SA Health

Policy

Ambulance Transport

Version 2.0
Approval date: 28 July 2023
PDS Reference No: D0446

Government of South Australia
SA Health

1. Name of policy

Ambulance Transport

2. Policy statement

This Policy sets out the mandatory requirements to ensure patients are transferred via the most appropriate mode of transport to the most appropriate destination with the level of clinical capability required to meet the patient's care needs and reduce occurrences of secondary transfers.

3. Applicability

This policy applies to all employees and contracted staff of SA Health; that is all employees, volunteers and contracted staff of the Department for Health and Wellbeing (DHW), Local Health Networks (LHNs) (including state-wide services aligned with those Networks) and SA Ambulance Service (SAAS).

4. Policy principles

SA Health's approach to ambulance transport is underpinned by the following principles:

- We will work collaboratively towards improved ambulance response times to Triple Zero ('000') calls.
- We will ensure patients are transported in a timely manner to the most clinically appropriate destination.
- We will share responsibility to expedite patient transfer of care to enable prompt release of ambulances (emergency, urgent and non-emergency) back into the community.
- We will ensure efficient and effective handover of patients from paramedics / ambulance officers to hospital clinicians to avoid delays in transfer of care.
- We will maximise utilisation of other modes of transport where safe and clinically appropriate to preserve ambulance resources for emergency and urgent situations.
- We will maximise utilisation of alternative care pathways where clinically appropriate to avoid unnecessary transport to hospital.
- We will ensure patients are transported to the most appropriate destination to meet their care needs to reduce occurrences of secondary transfers.

5. Policy requirements

- **DHW, LHNs and SAAS** must:
  - Ensure relevant dashboards and online resources relevant to ambulance transport and demand accurately reflect real time SAAS activity and LHN capacity, both in ED and inpatient wards.
- **SAAS** must:
  - Determine the most appropriate destination for ambulance transports in line with this policy and as outlined in Part 2 of the Mandatory Instruction at **Appendix 1**.
  - Manage non-emergency patient transports in line with Part 5 of the Mandatory Instruction at **Appendix 1** to minimise delays in releasing ED cubicles and inpatient beds.
- All **LHNs and SAAS** must:
  - Work collaboratively to achieve a timely transfer of care process and proactively manage delays in line with Part 3 and Part 4 of the Mandatory Instruction at **Appendix 1**.
- All **LHNs** must:
  - Determine the most appropriate mode of transport where non-emergency transport is required (excludes all transport modes provided by SAAS) in line with Part 1 of the Mandatory Instruction at **Appendix 1** and Attachment 1.

- Facilitate the timely transfer of safe clinical care of patients in less than/or equal to 30 minutes from ambulance (emergency, urgent and non-emergency) arrival at the hospital, as outlined in Part 3 of the Mandatory Instruction at **Appendix 1**.
- Proactively plan for required non-emergency patient transports and promptly notify SAAS as outlined in Part 5 of the Mandatory Instruction at **Appendix 1**.
- Provide up-to-date clinical service profiles upon the movement or decommissioning of any services to enable currency of the Destination Decision Matrix in Attachment 2.
- Establish local approval processes to ensure the costs associated with transport are authorised in line with financial delegations.
- Ensure patients are notified of any costs or fees associated with non-emergency transport (not including Patient Transport Service provided by SAAS) and eligibility criteria for transport assistance, as early as possible to prepare for discharge or transfer, in line with Part 6 and Part 7 of the Mandatory Instruction at **Appendix 1.**

6. Mandatory related documents

The following documents must be complied with under this Policy, to the extent that they are relevant:

- Clinical Communication and Patient Identification Clinical Directive
- Criteria Led Discharge Policy
- Direct Admission to a Hospital Inpatient Unit Policy
- Fit to Sit Pathways Policy
- LHN Hospital Escalation and Business Continuity Plans
- Managing Transfer or Discharge of Patients Policy
- Statewide Demand and Escalation Policy
- SA Health Fees and Charges Manual

7. Supporting information

- Public hospital charges for Medicare-ineligible asylum seekers living in the South Australian community.
- Aboriginal Health Care Plan 2010 – 2016

