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EXECUTIVE SUMMARY

In 2017, the Champlain LHIN In-Patient Mental Health and Addictions (MH&A) Capacity Plan (Optimus SRB, 2017) was approved by the LHIN Board of Directors. Embedded in this plan is a recommendation to address capacity for high-needs specialized populations and acute mental health services. The plan describes the current in-patient capacity challenges and identifies that capacity and flow issues or surges are currently being managed through local hospital workarounds rather than at a systems level. Capacity and flow need to be addressed at both the individual hospital and the regional level in an attempt to avoid these surges.

To date, there is no formalized protocol for addressing in-patient MH&A surge in the Champlain region despite the fact that many acute mental health units at regional hospitals experience chronic overcapacity. When this over-capacity becomes unmanageable at one or more hospitals, informal and irregular scrums occur where the hospitals work together on ad hoc workarounds which are short-term focused.

Overcapacity and surges in demand must be viewed primarily from the lens of patient safety. In surges, patient safety is of primary concern as acute hospitals may have MH&A patients on stretchers awaiting a room or placed on temporary wards. Key patient safety questions to be considered in this surge protocol are:

- At what levels of staffing, facilities and resources can hospitals provide high quality mental health care and when does that care begin to deteriorate by these demand pressures?
- How can patients be kept safe and their care unhindered if it becomes necessary to transfer them to another facility due to high levels of demand?
- What occurs as a surge is called off in terms of patient care and repatriation?

This project focuses on the collaborative development of a regional surge protocol across the Champlain LHIN that ensures patient safety and family support by properly balancing system pressures. It aims at ensuring all possible mechanisms for managing capacity are utilized and acts as a catalyst for collaboration across the region.

This overall project will occur in two phases. The main purpose of Phase I is to gain agreement to an interim surge protocol, dashboard and communications plan to begin to take some of the short-term pressure off of the Schedule 1 hospitals. In Phase II, this interim protocol will be refined using lessons learned from use in surge scenarios and a deeper analysis of surge trends, forecasting and target population analysis will be conducted to determine if primary care and / or community agencies could assist in terms of diversion or post-discharge care.

There are three stages with respect to a surge: pre-surge, surge, and post surge. This protocol mainly focuses on the surge and post surge phases, but will recognize the importance of pre-surge efforts (i.e. preparedness).

The protocol aims to clearly define MH&A surges and outline an integrated, coordinated and collaborative hospital response with clients and families at the center and where success is defined by improved outcomes for the Champlain region. Key components of this protocol include surge triggers, communication, patient transfers, roles and responsibilities, cessation and repatriation. Phase II is scheduled for the 2018/2019 fiscal year and is focused on continuous improvement; elements of this upcoming work are identified at the end of this protocol.
INTRODUCTION

Increases, or surges, in demand for mental health and addiction services, whether predicted or not, can pose risks to the capacity and ability to deliver safe and appropriate health care services\(^1\). This Surge Protocol was written to address situations where a hospital finds itself in a surge and covers the three basic levels of surge (Minor, Moderate, and Major) with each being more serious in nature than the previous level; Major surges will be further defined in Phase II.

All surge levels are addressed to recognize the interdependencies and transitions which can occur between the various levels. Furthermore, in the cycle of surges there are periods of regular operations (Normal Conditions) both before and after a surge and these are critical times to reflect upon past surges and make improvements and preparations for future surges.

Information and ideas from reference documents, emails, draft reviews, and meetings have been incorporated to reflect the protocol development process for Champlain.

DIRECTION

Purpose

To maintain patient safety and family satisfaction during and after the most intense periods of demand (i.e. surges) on the mental health system while balancing the demand on hospitals across the system.

A note from the client’s perspective:

“First…it’s crucial to have clear communications between health personnel, partner hospitals and patients. In addition, to have a straightforward easy to understand dashboard that is not cluttered and to have clear wording that constitutes a Minor, Major surge etc.

Second, is that what certain patients may experience at the ED or on the way to the ED could be the difference between a person recovering and never going back to a hospital for ED care. On the other hand a person/patient who is severely depressed, in crisis and/or suicidal that is bounced around between hospitals could take this experience very hard, negatively and very personally. They might say to themselves: If the hospital doesn’t care about me what’s the point of living!! and things can snowball from there thus straining hospital capacities.

Finally, a negative experience and poor discharge planning will affect visits to the ED and aggravate hospital capacity and resources. A positive experience for persons/patients with a proper surge protocol, adequate communication between partner hospitals and good discharge planning will most likely in my opinion minimize the strain on the ED and the need for more surge beds or in short minimize major surges and improve safety and care for staff and patients.”

\(^1\) Adapted for mental health and addictions from Critical Care Services Ontario (CCSO) (https://www.criticalcareontario.ca/EN/StrategicInitiatives/Pages/Surge-Capacity-Management-Planning.aspx)
Objectives
The following objectives have been created to guide the actions of all stakeholders participating in the development of the Champlain LHIN regional MH&A surge protocol:

- Ensure the quality of care for MH&A patients requiring admission to beds and the support of family members.
- Develop an interim written regional surge plan agreed to and in place early in the new fiscal year.
- Define clear roles and responsibilities to guide coordinated preventative and reactive steps.
- Operate as a test case for new levels of collaboration and mutual support amongst the hospitals in Champlain in the delivery of high quality MH&A care.
- Reduce the frequency and duration of MH&A surges experienced by Champlain hospitals.

Guiding Principles
In developing and executing the Champlain LHIN MH&A regional surge protocol, all participating organizations and individuals will be guided by the following agreed upon guiding principles:

- A systems approach needs to be taken to manage increased demand and prevent surges:
  - All beds belong to the system and not individual hospitals
  - Success is achieved when all Champlain hospitals are successful. All hospitals must make efforts to manage their patient flow (ex. LOS, emergency performance, time for patient bed). This has a direct impact on emergency services and surge beds.
- All the parties (hospitals, LHIN) agree to a shared responsibility to ensure every patient is in a funded bed:
  - Regular funded beds will be filled before unfunded surge beds.
  - A hospital cannot say a funded bed is unavailable unless it has a very good reason (ex. influenza outbreak, fire) - all hospitals must stretch themselves whenever a Champlain hospital is in an overcapacity situation.
  - Funded / partially funded beds must be included in the bed complement.
- The CritiCall Dashboard will be the primary data source used by the hospitals, the Daily Flow Management Call (DFMC) and the LHIN Mental Health Senior Integration Specialist in capacity and surge planning.
- Both administrative and clinical leaders should participate actively in surge planning and initiation of a regional surge.
- An understanding that if a surge occurs, every attempt to mitigate to a non-surge state will be made.
- A hospital can call a moderate surge when they have confirmed there is no capacity for other Partner Hospitals to safely accept a sufficient number of transfers, where sufficient means that transfers, if possible, would allow the hospital to deescalate.
- It is ideal for all hospitals in the system to set similar surge thresholds across the region

2 The LHIN has not yet identified who will be assigned to this position (as of May 22, 2018).
• An expectation that standards of care are maintained where possible including family and client involvement and communication.
• Patients should be kept at their current level of care if possible. If maintaining their current level of care is not possible, transfers should be safe, timely, close to home, and based on acuity34; these and other considerations will be defined and decided by each hospital.
• Hospitals responsible for a particular level of care should not select high acuity patients for transfers because they require greater/higher levels of care and resources.
• Patients should return to the most appropriate level of care after a surge has been terminated
• Patient and family considerations (such as proximity to home) should be strongly considered
• Clients generally want the fewest possible transfers, care close to home, care at the organization they prefer and service in their language (ex. English, French). If the client’s mother tongue is French, transfer the patient to Montfort. If mother tongue is not French or English and patient prefers to receive care in French, transfer the client to Montfort.

Participating Hospitals

This protocol is intended for the following hospitals5 within the Champlain LHIN.

Academic Health Science Centers:

• The Ottawa Hospital (Civic Campus)
• The Ottawa Hospital (General Campus)
• Hôpital Montfort

Community Hospitals:

• Queensway Carleton Hospital
• Cornwall Community Hospital
• Pembroke Regional Hospital

Specialized Psychiatric Hospital / Academic Health Science Center:

• The Royal Ottawa Health Care Group

Index and Partner Hospitals and Governance

The terms Index Hospital and Partner Hospital are used throughout this protocol.

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3 Acuity – “the level of severity of an illness. This is one of the parameters considered in patient classification systems that are designed to serve as guidelines for allocation of nursing staff, to justify staffing decisions, and to aid in long-range projection of staffing and budget” (Source: https://medical-dictionary.thefreedictionary.com/acuity).
4 Not necessarily an ED patient.
5 The Children’s Hospital of Eastern Ontario (CHEO) is not included in the list of hospitals as this protocol is only aimed at adults.
**Index Hospital:** A hospital experiencing a surge

**Partner Hospital(s):** Hospital(s) within the Champlain LHIN which support the Index Hospital.

**Regional Inpatient Capacity Governance:** The structure identified for MH&A surges (see below) was developed and captured within the Champlain LHIN In-Patient Mental Health and Addictions (MH&A) Capacity Plan and has the Champlain LHIN as the highest authority. The LHIN oversees the Executive Committee, which oversees the Operations Committee which oversees the Regional Program Working Groups (ex. System Capacity & Flow Working Group), Regional Program Office and MH&A Hospital Programs. It is anticipated that this protocol will fall under the auspices of the System and Capacity Working Group.

