Submission to the EMS Consultation Process
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Hamilton, Ontario

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Thank you for the opportunity to provide feedback and submission to the consultation process regarding modernization of land ambulance service delivery. This submission is provided to support the consultation process that has been initiated by the Ministry of Health regarding modernization of Land Ambulance Service in the Province of Ontario. Except where there are differences identified within this document support is expressed for the submissions of the Ontario Association of Paramedic Chiefs (OAPC) and the Association of Municipalities of Ontario (AMO) who have considered, and received input from our municipality, on many of these same issues. There are however some issues, and some approaches that are unique to the City of Hamilton, and some perspectives that have been gained from many years of leadership activity in EMS across both Ontario and Canada.

Summary

1. The foundational principles of seamless, accessible, integrated, accountable, and responsive ambulance service delivery should continue to guide the direction of ambulance system development.

2. Three outstanding consensus recommendations from the Land Ambulance Transition Taskforce (LATT) should be resolved in the modernization process. These include:

    a. Establishment of an operational dispute resolution mechanism;

    b. Establishment of a College of Paramedics; and

    c. Dispatch reform

3. Recommendations are provided in various sections of this submission on the following subject areas, summarized as follows:

    a. Dispatch services, including recommendations that operational responsibility for dispatch be transitioned to the Land Ambulance Service Provider and that core dispatch funding remain a Ministry responsibility;

    b. Accreditation should be pursued as a replacement for the existing Ambulance Service Review (ASR) process;

    c. Delays in transfer of care on arrival at hospital continue to create systemic pressures as paramedics perform hospital hallway medicine. Cost of this hallway staffing should be reimbursed by the Ministry to the ambulance service provider, removing the additional cost burden from the municipal tax base;

    d. Inter-facility transfers should be the subject of a fully integrated Provincial working group.

i. Terms of reference from successful implementation in another provincial jurisdiction are provided.
ii. All inter-facility transfers should be coordinated through the respective CACC and the process of booking and scheduling should be automated
iii. Legislation should be considered to provide for the capacity to contract out delivery of low acuity non-urgent patient transfers to an appropriately qualified patient transfer service; and
iv. The Ministry should fully fund the cost of all inter-facility patient transfer service.

e. Community Paramedic programs should continue to be developed to match specific community needs. These programs should be integrated fully with the respective Ontario Health Teams and funded through the respective Ontario Health regional delivery program;

f. Ministry funding of land ambulance delivery should continue at a minimum level of 50% of the respective council approved operational budget inclusive of municipal overhead costs. The current one year lag in funding should be eliminated through implementation of one time funding processes.

g. A College of Paramedicine should be established under the Regulated Health Care Practitioners Act. The scope of paramedic practice, and the performance of delegated medical acts should be revised to reflect a Certification – Registration – Authorization paradigm. Base hospital funding should be redistributed to the respective land ambulance service providers who would then be required to establish appropriate medical oversight for both delegation and quality review.

The details and background to these summarized recommendations are provided below.

Prior Reports

Before addressing the questions from this current consultation session on modernization it is important to recognize that some of the issues being addressed now have previously been addressed, and that joint consensus recommendations from prior consultation on these issues remain outstanding.

In March 1998 the Ministry of Health and the Red Tape Commission created the Land Ambulance Transition Taskforce (LATT) to address changes contemplated with the revisions to the Ambulance Act which were to take effect in the year 2000. The LATT mandate was:

1. review and analyze outstanding issues relating to the transition of land ambulance services and provide advice on resolving each such issue (e.g. criteria for licensing operator, criteria for Upper-tier Municipalities to assume full responsibility, etc.),

2. provide advice on proposed land ambulance service performance, patient care and delivery standards,
3. review and analyze the appropriateness and content of proposed implementation plans,

4. provide advice to the Ministry of Health on principles and practices for transferring financial and operational responsibility to municipalities for land ambulance services,

5. provide advice to the Ministry of Health on policies and practices relating to the recovery of funds from municipalities and the municipal role in information and decision-making during the transition period.

Representation on LATT was broad including Ministry of Health staff, ambulance service interest groups, central ambulance communications centres, Ontario Hospital Association, Association of Municipalities of Ontario, municipal staff representatives, and the Provincial Base Hospital Advisory Group.

By consensus, the LATT adopted the following principles which were used to develop its recommendations for a patient-focused ambulance system:

· **Seamless**: The closest available and appropriate ambulance will respond to a patient, at any time, or in any jurisdiction, regardless of the political, administrative or other artificially imposed boundaries.

· **Accessible**: Municipalities have a responsibility to ensure reasonable access to ambulance services. Municipalities have an obligation to ensure that ambulance services respond regardless of the location of the request.

