REGIONAL MUNICIPALITY OF OTTAWA-CARLETON — REPORT
MUNICIPALITÉ RÉGIONALE D'OTTAWA-CARLETON — RAPPORT

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DATE 3 March 1998

TO/DEST. Co-ordinator
Community Services Committee

FROM/EXP. Chief Administrative Officer
and Medical Officer of Health

SUBJECT/OBJET **LAND AMBULANCE SERVICES IN OTTAWA-CARLETON**

DEPARTMENTAL RECOMMENDATIONS

1. That Community Services Committee and Council receive this report for information;

2. That Community Services Committee recommend that Council authorize:

a) The Chief Administrative Officer and Medical Officer of Health to select an interim transition manager to oversee the work necessary for the Regional Corporation's assumption of the proper provision of land ambulance service in Ottawa-Carleton as soon as is practical;

b) The Chief Administrative Officer and Medical Officer of Health to establish an inter-departmental transition team and select its members, and;

3. That Community Services Committee recommend that Council commit to ensuring the provision of land ambulance service in accordance with the Ministry of Health's fundamental principles that the service be accessible, integrated, accountable and responsive.

EXECUTIVE SUMMARY

The transition to Regional responsibility for land ambulance service in Ottawa-Carleton is a complex issue involving many different, inter-connected stakeholders. Assuming the proper provision of land ambulance service in this region will involve working closely with the Ministry of Health, private ambulance providers, the Base Hospital Program Ottawa-Carleton, the local hospitals and fire departments. To begin this transition, Regional Council should examine such service components as the tiered response program, the role and control of dispatch, the base hospital program, the current distribution of fees for ambulance service and the responsibility of the Ministry of Health for fleet management, equipment supply and administration of service contracts.

The first of many issues to be addressed is the Ministry of Health's pending request for proposals for the Ottawa/Carleton Regional Ambulance Service and the province's apparent position regarding the upper-tier's ability to influence that process. Regional Council must address many other issues in assuming the proper provision of land ambulance service. These include impacts of collective agreements and labour relations requirements, cross-boundary funding, taxing options, proposed changes to and control of dispatch, fleet and equipment management and hospital amalgamations.

To effectively carry out this transition, the report recommends the appointment of a dedicated interim transition manager and inter-departmental transition team. The transition manager can assist and co-ordinate the activities of the inter-departmental transition team, research and evaluate world-wide industry practices, prepare draft policy and system standards, develop appropriate consultation tools and generally ensure the proper involvement and exchanges of information with the local emergency services community, Regional Council and the public in general.

Under the stewardship of the transition manager, Regional Council can begin to address such issues as:

- short-term and long-term strategies for the development of a cost-efficient, high quality ambulance service;
- options and strategies relating to the Ministry of Health's pending request for proposal for the Ministry ambulance service;
- maintaining French language service in designated areas;
- communications plan for stakeholders, local providers and the public;
- a compensation formula with upper-tier partners for cross-boundary service;
- monitoring and reviewing Ministry of Health financial and operational activities in the ambulance and related sectors;
- identifying unfunded liabilities (severance, WCB costs, long term leases, etc.);
- preparing human resources inventory, including staffing levels, contract issues, qualifications;
- preparing physical inventory including: vehicles, equipment, ambulance buildings; and
- exploring land ambulance communications options.

INTRODUCTION

Part I of this report identifies the emergency medical services providers and presents an overview of the existing emergency response system in Ottawa-Carleton. Part II of the report presents a preliminary list of key issues to be addressed in order to assume full responsibility for ambulance service. Part III contains recommendations for next steps to facilitate the transfer from the province to the Regional Municipality of Ottawa-Carleton. Given the specialized nature of this service, a glossary of commonly used industry terms is also included for your reference as Appendix "A" and defined terms are underlined in the text of the report.

PART I - OTTAWA-CARLETON'S EXISTING EMERGENCY RESPONSE SYSTEM

Current Land Ambulance Providers

In Ottawa-Carleton, land ambulance service is provided by four private and one public operator. The list of ambulance services and their base locations is attached as Appendix "B". Collectively, these ambulance services responded to approximately 96,000 calls in 1996. Although each of these ambulance services has an established base of operations, there are no geographic restrictions (within Ontario) on where they may be dispatched. These ambulances are generally dispatched through a voice-radio system on the basis of closest available vehicle. This same fleet of ambulances and attendants handle both emergency and non-emergency inter-facility transfers. With the exception of the Ministry of Health ambulance service, the *Ambulance Act* provides that the existing private ambulance services may continue until midnight, December 31, 1999.

The Ottawa/Carleton Regional Ambulance Service, a Ministry of Health function, has approximately 130 employees, 27 emergency vehicles and an annual operating budget of $5.9 million. In 1996 they responded to approximately 46,000 of the 96,000 calls in Ottawa-Carleton. The balance of Ottawa-Carleton's ambulance service is delivered by private companies.

The Ministry of Health ambulance service is subject to a collective agreement with the Ontario Public Service Employees Union (OPSEU). An overview of this agreement is provided later in the report. Private licensed ambulance providers also operate pursuant to individual collective agreements with OPSEU. These agreements are included in staff's' preliminary identification of issues and next steps.

Air Ambulance Service

Ontario's air ambulance system was established in 1977 to transport critically ill patients to hospital. The air ambulance system also transports specially trained neonatal teams from facilities such as the Hospital for Sick Children and the McMaster University Medical Centre. These teams travel to outlying hospitals to provide emergency intervention and transportation to premature babies. The critical care flight paramedics are Ministry of Health staff, while the pilots and aircraft staff are all from the private sector. The flight paramedics are trained at Sunnybrook Health Sciences Centre and take direction from doctors at the local medical bases.

At this time, the Provincial Government intends to retain responsibility and financing obligations for air ambulance services. In Ottawa-Carleton the Ministry of Health has a standing offer with Huisson Aviation. Huisson has available two pilots for a specialized helicopter capable of transporting two stretcher patients. In 1996, Huisson Aviation responded to 600 calls.

Emergency Services - Tiered Response Program

Currently, in Ottawa-Carleton, there exists a tiered response system, whereby fire personnel are deployed to certain medical emergencies concurrently with ambulance crews. As the demand for ambulance services has grown over the years, existing operators have found it increasingly difficult to maintain the rapid response time needed to save lives (a four-minute response is viewed as necessary). This is a phenomenon that is consistent throughout Ontario.

Over the course of recent years, fire departments have received a relatively smaller number of fire-related calls, many of which are false alarms. Given the greater availability of fire department personnel and their strategic placement throughout the Region, a tiered response program was established in Ottawa-Carleton, whereby fire personnel are often the first to arrive at a non-fire emergency scene. As a result, fire department staff are now trained by the Ministry of Health in first aid. Furthermore, fire trucks carry medical equipment (in some cases, semi-automatic defibrillators) in order to have the resources to provide basic medical care as soon as they arrive on the scene.

There are tiered response agreements in place which dictate which emergency agencies will respond in different scenarios. In July of last year, it was decided that the trigger for the deployment of fire department vehicles in a medical emergency would be a Code IV emergency (the highest priority medical emergency; ambulances engage both their lights and sirens). This policy was modified in October, such that fire trucks now only respond in situations which meet the newly implemented "criteria for activation", which include:

- absence of breathing,
- severe bleeding,
- imminent threat to life,
- difficulty breathing, or
- chest pains.

It is the provincial dispatching centre which assesses whether any particular medical emergency fits the criteria for activation. Based on preliminary discussions and minutes of the Tiered Response Committee, there does not seem to be universal support for the current criteria.

Volume and Classification of Land Ambulance Services

Based on the most recent complete year of data, land ambulance services in Ottawa-Carleton responded to 96,000 calls in 1996. These calls can be generally divided into five major categories:

Code I	Inter-facility transfers
Code II	Inter-facility transfers
Code III	Non life-threatening emergencies
Code IV	Life threatening emergencies
Code VIII	Dispatch to a stand-by location to await a call

All calls are dispatched through the central dispatch service with non-emergency calls generally pre-booked 24 hours in advance. Approximately 50% of ambulance calls fall into the category of non-emergency, elective patient transfers. Most frequently, these calls are for inter-facility transfers. Inter-facility transfers are a publicly funded service under the *Health Insurance Act*. 1996 amendments to the *Ambulance Act* were intended to limit the scope of patient transfers that were included under ambulance services. The Province implemented a Patient Decision Matrix that was intended to assist hospitals in identifying patient transfers that could be done through alternate means of transportation.

In Ottawa-Carleton there are three multi-patient transfer vehicles used primarily for these inter-facility transfers. Two are operated by the Ministry of Health and one by a private ambulance service. These vehicles are able to respond to over 50% of the annual non-emergency inter-facility transfers. The balance of non-emergency transfers are generally handled by Paramedic I basic life support vehicles and a small number of private, unlicensed transportation services that may be retained directly by the patient.

