# Patient Care Model Standards

Version 1.1

**Comes into force on January 27, 2023**

**Emergency Health Regulatory and Accountability Branch**

**Ministry of Health**

Ontario

To all users of this publication:

The information contained in the Standards has been carefully compiled and is believed to be accurate at date of publication.

For further information on the *Patient Care Model Standards*, please contact:

Emergency Health Regulatory and Accountability Branch

Ministry of Health

5700 Yonge Street, 6th Floor

Toronto, ON  M2M 4K5

PPIU@ontario.ca



## Document Control

| Version Number | Date of Issue | Comes into Force Date | Brief Description of Change |
|---|---|---|---|
| **1.0.a** | | June 10, 2020 | Draft version (new publication) |
| **1.1** | January 27, 2023 | January 27, 2023 | Enabled "Treat and Discharge" model type; expanded patient eligibility. |

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# Patient Care Model Standards

Version 1.1

# Preamble

# Conventions

The Ministry of Health (ministry) has proceeded with the implementation of patient care models for eligible 9-1-1 patients, as enabled since the regulatory and legislative changes proclaimed on November 1, 2019. These patient care models will provide eligible patients with appropriate community-based care options to improve patients' timely access to care needed, and to reduce pressures on hospital emergency departments and ambulance services.

Patient care models shall follow the specific standard outlined in the following sections, as appropriate, in addition to the requirements specified below under "Model Design Enablers".

The standards in this document apply to paramedics employed by a certified Ambulance Service Operator (ASO) authorized to participate in a patient care model:

- Alternate Destination Standard, where patients are transported by paramedics to a health care facility that is not an emergency department (e.g. a mental health crisis centre, hospice, non-hospital affiliated urgent care centres/clinics, family practice offices, community-based family health teams, etc.) where they can receive appropriate treatment;
- Treat and Refer Standard, where patients may be treated on-scene by paramedics as needed, and referred to appropriate health care providers for follow-up care (e.g., primary care physician, home and community care providers such as diabetes clinics, chronic disease management resources in the community, internal referral program for community paramedicine, etc.); and
- Treat and Discharge Standard, where patients may be treated on-scene by paramedics as needed and discharged with recommendation for appropriate follow-up care if needed (e.g., with Health Connect Ontario, primary care physician, home and community care provider, urgent care centres, walk in clinics, community paramedicine program, etc.).

ASO(s) and local regional base hospital program(s) are encouraged to:

- Collaborate with other ASO(s), other base hospital program(s) and/or community partners to implement patient care model(s); and

- Explore patient care models for residents in long-term care homes and other congregate living settings.

Prior to implementation, ministry approval is required, which will incorporate a two-tiered approach determined by patient eligibility criteria. Patient conditions that are referenced in this standard will require notification to the ministry versus a proposal for additional patient groups. (*See Section ii on page 11 for additional information regarding patient eligibility and notification/approval process).*

Please see the ministry's website for a list of approved patient care model projects.

The ministry will continue to monitor and evaluate approved patient care models and may terminate at the ministry's discretion.

# Model Design Enablers

ASO(s), local regional base hospital program(s) and partners shall consider the following model design enablers when developing a patient care model. If a proposal is required, the proposal must demonstrate that model design enablers are in place. To determine when/if a proposal is required, please see Patient Eligibility section below.

## Patient Eligibility

There will be patient care models enabled through the ministry's standard process for inclusion as an auxiliary directive within the Advanced Life Support Patient Care Standards (ALS PCS) or Basic Life Support Patient Care Standards (BLS PCS). A repository of the approved directives will be catalogued and ASO(s) and associated local regional base hospital program(s) will only need to provide the ministry of notification that they are ready to proceed with the approved auxiliary directive. (See Section ii for additional information).

