RCA Special Edition Newsletter

Post-Fall Pathways

April 2026

Rehabilitative Care Alliance

Strengthening Pathways to Post-Fall Rehabilitative Care

In this special edition newsletter, we're spotlighting work across Ontario to strengthen pathways to rehabilitative care for older adults with frailty who have experienced a fall. Falls remain a leading cause of injury and functional decline for this population, often triggering a cycle of emergency department visits, delayed recovery, and loss of independence.

In response, the Rehabilitative Care Alliance (RCA), in collaboration with partners across the system, has developed coordinated pathways to support timely, connected care. Across the province, regions are advancing this work in different ways and at different stages, reflecting both local context and a strong culture of innovation. Importantly, many of these efforts demonstrate that best practice care can be achieved without additional funding by better aligning existing resources. By sharing these examples, we aim to both highlight the breadth of RCA's work in this area and encourage interest and continued spread across regions.

Spanning emergency departments, primary care, and community paramedicine, these pathways enable early identification of risk, streamlined referrals, and more consistent connections to the right level of rehabilitation. Together, they reflect a shift toward proactive, function-focused care that helps prevent future falls and supports recovery at home and in the community where possible, while reducing unnecessary visits to emergency departments.

Implementation continues to grow across settings, with strong uptake in community paramedicine. Older adults who experience falls are often known to paramedics through lift assists, where individuals are helped to right themselves but decline transport to the emergency department, with these encounters typically documented only in the paramedic medical record.

The paramedic post-fall pathway helps close this gap by enabling earlier intervention, supporting rehabilitative care referrals, and strengthening communication with primary care. Sustained by the continued commitment of partners to innovation and collaboration, the RCA continues to encourage broader spread of all three pathways and looks forward to working with partners to further embed them across the province.

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NORTHERN ONTARIO

Advancing Post-Fall Pathways in Northern Ontario

Across Northern Ontario, partners are making meaningful progress in advancing pathways to post-fall rehabilitative care, with early leadership and continued momentum across multiple settings.

In Thunder Bay, all three pathways have been implemented, with the region recognized as an early adopter of the emergency department pathway. Efforts have also extended into the community, including rollout of the primary care pathway to Nurse-Led Outreach Teams working in retirement homes, supporting earlier identification of risk and more timely connections to care.

In the North, community paramedicine has also been a key area of innovation. Under the leadership of Jim Greenaway, Commander of Community Safety & Planning, Superior North EMS has embedded the paramedic pathway into its electronic medical record and is actively supporting team-wide education. Building on this foundation, this team is exploring implementation of the RCA's Rehab Access Pathway to enable even more proactive follow-up for individuals after an emergency department visit.

In Sault Ste. Marie, implementation efforts reinforced important service gaps, helping to inform increased investment in outpatient geriatric physiotherapy and occupational therapy. While full pathway rollout is still pending, these developments reflect important system progress.

> This work has enabled Community Paramedicine to better bridge lift assist patients to appropriate frailty rehabilitation through closer integration with the Rehab Care Alliance and system partners. By advancing a senior-friendly approach and strengthening our ability to assess geriatric syndromes and functional needs, we are seeing promising early outcomes and improving access to care earlier in the patient journey. Continued collaboration will be key to sustaining and expanding these gains.

Jim Greenaway, *Commander*
Community Safety & Planning, Superior North Emergency Medical Service

TORONTO AND GREATER TORONTO AREA

Driving Implementation in Toronto Through Regional Collaboration

In the Toronto region, progress on pathways to post-fall rehabilitative care has been strengthened by the unique role of the GTA Rehab Network. As the only region in Ontario with a dedicated rehabilitation network, the GTA is benefiting from coordinated leadership, regional alignment, and sustained support for implementation across care settings.

The North Western Toronto Ontario Health Team (NWT OHT) has advanced through all three Plan-Do-Study-Act (PDSA) cycles, enabling the Toronto Paramedic Services team to test, refine, and embed the pathway in real-world practice. This structured approach has supported continuous improvement and helped build confidence among clinical partners; in December 2025, leadership of the pathway transitioned to the NWT OHT. The GTA Rehab Network is continuing to support next steps, with a focus on spreading and scaling the pathway across other OHTs across the GTA.

Momentum is also growing beyond this initial implementation site. Three additional Ontario Health Teams have committed to adopting the community paramedicine pathway, with discussions underway with several others to support broader spread. Together, these efforts highlight the value of regional infrastructure in accelerating adoption, strengthening collaboration, and supporting more consistent access to rehabilitative care following a fall.

