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Asclepius, the
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How Communication and Co-operation Eased a Patient Transport Crisis

Ann Toman and Perry Ferguson

It is not an overstatement to suggest that in 2000, a crisis was looming in the Ontario healthcare system with regard to patient transportation. Provincial government budget cuts and downloading of ambulance service responsibilities from the provincial health ministry to municipal governments has pushed patient transportation to the forefront as a major issue for municipalities across Ontario.

The Issue

In early 2001 London's Upper Tier Management (UTM) advised London hospitals they could no longer support non-emergency patient transports. The impact was significant considering more than 90% of the transfers between hospitals and long-term care facilities were non-emergency. The downstream impact of this decision by the UTM's ultimately compromised:

- Access to hospitals (emergency rooms, IP beds, specialists),
- Patient and staff safety, due to inappropriate staff/patient ratios,
- Timely diagnostics and patient care.

In May 2001, London Health Sciences Centre, St. Joseph's Health Care London and London Regional Cancer Care Centre (referred to herein as London Hospitals) could no longer ignore the growing risk to patient care. Thus, it was determined that a separate patient transfer system for non-emergency patient transports was required. Together the London Hospitals developed a partnership to seek a citywide solution.

London Hospitals provide tertiary services for the region of Southwestern Ontario. Collectively, the London hospitals operate 1,050 acute care beds and 1,500 non acute beds. The emergency departments service 160,000 visits annually and outpatient visits exceed one million. Annual patient outbound transfers from and between the London hospitals total over 22,000. Programs include: paediatrics, (Children's Hospital of Western Ontario) paediatric critical transport team, regional dialysis, acute care medicine and surgery, women's care, acute and regional mental health, regional stroke, trauma, neurology, cardiac, rehabilitation, long-term and continuing care, and regional oncology.

The Model

As the hospitals embarked on this partnership, two deliberate decisions were made. Patient-care divisions needed to provide leadership in the development, implementation and ongoing management of the non-ambulance patient transport plan and

duplicating ambulance level service would not be considered (this was seen to be expensive and inappropriate). It was recognized that the Emergency Medical Services Branch continued to be responsible for providing ambulance level of service to support all emergent/urgent transfers including those originating in a hospital.

In the absence of provincial direction or provincially defined standards, the responsibilities of delivering, monitoring and maintaining safe non-emergency patient transfer services, by default, fell to the healthcare institutions. However, the London Hospitals recognized their expertise was in patient care and sought-out expert advice in logistics, vehicle maintenance and standards, staff training and dispatch. It was identified that a partnership relationship with a transportation vendor along with the municipality would be the appropriate model to develop the service

In this model, stakeholders (i.e. hospital leadership, EMS, Central Ambulance Call Center (CACC), London UTM and Voyageur Transportation) worked together identifying and developing critical components that would support safe and effective patient transport. These included:

- The establishment of appropriate patient transport decisions (non ambulance vs. ambulance) based on the patient's medical condition and care needs.
- The development of guidelines to identify escort requirements.
- The creation of standards for transportation service providers related to scope of service, deliverables for responsiveness and patient safety.
- The development and implementation of a monitoring and evaluation system



Voyageur attendants unloading an isolette in front of London Health Sciences

This partnership resulted in the development of systems, policies and standards to manage non emergency patient transports and was fundamental in addressing gaps in urgent hospital transports.

The Process

A London Hospitals oversight committee was created comprised of representatives from the following areas:

- Three London hospitals in areas of patient care and corporate support
- District Health Council EHS
- Medical Director - Base Hospital
- VP Medical affairs and Chair of MAC

This committee reported to the hospitals' Joint Senior Leadership Team and maintained an ongoing link with the Ministry of Health and Long-Term Care (MOHLTC).

Step One: Develop a Request for Proposal: A Request for Proposal (RFP) was developed by the hospitals using recommendations from a regional document (Non-Emergency Ambulance Transport (NEAT)) as well as input from the oversight committee

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and legal counsel. The RFP defined service expectations for a non-emergency patient transport system and included details such as:

- Scope of service (volume of trips, hours of service, response time expectations),
- Skill sets required for attendants and training programs,
- Vehicle, equipment and safety,
- Communications and reporting.

