January 21, 2020

Paramedic Standards Consultation
Emergency Health Services Branch
Ministry of Health
5700 Yonge Street, 6th Floor
Toronto, Ontario
Canada M2M 4K5

RE: EMERGENCY HEALTH SERVICES PATIENT CARE MODEL STANDARDS DOCUMENT v1.0a

Introduction

The Ontario Community Paramedicine Secretariat (OCPS) was established by Ontario's LHINs in 2018 to support the province's growing network of community paramedicine providers, enabling and facilitating work around the creation and dissemination of standardized care processes, performance reporting and measurement activities, and aspects of knowledge translation and exchange.

The OCPS Steering Committee, leads the work of the OCPS and has representation from multiple key stakeholders including the Ministry of Health, Ministry of Seniors Affairs and Accountability, Ontario Health Regions, the Ontario Association of Paramedic Chiefs, Homecare Ontario, Advantage Ontario, municipal paramedic services, and front-line Physicians and Community Paramedics.

Both the Secretariat and its Steering Committee are optimistic about how community paramedicine programs continue to adapt and develop new priority and patient/public aligned models of care that can further support partnerships that can reduce hallway healthcare, prevent hospitalizations, and improve the delivery of patient-centred care as part of a modern Emergency Health Services (EHS) system.

What follows is a response that the Secretariat has prepared with the support of its Steering Committee to the January 7, 2020 request for comment around the EHS *Patient Care Model Standards Document V1.0a.*

Our Feedback

The EHS *Patient Care Model Standards V1.0a* sets out requirements for municipal ambulance services seeking approval from the ministry to implement new models of care that would permit *select low-acuity 9-1-1 patients* to receive appropriate community-based care, rather than transport to the Emergency Department. This includes requirements of paramedics for providing patient care currently outside of the "Basic Life Support Standards" and the "Advanced Life Support Standards" for the purposes of implementing new models of care.

The delivery of community paramedicine programs, in accordance with the Ministry of Health's *Community Paramedicine Framework for Planning, Implementation, and Evaluation*[1] has many components that also enable delivery of patient care outside of existing standards. Today, multi-dimensional community paramedicine programs are leveraging the 24/7 access that patients have to municipal paramedic services in addition to their existing referral, clinic, or home-visit programs[2]. Multi-dimensional community paramedicine programs are ideally situated to complement paramedic emergency operations where:

- Appropriate treatment may be arranged in settings other than an emergency department
- Delivery of integrated care may be arranged with health system partners
- The safe discharge of patients follows appropriate treatment
- Low acuity patients are able to be directed to appropriate health system partners through integrated management of 9-1-1 calls.

All of these conditions present parallel conditions to the 9-1-1 system and established practices in community paramedicine programs should be expanded or adapted to support the proposed standards. Findings from other jurisdictions have indicated that the models of care enabled through integration of community paramedicine programs and emergency response have demonstrated an overall reduction in rates of patient transport to hospital and an increase in

[1] Ministry of Health and Long-Term Care (MOHLTC). Community Paramedicine Framework for Planning, Implementation and Evaluation. 2017.

[2] Leyenaar MS, Strum R, Haque M, Nolan M, Sinha SK, Ontario Community Paramedicine Secretariat Steering Commitee. Report on the Status of Community Paramedicine in Ontario [Internet]. 2019. Available from: https://www.ontariocpsecretariat.ca/resources

referral to primary care providers[3,4]. Having reviewed the document, the Ontario Community Paramedicine Secretariat and its Steering Committee would like to provide the following feedback for consideration around four particular areas:

