

ONTARIO NURSES' ASSOCIATION

SUBMISSION

ON

New Patient Care Models for Emergency Health Services

**(Proposed Amendments to Regulation 257/00 under the *Ambulance Act* and Regulation
552 under *Health Insurance Act*)**

Ministry of Health, Enhancing Emergency Services in Ontario Branch

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ONA's Recommendations

ONA proposes the following recommendations:

1. That the Ministry of Health develop and release a detailed discussion paper that answers the following questions for clarity:
 - Which destinations other than emergency departments will patients be transported? Does this include walk-in-clinics, doctors' offices, and mental health clinics? What will be the process for 911 patients calling after hours in such settings?
 - What is the government's definition of "select 911 patients"? What is the target population the government is seeking to reach with these proposed regulations?
 - What is the government's timeline for introducing these changes? Will changes be phased in? Will there be a pilot?
 - Will there be well-established criteria that will clearly define the level of care that will be provided to patients "on-scene" by the paramedics?
 - At what point can it be determined that the patient does need to be seen by a physician?
 - Should the patient or the patient's family decline being treated by a paramedic and want to proceed being transported to the hospital, what will be the process?
 - What criteria will be in place for those patients treated on scene and released? What follow up instructions will be provided? Who will follow up? Will documentation be forwarded to the family doctor alerting of the visit, change in health condition, etc.?
 - With respect to the referral of 'select low acuity' patients during the 911 call to appropriate care in the community: What are the criteria that will be used to "select the low acuity patients"? Who will make this decision with the requisite skill, knowledge and judgement about the type of appropriate care in the community?
 - Will municipalities be able to opt out of this service or will it be mandatory?
 - With the implementation of this service, what will be the estimated costs for the change to ambulance services?
2. ONA is calling on the Ministry of Health to ensure that proposed changes to emergency health services clearly preclude any transfer of care to private, for-profit health facilities where patients will be charged user fees. The principles of the *Canada Health Act* require that patients be guaranteed access to health-care services on the basis of need and not ability to pay.
3. ONA opposes the expansion of ambulance co-payments in the proposed regulations because these fees are regressive and can amount to cost barriers to accessing health care for low-income patients. In keeping with the principles of the *Canada Health Act*, ambulance services should be covered on a first-dollar basis regardless of the destination of the ambulance.
4. The gap in care by registered nurses (RNs) for Ontario patients now amounts to 20,000 RNs needed in Ontario just to match the ratio of RNs-to-population in the rest of the country. As part of the government's transformational strategy to address hallway care, we urge the

government to develop a funded plan to close the gap in RN care in Ontario over the next four years. Changes to the patient care models for emergency health services should not be a substitute for addressing severe gaps in appropriate health-professional staffing levels in hospitals.

5. ONA is calling for hospital funding to offset increased cost pressures of at least 4.5 percent in 2019 based on estimates of population growth, aging and inflation produced by the Financial Accountability Office of Ontario. This is to ensure our hospitals have the resources to properly maintain RN staffing for safe, quality patient care. To ensure appropriate capacity in the hospital sector, the government should develop a strategy for multi-year funding.

Introduction

The Ontario Nurses' Association (ONA) is the union representing 65,000 registered nurses and health-care professionals as well as more than 18,000 nursing student affiliates, providing care in hospitals, long-term care facilities, public health, the community, clinics and industry.

We welcome this opportunity to provide feedback from the perspective of front-line nurses and health-care professionals on the government's proposed amendments to Ontario Regulation 257/00 under the *Ambulance Act* and Regulation 552 under the *Health Insurance Act* to enable new patient care models for emergency health services.

The government is proposing changes to regulations to provide 'select' 911 patients with alternative care options for pre-hospital care other than transport to emergency department. As part of the models of care proposed, it includes enabling paramedics to take patients to facilities other than a hospital emergency department, or to treat and release patients 'on scene.'

While we make substantive comments below, we are expressing our disappointment at the outset that the Ministry of Health did not release a detailed discussion paper on these proposed changes, nor did it consult at an earlier stage with ONA prior to announcing the proposed regulations. As a result, these changes bring many questions forward that need to be addressed.

