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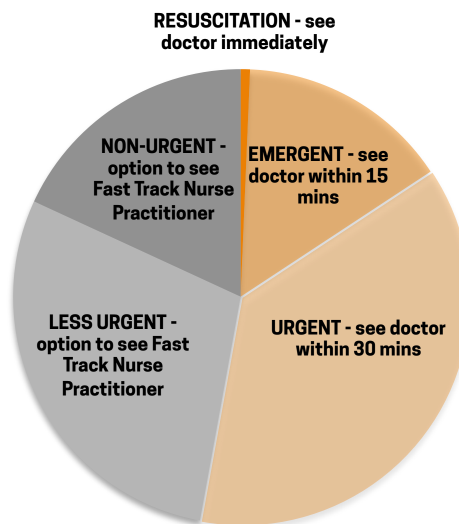
Backgrounder: ER waits measured in minutes, not hours

CTAS 1 (Resuscitation)	Immediate
CTAS 2 (Emergent)	Within 15 minutes end of 2018
CTAS 3 (Urgent)	Within 30 minutes end of 2018
CTAS 4 and 5	Within 60 minutes end of 2019



Anyone requiring less urgent care will have the option to be seen by a nurse practitioner for quicker assessment, diagnosis and treatment.

- The ER triage nurse will refer low-acuity patients to the Fast Track stream.
- Other options, including Quick Care clinics and a Community Paramedic program, will reduce the burdens on ERs.

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Fast Track system

- The NDP will hire 35 nurse practitioners over four years to work in ERs
- The four-year operating cost is $10.8 million.

Quick Care clinics

- The NDP will add four clinics over four years.
- In 2013, Manitoba spent approximately $3.2 million per year to operate four Quick Care clinics.[1] With inflation, that's roughly $840,000 per clinic. Increased hours at Saskatchewan's clinics will result in a cost of $1 million per clinic for a four-year cost of $10.4 million.

Community Paramedic program

- The NDP will implement Community Paramedic pilot programs in Saskatoon and Regina,
- The cost is $400,000 per year, per city, with the program starting operations halfway through the 2016-17 budget year. The anticipated four-year operating cost is $2.8 million. A Winnipeg (population 718,000) Community Paramedic program costs $800,000 per year.[2]

Approximate incremental operating costs, per year: $6 million.

[1] Kusch, L. (Sept 21, 2013). Manitoba's quick health-care fix. *Winnipeg Free Press.* http://www.winnipegfreepress.com/local/manitobas-quick-health-care-fix-224681262.html

[2] Kusch, L. (Oct 2, 2015). Hanging up on 911: Unique paramedic program helps cut calls to city's emergency line. *Winnipeg Free Press*. http://www.winnipegfreepress.com/local/Hanging-up-on-911-330361141.html

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Fast Track system

A triage nurse can refer patients with low-acuity conditions to a Fast Track stream, where they will be assessed and treated by a nurse practitioner, and connected back to a primary care provider for any follow-up that may be required. Academic research supports this approach[3] and other provinces have had success with Fast Track streams.[4] An example of a patient that would benefit from the Fast Track system is a patient who needs stitches.

Quick Care clinics

These clinics are intended to help meet unexpected health care needs, save trips to an emergency room, and avoid people having to wait to see their family doctor. Staffed by nurse practitioners and registered nurses, these clinics improve accessibility to primary care services and treat people for minor health issues, such as skin problems, stomach issues, cuts, colds and flu symptoms. These clinics can also assist with mental health assessments. Nurse practitioners are able to order diagnostic tests and prescribe medications when needed. Quick Care clinics were introduced in Manitoba in 2012, and have since been expanded. 98 per cent of Manitobans who have accessed services at a Quick Care clinic report their experience was "excellent," and almost 100% would access services at a Quick Care clinic again.[5]

Community Paramedic Program

Currently, there is a pilot project in the Saskatoon Health Region for specially trained paramedics to collaborate with nurses and family physicians to provide care to residents of long-term care homes, in order to decrease ER visits. Services include pain management, cardiac monitoring, diagnostic collections, intravenous therapy, and respiratory treatment. On-site diagnostics including specimen collection, ECGs, blood glucose, oxygen saturation and CO2 levels. Immediate on-site intervention can include IV rehydration, pain management, suturing, medication administration and facilitated prescription orders.[6] In other provinces, including Ontario, Manitoba, Alberta and British Columbia, this program is provided in the community, and in people's homes.[7]