Other conditions that may be considered for patient care models will require a formal proposal to the ministry (see Section II for additional information). Examples may include, but are not limited to, the following:

- Mental Health and Addictions (excluding cognitive conditions such as dementia)
- Palliative/end-of-life care for patients
- Minor illness or condition exacerbations that can be treated or resolved with minimal paramedic intervention, including but not limited to:
    - nausea, vomiting
    - minor dehydration
    - cold/flu like symptoms
- Minor, low-risk injuries including but not limited to:
    - Soft tissue injuries (i.e. abrasions, lacerations, sprains, strains and small burns)
- Managed chronic conditions (patients who are already connected to a health care team)

## Education and Training

ASO(s) and local regional base hospital program(s) must ensure that appropriate education and training requirements are in place. Additional education and training

required for paramedics shall be delivered by the ASO(s) or their respective base hospital program(s) and where appropriate other health care professionals (e.g. palliative care providers/experts) as required to ensure safe, effective implementation.

## Patient Consent

Patient care models shall meet the elements of consent as set out in section 11 of the *Health Care Consent Act, 1996* which is consistent with the current required practice and the Consent to Treatment in Non-Emergency Situations section in the ALS PCS Preamble.

## Transfer of Care

For Alternate Destination model, ASO(s) and local regional base hospital program(s) shall ensure appropriate patient transfer of care to another provider in accordance with the *Transfer of Care Standard* as contained in the BLS PCS.

For Treat and Refer model, ASO(s) and local regional base hospital program(s) shall ensure appropriate referrals are made (e.g., to an on-scene mobile response team, or virtually to a medical consultation service, or to be followed up by another service provider at a later time, etc.) and ensure the referred service provider is provided information such as chief complaints and problem(s) at the time of calling 9-1-1, relevant past medical history, pertinent assessment findings, pertinent management performed and responses to management and vital signs. The model design shall consider if patients have the ability to access the referred care service.

For Treat and Discharge model, ASO(s) and local regional base hospital program(s) are encouraged to enable connections with the most appropriate provider within the circle of care to provide an update on the interaction. Similar to the Treat and Refer model above, the design of Treat and Discharge model shall consider if patients have the ability to access follow-up care recommended. For example, patients with chronic disease may be already connected to a health care team and they can be notified for follow-up care. The Treat and Discharge model should also be in accordance with the Discharge from Care section under the ALS PCS Preamble.

## Patient Safety

Upon assessing a patient for eligibility under the patient care model, paramedics shall provide patient care under the delegation of the local regional base hospital for controlled acts, as defined under the *Regulated Health Professions Act* and in accordance with the BLS PCS, ALS PCS and other medical directive(s)/protocol(s)/procedure(s) approved under the patient care model project. Should a patient be deemed ineligible for a patient care model the attending

paramedic(s) shall provide care in accordance with the BLS PCS and ALS PCS, as appropriate.

Paramedics are also responsible for completing thorough documentation detailing patient assessment, patient disposition and if applicable, a discharge plan (such as treatment plans, etc.) as detailed in the Ontario Ambulance Documentation Standards (OADS).

In addition, the paramedic is responsible for reporting the occurrence of adverse patient incidents in accordance with OADS.

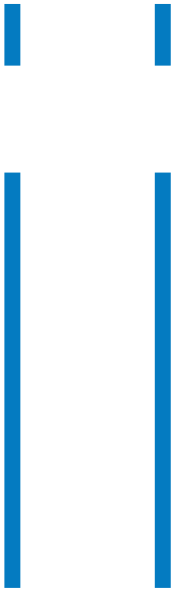
The ASO(s) and local regional base hospital program(s) must also report the occurrence of an adverse patient incident as a result of or related to Patient Care Models to the ministry.

Please refer to “Section iii: Standards for Model Types” for additional considerations for patient safety.

