January 31, 2018

Waterloo Wellington Local Health and Integration Network
141 Weber Street South
Waterloo, ON N2J 2A9

Attention: Sarah Farwell

Dear Ms. Farwell:

On behalf of the Region of Waterloo Paramedic Services and our community partners, please accept this document for consideration as our Mobile Integrated Health Care Program proposal.

During the past two months, we have had the opportunity to discuss and develop our proposal with our patients and community partners in mind. The result has been an action plan that will help move our system toward the broader shared vision of providing effective health care in our communities.

We thank you for this unique opportunity and look forward to working with the WWLHIN on this initiative that aims to improve patient access to the right care at the right time and in the right place while decreasing the strain on our local health care system.

Respectfully submitted,

Signed by Michael Adair on Behalf of

Stephen Van Valkenburg,
Chief, Region of Waterloo Paramedic Services

SVV / MA
MOBILE INTEGRATED HEALTH CARE:

COMMUNITY PARAMEDIC ARM

REGION OF WATERLOO PARAMEDIC SERVICES

PROGRAM SUBMISSION

January 31, 2018
# Table of Contents

Contact Information ................................................................................................................. 5  
Introduction and Guiding Principles for Community Paramedicine and Mobile Integrated Health Care ........................................................................................................... 6  
Research Findings .................................................................................................................... 7  
Needs Analysis ........................................................................................................................... 9  
Proposed Mobile Integrated Health Care Models ............................................................. 10  
Additional Mobile Integrated Health Care Models for Discussion ............................. 11  
Mobile Integrated Health Care Program Objectives ..................................................... 11  
High Users of the Emergency Department .................................................................... 12  
High Users of 911 Paramedic Services ........................................................................... 12  
Referrals from 911 Paramedic Services ........................................................................... 13  
911 Transports to the Emergency Department that Leave Against Medical Advice (AMA) ........................................................................................................................ 13  
Specialized Geriatric Services Clinical Outreach Team ................................................ 14  
Shelter Referrals .................................................................................................................... 15  
Supportive Housing Referrals and Other Opportunities ............................................ 15  
Next Steps ................................................................................................................................. 16  
Cooperation and Partnerships .......................................................................................... 17  
Resource Sharing ................................................................................................................... 19  
Sustainability .......................................................................................................................... 20  
Tracking and Monitoring Key Performance Metrics .................................................... 20  
Governance, Policy and Accountability ............................................................................ 22  
  SCOPE of PRACTICE ................................................................................................................. 22  
  PRIVACY ........................................................................................................................................ 23  
  STAFFING and SEPARATION from 911 PARAMEDIC SERVICES .................................... 24  
  RECRUITMENT and TRAINING .................................................................................................... 24  
Budget ........................................................................................................................................ 25  
Core Team Members ............................................................................................................. 26  
Reference List ......................................................................................................................... 29  
Appendix A High Users of the Emergency Department ................................................ 30  
Appendix B High Users of 911 Paramedics Services ..................................................... 31
Appendix C Referrals from 911 Paramedic Services .................................................. 32
Appendix D 911 Users that Leave the Emergency Department AMA ..................... 33
Appendix E Specialized Geriatric Services Clinical Outreach Team Referrals ............. 34
Appendix F Shelter Referrals ..................................................................................... 35
Appendix G Supportive Housing Referrals .................................................................. 36
Appendix H Stream A Enrolment Process ................................................................ 37
Appendix I Stream B Intake Process ......................................................................... 38
Appendix J Stream C Navigation Process .................................................................... 39
Appendix K Community Partner Consultative List ...................................................... 40
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Introduction and Guiding Principles for Community Paramedicine and Mobile Integrated Health Care

An investigation into how Community Paramedicine can improve health care delivery for the Region of Waterloo was undertaken in order to assist with optimizing health services for our residents. For the purpose of this proposal the term Mobile Integrated Health Care has been selected to describe the relationship that Paramedic Services can leverage with system partners to enhance the delivery of health care within our system. Specifically, Community Paramedics will be referred to as the key care providers within the proposed programming. The goal of this research was to address system needs across the Waterloo-Wellington Local Health Integration Network (WWLHIN), specifically within the KW4 (Kitchener, Waterloo, Woolwich, Wellesley, Wilmot) and Cambridge, North Dumfries sub-regions.

Areas of interest included: the availability of services and health human resources to ensure timely access to care for the high risk, vulnerable populations; the sufficiency and equality of access to primary care; and the identification of unnecessary ambulance transports to local emergency departments which strain both hospitals and Paramedic Services. In addition, we took the first steps in identifying specific demographic areas of local populations that have had difficulty connecting to the health care system. Population targets included isolated individuals with limited supports (i.e., homeless, seniors, or those with mental health conditions), patients living in rural areas, patients with four or more chronic conditions, and patients not connected to primary care.

In this proposal, we have identified key steps toward implementing an effective Mobile Integrated Health Care Program that supports the broader health care system. First, partnerships, collaborations, and resource sharing amongst varied health care providers and community service organizations are imperative. This would allow a Mobile Integrated Health Care Program to support healthy communities by offering significant improvements to the local health care system through improved delivery and coordination of service within the WWLHIN. Fiscal challenges within health care funding highlight the need to reduce or eliminate duplication of services in achieving the objective of health care for all. Communication between the Community Paramedic and a patient’s circle of care through electronic charting and Telehomecare programming is fundamental in order to create a portal that will improve the patient experience and provide the right care, at the right time, in the right place. Lastly, Mobile Integrated Health Care Program output measures and key performance indicators will be identified and shared for determining/defining program success.
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Region of Waterloo Paramedic Services

Research Findings

Recognizing that 1 in 5 emergency department (ED) visits are avoidable and often deal with less or non-urgent problems\(^2\), shifting these patients away from hospitals will allow acute care resources to be focused on more appropriate patients. Waterloo Region data (2017)\(^3\) indicated that the most frequent users of Paramedic Services, which resulted in visits to the hospital, are residents averaging 65 years of age (median = 71 y/o) (Figure 1). This group of 2,139 individuals averaged five calls per person (one individual requested assistance 86 times), calling Paramedic Services 9,908 times in a 12-month period. This indicates that 7% of all patients using Paramedic Services generated 23% of the total calls for the year. These frequent callers utilized 411 days of ambulance time over the course of the year (or 9,874 service hours) and were more likely to present with less or non-urgent problems\(^3\) (Figure 2). The top five reasons for calling Paramedic Services for transport to the hospital were: assessment only/no injuries; unwell/weakness/dizziness; musculoskeletal; abdominal/pelvic/perineal/rectal pain; dyspnea; and mental health conditions. In comparison to non-frequent users, the frequent user group presented with significantly higher rates of mental health conditions, diabetic problems, seizures, falls, and lift assists\(^3\). (Figure 3).

