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Business Case: Non-Urgent Patient Transfers

Report To:	Minister of Health and Long-Term Care
From:	Manitoulin-Sudbury District Services Board
Date:	September 22, 2011

Purpose

To provide a detailed analysis on the issue of non-urgent patient transfers in relation to the responsibilities of Municipalities and Direct Delivery Agents in Northern Ontario, specifically within the areas encompassed by the Manitoulin-Sudbury District Services Board (DSB). Furthermore, to provide a solution to the non-urgent transfer problem by the establishment of a "two tiered" Emergency Medical Services (EMS) structure; one for emergency medical calls financed under the current legislated guidelines, and one for non-urgent patient transportation financed 100% by the Ministry of Health & Long-Term Care (MOHLTC). Lastly, it is anticipated that the MOHLTC gives serious consideration to implementation of the plan for non-urgent transfers as detailed within this business case.

Background

Historically, non-urgent patient transfers have been completed by Ambulance Services. In the somewhat distant past when private operators ran the service for the MOHLTC, completing non-urgent transfers was a normal occurrence. For many services in rural Northern Ontario, it is still the case, despite municipal download in 2000.

There is much history on this topic in the province of Ontario but there has been a lack of clarity in terms of responsibility for the non-urgent transfers until somewhat recently. Most recently the provincial Government has indicated that they will be looking to introduce legislation to regulate the Medical Transportation Service (MTS) industry by setting core standards and requirements on transporting passengers between health care facilities in non-emergency situations. It is still unsure as to how this will affect those ambulance services that are currently performing this service.

Many previous reports and documents have dealt with this matter from an ambulance service perspective. In 1991 this issue was quoted in the Emergency Medical Services Review "Swimmer Report". Noted within was a 40% increase in non-urgent transfers

in the 1980's. Additionally noted was the inappropriateness and inefficiency of local Ambulance services to provide this service.

The Ontario Hospital Association (OHA) produced 2 papers that reflected on non-urgent transfers: one in 1999 and one in 2004. Both reports called into the question the efficiency and appropriateness of ambulances performing non-urgent transfers.

In 2002 the MOHLTC itself commissioned a study by the well respected IBI Group entitled, "Non-Urgent Inter-facility Patient Transfers. While the final report was not originally released it was made public through a freedom of information request. Four major themes were drawn out of that report.

1. Patient Transfer Arrangements Need to be Improved
2. Mode Choice Should Reflect Patient Care Needs
3. Ambulances Should be Used Predominantly for Emergencies
4. MTS Operations need to be regulated.

This topic was reviewed by the Auditor General of Ontario in their report of 2005 and again in 2007.

Most recently, position papers to deal with this issue were created by both the Northwestern Ontario Municipal Association (*NOMA)* and Northern Ontario Service Deliverers Association (*NOSDA)* in 2010. Then in April of this year, the President of the Association of Municipal Emergency Medical Services of Ontario (AMEMSO), *Norm Gale* spoke at the NOSDA Annual General Meeting on the topic. Many issues were detailed including:

1. Increased demands on EMS – emergency call volumes are rising as indicated previously mainly due to an aging population not due to increased population levels
2. Providing a service not within the legislated mandate – Ambulances are meant for emergency use. When considering usage for transfers the person should have been judged by a physician to be in an unstable medical condition ***and*** to require, while being transported, the care of a physician, nurse, other health care provider, emergency medical attendant or paramedic ***and*** the use of a stretcher. Often times these factors are not met and performing these non legislated requests hinders our ability to meet our legislated demands.
3. Inefficient, ineffective – cannot guarantee that EMS will be on time, cannot guarantee that EMS can bring the patient or nurse escorts back, paying highly trained well paid professionals for something that does not require their skills.
4. Comes at the expense of emergency coverage (the legislated mandate) – when an ambulance is out of the rural community emergency coverage is almost always sacrificed. Crews sit on standby to balance the issue.

