SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK
STROKE CARE REPATRIATION/TRANSFER AGREEMENT
For the London-Middlesex Oxford Stroke District

Between the Designated Stroke Centres (Regional Stroke Centre, London Health Sciences Centre, University Hospital and the District Stroke Centres), the Stroke Rehabilitation Centres at St. Joseph's Health Care London and Woodstock Hospital and Community Hospitals (Local, Non-Designated Hospital)

PURPOSE

The Repatriation/Transfer Agreement involving the Regional Stroke Centre (RSC), London Health Sciences Centre (LHSC), University Hospital (UH), Stroke Rehabilitation Centres, at St. Joseph's Health Care London and Woodstock Hospital and the "Parties" (referenced in Schedule A) will serve to guide on-going collaboration among the "Parties". It is based on the principles of mutual respect, trust, and a shared commitment to providing excellence in patient care.

GOAL

Under the terms of this agreement, the "Parties" agree to ensure that patients requiring the services of the RSC, LHSC UH for stroke Tissue Plasminogen Activator (tPA) / Endovascular Treatment (EVT) and/or Acute Stroke Unit care will be able to access such services in a coordinated and timely manner. All patients that are indicated for patient redirect or transport under the stroke protocol with a symptom onset time of < and / or > than the current Ministry of Health and Long Term Care (MoHLTC) Acute Stroke Protocol Paramedic Prompt Card will be transported to the RSC, LHSC UH. Patients admitted to LHSC UH for Acute Stroke Unit care requiring inpatient stroke rehabilitation will be discharged to St. Joseph's Health Care London or Woodstock Hospital for care on the Stroke Rehabilitation Unit or transferred to the most appropriate Designated Stroke Centre.

Please note: Patients with signs and symptoms of stroke in Elgin, South Oxford, and West Norfolk Counties who do not meet the MoHLTC Acute Stroke Protocol Paramedic Prompt Card will be redirected or transported to St. Thomas Elgin General Hospital. Patients from North Oxford County who are cared for at LHSC UH and require inpatient rehabilitation will be discharged to Woodstock Hospital as appropriate.

GUIDING PRINCIPLES

1. The primary priorities for repatriation/transfer of patients are ensuring quality care, timely access to an appropriate level of care, and patient safety.
2. Patients presenting with stroke-like symptoms will receive best practice stroke care at the Designated Stroke Centres and will be transferred immediately from the non-designated hospital.
3. Patients who have had a stroke and no longer require care on an acute, integrated or stroke rehabilitation unit, and are unable to be discharged, will be repatriated/transferred to their local, non-designated hospital or delegate (e.g. Complex Continuing Care) for most appropriate care. The decision making process will comprise a number of considerations including: ensuring the medical needs of the patient can be met, patient preference, care close to home, regional access and flow.
4. Patients who require inpatient rehabilitation will remain on the acute stroke unit until discharged to the inpatient stroke rehabilitation program.
5. Patients who did not experience a stroke will receive appropriate care at their local, non-designated hospital.
6. Repatriation/transfer will occur seven days a week and 24 hours of each day.

7. All repatriation/transfers will follow direct physician to physician conversation for appropriate transition of patient care.
8. Barriers for transfer should not be created due to pharmaceutical or medical supply issues. The sending hospital will provide a quantity sufficient to support patient care until the receiving hospital can acquire.
9. Barriers for transfer should not be created due to perceived lack of skills or expertise. The sending and receiving hospitals should ensure that the plan of care is developed and communicated to ensure that the patient is receiving appropriate and best practice care.
10. If the accepting Most Responsible Physician (MRP) is not on-call when the patient transfer is occurring, this should not be a barrier to patient transfer - hospitals need to develop internal procedures / protocols to address the need for appropriately identifying an MRP in a timely manner.
11. All hospitals will:
    - Provide appropriate education to staff and physicians;
    - Hold themselves accountable to system expectations, i.e. Agreements;
    - Present suggestions for improvement to the Southwestern Ontario Stroke Network;
    - Escalate concerns immediately;
    - Be proactive to ensure transfer processes are efficient;
    - Provide the appropriate documentation with patient repatriations and transfers.

EXPECTATION OF THE PARTIES

The Parties shall work together on an on-going basis to lead, plan, and manage the work associated with this Agreement.

CHANGE IN PARTIES

Other organizations may become Parties to this Agreement with the mutual agreement of the Parties who have signed this Agreement.

FINANCIAL COMMITMENTS

- Under this Agreement, LHSC will cover the costs associated with the administration of tPA, EVT and Acute Stroke Unit care. It is understood that LHSC will receive quality based funding from the Ministry of Health and Long-Term Care for these costs. St. Joseph's Parkwood Institute and Woodstock Hospital will assume the costs associated with Stroke Rehabilitation Unit care.
- Responsibility for costs associated with inter-facility patient transfer will belong to the sending hospital. This will be inclusive of patient's transfers home who do not have the means to cover this cost.

