

Reducing Patient Transportation Costs

Lynda A. Monik

1

ABSTRACT

Hotel-Dieu Grace Hospital (HDGH) in Windsor, Ontario was faced with a \$20 million deficit in 2002-2003. In an effort to reduce and/or eliminate this deficit, cost-cutting strategies were explored. Patient transportation costs were identified as one of the areas where cost-cutting opportunities could be realized. In 2003-2004, HDGH reduced patient transport costs by \$46,000.00. Cost-cutting strategies included a scripted dialogue for approaching patients and families, clear communication about the importance of cutting costs and progress updates on the cost-savings. Suggesting to patients and families that they could pay for the transport has resulted in better outcomes for patients and families, the hospital and the community.

INTRODUCTION

Hotel-Dieu Grace Hospital (HDGH) is one of three hospitals serving approximately 350,000 residents of Windsor-Essex. HDGH is a medium-size community hospital with over 300 acute care beds. The local restructuring process undertaken by the Windsor-Essex hospitals designated specific patient services to each site. During the course of a day, patients may be transferred from one hospital to another for a procedure/investigation, to physician offices for consults or moved from one level of care to another, including discharge to a patient's place of residence.

BACKGROUND

From 1997 to 2004, HDGH spent over \$500,000 on patient transport costs. Some patients/families became dependent on the hospital to pay for the transport service.

In 2002, the hospital faced a \$20 million deficit. Staff, physicians and management reviewed all aspects of hospital operations to identify cost-savings opportunities. Patient transportation costs were identified as one of the potential cost-saving areas.

INTERVENTION

Staff looked to the current practice of other hospitals, the practice of U.S. hospitals and to the legislation for guidance, including the Public Hospitals' Act, the Ministry of Health and Long Term Care Act and the Health Insurance Act.

HDGH staff was aware that patients transferred back to their place of residence, a long term care facility were entitled to "free" ambulance transportation. However, ambulance transfers became "unreliable." Emergency calls for the ambulance remained a priority. Even when the ambulance service designated ambulance vehicles for patient transport, the arranged and actual pick-up times were not always the same.

When patients were not picked up by the ambulance at the scheduled time, they and their families became anxious. The receiving facilities sometimes refused the patient transfer if the transfer was late in the day and inpatient beds could not be turned over in a timely manner to meet the acute care needs of patients waiting in the ER for an inpatient bed. It became apparent that, by asking patients and their families to pay for the transport, the hospital could save money and meet the needs of patients and families, while freeing-up ambulances to respond to emergency calls.

2

The first group of hospital employees to initiate dialogue with patients/families about paying for patient transport was the Social Work/Discharge Planning staff. The Social Work/Discharge Planning staff assists discharged patients and their families in making transfer arrangements to long term care facilities, rest and retirement homes, complex continuing care and/or the patient's residence.

CHANGE PROCESS

The success of convincing some patients and/or their families to pay for the transportation appears to be in the "approach." The social workers developed a scripted dialogue to convince patients and their families that the viable choice for transfer is not an ambulance but a patient transport vehicle, taxi or some other mode of transportation, including their own personal vehicle. The scripted dialogue includes a statement about the Ministry of Health and Long Term Care (MOHLTC) waiving the fee for patient transfer from the hospital to a long term care facility, if an ambulance is used.

Patients and families are told that when an alternate patient transfer service is used, a specific date/time for the transfer can be established and agreed upon by the patient/family, receiving facility and the inpatient unit. A daytime transfer is preferred. Daytime transfers help the receiving facility staff (if applicable) or Community Care Access Centre (CCAC) staff, and others, settle the patient into his or her surroundings. The scripted dialogue used by the social worker/discharge planner also identifies the benefits of a family member being present when the patient arrives at a facility or home. Most patients do not have a chance to tour their new home when discharged to a facility. A family member's presence can help to alleviate some of the anxiety the patient may have about the move to a facility or back home.

Patients/families are also told that when an ambulance transfers a stable patient from facility to facility, it means that the community may offer a reduced level of emergency 9-1-1 service. Patients and families appear to appreciate that if they were in need of

an ambulance, one might not be available because it was providing a non-emergency service, which can be provided by other vendors.

For the hospital, the benefit of using patient transport services includes adherence to hospital discharge and facility admission times. As a result, the hospital can move patients through the ER to the inpatient units.

HDGH has chosen not to engage in a contractual agreement with any of the patient transport vendors. In the past, the hospital signed a contract with one vendor. The hospital was at the “mercy” of the one vendor and the vendor’s ability to meet patient transfer and discharge demands. Today, the hospital takes advantage of competitive market forces to help keep patient transport costs reasonable.

