



CritiCall Ontario

Successes and Challenges

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Medical Director
CritiCall Ontario



Connecting physicians, resources and care 1-800-668-HELP



Core activity

MOHLTC-funded program, under the Critical Care Secretariat

- 24-hour-a-day ‘medical 911’ emergency consultation and referral service for hospital-based Ontario physicians; using *1-number to call*, supported centrally and locally.
- Activity reports – acceptances, refusals, volume of activity by specialty
- Provides a capacity management system that documents the ‘status of’ and ‘access to’ Ontario’s acute care beds (“voluntary bed registry”)
- CritiCall Ontario provides implementation, training and problem-solving assistance for the Critical Care Information System (CCIS) to Ontario hospital critical care units



Core components

Call Centre (Hamilton)

4 call agents & team lead

Area account managers

Assigned to each LHIN (and their hospitals)

Liase with physician and non-physician stakeholders in the field

Associate Medical Directors

Content expertise and regional representation

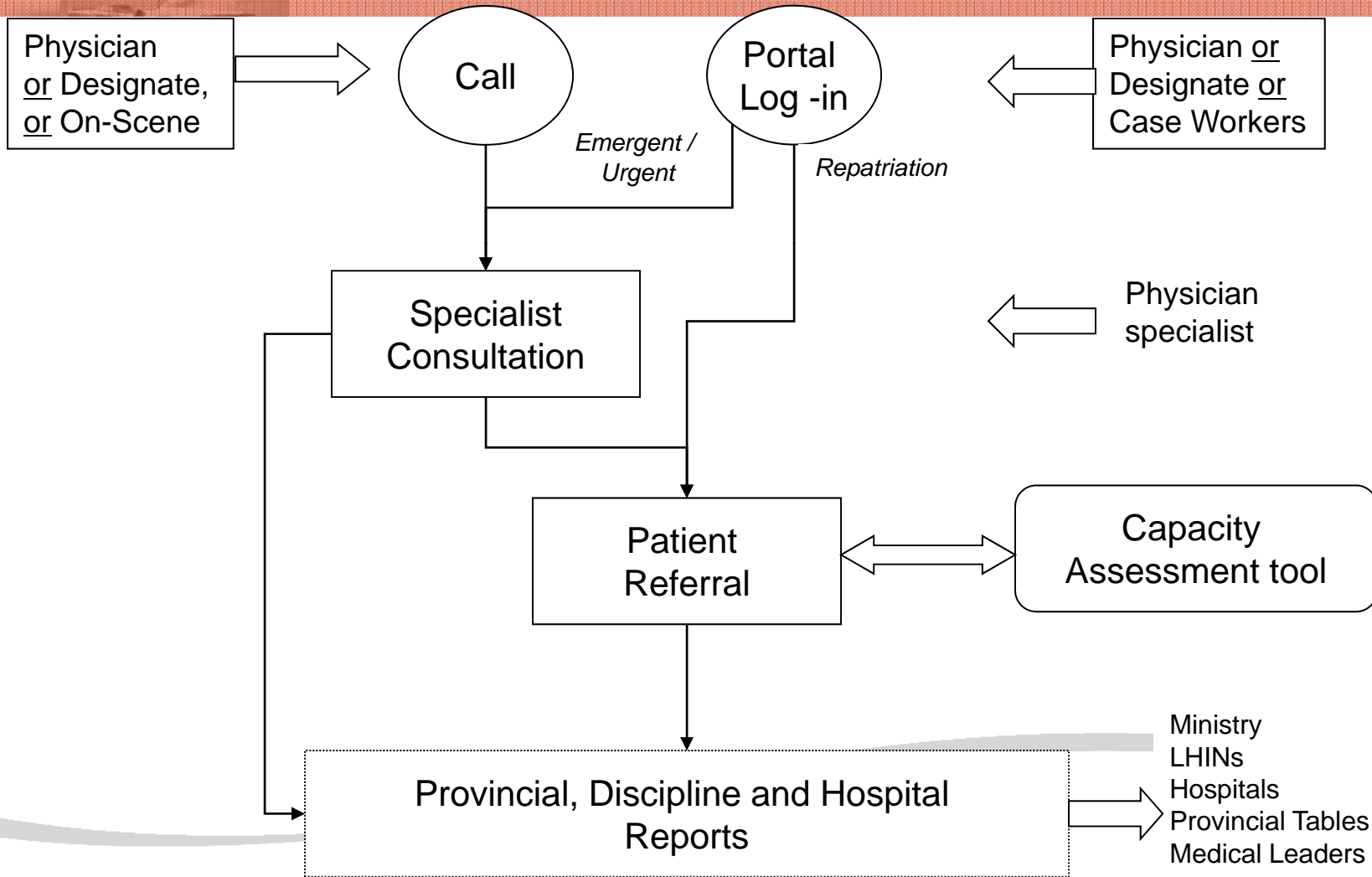
Develop policy and procedure with Medical Director