REPATRIATION/TRANSFER SCENARIOS (or PATHWAYS)

A. Transfer to RSC, LHSC UH for tPA and/or Endovascular Treatment (EVT) Candidates, and Patients with signs and symptoms of stroke who do not meet the criteria for tPA/EVT

- Patients who access Emergency Medical Services (EMS) will be assessed by paramedics as candidates for tPA and/or EVT according to the most current MoHLTC Acute Stroke Protocol Paramedic Prompt Card.
- "Walk-in" patients (those who do not access EMS) will be identified by their local hospital as possible candidates for tPA and/or EVT.
- Patients with signs and symptoms of stroke including those who are possible candidates for tPA and/or EVT will be transported to the Stroke Centre Emergency Department.
- Patients who require acute stroke unit care including those who receive tPA and/or EVT will be admitted to LHSC, UH.

NOTE: Elgin, Oxford and Norfolk resident patients will receive tPA or EVT at LHSC-UH and once stabilized patients will be transferred to St. Thomas Elgin General Hospital for the balance of their acute and in-patient rehabilitation stroke care.

B. Repatriation/Transfer of tPA/EVT and Non-tPA/Non EVT Patients to District Stroke Centre (DSC) Hospitals from the RSC (if RSC is not the patients local Designated Stroke Centre)

- Timeframe: 12-24 hours
- Medically stable patients who receive tPA/EVT will be transferred to their closest DSC within 12-24 hours of receiving tPA/EVT. Upon admission to the RSC, LHSC UH, communication will occur between the RSC, LHSC UH and DSC to identify pending repatriation requests.
- Patients who are medically unstable for transfer to their local hospital at 24 hours will remain at the RSC, LHSC UH until medically stable.
- The Acute Stroke Unit at LHSC UH will complete the repatriation referral form according to the One Number process (Attached in Appendix A) and flag the referral patient as stroke medical redirect (bypass) and send the referral to Admitting. The sending hospital will enter the repatriation into the Provincial Hospital Resource System (PHRS) as per the ONE Number process.
- Access/Admitting office will notify the receiving hospital of the patients return. Access/Admitting office will obtain physician contact information and facilitate connecting the attending physician at UH with the receiving physician. After the attending physician has spoken to the receiving physician, the patient will be notified and be returned to home DSC.
- Nursing staff complete the appropriate transfer documentation.
- A representative from the sending facility will use a Patient Transport Decision Guide (attached in Appendix B) to determine if emergent or non-emergent medical transfer service is appropriate.

C. Repatriation/Transfer to local, Non-Designated Hospital for Stroke patients who have completed their acute stroke unit care at a Designated Stroke Centre and do not qualify for inpatient rehabilitative care and are unable to be discharged.

- Timeframe – 24 hours
- Most Responsible Physician (MRP) at the Designated Stroke Centre initiates the order for medically stable patient's repatriation/transfer to receiving hospital.
- The Designated Stroke Centre Access/Admitting office coordinates the repatriation/transfer with the receiving hospital and facilitates a phone call between the Designated Stroke Centre MRP and the receiving Physician.
- The Designated Stroke Centre MRP notifies the patient and family/next of kin and informs the care team of the transfer time and destination.
- A representative from the sending facility will use a Patient Transport Decision Guide (attached in Appendix B) to determine if emergent and non-emergent medical transfer service is appropriate.
- Nursing staff complete the appropriate transfer documentation.
- In addition, the Designated Stroke Centre stroke team would have engaged patient and family in discharge care planning early in the patient's acute length of stay.
- Receiving hospital physician accepts responsibility for patient upon arrival.
- In instances where the patient's condition improves at the local hospital, so that they are ready for rehab, the local hospital can contact the Stroke Navigator, as appropriate.

D. Repatriation/Transfer to local, Non-Designated Hospital for Stroke Patients who have completed their inpatient rehabilitative journey but are not suitable to be discharged.

- Timeframe – 24 hours
- MRP at the rehab Designated Stroke Centre initiates the order for medically stable patients' repatriation/transfer to receiving hospital.

- Rehab Designated Stroke Centre coordinates the repatriation/transfer with the receiving hospital and facilitates a phone call between the rehab Attending Physician with the receiving Physician.
- Rehab Designated Stroke Centre MRP notifies the patient and family/next of kin and informs the care team of the transfer time and destination and appropriate mode of transport, using the Patient Transport Decision Guide (attached in Appendix B) to determine if emergent or non-emergent medical transfer service is appropriate.
- Nursing staff completes appropriate transfer documentation.
- Receiving hospital physician accepts responsibility for patient upon arrival.

