SSC SPECIALIST SERVICES COMMITTEE

PQI PHYSICIAN QUALITY IMPROVEMENT Specialist Services Committee

SQI SPREADING QUALITY IMPROVEMENT Specialist Services Committee

Physician Quality Improvement & Spread

Cohort 8, Alumni & Spread Projects

2024 - 2025

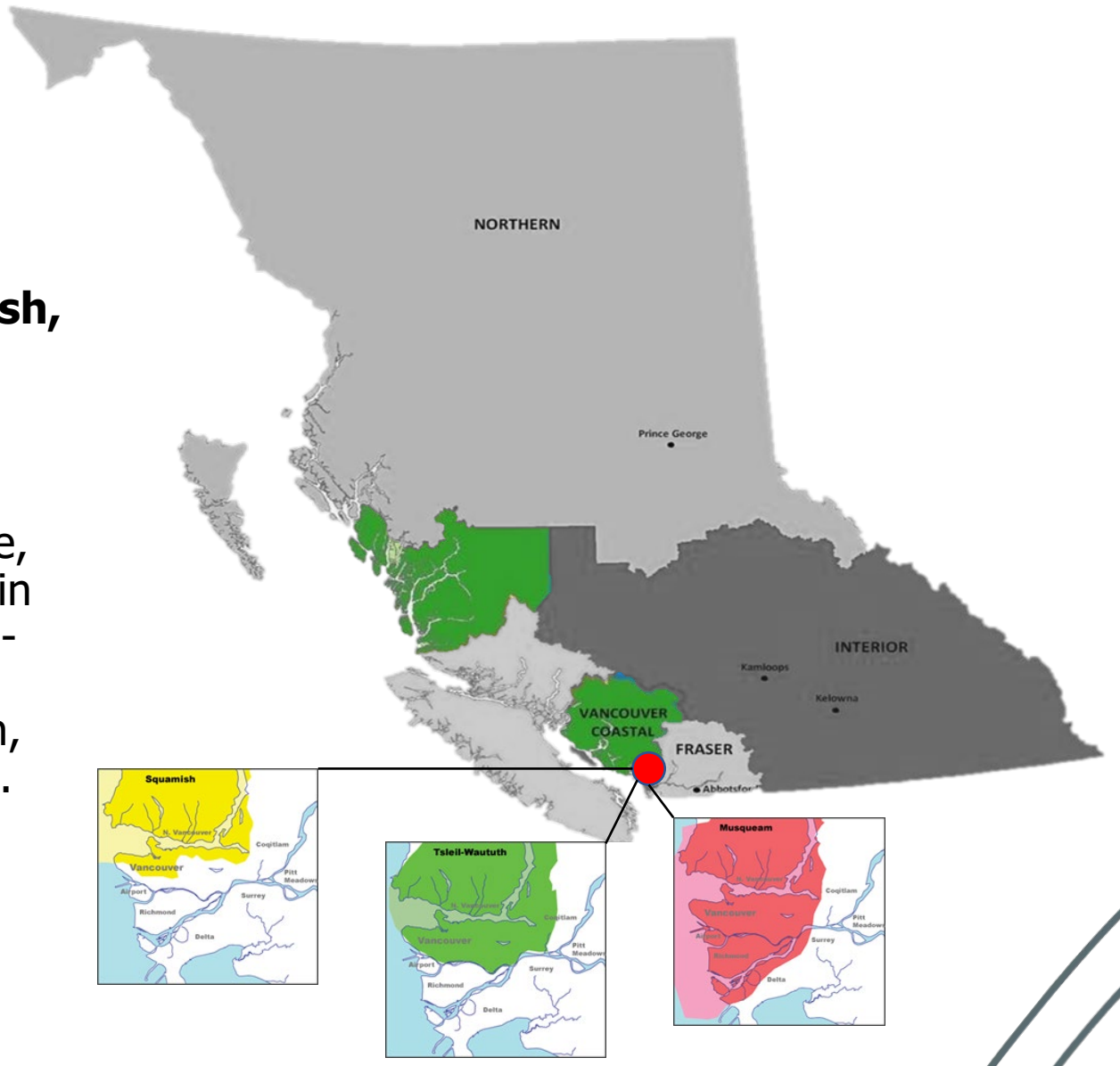
Vancouver CoastalHealth

Providence Health Care
How you want to be treated.

Territory Acknowledgement

We wish to acknowledge that the land on which we gather is the traditional and unceded territory of the Coast Salish Peoples, including the Musqueam, Squamish, and Tsleil-Waututh Nations.

Vancouver Coastal Health is committed to delivering exceptional care to 1.25 million people, including the First Nations, Métis and Inuit, within the traditional territories of the Heiltsuk, Kitasoo-Xai'xais, Lil'wat, Musqueam, N'Quatqua, Nuxalk, Samahquam, shíshálh, Skatin, Squamish, Tla'amin, Tsleil-Waututh, Wuikinuxv, and Xa'xtsa.



Indigenous Health | Vancouver CoastalHealth

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Introduction

The Physician Quality Improvement & Spread (PQI&S) initiative is a province wide initiative and a partnership between Vancouver Coastal Health (VCH), Providence Health Care (PHC), and the Specialist Services Committee (SSC). The vision of PQI&S is to "empower physicians to enable a continuous improvement culture, to achieve excellence in care for patients and families, where BC is a model for health and wellness globally" – PQI&S Vision, Mission, Values

This years' 2024-2025 booklet showcases the effort and results of 12 Cohort projects, 4 Alumni projects, and 4 Spreading Quality Improvement (SQI) project completed or near completion this year.

Congratulations to all the physicians and their team members who dedicated their time and effort to improving care for patients.

PQI&S Team

Leadership
Dr. Stephen van Gaal, Neurology, Chair
Vivian Chan, Health Authority Sponsor, Senior Director
Enrique Fernandez, PQI Manager
Amy Chang, SQI Manager

Physician Coaches
Dr. Cole Stanley, Family Medicine

Physician Faculty
Dr. Amrish Joshi, Palliative Medicine
Dr. Andrew Kestler, Emergency Medicine
Dr. Jane Lea, Otolaryngology
Dr. Justin McGinnis, Gynecologic Oncologist
Dr. Marla Gordon, Family Medicine
Dr. Matthew Kwok, Emergency Medicine
Dr. Paul Huang, Emergency Medicine
Dr. Penny Tam, Internal Medicine
Dr. Stephanie Chartier-Plante, Surgery
Dr. Trina Montemurro, Anesthesiology
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Bianca Grosu, QI Advisor

Spreading Quality Improvement
Manu Kalia, Change and Improvement Specialist

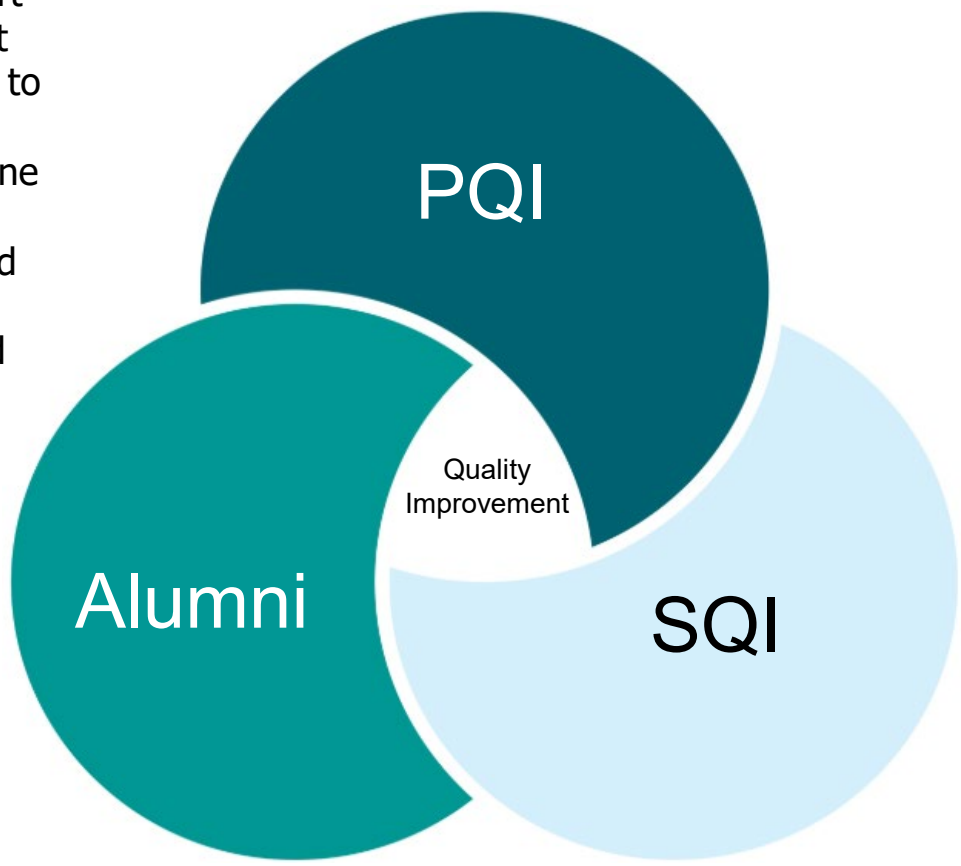
Supporting Medical Staff to be Powerful Health System Partners

Physician Quality Improvement (PQI)

PQI provides training and project support to physicians for in-depth learning about QI theory and tools, and an opportunity to conduct their own QI project. Training opportunities range from self-paced online learning (Level 1), class-based half day zoom sessions (Level 2), to cohort-based learning with full project support (Level 3). We also offer QI coaching as needed and Quality Quest for team-based learning.

Alumni

This strategy aims to continue supporting physicians in their QI journey (alumni). The key components we offer are project funding, quality leader support, and data analytics. We continually strive for physicians to become QI leaders within their team and their organization.



PQI Website

SQI Website

Spreading Quality Improvement (SQI)

SQI is an initiative that aims to foster collaborative relationships at the provincial, regional/ organizational and local levels resulting in the spread of QI work funded by the SSC and Shared Care Committee. The goal is to spread successful QI projects to accelerate the impact and transformation for our health care system within the Institute for Health Care Improvement (IHI) Modified Triple Aim framework. SQI provides support to sending and receiving sites in the form of physician funding, QI education, data support, project/change management, and system navigation.

Cohort 8 Projects: Institute for Healthcare Improvement (IHI) – Modified Triple Aim

Cohort 8 Projects	Patient Experience	Population Health	Cost of Care	Provider Satisfaction	Health Equity	Planetary Health
Dr. Alana Fleet *Optimizing the Efficiency and Accuracy of the Intake Process at the Lions Gate Hospital Physical Medicine & Rehabilitation Clinic*						
Dr. Kamyar Keramatian *Integrated Care Planning for Concurrent Disorders at Coastal Early Psychosis Intervention (EPI) Program*						
Dr. Angela Jennings *Increasing Patient Usage of Online Appointment Booking System*						
Dr. David Cook *Improving Smoking Cessation Screening and Treatment at Hope to Health Clinic*						
Dr. Mandeep Mann *Improve patient awareness and availability of resources for patients recently diagnosed with cancer at SPH's ED*						
Dr. Wendy Davis *Reduce patient time spent on transfusion care*						
Dr. Adam Soares *Improve the efficiency of hospitalists at VGH*						
Dr. Daljeet Chahal *Decreasing time from patient admission to decision about transplant listing at VGH ICU*						
Dr. Dominic Tse *Reducing Door to Needle Time for Thrombolysis in Stroke Patients at VGH*						
Dr. Krista Marcon *Improving Bone Marrow Scheduling and Workflow at VGH Hematopathology Laboratory*						
Dr. Harkiran (Kiran) Sandhu *Better supporting palliative patients with comorbid substance use disorders at May's Place Hospice*						
Dr. Junella Lee *Reducing Plastic Waste from Urine Specimen Containers at Richmond Foundry*						
Dr. Laura Knebel *Improving consistency in collecting wound cultures in infected wounds at DCHC*						

Patient Experience
Improving patients' (individual's) experience of health care

Population Health
Improving health in the population (addressing cause of illness)

Cost of Care
Improving cost efficiency in health without reducing efficacy

Provider Satisfaction
Improving the experience of those working in health care

Health Equity
Addressing disparities in health outcomes and ensuring that everyone has access to quality care

Planetary Health
Transforming healthcare to reduce our environmental impact and support low-carbon, sustainable systems.

COHORT 8 HIGHLIGHTS

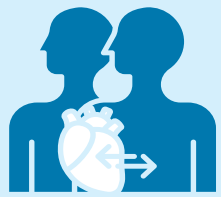
10 MONTHS
12 SESSIONS
13 PROJECTS

Dr. Mandy Mann

aims to bridge the gap between a new cancer diagnosis and BC Cancer Agency referral by connecting patients with community resources

Dr. Daljeet Chahal

decreases time from patient admission to decision about transplant listing



Dr. David Cook & Chase Fisher

increases smoking status and stage of change for active patients at Hope to Health Clinic

Dr. Angela Jennings

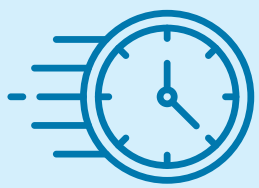
increases patient usage of online appointment booking system

Dr. Junella Lee

reduces plastic waste from urine specimen containers

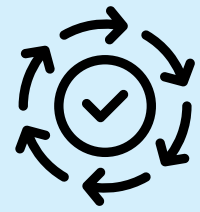
Dr. Dominic Tse

reduces Door to Needle Time for thrombolysis in stroke patients by 10 minutes



Dr. Laura Knebel

improves consistency in collecting wound cultures in infected wounds



Dr. Krista Marcon

optimizes bone marrow scheduling and workflow in the VGH Hematopathology Laboratory

Dr. Kamyar Keramatian & Ashley Forbes

enhances care for patients with concurrent disorders at the Coastal Early Psychosis Intervention Program

Dr. Wendy Davis

reduces average time spent in accessing transfusion care

Dr. Adam Soares

improves the efficiency of hospitalists by improving the efficiency of i-Care rounds

Dr. Alana Fleet

improves the intake process by ensuring new patients are timely and appropriately triaged and booked with complete referral packages

Dr. Kiran Sandhu

aims to support palliative patients with comorbid substance use disorders

PQI PHYSICIAN QUALITY IMPROVEMENT
Specialist Services Committee

PLANETARY HEALTH IMPACTS

We continue to prioritize incorporating planetary health impacts into our QI projects to ensure that our initiative not only improves patient care but also contributes positively to environmental sustainability. Under the guidance of our PQI alumni Dr. Andrea McNeill (VCH Regional Medical Director for Planetary Health) and her team, we guide our Cohort physicians through including a planetary health lens in their QI projects. A few examples include:

Reducing the use of antibiotics help minimize the spread of antibiotic resistance, prevent water/soil/ food system contamination, and ensure healthier, more sustainable ecosystems for future generations.
(see Dr. Laura Knebel)

Faster stroke treatment reduces hospital stays, limits resource use like contrast dye, and eases provider strain—supporting both human and planetary health.
(see Dr. Dominic Tse)

Streamlining referrals and shifting to electronic charting reduces waste, prevents unnecessary tests and visits, and optimizes physician time—advancing both patient care and environmental sustainability.
(see Dr. Alana Fleet)

Shortening travel distances reduces carbon emissions, helps conserve energy, and minimizes air pollution, all of which contribute to a healthier planet. *(see Dr. Wendy Davis)*

Reducing the use of plastic urine containers helps decrease plastic waste that often ends up in landfills or the environment, where it can take centuries to decompose. This reduction lowers pollution, conserves natural resources, and cuts down on the carbon emissions associated with plastic production and disposal.
(see Dr. Junella Lee)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PQI PHYSICIAN QUALITY IMPROVEMENT
Specialist Services Committee

Cohort 8 Projects

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Improving Interdisciplinary (iCare) Rounds on the Hospitalist Wards

Dr. Adam Soares (Project Lead)

CONTEXT

- Project was targeted on the interdisciplinary (iCare) rounds on the hospitalist wards at VGH with multiple groups involved, including hospitalist physicians, CMLs, PCCs, SW, PT, OT, Pharmacy and TST.
- Worked on improving the efficiency of rounds and ultimately the duration of rounds.

