Conseil des Services du District de
Manitoulin-Sudbury
District Services Board

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Report To:	Manitoulin-Sudbury District Services Board
From:	Michael MacIsaac Chief of EMS
Date:	October 23, 2014
Re:	2015 EMS Response Time Standard – Issue Report

RECOMMENDATION

That the Manitoulin-Sudbury DSB submits the ambulance response time performance plan to the Ministry of Health & Long Term Care (MOHLTC) as attached to this document. This submission will be made by October 31, 2014 as per the required legislation.

Purpose

The purpose of this report is to provide the Board with a final numerical response time strategy in time for submission to the MOHLTC by October 31, 2014, as dictated in the Ambulance Act O. Reg. 257/00. Additionally this report should provide the Board with information on timelines for future developments of this plan.

Background

For a full background on the topic of the new ambulance response time standard for Ontario, this report should be taken in conjunction with the previous Response Time Standard - Issue Report presented at the June 2010 Board meeting.

History

2014 marks the second full year under this new Response Time Standard. So far we have consistently been tracking performance better than our established standard. A number of factors have contributed to this success; namely the establishment of our alternative non-urgent patient transportation system and the redevelopment of our Deployment Plan in June of 2013.

In order to understand the definitions of the standard, background knowledge of the Canadian Triage Acuity Scale is essential. The following is a table detailing the meaning of each CTAS level.

CTAS 1: Severely ill, requires resuscitation

- Requires resuscitation and includes conditions that are threats to life or imminent risk of deterioration, requiring immediate aggressive interventions (for example, arrest, and major trauma or shock states).

CTAS 2: **Requires emergent care and rapid medical intervention**

- Requires emergent care and includes conditions that are a potential threat to life or limb function, requiring rapid medical intervention or delegated acts (for example, head injury, chest pain or internal bleeding).

CTAS 3: **Requires urgent care**

- Requires urgent care and includes conditions that could potentially progress to a serious problem requiring emergency intervention, such as mild to moderate asthma, moderate trauma or vomiting and diarrhea in patients younger than 2 years.

CTAS 4: **Requires less-urgent care**

- Requires less-urgent care and includes conditions related to patient age, distress or potential for deterioration or complications that would benefit from intervention, such as urinary symptoms, mild abdominal pain or earache.