Dispatch

Ambulance communications centres will continue under the control of the Provincial Ministry of Health. The Ottawa-Carleton based dispatch service is contracted out by the Ministry on an annual basis to the Elizabeth Bruyère Health Service. The deployment of all ambulances in this region are to remain under the control of the Provincial Dispatch Centre. The geographic area of this dispatch centre, in fact includes dispatching ambulances in most of Eastern Ontario - west to Almonte and Carleton Place coverage area, east to the Quebec border and south to Kemptville, Morrisburg coverage (see appendix "E"). Under the *Ambulance Act*, dispatching responsibilities and financing of this service are to remain with the Provincial Government.

The Government of Ontario is also working to combine all government mobile communications on a single government network. It is the Provincial Government's intention to form an agency as a partnering arrangement between the government and private industry. The intention is that at some future date all telecoms equipment would become the property of this new agency. Regional Staff have no details relating to the status of this project. Available Ministry literature suggests that it is Ministry staff who will be responsible for co-ordination of activities between the agency, Central Ambulance Communications Centre, ambulance service providers and the Ministry.

Base Hospital Program

The Base Hospital Program of Ottawa-Carleton is housed at the Ottawa General Hospital. There are 21 base hospital programs in Ontario, serving 50 consolidated service delivery agents, at a total cost of $6 million per year. Funding for the base hospital program is, at this time, to remain a responsibility of the Ministry of Health. Further financial support for the program is provided through a portion of the patient transfer fee described below under Fees for Ambulance Service.

The base hospital program provides medical direction, leadership and advice in the provision of ambulance based patient. It offers training, quality assurance, continuing education and guidance to all paramedics and their management. The base hospital program also supplies selected medical equipment and drugs to ambulance operators. The base hospital oversees quality control and standards of practice for ambulance services and collects statistics and compiles data on emergency medical services in its area with a view toward improving pre-hospital patient care. The Ministry of Health document entitled "Base Hospital Roles and Responsibilities" is attached as Appendix "D".

The Ottawa-Carleton base hospital has been influential in the implementation of an advanced life support program in Ontario, the introduction of a High School CPR Program and the development of a region-wide Tiered Response agreement, among other things. The continuation of the base hospital program is assumed at this time.

Fees for Ambulance Service

Currently, medically necessary ambulance trips are funded under the Ontario Health Insurance Plan (OHIP) with the patient responsible for a $45 co-payment. Senior citizens, patients on social assistance/disability and inter-facility transfers are exempt from this co-payment. This money does not flow back to the ambulance service. Hospitals or other receiving institutions bill for and collect the $45.00 fee and keep $30 per call. The remaining $15 is remitted to the Province. The Province has no plans to remit its share of the co-payment to municipalities, stating that the $15 is used to support air ambulance services and the base hospital program.

In the event that the land ambulance service in any single case provided is deemed to be a medically non-essential ambulance trip or the individual transported does not have a valid Ontario Health Card, then there is a $240 fee charged to that person. This fee is payable to the Minister of Finance.

Ownership of Vehicles, Equipment and Assets

Under the existing legislative regime all ambulances, medical equipment and other items necessary for the provision of ambulance services are owned by the Ministry of Health. Vehicles are purchased centrally and maintained locally by the Ministry of Health. Emergency Health Services Branch (EHSB) receives regular, required preventive maintenance reports from each ambulance service.

All ambulances being operated must be in compliance with the "Ontario Provincial Land Ambulance and Emergency Response Vehicle Standard" and approved for use by the Director, Emergency Health Services Branch. In addition, medical equipment and supplies must also be in compliance with these standards. Buildings used for the purpose of supporting ambulance service in this region are either owned by the Province, local hospitals or leased by the private ambulance services from a third party. In the case of third party leases, those costs are charged back to the funding agency through the individual operating budgets.

When ambulances are transferred to the upper-tier, the Ministry intends that they will be "uncertified" and therefore will require fitness re-certification and re-licensing. A request has been made to exempt payment of provincial sales tax on transfer through an Order in Council. Based on information received from the Ministry of Health, Ford of Canada (the current chassis supplier) will honour any remaining balance of their standard warranty on transfer to the upper-tier. Paul Demers & Fils (the current conversion vendor) will also honour the balance of the Emergency Health Service warranty on ambulance conversions.

Prices currently paid by Emergency Health Services (excluding taxes) for new ambulances built on 1998 Ford diesel with an ambulance package chassis are:

- $60,800 Type II single main cot (high rise roof on a van chassis),
- $78,000 Type III single main cot (modular body on a RV cutaway),
- $77,500 Type III two main cot (modular body on a RV cutaway).

These prices reflect a minimum volume of business of 60 to 80 units per year. Other volumes may affect pricing. In Ottawa-Carleton, approximately five to six units are replaced each year. The Ministry's Judson Distribution Centre also stocks ambulance automotive parts and conversion components that are difficult to obtain locally in order to reduce vehicle downtime and operating costs.

In addition to complete unit replacement, Type I and Type III ambulances are built with a re-mountable modular body which contains the patient compartment. This body is installed on a light truck chassis. When the chassis has reached the end of its economic life, the body may be removed and reinstalled on a new chassis. This generally represents approximately a 30% savings over complete unit replacement. The remounted vehicle is considered to be equal in service life to a new ambulance.

Under the Federal *Motor Vehicle Safety Act*, the remount is a "new motor vehicle" and the contractor who completes a remount is a "manufacturer". Therefore, the contractor must be in compliance with the *Motor Vehicle Safety Act* and the ambulance must comply with the Canadian Motor Vehicle Safety Standards (CMVSS). Ministry of Health staff have advised that Transport Canada has expressed concern to the ambulance industry because this process in effect manufactures a new vehicle from used parts. The Ministry of Health states that these concerns appear to have been overcome (for Ministry owned vehicles) by having detailed engineering and technical involvement in the process.

For other jurisdictions, Transport Canada has implemented a 12 point certification program which enables remounts to be built with a compliance label. This new program will likely be imposed on ambulances, once they are transferred to the upper-tier. The program requires that:

- the old module must be from a vehicle which was in compliance with CMVSS,
- the structural integrity of the old module and key components must be verified,
- the old module and new chassis must be properly matched,
- certain components must be replaced to assure safety compliance, and
- the resultant new ambulance must be in compliance with CMVSS.

Inventories of basic life support patient care and accessory equipment now held by the Ottawa-Carleton services will be transferred to the upper-tier municipality at no cost, when we have assumed full responsibility for ambulance service. The Ministry of Health is investigating the status of any remaining warranties for new and reconditioned equipment. Current contracts with suppliers reflect Ministry supply specifications and the present multi-year contracts and volume purchasing. Items listed in the Ministry's catalogue are held in stock at the Judson Distribution Centre and are available for next day delivery.

Administrative Role of the Ministry of Health

The Emergency Health Services Branch (EHSB) of the Ministry of Health, oversees approximately 173 ambulance services, over 790 ambulance vehicles, 22 centralized land ambulance dispatch centres, 1 centralized air ambulance dispatch centre, 5 dedicated air ambulance aircraft, over 100 chartered air ambulance aircraft and 21 base hospital programs. Financial activities include forecasting and budget settlement. In addition to vehicle and equipment purchase and maintenance described above, the Ministry of Health carries out a number of other administrative functions relating to ambulance service.

Each ambulance service works with two budgets from the Ministry of Health - an operating budget and an administrative budget. Each ambulance provider is given a line by line operating budget by EHSB and funding is forwarded by the Ministry to these ambulance services twice per month. Approximately 85% of the operating budget goes to salaries. Any surplus in the operating budget is returned to the Ministry at the end of the year. The EHSB can review and challenge any expenditure included in the operating budget. Random audits by an external auditor are also carried out. In the event of unforeseen one-time expenses, the Ministry of Health may also approve additional funding. A Ministry-directed administrative process is in place to address these additional funding requests.

By contrast, the administrative budget provided to each ambulance service by the Ministry of Health is a standardized pre-set amount calculated on the basis of such measures as call volumes and numbers of stations managed by the operator. The EHSB does not audit or review how the ambulance services use their administrative budget. Surpluses are not returned to the Ministry at year end. The use of money provided through the administrative budget is entirely at the discretion of the operator.

In addition to financial and budget management functions, the Ministry of Health issues mandatory training programs for paramedics annually and funds sixteen hours of training per

paramedic per year. Each of the six Ministry regional offices has one training co-ordinator who is responsible for tracking all mandatory and voluntary training programs completed by the paramedics in their region. This individual is also responsible for teaching the mandatory training programs to a small group of training instructors who, in turn, teach in-service instructors these programs. Each ambulance service has its own in-service instructor who is responsible for teaching all mandatory training programs to the staff at that service. These training programs are in addition to those provided by the base hospital.

Ontario Pre-hospital Advanced Life Support (OPALS)

Under a five year study known as OPALS, the Provincial Government approved the training and funding of up to 398 advanced paramedics across Ontario. The study is evaluating the impacts of rapid cardiac defibrillation, together with other advanced life support procedures. Advanced Paramedic candidates are chosen from full-time basic paramedics, by their employer and the base hospital to receive an additional three months of intense training.