### SURGES - OVERVIEW

**Surge Cycle**

Ideally, hospitals will have the capacity they require for the demand and will not experience a situation where the demand exceeds capacity allowing hospitals to provide the best health care services possible. Surge protocols exist because this is not always the case.

When a hospital transitions from a normal state (See Figure 1) where demand is less than capacity to a situation where demand exceeds a hospital's normal capacity, a threshold trigger occurs and the hospital enters into a surge phase where its capacity is exceeded by varying, and potentially escalating, degrees. There are three levels of surge (Minor, Moderate and Major – See Table 1) where an increase in the total length of stay and increased crowding of emergency departments (ED) occurs.

At each level of surge (overcapacity) the desire is to return to the next lowest surge level and ultimately return to a normal state. In working toward re-establishing the normal state, individual organizations and partner organizations must implement multiple strategies and tactics while ensuring patient safety is not compromised.

Successful implementation of these strategies and tactics will cause a reduction in overcapacity; this process may take a few days. When demand dips below a hospital's capacity threshold this triggers an indication that the surge is over and criteria for a normal state is re-established.
Normal Conditions: A hospital situation where MH&A in-patient services demand is lower than capacity. Within CritiCall (Appendix A) this is indicated with the colour GREEN.

Surge: A hospital situation where MH&A in-patient services demand is greater than capacity.

Surge Types: There are three types of surges called Minor, Moderate, and Major surges. Minor and moderate surges are colour coded YELLOW and RED (as per CritiCall) and Major Surges are indicated as BLACK in this protocol (Major surges are not given a colour in CritiCall).

Table 1 provides definitions for each surge type for hospital bed capacity and demand thresholds as well as accountability and surge management information.

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6 Source: Adapted from CCSO’s Moderate Surge Strategy Toolkit
## Table 1 - Surge Categorization

<table>
<thead>
<tr>
<th>SURGE THRESHOLDS</th>
<th>Normal</th>
<th>Minor Surge</th>
<th>Moderate Surge</th>
<th>Major Surge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Definitions</strong></td>
<td>Where demand is less than or equal to capacity.</td>
<td>An acute increase in demand for MH&amp;A in-patient services <strong>limited to an individual hospital</strong> where the mitigation response is localized.</td>
<td>A larger increase in demand for MH&amp;A in-patient services at the regional LHIN level. The increased demand beyond the critical threshold <strong>requires the support of partner hospitals</strong> and mitigation response occurs at the regional level.</td>
<td>An extreme demand for MH&amp;A in-patient services for an extended period of time which cannot be accommodated at a regional level and instead <strong>requires a provincial or national response.</strong></td>
</tr>
<tr>
<td><strong>Champlain Threshold Definitions</strong></td>
<td>Normal situation occurs when capacity ≤ 100%</td>
<td>Minor Surge occurs when capacity &gt;100% and &lt;115%.</td>
<td>Moderate Surge occurs when capacity &gt;/=115%). All MH&amp;A beds within a hospital are full and reaching out to have other hospitals help is the only option.</td>
<td>A state in which all Champlain hospitals listed in this protocol are in a state of Moderate Surge. There is no capacity in the region to accommodate additional clients.</td>
</tr>
<tr>
<td></td>
<td><strong>Green bar</strong> indicated in CritiCall MH&amp;A Adult Bed Board</td>
<td><strong>Yellow bar</strong> indicated in CritiCall MH&amp;A Adult Bed Board</td>
<td><strong>Red bar</strong> indicated in CritiCall MH&amp;A Adult Bed Board</td>
<td><strong>Colour NOT indicated</strong> in CritiCall MH&amp;A Adult Bed Board</td>
</tr>
<tr>
<td><strong>Accountability (Oversight)</strong></td>
<td>Individual hospital</td>
<td>Individual hospital with notification to LHIN Mental Health Senior Integration Specialist and partner hospitals</td>
<td>System Capacity &amp; Flow Working Group with escalation as per the Governance structure.</td>
<td>MOHLTC</td>
</tr>
<tr>
<td><strong>Surge Management</strong></td>
<td>Hospital has the internal resources or can obtain them independently.</td>
<td>Hospital has the internal resources or can obtain them independently.</td>
<td>Human resources obtained from within the LHIN</td>
<td>Human resource must be obtained outside the LHIN to meet the demand</td>
</tr>
</tbody>
</table>
| | Not required. Preventative measures and improvements only. | Hospital’s internal data, protocols and procedures | - Regional Surge Protocol  
- Collaborative real-time solution development via DFMCs  
- Patient transfers | |

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7 Critical Care Services Ontario (CCSO) surge protocol threshold definitions are used and are deemed to apply well to mental health, especially for Normal, Minor and Moderate thresholds.
**Surge Beds - Bed Capacity and Location**

Within the Champlain LHIN there exist various types and numbers of MH&A bed resources distributed among Champlain hospitals. In early 2018, the Champlain hospitals requested an inventory of MH&A beds including funded and unfunded surge bed capacity. Since the initial bed inventory there has been an attempt to consolidate the information between the Winter 2018 bed capacity table with the data available through CritiCall. The results of this work are captured in Appendix B.

An annual review of the physical location of surge beds will be undertaken by the Operations Committee to ensure these beds are in the best location to be effectively utilized.

**PRE-SURGE**

**Normal Conditions**

Under normal conditions hospitals will have the capacity they require for the demand thus creating the best conditions to provide health care services. Hospitals will not experience a situation where the demand exceeds capacity.

Under normal conditions clients flow through the following process below without a bottle neck at any step:

**Patient Flow**

1. Person enters ED
   a. Self-directed – Client (with or without friend or family)
   b. Ambulance and police directed -paramedics and police will direct MH&A clients to the hospitals / EDs,
2. ED triages person
3. ED decides:
   a. Person is discharged
   b. Person is admitted
   c. Person is admitted/no bed
4. Bed opens in Index Hospital – admit-no-bed patient is admitted
5. No beds opens in Index Hospital
   a. Patient stays as admit-no-bed
   b. Hospital seeks open funded bed in Partner Hospital
      i. Index Hospital views bed openings in CritiCall
      ii. Index Hospital sees funded bed open at Partner Hospital
      iii. Index Hospital contacts Partner Hospital
      iv. Partner Hospital declines transfer (return to 4 and 5b)
      v. Partner Hospital accepts transfer
      vi. Index Hospital arranges transfer
6. Both Index Hospital and Partner Hospital update the CritiCall Bed Board
Definitions:

**Repatriation** - It is the decision and process of transferring a patient to a lower level of care.

**Transfer** – It is the process of physically moving a person from one facility to another.

**Discharge** – It is the process recognizing and stating the patient no longer needs the facility’s services.

**Receiving Hospital** – The hospital to which the patient is being transferred.\(^8\)

**Sending Hospital** – The hospital where the patient is currently receiving services.\(^9\)

**PATIENT TRANSFERS**

**Assessment of Need to Transfer**

Hospitals must assess ability and readiness when selecting patients for transfer. Key assessment criteria include acuity (medically stable patients for The Royal), stability, progress versus treatment plan, discharge destination (ex. going to tertiary versus the community), and whether or not patients will be transferred from the ED, the unit or both. A key consideration is patient and family comfort and willingness.

**Decision to Transfer**

When hospitals are making patient transfer decisions, apply the following decision guidelines below. In all cases, consulting patients and families on the transfer must be standard communication (See ‘Patient and Family Communications’):

- Send patients from the ED.
- Look for patients who can be safely transferred and have a willingness to transfer.
- Look for those who are known to other hospitals for continuity of care.
- Clients being transferred to the Royal must be Royal patients or from their waitlist\(^10^{11}\).
- Look for francophone patients who can be safely transferred to Hôpital Montfort.
- Patients for transfer to tertiary care should be those that the index (referring) acute care hospital feel are at the highest severity and complexity (i.e. those most in need of tertiary care)
- *Then go down the list:*
  - Have the client sent from the unit because there is no one suitable to transfer from the ED;
  - Pre-emptively identify clients for transfer on intake in case they are offered beds;
  - Patient and family sensitivity to be transferred is assessed. Those who would not like to be transferred will not be;

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8 Ibid
9 Ibid
10 This will be evaluated during the development of the Major surge response in Phase II.
11 Consideration may be given by The Royal to include accepting patients deemed to require longer inpatient stay.
Patients need to be deemed medically cleared for transfer.
If there are specific exclusion criteria, they should be made transparent; physicians can't have their own individual criteria.
Physicians decide if the patient is suitable for transfer.

Patient and Family Communications

Communication with patients and families is an important and major consideration. The following should be considered when communicating with patients and families:

- Patient and family considerations should be at the forefront of communications.
- Communication around transferring a client to another hospital needs to be done in a way that is clear and in a way that patients and families have all of the necessary information.
- Over capacity needs to be expressed in a way in which patients and family members do not feel it is affecting their loved one’s ability to be admitted or cared for. For Example, saying that there are no free beds available for the patient at this time while also telling the family they do not believe the individual needs to be admitted sends the wrong message to families.

Timing of Transfers

Day transfers between hospitals will occur as early as possible. For example, as soon as someone comes to an ED and an admission is needed, the transfer would occur – even if this is after hours. This decision would be made during the consult before all assessments are done.

Every effort will be made to transfer patients before 17:00, or at least identify the transfer before 17:00 thus allowing the receiving hospital time to get prepared.

The participating hospitals should consider standardizing their daily discharge times to facilitate planning.

Once a transfer has been agreed upon, the client must be admitted at the receiving hospital.

