ISSUE SHEET

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Non-Emergent Patient Transportation in Kenora & Rainy River Districts: An Evidence-Based 3rd Party Review

A) EXECUTIVE SUMMARY

The Non-Eemergent Patient Transportation in Kenora & Rainy River Districts Review clearly demonstrates several trepidations from all participants regarding low priority transport of patients between facilities. These concerns cover many aspects of Hospital & Emergency Medical Services (EMS) operations including, funding, staffing levels, level of care for patients in transit, legislated barriers, operational barriers and a lack of global system planning & oversight.

While many of the recommendations endeavour to correct the concerns, several of them are outside of Provincial mandates, legislation and funding responsibilities. Assumption of many of the recommendations for the EMS sector will only generate a further disparity across the Province from a funding perspective and delivery of services model. Implementation of the recommendations in their entirety as presented would pose a liability to the Rainy River District Social Services Administration Board (RRDSSAB) and assume responsibility for services outside of Provincial mandates.

The global oversight of non-emergent patient transportation is non-existent in the Province of Ontario. Each local hospital and corresponding EMS service attempts to correct systemic issues with local workaround solutions. While many of the issues are perceived to be Provincial responsibility, the workaround solutions applied impact directly on the local taxpayers. A disparity between large urban and small rural EMS services continues to expand with many Local Health Integrated Networks (LHINS) directly funding non-emergent patient transportation services outside of EMS, without a clear mandate from the Ministry of Health & Long Term Care (MOHLTC). Proposed recommendations that utilizes existing staff hours or imposes a funding requirement on the local taxpayers outside of legislation should not be considered by the RRDSSAB.

Participation in a Northwest Local Health Integration Network (LHIN) Coordination Panel has merit in bringing all the issues to one central panel. If the issues are acknowledged by key stakeholders, global solutions and lobbying for transformation may be accomplished. The participation in this panel should be considered within the current budget and staffing commitments. The RRDSSAB should also consider supporting the identification of key factors and statistics to support the change process.

Patients, stakeholders and the local taxpayers are all affected by the current situation of non-emergent patient transportation. The RRDSSAB should consider supporting the continued lobbying to all levels of government for a clear resolution to this issue. The solution should ensure clear accountabilities for service delivery and appropriate levels of Provincial funding to provide the services.

B) BACKGROUND

Todd MacDonald of Performance Concepts was contracted to provide a report within the following parameters:

"The Project is intended to generate feasible solutions and options for the provision of the non-urgent/non-emergent transfers (NEAT) for NW Ontario including the District of Kenora and Rainy River. Options and solutions presented must be scalable and flexible to meet the future demand and environmental factors; operationally and financially sustainable within existing system resources; and integrated with the operations of health service providers including ORNGE, regional hospitals, The Thunder Bay Regional Hospital, the Winnipeg Regional Health authority, the MOHLTC regulatory and finance branches and the two ambulance services in the area."

The report was funded by the NW LHIN and prepared for a consortium comprised of the following organizations and participants:

1. Dryden Regional Health Centre;
2. Lake of the Woods District Hospital;
3. Red Lake Margaret Cochenour Hospital;
4. Riverside Health Care Facilities Inc;
5. Sioux Lookout Meno Ya Win Health Centre;
6. Atikokan General Hospital;
7. ORNGE
8. Rainy River DSSAB (RRDEMS)
9. Kenora DSSAB (Northwest EMS)

The final report was received by the consortium on September 19, 2013 and reviewed on October 10th, 2013.