8. Definitions

- **Ambulance clearance time:** means the time for SAAS paramedics or ambulance officers to complete patient care record, supply restock and clean vehicle. Ambulance clearance must be completed within an additional 20 minutes from transfer of care.
- **Ambulance turnaround time:** means the total time from ambulance arrival at the hospital ambulance arrival bay to the time the ambulance is ready and available for another emergency dispatch (less than or equal to 50 minutes). The Patient Transfer of Care Time (less than or equal to 30 minutes) is the responsibility of the public hospital, and the Ambulance Clearance Time (less than or equal to 20 minutes) is the responsibility of SAAS Paramedics/Ambulance Officers. Please note, the Ambulance Clearance time is in addition to the Patient Transfer of Care Time.
- **Emergency:** means ambulance responses identified as priority 1 and 2.
- **Non-emergency:** means planned ambulance responses, identified as priority 6 to 8. This includes involuntary patients under Section 56 of the *Mental Health Act 2009* in an ED or inpatient unit.
- **Priority:** means the level and urgency of response assigned by SAAS following an algorithmic primary triage with a call taker (non-clinician), without face-to-face assessment of the patient.
- **Priority 1:** means an emergency incident which is immediately life-threatening requiring emergency response (lights and sirens).

- **Priority 2:** means an emergency incident with Increased risk of mortality or morbidity requiring emergency response (lights and sirens).
- **Priority 3:** means an urgent incident with Increased risk of morbidity requiring urgent response (no lights and sirens).
- **Priority 4:** means an urgent incident with Increased risk of morbidity requiring prompt response (no lights and sirens).
- **Priority 5:** means an urgent incident with Reduced risk of morbidity requiring a prompt response (no lights and sirens).
- **Priority 6:** means a routine incident where Clinical support (paramedic or intensive care paramedic level) is required at scene or en-route, but patient has been assessed as 'not at risk' of increased morbidity due to a delay in response.
- **Priority 7:** means a routine incident where Active treatment during transport is not required, but requires monitoring of clinical condition (i.e., observations and/or use of monitoring devices) (e.g., cardiac monitors, glucometer).
- **Priority 8:** means a routine incident where Treatment or clinical monitoring is not required during transport.
- **Transfer**: means transportation of a patient to another location determined by the treating health care team. A transfer includes all transport segments required for the patient to reach their destination.
- **Transfer of care**: means handover from SAAS to hospital clinical staff for ongoing clinical care and the SAAS paramedic or ambulance officer and their equipment is no longer required. Transfer of care must be completed within 30 minutes of arrival at hospital, including triage, the physical transfer of the patient, and clinical handover to hospital clinical staff. Transfer of care is recorded at the time the SAAS paramedic or ambulance officer makes a 'handover' radio call to dispatch.
- **Triage:** means the formal process used to immediately assess all patients arriving in an ED to determine the urgency of their care requirements.
- **Urgent:** means ambulance responses identified as priority 3 to 5.

9. Compliance

This policy is binding on those to whom it applies or relates. Implementation at a local level may be subject to audit/assessment. The Domain Custodian must work towards the establishment of systems which demonstrate compliance with this policy, in accordance with the requirements of the Integrated Compliance Policy.

Any instance of non-compliance with this policy must be reported to the Domain Custodian for the Services, Planning and Programs Domain and the Domain Custodian for the Risk, Compliance and Audit Policy Domain.

10. Document ownership

Policy owner: Domain Custodian for the Services, Planning and Programs Policy Domain.

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11. Document history

Version	Date approved	Approved by	Amendment notes
2.0	28/07/2023	Chief Executive, DHW	Reviewed and updated in line with SA Health Policy Framework. Previously named Ambulance Distribution for Demand Management Policy Directive.
1.4	03/07/2020	Executive Director, Health Services Programs and Funding	Minor updates to reflect LHN and SAAS feedback.
1.3	28/02/2020	Executive Director, Health Services Programs and Funding	Updates to reflect changes to escalation during delays in transfer of care (as agreed by HSP Strategic Oversight Group).
1.2	16/12/2019	Executive Director, Health Services Programs and Funding	Minor updates to reflect strengthened escalation processes for ambulance transfer of care delays, department name and other staff title changes.
1.1	01/04/2019	Executive Director, Operational Service Improvement and Demand Management	Minor updates to reflect LHN feedback.
1.0	18/05/2017	Executive Director, Operational Service Improvement and Demand Management	Original approved version.

