

Chapter 4

Section 4.04

Ministry of Health and Long-Term Care

Land Ambulance Services

Follow-up to VFM Section 3.04, 2013 Annual Report

RECOMMENDATION STATUS OVERVIEW					
	# of Actions Recommended	Status of Actions Recommended			
		Fully Implemented	In Process of Being Implemented	Little or No Progress	Will Not Be Implemented
Recommendation 1	6	2	4		
Recommendation 2	4	1	3		
Recommendation 3	2		1	1	
Recommendation 4	5		4	1	
Recommendation 5	3	2		1	
Total	20	5	12	3	0
%	100	25	60	15	0

Background

Under the *Ambulance Act*, the Ministry of Health and Long-Term Care (Ministry) oversees land ambulance services in Ontario. It must ensure “the existence throughout Ontario of a balanced and integrated system of ambulance services and communication services used in dispatching ambulances.”

The Ministry is also responsible for setting patient-care and ambulance equipment standards, monitoring compliance with those standards and, through service reviews, certifying ambulance service providers. Forty-two municipalities and eight

other designated delivery agents are responsible for providing land ambulance services.

In total, 50 Ontario municipalities have about 830 ambulances and 300 other emergency response vehicles, which carry paramedics but do not transport patients.

There are 22 Ministry-controlled dispatch centres in Ontario—11 run by the Ministry, six by hospitals, four by municipalities and one by a private operator. Physicians in seven base hospitals are responsible for providing medical support to paramedics with complex or risky medical procedures. In 2012, about 1.3 million ambulances were dispatched and about 970,000 patients were transported, an increase of about 15% for both

since 2008. In 2014 about 1.4 million ambulances were dispatched and about 1,028,000 patients were transported, an increase of about 8% and 6% respectively since 2012.

Over the last several years, the Ministry has funded approximately 50% of each municipality's prior-year costs for ambulance services, plus an increase for inflation, as well as 100% of approved costs for ambulance dispatch centres and base hospitals. The Ministry funds 100% of the cost of 10 First Nations ambulance services and those in other remote areas. In 2014/15, total ambulance costs were \$1.2 billion (\$1.1 billion in 2011/12), of which \$715 million (\$627 million in 2011/12) was funded by the Ministry and \$472 million (\$477 million in 2011/12) by municipalities.

From 2004/05 to 2011/12, ministry funding to municipalities for land ambulance services nearly doubled. However, the number of patients transported increased by only 18% during that time. We noted in our 2013 audit that the Ministry did not know whether the increased funding resulted in faster response times or better patient outcomes. From 2011/12 to 2014/15, ministry funding to municipalities for land ambulance services increased a further 17% and the number of patients transported increased by 6%.

The Ministry's funding formula automatically provides more funding each year to ambulance services that spend more, regardless of the level of service they provide. At the time of the 2013 audit, the Ministry had not analyzed the relationship between funding and levels of service, and it had not determined the reasons that some municipalities spent and received more compared to others. In 2012, only about 60% of the 50 municipalities responded to 90% of their emergency calls within 15 minutes. This remained unchanged in 2014.

Our 2013 audit noted other areas where action was needed, including the following:

- The Ministry had set meaningful response time standards for the most time-sensitive patients, such as those who are choking or experiencing cardiac arrest, but not for other

urgent cases, such as those suffering a stroke. Each municipality sets its own response-time targets for these patients and they varied significantly, from 9% (in rural areas) to 85% within eight minutes.