Voyageur Patient Transfer Service was the successful vendor in the response to this RFP and was awarded a contract based on its demonstrable understanding of the transportation industry, experience within the healthcare sector, expertise in logistics management, centralized dispatch, service reliability, data tracking systems, financial stability, proven systems that could attend to the diverse population needs, and the ability to respond quickly to the dynamic changes occurring in the healthcare sector.

Step Two: Establish an Implementation Team: An implementation team was established with representatives from the emergency departments, inpatient units, risk management/health records, nursing professional practice, diagnostics, security and Voyageur Transportation.

Step Three: Establish Short-Term Working Groups: Several short-term working groups were established. These groups reported to the Implementation Team and worked on targeted assignments in areas such as: logistics planning, decision guide development, education planning, communications, issue resolution process, data management process, patient payment, and evaluation tasks. Voyageur, CACC and UTM participated on all teams. This was important in ensuring the process was transparent, building trust, setting reasonable expectations and establishing sustainable linkages between ambulance and non-ambulance systems.

Step Four: Implementation: Implementation development occurred over six months. The first draft of the decision guide and the education materials were developed. A three-month pilot project was established providing opportunities for the hospitals' and Voyageur to evaluate the system. In January 2002, a full roll-out of the project occurred and over the next several months feedback was managed by the implementation team. Key areas for resolution included:

- Weaknesses in the decision guide,
- Continued delays with urgent transports,
- Choice of appropriate mode of transport i.e. less stable patients were being transferred via non-emergency transport,
- Lack of a transport Do Not Attempt Resuscitation (DNAR) policy,
- Documentation issues such as patient assessment and transport tracking forms.

By August 2002, a new and more robust set of tools were developed and implemented. This time, education was much more comprehensive. The hospitals targeted nursing and inpatient unit clerks via nurse educators. Of significance, was the addition of new language to guide staff and CACC with respect to urgent hospital calls. This proved to be very successful and improved satisfaction for all stakeholders. Thus paramedics and CACC dispatchers were also trained using the same tools. In each case, the training was a joint effort by the hospitals, CACC and Voyageur, and strongly endorsed by the UTM.

Key Success Factors

In reviewing our experience, we have identified the following important factors:

1. Partnership and a shared vision: to create a safe, reliable, cost-effective transport system focusing on patient care.
2. Patient care leadership to change practice: staff and physicians are required to select the appropriate vehicle for patient transport based on assessment of the patient's care needs. This is a significant change in clinical practice that could only happen through clinical leadership.
3. A user-friendly system: well-defined service expectations, clear and concise guidelines, clear decision and education guides, and effective communication and education processes.
4. Stakeholder involvement: the co-operation of the CACC, the UTM, Voyageur Transportation and the London Hospitals was paramount to the success. The process was transparent and respectful to all parties.

Ongoing Industry Issues

Despite London's significant progress in three years, systemic issues related to patient-transfer services continue. There are no province-wide standards for care, no coordination of delivery of service, and no evaluation methods to monitor service delivery. There is no funding to hospitals from the provincial government and no clear idea as to what direction the province will give the patient-transport industry. While private patient-transfer services may be "cost effective," it is not a "cost savings" for hospitals. In fact, it represents a new expense, new practice and risk. Thus a long-term, coordinated strategy is required to develop this evolving industry.

While the London-Voyageur model has successfully eased many of the patient transfer issues in London, there remain a number of issues and opportunities outside the city, between healthcare institutions and transfer providers. Healthcare institutions must work together, and with Queen's Park, to set the bar on service standards, accountability framework, policies, patient assessment tools, escort requirements, risk management and patient payment guidelines to name a few.

Future Directions

Currently, there is a patchwork system in place across Ontario with every hospital managing patient transport differently. Although there has been some voluntary collaboration between hospitals, a centralized system would speed improvements. Non-emergency patient transport is here to stay and will continue to play a significant role in healthcare delivery. The need to remove the burden of non-urgent transports from the ambulance system is clearly evident and health care institutions must move forward with shaping a system that is safe and that works to improve patient access and care delivery. The risk of not taking the lead is that hospitals may find themselves with a fragmented system that does not meet their needs.

Perhaps the London model can act as a platform for the development of a province-wide system for transporting stable, non-urgent patients. Ongoing development requires provincial policy to ensure a truly effective, efficient and safe patient transportation system that complements, rather than competes with Emergency Medical Services.

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