Joint Collaborative Committees

CREATING CONNECTIONS FOR HEALTH

STORYBOARD + RAPID FIRE GUIDE

BRITISH COLUMBIA

doctors of bc

BC PATIENT SAFETY & QUALITY COUNCIL
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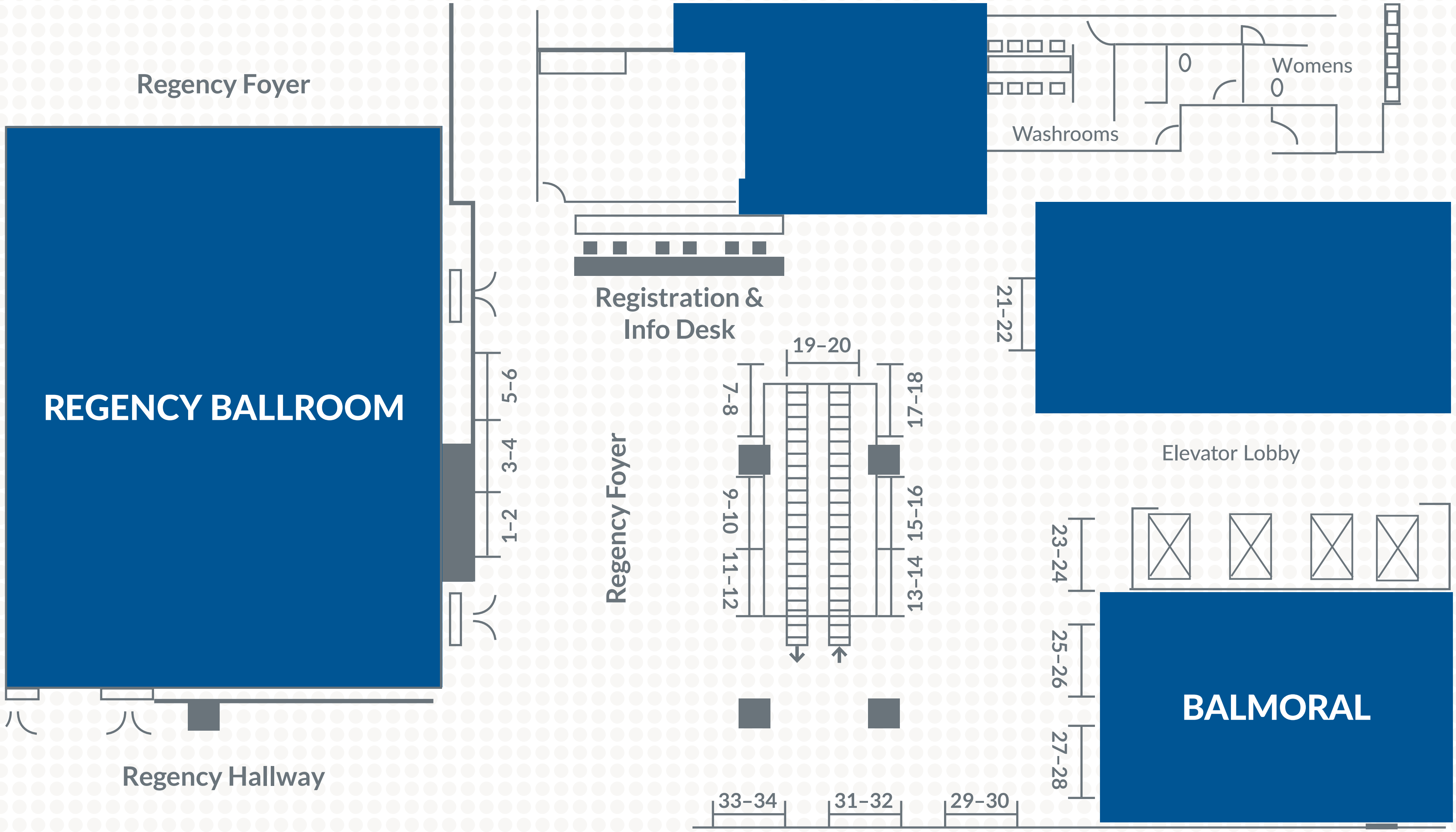
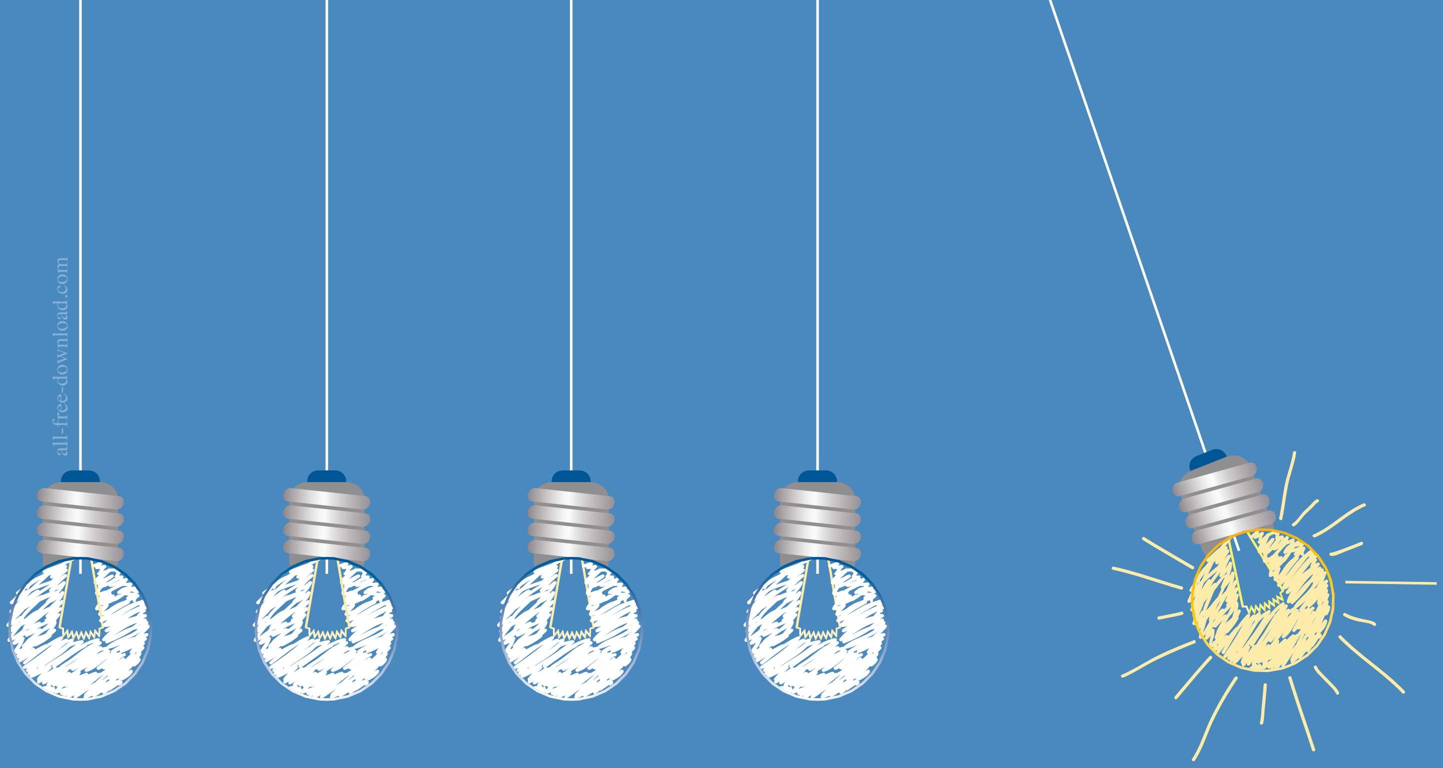
3rd FLOOR STORYBOARD MAP





HOW TO

USE THIS STORYBOARD AND RAPID FIRE GUIDE

This brochure has been designed as a convenient guide for JCC 'Creating Connections for Health' participants to learn more about the work being featured at this event.

With over 40 rapid fire presentations, and 34 storyboards on display, the guide provides you with the opportunity to preselect storyboards you most want to visit during the day, and to learn more about the work presented that you may not have seen.

Spreading Success & Keeping in Contact

In the interest of spreading success and innovation, a contact name and email accompanies each abstract to help you connect with colleagues before, during and after the event.

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CREATING CONNECTIONS FOR HEALTH

STORYBOARD ABSTRACTS

1

BC Cancer Standardized Referral Process for Hepatocellular Cancer Patients

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Hepatocellular cancer (HCC) patients require multidisciplinary care due to the complexity of diagnosis and treatment, and coordinating care is challenging for patients in remote areas of the province. In BC, access to multidisciplinary care occurs with weekly provincial liver tumor rounds (LTR) to determine the most appropriate treatment strategies, but LTR was difficult to access due to procedural and timeliness factors.

Our goal was to streamline the referral process for BC Cancer HCC patients to LTR to ensure all can be evaluated for best treatment options, and to decrease time to treatment decisions and improve outcomes. Our aim was aim was to decrease turnaround time from referral to LTR review by 20%.

We began by mapping the current referral process. Patient process maps highlighted suboptimal turnaround time from LTR referral to review (14 days). Results from a provider survey indicated that key areas to address were unclear referral process and delays in presenting cases at LTR. We also focused on completeness of referral information.

Standardizing the referral process and revising the referral form helped improve the turnaround time (mean 5 days from referral to reporting). Additionally, the LTR report is now available on the electronic medical record. Another provider survey is being conducted to assess satisfaction and identify areas for further improvement.

2

The BC Emergency Medicine Network: Connecting Our Voices to Improve Patient Care

Contact: Sharla Drebit | Network Manager
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BACKGROUND

The BC Emergency Medicine Network (EM Network) launched in September 2017 with the vision of Exceptional Emergency Care. Everywhere.

Our Mission focuses on emergency practitioners, patients, health care leaders, and researchers – sharing, supporting, and innovating to improve patient care.

WHAT MAKES US A UNIQUE CLINICAL NETWORK?

Many organizations call themselves networks. But an inter-organizational network has specific characteristics. It is not simply a distribution platform. To be consistent with Network science principles, the EM Network aims are driven from the bottom-up: front-line clinician defined and driven. We are patient-centred. Patients are engaged in our governance committees and are actively participating in Network initiatives. We are committed to evaluation of the Network itself, the impact of patient engagement and the effect on practice change.

IMPACTING OUR HEALTH CARE SYSTEM

We've had many successes to date, and equally, many lessons to share. There are 890 (out of 1400 eligible) emergency physician members from 88/108 hospital sites across BC. We have an innovative web platform which houses over 400 BC-relevant point-of-care clinical resources and enables conversations among providers By providing an organization that clinicians want to join, and by ensuring our website is on every computer in every emergency department in BC, we share information across the province in a millisecond! More importantly because users are engaged, they share their wisdom and solutions to problems across the province. Through our central clinical resource repository, we are reducing the redundant development of like clinical resources done in the past by individual hospitals and health authorities.

The EM Network is becoming the place to go for clinicians, patients, policy makers and leaders if they want to discuss issues, make changes, share experiences, and be a part of a true learning emergency care system.

3

BC Guidelines: Supporting Primary Care Practice in BC

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BC Guidelines are evidence-based clinical practice guidelines produced by the Guidelines and Protocols Advisory Committee (GPAC), a committee of the Medical Services Commission and a joint collaboration between Doctors of BC and the Ministry of Health. BC Guidelines are concise, user-friendly, and tailored to a primary care context in BC by providing local content and resources. Over the past 20 years, GPAC has developed more than 60 BC Guidelines on a wide range of topics, such as diabetes, asthma, heart disease, and opioid use disorder.

Our storyboard will highlight how BC Guidelines are developed, how GPAC collaborates with stakeholders across the BC health care system, and how both stakeholders and practitioners can contribute to developing guidelines. We will report on guideline implementation and evaluation strategies (e.g., monitoring changes in lab test ordering, web analytics), and will describe the impact of redesigning our external review process. The latter involved adding an online survey to complement our traditional paper-based process of consulting over 600 BC practitioners (family physicians, nurse practitioners, and other key specialties and stakeholders). We will also highlight recently released guidelines, including Viral Hepatitis Testing, Vitamin D Testing, Chronic Kidney Disease in Adults, Appropriate Imaging for Common Situations in Primary and Emergency Care, Adverse Childhood Experiences, and Managing Pain.

4

A Collaboration of CHANGE in BC

Contact: Dr Greg Linton | Family Physician
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Metabolic Syndrome (MetS) greatly increases the risk of developing cardiometabolic diseases. An efficacious diet and exercise program aimed at reducing MetS is needed. However, the uptake of lifestyle modification programs in primary care is inconsistent and evaluation on clinically relevant outcomes is lacking. The Pacific Northwest Division participated in the CHANGE BC program from December 2017-2019. This was a true team-based care collaboration between Metabolic Syndrome Canada, University of BC, Family Physicians, PNW Division of Family Practice, participating patients, Local Governments and Health Authorities (NHA, FNHA). This project of change entailed inter-professional approach to integrating lifestyle interventions into primary care clinics. As part of the implementation of the CHANGE BC program into practice, patients from 4 locations, Smithers, Houston, Massett & Terrace were identified as having MetS by the Family Physicians and were referred to the Registered Dietitian (RD) and an Exercise Specialist (ES) for implementation of an individualized diet-exercise plan. The distinguishing factor of the CHANGE program is the gradual team-based intervention over a 12-month period as well as collection and analysis of data. Measurements were taken at baseline, 3 months and 12 months to ascertain progress in the program and regroup. The measurements create accountability and provides a chance to intervene and update the program to ensure success. Each patient was also followed weekly for 3 months and monthly for 9 months by the RD and ES and saw the Family MD for review of blood work. At the 3-month mark, 50 participants from the BC sites provided measurements compared to the baseline. The Mets reversal rate was 21.5% with the reduction in one or more Mets components being 44%. In all sites across Canada (242 participants), the reversal rate was 17.4% and the reduction rate was 35.4%. At the 12-month mark, 29 participants from the BC sites provided measurements with 21.3% Mets reversal rate and 45.0% reduction in one or more Mets components. All sites or 88 participants at the 12-month reporting 15% Mets reversal and 35.2% reduction of Mets components. Through this team-based care approach, the hope of the CHANGE program is that it will become the model of primary care for the reversal of chronic disease risk factors ultimately resulting in a cost-effective intervention that will prevent and treat chronic diseases in Canadian families.