- The Ministry did not have a patient-centred measure of the ambulance service system's overall response time, that is, from the time of call receipt to when an ambulance arrived at the patient's location.
- While the Ministry expected to publicly report ambulance response times starting in 2014, the reporting method was to be based on patient urgency, measured by ambulance paramedics after they reached a patient (i.e., retrospectively), rather than on information provided by callers at the time of dispatch. Most other jurisdictions report response times based on information available at the time a call is dispatched. We found no other jurisdiction that used a retrospective response time measure.
- In 2012, none of the 20 dispatch centres that measure their time to respond to emergency calls complied with the Ministry's policy of dispatching 90% of calls within the target of two minutes. However, all dispatched 90% of these calls within three-and-a-half minutes. As of 2013, each dispatch centre was allowed to choose the percentage of urgent calls it would need to dispatch within two minutes. As a result, dispatch centres' compliance rates ranged from 70% to 90%, depending on the centre.
- While dispatch protocols are generally designed to over-prioritize calls when there is uncertainty about a patient's condition, the Ministry's dispatch protocol prioritized more than two-thirds of calls at the most-urgent level, when only about 25% of patients actually required an urgent response. This can leave few or no ambulances available to respond to new calls that are truly urgent.

- The Ministry had not assessed whether the current number of dispatch centres is optimal, or whether centralized dispatch would be more cost-effective.
- The Ministry had no provincial policy to ensure appropriate care of certain heart attack patients, and a June 2013 survey indicated that some ambulances did not have trained paramedics and appropriate equipment to ensure proper patient care for such heart attack patients.
- Municipalities acquired patient-care record software that could not electronically share patient records with hospitals. As a result, hospital emergency room staff often had no access to such records until a day or two later, relying instead on verbal briefings from ambulance paramedics.
- Municipalities were responsible for overseeing most paramedic patient-care activities, even though base hospital physicians had indicated municipal land ambulance service providers may not have had the expertise to provide proper oversight.
- In 2012, over 25% (or about 350,000) of dispatched ambulances did not transport a patient. The Ministry had not assessed the underlying reasons.
- The Ministry had not evaluated whether the patient offload nurse program was providing value-for-money. Between 2008/09 and 2012/13, ministry funding for this program totaled \$40 million. We found that, since this program was implemented, ambulance waiting times while stationed at the hospital had actually increased at 20% of the funded hospitals.

We made a number of recommendations for improvement and received commitments from the Ministry that it would take action to address our recommendations.

Status of Actions Taken on Recommendations

According to information received from the Ministry, progress has been made in implementing most of the recommendations in our *2013 Annual Report*. The Ministry has established consistent response times for Sudden Cardiac Arrest and Canadian Triage and Acuity Scale (CTAS) 1 calls for all dispatch centres to better ensure that patients receive timely and high-quality ambulance services. The Ministry now consistently accounts for time spent at a hospital by an ambulance until the patient is accepted and the ambulance is available to respond to another call. To ensure consistent quality in ambulance services, the Ministry implemented a tool for performing unannounced reviews of dispatchers' calls. The Ministry assesses the summary information from these reviews to ensure systemic issues are identified and resolved. The Ministry assigned 22 additional staff to Ministry dispatch centres so that dispatchers would not have to handle more calls than the target number, which helps ensure all calls can be responded to in a timely manner.

The Ministry has fully committed to implementing most of our other recommendations and was working on: establishing performance benchmarks for public reporting; assessing the effectiveness of the Dispatch Priority Card Index II (DPCI II) as compared to the Medical Priority Dispatch System (MPDS) so it could make adjustments where needed to reduce over-prioritization of patients; evaluating the cost-effectiveness of emergency response vehicles to determine how many such vehicles are needed and how to best use them to meet patient needs; and performing a review of the Land Ambulance program to determine why there are differences in service levels and costs for similar populations and geographic areas.

The Ministry has made little progress in implementing three of our recommendations. The Ministry indicated that it plans to evaluate the cost-effectiveness of non-ambulance emergency

response vehicles; however, no definitive timelines have been set for when this will occur. The Ministry has not directed base hospitals to periodically review paramedics' basic life support skills because it was waiting for a government decision on whether changes will be made on regulating Ontario's paramedics. The Ministry has not yet developed processes, such as introducing incentives as part of its transfer payments to municipalities, to promote more efficient ambulance service delivery.

The status of actions taken on each of our recommendations is described in the following sections.