1. **Case Management.** Case management approaches in emergency medicine are not the same as case management approaches in other healthcare settings. Where the *Patient Care Model Standards V1.0a* are based in emergency medicine, we would suggest that other approaches to case management be considered that extend beyond the isolated occurrence of a single 9-1-1 call. We would suggest that the proposed Standards should recognize that patient care may include both previous and/or subsequent 9-1-1 calls by a patient and that paramedic services should better support patients in community settings outside of single occurrences. Case management by community paramedics should also include referrals from frontline paramedics for identified patients (an already existing practice). With such a perspective, it is imperative for community paramedic-led case management to ensure patient care can be delivered that results in improved outcomes and patient safety while also mitigating the need for a future 9-1-1 response[5]. Case management by community paramedics would provide an important measure of patient safety whereby patient care includes the provision of scheduled follow-up care, either by phone or in-person and the referral of individuals to appropriate home care and community services, primary care providers, mental health services, palliative care providers, or other healthcare providers (including Ontario Health Team services) when necessary. Such an approach would be complimentary to existing community paramedicine programs AND has been initiated in a number of municipalities already. Community paramedicine programs enable an ongoing community paramedic-to-patient relationship that supports chronic disease management and health promotion, practices that should be spread through uptake of the new *Patient Care Model Standards*.

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[3] Swain AH, Hoyle SR, Long AW. The changing face of prehospital care in New Zealand: the role of extended care paramedics. J New Zeal Med Assoc NZMJ [Internet]. 2010;19(123):11–4. Available from: http://www.nzma.org.nz/journal/123-1309/3985/

[4] Evans R, McGovern R, Birch J, Newbury-Birch D. Which extended paramedic skills are making an impact in emergency care and can be related to the UK paramedic system? A systematic review of the literature. Emerg Med J [Internet]. 2013 Apr 10;594–603. Available from: http://www.ncbi.nlm.nih.gov/pubmed/23576227

[5] Nolan M, Sinha S. Lessons Learned From Renfrew County's Community Paramedic Response Unit Program. Innov Aging [Internet]. 2017 Jul 1; 1(suppl_1):50–50. Available from: https://academic.oup.com/innovateage/article/1/suppl_1/50/3898946

2. **Community Paramedic On-Call.** Numerous community paramedicine programs across the province provide the opportunity for patients to speak directly with a community paramedic over the phone. Alternative models to ambulance dispatch have had successful results elsewhere[6], particularly when callers are able to speak with an individual who has experience as a frontline responder[7]. The experience of paramedics as responders provides them with unique insight during a 9-1-1 call for help.

   Examples of "community paramedic on-call" availability have demonstrated promising results in helping maintain individuals safe in their homes who are waiting to transition to long-term care[8] and those who are managing chronic diseases[9]. Integrating community paramedics into ambulance communication centres and supporting the success of these programs by aligning the *Patient Care Model Standards V1.0a* to their delivery would be expected to have a significant impact on improving care in the community, reducing ED visits, and hospital admissions that contribute to the hallway health care problem.

3. **Online and Virtual Medical Support OR Base Hospital Support.** The *Patient Care Model Standards V1.0a*, while recognizing the importance of Community Provider Support, maintain a greater emphasis on the role of Base Hospitals (particularly in regard to paramedic education and training). Online and virtual medical support (as a primary access point for consideration rather than a Base Hospital patch point) may be provided by other physicians or regulated health professionals and would be consistent with the *Community Paramedicine Framework for Planning, Implementation, and Evaluation*.

   Community paramedicine programs often provide a direct connection between community paramedics and a patient's primary care provider (also referred to as using paramedics as "extenders" of primary care). We believe that the onus on paramedic education and training should be the responsibility of municipal paramedic services in coordination with both the Base Hospital and the Community Provider. Paramedic services that are delivering

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[6] Jensen JL, Carter AJE, Rose J, Visintini S, Bourdon E, Brown R, et al. Alternatives to Traditional EMS Dispatch and Transport: A Scoping Review of Reported Outcomes. Can J Emerg Med. 2015;17(5):532–50.
[7] Dib JE, Naderi S, Sheridan IA, Alagappan K. Analysis and applicability of the Dutch EMS system into countries developing EMS systems. J Emerg Med. 2006;30(1):111–5.
[8] Ruest M, Stitchman A, Day C. Evaluating the impact on 911 calls by an in-home programme with a multidisciplinary team. Int Paramed Pract. 2012;1(4):125–32.
[9] Brohman M, Green M, Dixon J, Whittaker R, Fallon L. Community Paramedicine Remote Patient Monitoring (CPRPM): Benefits Evaluation & Lessons Learned. Toronto, ON; 2018.