PROBLEM

- iCare round were taking on average 70-75 minutes a day which was seen as too long.
- Survey of staff involved in the rounds showed that people felt the rounds were beneficial but inefficient.
- The causes of the problem revolved around poor quality of information, inefficient use of time and poor communication.

AIM STATEMENT

- Reduce the duration of iCare rounds by 20% over the 4-month course of the project.
    - Goal of ~21 min/doctor or 56-60 min total.

STRATEGY FOR CHANGE

- Project was implemented with the help of the supervisors/managers of the groups involved.
- Multiple meetings with supervisors and operations managers were conducted with the changes being disseminated to the ward L8a staff.

MEASURE FOR IMPROVEMENT

- Duration of rounds were recorded in minutes.
- Initial plan was to track satisfaction as it was not certain whether changes in duration would be achieved in a short duration.
- However, the opposite was true, and shortening the duration was achieved!
- Satisfaction was hard to assess by the end of the project since changes were not implemented on other wards yet.

EFFECTS OF CHANGE

- Changes reduced the duration of rounds and allowed the staff involved to have more time for other tasks (e.g. patient assessments).
- Duration of rounds was reduced to 55-60 min (previously 70-75 min) with each doctor being 15-20 min (previously 30 min) -> reduction of ~21%.

ACKNOWLEDGEMENTS

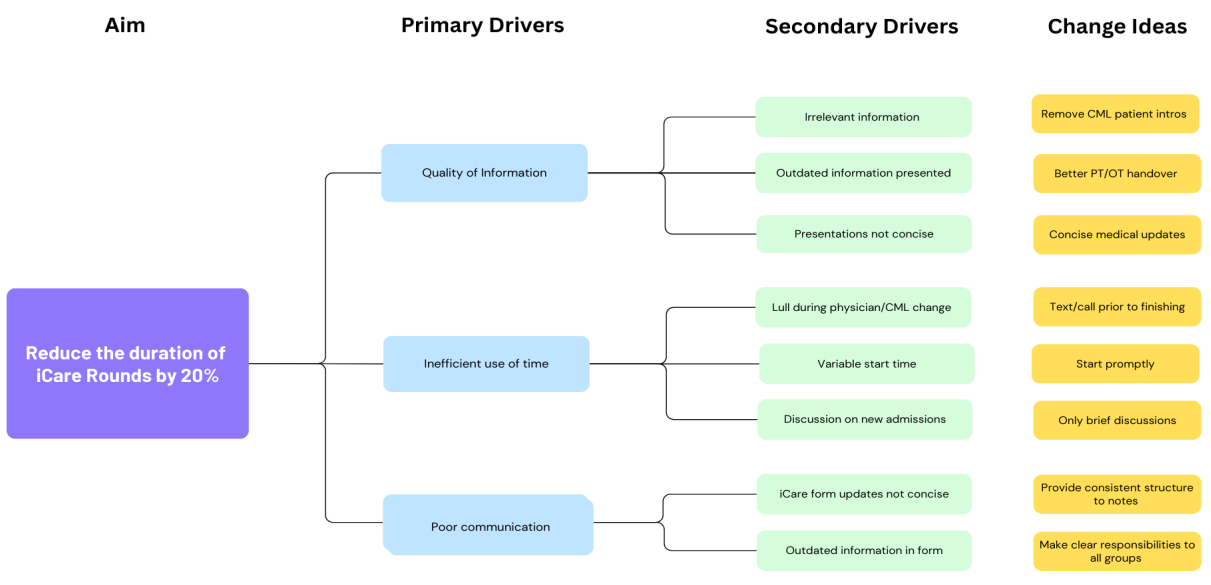
Sheri Kember (Operations Manager, Hospitalist unit)
Hing Yi Wong (PQI Leader)
Dr. Stephen Van Gaal (PQI Mentor)

GLOSSARY OF ACRONYMS

CML: Care Management Leader;
PCC: Primary Care Coordinator; SW: Social Work
PT: Physiotherapy; OT: Occupational Therapy
TST: Transitional Service Team

For questions or comments, contact Dr. Adam Soares at adam.soares@vch.ca

Driver Diagram



LESSONS LEARNED

- Challenges included encountering disagreements between groups which made it difficult to implement some changes.
- Next steps will be to implement the changes on our other three hospitalist wards.
- PQI Reflection: there are many frustrations shared by people with pent-up energy to make changes, but a leader to get things started is missing -> physicians can serve this role well.

SUSTAINABILITY

- Ward operations managers will be involved is sustaining the changes to the rounds and having them implemented on the other hospitalist wards.
- All supervisors/group managers involved are responsible for sustaining the changes within their groups so there is consistency.

IMPACT

- Patient Experience: More face-to-face time with staff as there is less time in meetings.
- Cost of Care: Reduce length of stay in hospital with more time for staff to work of disposition planning.
- Clinician Wellbeing: More efficient work-day which will reduce stress and reduce after hours time.
- Better Outcomes: Better team communication and engagement within rounds to provide better care to patients.
- Health Equity: Allows staff to spend more time with patients who need it and less time in meetings.

Reducing Door-to-Needle Time for IV Thrombolysis in Stroke Patients at VGH Emergency Department

Dr. Dominic Tse (Project Lead), Hing Yi Wong (QI Leader),
Dr. Penny Tam (QI Mentor)

CONTEXT

Location: Vancouver General Hospital, Emergency Department (VGH ED)
Staff involved:

- ED: ED physicians, residents, triage nurses, ED nurses
- ED Radiology: Radiologists, residents, radiology technicians
- Stroke team: Attendings, fellows, residents, stroke nurses

PROBLEM

- Canadian Stroke Best Practice recommends median door-to-needle time of <30 minutes.
- Between July 2023 to June 2024, median door-to-needle time at VGH ED was 45 minutes.

AIM STATEMENT

- To reduce the door-to-needle time for administering IV thrombolysis to eligible patients presenting with a hyperacute ischemic stroke by 30% at VGH ED by April 2025.

STRATEGY FOR CHANGE

- Change idea: ED radiology and stroke team to adhere to the 3-minutes time window between CTA and CTP.
- Monthly updates of door-to-needle time to the groups involved
- Test runs in December 2024
- Implemented on January 11, 2025
    - Announced to stroke staff at quarterly stroke meeting
    - Emailed ED radiology lead and technician lead

MEASURE FOR IMPROVEMENT

- Outcome measure:
    - Door-to-needle time
- Process measures:
    - Door-to-CT time
    - CT-to-needle time
- Balancing measures:
    - Staff dissatisfaction
    - TNK administration error

ACKNOWLEDGEMENTS
Lourdes Cua (Stroke Coordinator)
Stroke team, ED staff, ED radiology staff,
PQI team, Cohort 8 colleagues,
Cameron Rankin (Patient Partner)

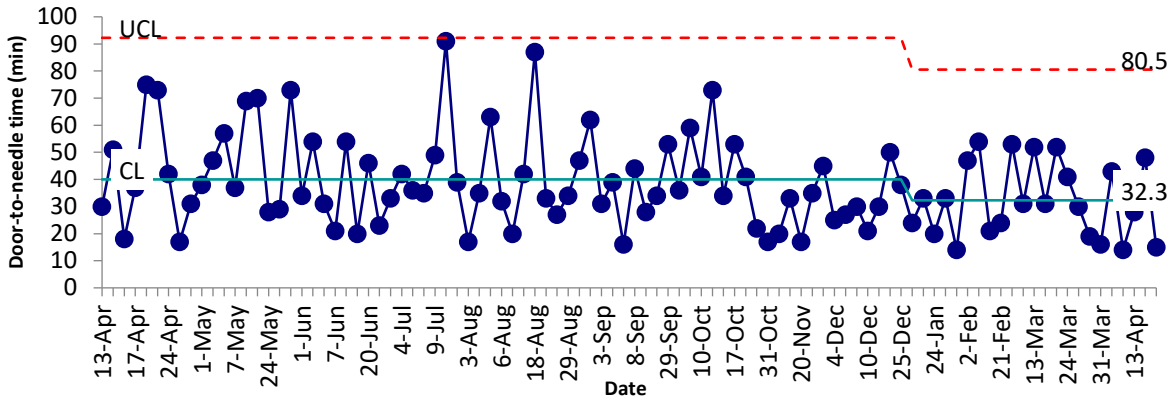
GLOSSARY OF ACRONYMS
IV: Intravenous; CT: Computed Tomography;
CTA: Computed tomography angiography;
CTP: CT perfusion; ED: Emergency Department
TNK: Tenecteplase; VGH: Vancouver General Hospital

For questions or comments, contact Dr. Dominic Tse at dominic.tse@vch.ca

EFFECTS OF CHANGE

- Median door-to-needle time reduced from 42 minutes to 32 minutes
- The median door-to-needle time is now within 2 minutes of the Canadian Stroke Best Practice Recommendations
- Staff dissatisfaction
    - Stroke attendings concerned about lack of time to review CT between CTA and CTP
    - Resident opening/reconstituting tenecteplase prior to CT
    - Resident forgetting to reconnect IV following thrombolysis administration leading to wastage of IV contrast

Door-to-needle time from April 2024 to April 2025



LESSONS LEARNED

- Overall reduction of median door-to-needle time by **20%**
- QI process had a positive impact on the outcome measure
- Patients receiving better quality stroke care
- More efficient use of CT

SUSTAINABILITY

- Addressed staff dissatisfaction
    - Stroke staff to review scan in detail in the radiology reporting room
    - Resident teaching about cost of thrombolysis and standard operating procedure
    - Stroke simulations in ED with staff involved, starting in August

IMPACT

- Improved patient experience by providing better quality of stroke care i.e. median door-to-needle time of 32 minutes
- Planetary health in terms of more efficient use of the CT scanner

Optimization of Bone Marrow Scheduling & Workflow at Vancouver General Hospital

Dr. Krista Marcon (Project Lead), David Puddicombe (QI Lead),
Dr. Paul Huang (QI Mentor)

CONTEXT

- Bone marrow biopsies are often required to investigate patients with suspected hematological conditions
- Urgent/STAT diagnosis is required for life-threatening hematological malignancies such as acute leukemia and lymphoma.
- Approximately 1200 bone marrow biopsies are performed annually at Vancouver General Hospital (VGH).
- VGH provides province-wide care for the adult Leukemia/Bone Marrow Transplant (LBMT), and Hematology programs.
- Laboratory Technologists from the Hematopathology Lab accompany the clinical physician for up to 7 procedures per day.

PROBLEM

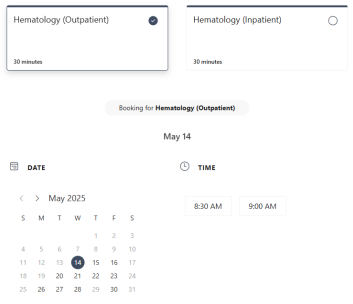
- Baseline data audit highlighted a lack of capacity for urgent and STAT bone marrow requests due to scheduling process allowing over-scheduling of outpatient non-urgent cases, despite adequate overall capacity on a weekly and monthly basis.
- Provider surveys, key partner meetings, and process mapping highlighted the inefficiencies and lack of transparency in the bone marrow scheduling process, leading to challenges in securing bone marrow bookings.

AIM STATEMENT

- Global Aim: To optimize bone marrow scheduling and workflow in the VGH Hematopathology Laboratory.
- By April 2025, the variability of bone marrow bookings will be reduced; the percentage of days with greater than 6 marrows will reduce by 80%; 80% of weekdays will have two or more urgent bone marrow appointments available.

STRATEGY FOR CHANGE

- Hematology group selected for first PDSA: Digital scheduling platform for inpatient and outpatient Hematology marrows.
- Hematology in full control of their timeslots.
- Agreement to not overschedule outpatient bookings (leaving 2-3x per week).
- Scheduling system implemented February 10th for all Hematology bookings.
- Involved parties were notified of change via email (residents, fellows, hematologists, laboratory staff, booking secretary).



MEASURE FOR IMPROVEMENT

- Number of Bone Marrows/day; % of days per week with >6 marrows was graphed on a control chart (Outcome Measure).
- Number of bookings available at Day-2; % of days per week with >/= 2 Urgent bookings available (Outcome Measure).
- Percentage of Hematology bookings using the system (Process Measure).
- Number of Hematology bookings outside of the 10 available timeslots/week (Balancing Measure).
- Number of times technologist late due to travel time (Balancing Measure).
- Clinician satisfaction with booking process measured on Likert Scale 1-5 (Balancing Measure).

ACKNOWLEDGEMENTS
Laboratory Team: Jennifer Khokar, Kanwal Deol, Geoff Chan, Lena Lum, Anas Khan, Lawrence Sham, Sangeetha Gobikannan Clinical Team: Dr. Gayatri Sreenivasan, Dr. Judith Rodrigo, Dr. Donna Forrest, Dr. Stephen van Gaal

For questions or comments, contact Krista Marcon at: krista.marcon@vch.ca

EFFECTS OF CHANGE

- Reduction in variance of weekly bone marrows (narrowing of highest and lowest days).
- Reduction in days with >6 bone marrows from 18.3% to 13.9% (FIGURE 1).
- No apparent change in % of days with >/= 2 urgent bookings available.
- Increased interval between days with < 2 urgent bookings available: 7.4 days to 12.4 days (FIGURE 2).
- Improved clinician satisfaction for inpatient and outpatient bookings (Figure 3).