12. Appendices

1. *Ambulance Transport Mandatory Instruction*

Appendix 1: Ambulance Transport Mandatory Instruction

The following Instruction must be complied with to meet the requirements of the *Ambulance Transport Policy*.

1. Transport Mode

1.1. The transport platform (road and/or air) for all emergency (Priority 1 and 2), urgent (Priority 3 to 5) and non-emergency (Priority 6 to 8) incidents must be determined by SAAS.

1.2. Where transport is required for circumstances outlined below, the referring hospital must determine the most clinically appropriate and cost-effective mode of transport in line with Attachment 1 and with consideration to the patient's clinical condition and required medical intervention.

a) Transfer to a metropolitan facility (public or private), if a higher level of care is needed, or the required service is not available at the referring facility (includes overnight and same day).

b) Transfer back to the referring facility or a facility with an equivalent level of capability geographically close to the patient's home location when specialty services are no longer required.

c) Transfer to a step-down facility (public or private) when acute episode of care is complete, and rehabilitation is required before discharge.

d) Patient requests to transfer to a private or public facility geographically close to the patient's home location and/or family and/or access to a preferred physician (this includes returning to SA from another State or Territory where they have been receiving treatment).

e) Transfer of a patient to their home location (e.g., private residence, residential aged care facility, supported accommodation) when hospital-level care is no longer required.

If it is determined by the referring hospital that an ambulance is required for circumstances outlined in section 1.2, a booking must be made in line with Section 5 and the transport platform (e.g., road and/or air) will be determined by SAAS.

1.3. In addition to the criteria outlined in Attachment 1, consideration must be given to cultural needs with every effort made to accommodate a patient's requests.

2. Destination Decision Making

2.1. Where transport is via ambulance (emergency, urgent and non-emergency), patient requests must not determine the destination, with exception to compelling circumstances outlined in Table 1.

Table 1: Criteria for Transport to Patient's Preferred Destination

Circumstance	Criteria
Known Patient	• Patients who have a significant history and/or existing relationship at a particular site.
Clinical Condition	• Chronic condition. • Obstetric patients booked into a specialist site.
Clinical Trial	• Patients who are entered into an approved clinical trial at a particular site where the presentation may be related to that trial.

2.2. The Paramedic or Ambulance Officer must explain to the patient they will be taken to the most appropriate destination based on their clinical needs, to assist in commencing treatment as quickly as possible at the destination that has capacity to treat them.

2.3. In the event a patient is transported to their preferred destination, other than the most appropriate as determined in line with this Policy, the destination decision must be documented in the patient care record by SAAS.

2.4. When determining the most appropriate destination, patients must be taken to the most appropriate and geographically closest ED, with exception to:

a) Patients who have a known significant history and/or existing relationship at a particular site.

b) Patients who are suitable for established clinical pathways (e.g., stroke, STEMI), including specialised pathways with the private sector (e.g., SALHN chest pain and long bone fracture).

c) Patients who require review by or admission to a specialist unit. This cohort must be transported to a destination in line with Attachment 2.

d) Patients with complex and emergency needs who require a specific service. This cohort must be transported to a destination with the appropriate level of clinical capability in line with Clinical Services Capability Framework.

e) Patients who are suitable for referral to alternative care pathways.

f) Patients with mental health conditions under care and control with an inpatient treatment order. This cohort must be transported to approved treatment centres or authorised community mental health facilities in line with the *Mental Health Act 2009*.

g) Patients who have been discharged from a metropolitan public hospital in the previous 72 hours. For a related issue, every effort must be made to transport the patient to a hospital within the same LHN.

h) Major emergencies or incidents (e.g., bushfire, pandemic) where ambulance or command roles direct patient distribution in conflict with existing policies and procedures as part of an overall incident management approach, including the use of temporary medical facilities.

i) Peak travel times and periods of interruptions to travel flows (e.g., motor vehicle crashes, hazmat incidents etc) when it may be more appropriate to minimise travel time, transporting the patient to a hospital that is outside of the local area.