It is expected that frequent users of Paramedic Services will overlap with frequent users of the emergency departments. In contrast, users of the emergency department do not always take an ambulance to the hospital yet will cause strain on the health care system (Figure 4). Discussions with local emergency department Clinical Leads indicated that there were frequent users of the emergency department that do not arrive by ambulance and use the hospital as their source of primary care provision. Further to this, WWLHN data (2014-15) identified 5925 complex patients (four or more chronic conditions) in Waterloo Region who are not attached to primary care, with 60% of this group being 65 years of age or older\(^4,5\).

Figure 1

![Differences by age](image)

There were a higher proportion of frequent callers aged 0 to 4, 15 to 24, and 70+. 

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Region of Waterloo Paramedic Services

**Figure 2**

Differences by severity

- **Non-frequent caller**
- **Frequent caller**

CTAS

Resuscitation: Emergency, Urgent, Less Urgent, Non-urgent

Frequent callers were more likely to have CTAS 4 and 5 calls, less likely to have CTAS 2 and 3 calls.

**Figure 3**

Differences by final problem code

**Figure 4**

Differences by transport

- **Non-frequent caller**
- **Frequent caller**

Frequent callers were less likely to require transport.
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Region of Waterloo Paramedic Services  

The rapidly expanding population of individuals 65 years and older\(^{6,7}\), translates into higher occurrences in morbidity including risk of fall, frailty, diabetes mellitus, congestive heart failure, chronic obstructive lung disease, mental health conditions, asthma, and hypertension\(^{2,5,8}\). This aging group, which is currently 13% of the local populace\(^9\) and predicted to reach 19% by 2031\(^9\), generates 43% of 911 calls for service. Furthermore, the Paramedic Services Master Plan forecasts that call volume during this same timeframe will climb from 46,700 (2016) to 88,000 in 2031\(^9\). This equates to an increase in emergency services demand of over 90%\(^9\). These various chronic diseases and comorbidities indicate a need to incorporate new strategies of delivering care in order to better meet the demands of this growing sector of the population. Additionally, the increasing need for mental health and addiction support within the community has created another challenge that is impacting the local health care system, as well as the social support resources.

The WWLHIN's annual performance plan indicated several challenges in reaching the defined goals applicable to the local health care system. These areas included: repeat visits to the emergency department for both mental health and substance abuse conditions; utilizing acute care hospital beds when there is a more appropriate location; and treating and admitting or discharging complex patients from the ED within eight hours or less. In addition, the target to decrease the rate of hospital readmissions for those with chronic conditions continues to be a focus over the past year\(^5\).

**Needs Analysis**

As part of the Mobile Integrated Health Care Program development, a needs analysis was undertaken in order to identify gaps and opportunities within our broader local health care ecosystem. Due to the abbreviated timelines for the research element of the Mobile Integrated Health Care Program, access to current quantitative data was limited. For a list of community partners’ consultants see Appendix K.

Results from this analysis generated several concepts aimed at improving the health of populations, the quality and satisfaction of care, and the efficiency of our health system while decreasing overall costs. The priority would be to provide care to residents who are vulnerable and complex due to chronic diseases, mental health considerations, a lack of supports, or isolation. The general consensus was to target high users of the emergency departments and Paramedic Services, followed by collaborating with Specialized Geriatric Outreach Teams, shelters and supportive housing. Partnership with a rural Community Health Centre was also identified as a potential model, as was collaboration with the Palliative Care Support Team.

Community partners expressed that there was a need for the Remote Patient Monitoring program (Telehomecare) for some of their high-needs chronic disease patients, living locally or remotely. It was suggested that a lack of mobility was often
perceived as a barrier to receiving treatment at an office or clinic. The extended scope of practice for the Community Paramedic was generally preferred, and thought to be more useful in treating patients where they reside. As an adjunct to performing under an extended scope of practice, community partners often identified the need for a Community Paramedic extending beyond regular office hours.

**Proposed Mobile Integrated Health Care Models**

With the overarching goal of optimizing our local health care system performance, and guided by a systems-based approach, it is recommended that the Region of Waterloo’s Mobile Integrated Health Care Program focus on the following population and Community Paramedicine activities:

- **Phase 1a** High Users of the Emergency Department
- **Phase 1b** High Users of 911 Paramedic Services
- **Phase 1c** Referrals from 911 Paramedic Services
- **Phase 1d** 911 transports to the Emergency Department that leave AMA
- **Phase 2** Specialized Geriatric Services Clinical Outreach Team
- **Phase 3** Shelter Referrals
- **Phase 4** Supportive Housing Referrals and Other Opportunities

The Community Paramedic’s role will be to enhance the delivery of community and health care services to the patients that are enrolled in the Mobile Integrated Health Care Program. This will be achieved through scheduled home visits, which will include an overall health appraisal. This assessment will evaluate health risk factors, and provide health and community care referrals along with assistance with system navigation. The Community Paramedic will aim to be an advocate for these patients outside of the hospital environment, and within the patients’ familiar surroundings (i.e., residence, shelter, etc.). The Remote Patient Monitoring (RPM)/Telehomecare service will be investigated for all phases of the program and implemented for appropriate patients enrolled in the Mobile Integrated Health Care Program. Patients with chronic diseases such as diabetes, hypertension, congestive heart failure, and chronic obstructive pulmonary disease are generally suitable for RPM/Telehomecare.

Community partners not initially involved in a Mobile Integrated Health Care Program partnership will be offered an opportunity to provide future input into our program. As an example, we will provide such partners with a template in order to track occurrences where a Community Paramedic may have enhanced or supported their programming. Information related to the number of instances a Community Paramedic could have been utilized, the capacity for utilization, (RPM, wellness checks, point of care testing, extended scope) and the type of patient (age, medical
conditions, place of residence) will be used for future program expansion, revision and/or modification.