Figure 1

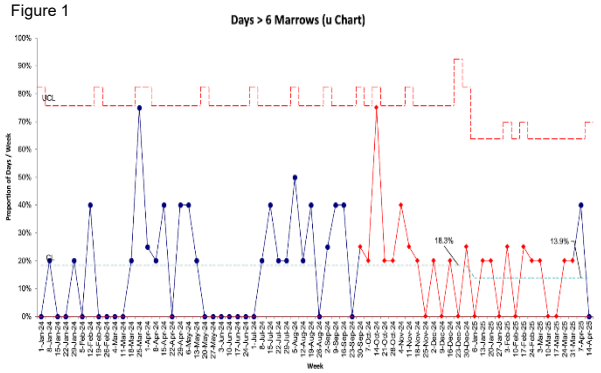


Figure 2

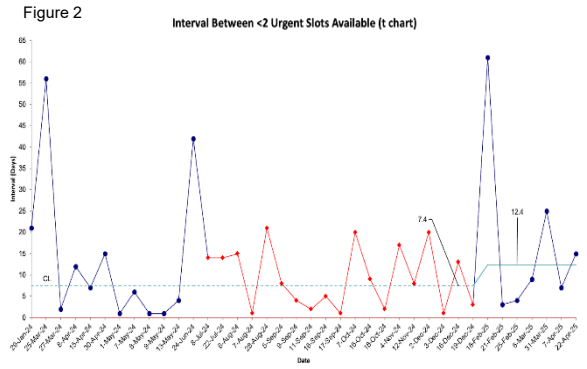
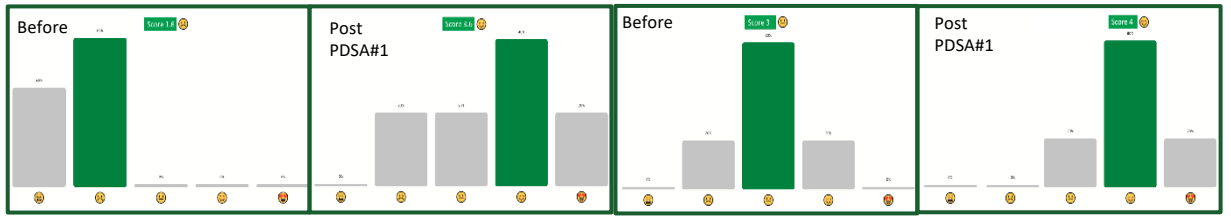


Figure 3



LESSONS LEARNED

- Many involved parties are willing to give unfiltered feedback, particularly with confidential surveys.
- Importance of considering the timing of implementation: delays in implementation due to Winter holiday periods, impacts of vacation of regular booking secretary, and possible effects of March Break/multiple clinicians on vacation for bookings.
- Challenging to on-board multiple clinical groups, change champions from each care area needed.

SUSTAINABILITY

- Sustainability is a challenge - Microsoft Bookings is a Pilot platform at VCH.
- Reliant on single non-laboratory provider to make changes going forward with no IMITS support.
- Laboratory is not yet in control of own booking platform to make changes.
- Limitations on future changes/PDSA cycles with booking secretary not having control of system.
- Largest provider group (LBMT) has barriers to on-board to digital system.

IMPACT

- Possible improved Clinician Wellbeing.
- Improved clinician satisfaction!

Optimizing the Efficiency and Accuracy of the Intake Process at the Lions Gate Hospital Physical Medicine & Rehabilitation Clinic

Alana Fleet (Project Lead)

CONTEXT

- Hospital based group practice with five physiatrists.
- Treat patients experiencing life altering injury or disease with particular focus in stroke, brain injury, spinal cord injury and complex orthopedics. Most, if not all, of our patients are living with disabilities.
- Referral base from other LGH physicians, following an inpatient admission or from subspecialist clinic.
- Serving patients across the North Shore.

PROBLEM

- Growing outpatient clinic, sharing resources with other departments creating administrative and technical barriers for clinical practice and QI work.
- Inefficient workflow, especially for new patients: missing documents, unclear referral questions, inconsistent triage.
- Duplication of work, delay in care, missed investigations and less time available for direct clinical care.

AIM STATEMENT

- Improve the **intake process** at the LGH PM&R clinics by May 2025 to have new patients appropriately **triaged** and **booked** with **complete referral packages** (95% completion rate) within 6 weeks of referral date.

STRATEGY FOR CHANGE

- Process mapping, Fishbone, and PICK chart exercises with QI team and key partners (PM&R, rehab coordinator, admin staff, allied health).
- Change ideas – admin: clerk review process, dedicated PM&R clerk, auto-reply template
- Change ideas – technical updates, standardized triage process, EMR automation and order sets
- Feb – May 2025 testing change ideas with biweekly meetings with MDs, and one-on-one check-ins with admin staff. NB: project paused Mar 2025 due to hospital tower move.

MEASURE FOR IMPROVEMENT

- Outcome: (1) complete referral packages; (2) MD experience
- Process: survey form completion rate
- Balancing: (1) admin staff experience; (2) triage time to MD visit
- Baseline – referrals only 50% complete, and 30% of the encounter's MDs felt had inadequate info for referral.
- Baseline – MD satisfaction with intake referral 3.5 on 5-point Likert scale.

ACKNOWLEDGEMENTS

Drs Paul Adamiak, Arezoo Azadi, Aaron Chan, Nicola Hahn, Ms. Nickayla Dallas, Hope Pearmain, Sabeena Patni and Shaunene Smyth
Mr. David Puddicombe and Dr Kelly Mayson

GLOSSARY OF ACRONYMS

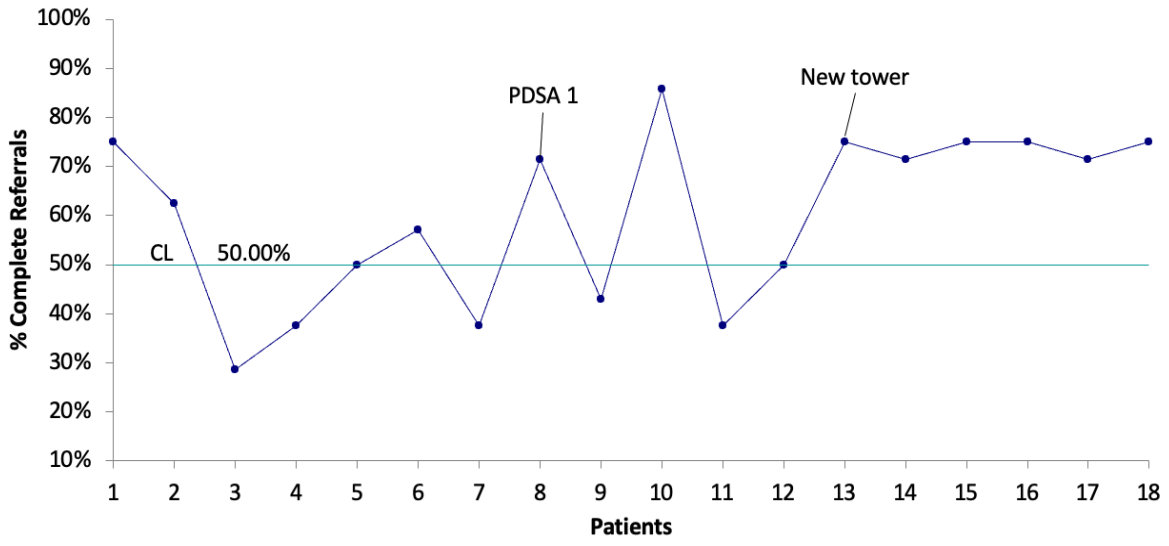
LGH: Lions Gate Hospital
PM&R: Physical Medicine & Rehabilitation
EMR: Electronic Medical Record
MD: Medical Doctor
NB: nota bene' a latin phrase literally meaning 'note well'
QI: Quality Improvement

For questions or comments, contact Dr Alana Fleet at: alana.fleet@vch.ca

EFFECTS OF CHANGE

- Increased new referral completeness, increasing to new median 71%.
- Initial learning curve, but now clinicians and staff reporting less stress and duplication of work. Physician satisfaction now consistently 4/5 on scale. Admin staff satisfaction also has improved to 5/5.
- Streamlined intake process, standardization, improved use of technology, new clinical environment.
- Increased priority for outpatient clinic, building ownership amongst team of clinicians & admin staff.

Referral package completeness (%) for new patients



LESSONS LEARNED

- Find the silver linings: new tower move provided unique opportunities and built momentum for change.
- Do not overthink it: moving on a timeline that works for the team increases willingness for change, even if not a 'perfect' schedule.

SUSTAINABILITY

- Collaboration with administrators: formalized and ongoing updates to standard operating procedures
- Iterative process to implement increased technology use and broader adoption amongst outpatient rehab teams.
- Formal QI training undertaken by key partners.

IMPACT

- Improved clinician wellbeing and the patient experience
- Planetary health: reduce waste and appropriate stewardship of healthcare resources

Integrated Care Planning for Concurrent Disorders at Coastal Early Psychosis Intervention (EPI) Program

Dr. Kamyar Keramatian (Project Lead), Ashley Forbes (Project Co - Lead), Allison Zentner (QI Lead)

CONTEXT

- Early Psychosis Intervention (EPI) is a specialized outpatient mental health team for individuals between 13-30 who are in the early stages of a psychotic illness.
- EPI team is made up of interdisciplinary case managers (nurses, occupational therapists, social workers, clinical counsellors) who support their clients to improve recovery.
- Work was done with case managers, clients and families at the EPI team (Hope Centre in North Vancouver).

PROBLEM

- Up to 74% of individuals with first-episode psychosis have comorbid substance use disorders (Brunette et al. 2018).
- There is a lack of integrated care planning at the EPI program for patients with co-occurring substance use disorders. This can result in these patients receiving suboptimal care, placing them at risk of disengagement from the program.
- The problem was identified through an initial audit of patient charts.

AIM STATEMENT

- The overall objective of this QI project was to enhance care for patients with concurrent disorders at the Coastal Early Psychosis Intervention (EPI) Program.
- Specifically, we aimed to increase the completion of MH&SU Screener and Integrated Care Plan for Coastal EPI clients to 80% by June 2025.

STRATEGY FOR CHANGE

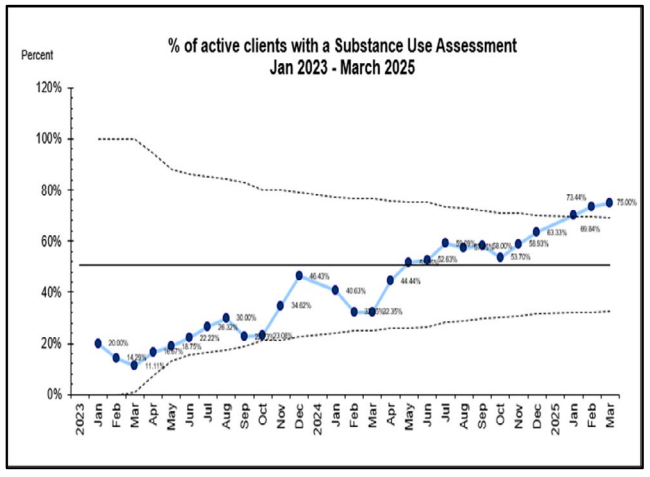
- Completed a Fishbone Exercise and Driver Diagram with EPI clinicians/case managers.
- From this, implemented Substance Use Care Rounds: a bi-weekly collaborative educational rounds aimed at improving competence and confidence around providing substance use care to clients.
- Between January 2025 and May 2025 completed 7 Substance Use Care Rounds on varying topics and tasks related to substance use, including: MH&SU screeners and care plans, motivational interviewing, stages of change, harm reduction, relapse prevention, continuum of care and treatment readiness, and medications for substance use.

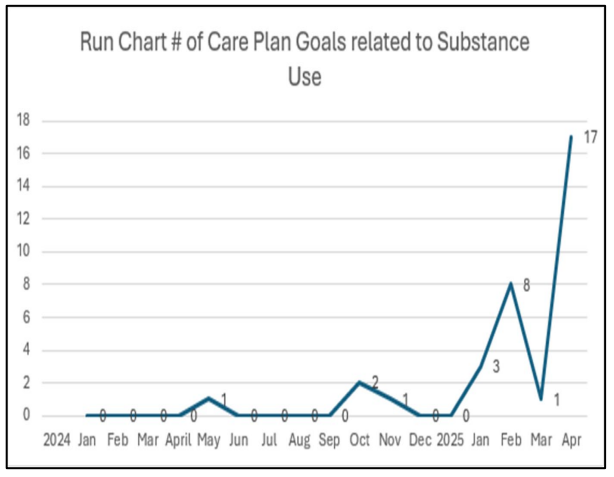
MEASURE FOR IMPROVEMENT

- Completed Staff Surveys pre–Substance Use Care Rounds and again in May.
- Completed Client and Family Satisfaction Surveys regarding their experience with services.
- Monitored completion rate of assessments and clinical care plans.
- Completed Run Charts and P Charts regarding completion of Substance Use Assessments and Clinical Care Plan.

EFFECTS OF CHANGE

- Our findings highlight the potential benefits of staff education on substance use care.
- Completion rate of the MH&SU screener increased to 75%, and Clinical Care Plan rose to 80%, with a notable increase in the inclusion of substance use–specific goals within care plans.
- Further PDSA cycles need to be conducted to address other barriers to integrated substance use care in an EPI setting.





LESSONS LEARNED

- Overall, this was a successful project with great collaboration between the physician lead and team lead as a dyad partnership.
- Clinicians engaged well in the process and interventions, and the flex student role was extremely helpful.
- We faced challenges with collecting and assessing data, given EMR limitations.
- We learned the importance of auditing data, reviewing results as early in the process as possible.

SUSTAINABILITY

- We plan to continue with SU care rounds.
- We aim to continue data collection through clinical informatics or involve administrative staff to support manualized processes of data collection.

IMPACT

- Our findings highlight the potential benefits of staff education on substance use care in an early psychosis intervention setting.
- Further PDSA cycles need to be conducted to address other barriers to substance use care in an early psychosis program setting.

ACKNOWLEDGEMENTS

Andrew Kestler, MD (PQI Physician Mentor)
Christa McDiarmid (Peer Support – EPI Coastal)
Saad Qureshi, Michelle Yang (UBC Flex Student),
Jas Parmar (Co-op student)
Would not be possible without the generous support of SSC funding

GLOSARY OF ACRONYMS

QI: Quality Improvement
MHSU: Mental Health and Substance Use
EMR: Electronic Medical Record
SU: Substance Use

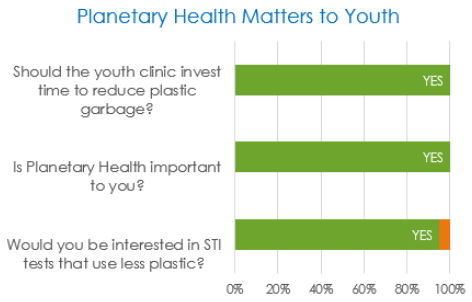
For questions or comments, contact Dr. Kamyar Keramatian at: Kamyar.Keramatian@vch.ca

Adding to Healthcare Pollution: Single-Use Plastic Urine Containers

Dr. Junella Lee (Project Lead)

CONTEXT

Single-use plastic urine containers used for sexually transmitted infection (STI) and pregnancy testing contribute to environmental pollution.



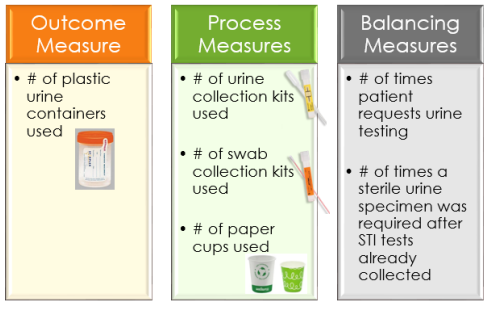
We have the ability and obligation to reduce single-use plastic urine container pollution.