Transfer Process

When transferring patients is required, the following process for transferring/distributing admitted mental health patients from the Index Hospital to a Partner Hospital will be followed:

- Patient transfers between hospitals happen on a daily basis with the goal of transferring the client before the client is in a bed (i.e. not placed in a bed and then moved);
- Initiate transfer process as per regular procedures and checklists such as Appendix C – (DRAFT) Regional Medical Clearance and Repatriation Form which was developed with the current medical clearance used at Montfort and with the documentation from TOH;
- Ensure all necessary Patients (Substitute Decision Maker) Informed Consent is captured;
- Ensure all patient level information is available and transferable (lab results, medication, dietary, etc.);
- Ensure physicians are involved in and are aware of the most up to date patient level data;
• In alignment with the Patients First philosophy, those clients being impacted in the wake of a moderate surge are vital stakeholders. Communication with clients and families is crucial in ensuring smooth discharges and transfers during surge;
• Ensure clear communication with patients and family members regarding the transfer;
• Processes for transfers should be simple and not lengthy, which is always important but especially so during surges.

REPATRIATION

• Repatriation is the process of transferring patients from the discharging hospital to a setting more suitable to the person’s, now lower, level of care needs. Repatriation happens as soon as the need for a higher level of care is over, as determined by a physician.
• Repatriation is an ongoing activity and occurs under normal conditions as well as within a surge situation and ensures the delivering of the right level of care to patients who need it the most at the right time12.
• Repatriation, Transfers and Discharges need to be part of pre-surge mitigation processes and also be addressed throughout surges.
• Repatriation should always consider the client’s continuity of care.
• Once a transfer has been completed the patient will not be returned to the originating hospital with possible exceptions for patient / family considerations.
• Repatriation can happen during surge to reduce overcapacity. Repatriation will NOT occur between the Schedule 1 hospitals in Ottawa. Once a client is sent from one Schedule 1 to another Schedule 1, they will stay and complete their care at that hospital until discharged. An exception may be made to this rule when the patient in question is a well-known patient of another hospital, in which case the patient may be repatriated for treatment based on clinical judgement.
• Repatriation will occur from Schedule 1 hospitals back to Community Hospitals.
• CritiCall is not involved in repatriation because Flow Coordinators will be facilitating a hand off of the patient back to the sending hospitals.
• A Schedule 1 hospital who accepts a patient via a surge transfer should not necessarily be asked to provide outpatient care after the patient is discharged; consideration should be given to the mother tongue services offered by the hospital. Flexibility is permitted in situations where the receiving hospital is closer to the home of the patient or when a patient is new to the system.

12 Repatriation – FAQs. https://sunnybrook.ca/content/?page=discharge-planning-repatriation
<table>
<thead>
<tr>
<th>Repatriation</th>
<th>Transfers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client is stable and no longer needs higher level of care (i.e. return to original facility)</td>
<td>Hospital no longer has capacity (Surge)</td>
</tr>
<tr>
<td>Client resides outside of the Champlain LHIN</td>
<td>Client already has relationship with other Hospital (outpatient/psychiatrist) (i.e. TOH -&gt; QCH)</td>
</tr>
</tbody>
</table>

- Patients deemed stable, suitable and willing to transfer, will be repatriated to the referring hospital if a bed is available, (including to Pembroke) as soon as the patient is no longer on a Form, to the smaller non-schedule 1 hospitals without psychiatrists as long as the client no longer needs the care of a psychiatrist.
- After patients’ acute care needs have been addressed, the receiving hospital will strongly encourage patients to seek follow-up care at the hospital closest to home, as appropriate.
- The receiving hospital will follow their internal discharge planning process for patients that were transferred and have completed their inpatient stay, including communicating the treatment received, discharge details and post-discharge treatment plans to the patient’s health care providers.
- For patients that ARE connected to community/outpatient services, the receiving hospital will first ask the patient or substitute decision-maker (SDM) if follow-up post discharge by community agency or current outpatient program is desired. If yes, hospital will follow their internal discharge planning process and reconnect patient with their current provider(s) in the community.
- For new patients not connected to services and who need acute hospital outpatient care, the accepting hospital should be able to provide the outpatient care. The Royal’s outpatients are tertiary so unknown and not complex clients don’t meet the criteria for tertiary services; they need secondary level support which would look at what is closest to their home. For Montfort, if the person is English speaking, they would need to be transferred to a hospital which can provide English outpatient services. Patients should receive outpatient care in their language of choice.
- Using a common repatriation form can help streamline the repatriation process. For an example, see Appendix C – (DRAFT) Regional Medical Clearance and Repatriation Form which was developed with the current medical clearance used at Montfort and with the documentation from TOH. Additionally, Appendix D – Emergency Services Referral Form, which was developed by the 5 ACT teams in Ottawa and The Ottawa Hospital, is a form that teams are to send to the Emergency Department at TOH when a client has been referred/ formed under MH&A.
Preparedness

Being prepared ahead of a surge will improve the management of a surge when it occurs. Preparedness involves understanding and creating a readiness level to deal with all probable scenarios which may occur in a surge situation whether it is a Minor, Moderate or Major surge.

This work involves education, training, practice, systems, equipment, processes and protocols for patient and information flow and all communications tying these elements together. The best time to undertake these preparation activities is before and after a surge occurs.

Pre-Surge Mitigation Strategies (Under Development)

<table>
<thead>
<tr>
<th>NORMAL OPERATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Daily flow calls</td>
</tr>
<tr>
<td>• Accurate and timely CritiCall data</td>
</tr>
<tr>
<td>• Repatriation</td>
</tr>
<tr>
<td>• Placing ALC patients in the community</td>
</tr>
</tbody>
</table>

Patient Safety

It is critical for hospitals to monitor and manage their bed capacity levels, especially in relation to surge thresholds, when they are under normal conditions. This is important for the effective and efficient provision of health services but it is especially important in maintaining and improving patient safety during impending surges. A patient’s safety can be compromised:

• As soon as unfunded overcapacity beds are being opened;
• If discharges or admissions are being affected due to capacity issues;
• Due to changes in staffing levels where people are not being seen in a timely manner which can create discomfort;
• Due to higher than normal patient levels, where placing patients off-service or in unfunded beds creates the potential for distress and unsafe practices; and
• Discharge planning and execution of the discharge does not include a seamless supported transfer to community.
• Insufficient outpatient services (i.e. preventative measures) are available resulting in avoidable ED visits and admissions.

DAILY FLOW MANAGEMENT CALLS (DFMC)

A core element of managing surges as a system within Champlain involves frequent and transparent communication with an openness to collaborate on solving regional challenges related to surges. It is also understood that best practices related to surge prevention will be established and implemented in each individual hospital to mitigate Minor Surges to prevent escalation to a Moderate Surge which impacts other hospitals in the Champlain region.
A key practice which will help ensure effective and efficient patient flow between hospitals and provide an early detection system for potential impending surges is the participation in Daily Flow Management Calls (DFMC).

As an interim solution, until the LHIN Mental Health Senior Integration Specialist is identified, Alice Hutton and Andrew Savard from Champlain Pathways to Better Care will be the third party facilitator, a role commonly identified in Quality Improvement and Change Management practices. This interim third party measure, beginning in May 2018 and stopping on September 28, 2018, will allow individual hospitals to fully engage in the call by representing their hospitals and engaging in the development of solution (i.e. content) while the facilitator manages the meeting process.

The DFMC will be held by TOH, Montfort, Queensway each normal working day (See Appendix E –List of Daily Flow Management Call (DFMC) Participants), regardless of whether a current surge condition exists, with the following considerations:

- **Cornwall Community Hospital and Pembroke Regional Hospital**: these hospitals will access the CritiCall bed board prior to the 9:30 DFCM to determine if there is a Moderate surge occurring in Champlain hospitals. If a Moderate Surge is occurring these hospitals will participate in the DFCM to determine if they can support the other hospitals. If, upon joining the call, the DFMC team concludes that the assistance of these hospitals is not required these hospitals may immediately leave the call.

- **The Royal** will participate at least once a week on Tuesdays (as opposed to attending the LHIN 11:00 call). Additionally, The Royal will access the CritiCall bed board prior to the 9:30 DFCM to determine if there is a Moderate surge occurring in Champlain hospitals. If a Moderate Surge is occurring The Royal will participate in the DFCM to support the other hospitals where possible.

A standard template identifying key information to be shared at the DFMC will make the meetings more efficient, structured and standardized. The Situation, Background, Assessment, Recommendation, Repeat back (SBARR) (Appendix F) template will be understood by all DFMC participants and delegates. This form should be filled out for a delegate to attend the 9:30 call or used in a Moderate Surge.

Meetings should be short (approximately 15 minutes), regular and daily on each normal working day (Monday to Friday).

Participants are expected to attend with an inpatient census identifying how many discharges and timing of discharges will provide a sense of where clients will go (ex. housing); getting people to a safe place is very important in facilitating discharges.

This evidence based, real time rapid decision making teleconference call will provide hospital leaders with a snapshot of the top priorities for the region related to patient flow and active or potential surges within the region. The DFMC meeting process is outlined below.
**DFMC Process**

1. The CritiCall Provincial Hospital Resource System (PHRS) provides information on the availability of acute care and psychiatric beds and resources in Ontario hospitals. All Schedule 1 hospitals, the Royal and Pembroke Regional hospital, will designate a staff or staff members (administrative and clinical leaders) to access and update, in a timely manner, the CritiCall Bed Board.

   https://www.phrs.criticall.org/User/LogIn?ReturnUrl=%2f

2. Two times a day (at minimum\(^{13}\)) each hospital will update the CritiCall Bed Board at 8:00, 16:00:

   - 0800 – Data entered between 0600 – 0915 hrs (See point #3 below)
   - 1600 – Data entered between 1400 – 1759 hrs

3. The **CritiCall bed board must be updated before the Daily Flow Management Call.** Compliance and reporting standards will be monitored and evaluated.

