
Study of Non-Urgent Patient Transportation
on behalf of the Hospital Corporations Operating in the CE LHIN

Report Overview
Long-Term Care Sector Webinar
February 17, 2010



Presentation Agenda

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Study Background & Objectives

- ▶ Hospital concerns led to this study
 - ▶ Concerns voiced by hospitals regarding current transport systems failures to be responsive, reliable and safe
 - ▶ Similar findings expressed by the Central East LHIN Emergency Department task group
 - ▶ Hospital Clinical Services Plan (CSP) and the increasing dependency on transportation to facilitate patient flow and access

- ▶ The Client group consists of the 9 hospital corporations that operate in the Central East LHIN plus the LHIN Board.

- ▶ Oversight and direction was provided by a 6-member Steering Committee. The Committee included executive level management from 4 hospitals, the LHIN and a local land ambulance service.

- ▶ Expected outcomes from this study
 - ▶ Better understanding of the current state of hospital-generated patient transport in the Central East LHIN, and
 - ▶ A model, based on Best Practices, that will provide safe, reliable and fiscally responsible patient transportation services, regardless of future growth and the impacts of the hospital CSP

Study Scope

- ▶ As an initial response to the aforementioned concerns the focus of this study is on ...

Non-urgent Patient Transfers Generated by Central East LHIN Hospitals

- ▶ The study includes 'inter-hospital transfers' and 'patient discharge transfers' that are carried out by:
 - ▶ 3rd party operators of non-urgent patient transfer services, and
 - ▶ Municipally-operated land ambulances dispatched as a low Priority 1 or 2.

- ▶ Patient discharge transfers following hospital treatment that are arranged, paid for and/or carried out by parties other than hospitals are excluded from this current study (i.e., transfers by patient, family, friends, volunteers, social services, other institutions, etc).

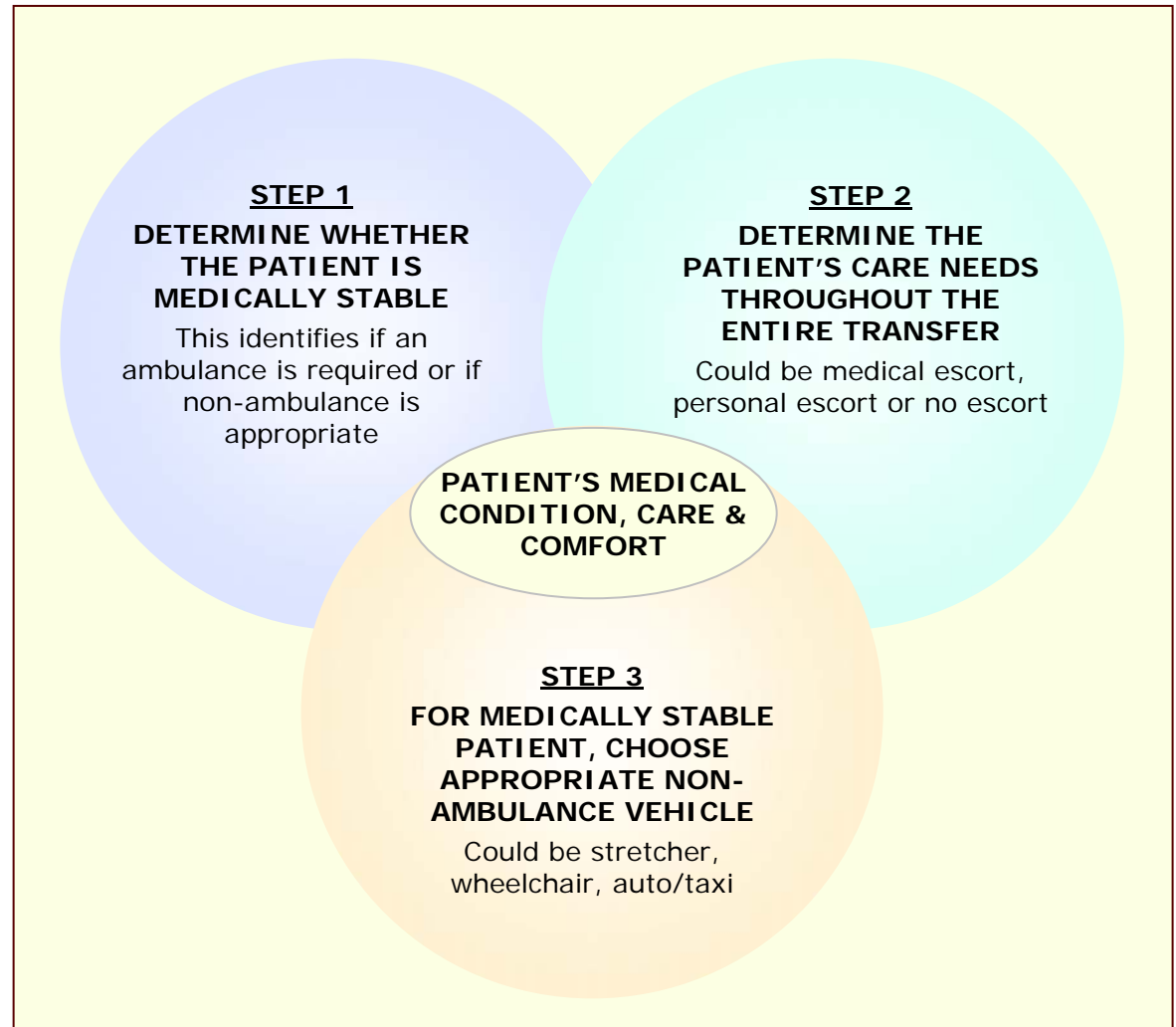
- ▶ Medical emergency transfers where the patient's condition is judged to be medically unstable also are excluded from the scope of this current study. This includes land ambulance transfers dispatched as a high Priority 3 or 4, and critical care transfers, by land ambulances or by air ambulances operated by Ornge.

