Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg — Caring for Health / À l'écoute de notre santé **PRIMARY HEALTH CARE OPERATIONAL GUIDELINE**	**Operational Guideline:** Transfer of Patients to Emergency Departments / Urgent Care or Crisis Response Service	**Guideline Number:** PCOG#18
	Approved By: Community Primary Care Council	**Pages:** 1 of 10
	Approval Date: April 11, 2017	**Supersedes:** July 20, 2012

1. INTENT:

1.1. To partner with facilities, programs and services to implement strategies to provide individualized care congruent with primary health care and health equity principles in order to increase safety and optimize care when individuals are transferred between facilities or services.

1.2. To outline the communication process and relationship between Primary Care, Emergency Departments / Urgent Care and Crisis Response Services to foster timely and relevant exchange of pertinent information is transferred at time of transition.

1.3. To align with WRHA Regional Policy Committeeship under the Mental Health Act [pending release link once available] to ensure clear lines of communication are identified between the Primary Care team, Delegated Case Manager and Adult Services Administrator to foster timely and relevant exchange of pertinent information when transferred to the Emergency Department / Urgent Care or Crisis Response Centre.

2. DEFINITIONS:

- **Adult Services Administrator (ASA):** Employees of the Public Guardian and Trustee (PGT) of Manitoba who manage the personal and financial affairs of adult individuals with an order of Committeeship.[1]

- **Delegated Case Manager:** Staff in a community program, most commonly either the Community Mental Health or Home Care Program who has case management responsibility for the patient whose personal care has been delegated to the delegated authority by the PGT.[1] Delegated Authority occurs when the PGT is the Committee for personal care and property of a Patient pursuant to The *Mental Health Act*, and the PGT has delegated some or all of its authority with respect to the personal care of a Patient to the WRHA.

- **Health Care Facility:** A hospital, personal care home, psychiatric facility, medical clinic, laboratory, CancerCare Manitoba, community health centre, or other facility in which Health Care is provided and that is designated in the PHIA regulations. *For the purposes of this guideline facilities refers to Urgent and Emergency Departments and Crisis Response Services.*

    - **Crisis Response Centre:** The Crisis Response Centre delivers a full range of mental health crisis response services for Winnipeg. A central point of access for adults experiencing a mental health crisis, accessible 24 hours a day, seven days a week.

    - **Emergency Department:** The unit/department within an acute care hospital that receives citizens who are experiencing acute/chronic health problems. Emergency Department specializes in managing life-threatening medical emergencies, providing assessment and treatment for urgent life-threating concerns (Concordia Emergency Department, Grace Hospital Emergency Department, Health Sciences Centre (Adult / Children's) Emergency Department, Seven Oaks Emergency Department, St. Boniface Emergency Department).

  - **Urgent Care:** specializes in handling non-life-threatening medical emergencies, providing assessment and treatment for urgent health concerns (Misercordia Urgent Care Centre).

- **Family:** the word family refers to persons who are related in any way – biologically, legally, or emotionally. In a patient and family-centered approach, the definition of "family" as well as the degree of the family's involvement in health care is determined by the patient. This is including, but not limited to, relatives, informal care givers, and friends. When the patient/resident/client is unable to define family, the patient/client/ resident's next-of-kin or substitute decision-maker provides the definition.

- **Patient/Individual:** any individual receiving health care provided by a WRHA facility, site or program, or funded facility, regardless of whether he/she is referred to as a Patient, client or resident. This includes either in-person, over the phone or via home visit. Also included are individuals who may not be a patient but are on the WRHA premises and experience an acute event that requires transfer to the Emergency Department / Urgent Care or Crisis Response services.

- **Winnipeg Fire Paramedic Service (WFPS):** In partnership with the WRHA, are responsible for pre-hospital emergency paramedical care and transport of the sick and injured in Winnipeg.

- **WRHA Staff**: includes all directors, officers, employees, volunteers, students, researchers, medical Staff, educators, information managers (as defined by Personal Health Information Act), trustees (as defined by PHIA), health agencies, contracted persons, or agents of any of the above, that work, provide services, or otherwise operate in connection with a WRHA facility or a WRHA funded facility unless excluded as set out within a particular service purchase agreement or funding agreement of the funded entity or program. This includes regulated and non-regulated health care providers.

  - **Primary Care Provider:** Licensed Physician, Physician Assistant, Nurse Practitioner, or Midwife that has assessed the individual.