4. All hospitals will assign Daily Flow Call Participants and Delegates to ensure consistency in the Daily Flow Management Call.
   a. Daily Flow Management Call Participants and their Delegates will have access to the CritiCall dashboard
   b. Participants on the call must have decision making authority and the ability to communicate swiftly with clinical directors and physicians who would discharge or admit patients transferred as the result of the call.
   c. Daily call representatives must have familiarized backup staff to ensure all hospitals participate and contribute to rapid fire solution development
   d. Non-Schedule 1 facilities should be involved in the flow call when they have a patient that the DFMC decides should be transferred or repatriated.
   e. In the case of a Moderate surge, non-schedule 1 hospitals should be included in the Daily Flow Management Call.
   f. A CritiCall suspension needs to be escalated to the Vice Presidential / Chief of Staff or Psychiatry level.

5. The Daily Flow Management Call (teleconference) will have Partner Hospitals communicate their surge status (Normal, Minor, Moderate) and flag any potential escalations (ex. ALC\(^{14}\) levels), discuss flow, pending discharges, and mitigation strategies.

\(^{13}\) Additional data entry times are: 1200 – Data entered between 1000 – 1359, and 2400 – Data entered between 1800 – 0559.
6. The Daily Flow Management Call will be hosted by the LHIN Mental Health Senior Integration Specialist\(^{15}\) and will occur **every normal working day morning (Monday to Friday)** amongst all participating hospitals **at 9:30** as this is a time when discharges are generally decided.

7. Attendance will be tracked and monitored.

8. The length of time in minor surge can be taken into consideration and may indicate a need to escalate (i.e. LoT waiting in ED) and will involve sharing information and making decisions pertaining to flow, including:
   a. A moderate surge can be called if a single hospital is in minor surge for more than 5 days
   b. Surge Status (if an Index Hospital is in a Moderate Surge, they will declare it and follow the procedure under Moderate Surge (“Declaring a Moderate Surge”).

9. As noted above it is crucial that follow-up actions including timely communication with clinical directors and physicians who will be involved in admissions and discharges.

10. Brief post surge reviews will be initiated by the LHIN Mental Health Senior Integration Specialist to help identify areas of improvement (what worked, what did not work, and what changes can be implemented) to better prepare for future surges. Changes to internal hospital protocols, inter-hospital collaboration, and shared processes such as the surge protocol should be considered in this post surge review.

**10:30 Physician to Physician Call**

The 10:30 daily teleconference enables physicians to collaboratively make medical decisions regarding potential transfers and repatriation. The information will be shared in alignment with the confidentiality standard for a "Circle of Care".

A standard agenda will help facilitate the 10:30 Physician to Physician call during minor, moderate and major surges.

**11:00 LHIN Call**

The 11:00 call is mainly focused on critical care but does include a brief exchange of information on MH&A.

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\(^{14}\) “Alternate Level of Care (ALC) - When patients no longer need acute care in hospitals, they often remain in acute care beds while waiting to be discharged or transferred. They need an alternate level of care such as an appropriate community care setting or home care.” Central LHIN (http://www.centrallhin.on.ca/goalsandachievements/moreinitiatives/emergencydepartmentalc.aspx)

\(^{15}\) As an interim practice, Pathways will facilitate the DFMC until September 28, 2018.
A status report containing the outcomes from the 9:30 DFCM will be communicated via email to the LHIN prior to the 11:00 call by the LHIN Mental Health Senior Integration Specialist.\textsuperscript{16}

To recognize MH&A clients as part of the larger health system, and as people who may also need critical care, an Oversite Committee representative will attend the 11:00 teleconference whenever there is a moderate or major surge to communicate pressures within the MHA system.

**High Level Mitigation Strategies**

Mitigation strategies are plans and actions which reduce the impact of a Minor, Moderate or Major Surge. Prior to entering a Moderate or Major Surge call, each Index Hospital must ensure that mitigation strategies are being initiated or are in place so that Partner Hospitals know that predefined mitigation strategies have been exhausted. A sample list of shared mitigation strategies are identified in Appendix G – Surge Mitigation Strategies, for Normal Conditions, Minor, Moderate and Major Surges.

**MINOR SURGE**

**Triggering a Minor Surge**

When the demand exceeds a hospital’s normal capacity, a threshold (trigger) occurs and the hospital enters into a surge phase where its capacity will be exceeded by varying, and potentially escalating, degrees (minor -> moderate -> major). It should be noted that escalation may occur rapidly and appear as if lower level surges did not occur (ex. fire or flood of an ED would quickly become a Major Surge).

A hospital enters a Minor Surge when it fulfills the criteria outlined in Table 1 - Surge, An Index Hospital therefore declares a Minor Surge when...

**Thresholds - Champlain Definitions**

A Minor Surge will be called by an Index Hospital when it reaches capacity of >100% and <115% or Code Yellow on the CritiCall Dashboard.

**Surge Project Team Understanding:**

<table>
<thead>
<tr>
<th>Minor Surge (experienced within a single hospital setting)</th>
<th>TOH</th>
<th>QCH</th>
<th>Montfort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regularly Funded Inpatient Beds are full</td>
<td>Regularly funded inpatient beds are full</td>
<td>Regularly Funded Inpatient Beds are full</td>
<td>Regularly Funded Inpatient Beds are full</td>
</tr>
<tr>
<td>As soon as “surge” beds are starting to be used</td>
<td>As soon as “surge” beds are starting to be used</td>
<td>As soon as “surge” beds are starting to be used</td>
<td>As soon as “surge” beds are starting to be used</td>
</tr>
<tr>
<td>Psychiatric Emergency Beds are full</td>
<td>Availability of psychiatric coverage is a factor taken into consideration</td>
<td>Availability of psychiatric coverage is a factor taken into consideration</td>
<td>Availability of psychiatric coverage is a factor taken into consideration</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{16} As an interim practice, Pathways will facilitate the DFMC until September 28, 2018.
Minor Surge Approach

Each individual hospital is responsible for monitoring its capacity levels with respect to surge status and is to communicate this information at the DFMC and to the LHIN Mental Health Senior Integration Specialist.

When a hospital experiences a Minor Surge it is its responsibility to manage and deescalate the surge internally. The response therefore involves individual hospitals managing their increased capacity demands in-house with their own localized pre-determined mitigation strategies.

Individual hospitals will focus on transferring patients to other hospitals that have funded bed capacity BEFORE having to open and fill their own internal unfunded beds. This practice will help avoid situations where, for example, one hospital experiences a situation of a 115% capacity (with patients in unconventional bed spaces) while another schedule 1 facility has empty funded beds.

Minor Surge - Mitigation Strategies (Under Development)

<table>
<thead>
<tr>
<th>MINOR SURGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Filling funded beds in the system before opening surge beds (includes the Royal’s acute care beds)</td>
</tr>
<tr>
<td>• Interhospital transfers (TOH)</td>
</tr>
<tr>
<td>• Expedited discharges through active discharge rounding (bullet rounds)*</td>
</tr>
<tr>
<td>• Repatriation</td>
</tr>
<tr>
<td>• Hospital level Public Communication Strategy (similar to CHEO’s website advising of a busy ED which offers alternative solutions)*</td>
</tr>
<tr>
<td>• Physician overcapacity memo (communicates to the physician’s that a MH ward is over capacity at a specific site so that they can actively aid in supporting, and communicates to ambulance and police to redirect before a potential moderate surge)*</td>
</tr>
</tbody>
</table>

*Not yet in effect – for development in Phase 2

MODERATE SURGE

Triggering a Moderate Surge

If a Minor Surge escalates and the Index Hospital reaches the Moderate Surge threshold where it is no longer able to safely sustain MH&A in-patient services, a Moderate Surge response will be initiated.

A hospital enters a Moderate Surge when it fulfills the criteria outlined in Table 1 - Surge Categorization. An Index Hospital therefore declares a Moderate Surge when...

**Thresholds: Champlain Definitions**

Adopting Champlain threshold levels, a Moderate Surge will be called by an Index Hospital when capacity >=115% or Code Red on the CritiCall Dashboard.

**Surge Project Team Understanding:**

<table>
<thead>
<tr>
<th>Moderate Surge (starting to impact more than one hospital)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Any Hospital</strong></td>
</tr>
<tr>
<td>All beds within the Index Hospital are confirmed full (including surge beds – unfunded &amp; funded) and reaching out to have partner hospitals help is the only option.</td>
</tr>
<tr>
<td>The Index Hospital in question must ensure it has reviewed and exhausted all mitigation strategies to reassure Partner Hospitals that it has done its due diligence (Appendix G - Surge Mitigation Strategies).</td>
</tr>
</tbody>
</table>

**Moderate Surge Approach**

Addressing a Moderate Surge requires tools and processes to handle the dramatic increase in demand for in-patient MH&A services within the Champlain LHIN. During a surge all MH&A patients are to continue receiving safe and timely care in the most appropriate setting. The key elements of the plan are:

- The mobilization of hospital staff, space, equipment, and technology from other parts of the hospital to respond to an increased demand for MH&A services
- Enhanced communication between regional hospitals and the Champlain LHIN
- A swift response to increased demand for MH&A in-patient services by enabling a coordinated and regional response to capacity pressures affecting the system

**Declaring a Moderate Surge**

Any one hospital can call a Moderate Surge if it is overcapacity and must now depend on Partner Hospitals to help it deescalate to a Minor Surge but prior to calling a Moderate Surge the following must be completed:

- The Index Hospital has confirmed that there is no capacity to accept a sufficient number of transfers at any Partner Hospitals; sufficient number meaning the ability to decreasing the Index Hospital’s number of admitted patients to below their predetermined critical surge threshold.
- The length of time that a hospital is in surge is a reason to escalate (LoT waiting in ED).

