

Community Paramedic Post-Fall Rehab Care Pathway: GTA Rehab Network

Fall 2025



Healthcare Excellence Canada would like to formally acknowledge the GTA Rehab Network’s generosity in sharing their skills, knowledge, expertise and experiences to inform this promising practice.

About Healthcare Excellence Canada

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Enabling Aging in Place collaborative

The Enabling Aging in Place collaborative brought together health and social service organizations from across the healthcare continuum to implement promising practices that can delay people’s entry into long-term care. The collaborative aimed to improve safety, health and quality-of-life outcomes, while also reducing emergency department visits, lessening demands on care partners and making better use of health and social care resources.

Teams from communities across the country participated in the Enabling Aging in Place collaborative.

Community Paramedic Post-Fall Rehab Care Pathway

The Community Paramedic Post-Fall Rehab Care Pathway (PFP) was developed by the [Rehabilitative Care Alliance](#) (RCA), a provincial organization, following a comprehensive literature review and extensive input from subject matter experts and interest holders across Ontario, Canada and the United States. The initiative aims to reduce functional decline and prevent future falls for older adults by providing navigation to rehabilitative care.

Falls are a leading cause of injury and related hospitalizations amongst individuals over 65 years of age.¹ They often have serious impacts for older adults and can be a key reason why an individual is no longer able to age in place and must move into long-term care.¹

The PFP aims to reduce functional decline and prevent future falls for older adults who called 911 after falling, or reported a fall to paramedics, but were not transported to the hospital. Given that paramedics frequently respond to such incidents, they are well positioned in the patient journey to evaluate risks and support individuals who may benefit from rehab care referrals, resources or other programs to help prevent additional falls.

The PFP initiative is a collaboration between the GTA Rehab Network, Toronto Paramedic Services (TPS) and the North Western Toronto Ontario Health Team (NWT OHT).

Key Features

Objectives

The objectives of the PFP initiative for older adults include:

- preventing future falls
- reducing functional decline
- improving access to appropriate geriatric or specialized rehabilitative care services

Population served

The PFP is activated for individuals 55+ years of age in the NWT OHT area who called 911 for a lift-assist or have reported a fall to a community paramedic. A lift-assist “occurs when a person calls paramedic services and requests assistance to get up or mobilize, usually after experiencing a fall. The patient refuses transport to the emergency department for further medical attention.”²

Community paramedics provide service to clients regardless of whether they have provincial health coverage, ensuring that all clients over 55 years of age have access.

¹ Sinha S. Why Better Preventing Falls Will Be Key to Helping Us Age in Our Places of Choice. 2020.
² Schierholtz T, Carter D, Kane A, Kemp O, Gallant C, Sheikh B, Johnston W, Zecevic A. Impact of Lift

Assist Calls on Paramedic Services: A Descriptive Study. *Prehospital Emergency Care*, 23(2), 233–240. 2018.

Program team

The PFP is delivered by TPS Community Paramedics (CPs). Over 40 TPS CPs are supported by their superintendent, who provides oversight and has supported implementation, evaluation and sustainability of the PFP.

In preparation for PFP implementation, all Toronto CPs received a comprehensive geriatric orientation on senior-friendly care (through self-directed [e-learning modules from the Regional Geriatric Program of Toronto](#)) and education from the GTA Rehab Network on PFP standardized assessments.

Development and implementation of the PFP were supported by GTA Rehab Network project managers in partnership with NWT OHT system planners and service provider representatives from the community. As part of the development, an inventory of PFP geriatric and specialized rehabilitative care services was created, including referral guidelines and processes for these services. The inventory was validated with community and hospital service providers.

Rehab-related services are delivered by a multitude of existing community and hospital providers in NWT OHT.

Community Paramedic Post-Fall Rehab Care Pathway

The PFP initiative aims to prevent future falls and associated complications for older adults by supporting them to access an appropriate stream of rehab services after a fall.