In the event of a time critical or deteriorating condition and/or transport is by a volunteer ambulance crew, the patient must be taken to the most clinically appropriate and geographically closest ED (notification to the receiving hospital is required for this patient cohort).

2.5. Where clinically appropriate:

a) Activity levels (ambulance and hospital) and available ambulance resources must be considered.

b) Utilisation of alternative care pathways must be considered to avoid unnecessary transport to hospital. This includes the use of alternative pathways as an early assessment or pre-admission destination for relevant complex cases.

c) Transport to peri-urban public hospitals must be considered.

d) Patients with private health insurance must be offered the option to attend a private or public hospital, with exception to emergency circumstances such as clinical condition (e.g., STEMI pathway).

3. Transfer of Care

3.1. In instances where a hospital has been determined as the most appropriate destination, every effort must be made to support the release of ambulances for further tasking to reduce the risk to other patients in the community requiring emergency or urgent care by:

a) Moving patients from the ambulance to an appropriate place in the receiving hospital (which may include triage, assessment/treatment area or waiting room) as soon as possible.

b) Prioritising ambulance patients for placement, where clinically appropriate, if the patient has arrived via ambulance and is triaged (as per the Australasian Triage Scale (ATS)) as an equal category to those patients already in the waiting room. For example, where two patients have been triaged as ATS Category 4 (one arriving via ambulance and one walk-in), the ambulance patient will be considered for placement first to allow the attending Paramedic or Ambulance Officers to be available for further tasking.

3.2. The transfer of clinical care from paramedic or ambulance officer to hospital clinician must occur in less than or equal to 30 minutes from ambulance arrival at the hospital.

3.3. The ambulance must be available for further tasking within an additional 20 minutes, except where additional time is identified to be required and authorised clearance codes have been obtained (e.g., cleaning, restocking, complex documentation and/or clinical/operational

debriefing) or as soon as practicable without compromising the operational readiness of the ambulance.

3.4. All metropolitan public hospitals must monitor compliance against the 30-minute transfer of care target as stipulated in the annual Service Agreements. Whilst regional public hospitals are not expressly monitored against this indicator, it is seen as a best practice model, and every effort must be made to achieve transfer of care within 30 minutes of ambulance arrival at hospital.

3.5. SAAS must monitor compliance against the 20-minute ambulance clearance time target as stipulated in the annual Service Agreements.

3.6. Ambulance and hospital staff must work collaboratively, with a commitment to ongoing effective communication, to ensure a timely transfer of care process with an overall aim to avoid delay in commencing patient treatment and to ensure ambulances are available for other cases as soon as possible.

3.7. Alternative care service providers are obligated to accept suitable patients (in line with their service agreement) upon arrival and must transfer care and enable release of the ambulance within 30 minutes of arrival.

3.8. Upon transfer of care to a hospital, paramedics or ambulance officers and hospital clinical staff must comply with the actions outlined in Table 4.

Table 4: Actions Taken Upon Transfer of Care at Hospital

Responsible Party	Action
SAAS Paramedics or Ambulance Officers	• Provide patient details and clinical information to hospital clinical staff. • Immediately notify the SAAS Emergency Operations Centre that transfer of clinical care is complete (handover). • Promptly prepare the ambulance within 20 minutes for further tasking in the community, except where extended clearance time is required for appropriate paperwork, restocking and/or debriefing. An authorised clearance code must be obtained for extended clearance time.
Hospital Clinical Staff	• Record patient details and clinical information in the Sunrise Electronic Medical Record (EMR) as provided by SAAS paramedics or ambulance officers. • Clinically triage patient. • Determine if clinically appropriate for transfer from ambulance to chair in ED waiting room to await further assessment (Fit to Sit) in line with the Fit to Sit Pathway Policy. • Move patient to a cubicle, waiting room, or holding bay, until the allocated hospital clinician is available to continue care and ensure location is assigned in Sunrise EMR to signal transfer to ED (TED) time. • Patients requiring ongoing clinical care in a bed or stretcher shall only be offloaded to designated treatment spaces.