The final report is broken into:

A. Introduction & Overview of Non-Emergent Transportation in Ontario
B. Situation Analysis in Kenora & Rainy River Districts
C. Findings, Recommendations & Commentary
D. Proposed Implementation Timeframes (2013-2015)

C) ANALYSIS OF RECOMMENDATIONS

SECTION: System Restructuring

System Restructuring Action #1-A

Establish a NW LHIN Non-Emergent Patient Transportation Coordination Panel with the following "integration" mandate:

1. *Annual Business Planning*
2. *System Business Rules & Dispute Resolution*
3. *Annual Results Reporting*

System Restructuring Action #1-B

Establish NW LHIN Coordination Panel, Co-Chairs & key stakeholder membership to oversee required Non-Emergent Patient Transportation system integration & improvements

- *Rotating Co-Chairs from a selected EMS service & community hospital (2 year cycle)*
- *Coordination mandate, not a binding/voting governance mechanism (LHIN secretariat support)*
- *Ensure system reform issues from Kenora, Rainy River, & Thunder Bay districts integrated/resolved across entire LHIN*
- *Rotating representatives from cross-section of NW LHIN community hospitals…however any/all hospitals can participate on any issue they deem important*
- *All 3 EMS services in NW LHIN represented…also ORNGE, TBHRSC, Winnipeg hospitals, CACC, MOHLTC*

Analysis #1A & #1B: Currently there is no global oversight of patient transportation issues. A committee structure may bring stakeholders together to discuss common issues, however without a clear mandate or funding to accomplish this initiative participation will be at the discretion of the individual partners within their current funding and staffing limitations.

RRDSSAB recommendation: Support in principle the concept of a non-emergent Patient transportation Coordination Panel subject to available funding and staff commitments.

System Restructuring Action #1-C

Coordination Panel to develop an annual system-wide Non-Emergent Patient Transportation business plan for the entire NW LHIN. The business plan will feature evidence based system performance targets & consensus based implementation actions.

- *Initiate ongoing plan-deliver-evaluate system planning & management cycle*
- *Combine the business plan with annual integrated system budget - building on already-established EMS & hospital resources/budgets*

Analysis #1C: EMS is not mandated to provide non-emergent patient transportation and existing budgets should not be used to support this initiative. Patient transport between facilities is a function of patient treatment and not Emergency Medical Services. It should be funded by the Province at 100%, not cost shared with the municipal taxpayers. Current practices across the province, clearly demonstrates

inequities between large urban ambulance services and small rural services. Where large volumes of patient transfers exist, patients are moved by non-EMS transport services with costs borne by the Ministry through the LHIN at 100%.

RRDSSAB recommendation: Assist in the development of the plan as part of the coordination panel and continue to provide services to fulfil patient needs at current levels. Continue to lobby for 100% funding for non-emergent patient transfers to correct the funding inequity between large urban and small rural EMS providers. Consider options for transit outside of EMS.

System Restructuring Action #1-D

Coordination Panel to design & oversee annual Non-Emergent Patient Transportation results report card, derived from evidence based key performance indicators (KPIs).

- *Key performance indicators (KPIs) addressing service delivery outputs, unit costs, timely business process execution, patient impacts*
- *KPIs set out in this report to form basis of report card put forward by Coordination Panel*
- *Important system-wide accountability tool…annual public reporting to DSABS, hospital boards & MOHLTC in 2015*
- *Report Card indicator data trends to support Panel's annual business plan target setting process*

Analysis #1D: Currently no shared data exists. A comprehensive "Report Card" may allow the parties to review the impact of decisions, impact on patients, budgets and provide information for future planning. Depending on the workload of this initiative it may be accomplished with existing staff and within existing budget allocations.

RRDSSAB Recommendation: Support the "Report Card" and participate as required subject to existing staffing and budget.

SECTION: Funding Restructuring

Funding Restructuring Action #2-A

Implement a 2014 NW LHIN "integrated' funding model for Non-Emergent Patient Transportation

- *The proposed integrated funding model would feature MOHLTC annual gap reduction ($) funding to be allocated by MOHLTC based on proposed new Coordination Panel input*
- *Funding would be incremental - building on existing community hospital, TBRHSC, ORNGE & EMS resources. Focus on eliminating high-priority systemic gaps in Code 2 service delivery processes & practices*
- *Funding model should have due regard for the realities of the Northern local tax base, and should attempt to blunt the province-wide funding inequities disadvantaging Northern actors in the Non-Emergent Patient Transportation system.*

Analysis #2A: New funding is required to eliminate identified gaps. Funding should be equitable across the province.