Referrals

Potential clients are identified daily by community paramedics through review of 911 call data. Clients are then contacted by telephone to obtain consent for an in-home assessment by community paramedics.

Services

Community paramedics complete a multi-factorial assessment of the client in their home post-fall, using standardized PFP assessments. They aim to evaluate clients in their homes within 48 hours of the initial fall.

Based on the results of the assessments, as well as client needs, community paramedics then refer older adults to receive services from one of the three PFP streams:

1. community-based intervention
2. outpatient community clinic/in-home care/specialized geriatric services
3. direct access to inpatient rehab care

The PFP includes a filterable list of services available within the NWT OHT that allows community paramedics to quickly access potential service options based on the specific stream of services. Community paramedics can then refer the client to the appropriate services based on their functional level. Community paramedics consider client preferences and aim to problem-solve challenges and barriers to accessing services within the NWT community.

Stream 1: Community-based intervention

Older adults referred to the first stream:

- are not frail or medically complex (e.g. Clinical Frailty Scale (CFS) 1–3)

- have few fall risk factors
- are mostly independent with basic activities of daily living

In this stream, older adults are supported to learn more about preventative measures for falls and how to improve or maintain their strength and balance (e.g. referred to group exercise classes, fall prevention programs). Community paramedics may also identify other care needs through their assessments and make additional referrals (e.g. foot care).

Stream 2: Outpatient community clinic/in-home care/specialized geriatric services

Older adults referred to the second stream:

- are mildly to moderately frail (e.g. CFS 4–6)
- may have multiple fall risk factors
- may be medically or psychosocially complex
- are reasonably mobile

In this stream, older adults are referred to services to address risk factors (e.g. gait and balance, cognitive impairment, frailty, fracture and fall risks, level of function) identified during an evaluation by community paramedics. Service providers in this stream include hospital-based outpatient or in-home physiotherapy or occupational therapy services and specialized geriatric services.

Stream 3: Direct access to inpatient rehab care

Older adults referred to the third stream:

- are moderately to severely frail (e.g. CFS 6–7)
- may have multiple fall risk factors

- require nursing care that exceeds what can be provided in the community setting
- must be medically stable to participate in a rehab program

Following community paramedics' evaluation, older adults who have appropriate rehab goals that cannot be addressed in the community are referred directly to inpatient rehab care. The PFP for NWT OHT has two participating inpatient rehab programs.

Implementation context

The development and implementation of the PFP were led by the GTA Rehab Network, which provided project management support to an implementation team. They coordinated an implementation working group with contributing members from many healthcare and community-based organizations within the NWT OHT. Further, a half-day in-person service provider forum facilitated orientation to the PFP and focused on relationship building between the GTA Rehab Network, NWT OHT, TPS CPs and community service providers.

The PFP has moved into the sustainability stage in this health region, and leadership has been handed over from the GTA Rehab Network to the NWT OHT. The GTA Rehab Network is leading engagement with other Ontario Health Teams (OHTs) and regional paramedic services in the GTA for expansion of the PFP initiative into these health regions.

Outcomes³

Reducing avoidable emergency department visits

As part of the evaluation plan to monitor the effectiveness of the PFP, the post-visit emergency call rate was monitored for those who had received a community paramedic visit. Thirty-four out of 212 registered clients (16 percent) called 911 after a community paramedic visit.

A community paramedic focus group indicated that community paramedics felt the PFP is valuable in providing referrals to prevent falls. By proactively identifying community-dwelling older adults after a fall and linking them with appropriate rehab services, the program helps improve their function and mobility, reducing the chances that they will present in the emergency department because of another fall.

Improving access to services for older adults living in the community

Between July 2024 and September 2025, community paramedics provided 114 new referrals to older adults living in the NWT OHT region. These referrals provided information and access to services for older adults to help them prevent future falls.

“With early detection with dispatch data, we are capturing a population of patients who are not getting home services of any kind ... this has been quite valuable, many do not know these services exist.”

– Community paramedic

The significant impact of having access to services through the PFP was echoed by family care partners.