Response Prioritization and Time

Recommendation 1

To better ensure that patients receive timely and high-quality ambulance services, the Ministry of Health and Long-Term Care should:

- *establish consistent provincial dispatch centre targets for the percentage of calls to be responded to within the legislated response-time measures for patients experiencing sudden cardiac arrest and other patients whose conditions are assessed as fitting into the highest priority according to the Canadian Triage and Acuity Scale (CTAS)—that is, all CTAS 1 patients—and establish response-time targets and compliance targets for CTAS 2 (second-highest priority) calls, since such calls also involve time-sensitive emergencies;*

Status: Fully implemented.

Details

The Ministry completed an analysis of 2012 and 2013 CTAS 2 dispatch data and 2013 Sudden Cardiac Arrest and CTAS 1 data in April 2014. The Ministry then began consultations with the management of dispatch centres to establish consistent CTAS 2 dispatch benchmarks for the centres. On September 24, 2014, the Ministry released a memo to senior managers stating that, effective January 1, 2015, a dispatch response time benchmark for processing calls would be adopted

requiring they be processed within two minutes as follows:

- Sudden Cardiac Arrest: 80% of the time
- CTAS 1: 80% of the time
- CTAS 2: 75% of the time

These metrics are to be reported to and monitored by the Ministry on an annual basis.

- *monitor ambulance response times for all calls dispatched as emergencies in addition to the legislated evaluation of response times based on the paramedics' determination of the patient's condition after reaching the scene;*

Status: In the process of being implemented by March 31, 2017.

Details

In December 2013, the Ministry completed an analysis of other jurisdictions to identify possible options for consistent reporting on emergency dispatch response times. It still must consult with the Ontario Association of Paramedic Chiefs (OAPC) to arrive at a consensus on the reporting format for response times for these calls. At the time of our follow-up, the Ministry advised us that the Ministry and stakeholders were unable to meet earlier due to last year's Ebola outbreak and the need to make province-wide preparations to ensure patient safety. The Ministry advised us that discussions with the OAPC started in fall 2015 on establishing a reporting format to monitor response times for all calls dispatched as emergencies. The expectation was for the processes to be in place by March 31, 2017.

- *finalize a provincial protocol for ST-segment elevation myocardial infarction (STEMI) heart attacks—such as ensuring that all ambulances are equipped with the appropriate type of electrocardiogram (ECG) machines, that paramedics are appropriately trained to interpret the ECG test results, and that paramedics are directed to conduct such tests for all potential STEMI patients—and implement electronic*

prompts throughout the dispatch system for transporting these patients to specialized care centres; and

Status: In the process of being implemented by March 31, 2016.

Details

The Cardiac Care Network, an organization funded by the Ministry that works with Ontario hospitals to provide cardiac services, is the lead on the provincial STEMI protocol. The Network provided the Ministry with an implementation plan for the STEMI protocol in December 2014. A STEMI-Emergency Medical Services Working Group was established to standardize STEMI care across Ontario, and has produced a draft Ontario STEMI Bypass Protocol in March 2015, which was shared with the Ministry. The Ministry advised us that the Cardiac Care Network is finalizing this draft protocol in consultation with emergency medical services stakeholders, including the Ministry's Medical Advisory Committee, the Ontario Base Hospital Group, the OAPC, Ornge air ambulance and Toronto Paramedic Services. The protocol is expected to be completed by fall 2015. The Ministry advised us that, once the provincial STEMI protocol has been finalized and accepted, each dispatch centre will incorporate STEMI dispatch information into its local operating practice by March 31, 2016 to determine where to transport patients.

The Ministry's Medical Advisory Committee recommended in May 2014 that all ambulances be equipped with a 12-lead electrocardiogram-capable machine. In January 2015, the Ministry approved and released the updated Advanced Life Support Patient Care Standards and Provincial Equipment Standards for Ontario Ambulance Services, which include 12-lead electrocardiogram-capable machines as mandatory equipment. The updated standards come into effect on February 1, 2016.

Base hospitals ensure paramedics know the applicable patient care standards and are trained to perform delegated controlled acts. The Ministry advised us that it expects that all paramedics

employed by land ambulance services will have completed all required training relating to its Paramedic Service and Regional Base Hospital Program and be authorized to use 12-lead electrocardiogram-capable machines.

