The Ontario Hospital Association

Non-Emergency Ambulance Transfer Issues for Ontario's Hospitals

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Issue

Ambulance services are an integral component in the overall delivery of health care to the public of Ontario. The results of hospital restructuring, new technologies, a growing and aging population and the newly introduced Local Health Integrated Networks all impact on the rapidly changing environment and the demands that are being placed on the whole spectrum of health care services.

Ambulances are used in emergency and urgent situations (when it is necessary to get a skilled paramedic to the person, then to transfer the person to the hospital), and in non-emergency transfer situations such as transporting a hospital patient to another facility for treatment or specialized test procedures, or returning a patient from hospital to a long term care facility *(OHA Ambulance Position Paper, December 1999).*

Non-emergency ambulance transfers (NEAT) are a growing concern among hospitals as municipalities increasingly reduce their financial support for non-emergency ambulance transport resulting in the need for many hospitals to contract directly with non-ambulance medical patient transport services. This has resulted in added operating costs to hospitals; unregulated non-ambulance medical transport services and increased liability for hospitals. Exacerbating these impacts is the absence of a coordinated, comprehensive and consistent provincial and municipal strategy.

BACKGROUND

Following legislative changes to the *Ambulance Act R.S.O. 1990* as amended by the *Services Improvement Act 1997 (Bill 152)* upper-tier municipalities (UTM's) assumed full responsibility for land ambulance services across the province on January 1, 2001. Approved operating costs for the provision of land ambulances are shared on a 50/50 basis between the Ministry of Health and Long-Term Care and the UTM's.

Individual communities have been attempting to address NEAT issues through the establishment of issue specific committees. A plethora of community specific reports have been developed, yet they appear to have had little impact on enhancing the provision of services.

In 1999, OHA developed a comprehensive position paper titled *Land Ambulance Issues for Ontario's Hospitals* that contained 8 recommendations. It is timely that these 8 recommendations be reviewed to determine their advancement by the MOHLTC. Specific recommendations related to NEAT are: *(see appendix A for list of all the recommendations)*

- Dispatch centres should continue to be responsible for dispatching both emergency and non-emergency ambulance calls since both components are integral to an effective and efficient ambulance system.
- The government of Ontario should designate non-emergency inter-facility transfers as part of the ambulance service system and the continuum of care, and the cost of these transfers should be funded accordingly.

The now defunct Land Ambulance Implementation Steering Committee was a joint MOHLTC and Association of Municipalities of Ontario committee that oversaw the shared responsibility of the province and municipalities for land ambulance services. Since March 2001, OHA has been actively involved in attempting to resolve the NEAT issue through member surveys, a Working Group, meetings with and letters to MOHLTC and AMO officials, OHA resolutions. In addition, the OHA engaged in discussions with IBI Consulting Group regarding a study of the current state across the province and recommendations for enhancement. Their August 2002 report has not been released. However, it has been widely distributed through release under the *Freedom of Information and Protection of Privacy Act*. Key recommendations of this report are:

- Patient transfer arrangements need to be improved
- Mode of choice should reflect patient care needs
- Ambulances should be used predominately for emergencies
- Support for private and publicly operated medical transport services (MTS) (i.e. relying solely on a single MTS delivery model would not be appropriate solution for all communities)
- Medical transport service operations need to be regulated
- Community networking preferred as a public policy instrument
- Improved transfer arrangements are contingent upon funding
- Incentive (grant) funding strategy favoured in short term

RESULTS OF OHA'S NEAT SURVEY-MARCH 2004

In March 2004, the OHA's NEAT Working Group developed a survey that was sent to hospitals to capture the ongoing issues of NEAT and specifically to measure the costs incurred by hospitals in accommodating NEAT's.

Eighty-four surveys were returned, and 91% of respondents indicated that they had experienced delays or difficulties with NEAT. The top three difficulties cited were:

1. Delayed departure/return (97%);
2. Problems associated with backfilling for staff (i.e. when escorting patients) (88%); and
3. Inefficient use of resources due to missed/delayed departure and late/missed appointments (both 87%).

While some hospitals have long standing contracts with non-ambulance medical transport services, other hospitals are just beginning to experience either absence of or heavy restrictions around NEAT's (such as time-limited availability) and the resultant financial impact to hospital operating budgets.