Call reviews and ongoing quality improvement



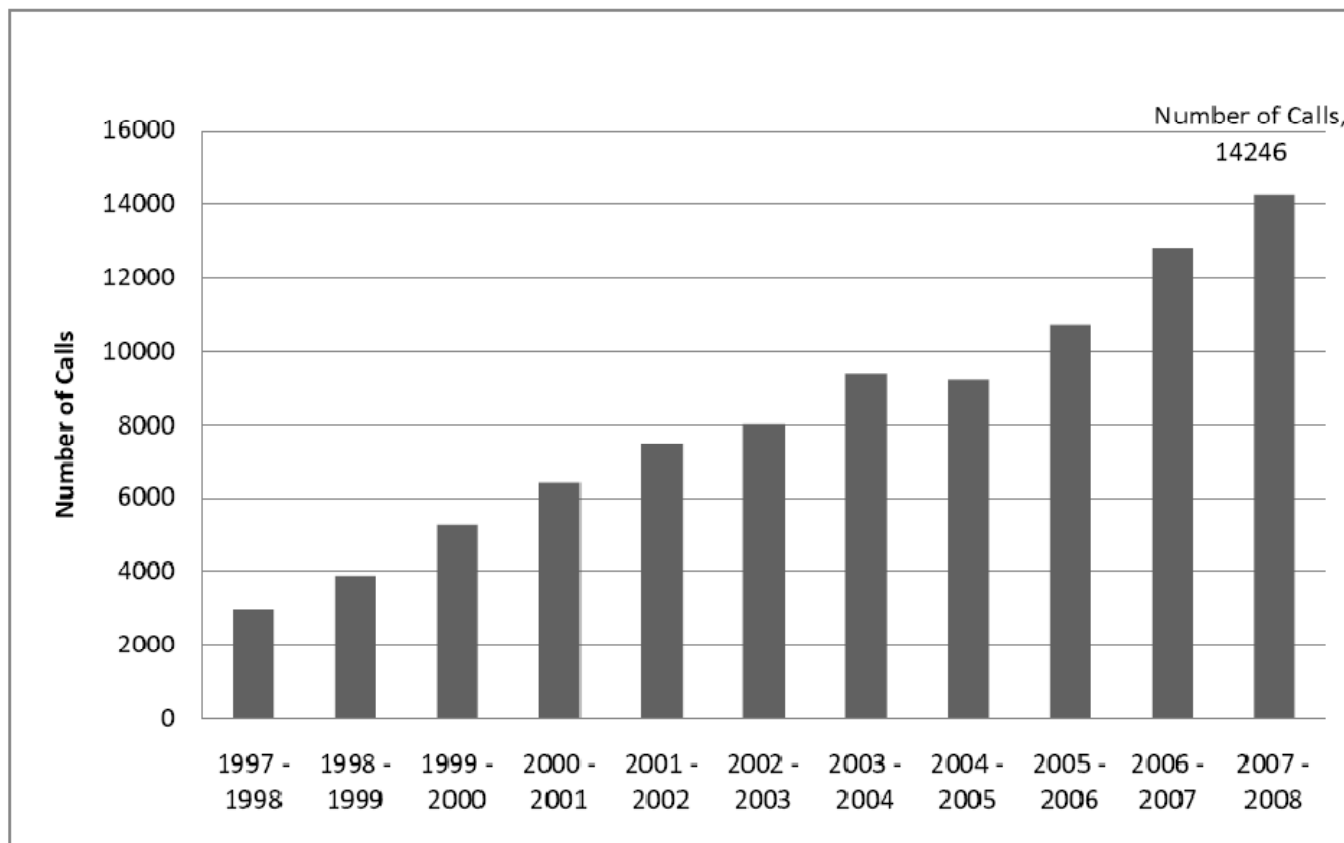
Accessing CritiCall

1-800- 668- 4357



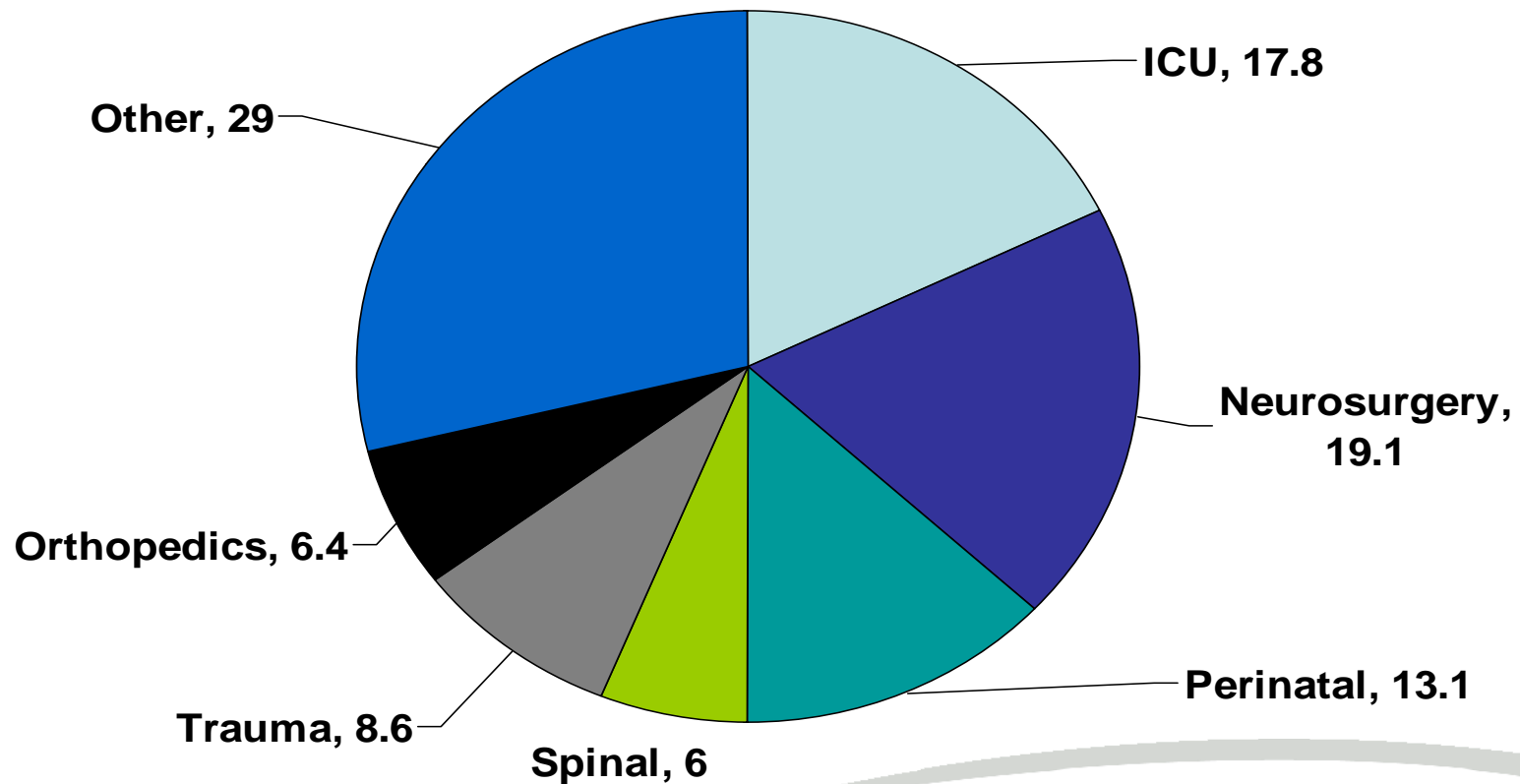


Critical activity: 1997-2008





Activity by specialty





CritiCall Ontario Activity

Number of calls to CritiCall Ontario: 14,246

- Only 63% of calls lead to transfer
 - Emphasizes “consultation” component of call
- Average time to patient acceptance: 55.4 (min.)
- Total # of MD’s participating = 7,324
- Average # of MD’s contacted to place a patient = 2.4
- Average # of calls made per transfer: 10.4



Major initiatives

Extramural Pediatric Critical Care Response Team

Consultation + transfer (if necessary)

Assurances of prompt access to knowledge and resources

Telestroke (with OTN)

