Breath of Fresh Air

Smoke-Free at Victoria Detox

Project Team

Project Lead: Dr. Abhinav Joshi (Additions)

Project Participants:

- Dr. Janet Ray (Addictions)
- Dr. Ramm Hering (Addictions)
- Dr. Caroline Ferris (South Island Addictions Lead
- Melanee Szafron (Detox Operations Lead)

BACKGROUND

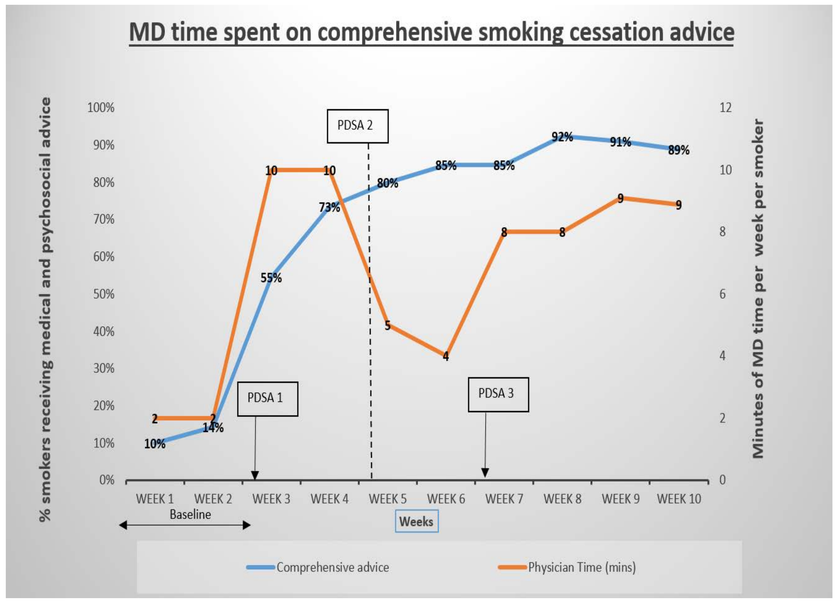
- Victoria detox is a 22 bed facility with an average treatment stay of 7 days.
- 65% of admissions to the facility have nicotine use disorder.
- Medications and psychosocial support can increase the likelihood of a successful quit attempt by 4-5x.

PROBLEM STATEMENT

Patients are not able to smoke during their detox stay. How can we use this opportunity to better engage them in smoking cessation longer term?

AIM STATEMENT

90% of smokers discharged from Victoria Detox will receive comprehensive smoking cessation advice during their stay by June 2023.



KEY FINDINGS

1. Simple changes to admission history taking can improve rates at which we are able to engage people in smoking cessation advice.
2. Taking advantage of education resources and patient text reminders from provincial agencies (Quit Now) can reduce MD time spent.

"Well, I got it half right, I quit smoking!"

Quote from patient with history of smoking 1 pack per day and alcohol use disorder seen with relapse to drinking 2 months later

MEASURES

1. Outcome: % smokers receiving medical and psychosocial advice regarding smoking cessation.
2. Balancing: Time spent by MD and RN per patient per week.

PDSA CYCLES

1. By updating the physician admission history with specific questions regarding smoking cessation, we will improve our primary outcome. This assumption was found to be true.
2. Having standardized patient education pamphlets from Quit Now will be helpful in reducing our balancing measure. This assumption was found to be true.
3. Pre-printed prescriptions for NRT, Varenicline/Wellbutrin and medication coverage forms will improve out primary outcome since patients may be hesitant to try medications that they will not be able to continue outpatient. This assumption was found to be false.

DATA ANALYSIS

- Retroactive chart reviews were conducted to establish baseline data
- Ongoing project data was collected through a brief patient "smoking cessation tracker" that staff completed

BARRIERS

- Limited capacity for longitudinal follow up
- Can feel overwhelming for some patients
- Significant staff turnover made ongoing staff awareness about the project challenging

CONCLUSION

- Practicing QI methodology allowed me to educate and support patients in addressing a key determinant of health outcomes
- Dream big but think in small iterative steps

NEXT STEPS

- Try to get longitudinal patient feedback to improve quit rates
- Collaborate with other withdrawal management services in VIHA (Nanaimo/Youth Detox

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Improving Care for Frail Older Adults in the Emergency Department

Reducing length of stay for patients referred to the Geriatric Emergency Management (GEM) team at Royal Jubilee Hospital Emergency Department

PHYSICIAN QUALITY IMPROVEMENT
An SSC Initiative

PROJECT TEAM

Project Lead: Alyson Osborne (Geriatrician)
Project Participants:

- Jeanine Marshall (Geriatric psychiatrist)
- Kathleen Norman (Registered Nurse)
- Angela Dejong (Occupational Therapist)
- Kelly Branchi (Registered Nurse)

AIM STATEMENT

Reduce length of stay in RJH ED for patients admitted to hospital who are referred to the GEM team from the ED by 30% by June 2023

BACKGROUND

Frail older adults have complex care needs challenging to meet in the ED. The GEM team identified prompt identification of frail older adults in the ED and expediting their movement out of ED as a priority for change to prevent hospital acquired physical and behavioural deterioration

PATIENT VOICE

"The person I help has Parkinson's with paranoia and mild dementia. It was all I could do to keep him calm. The longer we were there, the more hysterical he got. "

PROBLEM

Many frail older adults at RJH are spending prolonged periods of time in the ED awaiting transfer to an in-patient bed. This puts them at risk of confusion, requiring restraints, and deconditioning A review of patients referred to the GEM team at RJH in October 2022 showed average wait time of almost 24 hours in ED.

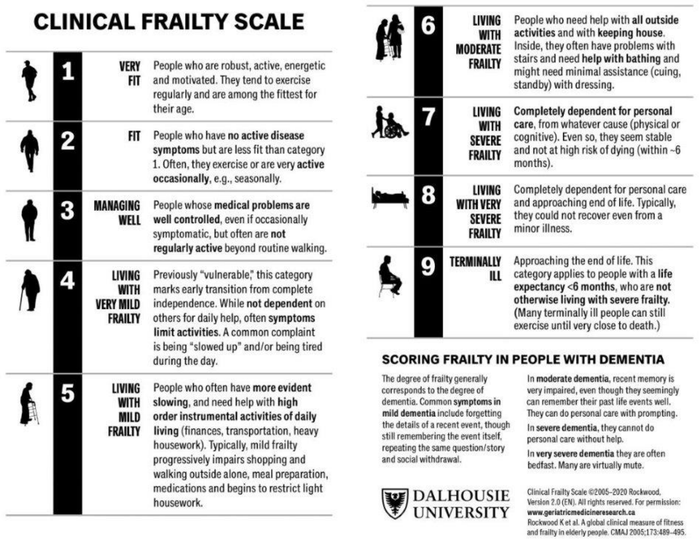
CHANGE IDEAS

- ED CNL's identify frail older adults for expedited transfer to in-patient bed
- Hospitalists identify frail older adults for expedited transfer to in-patient bed

PDSA CYCLE

ED CNL use new Screener to Identify Frail Patients
To expedite transfer to ward

Hospitalists to Identify Frailty
Asked to add frailty to problem list if Clinical Frailty Scale >or=5



DATA ANALYSIS

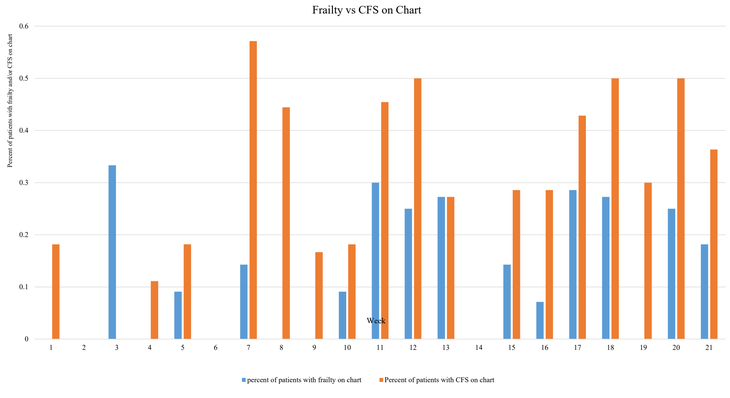
Measured LOS for all patients referred to GEM from ED:

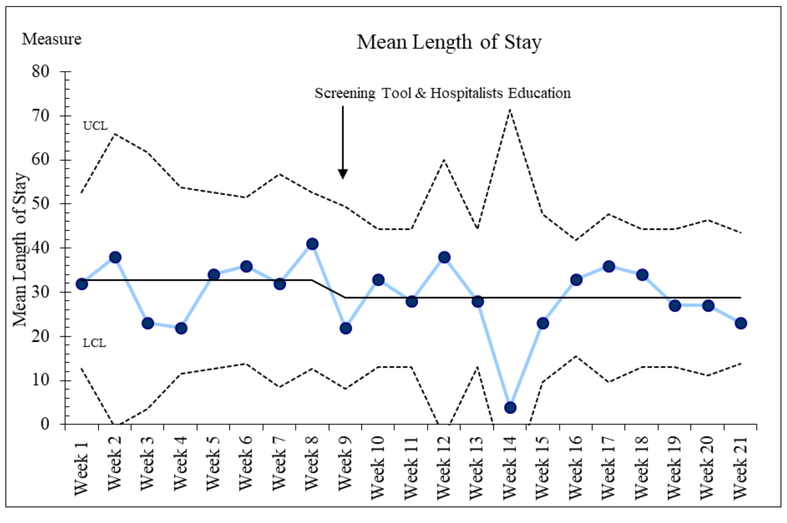
- Frailty on PowerChart Problem List (Y/N)
- CFS documented (Y/N)
- Collected data weekly
- Data analyzed at end of June

FINDINGS

Mean LOS for patients: 31.67 hours

- No significant change in LOS with interventions
- ED CNL felt screening tool useful
- Small improvement in hospitalist identification of frailty (none felt was time-consuming)





CONCLUSION

Mean LOS MUCH longer than 10 hour benchmark identified by Island Health

Many factors at play in ED LOS

- Bed management will always be an issue
- Need an enhanced protocol/dedicated resources for frail patients in ED

NEXT STEPS

Working with ED colleagues to improve care for frail older patients in ED

- ED CNL to continue to use screening tool
- Consider frailty-specific ED order set for patients
- Advocate for dedicated ED staff for frail patients

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PHYSICIAN QUALITY IMPROVEMENT
An SSC Initiative

Found in Translation(al Simulation)

Translational Simulation for Improving Difficult Airway Management in an Urban/Rural Hospital

PROJECT TEAM

Project Lead: Dr. Ava Butler
Terra Lee, Clinical Nurse Educator
Liam Raudaschl, Medical Student

AIM STATEMENT

To decrease the time to obtain the equipment needed for difficult airway management by nurses and physicians in the Cowichan District Hospital Emergency Department to less than 90 seconds by May 2023

PROBLEM

Nurses and physicians at Cowichan District Hospital Emergency Department (CDH ED) were not comfortable with obtaining the equipment for difficult airway management, especially if no respiratory therapist was available. It took an average of 319 seconds to just obtain the equipment for a procedure that needs to be completed within a maximum of 4 minutes (ideally faster).

PATIENT VOICE

"For any (patient) who is even slightly coherent to have people run around to get the equipment to help them to breathe is unbelievable. This will help so that patients will not suffer more. Not just the patients, but also the doctors and health care workers."

