Collaborative Models of Community Care and Paramedicine

Program themes and definitions: (as defined on June 16, 2022 partners call)

1. Coordination of care

Patients discharged from acute care /rehab settings require coordinated, multidisciplinary care management in order to provide ongoing quality care, prevent worsening of their acute or chronic medical conditions and ensure their ability to remain in the home setting. The program will coordinate care among a diverse group of providers with variable skill sets to improve communication, coordinate follow up care, provide in home care, and provide assistive home services, as needed.

2. Reducing ED admissions

Patients often use the Emergency Department as their only or last resort location for low acuity care needs. The program will work to allow EMS providers to assess and treat patient's low acuity complaints with onsite care and/or referral to treatment locations/providers other than the ED, so as to reduce Emergency Department admissions. This will be done in coordination with other community services (i.e.- social service, home care) to ensure appropriate ongoing care needs are met.

3. Reducing hospital readmission

Patients discharged from acute care facilities are often readmitted within a short period of time, often for issues that could be managed with improved care coordination and integrated home care. The program will develop and offer a multidisciplinary team approach to ensure discharged patients have access to help manage their post-acute care. Examples would include assessment of social/medical support, medication management (as below), mobility assistance, management/referral for low acuity medical problems, nutrition assistance, etc.

4. Medication management

Patients discharged from acute care facilities often do so with multiple new or changed medication prescriptions. Especially for the elderly with poor support structure, medication errors can result in adverse drug reactions, disease relapse and hospital readmission. The program will develop mechanisms, with multidisciplinary teams to assist patients in obtaining needed medications, and ensuring proper use, thus decreasing potential medication errors and adverse medication reactions.

5. Home inspection

For patients discharged from acute care facilities, a return to home is often fraught with safety issues relating to personal mobility, physical safety hazards, and location challenges. The program will develop and implement multi-disciplinary home assessment teams to work with discharged patients to ensure their home circumstances are safe, and can contribute positively to their ongoing care needs.