Mental health

Form 1 and Schedule 1 mental health patient consultation , referral & capacity assessment; Pilot Champlain and Toronto Central LHIN – went live March 2009

Performance improvement

Internal and external (system) through sentinel events, audit filters, and stakeholder interaction

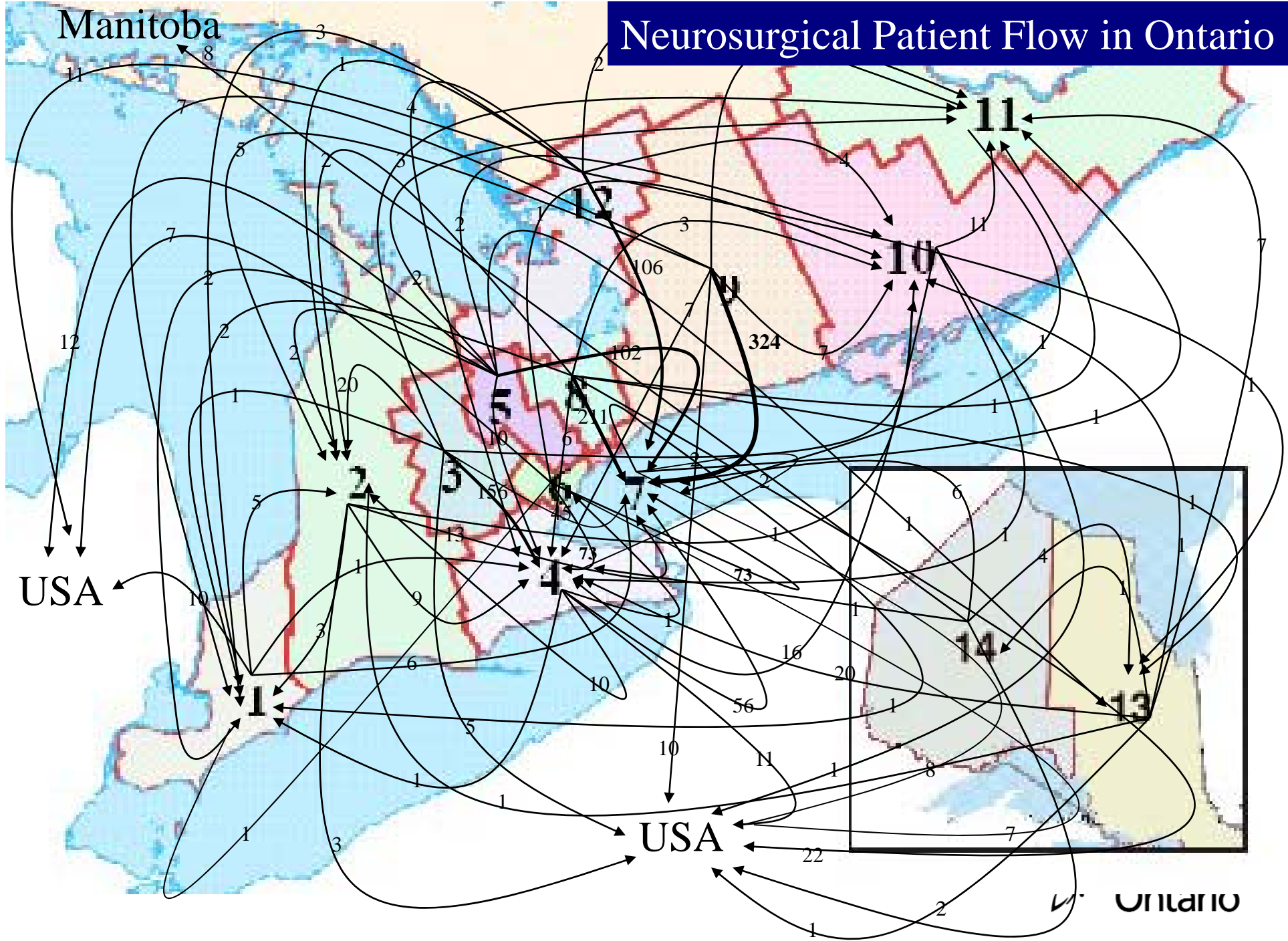


Patient Referral Framework

Principle Components of the patient Referral Framework

- Hospital programs and services inventory by site
- Referral grid by specialty, within LHIN, between LHINs and transfers to specialty care centers across the province
- Data over time allows tracking gaps between needs and local resources
- Critical for surge planning

