Life or Limb Policy

Implementation Guide

Critical Care Services Ontario

CCSO Critical Care Services Ontario

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INTRODUCTION

PURPOSE OF IMPLEMENTATION GUIDE

There is no one-size-fits-all method for implementing the Life or Limb Policy. However, there should be a standard to which all clinicians and hospitals can practice to ensure these patients have timely access to care. This guide is intended as a starting point to facilitate implementation of the Life or Limb Policy at hospitals across Ontario. This guide provides an overview of change management frameworks, communication and engagement strategies, and tools to support hospitals with the implementation process.

This implementation guide will be of value to the following:

- Local Health Integration Networks (LHINs)
- Hospital Administrative Leaders
- Hospital Clinical Leaders
- Critical Care Physicians, Nurses and Staff
- Emergency Department Physicians, Nurses and Staff
- Patient Access and Flow Department
- Emergency Medical Service Providers

The Life or Limb Policy is available online at the Ministry of Health and Long-Term Care (MOHLTC) website at: http://www.health.gov.on.ca/en/pro/programs/criticalcare/life.aspx.

POLICY STATEMENT

Patients with life or limb threatening conditions will receive timely medical consultation, and if necessary, will be transferred to a hospital that can provide the clinical services required within a best effort window of 4 hours. For clinical conditions with existing procedures for medical consultation, patient transfer and/or repatriation, established processes and timelines must be adhered to.

OBJECTIVE

To enable the development of standardized procedures for all health care providers within and across LHINs to ensure that patients with life or limb threatening conditions receive timely and appropriate care.

CHANGE MANAGEMENT FRAMEWORKS

This section provides an overview of relevant, evidence-informed approaches to support change in health care systems. The purpose of this section is to demonstrate examples of change management concepts, which may be useful for adopting the Life or Limb Policy within your organization. It is necessary to choose an approach that is useful and applicable within a particular environment, and can be adapted to address situational needs. A multi-method approach may prove most suitable for managing the dynamics of a change process.

Phase: Getting Ready for Change

Category	Purpose	Examples
Understanding the context and dynamics of change	Approaches included in this category can be used to conceptualize and understand the context of a change initiative and the dynamics of the change process	▪ Complex Adaptive Systems Approach ▪ LEADS Model ▪ Institute of Healthcare Improvement Models ▪ Bridges Model
Determining readiness and/or capacity for change	Approaches included in this category can be used to assess the readiness of people situated in different levels of their organization or broader health system to be receptive to, and engaged in, implementing a change initiative	▪ Change-Related Commitment Measure ▪ Readiness for Change Instrument ▪ Klarner Model

Reference: Canadian Health Services Research Foundation (2012). *Evidence-informed change management in Canadian healthcare organizations*. Ottawa, ON: Dickson, G., Lindstrom, R., Black, C., & Van der Gucht, D.

Phase: Implementing Change

Category	Purpose	Examples
Setting direction to improve effectiveness (i.e. safety, quality)	Approaches included in this category can be used as a specific lens through which an organizational change initiative can be developed, conducted, and evaluated	▪ PDSA Cycles ▪ Institute of Healthcare Improvement Rapid Cycle ▪ QUERI ▪ Donabedian Quality Assurance Model
Setting direction to improve efficiency, accountability and sustainability	Approaches included in this category can be used as a specific lens through which an organizational change initiative can be developed, conducted, and evaluated	▪ Kotter Model ▪ Process Mapping ▪ LEAN ▪ CANDO ▪ Balanced Scorecard

Reference: Canadian Health Services Research Foundation (2012). *Evidence-informed change management in Canadian healthcare organizations*. Ottawa, ON: Dickson, G., Lindstrom, R., Black, C., & Van der Gucht, D.

Phase: Spreading Change

Category	Purpose	Examples
Strategies and tactics to spread change across large systems	This category can be used by health care administrators, and providers to identify those approaches that have been proven to work and adopt such practices to their own organizations	▪ Complex Adaptive Systems Approaches ▪ Institute of Healthcare Improvement Framework for Spread ▪ QUERI

Reference: Canadian Health Services Research Foundation (2012). *Evidence-informed change management in Canadian healthcare organizations*. Ottawa, ON: Dickson, G., Lindstrom, R., Black, C., & Van der Gucht, D.

Phase: Sustaining Change

Category	Purpose	Examples
Monitoring and assessing change effectiveness	Approaches in this category can be used to assess the effectiveness of change initiatives and to execute the necessary adjustments	▪ Balanced Scorecard ▪ Institute of Healthcare Improvement Triple Aim ▪ Baldridge

Reference: Canadian Health Services Research Foundation (2012). *Evidence-informed change management in Canadian healthcare organizations*. Ottawa, ON: Dickson, G., Lindstrom, R., Black, C., & Van der Gucht, D.

For further information on the above-listed approaches, see Appendix A: Evidence-Informed Approaches to Change in the Health System.

COMMUNICATION AND ENGAGEMENT

Effective implementation of the Life or Limb Policy requires a cultural shift in the perceptions of "limited resources" by clinicians and hospitals and how these are applied when faced with a request to assist with a patient in a life or limb threatening scenario. For example, frequently it has been experienced that a patient will be deferred access because of the perception of "no bed". Deploying patient flow strategies, the Critical Care Surge Capacity Management Plan and involving administrators capable of making bed resource decisions can often result in the creation of an appropriate environment into which the care of a patient can be arranged.

COMMUNICATION CHECKLIST

Promoting multi-stakeholder and multi-level participation is an effective strategy for inclusive and collaborative dialogue on how to implement the Life or Limb Policy. The list below provides examples of the stakeholders to communicate to about the Life or Limb Policy (Note: This list should be adapted to suit hospital environment and needs):

- Life or Limb Policy LHIN Representatives
- Hospital Board of Directors
- Hospital Chief Executive Officers
- Corporate Communications
- Administrative and Clinical Leaders
- Medical Advisory Committee
- Medical Chiefs of Staff
- Surgical Department Chairs
- Medical Directors of Critical Care Departments
- Medical Directors of Emergency Departments
- Critical Care Physicians, Nurses and Staff
- Emergency Department Physicians, Nurses and Staff
- Charge Nurse(s) of Critical Care Department(s)
- Charge Nurse(s) of Emergency Department
- Patient Access and Flow Department
- Coordinators of Patient Access and Flow
- Admitting Department Staff
- Repatriation Coordinators
- Bed Management Clerks
- Information Technology Representatives
- Telecommunication Representatives
- Emergency Medical Services

COMMUNICATION PLAN

It is recommended that hospitals develop a communication plan that identifies the topics that will be discussed during stakeholder meetings to ensure that appropriate messages are conveyed. The concerns of administrative staff may differ from those of health care providers, thus the communication plan should consider the needs of the audience, in addition to the outcomes desired following each meeting. It may be useful to also communicate the changes to administrative processes and clinical practice due to the introduction of the Life or Limb Policy. Listed below are examples of the topics to discuss with stakeholders, key messages to share with each stakeholder group, as well as a summary of key changes.
Examples of topics for discussion include:

- Objective of the Life or Limb Policy
- Intended Outcomes of the Life or Limb Policy
- Implications for Patient Care
- Accountabilities
- Roles and Responsibilities
- Communication Channels
- Review of Critical Care Surge Capacity Management Plan/ Existing Bed Capacity Management Protocols

- Integration of Life or Limb Policy into existing Bed Capacity Management Protocols to Ensure Alignment of Practice and Priorities
- Reporting and Monitoring of the Life or Limb Policy
- Challenges Related to Adopting Life or Limb Policy
- Strategies to Mitigate Challenges/ Support Implementation