ONA's position is clear: the priority for improving Ontario's Emergency Health Services system must be to restore the capacity of public hospitals to provide services at levels that are safe; this includes appropriate staffing and funding levels. Even with the proposed changes, public hospitals will always be the appropriate destination for the majority of 911 patients.

This year marks the fourth year in a row that Ontario has the lowest RN ratio per 100,000 population in the country. We urge the government to develop a funded plan to close the gap in RN care in Ontario. Hiring more RNs is critical for better patient care and must be part of the government's transformational strategy to address hallway care.

Nurses have long advocated for an integrated health-care system – where patients can access the right care, in the right place, at the right time, by the right provider. Currently, we have concerns about the government's proposed changes that have unintended consequences, and drafted without due consideration to patient consent and the impact on other health-care professionals operating in the system.

Proposed new models of care – transporting patients to destinations other than the emergency department

Amendments proposed will include regulations that will allow ambulance services to provide patients with alternatives to care other than transport to the emergency department, and sets out fees for different types of ambulance services.

The Ministry is planning to enable new patient care models for select 911 patients to alternative care options for pre-hospital care other than transport to the hospital emergency department and is of the opinion that this will “end hallway health care and ensure the delivery of high quality, integrated care.”

The new model of care proposed will include the following changes:

- Transporting patients to destinations other than the emergency department where they can receive appropriate care;
- Treating patients on-scene and referring them to another health-care provider;
- Treating and releasing patients on-scene; and
- Referral of select low acuity patients during the 911 call to appropriate care in the community.

The government is proposing to transport patients to destinations other than the emergency department where they can receive appropriate treatment. No definition is provided for “destinations other than the emergency department.” As a result, destinations could refer to any non-hospital facility, whether or not such a facility is a private, for-profit facility.

In 2017, ONA joined many health-care stakeholders in raising concerns about a similar proposal under the previous government’s Bill 160, Strengthening Quality and Accountability for Patients Act. Our position then – as it remains now – was that this appears to be a further step to facilitate moving service out of public hospitals and towards further privatization of our health-care services in Ontario.

There is no consideration of whether these alternate destinations have capacity for ambulance off-loading. How will communication occur with a destination prior to arrival with a patient to ensure capacity and the ability to provide care from the right provider? Will they employ RNs with triage expertise? What type of oversights are in place? Will patients be charged user fees? The government must provide clear answers to these questions before moving forward.

ONA urges the government to clearly name these alternate destinations upfront so that everyone is clear. We also urge the government to clearly state that Ontario will firmly stand behind the overarching goals of medicare, including public health-care delivery by not-for-profit providers.

Proposed new models of care – ‘treat and release,’ ‘treat and refer’

The government is also proposing significant changes to the paramedic scope of practice, including giving paramedics the ability to treat patients on-scene and refer them to another health-care provider; or treat and release patients on-scene.

Presently, there are two classifications for ground paramedics – Primary Care Paramedic (PCP) and Advanced Care Paramedic (ACP). The Primary Care Paramedic is a 2-year Community College Diploma Program that includes classroom learning and clinical hours working directly in the field. The Advanced Care Paramedic is a 3-year Community College Diploma Program. The difference between these two classifications is that to apply and be considered for the ACP program, one must have a minimum of 2 years of experience in the paramedic field before applying and it has a 3rd year in length for a total of 3200 hours.¹

Currently these unregulated health-care workers are able to perform 8 of the 13 controlled acts within the paramedic scope of practice. The paramedic is certified to perform these controlled acts under the base hospital physician. If the goal is to have paramedics provide a higher level of care or service than they are presently providing, will the core education for the paramedic program change and be more comparable to that of a physician? Do hospitals have the capacity for base hospital physician support without causing undo disruption in the hospital? What is the government's explanation for the particular expansion of responsibilities and treatment models for patients that can safely be undertaken by paramedics?