5

A Compassionate Approach to Detecting and Treating Skin Cancer in the Institutionalized Elderly Population

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Malignant and premalignant skin lesions commonly occur in nursing home residents, yet early cancer detection and treatment can be challenging for this population who may have limited lifespans and mobility challenges. Radiation oncologist Dr Jan Lim brought his expertise to detecting cancerous skin lesions in residents in an efficient and compassionate manner given their special considerations. He devised a plan to visit each residential care facility to provide an on-site assessment to identify and distinguish cancers that can be watched; those that needed to be treated fairly quickly; as well as situations where a biopsy was necessary.

After discussions with the Long-Term Care Medical Advisory Committee and the medical director of Residential Services for Island Health, in-house consultations began in February 2018. Over 14 months, Dr Lim performed 49 in-house consultations on 42 residents of long-term care facilities in Greater Victoria. In this pilot study, 26 of the 42 residents did not require or were unsuitable for radiation therapy. Thus, in-house assessment reduced the amount of required travel for assessment and treatment by 79%, improving the level of care and convenience to the residents as well as reducing the resources expended for transfer and clinic space at the cancer centre. 14 of the residents who had early skin cancers detected were able to be treated with fewer visits to the cancer centre.

This study indicated that the prevalence of skin cancer in the nine residential homes in Victoria appears to be much lower than the 10-15% reported in Australian studies. Based on the referred cases, the prevalence appears to be around 1–3%. It is hoped that this study will lead to future initiatives to provide in-house services to residential patients.

This study also indicated that the prevalence of skin cancer in the nine residential homes in Victoria appears to be much lower than the 10% to 15% reported in Australian studies. Based on the referred cases, the prevalence appears to be around 1% to 3%. It is hoped that this study will lead to future initiatives to provide in-house services to residential patients.

6

Creating the Urgent Pediatric Access Clinic

Contact: Dr Jennifer Balfour | Pediatrician
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Pediatric patients and their families face challenges when they present at the ER, getting referred either to the on-call pediatrician or the community-based pediatrician's office. Either option can result in lengthy wait times and significant uncertainty for the family. Families sometimes return to the ER multiple times rather than risk the wait, resulting in overuse of ER services.

To address this problem, a group of pediatricians in the South Island created the Urgent Pediatric Access Clinic (UPAC), a designated facility and staff to address those patients who require follow-up within two weeks. Drawing on expertise and input from ER physicians, pediatricians, ER nurse clinicians, pediatric nurse clinicians, and family practice physicians, the group brainstormed what such a service would look like, and engaged with Island Health about logistics for the space and staff required for the clinic. UPAC has now been operating since January 2019, seeing an average of 10 to 12 patients a week.

The staff have received encouraging feedback from ER and pediatric clinicians, families, and residents. The clinic has also benefited undergraduate and postgraduate trainees who need to see patients in an environment where they can learn how to assess and manage common pediatric problems in order to be ready for practice.

In future, the group would like to guarantee the use of two rooms with greater overall space capacity, allowing them to assist patients and their families without overcrowding in the exam rooms. They will also continue to engage with family practice physicians to ensure that this effort assists, rather than adds to, or competes with, their work.

7

Data Integration Initiative on the Sunshine Coast: David & Goliath

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The Sunshine Coast is a small rural community with 37 family physicians across five medical clinics. Thirty-six of the 37 physicians have hospital privileges and have received privacy training. They work in areas such as emergency, acute services, and patient care, and in the Opioid Replacement Clinic. All five clinics used the Telus Med Access EMR.

The division initiated an innovation project to merge patient information from each of the five EMR databases into just one EMR. This data merger will enable physicians to access their patients' information regardless of where or when they are seen (ER, after hours, etc.). This project supports consistent seamless care by creating one community chart per patient whether they are receiving primary or complex care.

We are in the process of developing a "sandbox" environment with our working group and Telus. (The College recently granted us permission to proceed with the sandbox without requiring patient consent for this phase of the work.) The sandbox will allow us to test how the actual data merge will happen, what functionality might be needed, and which parts of a chart would be accessible. It will also help identify any issues with the merging process and enable the team to mitigate accordingly.

Our presentation will describe the journey of engagement with physicians, finding enablers such as a health technology manager we hired who could advocate with Telus, shifting from a vendor-client relationship to a collaboration model, and overcoming barriers (technology, human resources, clinic independence).

8

Default Mode: Happiness

Contact: Katie Blaxland | Project Manager
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INTRODUCTION:

Modern Western Healthcare systems provide care to the three quadrants of wellbeing (Emotional, Physical, and Mental), but does not often fulfill the fourth quadrant: Spirituality. This project will seek to understand further and promote the importance of Spirituality in healthcare; propose the Default Mode Network (DMN) as a biological treatment target; propose Philosophical, Energetic, and Symbolic levels of body control as DMN modulators; introduce psychophysiological coherence as biomarkers for holistic wellbeing. Spirituality has always been a part of our humanity. It provides us with an understanding of who we are and why we are here. Religion is the structure of our knowledge of Spirituality, but our churches are closing by the thousands. This void is palpable, and the consequences are spilling over into our clinics and our Emergency Rooms. This project will utilize a collaboration between Family Physicians, the PNW Division of Family Practice, patients, and spiritual healers in the Pacific Northwest.

METHODS:

The hypothesis of the project is that scientific evidence required for Spiritual treatment options will include a remodeling of the DMN, the location of the SELF, as discovered through modern neuroimaging (fMRI and EEG). Improved Dynamic Functional Connectivity within the DMN; tracking of emotional granularity and individual Coherence monitoring with EEG and heart rate variability (HRV) monitoring would aid such re-modeling process.

RESULTS:

Default Mode: Happiness is still in its exploratory phase. The results will be portrayed in a visual experience through film. Research is currently underway for such a film. A production pitch video will begin in January – May 2020. Further fundraising, scientific collaboration, and eventual production will take place in 2020.

CONCLUSION:

The Default Mode Network (DMN) functional connectivity is a prime target for understanding the pathophysiology of depression, with particular relevance to revealing the mechanisms of effective treatments. In a time of global DISEASE OF THE SELF, Default Mode: Happiness is an exploration in search of a cure.

9

Developing an Early Psychosis Order Set

Contact: Dr Daniel Boston | Psychiatrist
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Clinical order sets (COS) guide the treatment of specific conditions when patients enter the hospital. However, until recently, there was no specific COS to guide the care of first episode psychosis. The first time a person experiences psychosis can be a challenging, frightening time. The care they receive during this episode can set the stage for all future engagements with the mental health care system, underscoring the importance of developing a detailed, evidence-based COS for treating these patients.

The project involved coordinating a series of meetings to develop the COS, drawing on insights and expertise from physicians, managers, nurses, occupational therapists, and administration. The team worked to ensure the COS was well tailored to the clinical realities of these patients. Details included specifying which health indicators would be collected at baseline, determining which medications would go on the order set, and addressing the needs of specific patients, such as those diagnosed with schizophrenia or bipolar spectrum disorders, or substance-induced psychosis.

After four different iterations, the final COS has been implemented and is showing positive results. Not only was use of the COS associated with an 11.4% decrease in total polypharmacy use, it was also associated with a 10.8% decrease in the length of stay, from 20.3 days to 18.1 days. Next steps include ensuring that the COS is used in 100% of first episode psychosis admissions and getting it uploaded to facilitate computerized point of entry.

10

Emergency Preparedness: A Coordinated Community Approach to Care

Contact: Rhonda Eden | Project Lead
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This project addresses commitments and recommendations made in the Doctors of BC 2018 policy paper "Improving Collaboration in Times of Crisis: Integrating Physicians in Disaster Preparedness and Health Emergency Management." It will endeavor to create a program for a coordinated and collaborative community and regional approach to preparing for and responding to health care needs during an emergency. It will also support family physicians to prepare themselves and their patients for an emergency, as well as respond and recover if their clinic becomes the target of an emergency.

ANTICIPATED OUTCOMES INCLUDE:

- An informed approach that includes patients, family physicians, specialists, and other health care providers (e.g., pharmacists).
- A proactive, coordinated approach that enables division members to support one another to continue providing patient care in the event their practice is the target of an emergency.
- Business recovery supports and resources to family physicians and specialists.
- A community approach to emergency preparedness that will alleviate the burden on the hospital, especially the emergency room, and ensure safe, acceptable, effective, and coordinated patient care in a traumatic situation.
- Resources for patients that promote readiness and keeps them informed, if they are displaced from their physician in an emergency.
- Increased patient accessibility to health care, especially their family physician, during a disaster.
- A model that can be shared with divisions and other health care partners and communities across the province.

11

Endoscopy Services in a Rural Environment

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The St John Hospital Endoscopy program in the rural community of Vanderhoof set out to develop and implement a comprehensive quality endoscopy program within existing structures. The team had limited resources and a unique set of challenges that come with rural practice. The aim was to improve clinical quality and the patient/provider experience.

The need for endoscopy services is growing. Screening and diagnostic endoscopies can be safely performed in rural facilities and serve to stabilize operative services. Endoscopy quality outcome and process indicators are well established; however, currently our system cannot consistently provide timely data. The endoscopy program in Vanderhoof has been working toward Canada-Global Rating Scale (C-GRS) certification since 2015. The Physician Quality Improvement program offered an opportunity to build on the C-GRS work with particular attention to patient access, process efficiency, information management, and patient-reported outcomes.

To assess the current state of our endoscopy program and understand where improvements could be made, we used QI methodology and tools focused on 1) establishing a collaborative quality committee 2) implementing C-GRS recommendations 3) developing strategies to improve access 4) improving methods of collecting data and sharing information 5) improving methods for patient feedback and using the information received 6) improving the referral process 6) building a provider network.

We held regularly scheduled quality committee meetings to review outcome data against established standards, i.e., provincial benchmarks for wait times, tracking of program demand and capacity, clinical quality indicators, and patient survey feedback and completion rate.

WE LEARNED SEVERAL LESSONS FROM THIS PROJECT:

- Endoscopy service delivered closer to home is essential
- Rural endoscopy services are high quality and can be provided safely
- Rural primary and specialized services are strongly interconnected
- Improvement work requires a team with dedicated resources
- QI needs administrative support and an openness to change

12

Engaging Hospitalists in Participating in the Vested Process in South Island

Contact: Ken Smith | Hospitalist
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Negotiating new contracts is often a complex endeavor, particularly when parties have had a challenging relationship in the past. This was particularly true in the contract negotiations between the Victoria Hospitalist Service and Island Health, which had stalled during 2014 and 2015, reaching an all-time low in March 2015 when the interim contract had expired and nothing had been agreed upon to replace it. It was at then that Kim Kerrone, Island Health's vice-president, chief financial officer, became familiar with Vested, a novel methodology to guide contract discussions.

Vested focuses on building relationships between parties rather than the more traditional transactional negotiation. The Victoria hospitalists and Island Health agreed to use the Vested methodology to rebuild trust and establish the groundwork for a new contract negotiation. Not only was this the first time the Vested methodology was used within Island Health, it was also the first time it was used with a physician contract anywhere in BC and Canada.

No matter how promising the methodology, having hospitalist physicians attend the Vested team meetings on their days off was essential to success. To address this challenge, this project sought to compensate numerous hospitalists to regularly attend the meetings. The funding ensured regular hospitalist attendance at meetings (three to five per month) of the five different Vested teams (Governance, Excellence, Best Value, Sustainability, and Relationship). Their attendance led to improved communication, relationship building, and idea sharing. As hospitalists participated, others came to see the value of attending these meetings.

As a result of these collaborations, a new hospitalist contract was signed and physician-administration relationships significantly improved. In addition to cementing the new contract, the negotiations gave rise to several new quality improvement ideas which have subsequently been generated within the hospitalist team.

13

Establishing a New Pre-operative Pain Management Pathway for Hip Fracture Patients at Providence Health

Contact: Dr Trina Montemurro | Physician
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Approximately 300 patients arrive at Providence Health Care (PHC) with fractured hips every year. These patients typically receive intravenous opioids for preoperative pain control. This leads to delirium, decreased levels of consciousness, and other medical complications in this frail, elderly population—in-hospital mortality is high.

Evidence in the literature demonstrates if patients receive a femoral nerve block prior to surgery, their pain control is much improved, reducing their opioid consumption while they wait for surgery. Our QI project set out to develop and implement a pathway so that anesthesiologists could assess all hip fracture patients and perform a femoral nerve block (if appropriate) as soon as these patients were admitted. This required the teamwork of many health care providers: emergency medicine, orthopedics, anesthesiologists, internal medicine, and the acute pain service. Additionally, our emergency and ward nurses needed to be involved and aware of the nerve block pathway.

We have successfully begun to perform nerve blocks on many of our hip fracture patients early in their admission to hospital. We are assessing for decreases in opioid consumption and other complications. The pathway has now been implemented for 6 months and is gaining traction. We are currently doing an audit on all patients that have had hip fracture surgery at PHC to assess whether they received a preoperative nerve block and how this impacted their preoperative pain management. We have seen a steady increase in the percentage of hip fracture patients receiving nerve blocks since implementation. We continue to monitor how the new pathway is working for our patients using PDSA cycles, and changes are made as necessary. In future, we hope to spread this skill to our emergency physicians so even more patients can get a nerve block early in their admission to hospital when anesthesiologists are unavailable.