4. Delayed Transfer of Care

4.1. Where a delay impacting transfer of care is anticipated, the ED triage clinician must inform the attending Paramedic or Ambulance Officers, providing information on the cause and actions taken to resolve any delay. If delays in transfer of care are frequent or prolonged, escalation must occur in line with the Statewide Demand and Escalation Policy.

4.2. Where ambulance delays occur, a whole-of-hospital approach is required to identify capacity to ensure patient transfer of care time does not exceed 60 minutes, to ensure adequate ambulance resources are available to respond to the needs of the community. At this time, consideration must be given to suitability for patient transfer to an available space in the ED, including triage, assessment/treatment area or waiting room.

5. Booking Non-Emergency Ambulance Transports

5.1. All bookings for non-emergency ambulance transports from SA Health facilities must be made via the SAAS External Booking System (EBS) where available in line with Attachment 3.

5.2. The booking process must commence as early as possible from decision to transport patient to ensure appropriate SAAS resources can be allocated.

5.3. Prior to booking a non-emergency ambulance transport for an inter-facility transfer, the referring facility must ensure the transfer is accepted by the receiving facility in line with the Inter-Facility Transfer Policy [IN DEVELOPMENT] before a booking is made.

6. Transport Costs

6.1. It is expected, wherever possible, patients will assume responsibility for payment and the management of their own transport requirement, however in some circumstances, responsibility for payment must be assumed by the health service in line with Attachment 4.

6.2. Where it has been determined the medical needs of a patient prevents them from using an alternative mode of transport (refer to Attachment 1), the booking of a non-emergency ambulance transport must be made in line with Attachment 3 and with regard to Section 5.

6.3. Where an interstate transfer is required for essential specialist care or treatment, the associated costs, including all transport to reach destination (e.g., flights, ambulance, or public transport), must be negotiated between the referring and receiving hospitals. All cross border arrangements, including Service Agreements or Memorandums of Understanding between regular referring/receiving hospitals across jurisdictions, must be governed by principles described within Clause A88 of the National Health Reform Agreement.

6.4. If a patient clinically deteriorates and requires transport to an ED via SAAS, this must be treated as an emergency or urgent transport. In the case of an inter-hospital transfer, the referring hospital is responsible for the costs associated with the transport.

7. Transport Assistance

7.1. The hospital treating clinician must consider providing transport assistance in circumstances outlined in Table 5. All requests for transport assistance (including patient escort) must be assessed and approved on a case-by-case basis.

Table 5: Circumstances Requiring Transport Assistance

Circumstance	Description
Medical	• Visual impairment where mobility is impacted (e.g., legal blindness). • Significant communication difficulties (e.g., learning difficulty, profound deafness, speech impairment). • Mental health condition that presents risk to the patient if travelling alone.
Social / Financial	• Language barriers. • Cultural support. • Unemployment or financial hardship.
Compassionate Grounds	The repatriation of a: • Patient from an overseas destination where all options have been exhausted. • Palliative care patient to their hometown/residence, or closer to home, to die. • Deceased patient to their hometown/residence following treatment (including organ/tissue donation) in a public hospital. • Deceased patient to the originating hospital, if the patient is sent interstate to receive treatment and dies during the treatment episode.

7.2. Where financial support for transport is sought based on inability to self-fund, a financial assessment must be undertaken using the SA Health Patient Financial Assessment Form.

7.3. The necessity for continuing transport assistance must be reviewed in line with the eligibility criteria, four weeks from date of initial approval.

7.4. Transport assistance may be declined or withdrawn where:

a) It is not considered medically necessary.

b) The patient is deemed to have the financial means to self-fund transport costs; or

c) The patient demonstrates non-compliance with agreed transport arrangements.

7.5. Where a request for transport assistance has been declined or withdrawn, the patient may appeal the decision in writing. Upon receipt of application, the outcome of the appeal must be advised within 10 working days.