community paramedicine programs already (as guided by the MOH framework) have established relationships with physicians or other healthcare professionals in fields other than emergency medicine to support the setting and service appropriate medical delegation of controlled acts in the delivery of care outside of emergency operations. Currently, community paramedicine programs are most frequently enabling a direct link to a patient's primary care providers and facilitate shared care planning that enables these patients to avoid ED visits[10]. Furthermore, the specific aims of respective community paramedicine programs help to dictate the medical specific expertise and health system partners that can inform and guide these initiatives – such as the fields of primary care, public health, mental health, palliative care, or geriatric care.

Given the progress made to date, we would encourage the continued enablement of municipal paramedic services to formalize and expand existing partnerships for delegation of medical acts in new models of care beyond the Base Hospital system where this makes sense.

4. **Primary Care Providers and Ontario Health Teams.** One of the contributing factors to the generation of low acuity 9-1-1 calls are difficulties in accessing primary care. When community paramedicine programs enable a direct link to primary care providers, they can facilitate shared care planning that enables these patients to avoid ED visits[11]. Community paramedicine programs can also build around other established patient-physician models that align with the College of Physicians and Surgeons of Ontario guidelines for medical delegation. It is therefore recommended that within the standard under points directing paramedic care, an addition of "Or in consultation with patient's primary care provider" should be added to the direction about both the enactment of medical directives and base hospital patching. If models of care include establishing a "virtual" relationship between a patient and healthcare provider (as described above), subsequent allowance for this should be provided. Community paramedicine programs align with the vision for Ontario Health Teams. Integration between emergency operations facilitated through these standards and community paramedicine programs can improve patients access to care 24/7.

[10] Leyenaar M, Mcleod B, Chan J, Tavares W, Costa A, Agarwal G. A scoping study and qualitative assessment of care planning and case management in community paramedicine. Irish J Paramed. 2018;3(July):1–15.
[11] ibid.

5. **Evaluation Considerations including IC/ES.** The objectives and methods for evaluating the implementation and results of new models of care demonstration projects should include comparators to existing paramedic practice and account for variations in access to other care providers as applicable. Comparators to existing practice could include either a pre/post analysis or an analysis against a comparable cohort outside of the catchment area of the demonstration site. For these reasons, evaluation should include partnering with the Institute for Clinical and Evaluative Sciences (IC/ES). The 2019 *Report on the Status of Community Paramedicine Programs in Ontario* and the work of the Ontario Community Paramedicine Secretariat can provide useful insights into the state of access to care through community paramedicine programs, where this consideration is applicable to the evaluation process. By leveraging province-wide data regarding health system utilization, clear performance indicators could be established with respect to low-acuity use of 9-1-1 and other aspects that influence access to care over a longer period of time while also controlling for ongoing disease diagnoses or conditions.

The Ontario Community Paramedicine Secretariat and its Steering Committee believes that the successes that have been realized through the evolution of community paramedicine programs across Ontario are the ideal "testing" ground for new models of care. The majority of paramedic services have adopted multi-dimensional community paramedicine strategies, that increasingly involve the facilitation of safer and more robust care transitions from hospital, assisting in the provision of palliative care, supporting individuals to age in place, strengthening the provision of public health services, and supporting an increase level of responsiveness for health system partners. We support the move towards the development of these standards as we see them as enablers towards this overall agenda and look forward to continuing to support the Ministry of Health in the modernization of the Emergency Health Services system.

Yours Sincerely

Matthew Leyenaar
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