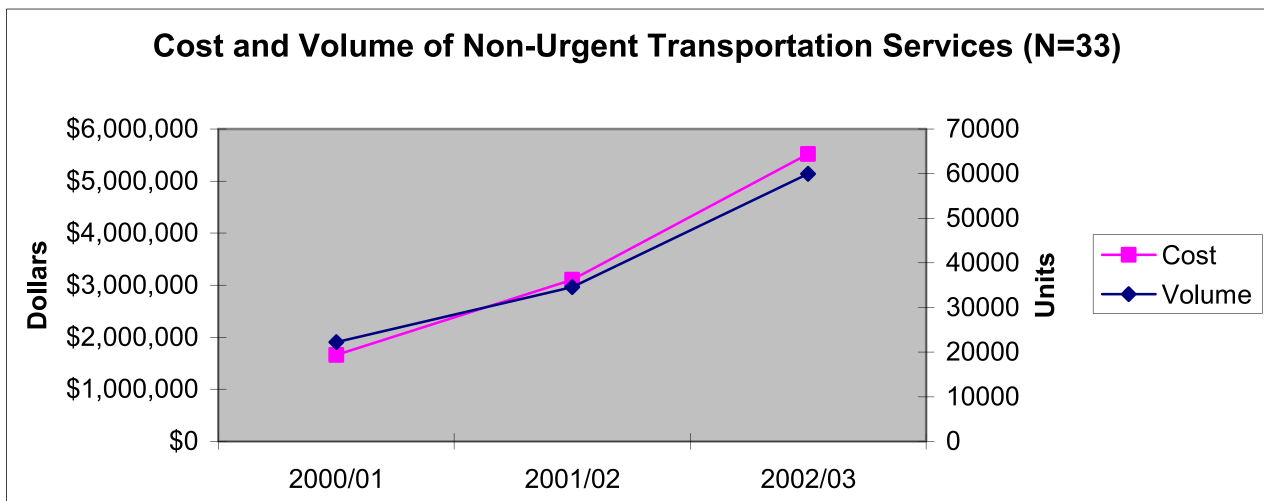
Sixty-three respondents reported financial costs incurred because of NEAT. Of those respondents that did not record financial data, the majority indicated they were unable to obtain specific NEAT related financial data and in a few instances indicated that they did not incur NEAT related costs (most notably hospitals in the North).

Financial Costs

Reported costs in 2002/2003 to hospitals varied from $187.79 (for one NEAT using a non-ambulance medical transfer service) to $1,969,700 for an unspecified number of transfers. Cumulatively, the 55 hospitals reported a cost of $9.7 M in 2002/03 for NEAT using Non-ambulance medical transport services, taxi, Wheeltrans and other modes of transport services.

The figure below illustrates the rising costs and volumes of NEAT to hospitals. For the purposes of the figure, only those hospitals that reported financial costs for **each of the three** requested fiscal years (2000-2003) were included. This was 33 of the 84 responding hospitals (39%).

Figure 1



Of interest, and as noted in Figure 2 is that costs to hospitals are increasing more rapidly than volumes.

Figure 2

	% Change	
	From 2001 to 2002	**From 2002 to 2003**
Volume	55	74
Cost	87	76

Cost per NEAT carried out by a private patient transport service can be estimated at approximately $74.55, $89.93 and $92.13 for each of Years 1, 2 and 3 respectively.

The March 2004 OHA NEAT survey asked respondents to indicate their solutions in addressing NEAT. The top three solutions to the NEAT issue, as chosen by respondents were:

1. Provide a funding mechanism for NEAT that allows payment to non-emergency ambulance service and/or to existing EMS operations as well as increase public awareness of co-payment, when appropriate
2. Develop standards for non-emergent transfer system, including vehicles, staffing qualifications, equipment, insurance etc.
3. Hospital/EMS/CACC to dialogue to improve the coordination of transfers

As reported at the OHA's Patient Transportation Education Session on June 18, 2004 by Dennis Brown, Senior Manager, Operations and Quality Management (Acting), MOHLTC, overall calls to the Central Ambulance Communication Centre's (CACC) have increased 18% between 2000 and 2003. What is more interesting is where the volumes have changed.

