Minutes – Executive Policy Committee – April 17, 2018

REPORTS

Item No. 4 Transition of Operational Responsibility for Ambulance Services to Shared Health/Winnipeg Regional Health Authority

EXECUTIVE POLICY COMMITTEE DECISION:

The Executive Policy Committee concurred in the recommendation of the Winnipeg Public Service and received the report as information.

DECISION MAKING HISTORY:

Moved by Councillor Pagtakhan,

That the recommendation of the Winnipeg Public Service be concurred in.

Carried

EXECUTIVE POLICY COMMITTEE RECOMMENDATION:

On March 14, 2018, the Executive Policy Committee granted an extension of time of 30 days for the Winnipeg Public Service to report back with detailed options to transition operational responsibility for ambulance services to Shared Health / WRHA.

On December 6, 2017, the Executive Policy Committee passed the following motion:

WHEREAS the Winnipeg Regional Health Authority (WRHA) has the responsibility to provide health services in the City of Winnipeg including ambulance services;

AND WHEREAS the City of Winnipeg is currently providing ambulance services on behalf of the WRHA under the terms of an agreement that expired on March 31, 2016;

AND WHEREAS under the expired agreement, fifty percent of the total cost of the ambulance services are to be funded from ambulance user fees, twenty five percent of the cost funded by the WRHA and twenty five percent by the City of Winnipeg;

AND WHEREAS the funding formula for ambulance services has proven to be complex and administratively burdensome;

AND WHEREAS despite the best efforts of the City of Winnipeg, the WRHA has been unwilling to commit to a renewal of the ambulance funding agreement;

AND WHEREAS on November 22, 2017 the WRHA advised the City of Winnipeg of its unilateral decision to freeze its ambulance funding at 2016 levels for 2017 and 2018 with possible consideration being given to additional funding;

AND WHEREAS without the additional funding or a change in service levels, 2016 funding levels will create an estimated funding shortfall for the City of $2.5 million in 2017 and $4.6 million in 2018 which will continue to increase in 2019 and beyond;

DECISION MAKING HISTORY (continued):

EXECUTIVE POLICY COMMITTEE RECOMMENDATION (continued):

AND WHEREAS according to the City of Winnipeg Charter council must ensure that the estimated expenditures for a fiscal year do not exceed the estimated revenues for the year when adopting an operating budget;

AND WHEREAS the City of Winnipeg Preliminary Operating Budget has been drafted with estimates that are based on continuity of historical funding relationships and assumed:

- consistent funding levels for the City of Winnipeg's portion of costs; and
- consistent funding levels for the WRHA's portion of costs;

AND WHEREAS on the basis of estimates and assumptions presented in the City of Winnipeg's 2018 Preliminary Operating Budget the 2018 Preliminary Budget is in balance;

AND WHEREAS should the estimates and assumptions presented in the 2018 Preliminary Budget be inaccurate, it is incumbent on the WRHA to indicate whether additional funding will ultimately be provided or service changes they would like to make to meet the City of Winnipeg estimates;

AND WHEREAS in their letter dated November 22, 2017, the WRHA confirms the responsibility for managing the agreement with the City of Winnipeg will be transitioned from the WRHA to Shared Health effective April 1, 2018;

AND WHEREAS Shared Health was created to provide centralized clinical and business services for regional health authorities across Manitoba;

AND WHEREAS the restructuring of the health care system currently underway may present an ideal opportunity for Shared Health / WRHA to regain operational control of ambulance services in Winnipeg;

THEREFORE BE IT RESOLVED THAT the Public Service return to Executive Policy Committee with a report within 90 days outlining detailed options to transition operational responsibility for ambulance services to Shared Health / WRHA.

ADMINISTRATIVE REPORT

Title: Transition of Operational Responsibility for Ambulance Services to Shared Health/Winnipeg Regional Health Authority

Critical Path: Executive Policy Committee

AUTHORIZATION

Author	Department Head	CFO	CAO
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EXECUTIVE SUMMARY

Winnipeg's municipally-based integrated fire-emergency medical services (EMS) delivery model is rooted in a 1978 bylaw affirmed by Council to address severe shortcomings in third-party based EMS service. When the 1996 Regional Health Authorities (RHA) Act placed EMS service responsibility with the RHAs, the Winnipeg RHA (WRHA) continued this highly effective and efficient model in a service purchase agreement with the City of Winnipeg. This mirrors similar agreements in Brandon and Thompson.