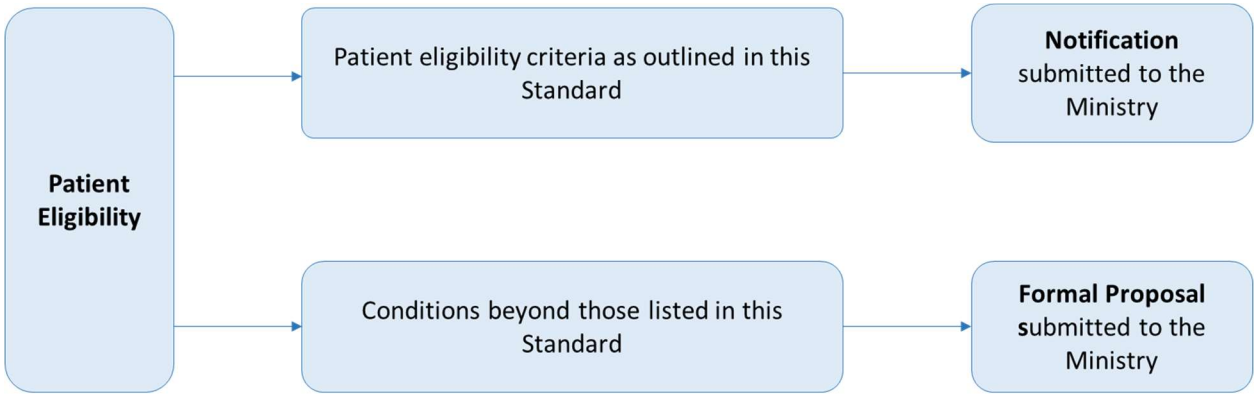
## Central Ambulance Communications Centre (CACC)

ASO(s)/partners shall ensure the deployment plan is incorporated within the Patient Priority System.

# Submission Requirements



# Submission Process




# Notification Requirements

Prior to implementation, ASO(s) and local regional base hospital program(s) **must** inform the ministry of their intent to implement patient care model(s) in order to confirm ministry approval.

Notification requirements include:

1. **Confirmation of adoption of established auxiliary medical directives under ALS PCS.**
2. **Confirmation of support from the local regional base hospital program(s) including readiness of ASO(s).**

Notification to the ministry should be submitted to PPIU@ontario.ca.

By submitting notification to the ministry, ASO(s) and local regional base hospital program(s) are confirming that all requirements under the *Ambulance Act*, Regulations, and Standards are met by the implementation start date.

# Proposal Requirements

To obtain a proposal template please contact PPIU@ontario.ca.

1. **A description of model type and patient eligibility criteria**
2. **Training and education**

   An overview of education and training for paramedics: appropriate educational objectives for paramedics – such as those who will be performing new medical acts

under the approved medical directive(s)/protocol(s)/procedure(s) – should be outlined. This includes, but is not limited to, the knowledge, skills and judgment required to provide the care provisions of the models as approved by the local regional base hospital program, other health care professionals (as required) and the ASO(s). Training and education objectives should be developed in collaboration with participating project partners.

3. **Locally-developed medical directive(s)/protocol(s)/procedure(s)**

   A locally-developed medical directive(s)/protocol(s)/procedure(s) (i.e., beyond the auxiliary medical directives listed in the ALS PCS) that follows the current standard or medical directive/protocol/procedure conventions, is publicly accessible and includes, but is not limited to:

   a. Inclusion and exclusion criteria to guide patient assessment for appropriateness for treatment under proposed models; the specific Indications, Conditions, Contraindications and Treatment (e.g., practices, dose, route, etc.) for each controlled act or other medical procedure;

   b. Approach to obtain and document patient consent;

   c. Documentation required as per the OADS and the Ambulance Call Report Completion Manual (ACRCM);

   d. Proposals must identify which components of the BLS PCS/ALS PCS differ from patient care practices in the drafted medical directive(s)/protocol(s)/procedure(s);

   e. Proposals shall comply with necessary medical oversight and quality assurance program as per the BLS PCS and ALS PCS;

   f. Proposals must identify any additional roles for clinicians/care providers beyond base hospital physicians, if needed/applicable (e.g., facilitating transfer of care; base hospital consult with sub-specialties, etc.);

   g. Identification of public posting location.

4. **Confirmation of support from project partners including local regional base hospital program, ASO(s) and if required, other health care professionals and community partners which should consider:**

   a. Willingness to accept patients eligible for care in community-based settings as determined through assessment in the approved medical directive(s)/protocol(s)/procedure(s);

   b. Capacity at different times of the day to receive eligible patients and provide appropriate patient care;

c. Process to disclose patient health information between the ASO and other service providers (if applicable); and

d. Confirmation that they are a publicly funded health care facility.