The initial “pilot project” using paramedics was introduced in Deep River in 2011 when it was recognized that the majority of the 911 calls were coming from seniors living alone, and that by introducing this service, this was proving to cut the number of 911 calls from seniors in half. Paramedics working in this “pilot project” would visit these elderly patients and perform a basic health check, that could include making sure the clients are eating right and helping them to complete exercise regimes.² It would appear that this initial pilot project is significantly different than what is now proposed.

We also encourage the government to look closely at existing pilot projects in communities where paramedics are providing wellness checks to seniors that can include transporting patients to a local walk-in-clinic such as in Bancroft, Ontario, to be assessed by a registered practical nurse (RPN) and then via telemedicine, the patient is assessed by a physician. In Barry's Bay, paramedics are offering a monthly “Paramedic Wellness Clinic” for patients who are currently taking Coumadin/Warfarin and will draw blood for those requiring blood work. The paramedics will check the patient's INR level³ and make adjustments to the patient's dose and should the patient's INR results be far out of range or if the patient needs a new prescription, they will be referred to the emergency at the local hospital. ONA is supportive of recruiting Nurse Practitioners (NP) to work in local clinics. Given the scope of the NP, the patients will not need to go to the local hospital emergency department. We believe there are many important lessons to be learned from these pilots that could assist the government in meeting the health-care needs of Ontarians.

Further, we urge the government to take a holistic view and consider other health-care professionals operating in the system. For instance, Care Coordinators, as a job requirement,

¹www.OntarioParamedic.ca Ontario Paramedics Association, Scope of Practice, Retrieved August 8, 2019.

² <http://www.cbc.ca/mews/seniors-911-calls-cut-in-half-by-weekly-paramedics-visits> “Seniors’ 911 calls cut in half by weekly paramedics’ visits, November 6, 2013.

³ A prothrombin time (PT) is a test used to help detect and diagnose a bleeding disorder or excessive clotting disorder; the international normalized ratio (INR) is calculated from a PT result and is used to monitor how well the blood-thinning medication (anticoagulant) warfarin (Coumadin) is working to prevent blood clots.

must be regulated health professionals. The RNs, NPs and health-care professionals who work as Care Coordinators provide a vital role coordinating care in Ontario's health-care system. If they could do home visits and perform the full scope of their role, they would see and assess many of their patients, and divert them from hospital emergency to primary care or to other community supports or services. With Ontario's aging population and growing complex care needs, the demand for front-line Care Coordinators will only increase. ONA believes that a prominent role for Care Coordinators means that Ontarians will have access to the best quality assessment and coordination of front-line health-care services.

Establish charges for transportation to non-hospital destinations

The government proposes to establish charges for transportation to non-hospital destinations that align with existing ambulance service charges. Currently, patients are charged a co-payment of \$45 for transportation by ambulance to or from a hospital.

ONA believes that ambulance services are a medically necessary health service. Ontarians should not be required to pay for an ambulance in these situations. We also recognize that the co-payment is a significant barrier to accessing care for those from marginalized and disadvantaged communities.

We urge the government to eliminate ambulance co-payments. This would enable Ontarians to use their health-care card and not any other payment to access medically necessary care.

Conclusion

ONA believes that quality patient care must be at the heart of any consideration of changes to models of care. Accordingly, it is essential that the government release a detailed discussion paper that provides the full details of its vision and planning for the Emergency Health Services system, and that it takes the time to consult with the experts with front-line expertise in emergency triage.

Ultimately, we are left with the question of how will these changes “end hallway health care and ensure the delivery of high quality, integrated care?” The service currently provided by paramedics is not why hallway health care exists. Rather, hallway health care exists because of a lack of capacity in the public hospital system and the inability to discharge alternate level of care patients to more appropriate settings in home care and in long-term care because of extensive wait lists for access, among other factors.

There is ample evidence of the cost-effective improvements to care that RNs and NPs provide and we are concerned that the proposed changes could result in a reduction to the number of RN positions in Ontario, threatening the level of RN care required for patients in hospital and other settings.

We ask that the government reconsider these proposed amendments based on our feedback.