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1.1 Background

The Paramedic Referral process was conceived and developed to directly support Ontario’s Action Plan for Health Care. This document provides a best practice framework for community referrals that improves access to the appropriate patient-centered care, connects patients to relevant community-based services and supports informed decision-making.

This toolkit has been developed with the generous support of the Ontario Ministry of Health and Long Term Care Implementation Branch. The tools have been tested to ensure that areas ranging from curriculum and learning through to electronic data transmission are robust and inclusive of implementation resources, designed to support Paramedic Services and their patients across the province.

Included in this toolkit are the resources to support and implement best practices for community referrals made by Paramedic Services. Resources include the following evidence-based components:

- Education and Training
- Clinical Prediction Rule, which is based upon the following research and evidence:
  - Paramedics assessing Elders for Independence Loss (PERIL) Assessment Tool
  - Paramedic and Community Care Team (PAACT) programs
  - Community Referral from Emergency Medical Service (CREMS)
- Referral Process
- Electronic Referral

1.2 Rationale

Paramedicine is about caring for people and supporting their immediate health needs. Collaborative care between paramedics and other health care specialists, social services and community members provides an optimal integrated approach to build patient-centred care into our system. Knowledgeable and evidence-based referral systems use a community’s existing resources efficiently and effectively.

The development of the Paramedic Referral Toolkit integrates local assets, fosters existing partnerships and builds new partnerships to support a patient-centred approach to care.
It provides an integrated model for health care service delivery, using local resources, non-traditional partnerships, training and expertise in non-emergent community based care.

This standardized referral system was developed in collaboration with the Province of Ontario, Paramedic Services, the Ontario Association of Community Care Access Centres, Dr. Jacques Lee, Dr. Samir Sinha, Paramedic Programs at Ontario Colleges, 211, Ontario Provincial Police, Behavioural Supports Ontario, Public Health, Municipalities, Premergency, technology sector, private sector and other community partners. It improves quality of care by supporting Paramedics to quickly refer clients to their local Community of Care Access Centre or other community partners for further assessment or support.

The electronic referral process increases efficiency and replaces the current manual approach to referral with an automated, appropriate and immediate response. The education and community engagement components build on collaboration, prevention and an understanding of the social determinants of health, proactively addressing health issues before they become acute. This toolkit is built on existing systems and resources with a sound evidence base. Paramedic Referral provides value, high quality care and efficient use of funds to support the sustainability of our health care system.

1.3 Benefits

Patient Benefits

- Provides timely and effective community based referrals
- Improves access to higher quality care through efficient patient focused decision making
- Efficient decisions focused on patient care provides access to higher quality care
- Supports upstream health needs
- Connects patients to appropriate resources as close to their home and community as possible
- Provides patients with information and education to make informed decisions about their own health
Paramedics providing community surveillance and referral is a safety net for our most vulnerable population.

Peter Emon, Warden, County of Renfrew

Provider Benefits

- Provides accurate and appropriate referrals
- Creates efficiencies by replacing the manual “fax and re-key” approach with an automated approach
- Generates improved data quality
  - CCACs will receive higher-quality data with fewer errors. This will lead to fewer errors in patient care, resulting in savings as the right care will be provided to patients at the right time.
  - Higher data quality will improve decision support capabilities, allowing CCACs to better evaluate program effectiveness, leading to more efficient and more effective use of scarce resources.
- Provides improved data timeliness
  - Less lag between provider activities and provider reporting.
- Affords improved provider efficacy
  - Providers will spend less time entering data into systems and more time on patient-related and other value-added activities
- Co-ordinates services through provider collaboration
- Supports multi-sector and non-traditional integration of service providers

System Benefits

- Provides an evidence-based approach to patient care
- Supports early detection and case finding
- Delivers an intervention to support the highest standard of care
- Upholds the development of a Senior’s Strategy for Ontario
- Improves care by enabling paramedics to quickly refer clients to CCAC and additional community and social services for assessment
- Supports system integration through multi-sector collaboration and implementation
• Saves money by making a referral process widely available to service providers at no cost
• Provides faster access to the right care
• Contributes to health care system transformation

1.4 Approach

An effective community based referral process recognizes and responds to a patient’s needs and predicts their loss of independence in the absence of support. Hand in hand with improved community collaboration, coordination, and provision of services, this approach is unique in its ability to observe or note root causes of health issues and tap into existing efforts, skills, and roles of multiple health providers and appropriate community agencies. Improved communication between multi sector community based services and enhanced patient-centred care are the outcomes.

A co-ordinated approach to change management that includes the necessary supports such as mental health services, supportive housing, police, municipal social services, public health, recreation, falls prevention and physical activity programs, community based care, local and regional hospitals is required to maximize the impact of this program. This referral process moves beyond traditional parameters of care and identifies immediate patient needs, using technology and community collaboration to meet those needs in patients’ homes and communities.