The hospital’s efforts to reduce transportation costs were communicated to social worker/discharge planners by memos, reminders at meetings and face-to-face dialogue to problem-solve specific patient/family situations. Cost-savings for this initiative were communicated to the staff in terms of full-time equivalent jobs. The cost-savings for 2003 to 2004 was \$46,000.00 or equal to the salary of a full-time equivalent.

3

A Decision Guide for transferring patients from the London Health Sciences Centre (LHSC) used with LHSC’s permission has been modified for local use. The Guide provides staff with some insight about when to use the various patient transport alternatives – ambulance, private patient transport, cabs, and so on.

RESULTS

Unit clerks of other hospital disciplines, including nursing, have adopted the scripted dialogue when speaking with patients and their families about patient transport. Hospital staff has come to support the concept of asking patients and families to share in the responsibility for payment of the transfer, because the result is patient/family focused, the alternatives are safe when the Decision Guide is used and cost-savings affect the hospitals bottom line.

HDGH staff is committed to reducing patient transport costs and continues to look at alternatives to ambulance transport and even private patient transport services. One staff member, a unit clerk, in consultation with the patient’s healthcare professionals suggested a patient be transported by wheelchair cab instead of a patient transport vehicle. The cost-savings for one trip was \$120.00.


HDGH transfers over 400 patients a year to facilities including long term care facilities. These patients are stable and do not require an ambulance. Each transfer takes approximately one hour. Eliminating 400 ambulance transfers amounts to over 400 hours that ambulances are available to serve the acute care needs of the public. For trauma patients and patients with extended benefits, the social workers continue to work with patients and families to determine if the cost of the patient transfer can be covered by the insurance company, further reducing the transport costs that the hospital might have to pay.

A recent audit of the modes of transportation used by patients on discharge revealed that most patients and families pay for a patient transport service.

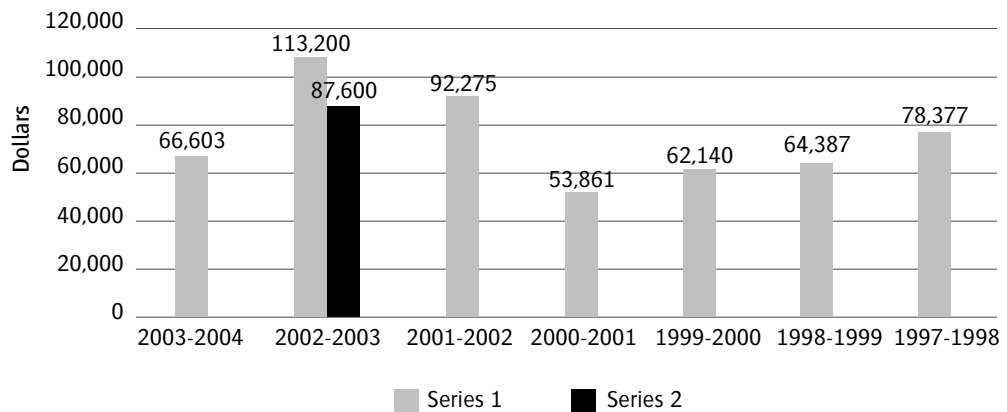
In Windsor-Essex, there was one patient transport vendor who “owned” the market share. With the restructuring of patient services and the elimination of duplicate services at hospitals, the need to transfer patients has become even greater. Entrepreneurs started looking at the patient transport business as a viable business opportunity. Today, there are four patient transport services in Windsor-Essex.

CONCLUSION

Every patient transfer is viewed from the perspective of patient safety, patient-focused care, minimizing cost to both the hospital and patient, and reducing reliance on ambulance services for patient transport.

The experience at HDGH demonstrates that opportunities exist when we re-examine current practices. Changes to the current practice resulted in better outcomes for patients and families, the hospital and the community. 

By implementing the strategies used at HDGH, other hospitals may be able to replicate the cost-savings achieved.



**In 2002-2003 there was a provincial ambulance strike, which increased the costs of patient transport to the hospital sector.

About the Author

Lynda A. Monik, B.A., Reg. N., MBA, P. Mgr., Director, Social Work and Resource Utilization, Hotel-Dieu Grace Hospital, Windsor, Ontario. Contact: 1030 Ouellette Avenue, Windsor, Ontario N9A 1E1, Tel: (519)-973-4411 ext. 3282

Acknowledgements:

Social Worker/Discharge Planners, HDGH, Toni Janik, Director, Library Services, HDGH, Peggy Oldfield, Resource Utilization Nurse, HDGH, Janice Dawson, Master of Nursing Student, University of Windsor, Shannon Tompkins, Director, Public Affairs, HDGH