Attachment 1: Patient Transport Decision Making Matrix

Where a non-emergency transport is required, the referring hospital must determine the most clinically appropriate mode of transport and level of assistance required with consideration to the patient's clinical condition and required medical intervention as specified below.

In some instances, ambulance may be the only suitable transport option.

Risk Level	Clinical Criteria	Modes of transport
Low	Patient can travel independently by road/air if: • Clinically stable and at low risk of deterioration in transit. • Independently mobile. • No cognitive impairment.	• Volunteer transport services. • Public transport. • Taxi services. • Commercial flight. • Commercial bus.
Medium	Patient can travel by road/air with assistance if: • Clinically stable and at medium risk of deterioration in transit. • Independently mobile over short distances with aids (e.g., crutches, walking stick / frame, wheelchair). • Light assistance (x1 person) with mobilisation and transfer is required at arrival and departure points. • Moderate to severe communication difficulties (e.g., vision, hearing, speech, limited English). • Severe to moderate cognitive impairment (e.g., Dementia).	• Access Cab. • Corporate Shuttle. • Patient escort.
High	Patient must travel in ambulance* by road/air with comprehensive assistance if: • High risk of clinical deterioration in transit. • Significant risk of harm to themselves or others. • High level of monitoring or intervention required in transit (e.g., ventilation, intravenous infusions). • Immobile and requires barouche in transit. • Highly infectious and presents a community risk which is unable to be mitigated through protective measures (e.g., application of wound dressing, patient education). • Heavy assistance (x2 persons +/- lifting aids) with mobilisation and transfer is required at arrival and departure points. **requirement to transport via ambulance must be reviewed by SAAS.*	• Ambulance (metropolitan and intrastate) • MedSTAR

Attachment 2: Destination Directory of Services for Specialist Review or Admission

Patients likely to require review by or admission to a specialist unit must be transported to a destination with appropriate clinical services, as outlined below, to ensure timely access to definitive care and minimise incidence of secondary inter-facility transfers. Please note, detailed criteria are available in SAAS Clinical Practice Guidelines.

In the event of a time critical or deteriorating condition and/or transport is by a volunteer ambulance crew, the patient must be taken to the most clinically appropriate and geographically closest ED (notification to the receiving hospital is required for this patient cohort).