Social Determinants of Health

Paramedics are in a unique position to observe and assess many of the social and environmental determinants of health with their patients. Timing and situational assessment provides Paramedics with the opportunity to integrate social and environmental factors into a patient assessment.

Community based Paramedicine provides our health care system with an upstream approach to health, improving service delivery, efficient use of existing resources and realizing a broad scope of practice. Paramedics have a window into social disparity and factors that contribute to an appropriate referral which supports a patient’s ability to self-manage chronic disease.
The needs of Ontarians are evolving and our sector must continue to evolve along with them to predict rather than react so that our interventions are smart and targeted and effective. Accessible care that is connected with patients is the driver, this is how we will build a more efficient and effective health care system, a health care system that rewards value over volume, one that is capable of adapting as patients’ needs change.

Dr. Eric Hoskins, Minister of Health and Long-Term Care, Province of Ontario

Community Collaboration

Referral to the appropriate community service connects each patient with the right care, supporting their unique needs and providing timely access to the appropriate care. The development of this toolkit integrated the expertise of critical resources.

Project partners have provided expertise and insight into existing systems. This shaped a robust referral process and acknowledges the strength of local resources. 211, the Ontario Provincial Police, Health Links and community partnerships play strong and relevant roles in each community’s toolkit of community based referrals.

Referral Flow

- Paramedic
  - 911 call
  - Community Paramedic

- Ontario Provincial Police
  - 911 call
  - Community Policing

- Referral Pathway
  - Community Care Care Access Centre
  - 211
    - Community based program
    - Social Service
  - Ontario Provincial Police
  - Community Paramedicine
Evidence and Best Practice Approach

The toolkit process was based on a foundation of evidence-based practice. The Stetler model of evidence-based practice informs the health care provider to use evidence in daily practice, program planning and implementation of tools. Core organizational elements are identified as important components for the successful use of evidence based practice.

- Leadership support of evidence-informed practice and culture
- Capacity to engage in evidence-informed practice, including an effective implementation framework
- Infrastructure to support and maintain a culture of evidence-informed practice and associated initiatives

The development of an evidence-based toolkit meets the following criteria to effectively address improved patient care. There is substantiating evidence and current practice that identifies the need for change and models that work. The evidence identifies a strong fit with existing Paramedic Services. The research identifies the feasibility of implementation. Implementation phases are designed to facilitate critical thinking about the practical application of research findings; result in the use of evidence in the context of daily practice; and mitigate errors made in decision making. The following phases support evidence-based practice. This referral toolkit process has accomplished the first phase:

- Validation of Evidence
- Comparative Evaluation and Decision Making
- Operationalize
- Evaluate

Integration of health and social service provision through community partnerships and multi-sector collaboration has a strong base of evidence to support improved efficiencies and effective approaches to health care delivery. Integration accomplishes the following:

- Increases access to local services
- Supports well-being through preventative care
- Locates people at the centre of the system
- Taps into a whole system approach
The paramedics in Thunder Bay and the rest of Ontario are excited to be taking a more active role in the health of Ontarians. Through community paramedicine initiatives, we are able to improve health care services for our patients, their families and the community by leveraging paramedic training, and our connections in the community.

Norm Gale, President of the Ontario Association of Paramedic Chiefs and Chief of the Superior North Emergency Medical Service

Evidence-based examples are emerging as best practices within Canada. Identified as a model of collaborative best practice, the Prince Albert hub model provides an example of exemplary collaborative practice. The evidence to support collaboration amongst multidisciplinary professionals provides a strong case for the role it plays improving patient outcomes in prevention, chronic disease management, mental health, disability care, seniors care and others.

An understanding of the evidence to support integration and collaborative practice is identified as a key to the successful development and implementation of the referral process. A common understanding of privacy, sharing information and consent was confirmed and key partners were continuously included in the process.

1.5 Implementation

How to use this referral tool effectively in your Paramedic Service and community:

1. **Know Your Community** – understand and share community data, local resources, assets and service gaps.

2. **Engage Community Partners and Collaborate** – build effective and trusted relationships.

3. **Share the Evidence and Research** – build your program on the existing evidence base.

4. **Implement the Training and Education** – integrate the learning tools into your Paramedic Service and community.
2.1 Collaboration

The development of the toolkit followed the identification of a unique opportunity to improve efficiencies in our health care delivery system. Development was supported by a fully collaborative process which included ongoing engagement opportunities and communication to improve and enhance the developing tools. The following steps supported an evidence-based process.

- Identify opportunity
- Develop shared vision
- Engage broad group of stakeholders
- Build trust and ownership of process
- Strategic planning
- Tool development
- Measurement and evaluation

The foundation of this referral process is built on input from expertise across Ontario and Canada. Three working groups contributed to the main components of the tool including the research and evidence, the community referral and electronic referral process and the education and training.