Subsequent to a change in provincial government, the funding arrangement for the service purchase agreement has recently changed. This generated direction from the Executive Policy Committee in December 2017 to explore the option of discontinuing the service purchase agreement, and transferring the service operation to the WRHA/Shared Health (SH).

If the City were to transition EMS operational responsibility to the WRHA/SH, assuming the original funding model, a cursory analysis of the current service estimates a savings of $3m per year. However, the integrated model is intricate and complex. Thorough characterization of the transition process will require a significant amount of time and expertise and it is envisioned that the process would take, at minimum, 24 months to complete. This report outlines the steps that are likely required and the further work necessary to fully illustrate the process, related costs and service impacts.

As well, this report provides information to ensure that all relevant risks and concerns are disclosed when making what will be a pivotal decision, as risks exist with any option. Retention of operational responsibility carries funding uncertainty risk. Negotiations continue with WRHA/SH. The 2017 deficit (originally estimated at $2.3m, now more certain at $2m) is expected to be settled. However, funding for 2018 and beyond continues to be uncertain. WRHA/SH has not yet committed to either increased funding to preserve service levels while maintaining the proportionate City funding, or to detailing the service reductions necessary to reduce costs in similar proportions.

The City's involvement in EMS results in a broad range of cost benefits/cost avoidance measures to the health care system at large, including improved patient outcomes and reduced chances of further health complications through fast and focused responses.

RECOMMENDATIONS

1. That this report be received as information.

REASON FOR THE REPORT

On December 6, 2017 the Executive Policy Committee directed the Winnipeg Public Service to report back within 90 days outlining detailed options to transition operational responsibility for ambulance services to WRHA/SH.

IMPLICATIONS OF THE RECOMMENDATIONS

There are no implications to receiving this report as information.

HISTORY/DISCUSSION

Preceding Winnipeg's amalgamation, ambulance service was provided by an assortment of private and public organizations, including funeral homes, police and fire department rescue wagons, and other private entities. Service level concerns led to the establishment of the Winnipeg Ambulance Service (WAS) in 1975, in which a Civic Board/Committee oversaw a private contractor, namely Blue Cross' predecessor. Continuing concerns prompted Council to bring the service in-house in 1978 under a bylaw.

In 1982, the Winnipeg Fire Department (WFD) began providing First Responder services to augment the slow ambulance response times. Ambulance response was still required for every incident. This time period marked the beginning of intense consultation and debate on the potential merger of the fire and ambulance departments. All consultants recommended City retain control of EMS and benefit from the integration of fire. Concurrently, the WAS and WFD both evolved in their respective provision of emergency medical services.

In 1996 the Regional Health Authorities Act was enacted placing the responsibility for local ambulance service with the Regional Health Authority. In order to comply with the new Act the WRHA entered into an agreement with the City of Winnipeg for the provision of ambulance service.

In the late 1990s, merger of the WFD and WAS occurred and in 2007 several measures were implemented that furthered the development of the integrated model and its benefits. These included merging the two separate communication centres, entrenching Primary Care Paramedic (PCP) and Advanced Care Paramedic (ACP) levels of practice respectively in the WFD and Winnipeg Emergency Medical Services (WEMS, WAS' successor), and developing the electronic patient care reporting (EPCR) system. These measures allowed firefighter-primary care paramedics (FFPCPs) to function independently on many calls where advanced care was not required and patient transport was unlikely. A funding model was agreed upon which recognized the fire contribution to emergency medical services (EMS) service delivery

and appropriately shared half of EMS cost between the WRHA and the City, with the remaining half assumed by patients.

CURRENT STATUS

In brief, the medical components of the Winnipeg Fire Paramedic Service include:

Emergency Service (2016 statistics)

- 71,879 emergency medical calls in Winnipeg
- 13,069 were handled solely by fire resources
- 38,396 required combined Fire and Ambulance response
- 20,414 were handled solely by Ambulance Paramedics
- Total emergency medical calls serviced by fire resources were 51,465
- Total emergency medical calls serviced by ambulance resources were 58,810
- Response times on par or better than comparators with lowest cost per unit hour
- The 13,000 fire-only responses are serviced by 38 fire trucks, each staffed with at least one cross-trained FFPCP, which are concurrently required to meet fire response standards. This offers the rapid response effectiveness of a similar number of ambulances
- Emergency medical services are provided concurrently with comprehensive fire and rescue response. Winnipeg experiences the most fires per capita among its comparators, with significant property loss, injury, and fire death rates.