**Additional Mobile Integrated Health Care Models for Discussion**

In terms of meeting local needs in a responsive and timely manner, specialized and tactical programming can also be considered for development after the initial Mobile Integrated Health Care Program is established. These may include but are not limited to:

- Flu Outbreak Containment (retirement homes, supportive housing, private residences, extended care homes, or as identified by WWLHIN/Public Health)
- Flu Shot Programs (allied agencies, as identified by Public Health)
- Active Recovery Waterloo & Cambridge (Outreach Group Collaboration)
- Overdose Follow-up (911 data)
- Palliative Care Support Team Collaborative
- Mennonite Population Outreach

**Mobile Integrated Health Care Program Objectives**

The intention of the Mobile Integrated Health Care Program is to provide appropriate support to the target patient populations identified in the models. This support may include the following:

- Navigating patients to appropriate community resources
- Ensuring patients connect with their primary care physician
- Referring patients to Home and Community Care Coordinators at the WWLHIN
- Directing patients to Specialized Geriatric Services Clinical Outreach Teams
- Determining whether patients need short term assistance or will require long term support
- Directing patients to the emergency department when needed

The main objectives for full rollout of the Mobile Integrated Health Care Program are to:

- Reduce emergency department visits
- Experience fewer requests for Paramedic Services
- Keep the aged population ‘healthy at home’
- Improve the knowledge of self-care and available community supports for all patient groups
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- Reduce costs at the hospital level
- Reduce costs to Paramedic Services and the Region of Waterloo
- Improve the patient and caregiver experience and outcomes
- Improve the connections between those providing health and social services within the Region

Phase 1

High Users of the Emergency Department
(Implement within four (4) to eight (8) weeks of Program launch)

The hospital emergency department team will identify patients that meet the inclusion criteria for referral to the Mobile Integrated Health Care Program. The initial inclusion criteria will be developed in partnership with the WWLHIN and emergency departments and may include:

- Repeat user of the emergency department
- Flagged as a high risk to revisit the emergency department

When the patient meets the inclusion criteria, the hospital discharge team may refer the patient to the Mobile Integrated Health Care Program. The referral will be processed and the patient may be enrolled. The intent of the assessment visit will be to perform a wellness check and to assist in navigating the patient to appropriate community resources to alleviate subsequent use of the emergency department or Paramedic Services. The Community Paramedic will work closely with the patient’s primary care physician to ensure safe, ongoing care is established. It should be noted, that these patients might actually appear on the lists of both the High Users of the Emergency Department and the High Users of Paramedic Services, affecting current use statistics. As such, they would subsequently be identified, categorized and then provided with the appropriate support. See Appendix A for High Users of the Emergency Department flowchart.

High Users of 911 Paramedic Services
(Implement within four (4) weeks to six (6) months of Program launch)

On a monthly basis, the Region of Waterloo Paramedic Services will identify high users of Paramedic Services over the preceding rolling 12-month period. These patients will be considered for enrolment into the Mobile Integrated Health Care Program and contacted by the Mobile Integrated Health Care Program Designate within a target of three business days in order to organize a home visit by the Community Paramedic. The Community Paramedic will perform a wellness check...
and assist in navigating the patient to appropriate community resources to alleviate subsequent use of Paramedic Services or the emergency department. See Appendix B for High Users of Paramedic Services flowchart.

**Referrals from 911 Paramedic Services**
(Implement within first year of Program launch)

In this model, the Mobile Integrated Health Care Program will utilize the experience and training of the Region’s paramedics in order to identify patients that are using Paramedic Services who choose not to go to the emergency department, who do not seem to be connected to community agencies, and are not utilizing, or do not have, a primary care physician. Once identified, this group of patients may require additional community supports, which the Community Paramedic will help to coordinate through this program. The Mobile Integrated Health Care Program Designate will review the patient record and make contact via telephone if the inclusion criteria for enrolment are met. If the patient provides consent for the referral, they will be enrolled, and a follow up appointment will be made and carried out by the Community Paramedic. The Community Paramedic will perform a wellness check and assist in directing the patient to appropriate community resources in order to alleviate subsequent use of Paramedic Services or the emergency department. Where capacity allows, and in an effort to further optimize the overall Program, the Mobile Integrated Health Care Program Designate will review the Patient Call Report of any patient that refuses transport after calling 911 and potentially meets the inclusion criteria. See Appendix C for Referrals from 911 Paramedic Services flowchart.

**911 Transports to the Emergency Department that Leave Against Medical Advice (AMA)**
(Implement within first year of Program launch)

The hospital emergency department team will identify patients that meet the inclusion criteria for referral to the Mobile Integrated Health Care Program. The inclusion criteria is as follows:

- Arrival at the emergency department by 911 Paramedic Services
- Repeat user of the emergency department
- Flagged as a high risk to revisit the emergency department
- Leaves the emergency department AMA

When the patient meets the inclusion criteria, the hospital discharge team will refer the patient to the Mobile Integrated Health Care Program. The referral will be processed and the patient will be enrolled. The Community Paramedic will perform
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Region of Waterloo Paramedic Services

a wellness check and assist in navigating the patient to appropriate community resources to alleviate subsequent use of Paramedic Services or the emergency department. See Appendix D for High Users of the Emergency Department flowchart.

Phase 2

Specialized Geriatric Services Clinical Outreach Team  
(Future consideration)

The goal of this model is to support, when and where needed, the Specialized Geriatric Services (SGS) Clinical Outreach Teams in the home-based care of the aged population. This may include Remote Patient Monitoring/Telehomecare programming, wellness checks, and the performance of extended skills as defined by the program partners. The identified outcomes of this support model would include keeping these patients safe in their homes, while preventing exacerbations from chronic diseases.