We have to understand that for the most part the issue of Non-Urgent Patient Transportation has been largely rectified in the urban centres of the province. The private sector has found a niche in major parts of Ontario but there are minimal to no

private-for-profit MTS in rural remote areas of Northern Ontario. MTS is not without its controversy however as the issue of regulation within the industry has come up culminating in an investigation by the Special Ombudsman Response Team (SORT) earlier this year. The Premier of Ontario has since announced that this topic will be reviewed by the appropriate ministries with the intention of introducing legislation to regulate the industry, at the earliest opportunity. Regardless, it is highly unlikely that MTS will expand into the rural North, as the geographical distribution and lack of population density of clients precludes a reasonable profit margin.

Furthermore, the Local Health Integration Networks (LHIN's) in south and central Ontario have analyzed this issue and found how ineffective and inefficient current EMS operators are in providing this service. Interestingly, an IBI study commissioned by the Central East LHIN found that EMS in that area are still providing 18% of non-urgent transfers. That 18% was noted as a "relatively heavy reliance". In the Manitoulin-Sudbury DSB jurisdiction, with no MTS, we are performing 100% of the non-urgent patient transfers. It is with all of the above in mind that a different approach should be taken by leaders in Northern Ontario.

Current Issues

The reality of Emergency Medical Services in the province of Ontario is that we are seeing a disproportionate increase in call volumes in comparison to an ability to provide the service. Call volumes are on the increase, rising at an astronomical pace. For instance, call volumes have risen nearly 50% in the past 6 years within Manitoulin-Sudbury DSB to a total of over 13,000 calls for service in 2010. It is not necessarily the non-urgent transfers that are rising but we are seeing an older, sicker population calling more often for medical emergencies. While our ambulances are performing relatively the same number of non-urgent transfers, our ability to respond to the increasing number of true medical emergencies is compromised.

The role of EMS with respect to non-urgent transfers is somewhat unclear. What is clear is that non-urgent inter-facility transfers are not part of the core mandate for EMS. While the Ambulance Act does not outright prohibit the use of Ambulances for non-urgent transfers (it does not prohibit the use of an Ambulance for any purpose), it does define ambulance to be *"a conveyance used or intended to be used for the transportation of persons who;*

a) *have suffered a trauma or an acute onset of illness, either of which could endanger their life, limb or function;*

b) *have been judged by a physician or a health care provider designated by a physician to be in an unstable medical condition and to require, while being transported, the care of a physician, nurse, other health care provider, emergency medical attendant or paramedic, and the use of a stretcher."*

A significant number of patients being transferred by Manitoulin-Sudbury DSB EMS from one facility to another do not fall within the criteria as listed above.

When faced with an increasing difficulty to provide a timely response to medical emergencies we must re-evaluate our responsibilities. The situation in the Manitoulin-Sudbury DSB area cannot be understated. There are 12 EMS stations over a 45,000 square kilometer area. The closest distance between any 2 stations is 30km (Espanola & Massey). The largest distance between stations is 168km (Foleyet & Gogama). With the exception of one station, we are staffed with only one ambulance at any given time. That means when that one ambulance is occupied, for whatever reason, there is no immediate coverage for the area. We are at either minimum or maximum capacity at any given time. There is **no** middle ground.

One final issue which has yet to be mentioned involves the newly established MOHLTC Ambulance Response Time Performance Plan. In keeping with the concept of transparency and public reporting, EMS in Ontario will be required to develop response time plans and report their achieved times on a yearly basis. Part of this new response time standard entails reporting on ability to respond to Sudden Cardiac Arrest patients within 6 minutes and Canadian Triage and Acuity Scale (CTAS) 1 patients within 8 minutes. Understanding the aforementioned geographical and staffing situations within Manitoulin-Sudbury DSB, it will be extremely hard to meet this standard within a reasonable percentage of time, even under optimally deployed circumstances, as our geography is a huge barrier. Regardless, we must attempt to perform as best as possible and any unnecessary usage of Emergency Medical Services minimizes the ability to do so.

Essentially we have now come to a point where capacity planning for all types of inter-facility transfers must be undertaken, to ensure that safe and effective patient transport exists across the spectrum of acuity. The current issue at hand is that the EMS in Northern Ontario can no longer support the dual role of providing emergency medical services and non-urgent inter-facility transport.

Northern Ontario Non-Urgent Transfers

Many EMS in Northern Ontario face this issue. Some perform greater amounts of non-urgent transfers than others. The following chart depicts emergency call volumes in comparison to non-urgent transfers.

