

2025-2026 ANNUAL REPORT



Centre for Prehospital Care

Health Sciences North

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Centre for Prehospital Care

Health Sciences North

INTRODUCTION

On behalf of the staff, including the Medical Directors and Advisors, of Health Sciences North's Centre for Prehospital Care (HSN CPC), we are pleased to present our Annual Report for the 2025–2026 fiscal year.

This report follows the template provided by the Emergency Health Regulatory and Accountability Branch and outlines how our organization has met the key performance indicators established in our Performance Agreement.

We are proud to report another productive and successful year. Key achievements during this reporting period include:

- Certification of 133 new paramedics
- Provision of medical advice and online medical direction during 665 patch calls
- Processing of 122,828 Ambulance Call Reports (ACRs) through our clinical filter identification system between April 1, 2025, and March 31, 2026
- 48,102* ACRs matched clinical filters and were electronically audited
- 5,103* cases were flagged for further review by a clinical auditor

*Does not include Elite data from January 1-March 31, 2026

We continue to experience challenges related to accessing and importing vendor data from Prehos into IQEMS. This issue impacts 3 of our 9 services, representing more than 33,000 calls. Ongoing data integration limitations have affected reporting timelines and the overall functionality of the centralized system.

We would like to acknowledge the exceptional work and dedication of our staff. As we move forward, we remain committed to exploring innovative approaches to service delivery while continuing to meet—and in some cases exceed—the expectations outlined in our Performance Agreement.

DR. JASON PRPIC
REGIONAL MEDICAL DIRECTOR

COREY PETRIE
INTERIM REGIONAL MANAGER

Our Purpose

To provide high-quality health services, support learning, and generate research that improves health outcomes for the people of **Northeastern Ontario**.

Our Commitments

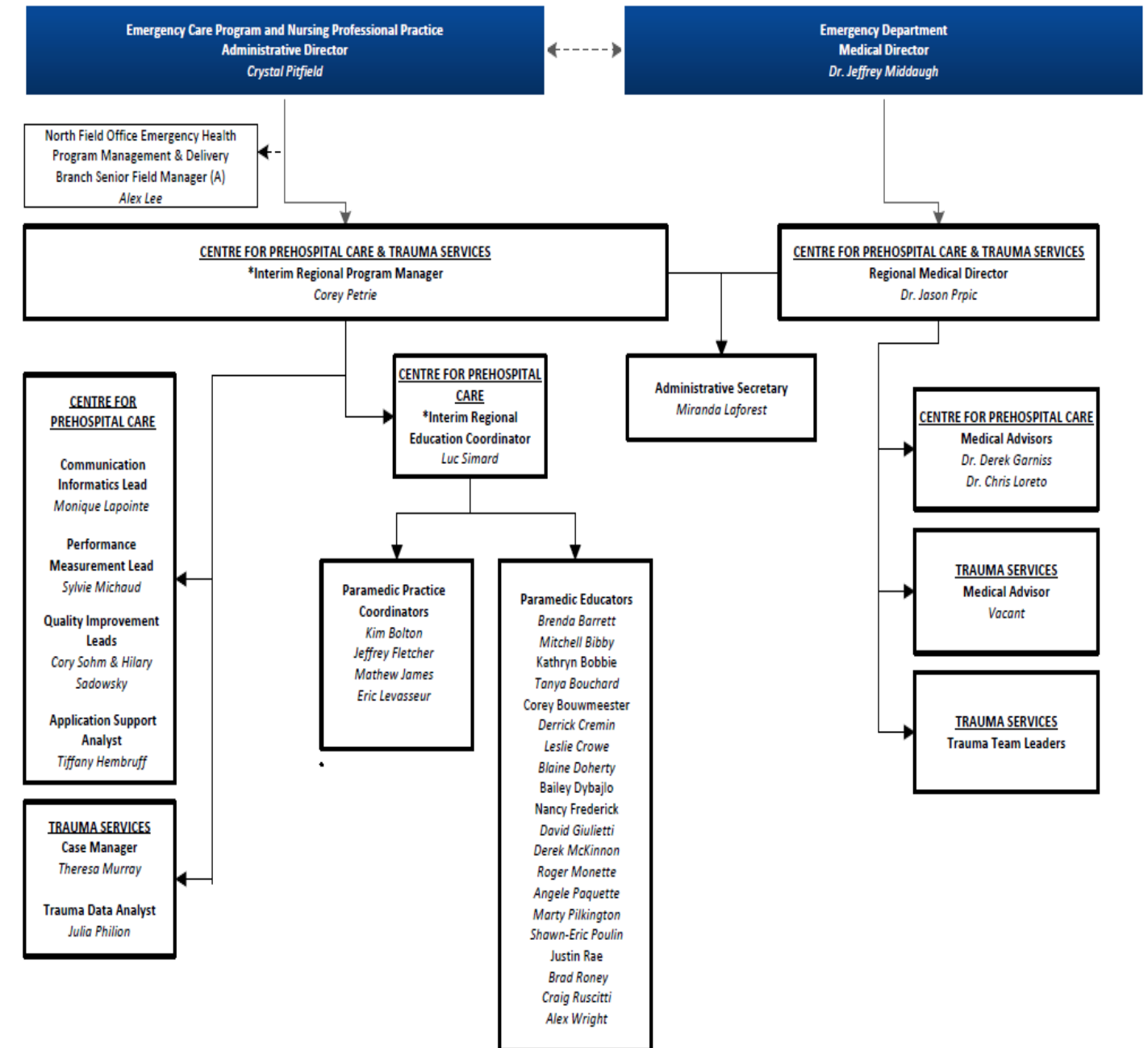
-  We show positive regard for each person's strengths, qualities, and values.
-  We partner with humility, valuing the strengths and ideas of individuals and communities to deliver the best care, education, and research solutions.
-  We provide a physically, psychologically, and culturally safe environment that fosters positive care, working, and learning experiences.

Our Values

Respect	Quality	Transparency	Accountability	Compassion
				
We show positive regard for each person's strengths, qualities, and values.	We provide patient- and family-centered services that are safe, reliable, accessible, efficient, effective, and equitable.	We share information in a timely and truthful manner, within the limits of law and policy.	We take personal responsibility for our actions, behaviours, and decisions.	We respond to the needs of others with kindness and empathy.



Organization Chart





Corey Petrie



INTERIM
REGIONAL MANAGER

Dr. Jason Prpic



REGIONAL
MEDICAL DIRECTOR

Miranda Laforest



ADMINISTRATIVE
SECRETARY

Dr. Derek Garniss



MEDICAL ADVISOR

Dr. Chris Loreto



MEDICAL ADVISOR

Tiffany Hembruff



APPLICATION SUPPORT
ASSOCIATE

Sylvie Michaud



PERFORMANCE
MEASUREMENT LEAD

Eric Levasseur



PARAMEDIC
PRACTICE COORDINATOR

Mathew James



PARAMEDIC
PRACTICE COORDINATOR

Hilary Sadowsky



QUALITY IMPROVEMENT
LEAD

Cory Sohm



QUALITY IMPROVEMENT
LEAD

Jeff Fletcher



PARAMEDIC
PRACTICE COORDINATOR

Kim Bolton



PARAMEDIC
PRACTICE COORDINATOR

Luc Simard



INTERIM REGIONAL
EDUCATION & CERTIFICATION
COORDINATOR

Monique Lapointe



COMMUNICATIONS &
INFORMATICS LEAD

Paramedic Educators

- | | | | | |
|-------------------|---------------------|-------------------|------------------|---------------------|
| • Alex Wright | • Blaine Doherty | • Craig Ruscitti | • Justin Rae | • Nancy Frederick |
| • Angele Paquette | • Brad Roney | • Leslie Crowe | • Kathryn Bobbie | • Marty Pilkington |
| • Bailey Dybajlo | • Brenda Barrett | • David Giulietti | • Derek McKinnon | • Shawn-Eric Poulin |
| • Mitchell Bibby | • Corey Bouwmeester | • Derrick Cremin | • Roger Monette | • Tanya Bouchard |

Airway Simulation Day: Every Breath Counts - Advancing Respiratory Care Through Innovation

On March 9, 2026, the HSN Centre for Prehospital Care (CPC) delivered an Elective Continuing Medical Education (CME) event focused on airway management and high-acuity respiratory care. *Airway Simulation Day: Every Breath Counts* brought together paramedics from across Northeastern Ontario for an immersive, simulation-based learning experience.

Facilitated by Paramedic Practice Coordinator Mathew James (ACP) in collaboration with Regional Critical Care Educator Danny Raghunandan (RRT), the session emphasized strengthening airway fundamentals while advancing clinical decision-making under pressure. Participants engaged in realistic, scenario-based simulations targeting oxygenation strategies, ventilation techniques, and dynamic patient assessment, with integrated respiratory therapy perspectives enhancing interprofessional learning.

The session was delivered using a hybrid model, with live facilitation from the Sudbury CPC site and simultaneous participation from North Bay, Timmins, and Sault Ste. Marie. This approach ensured consistent educational delivery across the region while maintaining hands-on, site-based simulation and coaching led by local PPCs.

Feedback from participants and faculty was overwhelmingly positive, highlighting the value of collaborative teaching, high-fidelity simulation, and real-time clinical application. The session also reinforced HSN CPC's commitment to innovative, accessible education that aligns with evolving clinical standards and supports improved patient outcomes.

This event represents a continued shift toward integrated, simulation-driven CME that is responsive to both frontline needs and regional system priorities.



Research and Simulation Initiatives

HSN CPC engaged in a collaborative research initiative with Dr. Nick Fortino, exploring the effectiveness of prehospital simulation in optimizing care transitions during cardiac arrest management.

As part of this initiative, paramedics from across the north east region participated in high-acuity, simulation-based scenarios conducted within the HSN Simulation Lab. These sessions fostered strong interdisciplinary collaboration, bringing together Emergency Department physicians, nursing professionals, and respiratory therapists from Health Sciences North.

This work highlights HSN CPC's ongoing commitment to integrating research, simulation, and education to enhance patient outcomes and system-level performance



Honouring Excellence in Prehospital Care: HSN Team members recognized for decades of service

HSN is proud to celebrate two members of our Centre for Prehospital Care (CPC) team who were recognized in Toronto on November 19 for their exceptional, decades-long commitment to prehospital patient care. These medals are part of the Governor General's Emergency Medical Services Exemplary Service Medal program, honouring paramedics who have demonstrated outstanding professionalism, dedication, and service in roles involving significant responsibility and risk.

At this special ceremony hosted by the Ontario Association of Paramedic Chiefs, the following awards were presented to our very own:

- Sylvie Michaud, received her second bar in recognition of 40 years of service. Sylvie served for many years as both a land and flight paramedic.
- Corey Petrie received his first bar in recognition of 30 years of service. Corey continues as a front line paramedic.

Congratulations Sylvie and Corey for this well-deserved recognition, and for their exceptional contributions to patient care and paramedic excellence across the Northeast.



Staff Recognition

Miranda Laforest, Administrative Secretary, was recognized for her contributions to the Centre for Prehospital Care with the presentation of her 5-year service pin. She is pictured with Interim Regional Manager Corey Petrie. In addition to her administrative role, Miranda has been filling in admirably during a vacancy in the Application Support Associate position. Her dedication, flexibility, and commitment have made a meaningful impact on the program. Congratulations Miranda! You are a highly valued member of the CPC family.