AIM STATEMENT

To reduce single-use plastic urine container use by 50%

- I focused on my clinical practice at Foundry Richmond
- I focused on STI and pregnancy tests for female patients
- The approach was PDSA cycles to use alternate test collection options

MEASURES OF IMPROVEMENT



ACKNOWLEDGEMENTS

Foundry Richmond Team
VCH Youth Clinic Team
VCH PQI Team

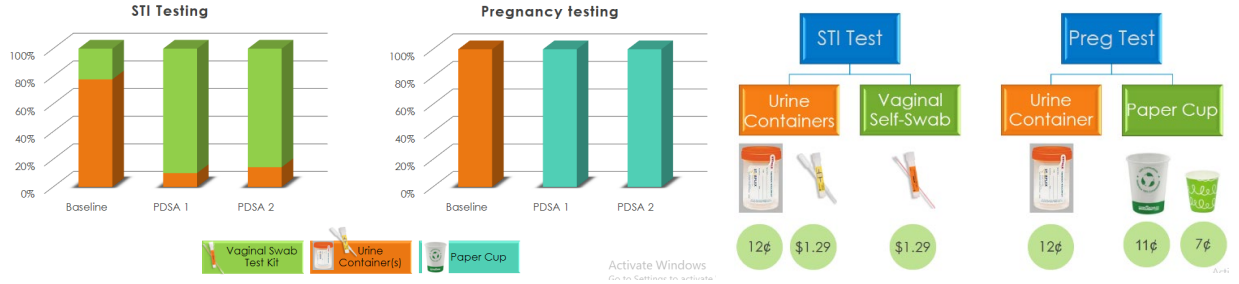
New West Youth Clinic Team
Dr. Jennifer Grant (BCCDC)
Dr. Marthe Charles, Allyson Hankins (VCH Lab, Infection Control)

Dr. Rashmi Chadha, Arianna Cruz (VCH Planetary Health)
Stephanie Tinson (Richmond Birth Centre)
Fraser Health Authority, SHBBI Program

For questions or comments, contact Dr. Junella Lee at junella.duong@gmail.com

EFFECTS OF CHANGE

- Patients are receptive to using vaginal swab test kits for STI testing.
- Patients are receptive to using paper cups for pregnancy testing.
- Vaginal swab test collection kits and paper cups use less plastic and cost less.



IMPACT

Improved Patient Experience	Cost of Care	Clinician Wellbeing	Better Outcomes	Health Equity	Planetary Health
Patients have more options to choose from for test collection	↓ test supply costs ↓ waste incineration costs	Reduce extra steps (decanting urine)	More accurate STI testing with vaginal swabs		Reduce single-use plastic pollution

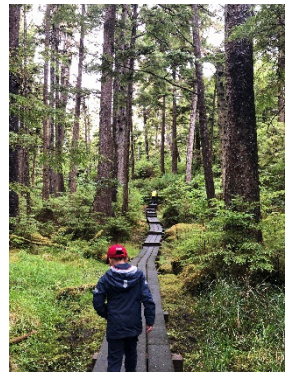
We have the ability to reduce single-use plastic urine container pollution and have a positive impact.

SUSTAINABILITY

Across BC, ~18,000 urine STI tests from female patients are collected each month.

Vaginal self-swab test collection can be offered to female patients and are the preferred STI test method for female patients.

Choosing STI and pregnancy test collection options that use less plastic can have a large impact on our environment.



Reducing Transfusion Time Spent for Myeloid Patients

Dr. Wendy Davis (Project Lead), Fazila Kasam (FLEX Student)
Soojee Sim (Project Coordinator), Dr. Hayeley Merkeley (FRCPC Lead)

CONTEXT

- Most patients with myeloid malignancies (acute myeloid leukemia, myelofibrosis, myelodysplastic syndrome) will require chronic blood transfusion support, typically at the St Paul's Hospital MSSU
- Due to risk of allo-antibody formation, every PRBC transfusion requires a recent G&S 1-3 days prior.

PROBLEM

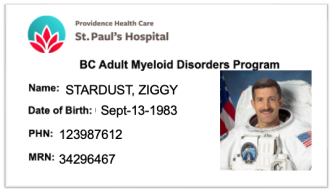
- The time burden and negative impact on quality of life (QOL) for these patients is significant.
    - A single transfusion appointment can take an entire day, and most patients require multiple transfusions per month.
- Root causes were assessed and included external, patient, blood product, process, and health care system factors.

AIM STATEMENT

- Reduce average time spent by transfusion-dependent myeloid patients (and their caretakers) in accessing transfusion care by 10% by June 2025.

STRATEGY FOR CHANGE

- Could we have the crossmatch sample drawn at laboratory near patient's home in advance of transfusion and forward to hospital blood bank for testing
  Built on existing model implemented for adult red cell disorder (e.g., thalassemia) patients receiving chronic transfusion support in MSSU – "Community Crossmatch"
- Project idea shared with colleagues, operations, MSSU team, blood bank and hematopathology, patients (patient support group meeting)
- Plan to open program to new & existing myeloid patients January 2025



MEASURE FOR IMPROVEMENT

- Outcome measures: time spent at transfusion appointment (surrogate measure=on-site wait time), patient experience/QOL
- Process measures: number of patients enrolled, round trip km travelled for pre-transfusion G&S
- Balancing measures: # same-day crossmatch (needed if no pre-transfusion G&S done)

ACKNOWLEDGEMENTS
Patient partner: Beth Rizzardo
QI Coach: HingYi Wong,
Physician Quality Improvement Initiative
Jacob Pendergrast, MD, FRCPC,
University Health Network

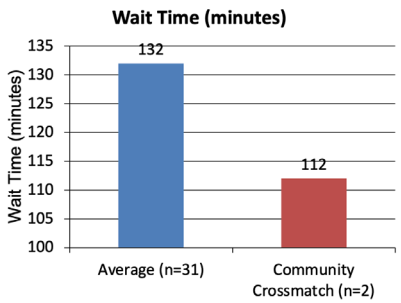
GLOSSARY OF ACRONYMS
G&S: group & screen;
MSSU: Medical Short Stay Unit;
PRBC: packed red blood cells
SPH: Saint Paul's Hospital

For questions or comments, contact Dr. Wendy Davis at wendy.davis@vch.ca

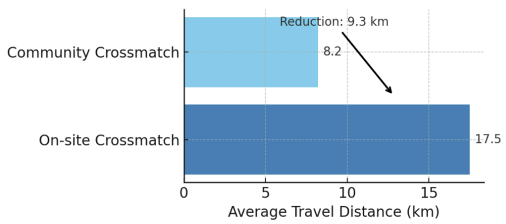
EFFECTS OF CHANGE

- On site wait time decreased (compared to average)
- Reduction in km travelled by patients and caregivers --> reduced time spent on transfusion care
- Reduced stress (parking, travel) with community crossmatch → improved QOL
- No same-day cross matches
- Some need for improved clarity on patient brochure

A) On-site wait time (from check in to start of transfusion)



B) Round trip travel for pre-transfusion blood work (G&S)



"Great, so convenient…the parking is great…the whole experience has been really good."
-Patient family caregiver

LESSONS LEARNED

- Access to good quality data is key to driving change
- Learning from other institutions and building on existing infrastructure gives your change a 'head start'
- Small improvement for small patient population can be meaningful

SUSTAINABILITY

- Ongoing recruitment of newly dependent myeloid patients in SPH Hematology/Oncology clinic

IMPACT

- Improved patient experience
- Clinician wellbeing (decreased moral distress at burden of care imposed)
- Better outcomes (more appropriate care)
- Health equity (reduced inappropriate same-day STAT G&S)
- Planetary health (decreased carbon emissions from vehicle travel)

Improving Patient Awareness and Access to Resources for Patients Recently Diagnosed With Cancer in SPH's Emergency Department

Dr. Mandeep Mann (Project Lead)

CONTEXT

- St. Paul's Hospital Emergency Department.
- Emergency physicians, nurses, social workers, and unit clerks.

PROBLEM

- There is a huge gap in cancer care in British Columbia. There are an increasing number of patients who do not have a primary care provider and are being diagnosed with cancer in the Emergency Department. This is a problem because they don't have anyone to coordinate their care, and they don't have follow up in the community.

AIM STATEMENT

- With this project I aim to bridge the gap between a new diagnosis of cancer and a BC Cancer referral; and provide patients with information about resources in the community to help them navigate this difficult time.

STRATEGY FOR CHANGE

- I created a resource sheet to hand out to the patients. My goal was to implement my first PDSA cycle by May. I was able to make providers aware via email and am in the process of coordinating a meeting with social work and nursing and the unit clerks to further involve other allied health care. Eventually I would like the resource to be online with a QR code that patients can easily use to access the information.

MEASURE FOR IMPROVEMENT

- Patient and provider surveys to ensure that patients are finding it useful and that there aren't any unintended negative downstream consequences such as adding more than 5 minutes to patient care or that patients are finding it too much information in the early stages of diagnosis.

ACKNOWLEDGEMENTS

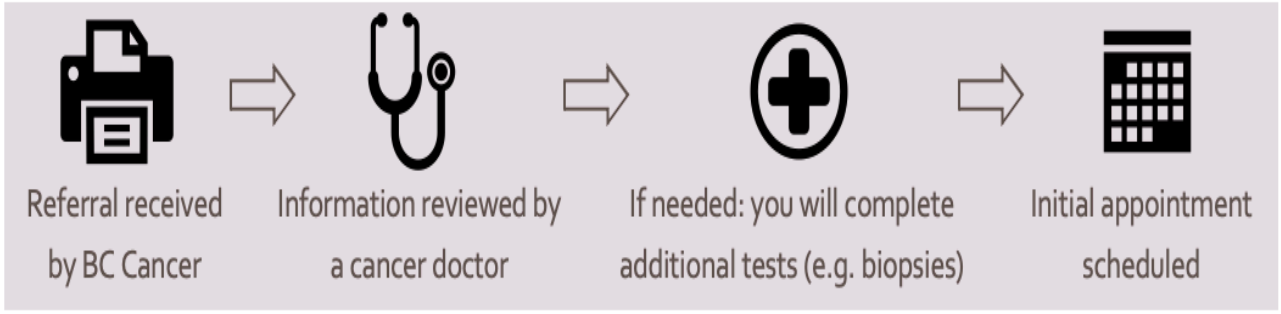
John Con, David Puddicombe, Justin McGinnis, Amanda Weatherston, Wayne Tse, Alexandra Mackinnon

For questions or comments, contact Dr. Mandy Mann at: mkmann.inc@gmail.com

EFFECTS OF CHANGE

- Feedback from staff have been that patients are thankful and that they feel it adds value to the care they provide.

Patient resource for cancer diagnosis in the ED, overview



LESSONS LEARNED

- Patient data is difficult to access so start early.
- Set small goals for each PDSA cycle.
- PQI is a great way to develop improvement ideas, test and implement changes.

SUSTAINABILITY

- Currently working with Patient Health Education Materials (PHEM) to see if they can take ownership of the resource and include it on their website.

IMPACT

- Improved patient experience
- Clinician well being
- Better outcomes

Improving Smoking Cessation and Treatment at Hope to Health Clinic

Dr. David Cook (Project Lead), Chase Fisher (Project Co - Lead)

CONTEXT

- Hope to Health Clinic, Interdisciplinary, longitudinal primary care clinic focusing on engaging and treating marginalized populations on the Downtown Eastside of Vancouver. Operated by the British Columbia Centre for Excellence in HIV/AIDS. Project involved whole team (nursing, social work, medical office assistants (MOA's), peer support workers, physicians, Quality Improvement (QI) team, operations, client engagement committee and more).

PROBLEM

- At baseline we had an up-to-date smoking status, meaning assessed within the past 1 year, documented for only 53% of patients. Only 37% of patient's had a stage of change documented.
- The root causes of this were lack of provider time and it was felt that smoking cessation was not an immediate priority of most patient visits.

AIM STATEMENT

- By June 2025 I would like to have smoking status and stage of change documented on 90% of active patient charts as well as appropriate, evidence-based counselling and treatment offered to all patients based on their stage of change.

STRATEGY FOR CHANGE

- Increased patient awareness with waiting room pamphlet and screensaver slide (Dec 18, 2024 – Jan 28, 2025).
- Used peer support worker in waiting room to discuss smoking status, enter information in EMR and offer NRT. Patient's put into a draw if they discussed smoking with peer (Dec 31, 2024 – Feb 18, 2025).
- Added section for smoking status into one of the templates the team commonly uses for OUD assessments (Jan 28, 2025 – Feb 25, 2025).
- Created a comprehensive substance use template to be embedded into our general issues and plan template (Mar 19, 2025 – Apr 1, 2025).

MEASURE FOR IMPROVEMENT

- We measured the percentage of patients whose smoking status had been updated in the previous 1 year as well as the percentage of smokers who had a stage of change documented.
- Measures were tracked in a dashboard built into the EMR and updated in an excel spreadsheet on a weekly basis.
- P-charts were created to measure improvements.

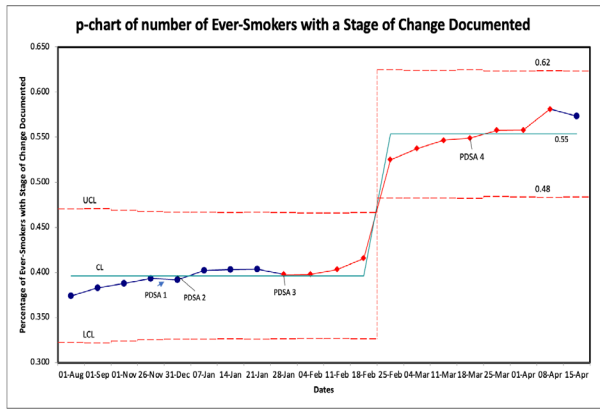
ACKNOWLEDGEMENTS
Allison Zentner, Dr Andrew Kestler, Dr Shirromi Sarveswaran, Travis Storteboom, all the staff at Hope to Health and funding from SSC

GLOSSARY OF ACRONYMS
EMR: Electronic Medical Record
NRT: Nicotine Replacement Therapy
OUD: Opioid Use Disorder

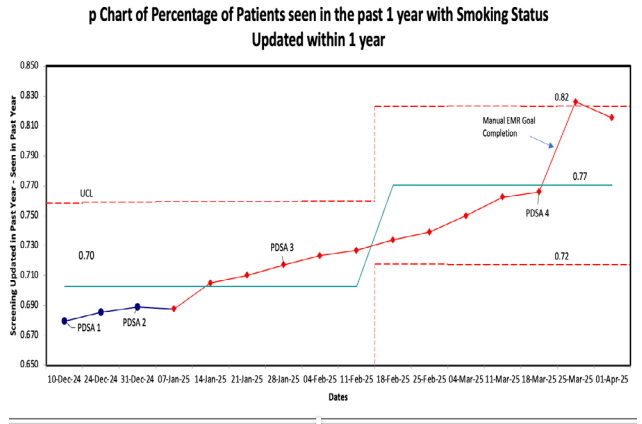
For questions or comments, contact Dr. David Cook at: dcook@bccfe.ca

EFFECTS OF CHANGE

- Up-to-date smoking status increased from 53% at baseline up to 82% by April 1, 2025
- Stage of change documented in chart increased from 37% at baseline up to 58% by April 15, 2025.
- Understanding patients smoking status and stage of change helps providers tailor patient-centered and evidence-based assessments and advice to patients.