Key Messages for LHIN Administrators

- Life or Limb Policy has been developed at the request of the MOHLTC in response to recommendations from the Office of the Chief Coroner for a provincial "no refusal" policy when critical injuries or conditions of life or limb are involved
- Implementation of the Life or Limb Policy will strengthen accountability for hospitals to provide care to patients who are life or limb threatened based on the clinical services available at their hospital
- Preparing for the implementation of the Life or Limb Policy will highlight where additional system planning is required at the LHIN level in order to improve coordination among hospitals, and patient flow
- Implementation of the Life or Limb Policy will facilitate collection of data related to where the most critically ill are being referred to and from, and will highlight opportunities for where system improvements can be made

Key Messages for Hospital Administrators

- Life or Limb Policy promotes a philosophy of care for our sickest, most vulnerable critically ill patients
- Cultural shift within hospitals will be facilitated through the recognition of a patient's clinical condition as a priority and identification of beds as a secondary consideration
- Hospitals will retain autonomy when determining whether a patient can or should be accepted for care. It is expected that hospitals with the clinical services and capabilities to provide care to patients will do so accordingly
- Implementation of Life or Limb Policy will improve hospital communication and coordination through standardization of processes both within and across LHINs
- Reports generated by CritiCall Ontario regarding the Life or Limb Policy will highlight where challenges arise in accessing acute care services, and areas for improvement

Key Messages for Physicians

- Patients with life or limb threatening conditions will receive medical consultation, and if necessary, will be transferred to an appropriate point of care within a best effort window of 4 hours
- Implementation of the Life or Limb Policy will support hospitals that are not able to care for the critically ill due to the nature of the care the patient requires and/or the complexity and severity of their condition
- CritiCall Ontario is a resource for facilitating timely access to medical consultation and/or patient transfer to an appropriate point of care. It is essential to use CritiCall Ontario to expedite communication between referring physician and most appropriate consulting physician/service, and also to respond to CritiCall Ontario within 10 minutes regarding a provisional life or limb case
- Repatriation is essential to ensuring that patients with life or limb threatening conditions continue to have access to centers with higher levels of care. Patients deemed medically stable and suitable for transfer will be repatriated within 48 hours to the referring hospital (or closest to home hospital that can provide the clinical services required)

What will change?

- Life or Limb Policy applies to all hospitals in Ontario

- Life or Limb Policy and related responsibilities will be incorporated into hospital policies and procedures

- If a hospital does not have the clinical services required to care for a patient with a life or limb threatening condition and therapeutic options exist, which are needed within 4 hours CritiCall Ontario is contacted to facilitate access to medical consultation and/or patient transfer to an appropriate point of care

- Hospitals will develop a process for paging physicians that will identify provisional life or limb pages separately from other pages and informs the physician to contact CritiCall Ontario directly

- Physicians contacted by CritiCall Ontario regarding a provisional life or limb case will respond to pages from CritiCall Ontario within 10 minutes

- The referring and consulting physicians discuss if the patient is life or limb threatened, with the final triage decision determined by the consulting physician

- Once patients are deemed medically stable and suitable for transfer, irrespective of if they are life or limb cases, they will be repatriated within a best effort window of 48 hours to the referring hospital (or closest to home hospital that can provide the clinical services required)

- Hospitals will utilize CritiCall Ontario's Repatriation Tool to track and monitor repatriation processes

- CritiCall Ontario's Weekly Life or Limb Hospital and System Response Report and CritiCall Ontario's Life or Limb Monthly Summary Data Report will be circulated to stakeholders and provides a mechanism to monitor performance of the Life or Limb Policy

- Following circulation of CritiCall Ontario's Weekly Life or Limb Hospital and System Response Report and CritiCall Ontario's Monthly Life or Limb Summary Data Report, the Data Review and Feedback Mechanism is used (and adapted to suit hospital/LHIN processes)

- CritiCall Ontario will refer to the Case Facilitation Algorithm (See Appendix B) for instances where there are disagreements between the referring and consulting physicians, or when medical consultation or transfer is not readily available at the hospital with the clinical services required

The table below provides an overview of communication styles and methods that can be used to communicate with stakeholders depending on the purpose of the meeting, and outcome desired. Each level of communication describes its own outcomes, with the culmination of all five levels, defining excellent stakeholder communication. The important step is developing relationships with the administrative staff and health care providers whose practice will be impacted by, and whose role will support adoption of the Life or Limb Policy.

Level of Outcome	Style	Media, Vehicles	Reaction when Achieved
Information Sharing	Telling; one Way	Lecture, presentation, memo, video	"Thank you for telling me this information."
Building Understanding	Dialogue; two-way; exploring and answering listener-generated questions	Small group meeting; breakouts to develop questions; facilitated Q&A; blogs	"Having explored my concerns and tested this, now I understand the focus of the change and why it is needed."
Identifying Implications	introspection; discussing with co-workers what this means to you and the organization; multi-directional	Group interactive discussions ranging from multi-level, large or small groups to individual team discussions; most relevant exploration done with work team and immediate supervisor; open Web-based discussion boards	"I get it! This change means X for my department and Z for me and my job."
Gaining Commitment	Sorting out inner feelings and choices	Alone time for personal introspection or "talk time" with trusted colleagues; opportunity to re-address issues with co-workers, direct supervisor and/or sponsor of the change	"I personally want this change to succeed, and I am willing to ensure that it does. I see that my boss and our organizational leaders feel the same way."
Altering Behavior	Demonstrating new behavior; may require training, feedback mechanisms, and coaching over time to ensure that the behaviors stick	Training, coaching relationships; opportunities for practice and learning	"I am learning the new behaviors and skills required for this change to succeed and I'm open to receiving your feedback and coaching to keep improving."

Reference: Ackerman Anderson, L., & Anderson, D. (2010). *Change Leader's Roadmap: How to Navigate your Organization's Transformation.* San Francisco, CA: Pfeiffer.

ENGAGEMENT STRATEGIES

The implementation of the Life or Limb Policy will be a gradual process, but with strong administrative and clinical leadership, consistent messaging regarding the objectives of the Life or Limb Policy and implications for patient care, and engagement of relevant stakeholders, changes to administrative processes and behaviour can result. In the context of the Life or Limb Policy, the purpose of engagement is not only to communicate to stakeholders, but to provide an opportunity to understand the needs and concerns of stakeholders and use the input received to inform subsequent implementation activities and phases. Communicating and engaging stakeholders as early on as possible will lead to a shared understanding of the purpose of the Life or Limb Policy, and expected behavioural changes. Described below are examples of how to engage stakeholders in order to support implementation of the Life or Limb Policy.

- Consider establishing a dedicated project team that will provide leadership and will support implementation of the Life or Limb Policy at the hospital level. Examples of key stakeholders to include on the project team include: Vice President of Clinical Services (or related role), Medical Chiefs of Staff, Medical Directors of Critical Care Department, Medical Director of Emergency Department, representatives from Patient Access and Flow Department, and Repatriation Coordinators. This group will be instrumental to:
    - Supporting formal adoption of the Life or Limb Policy into hospital policies and procedures
    - Outlining the roles and responsibilities of hospital administrators and clinicians
    - Identifying educational gaps within the hospital as related to the Life or Limb Policy
    - Providing education/ ongoing education sessions to administrators and clinicians
    - Reviewing CritiCall Ontario's Weekly Life or Limb Hospital and System Response Report and CritiCall Ontario's Monthly Life or Limb Summary Data Report
    - Integrating the Data Review and Feedback Mechanism into routine procedures to establish a process for ongoing review of data received, and to identify opportunities for process improvement and/or further education
    - Developing a sustainability plan for the Life or Limb Policy

- Organize joint meetings with senior hospital administrators and clinical leaders to discuss inclusion of the Life or Limb Policy into hospital policies and procedures. Meetings with senior hospital administrators and clinical leaders also provides an opportunity to review existing Critical Care Surge Capacity Management Plans and Bed Capacity Management Protocols to ensure there is a current plan for managing resources to accommodate for life or limb threatened patients.