The SGS Clinical Outreach Team will identify patients that meet the inclusion criteria for referral to the Mobile Integrated Health Care Program. The inclusion criteria is as follows:

- Any age chronic diseases (diabetes, hypertension, CHF, COPD)
- Flagged as high risk for disease exacerbation or other complications
- Vulnerable or homebound
- Flagged as high risk to revisit primary care physician or emergency department

When the patient meets the inclusion criteria, the SGS Clinical Outreach Team will refer the patient to the Mobile Integrated Health Care Program. The referral will be processed and the patient will be enrolled. The intent of the assessment visit will be to monitor the patient using Remote Patient Monitoring/Telehomecare, to perform wellness checks as requested by the SGS Team, and to assist the SGS in patient care as defined by the program. See Appendix E for Specialized Geriatric Services Clinical Outreach Team flowchart.
Phase 3

Shelter Referrals
(Future consideration)

The goal of this model is to support, when and where needed, the local shelter organizations in the mobile outreach-based care for this diverse population. The shelter resource team will identify patients that meet the inclusion criteria for referral to the Mobile Integrated Health Care Program. The inclusion criteria is as follows:

- Flagged as high risk to call Paramedic Services and/or visit the emergency department
- Unwilling or unable to utilize current community-based programs

When the patient meets the inclusion criteria, the shelter resource team will refer the patient to the Mobile Integrated Health Care Program. The referral will be processed and the patient will be enrolled. The intent of the assessment visit will be to perform a wellness check and to assist in navigating the patient to appropriate community resources to alleviate subsequent use of Paramedic Services or the emergency department. See Appendix F for Shelter Referrals flowchart.

Phase 4

Supportive Housing Referrals and Other Opportunities
(Future consideration)

The goal of this model is to support, when and where needed, residents of local supportive housing complexes using mobile outreach-based care. The supportive housing administrative team will identify patients that meet the inclusion criteria for referral to the Mobile Integrated Health Care Program. This phase may also include, or be adjusted to focus on, the needs of Indigenous or immigrant/refugee populations to ensure their access to health care. The inclusion criteria is as follows:

- Any age chronic diseases (diabetes, hypertension, CHF, COPD)
- Flagged as high risk for disease exacerbation or other complications
- Vulnerable or homebound
Mobile Integrated Health Care: Paramedic Arm
Region of Waterloo Paramedic Services

- Flagged as high risk to revisit primary care physician or emergency department

When the patient meets the inclusion criteria, the supportive housing administrative team or other outreach groups, will refer the patient to the Mobile Integrated Health Care Program. The referral will be processed and the patient will be enrolled. The intent of the assessment visit will be to perform a wellness check and to assist in directing the patient to appropriate community resources. If applicable, the Remote Patient Monitoring/Telehomecare program will be offered in order to reduce repeat visits to a primary care physician or the emergency department. See Appendix G for Supportive Housing Referrals flowchart.

**Next Steps**

The Region of Waterloo Mobile Integrated Health Care Program will launch each of these phases separately and in the order listed. An assessment of resources and population needs may change the timelines or revise the implementation of subsequent phases. As such, the implementation timeline is considered flexible and may change based on resources and capacity. Since this is an ambitious plan, prudent management might dictate that it is better to focus on the quality and impact of our mandate and grow steadily over time being cautious to not over promise and under deliver. Realizing that this particular proposal includes numerous phases for implementation, it is anticipated that Phase 1 in its entirety, will be our primary goal. Given that Paramedic Services is under the governance of Regional Council, members will be apprised of this new initiative upon confirmation of funding from the WWLHIN. This approach will be ongoing as Regional Council will continue to be updated with respect to the development of this program as required.

The success of each model within the program will be evaluated on a monthly basis in order to ensure patient safety and to maintain the ability to provide the needed supports intended with this program. The stepwise approach to model implementation will also allow the Community Paramedics to participate in educational support programs provided by system partners and/or other trainers. In addition, this approach will provide time to develop the technological supports required to ensure that documentation related to patients enrolled in the Mobile Integrated Health Care Program, is shared securely and appropriately amongst all providers. Finally, staging the implementation of the Mobile Integrated Health Care Program will afford the various stakeholders and partners the ability to clarify and adjust the roles and responsibilities and how they are subsequently shared amongst health care providers and community support groups.

The limited time parameter for the development of the Mobile Integrated Health Care Program has identified a number of gaps and opportunities present in the local
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Region of Waterloo Paramedic Services

health care system. As such, only the models and the order of implementation have been identified along with cursory model guidelines. After submission of this report to the WWLHIN, it is the intent of the Mobile Integrated Health Care Program Designate to continue with the development of formal agreements, mechanisms/processes, communication formats, and resource sharing between community partners.

**Cooperation and Partnerships**

The research and development phase for the Region’s Mobile Integrated Health Care Program has garnered enthusiastic support from community partners. Through ongoing dialogue, they have envisioned several and varied possibilities for the improved delivery of health care at the local level. In addition, as potential roles and intent of the Mobile Integrated Health Care Program have been shared, there has been an increased understanding amongst stakeholders, and many ideas for partnerships and unique programming have been generated (Appendix H).

The following excerpts from the Mobile Integrated Health Care Program Survey support these possibilities.

“at home care will decrease crisis admissions”
“beneficial for [emergency department] high users and [emergency department discharge] with high risk to return”
“improve patient experience – trust relationship”
“facilitate call to [primary care physician] for timely care”
“streamline individual to most responsive, timely appropriate and sustainable service”
“post [discharge] support and mental health and addictions”
“point of care testing = timely [medical] care”
“not tied to a particular service – can see bigger picture”
“[Community Paramedic Program] would add value to our team for complex geriatric population”
“value of ‘prevention’ programming”
“refugees and immigrants not attached to [primary care physician]”
“shelter and evening program – medical assist”
“ideally would be embedded into team-based primary care organizations as part of the team”
“acts as eyes and ears for people where they need care – enlarges the circle of care”
“can address access and accessibility to individuals at risk in the community (home bound seniors, [Mental Health] and Addictions)”
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Region of Waterloo Paramedic Services

“reduced [Emergency Department] visits in last 90 days of life/improved patient and caregiver experience”
“testing at home to prevent travel, [primary care physician] visit”
“those waiting for [Long Term Care] or assisted living”
“compares those in rural areas to seniors living independently in town – same barriers”
“valuable as an IN home team visa vis connection to [primary care physician], support [primary care physician] in assessment, treatment plan for homebound, socially isolated patients”
“community based residential addiction treatment could be monitored/supported by the [Community Paramedic Program]”
“helps manage patients that can’t easily be seen in the office”
“give [primary care physician] more insight into patient and their reaction”
“[Community Paramedic Program] adds value to your team by...improved P4R funding, reduced [Emergency Room] burnout, efficient use of limited resources (physical and human)”

While the Mobile Integrated Health Care Program models are in their infancy in terms of operational guidelines and performance measurements, the mandate of the Mobile Integrated Health Care Program is to help patients stay in their homes while receiving appropriate care by the most appropriate community or health care resource, and thereby avoid utilizing the acute care setting.