The table below illustrates a substantial decrease of C1 and C2 (deferrable and scheduled) calls to municipally run ambulance services. Since there is no reason to believe that there are fewer patients requiring transportation that would be categorized as C1 and C2, the inference is that hospitals are increasingly responsible to arrange and subsidize the non-emergency ambulance transfers of their patients. (See Appendix B for definition of Codes)

Percentage Change in Call Volume by Type of Call 2000-2003

C1	C2	C3	C4	C8	Overall Change
-32.6%	-16.6%	+7%	+26%	+81%	+18%

**Source: MOHLTC presentation at June 18 Patient Transportation Education Session*

Areas of Opportunity Identified by the NEAT Working Group

There already exists well-researched, representative information on NEAT that could be reviewed and leveraged in planning future NEAT service delivery. Ontario hospitals cannot continue to bear the burden of the unfunded financial responsibility for NEAT. The imminent development of Local Health Integrated Networks and the expectation that in the face of inadequate funding of hospitals, there will be rationalization of services, the volumes of non-emergency transfers are expected to increase. Therefore it is proposed that:

- The Government of Ontario designate non-emergency inter-facility transfers as part of the ambulance service system and the continuum of care, and provide a funding strategy for NEAT that allows payment to non-emergency ambulance services and/or to existing EMS operations.
- Private medical transport service operations need to be regulated and therefore standards for a non-emergent transfer system, including vehicles, staffing qualifications, equipment and insurance need to be developed.
- Dispatch centres continue to be responsible for dispatching both emergency and non-emergency ambulance calls and hospitals/EMS/CACC's to dialogue to improve the coordination of all ambulance calls to ensure an effective and efficient ambulance system.

Appendix A

Summary of the Recommendations excerpted from:

Land Ambulance Issues for Ontario's Hospitals, a position paper from the Ontario Hospital Association on land ambulance services in Ontario, December 1999.

**please note, these recommendations from the OHA's 1999 Ambulance position paper are provided as a point of reference only

1. The Minister of Health and Long Term Care should designate current hospital based ambulance operators in the North as the service providers in the future.

2. The Ministry of Health and Long Term Care should continue to fully fund and operate the Dispatch Centres - Central Ambulance Communications Centres.

3. Dispatch centres should continue to be responsible for dispatching both emergency and non-emergency ambulance calls since both components are integral to an effective and efficient ambulance system.

4. The government of Ontario should designate non-emergency inter-facility transfers as part of the ambulance service system and the continuum of care, and the cost of these transfers should be funded accordingly.

5. The Ministry of Health and Long Term Care should establish a process by which all stakeholders, including hospitals, can provide ongoing input into the operations of their local dispatch centres.

6. To ensure that a restructured land ambulance system starts from a realistic and adequate funding base, the Ministry of Health and Long Term Care in concert with providers should calculate the true costs of land ambulance services and ensure that funding is provided to cover these costs.

7. The Ministry of Health and Long Term Care should create and convene, as soon as possible, a Provincial Ambulance Advisory Council with representation from all relevant stakeholders to oversee ambulance issues and reform.

8. All ambulance service employees across the province should be declared "essential" and be governed by the Hospital Labour Disputes Arbitration Act.

Appendix B

There are five Dispatch Codes that are important in understanding the relative volumes of ambulance services:

- ***Code 1 (deferrable)***: referring to a non-urgent, deferrable call that does not have a time element associated with it (e.g. a patient being transferred from hospital to a long-term care facility)
- ***Code 2 (scheduled):*** referring to a patient transfer that has a time element associated with it (e.g. a patient requires transport from one hospital to another hospital for a diagnostic test at a specific time)
- ***Code 3 (prompt):*** a person being transported with an urgent but not life threatening condition, when a slight delay in transit time will not negatively affect the outcome (e.g. a patient is transported to a hospital for treatment after breaking a leg, when the neurovascular status of the limb in intact)
- ***Code 4 (urgent):*** a person begin transported with a life threatening or potential life threatening condition, or when a delay in transport will or could have a negative effect on outcome (e.g. a patient transported with acute chest pain that has not been relieved with paramedic treatment)
- ***Code 8 (standby):*** a crew is dispatched to a geographical midpoint between two available ambulances or to a location with improved ease of access routes to potential locations (e.g. an ambulance is dispatched to a very busy highway during long weekend traffic).

Source: December 1999. Land ambulance issues for Ontario's hospitals. Ontario Hospital Association.