2.2 Engagement

**August 2013 - Calabogie**
Prediction Tool and Evaluation Working Group Formed

**January 2014**
Funding Approval from the Ministry of Health and Long Term Care

**March 2014 - Toronto**
Stakeholder Engagement

**October 2014 - Grey County**
Final Consultation and Training

To view Ontario Association of Community Care Access Centres Referral Timelines: see Appendix 1 and Appendix 2.
2.3 Development

In order to effectively develop the e-referral tool the Ontario Association of Paramedic Chiefs worked closely in collaboration with the Community of Care Access Centres, the Ontario Association of Community of Care Access Centres and three main ePCR (electronic Patient Care Reporting) vendors, Interdev, Medusa and Zoll to arrive at the standardized referral process.

To build a strong foundation of collaborative practice and community referral expertise, the Education and Training working group worked with 211 and the Ontario Provincial Police to integrate existing systems and share knowledge to support the appropriate referral.

Patient-Centered Care
Finding help in Ontario is easier when you Make the Right Call.

2-1-1
Information and referral helpline to community, social, government and health services.

3-1-1
Customer service and municipal information hotline in Toronto, Halton, Windsor, Peel, Ottawa and Greater Sudbury.

9-1-1
Emergency number for police, fire and paramedic services.

Make the Connection. Call 2-1-1
Free | Confidential | 24/7 | 150+ Languages | Live Answer
www.211Ontario.ca | TTY: 1.888.340.1001

When you don’t know where to turn.
3.1 Research

Dr. Jacques Lee, Scientist with the Sunnybrook Research Institute, supported the research and evidence base to inform the referral process and evaluate the practice of Community Paramedicine. The research was accomplished with support from the Canadian Institute of Health Research. The following objectives were identified to define the scope of the research. These reviews provide a body of evidence to support the development of the Paramedic Referral Toolkit.

• Existing literature on Community Paramedicine
• Evolving Community Paramedic initiatives
• Evaluation of Provincial Community Paramedic toolkit components

The evidence base to support Community Paramedicine is rapidly evolving. A systematic review of 3,089 articles revealed 11 relevant articles in 2013. One high quality Randomized Control Trial (RCT) was identified, testing the efficacy of Community Paramedicine as the identified intervention. There were 10 case control observational, economic and qualitative studies.

The overview of Community Paramedicine Literature identified the following results from the Randomized Control Trial: Mason et al., U.K. - Sheffield Ambulance Service.

Results: 3018 eligible patients
• Fewer ED visits: 970/1549 (63%) vs. 1286/1469 (88%)
• Fewer Hospitalizations: (40% vs. 47%)
• More satisfaction: (86% vs 74%)
• More paramedic time: (278 vs 235 min)
• Trend to lower costs: (£140 pp, p=ns)

Shah et al measured the impact of Paramedic program to screen for pneumococcal and influenza vaccine, falls risk. The results included:
• Successfully screened 83%
• Increased pneumococcal vaccine rate
• Suggested more aggressive intervention than simple educational materials
10/11 studies demonstrated positive results, favouring Community Paramedicine initiatives including three separate cohorts over 1000 patients. Positive results were identified from initiatives based in the UK, US Australia and Canada.

Evolving Community Paramedic programs were identified. Nova Scotia’s Long & Brier Island model included clinics, vaccinations, wound care, falls prevention and provided an evidence base to support the highly relevant role of Paramedics in a community context. Models included the study of Paramedic use in Emergency Departments, community referrals, referrals to CCAC based on Paramedic judgement and a consistent outcome of reduced frequency of Paramedic Service use.

The rationale for Community Paramedic screening and use of a referral tool include the evidence base that Paramedics frequently interact with older people. Seniors use Paramedic Services 5x more often versus populations younger than 65. 33% of calls are for mobility problems (eg: unable to get up after a fall). Finally, there is a high rate of repeated EMS use. 18 to 40% of 911 calls are among people ages 65 and older.

Evolving evidence from the PERIL Study provides further support for the development of a Referral Toolkit to support community based Paramedicine. PERIL was a Canadian Institute of Health Research funded, multi-centred trial. It trained over 1600 paramedics in four Paramedic Services in four locations, including Edmonton, Ottawa, Renfrew & Toronto. 1944 eligible patients have been enrolled to date, with 1158 in the Derivation Cohort and 785 in the Validation Cohort. The study resulted in the PERIL Prediction Rule.

[Paramedic]
1. Any problems in the home that would prevent safe D/C? OR = 1.6

[Patient]
2. Any 911 calls in the last 30 days? OR = 1.6
3. Medications disorganized? OR = 1.5

Results in the PERIL prediction rule are the following:
1. If the PERIL score = 3/3, 93% of patients will have an adverse outcome within 30 days.
2. If the PERIL score = 2/3, 68% of patients will have an adverse outcome within 30 days.

The proposed pathway is to refer all patients with a PERIL score of 2/3 for assessment and to prioritize patients with PERIL scores of 3/3 to receive urgent intervention.