This will be accomplished by:

- Creating sub streams in each model in order to navigate the patient to the correct provider
- Collaborating with community partners to avoid duplication of services and the overlapping of roles
- Sharing information (with the patient’s permission) to others in the circle of care
- Ensuring the Community Paramedic is knowledgeable about the community services in our area
- Utilizing the Community Paramedic’s expertise, training, and abilities to complement community partners’ efforts in meeting the patient’s needs

In addition, it is hoped that relationships with primary care physicians, family health care teams, and community health centre professionals, as well as other outreach groups will develop and/or strengthen as a result of program implementation. As such, discussions with local physicians for Mobile Integrated Health Care Program medical oversight or Mobile Integrated Health Care Program tactical programs will be pursued.
Resource Sharing

Through engagement with many of the key stakeholders, the links needed to create these new models of patient care are already taking shape. It is evident that resource sharing between organizations is required in order to avoid redundancy in services and to share care plans and technological platforms. It is important to utilize educational resources for specific patient populations and to share data that will ultimately evaluate the success of the program.

Partner organizations may be approached for the following needs:

- WWLHIN (provide data and consultation)
- Home and Community Care WWLHIN (communicate client referrals, provide data, system navigation, consultation)
- Care Coordinator WWLHIN (communicate client referrals, provide data, system navigation, consultation)
- Region of Waterloo Public Health and Emergency Services, Epidemiology and Data Analytics (clinical research support and development, statistical analysis, education, consultation)
- Cambridge Memorial Hospital Emergency Department (communicate client referrals, patient screening, provide data)
- Grand River Hospital Emergency Department (communicate client referrals, patient screening, provide data)
- St. Mary’s General Hospital Emergency Department (communicate client referrals, patient screening, provide data)
- KW4 Health Links (leverage other programs, possible funding, patient data, technology platforms, consultation, medical oversight)
- Cambridge and North Dumfries Health Links (leverage other programs, possible funding, patient data, technology platforms, consultation, medical oversight)
- Centre for Family Medicine/Community Ward (education, consultation)
- Langs Community Health Centre (education, consultation)
- University of Waterloo, School of Public Health and Health Systems (clinical research support and development, statistical analysis, education, consultation)
- Wilfrid Laurier University, Health Studies (clinical research support and development, statistical analysis, education, consultation)
- Conestoga College, Health and Life Sciences and Community Services (education, consultation)
Sustainability

Upon evaluation of the one-year term of the Mobile Integrated Health Care Program for the Region of Waterloo, the Program Designate will consult the WWLHIN for guidance in accessing the financial resources needed to further develop and maintain the program. While partnerships add value to a health care system, Paramedic Services participating in such programs should not compromise the provision of core emergency response programs operated by the Region of Waterloo. As such, Paramedic Services resources utilized by the municipality to deliver emergency care should not be used to deliver Community Paramedic programs. Unless directed by Regional Council, funding models would also need to ensure 100% support through non-regional tax-levy sources, such as those specifically designated to provide health care services within the province of Ontario. There may be future opportunities where community paramedicine aligns with departmental or regional objectives, and where additional internal proposals or requests for funding are brought forward to regional council. External partnership funding is also a possibility where the objectives of the health system can be met through Community Paramedicine models.

It is important to recognize the factors that will impact the actual cost savings experienced as a result of adding a Mobile Integrated Health Care Program to the local health care system. The first concept is that savings should be realized at an overall systems level and be aligned with the WWLHIN's or regional visions rather than merely focusing on savings within specific organizations. Second, health care costs are rising exponentially and are associated with the changing population demographics along with health and social issues that are occurring nationwide. It is anticipated that the significance of adding an innovative Mobile Integrated Health Care Program will translate into added value for the overall local health and wellness strategy. For the purpose of sustainability, system savings should be reallocated to the Mobile Integrated Health Care Program, as well as, to other programs that may contribute to further savings. This will ultimately support and control the wellbeing of a growing population as it eases the subsequent cost to taxpayers.

Tracking and Monitoring Key Performance Metrics

In order to understand and evaluate the function and overall impact of the Mobile Integrated Health Care Program, procedures will be established to ensure the collection of data pertinent to the measurement of processes, services, and outcomes. This will include mechanisms for tracking key performance metrics that reflect the contributions towards improved patient outcomes and continued cost effectiveness relative to other available service options versus those resulting from Community Paramedic intervention.
Mechanisms for data collection and tracking that will be considered may include, but are not limited to:

- Community Paramedic Data Reporting Tool
- Emergency department electronic medical record or paper documentation
- Documentation platform used by primary care physicians
- Standardized and validated questionnaires/forms which may include:
  - Patient and Caregiver Satisfaction
  - Social Determinants of Living
  - Falls Risk Assessment
  - Frailty Assessment
  - PERIL Tool
  - Assessment and Urgency Algorithm
  - The InterRAI Assessment

In the first twelve months, the key performance metrics based on the relevant indicators that the WWLHIN provides to the Ministry of Health and Long Term Care will be tracked and reported. These would be specific to patients enrolled in the Mobile Integrated Health Care Program and may include:

- Reporting on the number of 30-day readmissions for those with chronic conditions to hospital
- Reporting on the number of avoidable emergency department visits for patients with conditions best managed elsewhere
- Reporting on unnecessary admissions to hospitals
- Reporting on repeat visits to the emergency department for mental health conditions
- Reporting on repeat visits to the emergency department for substance abuse conditions
- Reporting on the treating and admitting or discharging patients with chronic conditions within eight (8) hours
- Monitoring the health system experience for patients with the greatest health care needs

In addition, specific key performance metrics will be tracked and reported following Q4, as specified by the WWLHIN:

**Monthly**

- Enrolment rate of eligible patients
- Number of Community Paramedic visits per enrolled patient (reported as Mean and Standard Deviation)
  - Scheduled visits
    - Mean number of days between visits
  - Unscheduled visits

Document Number: 2630246
Mobile Integrated Health Care: Paramedic Arm
Region of Waterloo Paramedic Services

- Mean number of days between visits
  - Missed visits
    - Patient cancels or is not at home on arrival
- Any adverse events per enrolled patient

