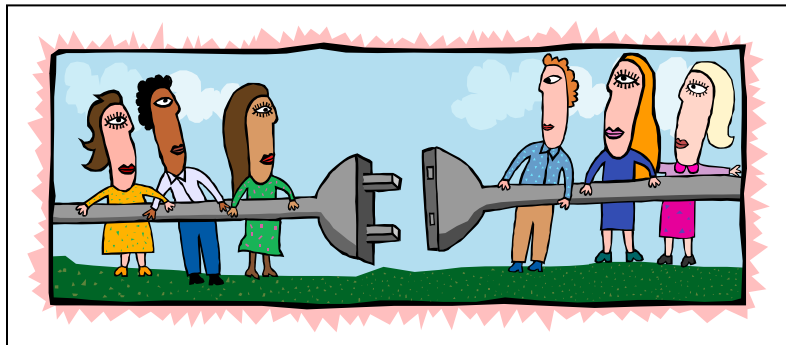


**Hospital Patient Access & Flow Project  
– South West LHIN  
Improving access through collaboration**

**Report # 3 – February 9, 2010**



**Purpose of this Report**

The purpose of this Project Status Report is to keep everyone with an interest in the project informed about project developments on an on-going basis.

**Communications Update**

Since the last report the following major communications/meetings have taken place:

- The Project Steering Committee has met three times (December 16<sup>th</sup>, January 20<sup>th</sup> and February 17<sup>th</sup>).
- Paul Collins, President and CEO, St. Thomas Elgin General Hospital has assumed the role of Steering Committee Chair with the departure of Margret Comack.
- Chiefs of Staff and Chiefs of Emergency were briefed on the protocol through a series of regional meetings in January. These meetings provided an excellent opportunity to talk about the protocol, get feedback and suggestions about how to make it better.
- On January 29<sup>th</sup> CEOs from across the SW LHIN were briefed on the protocol and they agreed to support the work done to date and next steps.
- The Project's Physician Leaders Group continues to meet on the first Wednesday of each month and last met on Feb 3<sup>rd</sup>. Dr Don Neal, a family physician and coroner from Alexandra Marine & General Hospital in Goderich has joined this group. They continue to focus attention on the process and how to improve it.
- Primarily through the Project Steering Committee members hospitals throughout the region continue to talk to staff and physicians about the protocol and its impact on their organization. In most cases this project has become a standing item on the MAC agenda. This is very important work leading up to finalization of the protocol.
- On January 25<sup>th</sup> a meeting was held with CritiCall to discuss operational impact and feasibility of protocol.
- At LHSC, the Joint MAC has endorsed the project and multiple internal stakeholder meetings are occurring to refine and implement processes.

**Process Update**

- The project team will begin to 'test' the protocol shortly through a series of table top exercises to 'walk through' the protocol using different scenarios.
- Steps will be taken to test the protocol with hospital staff (primarily Admitting Department staff) who will be involved at the front line of the protocol. This will involve one day long region-wide meeting and follow-up meetings in Grey Bruce, Huron Perth and Thames Valley. LHSC will be involved in each meeting.
- After this, steps will be taken to field trial the protocol 'off line' that is through a mock exercise that will simulate real scenarios.
- These steps will allow the project team to address opportunities for improvement that have not yet been identified.

- A task group from GBHS, WGH, LHSC, and HPHA are developing a standardized patient transfer form and a draft version has been developed.
- The need for documentation of actions taken under the protocol is currently being investigated
- A Letter of Agreement , in final form, will be signed off by the hospital CEOs and Chiefs of Staff. A draft version was tabled with the CEOs on January 29<sup>th</sup>.

### **Updated Project Schedule**

#### **1. February 2010**

- Finalize the content of the protocol (i.e. ready for field testing)
- Ask Chiefs of Staff what key information referring physicians need to make an informed decision about where to transfer their patient
- Proceed to field testing in March 2010

#### **2. March 2010**

- Conduct education sessions on the protocol at each hospital
- Perform numerous field tests of the protocol in an operational environment (by running through typical scenarios) and 'iron out' any operational or procedural issues that arise
- Finalize the standardized patient transfer form that will be used throughout the LHIN
- Meet with the CEOs to brief them on the development of the protocol

#### **3. April 2010**

- Arrange for a combined Chiefs and CEOs meeting (T-con) to review the final version of the protocol
- Ensure protocol is ready to become operational (except for pre-implementation education)
- Finalize the content of the protocol based on field testing experience
- Request formal sign off on Letter of Agreement by CEOs and Chiefs of Staff
  - The Letter of agreement will permit changes to the protocol to be made without having to get the agreement re-signed
- Conduct information sessions on the protocol focusing on operational roles and responsibilities

#### **4. May 2010**

- Launch the protocol
- Closely monitor during first 30 days of launch when operational and adoption issues are most likely to arise

#### **5. June 2010**

- Review and assess program operations
- Make changes as necessary

#### **6. September and December 2010**

- Three and six month evaluation

## **What difference will the Regional Patient Access & Flow Project make?**

- There is currently no standardized process to guide the patient transfer and repatriation process other than CritiCall. This proposed process will improve the CritiCall process and develop a new one for urgent care patients that currently does not exist.
- The protocol asks each hospital to establish (if it does not have one already) a centralized “One Number to Call” as the point of contact. "One Number" refers to the phone number or department or person that is consistently able to respond to calls, knows the current bed situation, and knows how to connect the incoming request with the consulting or specialist physician.
  - The intent behind introducing a “One Number” is to expedite physician contacts, ensure the referral decision includes the most current information on service and bed availability, and expedite the follow-up logistics and communications required once the decision to transfer the patient has been made.
- Emergent/urgent patients will not be transferred unless a most responsible physician has been identified. This includes patients who, under this protocol, are transferred for diagnostic services only at the outset.
- Patients who are transferred who do not need to be admitted will be returned to the referring hospital the same day. Until a patient is accepted for admission at the receiving hospital, the patient will remain the responsibility of the sending physician.
- Patients who are transferred who do not need to be admitted will be returned to the referring hospital as soon as possible and appropriate.
- Patients who are assessed as being ready for repatriation will be accepted back by the referring hospital at the first available opportunity, assuming that the hospital has the acute care services required by the patient.
- At LHSC, the physicians receiving the call will be a consulting physician on call or a senior resident in situations where this has been determined to be appropriate. A key factor is that the LHSC physician who talks to the referring physician is able to make a Yes/No decision.
- Patients who are critically ill and require transfer within four hours will be transferred to the most appropriate facility as quickly as possible.
- Referring hospitals will be expected to take another patient back if the specialized hospital can only accept an emergent/urgent care patient under these circumstances.
- Hospitals that transfer patients will be expected to send patients to the nearest appropriate level of care (secondary or tertiary) and to accept patients back as quickly as possible to ensure secondary care hospitals maintain the capacity to serve secondary care patients, and tertiary care hospitals maintain the capacity to serve tertiary care patients.

## **What will stay the same after the Regional Patient Access & Flow Project has been implemented?**

- Physicians will continue to be the key clinical decision-makers concerning the acceptance of patients who will be provided care under their direction.
- CritiCall will be the first point of contact for hospitals needing to transfer emergent care patients (including trauma and critical care).