Once certified by the base hospital, advanced paramedics are then permitted to perform a wide range of controlled medical acts including administration of emergency drugs, advanced airway procedures, intra-venous therapy, defibrillation and other advanced emergency skills. To date the Region of Ottawa-Carleton has 46 advanced paramedics certified under the OPALS study, with a further 12 to be trained in 1998. OPALS is in its fourth year.

Collective Agreements

Staff of the Ottawa-Carleton Regional Ambulance Service - some 130 provincial government employees - are designated Crown employees and are covered by the *Crown Employees Collective Bargaining Act.* Each of the other four private operators are covered by separate collective agreements with OPSEU. The terms of these collective agreements are very similar. The operators are designated as Crown Agency Employees and are also covered by the terms of the *Crown Employees Collective Bargaining Act*. Section 69 of the *Labour Relations Act,* 1995, relating to successor rights, does not apply to either the private or provincial employees.

Currently, all five groups are covered under the *Crown Employees Collective Bargaining Act.* Upon transfer of the business, it is unclear which piece of labour legislation would govern these employees.

PART II - KEY ISSUES

Inherent in the identification of key issues and decisions that need to be taken, is the importance of ensuring the continued priority for public safety, maintenance of service levels, participation of stakeholders, current providers and the public, promoting the ongoing confidence in land ambulance service and ensuring a smooth transition. Ambulance service in Ontario is currently a seamless program that crosses all municipal boundaries without regard to residence. Resolution of issues and implementation of next steps must preserve this seamlessness.

Ottawa/Carleton Regional Ambulance Service

The first critical issue relates to the Ministry of Health's recent communication regarding the status of the Ottawa/Carleton Regional Ambulance Service. The Ministry of Health has advised the Regional Corporation verbally that even with the early assumption of responsibility for the proper provision of land ambulance service, the Provincial Government remains in complete control of decisions relating to the Ottawa/Carleton Regional Ambulance Service. The Ministry of Health appears to believe that the current *Ambulance Act* supports their ability to exercise complete unfettered control over this service.

Ministry staff have indicated that the RFP process will proceed even though the Regional Corporation has approved the early transfer provisions of the *Ambulance Act*. Regional staff do not agree with the Ministry's interpretation of the *Ambulance Act*. It continues to be staff's position that the new *Ambulance Act* allows the upper-tier municipality to assume responsibility for the proper provision of land ambulance service and the Ministry-run ambulance service is not exempt from the responsibilities we are required to assume. However, should the Ministry of Health choose to proceed to issue an RFP notwithstanding the Region's assumption of responsibility, the Regional Corporation still has a right to submit a bid.

Regional staff are awaiting a written explanation of the Ministry's position. It is a matter of highest priority. In the interim staff are identifying all available tools at our disposal, including court intervention, to resolve the difference in legislative interpretation and prevent the release of the request for proposals.

Ministry of Health Criteria and Principles

On the afternoon of March 2, 1998, the Ministry of Health forwarded the documents attached as Appendix "F". In addition to stating that the ministry will "immediately proceed to negotiate the transfer of responsibility", these documents outline Ministry-developed criteria and principles to be applied by upper-tier municipalities for the assumption of responsibility for land ambulance service. To date this is the only information available from the Ministry of Health on the steps to be followed by the Regional Corporation in order to assume land ambulance service responsibilities.

In essence, the Ministry of Health documents state that in order to begin negotiations for the transfer of responsibility of land ambulance service, Regional Council is obliged to adopt the "Fundamental Principles for Land Ambulance" developed by the Province. These fundamental principles are to ensure that land ambulance service is accessible, integrated, accountable and responsive.

To be "accessible", municipalities are obliged to ensure that the land ambulance system responds regardless of the location of the request. A land ambulance service that is an "integral part" of the provincial health care system will meet the "integrated" requirement. An "accountable" service requires that municipalities meet provincial legislative and regulatory requirements. Finally, a land ambulance service that addresses changes in demographic, socio-economic and medical needs will be deemed "responsive".
All of these fundamental principles will be addressed as we proceed with the negotiations with the Ministry of Health and the implementation of an Ottawa-Carleton ambulance service.

General Labour Relations Considerations

The issue of varying rights and obligations under various service delivery scenarios must be kept in mind during this transition period. The Regional Municipality may assume responsibility for ambulance services essentially either by setting up its own ambulance service to replace the other providers, by contracting with the existing providers to continue to provide the service within the Region or some combination of these other two options which would see the Region providing some service directly and, in addition, contracting with other service providers.

If it is to be in whole or part a service provided directly by the Regional Municipality, we will have to establish a qualified workforce and both obtain and maintain vehicles and equipment appropriate for the job. This organization will have to be in place so as to ensure a seamless transition from the existing private suppliers to the Regional enterprise.

If the Region were to hire the employees of the existing service providers as Regional employees they would be placed into the appropriate bargaining unit and salary scales and benefits would be negotiated for them. Since the private suppliers would have ceased operations at the end of their licence, there would be no question of the employees bringing their collective agreements with them. Indeed, since the employees of the private suppliers have been designated as Crown employees by regulation, there would be no successorship issue, even if the Region took over the existing businesses in circumstances which would normally give rise to a sale of business situation under the *Labour Relations Act*.

Under this first scenario, the predecessor employer would be responsible for any termination payments applicable under its collective agreement, together with severance payments to employees under the *Employment Standards Act*. In circumstances where the Region was taking over the businesses prior to the expiry of their licences, thereby creating a sale of business situation, there would be no severance pay under the *Employment Standards Act* for employees hired by the Region. However, the predecessor employer would have to pay severance to those employees the Region did not take as part of the sale.

Entitlements under the *Workers' Compensation Act* attributable to injuries which occurred prior to the transfer would continue to be the responsibility of the predecessor employer.

If the Region chose to contract with existing providers, different rules are applicable. Since work of this nature has never been performed by Regional staff, it would not qualify as bargaining unit work and there should be no question of the Region's ability to continue to contract this work out. Under this scenario, the existing suppliers would remain in place and would maintain the employment relationship which they have with their employees under whatever collective agreements they are a party to. Since the employees would not have changed employer, there would be no question of severance payments or any issue concerning W.C.B. payments, e.g. such things as trying to determine whether a subsequent problem arose as a result of an injury which pre-dated the transfer.

Collective Agreements

As noted, the current group of provincial government employees are designated Crown employees, covered by the *Crown Employees Collective Bargaining Act.* As such, the successor rights provision of the *Labour Relations Act*, 1995, does not apply. If the Regional Municipality does choose to assume responsibility for the provision of ambulance services, it will not automatically inherit the collective agreement between the Ontario Public Service Employees Union (OPSEU) and Management Board of Cabinet (otherwise referred to as the Ontario Public Service - or OPS).

The existing collective agreement between OPSEU and the OPS requires the OPS to make "reasonable efforts" to ensure that employees in the bargaining unit are offered positions with the new employer on terms and conditions that are as close as possible to their existing conditions of employment and that offers are made on the basis of seniority. This language places an onus on the OPS to negotiate with new employers. To date, efforts by OPS to meet this condition have been ruled to be insufficient. The OPS has been required to put increasing pressure on new employers to offer jobs to existing provincial government employees.

If the Regional Municipality did decide to hire previous Provincial government employees, these employees would have the right to bargain. A determination would have to be made as to which bargaining unit they should fall under. Once this service is brought in-house, the language of the collective agreement may restrict the Regional Corporation's subsequent ability to contract out.

Each of the other four private operators are covered by separate collective agreements with OPSEU. The terms of all remaining collective agreements are very similar. The operators are designated as Crown Agency Employees and are also covered by the terms of the *Crown Employees Collective Bargaining Act*. As such Successor Rights do not apply to this group.

Language dealing with sale or transfer of business does exist in each of the collective agreements, but the language is less onerous than the reasonable efforts language in the OPS agreement. It states that current employers will "recommend" to purchasers that it give first consideration to the full-time employees in the bargaining unit for available positions.

<u>Region's Insurance Coverage Costs and Other Risk Management Issues</u>

In assuming responsibility for the proper provision of land ambulance service by the Regional Corporation, it is necessary to determine the insurance costs for liability, property and automobile coverage. A preliminary identification of risk management issues to be addressed includes, appropriate deductible levels for liability and automobile coverage, self-insurance option, insurance coverage for non-regional service providers answering calls within our geographic boundaries and insurance pooling possibilities with other ambulance services. Furthermore, the Ministry of Health has been self-insuring its vehicles for replacement and repair from collision. The latest cost analysis offered by the Ministry is approximately $558 per year per ambulance. Staff, together with our insurers, must identify and quantify these and other insurance-related issues.

<u>Cross-Boundary Funding</u>

Currently, ambulance service in Ontario is seamless and until January 1, 1998 it was wholly funded by the Province (with few exceptions). In light of this structure, within the province of Ontario there was no need for mutual aid agreements or reimbursement for cross-boundary ambulance trips. However, the Ministry will continue to dispatch whatever ambulance can provide the quickest and most efficient response to both emergency and non-emergency calls. Therefore, out of town ambulances will be sent to a call if that vehicle is the closest available unit to the patient and R.M.O.C. based ambulances will be dispatched outside of the region as deemed necessary by the dispatcher.