RRDSSAB Recommendation: Support an integrated funding model with new 100% Provincial funding to address systemic gaps and maintain Provincial equity.

Funding Restructuring Action #2-B

Initial 2014 Non-Emergent Patient Transportation "integrated" gap budget funding priorities to include the following:

- *EMS up-staffing costs generated by Code 1-2 workload at EMS bases with an annual peak daytime UHU >35%*
- *EMS up-staffing costs for single unit coverage bases required to do Code 1-2 transfers outside their established response zones (calls significantly compromising Code 4 coverage)*
- *ORNGE fixed wing air transport replacing EMS land transfer "legs" greater than 200 kilometres & annual volumes > 50 trips*
- *Patient "care & control" staffing investments at TBRHSC (or in Winnipeg) that significantly reduce the need for community hospital nurse escorts*
- *Expanded non-paramedic transfer contracted service hours to improve timeliness of Code 2 patient transfers from T-Bay Airport tarmac to TBRHSC*
- *Re-imbursement to hospitals for police escort costs for Psychiatric "Form 1" patients*
- *New non-paramedic transfer service hours to repatriate low risk Ontario patients back from Winnipeg Code 2 procedures (originally delivered to Winnipeg by EMS or ORNGE)*

Analysis # 2B: Unit Hour Utilization (UHU) is a poor indicator of a low volume, single vehicle station, where geographic coverage is a primary concern. UHU is predominately used in large call volume stations with multiple units available for deployment. In the north, a vehicle may be covering a large geographic area in excess of 300 square kilometers. Removal of an ambulance from its operational area may place the core population in the geographic area at risk for prolonged periods of time. In this case, UHU is being used to substantiate excess capacity to perform non-emergent transfers, a function not within the EMS mandate. This is not reflective of other EMS locations, particularly in large urban centers.
Air guidelines which adopt a triggering mechanism based on number of trips is unrealistic. Risk exposure is the same for each one of the fifty trips. Adoption of this concept would affect one station in the Rainy River District. There is no supporting documentation to justify the 200 km zone. As Ministry reporting requirements for Response Times focus on responses of 6 to 8 minutes for urgent patients, any use of EMS outside the urgent call in a rural area may dramatically affect the Response time in that area.
"Patient care & control" staffing has already been adopted in Ontario with off load nursing. A similar process could be adopted for Manitoba however differences in Provincial protocols may limit achievability.
Code 2 transfers at Thunder Bay Airport continue to bottleneck patients both arriving and departing Thunder Bay. Any initiative to expand transport services would decrease delays and improve patient flow.

Reimbursement to hospitals for psychiatric patient transfers is only one aspect of the problem. Psychiatric patients are generally assigned a very low priority within the ambulance system. Patient generally must be assessed within 72 hours from the time they are issued a Form 1 for assessment. Small hospitals do not have the facilities to hold patients without additional costs and therefore expect the patient to be transported immediately. In the Rainy River District it is further complicated by the fact that both psychiatric facilities are out of the district, Thunder Bay and Kenora. Use of ambulance has increased due to OPP initiation of a billing policy for transport where previously none existed. Consideration might also include the province adopting the requirement for the OPP to transport without billing. "One taxpayer" concept.
Repatriation of out of province patients can already be achieved utilizing Manitoba stretcher services. Currently, as the hospitals must pay for these services, they choose to call on EMS which is provided at no cost to the hospital or patient. This cost should be directly funded by the province, through the hospital or OHIP.

RRDSSAB Recommendation: Support all funding initiatives provided EMS does not assume any roles that are not provincially mandated. Continue to lobby for equitable provincial funding at all levels of government.