Study Work Program

- ▶ Review of Best Practices relevant to hospital-generated non-urgent patient transportation
- ▶ Environmental scan of hospital-generated non-urgent patient transfer practices, volumes and expenditures
- ▶ Assessment of potential changes in non-urgent patient transfer activity due to future growth and the changes proposed by the Clinical Services Plan
- ▶ Consultation with 40 staff from locally-based hospitals, staff of the Central East LHIN, privately-operated and not-for-profit providers of non-urgent patient transfer services, and municipally-operated land ambulance services.
- ▶ Strategy formulation, based on Best Practices, that will provide Central East LHIN hospitals with safe, reliable and fiscally responsible patient transportation services

Best Practices Models for Hospital-Generated Non-Urgent Patient Transport

- ▶ Best Practice Models are founded on quality and risk management considerations (i.e., patient needs, patient safety, service reliability and fiscal accountability)
- ▶ Transport decisions are clinically-driven.
- ▶ Supporting infrastructure including documented protocols, business processes, systems, user training and budget.
- ▶ Active “clinical” oversight of the patient transfer service.



Systems Review Findings

- ▶ In 2009, Central East LHIN hospitals generated 31,000 non-urgent patient transfers.
- ▶ 82% were carried out by non-urgent patient transfer services at the hospitals' expense. Land ambulances completed 18%.
- ▶ 60% were inter-hospital transfers, 35% were patient discharges to LTC and 5% were patient discharges to private dwellings.
- ▶ Contrary to Best Practice models, in the CE LHIN risk avoidance appears to be the key driver underlying current transport arrangements.
- ▶ Patients are almost always transported by relatively expensive stretcher transportation. Frequently they are accompanied by hospital nurse escorts, irrespective of patient care needs.
- ▶ In return for relative 'peace of mind' hospitals pay a cost premium. This notwithstanding, current transport arrangements lack the necessary clinical oversight and supporting infrastructure to achieve this objective.
- ▶ In 2009, the Central East LHIN hospitals spent about \$5 M to carry out the 31,000 non-urgent patient transfers that they generated.
- ▶ 83% of the money was spent on inter-hospital transfers, 15% was spent on patient discharges to LTC and 2% was spent on patient discharges to private dwellings.
- ▶ In 5 years the volume of non-urgent transfers is projected to increase by 15% and the cost is projected to increase by over 35%.

Recommended Strategy for Hospital-Generated Non-Urgent Patient Transport

1. CE LHIN hospitals to jointly develop and implement a clinically-driven process map for determining transport and in-transit escort requirements. The process map to be consistent across the CE LHIN. Options for non-urgent patient transport to include stretcher, wheelchair and auto/taxi. Escort options to include medical escort, personal escort or no escort.
2. Hospitals to jointly define their service needs and a set of consistent standards for the LHIN.
3. Hospitals to jointly define clinical oversight and supporting infrastructure requirements. Implementation approaches may vary to suit individual hospital needs, or corporate objectives.
4. Hospitals to jointly select a preferred vendor delivery model(s) taking into account volume, geography, cost and other applicable considerations. Options to include single vendor, consortium and brokerage.
5. For service arrangements involving multiple vendors, key accountabilities are to be clearly defined. These to include lead vendor responsibility for the administration of the contract, finance, and for upholding service standards and quality.
6. For the convenience of hospital staff, the lead vendor to establish a single window point of entry for call taking, booking, scheduling, dispatch, communications and service coordination.
7. In consideration of an existing contract for transportation services involving LHN, RVHS and TSH, it may be necessary to implement the strategy in phases (i.e., initially by the other CE LHIN hospitals).
8. CE LHIN to assume leadership responsibility for implementation.
9. Post-transition service oversight to include periodic peer comparisons and system adjustments.

Outcome Expectations

Current Systems

Patient is almost always transported by relatively expensive stretcher transportation. Patient is frequently accompanied by a hospital nurse as escort

Transport mode and attendant care frequently exceed non-urgent patient's needs

Relatively heavy reliance on land ambulances for backup

Risk avoidance is the key driver underlying current transport arrangements. In return for relative 'peace of mind' hospitals pay a cost premium

Cost premiums notwithstanding, current arrangements lack the necessary clinical oversight and supporting infrastructure to achieve this objective

Expected Outcomes Post-Transition

Makes use of all transport modes (stretcher, wheelchair and conventional auto). Accompaniment of an in-transit escort only when required

Mode of transportation and escort are appropriately matched to the patient's medical condition, care & comfort requirements

Less reliance on land ambulances. These limited, and specialized, resources are preserved for high priority medical emergencies including emergency transfers

System includes built-in safeguards through active clinical oversight and supporting infrastructure to maintain quality and for risk management

Projected cost containment & fiscally responsible patient transport decisions due to use of lower cost, locally-based, specialized transit & taxi (where they apply)