· **Accountable**: Municipalities have an obligation to ensure that ambulance services be provided according to the legislation and regulations. The level and quality of care that is provided to patients by municipalities will be monitored by a designated base hospital program.

· **Integrated**: Municipalities are required to ensure that land ambulance service be an integral part of the health care system of the province. The province is required to ensure the transport of patients by ambulance between health care facilities for medically essential services.

· **Responsive**: Municipalities will be responsive to the fluctuating health care, demographic, socio-economic and medical demands of the constantly changing environment.

While many aspects of the LATT, and of the subsequent Land Ambulance Implementation Steering Committee (LAISC), have been addressed there remain three major outstanding consensus recommendations from the final LATT 1998 report:

1. **Operational Dispute Resolution**: The establishment in Regulation or legislation of a dispute resolution mechanism to resolve disagreements on non-medical operational issues arising between the MOH, designated Base Hospital programs, and the Designated Delivery Agents / Upper Tier Municipalities;

2. **College of Paramedics**: The establishment of a self-regulatory college for paramedics under the Regulated Health Professions Act at the earliest possible date;

3. **Ambulance Dispatch Reform**: That government undertake an immediate review of ambulance dispatch in consultation with stakeholders to determine the most appropriate option for providing this service, taking into consideration the interests of the patient, the fundamental principles of an ambulance system, and considering all governance, financial, operational, administrative and ownership issues.

These issues will arise again in response to the specific questions being raised within the consultation request.

Dispatch

While the questions within the consultation paper revolve around technology and communications processes with the dispatch system the largest challenges are operational and functional in nature. While technology is important you have to have the right level of staffing approved, in place, and trained appropriately in order to make technology function. Technology is not a panacea.

From the operational perspective while the dispatch system is not totally broken elements of it appear to be. The LATT process identified the need to align the operation of the dispatch with the municipal service delivery. The 2001 IBI Report identified numerous challenges within the Hamilton CACC. These challenges remain across the Ministry operated CACC's despite efforts to address them:

- Serious shortage of personnel at all levels
- Inability to sustain minimum coverage
- Absence of experience at Communicator level due to high staff turnover
- Rapid turnover in staff attributed to high workload, stress and relatively low wages
- Present communicator staffing falling short of the calculated model requirement
- CACC staffing model underestimates the true staffing requirements
- CACC would benefit from a well defined and active quality assurance program
- Management presence needs to be strengthened
- Communications protocols between fleet and CACC should be reviewed.

The IBI report, while dated, outlined the differences between “level of effort” land ambulance provision as opposed to “performance based” land ambulance service. In this distinction the report nicely identified the need for accountability of the ambulance dispatch operations to municipal officials responsible to monitor the quality of their ambulance operation performance while attempting to control costs. A performance based system is only made possible where the operation of the dispatch centre which controls both the assessment and prioritization of calls and the movement and activities of the ambulance resources is wholly aligned and responsive to the actual ambulance service operations.

The proof of this approach was demonstrated by Toronto well before downloading. Toronto is an internationally recognized model for best practices in ambulance service delivery. The principles were reinforced with the evaluation completed following the Niagara ACS five year trial initiated in 2005. During that trial off the shelf technology (COTS) of several types supporting communicator decision making and operational performance were implemented successfully in combination with the MOH CAD. Epidemiological screening in support of public health was implemented. MPDS, along with the ProQ&A system, was put into place, integrated with the MOH CAD, and operationally accredited, in record time. Successfully integrated technology included MARVLIS, CADPortal, Headstart, smartphone digital paging, and of course MPDS.

Progress by Niagara, similar to that experienced in Toronto and more recently Ottawa, compares favourably to the current MOH implementation of MPDS. Following the Ministers commitment to change all CACC’s over to MPDS province wide the Ministry has now taken twice as long as Niagara to implement the system – and to date not a single dispatch centre has been converted.

Where the operation of the dispatch has been aligned wholly with the operational performance of ambulance service delivery maintaining the core principles established by LATT, as in Toronto, Niagara, and Ottawa, there has been successful MOH certification achieved at every review.

The reality from a service provider perspective is that fully integrating and aligning the CACC operations with the service provider requirements provides for innovation and improved service to the public. With a 90th percentile emergency dispatch call handling time of more than three (3) minutes the dispatch operations continue to consume a large portion of the response time envelope, service providers are unable to effectively influence the operations of the CACC, and barriers to good practice take time.