COLLABORATION

OBHG Education SubCommittees

Annual Curriculum Working Group

The Health Sciences North Centre for Prehospital Care (HSN CPC) continues to support evidence-informed curriculum development for over 9,000 paramedics across Ontario. Through participation in the OBHG Annual Curriculum Working Group, HSN CPC contributed to the 2026 education cycle, with a focus on cardiovascular and respiratory emergencies. This work promotes provincial consistency and alignment with evolving best practices.

Autonomous IV Working Group

In 2025, HSN CPC contributed to the advancement and standardization of Autonomous IV (AIV) education. A full content review ensured alignment with current clinical standards, and updated materials were distributed provincially. HSN CPC supported refinements to eLearning content and contributed to the revision of Scenario 14 (Tranexamic Acid), achieving consensus through physician and working group collaboration. The updated scenario has been implemented across Base Hospitals.

PCP OSCE Scenario Development

HSN CPC played a key role in developing PCP OSCE scenarios through leadership at the 2025 AGM. In collaboration with Base Hospitals, five new scenarios and one revision were created, aligned with ALS PCS v5.4 and focused on assessment, communication, and medical directives. HSN CPC also supported standardization of naming, version control, and distribution. All scenarios, including an updated postpartum hemorrhage case, have been implemented provincially.

Certification Standards Working Group

CPC collaborated with provincial Base Hospital Programs in the development and implementation of a standardized GRS Rater Training presentation. This work supports a consistent approach to training new faculty across programs, enhancing rater preparedness, reliability, and confidence in evaluating candidate performance. By promoting standardized expectations and evaluation practices, this initiative strengthens the quality and consistency of certification events across Ontario.

Controlled Substance Working Group

HSN CPC continues to support the PCP Controlled Substances Working Group through ongoing leadership and collaboration. Building on foundational contributions, HSN CPC has helped advance curriculum development, including online and in-person components, while improving structure, reporting, and consistency across Base Hospitals. This work supports a coordinated provincial approach to safe, standardized controlled substances education.



Mandatory Continuing Medical Education (CME) Highlights

The Centre for Prehospital Care's Mandatory Continuing Medical Education (CME) program continues to reflect its commitment to maintaining high standards in prehospital medical practice. This year's education events focused on reinforcing clinical excellence through a blended learning model, combining online theory with in-person application, while aligning with Ontario Base Hospital Group priorities and evolving ALS Patient Care Standards (ALS PCS).

The Centre for Prehospital Care's educational mandate remains focused on the standardization and delivery of practical skills required for the certification and delegation of controlled acts, as defined in the ALS PCS. The 2025–2026 program further advanced a data-informed approach, incorporating quality improvement findings and frontline feedback to ensure education remains relevant and impactful.

The 2025–2026 mandatory education events focused on the continued application and refinement of core directives and high-risk, low-frequency skills. Some of the education highlights included:

Traumatic Hemorrhage – Tranexamic Acid (TXA):

Paramedics reviewed the pathophysiology of hemorrhagic shock and the role of TXA in reducing mortality. Emphasis was placed on early recognition, indications, contraindications, and integration into trauma management.

Emergency Childbirth (ECB) & Newborn Resuscitation:

Paramedics reviewed the physiological processes of labour and delivery, including recognition of complications and appropriate management strategies. Newborn resuscitation principles were reinforced to support both routine and high-acuity neonatal care.

Defibrillation Strategies – DSED & Vector Change (VCD):

Paramedics reinforced high-performance resuscitation practices, including defibrillation strategies for refractory ventricular rhythms. Education emphasized appropriate application of Vector Change (VC) and Double Sequential External Defibrillation (DSED), aligned with current evidence and service authorization.

Medication Administration Cross Check (MACC):

Medication safety remained a key focus, with paramedics reviewing structured cross-check processes to reduce error and improve patient safety. Emphasis was placed on communication, verification strategies, and real-world application in high-stress environments.

Cardiovascular and Respiratory Emergencies:

Seasonal education themes supported paramedics in managing high-acuity presentations, including ischemia, cardiogenic shock, and respiratory distress. Sessions reinforced clinical assessment, decision-making, and alignment with ALS PCS directives.

Quality Improvement & Documentation:

Education sessions incorporated system-level improvement opportunities, reinforcing accurate documentation practices and aligning clinical care with quality assurance findings. This approach supports continuous improvement and ensures that paramedic care is both measurable and defensible.

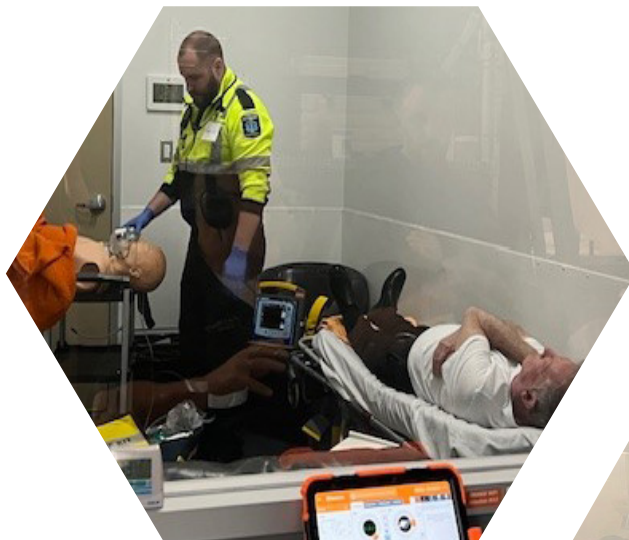
The 2025–2026 program was delivered through a structured, blended format requiring completion of online modules prior to in-person attendance. In-person sessions emphasized case-based learning, simulation, and hands-on skill development, delivered in small group settings to optimize engagement and facilitator support.

The CME program continues to evolve toward a more integrated and standardized model across the region, ensuring consistent delivery while allowing for service-specific training needs. This approach supports paramedics in maintaining competence, adapting to system changes, and delivering safe, evidence-based care to the communities they serve.

2025-2026 Certification Highlights

During the 2025–26 fiscal year, the Centre for Prehospital Care (CPC) at HSN successfully delivered 22 certification events supporting new Primary Care Paramedics (PCPs) and Advanced Care Paramedics (ACPs) across the Base Hospital region. These events also supported work-force mobility and professional continuity, with three paramedics completing certification as part of their reactivation process and seven participants joining from other Base Hospitals across Ontario. CPC's certification model is grounded in evidence-based assessment practices, utilizing Objective Structured Clinical Examination (OSCE) methodology and the Global Rating Scale (GRS) to ensure a standardized, comprehensive evaluation of clinical competence at entry-to-practice.

In addition, CPC continues to support academic partners by offering certification-style assessment opportunities for paramedic students. These academic certification experiences allow students to test their knowledge, clinical reasoning, and practical skills in a structured, high-fidelity environment prior to beginning their preceptorship. This early exposure to certification standards helps bridge the transition from classroom learning to clinical practice, enhancing student confidence and readiness for real-world patient care.



The 2025 Ontario Base Hospital Group Annual General Meeting (OBHG AGM) was hosted by Sunnybrook Base Hospital in the fall of 2025 at Horseshoe Valley Resort.

The AGM featured sessions were divided into three themes:

1. Making Connections: Pregnancy and Infant Loss, and Trauma Informed Investigations
2. Innovations in Education: AI in education and AI tools for paramedics as well as Podcasting and Paramedicine
3. Improving Foundations: Whole Blood's Journey in Prehospital Care, Cardiac Arrest, and Paramedic Service Partnerships

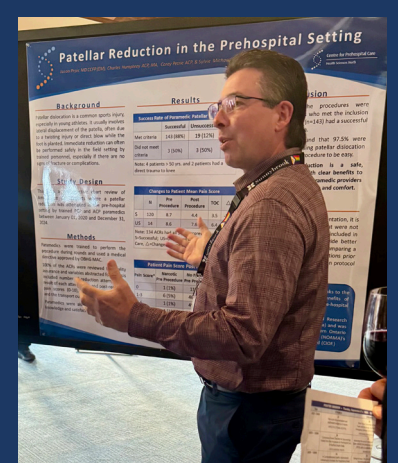
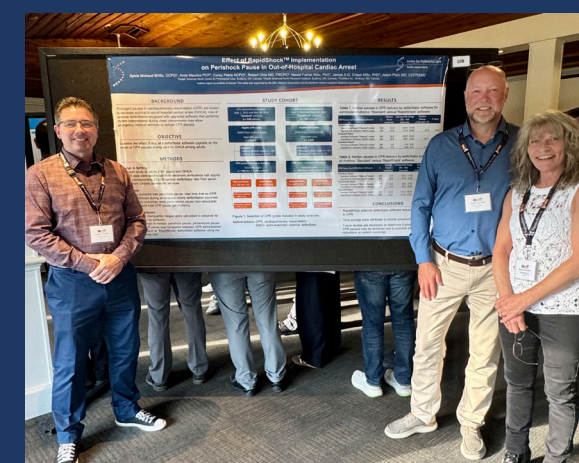
On behalf of the Ontario Base Hospital Group, Martin Pilkington, Corey Petrie, and Eric Levasseur were recognized and sincerely thanked for their years of exemplary service, dedication, and commitment to the Ontario Base Hospital System. Their contributions have had a lasting impact on prehospital care, as well as on the many professionals and communities they have supported throughout their distinguished careers.

Martin "Marty" Pilkington was honoured for 25 years of service, while Corey Petrie and Eric Levasseur were each recognized for 15 years of dedicated service.

Dr. Jason Prpic and Corey Petrie presented the following two research projects:

- Effect of RapidShock Implementation on Perishock Pause in Out-of-Hospital Cardiac Arrest
- Patellar Reduction in the Prehospital Setting

Notably, the lateral patellar dislocation research directly contributed to the development of a provincial medical directive, now utilized by Ontario paramedics, underscoring its significant impact on patient care and clinical practice.





The OBHG Annual General Meeting is more than a forum for updates—it's a vital opportunity to strengthen the connections that drive our shared mission forward. Networking at the AGM brings together diverse perspectives, fosters collaboration, and opens the door to new partnerships that can amplify our collective impact. Through intentional team-building, we reinforce trust, align our goals, and build the relationships that make our work more effective and resilient. By investing in these connections, we ensure that OBHG continues to grow as a cohesive, innovative, and supportive community.

Recognizing Combined 73 years of Service

We would like to recognize the recent retirements of several dedicated paramedics. After a combined 73 years of service, Nipissing District Paramedics Pierre Legault and Marilynne Herard have retired. Pierre and Marilynne have devoted themselves to serving the residents of West Nipissing.

Also retiring later this month are long-time Timiskaming Paramedics Dan Lemay and Holly Packard. Dan has been serving his community since 2005, and Holly since 2007.

Congratulations. We wish you all the best in this exciting next chapter of your journey.



Recognizing Paramedics who Exemplify Leadership

During Paramedic Week 2025, CPC proudly recognized paramedics who exemplify leadership through compassion, clinical expertise, and integrity in their work. These individuals were selected for their outstanding care of patients and families, their positive contributions to team culture, their commitment to ongoing professional growth, and their excellence in high-pressure clinical environments.