  - **Primary Care Clinicians (PCC):** Refers to Primary Care Nurses, Dietitians and Pharmacists who are an essential part of a patient's medical home team.

3. GUIDELINE:

3.1. Upon determining the individual requires the services of an Emergency Department / Urgent Care or Crisis Response Centre the Primary Care Provider is responsible for contacting the site.

3.2. The emergency treatment reference guides attached to the Primary Care Practice Guidelines for individualized treatment in primary care shall be followed and treatment initiated as required.

3.3. Depending on the severity of the health concern, the Primary Care Provider will be responsible for ensuring the appropriate method of safe transportation occurs when the decision to transfer

the individual to an Emergency Department is made based on the their medical condition. Transportation options include:

- Individual transports independently
- Individual and escort transports independently
- Winnipeg Fire Paramedic Service

3.4. Incapacity is common and often not recognized. **Determining an individual's capacity is complicated; if the individual is not formed and subsequently there is a bad outcome any provider could still be liable for not transferring the individual.**

WRHA Legal Aspects: The law doesn't recognize "probably capable" or "probably incapable". The individual either is competent or not competent. From a Legal perspective if the clinical determination cannot be made, the presumption is that patients are competent and we cannot form under a Form 4 or proceed against their wishes.[2]

3.5. The Mini-Mental State Evaluation (MMSE) is useful only at extreme scores. The "Aid to Capacity Evaluation" (ACE) is the only instrument evaluated against a gold standard with an acceptable level-of-evidence score and robust test characteristics. It is based on the actual decision the individual is facing and is the best available instrument to assist Primary Care Providers and Clinicians in making assessments of medical decision-making capacity. More studies are needed, but in the interim, the authors recommend using the ACE to assist Primary Care Providers and Clinicians in capacity determination for primary care patients.[5] See APPENDIX A "Aid to Capacity Evaluation" http://jcb.utoronto.ca/tools/documents/ace.pdf

3.6. Capacity is influenced by a variety of factors, including situational, psychosocial, medical, psychiatric, and neurological factors. Accordingly, capacity exists on a continuum, can be evanescent, and can be optimized. Optimization can include treating reversible disorders that affect cognition (i.e, drug-induced or metabolic delirium), thought processes, or communication (i.e., patient with moderately severe Parkinson disease whose ability to communicate could be improved with medication adjustment); shortening and simplifying the information given to and asked of the patient; and using alternative methods of communication. Capacity is a basic requirement for informed consent and is determined based on the process of the patient's decision making rather than the final decision itself."[5]

3.7 **AID TO CAPACITY EVALUATION CLINICAL SCENERIOS:**

The initial ACE assessment is the first step in the capacity assessment process. If the ACE is definitely or probably incapable, considerable treatable or reversible causes of incapacity (e.g. drug toxicity). Repeat the capacity assessment once these factors have been addressed. If the ACE result is probably incapable or probably capable, then take further steps to clarify the situation. For example, if you are unsure about the person's ability to understand the proposed treatment, then a further interview which specifically focuses on this area would be helpful. Similarly, consultation with family, cultural, and religious figure and/or psychiatrist, may clarify some areas of uncertainty.[6] For more information on WRHA Mental Health Service and Support for Primary Care Providers please refer to the Stepped- Care Navigation Guide.

<u>Clinical Scenario 1:</u> The Primary Care Provider's overall impression on the Aid to Capacity Evaluation (ACE) falls into the category "Definitely Capable", but the individual is refusing ambulance transport to ED due to EMS cost

If the overall impression is "Capable" but the individual is refusing ambulance transport to ED due to financial hardship, the Primary Care Provider shall document in the individual's chart they are aware of the medical risks and risk to public safety. The Primary Care Provider does not need a specific form or waiver of any sort. It is sufficient to document within the EMR **"*Clinical Note"*** the individual has refused and is aware of the risks of not being transported via ambulance. [2]

- If refusal to transport via EMS is related to financial hardship and the Primary Care Provider manages to convince the individual through the course of the conversation be transported via EMS, the Primary Care Provider could consider writing a letter on behalf of the individual to see if it is possible to reduce or waive the EMS fees. The letter would be sent to:

  Emergency Medical Services
  Attention: Chief Operating Officer, Emergency Response and Patient Transport
  FAX: 204-926-7835
  CC: Chief Operating Officer, Senior VP Clinical Services and Chief Medical Officer
  FAX: 204-926-7007
  Primary Health Care Medical Director FAX: 204-940-8575

<u>Clinical Scenario 2:</u> The Primary Care Provider's overall impression on the Aid to Capacity Evaluation (ACE) falls into the category of "Probably Capable" and the individual is refusing ambulance transport to ED due to EMS cost

If the overall impression is "Probably Capable" but the individual is refusing ambulance transport to ED due to financial hardship, the Primary Care Provider shall document in the individual's chart they are aware of the individual's medical risk to themselves and to public safety. The Primary Care Provider does not need a specific form or waiver of any sort. It is sufficient to document within the EMR "***Clinical Note***" the individual has refused and is aware of the risks of not being transported via ambulance.[2]

- If refusal to transport via EMS is related to a financial hardship and the Primary Care Provider manages to convince through the course of the conversation the individual be transported via EMS, the Primary Care Provider could advocate writing a letter on behalf of the individual to see if it is possible to reduce or waive the EMS fees. The letter is to be sent to:

  Emergency Medical Services
  Attention: Chief Operating Officer, Emergency Response and Patient Transport
  FAX: 204-926-7835
  CC: Chief Operating Officer, Senior VP Clinical Services and Chief Medical Officer
  FAX: 204-926-7007

Primary Health Care Medical Director FAX: 204-940-8575

Clinical Scenario 3: The Primary Care Provider's overall impression on the Aid to Capacity Evaluation (ACE) falls into the category of "Probably Incapable" and the individual is refusing ambulance transport to ED due to EMS cost.

"Since the ACE requires individuals who are probably incapable, may need considerable treatable or reversible causes of incapacity (e.g. drug toxicity)."[6] If the individual requires further assessment and observation in an acute care setting as it may take further assessment and treatment to clarify the situation. As clarification may need to be completed in an acute care facility to ascertain the treatable or reversible causes of incapacity can be achieved.

If the individual refuses to transport via EMS is related to a financial hardship and the Primary Care Provider manages to convince through the course of the conversation the individual be transported via EMS, the Primary Care Provider could advocate writing a letter on behalf of the individual to see if it is possible to reduce or waive the EMS fees. The letter is to be sent to:

Emergency Medical Services
Attention: Chief Operating Officer, Emergency Response and Patient Transport FAX: 204-926-7835
CC: Chief Operating Officer, Senior VP Clinical Services and Chief Medical Officer FAX: 204-926-7007
Primary Health Care Medical Director FAX: 204-940-8575

Determining an individual's capacity is complicated; if the individual is not formed and subsequently there is a bad outcome any provider could still be liable for not transferring using the Form 4 process.

Clinical Scenario 4: The Primary Care Provider's overall impression on the Aid to Capacity Evaluation (ACE) falls into the category "Definitely Incapable" or MMSE > 30 and the individual is refusing ambulance transport to ED due to EMS cost refer to 3.7 of the guideline

3.7 INDIVIDUALS WHO REQUIRE INVOLUNTARY PSYCHIATRIC ASSESSMENT WHICH AUTHORIZES AN INDIVIDUAL BE TAKEN TO A PSYCHIATRIC FACILITY FOR AN ASSESSMENT BY A PSYCHIATRIST

- The PCP shall discuss with the individual the recommendation for voluntary or involuntary assessment. If involuntary assessment is required, a Physician shall complete Form 4 under Manitoba's - Mental Health Act for involuntary assessment (Application by Physician for Involuntary Psychiatric Assessment -Form #4 in triplicate) which authorizes an individual to be taken to a psychiatric facility for an assessment by a psychiatrist. See Management of Behavioural Emergencies Toolkit (Adult) Appendix D Guide to Complete Form 4 Application by Physician for Involuntary Psychiatric Assessment and Form 21 Certificate of Capacity on how to complete the form.

- The Central Police Number is **204-986-6222**. They will connect you with the appropriate District. If unsatisfied with the response time or response contacts the Duty Inspector at **204-986-6033.**

3.8 INDIVIDUALS WHO ARE KNOWN TO BE UNDER AN ORDER OF COMMITTEESHIP:

- If known, the Primary Care Providers and Clinicians shall advise and obtain a decision and instructions from the ASA for when a Patient has been transferred to a WRHA site.