E. Repatriation/Transfer to local, Non-Designated Hospital for Non-Stroke Patients who arrive at a Designated Stroke Centre Emergency Department (ED) and are unstable and require admission/care for another condition and once stable will receive remainder of care at their local hospital.

Includes patients who present to the Designated Stroke Centre ED with a possible stroke and/or TIA who are, after assessment, deemed non-stroke, but require admission due to their condition, and who now require repatriation/transfer to the local/Non-Designated Hospital for that care.

- Timeframe -– 24 hours
- Most Responsible Physician (MRP) at the sending hospital initiates the order for medically stable patients' repatriation/transfer to receiving hospital.
- The sending hospital Access/Admitting office coordinates the repatriation/transfer with the receiving hospital and facilitates a phone call between the sending hospital MRP and the receiving Physician.
- The sending hospital MRP notifies the patient and family/next of kin and informs the care team of the transfer time and destination.
- A representative from the sending service will use a Patient Transport Decision Guide (attached in Appendix B) to determine if emergent or non-emergent medical transfer service is appropriate.
- Nursing staff complete the appropriate transfer documentation.
- Receiving hospital physician accepts responsibility for patient upon arrival.

F. Repatriation/Transfer to local, Non-Designated Hospital for Non-Stroke Patients who arrive at a Designated Stroke Centre ED and are stable, and do not require admission, but are not able to be discharged home.

- Time frame – immediate to 1 hour
- When repatriation to Non/Designated Hospital ED is deemed appropriate, patient who is medically stable for transfer/repatriation to receiving hospital ED will be sent as soon as possible.
- Charge nurse or nurse responsible will contact the access office and share information relevant to patient's transfer/repatriation.
- Access/Admitting office will notify the receiving hospital of the incoming transfer. Sending hospital's access office will facilitate and set up the ED to ED repatriation/transfer conversation, within immediate timeframe, for nurses and physicians.
- Once repatriation/transfer is accepted by the receiving hospital ED, communication fan out will occur to notify sending hospital Access/Admitting office, ED clerk, ED charge nurse, patient and family/next of kin.
- Nursing staff complete the appropriate transfer documentation.
- ED clerk or charge nurse will coordinate transport to receiving hospital using a Patient Transport Decision Guide (attached in Appendix B) to determine if emergent or non-emergent medical transfer service is appropriate.

DECISION MAKING/ACCOUNTABILITY

Patients meeting any of the pathways (C-F) outlined in the agreement will be evaluated by the Designated Stroke Centre for repatriation/transfer on a case by case basis.

Decision Criteria: The Guiding Principles within this agreement will be used to direct decision making.

Escalation Process

Patients whose transfer cannot be arranged within the timeframes identified within this agreement will be discussed between the clinical vice-presidents or the appropriate highest administrative individual in the respective hospitals. Hospitals need to have identified escalation procedures for managing these types of scenarios. If required, Medical Chiefs of Staff will be asked to participate in decision making to facilitate a timely repatriation. The effectiveness of the escalation process will be evaluated and iterated as needed to ensure guiding principles are followed by all parties within the agreement.

Designated Stroke Centre or Non-Designated Hospital Repatriation/Transfer Decline

- In the event that the Designated Stroke Centre or Non-Designated Hospital declines the patient, the sending hospital staff will notify area Clinical Coordinator who will work with Admitting to determine reason for refusal and how to proceed.
- If after further repatriation attempts have been made by Admitting and the area Clinical Coordinator (or After Hours Coordinator if issues arise outside of regular office hours) is unsuccessful, the area Manager should be involved.
- This process of escalation should continue through the levels of leadership up to executive until the issues achieves resolution.

Patient/family Preference for Repatriation/Transfer

- In the event that the patient/family prefers not to be repatriated/transferred, ED, Acute or stroke in-patient staff will notify area Clinical Coordinator who will discuss plan with patient/family in order to try and resolve situation at the earliest opportunity.
- If area Clinical Coordinator is unable to resolve situation, this should be escalated to area Manager and a family meeting arranged to further discuss repatriation.
- If further intervention from operational leadership proves unsuccessful and extreme access and flow pressures necessitate the need to consider overall patient experience over individual patient experience, a letter advising of per diem payment should be issued at the earliest opportunity when applicable.

Sustainability/Measurement

- Data will be captured and reviewed on a monthly/quarterly basis.
- Adjustments will be made to ensure system efficiency.
- Follow up will be conducted with hospitals leadership for those hospitals who are not adhering to the agreement.