Funding Restructuring Action #2-C

Initial 2014 Non-Emergent Patient Transportation "integrated" budget gap reduction funding priorities to include the following budgeted amounts:

Non-Urgent Patient Transportation: Recommended Gap Budget for MOHLTC Funding Consideration		
	Gap Budget Rationale & Commentary	Recommended Gap Budget Amount
ORNGE Assumption of Kenora to Winnipeg Transfer "Leg" for Code 2 Non-Emergent Patients	Reduction in patient risk & condition erosion during a 200km one-way transfer with no hospital between destination points Claw back of estimated 1,000 Code 4 coverage hours for Kenora EMS Some fiscal room for ORNGE may be available due to reduced tarmac detention fees at T-Bay airport due to Ambutrans assumption of Code 2 transport to TBRHSC	Estimated annual 60 trips for total of $250,000 Assume $50,000 offset from T-Bay tarmac saving Net new cost $200,000
Offset Funding for Community Hospital Nurse Escort Costs (5 year transition funding)	Community hospital costs are driven by receiving hospital patient care & control policies No established patient transportation cost centre in hospital budgets...robbing other program priorities within hospital	Estimated $300,000 across Kenora & Rainy River Districts annually Funding phased out once Regional hospital care and control barriers resolved (Example: LHIN/TBRHSC pilot to establish Transfer Nurse to asume care and control)

Funding Restructuring Action #2-D

The three NW LHIN EMS services to develop common 2014 business plan performance targets for Code 1-2 Non-Emergent Patient Transportation - distinct from their existing performance plan targets developed primarily for pre-hospital emergency Code 3-4 response.

Analysis #2C & 2D - EMS is not mandated to address Code 1 – 2 Non-Emergent Patient Transportation for in-hospital patients. Inter-facility transport of patients is the responsibility of the sending facility for all non-emergent patients, including nursing home patients. In larger centers, the majority of transfers are accomplished using private transport services or in house services, not EMS. Use of air ambulance in these situations is not cost effective, as air costs average $5,000 per hour versus land at $250 per hour.
EMS usually ends up as the preferred provider due to the continued lack of alternative transportation, such as stretchers services or handicap accessible taxis.

RRDSSAB Recommendation: Continue discussions with Non-emergent transportation committee as recommended in #1A and continue to lobby for effective funding and patient appropriate transportation.

Funding Restructuring Action #2-E

NW LHIN community hospitals to develop common business planning performance targets related to timely, patient-centric non-emergent transportation.

- *Hospitals to track forecast versus actual "medically necessary" Code 1-2 Nurse Escort volumes, hours or replacement staff hours (straight time & overtime funded)*
- *Each community hospital should initiate detailed hourly effort and cost monitoring – including staffing "ripple effect" when Nurse Escorts' scheduled floor shifts need to be re-assigned following long transfers.*

Analysis #2E – No effect on EMS, other than time waiting for an escort to accompany patients.

RRDSSAB Recommendation: Provide assistance in gathering data for local hospitals as requested.

Restructuring Action #2-F

ORNGE to develop 2014 performance targets & internally approved gap reduction budget for SOA fixed wing service delivering Code 1-2 Non-Emergent Patient Transportation

- *Present MOHLTC with 2014 ORNGE gap funding budget that includes new Code 2 air transfer "legs" replacing previous long-haul land EMS transfer "legs" > 200 km & 50+ annual trips*
  - *Also replacing EMS Code 2 transfer "legs" with average road travel time 2.5 hours or greater*

Analysis #2F – At $4,500 to $5,500 per hour for an aircraft compared to an overtime cost of a land ambulance at $250 this proposal has limited feasibility, unless patient

transit time is a concern. Where rapid transport is required an aircraft may be a reasonable alternative.

RRDSSAB Recommendation: Support the recommendation if the province is willing to adopt and fund the initiative. If the province is unwilling to fund this initiative, continue lobbying to adequately fund non-emergent transportation at 100% Provincial cost.

SECTION: Service Delivery Restructuring

Service Delivery Restructuring Action #3-A

In parallel with MOHLTC gap funding reforms, Councils, DSABs & EMS services commit to ongoing Paramedic based direct delivery of Non-Emergent Patient Transportation Services across the Kenora and Rainy River districts. Direct paramedic delivery is the only viable option in Northern/emote systems with highly dispersed, relatively low Code 2 call volumes – as demonstrated by 2012 Thunder Bay District Review, and by the failed 2013 Timiskaming non-paramedic transfer service pilot project funded by the NE LHIN.