STEMI Care

- Winnipeg leads the nation in treatment times and survival rates from ST-elevated Myocardial Infarction (STEMI, an often lethal type of heart attack)
- Mortality has decreased from 15% to 4% over ten years with paramedic 12-lead Electrocardiogram (ECG) acquisition
- 12-lead ECG acquisition was included in FFPCP practice in 2016, and treatment time has dropped since this implementation. Effect of this on survival rate is currently being measured
- Further cost reductions arise for the health care system from reduced morbidity rates as less heart damage is incurred from the earlier treatment.

Community Paramedicine

- Includes the Main Street Project and Emergency Paramedics in the Community (EPIC) programs
- Provides emergency and ongoing medical services to many of Winnipeg's most vulnerable citizens, avoiding many emergency responses and hospital visits. This is a saving to both the WFPS and the wider health care system, and more importantly creates better health care outcomes for the individual
- Increasing number of patient contact every year; 16,446 in 2016
- EPIC helps to determine most appropriate destination for a patient, avoiding Emergency Department triage, assessment and treatment. Notionally saving $1,000 per triage, which equates to an approximate saving of $0.8m per year before assessment and further treatments are considered
- Pre-screening for HIV helps reduce the spread of infection in the at risk community and saves in the order of $1m per year, per patient identified
- Disease management avoids exacerbation of existing conditions and therefore further health care costs.

Inter-Facility Transport

- Wholly WRHA funded service that dispatches and coordinates inter-facility transfers in Winnipeg using WEMS and Stretcher Service resources and WRHA medical transport personnel
- Integrated with emergency dispatch to ensure most efficient and effective resource use
- Communication site provides a live backup location for the main emergency dispatch centre.

Tactical EMS (TEMS)

- Specially trained TEMS paramedics are deployed to the inner perimeter of high risk incidents with the Winnipeg Police Service Tactical Support Team. TEMS members are able to provide immediate advanced medical life support to injured victims, bystanders, police and suspects while arranging for evacuation of the injured in a safe and timely fashion. With serious traumatic injuries this greatly improves the chances of survival.

Injury Prevention and Public Education

- The WFPS carries out extensive public education, most recently with schools and community groups concerning the emerging opioid crisis.

Research

- The WFPS is actively involved in several medical research initiatives that have benefited the City and advanced the body of EMS knowledge. Specific recent examples include:
    - Implementation of the smartphone medical app PulsePoint and research into its effectiveness
    - SPARK grant of $50,000 to examine effect of direct home care referral by community paramedics
    - Effectiveness of widespread naloxone administration by fire-based and ambulance-based PCPs on improving opioid overdose patient status
    - Joining the Manitoba Health Care Policy database at the University of Manitoba to enable greater understanding of the impact of EMS care
    - Joining a pan-Canadian consortium of researchers to improve resuscitation outcomes (CanROC).

Paramedic Training and Education

- Skilled senior paramedics begin to train a new cohort of advanced care paramedics (ACPs) each year. The accredited program requires three years to complete, and ensures the WFPS continues towards its goal of one ACP on all emergency ambulances. The paramedic training staff also conducts training in a number of specialty programs, conduct skill maintenance among practicing paramedics, and field preceptorship.

If transition were to occur, there is no certainty surrounding the continuation of any of these services beyond basic emergency response. Council will have no control over this outcome under a provincially delivered service.

STEPS TO TRANSITION OPERATIONAL RESPONSIBILITY

If the decision is made to transition operational responsibility, the following are the suggested steps. Complete detailing of the process requires extensive ongoing consultation.

- **Serve Notice to WRHA/SH**

Due to the complexity of transition process and the initiation of SH imminent in April 2018, a long lead time is required (24 months minimum recommended) in order to safely and securely hand over responsibility.

- **Retain Transition Consultant**

WFPS leadership is fully tasked with normal service responsibilities. A transition team is required to plan and implement the process to ensure full and thorough consideration and treatment of all aspects. This will involve a consulting change agent to lead the process.

- **Determine Budget for Transition Costs**

The determination and implementation of the transition process will require significant budget support for consultants, legal advice, contract termination, equipment reconfiguration, etc.

- **Asset Ownership Determination**

The Province already owns the majority of the ambulance fleet. The equipment and supplies contained in them have been purchased by the City under the EMS partnership funding agreement. This includes several investments that are specific to the City of Winnipeg, such as power stretchers, stair chairs, defibrillator/cardiac monitors, electronic patient care report laptops and tablets, all advanced care paramedic equipment, etc.

Determination of the present value of these assets and ownership is required, followed by negotiation with SH for the potential purchase of this equipment. It is uncertain if SH will seek to purchase this equipment; if not, alternative disposal will be required as there is no obvious alternative use with the City.