- *consistently account for the time spent by an ambulance at a hospital until the patient is accepted, based on patient urgency and any additional time the ambulance spends at hospital until it is free to return to service.*

Status: Fully implemented.

Details

All dispatch centres now consistently record the amount of time an ambulance spends at a hospital, from arrival to when the patient is accepted and the ambulance departs, in the Computer Aided Dispatch system. This was introduced and implemented by January 2015 across the province (with the exception of Niagara, which was completed in June 2015). This "paramedic transfer of care time" information is now available to the Ministry and is being made available to paramedic services through the Ministry's dispatch reporting system. This will enable the Ministry to measure and report on how much time paramedics spend with the patient at a hospital, after the patient transfer, prior to departing from the hospital, and on activities such as cleaning the ambulance.

To ensure that Ontarians have access to relevant information on the performance of dispatch centres and municipal land ambulance services, the Ministry, in conjunction with municipal land ambulance services and base hospitals, should:

- *establish other key measures (including outcome measures) of land ambulance performance (for example, total ambulance response time from call receipt to arrival at the patient location, and the survival rates of patients with certain conditions such as stroke and cardiac arrest); and*

Status: In the process of being implemented by March 31, 2016.

Details

The Ministry's Medical Advisory Committee was engaged in December 2013 to advise on performance measures for ambulance patients. In May 2014, the Ministry received evidence-based performance measures that had been endorsed by the Medical Advisory Committee. These included:

- medical performance measures, including the percentage of cardiac arrest patients discharged from hospital as neurologically independent;
- surgical performance measures, including the percentage transported to the designated trauma centre (i.e. usually the closest hospital with specially trained physicians and specialized equipment); and
- airway performance measures, including the percentage of intubations that were successfully performed.

At the time of our follow-up, the Ministry informed us that the next step is to have discussions with the OAPC regarding the measures endorsed by the Medical Advisory Committee and other possible measures, such as total ambulance response times. The discussions with the OAPC are necessary to determine the feasibility of gathering the required data and obtaining feedback on which measures are worthwhile for public reporting. Discussions with the OAPC commenced in fall 2015 and a decision on which key measures to report on was expected by March 31, 2016.

- *publicly report on these indicators and on response times for each municipality in a consistent and comparable format (for example, separately by urban and rural areas, as well as by patient urgency levels).*

Status: In the process of being implemented by March 31, 2017.

Details

The Ministry informed us that once performance metrics have been determined (expected by

March 31, 2016), it will begin collecting the information related to those measures to allow for public reporting starting the year ending March 31, 2017.

Dispatch

Recommendation 2

To ensure the most efficient use of land ambulance services, the Ministry of Health and Long-Term Care should:

- *assess the effectiveness of the two protocols used in Ontario to prioritize calls and dispatch ambulances, including comparing the dispatch priority determined by the protocols with the paramedics' evaluation upon reaching the patient, and adjusting the protocols where needed to reduce excessive over-prioritization of patients.*

Status: In the process of being implemented by September 30, 2018.

Details

At the Ministry's request, the Sunnybrook Centre for Pre-Hospital Medicine researched the two protocols used in Ontario to prioritize 911 calls—the Dispatch Priority Card Index II, which is used in 20 dispatch centres and the Medical Priority Dispatch System, which is used in Niagara and Toronto—and concluded that the Medical Priority Dispatch System is a more accurate system.

In December 2014, the Provincial/Municipal Land Ambulance Dispatch Working Group—created by the Ministry to provide advice on improving the dispatch process—met for the first time. The working group is composed of ministry staff, as well as municipal representatives from the OAPC and the Association of Municipalities of Ontario. The working group's report was expected to be received by the Minister by fall 2015 and to include recommendations to improve the dispatching of ambulance services and the prioritization of emergency calls. The Ministry anticipated it would take up to three years to plan and complete improvements to ambulance dispatch triaging in Ontario.