“We felt a sense of relief in that the community was finally stepping up to help seniors ... resources are limited ... and finally we were able to spend a little more time on ourselves because we knew that my dad was being cared for ... as a caregiver and healthcare worker I have to say it was an excellent program.”

– Care partner of client

Delaying entry to long-term care

Delaying entry to long-term care was also an important objective of the PFP initiative. One out of 212 registered clients was admitted to long-term care after a community paramedic assessment. PFP programs and services provide tools to improve function and overall health, enabling clients to age in place longer and delay potential entry into long-term care.

Further, 57 percent of clients surveyed rated their overall health as better after participating

³ The outcome and impact information shared reflects information available at the time of writing this promising practice. HEC would like to acknowledge that evaluation activities are an ongoing process for many promising practices, and

the type of data collected is influenced by program goals, the length of time the program has been implemented and the level of resources available to support evaluation.

in PFP programs and services. Referring clients early to appropriate programs and services is crucial to improving physical function, as well as addressing medical issues that can increase the risk of another fall.

Improving community paramedic referrals to services

Community paramedics provided feedback that the list of NWT OHT services and their descriptions was instrumental in identifying and filtering services based on client characteristics, enabling them to make the appropriate rehab referrals for older adults.

“It feels good when you can refer patients to somewhere that can improve quality of life.”

– Community paramedic

The evaluation also demonstrated that over the course of the pilot, community paramedics expanded their referrals to a broader range of services compared to their baseline practices. This included increased referrals to community-based rehab and fall prevention clinics.

Funding

Ongoing operations are funded through existing resources and supports from the Toronto Paramedic Services, NWT OHT and GTA Rehab Network.

Asset-Based Community Development Approach

Asset-Based Community Development (ABCD) is a strengths-based approach to solving challenges in communities that focuses on and develops the strengths of local assets (e.g. people, physical assets) that are key to ensuring a sustainable community.

The GTA Rehab Network team utilized an ABCD approach to develop an understanding of the local context and an inventory, or asset map, of services to support the PFP. The asset map extends beyond rehabilitative care to include services that facilitate access and address socioeconomic and other barriers to care – needs that were prevalent in the NWT OHT community. The team engaged in one-on-one meetings with community service providers to build their understanding of current programs and their eligibility criteria and challenges in service delivery. This also enabled them to build partnerships and trust and learn from each other about the services, values and mission/vision of programs.

As part of their asset mapping for the PFP, the team identified services accessible to older adults without a primary care provider, as well as options for those without health insurance (e.g. OHIP). These considerations were essential because many individuals in the catchment area lack access to primary care. Further, since community paramedics provide care regardless of health insurance status, ensuring referral options for unattached patients was a priority to support comprehensive service delivery.

The asset map is a critical component of the PFP that helps ensure older adults can receive access to services through the three streams. Priorities for this ongoing work include continuous updates to the asset map as well as continuing to engage community service providers to obtain feedback, discuss improvements to the PFP and identify gaps in the NWT OHT community.

Partnerships

The PFP is enabled by the many partnerships, including those that supported the pathway's development, many of which are also service providers that support older adults referred using the PFP. These include:

- Toronto Paramedic Services
- GTA Rehab Network
- Rehabilitative Care Alliance
- North Western Toronto Ontario Health Team
- Black Creek Community Health Centre
- Unison Health and Community Services
- Lumacare
- ESS Support Services
- Humber River Health
- LOFT Community Services
- University Health Network/West Park Healthcare Centre
- Runnymede Healthcare Centre
- Emery-Keelesdale Nurse-Practitioner Led Clinic
- Schulich Family Medicine Teaching Unit

This promising practice was co-produced with the GTA Rehab Network. Information was compiled in fall 2025. To reflect the changing and evolving nature of care, information may change. We encourage you to reach out to this team for any information that could help you as you work to improve care for those you serve.

How can I learn more?

Please send questions or inquiries to Charissa Levy, Executive Director, GTA Rehab Network

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