP rather than 911 for appropriate/non-urgent reasons	Count	CP files
Patient Satisfaction	Collated responses to determine average responses for level of satisfaction (stratified by question) Combined responses of Very Satisfied AND Satisfied	Scale/count	Survey
Evaluation			
911 Activations Pre-90 Day Enrollment	Total Number of 911 activations by all clients in 90 days prior to program enrollment. **NOTE:** Clients must be enrolled for minimum 90 days to report this metric.	Count	ACR Database
911 Activations Post-90 Day Enrollment	Total Number of 911 activations by all clients in 90 days post program enrollment. NOTE: Clients must be enrolled for minimum 90 days to report this metric.	Count	ACR Database
911 Activations Pre-365 Day Enrollment	Total Number of 911 activations by all clients for 365 days prior to program enrollment **NOTE:** Clients must be enrolled for minimum 365 days to report this metric.	Count	ACR Database
911 Activations Post-365 Day	Total Number of 911 activations by all clients in 365 days post program enrollment. NOTE: Clients must be enrolled for minimum 365 days to report	Count	ACR Database

Enrollment	this metric.		
911 Activations: Enrolled vs Non-Enrolled	For all patients that have called 9-1-1 more than once, comparison between patients who have been enrolled in a community paramedicine program and those that have not. Number of calls per patient.	Number of calls per patient.	ACR Database

2 – Patient Encounter Minimum Data Set Elements Requirements

1. An electronic Medical Record (eMR) entry shall be completed for each ***face to face*** and ***telephone*** patient encounter.
2. The community paramedic who has contacted, assessed, and/or provided patient care to an individual, shall be responsible for completing the eMR entry.
3. The eMR shall be completed according to the core and optional requirements of the OCPS MDS in section below.
4. The eMR entry shall be completed as soon as possible and no later than the end of the scheduled shift or work assignment during which the encounter occurred.

Data Element	**Program Type (Core or Optional Element)**				
Identifiers	**Assessment & Refer**	**Community Paramedic-led Clinic**	**Home Visit**	**All other Programs**	**Flu Shot Initiative**
Patient ID	Core	Core	Core	Core	Core
Case Opened Date	Core	Core	Core	Core	Core
Patient Intake Date	N/A	Optional	Optional	Optional	NA
Case Closed/Discharge Date	N/A	Core	Core	Core	NA
Case Closed/Discharge Reason	N/A	Optional	Optional	Optional	NA
Type of Enrollment	Core	Core	Core	Core	Core
Referral Source	Core	N/A	Core	Core	NA
Reason for Referral	Core	N/A	Optional	Optional	NA
Number of Referrals to CP	Optional	Optional	Optional	Optional	NA
Demographics	**Assessment & Refer**	**Community Paramedic-led Clinic**	**Home Visit**	**All other Programs**	**Flu Shot Initiative**
Gender	Core	Core	Core	Core	NA
Age	Core	Core	Core	Core	NA
Housing	Core	Core	Core	Core	NA
Living Status	Core	Core	Core	Core	NA
Marital Status	Optional	Optional	Optional	Optional	NA
Baseline Assessment	**Assessment & Refer**	**Community Paramedic-led Clinic**	**Home Visit**	**All other Programs**	**Flu Shot Initiative**

Chronic Conditions	Core	Core	Core	Core	NA
Palliative Care	Core	Core	Core	Core	NA
History of Falls	Core	Core	Core	Core	NA
Chronic Pain	Core	Core	Core	Core	NA
Medications	Core	Core	Core	Core	NA
Interventions	**Assessment & Refer**	**Community Paramedic-led Clinic**	**Home Visit**	**All other Programs**	**Flu Shot Initiative**
Referrals to Primary Care	Core	Core	Core	Core	NA
Referrals to Home/Community Care	Core	Core	Core	Core	NA
Provider Consultations	Optional	Optional	Optional	Optional	NA
Increased Services	Optional	Optional	Optional	Optional	NA
Patient Interactions	NA	Core	Core	Core	NA
Home Visits	NA	Core	Core	Core	NA
Clinic Visits	NA	Core	Core	Core	NA
Remote Patient Monitoring	NA	Core	Core	Core	NA
Health Teaching/Education	NA	Optional	Optional	Core	NA
Point of Care Tests	NA	Core	Core	Core	NA
Patient Care/Treatment	NA	Core	Core	Core	Core
Outcomes	**Assessment & Refer**	**Community Paramedic-led Clinic**	**Home Visit**	**All other Programs**	**Flu Shot Initiative**
911 Activations	Core	Core	Core	Core	NA
Hospital ED visits	Core	Core	Core	Core	NA
System Utilization	Core	Core	Core	Core	NA
Patient Satisfaction	Optional	Optional	Optional	Optional	Optional
Evaluation	**Assessment & Refer**	**Community Paramedic-led Clinic**	**Home Visit**	**All other Programs**	**Flu Shot Initiative**
911 Activations Pre-90 Day Enrollment	Optional	Optional	Optional	Optional	Optional
911 Activations Post-90 Day Enrollment	Optional	Optional	Optional	Optional	Optional
911 Activations Pre-365 Day Enrollment	Optional	Optional	Optional	Optional	Optional
911 Activations Post-365 Day Enrollment	Optional	Optional	Optional	Optional	Optional

3 – Reporting Submission Requirement

CP Programs are required to submit their quarterly reports for a period of twelve months ending March 31, 2020 utilizing the Reporting Template attached (one template per program stream). It is due to be submitted the first Friday two months after the reporting period. Data from active clients within the reporting period below should only be included in the respective report. Reports will be sent to **INFO@ONTARIOCPSECRETARIAT.CA** for the following time periods:

Reporting Period	Dates of Reporting Period
Quarter 1 Report	**April 1, 2020 - June 30, 2020**
Quarter 2 Report	**April 1, 2020 - September 30, 2020**
Quarter 3 Report	**April 1, 2020 - December 31, 2020**
Year-End Report	**April 1, 2020 - March 31, 2020**