** CL was re-calculated as there were 12 consecutive data points above the initial center line



* CL was re-calculated as there were 12 consecutive data points above the initial center line

LESSONS LEARNED

- The importance of involving patients early as this showed us that our perception that smoking and smoking cessation were not patient priorities was incorrect.
- The importance of defining measures early and tracking them early in order to establish good baseline data so you can assess improvements.

SUSTAINABILITY

- Ongoing monitoring and tracking will be done by the quality improvement team at Hope to Health.
- A Slack channel has been created to share smoking cessation related information and to discuss ongoing QI initiatives.
- Will be exploring continuation funding to continue working on EMR changes.

IMPACT

- Improved patient experience by reducing repetitive questions and providing tailored interventions to a patient's stage of change.
- Advanced health equity by prioritizing smoking cessation for a population with high smoking-related harm, but often inequitable access to cessation supports.

Increasing Patient Utilization of Online Appointment Booking at Coppersmith Medical Clinic

Dr. Angela Jennings (Project Lead)

CONTEXT

- This project was undertaken at Coppersmith Medical Clinic, a community-based private practice.
- Physicians, medical office assistants (MOAs) and patients registered with the clinic were involved.

PROBLEM

- Sometimes there can be long wait times for patients to reach the office via telephone.
- Patients will become frustrated at having to wait to speak to staff and direct their frustration toward clinic staff.
- Longer wait times may be due to staffing limitations, such as unexpected illnesses, or may also occur at peak times (Monday mornings).

AIM STATEMENT

- To increase patient usage of an online appointment booking system for telephone appointments within my practice at the Coppersmith Medical Clinic from 35% to 50% by April 2025.

STRATEGY FOR CHANGE

- Multiple PDSA cycles were completed between Sep 2024 to Apr 2025.
- Staff sent email recall notices to patients to book a follow-up appointment, with an online booking link included in the email.
- Physician provided reminders during appointments to patients who not use the online booking system.
- Physician provided handouts and instructions to new patients (newborn visits).

MEASURE FOR IMPROVEMENT

- % of appointments each week booked online vs through the phone (P-chart).
- % of patients who have utilized the online booking system at start and end of the project .
- % of staff satisfied with the changes implemented.

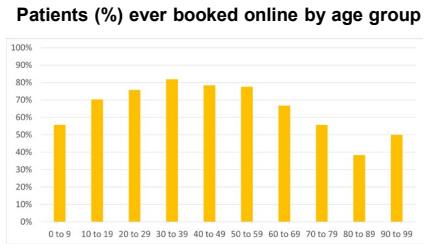
ACKNOWLEDGEMENTS

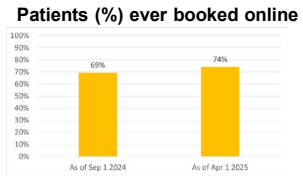
Thank you to the Vancouver Coastal Health Physician Quality Improvement team, including my project mentors David Puddicombe and Dr. Cole Stanley, for guiding me in the development of this project.

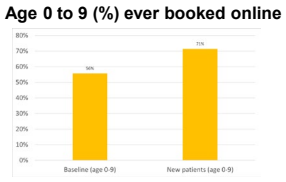
For questions or comments, contact Dr. Angela Jennings at: dr.angela.jennings@gmail.com

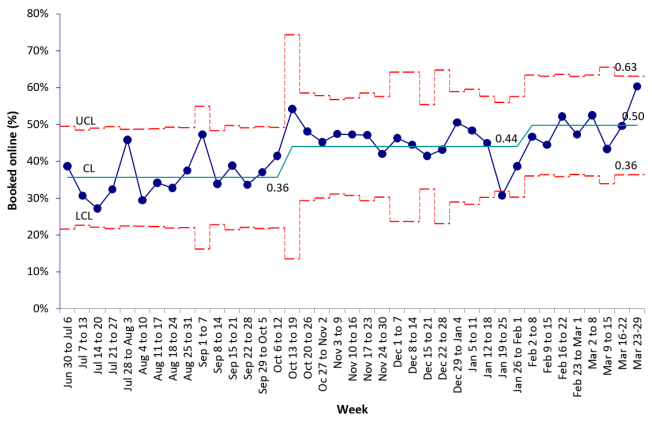
EFFECTS OF CHANGE

- Weekly online bookings from 35% to 50% (this is at least 15-20 fewer phone calls initiated by staff each week).
- 74% of patients had utilized the online booking system (compared to 69% initially)
- No patients have complained about the wait time since this project began.
- An increased number of patients are now aware of the availability of the online booking system.
- Staff vacations affected the ability to send email appointment notices, as not all staff were trained during the project.









LESSONS LEARNED

- Sending email notices to patients to schedule their own appointments was more successful than giving reminders or handouts.
- Online booking can be a valuable tool to reduce or redistribute workload among staff.
- It may be easier for new patients to use a novel system as existing patients may be used to the status quo.

SUSTAINABILITY

- Ensuring staff are trained and able to navigate new software tools (such as Ocean) to send email messages to patients will help sustain this change.

IMPACT

- Provider experience - increased flexibility of notifying/recalling patients.
- Patient experience - increased autonomy and access for scheduling appointments.
- Per-capita cost of healthcare - increased utilization can reduce staffing burdens and on a larger scale, fewer staff hours may be required.

Addressing Staff Familiarity and Comfort in Caring for Patients at May's Place Hospice Who Use Substances

Dr. Kiran Sandhu (Project Lead)

CONTEXT

- May's Place – 1990, first BC hospice
- 6 beds, DTES
- 1 Nurse, 1 patient care aid/shift
- Other staff: MD, Clinical Site Coordinator, SW, Spiritual Care, Indigenous Patient Navigator, Housekeeping, Cook
- Summer 2024: 30-40% of patients with a history of substance use disorder (SUD)

PROBLEM

- Complex symptom management in this patient population
- Life-limiting illness and substance use – pain, medications, psychiatric symptoms
- Can be active substance use
- Withdrawal, overdose, behavioral side effects
- Polysubstance - including opioids

AIM STATEMENT

- Increase nurse and care aid comfort and familiarity in caring for patients at May's Place Hospice who use substances.

STRATEGY FOR CHANGE

- Worked with medical director, clinical site coordinator

Primary Drivers & Change Ideas:

- Distress tolerance: Case de-briefing, ethics involvement
- Safety: Review and reinforce protocols for occupational hazards
- Management of complications of active substance use: Optimize low-dose naloxone protocol, identify patient's naloxone preference

INTERVENTIONS THUS FAR: Monthly progressive education series with urban health on substance use; Case-debriefing with VCH, PHC ethics

MEASURE FOR IMPROVEMENT

OUTCOME: Average 1patient improvement in lowest 4 DDPQ Questionnaire responses

PROCESS:

- % of patient asked about naloxone preference on admission; % transcribed to the Kardex.
- # of participants per debrief/training session.

BALANCING

- # of hours outside of shift (i.e. group interventions).
- Average time spent on admission protocol, as reported by staff.

ACKNOWLEDGEMENTS

Nurses and Care Aids at May's Place , Allison Zentner
Nadine Dennis, Harvey Bosma , Dr Nori MacGowan,
Dr Catriona Aparicio, Chris Rauscher, Dr Marla Gordon
PHC and VCH Ethicists – Dr Kris Smith, Kirstie Russell,
Rucha Sangole

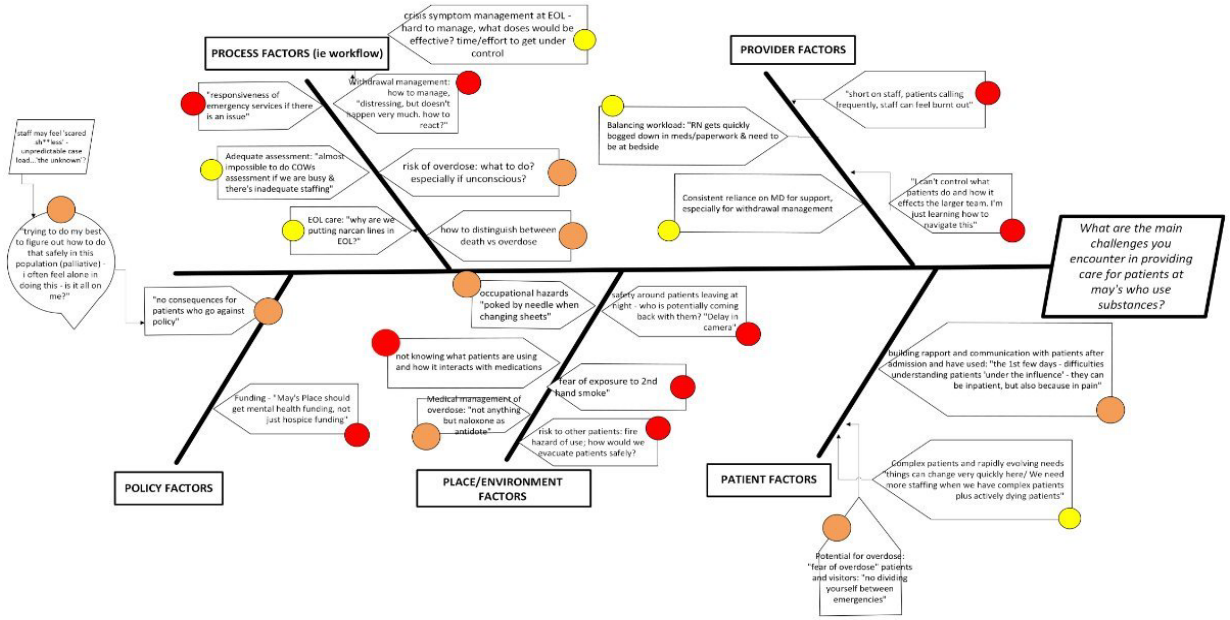
GLOSARY OF ACRONYMS

DTS: Downtown Eastside; MD: Medical Doctor
SW: Social Work; VCH: Vancouver Coastal Health
PHC: Providence Health Care;
DDQP: Drug and Drug Problem Perceptions
EOL: End of Life Care

For questions or comments, contact Kiran Sandhu at: kiran.sandhu2@vch.ca

EFFECTS OF CHANGE

- 'Post-interventions' survey of staff: Not enough respondents to analyze data
- Project is ongoing, will continue with PDSA/interventions



LESSONS LEARNED

- Addressing substance use in patients – very complex, dynamic issues
- Affects all areas of health care, including hospice/EOL care.
- Clear degree of distress amongst staff (see fishbone): Need to address the distress --> more staff buy-in.
- Not only clinical solutions.

SUSTAINABILITY

- Continuing to work on project : address challenges encountered, continuity funding, more on site collaboration with staff.
- Many people in our healthcare system eager to help address this concern.

IMPACT

- Improved patient experience.
- Clinician Wellbeing.
- Better Outcomes.
- Health Equity.

Improving Consistency in Wound Culture Practice at the Downtown Community Health Centre

Dr. Laura Knebel (Project Lead)

CONTEXT

- Large inner city Community Health Centre on Vancouver's Downtown Eastside, providing comprehensive team-based substance use, mental health, and primary care.
- High burden on primary care nursing team managing complex chronic wounds (can take many hours per patient per week).
- Medical providers often consulted on managed suspected wound infections.

PROBLEM

- When clients with chronic wounds present at DCHC, clinicians have an inconsistent approach to collecting wound cultures on potentially infected wounds. This wide variation in approach increases clinician and administrative follow up time and it can result in unnecessary antibiotic prescriptions, leading to the development of multi-drug-resistant organisms.

AIM STATEMENT

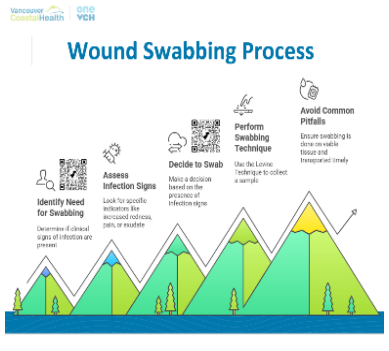
- In order to reduce unnecessary wound cultures and increase consistency in swab collection from chronic wounds, we aim to improve staff self-reported utilization of the provincial Decision Support Tool (DST) for C+S in suspected wound infection from 10% to 50% by March 2025.

STRATEGY FOR CHANGE

- PDSA 1 – Email blast with DST and other educational resources; November 2024.
- PDSA 2 – Creation of comprehensive education sessions in conjunction with Patti Van Ham NSWOC and Jeff Wang NSWOC Clinical Resource nurse; February 2025; 2 separate staff sessions; 34 participants in total.
- PDSA 3 – Creation and display of infographic with indications for wound culture; Lucy Wang UBC Flex Student and Jeff Wang NSWOC Clinical Resource nurse; April 2025.

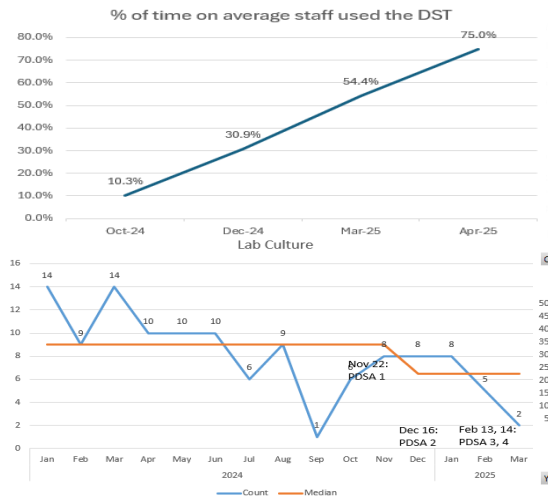
MEASURE FOR IMPROVEMENT

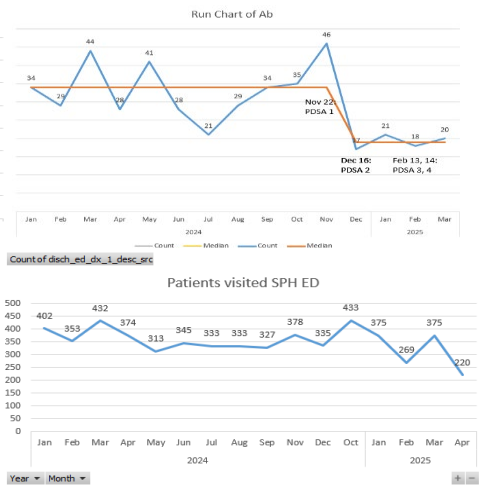
- Outcome Measures:
  - % time staff report using DST to decide to culture a wound – SURVEY
  - % staff familiar with Levine Technique (gold standard for swabs) - SURVEY
- Process Measures:
  - # wound cultures/month
- Balancing Measures:
  - # visits to ED for cellulitis/month
  - # typical SSTI antibiotic prescriptions/month



EFFECTS OF CHANGE

- Reduction in number of cultures and prescribed antibiotics.
- Improved utilization of DST from 10% to 75%.
- Improved knowledge of wound culture technique (24% to 100%; Levine technique).
- Improved staff satisfaction anecdotally.
- More consistent approach to wound cultures as staff are applying principles from DST to make decisions.





LESSONS LEARNED

- It's empowering to be able to effect meaningful change at a grassroots frontline level
- Change happens when there is authentic engagement with front line staff and trust in the change agents.
- Collaborative education sessions allowing for dialogue were the most profoundly impactful change idea.