- Operationalization of the Life or Limb Policy requires engagement and buy-in from administrators, clinicians, and physicians in particular. One approach for engaging physicians is for the Critical Care LHIN Leader and Emergency Department LHIN Leader to meet with critical care and emergency department physicians to introduce the Life or Limb Policy, provide clarification on what is a life or limb patient, and discuss implications for practice. This will provide an opportunity to communicate directly with physicians in order to avoid misinterpretation and to provide clarity on the purpose of the Life or Limb Policy. In addition to face-to-face meetings, listed below are suggestions for engaging all physicians impacted by this change:
    - Presentations at Medical Advisory Committee
    - Presentations at Post-Graduate Education Group
    - Presentations at Resident or Physician Education Event or Grand Rounds
    - Medical Affairs Website and E-mail Distribution List
    - On-Line Education Forums
    - Posters on Life or Limb Policy in Call Rooms
    - Access to Life or Limb Policy Diagnosis List on Desktop Computers in the Intensive Care Unit and Emergency Department
    - Resident Handbook
    - Include as Agenda Item for Orientation Day

- Organize meetings with the physicians, nurses and unit manager/clinical leader working in the sub-specialty areas that may refer or accept life or limb patients in order to introduce and discuss the objectives of the Life or Limb Policy, and implications for practice. Use this opportunity to share the Life or Limb Policy Diagnosis List (Included in the Tools Section of Life or Limb Policy Implementation Guide), and discuss the specific diagnosis that can be cared for by each sub-specialty area. Forward this updated hospital services inventory, which is based on the Life or Limb Policy Diagnosis List (See Appendix C for Template) to CritiCall Ontario. Reviewing the Life or Limb Policy Diagnosis List and providing an update to include detail on which diagnosis can be cared for by each sub-specialty area will improve communication between CritiCall Ontario and hospitals, as CritiCall Ontario will be aware of the services available at the hospital, the life or limb threatening conditions that can be cared for, and level of coverage (24/7, 5-days per week, etc.). A robust hospital services inventory will contribute to streamlining patient referrals and transfers, and will help to ensure that hospitals provide care to patients based on the clinical services available.

- Establish relationships with your regional hospital partners to discuss operational logistics associated with life or limb calls or to discuss where further system planning is required. This in turn will enhance coordination among hospitals, and will foster effective dialogue when more complex issues arise. Examples of system level topics that will support the effective implementation of the Life or Limb Policy includes but is not limited to:
    - Utilization of CritiCall Ontario
    - Ensuring that LHIN geographic boundaries will not limit a patient's access to appropriate care
    - Establishing referral patterns for clinical services
    - Organizing physician coverage for clinical services offered within the LHIN
    - Developing repatriation agreements/processes, where necessary, with the aim of repatriation within a best effort window of 48 hours

PROVINCIAL HOSPITAL RESOURCE SYSTEM

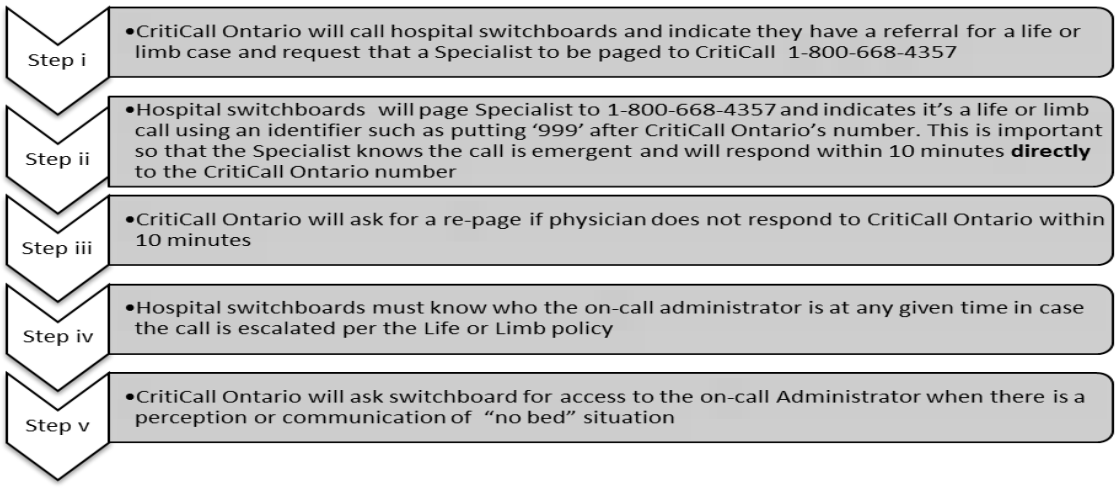
The Provincial Hospital Resource System (PHRS) is a web-based system available to all Ontario hospitals at https://www.phrs.criticall.org or through the CritiCall Ontario web site www.criticall.org . This is an updated and enhanced version of the former Provincial Bed Registry. The PHRS has several functions:

- Provides up-to-date information on bed and resource availability within the province
- Assists with facilitation of emergent and urgent cases by CritiCall Ontario. Critical care bed information is automatically available through an interface with the Critical Care Information System (CCIS). Non critical care bed information is provided by hospitals each day
- Supports deployment/decanting of patients during Critical Care Moderate Surge events or hospital disaster situations such as Code Orange (large influx of patients) or Code Green (evacuation)
- Allows hospitals to view the availability of beds for direct referrals
- Maintains the inventory of hospital services and resources for the province. The PHRS is formally updated yearly and as required as CritiCall Ontario is made aware of changes to provincial hospital service availability

ROLE OF CRITICALL ONTARIO

- Facilitates consultation and referral for life or limb (care required within 4 hours) and urgent (care required within 4-24 hours) cases. Calls for non-urgent cases, follow up appointments, radiological scans, etc., are not facilitated through this process
- Follows referral maps as determined by the provincial specialty groups, and inter-hospital agreements
- Requires that a physician or clinical delegate (Registered Nurse, Physician Assistant) provide the initial information describing the clinical condition of the patient and to declare whether the case is deemed to be 'Life or Limb'
- CritiCall Ontario Call Agents will not relay in-depth clinical detail to physicians, their designate or hospital switchboards
- Will contact the referring physician when the Specialist calls into CritiCall Ontario and is available to provide consultation
- Specialist consultations will be provided to the referring physician
- Will document only those cases that are facilitated by the CritiCall Ontario call agents using the standard operating procedures
- Relies on hospital switchboards to have correct physician on-call information and physician contact information.

SWITCHBOARD PROCESSES



PATIENT REFERRAL PROCESS

i Referring physician contacts CritiCall Ontario at 1-800-668-HELP (4357) and identifies a provisional life or limb diagnosis
ii CritiCall Ontario facilitates consultation with the specialist who is on-call at the closest, most appropriate institution
iii The referring and consulting physicians discuss if the patient is life or limb threatened, with the final triage decision (e.g. medical consultation only, no transfer required, appropriate for urgent transfer) determined by the consulting physician
iv If it is determined that patient transfer is required within 4 hours, the transfer will not be delayed due to bed capacity
v If an intensive care bed is required, and an intensivist has not been contacted, he/she should be patched into the call at this stage
vi Hospitals will implement their Critical Care Surge Capacity Management Plan to facilitate appropriate capacity and timely transfer

PATIENT TRANSFER PROCESS

i. Referring hospital will be responsible for making the arrangements for patient transfer. If the referring hospital confirms that air ambulance transport is necessary while on the line with CritiCall Ontario, CritiCall Ontario will connect the referring hospital directly with the Ornge Communication Centre
ii. Subject to the *Personal Health Information Protection Act,* 2004, all records must accompany the patient at time of transfer, including a transfer note detailing patient name, age, history, diagnosis, relevant investigations, treatment summary and receiving hospital
iii. If the patient cannot be transferred to a suitable point of care within Ontario, CritiCall Ontario has the authority to arrange a transfer to an out of country (OOC) facility as per the MOHLTC OOC Prior Approval Program (OOC PA Program). CritiCall Ontario will find an available bed and a physician to accept the patient and the referring hospital is responsible for making the OOC transportation arrangements. The referring physician is required to submit a prior approval application, as soon as possible to the MOHLTC on behalf of the patient