The following paramedics were nominated for this recognition:

Martin Fournier
Travis McLeod
Michel Lemyre
Bryce Britton
Jenny Papineau
Darren Rowntree
Chris Bentley

Andrew Pugliese
Makayla Nowee
Kristin Furino
Trevor Gilchrist
Justina Hric
Stephen Douglas
Gregor Thimmig

Samantha McLean
Nicky Bernard
Jordan Raciborski
Mark Pearce
Wesley Custodio
Sophie Mackewn
Jordan Ragogna

Justin Berthiaume
Marissa Dumont
Sandy James Norris
Matthew Van Horne
Josh Sloan
Pauline Reuben

"Compassionate,
and truly listens"

"Positive, supportive, and
always ready to help."

"Calm and exceptional
under pressure."

"A mentor who inspires
the next generation."

"Creates a respectful,
supportive environment."

"Goes above and beyond
for patients and team."

"Committed to learning and excellence."

RESEARCH

CanROC

The CanROC Cardiac Arrest Registry collects data on cardiac arrest events, including patient demographics, bystander interventions (such as CPR or defibrillator use), emergency response times, treatments provided by emergency medical responders (including drug therapy and CPR quality), and patient outcomes. By analyzing this data CanROC is able to look for trends, best practices, and guide future protocol development, all of which can help increase survival. Additionally, participating services have access to this data to determine areas that can be improved locally to help give patients the best chance at surviving cardiac arrest. Data collection is currently ongoing at three Canadian sites representing a population of approximately 15 million people in the provinces of Ontario and British Columbia. In 2025, approximately 86 patients from the Greater Sudbury Paramedic region were included in the Registry.

Pediatric Out-of-Hospital Cardiac Arrest Resuscitation: Evaluation of IM Epinephrine (The PRIME Trial)

Pediatric out-of-hospital cardiac arrest (POHCA) is a life-threatening event associated with extremely poor outcomes. Survival rates of POHCA have been reported at 10.2%. Many children who survive have a significant new neurological impairment. The PRIME Trial evaluates the effectiveness of epinephrine administration via intramuscular (IM) injection in improving POHCA outcomes when provided as part of prehospital emergency care.

In this study, all pediatric patients who are confirmed to have experienced a cardiac arrest, are ≥ 24 hours of age and <18 years old, and have not experienced an obvious traumatic event will be eligible for study inclusion.

This is a province-wide study with 19 paramedic services participating from five different Base Hospital regions.

As of the Fall of 2025, Paramedics in the Sault Ste Marie Paramedic Service are able to provide immediate, on-scene management by administering early epinephrine via intramuscular injection. This is a new study protocol for Primary Care Paramedics.

Dual Evaluation Objective Structured Clinical Evaluation (OSCE)

In 2025, HSN CPC supported and participated in Phase 1 of the Dual Evaluation OSCE research project, led by Sunnybrook Base Hospital. Traditionally, paramedics work in teams of two, with one paramedic acting as the “attending” (lead) and the other serving as the partner. During formative paramedic education, service recruitment, and Base Hospital certification processes, assessment has historically focused on the competencies and performance of the attending paramedic. This research aims to identify and define the competencies and behaviours of the partner paramedic and develop an assessment tool for evaluating these competencies as apart of an entry-to-practice certification OSCE. Phase 1 consisted of a focus group involving up to 10 submit matter experts who reviewed and defined key partner competencies and behaviours. Phase 2 is anticipated to occur in 2026 and will build on the findings of the initial phase.

MEDICAL DELEGATION

Q1 The Host Hospital shall ensure that Emergency Medical Attendants and Paramedics are qualified to perform the Controlled Acts and/or other medical procedures as recommended by the Provincial Medical Advisory Committee (PMAC) and the Director. Describe the process.

The HSN CPC is mandated by the Ambulance Act (Ontario Reg. 257/00) to ensure that paramedics are competent to practice. The method by which paramedics are certified is strongly influenced by the Delegation of Controlled Acts policy developed by the College of Physicians and Surgeons of Ontario. In short, it is the responsibility of the Regional Base Hospital Programs to provide an ongoing process by which the “Providers” are continuously informed of best practice guidelines and new trends and are competent to practice in the prehospital environment. As no single process can accomplish these goals, the HSN CPC combines various methodologies and techniques to be utilized as part of a comprehensive continuing medical education program (CME). The goal of the CME program is to prepare paramedics to respond appropriately to a wide range of patient situations, both routinely and infrequently, encountered in the field. Paramedics who do not meet the requirements as laid out in the Certification Standard may be subject to a skills review by the Medical Director or delegate. In rare cases, a Paramedic may have their certification temporarily suspended until such a time that all mandatory CME credit hours are accumulated. Paramedic Services present paramedics who have, at a minimum, an offer of employment at the requested paramedic level to the Base Hospital for certification. Primary Care Paramedics (PCP) complete an orientation process to ensure that they are properly prepared for the evaluation process. They demonstrate competency through a process of scenarios and written questions mapped to their respective scope of practice. During the certification event, they are required to demonstrate competency through a series of scenarios, skills stations and oral questions. In addition to the requirements of a PCP, all Advanced Care Paramedic (ACP) candidates are required to have written the Ministry of Health Advanced Care Paramedic (MOH ACP) exam prior to attending.

Q2 The Host Hospital shall ensure that the Base Hospital Program establishes and maintains a procedure whereby Paramedics already certified under the authority of another Base Hospital Program Medical Director are recognized by the Base Hospital Program.

2.1 Describe the procedure used to ensure paramedics already certified under the authority of another Base Hospital Program Medical Director are recognized by the Base Hospital Program.

Cross Certification applies to paramedics already certified by an Ontario Base Hospital who are seeking certification from another Base Hospital. Once the paramedic is deemed eligible for cross-certification, the Paramedic must complete the Certification Request Form which includes:

- Certification from any Ontario Base Hospital that has occurred within a 10-year period immediately preceding the application
- A declaration of any previous deactivations and/or decertifications that has occurred within the 10-year period immediately preceding the application.
- Current certification status from all Base Hospitals under which the paramedic is certified.
- Permission for the prospective Base Hospital to obtain information from other Base Hospitals regarding the paramedic's previous practice.

The paramedic must successfully complete an evaluation by the Base Hospital and any orientation and training required by the Base Hospital. The evaluation may include:

- An assessment of knowledge and skills;
- Scenario evaluation; and,
- Oral interview or clinical evaluation with the Medical Director

Upon meeting the above requirements for Cross Certification, the Medical Director shall certify the Paramedic.

2.2 Total number of paramedics that work for more than one employer.

As of March 31, 2026, HSN Centre for Prehospital Care had 30 paramedics who worked for more than one employer.

Q3 Provide a list of affiliated Ambulance Services with whom the Base Hospital has signed agreements.

- Algoma District Paramedic Services
- Greater Sudbury Paramedic Services
- Cochrane District Paramedic Services
- District of Sault Ste. Marie Paramedic Services
- District of Nipissing Paramedic Services
- Manitoulin-Sudbury DSB Paramedic Services
- Parry Sound District Emergency Medical Services
- Timiskaming District Emergency Medical Services
- Weeneebayko Area Health Authority Paramedic Services

3.1/3.2 Total number of ACPs and PCPs for this reporting year.

The data below is reflective of the date of data extraction: April 15, 2026. Numbers represent positions (one paramedic may work for two or more services and be represented as such in the data below)

REPORTING PERIOD	TOTAL ACP	TOTAL PCP	TOTAL #
April 1, 2025 to March 31, 2026	100	890	990

*This section includes multi-service medics (i.e. a single medic who works in Service A and Service B would be counted twice).

SERVICE	TOTAL ACP	TOTAL PCP	TOTAL #
ALGOMA DISTRICT PS		91	91
COCHRANE DISTRICT PS		98	98
GREATER SUDBURY PS	68	148	216
MANITOULIN-SUDBURY DSB PS	5	140	145
NIPISSING DISTRICT PS	27	87	114
PARRY SOUND DISTRICT EMS		95	95
SAULT STE. MARIE DISTRICT PS		99	99
TIMISKAMING DISTRICT EMS		69	69
WAHA DISTRICT PS		63	63

3.3 A list of the delegated Controlled Acts

Note: Not all components of the scope of practice are Controlled Acts

SCOPE OF PRACTICE BY PARAMEDIC CERTIFICATION LEVEL

	PRIMARY CARE	ADVANCED CARE
MEDICATIONS		
Acetaminophen	✓	✓
Adenosine		✓
Amiodarone		✓
Antibiotics	✓	✓
ASA	✓	✓
Atropine		✓
Buprenorphine/Naloxone	✓	✓
Calcium Gluconate		✓
Dexamethasone	✓	✓
Dextrose	✓	✓
Dimenhydrinate (Gravol)	✓	✓
Diphenhydramine (Benadryl)	✓	✓
Dopamine		✓
Epinephrine	✓	✓
Fentanyl		✓
Glucagon	✓	✓
Glycopyrrolate	✓	✓
Haloperidol	✓	✓
Hydrocortisone Sodium Succinate	✓	✓
Hydromorphone		✓
Hydroxocobalamin	✓	✓
Ibuprofen	✓	✓
Ketamine		✓
Ketorolac	✓	✓
Lidocaine		✓
Midazolam		✓
Morphine		✓
NaCl 0.9%	✓	✓
Naloxone	✓	✓
Nitroglycerin	✓	✓
Ondansetron	✓	✓
Oxytocin	✓	✓
Oxygen	✓	✓
Salbutamol (MDI and Nebulization)	✓	✓
Sodium Bicarbonate		✓
Tranexamic Acid	✓	✓
OBSTETRICAL/NEONATAL		
Assess and Recognize Obstetrical Emergencies	✓	✓
Delivery of the Neonate	✓	✓
TRAUMA		
Lateral Patellar Reduction	✓	✓

3.3 A list of the delegated Controlled Acts *continued*

SCOPE OF PRACTICE BY PARAMEDIC CERTIFICATION LEVEL

AIRWAY/VENTILATORY		PRIMARY CARE		ADVANCED CARE						
CPAP		✓		✓						
Endotracheal Intubation (Oral)				✓						
Endotracheal & Tracheostomy Suctioning		✓		✓						
iGel Insertion		✓		✓						
Magill Forceps Utilization				✓						
Needle Thoracostomy				✓						
Oral/Nasal Airway		✓		✓						
Oximetry		✓		✓						
Positive Pressure Ventilation with BVM		✓		✓						
Suctioning through SGA Port		✓		✓						
Suctioning Mouth and Nose		✓		✓						
Tracheostomy Reinsertion		✓		✓						
CARDIOVASCULAR		PRIMARY CARE		ADVANCED CARE						
V4R/15 Lead ECG Acquisition and Interpretation		✓		✓						
12 Lead Acquisition		✓		✓						
12 Lead Interpretation		✓		✓						
ECG Interpretation (PCP-five basic rhythms only)		✓		✓						
Pacing				✓						
Fluid Bolus Initiation		✓		✓						
Intravenous Cannulation		✓		✓						
Intraosseous Access				✓						
Manual Defibrillation		✓		✓						
Valsalva Maneuver		✓		✓						
Synchronized Cardioversion				✓						
Emergency Home Dialysis Disconnect		✓		✓						
DRUG ADMINISTRATION		PRIMARY CARE		ADVANCED CARE						
Administer Drugs via SL; SC; PO; IM; IN, MDI and Nebulized Routes		✓		✓						
Administer Drugs via ETT; IO				✓						
Administer Drugs via IV		✓		✓						
CVAD Access				✓						
Hydrocortisone		✓		✓						
PRIMARY CARE PARAMEDIC MEDICAL DIRECTIVES		GSPS	IMSPS	DSSMPS	ADPS	DNSSABPS	PSDEMS	TDEMS	CDPS	WAHA
CORE DIRECTIVES v5.4										
Acute Cardiogenic Pulmonary Edema	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Advanced Airway and Tracheostomy Suctioning and Reinsertion	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Analgesia	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bronchoconstriction	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