There is strong evidence to support the inclusion of the additional variable that the patient “overall, lacks social support”. Further research is being conducted. No other published prediction rules exist to guide paramedics in predicting vulnerability. Currently, the PERIL study has been submitted for peer review in the Canadian Journal of Emergency Medicine.

### 3.2 Education and Training Modules

Learning objectives and online training have been developed in scenario based, interactive educational components. The goal of the education and training component of the toolkit is to provide the skills and knowledge to enable Paramedics to successfully complete community referrals. This training is available to all Paramedic Services at no cost and is in a format that enables asynchronous learning. Paramedic Services can deliver this content according to their local context.

We have been fortunate to work with the Ontario Provincial Police lead by Sergeant Robin Sanders throughout the design and implementation of the referral process. As a result, the Ontario Provincial Police will be providing this program to all officers expanding the network of providers and community referral integration and training.

The online education and training was initiated on June 3, 2014. Since then, 1339 people have been trained and met the requirements for the following learning objectives:

### Learning Objectives

1. To provide Paramedics and Police with the knowledge to assess patients for a Community Referral.

   This program will enable the learner to:

1.1 Describe the consequences of healthy aging versus disease.
1.2. Compare the older adult with the chronically ill.
1.3. Recognize social problems and functions, including the activities of daily living for older adults.
1.4. Recognize that the chronically ill may have similar needs to the older adult.

2. To provide the Paramedic and Police with the knowledge required to assess for factors that may affect a patient’s ability for independent living.

This program will enable the learner to:
2.1. Identify environmental hazards and safety issues for older adults through patient home assessments.
2.2. List the instrumental activities of daily living for older adults.
2.3. Understand the concept of ‘frailty’ as it applies to older adults.

3. To provide Paramedics and Police with the ability to implement Community Referrals.

This program will enable the learner to:
3.1. Utilize a clinical prediction tool to screen for risk of independence loss.
3.2. Apply the process and factors associated with gaining consent.
3.3. Advocate for patients around relevant health and social issues.
3.4. Describe community resources available and referral pathways to assist in the management of the older adult.

Resources in the online interface include:
- Aging Summary
- Hazards, Safety and Activities of Daily Living
- Prediction, Consent and Advocate
- Information Sharing – Ontario Working Group
- Community Mobilization Model
- 211 Ontario
If we want to keep seniors in the community and out of hospitals and long-term care facilities – and that should be our goal for financial and humanitarian reasons – then we need to provide better community-based health care.

Andre Picard, The Globe and Mail

- 211 First Responder Cards
- Ontario Association of Community Care Access Centres link
- Behavioural Supports Ontario link
- Existing Reasons for Referral – Ontario Association of Paramedic Chiefs

### 3.3 Clinical Prediction Rule

The three questions included in the eReferral follow the PERIL prediction rule, derived and re-validated from the Paramedics assessing Elders for Independence Loss study, Paramedic and Community Care Team (PAACT) programs and the Community Referral from Emergency Medical Service (CREMS). Details are documented in the research component of this toolkit.

1. Any problems in the home that would prevent safe D/C?
2. Any 911 calls in the last 30 days?
3. Medications disorganized?

If the PERIL score is 3/3, then 93% will have had an adverse outcome in the next 30 days if no referral had taken place. If the PERIL score is 2/3, 68% of patients with a score will have had an adverse outcome if no referral had been completed.

### 3.4 Referral Process

#### Standards Based System

Historically, the referral process has been a manual system whereby a paramedic telephones the local Community Care Access Centre, or a form is filled out and faxed to the local Community Care Access Centre. This information is then passed along within the local Community Care Access Centre manually and re-entered into the Client Health Related Information System (CHRIS) database. There has been no standardized method of identifying patients at risk or process to notify the local Community Care Access Centre.

The goal of electronic referrals from Paramedic care to Community Care Access Centres is to reduce unnecessary emergency department hospital visits, and/or to expedite the process of discharging patients from hospitals into home care and community support, consequently
reducing the number of days that patients remain in hospital and/or reducing the number of patients admitted or re-admitted to hospital.

The electronic Community Care Access Centre Referral solution implements a standards based system to interface between the Paramedic Service and the Community Care Access Centre application environment managed by the Ontario Association of Community Care Access Centres.

The project standardized the Community Care Access Centre eReferral from Paramedic Services by adding to the existing Community Care Access Centre eReferral from Acute Care Minimum Data Set (MDS)

The Community Care Access Centre Referral process flow is initiated through a new referral event triggered by the Paramedic.

The Community Care Access Centre staff will receive the event through the Community Care Access Centre Referral interface and begin implementing the referral workflow in the Client Health Related Information System (CHRIS). As part of the referral workflow, Community Care Access Centre Staff will progress the initial referral through different stages. The following stages will be communicated by the system back to the referral source (the Paramedic Service). The referral status communicated from the Community Care Access Centre workflow are:

• CCAC accepts referral.
• CCAC cancels referral.
• CCAC completes referral.