- If known the Primary Care Provider needs to indicate clearly and provide to the transferring WRHA site whether the person has an Order of Committeeship or a Substitute Decision-Maker (either public or private) and if they have the contact information for the Public Guardian Trustee, Adult Services Administrator (ASA) and Delegated Case Manager.[1]

- The Delegated Case Manager, or other informal delegate, shall be notified by the Primary Care Provider or Clinician as they manage the following areas of care for an Individual who is subject to an Order of Committeeship for medical appointments.[1]

- The Primary Care Provider and Clinicians shall clearly flag a Patient's Committeeship status on the Patient's health record. This shall include a statement about the existence of the Order of Committeeship, the name and contact information of the Committee or ASA and the Delegated Case Manager along with any specific care recommendations such as a need for supervision or accompaniment to appointments.[1] See Appendix D Guide to Complete Form 4 Application by Physician for Involuntary Psychiatric Assessment and Form 21 Certificate of Incapacity on how to document in the EMR.

- WRHA Staff shall facilitate the transfer of information about the Committeeship status of a Patient if the care of that Patient moves to another program/site/facility within the WRHA.[1]

- WRHA Staff shall, when referring a Patient subject to an Order of Committeeship to an Emergency Department / Urgent Care or Crisis Response Centre shall transfer all of the relevant information by phoning the site and sending written communication via facsimile outlining:

  - The reason for the referral;
  - The relevant contact information for the Patient, his or her Family or Caregivers and the PGT;
  - Any recommendations for supervision or support;
  - The expectation that the WRHA Staff at the Hospital/Urgent or Emergency Departments shall consult with the PGT in accordance with the Committeeship under the Mental Health Act policy[1]

- Upon discharge/transfer from a site or program, WRHA Staff shall notify:
  - The Committee of the Patient;
  - The Delegated Case Manager and any WRHA Staff who are/or will be providing service to the Patient;
  - Family and Caregivers with relevant consents, as set out in the policies and procedures of the WRHA
  - The ASA and/or the office of the PGT.[1]
- Primary Care Providers and Clinicians shall discuss with the individual subject to an Order of Committeeship (and Family or Caregivers as appropriate), his or her consent for medical or psychiatric treatment decisions and determine each time if the individual:
  - understands the condition for which the treatment is proposed;
  - understands the nature and purpose of the treatment;
  - understands the risks and benefits involved in undergoing the treatment;
  - understands the risks and benefits involved in not undergoing the treatment;
  - has a mental condition affects his or her ability to appreciate the consequences of making a treatment decision;
  - is unable to provide consent or understand the implications of treatment, and if so, shall seek consent from the PGT. [1]
- Primary Care Providers and Clinicians shall consult with senior leadership on issues of disagreement between the WRHA and PGT, particularly in regards to:
  - any inability to engage with Patients or the ASA;
  - ethical decision making;
  - conflicts in expectations regarding activities to support the Patient;
  - conflicts in who shall be the Delegated Case Manager. [1]

3.9 The Primary Care Provider or designate may contact the WFPS for assistance in providing immediate treatment to the individual and transfer if necessary. Choice of Emergency Department destination will be determined by WFPS, in collaboration with the Primary Care Provider, based on the services required.

3.10 The Primary Care Provider (or Clinician who provides over the phone triage to ED/Crisis Response Service) shall provide the below information via phone / fax in advance of the transfer:

- Demographics: individuals name, address, and phone number, next of kin, Manitoba Health number and PHIN
- Relevant health history, medications, allergies, and advance care planning information
- If individual is being triaged over the phone the Clinician is to follow PCOG #5 Management of Telephone Inquiries as outlined
- Reason for transfer to acute care / crisis service and description of care provided at the clinic

- Name of Primary Care Provider and contact information
- WFPS to identify with the PCP and the Patient which Emergency Department the Patient will be transported to ensure the transition summary and associated documents are sent
- In cases where a Clinician is providing phone triage, the Clinician and individual will jointly determine which Emergency Department the patient will attend. Refer to current WRHA Emergency Department and Urgent Care Waiting Times
- The Clinician shall also follow up directly with the Emergency Department / Urgent Care or Crisis Response Service and ensure the transition summary and associated documents are sent.