- *consider updating software that assists dispatchers in choosing the best ambulance to dispatch so that it identifies both the ambulance with the shortest actual travel time and the most appropriate one in order to maintain emergency coverage across the entire geographic area involved, as two municipalities have already done; and*

Status: In the process of being implemented by March 31, 2017.

Details

The Ministry informed us that, as of 2014, five of the 22 dispatch centres (Toronto, Niagara, Ottawa, Georgian and Mississauga) used tools to identify the most appropriate ambulance to dispatch so that emergency coverage was maintained.

In December 2014, the Ministry began upgrading the Computer Aided Dispatch system at some dispatch centres. Once upgraded, the system will support the Routable Streets module, which provides dispatchers with more precise ambulance travel times to the call location based on actual streets. This will enable dispatch centres to choose the best ambulance available to dispatch based on the fastest predicted travel time, while still maintaining emergency coverage. The Ministry advised us that the installation of the Routable Streets module will be phased in to minimize disruption to dispatch centres' operations and completed by March 31, 2017.

- *work with dispatch centres to best match staffing with call volumes, with a view to reducing the number of staff handling significantly more calls than the Ministry's target, and thereby helping to reduce the potential for delays and errors.*

Status: In the process of being implemented by March 31, 2017.

Details

As a result of an analysis of dispatch centre call volumes to identify areas where more dispatch staff-

ing was needed, the Ministry added 22 dispatch staff positions to certain ministry dispatch centres between August 2014 and March 31, 2015.

The Ministry informed us it was waiting until March 31, 2016, to analyze the impact of the new staff on the number of calls handled by individual staffers. The Ministry also indicated it plans to assess the benefits of load balancing, which would allow calls to be transferred from high-volume dispatch centres to lower-volume dispatch centres. The Ministry expects that any additional initiatives taken to address this recommendation will be fully in place by March 31, 2017.

To better enable patients experiencing cardiac arrest to receive treatment as soon as possible, the Ministry should incorporate information on the locations of publicly available automated external defibrillators (AEDs) into dispatch protocols.

Status: Fully implemented.

Details

In January 2014, the Ministry asked its Medical Advisory Committee to assess the efficiency of incorporating AED location information into dispatch protocols. The Medical Advisory Committee agreed that a dispatch-based registry of available AEDs would be beneficial. The Ministry informed us that in August 2014, it started integrating AED information (provided by municipalities) into the Computer Aided Dispatch system. The AED information includes detailed directions that dispatchers can give to callers on how to immediately find available public AEDs.

As of June 2015, the Ministry had completed the integration of AED information at 13 of the 22 dispatch centres in Ontario and had a process in place at all dispatch centres to incorporate AED location information provided by municipalities. The Ministry informed us that while they are providing the necessary infrastructure to allow each municipality and dispatch centre to incorporate AED information into the Computer Aided Dispatch system, it is up

to each municipality to maintain an accurate AED registry. The Ministry indicated that the success of this new dispatch process is dependent on the availability of up-to-date listings of AED locations, which is the responsibility of municipal Public Access Defibrillation Programs.

Alternatives to Transporting Patients to Emergency Rooms

Recommendation 3

To ensure that patients receive necessary care that meets their needs and that patients are not unnecessarily transported to an emergency department, the Ministry of Health and Long-Term Care should consider introducing emergency room diversion policies, similar to those used in other jurisdictions, that meet patients' care needs by, for example, providing referrals to Telehealth for telephone medical advice, and treating at the scene.

Status: In the process of being implemented by March 31, 2016.

Details

While the Ministry told us that it was receptive to municipalities, hospitals and Local Health Integration Networks initiating additional emergency room bypass protocols, the Ministry had not introduced additional emergency room diversion policies for land ambulance services. The Ministry advised us that it was addressing this recommendation instead by funding programs at municipalities to help reduce calls for emergency services.

In January 2014, the Ministry announced the Community Paramedicine project, the goal of which was to reduce the number of calls for emergency 911 services. The project would have paramedics apply their training and skills in ways other than providing emergency response, such as helping seniors and other patients manage chronic conditions.