- *Regardless of intergovernmental debate concerning Ambulance Act legislative mandates, Service Boards & EMS across the NW LHIN should recognize Code 1-2 Non-Emergent Patient Transportation as a legitimate "line of business" to be delivered primarily by EMS paramedics*
  - *Local taxpayers have invested significant "fixed costs" in EMS paramedic services. These EMS services have sufficient overall resource capacity to deliver Code 1-2 Non-urgent Patient Transportation in addition to Code 3-4 pre-hospital emergency medical services.*
  - *Non-paramedic transfer services can play an important role in urban Thunder Bay and repatriating Winnipeg non-emergent patients, but are not feasible in a non-urban environment across much of NW LHIN. Paramedic delivery is the only viable option.*

Service Delivery Restructuring Action #3-B

Consolidate and expand the existing TBRHSC non-paramedic, non-emergent patient transportation contract in Thunder Bay under the oversight of Superior North EMS – eliminating expensive airport tarmac delays for ORNGE and delivering timely patient movement to TBRHSC

- *Initiate 2014 contract expansion (to approximately 5,000 hours) to provide new transport hours devoted to timely Thunder Bay airport tarmac Code 2 trips to TBRHSC – thereby reducing excessively high Code 3-4 UHU for Superior North EMS urban bases*
- *Contract expansion in 2014 to also include new transport hours devoted to land based repatriation of medically appropriate patients back to community hospitals after Code 2 scheduled TBRHSC tests/procedures*
  - *Accomplished via patient repatriation "hand-offs" from non-paramedic contracted provider to Kenora or Rainy River EMS paramedics as required to complete repatriation to patient's hospital of origin*
- *Advocate for MOHLTC funding of expanded non-paramedic contract, recognizing potential system-wide benefits & cost savings to NW LHIN community hospitals, ORNGE, Kenora EMS & Rainy River EMS*

Analysis #3A & 3B– Accepting the role of non-emergent Patient transportation services without a Provincial mandate, although not reflective of current patient needs, could place the DSSAB at a disadvantage in the future. Without mandate any changes in program delivery or expectations of the public could lead to increased costs and potential liabilities to the DSSAB. Assumption of this role would lead to a further disparity in delivery of services across the province.
Acceptance of a SNEMS solution without justification/costing would further entrench EMS in a non-mandated role without Ministry funding and further increase the inequities across the Province.

RRDSSAB Recommendation: That the DSSAB not support this recommendation unless adopted provincially.

Service Delivery Restructuring Action #3-C
Implement evidence based Nurse Escort decision-making model between NW LHIN community hospitals, TBRHSC& Winnipeg receiving hospitals. Secure BLS regulatory standard "special circumstances" exemption for Northern/remote EMS services executing lengthy non-emergent transfer legs.

- *Establish consistent patient acuity checklist tools at all NW LHIN community hospitals by end of Q1 2014 in order to make evidence based Yes/No decisions for sending a Nurse Escort*
- *Consider recently developed TBRHSC patient acuity checklist tools as potential models for wider application across NW LHIN community hospitals*

Service Delivery Restructuring Action #3-D
Modify existing Code 2 patient coding admin practices at Kenora and Rainy River community hospitals to create new "Urgent But Scheduled" Code 2 transfer arrangement with EMS services (6 month or 1-year pilot period)

- *Establish two distinct Code 2 patient coding admin processes – the existing "non-urgent and scheduled" category plus a new "urgent but scheduled" category. Categories differentiated by EMS preparation "window" of time to pick up patient.*
- *EMS to promptly respond to "urgent but scheduled" Code 2 admin requests following a 5-hour preparedness window (to arrange up-staffing coverage when deemed necessary).*
- *"Non-urgent but scheduled" calls subject to existing "window of prep time" for EMS to respond.*
- *Community hospital medical staff will make the final call on when this new "urgent but scheduled" Code 2 admin practice is to be invoked*
  - *Deepest understanding of patient care issues/requirements*
  - *Periodic peer review with EMS re. disputed decisions to invoke new Code 2 admin practice*
- *No Code 3 up-coding of "scheduled but urgent" non-emergent patient transfers by hospital medical staff, ORNGE physicians or CACC. ORNGE & community hospital physicians to be briefed by EMS Chiefs & hospital executive management on new "urgent but scheduled" coding admin arrangements.*