Six and 12 months

- Number of hours for Mobile Integrated Health Care Program staff to review, archive or follow up
- Data completion rates by Community Paramedic (data quality and timeliness)
- Number of primary health care visits per enrolled patient (reported as Mean and Standard Deviation)
- Number of Home and Community Care visits per enrolled patient (reported as Mean and Standard Deviation)
- Total calls to 911 for enrolled patients
- Total visits to the emergency department for enrolled patients
- Total number of hospital admissions for enrolled patients
  - 30-day readmissions for chronic conditions
- Length of hospital stay for enrolled patients
- Collect and collate patient surveys and case studies (qualitative analysis)
- Total numbers referred to Home and Community Care and other community services
- Number of patients not attached to a primary care physician
- Patient demographics (i.e., age, gender, etc.)
- Specific interventions provided per patient (reported as Mean and Standard Deviation)
- Number of community referrals (increased access to services)
- Number of Community Paramedic assessments of patients
- Length of time the patient is enrolled in the Mobile Integrated Health Care Program (reported as Mean and Standard Deviation)
- Financial indicators including program costs and mid-year forecast

Additional qualitative or quantitative measures will be collected and disseminated as directed by the WWLHIN for the purposes of meeting future needs and plans.

**Governance, Policy and Accountability**

**SCOPE of PRACTICE**

The Centre for Paramedic Education and Research (CPER) is the current legislated oversight for the Region of Waterloo Paramedic Services when providing care in an emergency setting. This group provides medical supervision through Scope of
Mobile Integrated Health Care: Paramedic Arm
Region of Waterloo Paramedic Services

Practice guidelines for paramedic practice (offline), and occasionally through direct phone consultations from a paramedic to an emergency physician (online). Due to the nature of the position, Community Paramedics will be required to maintain their certification since the possibility exists that they may encounter an emergency or a patient requiring acute care. If a Mobile Integrated Health Care Program patient requires care, which is outside of the Community Paramedic’s scope, the primary care physician will be consulted. That physician may direct the Community Paramedic to provide such care, only if such medical acts have previously been identified and agreed upon through partnership agreements. Securing medical oversight by a primary care physician will assist in the overall development of the Mobile Integrated Health Care Program in terms of policy and would support the decision-making capabilities of the Community Paramedic. As an adjunct, if partnerships develop and there is a request on behalf of a specific patient group (i.e., patients of Family Health Care Teams, Community Health Centres, individual physicians, palliative groups), for extended care to be provided by the Community Paramedic, additional medical support and oversight would be required in order to manage the program effectively. Working closely with the WWLHIN to establish in-kind medical oversight is part of this proposal.

Once a Community Paramedic is providing care an Action Plan will be developed and the Community Paramedic will assist in its administration. This action may consist of additional point of care testing, acquiring prescriptions, or other treatments that are within the paramedic’s scope of practice (i.e., IV initiation, medication initiation or assist, etc.). All relevant direction, procedures, plans and assessments will be documented in the Community Paramedic Data Reporting Tool as well as in the patient’s electronic medical report, or similar program.

At this point in time, the Community Paramedic’s scope of practice has yet to be defined; this may change with the opening of Bill 160 (Strengthening Quality and Accountability for Patients Act, 2017). The Mobile Integrated Health Care Program Designate, in partnership with the Chief of the Region of Waterloo Paramedic Services, will continue to monitor and evaluate the changes to the legislation for Program revisions and transitions. Specifically, deferrals away from hospitals and emergency departments, plus changes to scope of practice, will guide the needs for possible modifications to Community Paramedicine/Mobile Integrated Health Care Program governance, policy and accountability.

**PRIVACY**

All aspects of the Mobile Integrated Health Care Program will be Personal Health Information Protection Act (PHIPA) compliant. As patients are identified and enrolled in the Mobile Integrated Health Care Program, verbal consent, followed by written consent, will be obtained and kept on file for the required length of time as per PHIPA regulations. Furthermore, evaluation of the Mobile Integrated Health
Mobile Integrated Health Care: Paramedic Arm
Region of Waterloo Paramedic Services

Care Program on a clinical research level will require research ethics board approval from the Region of Waterloo and the investigating institution as required by the Public Health and Emergency Services Research Ethics Board.

**STAFFING and SEPARATION from 911 PARAMEDIC SERVICES**

This section of the proposal has been written to reflect a perfect scenario of resources. Depending on funding levels, the strategy will be altered to work within the means of the inaugural Program funds. Community Paramedic staffing hours will be dependent upon funding allocation. The Community Paramedic will conduct home visits solely related to the Mobile Integrated Health Care Program and, as such, will not overlap the Region of Waterloo Paramedic Services by responding to 911 calls. While on duty, the Community Paramedic will also not receive any emergency calls normally answered by paramedics. Furthermore, while on a home visit, the Community Paramedic may deem that a patient requires emergency transport to the hospital and may request 911 services. In addition, if a patient enrolled in the Mobile Integrated Health Care Program calls 911, normal paramedic response will occur, and this action will not affect their status in the Mobile Integrated Health Care Program.

**RECRUITMENT and TRAINING**

The selection and recruitment of up to two (2) paramedics and one (1) support person will occur through a competitive process upon approval of the program. Key qualifications will include experience, knowledge of the community, and communication proficiency that will facilitate relationship building with external providers. Although the process is still to be determined, the training options may include: classroom, online or distance learning from subject matter experts or academic personnel; the shadowing of clinicians; and peer-to-peer learning from experienced Community Paramedics. In addition, customized training should include the following:

- Patient assessment of chronic, non-acute care conditions
- Clinical governance, support and provision for clinical reporting
- Relationships/working with other health care providers
- Clinical referral pathways and available community resources
- Patient satisfaction/informed consent
- Documentation and contributing to the patient’s record
- Patient and paramedic safety including mental wellness

Education for initiating a Mobile Integrated Health Care Program referral, and how to identify appropriate patients who require additional care and resources will be delivered to all Region of Waterloo Paramedic Services paramedics over a period of

Document Number: 2630246
eight (8) weeks during the summer/fall training session. This will include information about the Mobile Integrated Health Care Program, delineation of the process, and will outline the various community partners providing services for the various population groups.

**Budget**

The initial and ongoing operational costs for a Mobile Integrated Health Care Program are presented below. It should be noted that, depending upon the actual amount of funding available, the budget might be adjusted accordingly. The expenditures outlined are based on a staffing model of 2.5 full time employees and is inclusive in terms of both the supervisory and coordination activities associated with the program.