Service	2010 Call Volume (excluding emergency standbys)	Non-Urgent Transfers	%
Cochrane DSSAB	14532	5168	36%
Manitoulin-Sudbury DSB	**7014**	**2251**	**32%**
Algoma DSSAB	6711	1974	29%
Parry Sound	7712	965	13%
Nipissing DSSAB	13841	1166	8%

It is important to note the differences in different areas. While not shown in the statistics, the City of Greater Sudbury does benefit from the Hôpital Régional de Sudbury Regional Hospital (HRSRH) having one of the few MTS in Northern Ontario working under contract to them. The HRSRH pays out of their budget to keep this

resource active as a vital part of their wait time strategy. Ensuring that patients leave this regional resource and referral facility when appropriate is of utmost concern. A few years ago the local EMS made it known that they were unable to keep up with transfer demand and the hospital assumed responsibility to ensure that their wait times were lessened.

North Bay General Hospital (NBGH) is utilizing an old decommissioned ambulance as part of a program to help with their wait time strategy. Operating this internal MTS from December to July of this year reveals that 275 non-urgent patient transfers were performed under this program which greatly reduced the hospital's reliance on EMS to provide this service. This translates into 275 patient transfers in approximately 200 days. This pilot project shows great promise, although still in its infancy.

Ontario's Health Care Strategy

There are 2 programs developed by the Province of Ontario that deserve noting here: Ontario's Wait Time Strategy and Bill 46, Excellent Care for All Act.

A Canadian Health Wait Time Strategy was introduced in 2004. It was felt through transparency and public reporting that success can be achieved. Since inception there has been a vast improvement from the baseline. Ontario is actually the highest ranking province in terms of success in 5 key area wait times. One of the 5 key area reportable wait times is in the Emergency Departments (ED). It is a well known fact that one of the biggest barriers to the decrease of wait times throughout the hospital system is the lack of Alternative Level of Care (ALC) options. Patients requiring ALC are being left in hospitals due to a lack of suitable offsite accommodations. Then when a bed becomes available the need to transport the person becomes apparent. As an example of the impact of ALC patients, it was reported in 2005 by the Canadian Association of Emergency Physicians that one ALC patient in the ED denies access to four patients each hour. This is an extreme impact, indicative of an inefficient system. Compound the problem of lack of suitable alternatives with the lack of proper transportation in Northern Ontario and the issue becomes larger.

It is this ALC topic which is identified as one of the biggest issues for the NELHIN. In 2010, to help with the ALC issue, patient transportation was addressed at HRSRH and NBGH. Patient travel is an important initiative with the LHIN considering their posted statement of moving toward a "fully integrated health care system that ensures the right care at the right time in the right place". As stated in a recent press release, "getting people discharged from the hospitals faster and into a more appropriate setting of care is what drives the NELHIN's ED/ALC strategy". There needs to be an effective means of transport to support this statement and under current constraints one does not exist in the rural Northern Ontario hospital setting.
The second program deserving mention is Bill 46. Passed in June 2010, Bill 46, the Excellent Care for All Act, introduced comprehensive new initiatives to improve the quality and accountability of the province's health care system with an aim of ensuring that the needs of patients came first. The legislation requires health care organizations, starting with hospitals, to:

- Develop and post annual quality improvement plans

- Create quality committees to report to each hospital board on quality related issues, including the public annual quality improvement plan
- Link executive compensation to achievement of quality plan performance improvement targets
- Implement patient and employee satisfaction surveys and a patient complaints process

Additionally, according to the MOHLTC website, the Province will also be developing ways to make better use of health care resources, such as reducing avoidable hospital admissions and readmissions, and the unnecessary use of diagnostic equipment. The province is also looking to ensure patients can access the best quality treatment, by moving towards a patient-based payment system of hospital funding where large hospitals are reimbursed based on the types and volumes of patients they treat. It is with this and the understanding by the above invoked legislation, that we believe the provincial government is serious about quality and timely healthcare.