The CCAC Accepts Referral event will always precede the CCAC Completes Referral event.

The CCAC Cancels Referral event will be independent of any other event and may occur at any time during the referral lifecycle. The cancellation event will bring the referral to a final state and as such no other event for this particular referral can succeed.

The CCAC Completes Referral event will also bring the referral to a final state.

The Referral Status Update will only depend on the existence of a new referral event initiated by the ePCR system.
3.5 Electronic Referral Process

The electronic referral process will begin with the Paramedic. Using any ePCR solution, the Paramedic will open a referral form and subsequently fill out the required information for a patient. After the Paramedic has completed the form, the form will be saved and then converted to HL7 format where it will subsequently be sent via a secure Virtual Private Network tunnel to the Ontario Association of Community Care Access Centres’ server.

The Electronic Referral Process Diagram provides a high level visual of the electronic referral process between the Paramedic Service and the Ontario Association of Community Care Access Centre system.
The eReferral component of the toolkit was developed collaboratively with the Ontario Association of Community Care Access Centres. Included in the scope of Community of Care Access Centres' referral are the following:

- Standardized CCAC e-Referral from Paramedic Services by adding the existing CCAC eReferral and Acute Care Minimum Data Set
- The OACCAC and EPCR vendors in Ontario, Interdev, Medusa and Zoll, and Ontario Paramedic Services created these standards
- Implemented the three PERIL questions in the Client Health Related Information System (CHRIS) system
- Enabled e-notification from Paramedic to CCAC

### 3.6 Provincial Access and Implementation

As designed, the education and training components of the toolkit are now available for Ontario wide use online and at no cost. This ensures that it is accessible for every Service to integrate into operations.

### 3.7 Evaluation and Measurement

#### Referral Pathway Evaluation

An evaluation working group was established at the onset of this project, comprised of a broad representation from Paramedic Services across Ontario. Engagement took place in person in Gravenhurst, Calabogie, Toronto and by teleconference. Work was guided by the following principles:

1. High quality evaluation of any Community Paramedic Service is necessary to allow the assessment of the return on investment of such initiatives.
2. Any such evaluation must recognize the existing variability in research and evaluation capacity among different Paramedic Services.
3. While the PERIL tool to identify high-risk seniors is the best available existing evidence, there is an opportunity for further assessment with province-wide implementation.
We don't have to choose between bending our cost curve and putting patients first, both are possible. But it means being willing to challenge the status quo to find ways to better serve patients, by strengthening community-based care, improving transparency and accountability and developing evidence-based models that will tell us whether what we are doing is working.

Dr. Eric Hoskins, Minister of Health and Long-Term Care, Province of Ontario

Referral Form Evaluation Approach

Quantitative and qualitative analysis demonstrated the feasibility of the evaluation framework to support the development of the standardized referral form. The Community Paramedic Referral form evaluation is based on the following:

• Leverage ePCR’s for cost-effective data collection
• Standardize data collection across Ontario wherever possible
• Link data from Community Paramedicine Programs to Community of Care Access Centres and Provincial databases to determine outcomes
• Capitalize on ongoing evaluation of Community Paramedic Programs
• Minimize duplication
• Recognize diversity and desire/need for local data
• Manage shared and local visions

3.8 Perceptions and Barriers Associated with Community Referral

Madison Brydges and Walter Tavares conducted a qualitative study with existing Community Referral from Emergency Medical Services (CREMS) programs. Purposeful criteria and maximum variation guided the study. Methods included interviews, inductive thematic analysis and saturation. Despite value and efforts, what is the data to support underutilization? The results concluded that there was:

1. Limited understanding of the program. The program purpose was not translating to the frontline, with uncertainty regarding patient types, eligibility and services. There were no concerns with the process.

2. Role Dissonance: emergency versus long term medical and social needs; there were competing and confusing expectations; culture change was lacking.

3. Accountability: programs required accountability between services (eg: paramedic, ccac, community referrals). Selective referrals and hidden curriculum.

4. Feedback was limited, insignificant, not timely, inconsistent in its type and therefore unable to support development of expertise.

6. Patient Advocacy: major motivator; altruistic and self-serving; robust (despite absence of validation); not widely adopted.

These findings provided input into the development of the educational toolkit components.

Based on the literature review and evaluations of existing evidence-based programs, we can draw the following conclusion. Existing literature shows feasibility, acceptability, positive process evaluations and reduced Emergency Department visits.

There is a clear trend toward cost effectiveness. Rapidly evolving literature exists and will require further review. Through this toolkit development process, a standardized referral form was developed within a collaborative framework. Qualitative and quantitative analysis demonstrated the feasibility of the evaluation framework and included approximately 4000 patient referrals.

3.9 Summary

The implementation of this Paramedic Referral process provides the evidence and pathways to engage community partners in non-traditional program delivery and supports identification of populations at risk. Paramedic Referral is complementary both to existing care provider systems as well as emerging models of care, including Community Paramedicine and Health Links.