14

How a Collaborative AED (Automated External Defibrillator) Project is Benefiting Heart Patients

Contact: Dr Daisy Dulay | Cardiologist
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Sometimes the cause of an out-of-hospital cardiac arrest (OHCA) for patients who survive and are admitted to the coronary care unit is not immediately clear. Having the information from the automated external defibrillator (AED), if used, can provide clues about the cause, particularly when the cardiac arrest is not related to a heart attack. It also allows for timely management and investigation decisions, and it permits staff to focus on patient care rather than chasing down the information (which, if successful, would often take days).

In a small retrospective review, initially the team was getting only 50% of the information for OHCA prior to implementing a formal protocol. In Phase 1, the CCU charge nurse, quality project analyst, and a cardiologist worked collaboratively with BC Emergency Health Services (BCEHS) to develop a notification process. From November 2018 to February 2019, the access to the AED information improved to 80%. Over that time, it was noticed that OCHA patients were attended by firefighters first in many cases.

Phase 2 of the AED project began with a focus on fire services. Unlike BCEHS, which is a provincial body, working with fire services meant working with individual municipal fire departments. This led to an engagement event with local fire departments and then a subsequent invitation to the Provincial Fire Chiefs Education Summit in Penticton to explain why obtaining the AED information is part of the patient record and vital for the ongoing care of the patient in hospital.

Currently, nearly 78% of AED information is being obtained within 24 hours, exceeding our original goal of 80% being obtained within 48 hours. But as publicly owned AEDs become ever more ubiquitous, the process of getting the AED information is more difficult. The download process of AED is vendor dependent; there is no universal download method. Our project highlights the challenge of getting AED information when they are owned by public entities or private citizens or businesses. Sustainability and spread has been a focus as well; there is interest from cardiologists from Kelowna and Vancouver who want to implement the changes that the Heart Health team at Island Health worked on with the local fire services and BCEHS.

This project also illustrates the collaboration with first responders and Heart Health team with the common goal to provide the patient the best possible care efficiently.

15

Improving Communication, Patient Access, and Shared Care Ideals to Better Coordinate Care for Older Adults

Contact: Chelsea Brookes | Project Lead
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Communication between specialists and family physicians can be challenging. Family physicians face difficulties with information flow from specialists and subsequent updating of patient records in a timely manner. It can also be unclear what information specialists would like to receive from family physicians when medication changes are made.

To address these challenges, we intend to trial a mentoring program in the Thompson Region. Specialists and family physicians will engage in care coordination of older adults by exploring the idea of shared decision making between the specialist, family physician, and patient.

The intention is that an internal medicine specialist will come into a family practice to collaborate on the diagnosis, assessment and treatment of patients in the context of the family physicians' office. Internists were selected as they are an engaged group able to consult on older adults with multiple chronic comorbidities.

One of the desired outcomes is an enhanced understanding of the internist's medical management decisions. Joint appointments can ensure that both providers and the patient agree on the care plan, and that the medication record on the patient's profile is updated in a timely manner after the specialist consult. A major intended benefit is education for the family physician to apply to other patients.

This trial is in the planning phase, but family physicians and internal medicine specialists have expressed interest. Potential barriers may be capacity, buy-in from family physicians, and concerns about patient access. However, this opportunity should better prepare participating family physicians to care for older adults as they can apply what they learn to future cases.

The project is funded by Shared Care under the Coordinating Complex Care for Older Adults initiative. It aligns with several patient medical home service attributes and primary care network principles. We hope to begin the trial in November.

16

Improving Mental Health Supports for Children and Youth on the Sunshine Coast: It Takes a Village

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Building on the experience of the Child and Youth Mental Health and Substance Use (CYMHSU) Local Action Team, the Sunshine Coast identified mental health supports for children and youth as a priority for their patient medical home initiative. Over 15 months, the working group defined gaps and co-designed solutions to lesson those gaps in mental health supports.

The group implemented specific processes: Beginning with an appreciative inquiry approach, stakeholders (physicians in clinics and hospital, VCH mental health team, school, Ministry of Family of Children and Family Development) were asked to define assets, barriers, and improvements. Research and development was carried out to learn from other divisions and communities. A small task group of stakeholder representatives was convened to co-design multiple solutions and responses. The group hosted an Adverse Childhood Experiences workshop for all stakeholders, which was developed and delivered by physicians, in order to create a common reference point. Multiple supports and changes in the continuum of mental health supports were co-designed.

The results include a resource guide targeted at all providers; psychiatrist youth clinic/outreach; a half-day workshop with all stakeholders, entitled Equalizing Knowledge; Doc in School in two secondary schools, and improved relationships and communication pathways for all providers.

While our original focus was to develop wraparound services and a team, that wasn't possible, but we persevered to create alternatives that still improved supports for children and youth.

17

A Journey into Collaborative Practice: A Shared Care Maternity Initiative

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Recognizing that maternity care on the Sunshine Coast would be in crisis due to low provider numbers, a group envisioned building a hard call system that would evolve into a collaborative practice model, operating in partnership with the local health authority.

The group of practitioners foresaw building a leadership model consisting of family practitioners and registered midwives as leads, working alongside obstetricians and engaging with other allied health and health authority representatives, and relevant stakeholders.

That vision has resulted in a group of six providers (four general practitioners and two registered midwives) working closely together, implementing group-run prenatal clinics in advance of implementing the collaborative model. The A-to-Z of providing perinatal and postnatal care have been, and continue to be, negotiated collaboratively. Systems for sharing billing, dissemination of provider information (website, a newspaper press release, pamphlets, rack cards, visits to local mom-and-baby groups), patient tracking (including due date tracking), advocating for training and SIM module opportunities, and prenatal care have been developed and continue to evolve as the group encounters new opportunities for shared learning.

The work of the committee has been enriched and guided by looking to and connecting with other communities on similar journeys. The result has been a collaborative model of practice for maternity care that embraces sensitivity, trust, relationship building, and a collective and dedicated shared vision for a community or population of care.

18

Launching the Point-of-Care Ultrasound Service in Victoria

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When a patient arrives in the hospital with a health issue, it can take hours to run the tests to identify the problem. However, targeted investigations and care plans can be expedited if hospitalists can perform point-of-care ultrasound (POCUS) as part of the clinical examination, much as they would use a stethoscope. In response, a project was launched with the aim of training the hospitalists in Victoria in to use POCUS, which is often referred to as a "bedside ultrasound process."

A group of hospitalists in Victoria met to discuss integrating POCUS into hospitalist practices. The meeting was an essential step for building consensus among the group for this service and training. Following the meeting, a survey was launched to assess the staff's existing comfort and familiarity with the technology, as well as their knowledge of existing training pathways. The survey also assessed hospitalist interest and availability in receiving POCUS training.

The group identified the need for more ultrasound machines if they were to learn, maintain skills, and have access to POCUS on the wards. They subsequently requested the purchase of more POCUS machines through Island Health to be used in both Royal Jubilee and Victoria General Hospitals. The group is currently navigating challenges to ensure that the IMIT security and privacy assessments will work with this new technology.

In addition to making progress on purchasing the ultrasound machines, the group has established a pathway for hospitalists to obtain ultrasound experience and proficiency through supervision within the hospitalist group. Point-of-care ultrasound guidelines for Victoria hospitalists are now ready for implementation.

19

Listening First: Supporting Heart Failure Patients and Their Families

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"Rollercoaster" describes the course for advanced heart failure: multiple exacerbations of symptoms with each recovery returning to an ever-lower baseline. As the patient gets sicker, their quality of life worsens with increasing symptoms, visits to the emergency room, and hospitalizations. Challenges with prognostication and clear communication to the patient and their circle of care make for a bumpy transition from aggressive care to a palliative or symptom-focused approach.

The limited capacity of services in Victoria, including the Heart Function Clinic and the Home Health Monitoring Program, means that these services aren't available to everyone. Additionally, the services have tended to focus more upstream and not on supporting patients in the final stages of heart failure. To increase supportive care for these people, the Supportive Cardiology Project adopted a two-phase approach, with phase one anchored in patient journey mapping to identify 1) gaps in resources and services, and 2) current resources and services providing positive impact.

Prior to mapping the patient perspective, the stakeholders—including a variety of health care providers—attempted to map the journey from a clinical perspective. Questions arose: How well defined was the care pathway? Would patient journey mapping be easy or problematic? The fact that subject matter experts (SMEs) had difficulties even approximating the clinical pathway foretold trouble ahead.

To accommodate the frail cardiac patients, one-on-one interviews at the patients' homes were chosen over group sessions. The SMEs helped formulate questions to standardize the interview process but not impede or restrict patient stories. Overlaid on four-part grids (self-management, events, symptoms, comorbidity management) and highlighted by descriptions of feelings and quotes, the majority of patient journeys were visualized.

After studying and correlating the issues from both patient journey and clinical pathway mapping, phase two work will be undertaken to enhance support for patients with heart failure and their families.

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Making Maternity Care EASI (Effective and Seamlessly Integrated) for Patients and Providers

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The EASI Maternity Care Project is a Vancouver-focused, multiphase project that is a collaborative undertaking between the Vancouver Division of Family Practice, BC Women's Hospital, and St. Paul's Hospital, with representation from Vancouver Coastal Health. Clinician and patient surveys, patient journey mapping, data, detailed experiences, and diverse perspectives have all informed our work, which focuses on responding to gaps in patient preparedness along the various stages of the maternity care journey.

The aim of the project is to create an online "one-stop-shop" maternity information hub for patients and providers based in Vancouver, with emphasis on meaningful engagement through the various stages of resource curation, platform development, and user experience design. The hub is being developing through an interprofessional and collaborative process, with appropriate content highlighted and relationships strengthened. This alignment of information benefits patients and providers alike, offering an accessible and effective platform that responds to a longstanding need within the maternity care system in Vancouver. Moreover, by curating from established repositories, the information hub aims to respond directly to the need for clear, consistent, and reliable information across the prenatal–postpartum spectrum.

The outcomes of this project align with the BC Quality Health Matrix. The value of this common goal has created much excitement for collaboration. With active engagement of institutions, leaders, providers, and a broad spectrum of voices, this online platform will go a long way to make maternity care EASI—effective and seamlessly integrated—for both patients and providers.

21

The MedWatch Program: A Collaborative Approach to Ensure First Responder Access to Advance Care Plans

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First Responders often find it challenging to gather crucial patient medical information. The MedWatch Program and form were created to ensure that vital medical information is available to first responders when responding to an emergency call.

The MedWatch Program is a community-wide partnership of the Langley Division of Family Practice, Langley physicians, Langley Memorial Hospital Emergency Department, local first responders and seniors' residences. The idea stemmed from a Township of Langley Fire Department firefighter, who felt that having access to this information when answering an emergency call made a first responders' job easier, while enabling patients' health care wishes to be honored. Partnering with the division, and using the existing Fraser Health Authority Greensleeves initiative, the MedWatch program and form were developed.

The development of the MedWatch Form, in combination with the use of green stickers, was vital for First Responders to be able to locate vital information, but also for patients to keep their medical history together in one place. Seniors advised they did not keep their Greensleeve on the fridge because they did not want this information available for others to see. This concern led to the idea of placing a sticker on the drawer or cupboard where the information was being kept and a second sticker on the entry door notifying First Responders that the patient is a part of the program. Training and education continue to be presented to Physicians and Nurse Practitioners, Medical Office Assistants, First Responders and community groups. In addition to the MedWatch form, Greensleeves contain Advanced Care Plan documents (MOST and NO CPR), a representation agreement, and a current list of the patients' medications. Community education sessions help guide seniors through the importance of having a decision-maker if unable to speak on their own behalf, and on having a dialogue with their primary care provider on their health care wishes. Over 126 presentations have been completed throughout Langley, including some directly to Public Educators from the Lower Mainland and Vancouver Island with the goal of spreading the program to additional communities.

22

MRI Appropriateness Checklist: Checking What Resonates with Family Physicians

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Reducing wait times and improving access to specialist services have been identified as priorities of the Canadian government—but long waits for specialists continue. In fact, in 2017, the Canadian Institute for Health Information reported wait times for both MRI and CT scans as continuing to increase.

In 2018, Providence Health Care, in partnership with the Shared Care Committee, began work to strengthen the interface between primary and specialist care to facilitate more timely access to these necessary services. Concurrently, Lower Mainland Medical Imaging (LMMI) was working on numerous projects to smooth waitlists and increase capacity for MRI studies. In an effort to ensure a collaborative approach that included input from family physicians (FPs), Providence Health Care partnered with LMMI to bring FPs to the discussion and design table.

The collective working group included FPs, radiologists, MOAs, and patients. LMMI contributed by working on a comprehensive, easy-to-use referral form and a process to ensure the MRI studies are ordered appropriately by referring physicians. The main areas of this collaborative work included FP feedback on the MRI referral form and input on the creation of an appropriateness checklist (ACL) to help clarify which patients are eligible for low-utility MRI scans for knee, hip, or lumbar spine. Other work included the addition of radiology expertise on the RACE line as a decision support tool. The next steps to coordinate medical imaging for patients include expanding the guidelines to further reduce low-utility studies of the shoulder and head.

We will share impacts of the collaborative process from the different perspectives and present the lessons learned from the PDSA cycles: what worked well and what required revision. As well, we will present the early results of the referral process and the ACL.

23

North Shore Opioid and Chronic Pain Initiative

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Members of the North Shore Division of Family Practice identified the opioid crisis and chronic pain management as a community priority in May 2017. An expression of interest was approved by the Shared Care Committee in February 2018, and full project funding was granted in June 2018.