SUSTAINABILITY

- Infographics remain in place in clinical areas to keep this top of mind when considering a wound culture.
- Package of materials created that can be shared with other teams (Thanks to Jeff Wang, NSWOC Clinical Resource Nurse/Education, Professional Practice).

IMPACT

Improved Patient Experience	Cost of Care	Clinician Wellbeing	Better Outcomes	Health Equity	Planetary Health
Reduction in potentially painful swabs Faster experience	Decreased cost of swabs Reduced provider time dedicated to follow up	Improved sense of agency and clarity for nursing/medical providers as an antidote to burnout	Reduction in inappropriate antibiotic prescribing	Disproportionate impact on folks with housing and food insecurity/ poverty	Reduced medical waste due to reduced swabs

ACKNOWLEDGEMENTS

Hing Yi Wong, Dr. Jane Lea, Guanyi Lu, Rochelle Szeo, Patti Van Ham, Jeff Wang, Lucy Wang, Christina Hagner, Dr. Val Montessori, Dr. Matthew Laing, Manda Harmon, Irma Edwin, Lauren Chant, Julie Balderston, and our wonderful nursing and medical provider team!

GLOSSARY OF ACRONYMS

DCHC: Downtown Community Healthcare Clinic
NSWOC: Nurse Specialized in Wound and Ostomy Care
ED: Emergency Department
SSTI: Skin and soft tissue infection
DST: Decision Support Tool

For questions or comments, contact Dr. Laura Knebel at laura.knebel@vch.ca

PQI PHYSICIAN QUALITY IMPROVEMENT
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Improving Psychiatric Assessment of ADHD in Adults in Community Mental Health Care

Betty Tang (Project Lead), Leanne Komm (Clinical Operations Manager) ,
Allison Zentner (QI Lead), Shren Chetty (Continuation Psychiatrist)

CONTEXT

- Sunshine Coast and qathet Mental Health and Substance Use Services (MHSU) are two outpatient community psychiatric teams under Vancouver Coastal Health Authority. The client group involved was general adult psychiatric patients. Staff consisted of the MHSU managers; team leaders; two community outpatient psychiatrists; and receptionists.
- This work was done remotely. These are underserviced areas in remote / rural Coastal Health region.

PROBLEM

- Adult ADHD has high comorbidity with other psychiatric and medical conditions, and is frequently missed, leading to increased utilization of health resources and increased functional impairment.
- I noted that 30 to 50% of patients that I was seeing for psychiatric consultation had ADHD either not at all identified, or identified in childhood and not treated in adulthood.
- Many of these patients were being referred for chronic Depression or Anxiety; Posttraumatic Stress Disorder; query Borderline Personality Disorder; and had struggled for years. ADHD, even if previously diagnosed, was typically not addressed.

AIM STATEMENT

- Initial AIM statement: Increase ADHD rating skills used in general practitioners' office by 50%, as part of referral package sent. This proved difficult to implement.
- Revised AIM statement**: Increase ADHD (and depression and anxiety) rating scales sent by and returned to Sunshine Coast and qathet Mental Health and Substance Use Treatment Centre, prior to first psychiatric assessment, from 0% to 50%.** These rating scales were the ASRS, PHQ-9, GAD-7, and WURS.

STRATEGY FOR CHANGE

- MHSU receptionists emailed the rating scales to patients at the same time as the videoconferencing appointment was booked. This is for all outpatient psychiatric patients referred for depression, anxiety, and / or ADHD, not just those referred for ADHD.
- The time frame for this was September 2024 to the end of February 2025.
- Phone calls as needed with Sunshine Coast MHSU manager, psychiatrists, and receptionists to review ideas, plans for change, results.

MEASUREMENT FOR IMPROVEMENT

Outcome Measure	• # of Rating Scales
Balancing Measures	• Patient Satisfaction • Patient functional outcomes

ACKNOWLEDGEMENTS

I would like to thank the PQI team;
Sunshine Coast Mental Health and Substance Use Services staff:
Leanne Komm, Jared Hurdman, Jayme Watts, Leslie Bing,
Jill Galway;Shawna G. (patient partner);
Shirromi Sarveswaran (4th year flex student).
I am also grateful for the funding provided from SSC.

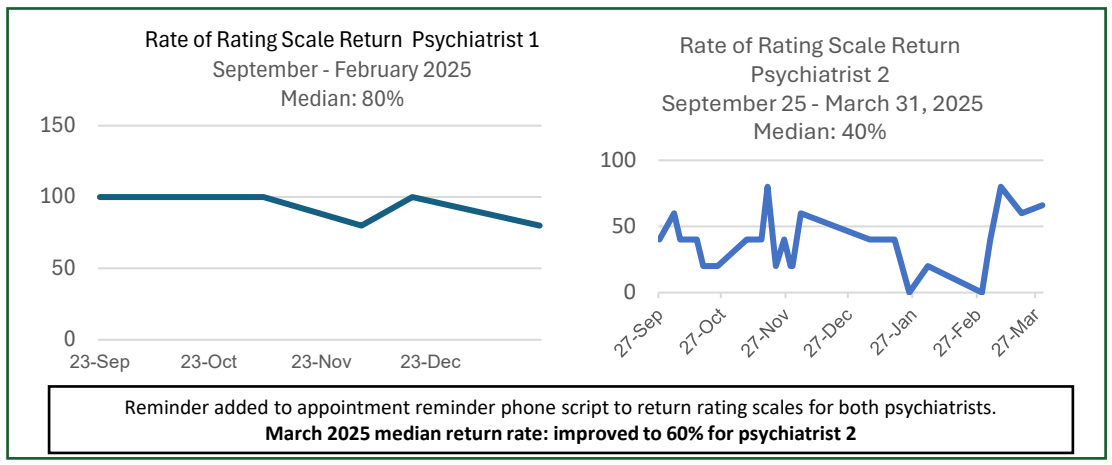
GLOSSARY OF ACRONYMS

ADHD: Attention-deficit/hyperactivity disorder
ASRS: Adult ADHD Self-report scale;
GAD-7: Generalized Anxiety Disorder;
MHSU: Mental Health and Substance Use
PHQ-9: Patient Health Questionnaire;
WURS: Wender Utah Rating Scale for childhood symptoms.

For questions or comments, contact Dr. Betty Tang at: betty.tang@vch.ca

EFFECTS FOR CHANGE

- Improved standardization of assessment and follow-up review of psychiatric symptoms of ADHD, depression, anxiety
- Patients commented that the rating scales helped them to organize their thoughts prior to psychiatric assessment. This helped to save time during psychiatric assessment, in addition to the information obtained from the rating scales.
- Balancing measure noted few negative effects:
  - Patient Experiences Survey of rating scales (19% return rate) was positive for ease and use of surveys.
  - Patient functional outcomes survey (19% return rate) was positive for understanding symptoms; about 50% noted improvement in functioning.
- Based on previous patient feedback, explanation of how rating scales are used was noted to be helpful to future patients.



SUSTAINABILITY

- This process is easily sustainable. Receptionist feedback has been positive without significant additional workload. A standardized operational procedure for this process can be done. This project has been spread to one additional psychiatrist and one additional remote community to date.

LESSONS LEARNED

Doing standardized rating scales for depression, anxiety, and ADHD is not onerous, helps to guide psychiatric assessment, saves time during the interview process, and helps to identify underlying ADHD symptoms that may be contributing to depression and anxiety comorbidity, **that would not otherwise have been recognized. For this project, this was the case for 20 / 119 patients over 15 months (17%).**

IMPACT

1. Improving patient experience - patient surveys noted that they appreciated the increased rigour and thoroughness of evaluation
2. Improving provider experience - use of rating scales improved flow of assessment and saves time during assessment; and providers can improve their identification of adult ADHD that could be affecting other chronic health conditions

Improving Vaccination Rates of At-Risk Rehabilitation Populations

Dr. Darren Lee (Project Lead)

Vancouver CoastalHealth | Providence Health Care — How you want to be treated. | PQI Physician Quality Improvement, Specialist Services Committee

CONTEXT

- This project involved patients admitted to GF Strong inpatient rehabilitation units.
- Initial data analysis and interventions began on the spine unit and spread to the three other units at GF Strong: the transitional rehabilitation unit (TRU), neuromuscular service (NMS), and acquired brain injury unit (ABI).

PROBLEM

- In 2023-2024, pharmacy identified concerns about the vaccination rates of admitted patients on the spine unit. A manual chart review was performed reviewing pre-printed order set (PPO) usage and vaccine administration rates for patients admitted to the spine unit in November 2023, revealing inconsistent completion of the vaccination protocol.
- A multidisciplinary meeting team performed process mapping, revealing redundancies and multiple opportunities for error in the existing PPO process.

AIM STATEMENT

Our aim was to increase vaccination rates of influenza (Flu) and pneumococcal pneumonia (PCV) for qualifying at-risk populations admitted to GF Strong by 50% by April 2025.

STRATEGY FOR CHANGE

- Initial PDSA cycles were piloted on the spine unit, beginning with an end-of-month review of all admitted patient charts for vaccine status by a nurse educator. If PPOs were incomplete or vaccines had not been administered, the nurse educator contacted the appropriate providers to complete these tasks.
- Weekly review of PPO completion status was subsequently implemented, set on a scheduled day.
- The vaccine PPOs have nurses review for vaccination status when admitting a patient. If no vaccine has been administered, the PPO is given to the physician to consent for vaccine administration. This two-step process was identified as redundant, as physicians can ask vaccine history at the same time as consenting, so the PPO was removed from the nursing admission chartlet and placed in the physician admission chartlet. This was initially piloted on the spine unit and then spread to other units after reviewing feedback from all team providers involved.
- Change ideas were discussed with the medical directors and nurse educators of each unit before spreading to the other units.
- Interventions were implemented monthly beginning in December 2024 through March 2025.

MEASUREMENT FOR IMPROVEMENT

- All admitted patients were eligible, unless PPOs documented refusal or contraindication to vaccine administration.
- Measurements were done through manual chart review of recent discharges on a monthly interval.
- Data included dates of admission, PPO completion, and vaccine administration.
- The outcome measures were the rates of PCV and Flu vaccination for eligible patients.
- Process measures included the rates of PPO completion, time from admission to PPO completion, and time from PPO completion to vaccine administration. Balancing measures included feedback from clinical staff.

ACKNOWLEDGEMENTS

This work was supported through funding from the SSC and PQI program. Participation of my colleagues at GF Strong was critical to developing and implementing change ideas including: Glenda Kusch and Peter Ngsee (pharmacy), Gagandeep Rihal (Clinical Operations Manager), Kari Birimcombe,Karen Marquez, and Dawn Coney (Clinical Nurse Educators), Dr. Stacey Reebye, Dr. Sarah Courtice, and Dr. Rhonda Willms (Medical managers for NMS, TRU, ABI, and Spine units)

GLOSSARY OF ACRONYMS

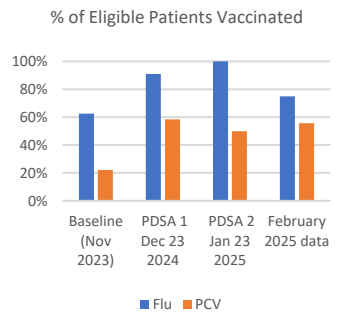
PQI: Physician Quality Improvement; SSC: Specialist Services Committee; TRU: Transitional Rehabilitation Unit; NMS: Neuromuscular Service; ABI: Acquired Brain Injury; PDSA: Plan-Do-Study-Act; PPO: Pre-printed order set.

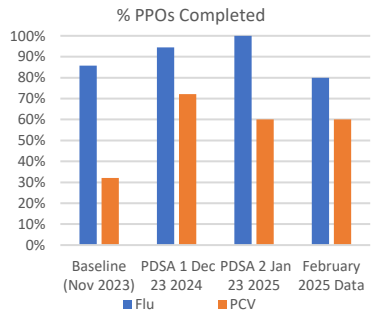
For questions or comments, contact Darren Lee at: darren.lee@vch.ca

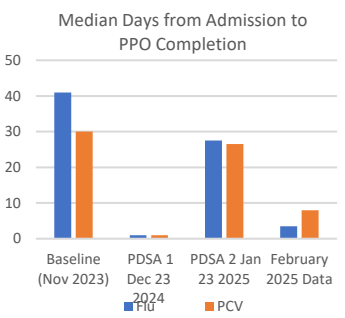
EFFECTS OF CHANGE

- Flu vaccine rates improved from a baseline of 63% to 82%.
- PCV vaccine rates improved from a baseline of 22% to 59%.
- Baseline data reflects spine unit rates from November 2023 and final outcome measures reflect rates for all units between December 2024 and March 2025.
- All process measures trended toward improvement compared to baseline data.
- No significant negative consequences of the interventions were identified by nursing staff, pharmacists, or physicians.
- Overall, the project aim was achieved and the new processes are more efficient and are sustainable.

SPINE UNIT DATA







LESSONS LEARNED

- Vaccination of patients admitted to inpatient rehabilitation reduces the risk of respiratory complications during and after admission.
- By streamlining the process used for vaccine assessment and administration, we were able to increase rates of vaccination.
- A review of vaccination processes should be considered at all health care rehabilitation facilities given the risk of respiratory illness in these settings (with lengths of stay often on the order of months) as well as the increased risk of respiratory infection in the rehabilitation population (many patients with compromised respiratory musculature or risk of aspiration)..

SUSTAINABILITY

- An end-of-project meeting with key stakeholders was conducted, reviewing the data collected and changes implemented. All providers committed to maintaining the process changes and are open to discussion if future concerns are noted.

IMPACT

- Improving vaccination rates successfully improved the following components of the Modified Triple Aim: Improving patient experience, improving the health of populations, reducing the per capita cost of health care, improving provider/care-team experience, advancing health equity, and improving planetary health.

Automatic syphilis screening for hospitalized patients at Vancouver General Hospital

Dr. Shaqil Peermohamed (Project Lead)

PROBLEM

- There were 13,953 cases of infectious syphilis reported in Canada in 2022, corresponding to a rate of 36.1 cases per 100,000 population, which is a 109% rate increase since 2018.
- In 2023, there were 2066 cases of syphilis reported in British Columbia (which is a rate of 37.4 per 100,000).
- On average, only 5.28% of hospitalized patients admitted to Medicine at Vancouver General Hospital underwent screening for syphilis during their hospitalization in 2023.

AIM STATEMENT

- We aim to increase syphilis screening rates amongst patients admitted to Medicine units at Vancouver General Hospital by 10% by April 30, 2024.

STRATEGY FOR CHANGE

- Monthly teaching sessions with Clinical Teaching Unit residents and attending physicians (our first syphilis teaching session took place on May 16, 2024).
- Implementation of checkbox for syphilis screen in Cerner Medicine admission order sets (live on October 9, 2024).
- Creation of digital syphilis campaign in collaboration with BCCDC - printed materials for public awareness and provider awareness to increase screening (posters put up on February 26, 2025).

MEASURES FOR IMPROVEMENT

- Outcome Measure → Proportion of screening tests sent per month standardized for the number of patients admitted to Medicine at VGH.
- Process Measures→ Proportion of syphilis screens for patients admitted to medicine units at VGH that were sent through the checkbox nudge in the Medicine admission order set (per month).
- Balance Measures → % of increased syphilis screening volumes/ capacities (staffing requirements); Feedback from Medicine about Cerner changes; Feedback from ID, Public Health, Pharmacy teams about increased test results.