TRANSLATIONAL SIMULATION

Translational simulation uses representation of clinical scenarios to "directly improve patient care and health care systems." The *purpose* is what is different from traditional simulation; instead of changing individual or team performance, it aims to identify areas of the *system* that need improvement and provides simulation based interventions.[1]

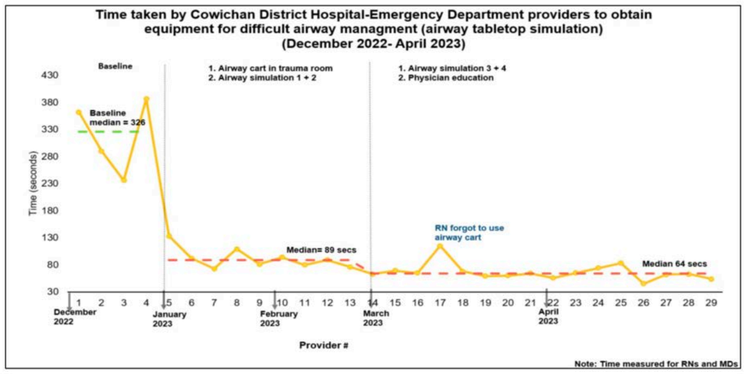
DATA COLLECTION

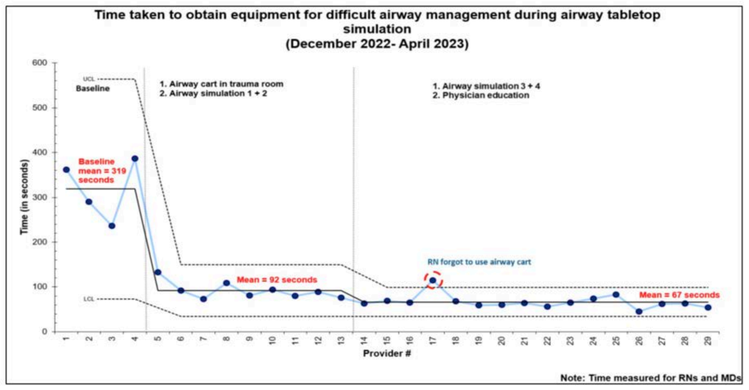
- Biweekly tabletop simulations of time to obtain airway equipment done with nurses and physicians (Outcome measure)
- Qualitative semi-structured interviews with staff about actual intubation cases (Process measure)
- Tracked attendance at non simulation education events (Balancing measure)

FINDINGS

- Average time to obtain equipment for difficult airway management decreased from 319 seconds (5.3 MINUTES!) to 61 seconds
- Staff interviews demonstrated growing comfort with both the equipment and the process for managing a difficult airway
- There was no significant change in attendance at non-simulation educational events

FINDINGS





Initial Discomfort with Equipment & Process

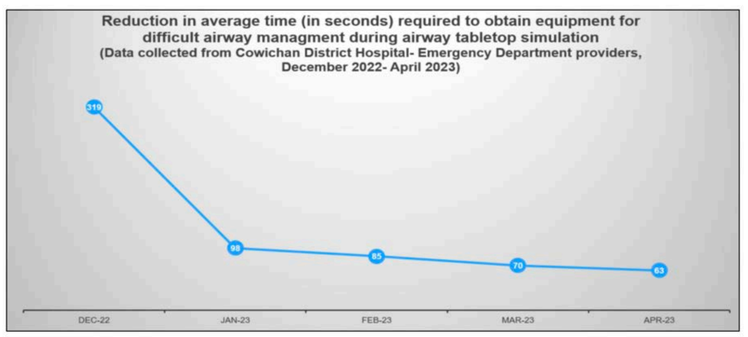
- "I was asked to find the equipment for intubation because, obviously, the doctor was running the show, and I had no idea what to even look for. So, I passed it on to a colleague, who also didn't really know what they were looking for."
- "My biggest fear with intubations is not having all the equipment available."
- "It wasn't like there was any time for anybody to brief anybody… so, I was not prepared for a Plan B."

Comfort with Equipment Layout

- "It was very helpful to have that airway cart there with all the extra rescue devices at the ready."
- "I've looked through that airway cart, it sure increases my confidence with finding stuff that I need"
- "Well, shoot! This is pretty handy!"

Comfort with Process in Teams

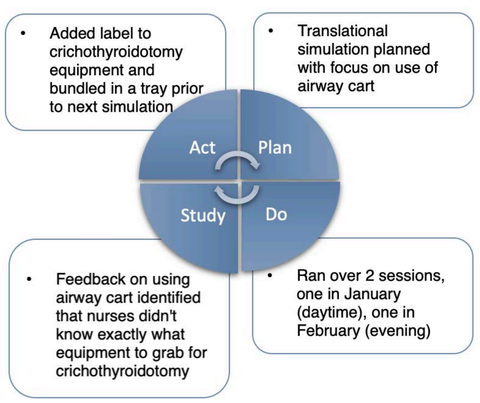
- "We've done so many sims and we do them with the people that we work with, so I feel that the more we practice them the more comfortable we are."
- "We've done a lot of team-building exercises in the past and simulations which I think have really optimized the team."



CHANGE IDEAS

- Co-develop a shared mental model for MDs/nurses for difficult airway (discussions at sim sessions, literature review)
- Organize airway equipment into an airway cart
- Use translational simulation to identify problems with airway cart and mental model and to optimize mental model and airway cart use

SAMPLE PDSA CYCLE



CONCLUSION

- Translational simulation was a successful tool for quality improvement in this community hospital emergency room
- Translational simulation was achievable within current finances, did not require extra time away from work for staff, and did not require any new equipment to be purchased
- Both time to obtain equipment and qualitative reports of staff comfort with the system improved with translational simulation used as a methodology

NEXT STEPS

- Ongoing simulation in the CDH ED will continue to focus on identifying areas for system improvement, one possible area already requested by staff is paediatric airway management
- The CDH ED will be moving into a new facility in the near future so translational simulation could be used to optimize resuscitation space design and function

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REFERENCE LIST

1. Nickson CP, Petrosoniak A, Barwick S, Brazil V. Translational simulation: from description to action. Advances in Simulation. 2021 Mar 4;6(1).

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Victoria Deep Vein Thrombosis Pathway

Improving Patient Access to DVT Clinic

PROJECT TEAM

Project Lead: Ben Schwartzentruber
Project Participants:

- Stephan T, Jennifer L, Chris King (Medical Imaging)
- Fraser / Beck / Otremba (Internal Medicine)
- Ali Tafti (Emergency Department)
- Shari J, Andrea L (Clinic Nursing)
- ZV, patient partner

BACKGROUND

Deep Vein Thrombosis (DVT) is a common diagnosis requiring prompt management, patient education, and often longitudinal follow-up

Thrombosis clinics elsewhere in BC provide early access to specialist care and reduce ED visits

PROBLEM

Currently, patients with positive ultrasounds for DVT are often referred to the Emergency Department for management, leading to long wait times and excess cost.

- Lack of alternative care pathways / use of DVT pathway
- Time of day ultrasound performed and reported

AIM STATEMENT

To increase patient visits to the Victoria Deep Vein Thrombosis Clinic by 25% by June 2023

PATIENT VOICE

Interviews carried out by patient partner showing need to streamline the care pathway to avoid confusion and highlighting need for educational materials and follow-up. Working on patient experience survey.

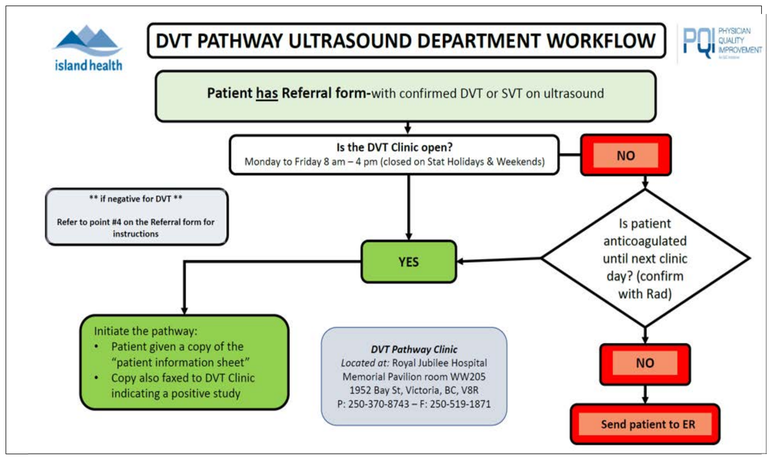
CHANGE IDEAS

- Expand referrals to VGH and IDC
- Connect patients from community to clinic rather than being sent to ED
- Medical Imaging book DVT exams in the morning
- Improve documentation of care pathway in Medical Imaging

PDSA CYCLE

Small Test of Change

1. See non-ED patients same day
2. Ask medical imaging to book outpatient US before noon
3. US department workflow



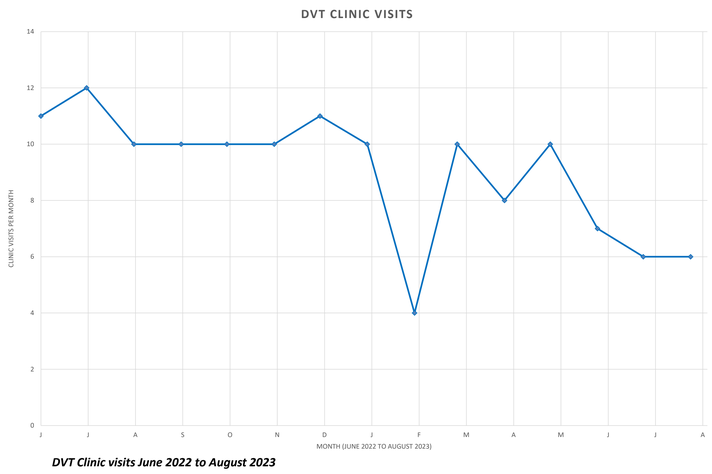
DVT Pathway Workflow

DATA ANALYSIS

- Two datasets yielded different numbers
- Data for patients seen in clinic entered into RedCAP by CNL
- Lists of positive studies sent to me for chart review monthly (Feb missing, SVT not included, results filtered to only include patients with registered ED visit within 72 hours)

CONCLUSION

- DVT pathway is preventing ED visits and providing early specialty care for DVT
- It has been difficult to increase total number of patients seen with plenty of "missed opportunities"
- Important to identify all key stakeholders early (even if you think you already have)
- Two key team members lost May/June with little time for handover, highlighting importance of people, handover, and redundancy in robust care pathways
- Agreeing on a change is different from it actually being implemented
- Don't try to do everything yourself



DVT Clinic visits June 2022 to August 2023

Chart Review Data	
DVTs seen	80
Distal	25
ED visits prevented	38
Missed opportunities	76

RedCAP Data	
Patients seen in clinic	139
Significant SVT	25
DVTs	104
Missing data	11

NEXT STEPS

Continue work by directly connect Emergency, Medical Imaging and UMAC leads to work on logistics of the pathway.
Highlight potential benefits of booking outpatient studies in the morning.