The Opioid Crisis and Chronic Pain Initiative focused on providing education and support for patients and their clinicians with an eye toward sustainability in the community. The project was subdivided into three areas of focus. The first group organized education events on pain management and opioid use disorder management, and researched suboxone mentorship programs. The second group created a comprehensive list of chronic pain resources for physicians to access via Pathways. This group also collaborated with Pain BC to successfully pilot and evaluate a Gentle Movement Program by partnering with the North Vancouver Recreation and Culture Commission, who will continue to sustain this program. Finally, a chronic pain patient journey mapping session was held to guide the design and implementation of a chronic pain pathway communication tool (adapted from the Powell River Division of Family Practice) to be used in the emergency room and primary care provider offices.

Our evaluation strategies included education reports for the 87 physicians who attended learning sessions, and a PHQ-9, a functionality scale, and a qualitative analysis for the 30 participants of the gentle movement program. The greatest challenge came with recruiting participants for our pilot movement program. We switched our focus from being GP to patient-centred and noticed an immediate uptake in registration.

This initiative was a community effort and helped to foster new relationships between health care providers, community groups and patients that lead to an exceptional service outcome.

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Open Conversations in Palliative Care

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The East Kootenay Shared Care Palliative Team wonders what palliative care could look like if we connected with patients, caregivers, and other providers about what it means to live our very best life story. What would it mean if we connected meaningfully with the past, the now, and planned together for the future? Who is that person we call patient, caregiver, or health care professional? How could learning more about who they are as individuals support how we communicate and contextualize their evolving frailty or disease, particularly at the end of life?

Community-based palliative health care teams come together to talk about this concept over supper. The challenging work of palliative care is acknowledged and celebrated. A family member of a person who had died in the community talks about their experience of the end of life of their loved one. The story and the person are acknowledged without being discussed further. The caregiver's story acts as a powerful catalyst for holding the focus of the participants hearing the story. The remainder of the evening focuses on facilitated discussions.

The discussions further support each participant's awareness of the importance of taking time for curiosity, empathy, and important conversations. Emphasis is placed on the importance of the community working together.

Our intention is to create a palliative care culture shift in our communities. The evaluations of the evenings have been very good, with participants expressing enthusiasm and willingness to change their practice. However, it is challenging to meaningfully measure a shift in culture. We are part of each other's stories. How we choose to see others will impact the care we deliver, the teams we develop, and the culture of the community. Until it's our turn, let us be a part of someone else'' best possible last chapter.

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Physician Networks: Improving Physician Satisfaction and Patient Care, One Network at a Time

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Maple Ridge and Pitt Meadow's Primary Care Network Vision includes a "physician networks" strategy that allows physicians to foster subspecialties in patient care. Informal networks of physicians developing a subspecialty in the areas of long-term care and child and youth mental health/substance use already existed. The division identified the need to formalize networks to spread the success being realized through these existing informal networks to other patient populations.

In consultation with the GPs, a framework was designed for the network model, and the overarching purpose and goal were agreed to. Projects involving networks of physicians, community partners and patients have been initiated in four priority patient populations: Adult Mental Health & Addictions, Women's Health, Male Health, Chronic Pain, Seniors, Maternity, Child & Youth and End of Life.

The purpose of the networks is to bring family physicians, specialists, and community partners together around a patient care or physician improvement need, and then work toward developing creative, innovative solutions. These solutions will improve physician satisfaction and patient health care outcomes, which will ultimately result in better quality of care, improved access, and attachment.

The goal is to create a physician network model that will assist with improving care and maximize available or future supports for physicians with colleagues who have shared patient interests. Shared experiences by physicians will allow for knowledge transfer and improve communication and understanding between physicians themselves as well as with other health care providers and community resource supports. Ultimately, patient care practice will improve, along with physician well-being.

Although all of projects have evaluation strategies attached to them, the best evidence of the success of the physician network model is through the GPs themselves, such as Dr Ursula Luitingh, who inspired the creation of the networks and now has a subspecialty in child and youth mental health and substance use.

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Preterm Labour: Improving Diagnostic Evaluation in BC

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Two biochemical tests, fetal fibronectin (fFN) and Actim Partus (AP), are available to exclude preterm labour. Direct comparisons of these two tests with adequate sample sizes are lacking. fFN is the more expensive gold standard, but it is available only in core lab facilities in BC. Further, fFN results are required by BC Ambulance Services before transfer decision can be made.

On Vancouver Island, many pregnant women receive their antenatal care in rural areas. Turnaround time can be 3 to 4 hours, which introduces additional anxiety for physicians, patients, and family members. The AP is a bedside test that offers an effective solution.

We ran a pilot project to conduct a retrospective analysis to compare diagnostic accuracy of these tests in predicting preterm delivery in symptomatic women. Both the fFN test and bedside AP test were made available for allied health workers to use in patient care. We were able to identify 2911 cases with fFN and/or AP results.

We concluded that, individually, these tests have comparable negative predictive values in excluding preterm labour. Concurrent testing offers the highest, but insufficient, positive predictive values (PPV) of 24.2%. The net gain in PPV comes with 1% loss in NPV, when compared to either of individual test.

The project identified that AP is a faster, cheaper, and equally effective tool as fFN to allow rapid exclusion of preterm labour. The new algorithm we developed avoided fFN testing when AP was negative. Patients were assured at bedside, and the total number of fFN decreased by 35%. The estimated annual saving was $37 000.

This pilot project was successful in providing the appropriate test, but fFN results are still required before transferring a patient. Further discussions need to take place with a provincial scope.

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Public Health Emergency in the Pacific Northwest: Sentinel Health Crisis in Canada

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Childhood obesity has been widely reported on a global scale as an epidemic, as is its adverse impact on patients, health outcomes, and cost to the system. Health Canada, specifically, has also reported epidemic levels due to the prevalence of paediatric overweight and obesity in 30% of children aged 5-17. In March of 2018, this research project, funded through the Rural Coordination Centre of British Columbia, began to explore the prevalence rates of overweight and obese children in the Pacific Northwest in British Columbia. The original framework of the project was to determine diagnostic criteria for MetS (Metabolic Syndrome); to work with the Health Data Coalition in an attempt to determine the prevalence of metabolic syndrome in British Columbia's rural pediatric population, focusing on the Pacific Northwest; to develop recommendations for the most appropriate clinical pathway for pediatric patients with MetS/obesity, and a framework for community supports within the context of Primary Care Network Partnership. This physician lead initiative was a collaborative effort involving 8 family physician offices in 3 communities, local paediatricians, practice support coaches, and staff from the PNW Division of Family Practice. Using the anonymous height and weight measurements, Body Mass Index (BMI) data was calculated for 2,002 children aged 5-17 in the communities of Smithers, Terrace and Prince Rupert. Using World Health Organization's (WHO) weight charts, calculations were made pertaining to the prevalence of children who were overweight (between one and two standard deviations above the mean) and who were obese (two or more SD above the mean). Early findings demonstrate a paradox in the Pacific Northwest in that not only are the rates of overweight and obesity higher than the national and global averages, the trend does not follow any pattern seen previously. Differing overweight/obesity trends were noticed in that the rates of obesity are higher than the rates of overweight. This research demonstrated a significantly higher prevalence rate for obesity in the Pacific Northwest and it can be leveraged to support health care implementation programs within the Primary Care Network development. The consequences of childhood obesity bare significant consequences to the individual, their families, communities and to healthcare delivery.

28

Royal Inland Hospital Physician Performance Enhancement Project

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Historically emergency department (ED) physicians have received little or no feedback on their performance. The Physician Performance Improvement Project (PPIP) in the Kamloops Royal Inland Hospital ED piloted a set of tools for self, peer, and patient assessment in partnership with the Medical Council of Canada 360 Program (MCC360). Once physicians received their individualized feedback, they met with a physician mentor and developed a self-learning plan.

The project aimed to ensure that 80% of ED physicians working in the Royal Inland ED participated in physician performance improvement by April 30, 2019. The intent was to demonstrate how feedback from patients and colleagues can improve patient care and ignite opportunities for learning. Qualitative assessment of physician performance was collected from self-assessment, peer assessment (physician colleagues and non physician co-workers), and patients. The pilot used an evidenced-based program developed by the Medical Council.

Each physician completed a self-assessment, then received anonymous assessments from 16 peers and 25 patients. Feedback data were collected and analyzed by MCC360, and then shared only with the individual physician. The physicians were provided with the data to review with a mentor they chose from physician colleagues. The review allowed the physicians to develop a self-learning plan to identify areas of improvement with progress to be assessed with their mentor at 6 months and 1 year.

A confidential online survey of participants assessed the perceived value of this pilot project. One hundred percent indicated they saw value in the Physician Performance Improvement Project and that it positively impacted the quality of patient care. Planning is underway with Interior Health to cycle this project out across other EDs within the region in a way that will maintain the value of the methodology while enabling customization to local contexts.

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Shared Care Spread Networks: Development and Implications of Using Standard Patient and Provider Surveys

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Effective evaluation uses measures that are sufficiently sensitive to detect changes at the project-level. Yet specific project-level results are challenging to aggregate effectively to identify provincial trends and to discern system-wide impacts of quality improvement initiatives.

In 2017, Shared Care developed Spread Networks, a funding initiative designed to spread successful work across communities. Currently, there are 44 Spread Network projects in maternity care, chronic pain, and adult mental health and substance use. As part of the Spread Networks, standard patient and provider surveys were developed through an extensive review and consultation process. These surveys are run by each community at the onset of their project, and each community can add custom questions to the surveys and receive central support including a data report.

To date, 2145 patients and 578 providers have completed surveys across 14 communities in the Maternity Spread Network. We are expecting the number to exceed 6000 patient surveys and 1500 provider surveys across three Spread Networks by 2020/21.

THE KEY FINDINGS OF THE MATERNITY SPREAD NETWORK ARE AS FOLLOWS:

- 36% of patient respondents reported experiencing mental health concerns during pregnancy (12.3%), postnatally (11.6%), or both (11.6%).
- Patient satisfaction decreases significantly for postnatal care (p <.001).
- Provider satisfaction is moderate with the quality of care (77%), their community as a place to provide care (75%), and their relationships with other providers (74%), but is low with work-life balance (46%).

The survey results apply to three levels: provincial (across all networks), network (within each network), and project (needs assessment). Furthermore, implementing standard surveys enables comparison across different patient groups, provider types, and a variety of health system factors to identify patient and provider issues and trends.

Our presentation will cover the survey development process, data collection and analysis, and key findings to date.

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A Shared Provider and Patient View: Gaps and Strengths in Addictions Care Services

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How can considering the patient voice illuminate gaps in care? If most overdose victims had one or more prior medical encounters leading up to their death, with the majority being in the ER, where can we be better tie in patients to an effective flow of services and supports?

To explore these questions a community inquiry process was carried out. Twenty health care providers who routinely provide care to substance-using patients were interviewed in open-ended interviews. The intent was to create an insightful and robust body of qualitative data, and so a phenomenological approach was taken. Themes were pulled from the qualitative interview data, and from those themes a second set of questions was generated, designed to engage and survey patients with substance use disorder.

Throughout the process, extensive liaison with the local peer-led community action team was carried out. Fourteen patients with substance use disorder—or, as they self-identify, who use drugs (PWUD)—were then interviewed. The interviews were again open-ended and took a phenomenological approach.

In the course of the project, both a provider journey map and a patient journey map were created. A report was written to support the more detailed context of what was learned. Our findings are peer informed and will help to support stakeholders in building effective pathways of care for people with addictions. They clarify that opportunities for education in evidence-based addictions care modalities, training on opportunities for systemic changes in service delivery, and an understanding of the socioemotional drivers in service delivery are all necessary to support GPs and all care providers both in and out of the ER to thrive in providing effective and accessible care to PWUDs.

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Strategies to Engage and Empower Healthier Physicians

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Physician engagement is a key factor in physician health and well-being. Engagement is also an important component of any health care system that wishes to make adaptive and meaningful changes.

The Specialist Services Committee (SCC) sought to confront disengagement, improve culture, and counter physician burnout by bringing physicians back to the table through two initiatives: Facility Engagement (FE) and Physician Quality Improvement (PQI). Both aim to support physicians to develop a meaningful voice and to engage in making meaningful change.

These initiatives provide funding to support activities that strengthen relationships and communication between physicians and health authority leaders with the aim of improving physicians' work environment, their involvement in decision making, and their ability to provide better patient care. Structures and financial resources are provided to support physicians to address issues and participate in activities at their site.

The SSC also partnered with health authorities to develop an approach to get physicians involved in quality improvement, which organically became a powerful tool for engagement. This bottom-up approach of supporting physician-led quality improvement projects has ignited an inner passion within the physician community. Each health authority has committed to support greater engagement and collaboration with physicians. Over 75 different medical staff associations are now involved province-wide. Although the approach is different from facility to facility, physicians are feeling the culture change. From 2017 to 2018, there was a 10% increase provincially in physicians' overall feeling of satisfaction with their organization as a place to practise medicine. Physicians have also been given the chance to identify areas where improvements could be made in their own department. They are then provided with the knowledge, tools, and support they need to become engaged owners of these changes. Engagement has increased to 65% for physicians undertaking the PQI initiative.

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The Uptake of Technology in Long-term Care: Evaluation of Portable Bladder Scanners

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This project partnered the Thompson Region Division of Family Practice (TRDFP) Residential Care Initiative (RCI) with nursing professors from Thompson Rivers University (TRU) to evaluate the use of portable bladder scanners in several long-term care homes in Kamloops. Evidence related to the prevalence of urinary incontinence in long-term care home residents, associated poor outcomes, and complications arising from standard interventions supported the purchase of scanners to prevent hospital transfers and improve patient care.