Analysis #3C & #3D– Implementing a standard or practice under Basic Life Support Standards (BLS) or Regulation that is not provincially implemented could lead to increased costs and potential liabilities to the DSSAB. Assumption of this role would also lead to a further disparity in delivery of services across the province.
Although check sheets may be used to further determine patient acuity for a hospital, in EMS, Dispatch Priority Card Index (DPCI II) (set of predetermined sequential questions) determines the patient priority.
Physician up-coding should not be occurring at any time as current provincial practice is to move patients as determined by their current acuity not a perceived future need.

RRDSSAB Recommendation: That the DSSAB not support this recommendation unless adopted provincially.

Service Delivery Restructuring Action #3-E

Implement evidence based adjustment of the existing ORNGE "Fly/No Fly" 240 km distance trigger across Kenora
and Rainy River districts

- *New "Fly/No Fly"* Trigger: *Air transfers for Code 2 trip "legs" of 200 + km and historic trip volumes exceeding 52 annual Code 2 transfers (CTAS 4-5)*
- *New "Fly/No Fly" Trigger: Air transfers for current EMS Code 2 land transfer "legs" requiring 2.5+ hours of average road travel time – applied only to "urgent but scheduled" patient transfers*
- *Utilize ORNGE SOA fixed wing contracted providers & consider adopting regularly scheduled transfer flight model (weekly or twice weekly) for legs where volumes warrant*
    - *Benefit: Reduced patient risk by minimizing "on the road" time outside a medically staffed facility*
    - *Benefit: Reduced EMS Code 4 overage erosion caused by long duration land trips*
    - *Benefit: Side steps land trip repatriation problems associated with insufficient EMS turnaround wait times at receiving hospitals*

Service Delivery Restructuring Action #3-F

Initiate ORNGE fixed-wing SOA air transport of Code 2 Non-emergent patient transfers between Lake of Woods & Winnipeg hospitals

- *EMS delivers Code 2 patient to Kenora airport as per recommended new coding admin practices*
- *ORNGE SOA fixed wing contracted provider (i.e. Primary Care Paramedic) delivers patient to Winnipeg airport tarmac*
    - *ORNGE to conduct detailed assessment of Scheduled Code 2 transfer run (weekly or 2x weekly) plus "urgent but scheduled" Code 2 trips as required*
- *Winnipeg airport tarmac-to-hospital transfers by private non-paramedic transfer service or Winnipeg EMS*
    - *Nurse Escorts required throughout process at this time*
- *Repatriation of expected majority of lower risk patients by Winnipeg hospitals – to be executed by non-paramedic transfer service, or by ORNGE (according to case-by-case logistics).*

Analysis #3E & #3F- Current provincial guidelines use 240km as a limit for all air transport with some specific location exemptions down to 200km where staffing is an issue. Implementation of a limit on the number of trips as well as distance may actually decrease current air usage in some locations. Group transport has been previously attempted and failed due to a lack of coordination between facilities and the sporadic nature of patients requiring transport. The high cost of air transport is anticipated to further limit implementation of this initiative.

RRDSSAB Recommendation: That the DSSAB not support these recommendations unless adopted provincially without effect on current service levels.