Existing literature shows feasibility, positive process evaluations and cost effectiveness. It is designed to increase opportunities that mitigate future repeat use of our highest frequency health care users. Outcomes include improved access to health services, increased cost efficiency and improved patient centered care for Ontarians.
Education and Training Online Interface:
www.paramediccommunity.com
### Paramedic Referral to CCAC

**Based on RM&R initiative**

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#### Patient Details and Demographics

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#### Health Information

- **Referral Reason and Validated PERIL assessment**

- Are there any problems observed in the home that would prevent this client from being safely discharge back home from the ED, or contribute to recurrent EMS / Emergency use?
- Has the client used 911 in the last 30 days?
- Medications Disorganized (Meds not clearly labeled, Ad-lib containers, old meds mixed with current medications)?

Score: ______

If #1 indicated or Score is either 2/3 or 3/3, then obtain verbal consent for referral.

#### Relevant Diagnosis for referral:

- Alcohol/Substance Misuse
- Care Giver Strain
- Chronic Disease/Condition
- Cognitive Impairment
- Fail to Cope
- Fail History Last Year
- Fall in the last 30 days

- Gait or Mobility
- Mental Health
- Palliative Care
- Potential Abuse
- Discharge from Hospital (30 days)
- Wound Care
- Falls/Tripping Hazzard

#### Infection control:

- MRSA+
- VRE +
- CDIFF
- ESBL
- TB
- N/A
- Other (Specify):

#### Medical Orders/Care Plan:

- No
- Attached
- To follow

---

**Completed by:**

**Primary Problem:**

**Contact #:**

---

**Date:** DD/MM/YYYY

---

**V1.3 Sept 30 2013 CCAC Referral**
It’s simple, call 211

MAKE THE RIGHT CALL

2-1-1 Information and referral helpline to community, social, government and health services.

3-1-1 Customer service and municipal information hotline in Toronto, Halton, Windsor, Peel, Ottawa and Greater Sudbury.

9-1-1 Emergency number for police, fire and paramedic services.

How do you connect with over 60,000 community & social services across Ontario?

211 Make the Right Call
About CCAC
The CCAC acts as a referral and service agency for communities throughout Ontario. They can arrange for a variety of services as well as link people to important resources in their community.

Community Care Access Centre (CCAC) is funded by the Ministry of Health and Long-Term Care through regional Local Health Integration Networks (LHINs). Services provided by CCACs are covered by the Ontario Health Insurance Plan for those holding a valid health card. A physician’s referral is not required; anyone can use the CCAC.

About GCEMS
On September 4, 2004, the County of Grey became the direct operator of the land ambulance service through the Grey County Emergency Medical Services (GCEMS) department.

GCEMS also coordinates and administers the county’s Public Access Defibrillation program (website: www.grey.ca/pad).

Administration for GCEMS is located at the Grey County Administrative building in Owen Sound.

Contacting GCEMS
If you have any questions or comments, you may contact GCEMS at 519-533-6884.

What happens next?
If you have consented to a referral for care and support services, you will get a telephone call within 24 hours from a CCAC staff member.

They will ask you a few questions to determine if and what services you might need. If CCAC services are the right fit for you, you can expect a care coordinator to come to your home within 2 weeks to complete a health check.

CCAC will also provide you with referrals to services that they may not provide but may benefit you from including exercise programs and meals.

Who gets referred?
The referral is open to people of all ages, but is designed primarily for older adults who:

- wish to remain independent in their own homes
- are experiencing some difficulties performing the daily activities required to live independently (e.g. bathing, dressing, caregiving etc.)
- are willing to be active in their own care, and
- would benefit from learning more about how to remain independent

How does it work?
Clients benefit from a coordinated approach to providing you with the information, skills and tools to return to, and maintain, your independence. Personal support workers and rehabilitation professionals will work with you in your home.

How much does this cost?
CCAC services are covered by the provincial health insurance plan for those holding a valid Ontario Health Card. Clients are responsible for purchasing specialized in-home equipment (e.g. bath grab bars) if required.

Some community support services require minimal fees for participation in their programs.
The South West Community Care Access Centre helps people get the care and support they need in their homes and communities.

**Home Care**

CCAC Care Coordinators are dedicated nurses, occupational therapists, social workers and other care professionals. Through personal visits and regular check-ins, they help determine the right care and health supports for people and get them the care they need. Care may include in-home nursing and personal support, visits to CCAC community clinics, connections to community organizations such as Meals on Wheels and Adult Day Programs, transition to long-term care homes and more.

**Always striving to do better**

At the South West CCAC, we are always working to improve the care we provide. Recently our commitment to excellence was recognized by Accreditation Canada, which awarded us its highest rating.

**Call the South West CCAC when you or a loved one:**

- Needs information about care and support services and programs in your community.
- Needs support to live safely at home.
- Is considering moving from home to long-term care and/or another housing option.
- Needs help managing one or more chronic conditions.
- Needs to find a family doctor.
- Has health concerns and isn't sure where to turn.