Planning and knowledge use are key elements in addressing gaps, and research results may influence practice and policy changes. Therefore, we engaged researchers, stakeholders, and knowledge users in a roundtable prior to the evaluation. The aim was to increase understanding of the issues and gaps related to the implementation of bladder scanners and identify further research in the care of the elderly in long-term care settings.

Following the research roundtable event, we invited staff at six participating care homes to complete a demographic questionnaire and a bladder care knowledge survey, and to participate in a focus group discussion. We engaged 34 staff (registered nurses, licensed practical nurses, health care assistants, and registered practical nurses) in the evaluation.

The results indicate that the use of portable bladder scanners by long-term care home staff is affected by several factors. These include access, habit/routine, presenting symptoms of the patient, and physician orders. The level of comfort for using bladder scanners depends on knowledge, education, and training of staff. Deficits in bladder care knowledge were identified along the spectrum of care providers.

Increasing staff knowledge of bladder care and changing scopes of practice and care home policies will support the effective use of bladder scanners. Collaborative partnerships between TRDFP, TRU, Interior Health, and long-term care homes are essential to facilitating the change.

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Using Social Network Analysis to Measure Connections among Emergency Department Staff

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Social network analysis can be used to evaluate the structure of relationships and speed of communication. Practising emergency medicine in rural and isolated areas mean practitioners rely on strong communication and trust with colleagues in referral centres. The Kootenay Boundary Emergency Medicine Network project aims to use social network analyses to measure pre- and post changes in intercollegial connections between primary and secondary emergency department (ED) sites.

Each ED physician and nurse was asked to rate their level of connection with every other ED physician and nurse in the region, using an online survey. The survey data was then imported into Gephi, a social network mapping software tool. The survey response rate was 36.4% (n=55/151) and 151 nodes (individual people) and 2,687 edges (connections among those people) were identified. The average path length for the network was 1.77. The graph density was 0.12, indicating the Emergency Medicine Network was sparsely connected with room for improvement.

The baseline social network results were used to inform project activities to help improve connections between EDs. Activities included regular project meetings to discuss regional issues, a regional 2-day emergency medicine network gathering, and local team-building engagements where the baseline social network analysis was discussed. A follow-up social network analysis will be completed in late 2019 to determine changes in intercollegial connections at primary and secondary ED sites.

This presentation will cover social network analysis methods and the results of the follow-up. Lessons learned on using social network analyses in project work will also be presented, from engagement to making results meaningful to the survey respondents.

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Vancouver Island Thoracic Surgery Oncology Program Referral Project

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Inefficiencies in the transfer of patients between the initial abnormal CT scan, further diagnostics with specialists, and scheduling the surgery can create harmful delays in the treatment of lung cancer. This project aimed to encourage family physicians to direct their patients with abnormal CT scans of the lungs through a central pathway. The Vancouver Island Thoracic Surgery Oncology Program (VITOP) was launched to streamline the management of patients with lung cancer, involving thoracic surgeons, respirology, radiology, thoracic surgery office staff, medical and radiation oncology, ER doctors, and family practitioners.

The VITOP began on November 1, 2018, with the aim of seeing patients in as few as 10 to 14 days. Prior to the initiation of this pathway, patients sometimes waited as long as 6 to 8 weeks to be seen by a surgeon. An evaluation of the program is currently underway, measuring wait times and capturing where delays arise in the referral process. The next step of this project is to make it an island-wide process, bringing radiologists, respirologists, and GPs from up-island on board.

CREATING CONNECTIONS FOR HEALTH

RAPID FIRE PRESENTATIONS

A1
TECHNOLOGY & VIRTUAL CARE

Community Paramedicine Telehealth: Improving Access to Primary Care

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Launched in 2016, the community paramedicine program has grown to include 99 rural and remote communities, and over 120 community paramedics (CPs) across the province. The program involves CPs making scheduled visits to patients' homes, with the goal of improving access to health care in rural and remote BC.

In fall 2018, Dr Nancy Humber saw an opportunity to use both CPs and telehealth to improve access to primary care for patients living in Seton Portage and Gold Bridge. Around the same time, Dr Josh Greggain saw a similar opportunity for patients living in Boston Bar. Patients in all three communities faced barriers limiting their access to primary care, and both physicians recognized a gap that needed to be filled.

Plans to develop the project began in February 2019, when BC Emergency Health Services partnered with the Office of Virtual Health to begin a trial using the VirtualCare platform by Think Research, with the first telehealth visits being held in the beginning of July 2019. The concept involves a CP visiting the patient's home to facilitate a videoconference between the patient and their primary care provider. The CP is on hand to perform assessments, give reports, and relay information. The goal of the program is to reduce the need for the patient to enter the acute care system by increasing their access to primary care. Recognizing that many of these patients also have limited access to technology, the CP uses their laptop and phone to facilitate the visit—eliminating any technology barriers. To date, we have had over 50 successful CP telehealth visits, and interest in the program is growing around the province.

A1
TECHNOLOGY & VIRTUAL CARE

Data Integration Initiative on the Sunshine Coast: David & Goliath

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The Sunshine Coast is a small rural community with 37 family physicians across five medical clinics. Thirty-six of the 37 physicians have hospital privileges and have received privacy training. They work in areas such as emergency, acute services, and patient care, and in the Opioid Replacement Clinic. All five clinics used the Telus Med Access EMR.

The division initiated an innovation project to merge patient information from each of the five EMR databases into just one EMR. This data merger will enable physicians to access their patients' information regardless of where or when they are seen (ER, after hours, etc.). This project supports consistent seamless care by creating one community chart per patient whether they are receiving primary or complex care.

We are in the process of developing a "sandbox" environment with our working group and Telus. (The College recently granted us permission to proceed with the sandbox without requiring patient consent for this phase of the work.) The sandbox will allow us to test how the actual data merge will happen, what functionality might be needed, and which parts of a chart would be accessible. It will also help identify any issues with the merging process and enable the team to mitigate accordingly.

Our presentation will describe the journey of engagement with physicians, finding enablers such as a health technology manager we hired who could advocate with Telus, shifting from a vendor-client relationship to a collaboration model, and overcoming barriers (technology, human resources, clinic independence).

A2

COLLABORATIVE SOLUTIONS

MRI Appropriateness Checklist: Checking What Resonates with Family Physicians

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Reducing wait times and improving access to specialist services have been identified as priorities of the Canadian government—but long waits for specialists continue. In fact, in 2017, the Canadian Institute for Health Information reported wait times for both MRI and CT scans as continuing to increase.

In 2018, Providence Health Care, in partnership with the Shared Care Committee, began work to strengthen the interface between primary and specialist care to facilitate more timely access to these necessary services. Concurrently, Lower Mainland Medical Imaging (LMMI) was working on numerous projects to smooth waitlists and increase capacity for MRI studies. In an effort to ensure a collaborative approach that included input from family physicians (FPs), Providence Health Care partnered with LMMI to bring FPs to the discussion and design table.

The collective working group included FPs, radiologists, MOAs, and patients. LMMI contributed by working on a comprehensive, easy-to-use referral form and a process to ensure the MRI studies are ordered appropriately by referring physicians. The main areas of this collaborative work included FP feedback on the MRI referral form and input on the creation of an appropriateness checklist (ACL) to help clarify which patients are eligible for low-utility MRI scans for knee, hip, or lumbar spine. Other work included the addition of radiology expertise on the RACE line as a decision support tool. The next steps to coordinate medical imaging for patients include expanding the guidelines to further reduce low-utility studies of the shoulder and head.

We will share impacts of the collaborative process from the different perspectives and present the lessons learned from the PDSA cycles: what worked well and what required revision. As well, we will present the early results of the referral process and the ACL.

A2
COLLABORATIVE SOLUTIONS

Creating the Urgent Pediatric Access Clinic

Contact: Dr Jennifer Balfour | Pediatrician
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Pediatric patients and their families face challenges when they present at the ER, getting referred either to the on-call pediatrician or the community-based pediatrician's office. Either option can result in lengthy wait times and significant uncertainty for the family. Families sometimes return to the ER multiple times rather than risk the wait, resulting in overuse of ER services.

To address this problem, a group of pediatricians in the South Island created the Urgent Pediatric Access Clinic (UPAC), a designated facility and staff to address those patients who require follow-up within two weeks. Drawing on expertise and input from ER physicians, pediatricians, ER nurse clinicians, pediatric nurse clinicians, and family practice physicians, the group brainstormed what such a service would look like, and engaged with Island Health about logistics for the space and staff required for the clinic. UPAC has now been operating since January 2019, seeing an average of 10 to 12 patients a week.

The staff have received encouraging feedback from ER and pediatric clinicians, families, and residents. The clinic has also benefited undergraduate and postgraduate trainees who need to see patients in an environment where they can learn how to assess and manage common pediatric problems in order to be ready for practice.

In future, the group would like to guarantee the use of two rooms with greater overall space capacity, allowing them to assist patients and their families without overcrowding in the exam rooms. They will also continue to engage with family practice physicians to ensure that this effort assists, rather than adds to, or competes with, their work.

A2
COLLABORATIVE SOLUTIONS

Pre-hospital STEMI Thrombolysis: Paramedic Simulation Training for CHAMP

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Currently, patients who present to Royal Inland Hospital (RIH) with an acute ST-elevation myocardial infarction (STEMI) are not consistently meeting the recommended first medical contact to needle times. Pre-hospital administration of fibrinolytics has demonstrated reduced treatment times and improved clinical outcomes.

The Collaborative Heart Attack Management Program (CHAMP) involves implementing standard pre-hospital STEMI therapies in our local environment to appropriately selected patients. The aim is to demonstrate that these therapies can be safely used in the pre-hospital setting. This project involves a significant collaboration between BC Emergency Health Services (BCEHS) and Interior Health Authority to optimize STEMI care. This involved developing an evidence-based protocol for a pilot trial of 10 patients, and creating and delivering a STEMI recognition and management curriculum to BCEHS paramedics.

A virtual patient-simulation of the entire process from patient contact to transport to hospital was designed in collaboration with staff from the Interior Health Rae Fawcett Simulation Centre. Development of the program was financed in part through the PHSA/SSC Joint Collaborative Committee Health System Redesign funding. The paramedics, under direction from the CHAMP protocol, perform a relevant history and physical, and then record and transmit the patient's EKG to the on-call cardiologist at RIH. If thrombolysis is indicated, patient consent to treatment is reviewed. Thrombolysis is administered after patient consent. If consent is not provided, the patient is transported to the hospital as usual.

The CHAMP simulation and education session was recorded and is now available for future training. The program was evaluated as being positive and applicable, with 100% strongly agreeing that their experience with the program will impact the quality and safety of patient care.

A3
MATERNITY

Preterm Labour: Improving Diagnostic Evaluation in BC

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Two biochemical tests, fetal fibronectin (fFN) and Actim Partus (AP), are available to exclude preterm labour. Direct comparisons of these two tests with adequate sample sizes are lacking. fFN is the more expensive gold standard, but it is available only in core lab facilities in BC. Further, fFN results are required by BC Ambulance Services before transfer decision can be made.

On Vancouver Island, many pregnant women receive their antenatal care in rural areas. Turnaround time can be 3 to 4 hours, which introduces additional anxiety for physicians, patients, and family members. The AP is a bedside test that offers an effective solution.

We ran a pilot project to conduct a retrospective analysis to compare diagnostic accuracy of these tests in predicting preterm delivery in symptomatic women. Both the fFN test and bedside AP test were made available for allied health workers to use in patient care. We were able to identify 2911 cases with fFN and/or AP results.

We concluded that, individually, these tests have comparable negative predictive values in excluding preterm labour. Concurrent testing offers the highest, but insufficient, positive predictive values (PPV) of 24.2%. The net gain in PPV comes with 1% loss in NPV, when compared to either of individual test.

The project identified that AP is a faster, cheaper, and equally effective tool as fFN to allow rapid exclusion of preterm labour. The new algorithm we developed avoided fFN testing when AP was negative. Patients were assured at bedside, and the total number of fFN decreased by 35%. The estimated annual saving was $37 000.

This pilot project was successful in providing the appropriate test, but fFN results are still required before transferring a patient. Further discussions need to take place with a provincial scope.

A3

MATERNITY

A Journey into Collaborative Practice: A Shared Care Maternity Initiative

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Recognizing that maternity care on the Sunshine Coast would be in crisis due to low provider numbers, a group envisioned building a hard call system that would evolve into a collaborative practice model, operating in partnership with the local health authority.

The group of practitioners foresaw building a leadership model consisting of family practitioners and registered midwives as leads, working alongside obstetricians and engaging with other allied health and health authority representatives, and relevant stakeholders.

That vision has resulted in a group of six providers (four general practitioners and two registered midwives) working closely together, implementing group-run prenatal clinics in advance of implementing the collaborative model. The A-to-Z of providing perinatal and postnatal care have been, and continue to be, negotiated collaboratively. Systems for sharing billing, dissemination of provider information (website, a newspaper press release, pamphlets, rack cards, visits to local mom-and-baby groups), patient tracking (including due date tracking), advocating for training and SIM module opportunities, and prenatal care have been developed and continue to evolve as the group encounters new opportunities for shared learning.

The work of the committee has been enriched and guided by looking to and connecting with other communities on similar journeys. The result has been a collaborative model of practice for maternity care that embraces sensitivity, trust, relationship building, and a collective and dedicated shared vision for a community or population of care.

A3
MATERNITY

Making Maternity Care EASI (Effective and Seamlessly Integrated) for Patients and Providers

Contact: Dr Ashnoor Nagji | Physician Lead
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The EASI Maternity Care Project is a Vancouver-focused, multiphase project that is a collaborative undertaking between the Vancouver Division of Family Practice, BC Women's Hospital, and St. Paul's Hospital, with representation from Vancouver Coastal Health. Clinician and patient surveys, patient journey mapping, data, detailed experiences, and diverse perspectives have all informed our work, which focuses on responding to gaps in patient preparedness along the various stages of the maternity care journey.