Inhaler Revolution to Save The Planet

Project Team
Dr. Christian Turner
& Liam King

BACKGROUND

The world is on fire

- Every industry needs to reduce their carbon footprint immediately
- Healthcare is no exception

PROBLEM

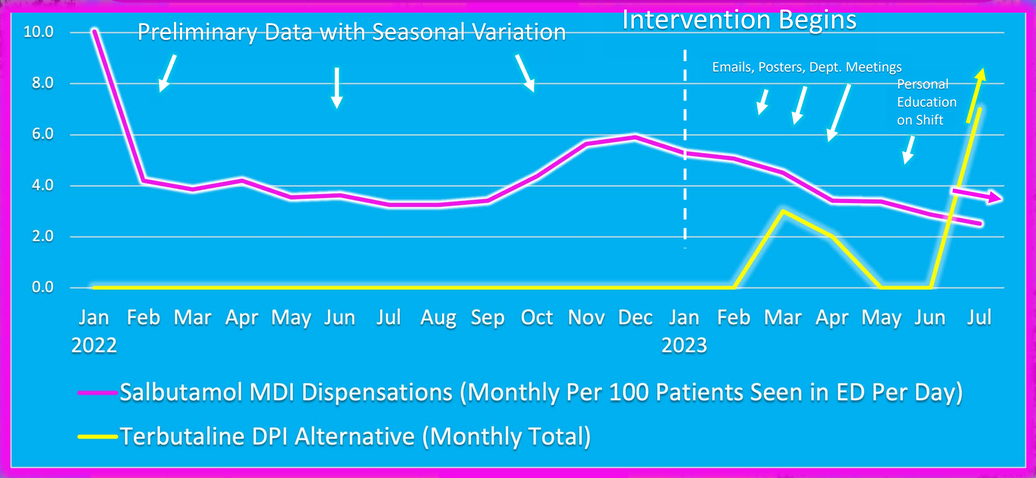
- Metered Dose Inhaler (MDIs) medications like Ventolin/salbutamol have a colossal carbon footprint
- They are over-used, frequently lost and thrown out after a couple inhalations in the ED
- There are equally effective alternatives readily available with similar cost

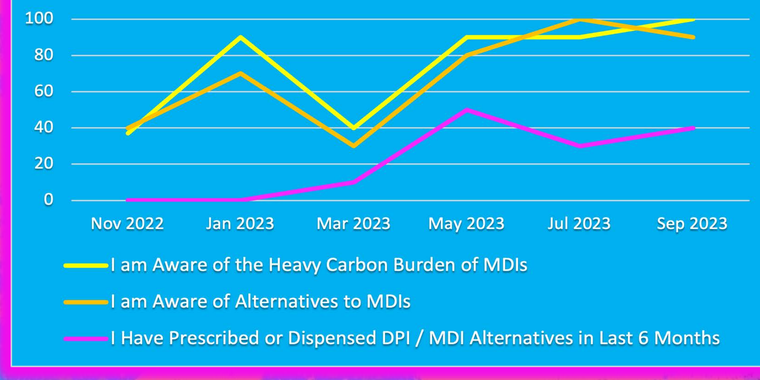
AIM

- Reduce Ventolin MDI Dispensations from the Royal Jubilee Emergency Department by Emergency Nurses and Physicians within 1 year by 25%

DATA

- We tracked the number of Salbutamol MDIs dispensations from RJH ED
- We surveyed Nurses and MDs to track knowledge of the MDI green house issue, alternative medications and prescribing practices
- Process measures included number of patient handouts given out by ED staff, lung testing requisitions sent and dispensations of terbutaline from ED (DPI alternative)





PDSA

- Staff surveyed every 2 months formally and;
- Informal discussion sought on shift regarding on which interventions were informative and beneficial vs neutral or nuisance

CHANGES

- Workstation post cards
- Bathroom, staffroom and ED wall posters
- Department meeting updates
- In person 2–5-minute education sessions on shift

DRIVERS

- Staff knowledge of carbon footprint and ED wastage of MDIs
- Staff awareness and availability of MDI alternatives in ED
- Staff willingness to order confirmative testing before prescribing new meds
- Perceived and real expectations of patients

FINDINGS

- We dispensed ~45 less MDIs per month relative to last year (19% reduction)
- This equates over 6 months to a decreased greenhouse gas emissions equivalent of driving ~ 2 x the circumference of the earth in a car
- Extrapolating to outpatient prescriptions (estimated 1:1 to inpatient) and sister hospital dispensations at VGH (similar ED visits per day), this figure may be 4-fold higher

BARRIERS

- Need for consolidated and easily navigable online resource for staff to reference when prescribing
- Overcoming therapeutic/historical inertia in prescribing
- Severe competing demands of overwhelmed ED to move patients quickly
- Lack of atient follow-up for diagnostic test results given crises level dearth of GPs

NEXT STEPS

- Continue in-person educations sessions on shift
- Department updates with successes
- Data collection to continue through coming flu season
- Expand to Hospitalist / House Physicians group

CONCLUSION

- Overburdened ED staff remain open to practice change for environmental sustainability
- Very brief in person education sessions we're well received and likely most impactful relative to passive education (posters, emails, etc.)
- A simple user-friendly online resource appeared integral to practice change:
- We used: WWW.BCINHALERS.CA

SPREAD

- After completion of data collection in spring 2024 we intend to broaden the scope to other hospitals within island health
- As more sustainable products come onto market, we will revamp education to track evolution in this dynamic area of emergency medicine
- Our hope is that success in this project will motivate healthcare workers to factor sustainability into treatment choices in all areas of medicine, and to demand the same from their health authorities

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Fostering Zero-Burnout

In Victoria's Infant & Early Years Mental Health Program

Project Team

Project Lead: Dr. Jane Ryan (Child Psychiatrist)

Project Participants:

- Sean Boulet (Team Lead, Occupational Therapist)
- Dawn Grunert (Infant Development Consultant)
- Alexis White (Social Worker)

BACKGROUND

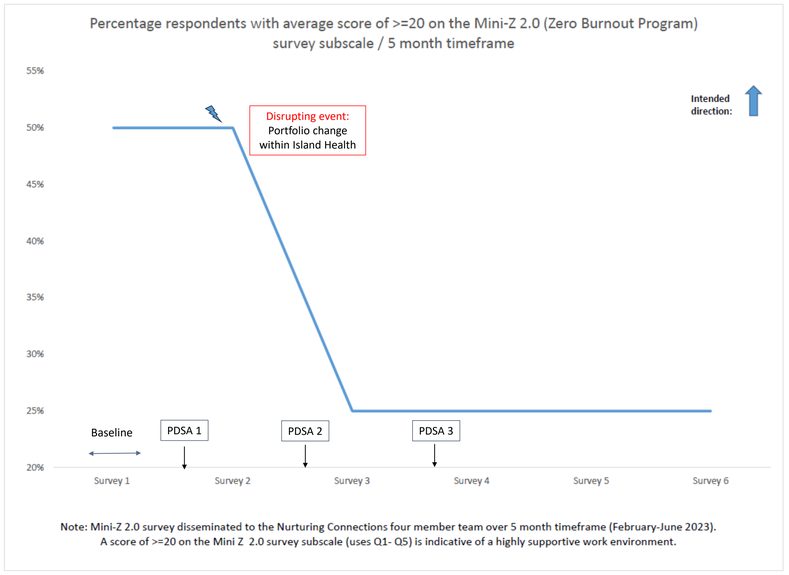
- 2022 BC ombudsperson's report identified that patient complaints about the health care services had reached a 10 year high.
- Since the Covid-19 pandemic, demand for mental health care has increased, leading to health care system overload (where demand exceeds delivery capacity) and resulting in empathy fatigue and clinician burnout.

PROBLEM STATEMENT

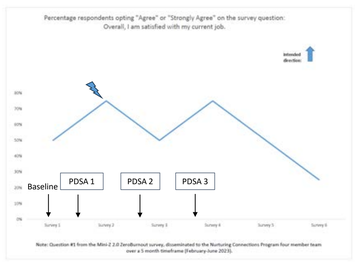
Clinician burnout is defined as an occupational syndrome driven by the work environment. Given this definition, how can we measure clinician wellbeing and make changes within a mental health clinic that improve occupational resiliency?

AIM STATEMENT

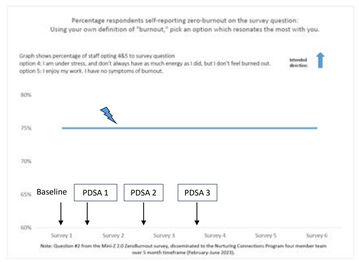
To increase staff reported joy at work and occupational resiliency (Measured using a validated survey – the MiniZ 2.0) in Victoria's Infant and Early Years Mental Health Program clinical team by 25% by June 2023.



Note: Mini-Z 2.0 survey disseminated to the Nurturing Connections four member team over 5 month timeframe (February-June 2023). A score of >=20 on the Mini Z 2.0 survey subscale (uses Q1- Q5) is indicative of a highly supportive work environment.



Note: Question #1 from the Mini-Z 2.0 ZeroBurnout survey, disseminated to the Nurturing Connections Program four member team over a 5 month timeframe (February-June 2023).



Note: Question #2 from the Mini-Z 2.0 ZeroBurnout survey, disseminated to the Nurturing Connections Program four member team over 5 month timeframe (February-June 2023).

KEY FINDINGS

1. Burnout, job satisfaction, and a supportive work environment are not interchangeable measures of the same construct.
2. Easiest to implement change idea brought choice (where/how) into an already occurring task (not adding or removing anything from a team member workload) PDSA change idea #1.

MEASURES

1. Outcome: Team composite score on the MiniZ 2.0 Burnout survey subscale (score >20 indicative of a supportive work environment).
2. Process: Team composite score on four self-compassion questions from the Stanford Professional Fulfillment Index.
3. Balancing: Forced choice survey question measuring potential survey fatigue and cynicism from participating in project.

PDSA CYCLES

1. Choice of location (outdoors) and method (walking) for scheduled meetings
2. Team Gratitude Journal
3. "Care for the Carers" in-service (15min contemplative compassion practice)

* All change ideas were collaboratively generated during team-building practices to identify what the team valued in a supportive work environment

"YESSSS!!!! That sounds amazing!"

Quote from patient when offered the choice of meeting outdoors.

DATA ANALYSIS

- Questionnaire (10 question MiniZ 2.0, 4 questions from Stanford Professional Fulfillment Index and 1 forced choice question for potential survey fatigue) collected via anonymous electronic survey distributed to 4 team members, at 6 time points over 5 month period.
- Anonymity maintained by using team composite scores for each measure.

BARRIERS

- Trade-off between protecting anonymity within a small team, and maintaining data sensitivity to show sufficient variation.
- Operational decisions (unanticipated portfolio change for program) disrupts PQI projects

CONCLUSION

- Collecting survey data to measure burnout and joy in work within Island Health is challenging …

… and

Qualitatively

&

Quantitatively

worth the effort !

Quotes from project team members

Balance Measure demonstrated that fostering a team culture that openly discusses occupational resiliency & explicitly collects quantitative survey data on burnout levels was unanimously and consistently rated as:

"a good use of my time and helpful in encouraging my wellbeing and overall job satisfaction."

"I very much appreciated the 'Care for the Carers' in-service yesterday."

"Thank you for asking these burnout questions!"

NEXT STEPS

- Retroactively compare outcome measures to clinic's patient satisfaction data collected during same timeline.

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PREGNANCY IS A STRESS TEST

Identification of Pregnancy Related Cardiovascular Disease Risk Factors

PROJECT TEAM

Project Lead: Dr Jennifer Kask

Project Participants:

Drs Valentyna Koval and Jayson Potts – Internal Medicine
Susanne Shelswell, Stacey Chow, Christa Clark-Corrigall RNs
Teralee Fisk – Registered Midwife
Erin Harrison – Manager, Primary Care - CRG
Angela Carriere - Clerk
Janet Baur – Patient Partner

The Campbell River Maternity Clinic (CRMat) is a Family-Medicine led perinatal clinic within the Wellness Centre at the North Island Hospital, Campbell River site (CRG.) It provides care for patients from Campbell River, communities in North and West Vancouver Island, and the Northern Discovery Islands

CONTEXT:

- Cardiovascular Disease (CVD) is the leading cause of death in women.
- Certain adverse pregnancy outcomes (APO) are associated with increased risk of CVD.
- Early preventative health care may improve health outcomes.