The Index Hospital experiencing the Moderate Surge will declare it at the regularly scheduled DFMC:

- The Daily Flow Management Call procedure will be enacted.
• Once each Partner Hospital has identified their Surge Status, the Index Hospital(s) experiencing the Moderate Surge(s) will provide a status update to Partner Hospitals (Current situation, mitigation strategies implemented, requested needs and services)
• The Partner Hospitals will identify available capacity for patients to be transferred as well as any other measures to deescalate the Moderate Surge, AND this needs to be communicated to the client upon admission to a hospital.
• Hospitals make the agreed upon arrangements for patient transfers (See ‘Transfers’)

Moderate Surge - Mitigation Strategies (Under Development)

<table>
<thead>
<tr>
<th>MODERATE SURGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Expedited discharges</td>
</tr>
<tr>
<td>• Enlist LHIN to respond to flow of ALC to sub-acute care(^{18})*</td>
</tr>
<tr>
<td>• Police Redirect*</td>
</tr>
<tr>
<td>• Ambulance Redirect (mindful that this redirects all patients, not just MH)</td>
</tr>
<tr>
<td>• System level public communications strategy potentially working with OPH or other partners to let the public know there is a moderate surge and to suggest diversions where appropriate.</td>
</tr>
<tr>
<td>• Suspension of CritiCall On-Call Responsibilities (Bypass)</td>
</tr>
</tbody>
</table>

**MAJOR SURGE**

**Triggering a Major Surge (Escalation)**

A Major Surge will be triggered when an unusually high increase in demand exceeds regional resources and exists for an extended period of time. Examples of a major surge could be a natural disaster, flood or fire within an ED

A hospital enters a Major Surge when it fulfills the criteria outlined in **Table 1 - Surge Categorization**

**A Major Surge is declared when...**

**Thresholds: Champlain Definitions**

Adopting Champlain threshold levels, a Major Surge will be called by the Operations Committee when ALL Champlain hospitals listed in this protocol are in a state of Moderate Surge.

**Surge Project Team Understanding:**

<table>
<thead>
<tr>
<th>Major Surge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Hospitals</strong></td>
</tr>
</tbody>
</table>

\(^{18}\) Not yet in effect – for development in Phase 2
Major Surge Approach (to be further developed in Phase II)

In the unlikely scenario where an unusually high increase in demand exceeds regional resources and exists for an extended period of time, the Operations Committee, Executive Committee, LHIN Leadership and CritiCall will hold a meeting.

The LHIN will be responsible for organizing a meeting for these key stakeholders and may include the MoHLTC representation.

Major Surge - Mitigation Strategies (Under Development)

<table>
<thead>
<tr>
<th>MAJOR SURGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Suspension of CritiCall On-Call Responsibilities (Bypass)</td>
</tr>
</tbody>
</table>

POST SURGE

De-escalation

Once back at the Minor Surge level, the affected hospital will use its own internal hospital response protocols to bring the hospital back to a normal state.

As noted above, following each Moderate or Major surge a review of the surge preparation and response will be initiated by the LHIN Mental Health Senior Integration Specialist. Moderate Surges will be reviewed at the Partner Hospital level, and Major Surges would include the highest levels of responsibility (Executive Committee, LHIN and MoHLTC).

Surge Cessation

A surge is deemed to be over (back to Normal Conditions) when 2 full days have passed. The LHIN Mental Health Senior Integration Specialist will make this determination and notify all hospitals.

The post surge period is an excellent time to reflect on the surge response (identify what worked, what did not work, and what changes can be implemented) to better prepare for future surges. Changes to internal hospital protocols, inter-hospital collaboration, and shared processes such as the surge protocol should be considered in this post surge review.

Surge Monitoring

Monitoring surge patterns regularly to identify underlying reasons for surges is key to understanding frequency of surge and sites most impacted, for example. A formal summary report with an evaluation will be produced every 3 months to the Operations Committee which will then review and provide recommendations to the Executive Steering Committee. The formal summary report may also be shared with community partners to enable their engagement in the surge prevention efforts.
DISPUTE RESOLUTION

Disputes may arise while working toward and maintaining the Champlain LHIN regional MH&A inpatient capacity improvements. Resolutions to disputes will seek understanding of all disputing partners and a desire to seek win-win solutions for all in the best interest of patients, families and the efficient and effective provision of care within the Champlain LHIN health system.

Potential areas of dispute may be related to, but not limited to, collaboration and implementation of this protocol, timely updates to the CritiCall Bed board, and acceptance of patient transfers.

When disputes cannot be resolved by the disputing members they will be first brought to the Operations Committee, and if not resolved presented to the Executive Committee, and can be further escalated to the Champlain LHIN.

COMMUNICATIONS

There are two main types of communication: proactive and reactive and both relate to surge planning and management.

Proactive Communications

Under Normal Conditions, Hospital Partners will support regular communications to educate the public on the variety of services available to them (in the community, online and via telephone) so that the public is fully aware of their options. The goal is to have clients access the right level of services when they need it before it becomes a crisis and before they choose to, or need to, access the ED. By addressing a person’s mental health and addictions needs earlier on, the demand on the ED can be reduced resulting in less mental health and addictions surges.

In Phase II procedures to inform paramedics and police as to the locations of the hospitals with the most MH&A capacity will be considered. This will help prevent a situation where one hospital experiences a surge and another hospital has unused capacity, especially where the two hospitals may be in close proximity to one another.

Reactive Communications

Once a surge has begun, shared key messages will be communicated to providers, paramedics, police, patients, families and the media. These messages are to educate, inform and reassure the target audiences that healthcare providers and the LHIN are working together, implementing strategies and taking actions to resolve the surge.

Proactive and Reactive Communications

The DFMCs are a great example of both proactive and reactive communications as they enable communications before surges, as soon as surges begin, during surges and after surges when lessons learned can be discussed.
Another example is the Surge Communication Plan (Patients & Families). This plan is a standardized plan that can be used to communicate capacity with patients and families based on patient/family expectations and knowledge exchange (Appendix H).

Phase II will consider broader measures to communicate with public regarding recommendations around how to deal with an individual in psychiatric distress and to notify the public that an MH&A surge is in process.

**ROLES & RESPONSIBILITIES**

**Governance**

This Surge Protocol will be implemented under the following governance structure 9below), identified within the Champlain LHIN Inpatient Mental Health & Addictions Capacity Plan Final Report 19. Resolution of issues, including disputes, will be attempted at the level in which they occur but can be escalated as needed. An interim process will be utilized until this governance structure is fully in place.

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Executive Level Governance

- People with lived experience
- Senior Executives – Hospital Inpatient MHA Programs
- Regional Program Leadership – Regional Administrative Lead and Regional Medical Lead

Operational Level Governance

- Regional Program Leadership – Regional Administrative Lead and Regional Medical Lead (co-chairs)
- Administrative leadership from Regional Program Inpatient MHA Programs

Delivery Level Governance

- Hospital Inpatient MHA program leadership

Regional Program Working Groups

- System Capacity and Flow
- Patient and Family Advisory
- Regional Standards
- People and Culture
- Reporting and Performance

*Note all working groups should include people with lived experience

Regional Program Office

- Regional Administrative Lead and Regional Medical Lead
- Project Management
- Communications Specialist
- Admin Support
- Data Analyst
PHASE II - CONTINUOUS IMPROVEMENT

The completion of Phase I will be marked by the Executive Steering Committee’s (ESC) approval of the Interim Surge Protocol, at which time this Interim Surge Protocol will be fully operationalized. In Phase II a Memorandum of Understanding (MOU) between hospitals will be created for the Final Surge Protocol.

In Phase II, the Phase I interim protocol is refined based on the lessons learned in its test implementation and will also include deeper analysis of surge trends, forecasting and target population analysis to determine if primary care and / or community agencies could assist in terms of diversion or post-discharge care.

Goals

Goals for this phase also include:

- Establish a regional surge plan process for continuous quality improvement.
- Provide a catalyst for, and support of, longer term capacity planning as envisioned within the IP Capacity Plan

Approach

- **Continuous Quality Improvement (CQI)** – Ongoing improvements

Team - Inclusion of Additional Stakeholders

- Police, Paramedics, Public, Dispatchers, Emergency services

Phase II

CritiCall Dashboard

- **Bed Complement**: Have surge beds reflected in the Complement because seeing the full actual Complement will help all hospitals in decision making; want to be more flexible with the denominator in the calculations. For example, the bed board does not identify the total existing off-services beds; only how many off-service beds are currently occupied. (Source: Surge Protocol Project Team Meeting: March 20th, 2018 Meeting Notes)

- **Barriers to CritiCall Use (Survey)**: A survey was suggested to identify barriers to using CritiCall by hospitals as well as capture best practices by those who have high compliance rates. The team agreed that: It is the hospitals’ responsibility to engage with the staff who do the data entry and ensure data quality and entry compliance to CritiCall dashboard, and it would be useful to collectively understand the CritiCall definitions, where interpretation comparisons can be made and the necessary education identified for common standards to be reached. (Source: Surge Protocol Project Team Meeting: March 20th, 2018 Meeting Notes)
**TOP PRIORITY: Alternate Level of Care (ALC):**

- **Develop strategies to address MHA ALC issues within hospitals**
- **ALC in dashboard** - Explore a dashboard which includes people waiting for a level of care that is not Acute (i.e. not ALC) such as people in the hospital awaiting transfers to residence care.
- **MH ALC cases: who are they?** Dual Diagnosis and ABI are well represented in this group. ALC population and impact on hospitals.
- **ALC as Early Detection Triggers** - In the pre-surge state, consideration should be given to the thresholds at which we think transfer of ALC’s to non-acute mental health beds might be made, and could be considered as part of the surge planning. Although the location of a bed is not known, if this issue is not addressed, there will be a perpetual state of surge.