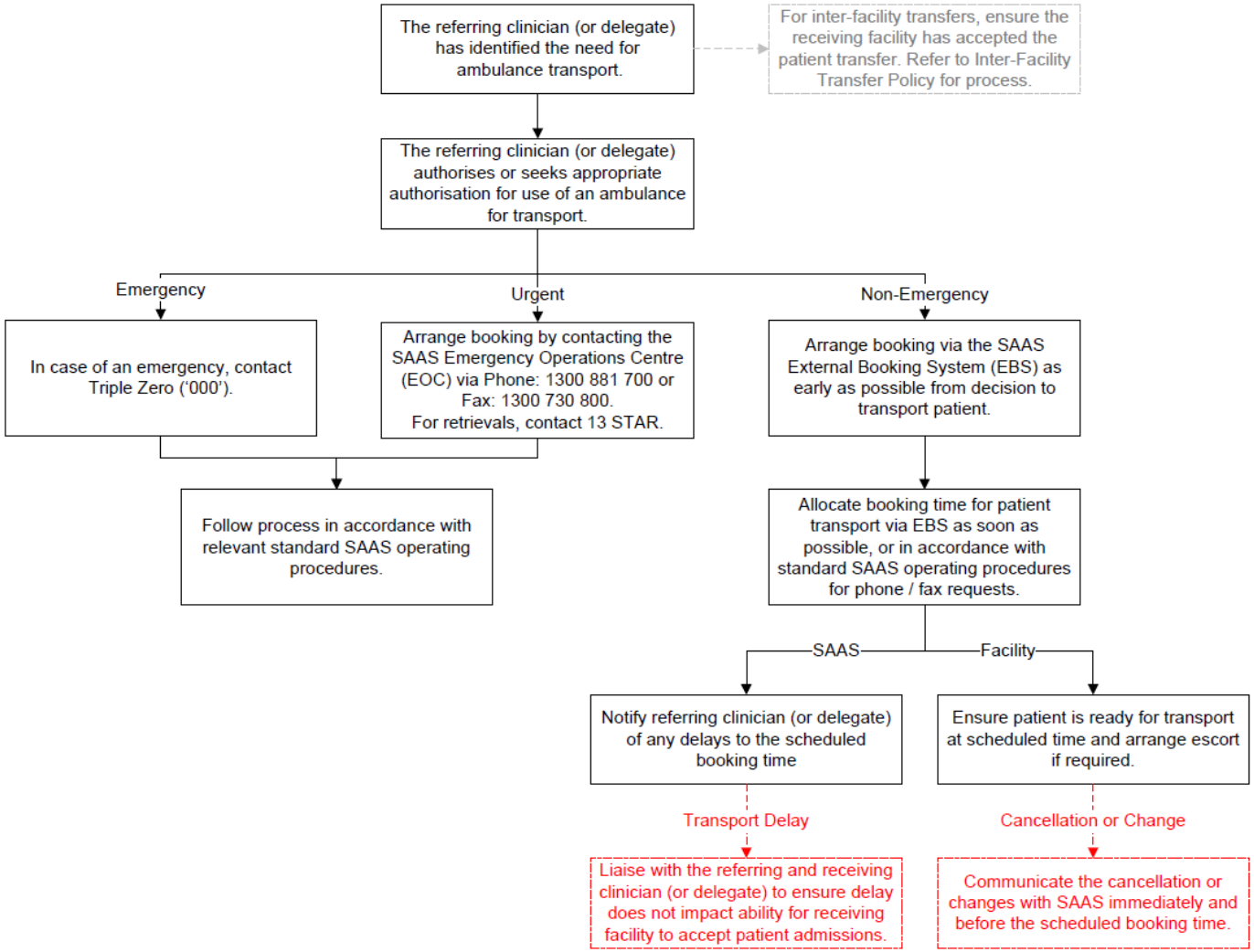
Where appropriate, transport to peri-urban public hospitals (Mt Barker, Gawler and Southern Fleurieu) must be considered, with exception to the following criteria:

- Diagnosed surgical problem.
- Involuntary patients.
- Acutely agitated or violent patients.
- Time critical diagnoses (e.g., stroke, cardiac event)
- Tertiary sub-specialist intervention.
- Major trauma.

Cohort	Criteria	Destination
Burns	• Serious.	• RAH or WCH.
Cardiology	• Pacemakers fail to capture, without physiological compromise. • Inappropriate discharge of implantable defibrillator. • Multiple activation of AICD (>1 in last 24 hours. • ACS, Cardiogenic shock, STEMI or NSTEMI.	• RAH, FMC, LMH or TQEH.
COVID-19	• PCR or RAT positive with identified risk factors.	• RAH, FMC, LMH or WCH.
Dialysis	• Haemodialysis (if known)	• RAH, FMC or LMH.
	• Peritoneal dialysis (if known), with complications needing admission.	• RAH or FMC.
General Surgery	• Obvious gastrointestinal haemorrhage. • Medical referral for an unscheduled surgical review. • Abdominal or back pain associated with physiological abnormality.	• RAH, FMC, LMH or TQEH. • WCH or FMC
Intensive Care	• Oncology patient with unexpected physiological abnormality* • Exacerbation of chronic respiratory illness with previous ICU respiratory admission. • ETT tube successful inserted by SAAS. • Jaundice with physiological abnormality. • Severe community acquired pneumonia. • Patient with an insulin pump. • Patient with panhypopituitarism on desmopressin.	• RAH, FMC, LMH or TQEH.
Major Trauma	• With or without the requirement for plastic surgery.	• RAH, FMC, WCH.
Neurosurgery	• Spinal injuries / paraesthesia requiring spinal precautions • Head injuries with altered consciousness.	• RAH, FMC or WCH.
Obstetrics	• PV haemorrhage.	• FMC, LMH or WCH.
	• Trauma	• FMC or LMH (low risk).