While understanding that there is the desire on the part of some to “consolidate” dispatch centres into smaller numbers of bigger centres provincially there has been absolutely no evidence put forward, and no business plan subjected to industry scrutiny, that would support such a model being either an improvement in service delivery or a reduction in cost. Most often the premise put forward in support of the concept is the OPP model of centralized dispatching which incorporates centralized concepts with an

entirely different dispatching model. OPP dispatching is not in the least comparable to the business design for paramedic services.

Shared infrastructure where appropriate, mutual back up capacity, and centralized core training all make some sense. However the solution to dispatch is to allow the services impacted by the dispatch to develop the solutions to the current challenges. Turn the operations over to the paramedic services.

Recommendations:

1. Dispatch operational responsibility should be transferred to the respective land ambulance services currently dispatched by the respective CACC. Where designated delivery agents enter into agreement to consolidate or group dispatch functions they should be allowed to do so;

2. The Ministry should continue to provide shared communications infrastructure to ensure provision of service in a seamless and accountable manner; and

3. Core funding of dispatch operations and regulatory oversight of the dispatch operation in accordance with established standards should remain a Ministry responsibility. Core funding should include, at a minimum, 100% of the cost of providing operational and technical functions at a level equivalent to the staffing ratios and technology innovations currently in place in Toronto, Niagara, and Ottawa.

Innovation, aligned with local operation, would include improvements in hospital offload performance through integrated oversight and responsiveness. Innovation could include secondary clinical advice, screening, and call diversion as was experienced in Vancouver during the 2010 Olympics to better triage calls. Innovation could include senior advanced care paramedic advice on aspects such as CBRN or other technical operational process as has been implemented in other centers. And innovation could include on line booking of inter-facility transfers, pre-populating and targeting the details of a transfer request, thereby minimizing the call taking detail processes that currently exist.

Accreditation:

The current Ambulance Service Review process is a quasi-regulatory compliance activity performed by peers with minimal training and experience. The process has moved from the original concept of establishing a unique Ontario accreditation program to a pedantic rules based compliance process.

I strongly recommend a shift from the “Ambulance Service Review” process to an accreditation process, preferably under the jurisdiction of Accreditation Canada (https://accreditation.ca/). This agency performs health care accreditation across numerous agencies including hospitals, long term care, community services, and

others. The driver in the accreditation process continues to be improvement in quality of service delivery.

Preliminary work has already been completed in the development of ambulance service accreditation. In Ontario some land ambulances are investigating pursuit of accreditation through this body and Ornge has already completed the accreditation process. In the Vancouver Island Region of BC accreditation was achieved in 2010 during the early trials of the program and in other provinces, such as New Brunswick, the ambulance service provider has also been accredited.

Savings from the current operation of the ASR team would be extensive as the Province currently expends at least 150 to 200 days of direct activity for a team of 10 to 15 people, plus travel, accommodation, oversight, and management costs for little operational benefit.

Offload Delays:

Ambulance offload time at hospitals continue to be a significant challenge in many jurisdictions. While the standard of transfer of care occurring within 30 minutes of arrival was established in the 2005 report (Improving Access to Emergency Services : A Systems Commitment) the reality is that the problem continues to hinder the performance of land ambulance services. Municipalities are forced through MOH Standards to require paramedics to wait with patients in the most basic forms of hallway medicine until transfer of care is achieved. In Hamilton the lost ambulance capacity resultant from this was more than 30,000 hours last year, and more importantly thousands of patients waited on ambulance stretchers for in excess of two hours.

While Dedicated Offload Nurse Program (DONP) funding helps to alleviate the pressures there is simply not enough capacity. Limited space within ED's prevents effective use of the DONP, there are fewer hospital beds per 1,000 population within the Hamilton area than in many other jurisdictions, there are inadequate community resources including Long Term Care beds and home care to fulfil the needs, and as result patient flow through hospitals is challenged. The DONP is a stop gap measure, it is helpful, but it is not resolving or addressing the root cause of delays in transfer of care. In the interim the municipal taxpayers of Hamilton are paying the cost of hallway medicine.

The MOH has the capacity to track and to mandate system performance and, to date, has declined to do so. Hospital ED staffing is being funded at peak times by municipally funded paramedics and it is doubtful that resolution to this will be speedy or easy. In the interim my recommendations are:

1. Hospitals and paramedic services be mandated to utilize consistent transfer of care software and reporting, including dual transfer of care swipe documentation, to accurately report the involved times; and

2. That the MOH fund 100% of the unit hour cost for the time period beyond the first 30 minutes after arrival. Assuming a current 50-50 funding match this would be an increase of 50% from the present funding. This payment to the designated delivery agent for the provision of hospital hallway medicine would provide the capacity for municipalities to replace lost unit hour response capacity.