**Data Analysis & System Process Mapping**

- **Intelligence** - (Occupancy Time Trends & Forecasts, Target Population Analysis, Interventions Indicated). ALC levels were suggested as a key predictor of surges; consider in forecasting / predictive modelling.
- **Hospital Transfer Data Analysis** - Possible hospital data request – history of transfers under current Criticall agreement
- **Availability of non-schedule 1 occupancy rates in Criticall (or elsewhere)** - investigate Daily Bed Census Summary for data availability
- **Consider small hospital occupancy data** - inform dashboard, or as contextual information
- **Process Mapping**: Mapping the current patient flow and identifying areas for quality improvement to achieve the desired future state
- **Criticall data analysis** – investigation of surge trends, population, data compliance, data quality, etc.
- **FTEs** - Collection of available MHA FTEs at all Champlain Hospitals
- **Erosion of MH funding within hospitals** - Investigate the erosion of MHA funding within hospitals over time.
- **Overnight Admissions from ED** - Analyze clients who are admitted (or transferred for admission) overnight from the ED for admission appropriateness.
- **Allocation of Regional Surge Beds** - Analyze the location of the "funded surge beds" for their appropriateness based on an organization's ability to properly staff the bed, space, etc.

**Alliance Services & ED Traffic Control**

- **Police and Ambulance services** - Develop partnerships with Police and Ambulance services to obtain their support during surge. Enable police and ambulatory staff access to Criticall information, communication of the surge protocol, keeping abreast of their processes, etc.
  - **Emergency Services Protocol** - Explore a protocol for police, ambulances and emergency services decisions related to the ED.
- **Community Services** - Add the role of, and access to, community services such as ACT teams, Case management and Supportive Housing.
• **ED Avoidance / Redirection** - “8. Emergency Department Avoidance Framework – Hospitals and Home and Community Care will work collaboratively to provide access to a full array of discharge options for patients from the emergency department, as a way to avoid an unnecessary admission or if the services are available and accessible in the community.” (ESC LHIN Surge Strategy – December 2017, p. 19)

• **CASH engagement** - Undertake site visits of all Champlain small hospitals to inventory their organizational and community MHA capacity. Assess actions that could support these organizations facilitate repatriations.

**Communications**

• **Emergency Services Access To Wait Times** - Explore benefits/risks of sharing the dashboard data with police, ambulances and the emergency services/paramedics (including dispatchers)

• **Public Access To Wait times** - Explore public access to wait times, as well as provide information on what clients can do before they need access to an ED.

• **Bed Locations** - Explore surge bed locations and evidence regarding demand and utilization. The surge beds should ideally be located at the hospitals with greatest surge. Exploration on how to free up space at the hospitals with greatest acute care/ surge to have room for those acute care/ surge beds can be undertaken.

**Surge Protocol Improvements**

• **Major Surge Protocol Expansion** - Expand protocol for Major Surge (i.e. before get/call a major surge, get LHIN involved as they can help with ALC beds)

• **Standardized Discharge Time** - “9. Standardized Discharge Time – Patient flow and capacity can be supported by enforcement of a discharge time from hospital (i.e. 11:00) as this will facilitate planning, patient transport, completion of discharge orders and provide the hospital with time to prepare the room/bed for the next admission. A standardized discharge time will allow for some predictability and planning to occur in support of flow.” (ESC LHIN Surge Strategy – December 2017, p. 19). This could help in terms of facilitating transfers during a surge. If all hospitals discharged at the same time it could cut down on after hours and late in the day transfers.

• **Patient Transfer with standardized transfer documentation** - Patient transfers between hospitals happen on a daily basis but there is no standardized transfer documentation, so this is a barrier. To create a standard form could be easy as only the program needs to approve the standard form (some issues with EPIC, Royal has some programs go through central intake and some not; no issues for Cornwall or Montfort.

• **Develop a protocol around exchanging patients** - Create a protocol that addresses patient exchanging during surge.

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20 It has been suggested that for Champlain, the discharge time should be 10:00 although some hospitals may find this is a barrier due to the length of time required for assessments and scheduling of family meetings to meet the 10/11 discharge time.
• **Discharge Process** - Developing a means to enhance the discharge process through partnerships to ensure that proper linking of clients to community services is occurring in a timely manner.

• **Psychiatric Emergency Services** - Leveraging the model in place at QCH whereby psychiatric emergency professionals are resourced within the ED helping to reduce admissions and link clients to community resources.

• **Weekend Transfers** - Explore having hospital transfers during the weekend.

• **Use of CritiCall for repatriation** - Consider advocating for the same standardized process for MH to mirror medicine and surgery where CritiCall is used for repatriation between organizations.

**Human Resources**

• Explore Health Human Resources (especially for psychiatrists) from attraction (including recruitment for education and employment), retention, and supply and demand forecasting for hospitals and potentially as a coordinated effort by the Champlain region.
Appendix A – CritiCall Dashboard (Sample Only)

CritiCall

The CritiCall bed board is a key resource supporting the Champlain LHIN regional surge protocol.

Background

Mental Health & Addiction Resource Board and Dashboard

CritiCall Ontario introduced the Adult and Child & Adolescent Mental Health & Addiction Resource Boards and Provincial Mental Health & Addiction Dashboards in March 2016 through CritiCall Ontario’s Provincial Hospital Resource System (PHRS). These resources provide up-to-date information about the number of available inpatient Mental Health & Addiction beds in all Ontario hospitals with mental health & addiction programs, as well as Mental Health & Addiction inpatient bed capacity information (based on the number of individuals waiting for inpatient beds).

(Source: CritiCall, http://www.criticall.org/Article/New-Noteworthy)
**Provincial Hospital Resource System**

“The Provincial Hospital Resource System (PHRS) provides a single source of information on the availability of acute care and psychiatric beds and resources in Ontario hospitals. Built and managed by CritiCall Ontario, the PHRS is available to all acute care and psychiatric hospitals in Ontario as a common system to keep bed and resource information up to date. CritiCall Ontario uses this information to assist with day-to-day case facilitation and during times of crisis or disaster when a coordinated effort to relocate patients from affected areas is required...”

This CritiCall Dashboard will be the primary data source used by the hospitals, the DFMC and the LHIN Mental Health Senior Integration Specialist in capacity and surge planning.

“CritiCall Ontario relies on hospitals to help keep the bed and resource information in the PHRS current. You can keep CritiCall Ontario informed of any changes to your resource or organizational information by completing the PHRS Service Inventory.

Hospitals and LHINs can request access to the PHRS. Once registered, PHRS users can visit the Document Library in the PHRS to access user manuals, educational materials including self-directed modules and webinar training schedules, and PHRS Hospital Reports for their organization. Contact your Client Relations Manager for more information including education and training opportunities.”

(Source: [http://www.criticall.org/Article/Provincial-Hospital-Resource-System](http://www.criticall.org/Article/Provincial-Hospital-Resource-System))
## Appendix B – Champlain LHIN MH&A Bed Capacity (SAMPLE ONLY: May 2018)

<table>
<thead>
<tr>
<th>Champlain Dashboard – Adult MH&amp;A Resources</th>
<th>Available Acute Beds</th>
<th>Specialized Beds</th>
<th>Surge Beds/Over Capacity Spaces</th>
<th>PES / Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General Acute</td>
<td>Short-Stay Crisis</td>
<td>Total Acute Beds</td>
<td>Complex Longer Term Mental Health (Schizophrenia North &amp; South)</td>
</tr>
<tr>
<td>11 - Champlain Total</td>
<td>184</td>
<td>8</td>
<td>192</td>
<td>40</td>
</tr>
<tr>
<td>Hôpital Montfort (Ottawa)</td>
<td>48**</td>
<td>48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queensway - Carleton Hospital (Ottawa)</td>
<td>24</td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ROHCG - Royal Ottawa Mental Health Care</td>
<td>8</td>
<td>8</td>
<td>40</td>
<td>14</td>
</tr>
<tr>
<td>TOH - Civic Campus (Ottawa)</td>
<td>42</td>
<td>42</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOH - General Campus (Ottawa)</td>
<td>39</td>
<td>39</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCH - McConnell (Cornwall)</td>
<td>16</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pembroke Regional Hospital</td>
<td>15</td>
<td>15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Includes Funded Surge Beds

Royal – 2 in Complex Longer Term/Schizophrenia, 1 in Geriatrics

NOTE: The Royal Bypass Beds - may need to suspend this practice during certain levels of surge - use these beds in an attempt avoid sending clients to the ED.