LESSONS LEARNED

- Implementing effective changes takes time and collaboration.
- While education may lead to an initial increase in syphilis screening, it does not appear to lead to sustained change.

ACKNOWLEDGEMENTS

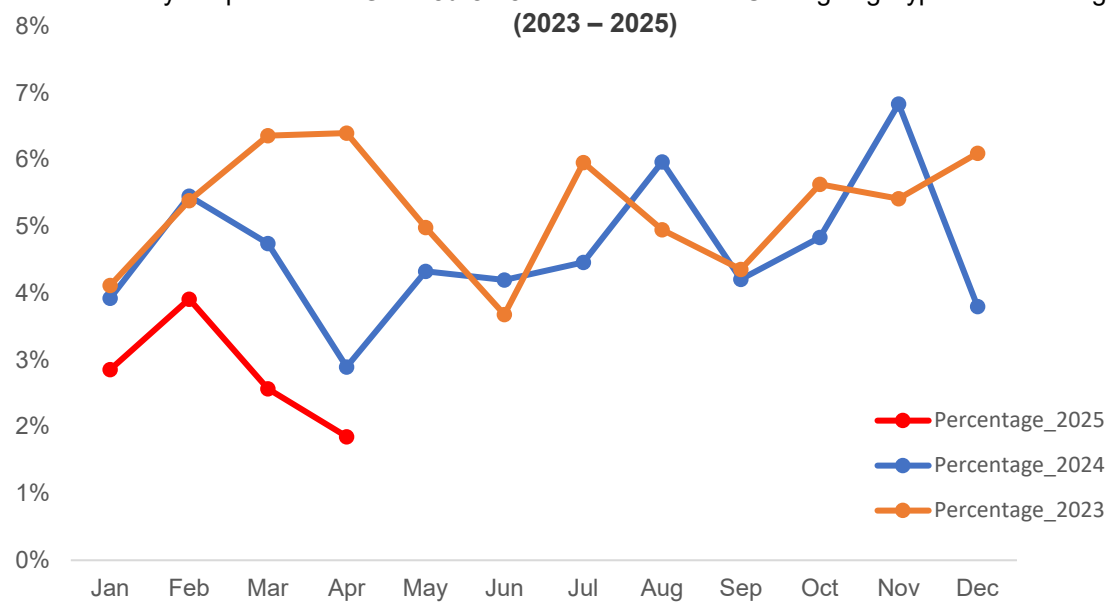
Dr. Penny Tam, Thresha Wanaththaiya, Allison Zentner, Hing Yi, Dr. Marthe Charles, Dr. Althea Hayden, Dr. Rohit Vijh, Dr. Stephen Van Gaal, Dr. Tristen Gilchrist, Dr. Laura Kuyper, Dr. Nancy Duan, Cameron Rankin

GLOSSARY OF ACRONYMS

VGH: Vancouver General Hospital
BCCDC: BC Centre of Disease Control

For questions or comments, contact Shaqil Peermohamed at: Shaqil.Peermohamed@vch.ca

Monthly Proportion of VGH **Medicine** Admitted Patients Undergoing Syphilis Screening **(2023 – 2025)**



SUSTAINABILITY

- Ongoing work to improve the syphilis screening nudges in Medicine admission PowerPlans.
- Future studies could investigate if we are diagnosing more patients with syphilis with increased screening amongst hospitalized patients, and if this leads to earlier treatment.

IMPACT

- Improved patient experience - Earlier screening can potentially lead to earlier diagnosis and treatment of syphilis.
- Cost of Care - Potential for cost savings if patients are treated earlier and complications from syphilis are avoided.
- Better outcomes - Earlier screening can potentially lead to earlier diagnosis and treatment of syphilis.
- Health Equity - Ensuring that patients can receive preventative care during hospital admissions and ensuring patients have access to screening for sexually transmitted infections.

Improving the efficiency of determining dispositional capacity on the VGH ACE unit

Dr. Bryan Chow (Project Lead), Jefferson Xu (QI Lead),
Dr. Justin McGinnis (QI Mentor)

CONTEXT

- Elderly patients presenting with complex acute medical issues are often admitted to the Vancouver General Hospital Acute Care for Elderly unit (VGH T11A/D).
- The ACE unit is run by an interdisciplinary team with Clinical Teaching Unit/CTU (Internal Medicine) social workers, occupational therapist, physiotherapist, dieticians, Care Management Leaders (CML) and Transition Services (TST) nurses.
- Geriatric Psychiatry is often consulted for patients with complex psychiatric and cognitive presentations.

PROBLEM

- One common consult to Geriatric Psychiatry is for **"capacity to go home",** also known as **dispositional capacity.**
  - This is often due to a patient's **complex medical and psychosocial circumstances** leading to uncertainty about their ability to return home.
  - The existing process to determine disposition is **complicated and time-consuming.**
- Causes include:
  - 1) **Knowledge gaps** around the concepts around capacity and relevant legislation (HCCFA, AGA, MHA).
  - 2) **Delays** in recognition of complexity, in timing of assessments, and in psychiatric consultation.
  - 3) **Inconsistent** assessment process.

AIM STATEMENT

- To reduce the average duration of time between identifying complex disposition to the determination of disposition by 3 days in 12 months on the Vancouver General Hospital Acute Care for Elderly unit.

STRATEGY FOR CHANGE

1. **Educational sessions** to ACE unit and CTU noon rounds about capacity and disposition on a regular basis.
2. **Early consultation** to Geriatric Psychiatry.
3. **Checklist** of recommended assessments to determine capacity.

- Implementation
  - Face-to-face time on the wards with teams
  - Frequent informal meetings with CML and TST
  - Changes first implemented in February 2024, ongoing process

MEASURES FOR IMPROVEMENT

- Data collected via manual chart review
- Days from identifying complex disposition to when disposition is ultimately determined
  - **From 34 days down to 17 days**
- Days from identifying complex disposition to geriatric psychiatry consultation
  - **From 16 days down to 8 days**

ACKNOWLEDGEMENTS

All the CTU attendings and residents, Sarah Dunlop, Matthew Zhiss, Candace Tegart, Shelley Goodwin, Robert Bush, Pam Papp, Scott Hobson, Dr. JJ Sidhu, Dr. Shao-Hua Lu, PQI Cohort 7

GLOSSARY OF ACRONYMS

VGH: Vancouver General Hospital; ACE: Acute Care for Elderly; CTU: Clinical Teaching Unit; HCCFA: Health Care Consent and Facilities Act; AGA: Adult Guardianship Act; Mental Health Act

For questions or comments, contact Bryan Chow at: bryan.chow@vch.ca

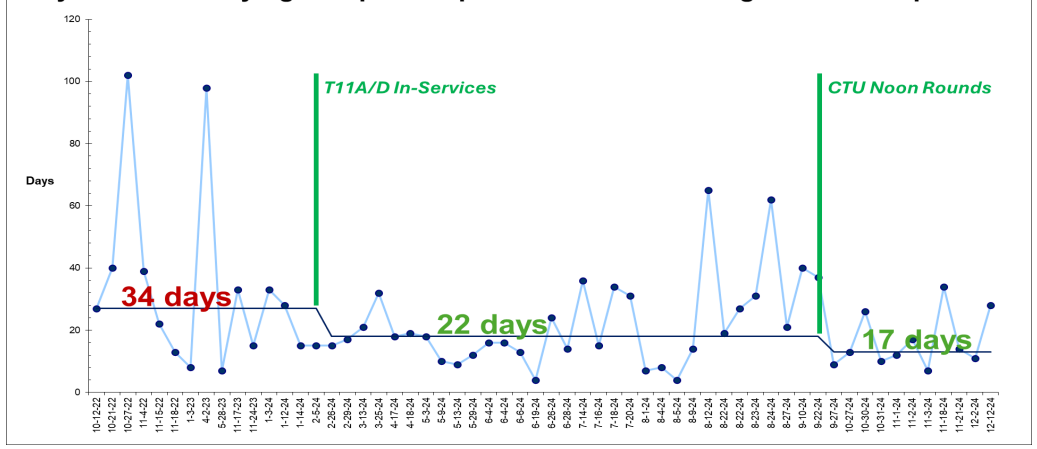
EFFECTS OF CHANGE

- Reduced time spent on disposition planning
- Increase clarity on the process for all team members
- Improved working relationships while disposition planning

Unanticipated Effects

- More informal consultations/patient discussions
- Reliance on individual clinicians and team members

Days from identifying complex disposition to determining ultimate disposition



LESSONS LEARNED

- **Improving efficiency** of complex processes like disposition planning is possible
- Potential use on **any other medical/surgical unit.**
- Value in **building connections** to improve personal and team understanding of a very complicated process.
- Value in **taking the time** to reflect, think and learn about problems.

SUSTAINABILITY

- Ongoing integration of dispositional capacity session into education series (CTU noon rounds, ACE in-services)
- Cerner implementation of checklist as PowerPlan
- Ongoing working relationships

IMPACT

- Patient experience: Increased clarity of disposition. Less time waiting for decisions, especially for those returning home.
- Population health: Improved effectiveness of system in hospital to facilitate population to live according to their values, while intervening when risk is no longer tolerable.
- Cost of care: Reduced length of stay. Reduced costs related to meetings. More efficient use of time in hospital.
- Provider satisfaction: Improved job satisfaction. Reduced role diffusion. Less time spent on disposition planning.

PQI

"It's been really rewarding to see the project progress and evolve as we worked through various challenges—like our initial struggles with data. Collaborating with the team from both a clinical and multidisciplinary perspective made it a truly valuable experience overall."

-Michelle Yang (UBC Flex Student)

SQi SPREADING QUALITY IMPROVEMENT
Specialist Services Committee

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Interdisciplinary Learning Reviews (ILR)

Dr. Roderick Tukker (Project Lead), Mandy Man (Interim Director, Quality and Patient Safety)

AIM STATEMENT

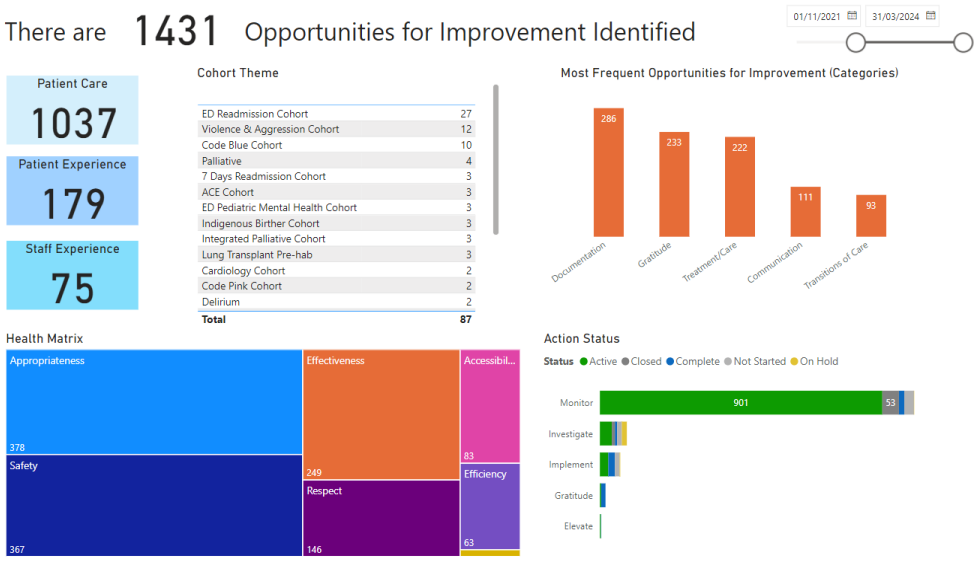
- Spreading Interdisciplinary Learning Reviews (ILR) to four sites: Vancouver Acute, Richmond Hospital, Lions Gate Hospital and Squamish General Hospital within three Communities of Care (Vancouver Acute, Richmond and Coastal).

STRATEGY FOR CHANGE

- Identified Physician champions at each of the sites to help with receiving the spread methodology for ILR.
- Multiple meetings and open-ended discussion between the sending site and receiving sites.

MEASURES OF SPREADING IMPROVEMENT

- Numbers of ILRs that run
- Staff and Medical Staff participation in ILR activities
- Learnings & QI actions from ILR



ACKNOWLEDGEMENTS

SQI funding, Operational leaders, Medical leaders, and Physician partners

GLOSSARY OF ACRONYMS

ILR: Interdisciplinary Learning Reviews
QI: Quality Improvement
SQI: Spreading Quality Improvement
VCH: Vancouver Coastal Health
CoC: Community of Care

For questions or comments, contact Dr. Rod Tukker at: roderick.tukker@vch.ca

EFFECTS OF CHANGE

Physician Care Team Impact:

- 36 physicians recruited and trained to become reviewer and/or facilitators for ILR
- Many physicians participated in review committees where cases were discussed, and learnings were shared

Investment Value:

- Review of our current system
- Created space and place for further discussions on how physicians can continue to engage in QI
- Building a culture of quality improvement.

Engagement:

32 Teams formed **21** Cohorts **87** Cases reviewed

LESSONS LEARNED

- Focusing on cohorts that aligned with team priorities
- Approach to large vs intimate committees
- Starting points for connections and future QI work

- Competing Priorities

SUSTAINABILITY

- ILRs are now embedded as a tool that teams can use to learn and spread QI.
- Ongoing discussions on supporting physicians in doing Quality and Safety work at Vancouver Coastal Health.

IMPACT

- Improved Patient Experience- This systematic review process focuses on the patient journey and experience to identify system level opportunities for improvement
- Clinician Well being - Participation in a multidisciplinary review process helps clinicians learn alongside members of their team. This collaboration on system improvement helps to foster stronger relationships within the care team enhancing provider experience in patient care
- Better Outcomes - Identifying System Level Opportunities for Improvement provides teams with areas to focus on improvement initiatives that will improve patient outcomes

SUSTAINABILITY

- Consider other sites for spread of this project
- Consider spreading to remote/rural areas

Reduction of Preoperative Group and Screen Testing: A Patient Centered Model

Dr. Jacqueline Trudeau (Project Lead), Dr. Andrew Shih (Director, Transfusion Medicine), Amy Chang (SQI Manager)

CONTEXT

- Original PQI project focused on reducing Group & Screen (G&S) testing for Primary Joint Arthroplasty procedures at VGH.
    - ~2,000 fewer GRS/year, ~2,000 fewer patient extra trips to hospital, ~$40,000 savings/year
- SQI project focused on spreading across 19 surgical subspecialties at Vancouver Acute (VA): VGH and UBCH
- Group & Screen (GRS) determines a patient's blood group and ensures safe blood transfusion.
    - GRS must be collected at the hospital where the surgery is occurring in the days prior to the operation.

PROBLEM

- Approx 55% of VA elective surgical patients come from outside of VCH → Nearly 70% come from outside Vancouver
- Home Health Authority for VA surgery patients (n=3803) → VCH: 43%, FH: 35%, IH: 9%, NH: 5%, VIHA: 4%
- Per year, about 7,000 VA patients require an extra visit to VGH for a preoperative group and screen.