Cohort	Criteria	Destination
Orthopaedic Surgery	• Open fracture. • Obvious bony deformity and/or crepitation associated with an acute traumatic injury (fractures and unresolved dislocations) to the lower or upper limb (e.g., femoral neck fracture). • Pain in an isolated single joint associated with clinical signs of a suspected local infection and patient's temperature >38°C.	• RAH, FMC, LMH or TQEH. • WCH or FMC
Previous Organ Transplant	• N/A	• RAH, FMC or WCH.
	• Renal transplant (more than one year post transplant [if known])	• RAH, FMC, LMH or WCH.
Stroke	• ROSIER positive and ACT negative • ROSIER positive and ACT positive	• RAH • FMC & LMH (0800-2000 hours)
Surgical Procedure (Previous 2 weeks)	• N/A	• RAH, FMC, TQEH, LMH or WCH • Within LHN where surgery was performed.
Vascular Surgery	• Abdominal aortic aneurysm. • Acute limb ischaemic. • Infection or necrosis of the feet or toes in a diabetic patient.	• RAH or FMC.

Attachment 3: Booking Non-Emergency Ambulance Transports



Attachment 4: Responsibility for Costs Associated with Transport and Assistance Options

Cohort	Responsibility	Assistance Options
Aboriginal	• Patient. • Health service.	• Refer to the Aboriginal Health Care Plan 2010 – 2016.
Asylum Seekers	• Patient.	• Public hospital charges for Medicare-ineligible asylum seekers living in the South Australian community. • Refer to Section 6.
Concession Card Holders	• Patient.	• SA Health Patient Financial Assessment Form (Refer to Section 7 in Policy).
Country / Regional	• Patient. • SAAS for RFDS transports (in case of interhospital transfers).	• SA Health Patient Financial Assessment Form (Refer to Section 7 in Policy). • May be eligible for subsidies through the Patient Assistance Transport Scheme (PATS).
Discharged	• Patient.	• SA Health Patient Financial Assessment Form (Refer to Section 7 in Policy).
Frequent Treatment Schedules (e.g., Renal Dialysis, Chemo)	• Patient.	• SA Health Patient Financial Assessment Form (Refer to Section 7 in Policy).
Hospital in the Home	• Patient. • Admitting Hospital (if patient clinically deteriorates)	• N/A.
Immigration Detainees	• International Health and Medical Services (IHMS).	• N/A.
Inter-Hospital *(including funded virtual beds)*	• Requestor (health service or patient).	• N/A.
Interstate / Overseas Visitors	• Patient. • Refer to Section 6.3	• Travel/private health insurance. • SA Health Patient Financial Assessment Form (Refer to Section 7 in Policy). • Refer to the Reciprocal Health Care Agreements (for overseas visitors).
Interstate Transfer (for essential specialist care / treatment)	• Initiating SA Health Service.	• N/A.
Mental Health Patients under Care and Control or Inpatient Treatment Orders	• First receiving metropolitan or regional health service. • SAAS for RFDS transports of country patients. *(Accounts must not be issued to regional LHNs or SA Health Mental Health Directorate)*	• N/A.
Motor Vehicle Accidents	• Compulsory Third Party (CTP) Insurance Regulator (70%) • SAAS (30%)	• N/A.
Non-Admitted and Ambulatory	• Patient.	• SA Health Patient Financial Assessment Form (Refer to Section 7 in Policy).
Patient Escort (Family/friend/carer or nurse/SAAS Nurse Retrieval Consultant).	• Patient escort. • Initiating health service.	• Refer to Section 6.
People in Custody	• Department for Correctional Services (for patients in prison, home detention, remand or other DCS facility) • Person in Custody (patients in police custody, excluding mental health patients under care and control or ITO)	• N/A.
Private Health Insurance	• Patient	• Private Health Insurer.
Residential Aged Care	• Patient.	• Refer to Section 6.
Return to Work SA Injury / Treatment	• Patient.	• Return to Work SA.
Veterans	• Patient.	• Department of Veterans' Affairs. • Refer to Section 6.