REPATRIATION PROCESS

i. All patients, irrespective of if they are life or limb cases, will be returned to the referring hospital within 48 hours once deemed medically stable and suitable for transfer. If the referring hospital cannot provide the patient with the clinical services required or is not in the LHIN geographic area where the patient resides, the patient will be sent to the hospital closest to the patient's home that can provide the clinical services required
ii. For clinical conditions with existing repatriation agreements, established processes and timelines must be adhered to
iii. Hospitals must utilize CritiCall Ontario's Repatriation Tool (please note CritiCall Ontario's Repatriation Tool does not replace the need for hospitals to verbally confirm repatriation acceptances and transfer arrangements)
iv. All repatriations must follow direct physician-to-physician conversation
v. Transport for repatriating patients will be arranged by the sending hospital
vi. CritiCall Ontario will facilitate repatriation for those patients with life or limb conditions transferred OOC by CritiCall Ontario

LIFE OR LIMB POLICY DIAGNOSES LIST

The Life or Limb Policy Diagnoses List is intended as a tool for CritiCall Ontario to facilitate medical consultation for patients who are life or limb threatened (require acute care services ≤ 4 hours). The Life or Limb Policy Diagnoses List is not a comprehensive list of all medical conditions that are considered life or limb threatening. This tool is not meant to replace the clinical judgment of physicians involved in managing life or limb cases. Triage decisions shall be based on patient condition, severity and progression.

CARDIOLOGY/CARDIAC SURGERY/VASCULAR SURGERY

Abdominal Aortic Dissection/Rupture
Acute Limb Ischemia
Ascending Aortic Dissection/Rupture
Cardiogenic Shock or Acute Valvular Problems, Mechanical Complications of Myocardial Infarction and Intra-Aortic Balloon Pump
Cardiology for Pacemakers (Temporary and Permanent)
Endocarditis Requiring Urgent Cardiac Intervention
Pericardial Tamponade with Cardiovascular Compromise
Post Heart Transplantation with Suspected Rejection
Refractory Cardiac Arrythmias (Including Repetitive Firing of Implanted Cardiac Defibrillator) or Symptomatic Heart Block
Thoracic Aortic Dissection/Rupture
Unstable Acute Coronary Syndrome Requiring Urgent Angiography and/or Intervention (Primary/Rescue Percutaneous Coronary Imaging or Surgery)
Unstable Complex Congenital Heart Disease
Vascular Trauma (e.g., Mangled Extremity, Blunt Thoracic Aortic Injury)

ENDOCRINOLOGY

Adrenal Crisis
Diabetic Ketoacidosis
Hyperglycemic Coma
Hypoglycemic Coma
Myxedema Coma
Pituitary Apoplexy

GASTROENTEROLOGY

Esophageal Perforation
Fulminant Hepatic Failure
Gastrointestinal Bleed with Refractory Shock
Toxic Mega Colon with Shock

GENERAL SURGERY

Gastrointestinal Bleed with Refractory Shock
Ischemic Bowel
Multiorgan Failure with Refractory Shock
Severe Pancreatitis with or without Shock
Perforated Viscus/Septic Shock
Toxic Colitis with Shock
Wound Dehiscence/Evisceration

HEMATOLOGY

Acute Leukemia
Disseminated Intravascular Coagulation with Thrombosis or Bleeding
Graft vs. Host Disease
Severe Hemophilia with Associated Bleeding
Urgent Leukapharesis
Urgent Red Cell Exchange (Sickle Cell Crisis, Malaria)

NEPHROLOGY

Acute Emergency Dialysis
Urgent Plasma Exchange (Thrombotic Thrombocytopenic Purpura, Hemolytic-Uremic Syndrome)

NEUROSURGERY/NEUROLOGY

Acute Spinal Cord Compression
Acute Stroke Requiring Thrombolysis
Cervical Spine Fracture
Guillain Barre / Myasthenic Crisis
Head Trauma Requiring Neurosurgical Intervention or Monitoring
Intracerebral Hemorrhage Subarachnoid Hemorrhage
Meningitis with Altered Level of Consciousness
Status Epilepticus
Stroke – non Tissue Plasminogen Activator Posterior Fossa/Brainstem

OBSTETRICS/GYNAECOLOGY

Acute Vaginal Bleeding with Shock
Anticipated Severe Shoulder Dystocia
Amniotic Fluid Embolism
Early Pregnancy, Severe Vaginal Bleeding and Hemorrhage
Early Pregnancy, Suspect Ectopic with Shock, Intra-Abdominal Hemorrhage
Fetal Distress
Intraperitoneal Hemorrhage
Maternal Cardiac Arrythmias in Labour
Multiple Gestation Requiring Emergency Obstetric/Paediatric Management
Obstructed Labour
Pelvic Inflammatory Disease with Shock and/or Disseminated Intravascular Coagulation
Post-Operative Intra-Abdominal Hemorrhage and Shock
Pre-Term Labour
Pre-Term Premature Rupture of Membranes
Severe Gestational Hypertension
Severe Postpartum Hemorrhage
Severe Antepartum Hemorrhage
Ovarian Torsion
Uterine Rupture
Umbilical Cord Prolapse

OPHTHALMOLOGY

Acute Orbital Hypertension/Glaucoma
Endopthalmitis
Severe Orbital Cellulitis
Ruptured Globe
Vision Threatening Conditions – Orbital Abscess, Orbital Hematoma, Optic Nerve Compression

ORTHOPEDICS

Compartment Syndrome
Compound Fractures
Femoral Neck in Patients Younger than 65 Years of Age
Fractures/Dislocation with Vascular Injury
Irreduceable Major Joint Dislocation (Non-Prosthetic Joint)
Major Pelvic/Acetabular Fractures
Multiple Large Bone Fractures

OTOLARYNGOLOGY

Acute Airway Obstruction
Epiglottitis
Esophageal Foreign Bodies
Major Bleeding: Neck Hematoma, Massive Hemoptysis/Hematesis
Mastoditis or Sinusitis with Central Nervous System Complications
Necrotizing Infections
Severe Neck Trauma/ Laryngeal Fracture

PLASTICS

Amputation of Extremity for Re-Implantation/Revascularization
Compound Fractures of the Hand
Major Burns
Necrotizing Soft Tissue Infections

RESPIROLOGY

Unstable Pulmonary Embolism Causing Shock and/or Respiratory Failure
Right Heart Failure with Shock
Respiratory Failure with Need of Invasive or Non-Invasive Mechanical Ventilation
Severe Cystic Fibrosis

SPINE

Acute Deteriorating Cauda Equine Syndrome
Acute Deteriorating Spinal Cord Function
Spinal Cord Injury
Unstable Spinal Injury

THORACIC SURGERY

Intrathoracic Airway Obstruction
Issues Related to Lung Transplant
Massive Hemoptysis
Massive Hemothorax
Ruptured Bronchus or Trachea
Ruptured Esophagus
Strangulated Diaphragmatic Hernia

UROLOGY

Acute Priapism
Necrotizing Scrotal Infection/Fornier's Gangrene
Obstructive Uropathy
Renal Infection with Vascular Impairment
Renal Trauma with Hemodynamic Instability
Testicular Torsion

HOSPITAL READINESS ASSESSMENT

Transformational change is about changing workflow and practice. This level of system change requires a high degree of engagement and open communication systems in order to implement and course correct as the change evolves. Once the change is implemented new information will become evident that will require ongoing consultation and dialogue to manage and resolve. It is useful to capture your lessons learned as you refine the process to fit with your hospital and culture. The template below can be used as a tool to identify your hospital's readiness for change.