Some form of mutual aid agreement must now be negotiated to reimburse the upper-tier municipality for ambulance service provided beyond our geographic boundary. A mutually acceptable formula for calculation of applicable fees must be developed. In addition, billing and collection mechanisms must be established to support the funding agreement(s).

Likewise, our upper-tier neighbours will expect to be reimbursed when one of their funded ambulance services provides service within Ottawa-Carleton. In 1996, Ottawa-Carleton based ambulances responded to 1,119 calls in locations outside our region. In that same year, operators located outside the boundaries of our region responded to 6,738 calls inside Ottawa-Carleton. We are the net beneficiary of the current seamless system and it is reasonable to expect that our upper-tier neighbours will expect to be reimbursed for the services they fund inside our geographic boundaries.

Taxing Issues

The upper-tier municipality must make a decision regarding how to recover the cost of land ambulance service from local taxpayers. Options that are available include, regional tax levy, reimbursement based on shared assessment values or billing to local municipalities based on usage. An identification of available options, together with a calculation of their respective financial impacts must be carried out. This will have to be carried out in conjunction with an evaluation of all legislated and regulatory conditions for recovery of costs.

Central Communication Facility - Ambulance Dispatch

While the province has expressed its intention to retain complete control of ambulance dispatch, the impact of that function on the delivery of service is a key issue to be examined. Available literature generally suggests that the integration of ambulance dispatch with service delivery is essential to achieve cost containment and performance management. Improved accountability and productivity in the delivery of ambulance service is dependent upon data available through dispatch practices and technology.

Inherent in the design of an emergency response system is response standards, cost calculations and performance efficiencies. Monitoring and evaluation of these components generally depends on dispatch functions and data. If Regional Council chooses to include performance incentives in the emergency services model, then it is difficult to imagine how they can be evaluated and enforced in the absence of a direct role in the dispatch function. The calculation of unit hour utilization, response time and cost per response are all dependent on dispatch practices.

While the Ottawa-Carleton dispatch facility is a voice-operated system, North America is seeing increasing reliance on global positioning systems with supporting sophisticated software for forecasting, identifying route optimization, daily updates of response times and categorization and monitoring of call types. Further detailed evaluation of the dispatch function, including the possibility of assuming that function, should be explored by the Region.

Furthermore, in light of recent limited information regarding a Provincial Government study for the creation of a single province-wide ambulance dispatch agency, regional staff must obtain detailed information on the terms of reference for this study, the status of the Government Mobile Communications Project, ensure that upper-tier concerns are properly addressed and assess whether a centralized system best meets the needs of Ottawa-Carleton.

Patient Co-Payment

At this time patients receiving a medically essential ambulance trip are charged a fee of $45. Certain classes of people are exempt. The co-payment is generally collected by the hospital and shared with the Province. None of the $45 is to be redirected to the upper-tier municipality. The volume and value of these recoveries should be identified and the area of co-payments should be further explored during the transition period.

Design of Service Delivery Model for Year 2000

By September 30, 1999, Regional Council is required by the *Ambulance Act*, to decide on the organization of land ambulance services for Ottawa-Carleton. The potential models include, but are not limited to, the creation of a new department or division within the Regional Corporation to administer, manage and deliver all or part of Ottawa-Carleton's ambulance services, the assumption of contract management functions within the Regional Corporation with service delivery contracted out to other providers or a public-private partnership in the delivery of land ambulance service.

In addition, the role of the base hospital program and tiered-response agreement must be included in the development of the service delivery model. Tiered response varies between municipalities, particularly in outlying areas where emergency services are often provided by volunteers. This may impact on the efficacy of the tiered response system. At this time, there is no guarantee that local municipalities will agree to continue 'loaning' their fire departments for a tiered-response program under a restructured system.

Staff are mindful that no decision should be taken between 1998 and December 31, 1999 without considering the impact of that decision on our ability to implement the January 1, 2000 ambulance service model. The province will continue to set minimum standards for levels of service, delivery and performance as well as minimum standards for equipment. However, Regional Council must decide how best to meet or exceed those standards and what impact those choices will have on our industry partners.

Emergency versus Non-Emergency Services

As noted earlier, it is possible to divide ambulance services into emergency versus non-emergency calls. Approximately 50% of Ottawa-Carleton's 96,000 annual ambulance calls fall into the general description of non-emergency. While over half of those non-emergency calls are currently handled by a small number of multi-patient transfer vehicles, Regional Council must decide how best to deliver this non-emergency service. There are two such transfer vehicles available during the day in Ottawa and one at night. There is also one transfer vehicle (day and night) operated by Rural/Metro Ontario's Nepean service.

Any consideration of reorganizing land ambulance service along these distinct lines must evaluate the impact on such things as the total number of providers and training required, response times and quality of care. The ability to use alternate means of transportation, the impact on patient care, hospital productivity and satisfaction, cost comparisons of alternate models, ambulance staffing levels, desired response time, cost per unit hour and unit hour utilization are some of the components of this issue that will require further examination. Finally, without control of dispatch, the Region lacks direct authority to redirect calls for an ambulance to an alternate service provider. This factor will be included in consideration of this issue.

Fleet and Equipment Management

Early assumption of responsibility for the proper provision of land ambulance service will include assuming the Ministry of Health's fleet and equipment management functions. Regional staff must obtain from the Ministry of Health detailed information relating to the scope of fleet maintenance, repair and replacement functions and details of existing contracts with external service providers. The nature of inquiries and data required are reflected in the preliminary list of questions developed by Corporate Fleet Services and attached as Appendix "C" to this report.

Currently, the Regional Corporation's Corporate Fleet Services provides equipment and automotive stores purchasing services. Regardless of the land ambulance service delivery method that may ultimately be implemented, the following items need to be addressed:

1. Access to existing equipment/parts specifications;
2. Status of the Ministry of Health's Toronto warehouse post-2000;
3. Inventory and usage data;
4. Status and terms of existing supply contracts;
5. Detailed data regarding total time and staffing expended in purchasing;
6. Financial data; and
7. Infrastructure data (inventory systems, plant, FTEs, etc.).

In order to assess the impact of accepting fleet management responsibilities or to develop specifications for contracted services the following issues need to be addressed:

1. Access to historical data regarding total fleet operating costs;
2. Determination of level of fleet management (i.e. how well managed is the fleet?);
3. Gaining a full understanding of existing procedures and decision making processes;
4. Detailed understanding of operating and capital budgets (historical);
5. Facilities and infrastructure assets and liabilities;
6. Maintenance facility requirements;

7. Depreciation calculations and reserve funds (if no reserves, how budgeted and funded?); and
8. Current fleet disposition (age, value, life expectancy, etc.).

Current contracts with equipment suppliers will need to be reviewed to determine if they may be transferred to the Regional Corporation, as well as the impact of changes in volume purchasing on quoted prices. Further, some contracts include provisions for negotiating equipment repairs. The transferability of these provisions must be reviewed.

Finally, under any service delivery model that is not wholly operated by the Regional Corporation, Council must also decide whether to continue to own and maintain the fleet of ambulances or enter into service agreements that see the ownership and responsibility for vehicles transferred to the ambulance service. The benefits and disadvantages must be addressed as fleet and equipment management issues are addressed.

Hospital Amalgamation

Hospitals play a key role in the delivery of ambulance service. The base hospital program, inter-facility transfers and decisions regarding medically essential ambulance trips all impact on the delivery and cost of land ambulance service in Ottawa-Carleton. The impact of proposed hospital amalgamations on the delivery and cost of ambulance service must be examined. Turn-around time for ambulances is already longer as the pressures on hospitals increase. Under the current system, hospital emergency department status falls into one of three levels:

1. Clear to receive ambulances;
2. Open for emergencies only; or
3. Closed - with no capacity to receive new arrivals.

As hospital restructuring further stretches hospital resources, ambulance operators fear increased incidents of level 2 or 3 emergency room access restrictions. In addition, private clinics, like the Orleans Emergency Clinic, and other specialized diagnostic and treatment centres, may become more common as the industry finds new, innovative ways to respond to the pressures and limitations experienced at area hospitals. Such satellite facilities will increase the demand for inter-facility transfers. These are just a few of the issues that must be examined in an evaluation of the impact of hospital restructuring on the delivery of ambulance service.

Base Hospital Program

The base hospital program has played a key role in such areas as initial and ongoing training of paramedics at the basic and advanced life support levels, medical delegation of acts controlled under the *Regulated Health Professions Act*, medical oversight during calls and quality assurance and the supply of certain medical equipment and drugs. With the introduction of the Advanced Paramedic Certification program, the role of the base hospital program in providing medical direction, control and quality assurance has significantly expanded. During this transition period, the Region should work with the Base Hospital Program, Ottawa-Carleton to identify any funding changes and pressures on their services together with an evaluation of the best possible role of the program within a revised emergency services model.

PART III - KEY DECISIONS

Overall system design is generally agreed to be the foundation on which an effective, cost-efficient system is built. Experts in the field have identified over twenty-seven pre-hospital emergency services delivery models. Whatever system is ultimately accepted it must include such key components as organizational and legal structures, financing strategy, quality control and performance incentives and an oversight function.