PROBLEM:

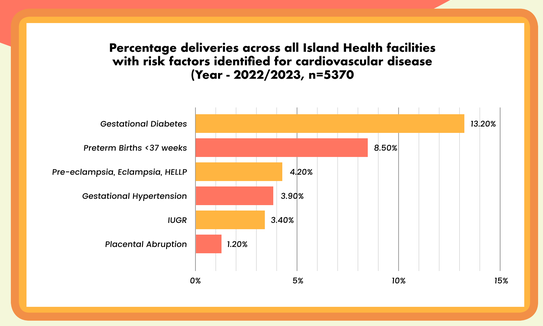
Variation in the format and content of the discharge summaries from Campbell River Maternity Clinic (CRMat) led to unreliable identification of the complications of pregnancy and the implications for subsequent pregnancies and life-long CVD risk.

40% of total patients at CRMat are "unattached." No longitudinal care provider to follow up with resulted in no discharge summary created.

AIM STATEMENT:

The Campbell River Maternity Clinic will increase the identification of individuals with pregnancy related cardiovascular disease risk factors to 100% at discharge from clinic care by June 2023

- 27% of Island Health pregnancies are affected by one or more of the following APO:
- Hypertensive Disorders of Pregnancy
- Gestational Diabetes
- Preterm Birth
- IUGR (term baby <2500g)
- Placental Abruption



"This clinic was very helpful as more people should know and be aware of their risk levels. I am aware I have to make changes for my health more quickly than I have been and would not have known my issues were sneaking back up without this clinic. I am very thankful to have been included and hope they are able to keep it going and help many others in the future"

- BRICH Clinic Patient Feedback

"... I would have had no idea the correlation between my preemie and my possible future cardiovascular risk .. "

- BRICH Clinic Patient Feedback

"Maternal events are more predictive of CV risks than I was aware"

- Provider feedback survey

EFFECTS OF CHANGE:

Education increased completion of DC Summaries.

- Changes were not sustained.
- Unattached patients often had no DC summary made.

A post-partum follow up clinic for patients at risk was proposed.

The BiRCH (Birth Related Cardiovascular Health) Clinic was created.

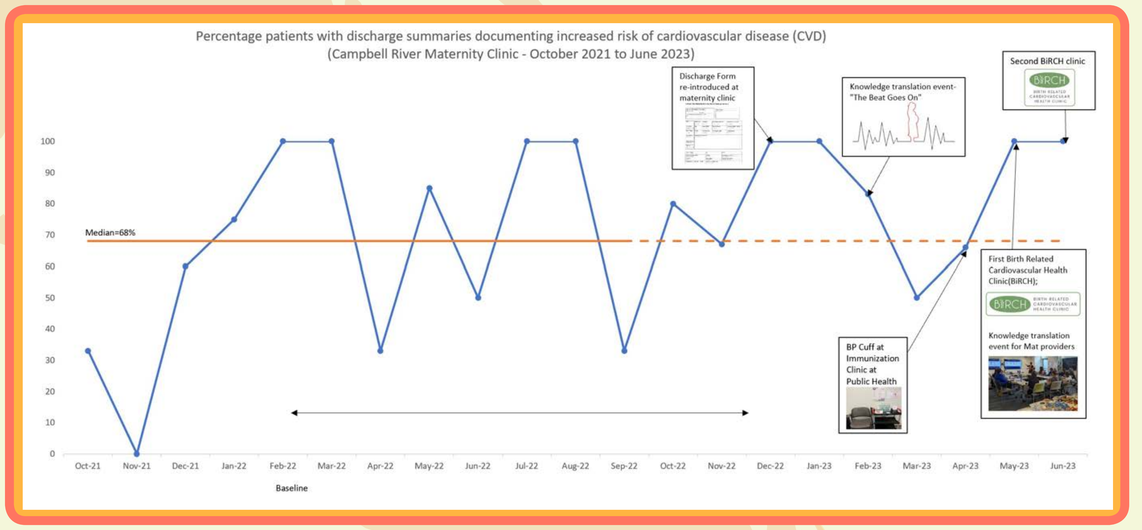
- Utilizing existing resources from the Wellness Centre (outpt dept CR Hospital)
- Model: 1-time visit (6 months post-birth)
  - explain risk
  - educate about modifiable factors
  - empower individuals to advocate for their own health

CONCLUSIONS:

- Pregnancy is a stress test; pregnancy unmasks predisposition to cardiovascular disease
- Cardiovascular Disease (CVD) is the leading cause of death among women; it is vital to offer follow-up after APO for cardiovascular disease risk assessment for health preservation and disease prevention
- The BIRCH Clinic is unique on Vancouver Island as the only joint family medicine/internal medicine hospital-based clinic providing follow-up for APO. The clinic attempts to bridge the gap for patients without longitudinal care by providing a one time visit with consult uploaded to PowerChart

NEXT STEPS:

- Appointments offered in a monthly clinic in the Wellness Centre at CRG
- Referral pathway formalized in July 2023
- Linkages between clinicians at other sites is taking place
- Interest in spreading has started
- Funding is being sought for evaluation of the BiRCH Clinic



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PROJECT SUMMARY

QI METHODOLOGY IN THE GAME OF MEDICINE

Failing at Quitting PQi

PLAYERS:
KELLY COX, PEDIATRICIAN NRGH
EMILY VANWAES, CNE NRGH
STACEY ROBINSONMURRAY, NURSE INFORMATICIST
KAMLA GAGE, MOST PATIENT PQI COACH

BACKGROUND

In 2015, WHO listed immediate skin to skin after delivery as one of the steps to successful breastfeeding (human milk feeding).

Benefits include:
- Improvd Human milkfeeding
- Improved regulation of infant temperature & glucose
- Improved infant gut flora
- Reduced pain response
- Reduced stress
- Improved infant and parent bonding

PROBLEM

At NRGH, babies born by elective c-section do not routinely go skin to skin
- Many birth parents watt heir baby skin to skin
- Dyads delivered by c-section miss out on benefits of skin to skin

FIVE WHYS

Physicians are not putting babies S2S
- There is not physical space
- IV and BP cuffs in the way
- Team not aware of benefits

AIM STATEMENT

At NRGH, increase percentage of dyads offered immediate skin to skin at elective c-section by 50% by June 2023.

PEDIATRIC VIRAL SURGE!

How do we bring QI into surge planning?

- **We need a team!**
- **Driver Diagram to ID change ideas**
- **PDSA each high acuity care**
- **Celebrate growth mindset**

BACK ON TRACK

DRIVER DIAGRAM

- Birth parent willing and available
- Baby stable
- RN staff available
- Physicians willing

CHANGE IDEAS

- Anesthesia to move leads and IV to left side
- Handout to birth parent in pre-op clinic
- Pediatricians education
- Add S2S to pre-op checklist

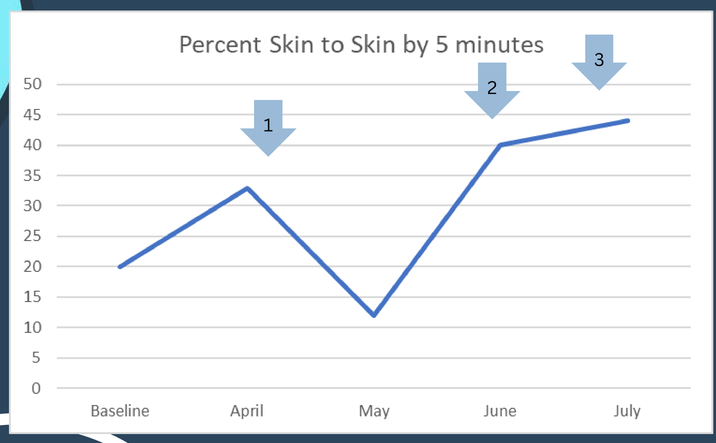
PEDIATRICIAN SHORTAGE

How can the PQI toolkit help in this crisis?

BACK ON TRACK

PDSA

- 1= Anesthesia moves IV and BP cuff
- 2=Education to Obstetricians
- 3=Education to Pediatricians



CONCLUSIONS

- You always need a team
- Data IS fun and motivates!
- QI is a burnout antidote
- Spreading QI
- The project continues....

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Island Health Outpatient COVID Therapeutics Clinic (OCTC)

Teamwork makes the Dream work

Project Team

Dr. Kelsey Kozoriz, MD, OCTC Medical Lead

- Kelly Saunders, RN, OCTC CNL
- Jo-Anna Wilson, RN, OCTC Manager
- Dr. Eric Partlow, MD, Infectious Disease
- Dr. Rina Chadha, MD, CATe Co-Director

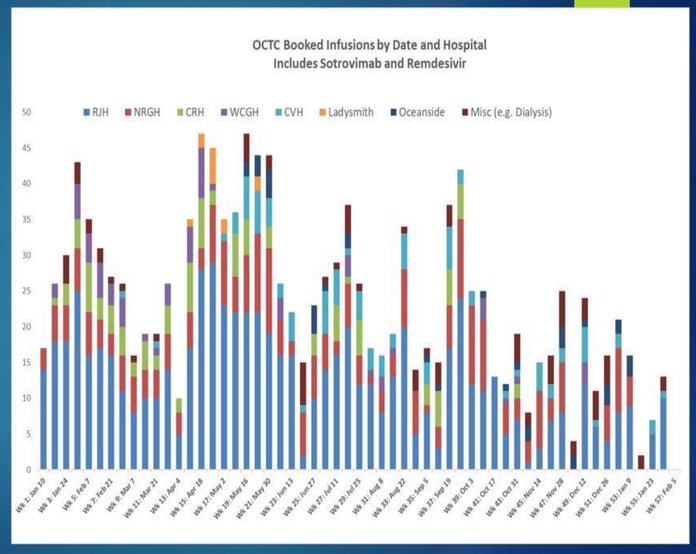
BACKGROUND

- The Outpatient COVID Therapeutics Clinic (OCTC) opened in January 2022. In Year 1, over 1200 patients were assessed by a physician and 800 received a therapy across the health region
- A multi-disciplinary team delivered timely treatment (Sotrovimab, Remdesivir, or Paxlovid) to COVID positive patients at highest risk for severe illness.
- The clinic endeavored to achieve the Quintuple Aim:
- **Enhanced patient experience** via delivery of high quality, team-based virtual care with provision for in-person assessment PRN
- Low barrier, low burden access to therapy at distributed sites for **equity**
- **Cost** effective: virtual (tele) nursing support during acute phase to reduce unnecessary urgent care and ED visits, avoidance of over-treatment with close nursing follow up option, and clinical service delivered by family physicians

OCTC Infusions by Week

The OCTC began providing Remdesivir the week of April 4th.

This graph represents infusions, not people and includes infusions booked through the OCTC
Misc includes OCTC infusions done in Emergency, Dialysis



PDSA CYCLE

- **Small Test of Change:**
- OCTC CNL reviewed & uploaded CATe referrals before pushing to MD for consult
- Initially clerical was tasked to upload; could not get appropriate access
- Percent of completed referrals improved (10-40% to 70-100%)

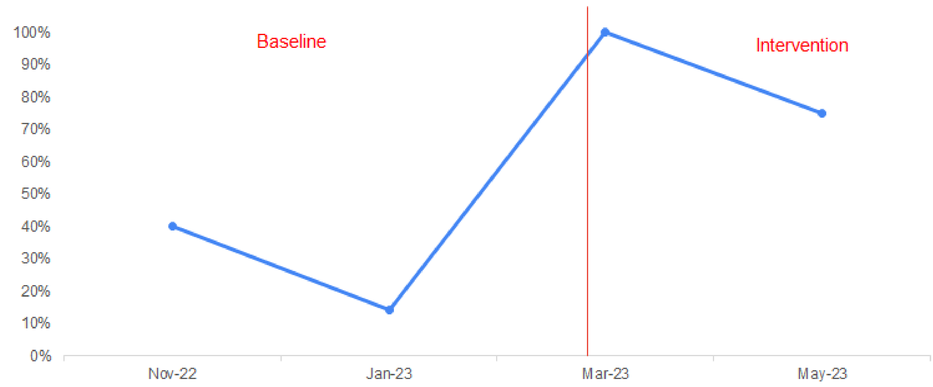
DATA ANALYSIS

- Project scoped to only look at referrals coming from the COVID Antiviral Therapeutics e-team (CATe) pathway
- OCTC chart audit of last 15 CATe referrals
- structured interviews with OCTC patients and CNL assessed patient satisfaction
- Physician satisfaction with CATe referral process was measured 4 times

PROBLEM

- The referral work flow at the OCTC is complex. This can lead to incomplete referrals causing delayed or missed treatments. It can also contribute to reduced satisfaction for referring clinicians, patients and OCTC team members.