Inter-facility Transfers:

One of the agreed upon principles from the LATT Consensus process was that municipalities needed to ensure their land ambulance service was an integral part of the provincial health care system. The province was to be required to ensure the transport of patients by ambulance between health care facilities for medically essential services, a presumption that included funding the cost of such patient transport..

The Ontario Hospital Association put forward a December 1999 position paper (Land Ambulance Issues for Ontario Hospitals) outlining the challenges that would be presented with the pending implementation of provincial downloading, and making recommendations for resolution. A further paper was put forward by the OHA in September 2004 (Non-Emergency Ambulance Transfer Issues for Ontario Hospitals) outlining concerns with the impact on patient care and timely service delivery that had developed since the 1999 report as well as the ongoing progression and cost shifting that was occurring.

The issues raised by the OHA in 1999 and 2004 have changed little. Non-Urgent Patient Transfer (NUPT) providers continue to provide service moving patients between hospitals in a totally unregulated manner, with oversight limited to RFP contractual compliance matters. Hospitals are funding these patient movements through increasing diversion of fiscal resources from global funding capacity as resource specialization increases. There is inequity in capacity between Northern and Southern geographic areas based on the speculative profit motives of the NUPT providers. Simply put, profitable transfer patterns and times are serviced, those that are not profitable are not. Unfortunately the land ambulance service providers have no choice – the MOH CACC will not refuse to service any call, and the land ambulance service provider must perform all calls assigned by the CACC. The predicted cream skimming continues to occur, with inter-facility patient transfer movement on less profitable routes being performed by the land ambulance service at no expense to the hospital or the patient, and instead by subsidy of the municipal taxpayer.

I recommend development of an Inter-facility Transfer (IFT) working group with terms of reference including the following objectives:

1. To define, in detail, the current state of inter-facility transfer operations between facilities within each Ontario Health (OH) geographic area, between facilities across OH boundaries, and between facilities across provincial or national boundaries. This definition shall include establishing who is responsible for the various types of patient transfers and identifying the resources required to conduct them.

2. To identify the desired state of inter-facility transfer operations between facilities within each OH area, between facilities across OH boundaries, and between facilities across provincial or national boundaries.

3. To identify gaps between the current state and desired state of inter-facility transfer operations and develop plans to implement changes that will increase operational efficiency and improve the transfer experience for patients.

4. To develop recommendations for an inter-facility transfer service delivery and funding model that is effective, efficient, and sustainable.

5. To establish a clear line of accountability for the practices and funding necessary to properly conduct inter-facility transfers, so that sufficient resources are available to match patient need.

6. To share information between Land Ambulance providers, OH Regions, Criticall, Ornge, and the Ministry of Health (MOH), and to accept submissions from other stakeholders that impact upon the provision of inter-facility transfer service

7. To build a body of data and knowledge on inter-facility transfers in Ontario.

Further, I recommend that:

8. Funding of medically necessary inter-facility patient transfer, whether by air ambulance, land ambulance, or by Non-Urgent Patient Transfer providers, be 100% covered by the Province of Ontario; and

9. That all patient transfer requests be channelled through the respective Central Ambulance Communications Centres (CACC); and

10. That the CACC be authorized to assign inter-facility patient transfer to air ambulance, land ambulance, or NUPT provider, as is appropriate for either operational or patient condition requirements; and

11. That the Ministry of Labour enact regulation specifying that the assignment of patient transportation to a NUPT as appropriate in the circumstances not be considered to be “contracting out” of service or any equivalent with respect to Collective Agreement interpretations; and

12. That all NUPT providers within a Land Ambulance Service provider jurisdiction be required to meet the standards of service and standards of care as set out by the Land Ambulance Service provider; and

13. That each CACC implement an on-line IFT booking process to facilitate the management and delivery of IFT activities.

Community Paramedic:

Community Paramedicine (CP), or Mobilized Health Care (MHC) as put forward in the EMS Chiefs of Canada White Paper (The Future of EMS in Canada : Defining the Road Ahead), means many things to many people. At its heart are the principles of:

- Providing health care in a timely, and appropriate manner taking into consideration the local operational priorities and the integration of care within the broader health care system; and

- Mitigation of both ambulance response and facilities based emergency health care provision where clinically appropriate.

CP is not intended, nor should it be put forth, as a method to supplant home care provision by an existing provider. It is an outreach mechanism where paramedic services can fill a health care gap existing within a particular community thereby improving the continuum of care for the patient. Taking many forms we have been using the principles for clinic management, remote patient monitoring, targeted complex care visits in support of hospital discharge, and management of high demands for patients also engaged in aspects of the judicial system.