EMS-related light fleet vehicles, such as the Medical Supervisor and EPIC SUVs and the Superintendent's vehicle, and specialized vehicles such as the Major Incident Response Vehicle (MIRV or EMS bus) are wholly owned or leased by the City. Sale of these assets will depend upon the EMS delivery model chosen and SH intention to purchase. These assets may then also require alternative disposal.

- **Light Fleet**

Light fleet vehicles will be incorporated into the Fire heavy fleet after transition.

- **Communications & Dispatch**

The WFPS Communications Centre is a fully integrated fire and EMS communications facility which cannot be easily separated. The computer-assisted dispatch system is also uniquely interfaced with the Winnipeg Police Service, further enhancing inter-agency communication.

SH does not have the capacity or infrastructure in place to assume these functions within the notice period. The province continues to utilize the legacy Fleetnet radio system which has been discontinued in Winnipeg and cannot be reactivated. Additional consideration is the negative experiences in other provinces and cities where separate EMS and fire communication centres exist, in particular with poor inter-agency communication and systemic delays in

notification of first responders for potentially life-threatening calls. Dis-integration will also jeopardize the effectiveness of the PulsePoint program that will be implemented soon in Winnipeg.

Therefore, if EMS operations are transferred to WRHA/SH, it is recommended that the City continue to provide integrated communications and dispatch services under a contract arrangement with SH. This action will also facilitate the possible contracting of fire first response in a post-transition environment.

The Communications Branch also operates a 100%-WRHA funded Inter-Facility Transportation Control Centre (IFTC) at 185 King Street. In the short term, this function must continue until the provincial successor to Fleetnet is functional. The IFTC synergistically serves to back up the primary Emergency Communications Centre at 700 Assiniboine Park Drive. The existence of a continuously functioning backup centre provides excellent service continuity in the case of failure in one of the centres. Migration of the IFTC functions to SH will eliminate this capacity.

- **Personnel Migration**

Approximately 350 personnel would no longer be required by the City, including almost all MGEU and WFPSOA positions. The employment of these individuals by SH will depend upon their service delivery model. There are several mechanisms by which this migration could occur as required by statute, collective agreement, etc. This will require extensive legal and labour relations consultation. Engagement of external labour legal expertise is required.

There will be no migration or reduction to fire staffing or resources as a result of EMS operational responsibility transition. Fire response staffing is based on the National Fire Protection Association 1710 standard. Winnipeg's current fire response times slightly exceed the maximum prescribed by the standard.

Leadership, management, and support functions of the integrated service capitalize heavily on the efficiencies of integration and the incremental increase in workload attributed to EMS provision. Leveraging this administrative body has prevented the duplication of management and supervision, human resources, recruitment, payroll, training and development, procurement and other support functions. Following the transition period, SH will require its own solution to provide effective administrative functions to support an EMS system. This may increase costs overall where duplication of function is required and the additional workload cannot be assimilated within existing structures.

SH will need to determine their plans for training specific to basic training as well as licensing of paramedics, public education, and for medical oversight.

- **Fire-based Service Level Determination**

Assuming that service level reductions will occur upon transition, determination of the desired level of EMS augmentation by WFD is required. This could range from none to advanced care provision. This decision requires much caution, as limiting contribution could have fatal consequences for life-threatening medical emergencies that are not serviced by nearby fire resources. Depending on the level of service (if any) required from fire-based services, the City will also need to retain appropriate support capability in order to maintain paramedic skills in the fire service given the absence of an integrated agency. This may again increase overall costs that would form part of the agreement that sets out any subsequent service provision.

- **EMS Facilities**

Establishment of facilities by SH within the notice period for ambulance and crew housing and deployment, complete with all of the necessary connectivity and infrastructure for receiving calls and other communications, will not be possible. To enable WRHA/SH to operate the service, the City may want to help identify facilities for interim use by WRHA/SH. These will be current WFPS stations with the required connectivity and communication equipment already in place. Lease arrangements for these locations will be required.

- **IT Considerations**

The City of Winnipeg deploys the only electronic patient care reporting (EPCR) system in the province. This system includes license agreements with software providers, records management systems, servers and all data collected since the system inception in 2007. If SH elects to continue with the electronic collection and management of patient care data, a new solution will be required. As the City of Winnipeg remains the trustee of existing data, legal opinion will be required prior to data sharing in the context of the Personal Health Information Act. Assuming the WFD continues to provide medical response in some capacity, continuation of the EPCR system will be required.