The aim of the project is to create an online "one-stop-shop" maternity information hub for patients and providers based in Vancouver, with emphasis on meaningful engagement through the various stages of resource curation, platform development, and user experience design. The hub is being developing through an interprofessional and collaborative process, with appropriate content highlighted and relationships strengthened. This alignment of information benefits patients and providers alike, offering an accessible and effective platform that responds to a longstanding need within the maternity care system in Vancouver. Moreover, by curating from established repositories, the information hub aims to respond directly to the need for clear, consistent, and reliable information across the prenatal–postpartum spectrum.

The outcomes of this project align with the BC Quality Health Matrix. The value of this common goal has created much excitement for collaboration. With active engagement of institutions, leaders, providers, and a broad spectrum of voices, this online platform will go a long way to make maternity care EASI—effective and seamlessly integrated—for both patients and providers.

A4
SUBSTANCE USE

Fostering Connections through the Provincial Perinatal Substance Use Project

Contact: Sara Pavan | Evaluation Specialist
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Relationship building is central to planning and designing substance use treatment, services, and supports that rely on connections across sectors and disciplines. It is also crucial to meaningfully engage women with lived experience. In this presentation, we illustrate how relationship and partnership building play a key role in advancing the Provincial Perinatal Substance Use Project (PPSUP). The project is led by BC Women's Hospital and Health Centre with the goal of enhancing provincial capacity and services for pregnant and early parenting women using substances, and their infants.

PPSUP serves as a catalyst for bringing together provincial stakeholders across services and settings to inform system-wide planning and improvements in perinatal substance use. Through provincial and regional working groups, and the Provincial Steering Committee, the project engages over 175 stakeholders to support the development of a blueprint for a perinatal substance use continuum of care. Working group and committee members share their expertise in Indigenous cultural safety, clinical education, knowledge to practice experience, service delivery experience, and system planning. Additionally, insights from women with lived experience provide key inputs to the project. We show how connections made through the groups and the committee will strengthen the health care system by integrating perinatal and substance use practices, enhanced principled practice, and improved access to health care and health outcomes for mothers and babies.

A5

PATIENT MEDICAL HOME WORKSHOP

Patient Medical Home: Stories of Change in Action

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The Most Significant Change evaluation collects stories from across the province about the most significant changes people have experienced through their work with the patient medical home (PMH). The stories are real-life examples of how the PMH has impacted GPs, patients, and partners. They help animate the personal meaning and different perspectives on system change in primary care.

At this session, participants will learn and connect with experiences of others with PMH change across the province, share how they relate to impacts of PMH system change, and celebrate success and shared work to improve team-based care in BC.

B1

EMERGENCY CARE

Bridging Teams across Rural and Regional Emergency Departments

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Relationships are the core of any team to build collegiality and a cohesive approach to quality improvement (QI). Yet in geographically dispersed regions, the ability to meaningful connect to build these relationships can be challenging.

The Kootenay Boundary region has seven distinct emergency department teams—five rural and two regional centres—that rely on each other to provide comprehensive patient care. A well-linked regional emergency team spanning rural and secondary sites can respond to immediate patient needs in emergent situations, provide on-site support in rural locations until transport is needed, and give better direct point-to-point care. The building blocks of this team are relationship and communications grounded in quality care guidelines, knowledge translation, and streamlined processes.

Throughout this project, emergency medicine physician and nurse leaders across Kootenay Boundary region identified some complex problems. These related to communications and trust between primary and secondary sites for patient care pre-transport, transport decisions and patient repatriation, diagnosis-specific decision support, transport enhancement, and developing the interprofessional capacity of primary emergent care teams. The project leaders used the opportunity to bring the teams together to improve processes and protocols between sites for patient care transitions, which allowed for leveraging of QI to build a regional emergency medicine team. The success of the project was measured through social network analyses, process improvement metrics, and provider feedback (nurse, physician, BCAS, and HART teams).

This presentation will describe how to build teams through QI, demonstrate the value of collegiality across dispersed teams and the impact on patient transitions in care, and examine the shift in conflict management with established relationships in place.

B1

EMERGENCY CARE

Using Social Network Analysis to Measure Connections among Emergency Department Staff

Contact: Leila Dale | Quality Improvement Evaluator
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Social network analysis can be used to evaluate the structure of relationships and speed of communication. Practising emergency medicine in rural and isolated areas mean practitioners rely on strong communication and trust with colleagues in referral centres. The Kootenay Boundary Emergency Medicine Network project aims to use social network analyses to measure pre- and post changes in intercollegial connections between primary and secondary emergency department (ED) sites.

Each ED physician and nurse was asked to rate their level of connection with every other ED physician and nurse in the region, using an online survey. The survey data was then imported into Gephi, a social network mapping software tool. The survey response rate was 36.4% (n=55/151) and 151 nodes (individual people) and 2,687 edges (connections among those people) were identified. The average path length for the network was 1.77. The graph density was 0.12, indicating the Emergency Medicine Network was sparsely connected with room for improvement.

The baseline social network results were used to inform project activities to help improve connections between EDs. Activities included regular project meetings to discuss regional issues, a regional 2-day emergency medicine network gathering, and local team-building engagements where the baseline social network analysis was discussed. A follow-up social network analysis will be completed in late 2019 to determine changes in intercollegial connections at primary and secondary ED sites.

This presentation will cover social network analysis methods and the results of the follow-up. Lessons learned on using social network analyses in project work will also be presented, from engagement to making results meaningful to the survey respondents.

B1
EMERGENCY CARE

The BC Specialist Trauma Advisory Network: Optimizing Complex Trauma Care across BC

Contact: Dr David Evans | Medical Director, Trauma Services BC
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Trauma Services BC (TSBC) provides oversight and stewardship for the BC trauma system, which aims to assure that all severely injured patients across the province receive timely, appropriate, and effective care. TSBC was awarded SSC funding in 2016 to engage surgeons in the establishment of a network of specialist advisory groups to guide, evaluate, and monitor the management of key major injuries that pose a particular challenge in connecting patients to timely definitive care. An ongoing endeavour, the BC Specialist Trauma Advisory Network (STAN) has emerged as a useful innovation to streamline the patient trajectory, assist providers, reduce practice variation, optimize care quality, and report on performance.

Currently, specialist advisory groups (SAGs) have been established for general surgery, orthopedic surgery, spine surgery, plastic surgery, pediatric trauma and radiology—and additional groups are planned. The SAGs have rigorously developed a process to generate evidence-based, consensus-driven provincially applicable clinical practice guidelines to manage select key injury groups that constitute complex trauma. Wide participation from specialists in all health authorities has been sought.

Supplementing the clinical practice guidelines are destination guidelines indicating the preferred referral pattern for key injuries requiring specialist attention, and performance reporting using a suite of predefined indicators that are meaningful to the specialist groups. With support from TSBC, STAN engages specialists in ongoing improvement of the provincial trauma system in a manner that is self-sustaining and meaningful to all stakeholders.

This network of regionally representative specialist advisory groups generates important secondary value as well. The clinical practice guidelines provide important references for CME and quality assurance work, assist BC Emergency Health Services in directing and prioritizing the movement of major trauma patients, and will help TSBC bring improved governance and accountability to the management of the organized injury care in BC.

B2
OLDER ADULTS

Improving Communication, Patient Access, and Shared Care Ideals to Better Coordinate Care for Older Adults

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Communication between specialists and family physicians can be challenging. Family physicians face difficulties with information flow from specialists and subsequent updating of patient records in a timely manner. It can also be unclear what information specialists would like to receive from family physicians when medication changes are made.

To address these challenges, we intend to trial a mentoring program in the Thompson Region. Specialists and family physicians will engage in care coordination of older adults by exploring the idea of shared decision making between the specialist, family physician, and patient.

The intention is that an internal medicine specialist will come into a family practice to collaborate on the diagnosis, assessment and treatment of patients in the context of the family physicians' office. Internists were selected as they are an engaged group able to consult on older adults with multiple chronic comorbidities.

One of the desired outcomes is an enhanced understanding of the internist's medical management decisions. Joint appointments can ensure that both providers and the patient agree on the care plan, and that the medication record on the patient's profile is updated in a timely manner after the specialist consult. A major intended benefit is education for the family physician to apply to other patients.

This trial is in the planning phase, but family physicians and internal medicine specialists have expressed interest. Potential barriers may be capacity, buy-in from family physicians, and concerns about patient access. However, this opportunity should better prepare participating family physicians to care for older adults as they can apply what they learn to future cases.

The project is funded by Shared Care under the Coordinating Complex Care for Older Adults initiative. It aligns with several patient medical home service attributes and primary care network principles. We hope to begin the trial in November.

B2
OLDER ADULTS

Coordinating Care: What GPs and Specialists Really Think about One Another

Contact: Rachel Schmidt | Project Manager
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In medicine, relationships with self, with other doctors, and with patients are crucial to provider well-being and patient care. Finding ways to break down and explore the unwritten codes that guide those relationships, and refocusing both GPs and specialists on best practices, is critical to providing high-quality care for medically complex older adults now and in the future.

The Kootenay Boundary GP/SP Consult Optimization Project taught us a great deal about relationships between GPs and specialists. This project approach and methodologies used to understand physician culture—and how that culture informs the GP-specialist relationship—resulted in a collection of knowledge not commonly discussed, but of fundamental importance as physicians constantly make use of it to generate behavior and interpret experience.

This session will share data gathered from a group of GPs and specialists committed to better understanding themselves and one another, and who used their collective intelligence to improve the consultative process and care coordination for patients living in Kootenay Boundary. Several themes will be unpacked and explored, including gender and geographic patterns to referrals and consults, "tit-for-tat" behaviour, walking a mile in each other's shoes, and the fundamental importance of civility.

B2
OLDER ADULTS

The Uptake of Technology in Long-term Care: Evaluation of Portable Bladder Scanners

Contact: Melanie Todd | Project Lead
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This project partnered the Thompson Region Division of Family Practice (TRDFP) Residential Care Initiative (RCI) with nursing professors from Thompson Rivers University (TRU) to evaluate the use of portable bladder scanners in several long-term care homes in Kamloops. Evidence related to the prevalence of urinary incontinence in long-term care home residents, associated poor outcomes, and complications arising from standard interventions supported the purchase of scanners to prevent hospital transfers and improve patient care.

Planning and knowledge use are key elements in addressing gaps, and research results may influence practice and policy changes. Therefore, we engaged researchers, stakeholders, and knowledge users in a roundtable prior to the evaluation. The aim was to increase understanding of the issues and gaps related to the implementation of bladder scanners and identify further research in the care of the elderly in long-term care settings.

Following the research roundtable event, we invited staff at six participating care homes to complete a demographic questionnaire and a bladder care knowledge survey, and to participate in a focus group discussion. We engaged 34 staff (registered nurses, licensed practical nurses, health care assistants, and registered practical nurses) in the evaluation.

The results indicate that the use of portable bladder scanners by long-term care home staff is affected by several factors. These include access, habit/routine, presenting symptoms of the patient, and physician orders. The level of comfort for using bladder scanners depends on knowledge, education, and training of staff. Deficits in bladder care knowledge were identified along the spectrum of care providers.

Increasing staff knowledge of bladder care and changing scopes of practice and care home policies will support the effective use of bladder scanners. Collaborative partnerships between TRDFP, TRU, Interior Health, and long-term care homes are essential to facilitating the change.

B3
HEALTHY RELATIONSHIPS

Engaging Hospitalists in Participating in the Vested Process in South Island

Contact: Dr Ken Smith | Hospitalist
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Negotiating new contracts is often a complex endeavor, particularly when parties have had a challenging relationship in the past. This was particularly true in the contract negotiations between the Victoria Hospitalist Service and Island Health, which had stalled during 2014 and 2015, reaching an all-time low in March 2015 when the interim contract had expired and nothing had been agreed upon to replace it. It was at then that Kim Kerrone, Island Health's vice-president, chief financial officer, became familiar with Vested, a novel methodology to guide contract discussions.

Vested focuses on building relationships between parties rather than the more traditional transactional negotiation. The Victoria hospitalists and Island Health agreed to use the Vested methodology to rebuild trust and establish the groundwork for a new contract negotiation. Not only was this the first time the Vested methodology was used within Island Health, it was also the first time it was used with a physician contract anywhere in BC and Canada.

No matter how promising the methodology, having hospitalist physicians attend the Vested team meetings on their days off was essential to success. To address this challenge, this project sought to compensate numerous hospitalists to regularly attend the meetings. The funding ensured regular hospitalist attendance at meetings (three to five per month) of the five different Vested teams (Governance, Excellence, Best Value, Sustainability, and Relationship). Their attendance led to improved communication, relationship building, and idea sharing. As hospitalists participated, others came to see the value of attending these meetings.

As a result of these collaborations, a new hospitalist contract was signed and physician-administration relationships significantly improved. In addition to cementing the new contract, the negotiations gave rise to several new quality improvement ideas which have subsequently been generated within the hospitalist team.

B3

HEALTHY RELATIONSHIPS

Strategies to Engage and Empower Healthier Physicians

Contact: Dr Karen Dallas | Medical Director, Hematopathology & Transfusion Medicine, PQI Physician Advisor
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Physician engagement is a key factor in physician health and well-being. Engagement is also an important component of any health care system that wishes to make adaptive and meaningful changes.

The Specialist Services Committee (SCC) sought to confront disengagement, improve culture, and counter physician burnout by bringing physicians back to the table through two initiatives: Facility Engagement (FE) and Physician Quality Improvement (PQI). Both aim to support physicians to develop a meaningful voice and to engage in making meaningful change.