Percentage of patients seen at OCTC with their CATe consult or CATe referral form uploaded to the electronic medical record (Cerner)



AIM STATEMENT

By June 2023, increase the percent of completed and uploaded referrals from the COVID Antiviral Therapeutics e-team (CATe) at the Island Health Outpatient COVID Therapeutics Clinic by 50%.

IMPROVING OUTCOMES

- **with monitoring 1 month outcomes data to ensure no signal of harm with emerging therapies and close monitoring of guideline changes, resources, and emerging therapies**
- **Team-based care to allow each health professional to work at top of scope and quarterly CME/case reviews to support improved work QOL of the OCTC team**

PATIENT VOICE

Patient interviews brought the team joy:

- "best experience I have ever had with the medical system"
- "nurses were excellent, easy to communicate with, personable"
- "had a wonderful experience. Less than 24hrs from initial call to infusion"

BARRIERS

- PQI Project had to be revised many times
  - Staff to upload was changed from clerk to CNL due to CareConnect access
  - Implementing the new referral form was done outside PQI process for efficiency
  - The technology almost killed the project lead (and she likes tech)

CONCLUSION

- The OCTC continues to evolve.
- The clinic moved to a referral-only model June, 2023.
- The physician team transitioned from a dedicated team of 6 family physicians to the physicians in the South Island ID department June 1, 2023.

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Bridging Housing and Primary Health Care:
Collecting past medical histories

Project Lead: Dr Kristina Williams
Project Participants:
- Karly Kennel (Primary Care Outreach Supervisor)
- Deenar Dhanji (Island Health Home Care Manager)
- Supporting housing Manager and staff

Primary Care Outreach (PCO)

Our Primary Care Outreach team in part, supports clients living in a new supportive housing site, with significant medical and social complexities. We provide team-based, low barrier, client-centered and trauma/violence-informed practice. Our work aims to support health and wellness, and build on the support safe housing provides to clients.

PROBLEM

Due to persistent and significant barriers, including histories of experiencing homelessness, trauma and addiction, as well as lack of consistent primary care, many clients lack a documented relevant past medical history (PMHx).

AIM STATEMENT

To increase documented past medical histories on Island Health EMR for unattached clients supported by the PCO team at a supportive housing site by May 31th, 2023 to 50%.

PDSA CYCLE

1. Leaving 3 question surveys with clients
2. Collecting and documenting relevant PMHx as per Home Care Manager's conversations with clients
3. Using housing staff's relationships to engage with clients

OTHER CHANGE IDEAS

- Put up posters on the floor regarding project
- Incentivize participation
- Host a past medical history event with food

Image 1: 1: Primary Care Outreach Team and our mobile van

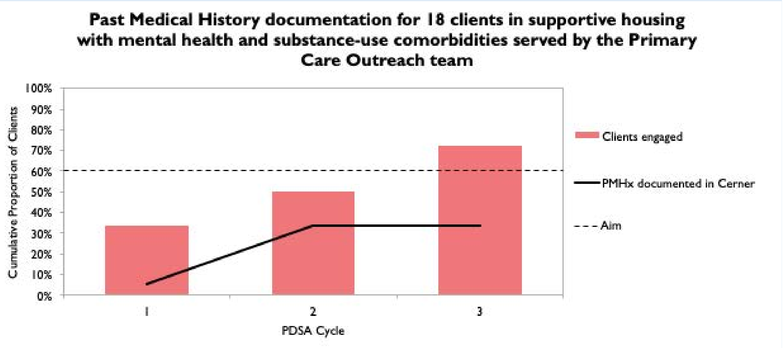
"It's already in my chart!"

"Go away!"

"Next week"…
then week later: "Next week!"

(Voices of clients)

DATA ANALYSIS



FINDINGS

- 18 clients on a designated floor of the supportive housing sites were attempted to be engaged to collect relevant past medical histories
- PDSA's were conducted over 14 weeks
- 6/18 past medical histories were documented on Island Health EMR at project completion (=33%)

BARRIERS

QI team:
- QI efforts were difficult in a very dynamic and non-physician-centric team in which composition varies daily, increased client-volume, and work is often more crisis-oriented

Other stakeholders (Island Health Home Care Manager and Supportive housing manager and staff):
- During PQI planning, such stakeholders were not involved given minimal (if any) existing formal relationship with the PCO team
- Competing demands made QI project challenging

Clients:
- Engagement was difficult (often off site, substance-affected, other immediate priority, perhaps lack of trust), etc.

Image 2: Example of survey collected incomplete

CONCLUSIONS

- Developing relationships with the various "carers" of clients is crucial to engagement and are often invisibly linked – a community is needed
- Even with staff relationships with clients over years, due to overwhelming day to day client needs and emergencies, QI efforts are not a priority
- The Patient Voices Network requires a social justice orientation to add voice to our most marginalized clients/populations

NEXT STEPS

Due to the high level of medical and social complexities of these clients, many will be supported under a new Complex Care Housing (CCH) program with increased supports, in addition to the care the Primary Care Outreach team is seeking to provide. This project seeks to inform future efforts within the CCH umbrella.

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Bring Back the Joy!

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Improving Joy in Work for Family Physicians providing Inpatient Care at Cowichan District Hospital

PROJECT TEAM

Dr Zoe Pullan & Dr Mark Sanders

Project Participants:

- Dr Maki Ikemura - IH Medical Director Cowichan Valley
- Dr Graham Blackburn – Site Med Director, Chief of Staff
- Jessica Marr – Medical Office Assistant
- Gwen Thompson- Medical Office Assistant
- Linda Neufeld – Patient Partner

BACKGROUND

- Family Physicians are leaving inpatient work at CDH
- Model of care and working environment have been named as deterrents to continuing this service
- Potential new recruits find the current system undesirable, hence attrition is not balanced by enrollment
- Increased number of unattached patients is increasing workload and leading to burnout and reduced joy in work for existing Family Physicians.

PROBLEM

- Family Physicians providing inpatient care at Cowichan District Hospital is seeing increase inpatient workload, in part due to increase number of unattached patients. This is resulting in physician burnout and reduction of joy in work that could have an impact on quality of patient care provided.

AIM STATEMENT

- Increase primary care provider satisfaction and Joy in Work for Family Physicians call group working at Cowichan District Hospital by 50% by June 2023.

> ***" Be honest and & forthcoming when asked questions by a patient. Share a joke, a smile, a laugh and ask about their life prior to being admitted "***
>
> Linda N.
> Patient Partner

CHANGE IDEAS

- Availability of "Doctor's Bag"
- Setting a limit on unattached CDH inpatients accepted for care.
- New Care Model at Ingram Clinic cohort with Flow Doc
- New Care Model at Somenos/Carebridge call group

PDSA CYCLE

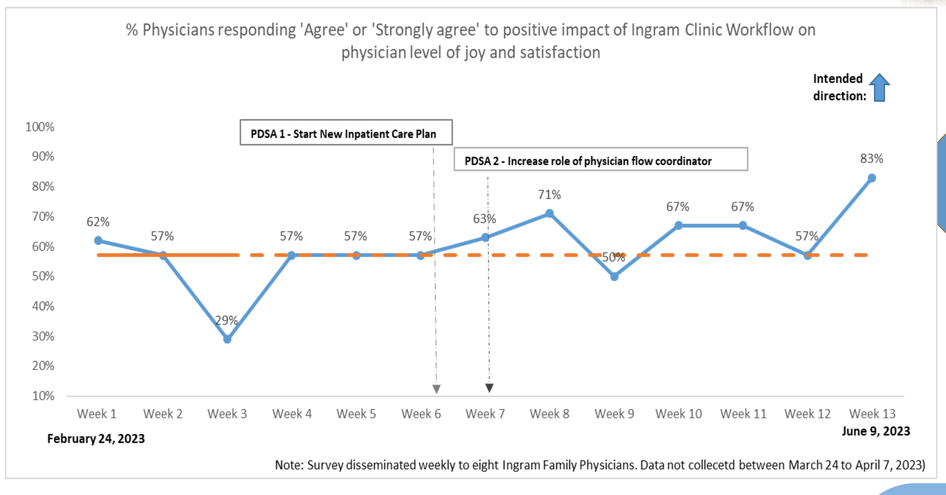
Small Test of Change

- Create schedule for new Care Model
- Flow Coordinator workflow
- Update workflow based on feedback

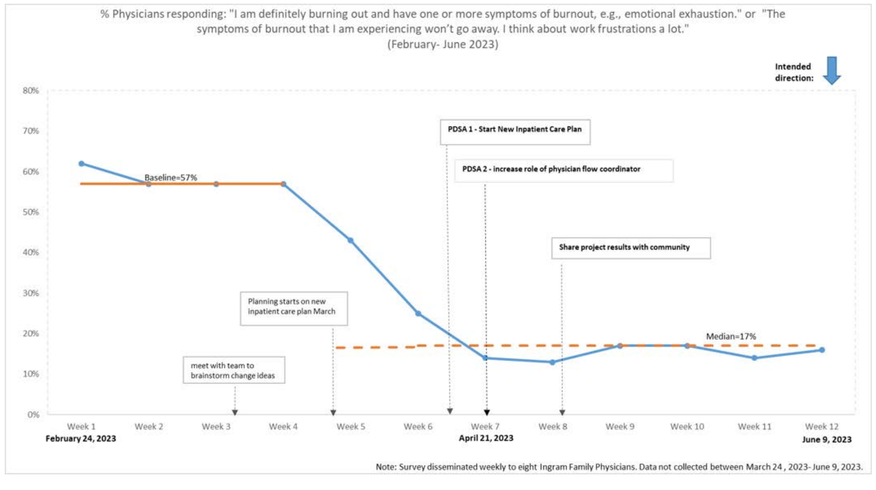
Physician feedback

SUSTAINABILITY & SPREAD

- Shared results via informational coffee sessions
- Shared learnings with other clinics
- Use WhatsApp to share learnings & foster connections
- Informal and formal opportunities to show our findings & discuss how other cohorts can similarly participate
- Eight inpatient call groups have adopted similar capacity limits after the PDSA we ran on our test group.



> ***" I feel that this project really brought us together, enhanced our teamwork, empowered us & allowed us to go forward with other decisions in a more cooperative fashion than before "***



FINDINGS

- Just the idea of setting boundaries & taking control improves Joy in Work
- Our Island Health colleagues are finding the reduced inpatient care provider numbers a significant challenge and appreciate the support offered by project
- Need to ask the right questions consistently to get a good assessment

DATA COLLECTION & ANALYSIS

- Data was collected via survey to the 8 Ingram Clinic. Physicians on a weekly basis.
- The Somenos/Carebridge group was subsequently added to the data collection process for weekly surveys.
- Analysis was done on a weekly basis to determine how to proceed with PDSA.