By now it is probably clear that the assumption of responsibility for the proper provision of land ambulance service in Ottawa-Carleton involves many inter-connected stakeholders and numerous complex issues. The changeover in responsibility for land ambulance services, together with the obligation to design an Ottawa-Carleton emergency services model to take effect on January 1, 2000 is a huge undertaking requiring the dedicated attention of a full-time transition manager. This report has not begun to touch on the possible linkages and integration between 911, fire departments, police and ambulance.

Under the stewardship of a transition manager, staff recommend the establishment of an inter-departmental ambulance transition team. The goals of this team would include the development of an efficient, effective and accessible land ambulance service in consultation with all stakeholders. The ambulance transition manager could assist and co-ordinate the activities of the transition team, research and evaluate world-wide industry practices, prepare draft policy and system standards, develop appropriate consultation tools and generally ensure the proper involvement and exchanges of information with the local emergency services community, Regional Council and the public in general.

The Transition Manager and Transition Team could begin by addressing such issues as:

- Short-term and long-term strategies for the development of a cost-efficient, high quality ambulance service.
- Identify options and develop a strategy relating to the Ministry of Health's pending request for proposal for the Ministry ambulance service.
- Ensure that French language service in designated areas is maintained.
- Develop a system to ensure that public safety and levels of service are maintained.
- Identify industry growth and demand projections.

- Develop communications plan for stakeholders, local providers and the public.
- Negotiate a compensation formula with upper-tier partners for cross-boundary service.
- Liaise and participate in information exchange with various government ministries, the ambulance sector, base hospital, fire departments, police.
- Promote co-operative working relationships with the Ministry of Health, existing providers, hospitals, health council and other allied agencies on issues pertaining to land ambulance service in Ottawa-Carleton.
- Work with existing organizations, service providers and other allied agencies to review the design and value of non-urgent transportation alternatives.
- Monitor and review Ministry of Health financial and operational activities in the ambulance and related sectors.
- Identify unfunded liabilities (severance, WCB costs, long term leases, etc.).
- Prepare human resources inventory, including staffing levels, contract issues, qualifications.
- Prepare physical inventory including: vehicles, equipment, ambulance buildings.
- Explore opportunities within existing or proposed legislation for service improvement efficiencies and standards for clinical and health issues.
- Review ambulance billing legislation and procedures with a view to an equitable distribution of land ambulance generated revenues.
- Assess industry's best practices.
- Explore models of ambulance service delivery and prepare an evaluation of their respective strengths and weaknesses.
- Explore opportunities to create service improvements and maximize efficiencies through an assessment of the integration or amalgamation of such services as police, fire and ambulance.
- Explore land ambulance communications options.
- Monitor the development and impact on roles and responsibilities of new regulations issued under the *Ambulance Act*.
- Analyse both mandatory and discretionary training requirements and their respective costs and benefits.

CONCLUDING COMMENTS

In carrying out Regional Council's direction, a smooth transition from provincial to municipal responsibility is critical. We are embarking on new ground. No other upper-tier municipality has decided to assume the operation of a provincial ambulance service and only the Region of Waterloo and Huron County have advised the Ministry that they wish to assume responsibility for the proper provision of land ambulance service. The challenge ahead is the creation of a system that simultaneously generates clinical excellence, response time reliability, economic efficiency and customer satisfaction.

Research completed to date strongly suggests that system design is the single most important influence on the ability of an emergency medical system to control cost while delivering high performance within reliable response times. Staff expect to work closely with the Ministry of Health, the private ambulance providers, the Base Hospital Program Ottawa-Carleton, the local

hospitals and fire departments and wish to acknowledge their assistance in the preparation of this report.

Approved by
Dr. Robert Cushman
Medical Officer of Health

Approved By
M. Beckstead
Chief Administrative Officer

KDM:cab

Attach. (6)

ANNEX A

GLOSSARY

A

Advanced Life Support - defined in the *Ambulance Act* as the following controlled acts that may be performed by an advanced care paramedic: administration of the drugs specified under basic life support, in addition to any drugs approved by the Director for the Emergency Health Services Branch on recommendation from one or more medical directors of a base hospital program, semi-automated external cardiac defibrillation, peripheral intravenous therapy, endotracheal intubation and non-automated external cardiac defibrillation and monitoring.

Advanced Care Paramedic - Also referred to as a Paramedic II, are certified to perform a wide range of controlled medical acts including administration of emergency drugs, advanced airway procedures, intra-venous therapy, defibrillation and other advanced emergency skills. Becoming an advanced paramedic requires additional training beyond Paramedic I requirements as well as base hospital certification in such skills as endotracheal intubation, foreign body removal from the airway and needle thoracostomy.

Air Ambulance - The provincial air ambulance program provides service to persons located in areas of the province that are remote or where land ambulance response times are great. Air ambulances also transport

B

Base Hospital Program - The medical director of a Ministry designated local base hospital program is responsible for certifying paramedics to perform controlled medical acts such as semi-automatic defibrillation and administration of drugs as well as several other controlled medical procedures. The program provides medical control, quality assurance, training, auditing and statistics.

Basic Life Support - Defined in the *Ambulance Act* as administration of the following controlled acts that may be performed by a primary care paramedic: administration of glucagon, oral glucose, nitro-glycerine, epinephrine, salbutamol and ASA, semi-automated external cardiac defibrillation and peripheral intravenous cannulation.

C

Cost per Response - Calculated by dividing the total expenses in a one-month period by the total number of responses in that same period. This is used primarily in the industry for the purposes of market and provider comparisons.

Cost per Unit Hour - Determined by dividing each provider's total expenses by total number of unit hours.

D

Dispatch - Central ambulance communication centre owned and operated by the Provincial Government for the dispatch of ambulances to all emergency and non-emergency calls. Provincial control of the system includes all telecommunications equipment including towers and tower sites, paging, radio frequency licenses and vehicle radios.

E

Emergency Calls - There are two types of emergency calls. A Code III emergency call refers to a patient who is suffering from a serious injury or illness, but is in stable condition or is in the care of personnel who are in the process of stabilizing the patient. A Code IV emergency call refers to life-threatening situations. Time is critical, the patient is not medically controlled and the level of care available is not sufficient to provide stabilization.

I

Inter-Facility Transfers - See definition of non-emergency calls.

M

Medically Essential Ambulance Trip - If a person is injured or very sick and the ambulance trip is judged to be medically essential by the attending physician or a physician states in writing before the ambulance is used, that the patient's condition makes an ambulance necessary, then the patient is only charged $45 for the ambulance trip.

Medically Non-Essential Ambulance Trip - If an ambulance trip is judged not medically essential by the attending physician or the person does not have a valid Ontario Health Card, then the patient must pay $240 for a land ambulance trip and the full assessed cost of an air ambulance trip. This is rare.

N

Non-Emergency Call - There are two types of non-emergency calls. A Code I non-emergency call refers to a non-urgent call which may be temporarily delayed without being physically detrimental to the patient. A Code II non-emergency call refers to any call which must be done at a specific time due to limited availability of special treatment or diagnostic facilities or other scheduled transportation facilities.

O

OPALS - The Ontario Prehospital Advanced Life Support (OPALS) study is a five year program, to evaluate the effects of rapid cardiac defibrillation, together with other advanced life support procedures, on cardiac arrest patient survival and reducing morbidity and mortality among other critically ill patients. The study is in its fourth year.

P

Peak-load Staffing - Patient demand and traffic congestion tend to cycle predictably on a weekly basis so rather than relying on 24-hour shifts and constant staffing practices, peak-load staffing matches supply of ambulance resources with demand and traffic pattern fluctuations.

Primary Care Paramedic - Also referred to as Paramedic I, all registered primary care paramedics must complete a one year college course in Ambulance and Emergency Care (or equivalent) and successfully complete a provincial certification examination in order to qualify for full-time employment as a basic level paramedic.

Protection Period - The period between January 1, 1998 and January 1, 2000 established in the revised *Ambulance Act* to address certain conditions and provisions during the transition from provincial to municipal ambulance responsibility.

R

Response Time - Response time is the interval between the moment the emergency medical system had enough information to initiate a response and the time a properly equipped vehicle arrived at the scene. There are two common ways to measure response time:

> **Simple Average Response Time** - All applicable response times are added then averaged to arrive at an eight minute performance standard; and
>
> **Fractile Response Time** - All applicable response times are stacked in ascending length, then the total number of calls completed within eight minutes are calculated as a percentage of the total number of calls with a 90th percentile response time under eight minutes deemed to be a high-performance system.

T

Tiered Response Program - A system whereby fire personnel are deployed to certain medical emergencies concurrently with ambulance crews. Agreements are in place which dictate which emergency agencies will respond in different specified scenarios.

U

Unit Hour - A unit hour is defined as each hour that a fully staffed and equipped ambulance is on duty and available to respond to calls.

Unit Hour Utilization - A method for calculating industry productivity that divides the total number of ambulance transports per month by the total number of unit hours in that same month.