These initiatives provide funding to support activities that strengthen relationships and communication between physicians and health authority leaders with the aim of improving physicians' work environment, their involvement in decision making, and their ability to provide better patient care. Structures and financial resources are provided to support physicians to address issues and participate in activities at their site.

The SSC also partnered with health authorities to develop an approach to get physicians involved in quality improvement, which organically became a powerful tool for engagement. This bottom-up approach of supporting physician-led quality improvement projects has ignited an inner passion within the physician community. Each health authority has committed to support greater engagement and collaboration with physicians. Over 75 different medical staff associations are now involved province-wide. Although the approach is different from facility to facility, physicians are feeling the culture change. From 2017 to 2018, there was a 10% increase provincially in physicians' overall feeling of satisfaction with their organization as a place to practise medicine. Physicians have also been given the chance to identify areas where improvements could be made in their own department. They are then provided with the knowledge, tools, and support they need to become engaged owners of these changes. Engagement has increased to 65% for physicians undertaking the PQI initiative.

B4
MENTAL HEALTH

Rural MHSU Care: Challenges and Opportunities for New Models and the Sharing of Care

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Dialogue with rural and remote communities comprising the Northern Gulf Islands of Vancouver Island and the northwestern community of Gold River revealed a need for enhanced support for practitioners and community members in the delivery of mental health and substance use (MHSU) services. Identified gaps were lack of timely access and coordinated care resulting in worsening conditions and/or fatality; MHSU not being part of the primary care system; rural cultural and socioeconomic factors negatively impacting patient willingness and ability to access care; navigating the system being extremely challenging; and lack of social support services.

As a result, three divisions of family practice collaborated on a Shared Care project to 1) build a team-based, integrated, and longitudinal model of care (shared care) that engages family physicians, psychiatrists, health authority MHSU staff and hospitals as partners in care; 2) improve patient access, coordination, quality of care, and the ability to navigate the system, and 3) support the development of community-level engagement and capacity building to address social determinants of health and other factors impacting MHSU. Two models of care were developed, one of which used virtual care for the team.

There were many lessons learned, including the importance of a shared language and the understanding that relationships take time and are the key to enhancing services. Community capacity building is challenging given the complexity of rural and remote needs and uniqueness of each community. Involving community members from various services and agencies is essential to increase the utilization of services already in place and to consider the development of new supports.

B4
MENTAL HEALTH

Developing an Early Psychosis Order Set

Contact: Dr Daniel Boston | Psychiatrist
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Clinical order sets (COS) guide the treatment of specific conditions when patients enter the hospital. However, until recently, there was no specific COS to guide the care of first episode psychosis. The first time a person experiences psychosis can be a challenging, frightening time. The care they receive during this episode can set the stage for all future engagements with the mental health care system, underscoring the importance of developing a detailed, evidence-based COS for treating these patients.

The project involved coordinating a series of meetings to develop the COS, drawing on insights and expertise from physicians, managers, nurses, occupational therapists, and administration. The team worked to ensure the COS was well tailored to the clinical realities of these patients. Details included specifying which health indicators would be collected at baseline, determining which medications would go on the order set, and addressing the needs of specific patients, such as those diagnosed with schizophrenia or bipolar spectrum disorders, or substance-induced psychosis.

After four different iterations, the final COS has been implemented and is showing positive results. Not only was use of the COS associated with an 11.4% decrease in total polypharmacy use, it was also associated with a 10.8% decrease in the length of stay, from 20.3 days to 18.1 days. Next steps include ensuring that the COS is used in 100% of first episode psychosis admissions and getting it uploaded to facilitate computerized point of entry.

B4
MENTAL HEALTH

Improving Mental Health Supports for Children and Youth on the Sunshine Coast: It Takes a Village

Contact: Susan Papadionissiou | Executive Director
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Building on the experience of the Child and Youth Mental Health and Substance Use (CYMHSU) Local Action Team, the Sunshine Coast identified mental health supports for children and youth as a priority for their patient medical home initiative. Over 15 months, the working group defined gaps and co-designed solutions to lesson those gaps in mental health supports.

The group implemented specific processes: Beginning with an appreciative inquiry approach, stakeholders (physicians in clinics and hospital, VCH mental health team, school, Ministry of Family of Children and Family Development) were asked to define assets, barriers, and improvements. Research and development was carried out to learn from other divisions and communities. A small task group of stakeholder representatives was convened to co-design multiple solutions and responses. The group hosted an Adverse Childhood Experiences workshop for all stakeholders, which was developed and delivered by physicians, in order to create a common reference point. Multiple supports and changes in the continuum of mental health supports were co-designed.

The results include a resource guide targeted at all providers; psychiatrist youth clinic/outreach; a half-day workshop with all stakeholders, entitled Equalizing Knowledge; Doc in School in two secondary schools, and improved relationships and communication pathways for all providers.

While our original focus was to develop wraparound services and a team, that wasn't possible, but we persevered to create alternatives that still improved supports for children and youth.

B5

THE PATIENT AND FAMILY JOURNEY

Listening First: Supporting Heart Failure Patients and Their Families

Contact: Dr Daisy Dulay | Cardiologist
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"Rollercoaster" describes the course for advanced heart failure: multiple exacerbations of symptoms with each recovery returning to an ever-lower baseline. As the patient gets sicker, their quality of life worsens with increasing symptoms, visits to the emergency room, and hospitalizations. Challenges with prognostication and clear communication to the patient and their circle of care make for a bumpy transition from aggressive care to a palliative or symptom-focused approach.

The limited capacity of services in Victoria, including the Heart Function Clinic and the Home Health Monitoring Program, means that these services aren't available to everyone. Additionally, the services have tended to focus more upstream and not on supporting patients in the final stages of heart failure. To increase supportive care for these people, the Supportive Cardiology Project adopted a two-phase approach, with phase one anchored in patient journey mapping to identify 1) gaps in resources and services, and 2) current resources and services providing positive impact.

Prior to mapping the patient perspective, the stakeholders—including a variety of health care providers—attempted to map the journey from a clinical perspective. Questions arose: How well defined was the care pathway? Would patient journey mapping be easy or problematic? The fact that subject matter experts (SMEs) had difficulties even approximating the clinical pathway foretold trouble ahead.

To accommodate the frail cardiac patients, one-on-one interviews at the patients' homes were chosen over group sessions. The SMEs helped formulate questions to standardize the interview process but not impede or restrict patient stories. Overlaid on four-part grids (self-management, events, symptoms, comorbidity management) and highlighted by descriptions of feelings and quotes, the majority of patient journeys were visualized.

After studying and correlating the issues from both patient journey and clinical pathway mapping, phase two work will be undertaken to enhance support for patients with heart failure and their families.

B5
THE PATIENT AND FAMILY JOURNEY

Open Conversations in Palliative Care

Contact: Dr Greg Andreas | Physician Lead
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The East Kootenay Shared Care Palliative Team wonders what palliative care could look like if we connected with patients, caregivers, and other providers about what it means to live our very best life story. What would it mean if we connected meaningfully with the past, the now, and planned together for the future? Who is that person we call patient, caregiver, or health care professional? How could learning more about who they are as individuals support how we communicate and contextualize their evolving frailty or disease, particularly at the end of life?

Community-based palliative health care teams come together to talk about this concept over supper. The challenging work of palliative care is acknowledged and celebrated. A family member of a person who had died in the community talks about their experience of the end of life of their loved one. The story and the person are acknowledged without being discussed further. The caregiver’s story acts as a powerful catalyst for holding the focus of the participants hearing the story. The remainder of the evening focuses on facilitated discussions.

The discussions further support each participant’s awareness of the importance of taking time for curiosity, empathy, and important conversations. Emphasis is placed on the importance of the community working together.

Our intention is to create a palliative care culture shift in our communities. The evaluations of the evenings have been very good, with participants expressing enthusiasm and willingness to change their practice. However, it is challenging to meaningfully measure a shift in culture. We are part of each other’s stories. How we choose to see others will impact the care we deliver, the teams we develop, and the culture of the community. Until it’s our turn, let us be a part of someone else” best possible last chapter.

B5

THE PATIENT AND FAMILY JOURNEY

The MedWatch Program: A Collaborative Approach to Ensure First Responder Access to Advance Care Plans

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First Responders often find it challenging to gather crucial patient medical information. The MedWatch Program and form were created to ensure that vital medical information is available to first responders when responding to an emergency call.

The MedWatch Program is a community-wide partnership of the Langley Division of Family Practice, Langley physicians, Langley Memorial Hospital Emergency Department, local first responders and seniors' residences. The idea stemmed from a Township of Langley Fire Department firefighter, who felt that having access to this information when answering an emergency call made a first responders' job easier, while enabling patients' health care wishes to be honored. Partnering with the division, and using the existing Fraser Health Authority Greensleeves initiative, the MedWatch program and form were developed.

The development of the MedWatch Form, in combination with the use of green stickers, was vital for First Responders to be able to locate vital information, but also for patients to keep their medical history together in one place. Seniors advised they did not keep their Greensleeve on the fridge because they did not want this information available for others to see. This concern led to the idea of placing a sticker on the drawer or cupboard where the information was being kept and a second sticker on the entry door notifying First Responders that the patient is a part of the program. Training and education continue to be presented to Physicians and Nurse Practitioners, Medical Office Assistants, First Responders and community groups. In addition to the MedWatch form, Greensleeves contain Advanced Care Plan documents (MOST and NO CPR), a representation agreement, and a current list of the patients' medications. Community education sessions help guide seniors through the importance of having a decision-maker if unable to speak on their own behalf, and on having a dialogue with their primary care provider on their health care wishes. Over 126 presentations have been completed throughout Langley, including some directly to Public Educators from the Lower Mainland and Vancouver Island with the goal of spreading the program to additional communities.

C1

CONTINUITY OF CARE

Pathways Referral Tracker: An Innovative Approach to Improving Referrals for Patients and Providers

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After identifying a common problem experienced by both family physicians and specialists—that being not having easy access to information about the status of patient referrals—the White Rock–South Surrey Division of Family Practice worked collaboratively with Pathways to identify a technical solution. Pain points in the referral process included challenges with clinics contacting each other, not knowing if documentation or even the referrals themselves were received, and the question of responsibility for notifying patients. Clearly a solution that solved these pain points for family physicians and specialists was required.

The Pathways Referral Tracker introduces a common dashboard to both GPs and specialists where each can see the status of a referral in real time. Very specific status updates are provided, including referral received, patient wait-listed, appointment made, appointment confirmed, patient seen, and referral closed. Patients are also automatically sent electronic notifications when they are wait-listed or have an appointment booked, along with appointment reminders. Patient instructions are automatically included in these notifications, populated from the specialist's existing Pathways profile. Family physicians and specialists can also send electronic messages to each other securely through the dashboard.

The initial results from the pilot community of White Rock–South Surrey are based on thousands of referrals already sent through the platform. Those results indicate that time to acknowledge referrals has dropped from what was, in many cases, several weeks to an average of only 48 hours. Sixty-nine percent of patients are choosing to accept electronic notifications of their appointments (via email or SMS), significantly reducing time spent by MOAs notifying and reminding patients of these appointments. The average no-show rate for specialist appointments has been halved from 5% to 2.5%.

C1

CONTINUITY OF CARE

How Patient Summaries are Bridging Transitions in Care

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As family physicians have given up hospital privileges, concurrent with an increase in hospitalist-based care in urban settings, there has been an erosion of communication between acute and community providers. While hospitalization notification systems may exist, these alone do not create the conditions for providers to collaborate. For instance, in hospitalist models, physicians providing inpatient services do not have access to longitudinal primary care information that is essential to understanding a patient's medical history, social circumstances, and current concerns.

A seemingly straightforward solution is to have family physicians provide a summary to the hospital. As our experience in urban Victoria has shown, however, this is anything but simple! Starting in 2015, using a quality improvement process, we worked to develop better care continuity through two change processes. The first was a systems change to identify barriers to information transfer and implement improvements to information flow. The second was a change management process focused on reducing the fragmentation between community and acute care, including helping GPs understand the value of their information beyond local uses, and helping hospital clinicians realize the benefits of longitudinal information for planning.

Our presentation documents the many steps required for this simple solution, emphasizing the need for strong partnerships and a shared vision. Our lessons learned will be of interest to those working on patient medical homes/primary care networks, as they demonstrate the complexities of coordinating across sites to enable continuity. The project is an example of collaboration across jurisdictions, where each achievement builds momentum for further success.

The presentation will report on analyses of administrative data, surveys, and interviews with participants. We will discuss the implications of these findings in terms of provider satisfaction and impacts on patient care weighed against the increased workload required to prepare and transmit information.

C1
CONTINUITY OF CARE

How a Collaborative AED (Automated External Defibrillator) Project is Benefiting Heart Patients

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Sometimes the cause of an out-of-hospital cardiac arrest (OHCA) for patients who survive and are admitted to the coronary care unit is not immediately clear. Having the information from the automated external defibrillator (AED), if used, can provide clues about the cause, particularly when the cardiac arrest is not related to a heart attack. It also allows for timely management and investigation decisions, and it permits staff to focus on patient care rather than chasing down the information (which, if successful, would often take days).

In a small retrospective review, initially the team was getting only 50% of the information for OHCA prior to implementing a formal protocol. In Phase 1, the CCU charge nurse, quality project analyst, and a cardiologist worked collaboratively with BC Emergency Health Services (BCEHS) to develop a notification process. From November 2018 to February 2019, the access to the AED information improved to 80%. Over that time, it was noticed that OCHA patients were attended by firefighters first in many cases.

Phase 2 of the AED project began with a focus on fire services. Unlike BCEHS, which is a provincial body, working with fire services meant working with individual municipal fire departments. This led to an engagement event with local fire departments and then a subsequent invitation to the Provincial Fire Chiefs Education Summit in Penticton to explain why obtaining the AED information is part of the patient record and vital for the ongoing care of the patient in hospital.