3.3 A list of the delegated Controlled Acts *continued*

SCOPE OF PRACTICE BY PARAMEDIC CERTIFICATION LEVEL

PRIMARY CARE PARAMEDIC MEDICAL DIRECTIVES	GSPS	MSPS	DSSMPS	ADPS	DNSSABPS	PSDEMS	TDEMS	CDPS	WAHA
CORE DIRECTIVES v5.4 - continued									
Cardiac Ischemia	✓	✓	✓	✓	✓	✓	✓	✓	✓
Croup	✓	✓	✓	✓	✓	✓	✓	✓	✓
Emergency Childbirth	✓	✓	✓	✓	✓	✓	✓	✓	✓
Home Dialysis Emergency Disconnect	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hypoglycemia	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medical Cardiac Arrest	✓	✓	✓	✓	✓	✓	✓	✓	✓
Moderate to Severe Allergic Reaction	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nausea and Vomiting	✓	✓	✓	✓	✓	✓	✓	✓	✓
Newborn Resuscitation	✓	✓	✓	✓	✓	✓	✓	✓	✓
Opioid Toxicity and Withdrawal	✓	✓	✓	✓	✓	✓	✓	✓	✓
Return of Spontaneous Circulation (ROSC)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Supraglottic Airway	✓	✓	✓	✓	✓	✓	✓	✓	✓
Suspected Adrenal Crisis	✓	✓	✓	✓	✓	✓	✓	✓	✓
Trauma Cardiac Arrest	✓	✓	✓	✓	✓	✓	✓	✓	✓
AUXILIARY DIRECTIVES V5.4									
Cardiogenic Shock	✓	✓	✓	*	✓	✓	✓	✓	*
Continuous Positive Airway Pressure (CPAP)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cyanide Exposure	✓			*			✓	✓	
Intravenous and Fluid Therapy	✓	✓	✓	*	✓	✓	✓	✓	*
Lateral Patellar Dislocation	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tachydysrhythmia	✓	✓	✓	✓	✓	✓	✓	✓	✓
Traumatic Hemorrhage	✓	✓	✓	✓	✓	✓	✓	✓	✓
AUXILIARY MEDICATIONS V5.4									
Advanced Airway and Tracheostomy Suctioning and Reinsertion - SGA Gastric Port Suctioning	✓	✓	✓	✓	✓	✓	✓	✓	✓
Opioid Toxicity and Withdrawal - Buprenorphine/Naloxone					✓			✓	
Medical Cardiac Arrest - Double Sequential External Defibrillation	✓								
DISCHARGE FROM CARE AUXILIARIES V5.4									
Seizure - Treat and Discharge	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hypoglycemia - Treat and Discharge	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tachydysrhythmia Treat and Discharge	✓	✓	✓	✓		✓	✓	✓	✓
PATIENT CARE MODELS									
Special Project Palliative Care	✓							✓	
PATIENT CARE MODELS MEDICATIONS									
Special Project Palliative Care - Congested Breathing	✓							✓	

3.3

A list of the delegated Controlled Acts *continued*

SCOPE OF PRACTICE BY PARAMEDIC CERTIFICATION LEVEL

PRIMARY CARE PARAMEDIC MEDICAL DIRECTIVES	GSPS	MSPS	DSSMPS	ADPS	DNSSABPS	PSDEMS	TDEMS	CDPS	WAHA
PATIENT CARE MODELS MEDICATIONS - CONTINUED									
Special Project Palliative Care - Dyspnea	✓							✓	
Special Project Palliative Care - Hallucinations or Agitation	✓							✓	
Special Project Palliative Care - Nausea or Vomiting	✓							✓	

* Note: Select paramedics are IV certified and authorized in Cardiogenic Shock, Intravenous and Fluid Therapy and Cyanide Exposure

ADVANCED CARE PARAMEDIC MEDICAL DIRECTIVES	GSPS	DNSSABPS	MSPS
CORE DIRECTIVES v5.4			
Acute Cardiogenic Pulmonary Edema	✓	✓	✓
Advanced Airway and Tracheostomy Suctioning and Reinsertion	✓	✓	✓
Analgesia	✓	✓	✓
Bronchoconstriction	✓	✓	✓
Cardiac Ischemia	✓	✓	✓
Cardiogenic Shock	✓	✓	✓
Central Venous Access Device (CVAD)	✓	✓	✓
Combative Patient	✓	✓	✓
Croup	✓	✓	✓
Emergency Childbirth	✓	✓	✓
Home Dialysis Emergency Disconnect	✓	✓	✓
Hyperkalemia	✓	✓	✓
Hypoglycemia	✓	✓	✓
Intravenous & Fluid Therapy	✓	✓	✓
Medical Cardiac Arrest	✓	✓	✓
Moderate to Severe Allergic Reaction	✓	✓	✓
Nausea and Vomiting	✓	✓	✓
Newborn Resuscitation	✓	✓	✓
Opioid Toxicity and Withdrawal	✓	✓	✓
Orotracheal Intubation	✓	✓	✓
Pediatric Intraosseous (IO) Infusion	✓	✓	✓
Return of Spontaneous Circulation (ROSC)	✓	✓	✓
Seizure	✓	✓	✓
Supraglottic Airway	✓	✓	✓
Suspected Adrenal Crisis	✓	✓	✓
Symptomatic Bradycardia	✓	✓	✓
Tachydysrhythmia	✓	✓	✓
Tension Pneumothorax	✓	✓	✓
Trauma Cardiac Arrest	✓	✓	✓

3.3

A list of the delegated Controlled Acts *continued*

SCOPE OF PRACTICE BY PARAMEDIC CERTIFICATION LEVEL

ADVANCED CARE PARAMEDIC MEDICAL DIRECTIVES	GSPS	DNSSABPS	MSPS
AUXILIARY DIRECTIVES V5.4			
Adult Intraosseous (IO) Infusion	✓	✓	✓
Continuous Positive Airway Pressure (CPAP)	✓	✓	✓
Cyanide Exposure	✓		
Lateral Patellar Dislocation	✓	✓	✓
Procedural Sedation	✓	✓	✓
Traumatic Hemorrhage	✓	✓	✓
AUXILIARY MEDICATIONS AND PROCEDURES v5.4			
Advanced Airway and Tracheostomy Suctioning and Reinsertion - SGA Gastric Port Suctioning	✓	✓	✓
Analgesia	✓	✓	✓
Combative Patient	✓	✓	✓
Medical Cardiac Arrest - Double Sequential External Defibrillation	✓	✓	
Opioid Toxicity and Withdrawal	✓	✓	✓
Tachydysrhythmia		✓	✓
PATIENT CARE MODEL STANDARDS			
Special Project Palliative Care	✓		
PATIENT CARE MODEL STANDARDS MEDICATIONS			
Special Project Palliative Care - Hallucinations or Agitation	✓		
Special Project Palliative Care - Nausea or Vomiting	✓		
Special Project Palliative Care - Pain or Dyspnea	✓		
Special Project Palliative Care - Terminal Congested Breathing	✓		

3.4 A list of the Controlled Acts that have been removed this reporting year.

There have been no Controlled Acts removed in the fiscal year 2025-26.

Q4 Does the Host Hospital adhere to the Provincial Medical Directives recommended by the PMAC and approved by the Director?

HSN Centre for Prehospital Care adheres to the latest version of the ALS PCS Version 5.4 which came into effect on June 2, 2025.

Q5 The Host Hospital shall adhere to Provincial Certification, Recertification, Change in Certification and Remediation policies, as recommended by PMAC within recommended timelines.

5.1 Have the provincial Certification, Recertification, Change in Certification and Remediation policies, as recommended by PMAC within recommended timelines been adhered to?

HSN CPC adheres to the Provincial Maintenance of Certification Policy, Appendix 6 in the Advanced Life Support Patient Care Standards, Version 5.4.

5.2 Total number of initial PCP and ACP certification awarded by Service in the reporting year.

REPORTING PERIOD	TOTAL ACP	TOTAL PCP	TOTAL
April 1, 2025 to March 31, 2026	2	131	133

SERVICE	ACP	PCP	TOTAL
ALGOMA DISTRICT PS		12	12
COCHRANE DISTRICT PS		13	13
GREATER SUDBURY PS	1	38	39
MANITOULIN-SUDBURY DSB PS	1	20	21
DISTRICT OF NIPISSING PS		14	14
PARRY SOUND DISTRICT EMS		5	5
DISTRICT OF SAULT STE. MARIE PS		7	7
TIMISKAMING DISTRICT EMS		10	10
WAHA PS		12	12

Note: A paramedic may have been hired by more than one service at the time of certification and reflected as such in the total numbers.

5.3 Total number of PCP and ACP reactivations in the reporting year.

REPORTING PERIOD	TOTAL ACP	TOTAL PCP	TOTAL
April 1, 2025 to March 31, 2026	5	55	60

SERVICE	ACP	PCP	TOTAL
ALGOMA DISTRICT PS		5	5
COCHRANE DISTRICT PS		2	2
GREATER SUDBURY PS	3	16	19
MANITOULIN-SUDBURY DSB PS		12	12
DISTRICT OF NIPISSING PS	2	5	7
PARRY SOUND DISTRICT EMS		3	3
DISTRICT OF SAULT STE. MARIE PS		4	4

SERVICE	ACP	PCP	TOTAL
TIMISKAMING DISTRICT EMS		3	3
WAHA PS		5	5

5.4 Total number of PCP and ACP deactivations in the reporting year.

REPORTING PERIOD	TOTAL ACP	TOTAL PCP	TOTAL
April 1, 2025 to March 31, 2026	9	88	97

SERVICE	ACP	PCP	TOTAL
ALGOMA DISTRICT PS		10	10
COCHRANE DISTRICT PS		7	7
GREATER SUDBURY PS	7	15	22
MANITOULIN-SUDBURY DSB PS		20	20
DISTRICT OF NIPISSING PS	2	10	12
PARRY SOUND DISTRICT EMS		8	8
DISTRICT OF SAULT STE. MARIE PS		2	2
TIMISKAMING DISTRICT EMS		7	7
WAHA PS		9	9

Q6.1 Does the Medical Director practice emergency medicine full-time or part-time in the hospital emergency unit?

The Medical Director currently works in the HSN Emergency Department and exceeds the minimum requirement of 250 clinical hours.