**LHIN - Proposed Budget**

<table>
<thead>
<tr>
<th>Program Staffing</th>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 FTE Primary Care Community Paramedic inclusive of benefits (this position provides clinical assessment and care)</td>
<td>125,309</td>
</tr>
<tr>
<td>1 FTE Advanced Care Community Paramedic inclusive of benefits (this position provides clinical assessment and care)</td>
<td>138,513</td>
</tr>
<tr>
<td>0.25 FTE Program Coordinator Position shared with paramedic services to make .50 FTE (this position supports the program by coordinating patient assessments, referrals, contacting clients and other activities)</td>
<td>34,241</td>
</tr>
<tr>
<td><strong>Total Staffing</strong></td>
<td><strong>298,063</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technology</th>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cell phones X2 for Community Paramedics</td>
<td>1,466</td>
</tr>
<tr>
<td>Computer tablet X1 (additional) for in-field recordkeeping</td>
<td>2,300</td>
</tr>
<tr>
<td>Computer desktop/workstations</td>
<td>2,900</td>
</tr>
<tr>
<td>Computer licenses</td>
<td>6,000</td>
</tr>
<tr>
<td><strong>Total Technology</strong></td>
<td><strong>12,666</strong></td>
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</tbody>
</table>
Other Operational / Administrative Costs

<table>
<thead>
<tr>
<th>Itemized list</th>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data research activities</td>
<td>In-kind</td>
</tr>
<tr>
<td>Medical oversight by primary care physician</td>
<td>In-kind</td>
</tr>
<tr>
<td>Specialized medical supplies as required depending on scope of the program (to be supplied by system partners or LHIN). Example would include dressings, diagnostic tools etc.</td>
<td>In-kind</td>
</tr>
<tr>
<td>Fleet/fuel</td>
<td>5,200</td>
</tr>
<tr>
<td>Vehicle</td>
<td>8,892</td>
</tr>
<tr>
<td>Fleet maintenance</td>
<td>3,600</td>
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<tr>
<td>Training and conferences</td>
<td>6,000</td>
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<tr>
<td>Allocated administrative fee</td>
<td>16,721</td>
</tr>
<tr>
<td><strong>Total Other Operational Costs</strong></td>
<td><strong>40,413</strong></td>
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<tr>
<td><strong>Total LHIN</strong></td>
<td><strong>351,142</strong></td>
</tr>
</tbody>
</table>

Region of Waterloo In-Kind Budget

<table>
<thead>
<tr>
<th>Itemized list</th>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.25 FTE Program Coordinator position (see above)</td>
<td>34,241</td>
</tr>
<tr>
<td>Uniforms</td>
<td>400</td>
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<tr>
<td>Printing</td>
<td>500</td>
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<tr>
<td>Landline phone</td>
<td>300</td>
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<tr>
<td>Medical supplies</td>
<td>2,400</td>
</tr>
<tr>
<td>Annual paramedic certification training</td>
<td>1,000</td>
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<tr>
<td>Electronic medical records software</td>
<td>2,000</td>
</tr>
<tr>
<td>Defibrillator</td>
<td>36,000</td>
</tr>
<tr>
<td>Desk/office space</td>
<td>In-kind</td>
</tr>
<tr>
<td><strong>Total Region of Waterloo budget</strong></td>
<td><strong>76,841</strong></td>
</tr>
</tbody>
</table>

Core Team Members

The roles and functions core team members is as follows:

Chief, Region of Waterloo Paramedic Services

- Endorse and provide strategic direction for the Mobile Integrated Health Care Program
- Ensure the project is implemented in the community and is compliant with the project design
Mobile Integrated Health Care: Paramedic Arm
Region of Waterloo Paramedic Services

- Monitor the project and ensure the deliverables are met

**Deputy Chief, Region of Waterloo Paramedic Services**

- Provide project management for the Community Paramedicine proposal and operational program
- Act as a liaison between community partners and the program
- Ensure that all documentation and communication meets applicable standards
- Ensure completion of operational, financial, and quality reports according to established deadlines
- Responsible for reporting program progress to stakeholders including the Region of Waterloo Public Health, Regional Council, regional hospitals, Waterloo Wellington Local Health Integration Network, KW4 and Cambridge North Dumfries Health Links Committees, the Ministry of Health and Long Term Care
- Manage the financial resources associated with the program

**Supervisor/Coordinator (currently Community Paramedicine Research Lead)**

- Develop the appropriate workflows and policies for implementation of daily operations of the Community Paramedics
- Supervise, on a day to day basis, the Mobile Integrated Health Care Program
- Develop and implement the recruitment for the Mobile Integrated Health Care Program
- Assist with the development and training associated with the Mobile Integrated Health Care Program
- Determine the technology format that will be used for the Mobile Integrated Health Care Program
- Develop the Key Performance Metrics to determine the success of the program, and collect and interpret the data
- Conduct call reviews to ensure Community Paramedics are adhering to approved patient care guidelines and operational processes
- Ensure that patient documentation is completed in accordance with applicable standards
- Oversee and manage research possibilities and activities related to the Mobile Integrated Health Care Program
- Determine additional opportunities for program improvements and develop business plans in cooperation with community partners, as identified
- Manage patients in the program, including returning phone calls, and ensuring patient’s contact information is correct
- Facilitate and assist with communication between the community services and the patient

Document Number: 2630246
Community Paramedic

- Complete necessary equipment and vehicle checks
- Schedule required appointments with clients
- Attend appropriate non-scheduled appointments with patients, and reschedule other patients to accommodate
- Assess and treat patients by following the applicable patient stream and workflow
- Provide care to patients within their scope of practice, collaborating with the patient’s primary care physician for any additional care modalities
- Provide community health/social resource navigation consistent with information provided by our community partners
- Determine the most appropriate community resource to assist the patient with current needs and refer the patient to that service
- Provide documentation and with the patient’s permission, share the documentation with the appropriate resource(s)
- Record all visits, assessments, referrals, and care plans in the Community Paramedic Data Reporting Tool and appropriate electronic medical record
- Participate in training modules as required and assist in evaluating the efficacy and effectiveness of the training as it applies to the delivery model
- Assist in the overall program evaluation as key members of the team

Data Support

- Assist the Community Paramedicine Research Designate with the QA process by running reports, preparing statistics and relaying this information to the Chief, Deputy Chief and appropriate community partners
- Coordinate all data pools from community partners
- Provide monthly reports on high users of Paramedic Services

Research Candidate(s) – essential next step

- Perform clinical research and develop research questions
- Assist with statistical analysis
- Lead the writing of analytical reports for both publication and operational submissions
Reference List


Appendix A High Users of the Emergency Department

CRITERIA:
- HIGH USER of ED
- HIGH RISK to RETURN

START

ED Stats Run Every Month for High Users

Hospital

Does Patient Meet Criteria for Follow-Up?