ANNEX B

LIST OF AMBULANCE SERVICE PROVIDERS BASE ADDRESSES IN OTTAWA-CARLETON

ARNPRIOR & KANATA AMBULANCE SERVICE

1. 37 Edgewater Street
   Kanata, Ontario
   K2L 1V7

   831-6073
   Douglas Powell

CARLETON PLACE RICHMOND AMBULANCE SERVICE

1. 118 Perth Street
   Richmond, Ontario
   K0A 2Z0

   257-7158
   Jim McIsaac

OTTAWA/CARLETON REGIONAL AMBULANCE SERVICE

1. 738 Gladstone Avenue
   Ottawa, Ontario
   K1R 6X3

2. 360 Hunt Club Road
   Ottawa, Ontario
   K2E 1A5

3. 1181 Parisien Street
   Ottawa, Ontario
   K1B 4W4

   737-9671
   Harry Terzotoulos, Acting Manager

ROCKLAND & ORLEANS AMBULANCE SERVICE

1. 1439 Youville Drive
   Orleans, Ontario
   K1C 4M8

   830-2341
   Michel Chretien, Jr.

RURAL/METRO ONTARIO

1. Queensway-Carleton Hospital
   3045 Baseline Road
   Nepean, Ontario
   K2H 8P4

   596-6336
   Jeff McNeil

2. 1073 Greenbank Road
   Nepean, Ontario
   K2J 4H8

   825-8731
   John Kibsey

3. 3207 Vance Street
   Osgoode, Ontario
   K0A 2W0

   826-0026
   Andrew Orchard

ANNEX C

1. CORPORATE FLEET

Required fleet services information and issues to be addressed regarding transfer of responsibility for proper provision of land ambulance service:

1. What type of vehicle/equipment replacement fund exists? What is the current balance? What is the replacement value of the fleet? How are reserve contributions made? How are contributions and draw-downs reconciled?

2. What is the agreement with the Contractors regarding their obligation to maintain the vehicles to prescribed standards and optimal life of the vehicle? What are the maintenance arrangements for these vehicles?

3. What are the operating and maintenance costs (multi-year history) for the various types of ambulances?

4. How are replacements decisions determined?

5. How many vehicles are in the Ottawa-Carleton Region?

6. Who owns the vehicles? Who owns the vehicle license plates and hence is responsible for the proper operation and maintenance of the vehicle (i.e. CVOR)?

7. Who is responsible for on-board equipment (e.g. vacuum pumps, oxygen, defribulators, etc.) and how is it managed?

8. How are the ambulances maintained? If contracted, why? What are the terms of the contract(s)?

BASE HOSPITAL

ROLES AND RESPONSIBILITIES

October 24, 1997

INTRODUCTION

A Base Hospital is a hospital that has applied for and been designated as such by the Ministry of Health. A Base Hospital provides medical direction, leadership and advice in the provision of ambulance based pre-hospital emergency health care within a broad based, multi-disciplinary, community emergency health services system in a specified geographical area. This involves the Base Hospital in acting as a resource centre and facilitator to assist in ensuring that ambulance based pre-hospital care and transportation is meeting a community's needs.

In addition, the Base Hospital provides training, quality assurance, continuing education and guidance to ambulance based pre-hospital emergency care providers. All such programs shall be approved in advance by the Ministry of Health. The Base Hospital also functions in an advisory capacity to the Ministry of Health on matters relating to ambulance based pre-hospital emergency care.

Monitoring and evaluating ambulance based pre-hospital emergency care is a primary responsibility of each Base Hospital.

The Base Hospital Program is one of several significant partners in an integrated Emergency Health Services System (EHSS) for the Province of Ontario.

REQUIREMENTS OF A BASE HOSPITAL PROGRAM

1. The Board of Directors or Trustees of a hospital that is hosting a Base Hospital Program must be in complete support of that Program.

2. The Base Hospital must maintain an emergency unit that operates on a 24 hour daily basis in compliance with the Guidelines for Hospital Emergency Units in Ontario as issued by the Ministry of Health, 1989.

3. In the case of an Advanced Life Support program, an on-site, qualified emergency physician must be readily available at all times.

4. The hospital administration and the emergency unit medical and nursing staff must be committed to participating in the Base Hospital Program.

5. The Base Hospital Program will participate in the development of agreements and protocols that will determine appropriate patient destinations and transfers.

6. The Base Hospital has entered into a Performance Agreement with Emergency Health Services Branch to provide the services specified in that agreement.

ROLES AND RESPONSIBILITIES OF A BASE HOSPITAL

1. **"IT IS A ROLE OF A BASE HOSPITAL TO PROVIDE MEDICAL DIRECTION, LEADERSHIP AND ADVICE IN THE PROVISION OF AMBULANCE BASED PRE-HOSPITAL CARE AT BOTH THE BASIC AND ADVANCED LIFE SUPPORT LEVEL."**

The responsibilities in fulfilling this role include:

GENERAL

- a Base Hospital will provide the Director, Emergency Health Services Branch with base hospital services as set out in and delivered in accordance with the Ambulance Act, regulations and a Base Hospital Performance Agreement.

- a Base Hospital will maintain an emergency unit that is available on a 24 hour a day basis

- in the event that ambulance workers within the designated area are approved by the Ministry of Health to perform controlled medical acts, a physician, approved to practice emergency medicine by the Board of the host hospital, will be available at all times in the emergency unit.

- the Base Hospital will designate a qualified[1] emergency physician to act as the Program Medical Director.

---

[1] Medical Director qualifications will include:

- being in full-time practice of emergency medicine and on the active staff of a hospital emergency unit, or
- be in part-time practice in emergency medicine (at least 50% of clinical practice hours) in an emergency unit, and
- hold a recognized medical specialty credential in emergency medicine (e.g. FRCPC, ABEM, CCFP(EM)), and
- is knowledgeable and experienced in supervising, training, delegating to and directing pre-hospital emergency care providers in the delivery of basic and advanced life support care emergency medical care.

- where approved by the Director, Emergency Health Services Branch, the Base Hospital Program Medical Director, on behalf of the Medical Advisory Committee and Trustees or Board of Directors of the Hospital will assume responsibility for the training and certification of paramedics to deliver controlled medical acts. In addition, the Program Medical Director will be responsible for delegating such acts and ensuring the quality of such patient care rendered.

- The Base Hospital Program will advise Emergency Health Services Branch of each complaint, received from any source, regarding ambulance service.

- The Base Hospital will on request from Emergency Health Services Branch or a service operator, conduct or assist in conducting a review or investigation of a complaint relating to the provision of ambulance service

- A Base Hospital physician will, upon request from an paramedic, or in accordance with approved protocol, provide medical direction or advice consistent with current Emergency Health Services Branch (EHSB) policies and the paramedic's approved scope of practice.

- the Base Hospital will appoint program administrative staff as required within approved funding.

- the Base Hospital Program will adhere to the usual policies and procedures of the host hospital for the recruitment of Program staff

- the Base Hospital Program will adhere to the policies of the host hospital regarding human resource documentation.

- the Base Hospital Program will have current job descriptions for each Program position.

- the Base Hospital Program will have an organizational chart which clearly depicts positional responsibilities and reporting relationships for each staff position within the Base Hospital Program

- the Base Hospital Program will have a current policy and procedure manual for the Program.

- the Base Hospital will have a co-ordinated and co-operative working relationship with:

    * other departments and programs within the hospital.

    * provincially licensed ambulance services and central ambulance dispatch services within the designated geographical area.

    * all associated and/or receiving hospitals within the designated geographical area.

    * public safety services (fire, police, etc.) within the designated geographical area.

    * District Health Council(s) and the Area Emergency Health Services Advisory Committee within the specified geographical area.

- the Base Hospital will have a Base Hospital Utilization Committee which will meet at least twice a year for hospital staff, ambulance service operator(s), central ambulance dispatch management, Regional Office staff, paramedics, tiered/first response agencies, municipal representatives and area receiving hospitals to communicate and address issues relating to ambulance based pre-hospital patient care.

- the Base Hospital Utilization Committee will have terms of reference which are agreed to by a majority of two-thirds of the members of the Committee.

Patient Care - General

The Base Hospital will:

- on request, assist ambulance service operators in the review and validation of the patient care elements of local policy and procedure manuals.

- ensure that paramedics and other ambulance workers are represented on the Base Hospital Utilization Committee to provide them the opportunity to input to program activities and to receive feedback.

- provide each service operator with assistance and information necessary for the development and implementation of the patient care components of a Continuous Quality Improvement program.

- where the patient care provided by a paramedic or other ambulance service worker does not meet the Provincial standard for patient care delivery the Base Hospital will provide the appropriate service operator with qualitative and quantitative feedback regarding the nature and type of patient care provided by the paramedic(s) and the nature of the identified patient care deficiency

Controlled Medical Acts

- the Base Hospital will ensure that prior to any expansion or change in scope of practice of paramedics in their area, or introduction of any training in an advanced life support procedure that such change is endorsed in writing by the Board of the hospital hosting the Program and by each affected ambulance service operator, and that prior written approval is received from the Director, Emergency Health Services Branch or his delegate.