**How to work with us**

- Be open and honest with your CCAC caregivers. Share your concerns.
- Let them know if your situation changes.
- Help them get to know your caregivers and let them know what things don’t work.

---

**The CCAC ensures that people get the care they need in their homes and communities.**

The CCAC coordinates care provided by nurses, other health care professionals, and community organizations.

**We help people heal at home and stay in their own homes longer.**

When home is no longer an option, we help people make the transition to other living arrangements.

---

**How to contact us**

Call 1 800-811-5146
Visit our website at www.healthcareathome.ca.
Drop into one of our offices across the South West.

- **London** (Head Office)
  - 156 Oxford Street West, London ON N6J 1T3
- **Owen Sound**
  - 1415 1st Avenue West, Suite 3009
  - Owen Sound ON N4K 4K8
- **St. Thomas**
  - Unit 70, 1061 Talbot Street
  - St. Thomas ON N5P 1G4
- **Seaford**
  - PO Box 380, 32 Centennial Drive
  - Seaford ON N0K 1W0
- **Stratford**
  - 65 Lorne Avenue East
  - Stratford ON N5A 6Y4
- **Woodstock**
  - 1147 Dundas Street, Unit S
  - Woodstock ON N4S 8W9

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Need Help at Home?
The South West CCAC will get you the care you need.

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For information about health services visit www.southwesthealthline.ca or call 310-2222 (CCAC).
Appendix 1: CHRIS 2.5 milestones

- **02/03/2014 - 25/04/2014**: Requirements - Mandatory Project (8 Weeks)
- **22/08/2014**: Feature Complete
- **12/09/2014**: User Preview Build (early build for IT)
- **30/09/2014**: Final User Preview Build
- **07/11/2014**: Project Final Build
- **09/11/2014**: Go-Live
- **06/10/2014 - 14/11/2014**: User Preview (Full)
- **20/01/2014 - 26/02/2014**: Initial Mandatory Projects Identified
- **26/03/2014**: Final Scope for R2.5 Confirmed
- **28/04/2014 - 05/09/2014**: Design/Dev/Functional Test Iterations (21 Weeks)
- **28/03/2014 - 25/04/2014**: Design/Spec Iteration (4 Weeks)
- **05/09/2014**: Functional Testing Complete
- **08/09/2014 - 14/11/2014**: Regression (10 Weeks)

**Appendix 1: CHRIS 2.5 milestones**
Appendix 2: Community of Care Access Centre Referral Network and Process
<table>
<thead>
<tr>
<th>REASONS FOR REFERRAL</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Modifying Factor:</strong> Alcohol/Substance Misuse</td>
<td>long-term, pathological use of alcohol or drugs, characterized by daily intoxication, inability to reduce consumption, and impairment in social or occupational functioning</td>
</tr>
<tr>
<td>Caregiver Support / Burnout</td>
<td>overwhelmed caregiver resulting in declining health of caregiver; patient needs exceed services available and caregiver resources/abilities</td>
</tr>
<tr>
<td>Medical Case management</td>
<td>Recent discharge from hospital, wound care, chronic disease condition, telehomecare where available</td>
</tr>
<tr>
<td>Mobility Issues (slips/trips/)</td>
<td>difficulty with ambulation including walking, standing/sitting (bed, chair, toilet), moving within bathroom; unstable/unsteady gait</td>
</tr>
<tr>
<td>Mental Health</td>
<td>diagnosed or admitted mental health conditions that are contributing to other medical issues and/or negatively impacting activities of daily living</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>diagnosed or undiagnosed end of life conditions requiring assessment for support including caregiver respite.</td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td>evidence of cognitive decline with associated risks (wandering, unsafe practices such as unattended cooking/heating appliances, public safety, combativeness)</td>
</tr>
<tr>
<td>Failing Activities of Daily Living (bathing, meals, dressing, etc)</td>
<td>Unable to perform activities of daily living such as bathing, dressing, meal preparation, groceries, laundry as evidenced by poor hygiene, poor nutrition (barren kitchen), or lack of home making (cleaning)</td>
</tr>
<tr>
<td>Falls</td>
<td>risk or evidence of falls</td>
</tr>
<tr>
<td><strong>Modifying Factor: Potential Elder Abuse</strong></td>
<td>Single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person”. Elder abuse can take various forms such as physical, psychological or emotional, sexual and financial abuse, intentional or unintentional neglect.</td>
</tr>
<tr>
<td>System Navigation</td>
<td>patient requires assistance with obtaining services or case management; these may include application for long term care, referral to community support services, referral to mental health or substance abuse programs, social work.</td>
</tr>
<tr>
<td>Safety Hazards</td>
<td>circumstances that are creating risk to health, safety, or well being of occupants; these include excessive clutter (hoarding), fire hazards (combustible materials, unsafe practices like using stove to heat residence or overloaded electrical circuits), structural compromise (building in disrepair, floors/roof/stairs unstable/unsafe), mould/mildew, animal or insect infestation, poor sanitation (raw sewage or garbage within residence), lack of essential utilities (power, water, heat)</td>
</tr>
</tbody>
</table>

- Added Falls as own category outside of mobility issues
- Kept system navigation on its own
- Kept safety hazards on its own
- Added definitions for – alcohol substance misuse, elder abuse, medical case management
**CCAC Referral Network Connectivity**

The interface is formalized using the HL7 referral standard. The present interface conforms to HL7 v2.5.