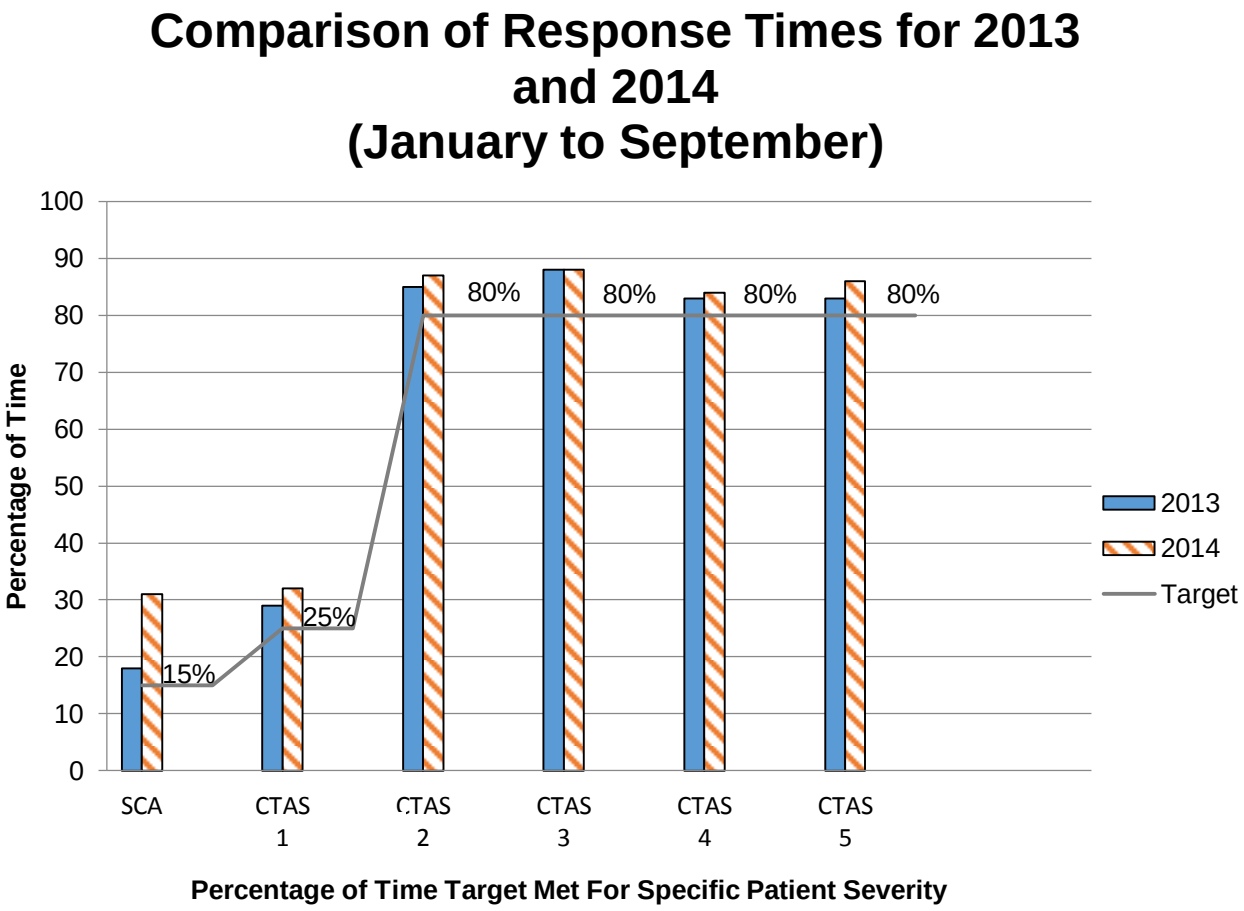
CTAS 5: Requires non-urgent care

- Requires non-urgent care and includes conditions in which investigations or interventions could be delayed or referred to other areas of the hospital or health care system, such as sore throat, menses, conditions related to chronic problems or psychiatric complaints with no suicidal ideation or attempts.

Past Performance and Establishing New Guidelines

As per the Ambulance Act we are to continually monitor our achievement in terms of response times. To achieve this goal the EMS Department has implemented a yearly review of the response times as follows. For the first 3 months in the year or, after a change in criteria, we will allow the system to play out and will run the appropriate reports following this period. Allowing for 3 months of data to accrue allows for a more accurate representation of the trends. When dealing with small datasets as is evident with the Sudden Cardiac Arrest (SCA) and CTAS 1 sections it wouldn't be appropriate to adjust unless there was sufficient data to review. After the first 3 months we will track our response times on a monthly basis to ensure our compliance with our established goals. If at any point we become non-compliant with our plan, we initiate a review of why we are no longer meeting our set criteria.

The following gives a graphical representation of the progress through the months of 2014 as it relates to the CTAS levels in the response time performance plan.



	SCA	CTAS 1	CTAS 2	CTAS 3	CTAS 4	CTAS 5
2014	31%	32%	87%	88%	84%	86%
2013	18%	29%	85%	88%	83%	83%
Target	15%	25%	80%	80%	80%	80%
2015 Target	**20%**	**25%**	**80%**	**80%**	**80%**	**80%**

From the above graphics it is noted that we have been successful in achieving our set goals in terms response time percentage. Most notable in terms of success is the 2014 percentage for Sudden Cardiac Arrests (SCA). Based upon this success we are recommending that the 2015 Response Time Standard submission to the MOHLTC be adjusted for SCA to be 20%. It is with caution that the recommendation to adjust the standard for SCA is being made as there is such a small dataset of those patients meaning that a couple of extended responses can skew the numbers. In 2013 we encountered 58 sudden cardiac arrests and in 2014 we have encountered 47 to date.

Timelines for Submission

The MOHLTC has set out some timelines regarding the new response time plan. It is suggested that October 1 of every year, the EMS Direct Delivery Agents begin development of their response time plans for the next calendar year. On October 31st of each year each Delivery Agent is to submit their plan to the MOHLTC. The plans are to run by calendar year. Every March 1 beginning in 2014 each Delivery Agent is to submit performance reports to the MOHLTC detailing their actual responses for the previous year based on their plan. The legislation emphasizes that each Delivery Agent shall ensure that throughout the year the established plan is continuously maintained, enforced and evaluated and, where necessary, updated, whether in whole or in part.

It is again the intent of this DSB to evaluate the plan on an ongoing basis but to not alter the plan in year unless absolutely necessary. It is important to allow a plan to balance itself out over time, however if the plan is not meeting the appropriate needs it should be altered in year and the legislation allows such.

CONCLUSION

The Manitoulin-Sudbury DSB will submit the new response time plan to the MOHLTC as attached to this report. As indicated previously we will monitor the plan and its effectiveness and only pursue a change in the plan, in year, if absolutely necessary.

MANITOULIN-SUDBURY DSB RESPONSE TIME SUBMISSION

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For the calendar year of ***2015***, from January 1 to December 31,

i. Designated Delivery Agent (DDA) - SUDDEN CARDIAC ARREST

20 percent of the time, within 6 minutes from the time ambulance dispatch conveys the call information to the paramedic, ***Manitoulin-Sudbury DSB*** will endeavour to have a responder equipped and ready to use an AED at the location of a patient determined to be in sudden cardiac arrest.

ii. EMS Designated Delivery Agent - CTAS 1

25 percent of the time, within 8 minutes from the time ambulance dispatch conveys the call information to the paramedic, ***Manitoulin-Sudbury DSB*** will endeavour to have a PARAMEDIC as defined by the Ambulance Act and duly equipped at the location of a patient determined to be CTAS 1.

iii. EMS Designated Delivery Agent - CTAS 2, 3, 4, 5

Manitoulin-Sudbury DSB will endeavour to have a PARAMEDIC as defined by the Ambulance Act and duly equipped at the location of a patient determined to be CTAS 2, 3, 4, 5 within a period of time determined appropriate by the DDA and noted below in Table 1, or as resources permit (level of effort):

Table 1, CTAS 2, 3, 4, 5 EMS Delivery Agent Commitment

CTAS	Target time from paramedic received until on scene	% Target
2	25 minutes	80%
3	25 minutes	80%
4	25 minutes	80%
5	25 minutes	80%