6.2 Does the Medical Director hold recognized medical specialty credential(s) in emergency medicine?

The Medical Director is credentialed in Emergency Medicine as CCFP (EM).

Q7.1 Do all Base Hospital physicians have knowledge of paramedic practice and provincial medical directives?

As of May 1, 2024, our Base Hospital—through a partnership with the Regional Paramedic Program for Eastern Ontario (RPPEO) and the Centre for Paramedic Education and Research (CPER)—joined a Ministry of Health-funded pilot project called the Online Medical Consultation (OMC) program. Under this initiative, paramedics no longer patch to a busy Emergency Department, but instead connect directly with dedicated physicians available 24/7.

New physicians undergo a robust onboarding process that includes self-directed learning activities such as listening to patch calls, reviewing clinical standards, and becoming familiar with auxiliary medical directives and region-specific patient care models. They also participate in mock patch calls with competency evaluations to ensure readiness. Each new physician is assigned a mentor who supports their development by listening to consultations and providing written feedback to help refine their skills.

7.2 Total number of online medical consultation physicians engaged as a Base Hospital Physician.

27 Online Medical Consultation Physicians were engaged as Base Hospital Physicians.

BASE HOSPITAL PHYSICIANS	
Michael Austin	Phil Moran
Kim Barker	Sara-Pier Piscopo
Dan Beamish	Jason Prpic
Renee Bradley	Rupinder Sahsi
Nick Costain	David Savage
Richard Dionne	Catherine Sellens
Chris Evans	Paula Sneath
Natasha Ewert	Margaret (Maggie) Vincent
Mark Froats	Ayesha Zia
Justin Godbout	PTM Fellows:
Connor Inglis	Harmine Christina Leo
Paul Miller	Mohammed Abdunnasser Molan Ahmd
Simeon Mitchell	Amanda Mattice
Jennifer Moore	Sabrina Slade

Q8.1 Total number of Base Hospital physician and paramedic online interactions that have been reviewed for medical quality.

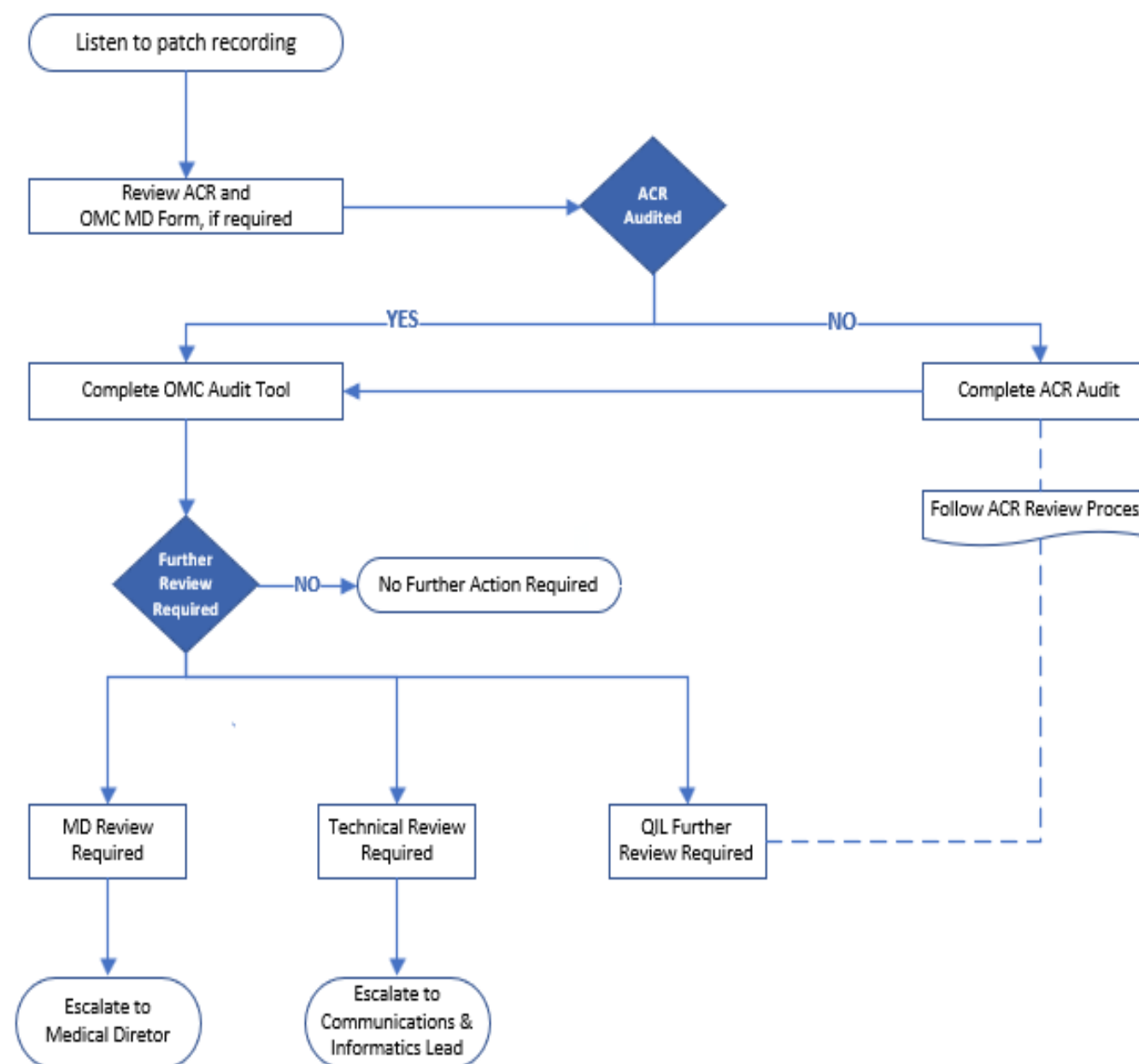
A total of 665 patches to a Base Hospital Physician occurred between 1 April 2025 and 31 March 2026. One hundred percent of patches were reviewed. Patches were characterised as a mandatory patch point, as a proposed request for orders or an extension of a medical directive, or as a consultation for advice.

Mandatory Patch Point	# of Patches	% of Patches
Medical Cardiac Arrest	337	89%
Trauma Cardiac Arrest	22	6%
TCP/Synchronized Cardioversion	10	3%
Medications	8	2%
Other	1	0%
Total	378	100%

Proposal/Extension of Orders	# of Patches	% of Patches
Medications	100	62%
Withhold Resuscitation	34	21%
Bypass to higher level of care	13	8%
Other	6	4%
Additional IV fluids	5	3%
Patient Care Models	3	2%
Total	161	100%

Consultation for Advice	# of Patches	% of Patches
Complex patient	102	81%
Refusal of Service	9	7%
Aid to Capacity	8	6%
Other	6	5%
Self-report following call	1	1%
Total	126	100%

8.2 Describe the medical quality review process.



MEDICAL OVERSIGHT

Q9 List the dates of Provincial Medical Advisory Committee (PMAC) meetings attended by a member of the Base Hospital Program.

- June 4, 2025
- September 9, 2025
- December 3, 2025
- March 4, 2026

Q10 Are Base Hospital Physicians available for online medical direction and control on a 24 hr/7 days a week basis?
Yes.

Q11 The Host Hospital shall ensure that the Base Hospital Program enters into and keeps in effect an agreement with each certified land ambulance service provider listed in Appendix D, with respect to the qualification, ongoing medical oversight, and re-qualification of Paramedics to deliver controlled medical acts under the authority of the Base Hospital Program Medical Director.

HSN CPC has an agreement with each land ambulance service in the Northeast. These agreements include details related to qualification, ongoing medical oversight and requalification of paramedics to deliver controlled medical acts under the authority of the Base Hospital.

Q12 The Host Hospital shall ensure that the Base Hospital Program monitors the delivery of patient care in accordance with the Advanced Life Support Patient Care Standards. Describe the actions taken to monitor the delivery of patient care in accordance with the Advanced Life Support Patient Care Standards.

The Quality and Information Management (QIM) Team at the Health Sciences North Centre for Prehospital Care (HSN CPC) provides a coordinated, system-wide approach to support high-quality paramedic practice, patient safety, and continuous improvement. Quality in prehospital care is multifaceted and requires alignment across clinical practice, data integrity, education, and performance oversight.

This document outlines the structure, guiding principles, and processes that guide the work of the QIM Team. It describes how data, quality assurance, quality improvement, and medical oversight are integrated to support learning, accountability, and system improvement. Through the meaningful use of data and a Just Culture approach, the team emphasizes understanding performance, identifying opportunities for improvement, and supporting paramedics and service operators in delivering safe and effective patient care.

Together, these elements form a comprehensive quality framework designed to monitor performance, drive improvement, and ensure alignment with Patient Care Standards and system priorities.

[Refer to Appendix C: Quality Programming Overview](#)

Q13 The Host Hospital shall ensure that the Base Hospital Program monitors the delivery of patient care in accordance with the Basic Life Support Patient Care Standards, if such monitoring is contained in the agreement with the Upper Tier Municipality and Designated Delivery Agent for land Ambulance Services as set out in Appendix D.

There are no agreements in place at this time. When a BLS issue is noted during the regular ALS auditing processes, service operators are notified for their follow up.

Q14 The Host Hospital shall ensure that timely advice is provided to each Upper Tier Municipality (UTM) and Designated Delivery Agent (DDA) for Land Ambulance Services as set out in Appendix D regarding medical issues in prehospital care.

Advice may be provided formally through either the HSN CPC Quality of Care Committee proceedings that are reported back to Paramedic Services or through the HSN CPC Program Committee. Discussions and resulting action items are tracked through the meeting minutes. Ad hoc advice is provided frequently via conversation, email and non-standing meetings.

14.1 Total number of prehospital medical care issues raised by the UTM or DDA that required advice from the Base Hospital.

When an official request is made by a Paramedic Service or the Ministry of Health (MOH) to review a specific occurrence, all information related to the call is tracked in the IQEMS database. It is forwarded to a Paramedic Practice Coordinator for review and may be analyzed by the QI Lead and the applicable Medical Director/Advisor. All reviews are completed via either the standard call review process or via a formal Event Analysis report in accordance with program policies.

For further information on the outcomes of program audit activities or event analyses, see Appendix B: Case Reviews.

14.2 List the top 5 subject areas that advice was requested from UTMs and DDAs (i.e. medical equipment, medical acts, policies, etc).

1. ePCR/IQEMS audits
2. Medical Directives and Companion Documents
3. Implementation of Patient Care Models
4. Medical equipment/medication
5. Policy and Procedures

Q15 The Host Hospital shall ensure participation in provincial, regional and community planning that affects prehospital care such as emergency planning, where the Host Hospital has the authority to do so. The total number and dates of provincial, regional, and community planning meetings, indicate the meeting hosts are listed below.

