Implementing a Community Paramedic Post-Fall Pathway: Ensuring rehabilitative care follow-up for older adults following a fall in the North Western Toronto Ontario Health Team community

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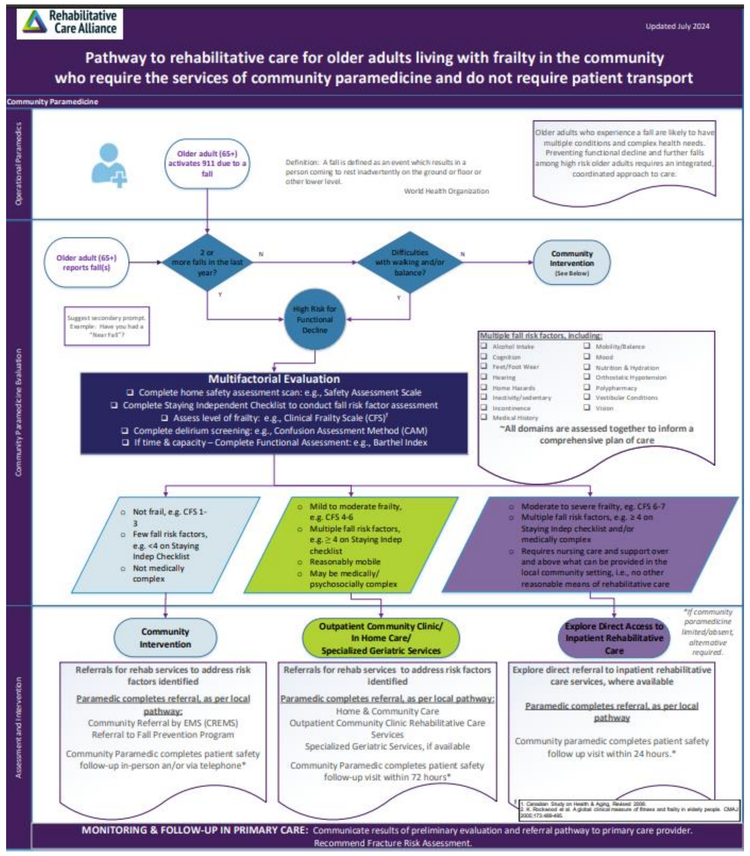
WHAT IS THE INITIATIVE ABOUT?

The GTA Rehab Network, in collaboration with Toronto Paramedic Services (TPS) - Community Paramedics (CPs) and the North Western Toronto Ontario Health Team (NWT OHT) implemented a secondary fall prevention initiative, adapted from the Rehabilitative Care Alliance (RCA)'s Community Paramedicine Older Adults Post-Fall Rehabilitative Care Pathway.

GOAL OF THE INITIATIVE

To reduce functional decline and prevent future falls for NWT OHT residents aged 55 and older who have called 911 for a fall, or who have reported a fall to paramedics, but who were not transported to the hospital.

RCA'S COMMUNITY PARAMEDICINE OLDER ADULTS POST-FALL REHAB CARE PATHWAY



OVERVIEW OF THE PATHWAY

- Potential clients are identified daily by CPs using 911 call data and contacted for a follow-up visit within 48 hours of the fall event.
- With clients' consent, CPs conduct a home visit and evaluate residents' fall risk factors using standardized assessment tools identified for this initiative.
- The following standardized assessments are administered by the CP during the initial visit and help determine the appropriate rehabilitative care stream for the client:
  - Clinical Frailty Scale
  - EQ-5D-5L
  - Staying Independent Checklist
  - Timed Up and Go
  - TPS safety checklist or Safety Assessment Scale
  - Confusion Assessment Method (if appropriate)
- Based on discussion and consent process, referrals for rehabilitative care services are made by CPs in either of the three rehab intervention streams:
  1. Community intervention
  2. Outpatient community clinic, Specialized geriatric services, or In-home care
  3. Inpatient rehab program

Community Intervention	Outpatient Community Clinic/ In-Home Care/Specialized Geriatric Services	Direct Access to Inpatient Rehab
• Black Creek Community Health Centre • Unison Health and Community Services • Lumacare • ESS Support Services	• Humber River Health's - Geriatric Medicine Clinic - Falls Prevention Program - Geriatric Outreach Team • LOFT Community Services • UHN/West Park Healthcare Centre - Geriatric Interprofessional Assessment Clinic - Geriatric Day Program - Seniors mental Health Outreach Services	• Runnymede Healthcare Centre • UHN/West Park Healthcare Centre
Emery-Keelesdale Nurse-Practitioner Led Clinic		
Schulich Family Medicine Teaching Unit (FMTU) at Humber River Health		

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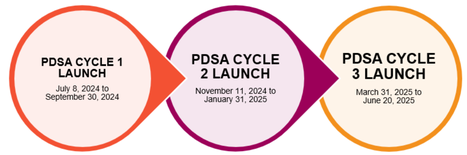
PREPARING FOR IMPLEMENTATION

Project managers at the GTA Rehab Network worked with the Community Paramedic Superintendent and OHT system planner to:

- Design an education program to further enhance CPs' expertise in providing care to older adults
- Conduct an asset inventory of fall prevention programs in the NWT OHT region. Community partners were engaged to participate in this initiative. A standardized list of programs was compiled, including information on referral eligibility and processes.
- Develop an assessment package and referral forms for use by community paramedics.



PRELIMINARY FINDINGS

- CP documentation chart reviews were conducted, as well as a baseline survey of community paramedics' practices related to clients who had a fall.
- Implementation is evaluated using a quality improvement approach with three 12-week Plan-Do-Study-Act (PDSA) cycles. At the end of each cycle, 10 random chart reviews of community paramedics' documentation of fall risks and referrals are compared to baseline and earlier PDSA cycles. Improvement opportunities are identified for implementation in the next PDSA cycle.
- From initial implementation, July 8, 2024 to March 31, 2025, there were 272 identified potential clients based on 911 calls. A total of 87 unique clients have been assessed (average age of 85, with an average of 3 visits either in-person or virtual).
- Within the quality improvement PDSA cycles 1 and 2:
  - 48 new referrals to services were made.
  - <5 called 911 after the community paramedic visit
  - 88% (n=8) would highly recommend this initiative intervention to others
  - Significant improvement in documenting fall risk factors, increased sharing of assessment findings with other providers (e.g., OH atHome, primary care), and referrals to a greater variety of services were noted as a result of this initiative as compared to baseline (n=30).

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