> 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 health care worker I have to say it was an excellent program.
>
> **Caregiver**

CENTRAL

Innovating Post-Fall Care in Ontario Health's Central Region

In Ontario Health Central, implementation of pathways to post-fall rehabilitative care is being shaped by strong partnerships and locally driven innovation.

Recognizing the challenges of serving a large and geographically dispersed population, the County of Simcoe Paramedic Services has introduced a hybrid paramedic model across the Simcoe County, where community paramedics respond to 911 calls and also provide community paramedicine home visits. In North Simcoe, these hybrid community paramedics also complete post-fall visits. This integrated role supports more timely follow-up after a fall.

Another key innovation has been the development of a lift assist dashboard, also designed to help close the gap between an initial paramedic response and access to community paramedicine services. By enabling paramedics in the field to identify where lift assists have occurred, the dashboard supports faster outreach and earlier intervention. County of Simcoe Paramedics partner with five Ontario Health Teams, and through a quality improvement process are developing a sustainable approach to pathway implementation and planning to scale up with their other partner OHTs.

Each of these approaches reflect a strong commitment to equity, collaboration, and practical solutions tailored to community needs.

> "Throughout the development and early implementation of the post-fall pathway in North Simcoe, our close collaboration with the North Simcoe OHT, local rehabilitation and seniors' care programs, and community support partners has helped us create more accessible and easier-to-navigate post-fall care. The pathway allows us to identify people's needs earlier, meet them where they are, and support our Hybrid CPs in delivering person-centred care that promotes independence and overall well-being."

McKenna Hill, *Community Paramedicine Patient Navigator*
County of Simcoe Paramedic Services

EAST

Building Momentum in Ontario Health East

In Ontario Health East, progress on pathways to post-fall rehabilitative care is being driven through strong community paramedicine leadership and growing regional collaboration.

The Eastern Ontario Association of Paramedic Chiefs' Community Paramedicine Group has created important opportunities to explore how the RCA's Paramedic Post-Fall Pathway can be implemented more broadly, with growing interest in advancing a coordinated approach across paramedic services in the region. The RCA has participated in recent quarterly meetings, supporting shared learning and early planning discussions focussed on building innovative, community-informed approaches that reflect local realities. Renfrew Paramedic Services and Cornwall SDG Paramedic Service have been the first in the region to move forward in collaboration with Ottawa Valley OHT and Great River OHT, respectively.

Collectively, these efforts signal strong regional momentum and a shared commitment to strengthening access to rehabilitative care for older adults with frailty who have experienced a fall.

> This work reflects what is possible when Community Paramedicine and other OHT partners come together around a shared goal. Our post-fall rehab pathway will ensure clear pathways for older adults after a fall, connecting them to the right supports and improving health outcomes.

Tracy Crowder, *Project Manager*
Great River OHT

WEST

Identifying Gaps and Driving Solutions in Ontario Health West

In Ontario Health West, early exploration of pathways to post-fall rehabilitative care has helped surface critical service gaps and catalyze local solutions.

At the Norfolk Family Health Team (FHT), initial pathway work highlighted a lack of access to outpatient geriatric rehab services in the region. In response, the FHT reallocated internal funding to hire a kinesiologist, creating new capacity to support individuals following a fall.

With support from the RCA, connections were made to provincial resources to inform the development of a fall prevention rehab program, delivered in partnership with community paramedics. Through this model, paramedics respond to lift assists and refer individuals directly to the program. The kinesiologist then conducts an in-home assessment and provides ongoing support, either individually or through an eight-week fall prevention group program, with referrals to additional services as needed. The Brant Brantford Norfolk OHT is learning from the Norfolk implementation and considering scaling up in the other communities within the OHT.

This integrated approach reflects how pathway implementation can not only improve coordination of care, but also uncover gaps and drive practical, community-based solutions to better support older adults.

> A patient recently said this program has improved her mobility considerably — and I've seen that firsthand. Objective measurements confirm faster movement, better balance, and greater independence. We're very pleased with the results.

Michele Kershaw, *R.Kin.*
Norfolk Family Health Team

Our Commitment

Across Ontario, these partnerships reflect the growing momentum behind more coordinated, proactive approaches to post-fall care. While implementation continues to evolve, the progress to date highlights what is possible through collaboration, shared learning, and a focus on improving outcomes for older adults. The RCA remains committed to supporting partners across the province to build on this work and continue advancing access to rehabilitative care following a fall.

Rehabilitative Care Alliance

Interested in learning more?

Please contact the RCA directly at rehabcarealliance@uhn.ca.