In March 2014, the Ministry began accepting applications from municipalities for funding of their community paramedic initiatives. The Min-

istry received more than 60 applications, 30 of which were approved for funding in August 2014, totalling \$5.8 million. Examples of funded initiatives include a program in Norfolk for paramedics to perform home visits and set up wellness clinics in social housing buildings, as well as a program in Toronto where paramedics visit seniors in Toronto Community Housing Corporation buildings with a history of recurring 911 use, in an effort to proactively reduce emergency room visits.

Each initiative selected received start-up funding and was expected to operate without ministry funding after one year. After this one-year period, the municipalities reported back to the Ministry on the benefits of their community paramedicine initiatives. The Ministry informed us that, even though it had been expected that the initiatives would be self-sufficient after the first year, it was considering allocating an additional \$2 million to some of the initiatives to help them continue their programs until they can be run by the community without ministry funding. The Ministry also expected to receive all reports related to the community paramedicine initiatives by fall 2015, which would allow it to conduct final program evaluations by March 31, 2016.

The Ministry, in conjunction with the municipal land ambulance services, should also evaluate the cost-effectiveness of non-ambulance emergency response vehicles, including how many are needed and how best to use them to meet patient needs. The evaluation should include a study of practices in other jurisdictions with better utilization.

Status: Little or no progress.

Details

The Ministry hired a consultant in November 2014 to review the Land Ambulance program, identify differences in ambulance service levels and costs for similar populations and geographic areas, and help the Ministry identify potential areas of improvement to reduce service variance across the province. The consultant was expected to use

knowledge of best practices from other jurisdictions in developing recommendations.

The consultant conducted four web-based workshops, communicating with 14 municipalities in total. The cost-effectiveness of using non-ambulance emergency response vehicles was among the issues discussed.

The consultant provided a report to the Ministry in July 2015. The report noted differences in the usage of non-ambulance emergency response vehicles between municipalities but did not provide any analysis on the current state of their usage. The consultant noted that only “some municipalities took a deliberate approach to determine the appropriate fleet mix to strike the balance between operational efficiency versus the provision of the most appropriate care to the local residents,” with other municipalities not determining the right mix between ambulance and non-ambulance emergency response vehicles. Some municipalities had not determined the most cost-effective mix of ambulance and non-ambulance emergency response vehicles to ensure service can be provided while still offering appropriate care to local residents. The report recommended that greater analysis be done by the Ministry to determine if there can be a better use of non-ambulance emergency response vehicles to reduce overall operating costs. The Ministry plans to share the report with the OAPC by fall 2015. At that time, next steps were to be determined on how to address the report’s recommendations. The Ministry advised us that it will continue to work with municipalities to determine the most cost-effective use of non-ambulance emergency response vehicles and that an evaluation would be completed by March 31, 2017.

Quality Assurance

Recommendation 4

To promote better-quality land ambulance dispatch services and patient care by paramedics, the Ministry—working in conjunction with municipalities where applicable—should:

- *require independent unannounced reviews of calls received by dispatch centres to ensure that they are being appropriately handled by all dispatch staff, including timely feedback to staff to prevent recurring problems, and obtain summary information on these reviews in order to identify any systemic issues;*

Status: In the process of being implemented by March 31, 2017.

Details

Starting April 1, 2014, the Ministry required a new process be implemented at all dispatch centres that involved the unannounced review of dispatchers’ handling of calls. Staffers who are reviewed are expected to have timely follow-ups with supervisors, who will tell them if any improvements are needed in their taking or dispatching of calls. A quarterly summary of calls for each region is now produced that contains performance statistics, as well as the provincial average for the previous four quarters. The summary also identifies common issues occurring among dispatch centres.

As of September 1, 2015, more than half of the dispatch centres did not have independent quality program officers conducting call reviews. Instead, reviews of dispatch staff continued to be performed by management staff (such as dispatch centre managers), potentially incentivizing them not to report poor call handling by staff they directly manage, since such reports could impact their own performance rating. The Ministry informed us that it was still considering various strategies to ensure that independent reviews of call handling are performed at each dispatch centre and that this recommendation will be fully addressed by March 31, 2017.