** 48 count from Winter 2018 census/ Count in Critcall is 46
## REGIONAL MEDICAL CLEARANCE & REPATRIATION FORM

### MD contact information

Phone: ____________________________
Fax: ____________________________

Is patient voluntary? □ Y □ N

Patient has a permanent address in Ontario? □ Yes □ No

Known history in mental health? □ Yes □ No

If certified, are you sending the original of the form 1? □ Y □ N

### HEALTH ASSESSMENT

1. Is the patient alert and oriented? □ Yes □ No
2. Are there any signs of psychosis? □ Yes □ No
3. Any problems with violence or aggression?
   If yes, please provide details: ____________________________________________

Vital signs: _______ Blood pressure: _______ Heart rate: _______ SAT: _______ Temperature: _______

1. Abnormal physical exam *(a physical exam must be done)* □ Yes □ No
2. New physical complaint(s) □ Yes □ No
3. History of active or chronic medical illness needing evaluations □ Yes □ No
4. Evidence of intoxication or withdrawal or know history of substance abuse □ Yes □ No
5. Altered level of consciousness or fluctuating mental status □ Yes □ No
6. Suspicion of pregnancy □ Yes □ No

If yes to any of the above questions, indicate which of the investigation are required. The investigations required must be completed before the transfer. Abnormal results must be discussed with the physician who accepts the transfer.

- □ CBC
- □ Electrolytes
- □ Urea
- □ Creatinine
- □ ETOH
- □ ASA
- □ Acet.
- □ Urine Toxicology
- □ ECG
- □ Diagnostic imaging

Other: ____________________________________________

Patient’s medical condition is sufficiently stable for interhospital transfer □ Yes □ No

### Treatments Done in the ED & Additional Comments

__________________________________________

Ongoing treatments needs ____________________________________________

I accept that the patient is returned if necessary when the mental health of the patient is stabilized. If a patient requires a repatriation, a request will be made through CritiCall.

Repatriation expected in the 48 hours? □ Y □ N

Please ensure the following:

- □ Patient’s belongings must accompany patient (identification, house keys and appropriate clothing for weather);

Physician Signature: ____________________________

Printed Name: ____________________________

Date: ________________ Time: ________________

34
# Emergency Services Referral Form

**Community Mental Health Teams – ACTT**

<table>
<thead>
<tr>
<th>Psychiatric Diagnosis:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Risk Factors for Harm:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Past Suicide Attempts or Self Harm (Date &amp; Method):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>History of Violence Towards Others (Describe):</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Absconding/Flight Risk:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Relevant History of Mental Health Issues (Describe):</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Significant Psychosocial History (Details):</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>History of Substance Use (Describe):</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Recent Mental Health Hospitalizations &amp; ER Presentations:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Best Possible Medication History (Details Incl. Negative Reactions &amp; Side Effects):</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Pharmacy:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Fax:</th>
<th></th>
</tr>
</thead>
</table>

*Please inform ACTT regarding any medication changes ASAP*

---

**ACTT Staff/Physician:**

Name & Discipline (please print): __________________________

**Time (24hrs):** ________________  **Date (DD/MM/YYYY):** ________________

*Additional information may be attached*

---

Page 2 of 2
Emergency Services Referral Form
Community Mental Health Teams – ACTT

Contact Information:
1. Bank ST ACTT
   Day Phone: (613)722-6521 x7300
   After Hours: (613)818-7547
   Fax: (613)739-8400
2. Carlington
   Day Phone: (613)722-9731
   After Hours: (613)223-4860
   Fax: (613)722-8244
3. Catherine ACTT
   Day Phone: (613)722-6521 x7109
   After Hours: (613)808-5585
   Fax: (613)233-6664

4. ECTI (Montfort)
   Day Phone: (613)688-1083
   After Hours: (613)722-6914
   Fax: (613)688-1087
5. FACTT-DD
   Day Phone: (613)722-6521 x7141
   After Hours: (613)915-5613
   Fax: (613)729-3315
6. PQ ACTT
   Day Phone: (613)820-4922 x3369
   After Hours: (613)220-5563
   Fax: (613)820-3955
7. Step Down
   Day Phone: (613)722-6521 x7370
   No After Hours service
   Fax: (613)739-8400

Demographic Information:
Name of Patient: ____________________________
DOB (DD/MM/YYYY) __________ Age: _______ Gender (Male/Female/Other): __________
Current Address: ____________________________

***ALLERGIES (Details): ____________________________

Mental Health ACT:
○ Voluntary ○ Section 17 – Case #: __________
○ Form 1 Issued: __________ ○ Form 2 Issued: __________
○ Form 47 Issued: __________ ○ NCR: __________
*Please attach copy of Form

Reason for ER Visit (Incl. Physical Health Concerns):
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

SDM or Power of Attorney for Personal Care: ○ Capable ○ Incapable
Name of SDM/POA: ____________________________ Relationship: ____________________________
SDM/POA Phone 1: ____________________________ SDM/POA Phone 2: ____________________________
Appendix E – List of Daily Flow Management Call (DFMC) Participants

<table>
<thead>
<tr>
<th>HOSPITAL</th>
<th>Clinical Representative</th>
<th>Administrative Representative</th>
<th>Additional Representative(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1)</td>
<td>(1)</td>
<td>(A)</td>
</tr>
<tr>
<td>TOH Civic</td>
<td>Name</td>
<td>Name</td>
<td>Name</td>
</tr>
<tr>
<td></td>
<td>Title</td>
<td>Title</td>
<td>Title</td>
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<td></td>
<td>Phone #</td>
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<td></td>
<td>Email</td>
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<td>Email</td>
</tr>
<tr>
<td>TOH General</td>
<td>Name</td>
<td>Name</td>
<td>Name</td>
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<td></td>
<td>Title</td>
<td>Title</td>
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<td>Email</td>
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<tr>
<td>Queensway Carleton Hospital</td>
<td>Name</td>
<td>Name</td>
<td>Name</td>
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<tr>
<td></td>
<td>Title</td>
<td>Title</td>
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<td></td>
<td>Email</td>
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<td>Email</td>
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<tr>
<td>Montfort Hospital</td>
<td>Name</td>
<td>Name</td>
<td>Name</td>
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<tr>
<td></td>
<td>Title</td>
<td>Title</td>
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<tr>
<td>The Royal</td>
<td>Name</td>
<td>Name</td>
<td>Name</td>
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<tr>
<td>Cornwall Community Hospital</td>
<td>Name</td>
<td>Name</td>
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<tr>
<td>Pembroke</td>
<td>Name</td>
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</tr>
<tr>
<td>LHIN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Champlain LHIN</td>
<td>Name</td>
<td>Name</td>
<td>Name</td>
</tr>
<tr>
<td></td>
<td>Title</td>
<td>Title</td>
<td>Title</td>
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<td>Phone #</td>
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<td>Email</td>
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</tr>
</tbody>
</table>

*not in current scope

http://www.champlainlhin.on.ca/~media/sites/champlain/Goals_Achvmnts/MHA/2017InptMHACapacityPln.pdf?la=en
### SBARR Report

**Date:**

**CALL DETAILS:** (613) 737-8999  Access Code: 731671 # (This number is not accessible from within TOH)  
TOH: 78999 (Extension)

**Hospital and Site:**

**Name of Index Hospital CEO/delegate:**

**Title (of delegate):**  
**Phone #:**

**Situation:** Please Provide Summary of the Situation in the section below

**What is your current status for MH/A beds? Please insert #:**

- _______ capacity at Moderate Surge level (≥ 115%)
- _______ # of funded Surge Beds Occupied
- _______ # of un-funded Surge Beds Occupied
- _______ # of ALC beds in MH/A
- _______ # of admits no-bed at facility
- _______ # of planned discharges – 1 to 7 days

**Confirm that your bed availability is updated daily (via Criticall)?**

- [ ] Yes  
- [ ] No

**Confirm that the hospital’s senior management team has been informed?**

- [ ] Yes  
- [ ] No

**Name of senior management who is informed:**

**Background: What Factors Led to the Moderate Surge Event?**

**Other Hospital Pressures:**

- __Total # of Patients (all conditions) in ED – admit/no bed

**Assessment: What are the threats to patients/operations (e.g. /beds/staff)**
What is your current patient complement? (Please insert the # of patients in each category)

___ # patients requiring 1:1 care
___ # patients are possible for a discharge in next 5-7 days
___ # patients are possible for a discharge in next 1-2 days

What responses have been executed? (e.g. flexed up, activated fan-out/call-in, called other sites)

List of patients requiring possible transfer? Fill out section below:

NOTE: For patient privacy this portion of the form will be for internal use only

<table>
<thead>
<tr>
<th>Pt #</th>
<th>Patient Identifier</th>
<th>Age</th>
<th>M/F</th>
<th>Diagnosis</th>
<th>Form 1 Y/N</th>
<th>Ideal Transfer Location</th>
<th>MRP Service</th>
<th>Necessity of 1:1?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>4</td>
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<td></td>
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<tr>
<td>5</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Recommendation

What are the recommended actions from the preamble call, proposed to sustain and provide safe patient care?

