



BUSINESS CASE SUBMISSION

October 8, 2019

Permanent Non-Urgent Patient Transfer Service

Executive Summary:

Non-Urgent Patient transportation has been provincially acknowledged as a major concern across Ontario. Locally, it has been the subject of focus by the North-East LHIN and stakeholder organizations, identified as one of the most pressing systems issues being faced by health care systems.

A North East LHIN funded a pilot project for delivery of Non-Urgent Patient Transfers within the Manitoulin and LaCloche areas that was implemented in 2013 using the Small Hospital Funding envelope. This pilot has been operational for 6 and half years (78 months) and has been proven to be efficient and successful. In 2019, the Northeast LHIN dispersed the Small Hospital Funding envelope across all small hospital in the North East LHIN Region. Once the hospitals received the funding, they were allowed to look at local priorities which included Non-Urgent Patient Transportation.

This business case is submitted to the Ministry of Health to allow for the funding of this successful program on a permanent basis.

History

Non-Urgent Patient transportation is required as a health system enabler, allowing for rural-remote hospitals to transport stable patients that require the services available exclusively at a tertiary centre (for example, CT and MRI), and then returning them in a timely manner back to the originating rural site to continue their care. Additionally, Non-Urgent movement of patients is often required to facilitate discharge and repatriation of patients not deemed suitable for normal vehicle transportation.

In 2013, the first year of Small Hospital Funding saw the inclusion of pilot revenue to support three Non-Urgent Patient transport projects across Northeastern Ontario. One project was operated in the Temiskaming area, while a second operated primarily for decanting control of Health Sciences North. The third program was operated by Manitoulin-Sudbury DSB in concert with Espanola Regional Hospital and Manitoulin Health Centre. While the initial pilot time frame was set at six months, extensions were approved by the LHIN.

Both the Temiskaming and Greater Sudbury Pilot projects were discontinued following varying periods of operation, while the Manitoulin-Sudbury DSB pilot has continued through nearly seven years.

Since the 2013 implementation of the PTS pilot program, Manitoulin-Sudbury DSB Paramedic Services has been able to shed significant volumes of Non-Urgent workload and manage the increasing volumes of 911 activities. Since 2012, the last year with no Non-Urgent pilot program, the service has reduced response for Non-Urgent scheduled calls (interfacility) by almost 81% while urgent and emergent calls (generally 911 calls) has increased by 39%. The capacity to manage the increasing 911 volumes from within the communities has been directly enabled through the use of Non-Urgent resources.

Patient Transfer Services Historical Workload

Year	Total Legs
2013	861
2014	937
2015	1038
2016	698
2017	1126
2018	1355
2019 (8 months)	747 (1120)

Benefit from Current Project

The Manitoulin-Sudbury DSB pilot project demonstrated the usefulness of a model that augmented Paramedic Services in a manor that coordinated the transportation between the rural hospitals, the hub hospital and community organizations. The Patient Transfer Service (PTS) model allowed for the movement of calls from Paramedic Services to PTS which allowed for improved emergency response capacity. Between program implementation and the end of 2018, Paramedic Services saw a nearly 80% reduction in Non-Urgent interfacility patient transportation and were able to absorb a 30% increase in 911 volume within established vehicle deployment. In 2018, the PTS staff completed more than 1,100 transports.

Proposed Model

The system model being proposed in this business case will mirror that of the Manitoulin-Sudbury DSB pilot project, including realized successes of the last seven years, while the addition of Personal Support Workers (PSW) into the crew dynamic would allow for potential reduced need for hospital escorts in specific instances. While it is unclear exactly how many transportations could be done without the need for hospital staff in attendance, that impact could be substantial.

Currently 50% of all transports require a hospital personal to accompany the patient based on the medical needs of the patient. It is believed that need for hospital personal could be substantially reduced with the deployment of a PSW as part of the PTS staffing model.

The proposed model would allow for a responsive system able to manage patients requiring transportation of diagnostics or treatment without advanced notice, something not built into a LHIN proposed regional system that would operate in more of a scheduled transit manor.

Financial Impact

The Manitoulin-Sudbury DSB business case proposes operating a system where two vehicles would deploy for 8 hours each day, exclusive of weekends and statutory holidays. The total operating cost for this system would be \$446,405. The costs set out are inclusive of \$30,000 for third party dispatching. Potentially, this cost could be mitigated with utilization of the CACC for this service.