Service Delivery Restructuring Action #3-G

While Recommendation #3-F decision-making/planning is pending at ORNGE, conduct a LHIN funded 8-month pilot project to consolidate Lake of Woods to Winnipeg long-run EMS land transfers by initiating a scheduled Code 2transfer leg (Monday-Wednesday-Friday scheduled runs) plus "urgent but scheduled" Code 2 trips as required

- *New delivery model; Paramedics in a de-commissioned ambulance (i.e. covered markings, no CACC radio) that is not included in the EMS deployment plan – a new EMS operated "pilot" transfer service vehicle with medical capabilities of staffed paramedics (NE LHIN Sudbury pilot project model)*
- *Patient "slot scheduling decision" to a Winnipeg destination hospital would be driven by timing of scheduled trips to Winnipeg (not vice versa)*
- *Ideally deliver scheduled Code 2 transfer runs, including repatriation, to Winnipeg with more than one patient in a customized vehicle (80+ transfers per year)*
- *Since ambulance decommissioned, no regulatory problem waiting for patients/nurse escorts for the repatriation trip back to Lake of Woods*

Analysis #3G- This is primarily a Kenora district issue, however implementation of additional funding from the LHIN would further increase funding inequities between Designated Delivery Agents (DDA). If funding is to be provided to DDAs it should be provided equitably across the province.

RRDSSAB Recommendation: That the DSSAB not support this recommendation unless adopted equitably across the province.

Service Delivery Restructuring Action #3-H

EMS services in NW LHIN should implement reasonable, medically appropriate wait times at destination hospitals in order to repatriate Code 2 patients & Nurse Escorts (1 year pilot)

- *Pending a Northern/remote "special circumstances" exemption from BLS standard governing patient wait times, Kenora & Rainy River EMS should voluntarily adjust current Code 2 patient wait time standards in deployment plans to account for realistic, competently executed hospital processing times for scheduled tests & procedures. Proposed new Coordination Panel to devise medically appropriate EMS patient wait times for common test/procedure profiles.*
- *New medically appropriate pilot wait time policies should be made permanent once 2014 MOHLTC Non-urgent transportation gap reduction budget funding is provided*

Analysis #3H- Wait times are determined by the service considering numerous factors, including but not limited to, crew duty cycle, impact on future shift schedules, cost, and legislative requirements. Given the hospitals "Center of Excellence Model" many services are only available in major centers necessitating additional movement of patients. This model was adopted without consultation in the EMS sector. On many occasions, EMS does wait, only to find a patient then admitted to hospital.

RRDSSAB Recommendation: That the DSSAB not support this recommendation unless adopted across the provincial with adequate funding.

Service Delivery Restructuring Action #3-I

EMS services should repeal the existing administrative practice of postponing Code 2 transfers of elderly, infirm patients late in the daytime staff shift; subject to the following conditions:

- *MOHLTC provision of recommended "gap" budget funding - designed to improved Code 2 scheduling flexibility & provide timely transportation*
- *Adoption of recommended "urgent but scheduled" Code 2 coding processes by hospitals, and the subsequent elimination of Code 3 up-coding of scheduled procedures*
- *Particular focus on not refusing Nursing Home calls late in EMS shift – avoid elderly infirm patients in Emergency Department hallways over night*

Analysis #3I- Gap funding would only address this issue if a fully dedicated transport vehicle was funded. Any requirement to utilize current on duty EMS resources will impact emergent calls. Secondly, nursing home patients returning to the facility, generally do not require EMS transport and alternative modes should be considered such as handicap taxis, stretcher services, or family. This is a direct cost to the hospital or patient and should not be a cost imposed on local taxpayers.

RRDSSAB Recommendation: That the DSSAB not support this recommendation unless adopted across the provincial with adequate funding.

Service Delivery Restructuring Action #3-J

Consider risk management based revisions to selected CACC deployment decisions in the remote North

- *Peer evaluate CACC deployment decision to pull EMS unit out of Base B to service a Base A Code 4 call (when Base A unit on a Code 2 airport call)*
  - *Northern Ontario CACC staff & EMS peers to deliver evaluation*
  - *Why needlessly compromise Code 4 coverage in Base B catchment area when it is a virtual certainty the Base A unit will clear its Code 2 transfer & be re-assigned to the Base A Code 4 call before the Base B unit arrives?*
  - *CACC one-size-fits-all procedure to deploy the nearest available ambulance unit is a "made in urban Ontario" deployment decision that does not always fit in the North?*

Analysis #3J- This CACC directive is supported by several Coroner inquest reports that demonstrated incidents where an ambulance was unable to clear to pick up the patient, patient transport was delayed and the patient outcome was affected. Legislated Response Time reporting would also be negatively affected by this proposal.