3.11 The Primary Care Provider will speak to the attending physician or attendant via telephone in advance of the transfer. The following numbers are direct numbers and associated fax numbers:

DIRECT CONTACT PHONE NUMBERS: (as of February 2017)

SITE/SERVICE	PHONE NUMBER	FAX NUMBER
Concordia Emergency Department	**204-661-7119**	**204-661-7232**
Crisis Response Centre CRC Attendant	**204-940-3113**	**204-940-1764**
Health Sciences Centre Children's Emergency Department	**204-787-2306**	**204-787-1775**
Health Sciences Centre ADULT Emergency Department	**204-787-3167** **ALT #: 204-787-3160**	**204-787-5134**
		204-774-2075
Grace Emergency Department	**204-837-0117**	**204-837-5421**
Seven Oaks	**204-632-3223**	**204-694-8276**
St Boniface Emergency Department	**204- 237-2260**	**204-235-3140**
Victoria Urgent Care	**204- 477-3148**	**204-269-7671**

NOTE: Only one Phone Number and Fax Number entry shall be listed in the EMR.

3.12 The Primary Care Clinician who is providing telephone triage will speak to the charge nurse of the Emergency Department / Urgent Care or Crisis Response Services Attendant via telephone in advance of the transfer. See Phone numbers listed as above.

The Primary Care Provider or Primary Care Clinician shall:

- Complete the Emergency Department / Crisis Response Service transition summary See Appendix A - Emergency Department / Crisis Response Service Transition Summary. See Appendix B CSIS training material on How to complete the Emergency Department / Crisis Response Services Transition Summary.
- Fax a copy of the Emergency Department / Crisis Response Service transition summary through to the attending physician or Crisis Response Services with pertinent lab, diagnostics, assessment or consultation reports **including verification of whether written documentation has been given to the individual to present to the Emergency Department staff.**

- In the event the (possibly with an escort) will be transporting independently to the Emergency Department from the clinic, the Primary Care Provider shall provide the same transition summary and pertinent lab, diagnostics, assessment or consultation reports to the individual to present to the Emergency Department staff.
- In the event WFPS is required for transport, the Primary Care Provider shall provide written documentation to the WFPS attendant. Upon arrival to the Emergency Department, individual care will be managed by that site per the WRHA Regional Policy - Emergency Department Triage #110.080.010.

3.13 Upon arrival to Crisis Response Services, individual care will be managed by the Crisis Response services. Once the provider faxes all relevant information to 204-940-1764 (Attendant at the front). All relevant information identified in Adult Mental Health Ensuring Informational Continuity to be provided. The CRC Attendant provides the hard copy to the CRC provider. This information is subsequently scanned into the individual's chart. Upon arrival to Crisis Response Services, individual care will be managed by the Crisis Response services

4.0 REFERENCES:

1. Regional Policy: Committeeship under the Mental Health Act [pending release]
2. Daniel Ryall, Associate General Counsel, WRHA Legal (September 2016) and (March 2017)
3. Brian Sinclair Inquest Report (Judicial Inquest Judge Tim Preston), http://www.manitobacourts.mb.ca/site/assets/files/1051/brian_sinclair_inquest_-_dec_14.pdf, December 2014
4. Self-study module: Consult & Referral Request Letters Dr. José Francois, Medical Director – Family Medicine http://home.wrha.mb.ca/prog/primarycare/files/APPENDIXA-Consult.pdf
5. Consultation with CSIS Lisa Rempel, Senior Data Analyst, Jolanta Gronowski Education and Training, How to complete the Emergency Department Transition Summary in under 2 minutes
6. Sessums LL, Zembrzuska H, Jackson JL. Does this patient have medical decision-making capacity? JAMA. 2011;306 (4):420-427 http://unmfm.pbworks.com/w/file/fetch/45203290/Does%20this%20patient%20have%20medical%20decision%20making%20capacity_JAMA.pdf
7. WRHA Regional Policy - Emergency Department Triage #110.080.010, Joint Emergency Department Council meeting September 2016

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7.0 APPENDICES:

- APPENDIX A: Aid to Capacity Evaluation
- APPENDIX B: Emergency Department /Crisis Response Services Transition Summary
- APPENDIX D: CSIS Guide to Complete Emergency Department /Crisis Response Services Transition Summary

SCOPE: Applicable to all WRHA Primary Care Direct Operated Clinics, Quick Care Clinics, Family Medicine Teaching Clinics, Antenatal Home Care, Midwifery Services, ITDI and My Health Teams