Regional

- Acute Stroke Protocol Improvement Team – Ad hoc
- Cambrian College Paramedic and Advanced Care Flight Paramedic Programs Advisory Committee - Bi-annual
- HSN CPC Audit Huddles – Bi-weekly
- HSN CPC Council (Sudbury/ Videoconference) – Monthly
- HSN CPC NEO Regional Data Advisory Group (Teleconference) - 3 times/year
- HSN CPC Program Committee (Sudbury/ Teleconference) - Quarterly
- HSN CPC Quality of Care Committee (Sudbury/ Videoconference) – Monthly
- HSN EVT Program Development – Ad hoc
- STEMI Bypass Steering Committee – Ad hoc

Provincial

- Base Hospital Managers/ Directors Business Meeting – Monthly
- CCSO Town Hall Meeting – Annual
- IQEMS Operational Working Group - Bi-weekly
- IQEMS Technical Working Group – Weekly
- IQEMS/ PPO Executive Steering Committee - Bi-weekly
- OBHG Annual Curriculum Development Group – Ad hoc
- OBHG Annual General Meeting - Annual
- OBHG Autonomous IV Working Group – Ad hoc
- OBHG Collaboration Working Group (Toronto) - Quarterly & Ad hoc (on hold)
- OBHG Data Quality Management (DQM) - Quarterly
- OBHG Education Sub-Committee – Quarterly
- OBHG Storage Working Group (Wiki site) - Quarterly
- OHBG Scenario Working Group – Ad hoc
- OMC Communications Working Group – Bi-weekly
- OMC Data Evaluation Working Group – Bi-weekly
- OMC Steering Committee – Bi-weekly
- Ontario Base Hospital Medical Advisory Group (MAC) (Toronto) – Quarterly
- Ontario Trauma Advisory Committee (OTAC) Quarterly Meeting (Toronto) - Quarterly
- Ontario Trauma Advisory Committee Medical Directors Working Group – Ad hoc
- Ontario Trauma Coordinators Network (OTCN) (Teleconference) - Quarterly
- PPO Operational Working Group - Bi-weekly
- PPO Technical Working Group - Weekly
- Sunnybrook/ HSN Joint Medical Council Meeting (Toronto & Sudbury) - Bi-annual
- Trauma Registry Advisory Committee - Quarterly

Community

- Critical and Emergency Care Program Council – Monthly
- HSN Emergency Preparedness Committee – Ad hoc
- Suboxone Working Group – Ad hoc
- Sudbury CACC Advisory Committee

National

- National Association of EMS Physicians - Canadian Relations Sub-Committee - Annual & Ad hoc
- Trauma Association of Canada - Performance Improvement Subcommittee - Bi-annual

Q16 The Host Hospital shall make every reasonable effort to ensure that each request for medical advice, direction, or assistance received from an Emergency Medical Attendant, paramedic or communications officer is provided expeditiously and that performance standards are set out in this Agreement are met.

16.1 How are requests for medical advice, direction or assistance from an emergency medical attendant, paramedic or communications office provided?

The following are primary methods of communication:

- 24/7 Online Medical Control through the Base Hospital Physicians
- IQEMS, which is used to discuss audit findings and patient care dialogues
- Ask Mac questions submitted to the Medical Advisory Committee and responses posted to the website
- Email, which is used for the communication of general information and notifications
- Live chats during webcasts are a means for paramedics to ask questions and interact with their medical directors
- Typically twice annual (at minimum) in person sessions with Paramedic Practice Coordinators in an interactive education setting
- Adhoc, all program staff provide support and advice to paramedics on a daily basis.

16.2 Total number of formal requests for medical advice direction or assistance from an Emergency Medical Attendant, Paramedic or communications officer provided.

There were 665 formal requests for medical advice direction or assistance.

Q17 Where a Host Hospital has not been available to expeditiously provide medical advice (eg. Radio patch), direction, or assistance to an Emergency Medical Attendant, Paramedic, or communications officer, the Host Hospital shall document the circumstances of the event in an incident report that will be provided to the Senior Field Manager within 48 hours of the event.

The total number and nature of incident reports provided to the senior Field Manager related to medical advice delays.

All patch failures found through IQEMS and/or reported by a paramedic or service are reviewed to determine root cause and recommend system improvements.

For 2025-2026, we had 0 patch failures to report to our senior field manager at the Northeast Field Office.

Q18.1 Describe the process used to assist operators with request for assistance and information regarding direct patient care components and elements of local policy and procedures.

Once a request for assistance and/or information has been received in writing by the program, it is triaged by the receiver to determine if its nature is Medical, Educational, CQI, Research, Operational or Other.

- Medical advice and/or inquiries are reviewed by the applicable Medical Advisor or the Regional Medical Director and, when required, forwarded to the Quality of Care Committee (QCC) to be reviewed by the Medical Program as a whole. Minutes of this committee are available to all staff and a report from this committee is provided at Regional Program Committee meetings.
- Educational advice and/or inquiries are assigned to the Regional Education & Certification Coordinator for review and, when required, brought to monthly Council or QCC meetings. A Medical Advisor or the Regional Medical Director may be consulted, as needed.
- Quality Improvement advice and/or inquiries are forwarded to the Quality Improvement Lead for review. A Medical Advisor or the Regional Medical Director may be consulted, as needed.
- Assistance or information related to reportable program metrics are forwarded to the Communication and Informatics Lead or Performance Measurement Lead for review.
- Operational advice and/or inquiries are forwarded to the applicable Paramedic Practice Coordinator and, when required, forwarded to the monthly Council meetings for review.
- Research inquiries are forwarded to the CQI Lead or Regional Manager and when required, the Regional Medical Director is consulted.

18.2 List the top 5 subject areas that information was requested from operators (i.e. medical equipment, medical acts, policies, etc).

1. Initial certification / Return to work requests
2. ePCR/IQEMS Audits
3. Event Analysis
4. Medical equipment purchase advice
5. Continuing Medical Education

EDUCATION

Q19 The Host Hospital will provide a process to confirm and/or ensure the education and standard of practical skills necessary for certification and delegation of specific controlled acts approved by the Provincial Medical Advisory Committee (PMAC) to Emergency Medical Attendants and Paramedics.

HSN CPC develops a yearly CME program that covers the paramedic scope of practice as per the ALS PCS. The goal of the CME program is to prepare paramedics to respond appropriately to a wide range of patient situations both routinely and infrequently encountered in the field.

The Ministry of Health Emergency Health Regulatory and Accountability Branch (MOH-EHRAB) has mandated that PCPs receive a minimum of 8 hours of CME and that ACPs receive a minimum of 24 hours of CME annually. To meet the needs of the service operators, the paramedics and the Regional Base Hospital Programs, these hours have been converted to credit hours (1 hour = 1 credit). Paramedics must have the required number of credits based on their scope of practice logged within the Paramedic Portal of Ontario no later than the third Monday in January.

Failure to meet these requirements will result in a Paramedic review by the Medical Director or designate and may result in the temporary deactivation of the Paramedic’s certification. Paramedics who do not meet these requirements are subject to a performance review by the Medical Director or delegate and may have their certification temporarily suspended until such a time that all mandatory CME credit hours are accumulated.

Q19.1
List the topic, date and length of each continuing medical education program offered to and held for medical, nursing and other allied health staff of the Host Hospital and receiving hospitals in the Ministry-approved geographic coverage area.

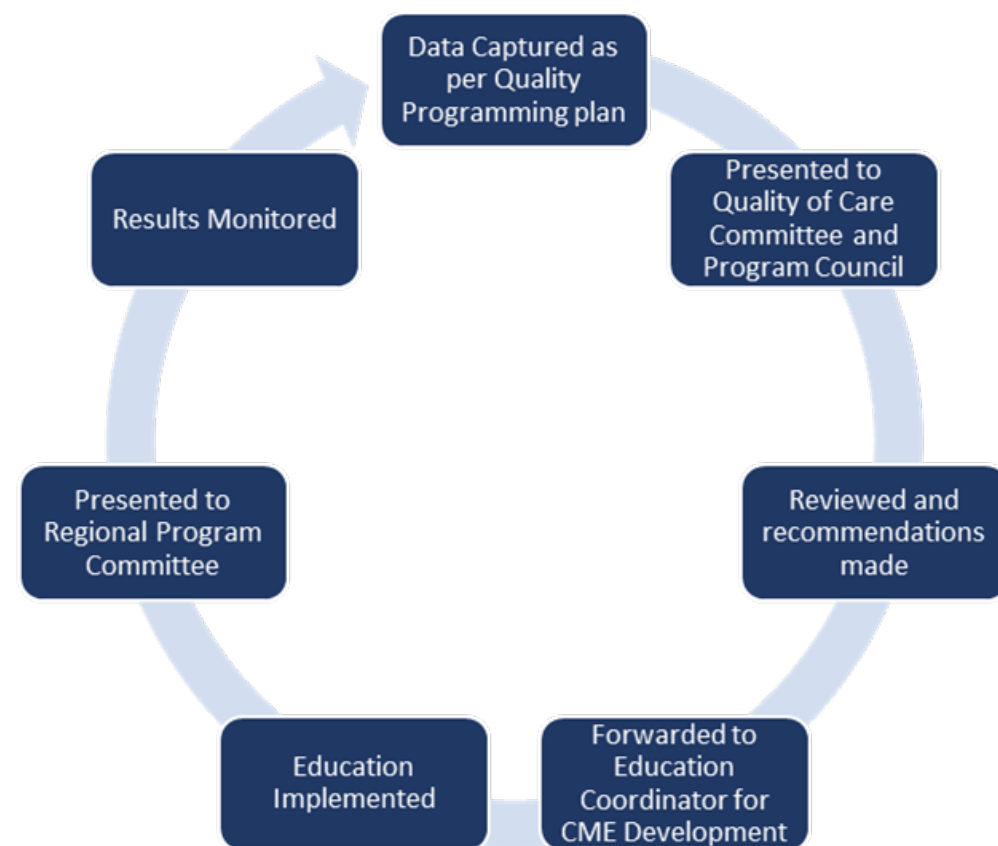
DATE	TOPIC/INSTRUCTOR	HOURS/CREDITS
June 5, 2025	SCORE Course Presented by Dr. Guscott and Paramedic Practice Coordinators: Kim Bolton, Mat James, and Luc Simard	8.0
June 11, 2025	OUD/Suboxone Presentation and Simulation Event Presented by Dr. Chris Loreto	2.0
September 18, 2025	Gate Way Conversation Presented by: Dr. Jason Prpic	3.0
October 17, 2025	Ketamine, Analgesia & TXA in the Prehospital Setting Presented by Dr. Jason Prpic	1.5
January 20, 2026	Combative, Violent Patient & CPAP Review Presented by Dr. Chris Loreto	1.0
March 9, 2026	Airway Simulation: Every Breath Counts Presented by: Paramedic Practice Coordinator Mathew James and Respiratory Therapist, Danny Raghunadandan	4.0
March 31, 2026	Let's Talk About Dex Presented by: Dr. Chris Loreto	1.0

Q20 The Host Hospital shall ensure that prehospital patient care education is provided in accordance with education standards approved by the Minister as may be implemented and amended from time to time. Provide the topics and time allotted for each educational session delivered this year to paramedics.

In addition to those noted above, the following Virtual sessions were provided specifically for the paramedics.

DATE	TOPIC/INSTRUCTOR	HOURS
April- June 2025	Paramedic Practice Rounds, presented by HSN CPC Paramedic Practice Coordinators	4
September - November 2025	Paramedic Practice Rounds, presented by HSN CPC Paramedic Practice Coordinators	4

Q21 The Host Hospital shall ensure the development and implementation of an educational plan for the Region linked to Continuous Quality Improvement initiatives.