- *consider establishing guidelines on the desired proportion of advanced-care paramedics (ACPs) and ensure that ACPs receive sufficient ongoing experience to retain their proficiency;*

Status: In the process of being implemented by March 31, 2016.

Details

The Ministry told us that, under the *Ambulance Act*, municipalities are responsible for deciding on the composition of their paramedic workforces based on the needs of each community and the resources that are available. The Ministry cannot dictate the proportion of advanced-care paramedics in each municipality, and did not consider it appropriate to establish guidelines that municipalities must follow.

The Ministry can establish minimum training requirements for ACPs, and is in the process of updating the Maintenance of Certification Standard for advanced-care paramedics. It informed us that updates will address our 2013 recommendation for minimum training requirements, including a certain number of hours with patients, as well as ongoing medical training.

The Ministry expected its internal update of the Maintenance of Certification Standard to be completed and shared with stakeholders (including the Ontario Base Hospital Group, the Medical Advisory Committee and the OAPC) by fall 2015. The Ministry advised us that it normally takes six weeks for stakeholders to collect feedback from their members and prepare for discussions with the Ministry. The stakeholder consultations are to be completed in time for the Standard to be released by March 31, 2016.

- *ask base hospitals to periodically review paramedics' basic life support skills, since these skills are used on every ambulance call;*

Status: Little or no progress.

Details

The Ministry has the authority to require base hospitals to review paramedics' basic life support skills; however, at the time of our follow-up the Ministry was waiting on a government decision on whether to create a College of Paramedicine to regulate paramedics in Ontario. In December 2013, the Health Professions Regulatory Advisory Council (established under the *Regulated Health Professions*

Act, 1991 with a statutory duty to advise the Minister on regulatory matters for health professions in Ontario) recommended to the Ministry that the government not allow self-regulation of paramedics as it was not in the public interest. Despite determining that self-regulation was not in the public interest, the Advisory Council identified some areas that the Ministry might want to consider overseeing.

The OAPC did not support the advisory council's recommendation. In May 2014, its board issued a resolution supporting the creation of a College of Paramedicine, which it felt would better provide for the safety and care of patients in Ontario.

At the time of our follow-up, the Ministry could not provide an estimated date of when a decision would be made by the government on whether to create a College of Paramedicine.

Starting in spring 2015, the Ministry began a jurisdictional comparison of quality assurance programs for paramedics' basic life support skills found in other countries. The Ministry expected the comparison to be completed by December 2015. The comparison will be used to initiate discussions with stakeholders, such as the OAPC, and assist the Ministry in determining whether or not it wants to recommend that base hospitals should periodically review paramedic basic life support skills.

- *ensure that paramedics provide patient information documents (including all available test results) to emergency departments in time for the information to be useful for making patient-care decisions; and*

Status: In the process of being implemented by March 31, 2016.

Details

In September 2014, the Ministry started updating the Ambulance Call Report Form, the Ambulance Call Report Completion Manual and the Ambulance Service Documentation Standards. The updated standards were shared with stakeholders, including representatives from the Ministry's

Medical Advisory Committee, the Ontario Base Hospital Group, the OAPC, Ornge air ambulance and Toronto Paramedic Services, in January 2015 to obtain their input before new standards were implemented.

The updated standards require that, for each assignment that includes transporting a patient to the hospital, the paramedic must provide a completed Ambulance Call Report to the hospital before leaving the hospital and the assignment ends, or by the end of the paramedic's shift. The Ambulance Documentation Standards set out the information that is required on the Ambulance Call Report, including general information on when and why an ambulance arrived at a location, details of any patient assessment and of the treatment provided prior to arrival at a hospital. The updated standards also require that biometric data, including electrocardiogram results and cardiopulmonary resuscitation (CPR) processes, be collected and included in the Ambulance Call Report when applicable.

At the time of our follow-up, the Ministry informed us it is targeting March 31, 2016, as the date the updated standards will be released and effective.