- **Stores**

Depending on the level of EMS service continued by WFD, purchase and stocking of EMS supplies will be reduced. EMS-personnel-specific uniform requirements will be eliminated. Costs for remaining supplies will increase due to loss of WRHA/SH funding contribution, reduced purchases, and loss of WRHA/SH collective purchasing prices.

FINANCIAL CONSIDERATIONS

The WRHA letter (November 22, 2017) retrospectively set base funding for 2017 at the funding level received in 2016. This was stated as $20,677,288 but assumed an additional $958,000 was paid to the City through other provincial agencies. This relates to a Council decision to use Public Safety Grant funds for EMS delivery. It is understood that the Public Safety Grant will be reduced by this amount permanently and then flowed to the City via SH/WRHA.

The letter also stated that the Regional Health Planning process would be used to secure increases to this base when related to negotiated or arbitrated wage increases.

Negotiations with Shared Health to date have been productive in resolving historical unpaid debt but have not progressed to a formal commitment from them to fund either 2017 or 2018 shortfalls. SH has also been unable (to date) to identify areas of service reduction in regards to WFPS EMS delivery or elsewhere across the SH organization to offset the shortfall.

Using confirmed baseline numbers, the following table provides the funding shortfalls for 2017 and a projected shortfall for 2018 based on the adopted budget:

	2017 draft year end actual	2018 adopted budget
Revenue		
Patient revenue	$27.92m	$25.65m
CoW mill rate funding	$13.04m	$11.34m*
WRHA funding (baseline 2016)	$20.68m	$20.68m
Total revenue	$61.64m	$57.67m
Expenditure		
EMS partnership cost	$63.65m	$62.28m
Shortfall to baseline		
Shortfall arising in year	$2.01m	$4.61m
Balanced budget adjustments		
Increase to WRHA funding above baseline 2016		$4.61m

* Reduction arising from the change in funding of capital projects from cash to capital to debt in 2018

The main reasons for the shortfalls noted above are:

- WRHA decisions to increase service provision in the Main Street Project
- Wage settlements – noting 85% of the WFPS cost relates to staffing
- Patient share of cost falling below the expected 50% threshold for a five year average

Other financial differences arising through negotiations to date include:

- Inability of WRHA to provide financial certainty to the City in terms of funding commitment for the services they wish to purchase in any calendar year
- Provincial wage settlements are fixed at zero percent through legislation whereas the City is reliant on negotiation or arbitration
- Cost reduction options on top of efficiency targets without creating service level impacts (noting 85% of the service cost is staff related) are hard to identify to bridge the existing funding gap. The department has proposed a number of options to WRHA and are working through a broader list in an attempt to reduce costs further
- No direction on options to balance the funding gap through service reductions or other revenue alternatives
- $2m shortfall in 2017 not confirmed as funded and will not increase the 2016 baseline
- The estimated shortfall of $4.6m in 2018 is being addressed in part but the gap remains and no formal confirmation received concerning final funding
- 2019 and future years have a widening gap, arising through:
    - Compounding future wage settlements
    - The previous cost sharing regimen with funding split between the patient at 50% and the Province and the City at 25% each is no longer being followed. The province will only provide an annual basket funding allotment

- The cap on ambulance charges against which the Province measures its subsidy is $529. Inflationary pressures will increasingly contribute to additional shortfalls. The patient portion of the cost is falling well below the threshold previously determined at 50%
- Volume based fee reduction impacts have been confirmed by the Province as not being funded through the fee reduction, but instead to be found potentially within the WRHA/SH

It is unclear how these issues are expected to be funded – either through increased funding from the City and SH or by SH through reductions across its wider service portfolio. However, service reductions are one option that may be necessary to meet financial limitations inherent in funding restrictions imposed provincially.

FINANCIAL IMPACT

Financial Impact Statement **Date:** March 9, 2018

Project Name:
Transition of Operational Responsibility for Ambulance Services to Shared Health/WRHA - Interim Report

COMMENTS:

There are no immediate financial impacts arising from the recommendations of this report as the full financial impact of service transition requires significant analysis and valuation.

Original signed by
John Hall FCMA, CGMA
Financial Controller
Fire Paramedic Service

CONSULTATION

This Report has been prepared in consultation with:

N/A

OURWINNIPEG POLICY ALIGNMENT

N/A

SUBMITTED BY

Department: Fire Paramedic Service
Division: Executive
Prepared by: John A. Lane, BSc, PBDM
Date: March 14, 2018