Currently, nearly 78% of AED information is being obtained within 24 hours, exceeding our original goal of 80% being obtained within 48 hours. But as publicly owned AEDs become ever more ubiquitous, the process of getting the AED information is more difficult. The download process of AED is vendor dependent; there is no universal download method. Our project highlights the challenge of getting AED information when they are owned by public entities or private citizens or businesses. Sustainability and spread has been a focus as well; there is interest from cardiologists from Kelowna and Vancouver who want to implement the changes that the Heart Health team at Island Health worked on with the local fire services and BCEHS.

This project also illustrates the collaboration with first responders and Heart Health team with the common goal to provide the patient the best possible care efficiently.

C2
CULTURE CHANGE

Royal Inland Hospital Physician Performance Enhancement Project
(also being presented at the Quality Forum)

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Historically emergency department (ED) physicians have received little or no feedback on their performance. The Physician Performance Improvement Project (PPIP) in the Kamloops Royal Inland Hospital ED piloted a set of tools for self, peer, and patient assessment in partnership with the Medical Council of Canada 360 Program (MCC360). Once physicians received their individualized feedback, they met with a physician mentor and developed a self-learning plan.

The project aimed to ensure that 80% of ED physicians working in the Royal Inland ED participated in physician performance improvement by April 30, 2019. The intent was to demonstrate how feedback from patients and colleagues can improve patient care and ignite opportunities for learning. Qualitative assessment of physician performance was collected from self-assessment, peer assessment (physician colleagues and non physician co-workers), and patients. The pilot used an evidenced-based program developed by the Medical Council.

Each physician completed a self-assessment, then received anonymous assessments from 16 peers and 25 patients. Feedback data were collected and analyzed by MCC360, and then shared only with the individual physician. The physicians were provided with the data to review with a mentor they chose from physician colleagues. The review allowed the physicians to develop a self-learning plan to identify areas of improvement with progress to be assessed with their mentor at 6 months and 1 year.

A confidential online survey of participants assessed the perceived value of this pilot project. One hundred percent indicated they saw value in the Physician Performance Improvement Project and that it positively impacted the quality of patient care. Planning is underway with Interior Health to cycle this project out across other EDs within the region in a way that will maintain the value of the methodology while enabling customization to local contexts.

C2

CULTURE CHANGE

A Road Map to Shifting the Quality Culture

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What is a “culture of quality improvement”? That term is now being widely used to describe a culture of continuous measurement and feedback on health care. This change movement provides a systematic approach to improving health services and the quality of care and outcomes for patients.

The Specialist Services Committee partnered with six health authorities to develop an approach to engage physicians and work toward a culture of quality improvement. This session will describe the journey of establishing a provincial initiative where leaders have moved away from a traditional top-down approach and have engaged front-line physicians and staff in problem solving. This initiative gives physicians the chance to identify areas where quality improvement could be made in their own department, and then provides them with the knowledge, tools, and support they need to become engaged owners of these changes.

A robust program is underway across the province, working toward the tipping point for culture change. More than 500 physicians have received training with over 180 projects underway. This session will comprise of rapid fire presentations on three quality improvement projects undertaken within the initiative.

C3

PRIMARY CARE NETWORKS

Rural Citizen-Patient-Community Priorities for Health Care: Findings from a Provincial Survey *(also being presented at the Quality Forum)*

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Over the past decade, British Columbia has increasingly recognized the importance of patient involvement in health care and, more recently, has codified this as a strategic priority through the British Columbia Patient-Centred Care Framework. Although the framework focuses primarily on patient involvement in their own care, it also invites "patients, families and caregivers ... to participate in: quality improvement and health care redesign."

The BC SUPPORT Unit and the Rural Coordination Centre of BC funded the Centre for Rural Health Research to engage rural communities in defining their evidence needs and determining priorities for scoping reviews through a rural lens. To inform this process, we engaged 182 communities in survey research and follow-up telephone interviews: 1476 rural citizen patients responded to the survey from 200 rural communities in the province. The average age of respondent was 52 years (range 16–89), and the average length of time lived in the community was 21 years (range 1 month to 83 years). Prioritized concerns included access to rural health services, difficulty traveling for care, and the holistic consequences of lack of local care. Suggestions included improving both local capacity and access to care in referral centres (transportation).

In keeping with the provincial mandate of patient-centred care and citizen-patient involvement in health care decision making, findings from the survey provide a framework for actualizing rural community voices in health planning. There are opportunities to create meaningful structures to ensure these voices are well represented through the primary care network infrastructure.

In this presentation, we will discuss international models of citizen-patient-community involvement in health care decision making and characteristics of these models that align with BC's priorities, including discrete recommendations for Indigenous-specific rural health councils based on successes in other jurisdictions. We will end with suggestions for an accountability framework and a method of evaluating of the efficacy of local health care initiatives as part of primary care networks.

C3
PRIMARY CARE NETWORKS

Physician Networks: Improving Physician Satisfaction and Patient Care, One Network at a Time

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Maple Ridge and Pitt Meadow's Primary Care Network Vision includes a "physician networks" strategy that allows physicians to foster subspecialties in patient care. Informal networks of physicians developing a subspecialty in the areas of long-term care and child and youth mental health/substance use already existed. The division identified the need to formalize networks to spread the success being realized through these existing informal networks to other patient populations.

In consultation with the GPs, a framework was designed for the network model, and the overarching purpose and goal were agreed to. Projects involving networks of physicians, community partners and patients have been initiated in four priority patient populations: Adult Mental Health & Addictions, Women's Health, Male Health, Chronic Pain, Seniors, Maternity, Child & Youth and End of Life.

The purpose of the networks is to bring family physicians, specialists, and community partners together around a patient care or physician improvement need, and then work toward developing creative, innovative solutions. These solutions will improve physician satisfaction and patient health care outcomes, which will ultimately result in better quality of care, improved access, and attachment.

The goal is to create a physician network model that will assist with improving care and maximize available or future supports for physicians with colleagues who have shared patient interests. Shared experiences by physicians will allow for knowledge transfer and improve communication and understanding between physicians themselves as well as with other health care providers and community resource supports. Ultimately, patient care practice will improve, along with physician well-being.

Although all of projects have evaluation strategies attached to them, the best evidence of the success of the physician network model is through the GPs themselves, such as Dr Ursula Luitingh, who inspired the creation of the networks and now has a subspecialty in child and youth mental health and substance use.

C3
PRIMARY CARE NETWORKS

Creating an Integrated Health Service Plan for the Thompson Region

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Primary care networks are being developed across BC with leadership by local Divisions of Family Practice and health authorities. Dr Nelly Oelke, associate professor at UBC Okanagan, is following the Thompson Region Division of Family Practice and Interior Health's innovative approach to their health service planning journey through 2019 and early 2020.

An integrated health service plan represents a shared vision for our region involving input from health care partners and communities. Clear roles, responsibilities, and accountabilities are identified in the implementation and delivery of this comprehensive plan. Six key attributes considered as foundational building blocks in the development of the plan are that 1) the spectrum of care is considered, 2) patient medical homes and community health centres are networked, 3) subspecialties and specialists are integrated, 4) community health providers are networked, 5) planning is community built, and 6) decisions are data informed.

Recognizing that the process is as important as the goal, the Thompson Region wanted to engage stakeholders and provide opportunity to contribute data and expertise to the planning. The journey is summarized in five steps: 1) framing using the BC Health Quality Matrix 2, 2) selecting participants using the Collaborative Services Committee (CSC) to create a special task force with invited clinical and administrative experts as needed, and 3) collecting data and preparing background documents with high-level data summarized to show the current state of care with a look to the future or ideal state of care, 4) deliberative dialogue sessions with purposeful, facilitated discussions among stakeholders to achieve consensus on priorities and collectively make decisions using evidence and contextual experience, and 5) writing a health service plan, debriefing with partners, and defining implementation strategies for various aspects of the vision The goal is to implement purposeful change and achieve better health outcomes throughout our region.

C4

PAIN MANAGEMENT

North Shore Opioid and Chronic Pain Initiative
(also being presented at the Quality Forum)

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Members of the North Shore Division of Family Practice identified the opioid crisis and chronic pain management as a community priority in May 2017. An expression of interest was approved by the Shared Care Committee in February 2018, and full project funding was granted in June 2018.

The Opioid Crisis and Chronic Pain Initiative focused on providing education and support for patients and their clinicians with an eye toward sustainability in the community. The project was subdivided into three areas of focus. The first group organized education events on pain management and opioid use disorder management, and researched suboxone mentorship programs. The second group created a comprehensive list of chronic pain resources for physicians to access via Pathways. This group also collaborated with Pain BC to successfully pilot and evaluate a Gentle Movement Program by partnering with the North Vancouver Recreation and Culture Commission, who will continue to sustain this program. Finally, a chronic pain patient journey mapping session was held to guide the design and implementation of a chronic pain pathway communication tool (adapted from the Powell River Division of Family Practice) to be used in the emergency room and primary care provider offices.

Our evaluation strategies included education reports for the 87 physicians who attended learning sessions, and a PHQ-9, a functionality scale, and a qualitative analysis for the 30 participants of the gentle movement program. The greatest challenge came with recruiting participants for our pilot movement program. We switched our focus from being GP to patient-centred and noticed an immediate uptake in registration.

This initiative was a community effort and helped to foster new relationships between health care providers, community groups and patients that lead to an exceptional service outcome.

C4

PAIN MANAGEMENT

Establishing a New Pre-operative Pain Management Pathway for Hip Fracture Patients at Providence Health

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Approximately 300 patients arrive at Providence Health Care (PHC) with fractured hips every year. These patients typically receive intravenous opioids for preoperative pain control. This leads to delirium, decreased levels of consciousness, and other medical complications in this frail, elderly population—in-hospital mortality is high.

Evidence in the literature demonstrates if patients receive a femoral nerve block prior to surgery, their pain control is much improved, reducing their opioid consumption while they wait for surgery. Our QI project set out to develop and implement a pathway so that anesthesiologists could assess all hip fracture patients and perform a femoral nerve block (if appropriate) as soon as these patients were admitted. This required the teamwork of many health care providers: emergency medicine, orthopedics, anesthesiologists, internal medicine, and the acute pain service. Additionally, our emergency and ward nurses needed to be involved and aware of the nerve block pathway.

We have successfully begun to perform nerve blocks on many of our hip fracture patients early in their admission to hospital. We are assessing for decreases in opioid consumption and other complications. The pathway has now been implemented for 6 months and is gaining traction. We are currently doing an audit on all patients that have had hip fracture surgery at PHC to assess whether they received a preoperative nerve block and how this impacted their preoperative pain management. We have seen a steady increase in the percentage of hip fracture patients receiving nerve blocks since implementation. We continue to monitor how the new pathway is working for our patients using PDSA cycles, and changes are made as necessary. In future, we hope to spread this skill to our emergency physicians so even more patients can get a nerve block early in their admission to hospital when anesthesiologists are unavailable.

C5
CANCER/ONCOLOGY

Developing a Prostate Cancer Guideline for Primary Care: Formal Collaboration a Must

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Primary care providers in BC and Yukon seek concise, evidence-based knowledge to support their care of cancer patients. Continuum-based guidelines meet this need and are a growing resource published by BC Cancer's Provincial Primary Care Program (PPCP) in partnership with BC Guidelines and Protocols Advisory Committee (GPAC). These guidelines focus on cancer prevention, diagnosis, and follow-up care, and include algorithms and patient/provider resources.

Beginning in September 2017, these organizations collaborated to develop a Primary Care Prostate Cancer Guideline focused on the continuum of cancer care, including guidance for discussions on PSA testing. The process rolled out in several steps.

First, a working group was established and chaired by the PPCP provincial lead. Membership included two GPAC representatives (research analyst; consultant), two family physicians, a GP in oncology, a urologist, and two BC Cancer oncologists (medical; radiation). Work was supported by a writer-researcher and PPCP staff.

Meetings were held seven times over 24 months to finalize the BC guideline through an evidence-based guideline adaptation process. GPAC conducted an external review of the draft guideline seeking feedback from family physicians, specialists, and other stakeholders. One of the major lessons learned was that the guideline development would have benefited from earlier involvement and stronger connections with BC Cancer groups.

Now that the stakeholder review has been done, the guideline is being revised, and once approved by the Working Group, it will be submitted for approval by BC Cancer, GPAC, and the Medical Services Commission prior to publication.

As a result of experience gained through this project, the PPCP drafted a guideline approval framework detailing a development and consultation process to guide future efforts. This framework has been submitted to BC Cancer leadership and will be piloted through the development of an upcoming primary care guideline on lung cancer.

C5
CANCER/ONCOLOGY

BC Cancer Standardized Referral Process for Hepatocellular Cancer Patients

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Hepatocellular cancer (HCC) patients require multidisciplinary care due to the complexity of diagnosis and treatment, and coordinating care is challenging for patients in remote areas of the province. In BC, access to multidisciplinary care occurs with weekly provincial liver tumor rounds (LTR) to determine the most appropriate treatment strategies, but LTR was difficult to access due to procedural and timeliness factors.

Our goal was to streamline the referral process for BC Cancer HCC patients to LTR to ensure all can be evaluated for best treatment options, and to decrease time to treatment decisions and improve outcomes. Our aim was aim was to decrease turnaround time from referral to LTR review by 20%.

We began by mapping the current referral process. Patient process maps highlighted suboptimal turnaround time from LTR referral to review (14 days). Results from a provider survey indicated that key areas to address were unclear referral process and delays in presenting cases at LTR. We also focused on completeness of referral information.

Standardizing the referral process and revising the referral form helped improve the turnaround time (mean 5 days from referral to reporting). Additionally, the LTR report is now available on the electronic medical record. Another provider survey is being conducted to assess satisfaction and identify areas for further improvement.

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