5. **Approach for access to patient history, i.e. rostering (if applicable)**

6. **Ambulance Call Report (ACR) Codes**

   ACR codes to support documentation for patient care models. All approved codes, including codes related to patient care model standards, are publicly posted on ministry's website. New ACR codes shall be submitted to the ministry via the "Living Standards Project – ACR Code Request Form".

Completed application packages should be directed to PPIU@ontario.ca.

# Evaluation

The ASO(s) and local regional base hospital(s) approved to implement patient care models under these Standards will conduct evaluation of approved models in accordance with the "**Patient Care Model Evaluation Framework**" referenced under section 11.0.1 of Regulation 257/00.

Proponents will be required to report back on key performance indicators to measure success, including reports on progress of implementation and preliminary results, to allow for adjustments, when required.

ASO(s) and local regional base hospital program(s) must demonstrate:

- Commitment to measure and report experiences of patients, caregivers and service providers in alignment with the Evaluation Framework;
- Commitment to collect, share and report quantitative data as required and in alignment with the Evaluation Framework; and
- History of quality and performance improvement.

# Approval

Upon receipt of a notification or new application proposal, the ministry will review and contact the applicant(s) with any follow-up, as required. Should the ministry determine that the proposal does not meet the requirements set out in the previous section

“Submission Requirements”, the applicant(s) will be contacted and provided with a summary of areas identified to be lacking the necessary supporting documentation.

Patient care model proposals approved by the ministry will be communicated to the applicant(s) outlining any other terms or conditions pursuant to the endorsement.

# Standards for Model Types

# Alternate Destination Standard

Project proponents will submit proposals as per the "Proposal Requirements" to implement a patient care model project that enables transportation of eligible patients to non-hospital destinations where they can receive appropriate treatment.

A non-hospital destination refers to any health care facility/provider that is not affiliated with a hospital corporation as defined under the *Public Hospitals Act.* Transport to a hospital-facilitated destination does not require approval under the patient care models.

## Paramedic Response

### The paramedic shall:

1. Conduct patient assessment as per the BLS PCS and ALS PCS and medical directive(s)/protocol(s)/procedure(s) (as part of ministry-approved patient care model project) to assess patient eligibility for transport to alternate destination;
2. Determine the opportunity for transport to alternate destination based on patient assessment as per the medical directive(s)/protocol(s)/procedure(s) (as part of ministry-approved patient care model project);
3. If additional support is required to make a decision on appropriate patient care, initiate a patch as per the *Patch to Base Hospital Physician Standard* in the BLS PCS and the Patching section under the ALS PCS Preamble, or the medical directive(s)/protocol(s)/procedure(s) (as part of the ministry-approved patient care model project);
4. Make reasonable efforts to inform the patient or Substitute Decision Maker (SDM) that treatment is available under the approved *Alternate Destination* model **as an alternative to transport to a hospital-affiliated facility, e.g., the emergency department,** which would provide the patient with appropriate care;
5. Obtain documentation that outlines patient consent as outlined in the "Model Design Enablers" section for "Patient Consent" of this document to receive care in accordance with a ministry-approved patient care model project, e.g., through creating specific ACR code(s) for documenting patient consent;
6. Confirm that the receiving health care facility have the resources and capacity to accept the patient and provide the care required by the patient;
7. Notify Ambulance Communications Officer (ACO) of the decision to transport to alternate destination;

8. Provide transfer of care to receiving healthcare provider as per *Transfer of Care Standard* in the BLS PCS; and
9. Complete the ACR to reflect the type of community-based health care facility the patient was transported to (if applicable), the patient group/condition (e.g., mental health patient with anxiety/depression), and the model type.

# Treat and Refer Standard

Project proponents will submit notification/proposals as per the "Notification/Proposal Requirements" to implement a patient care model project for eligible patients that provides:

a) On-scene treatment as needed; and

b) Referral to health care providers within community-based settings (e.g., primary care, home and community care, community paramedicine) and hospital-based settings (e.g., rehab). Referral may include to physical sites or virtual care.