End of Form
Appendix G - Surge Mitigation Strategies (DRAFT)

<table>
<thead>
<tr>
<th>NORMAL OPERATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Daily flow calls</td>
</tr>
<tr>
<td>• Accurate and timely CritiCall data</td>
</tr>
<tr>
<td>• Repatriation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MINOR SURGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Filling funded beds in the system before opening surge beds (also includes the Royal’s acute care beds)</td>
</tr>
<tr>
<td>• Interhospital transfers (TOH)</td>
</tr>
<tr>
<td>• Expedited discharges through active discharge rounding (bullet rounds)*</td>
</tr>
<tr>
<td>• Repatriation</td>
</tr>
<tr>
<td>• Hospital level Public Communication Strategy (similar to CHEO’s website advising of a busy ED which offers alternative solutions)*</td>
</tr>
<tr>
<td>• Physician overcapacity memo (communicates to the physician’s that a MH ward is over capacity at a specific site so that they can actively aid in supporting)*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MODERATE SURGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Expedited discharges</td>
</tr>
<tr>
<td>• Enlist LHIN to respond to flow of ALC to sub-acute care*</td>
</tr>
<tr>
<td>• Police Redirect*</td>
</tr>
<tr>
<td>• Ambulance Redirect (mindful that this redirects all patients, not just MH)</td>
</tr>
<tr>
<td>• System level public communications strategy potentially working with OPH or other partners to let the public know there is a moderate surge and to suggest diversions where appropriate.</td>
</tr>
<tr>
<td>• Suspension of CritiCall On-Call Responsibilities (Bypass)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MAJOR SURGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Suspension of CritiCall On-Call Responsibilities (Bypass)</td>
</tr>
</tbody>
</table>

---

22 Not yet in effect – for development in Phase 2
Appendix H - Surge Communication Plan for Patients and Families

[TO BE DEVELOPED]
# Definitions Quick Guide

## Adult MH&A Resource Board Fields

<table>
<thead>
<tr>
<th>Field</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Beds</strong></td>
<td></td>
</tr>
<tr>
<td>Psychiatric Intensive Care</td>
<td>Designated for adults with mental health issues that require continuous observation and/or containment in a secured unit. A higher nurse-to-patient ratio ensures the safe management of patients admitted to these beds.</td>
</tr>
<tr>
<td>General Acute</td>
<td>Designated to stabilize, assess and provide short term treatment of adults with mental health issues.</td>
</tr>
<tr>
<td>Short-Stay Crisis</td>
<td>Designated for the rapid assessment and stabilization of adults with mental health issues and/or for extended observation purposes. The average length of stay of patients in these beds is ≤ 72 hours.</td>
</tr>
<tr>
<td>Total Acute Beds</td>
<td>The sum of all Acute Mental Health Beds</td>
</tr>
<tr>
<td>Acute Beds Occupancy Rate</td>
<td>Acute Beds Occupancy Rate = Acute Beds Occupied</td>
</tr>
<tr>
<td></td>
<td>Total Acute Beds Occupied - Total Acute Beds Unavailable Beds</td>
</tr>
<tr>
<td></td>
<td>This will be represented as a percentage (%)</td>
</tr>
<tr>
<td></td>
<td>If the Occupancy Rate is ≤100%, then the bar will be green</td>
</tr>
<tr>
<td></td>
<td>If the Occupancy Rate is &gt;100% and ≤115%, then the bar will be yellow</td>
</tr>
<tr>
<td></td>
<td>If the Occupancy Rate is ≥115%, then the bar will be red</td>
</tr>
<tr>
<td><strong>Specialized Beds</strong></td>
<td></td>
</tr>
<tr>
<td>Complex Longer Term Mental Health</td>
<td>Designated for the longer term assessment and treatment of adults with severe and persistent mental health issues requiring psycho-social rehabilitation such as schizophrenia</td>
</tr>
<tr>
<td>Mood and Anxiety</td>
<td>Designated for longer term assessment and treatment of adults with severe and persistent mental health issues such as mood and/or anxiety disorders.</td>
</tr>
<tr>
<td>Dual Diagnosis</td>
<td>Designated for the treatment of adults who have a developmental disability and mental health issues.</td>
</tr>
<tr>
<td>Geriatric Mental Health</td>
<td>Designated for the assessment and treatment of seniors/geriatric patients with mental health issues</td>
</tr>
<tr>
<td>Addiction / Concurrent</td>
<td>Designated for the treatment of adults with mental health issues experiencing substance abuse challenges (excludes withdrawal management programs)</td>
</tr>
</tbody>
</table>
## Specialized Beds

<table>
<thead>
<tr>
<th>Total Specialized Beds</th>
<th>The sum of all Specialized Mental Health &amp; Addiction Beds (excludes Eating Disorders)</th>
</tr>
</thead>
</table>
| **Specialized Beds Occupancy Rate** | **Specialized Beds Occupancy Rate =**

\[
\frac{\text{Total Specialized Beds Occupied}}{\text{Total Specialized Beds Complement} - \text{Total Specialized Beds Unavailable}}
\]

This will be represented as a percentage (%)

If the Occupancy Rate is ≤100%, then the bar will be green

If the Occupancy Rate is >100% and <115%, then the bar will be yellow

If the Occupancy Rate is ≥115%, then the bar will be red

<table>
<thead>
<tr>
<th>Eating Disorders</th>
<th>Specialized inpatient beds designated for adults with eating disorders</th>
</tr>
</thead>
</table>
| **Eating Disorders Occupancy Rate** | **Eating Disorders Occupancy Rate =**

\[
\frac{\text{Eating Disorders Beds Occupied}}{\text{Eating Disorders Beds Complement} - \text{Eating Disorders Beds Unavailable}}
\]

This will be represented as a percentage (%)

## Mental Health and Addiction Capacity

<table>
<thead>
<tr>
<th>Admit No-Bed Emergency Department</th>
<th>Number of patients who, after assessment by an Emergency Department Physician or Psychiatrist, receive an admission order to a mental health or addiction bed but remains in the presenting hospital's Emergency Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admit No-Bed Psychiatric Emergency Service</td>
<td>Number of patients who, after assessment by the Psychiatric Emergency Services (PES) staff, receive an admission order to a mental health or addiction bed but remain in a Psychiatric Emergency Service within the Emergency Department or alternate location</td>
</tr>
<tr>
<td>Admit No-Bed Off-Service</td>
<td>Number of patients who have been medically stabilized and admitted to a non-mental health inpatient bed until a mental health or addiction bed is available</td>
</tr>
<tr>
<td>Pending Community Admissions</td>
<td>Number of patients who are scheduled for admission within the next 24 hours into a mental health or addiction bed either directly from the community or directly from another healthcare facility.</td>
</tr>
<tr>
<td><strong>Total Pending Admissions</strong></td>
<td><strong>Total Pending Admissions = Admit No-Bed Emergency Department + Admit No-Bed Psychiatric Emergency Service + Admit No-Bed Off-Service</strong></td>
</tr>
</tbody>
</table>
| Mental Health and Addiction Capacity Rate | Mental Health Capacity Rate = (Total Acute Beds Occupied + Total Specialized Beds Occupied – Pending Discharges + Total Pending Admissions) / (Total Acute Bed Complement - Total Acute Unavailable Beds + Total Specialized Beds Complement- Total Specialized Unavailable Beds)

This will be represented as a percentage (%) |
<p>| Awaiting Assessment Emergency Department | The number of adult mental health and addiction patients waiting for a psychiatric assessment in the Emergency Department in the presenting Schedule 1 facility |
| Pending Discharges | Number of patients scheduled to be discharged from a mental health or addiction bed (either to the community or transferred to another facility) |</p>
<table>
<thead>
<tr>
<th>Adult MH&amp;A Resource Board Fields</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surge Capacity&lt;sup&gt;23&lt;/sup&gt;</td>
<td>If ≥ 115%, then the bar will be red and inside the box it will read the mental health and addiction capacity rate. If demand for service is beyond 115%, the hospital will need the assistance of their partner hospitals and community partners to assist with them in managing the surge of mental health or addiction patients. If &gt;100 % and &lt;115%, then bar will be Yellow and inside the box it will read the mental health and addiction capacity rate. If demand for service is beyond normal capacity, the hospital will work to resolve the capacity challenges internally and with community partners but may need the assistance of their partner hospitals for support in managing the additional mental health or addiction patients. If ≤ 100% then the bar will be green and inside the box it will read the mental health and addiction capacity.</td>
</tr>
</tbody>
</table>

### Reasons Bed Unavailable

<table>
<thead>
<tr>
<th>Reason</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Unavailable</td>
<td>Insufficient staffing is available to manage new admissions safely</td>
</tr>
<tr>
<td>Patient Demographics</td>
<td>Reduced bed availability due to a patient’s demographics such as age or gender</td>
</tr>
<tr>
<td>Clinical Presentation</td>
<td>Reduced availability due to high risk clinical presentation(s) requiring additional resources</td>
</tr>
<tr>
<td>Room(s) Under Repair</td>
<td>Reduced bed availability due to room(s) being under construction, cleaning, repairs or other issues affecting the physical plant</td>
</tr>
<tr>
<td>Infection Control Issues</td>
<td>Restricted bed availability due to an infectious threat or outbreak</td>
</tr>
<tr>
<td>Planned Slowdown / Closure of Beds</td>
<td>Reduced bed availability due to a planned slowdown or closure of beds</td>
</tr>
<tr>
<td>Emergency Closure</td>
<td>An internal or external emergency has resulted in the need to limit new admissions</td>
</tr>
<tr>
<td>Anticipated Availability</td>
<td>The anticipated date the majority of the unavailable beds will be back into service.</td>
</tr>
</tbody>
</table>

<sup>23</sup> Surge Capacity’ rate is not specifically defined in the CritiCall documentation. The definition was obtained from communications with Denise Polgar of CritiCall: Surge Capacity = \( [(\text{Total Acute Beds Occupied} + \text{Total Specialized Beds Occupied} – \text{Pending Discharges} + \text{Total Pending Admissions}) / (\text{Total Acute Bed Complement} + \text{Total Specialized Beds Complement})] * 100 \)