APPENDIX A

REGIONAL ONE NUMBER PROTOCOL

South West Local Health Integration Network

BACKGROUND

The creation of the Regional One Number Protocol came about in response to patient access challenges being experienced in the South West Local Health Integration Network (LHIN). These challenges were a result of large volumes of Alternate Level of Care (ALC) patients, large Emergency Department (ED) visit volumes, and health human resources shortages. These conditions led to overcrowding in hospital EDs, long lengths of stay, service delays, and cancellations of surgeries. It was recognized that one major contributing factor was the lack of a uniform protocol among the hospitals in the South West LHIN to govern appropriate and timely access to beds and transfers between organizations.

PURPOSE

The protocol was created with the intent of ensuring patients from within the South West LHIN (and beyond for tertiary services) received the correct level of care in a timely manner, as close to the patient's own home and supports as possible.

THE ONE NUMBER PROTOCOL

The Regional One Number Protocol is a standardized protocol that has been created, implemented and is utilized amongst all of the hospitals within the South West LHIN to facilitate decision making regarding a consultation about and/or transfer of patients to a higher level of care within the South West LHIN on a critical (require care in less than four hours) or emergent basis (require care within 4-24 hours). The protocol details how patients requiring a lower level of care at an acute hospital are repatriated as soon as possible and as close to home as possible.

OUTCOMES

- Realization of widespread use of a standardized LHIN-wide protocol to facilitate referrals, transfers and repatriations.
- Realization of improved patient referral, consult, and transfer processes for patients with emergent or urgent (require care within 24-48 hours) care needs that cannot be met by the institution at which the patient is initially assessed.
- Creation of a uniform point of access to care in each South West LHIN hospital for patients being referred from another acute care organization, while utilizing health human resources in the most efficient manner.

GUIDING PRINCIPLES

- All of the South West LHIN hospitals and two Erie St. Clair LHIN hospitals (Bluewater Health, Chatham Kent Health Alliance) are signatories to the Regional Letter of Agreement. This means that each organization has a single point of access through which patients are referred for consult or transfer. All organizations utilize a standardized LHIN-wide protocol to facilitate this care.
- Inclusion of the most appropriate physicians and hospital staff on One Number calls is critical to maximize these resources and minimize the time and impact to the patient for a transfer.
- The principles of timeliness, appropriateness and care closer to home guide decision making associated with One Number patients.

KEY MESSAGES

- Physicians within the South West LHIN needing to refer patients to a higher level of care where the patient is critically or emergently ill must first contact CritiCall Ontario at 1-800-668-4357 (HELP).
- Physicians within the South West LHIN needing to refer patients to a higher level of care where the patient is urgently ill should contact the One Number of the organization to which the patient transfer is being requested. This will improve patient access to the timeliest and most appropriate treatment.
- Timely repatriation of patients from tertiary and secondary care centres to a lower level of care creates greater capacity and improves access for patients that require transfer to those tertiary or secondary centres.

Appendix B - Patient Transport Decision Guide:
http://www.southwestlhin.on.ca/goalsandachievements/Programs/Transportation/NonEmergencyTransportation.aspx

Schedule A - PARTIES TO THE AGREEMENT

London Health Sciences Centre
St. Joseph's Health Care London
Middlesex Hospital Alliance
Woodstock Hospital
Alexandra Hospital
St. Thomas Elgin General Hospital
Huron Perth Healthcare Alliance
Grey Bruce Health Services

Tillsonburg District Memorial Hospital (For those patients that come to UH (Via 911/or are a walk-in) that are in the window, but it is determined that they are not a stroke and need to be repatriated back to TDMH. If they are a confirmed stroke but need tPA/EVT they would be admitted to LHSC UH for 24 to 48 hours and transferred to STEGH for the remainder of their care on the ISU. If they are a confirmed stroke but do not need tPA/EVT they should be transferred to STEGH for care on the ISU).

Alexandra Marine and General Hospital (For potential EVT cases, but upon arrival at UH it is determined that they are not a candidate for EVT and need to be transferred to SGH. If they were a candidate for EVT they would be admitted to LHSC UH for 24 to 48 hours and transferred to HPHA-SGH for the remainder of their care on the ISU)

SIGNATORIES

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London Health Sciences Centre, CEO
Murray Glendining

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St. Joseph's Health Care London, CEO
Dr. Gillian Kernaghan

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Middlesex Hospital Alliance, CEO
Todd Stepanuik

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Woodstock Hospital, CEO
Natasa Veljovic

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Alexandra and Tillsonburg Hospitals, CEO
Frank Deutsch

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St. Thomas Elgin General Hospital, CEO
Dr. Nancy Whitmore

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Huron Perth Healthcare Alliance, CEO
Andrew Williams

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Grey Bruce Health Services, CEO
Lance Thurston

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Alexandra Marine and General Hospital
Bruce Quigley