## Paramedic Response

### The paramedic shall:

1. Conduct patient assessment as per the ALS PCS/BLS PCS and medical directive(s)/protocol(s)/procedure(s) (as part of ministry-approved patient care model project) to assess patient eligibility for treatment on-scene and referral to a health care provider/facility;
2. Determine the opportunity for treatment and referral on scene based on patient assessment as per the medical directive(s)/protocol(s)/procedure(s) (as part of the ministry-approved patient care model project);
3. If additional support is required to make a decision on appropriate patient care, initiate a patch as per the *Patch to Base Hospital Physician Standard* in the BLS PCS and the Patching section under ALS PCS Preamble, or the medical directive(s)/protocol(s)/procedure(s) (as part of the ministry-approved patient care model project);
4. Make reasonable efforts to inform the patient or SDM that treatment is available under the approved model/medical directive(s)/protocol(s)/procedure(s) **as an alternative to transport to a hospital-affiliated facility, e.g., the emergency department,** which would provide the patient with appropriate care;
5. Obtain documentation that outlines patient consent as outlined in the "Model Design Enablers" section for "Patient Consent" of this document to receive care in accordance with a ministry-approved patient care model project, e.g., through creating specific ACR code(s) for documenting patient consent;
6. Notify ACO of the decision to treat patient on-scene;

7. Provide treatment on scene as per ALS PCS/BLS PCS or medical directive(s)/protocol(s)/procedure(s) (as part of ministry-approved patient care model project);
8. Conduct patient referral as per approved medical directive(s)/protocol(s)/procedure(s) which shall include but is not limited to:
    a. Communication of patient assessment, care provided and status of patient at time of referral to the health care facility/provider the patient is referred to as outlined in the "Model Design Enablers" section for "Transfer of Care" of this document; and
    b. The receiving health care facility/provider's approach to patient follow-up including personnel conducting follow-up, the timeframe for follow up post referral (e.g., within 24-48 hours), and documentation requirements for capturing patient outcome.
9. Complete the ACR to reflect the patient group and the model type.

# Treat and Discharge Standard

Project proponents will submit notification/proposals as per the "Notification/Proposal Requirements" to implement a patient care model project that provides:

a) On-scene treatment as needed; and,

b) Discharge with recommendation to patients for follow-up care if needed.

## Paramedic Response

### The paramedic shall:

1. Conduct patient assessment under the *Treat and Discharge Standard* as per the BLS PCS and the auxiliary medical directive listed in ALS PCS, or the local medical directive(s)/protocol(s)/procedure(s) (as part of the ministry-approved patient care model project);
2. Determine the opportunity for treatment and discharge on-scene based on patient assessment as per the medical directive(s)/protocol(s)/procedure(s) (as part of the ministry-approved patient care model project);
3. If additional support is required to make a decision on appropriate patient care, initiate a patch as per the *Patch to Base Hospital Physician Standard* in the BLS PCS and the Patching section under ALS PCS Preamble, or the medical directive(s)/protocol(s)/procedure(s) (as part of the ministry-approved patient care model project);
4. Make reasonable efforts to inform the patient or SDM that treatment is available under the approved *Treat and Discharge* model **as an alternative to transport to a hospital-affiliated facility, e.g., the emergency department,** which would provide the patient with appropriate care;
5. Obtain documentation that outlines patient consent as outlined in the "Model Design Enablers" section for "Patient Consent" of this document to receive care in accordance with a ministry-approved patient care model project, e.g., through creating specific ACR code(s) for documenting patient consent;
6. Notify ACO of the decision to treat and discharge patient on-scene;
7. Provide treatment on-scene as per approved medical directive(s)/protocol(s)/procedure(s);
8. Provide patient with appropriate education and recommendations for follow-up care (e.g., patient's primary care provider/team if exists) should condition change or new

concerns arise, as per training and education provided to paramedics under the patient care model project; and

9. Complete the ACR to reflect the patient group and the model type.