Q22 The Host Hospital shall ensure the provision of the mandated hours of education per year for both PCPs and ACPs.

22.1 Total number of hours of CME delivered per PCP.

A minimum of 8 CME credits were provided to each PCP.

22.2 Total number of hours of CME delivered per ACP.

In this fiscal year, 24 hours minimum were delivered per ACP.

CONTINUOUS QUALITY IMPROVEMENT (CQI)

Q23 The Host Hospital shall ensure the implementation of a CQI program for each Paramedic employed or engaged by land ambulance service operators as set out in Appendix C and ensure the provision of regular commentary to each Paramedic and operator.

23.1 Total number of paramedics that have been provided with commentary by the host hospital and a brief description of their program.

All paramedics certified under the Program receive commentary on a regular basis, generally via the applicable Paramedic Practice Coordinator for their area. Commentary may include electronic distribution of memos, policies and other documents. As part of auditing activities, paramedics are provided commentary on all of their ACRs with a possible variance from the standard. Additionally, paramedics receive positive commentary via IQEMS.

23.2 Total number of commentary provided to all paramedics.

During the fiscal year 2025-26, HSN CPC made available approximately 788 commentaries to paramedics via the Ambulance Call Evaluation process. The Program also distributed various correspondence including 9 memos/letters to paramedics via email and the HSN CPC website.

23.3 Was a minimum of one chart review commentary provided to each paramedic?

Paramedics will receive access to their commentary via IQEMS utilizing the credentials provided in their notification email, 100% of paramedics who completed a call with an identified potential variance received feedback.

Q25 The Host Hospital shall include a report on all CQI activities and findings as part of the annual report submitted to the Ministry.

Several paramedic services in northeastern Ontario transitioned to new ePCR platforms during the previous reporting cycle; however, the impacts of these changes continued into the current reporting period, creating challenges with data extraction, integration, and consolidation. In addition, integration of Prehos data into the quality assurance software was only recently established, resulting in delays to auditing, analysis, and reporting activities. The transition of ImageTrend from manual data entry to automated electronic data transfers has also affected data availability and reporting timelines, coinciding with the implementation of a new ePCR to align with the updated provincial documentation standards.

As a result, data for the period January 1 to March 31, 2026 may be incomplete, and some records may not have been available at the time of analysis. Due to these data quality and availability limitations, the reporting frequency

was adjusted for this fiscal year to allow sufficient time for comprehensive auditing, data validation, reconciliation, and analysis.

Efforts are ongoing to consolidate and standardize and optimize data sources to improve the accuracy, consistency, accessibility, and timeliness of information. Centralizing these data systems will enhance the efficiency, reliability and sustainability of data access for education, certification, and quality assurance activities; streamline data transfer into the quality assurance system, reduce reliance on manual data entry, and support more accurate, complete and timely reporting.

Q26 The Host Hospital shall collaborate with Emergency Medical Services System Stakeholders to share relevant CQI data, as appropriate. How and when was CQI data shared with Emergency Medical Services System stakeholders?

WHAT	WHO	FREQUENCY	HOW
AMBULANCE CALL REPORT AUDIT Notification of any event or circumstance which appears as a variance from the standard.	Paramedics Service Providers	Upon review and closure	IQEMS
EVENT ANALYSIS Sharing of information and outcomes during and post analysis.	Service Providers MOH Field Office	Upon discovery and closure	Event Analysis Report
**AUDIT ACTIVITIES REPORT Number of audits completed / Paramedics	Service Providers	Quarterly	Performance Measurement Standard Reports
**AUDIT VARIANCE DETAIL AND SUMMARY REPORTS Breakdown of variance rates and outcomes by Service	Service Providers	Quarterly	Performance Measurement Standard Reports
**PARAMEDIC SELF REPORTS This report identifies the number of self-reports submitted by Paramedics. The summary categorizes self-reports by Service	Service Providers	Quarterly	Performance Measurement Standard Reports
BLS OMISSIONS/COMMISSIONS BLS issues discovered during an ALS audit are reported to the Service Operator during the auditing process.	Service Providers	Upon discovery	Performance Measurement Standard Reports
**PARAMEDIC SKILLS INVENTORY Number of calls where a particular ALS skill was used as part of the overall patient care plan	Service Providers	Bi-annual	Performance Measurement Standard Reports
CLINICAL AUDIT REPORTS Measures of current practice against a defined (desired) standard with the intent to improve systems vs individual practice.	Service Providers	Quarterly	Clinical Audit Reports
AD HOC FINDINGS	Service Providers	HSN CPC Program Committee	Discussion Minutes
**ONLINE MEDICAL CONTROL INTERACTIONS REPORTS	Ministry of Health Service Providers	Quarterly	Provincial Report Discussion Minutes

*** Refer to Q25 constraints and limitations*

Q27 The Host Hospital shall ensure that Host Hospital physicians will be available to provide “online” continuous quality improvement and advice on a continuous basis.

As of May 1, 2024, our Base Hospital—through a partnership with the Regional Paramedic Program for Eastern Ontario (RPPEO) and the Centre for Paramedic Education and Research (CPER)—joined a Ministry of Health-funded pilot project called the Online Medical Consultation (OMC) program. Under this initiative, paramedics no longer patch to a busy Emergency Department, but instead connect directly with dedicated physicians available 24/7.

New physicians undergo a robust onboarding process that includes self-directed learning activities such as listening to patch calls, reviewing clinical standards, and becoming familiar with auxiliary medical directives and region-specific patient care models. They also participate in mock patch calls with competency evaluations to ensure readiness. Each new physician is assigned a mentor who supports their development by listening to consultations and providing written feedback to help refine their skills.

Q28 The Host Hospital shall ensure the establishment of a mechanism to track customer inquiries and organizational responsiveness to these inquiries and survey land ambulance stakeholder groups on a regular basis, and that all consumer feedback will be reviewed and integrated into quality management planning.

All inquiries related to quality management are addressed in the same manner in which they were received i.e. an email is responded to with an email. Any inquiries/feedbacks relative to the quality management or education activities under the purview of the Base Hospital are considered as part of the Annual CME Plan and/or the Annual Quality Programming Overview. Each of these plans is provided to relevant stakeholders in draft form and feedback is actively solicited on each plan on an annual basis. All findings related to activities as laid out in the plan are distributed to key stakeholders and available upon request.

Refer to:
[Appendix B: Case Reviews 2025-26](#)

Q29 The Host Hospital shall ensure the conduct of clinically-focused audits of controlled acts performed on or indicated for a patient by a Paramedic employed or retained by an operator covered by this Agreement, to monitor paramedic compliance with Provincial Medical Directives, in accordance with the following chart audit process:

29.1 Total number of Ambulance Call Reports (ACRs) requiring auditing.

Utilization of IQEMS enables auditing of 100% of selected call types, exceeding the minimum requirements. In 2025-26 there were 48,102 calls audited.

29.2 Total number of medical directive/protocols and cases that have been audited.

In 2025-26 there were 48,102 ambulance call reports that matched a filter type. Of these, 5,103 were identified as requiring further review and of these 1,806 were escalated for additional review.

29.3 Have all paramedics that have performed at least 5 acts within the ALS PCS had a minimum of 5 ACR audited this year?

Yes.

29.4 Total number of new paramedics (less than 6 months) and total number who had 80% of their charts audited.

There were 2 newly certified ACPs and 131 new PCPs (defined as paramedics not having previous Base Hospital certification) in 2025-26. The Performance Agreement states 80% of charts where a controlled act or advanced medical procedure is performed must be audited, however IQEMS allows for 100% of paramedic charts to be audited.

29.5 Number of cancelled calls where paramedics made patient contact that were audited.

There were 283 cancelled calls identified as requiring further review, of which 43 were escalated for additional review.

APPENDIX A

ANNUAL PERFORMANCE MEASUREMENT STANDARD REPORT April 1, 2025 to March 31, 2026



Centre for Prehospital Care

Health Sciences North

Performance Measurement Standard Reports

April 1, 2025 to March 31, 2026

REPORTING CONSTRAINTS AND LIMITATIONS

Several paramedic services in northeastern Ontario transitioned to new ePCR platforms during the previous reporting cycle; however, the impacts of these changes continued into the current reporting period, creating challenges with data extraction, integration, and consolidation. In addition, integration of Prehos data into the quality assurance software was only recently established, resulting in delays to auditing, analysis, and reporting activities. The transition of ImageTrend from manual data entry to automated electronic data transfers has also affected data availability and reporting timelines, coinciding with the implementation of a new ePCR to align with the updated provincial documentation standards.

As a result, data for the period January 1 to March 31, 2026 may be incomplete, and some records may not have been available at the time of analysis. Due to these data quality and availability limitations, the reporting frequency was adjusted for this fiscal year to allow sufficient time for comprehensive auditing, data validation, reconciliation, and analysis.

Efforts are ongoing to consolidate and standardize and optimize data sources to improve the accuracy, consistency, accessibility, and timeliness of information. Centralizing these data systems will enhance the efficiency, reliability and sustainability of data access for education, certification, and quality assurance activities; streamline data transfer into the quality assurance system, reduce reliance on manual data entry, and support more accurate, complete and timely reporting.

SECTION 1: AUDIT ACTIVITIES SUMMARY BY FILTER TYPE (ALL SERVICES)

This is a cumulative report providing the breakdown of the number of Ambulance Call Reports (ACR) in the Northeast that matched a filter type, required further review and escalated for additional review.

SECTION 2: PARAMEDIC SELF-REPORTS

This report identifies the number of self-reports by filter type, submitted by northeastern Ontario paramedics, related to identified omissions and/or commissions, and patient care or documentation.

SECTION 3: SERVICE OPERATOR AUDIT REQUESTS

This report provides the number of service operator driven audit requests in the northeast and is listed by IQEMS Filter Type.

SECTION 4: BLS CONCERNS REPORTED TO SERVICE

This report is the number of BLS Patient Care Standard (PCS) concerns communicated to Service Operators during the auditing process. This summary is broken down by Filter Type.

Performance Measurement Standard Reports

April 1, 2025 to March 31, 2026

SECTION 1

AUDIT ACTIVITIES SUMMARY BY FILTER TYPE

FILTER TYPE	MATCHED THE FILTER TYPE		
	Total calls	Calls identified for further review	Escalated for additional review
Allergic Reaction	617	39	17
Analgesia	6548	472	149
Cancelled Calls	18700	283	43
Cardiac Arrest	1024	1024	381
Cardiac Ischemia	3917	1242	445
Chemical Exposure	0	0	0
Difficult Airway	367	22	5
Emergency Childbirth	53	53	21
Hypoglycemia	1108	454	152
Nausea & Vomiting	5026	167	57
Opioid Toxicity	1908	222	99
Palliative Care	77	67	16
Pulmonary Edema	5866	116	37
Sedation	104	50	22
Seizure	472	45	16
SOB (Asthma, Croup & Needle Thoracostomy)	1972	623	274
Suspected Adrenal Crisis	10	10	0
Symptomatic Bradycardia	180	110	33
Tachydysrhythmia	153	104	39
Total	48102	5103	1806

NOTES:

- **Matched the Filter Type – Totals:** This is the total number of Ambulance Call Reports (ACR) that matched the filter type in IQMES. It includes ACRs not requiring further review and those identified for further review.
- **Matched the Filter Type – Escalated for additional review:** Of the ACRs identified for further review, these are the ACRs that required an additional review.