Two HL7 channels with OACCAC will be established. The Outbound channel will be used for sending referral messages (REF) to the CCAC. The Inbound channel will be used for receiving referral status update messages (RRI) from the CCAC.

Both communication channels will have encryption of data in transit and will transmit via a secure VPN tunnel to ensure the data in transit cannot be tampered with.

Following is a table of referral events and stages:

<table>
<thead>
<tr>
<th>Item</th>
<th>Business Event</th>
<th>Description</th>
<th>Event Code</th>
<th>HL7 Message/Event</th>
<th>Sender</th>
<th>Recipient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>New Referral</td>
<td>Paramedic initiates a new referral to the CCAC.</td>
<td>NW</td>
<td>REF – I12</td>
<td>Paramedic</td>
<td>CCAC</td>
</tr>
<tr>
<td>2</td>
<td>CCAC Accepts Referral</td>
<td>CCAC staff receives referral and determines there exists sufficient information to process the referral.</td>
<td>RI</td>
<td>RRI – I12</td>
<td>CCAC</td>
<td>EMS System</td>
</tr>
<tr>
<td>3</td>
<td>CCAC Cancels Referral</td>
<td>CCAC staff receives referral however, determines they are unable to process the referral. The OACCAC system notifies EMS System of cancellation.</td>
<td>CA</td>
<td>RRI – I14</td>
<td>CCAC</td>
<td>EMS System</td>
</tr>
<tr>
<td>4</td>
<td>CCAC Completes Referral</td>
<td>CCAC completed the assessment and has determined patient eligibility. The system communicates completion of referral to the EMS System.</td>
<td>CT</td>
<td>RRI – I12</td>
<td>CCAC</td>
<td>EMS System</td>
</tr>
</tbody>
</table>

*Table 1: Referral Process Events and Stages*
**CCAC Referral Interfaces**

The referral interfaces are described below:

<table>
<thead>
<tr>
<th>REF – I12 – New Referral</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Segment</td>
<td>Description</td>
</tr>
<tr>
<td>MSH</td>
<td>Message Header</td>
</tr>
<tr>
<td>RF1</td>
<td>Referral Information</td>
</tr>
<tr>
<td>{PRD}</td>
<td>Provider Data</td>
</tr>
<tr>
<td>PID</td>
<td>Patient Identification</td>
</tr>
<tr>
<td>{DG1}</td>
<td>Diagnoses</td>
</tr>
<tr>
<td>{AL1}</td>
<td>Allergies</td>
</tr>
<tr>
<td>{NK1}</td>
<td>Next of Kin / Associated Parties</td>
</tr>
<tr>
<td>PV1</td>
<td>Patient Visit</td>
</tr>
<tr>
<td>PV2</td>
<td>Patient Visit - Additional Info.</td>
</tr>
<tr>
<td>OBR</td>
<td>Observation Request</td>
</tr>
<tr>
<td>[{OBX}]</td>
<td>Observation/Result</td>
</tr>
</tbody>
</table>

*Table 2: New Referral Interface*

<table>
<thead>
<tr>
<th>RRI-I12 – CCAC Accepts and Completes Referral</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Segment</td>
<td>Description</td>
</tr>
<tr>
<td>MSH</td>
<td>Message Header</td>
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<tr>
<td>RF1</td>
<td>Referral Information</td>
</tr>
<tr>
<td>{PRD}</td>
<td>Provider Data</td>
</tr>
<tr>
<td>PID</td>
<td>Patient Identification</td>
</tr>
</tbody>
</table>

*Table 3: CCAC Accepts Referral & CCAC Completes Referral*

The difference between the two events is expressed in the RF1-1.1 element:
- CCAC Accepts Referral – uses the code “RI”
- CCAC Completes Referral – uses the code “CT”

<table>
<thead>
<tr>
<th>RRI-I14 – CCAC Cancels Referral</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Segment</td>
<td>Description</td>
</tr>
<tr>
<td>MSH</td>
<td>Message Header</td>
</tr>
<tr>
<td>RF1</td>
<td>Referral Information</td>
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<tr>
<td>{PRD}</td>
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</tr>
<tr>
<td>PID</td>
<td>Patient Identification</td>
</tr>
</tbody>
</table>

*Table 4: CCAC Cancels Referral*
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