- the Base Hospital will work co-operatively with and assist the service operator in:

  - determining which paramedics will be eligible for training at the Paramedic and Advanced Paramedic levels.

  - using a provincially standardized methodology for pre-screening candidates, including standards for minimum qualifications.

  - utilizing a provincially standardized method for verifying applicant knowledge, skills and qualifications.

  - implementing standardized criteria for an interview process

- the Base Hospital will accept for advanced life support training eligible candidates provided by service operators and will ensure that an objective candidate training, evaluation and certification process is provided for each candidate.

- paramedic candidate training and certification records will be retained for a period of three years following completion of each selection competition.

- the Base Hospital will maintain and report to Emergency Health Services Branch a controlled medical act skills inventory for each paramedic employed by a licensed ambulance service operating within designated area of the Base Hospital.

- the Base Hospital Program will maintain current records of the following.

    * evaluation process and outcome for each candidate considered for advanced life support training.

    * training and continuing medical education for each paramedic.

    * certification, decertification, recertification, deactivation and reactivation of each paramedic.

    * remedial education activities for each paramedic, equipment failure and Base Hospital physician unavailability for on-line medical control, and any other unusual circumstance or occurrence.

    * complaints relating to ambulance based prehospital care received by the Base Hospital.

    * each failure by a paramedic to adhere to controlled medical act protocols or any related patient care error or omission.

- the Base Hospital will undertake a review of compliance with controlled medical act protocols on an annual basis.

- the Base Hospital will review and ensure that training and delivery policies and procedures for controlled medical acts are consistent with provincial standards on an annual basis.

- the Base Hospital will co-operate with each service operator to ensure that the policies and procedures for controlled medical act performance does not result in service operators or their staff being in conflict with their collective agreement, EHS policy or legislated requirements.

II "IT IS A ROLE OF THE BASE HOSPITAL TO PROVIDE, UNDER THE DIRECTION AND LEADERSHIP OF THE MINISTRY OF HEALTH, EMERGENCY HEALTH SERVICES BRANCH AND IN CO-OPERATION WITH THE AMBULANCE SERVICE OPERATORS, APPROVED TRAINING, CONTINUING MEDICAL EDUCATION AND QUALITY ASSURANCE AT THE BASIC AND ADVANCED LIFE SUPPORT LEVELS."

The responsibilities in fulfilling this role include:

GENERAL

- the host hospital will ensure that the Base Hospital Program staff are qualified to deliver such training, continuing medical education and quality assurance programs as they are approved to deliver

- the Base Hospital where approved to do so, will deliver or assist with the delivery of provincially approved patient care training programs for ambulance based pre-hospital care paramedics.

- the Base Hospital will promote awareness of its patient care, quality assurance and continuing education responsibilities to medical and nursing staff of receiving emergency units in its geographical catchment area.

- in response to a request, the Base Hospital will, initiate, co-ordinate or assist with educational programs for paramedic ambulance workers in co-operation with the service operator and Emergency Health Services Branch.

Controlled Medical Acts

- the training and certification of paramedics will occur under the supervision and responsibility of the Base Hospital Medical Director in accordance with provincial standards for content and methodology.

- the Base Hospital will develop and implement a quality assurance program for ambulance based paramedics which may include, but are not limited to the following:

    * monitoring the delivery of controlled medical acts through chart audits, ride-outs, out-come studies and clinical experience.

- monitoring the functionality and effectiveness of medical equipment and supplies
- ensuring the maintenance of medical equipment and supplies required for the performance of controlled medical acts.
- monitoring and maintaining controlled medical act skills maintenance programs.

- encourage an effective relationship between Base Hospital staff, receiving hospital emergency department staff and paramedics.
- the Base Hospital will deliver provincially standardized programs of continuing medical education for paramedics.
- the Base Hospital will use objective, provincially standardized criteria and format(s) to evaluate the quality of controlled medical acts provided by paramedics.
- the Base Hospital will on an annual basis conduct a minimum of one evaluation of patient care skills and delivery for each paramedic.
- the Base Hospital will provide individual feedback to each paramedic and collective service feedback respecting each service to the operator of that service regarding the findings of the patient care quality assurance program.
- the Base Hospital will evaluate the effectiveness of controlled medical act training, certification and continuing medical education programs using Emergency Health Services Branch approved methodology.
- the Base Hospital will conduct patient outcome audits on selected patients or types of medical conditions.
- the Base Hospital will undertake patient care evaluations through:
  - conducting chart audits of ambulance calls where a controlled medical act was performed by a paramedic or where a controlled medical act was indicated but not provided.

- soliciting emergency physician input
- monitoring % of cancelled calls
- monitoring on-line quality assurance activities.

- the Base Hospital will comply with the certification policy for each paramedic in accordance with the nature of the approved program and provincially accepted ambulance based pre-hospital policies and protocols.

- the Base Hospital will notify the service operator within 24 hours of each instance where a paramedic has had the delegation of one or more controlled medical act recinded by the Base Hospital Medical Director.

- the Base Hospital will maintain complete records as follows:
  - each ambulance call in which a "Controlled Medical Act" was initiated or indicated.
  - each ambulance call or incident reviewed or audited by the Base Hospital.
  - each training program conducted by or participated in by the Base Hospital.
  - all patient care provider CME programs
  - compliance with provincial certification policy
  - minutes from meetings
  - communications/correspondence
  - complaints/investigations and actions taken
  - equipment:inventory/use/training/maintenance/failure
  - physician unavailability for on-line medical quality assurance

- failure of paramedics or Base Hospital Physicians to adhere to a base hospital or patient care protocol relating to ambulance based pre-hospital emergency patient care.

- clinical errors relating to ambulance based pre-hospital care committed by paramedics or Base Hospital Physicians

- the base hospital program will have in place and maintain a health and safety program for its staff and for training activities.

- the Base Hospital will assist each service operator in establishing a health and safety program related to the provision of controlled medical acts and the use of the approved medical equipment.

III "IT IS A ROLE OF THE BASE HOSPITAL TO PLAN FOR AND MANAGE THE FINANCIAL, STAFFING, FACILITIES AND EQUIPMENT NEEDS AND RESOURCES REQUIRED FOR ITS PROGRAM".

The responsibilities in this area will include:

Capital Expenditures

- capital expenditures will be approved in writing by Emergency Health Services Branch, in advance and will be supported by a business case which includes a needs analysis, options considered and cost estimates.

Operational Funding

- base program funding will reflect the previous years allocation. Annual economic revisions to the base budget of a Base Hospital may be made.
- the base program budget will reflect the need for resources to provide the services requested and approved by the Ministry from the Base Hospital for the designated ambulance services.
- requests for base funding adjustment or one-time activities will be made through the Base Hospital proposal process.
- funding agreements with other agencies or organizations must have prior written approval by the Director.

Financial Management System

- the Base Hospital Program will ensure that a financial management system is in place which adheres to generally accepted business and financial practices.

THE MINISTRY OF HEALTH WILL ONLY FUND BASE HOSPITAL PROGRAM EXPENSES FOR WHICH PRIOR WRITTEN APPROVAL IS GIVEN.

A) Funding

the Base Hospital will make an annual budget submission in the designated format and time frame.

each annual submission will provide details of capital and operating expenditure for the budget period.

base budgets will not be exceeded except where written approval has been given prior to the commitment of funds.

funding obtained by the Base Hospital Program from sources other than Emergency Health Service shall be reported to the Director.

B) Expenditure management and control

expenditures will be monitored regularly by the Base Hospital and limited to the amounts approved by the Ministry in each category.

variances in expenditures will be reported by the host hospital to the Regional Manager, Emergency Health Services at the time of routine financial reporting.

each expenditure will be supported by individual invoice or employee time record as approved for payment by the host hospital

funds may only be used for the purpose that has been approved by the Ministry unless prior written approval otherwise has been received from the Ministry.

C) Accounting practices

the financial accounting program used by the host hospital for the Base Hospital Program will conform to general accounting practices, legislated standards and Ministry of Health financial policies and procedures.

a detailed accounting of each expenditure will be maintained for audit purposes. expenditures will be shown on the relevant lines of the reporting statements.

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a detailed accounting of each expenditure will be maintained for audit purposes. expenditures will be shown on the relevant lines of the reporting statements.

Report submissions

financial and operating reports using the form and format approved by the Director will be submitted to Emergency Health Services Branch through the Regional Manager within the time period specified by the Director.

a Base Hospital Program activity report in the form and format specified by the Director will be submitted on an annual basis to Emergency Health Services Branch through the Regional Manager.

the Base Hospital program will notify the necessary service operator and the Director through the Regional Manager, of any change in the status of a paramedic or other ambulance service worker. These reports will include, but not be limited to:

- certification changes (advise within 3 working days)
- level of training a paramedic has received
- Emergency Health Services Identification Number

Facilities

The Base Hospital will:

- undertake or in co-operation with service operators, facilitate the provision of space for training/continuing education for paramedics.
- provide appropriate accommodations for Program staff.

Equipment and Supplies

The Base Hospital will:

- ensure provision of such items of supplies and equipment as approved by Emergency Health Services Branch and as are necessary for the delivery of each controlled medical act by paramedics in the designated geographical area.