CONCLUSION

1. Burnout and stress are strongly related to a sensed lack of control over one's work volume.
2. Taking control of work volume is positively related to reduced stress and joy in work.
3. Providing autonomy in structuring how a team manages its own work empowers that team and can reduce burnout and attrition.
4. The inpatient care crisis at CDH could possibly be alleviated by organized primary care physician cohorts that are able to place limits on their volume of work.
5. People get really tired of answering surveys

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Identification & Therapy of Osteoporosis at Nanaimo Regional Hospital Cast Clinic

Project Team

Physician Name: Dr Nicole Baur

Project Participants:

- Dr Chris Cameron
- Dr Jane Yeoh
- Dr Kim King
- Lucina Baryluk
- Cast Clinic Nurses

BACKGROUND

- As per the 2010 Canadian osteoporosis guidelines if you are age >65 and have a prior fragility fracture there is good evidence you would benefit from consideration of pharmacological therapy to reduce further fracture risk. A Previous PQI project identified that patients were not being screened on a regular basis to see if they might be at risk for osteoporosis

PROBLEM

- Women over the age of 65 are at increased risk for fracture.
- If one has a fracture they are at high risk for further fractures, moreso within the first 2 years
- Would benefit from identification and therapy
- Patients presenting at the NRG Cast Clinic with recent fractures are not identified as at risk for Osteoporosis

AIM STATEMENT

- By Sept 2023, increase referrals for osteoporosis management by 50% for female patients over 65 years old presenting at Nanaimo General Hospital Cast Clinic with a recent fracture

DATA ANALYSIS

- **Data collected via survey during 2 clinics for 1 orthopedic surgeon at NRG**
- Patients were selected from booked appointments for given day who met criteria of being female, over 50 with recent fracture

PQI – Quality Improvement Project.

Dr Nicole Baur and her team are doing a quality improvement project to identify and provide therapy for patients at risk for future fracture due to Osteoporosis. This survey screens to see if you might benefit from consideration of pharmacological therapy to reduce further risk.

Please complete this survey only if you are:

- Female - Over 50 year old - Have had a recent fracture

1. Please enter your Date of Birth. DD/MMM/YYY. _____
2. Have you had a Bone Density performed? Yes No
3. If yes, when? _____
4. Are you on Osteoporosis Therapy? (Other than calcium/Vitamin D) Yes No
5. If yes, please circle which:

Risedronate weekly/monthly (Actonel)

Zoledronic acid IV (Aclasta)

Alendronate weekly (Fosamax)

Denosumab injections every 6 months (Prolia)

Teriperatide (Forteo) sc daily

Thank you for completing the survey. Please return to Cast Clinic Staff.

For additional resources: Osteoporosis Canada www.osteoporosis.ca

OUTPATIENT REFERRAL:

DATE: _____

☐ : Post Fracture osteoporosis assessment

REFERRING PHYSICIAN: PHYSICIAN'S SIGNTURE:

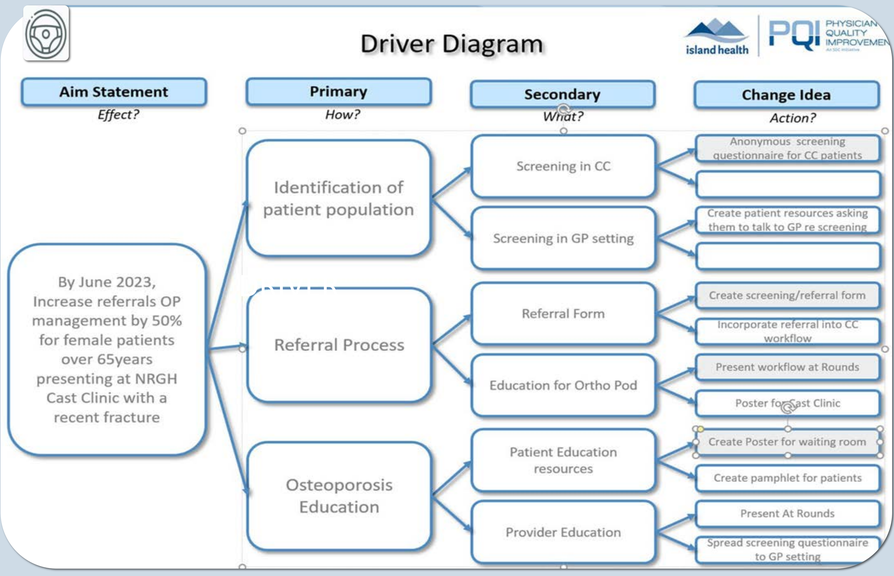
Funding for this initiative was provided by the Specialist Services Committee (SSC), a joint collaborative committee of Doctors of BC and the Ministry of Health.

PDSA CYCLE

- Test Identification Questionnaire:
  - No patients met criteria
- Orthopedic surgeon suggested
  - Reduced age >50 (as done in other FLS)
  - Saw an increase of patients meeting criteria
    - 6 seen in follow up - 1 started therapy, 5 BMD

CHANGE IDEA

- Create questionnaire to identified patients that met criteria
- Create referral form for therapy
- Provide patient resources



FINDINGS

- Initial surveys found patients that met criteria who would benefit from therapy
  - there was better response rate when patients were asked survey questions rather than simply giving questionnaire to them
- Difficult to test changes when outside scope of influence

BARRIERS

- Difficult to engage stakeholders
  - Initial interest waned
- Limited staff resources
  - Cast clinic very busy
  - Left surveys with no uptake

NEXT STEPS

- Approach Family Physician to test screening tool
- Provide posters/educational resources
- Screening still used as a referral base. If beneficial - increase spread to other surgeons in cast clinic

CONCLUSION

By providing a screening/referral to Dr.Yeoh's cast clinic patients we were able to identify and discuss osteoporosis risk with those >50 who have a new fracture. The goal will be to continue maintaining connections with cast clinic to help reduce future fractures.

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Ready to Go!

Improving Orthopedic Patients Readiness to fill Short Notice Operating Room Cancellation at Cowichan Valley Orthopedics

Project Team

Physician Lead: Dr Nimrod Levy

Project Participants:

- Tanya Bailey - MOA
- Samantha Levy - Manager
- Ricardo Velazquez – Consultant
- Robert Liston – Patient Voice

BACKGROUND

Patients on long Arthroplasty waitlist suffer from rapid deconditioning and pain. This often affects every aspect of their lives and of the lives of those around them.

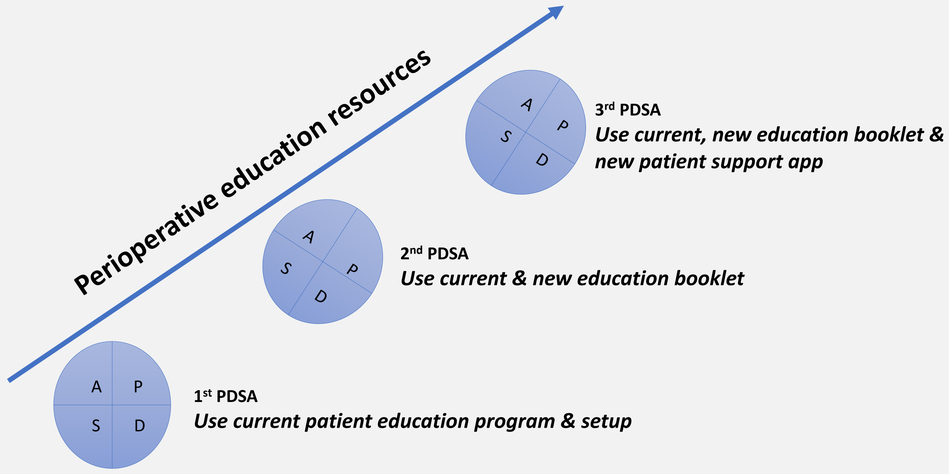
Unfilled Operating Room time due to late cancellations remains a major issue at Cowichan District Hospital. These cancellations are often avoidable and happen due to poor interdepartmental communications and a lack of established practices and clear protocols.

PROBLEM

Patients from Cowichan Valley Orthopedics experience a high percentage of short notice arthroplasty case cancellation which prolongs patient suffering and results in unnecessary delays to having their surgery

AIM STATEMENT

By August 2023, decrease by 50%, the number of Dr Levy's Arthroplasty Operating Room cancellations at Cowichan District Hospital, that was due to lack of patient readiness



PLAN-DO-STUDY-ACT ('PDSA')

Due to the time constraints of the program, it was decided to run 3 PDSAs concurrently to get data on changes tested:

1. *Use existing patient education resources*
2. *Use existing patient education resources & a new comprehensive education booklet*
3. *Use existing patient education resources, a new comprehensive education booklet & a new mobile patient support app called Mymobility*

KEY FINDINGS

- *72% of completed surveys from the third change cycle, where Mymobility (App) was introduced, really like it, with two requesting to use the App for their next orthopedic surgery*
- *The App allowed us to detect an infection at 110 days post-op and patient was seen within 48 hours of contact via App. Admitted 4 days later in preparation for surgery*
- *Positive feedback from family physicians contacted regarding their patients use of the App and supportive to further use of the App*

DATA COLLECTION

- 23 patients were involve in testing
- Surveys to given to patients 1 week pre-op and then 30-45 days for first two change cycles
- For the third change cycle, the pre-op survey was given 30 days prior to surgery to allow the app to be used as intended

BARRIERS

- Staff turn over impacted ability to test other changes that might have impacted Outcome measure
- Workflow bottlenecks within the Cowichan District Hospital OR booking system made it difficult to see impact of other changes
- Concurrent projects let to confusion over the impact of one over another. This resulted in not being able to move forward with this project when another was paused

CONCLUSION

- In a complex system it takes time to see impact of change
- Staff turnover made it difficult to keep momentum to test "low hanging fruit" changes

UNTESTED IDEAS

- Nurse Navigator
- Optimized Patient Standby List
- Earlier anesthesia assessments

NEXT STEPS

- Based on feedback from patients, will continue to offer App as an educational resource to patients at Cowichan Valley Orthopedics
- The positive responses from Family Physicians regarding the App indicate that expansion of use will be supported in the community and should be considered

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FIRST DO NO HARM:
Managing Legacy Opioid Prescriptions

Project Lead: Dr. Oona Hayes
Project Participants:
- Sue Lindstrom, Patient Voices Network
- Dr. Brian Cornelson
- Lindsey Strang, Nurse Practitioner
- Dr. Spencer Cleave

PROBLEM

Many patients of the High Complexity Care Team (HCCT) are on legacy (i.e. started before becoming attached to the team) long-term opioid therapy (LTOT) for chronic non-cancer pain. Medical practice has evolved to recognize the significant risks and modest benefits of LTOT in this population.

Ongoing prescription demands a rigorous, personalized approach to risk management that must be clearly documented in the patient's chart. The HCCT team lacked a process for ensuring that we were documenting standard compliance.

AIM STATEMENT

Increase the number of EMR-documented 'opioid benefit discussions' by HCCT prescribers in patients seen between May 2023 and August 2023 from 0% to 75%.