- *ensure that processes are in place to enable municipal land ambulance services to readily access dispatch information required for patient-care trend analyses and to periodically analyze hospital outcomes for ambulance patients.*

Status: In the process of being implemented by March 31, 2016.

Details

The Ministry created the Provincial/Municipal Land Ambulance Dispatch Working Group in December 2014 to examine potential improvements to parts of the dispatch process such as medical triaging and access to real-time ambulance data, including the time taken by ambulances from dispatch to transfer to a hospital. The working group included stakeholders from the OAPC and the Association of Municipalities of Ontario.

The Ministry asked the working group to standardize information-sharing protocols between municipalities and dispatch centres and told it to ensure that its improvements address the recommendations we made as part of our *2013 Annual Report*.

The Ministry said it expects to receive the working group's report by fall 2015. The Ministry anticipates its recommendations relating to the standardization of information-sharing between municipalities and dispatch centres will be considered and implemented by March 31, 2016.

Ministry Funding to Municipalities

Recommendation 5

To ensure a balanced land ambulance system throughout Ontario, the Ministry should:

- *determine—for example, through a review of municipalities' ambulance deployment plans and service costs—why there are differences in ambulance service levels and costs for similar populations and geographic areas; and*

Status: Fully implemented.

Details

As stated earlier, the Ministry hired an external consulting firm in November 2014 to independently review the land ambulance program to determine why there were differences in ambulance service levels and costs for similar populations and geographic areas. The consultant's work commenced in December 2014.

Data was collected by the external consultants from 14 of the 50 municipalities. This data was analyzed by the consultant and verified with the municipalities as part of four workshops conducted with the municipalities in February and March 2015 to better understand variances and potential drivers for these variances. The consultant provided their report to the Ministry in July 2015. The report stated that “while differences [in service levels between municipalities] were observed, throughout the study, there is no evidence of imbalance in the service system in such a state that can be described

as critical”. The consultant recommended utilizing process improvement reviews, as was done in one Ontario municipality, and collaboration between local hospitals, as was accomplished in another municipality, to reduce time spent by ambulances at hospitals and improve service delivery. The consultant concluded that there were limited opportunities for operational efficiencies that would result in cost savings. This was primarily due to all municipalities using unionized staff with relatively similar wages across Ontario.

However, the report also noted that improved call triaging could reduce costs overall in urban municipalities. Therefore, the consultant recommended that the province work with municipalities (especially larger urban ones) to increase the accuracy of dispatch systems’ prioritizing of calls. The Ministry is planning to address this recommendation in the Provincial/Municipal Land Ambulance Dispatch Working Group’s report, expected in fall 2015. The Ministry is planning to share the consultant’s report with the OAPC at that time and will then decide how to address the consultant report’s recommendations.

- *develop processes, such as incentives, to promote efficient ambulance service delivery—including minimum service levels or benchmarks—especially where differences exist.*

Status: Little or no progress.

Details

As identified above, the consultant provided a report reviewing the land ambulance program to the Ministry in July 2015. The consultant noted that

the Ministry’s current performance measures do not reflect the key outcomes of land ambulance services and recommended that the Ministry review the current measures. The Ministry plans to share the consultant’s report with the OAPC in fall 2015 and then develop processes to promote more efficient land ambulance services by March 31, 2017.

The Ministry should also clearly communicate planned funding levels to municipalities in time to support municipal planning processes.

Status: Fully implemented.

Details

The Ministry had discussions with the OAPC in July and August 2014 regarding the proposed wording of a 2015 planning document that was to be shared with each municipality. The Ministry obtained the OAPC’s input on the document and provided it to municipalities in August 2014. The document explained how the 2015 planned funding would be calculated, taking into account increases for salaries and inflation. The document also included a spreadsheet, which a municipality could use to determine its 2015 planned funding by using its 2014 approved operating budget. Municipalities must provide their forecasted expenditures to the Ministry on an annual basis.

The Ministry informed us that, going forward, the planning document will be provided to each municipality in July. Municipalities will be expected to identify their forecasted expenditures and return the document to the Ministry by August 31 of that same year. The 2016 planning document was sent out to municipalities in July 2015.