RRDSSAB Recommendation: That the DSSAB <u>not support</u> this recommendation.

Service Delivery Restructuring Action #3-K

Kenora & Rainy River district community hospitals & EMS services fully participate in upcoming NW LHIN 2013 pilot project (emerging from 2012 Thunder Bay District Reference Model study) with TBRHSC to reduce the need/costs for community hospital Nurse Escorts

- *Focus on providing dedicated nursing resources within TBRHSC to assume Code 2 patient care & control after patient hand-off from ORNGE or EMS*
- *Staffing located within specific TBRHSC business units featuring high volume of Code 2 transfers*

Service Delivery Restructuring Action #3-L

NW LHIN 2013 pilot project (emerging from 2012 Thunder Bay District Reference Model study) mandate should be expanded to investigate feasibility of establishing similar Code 2 patient "care and control" staffing resources in Winnipeg hospitals

- *Focus on dedicated staffing resources/strategies within Winnipeg hospitals to assume Code 2 patient care & control*
    - *Staffing located within specific Winnipeg hospital business units featuring high volume of Code 2 transfers*

Service Delivery Restructuring Action #3-M

ORNGE should participate in upcoming NW LHIN 2013 pilot project with TBRHSC (emerging from 2012 Thunder Bay District Reference Model study) to reduce the need/costs for community hospital Nurse Escorts

- *Accept medically appropriate Code 2 patients without requiring community hospital Nurse Escorts*
- *Care & control of patient according to ORNGE policy re. "matching" a primary care paramedic to Code 2 patients delivered by fixed wing SOA providers*
- *Transfer patient care & control at TBRHSC after a ride provided by non-paramedic contractor such as Ambutrans*
- *Scope expansion to include Winnipeg "hub" hospitals in order to serve ALL patients' interests in Thunder Bay, Kenora and Rainy River Districts*

Analysis #3L & #3M- A current initiative, in high volume EMS services, is to fund an EMS nurse in emergency departments to accept care & control of patients and decrease off load delays. It was set up as a temporary stop gap initiative to help improve current emergency department staffing. In the proposed model, the expectation is that these nurses would eliminate the requirement for EMS to have a sending facility nurse during transport. In EMS, an escort is sent for two primary reasons, patient condition/drugs requires a nursing level of care; and when on a

treatment and return the patient remains a patient of the sending facility and therefore requires an individual from that facility to maintain care & control of the patient. A legal opinion on the viability of this option from the sending facility prospective should be sought by the hospital partners.

RRDSSAB Recommendation: That the DSSAB support this recommendation provided that the level of care provided in transit meets both the patient & legislated requirements.

Service Delivery Restructuring Action #3-N

Conduct 3rd party "progress assessment" of NW LHIN Non-urgent patient transportation system (i.e. measurable results) at end of 2015.

- *Patient risk assessment*
- *Gap funding based improvements*
- *Process & integration improvements*

Analysis #3N- This recommendation is contingent on implementation of the initiatives and appropriate funding.

RRDSSAB Recommendation: That the DSSAB support this recommendation as a component of the Northwest LHINS Non-Emergent Patient Transportation Coordination Panel.

D) CONCLUSION

The Rainy River District Services Administration Board (RRDSSAB) is responsible for emergency pre-hospital care through the Rainy River District Emergency Medical Services (RRDEMS) as prescribed by the Ambulance Act, applicable regulations and standards. The Primary Health Care System is funded at 100% by the Province of Ontario. Currently, sustaining existing non-emergent patient transportation is in the best interests of patients and the citizens of the Rainy River District. This review notes that various models and funding levels exist for non-emergent patient care across the Province. The development of a LHIN panel to explore options, develop supporting data and lobby the Province for change is in the best interests of the RRDSSAB.

A resolution to reflect the above concepts should be considered by the RRDSSAB.

/dkm