PATIENT VOICE

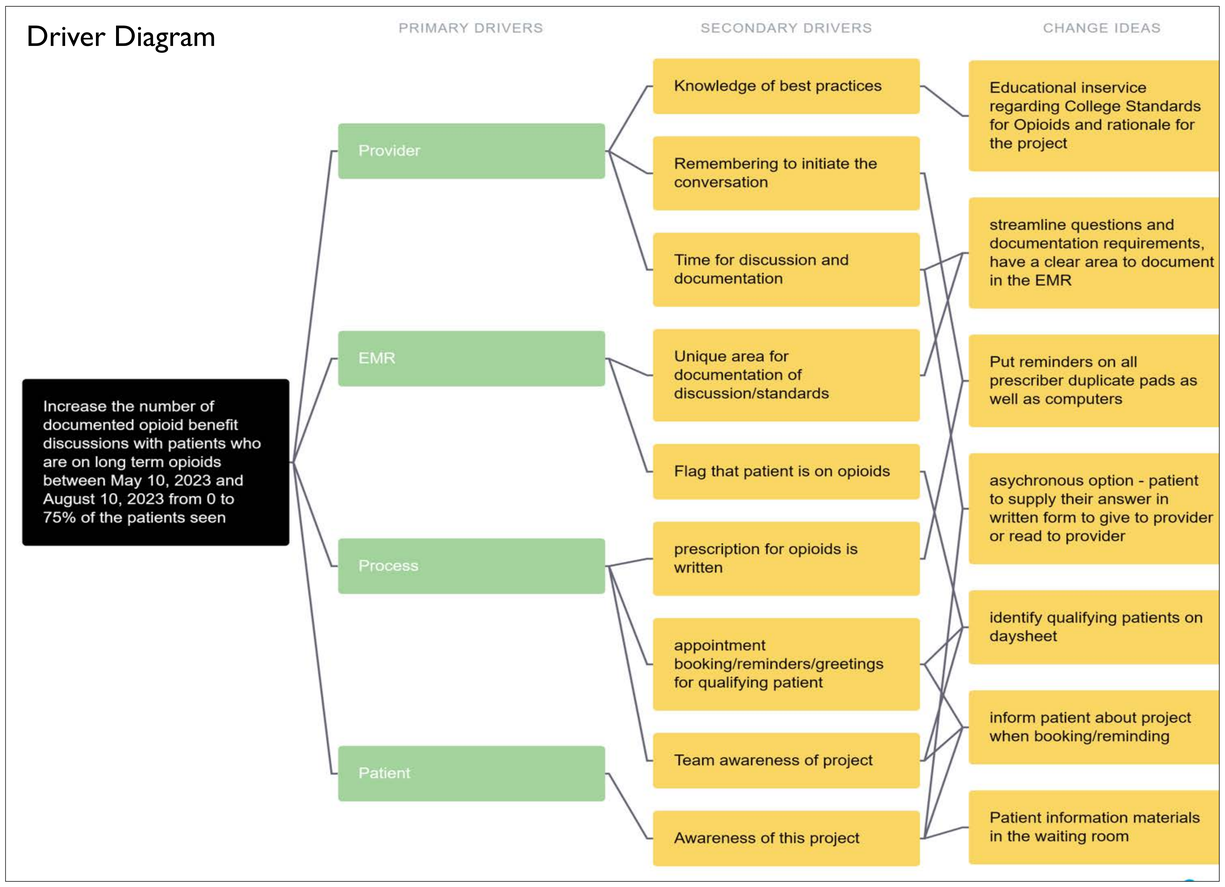
Sue Lindstrom has lived experience managing chronic non-cancer-related pain and its effects on her quality of life. Ms. Lindstrom was clear that she can only represent her own lived experience and that every patient has their own sets of strengths and vulnerabilities that affect their views. She shared her experiences of living through a time when opioid medication was normalized to now when we understand more about the significant risks of the medication.

Ms. Lindstrom shared how self-management resources, such as Self-Management BC, have helped her understand her challenges and advocate for her needs. She has found medication to be just one small part of her toolbox for managing chronic pain. She emphasized that patients understand that providers must work with them to balance the risks and benefits of medication.

PDSA & MEASURES

May 10 - 25, 2023 - email all providers and Zoom meeting with two out of three providers outlining the aim, intervention and measures. Providers documented three conversations with patients in the study period but some were missed, and calculating those was too onerous (calculations were done manually)

May 26 - June 29, 2023 - Paper questionnaire with three questions (outcome measure, process measure and balancing) was printed and placed by provider computers to provide a physical reminder of the study and for data collection. One conversation took place among the three eligible patients that were documented. There were more patients that were seen that were not documented.



BARRIERS

- The EMR the team uses is hard to customize and requires a lot of navigation and "clicks" to move data, causing data entry fatigue.
- Adding more work to providers who are already juggling multiple unrelated cognitive demands in visits by asking them to remember to do the intervention and then to document several measures.
- Staffing challenges that led to more provider work as they picked up the slack.
- Lack of dedicated, remunerated time to work on the QI project as a team.

CONCLUSIONS & LESSONS LEARNED

- Patients and prescribers found the question acceptable
- Asking open-ended questions about medication benefits can help patients identify discrepancies between their goals and behaviour and can support motivational interviewing to taper.
- Changing workflow for providers is challenging and requires active buy-in from all providers.
- Multi-step processes (e.g. safer opioid prescribing) could be distributed to non-prescribers of a team but must be evaluated to ensure the team can still meet its goals.
- PDSA cycles benefit from active measurement, which is more likely to be successful if the measures are co-designed with those implementing the measures.
- Quality improvement learning can be taught didactically but also benefits from real-life experience - don't let a quest for the "perfect" project keep you from trying a small change cycle as life gets in the way of the best-laid plans

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IMPROVING PATIENT SATISFACTION WITH GROUP MEDICAL VISITS

USING A SIX PART PERINATAL EDUCATION SERIES

DR PHILLIPPA HOUGHTON *PHYSICIAN LEAD*
EMILY SAYWARD *PROJECT MANAGER*
JAMIE MALLOF *RN. IBCLC. MA COUNSELLING.*

Background

- Survey results demonstrate that postpartum people feel ill-prepared for their postpartum transition
- Lack of education on postpartum transition can contribute to significant feelings of distress during this time

Problem Statement

- Group medical visits can be an efficient way to provide patient education and care; but they can be challenging to run well and maintaining patient satisfaction with the visits is necessary to ensure attendance and overall engagement

Aim Statement

- Improve patient visit satisfaction within my Perinatal Education Series from 3.5 to 4.5 by June 2023

What We Did

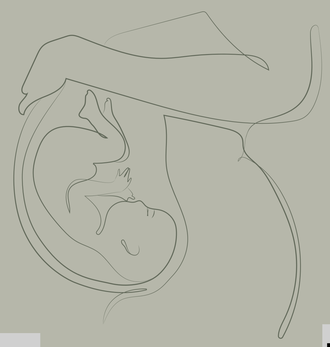
- We ran **four virtual cohorts** of the program between January and June (a total of 24 visits were run with an average of 12 patients/visit)
- Surveys were distributed after each visit and feedback collated to generate change ideas

The course was very well put together...I appreciate the first hand experience from Dr Pip in addition to the actual information and facts provided

I'll definitely be sharing this course I've already spoken about it a lot with some of my mom friends

PDSA Cycles Tested

- Reduce check-in time
- Increase Q&A time
- Addition of summary "top 5 take-aways" slide



Final Group Structure

- Each session includes check-in, didactic teaching, skill based teaching, peer connection and Q&A
- Weekly themes include: physical recovery, infant feeding, infant sleep, mental health, identity changes and relationship changes

Data Analysis

- Surveys were anonymously collected after each session
- We generally had about a 75% response rate if survey link was provided IN SESSION
- Qualitative feedback was collected both in formal surveys and in informal emails and messages sent by patients

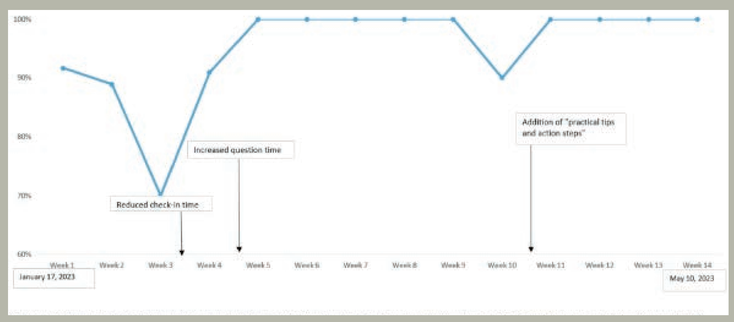
Group Registration Details Here

Key Learnings

- A system to reduce no-shows is needed for sustainability and group cohesion
- Registration and disseminating group resources, reminder emails and follow-up links is time intensive
- There is therapeutic benefit in shared experienced

Facilitator Outcomes

- Novelty in care delivery can improve feelings of joy and engagement with work
- More patients seen per hour of care delivery has the potential to streamline schedules and open up space in the work week



Next Steps

- We have run a pilot cohort for a fourth trimester group which had excellent feedback, cohort two is fully registered
- We are engaged with shared care for program spread options

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Delirium Identification in the Emergency Department at Victoria General Hospital

Project Team

Physician Name: Dr Savannah Forrester

Project Participants:

- Sandra McLeod – Clinical Nurse Educator
- Celine Edwards – Med Flex Student
- Daphne Wass – Patient Partner
- Trish Flanders – Patient Partner

BACKGROUND

- Approx. 30% of patients seen in the ED at VGH are over age 65. Of these, 30% are admitted to hospital and spend an average of 18.7 hrs in the ED before being transferred to an in-patient bed.
  - Early recognition of delirium allows for management strategies to be implemented more quickly thereby improving quality of care
  - Downstream effects of patients who develop delirium include increased patient mortality & hospital acquired harms, hospital length of stay and patients discharged to an already overburdened LTC system

PROBLEM

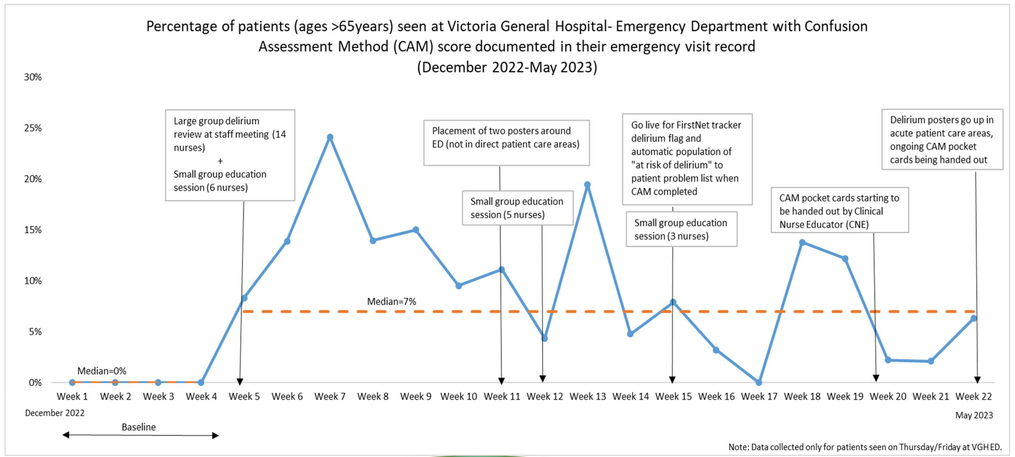
- Delirium is considered a medical emergency
- Rates of delirium recognition in VGH Emergency Department are dismally low.
  - Lack of recognition impacts the quality of care patients receive cross the spectrum of acute care
  - Staff survey shows low rates of confidence in delirium assessment

AIM STATEMENT

- By June 2023, there will be a 75% increase in self reported confidence in delirium assessment for patients over the age of 65 by Emergency Department nursing staff at Victoria General Hospital.

DATA ANALYSIS

- Weekly chart audit Jan-May 2023
- Recorded % CAM completion in VGH ED for patients age 65 and older
- Nursing surveys rating self-reported confidence using CAM and recognizing delirium
- CAM completion analyzed through run chart



"I recalled… my mother had to be restrained and medicated when she was admitted because of her behaviour. After reading this handout, it's obvious she was in delirium. I don't understand why the word delirium has never been conveyed to us by a healthcare professional."