Performance Measurement Standard Reports
April 1, 2025 to March 31, 2026

SECTION 2

PARAMEDIC SELF-REPORTS

N = 256

Filter Name	Total Self Reports
Allergic Reaction	2
Analgesia	72
Cancelled Calls	3
Cardiac Arrest	35
Cardiac Ischemia	48
Emergency Childbirth	1
Hypoglycemia	19
Nausea & Vomiting	10
Opioid Toxicity	9
Pulmonary Edema	6
Sedation	1
Seizure	2
SOB (Asthma, Croup & Needle Thoracostomy)	40
Symptomatic Bradycardia	3
Tachydysrhythmia	5

Performance Measurement Standard Reports
April 1, 2025 to March 31, 2026

SECTION 3

SERVICE OPERATOR AUDIT REQUESTS

n = 84

Filter Name	Total
Allergic Reaction	2
Analgesia	9
Cardiac Arrest	26
Cardiac Ischemia	27
Emergency Childbirth	1
Hypoglycemia	4
Nausea & Vomiting	1
Opioid Toxicity	5
Palliative Care	1
Pulmonary Edema	1
Sedation	2
SOB (Asthma, Croup & Needle Thoracostomy)	4
Tachydysrhythmia	1

Performance Measurement Standard Reports

April 1, 2025 to March 31, 2026

SECTION 4

BLS CONCERNS REPORTED TO SERVICE

N = 122

Filter Name	Total
Analgesia	9
Cancelled Calls	4
Cardiac Arrest	21
Cardiac Ischemia	18
Difficult Airway	1
Emergency Childbirth	6
Hypoglycemia	19
Nausea & Vomiting	3
Opioid Toxicity	8
Palliative Care	2
Pulmonary Edema	3
SOB (Asthma, Croup & Needle Thoracostomy)	20
Symptomatic Bradycardia	5
Tachydysrhythmia	3

APPENDIX B

CASE REVIEWS

Incidences and audits requiring additional reviews are identified in IQEMS by means of a "Case Review" entry. This module is interrelated with the audit platform and collects information in a centralized workspace to facilitate communication between paramedics, auditors, managers and medical directors.

For this fiscal year, 153 ACRs required a case review. Of those 15% (n=23) required an Event Analysis and a notification and/or report was forwarded to the Field Office.

The following table provides the final Base Hospital Outcome.

TABLE 1: TYPE OF REVIEW / BASE HOSPITAL OUTCOME	N	%
Case Reviews not Escalated for Further Review	130	85%
No Follow-up Required	1	
Paramedic Feedback Received/Remediated	33	
Reviewed - No Action Required at This Time	19	
Self Remediation	12	
Patch Audit Reviews	65	
Escalated for Event Analysis	23	15%
Equipment Issue Reviewed/Resolved	0	
Feedback Received/Remediated	2	
No Follow-up Required	0	
Paramedic Coaching Provided	10	
Remediation Plan Completed	7	
Self Report Remediation Completed	0	
Stakeholder Review Requested/Completed	4	
Total Case Reviews	153	100%

APPENDIX C

QUALITY PROGRAMMING OVERVIEW March 16, 2026



Centre for Prehospital Care

Health Sciences North

QUALITY PROGRAMMING OVERVIEW | March 16, 2026

CHANGE LOG

Version	Date	Author	Summary of change
2026.1.0	March 16, 2026	ML/HS/CS	Initial version for 2026.

VERSION DESCRIPTION:

- First number = year
- Second = major revision
- Third = minor edits

DEFINITIONS:

- Major Revision – impacts reporting / compliance
- Minor revision – wording / clarity

QUALITY PROGRAMMING OVERVIEW | March 16, 2026

INTRODUCTION

The Quality and Information Management (QIM) Team at the Health Sciences North Centre for Prehospital Care (HSN CPC) provides a coordinated, system-wide approach to support high-quality paramedic practice, patient safety, and continuous improvement. Quality in prehospital care is multifaceted and requires alignment across clinical practice, data integrity, education, and performance oversight.

This document outlines the structure, guiding principles, and processes that guide the work of the QIM Team. It describes how data, quality assurance, quality improvement, and medical oversight are integrated to support learning, accountability, and system improvement. Through the meaningful use of data and a Just Culture approach, the team emphasizes understanding performance, identifying opportunities for improvement, and supporting paramedics and service operators in delivering safe and effective patient care.

Together, these elements form a comprehensive quality framework designed to monitor performance, drive improvement, and ensure alignment with Patient Care Standards and system priorities.

MISSION STATEMENT

The Quality and Information Management Team is responsible for ensuring the accuracy, integrity, and meaningful use of data to support high-quality paramedic practice, education, and certification. It combines quality oversight with information management to drive performance, compliance, and continuous quality improvement across the organization.

QUALITY PROGRAMMING OVERVIEW | March 16, 2026

QUALITY FRAMEWORK

The HSN CPC Quality Programming establishes an Integrated Quality Framework that coordinates patient care across various settings (primary, secondary, community) and among different providers to meet population needs efficiently and effectively.

The framework creates accountability by defining specific goals and targets, measuring progress, and focusing on improving the quality of patient care. This is achieved through an integrated system of clinical measurements, quality improvement initiatives, continuous quality improvement (CQI), quality assurance, data management, education, and medical leadership.

The framework aligns with the Health Quality Ontario (HQO)¹ strategic objectives and the Ontario Base Hospital Group Data Quality Management Subcommittee (OBHG DQM) Quality Evaluation Framework, supporting a consistent approach to measuring the quality of care provided to patients in northeastern Ontario.

Strategic objectives

1. To embed quality in Ontario Health priority initiatives.
2. To drive and foster system improvement.

Core Functions

The following core functions maximize the impacts of our work, apply appropriate change levers, and spread and scale Quality Improvement (QI) across the system.

1. To understand quality gaps through data and monitor progress.
2. To synthesize evidence for clinical guidance and quality standards.
3. To engage patients, providers, and the health system.
4. To accelerate change using quality improvement and implementation science methods.

DIMENSION OF QUALITY

The HSN CPC has adapted the Health Quality Ontario (HQO) definition for the Ontario Base Hospital Group environment, defining a high-quality health system as:

A health system that delivers safe, effective, appropriate, patient-centred services, efficiently and equitably, in a timely fashion, resulting in optimal health care for all patients in Ontario.

¹ [Health Quality Ontario \(HQO\)](#)

QUALITY PROGRAMMING OVERVIEW | March 16, 2026

The framework evaluates patient care across seven dimensions, adapted from HQO and OBHG DQM.

DIMENSION	PATIENT MEANING	PROVIDER / SYSTEM MEANING
Equitable 	No matter who I am or where I live, I can access services that benefit me. I am fairly treated by the health care system.	Every individual receives high quality care that is fair and appropriate to them, no matter where they live, what they have, or who they are.
Effective 	I receive the right treatment for my condition, and it contributes to improving my health. Care is reasonable to perform in the care environment.	The care I provide is based on best evidence and produces the desired outcome.
Patient-Centered 	My goals and preferences are respected. My family and I are treated with respect and dignity.	Decisions about my patient's care reflect the goals and preferences of the patient and their family or caregivers.
Efficient 	The care I receive from all practitioners is well coordinated and efforts are not duplicated. The value of my time is respected.	I deliver care to my patients using available human, physical, and financial resources efficiently, with no waste to the system.
Timely 	I know how long I have to wait to see a doctor or for tests or treatments I need and why. I am confident this wait time is safe and appropriate.	My patient can receive care within an acceptable time after the need is identified.
Safe 	I will not be harmed by the health system, physically, emotionally or otherwise. The best practice care does not put my provider at unreasonable risk.	The care my patient receives does not cause the patient to be harmed. The care is safe for the provider to practice.
Appropriate* 	The care I receive is consistent with my underlying health condition and proportional to the disease severity.	I have the knowledge, skills, and ability to determine the appropriateness of care to provide to my patients.

*Added by OBHG DQM

QUALITY PROGRAMMING OVERVIEW | March 16, 2026

QUALITY MANAGEMENT AND CONTINUOUS IMPROVEMENT

The QIM Team ensures that data is trusted, quality is measured, and improvement is continuous. This integrates quality management, quality improvement (CQI) to strengthen system performance and support safe, effective patient care.

QUALITY MANAGEMENT

Quality Management focuses on developing, monitoring, and evaluating standards, KPIs, and performance measures to support safe paramedic practice. Key activities include:

1. Audits and Reviews: Ambulance Call Report (ACR) are evaluated against Patient Care Standards to assess compliance and quality.
2. Case Reviews: Clinically significant variances are analyzed using a Just Culture approach to understand what happened, why, and how to prevent recurrence.
3. Self-Reporting: Paramedics and service operators can report errors, incidents, or near-misses. Self-reports are reviewed and addressed through coaching, self-remediation, or formal case review.

When gaps are identified, the QIM Team supports corrective and preventive actions aligned with regulatory requirements, accreditation standards and organizational priorities.

INFORMATION MANAGEMENT

Information Management ensures that decisions and improvement efforts are grounded in accurate, complete, and reliable data. Responsibilities include:

1. Data governance and quality oversight for education, certification, performance monitoring, and reporting.
2. Managing information systems, dashboards, and workflows for usability and access.
3. Standardizing terminology, data definitions, and reporting structures in collaboration with data partners.

CLINICAL PERFORMANCE MEASUREMENT (CPM)

Clinical Performance Measures are evidence-based measures that guide and improve patient care. The QIM Team regularly evaluates measures to identify:

1. trends and variations in clinical performance, and
2. opportunities for improvement to enhance patient care.

QUALITY PROGRAMMING OVERVIEW | March 16, 2026

Indicators are reviewed and endorsed by the Quality of Care Committee to ensure clinical appropriateness, evidence alignment and consistency with system priorities.

QUALITY IMPROVEMENT (QI)

QI transforms data from CPMs into actionable insights, supporting evidence-based decisions in education, certification, and clinical practice. The QIM Team ensures indicators are valid, meaningful, and measurable, enabling targeted improvement initiatives.

CONTINUOUS QUALITY IMPROVEMENT (CQI)

CQI provides a structured, ongoing approach to understand and refine system processes:

- a) Uses improvement methodologies and problem-solving models to ensure standards are met.
- b) Supports safe, effective patient care.
- c) Embeds improvement into organizational culture by coordinating efforts among educators, quality staff, and data analysts.

Together, CPM, QI, and CQI form a continuous feedback loop that measures performance, drives improvement, and sustains high-quality patient care.

REPORTING AND SYSTEM ACCOUNTABILITY

Reporting supports transparency, accountability, and system oversight. Reports are generated to meet Performance Agreement requirements and provide insight into various aspects of the Emergency Medical System.

Reports are shared with Service Operators, the Ministry of Health (MOH) and system partners such as the Ontario Base Hospital Group (OBHG). Outputs inform decision-making, support improvement initiatives, and demonstrate compliance with regulatory and performance expectations.