Readiness Assessment

_____*Physician*_____ Top Risks

Risk	Mitigation Plans	Trigger	Contingency Plans
Ex. *On-Call Hospital Physician does not handle Life or Limb calls in a consistent manner resulting in unclear expectations for call takers and referring physicians*	Ex. *Physician protocol developed for key services (eg Out of LHIN referrals) with physician input.* *Physician training and standardized script to guide discussion and decisions*	*Ex.* *Feedback from internal call takers* *Feedback from Referring Hospitals/physicians* *Feedback from CritiCall Ontario*	*Ex.* *Monitor and discuss at weekly debriefs* *Life or Limb Physician Site Champion to follow up with physicians to discuss/influence based on feedback and data received*

CONDITIONS FOR SUCCESSFUL CHANGE

- Management and workforce share a common understanding and vision for change
- Good change governance is set up from the beginning
- Clear change leadership roles, structures and decision making
- Change effort tied to operations where leadership roles and accountabilities are defined
- Enterprise change agenda where there is a common methodology and infrastructure to execute change
- Accurate diagnosis of scope and magnitude of change required, including people and culture changes
- Multiple project integration
- Adequate capacity for change
- Leaders modeling the way
- Adequately engaging and communicating to stakeholders

CritiCall Ontario's Repatriation Tool

The Repatriation tool does not replace the need for physician dialogue and formal acceptance of a patient transfer.
CritiCall Ontario will provide access to the Repatriation Tool section of the PHRS once there are hospital agreements/commitments in place to ensure that both requesting and receiving hospitals are using the same method to communicate. The tool is currently available only for acute to acute hospital transfers.

The Repatriation Tool was developed to:

- Assist hospitals, LHINs and the MOHLTC to track the volume of patients being repatriated and the barriers to the efficient movement of patients
- Improve the efficiency of repatriation communications

The Repatriation Tool:

- Provides electronic ticketing of repatriation requests
- Allows hospitals to approach multiple sites with specific patient requirements
- Allows hospitals to receive requests, including details related to the patient's care requirements, and electronically signal their ability to accept or decline the request
- Tracks the reasons related to declines and the time to get an acceptance
- Provides summary reports on repatriation activity so that hospitals can work together to address any identified challenges

REPORTING AND MONITORING

The reporting and monitoring process provides an opportunity to review life or limb cases in order to identify system gaps and opportunities to improve access to acute care services. In the context of the Life or Limb Policy, cases requiring follow-up are characterized by system inefficiencies that permit delays in access to acute care services.

The reporting and monitoring process will be informed by the following sources:

- CritiCall Ontario's Case Records
- CritiCall Ontario's Weekly Life or Limb Hospital and System Response Report
- CritiCall Ontario's Monthly Life or Limb Summary Data Report

Outlined below are the Data Review and Feedback Mechanisms for addressing scenarios where there are delays in access to acute care services. Hospitals are encouraged to build on this framework to establish a process for ongoing review of data received in order to monitor hospital performance as related to the Life or Limb Policy, and to identify opportunities for process improvement and/or further education.

Scenario	Source	Process
Cases in which CritiCall Ontario contacts more than one hospital with the clinical services available to provide care to patients with life or limb threatening conditions	CritiCall Ontario's Case Records	i. CritiCall Ontario's Medical Director will follow-up with the Chief of Staff at the involved hospital(s) within two business days to discuss the life or limb case and barriers to care. Critical Care Services Ontario and the Critical Care LHIN Leader(s) from the involved LHIN(s) will be copied on this communication ii. Chief of Staff is required to follow-up with the involved physician(s) within their hospital to discuss the life or limb case, course of action, and areas for improvement iii. Chief of Staff will submit a response summarizing the outcomes of the follow-up to CritiCall Ontario's Medical Director and the Critical Care LHIN Leader within five business days

Scenario	Source	Process
Delays in access to acute care services (Greater than 4 hours) System inefficiencies that unnecessarily prolong access to acute care services (Within 4 hours)	CritiCall Ontario's Weekly Life or Limb Hospital and System Response Report	i. Weekly Life or Limb Hospital and System Response Report to: Critical Care Services Ontario, Critical Care LHIN Leader, Emergency Department LHIN Leader (for each LHIN), Hospital Chief Executive Officer, Vice President of Clinical Services (or equivalent) and Chief of Staff at the involved hospital(s)

Scenario	Source	Process
Ongoing system challenges related to the implementation of Life or Limb Policy	CritiCall Ontario's Monthly Life or Limb Summary Data Report	i. Life or Limb Summary Data Report to: Critical Care Services Ontario, LHIN Chief Executive Officer, Life or Limb Policy LHIN Representative, Critical Care LHIN Leader, Emergency Department LHIN Leader (for each LHIN) and Hospital Chief Executive Officer ii. Life or Limb Policy LHIN Representative is required to review Life or Limb Summary Data Report to monitor hospital responsibility as detailed in the Life or Limb Policy iii. Life or Limb Policy LHIN Representative will meet with Critical Care LHIN Leader and Emergency Department LHIN Leader to discuss system challenges requiring further discussion with the LHIN Chief Executive Officer and when necessary, hospital Chief Executive Officer

Critical Care LHIN Leader
The Critical Care LHIN Leader is available as a resource for all centres during the planning and implementation phase. The Critical Care LHIN Leader will play a role in reviewing data on life or limb cases and providing feedback to hospitals as necessary. The Critical Care LHIN Leader in collaboration with the Emergency Department LHIN Leader and Life or Limb LHIN Representative are available to hospitals to address ongoing systems challenges as required.

Life or Limb Policy LHIN Representatives
The Life or Limb Policy LHIN Representatives will work closely with the Critical Care LHIN Leader and Emergency Department LHIN Leader to monitor adoption of the Life or Limb Policy by hospitals within their LHIN. The Life or Limb Policy LHIN Representative, with feedback from the Critical Care LHIN Leader and Emergency Department LHIN Leader, will identify ongoing system challenges requiring further discussion with LHIN and/or hospital senior administration.

CritiCall Ontario
CritiCall Ontario provides assess, education and technical support for the PHRS and the CCIS. Both systems provide up to date information regarding hospital resources and enable the CritiCall Ontario call centre to provide timely life or limb case referrals to the closest hospital site where the appropriate resources are available.

CritiCall Ontario Medical Directors
CritiCall Ontario Medical Directors are on call 24/7/365 to support the CritiCall Ontario call centre. In accordance with the Life or Limb Policy Case Facilitation Algorithm, the Medical Director will be contacted to assist when the referring and consulting physicians are unable to obtain consensus on the life or limb status of a case. The Medical Director will also be contacted to assist in cases where CritiCall Ontario contacts more than one hospital with the clinical services available to provide care to patients with life or limb threatening conditions.

CritiCall Ontario Client Relations Manager
CritiCall Ontario Client Relations Managers, in partnership with CritiCall Ontario Decision Support, will provide weekly and monthly LHIN specific Life or Limb case reports. The reports will contain data that is collected for all Life or Limb cases that are facilitated by the CritiCall Ontario call centre. The Life or Limb reports will support performance monitoring by hospitals, LHINs, Critical Care Services Ontario and the MOHLTC.

Critical Care Services Ontario
Critical Care Services Ontario is available to respond to questions regarding the development of the Life or Limb Policy, and related responsibilities and processes. Critical Care Services Ontario is also committed to working with health system partners to support communication and education, and the ongoing monitoring and measurement of the Life or Limb Policy.

REFERENCES

Ackerman Anderson, L., & Anderson, D. (2010). *Change Leader's Roadmap: How to Navigate your Organization's Transformation.* San Francisco, CA: Pfeiffer.

Canadian Health Services Research Foundation (2012). *Evidence-informed change management in Canadian healthcare organizations*. Ottawa, ON: Dickson, G., Lindstrom, R., Black, C., & Van der Gucht, D.