PDSA CYCLE

- Increase awareness of assessment tool
- Big group didactic education session
- Smaller group interactive education sessions
- Create pocket card reminders
- Posters on delirium & CAM assessment tool
- Delirium flag and automatic addition to problem list on FirstNet

CHANGE IDEA

- Increase nurses awareness of CAM assessment tool
- Education sessions
- Easily accessible reminders
- Optimize FirstNet documentation
- Improve workflow to prioritize admitted patients to move to ward once identified

DRIVER DIAGRAM

- Primary Driver: Awareness of assessment tool
- Primary Driver: Belief in the cause
- Primary Driver: Optimize workflow
- Secondary Driver: Education
- Secondary Driver: Reduce time spent in ED

FINDINGS

- Difficult to make change in an unstable environment
- Completion of PDSAs complicated by difficulty accessing data
- Non standard documentation process impacts the % of CAM completion

BARRIERS

- Access to data from electronic medical record
- Staff workload
- Staff turnover
- Survey completion

NEXT STEPS

- Formalize regular nursing delirium education
- Make changes to location of CAM documentation
- Consider delirium care pathway including delirium reminders and clinical order set
- Formalize delirium handout for caregivers and patients
- Continue to work with executive to expedite admission for patients diagnosed or at risk of delirium

CONCLUSION

- Further interventions are required to promote delirium recognition and documentation
- Need to move beyond focus on educational initiatives to improve sustainability
- Working towards a delirium care pathway that focuses on involvement of caregivers and family members may ultimately create a culture of change

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Context: A Social Determinants of Health project

Project leads: **Dr. Sylvie Tellier and Dr. Tania Wall**
Nurse Lead: **Emily Dunkley**
Executive Sponsor: **Dr Jennifer Ross**
Operations Sponsor: **Fiona Griffin**

Social determinants of Health(SDoH) relate to an individual's place in society, such as income, education or employment. Increasing awareness of SDoH in our patient population will allow patient-centered care by improving patient health and reducing inequities.

Problem statement

It is well documented that a persons social determinants of health can create health inequity that greatly influences ones overall well being. Despite this, no unified way of learning about and documenting patients social determinants of health exists within our patients family practice chart.

Aim Statement

To increase the number of patient charts with documented ICD-9 codes relating to 6 key actionable Social Determinants of health* in our patient panels by October 2023.

*Poverty, Unemployment, Food insecurity, Insecure housing, Social Isolation, Lack of transportation

We offered patients the opportunity to self identify as someone who could benefit from SDoH screening and connection with resources by asking:

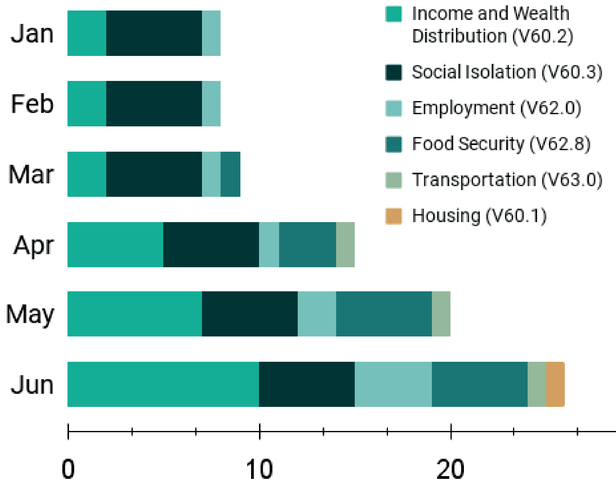
"Do you ever have trouble making ends meet at the end of the month?"

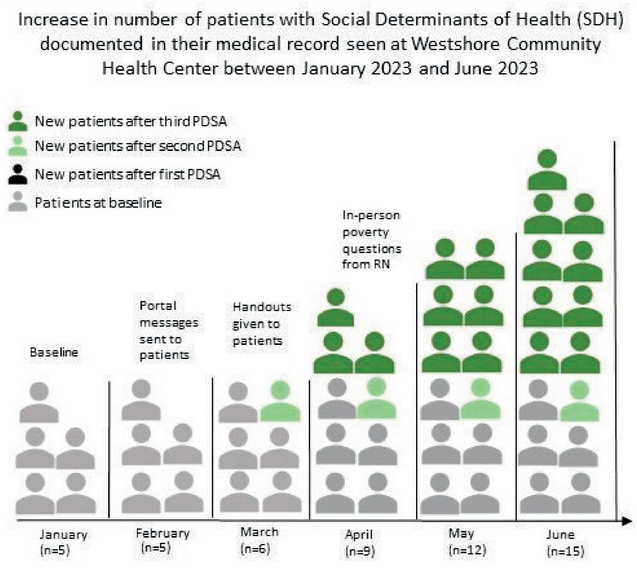
We conducted PDSA cycles using three different approaches to frame the question

1: MD sent EMR portal message
2: MD gave physical handout
3: RNs asked patients in person

A Patient partner was engaged to help
- **create the invitation message**
- **review the booking process**
- **create a template for the RN to screen for the 6 SDoH**

Patients were invited to book with the RN to:
- Screen for the 6 SDoH
- Discuss and receive resources
- With consent, to have this information added to their patient medical profile





Lessons Learned

- Screening for these SDoH was generally **well accepted** by patients
- **Physicians are working at max capacity,** making additional workflows unsustainable
- **In person screening** is the most effective way to engage
- A **team based approach** is necessary to engage patients
- Many of **these conversations were challenging** for providers to both participate in and to generate helpful resources.

FUTURE DIRECTIONS

- With an increase in team based primary care, there is potential to improve patient centred care regarding SDoH
- The workflow created would work well as part of an initial intake process for patients
- Patients who screened positive could be discussed at group rounds to both debrief and collaborate on resources

Patient Feedback

"it's one piece of the puzzle"

"EVERYONE HAVING THE SAME INFORMATION IS HELPFUL"

"It means I can get help"

"I strongly believe that it's all connected"

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MOATS – PC

Medical Office Assistant Triage System in Primary Care

Project Team

Team Lead: Dr Tim Troughton

Project Participants:

- Brenda Quan, MOA
- Jennifer Campbell, MOA
- Dr Michael Jones, Medical Office Lead

BACKGROUND

- **Existential experience demonstrates inefficiencies & risk with the current model:**
  - Patients are anxious about their symptoms
  - MOAs experience stress working outside of their scope
  - Potentially excessive upstream system costs engaging ER, 811 or unfamiliar WIC

PROBLEM STATEMENT

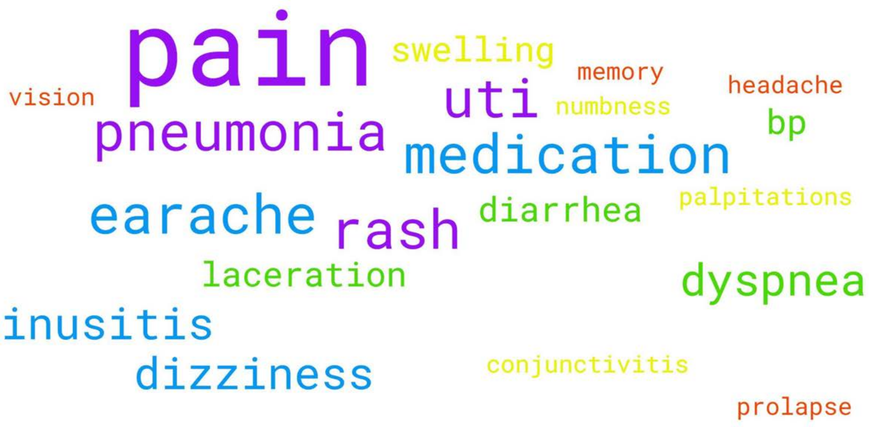
Patients contact our office with issues of varying urgency and with our MOAs who are not clinically trained, triaging these requests can lead to delays in assessing the urgency and addressing them in a timely manner. This delay and uncertainty can lead to additional stress for both patients and staff

AIM STATEMENT

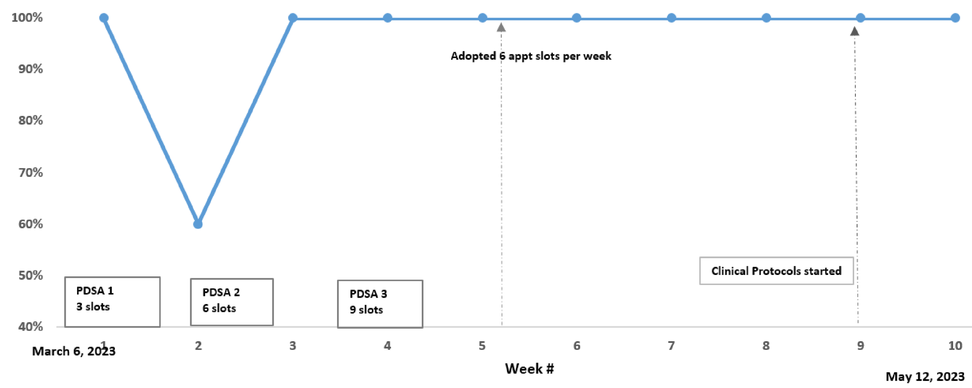
By June 2023, 100% of Dr Troughton's patients who contact Cook St Medical Clinic with urgent clinical needs will receive an appropriate and timely response within 90 minutes.

DATA ANALYSIS

- **Patient-initiated urgent requests were in scope while scheduling/rescheduling requests were out of scope**
- Baseline data was collected proactively by questionnaire and retrospectively via EMR chart review

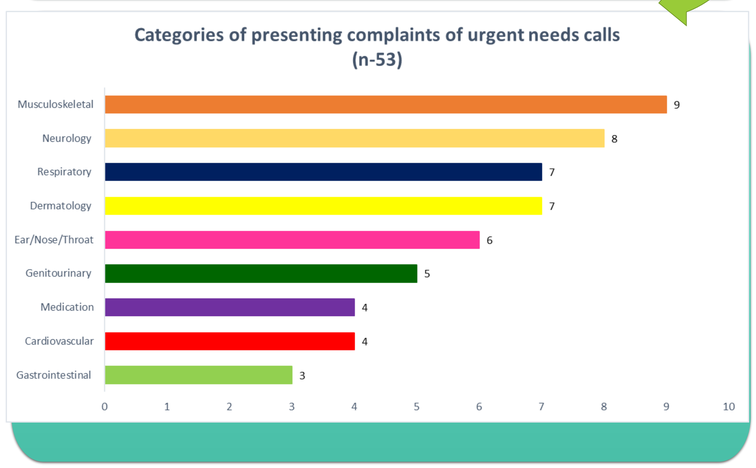


Percentage of urgent cases who received appropriate and timely response within 90 mins of contacting Cook St. Medical Clinic (March-May 2023)



CHANGE IDEAS

- ✓ Create more same day/next day fit in appointments (advanced access)
- ✓ Create clinical protocols triage tool based on call category - MOA to use as triage tool eg SOB/chest pain/rash/UTI/stroke symptoms etc
- ✓ More meaningful use of EMR message system



PDSA CYCLES

- **Plan:** Advanced Access
- **Do:** Created 3 protected "urgent only" appointment slots per week
- **Study**: All slots were filled & more needed
- **Act:** Increased to 6 open appointment slots per week

FINDINGS

- Advantage for patients by creating advanced access
- Reduction in staff stress & increase in joy
- Clinical protocols are a valuable tool

BARRIERS

- Designing Clinical Protocols that are user friendly and increase efficiency is challenging
- Difficult to measure cost savings from reduction in ED visits
- A noted balancing measure was the increase in staff time needed to employ clinical protocols

NEXT STEPS

- Develop questionnaire to determine impact on patients
- Consideration of central website with clinical protocols, or macros embedded in EMR
- Publish results

PROJECT SPREAD

- Test changes with other physicians in office
- Potential spread to other Patient Medical Homes

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