We support the ongoing development of CP or MHC as a value that can be added by paramedic services to any Ontario Health Team (OHT) Integration process. The major financial benefits from CP program delivery are with the broader health care system, recognizing decreased hospital utilization and extended time periods without hospital admission. As such the costs of CP programs should be borne fully by the main recipients. In the past this was LHIN based and I believe in the future should be OHT based.

Extension of the program should consider palliative care patient support as well as the existing complex continuing care patient profiles.

Funding Formula:

Recognizing that some areas of the Province have unique needs the minimal MOH funding should be maintained at 50%, and that for some areas, particularly in unorganized areas in the North, up to 100% funding may be appropriate. Further, as previously noted the MOH should be funding 100% of inter-facility transfer costs and 100% of extended transfer of care time based on average unit hour cost.

Resolution to the current funding lag problem must be found. The current process provides for submission of current year council approved budget in early fall, with the MOH funding for the following year typically being based on that financial submission.

This creates an essential full year lag in Ministry 50-50 funding for any municipal staffing enhancements. For Hamilton over the past 7 years where the City fulfilled it's obligation to determine the appropriate level of service as outlined in the Ambulance Act the funding lag has forced a municipal taxpayer subsidy of the MOH 50-50 portion in the amount of approximately $5.8M.

Funding during the first year of operation of staffing enhancement can be managed effectively through utilization of one time funding letters, a process that was utilized extensively and effectively by the Province prior to the 2000 downloading of land ambulance services.

College of Paramedicine:

In 1999 there was a consensus across all members of the LATT Committee that a College of Paramedics should be created under the Regulated Health Professions Act framework. This recommendation remains outstanding despite the submission some four years ago for creation of a college to match developments and initiatives in other provinces.

Base Hospital programs were initially developed in the 1980's under the guidance of Dr. Dennis Psutka as a mechanism to facilitate the implementation, and the legalization, of advanced life support procedure performance by ambulance personnel. Legends like Dr. Ronald Stewart helped drive the programs forward, creating some of the first ACP programs in the Province of Ontario, albeit a bit later than developed in other jurisdictions such as BC or Alberta. The original intent was to have the BHP's closely integrated with the ambulance service delivery, providing the needed services of training, quality improvement, and medical control under the guidance of the involved ambulance services. There was a distinctly local flavour, significant local involvement in the direction of the BHP, and at the same time a level of consistency across programs established through the provincial advisory group which included service providers, base hospital physicians, and Ministry staff all of whom had an equal say in the general direction of the programs.

This has unfortunately morphed as result of financial considerations into a smaller number of Base Hospital programs striving to exert control over direct service delivery and training, and disconnected from the feedback and guidance of those land ambulance services for which they were created.

The practice of paramedicine should properly be segregated into three fundamental principles:

1. **Certification**: The successful completion of the levelling examination process which ensures a standard base of knowledge across all educational programs aligned with the National Occupation Competency Profiles (NOCP) as periodically adjusted. Certification examinations are currently performed by the MOH and can continue to be done in that manner or that role can be handed over to the College which would

charge a fee for completion, much the same as currently exists for the College of Nurses;

2. **Registration**: This is the process by which paramedics, irrespective of employer, become registered with, and accountable to, the Paramedic College for their practice in paramedicine. Standards are established and maintained by the College;

3. **Authorization**: While a paramedic may have the training and certification to perform a procedure they still require authorization to perform particular medical acts and/or procedures. Such authorization must come from both their employer and from a physician who has particular knowledge and awareness of the normal standards, the individual specific training, and of specific skill competency. Just as with a Nurse who has a particular skill within their scope of practice a paramedic college does not supplant the requirement for actual authorization to perform to that specific scope.

I recommend:

1. That a College of Paramedics be established to fulfil the role of regulating the practice of paramedicine, across the entire spectrum of paramedic service providers, and to ensure the safety of the public when receiving paramedic care; and

2. That the current funding for provision of Base Hospital medical oversight and delegation activities be transferred proportionally, based on either a population or paramedic staffing ratio, to the respective Land Ambulance Service providers; and

3. That the Land Ambulance Service providers be required to contract appropriate qualified physicians to evaluate paramedic skills in the performance of delegated medical acts, to authorize the performance of delegated medical acts, and to oversee the provision of quality assurance and quality improvement in the provision of delegated medical acts.

These recommendations do not preclude the existing Base Hospital programs or staff from continuing activities as many services may opt to contract the required services from partners they currently work with. Instead the recommendations align the function of medical oversight, delegation, and quality review with the operation and provision of ambulance services in a new paradigm of authorization and delegation under a mutual performance agreement with the medical professional of choice.