APPENDIX A: EVIDENCE-INFORMED APPROACHES TO CHANGE IN THE HEALTH SYSTEM

Approach	Type	Purpose
Balanced Scorecard	Tool	The Balanced Scorecard integrates measures derived from strategy so managers can guide an organization to achieve results under a balance of related management perspectives. The perspectives focus on achieving the vision of the organization. In its classic form, a Balanced Scorecard defines performance objectives under financial, customer, internal business processes and learning and growth perspectives.
Malcolm Baldridge Excellence Model for self-assessment	Criteria and Tool	The Baldridge Criteria for Performance Excellence provide the framework and an assessment tool for understanding organizational strengths and opportunities for improvement. Performance excellence refers to an integrated approach to organizational performance management that results in delivery of ever-improving value to customers and stakeholders, contributing to organizational sustainability; improvement of overall organizational effectiveness and capabilities, and organizational and personal learning.
Bridges Transition Model	Model	Bridges approach addresses the psychological transitions of the people impacted by the change It is a three-phase process of: (1) ending, losing, and letting go of previous processes; (2) getting through the neutral zone; and (3) accepting a new beginning.
CANDO	Model	CANDO is a disciplined, bottom-up approach to improving conditions in a work environment so as to improve and maintain high levels of safety.
Change-Related Commitment Measure	Instrument	Jansen (2004) developed a Change-Related Commitment measure consisting of eight items assessing organizational members' agreement and willingness to work toward the change goal. It can be used to assess readiness for change in a sample of organizational members.
Complex adaptive systems approach	Conceptual Process	A four-stage conceptual approach, employing a Complex Adaptive Systems (CAS) perspective, is based on the premise that in large systems, CAS is more applicable than the more linear approaches.

Reference: Canadian Health Services Research Foundation (2012). *Evidence-informed change management in Canadian healthcare organizations*. Ottawa, ON: Dickson, G., Lindstrom, R., Black, C., and Van der Gucht, D.

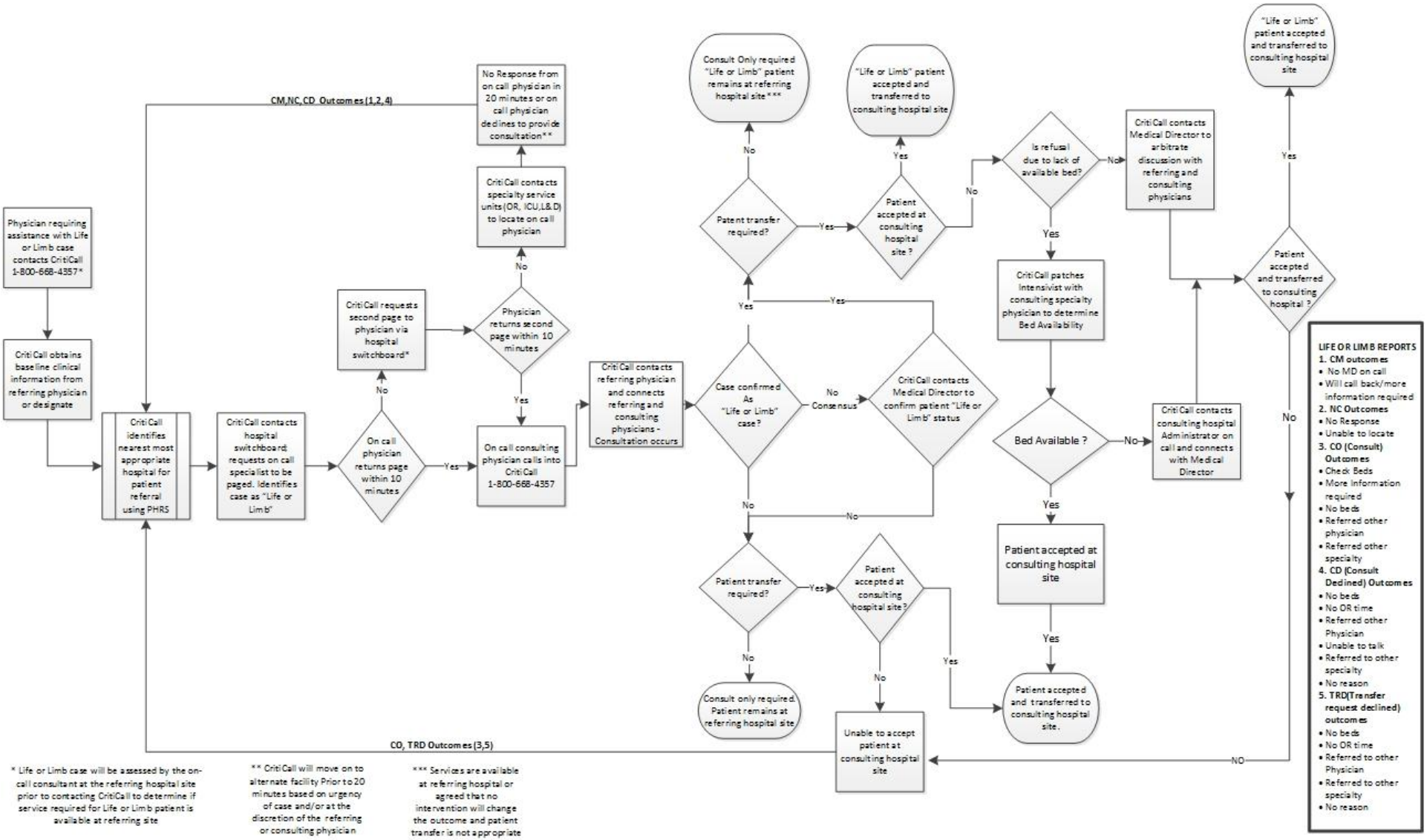
Approach	Type	Purpose
Donabedian's Quality Assurance Model	Model	Donabedian's three component (structure, process, and outcome) model is used for assessing safety and quality infrastructure. It can be adapted to assist in measuring whether or not the appropriate elements are in place to assure quality and/or safety.
IHI Framework for Leadership for Improvement	Model	Based on learnings from organizations, national initiatives, large-scale programs, fieldwork and interviews with healthcare clients and leaders outside of health care, IHI has developed a seven-factor framework for leadership of large scale quality improvement.
IHI framework for spread	Conceptual Process	IHI Framework for Spread identifies six components for planning and implementing spread. This framework suggests general areas that should be considered. Also included are 'checklists for spread' pertinent to leadership; knowledge transfer and communication; and measurement and knowledge management.
IHI rapid cycle Model for Improvement	Conceptual Process	The IHI Rapid Cycle Model for Improvement is a tool for accelerating improvement. The model is not meant to replace change models that organizations may already be using, but rather to accelerate improvement.
Klarner model	Assessment Tool	Klarner et al's (2007) instrument measures organizational capacity for change, based on a conceptual model for change that combines both the process and context determinants of change. An analysis of an organization's change capacity allows it to better deal with the determinants of change capacity, which increases adaptation and survival.
Kotter's 8 stages of change	Model	Kotter's model outlines eight critical components of generating transformation in organizations. These components take the manager through a disciplined process of initiating change, planning change, implementing change, and institutionalizing the change.

Reference: Canadian Health Services Research Foundation (2012). *Evidence-informed change management in Canadian healthcare organizations*. Ottawa, ON: Dickson, G., Lindstrom, R., Black, C., and Van der Gucht, D.

Approach	Type	Purpose
LEADS in a Caring Environment Framework	Model	LEADS is a model for change that takes the leader through a virtuous cycle of change based on the relationship between three primary components: clarity of intended results; relationship building; and understanding/executing change.
LEAN	Model/Technique	Lean is a core methodology for a total redesign of clinical health systems. Lean thinking brings together several strands of process improvement. Adaptations of Lean to many contexts and environments are popular in the Canadian health sector.
Lewin Model	Model	Kurt Lewin's change model is a simple three-step change model. The first step in the process of changing behavior is to unfreeze the existing situation. Only then can change, or movement, occur. Finally, to make the new behaviors stick, a third, refreezing step is necessary.
PDSA Cycle	Technique	This model tests ideas in rapid cycles for improving a component of the system, primarily related to quality and safety. The four steps are Plan the work; Do the work; Study whether the outcome was achieved, or not; Act on the change by adopting/adjusting as needed.
Process Mapping the Patient Journey	Technique	Process mapping is an explicit process that allows the provider to "see" and understand the patient's experience by separating the management of a specific condition or treatment into a series of consecutive events or steps (activities, interventions or staff interactions, for example).
QUERI Approach	Conceptual Process	The Quality Enhancement Research Initiative (QUERI) was designed to generate research-driven change initiatives that enhance health care quality. It is an evidence-based organizational framework focused on three contextual elements: re-orienting cultural norms and values; capacity building; and supportive infrastructures.
Readiness for Change Instrument	Instruments	Holt and colleagues (2007) developed a Readiness for Organizational Change Instrument. Herscovitch and Meyer (2002) developed a Commitment to Change measure.