The delivery of the Non-Urgent Patient transportation service since March of 2013 has allowed Manitoulin-Sudbury DSB to refine the delivery model thereby ensuring the proposed costs are accurate, and not subject to significant unforeseen impact.

In an environment where Paramedic Services were required to manage the established Non-Urgent volume of activity, and given the regionalized health care design, there would be a need to increase staffing deployment by 2 transport vehicles each weekday. The annual cost of this service would near one million dollars verses \$446,405 for a Non-Urgent system as set out below.

2020/21 PTS Budget						
Operating	Hrs/Wk	Rate	Annual	OT	Benefits	Total
2 Drivers	40	15.96	\$66,394	\$14,939	\$13,279	\$94,611
2 PSW	40	18.69	\$77,750	\$17,494	\$15,550	\$110,794
Sub-Total						\$205,405
Total Km per Year						
16,500	Fuel	Tires	Insurance	Mtce. Repairs		
	\$38,000	\$3,600	\$8,800	\$30,000	\$80,400	
Annual Direct Delivery						\$285,805
Onboarding (Orientation)						\$5,000
Technology and Medical Equipment						\$6,000
Uniforms						\$6,600
Coordination & Supervision						\$45,000
Annual Amortized Cost (new vehicles x 3) over 4 years						\$68,000
Dispatching Costs/Contracting Platinum						\$30,000
Total Annualized Cost						\$446,405

The current model uses decommissioned ambulance at the end of life which is normally 7 to 8 year old vehicles. If the Patient Transfer Service were to receive ongoing permanent funding, we could look at purchasing three new vehicles at the cost of \$91,000 each which would be replaced every 4 years. The three vehicles would cost \$273,000 amortized over four years is \$68,000 per year.

Our current model requires a maintenance and repair budget for the vehicles of \$93,500 annually. By purchasing new vehicles \$68,000, that still leaves \$25,500 annually available for regular maintenance and repair.

Under the current model funding is year to year. The pilot has operated for 7 years but there has never been approval for more than 6 months to a year at a time, which made the purchase of new vehicle amortized over 4 year impractical.

Challenge to Proposed Model

The challenge to success of the Manitoulin-Sudbury DSB proposal is to build upon the successes of the current pilot project. Unit utilization has operated well over 80% for more than 3 years, however staff retention has challenged system sustainability. The time-limited pilot project of only 6 months, extended for similar periods of time does not allow for any sense of permanency for staff.

A significant potential impact on system success stems from the lack of involvement by the Ministry of Health, Central Ambulance Communication centre (CACC) in Sudbury. Despite efforts of the ACO staff to coordinate where possible with the Manitoulin-Sudbury DSB staff, a single number for stakeholders to use for bookings would allow for significant improvement to the overall system. Were a "one number to call" system for interfacility transfers to exist, incidents of booking duplication would be eliminated, while the CACC ACO could ensure that the patient was placed into the most appropriate stream for service delivery. This effort would fall in line with the Ministry of Health design process intended to ensure patients are managed appropriately. A value added benefit to this design would extend beyond the direct \$30,000 saving, to include built capacity where patients awaiting care at a hub facility could be held for any additional resource traveling between that facility and a community site, thereby allowing resources to be freed up for additional work. The current model sees an unreasonable number of empty leg movements that CACC integration would mitigate.

Alternatives to Proposed Model

The Manitoulin-Sudbury DSB pilot project is one that this business case endorses, however it remains reasonable to explore alternative options. It would be prudent, firstly, to explore the LHIN designed alternative. This program is designed to operate on a scheduled route and to transport multiple patients on a single vehicle. This MPU style of delivery would allow for a better operating cost per KM as it would be divisible by a larger number of patients. The option would be less

responsive to the needs of the clients as bookings would be restricted to when the vehicle is set to move, not based upon the desires of the users.

The second option for alternative service delivery would be to contract out the service to a third party. While effective service delivery could be achieved, the costing may prove problematic given profit motives.

Conclusion

Non-Urgent Patient transportation continues to challenge the effective management of Paramedic Services. Regionalized health care has also impacted on Paramedic Services through deployment loss.

The North East LHIN pilot project for delivery of Non-Urgent Patient transfers within the Manitoulin and LaCloche areas has proven itself to be an effective and efficient model, allowing the shedding of Paramedic Services Non-Urgent volumes and allowing for absorption of 911 workload within deployment. The PTS system is able to allow for timely and coordinated movement of more than 1,100 trips each year. The adoption of a permanent model to continue this service to the patients and stakeholders across specific areas of the Districts will ensure continued effective service provision at a known and stable costing.