Lastly, as part of the Open Ontario Plan as stated in the Speech from the Throne on March 2010,

> *Ontario will lead by pursuing a path of constant reform to ensure that the health system -- and all our vital public services -- are there for our children and grandchildren. It will introduce legislation to make health care providers and executives accountable for improving patient care. Your government will build on the success of the wait time reduction strategy by ensuring that -- for more and more services -- money will follow the patient. Patients will have greater choice about where they can access the best quality treatment. Your government will review the Public Hospitals Act and introduce legislation to create a hospital system that taps into the expertise of community partners and all health care professionals.*

Objectives

It is with the above in mind that we present this business case to the MOHLTC as an attempt to seek equity with the rest of the province in terms of ability to provide emergency response/coverage combined with support of non-urgent transport capacity. We understand the needs of the hospitals and patients to be able to seek medical treatment that they do not have access to within their rural setting and are also cognizant of the fact that these hospitals have come to rely on us to provide for this transport. However, Manitoulin-Sudbury DSB EMS cannot continue to be available for the current amount of non-urgent calls that we receive from the hospitals given our current resource allocations, as it diminishes our response capability for more urgent service needs.

Recommendation

Upon review of this topic in totality, and through consultation with other stakeholders, there is one recommendation thought to fit the needs of all those involved. The solution involves the establishment of a separate level of non-urgent transportation within the current EMS structure. We see that second tier operating as

a distinct division within the Manitoulin-Sudbury DSB. We would expect that the MOHLTC would enter into a service agreement with Manitoulin-Sudbury DSB in a broad, evolving program under the acceptance of a firm commitment from the MOHLTC to continue to fund such an endeavour. The details are as follows:

a) MOHLTC allows the establishment of a 2 tiered Ambulance system within Manitoulin-Sudbury DSB; one to provide EMS and one to provide Non-Urgent Transportation.
b) MOHLTC, another Provincial Ministry or a combination thereof fund Manitoulin-Sudbury DSB to provide the new non-urgent transportation tier at 100%.
c) MOHLTC continue to allow the Central Ambulance Communication Centre (CACC) to be the agency booking the appointments and dispatching the non-urgent transport crews.
d) Manitoulin-Sudbury DSB provides its expertise in running medical transportation services on a 100% cost recovery basis.
e) Manitoulin-Sudbury DSB provides an actual mode of transportation by providing one of its suitable decommissioned ambulances for this endeavour at no cost.
f) Manitoulin-Sudbury DSB hires & appropriately trains employees to provide this level of non-urgent activity, creating a cost differential versus the EMS level of competencies.
g) Manitoulin-Sudbury DSB houses the vehicle(s) in Little Current (& possibly Espanola). The new employees will report to the EMS Stations for duty and will be deployed based upon the booked needs.
h) Manitoulin-Sudbury DSB operates this second tier in alignment with all applicable MOHLTC acts and standards.
i) This system is available for primary use in picking up patients on Manitoulin Island or the LaCloche area servicing facilities within the area and into the Hôpital Régional de Sudbury Regional Hospital (HRSRH). This service is then available to remain in the Sudbury area to repatriate any patients returning to the Manitoulin or LaCloche areas.

In seeking an internal solution, the many issues regarding the unregulated MTS are offset. In allowing the current medical transportation experts to run a secondary system there can be confidence that appropriate safety standards are maintained. In providing a made in the North solution, both the rural northern health care facilities and rural northern EMS can achieve their goals. The for-profit sector has not provided a solution in the rural North nor is it assumed that they ever will. If it was financially feasible to operate a private MTS in the rural North, the private sector operators would already be in the area.

An internal system must be established as the only alternative, otherwise patients will continue to miss their appointments, staff at the hospitals will continue to be frustrated, and people will continue to call for an ambulance due to a medical emergency and suffer while they wait for the closest response which could very well have been quicker if their local ambulance was not performing a non-urgent patient transfer outside of their community.

Funding Parameters

While the true costs of such a service are unknown, some factors required for its operation are known. We will utilize the known factors as a starting point for financial review. The tables in Appendices A & B represent an estimate of the costs of providing this additional service under the plan as detailed above.

While Manitoulin-Sudbury DSB is willing to supply some of the startup costs at our expense, we would not be willing to continue on a traditional 50% funding model as it is within the current Land Ambulance budget, as this is not feasible for our municipalities. The benefit of proceeding with this recommendation as opposed to any other option for consideration is that EMS already has the infrastructure and knowledge in the medical transportation field and there is the potential for some of the costs to be offset by using current group purchasing and rates.