Neurosurgical Patient Flow in Ontario





Neurosurgical Care

CritiCall handles **over 3500** neurosurgical calls annually

- 1695 (48%) calls resulted in transfer to a neurosurgical centre
- >150 NS patients transferred to the US for urgent NS assessment
- It is estimated that **~30-50%** of urgent transfers can be prevented with imaging available to the consultant neurosurgeon
- Decisions re transfer or urgency of transfer are constrained by the absence of imaging



Neurosurgical care

Emergency Neurosurgery Image Transfer System (ENITs)

- Pilot in LHINs 1 and 2, December 2008
- All LHINs, all PACS viewers to be implemented by the end of the year
- Access to ENITs is only available through CritiCall
- Early data suggests a significantly lower proportion of calls lead to transfer
 - Preserves resources for those who most require them
- Developing guidelines for NS consultation and referral



Reporting for System Improvement

- CritiCall Ontario captures information (voice, digital) related to every call
 - Voice recording critical for performance improvement
- System-wide reports
 - Provincial reports (referral, all specialties)
 - Specialty reports (Perinatal, neonatology, paediatrics, burn trauma, trauma, cardiac, critical care, neurosurgery, spine, orthopaedics, telestroke, out of province, psychiatry –pilot, vascular)
 - Hospital reports (referral out, referral in, non-accept)



Non – Acceptance (April 1 08 – January 31 09)

Hospital Contacted	Case Type	Specialty Contacted	Reason for Non Acceptance		
			No beds available	Physician has no OR time	Grand Total
St. Michael's Hospital (Toronto)	Adult	Cardiac Surgery	9		9
		Cardiology	52		52
		Cardiology - Invasive	4		4
		Gastroenterology	6		6
		General Paediatrics	1		1
		General Surgery	11		11
		Haematology	3		3
		ICU	91		91
		Nephrology	4		4
		Neurology	10		10
		Neurosurgery	574	1	575
		Obstetrics	4		4
		Ophthalmology	1		1
		Orthopedics	18	3	21
		Perinatal	24		24
		Plastic Surgery	4	1	5
		Spinal	25		25
		Trauma	2		2
		Vascular Surgery	17		17
	Peds	Neonatal	4		4
		Neurosurgery	1		1
		Orthopedics	1		1
		St. Michael's Hospital Total		866	5



System wide challenges

- Accountabilities are vague
 - Hospital accountability agreements often have a “Criticall” clause, but not enforced
 - HOCC agreements apply to hospital, not regional coverage
 - Perceived (real?) responsibilities for accepting patients vary across regions
 - Distorted understanding of the LHIN Act
 - Very dependent on goodwill of physicians and available resources & dependence on academic centres
- Physician concerns over liability
 - CMPA, March 2008



Information *Letter*

The Canadian Medical Protective Association

March 2008 — Volume 23, Number 1 — IL0810E

Being on call when resources are limited

LIABILITY RISK MAY BE REDUCED BY ACCEPTING THE CALL AND PROVIDING APPROPRIATE ADVICE

OF INTEREST TO ALL PHYSICIANS

On-call consultants frequently respond to calls from within their own hospital or from other institutions in or outside their normal referral area wanting to arrange care or transfer of a patient. Some CMPA members have voiced concern about providing advice when they are unable to accept the patient due to lack of resources and therefore cannot directly provide the

the chief of staff contacted the regulatory authority (College) about this matter, the College expressed concern that on-call consultants were refusing to provide advice to other physicians, and indicated that such consultants should at least provide direction to the referring physician, regardless of whether a transfer of the patient was possible.



Call challenges

- No one willing to provide consultation – “no beds, no conversation”
- Call agents being “led on”: “A bed might be available...call us back if you need us” – a big problem in Toronto
- Acknowledgment that patient needs to be transferred, no beds available
 - Update rule: every 20 minutes to ‘calling physician’
 - Notification / escalation rule: at 60 minutes a team lead, then regional CritiCall medical director is notified
 - Out of country protocols for border cities
- Transferring patients in extremis or brain dead patients across the border
- Patients who fall between specialty lines



Why use CritiCall?

As consultants, you can insist your referring docs call through CritiCall

Advantages

- Call is documented - protects all parties
- System problems can be addressed
 - Better understanding of system resource and capacity issues that can affect change – only data available
 - Major system issues can be brought to the Chief Coroner's Patient Safety Review Committee – avoids having to wait for an inquest
- You develop insights into your own institutions' capacity issues and can provide these data to your decision-makers