The Community Paramedicine Glossary: Frequently used terms and definitions

Included here are a number of frequently used terms and their definitions used by the Ontario Community Paramedicine Secretariat (OCPS).

Community paramedicine program: a program that uses paramedics to provide immediate or scheduled primary, urgent, and/or specialized healthcare to vulnerable patient populations by focusing on improving equity in healthcare access across the continuum of care (1).

Community Assessment and Referral Programs: This model of care represents a case finding strategy employed by front-line paramedics to connect individuals and patients with other care providers, most often Home and Community Care Services and local Community Support Services (CSS) Agencies. A specific model of assessment and referral that has been adopted by many Paramedic Services providers across Ontario is known as Community Referrals by EMS (CREMS). (2).

Community Paramedic-Led Clinics: This model of care has been established in areas with an identified need where community paramedics advertise and provide health promotion and preventative care services in partnership with local health system partners. Community paramedics in this model may provide flu shots, education about healthy living, chronic disease prevention education, blood pressure checks, blood glucose checks, or other services. (2).

Home Visit Programs: This model of care usually sees community paramedics working in a team with other health care providers to maximize the available “at home” support through the provision of proactive and preventative home visits for patients that have either repeatedly called 9-1-1 or who have been identified as high risk of 9-1-1 utilization due to their underlying medical conditions and unmet social needs. Some models have embedded community paramedics into primary care teams to support primary care providers in monitoring at-risk patients through more frequent home visits. Other models have embedded community paramedics into a circle of care led by an acute care hospital to support the early discharge of admitted patients and smooth the transition from hospital to home, especially among those patients identified as being at high-risk for re-admission. (2).

Remote Patient Monitoring Programs: This model of care involves patients with chronic health conditions like chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and diabetes who are at high-risk of a future emergency department visit or hospitalization in being enrolled in a home-based patient monitoring

program that can allow them to live with greater confidence in their own homes. In these programs, patients enrolled by their primary care providers are provided with remote monitoring devices that can transmit their vital signs to a 24-hour monitored communication hub that alerts a community paramedic when their readings fall outside of expected values. In partnership with their primary care providers, community paramedics work under pre-determined care protocols customized to each patient. Patients are contacted by a community paramedic by phone or visited in person to address any care issues proactively in order to pre-empt 9-1-1 calls or emergency department visits. (3).

Community Paramedic-Specialist Response Programs: These emerging models of care operating under names such as Community Paramedicine Response Units (CPRUs), Paramedic-Specialist Teams, or Mobile Integrated Health (MIH) Teams represent a growing level of service coordination and cooperation between traditional paramedic emergency response and emerging community paramedicine programs so that access to other health care providers can be better enabled and accessed in real time through an on-demand system that parallels a traditional 9-1-1 response. (3).

Integrated Care: The delivery of care that focuses on achieving the Quadruple Aim (4) through a coordinated effort within and between healthcare providers (5).

Case management: Comprehensive assessment and care planning activities that include combined efforts of other health care providers over a defined period of time, usually days, weeks, or months (6,7). Case management approaches may be general or specifically tailored to individual patient needs (8,9).

Transition of care: Also referred to as “discharge,” a transition of care involves a patient moving from one care provider to another. Typically used in reference to patient care moving from an in-hospital setting to an out-of-hospital setting. (10)

More information about the Ontario Community Paramedicine Secretariat is available on our website at: http://www.ontariocpsecretariat.ca .

References:

1. CSA Group. Community Paramedicine: Framework for program development. Toronto, ON: CSA Group; 2017.
2. Ministry of Health and Long-Term Care (MOHLTC). Community Paramedicine Framework for Planning, Implementation and Evaluation. 2017.
3. 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
4. Bodenheimer T, Sinsky C. From triple to Quadruple Aim: Care of the patient requires care of the provider. Ann Fam Med. 2014 Nov 1;12(6):573–6.
5. International Journal of Integrated Care [Internet]. [cited 2020 Jan 6]. Available from: https://www.ijic.org/about/
6. Sinha SK, Bessman ES, Flomenbaum N, Leff B. A systematic review and qualitative analysis to inform the development of a new emergency department-based geriatric case management model. Ann Emerg Med. 2011;57(6):672–82.
7. 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.
8. Rinke ML, Dietrich E, Kodeck T, Westcoat K. Operation care: A pilot case management intervention for frequent emergency medical system users. Am J Emerg Med [Internet]. 2012;30(2):352–7. Available from: http://dx.doi.org/10.1016/j.ajem.2010.12.012
9. Edwards MJ, Bassett G, Sinden L, Fothergill RT. Frequent callers to the ambulance service: patient profiling and impact of case management on patient utilisation of the ambulance service. Emerg Med J [Internet]. 2014;32(5):392–6. Available from: http://www.ncbi.nlm.nih.gov/pubmed/25312857
10. Health Quality Ontario. Quality Standards Transitions Between Hospital and Home Care for People of All Ages [Internet]. 2019 [cited 2020 Jan 14]. Available from: https://www.hqontario.ca/Portals/0/documents/evidence/quality-standards/qs-transitions-between-hospital-and-home-draft-quality-standard-en.pdf