Conclusion

The issue of non-urgent patient transfers had been going on for many years and remains unsolved in Northern Ontario. As pressures mount on EMS to respond to an increasing number of emergency calls, the ability of EMS to continue with its historical assistance in inter hospital transportation is decreased. At present time EMS is ineffective and inefficient in providing this unlegislated service. Areas in Southern Ontario, where the private sector has established their presence, do not have as great an issue with non-urgent transfers due to the abundance of MTS. While the MTS is unregulated and presently under scrutiny, it does allow for EMS to concentrate on its core mandate: emergency transport. Northern Ontario is like any other EMS in the province dealing with an aging population and increased demands on the emergency side; however there appears to be no current solution in place to deal with non-urgent transportation. There needs to be creative thinking and a unique approach to this matter in Northern Ontario. It is the focus of this business case to provide a recommendation drawing on the real issues in the North and the current administrative capacity of the Manitoulin-Sudbury DSB to oversee a local solution, if dedicated resources are allocated by the Province.

Appendix A

Estimated Costs to Staff Non-Urgent Transportation
One Non-Urgent Unit

Cost Centre	Item	Start-up	Ongoing	Per time	Year 1 Total	Annualized
Vehicle	Unit	$0.00			$0.00	$0.00
	Fuel		$1,000.00	mth	$12,000.00	$12,000.00
	Insurance		$290.00	mth	$3,480.00	$3,480.00
	Maintenance		$7,000.00	yr	$7,000.00	$7,000.00
Attendants	Wage		$15.00	hr	$62,400.00	$62,400.00
	Hours/Day		8			
	Days/Week		5			
Scheduling Assistant	Wage		$15.00	hr	$12,480.00	$12,480.00
	Hours/Day		8			
	Days/Week		1			
Medical Supplies	Oxygen		$220.00	mth	$2,640.00	$2,640.00
	Defibrillator	$2,500.00			$2,500.00	$0.00
	First Aid Supplies	$1,000.00	$100.00	mth	$2,200.00	$1,200.00
	Main Stretcher	$4,000.00			$4,000.00	$0.00
	Second Stretcher	$3,700.00			$3,700.00	$0.00
	Stair Chair	$1,250.00			$1,250.00	$0.00
	#9 Stretcher	$1,000.00			$1,000.00	$0.00
	Medical Bag	$360.00			$360.00	$0.00
	Other Misc.		$200.00	mth	$2,400.00	$2,400.00
Administration Fee	10% of total cost				$11,741.00	$11,741.00
TOTAL					**$129,151.00**	**$115,341.00**

Appendix B

Estimated Costs to Staff Non-Urgent Transportation
Two Non-Urgent Units

Cost Centre	Item	Start-up	Ongoing	Per time	Year 1 Total	Annualized
Vehicle	Unit	$0.00			$0.00	$0.00
	Fuel		$2,000.00	mth	$24,000.00	$24,000.00
	Insurance		$580.00	mth	$6,960.00	$6,960.00
	Maintenance		$14,000.00	yr	$14,000.00	$14,000.00
Attendants	Wage		$15.00	hr	$124,800.00	$124,800.00
	Hours/Day		16			
	Days/Week		5			
Scheduling Assistant	Wage		$15.00	hr	$12,480.00	$12,480.00
	Hours/Day		8			
	Days/Week		1			
Medical Supplies	Oxygen		$440.00	mth	$5,280.00	$5,280.00
	Defibrillator	$5,000.00			$5,000.00	$0.00
	First Aid Supplies	$2,000.00	$200.00	mth	$4,400.00	$4,400.00
	Main Stretcher	$8,000.00			$8,000.00	$0.00
	Second Stretcher	$7,400.00			$7,400.00	$0.00
	Stair Chair	$2,500.00			$2,500.00	$0.00
	#9 Stretcher	$2,000.00			$2,000.00	$0.00
	Medical Bag	$720.00			$720.00	$0.00
	Other Misc.		$400.00	mth	$4,800.00	$4,800.00
Administration Fee	10% of total cost				$22,234.00	$22,234.00
TOTAL					**$244,574.00**	**$218,954.00**