Reference: Canadian Health Services Research Foundation (2012). *Evidence-informed change management in Canadian healthcare organizations*. Ottawa, ON: Dickson, G., Lindstrom, R., Black, C., and Van der Gucht, D.

APPENDIX B: LIFE OR LIMB POLICY CASE FACILITATION ALGORITHM



APPENDIX C: HOSPITAL SERVICES INVENTORY TEMPLATE BASED ON LIFE OR LIMB POLICY DIAGNOSES LIST

Local Health Integration Network:

	Hospital Name: Unit Name	Hospital Name: Unit Name	Hospital Name: Unit Name	Hospital Name: Unit Name
CARDIOLOGY/CARDIAC SURGERY/VASCULAR SURGERY				
Abdominal Aortic Dissection/Rupture				
Acute Limb Ischemia				
Ascending Aortic Dissection/Rupture				
Cardiogenic Shock or Acute Valvular Problems, Mechanical Complications of Myocardial Infarction and Intra-Aortic Balloon Pump				
Cardiology for Pacemakers (Temporary and Permanent)				
Endocarditis Requiring Urgent Cardiac Intervention				
Pericardial Tamponade with Cardiovascular Compromise				
Post Heart Transplantation with Suspected Rejection				
Refractory Cardiac Arrythmias (Including Repetitive Firing of Implanted Cardiac Defibrillator) or Symptomatic Heart Block				
Thoracic Aortic Dissection/Rupture				
Unstable Acute Coronary Syndrome Requiring Urgent Angiography and/or Intervention (Primary/Rescue Percutaneous				

Coronary Imaging or Surgery)				
Unstable Complex Congenital Heart Disease				
Vascular Trauma (e.g., Mangled Extremity, Blunt Thoracic Aortic Injury)				
ENDOCRINOLOGY				
Adrenal Crisis				
Diabetic Ketoacidosis				
Hyperglycemic Coma				
Hypoglycemic Coma				
Myxedema Coma				
Pituitary Apoplexy				
GASTROENTEROLOGY				
Esophageal Perforation				
Fulminant Hepatic Failure				
Gastrointestinal Bleed with Refractory Shock				
Toxic Mega Colon with Shock				
GENERAL SURGERY				
Gastrointestinal Bleed with Refractory Shock				
Ischemic Bowel				
Multiorgan Failure with Refractory Shock				
Severe Pancreatitis with or without Shock				

Perforated Viscus/Septic Shock				
Toxic Colitis with Shock				
Wound Dehiscence/Evisceration				
HEMATOLOGY				
Acute Leukemia				
Disseminated Intravascular Coagulation with Thrombosis or Bleeding				
Graft vs. Host Disease				
Severe Hemophilia with Associated Bleeding				
Urgent Leukapharesis				
Urgent Red Cell Exchange (Sickle Cell Crisis, Malaria)				
NEPHROLOGY				
Acute Emergency Dialysis				
Urgent Plasma Exchange (Thrombotic Thrombocytopenic Purpura, Hemolytic-Uremic Syndrome)				
NEUROSURGERY/NEUROLOGY				
Acute Spinal Cord Compression				
Acute Stroke Requiring Thrombolysis				
Cervical Spine Fracture				
Guillain Barre / Myasthenic Crisis				
Head Trauma Requiring Neurosurgical Intervention or Monitoring				

Intracerebral Hemorrhage Subarachnoid Hemorrhage				
Meningitis with Altered Level of Consciousness				
Status Epilepticus				
Stroke – non Tissue Plasminogen Activator Posterior Fossa/Brainstem				
OBSTETRICS/GYNAECOLOGY				
Acute Vaginal Bleeding with Shock				
Anticipated Severe Shoulder Dystocia				
Amniotic Fluid Embolism				
Early Pregnancy, Severe Vaginal Bleeding and Hemorrhage				
Early Pregnancy, Suspect Ectopic with Shock, Intra-Abdominal Hemorrhage				
Fetal Distress				
Intraperitoneal Hemorrhage				
Maternal Cardiac Arrythmias in Labour				
Multiple Gestation Requiring Emergency Obstetric/Paediatric Management				
Obstructed Labour				
Pelvic Inflammatory Disease with Shock and/or Disseminated Intravascular Coagulation				
Post-Operative Intra-Abdominal Hemorrhage and Shock				
Pre-Term Labour				
Pre-Term Premature Rupture of Membranes				

Severe Gestational Hypertension				
Severe Postpartum Hemorrhage				
Severe Antepartum Hemorrhage				
Ovarian Torsion				
Uterine Rupture				
Umbilical Cord Prolapse				
OPHTHALMOLOGY				
Acute Orbital Hypertension/Glaucoma				
Endopthalmitis				
Severe Orbital Cellulitis				
Ruptured Globe				
Vision Threatening Conditions – Orbital Abscess, Orbital Hematoma, Optic Nerve Compression				
ORTHOPEDICS				
Compartment Syndrome				
Compound Fractures				
Femoral Neck in Patients Younger than 65 Years of Age				
Fractures/Dislocation with Vascular Injury				
Irreduceable Major Joint Dislocation (Non-Prosthetic Joint)				
Major Pelvic/Acetabular Fractures				

Multiple Large Bone Fractures				
OTOLARYNGOLOGY				
Acute Airway Obstruction				
Epiglottitis				
Esophageal Foreign Bodies				
Major Bleeding: Neck Hematoma, Massive Hemoptysis/Hematesis				
Mastoditis or Sinusitis with Central Nervous System Complications				
Necrotizing Infections				
Severe Neck Trauma/ Laryngeal Fracture				
PLASTICS				
Amputation of Extremity for Re-Implantation/Revascularization				
Compound Fractures of the Hand				
Major Burns				
Necrotizing Soft Tissue Infections				
RESPIROLOGY				
Unstable Pulmonary Embolism Causing Shock and/or Respiratory Failure				
Right Heart Failure with Shock				
Respiratory Failure with Need of Invasive or Non-Invasive Mechanical Ventilation				
Severe Cystic Fibrosis				
SPINE				

Acute Deteriorating Cauda Equine Syndrome				
Acute Deteriorating Spinal Cord Function				
Spinal Cord Injury				
Unstable Spinal Injury				
THORACIC SURGERY				
Intrathoracic Airway Obstruction				
Issues Related to Lung Transplant				
Massive Hemoptysis				
Massive Hemothorax				
Ruptured Bronchus or Trachea				
Ruptured Esophagus				
Strangulated Diaphragmatic Hernia				
UROLOGY				
Acute Priapism				
Necrotizing Scrotal Infection/Fornier's Gangrene				
Obstructive Uropathy				
Renal Infection with Vascular Impairment				
Renal Trauma with Hemodynamic Instability				
Testicular Torsion				

APPENDIX D: FREQUENTLY ASKED QUESTIONS

i. What is the Life or Limb Policy?

- The Life or Limb Policy is designed to ensure that any patient that requires care within a 4 hour period will be able to receive the care that he/she requires, 24 hours a day and 7 days a week. Building on the Critical Care Surge Capacity Management Plan, and leveraging the support of CritiCall Ontario, each of the 14 LHINs, and the MOHLTC, this province-wide policy mitigates the likelihood of preventable deaths due to barriers to resources. Tools and information technology systems (e.g. CritiCall Ontario's Provincial Hospital Resource System and Repatriation Tool) are in place to facilitate each aspect of the patient's journey.

ii. Why do we need a Life or Limb Policy?