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[3] Ardagh, M., Wells, J., Cooper, K., Lyons, R., Patterson, R., & O'Donovan, P. (2002) Effect of a rapid assessment clinic on waiting time to be seen by a doctor and the time spent in the department, for patients presenting to an urban emergency department: a controlled prospective trial. The New Zealand Medical Journal, 115.
Darrab, A., Fan, J., Fernandes, C., Zimmerman, R., Smith, R., Worster, A., et al. (2006) How does fast track affect quality of care in the emergency department? European Journal of Emergency Medicine, 13.
Morish, S. Streaming in the emergency department: An innovative care delivery design. University of British Columbia. 2012.
[4] http://www.nbms.nb.ca/leadership-and-advocacy/improving-the-health-system/emergency-room-wait-times-can-and-should-be-shorter/
[5] http://www.gov.mb.ca/health/primarycare/public/access/quickcare.html;
[6] Alberta Health Services. (2016). Community paramedics: Delivering health care before emergencies begin. http://www.albertahealthservices.ca/info/page12557.aspx
[7] Picard, A. (Feb 17, 2014). Why community paramedicine saves both money and lives. The Globe and Mail. http://www.theglobeandmail.com/life/health-and-fitness/health/why-community-paramedicine-saves-both-money-and-lives/article16905592/
Kusch, L. (Oct 2, 2015). Hanging up on 911: Unique paramedic program helps cut calls to city's emergency line. Winnipeg Free Press. http://www.winnipegfreepress.com/local/Hanging-up-on-911-330361141.html

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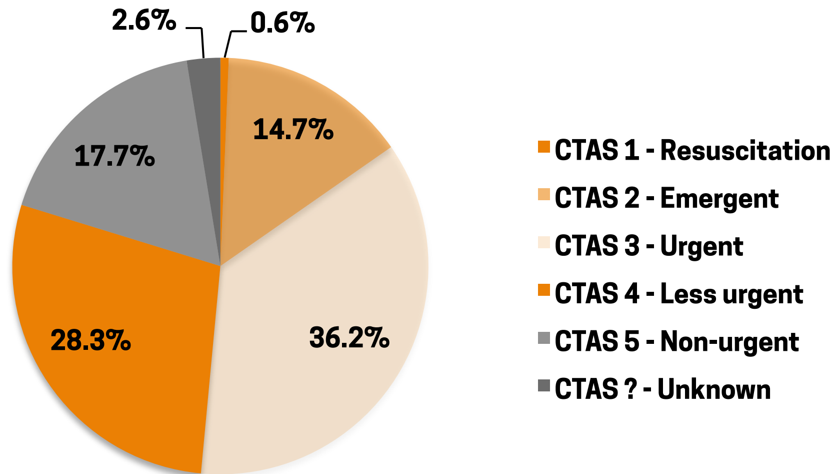
2014-15 ER visits by Canadian Triage and Acuity Scale (CTAS) ranking[8]



CTAS levels[9]

CTAS Level 1 – "Resuscitation" (1,606 patients in 2014-15)
Patients should be seen by a physician immediately

CTAS Level 2 – "Emergent" (36,562 patients in 2014-15)
Patients should be seen by a physician within 15 minutes – examples include severe trauma, head injury, chest pain, overdose, severe asthma, sepsis, acute psychosis, or assault.

CTAS Level 3 – "Urgent" (90,078 patients in 2014-15)
Patients should be seen by a physician within 30 minutes – examples include moderate trauma, seizure, suicidal, or acute pain.

CTAS Level 4 – "Less urgent" (70,375 patients in 2014-15)
Patients should be seen by a physician within 1 hour – examples include minor trauma, abdominal pain, headache, ear ache, chronic back ache and upper respiratory infections.

CTAS Level 5 – "Non urgent" (43,966 patients in 2014-15)
Patients need to be seen by a physician within 2 hours – examples include sore throat, vomiting and diarrhea (without signs of dehydration), and mild abdominal pain.

CBC. (Dec 11, 2013). Program to keep Alberta seniors out of ERs successful.
http://www.cbc.ca/news/canada/calgary/program-to-keep-alberta-seniors-out-of-ers-successful-1.2460754
BC Emergency Health Services. (Dec 2, 2015). Community paramedicine program launches on the BC coast.
http://www.bcehs.ca/about/news-stories/news-roll/Community-paramedicine-program-launches-on-the-BC-Coast
[8] Data for Regina, Saskatoon and Prince Albert hospitals obtained through Access to Information, Nov 20, 2015
[9] Implementation Guidelines for the Canadian Emergency Department Triage and Acuity Scale (CTAS).
http://caep.ca/sites/caep.ca/files/caep/files/ctased16.pdf