- enter into a written agreement with each service operator regarding the supply, use and maintenance of equipment and supplies specific to the delivery of each Ministry approved controlled medical act being provided by paramedics in their service.

- maintain an inventory of supplies and equipment required for the delivery of controlled medical acts approved for delivery by the Program.

- ensure that each item of equipment required to be carried in an ambulance for the delivery of a controlled medical act by paramedics is approved for such use by the Director of Emergency Health Services Branch.

- enter into a written agreement with each service operator to ensure the operational status of equipment and availability of supplies used in the ambulance services for the delivery of a controlled medical act.[7]

Planning

The Base Hospital will:

- maintain a plan for ensuring that all staffing needs of the Base Hospital Program will be met on an ongoing basis.

- have a plan in place to ensure the availability of operational, administrative and clinical support services needed to sustain the Program.

- provide a health and safety program for Program staff and trainees.

ANY SUCH PLAN REQUIRING ADDITIONAL RESOURCES SHALL HAVE PRIOR WRITTEN APPROVAL FROM THE MINISTRY BEFORE COMMITTING TO AN EXPENDITURE OF SUCH RESOURCES.

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7 In the Air Ambulance program this is generally the responsibility of the Air Ambulance base or the local Base Hospital Program.

In those instances where the Base Hospital contracts responsibility for equipment maintenance to an external biomedical maintenance facility the host hospital remains responsible for the operational status of all such equipment.

IV "IT IS A ROLE OF THE BASE HOSPITAL TO ACT AS A RESOURCE CENTRE FOR PRE-HOSPITAL CARE IN IT'S DESIGNATED GEOGRAPHICAL AREA."

The responsibilities of the Base Hospital in fulfilling this role include:

Ambulance Based Operations

The Base Hospital will:

- assist a service operator in assessing present and future staff training needs
- assist the service operator in monitoring patient care.
- monitor and evaluate the delivery of controlled acts by paramedics.
- bring to the attention of and discuss with the Regional Office and service operators any issues relating to the level and type of patient care service being offered.
- participate in the development of agreements that will determine appropriate patient destinations and transfers.
- participate in the development of tiered response agreements.
- on request from a dispatcher or ambulance crew, provide information or medical advice to CACC and paramedics regarding patient transportation or the selection of an appropriate receiving facility for specific patient needs.
- act as a resource to the CACCs and the service operators in the development of local service and dispatch policy on the transfer of emergency patients.

Community

The Base Hospital will on request:

- assist local health planning agencies in defining the level and type of pre-hospital care service required by the community.
- act as a resource to the development and delivery of public education for EHS

- assist local ambulance service operators and the Regional Office to ensure that the patient care that is being provided meets community, district and regional needs.

- act as a resource to the Ministry of Health through the Provincial Base Hospital Advisory Group on the emergency patient care skills required to meet the needs of the Province

- will assist with or facilitate communications and conflict resolution on ambulance based pre-hospital patient care issues.

Research

The Base Hospital may, with prior written approval from the Director, Emergency Health Services Branch[3]:

- promote and participate in research pertaining to ambulance based pre-hospital patient care procedures i.e. the benefit of a particular procedure in a particular community or patient care situation.

- promote research and field trials of procedures or equipment for ambulance based pre-hospital care and where requested by Emergency Health Services Branch participate in such research or field trials.

The Base Hospital will also:

- offer recommendations, through the Provincial Base Hospital Advisory Committee, to Emergency Health Services Branch on ambulance based pre-hospital patient care and transportation in general.

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3 This article in no way limits the participation of Base Hospital physicians or other Base Hospital staff from participating in research that is done outside of the realm of the Base Hospital Program

ROLES AND RESPONSIBILITIES OF THE ASSOCIATE BASE HOSPITAL

An Associate Base Hospital is a hospital which has been requested to and has entered into an agreement with a Base Hospital to perform specific designated duties of the Base Hospital Program. These duties must be mutually agreed upon and formalized in a written agreement.

The District Health Council should be and the Regional Office must be involved in the process of determining the role and responsibilities of an Associate Base Hospital.

Funding support to an Associate Base Hospital and all of its activities is the responsibility of the sponsoring Base Hospital.

An Associate Base Hospital is directly accountable to its sponsoring Base Hospital in all matters relating to the provision of Base Hospital services for ambulance based pre-hospital emergency patient care and transportation.

BASE HOSPITAL REVIEW PROCESS

METHODOLOGY:

The review process utilized for Base Hospitals will parallel that used for ambulance services and Central Ambulance Communications Centres. The significant features of this process are

- Ministry of Health developed criteria with base hospital input
- peer focused by including base hospital staff from other centres on review team.
- measurable, results orientated objectives that relate to base hospital contract.

Frequency of Base Hospital Review

The intent of the program is that all Base Hospitals will be reviewed by the Ministry of Health once every five years as part of the continuous quality improvement program for Base Hospitals programs.

Additional reviews of an individual base hospital program might be conducted if:

- recurrent problems or inadequacies are identified in the Program by the Ministry,
- a proposal for expansion or change is considered.
- a Base Hospital review identifies major Program deficiencies which require a follow-up review.

Notice of Review

The Base Hospital will be provided with ninety days notice.

Review Team Composition

Ministry of Health staff from

Emergency Health Programs Section staff
A peer Base Hospital Program Director
A peer Base Hospital Medical Director

Review Criteria

The criteria for the review are based on the Roles and Responsibilities document and the individual contract for each base hospital.

Documentation Review

Ministry files relating to the Base Hospital program containing documentation and correspondence will be reviewed by the team leader. The team is then briefed on the content of the files to familiarize them with the Base Hospital and assist them in preparing and conducting the field visit and interviews. Additional materials will be reviewed during the course of the field visit to validate data gathered through the interview and observation phases.

The team leader will be responsible for:

- identifying files and documents reviewed and by whom,
- identifying files, correspondence, documents, etc. copied and retained as part of the working documents.

Team members will be responsible for recording details from the documentation review.

Interviews

Input is valued from all levels within a base hospital program and from all agencies regularly interacting with the base hospital. Information will be gathered from service operators, receiving hospitals, CACCs, paramedics, DHCs and others outside of the Base Hospital Program.

Field Observations

Field observations may include:

visits with paramedics
Emergency Unit observations
radio-telephone patch review
documentation-chart audit reviews

Ministry of Health / Ministère de la Santé

Ontario

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March 2, 1998

To: CAOs of Upper Tier Municipalities

From: Graham P. Brand
Director

Re: Criteria to Assume Early Responsibility for Land Ambulance Service Program

As you will no doubt be aware by now, the Ambulance Act as amended by the Services Improvement Act 1997 provides for a two year protection period for existing licensed land ambulance operators. The Act also contains a provision that a County or Regional Municipality may elect to assume responsibility, between January 1, 1998 and December 31, 1999, for directly contracting with and funding the existing ambulance service providers. In those instance where an upper tier municipality chooses not to assume early responsibility, the Ministry of Health will continue to fund the service operators and bill the upper tier municipality for the costs associated with the provision of the ambulance service.

If an upper tier municipality wishes to assume early responsibility for the delivery of land ambulance service and the Minister agrees, the Ministry will immediately proceed to negotiate the transfer of responsibility. This transfer will include the funding of the services along with the ownership responsibility for the ambulances & equipment that are being used by the operators in that municipality at the time of the transfer. In order for a municipality to assume early responsibility that municipality is required to fulfil the commitments that are set in the attached documents and provide them to the Ministry in writing.

In agreeing to the early assumption of responsibility, the Ministry has an expectation that land ambulance services will continue to function within the health care system as an integral part of the provincial Emergency Health Services System. If you have any questions regarding the attached criteria do not hesitate to contact the Regional Manager for Emergency Health Services in your area.

c.c. Regional Managers
Land Ambulance Transition Taskforce

CRITERIA TO ASSUME RESPONSIBILITY FOR LAND AMBULANCE

To Meet The Requirements To Assume Responsibility For The Funding And Provision Of Land Ambulance Service An Upper Tier Municipality Will:

1. As an initial step provide a resolution from Council containing a commitment that the municipality will ensure provision of land ambulance in accordance with the fundamental principles that the service will be accessible, integrated, seamless, accountable and responsive, and

2. Commit to ensuring that land ambulance service is provided in accordance with the Ambulance Act, Regulations and other relevant legislation

3. As a final step in meeting the transition requirements provide a true copy of a by-law passed by the Council that establishes the municipality's willingness and authority to assume responsibility for ensuring proper provision of land ambulance service in the municipality in accordance with the needs of persons in the municipality.

FUNDAMENTAL PRINCIPLES FOR LAND AMBULANCE WITHIN A COMPREHENSIVE EMERGENCY HEALTH SERVICES SYSTEM

PREAMBLE

All residents of the Province shall have access to a seamless ambulance service regardless of socio-economic or demographic status and founded on the following principles:

1. 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.

2. INTEGRATED

Municipalities have a responsibility to ensure that land ambulance service be an integral part of the health care system of the province.

3. 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 appropriate hospital based medical staff.

4. RESPONSIVE

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