- The Life or Limb Policy was developed in response to recommendations from the Office of the Chief Coroner, and from a need to ensure that patients experiencing life or limb threatening conditions [requiring acute care ≤ 4 hours] receive access to medical consultation, and/or transfer to an appropriate point of care in a timely manner.
- The Life or Limb Policy will strengthen hospital's accountability to provide care to patients based on the clinical services available at the hospital, will ensure that patients with life or limb threatening conditions receive the timely care required, and will support hospitals that are not able to care for the critically ill.

iii. How will the Life or Limb Policy work?

- If a patient enters a hospital and is declared to urgently require critical care services or sub-specialty interventions that are not available at the hospital, his/her physician will phone CritiCall Ontario
- During this phone call, the physician will describe the patient's condition and specify the nature of services required. The referring physician will declare that the case is a 'Life or Limb' case
- CritiCall Ontario will then identify a consulting hospital and physician, and connect both physicians in a discussion about the patient's condition
- If the physicians determine that the patient requires immediate services that the referring hospital does not offer but that the consulting hospital can provide, arrangements will be made to transport the patient to the consulting hospital
- Once the patient is deemed medically stable, he/she will be repatriated back to the referring hospital or a hospital closest to the patient's home that can provide the appropriate level of care required within 48 hours

iv. Under the Life or Limb Policy, what will physicians need to do differently?

- Currently, initiatives such as the Critical Care Surge Capacity Management Plan—which is in place at every hospital in Ontario with critical care services—provide hospitals with the tools and strategies necessary to manage periods of surge. With these plans in place, hospitals are prepared for instances in which they may need to manage additional patients sent to their facilities. Given this, physicians will continue to care for their patients as they have already done. Physicians should be familiar with the Life or Limb Policy and its implications (e.g., they may be contacted by CritiCall Ontario and asked to provide consultations). A thorough understanding of the Life or Limb Policy from all parties will result in more timely access to services for the patients that require it most.

v. What purpose does the Life or Limb Policy Diagnoses List serve?

- The Life or Limb Policy Diagnoses List is a guiding document that outlines particular conditions that may qualify for care under the Life or Limb Policy. However, given the variability of factors (e.g., patient's overall condition, disease severity) that are apparent in each individual patient case, it is emphasized that the Life or Limb Policy Diagnoses List is only a guiding document. Physician judgment is considered paramount in the determination of whether a patient should be considered as a life or limb case. The Life or Limb Policy Diagnoses List is also a useful tool for hospitals to indicate which diagnosis can be cared for by their hospitals, which will then be communicated to CritiCall Ontario. This will contribute to streamlining patient referrals and transfers and will help to ensure that hospitals provide care to patients based on the clinical services available.

vi. How can I accept more patients when we are always at capacity?

- It must be remembered that the Life or Limb Policy is specifically focused on those patients with imminently life or limb threatening conditions whose outcome is dependent on immediate access to appropriate services. At times, the most appropriate bed for that patient is in the intensive care unit or operating room of a hospital capable of providing appropriate interventions. The ability to provide care for unanticipated patients is a necessary capability for hospitals today. To help hospitals accommodate for surges, the Critical Care Surge Capacity Management Plan was introduced in 2009 in hospitals across Ontario as part of Ontario's Critical Care Strategy. The Critical Care Surge Capacity Management Plan provides hospitals with the tools and strategies to manage minor, moderate and major surges. By following its Critical Care Surge Capacity Management Plan and Bed Capacity Management Protocols, hospitals should be able to accept additional patients and accommodate for their care if necessary.

vii. How many more patients do you anticipate will be cared for, under the Life or Limb Policy?

- Currently, the majority of patients that would fall under the Life or Limb Policy are already receiving timely acute care services. Historically, however, there have been cases of patients in Ontario that were unable to access acute care services in a timely manner. The Life or Limb Policy is intended to ensure that bed availability will no longer be a limiting factor in the health of patients that are in immediate need of services.

viii. If I need an external consultation about a potential life or limb patient, do I have to phone CritiCall Ontario to receive one?

- CritiCall Ontario has developed a number of tools that will support the Life or Limb Policy, and will facilitate timely access to physician consult, as well as track the repatriation of life or limb cases. It is in the best interest of patients and physicians that CritiCall Ontario be contacted at 1-800-668-HELP (4357) whenever a referral is required. Please note, the MOHLTC does not assume the expenses for transportation (transfer and repatriation) when CritiCall Ontario is not used for out-of-country transfers.

ix. When CritiCall Ontario initiates a life or limb call to my hospital, who will they contact?

- CritiCall Ontario will contact the hospital switchboard. In the South West LHIN, CritiCall Ontario will contact the Patient Access and Flow-One Number where available.

x. Once it has been determined that a life or limb patient should be transferred to an appropriate point of care, who decides which mode of transport is the most efficient and expeditious?

- The decision regarding mode of transport is commonly determined by the referring physician. This decision is informed by, but not limited to the following considerations: patient needs, weather conditions, geographic proximity to the receiving hospital, availability of transport resources, and response received from the initial transport service contacted.

xi. In the Life or Limb Policy, there is frequent reference to ensuring patients receive access to acute care services within a best effort window of 4 hours. What is the starting point of the 4 hour window?

- For confirmed life or limb cases, the starting point of the 4 hour window (time zero) is defined as the point when a referring physician contacts CritiCall Ontario regarding a life or limb case. The end of the 4 hour window is defined as the point when the patient is admitted at the receiving hospital.

xii. Is there a standard period by which medically stable patients are expected to be repatriated?

- Repatriation should occur when the patient is medically stable and suitable for transfer. Patients will be repatriated within 48 hours to the referring hospital once patient transfer orders have been written, provided the referring hospital can provide the patient with the appropriate level of care required. If the referring hospital cannot provide the patient with the appropriate level of care, or if the referring hospital is not within the geographic boundary the patient resides, the patient will be repatriated to a hospital closest to their home that can provide the appropriate level of care required.

xiii. As stated in the Life or Limb Policy, the aim of repatriating patients within a best effort window of 48 hours may be a challenge for emergency medical service providers considering the emphasis on emergency transports rather than non-emergency calls.

- The effective implementation of the Life or Limb Policy not only requires that patients access appropriate acute care services in a timely manner but are repatriated within 48 hours in order to enhance coordination among hospitals and ensure a dynamic system with ongoing access for patients with life or limb threatening conditions. Language emphasizing a best effort window of 48 hours was included in the Life or Limb Policy to recognize the focus on emergency transports rather than non-emergency calls. Nonetheless, repatriation is an essential component to patient flow.

xiv. What additional resource demands will the implementation of the Life or Limb Policy place on emergency medical service providers?

- It is not expected that there will be a sudden increase in the volume of patients with life or limb threatening conditions as a result of the implementation of the Life or Limb Policy. It is important to note that the vast majority of these patients already get to an appropriate point of care in an efficient manner. The implementation of the Life or Limb Policy will enable the collection of data related to access to medical consultation, transfer and repatriation activities in Ontario, thus highlighting the impact on health care resources and where further system improvements can be made.

xv. Who do I inform when the critical care services available in my hospital change?

- When the critical care services in your hospital change, please contact Critical Care Services Ontario and CritiCall Ontario to inform them of these changes.

xvi. How frequently will the Life or Limb Policy be revised?

- The MOHLTC is responsible for maintaining and updating the Life or Limb Policy. If any revisions are required, an updated version of the Life or Limb Policy will be posted online on July 1 of each year. The Life or Limb Policy is available online at the MOHLTC website at: http://www.health.gov.on.ca/en/pro/programs/criticalcare/life.aspx.

xvii. How can I find out more information?

- If you have any questions, please contact Critical Care Services Ontario via e-mail at ccsadmin@uhn.ca.