NO

Pt. Care Co-ordinator

YES

Complete MHC Referral Form

Pt. Care Co-ordinator

Forward to MHC Designate

Pt. Care Co-ordinator

Stream A

Mobile Integrated Health Care Program ENROLLMENT

Stream B

Mobile Integrated Health Care Program INTAKE

Stream C

Mobile Integrated Health Care Program NAVIGATION

HIGH USERS of the EMERGENCY DEPARTMENT
Appendix C Referrals from 911 Paramedic Services

Mobile Integrated Health Care Program - MHC

START

911 PSW Arrives Scene

Paramedic:

END

Paramedic

Appropriate for Community Referral?

Paramedic

Transport to the Emergency Department

Paramedic

Patient Refuses Transport?

Patient

YES

Appropriate for Community Referral?

YES

Accepts Referral to MHC?

Patient

YES

Forward Patient Referral to MHC Designate

Paramedic

Stream A

Mobile Integrated Health Care Program ENROLMENT

Stream B

Mobile Integrated Health Care Program INTAKE

Stream C

Mobile Integrated Health Care Program NAVIGATION

REFERRALS from 911 PARAMEDIC SERVICES
Appendix D 911 Users that Leave the Emergency Department AMA

CRITERIA:
- Arrive at ED by 911 PSI
- Repeat User of ED
- High Risk to Return to ED
- Leaves AMA

Mobile Integrated Health Care Program = MIHC

START

Patient Arrives ED and is Registered

Patient Leaves AMA?

YES

Assess Pt. Needs for MIHC Involvement

NO

END

Patient

Follow Current Discharge Process

YES

Does Pt. Meet Criteria for MIHC Follow-Up?

NO

END

Hospital

Hospital

Hospital

YES

Consent for MIHC Follow-Up?

Hospital

Hospital

Hospital

END

Complete MIHC Referral Form

Forward to MIHC Designate

End

Is Patient Active in MIHC Database?

NO

YES

Mobile Integrated Health Care Program ENROLLMENT

Mobile Integrated Health Care Program INTAKE

Mobile Integrated Health Care Program NAVIGATION

911 USERS that LEAVE the EMERGENCY DEPARTMENT AMA
Appendix E Specialized Geriatric Services Clinical Outreach Team Referrals

**Criteria:**
- Any Age Chronic Disease (Diabetes, Hypertension, COPD, CHF)
- High Risk for Exacerbation or Other Complication
- Vulnerable
- Homebound
- High Risk to Revisit Physician or the ED

**Flowchart:**
- START
- Asses Current Patient Roster
- SGS / GEMS Team
- Does Patient Meet Criteria for MHHC Involvement?
- YES
  - Complete MHHC Referral Form
  - SGS / GEMS Team
  - Notify MHHC Designate
  - SGS / GEMS Team
- NO
- Consent for MHHC Follow Up?
  - YES
    - Stream A
    - Mobile Integrated Health Care Program ENROLLMENT
  - NO
    - Stream B
    - Mobile Integrated Health Care Program INTAKE
    - Stream C
    - Mobile Integrated Health Care Program NAVIGATION

**Specialized Geriatric Services Clinical Outreach Team Referrals**
Appendix F Shelter Referrals

**Critiera:**
- High Risk to call 911 PR or Visit the ED
- Unwilling or Unable to Utilize Current Community-Based Programs

```
START

Does Patient Meet Criteria for MIHC Involvement?

END

Consent for MIHC Follow-Up?

YES

Complete MIHC Referral Form

Shelter Staff

NOT

Notify MIHC Designate

Shelter Staff

Stream A

Mobile Integrated Health Care Program ENROLMENT

Stream B

Mobile Integrated Health Care Program INTAKE

Stream C

Mobile Integrated Health Care Program NAVIGATION

END
```

**Shelter Referrals**
Appendix G Supportive Housing Referrals

**Criteria:**
- High risk to call 911 PSV or visit the ED
- Unwilling or unable to utilize current community-based programs

 Starter:

- Mobile Integrated Health Care Program = MHC

Does Patient Meet Criteria for MHC Involvement?

End:

- No

Consent for MHC Follow-Up?

Complete MHC Referral Form

- Yes

Notify MHC Designate

Stream A

Mobile Integrated Health Care Program ENROLLMENT

Stream B

Mobile Integrated Health Care Program INTAKE

Stream C

Mobile Integrated Health Care Program NAVIGATION

Supportive Housing Referrals
Appendix H Stream A Enrolment Process
Appendix I Stream B Intake Process
Appendix J Stream C Navigation Process
Appendix K Community Partner Consultative List

A. Waterloo Wellington Local Health Integration Network (WWLHIN) - Sarah Farwell
B. Home Community Care (HCC) – Lee-Ann Murray
C. Health Links KW4 Committee
D. Community Ward – Jennifer Fillingham
E. Woolwich CHC – Denise Squire
F. The Working Centre – Jennifer Mains
G. House of Friendship & ROW Hostels – Pam McIntosh
H. Supportive Housing of Waterloo – Gael Gilbert
I. Ray of Hope – Jon Hill / Harry Whyte
J. Sanguen Health Centre – Colin McVicker
K. Grand River Hospital Emergency Department – Sara Gascho
L. St. Mary's Hospital Emergency Department – Lisa Pell
M. Cambridge Memorial Hospital Emergency Department – Humberto Laranjo
N. Nurse Led Outreach Team (NLOT) – Carrie Heer
O. Region of Waterloo (ROW) Seniors Programs – Connie Lacy
P. ROW Supportive Housing – Deb Schlichter
Q. ROW Immigration/Refugee Services – Dan Vandevelt / Tara Bedard
R. Health Links Cambridge & North Dumfries Committee
S. Langs CHC – Kerry-Lynn Wilkie
T. Langs Program educators - Anka Brozic
U. OneROOF – Sandy Dietrich-Bell
V. Palliative Care / Hospice Waterloo Region – Emmi Perkins / Judy Nairn