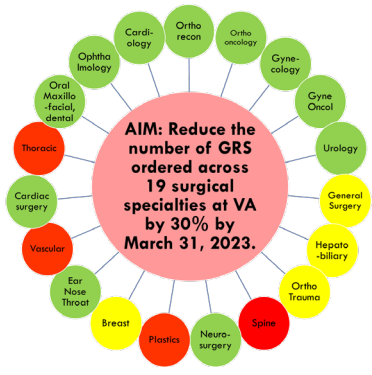
AIM STATEMENT

Reduce the number of GRS ordered across 19 surgical specialties at VA by 30% by March 31, 2023

Green depicts surgical service analyzed, engaged and recommendations made (each is in different stages of implementing change, where recommended).

Yellow depicts data analyzed, in the process of engaging and making recommendations.

Red depicts services where data analysis, engagement and recommendations have yet to be made.



STRATEGY FOR CHANGE

- Spread Initiative – Reduce the number of unnecessary preoperative GRS performed at VGH and UBCH
    1. **Transfusion Dashboard**: Create an accurate, validated and clinically relevant Transfusion Rate Dashboard to inform which procedures require a preoperative GRS, and which patients should be referred to the preoperative blood management program (PBMP) for anemia management
    2. **Subspecialty Engagement:** Engage with 19 surgical subspecialties to onboard onto dashboard and discuss strategies for reducing unnecessary GRS
    3. **"Home" Hospital GRS:** Following the systematic elimination of unnecessary tests, build a system that permits patients to obtain their preoperative GRS in their community (rather than making an extra trip to VGH preoperatively).

ACKNOWLEDGEMENTS

Allison Chiu (PQI Program Advisor), Emma Pienaar (Data Advisor), Zeinul Popatia (Registered Nurse)

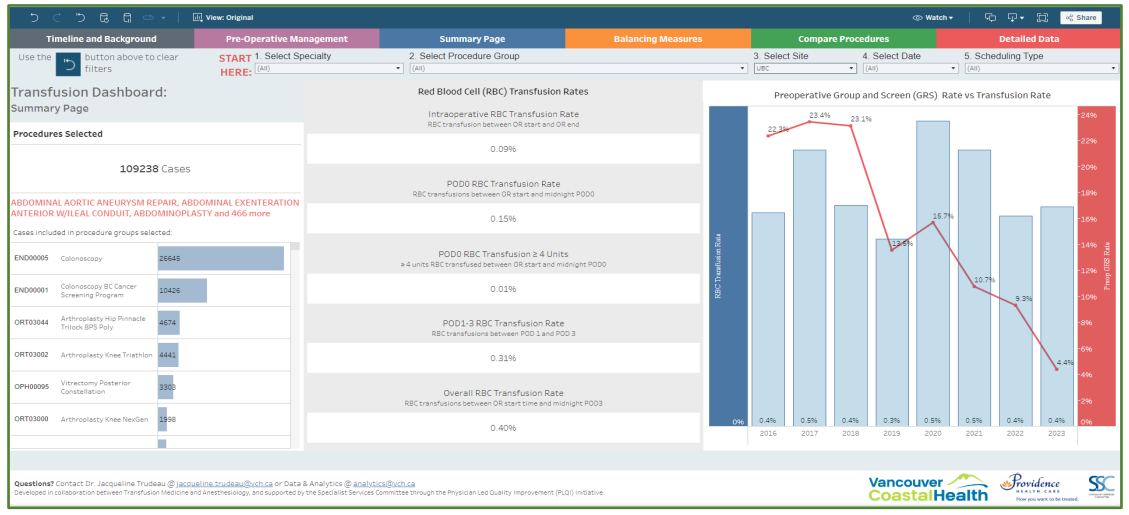
GLOSSARY OF ACRONYMS

PQI: Physician Quality Improvement
VGH: Vancouver Coastal Health
UBCH: UBC Hospital
VA: Vancouver acute
ILR: Interdisciplinary Rounds
MOA: Medical Office Assistant
CNE: Clinical Nurse Educator

For questions or For comments, contact Dr. Jacqueline Trudeau at: jacqueline.trudeau@vch.ca

MEASURES OF SPREADING IMPROVEMENT

- **Outcomes:** Decrease preoperative GRS rate and improve patient satisfaction.
- **Balancing:** Monitor RBC transfusion rate, provider satisfaction/anxiety, STAT GRS per procedure, use of group O blood.



IMPACT

- **UBC**: # GRS decreased by ~80% as compared to pre-intervention stage
- **VGH:** # GRS decreased by ~60% as compared to pre-intervention stage

(compared to pre-intervention)

2022 Cost Savings
($ 83,558)

2023 Cost Savings
($ 106,019)

2022 CO2 savings
-1.284 kg of CO_2

2023 CO2 Savings
-1.629 kg of CO_2

2022 Patient Trips
3218 fewer trips

2023 Patient Trips
4083 fewer trips

Cost of GRS Test: $24.16 + 1.8% retested at $100.34

Amount of CO_2: 394g + 1.8% retested at 273g

LESSONS LEARNED

- Start conservative and consider a staged change → Start with a win!
- Go slow enough to do it right and take the time to properly manage your data.
- Acknowledge potential negative consequences → Alleviate anxiety, create accountability and increase buy in
- Create reporting tools that showcase your work → Share often and think about what is meaningful to different groups.

SUSTAINABILITY

- Transfusion Dashboard maintained by VCH Data Analytics.
- Training and Education to Nurses, MOAs, Fellows/Residents.
- CNE embedded in the Anesthesia Consult Clinic to support and Grand Rounds with Surgeons.
- Work with Operations Director Andrea Bisaillon to bring forward to Regional Surgical Executive Committee to implement Medical Directives.

SPREAD

Spreading to Lions Gate Hospital, with focus on C-section and Ortho-recon.

PHC Chart Club

Dr. Adrienne Melck (Project Lead),
Liz Flores (PHC Director, Quality Improvement and Accreditation)

CONTEXT

Unique case review methodology founded through Mayo Clinic, by Dr. Jeanne M. Huddleston and Lacey A. Hart in 2015.
Aims to:

- Identify the process of care and system failures that get in the way of providers doing their best job.
- Break down silos and focus on systems and connections.

AIM STATEMENT

1. To create a ***meaningful mechanism*** to learn about the ***Safety and Quality*** of patient care at a ***systems-level***.
2. To engage healthcare providers in a new way.
3. To promote a culture of safety and learning.

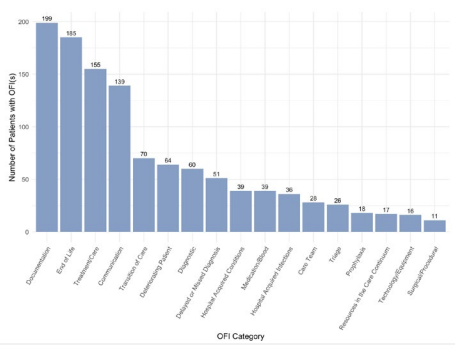
INTERVENTIONS OR STRATEGY FOR CHANGE

Communications

- Presentations at Medical Staff Association meetings
- Video created to recruit new reviewers
- Presentation at Hospital Board to advocate for ongoing funding
- Presentation at Nurse Practitioner department meeting
- Presentation at Patient Safety Week with “mock chart club”

MEASURES FOR IMPROVEMENT

- # of mortalities reviewed
  # of involved clinician reviewers



ACKNOWLEDGEMENTS

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Patricia Aguilera Aponte,
Dr. Jeanne Huddleston,
Our reviewers and patients

GLOSSARY OF ACRONYMS

QI: Quality Improvement; SSC: Specialist Services Committee; PHC: Providence Health Care; OFI: Opportunities for Improvement; CCM: Chronic care management; GOC: Goals of Care; QSR: Quality Safety Review

EFFECTS OF CHANGE

- More awareness around the importance of early Goals of Care (GOF) conversations.
- Recruitment of new and diverse reviewers including allied health allows for more widespread dissemination of learnings.
- QI projects underway to improve documentation based on Chart Club findings.
- Promising targets for QI work out of aspiration cohort data.
- Continued funding supported by PHC and inclusion of Chart Club in PHC’s Patient Safety Framework.

LESSONS LEARNED

☑ End of Life (OFI) data:
helped inform and spur on significant body of work around improving the timeliness and quality of Goals of Care conversations.
PHC metric: GOC conversations should be had within 48hrs of admission for all patients with a CCM >3 and documented in a GOC PowerForm.

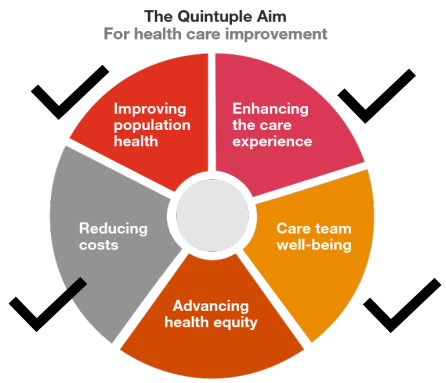
☑ Documentation data:

- Internal Medicine QI project to improve quality of nursing documentation

SUSTAINABILITY

- Hopes to recruit more reviewers, continue to share metrics and QI project update to board and QSR committee

IMPACT



SPREAD

- Moving from mortality cases and focusing on aspiration cases
- Highlighting different case categories will involve other departments and allow for more interdepartmental cooperation

For questions or comments, contact Dr. Adrienne Melck at: AMelck@providencehealth.bc.ca

Reducing Long Term Care Transfers to Emergency Department and Admissions to Acute Care

Dr. Marla Gordon (Project Lead), Amy Chang (SQI Manager)

CONTEXT

The original PQI project aimed to reduce inappropriate and avoidable transfers from Long-Term Care (LTC) to the Emergency Department (ED) and decrease unnecessary acute care admissions. The Banfield team, led by Dr. Marla Gordon successfully reduced transfers by 45% resulting in cost savings of approximately $58K within one year. More importantly, the project enhanced patient care and experience, and optimized care in the nursing home while improving care and flow in ED.

PROBLEM

- Significant numbers of residents being admitted to acute care with some deaths in acute
- Residents being transferred to ED for "common issues" including fever, urinary tract infections and pneumonia
- Residents with decreased levels of consciousness and dehydration being inappropriately sent to ED who are end of life
- Inappropriate transfers which can be managed in LTC causes extra stress for ED
- Many residents have severe/dementia and are MOST 2 & 3 (DNR)
- Transfers contributes to stress for frail and dementia patients

AIM STATEMENT

To avoid ***inappropriate and avoidable*** transfers to ED of our frail elders and/or prevent unnecessary admission to Acute.

STRATEGIES FOR CHANGE

1. Staff Education:
- SBAR worksheet and training
- Respiratory exam
- Goals of Care and End of Life

2. Family Education:
- Goals of Care
- Dementia

Collaboration with VGH ED lead to the following interventions:

3. Development of active medical problem list
4. Development of ED transfer communication tool
5. On-site contingency medications
6. Emergency Medications: IM and SC
7. Wound/suture kit

ACKNOWLEDGEMENTS

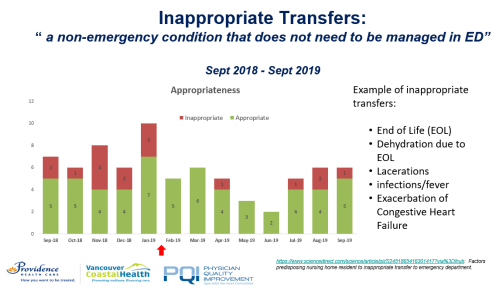
Banfield Interdisciplinary Team
Dr. Marla Gordon

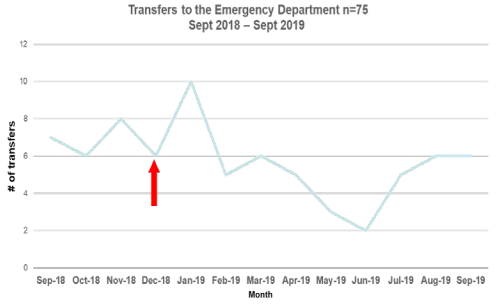
GLOSSARY OF ACRONYMS

VGH: Vancouver General Hospital
DNR: Do Not Resuscitate
MOST: Medical Orders for Scope of Treatment
SBAR: Situation, Background, Assessment, and Recommendation

For questions or comments, contact Dr. Marla Gordon: marla.gordon@providencehealth.ca and Amy Chang: Amy.Chang@vch.ca

MEASURES FOR IMPROVEMENT





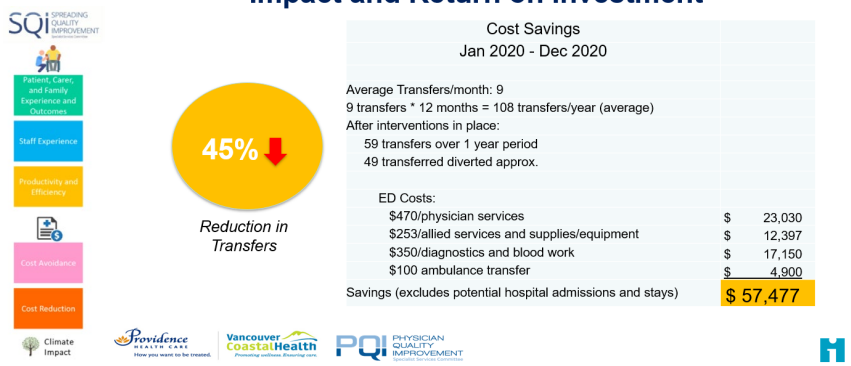
EFFECTS OF CHANGE

Improved patient Outcome and Experience:
- Fewer deaths in hospital, ensuring residents receive care in their preferred setting.
- More frequent Goals of Care (GOC) conversations leading to care that aligns with patient and family wishes.
- Empowered interdisciplinary teams, actively engaging in GOC discussions and decision-making.

Enhanced Quality of Care:
- Decrease inappropriate and avoidable transfers, reducing stress for residents and families
- On-site medical interventions and earlier treatments, preventing complications and hospitalization.

System efficiency & Sustainability
- Transfers to the ED occur with a clear, specific plan ensuring appropriate utilization of acute care services
- Reduced carbon emissions from fewer transfers, supporting environmental sustainability efforts.

Impact and Return on Investment



Cost Savings Jan 2020 - Dec 2020	
Average Transfers/month: 9	
9 transfers * 12 months = 108 transfers/year (average)	
After interventions in place:	
59 transfers over 1 year period	
49 transferred diverted approx.	
ED Costs:	
$470/physician services	$ 23,030
$253/allied services and supplies/equipment	$ 12,397
$350/diagnostics and blood work	$ 17,150
$100 ambulance transfer	$ 4,900
Savings (excludes potential hospital admissions and stays)	$ 57,477

SPREAD

Project originated from Banfield Pavilion, currently being spread to 4 Long Term Care facilities:

1. Villa Cathay – owned and operated
2. George Pearson – owned and operated
3. Dogwood – owned and operated
4. Louis Brier – contracted

Planning underway to run a collaborative fall 2025 to spread to LTC sites (owned and operated, contracted and private).

SSC
SPECIALIST SERVICES COMMITTEE

PQI
PHYSICIAN QUALITY IMPROVEMENT
Specialist Services Committee

SQI
SPREADING QUALITY IMPROVEMENT
Specialist Services Committee

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