
EDAC
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Howard’s “State of the Union”

An Ontario centric view of how we’re doing and a preview of our program



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Nothing to disclose?



"Whose idea was it that we give full disclosure?"

Overview

- Quick tour of the landscape in Ontario
- Today’s topics in context

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PROMISES, PROMISES
The Musical Comedy

Hallway Health Care: A System Under Strain

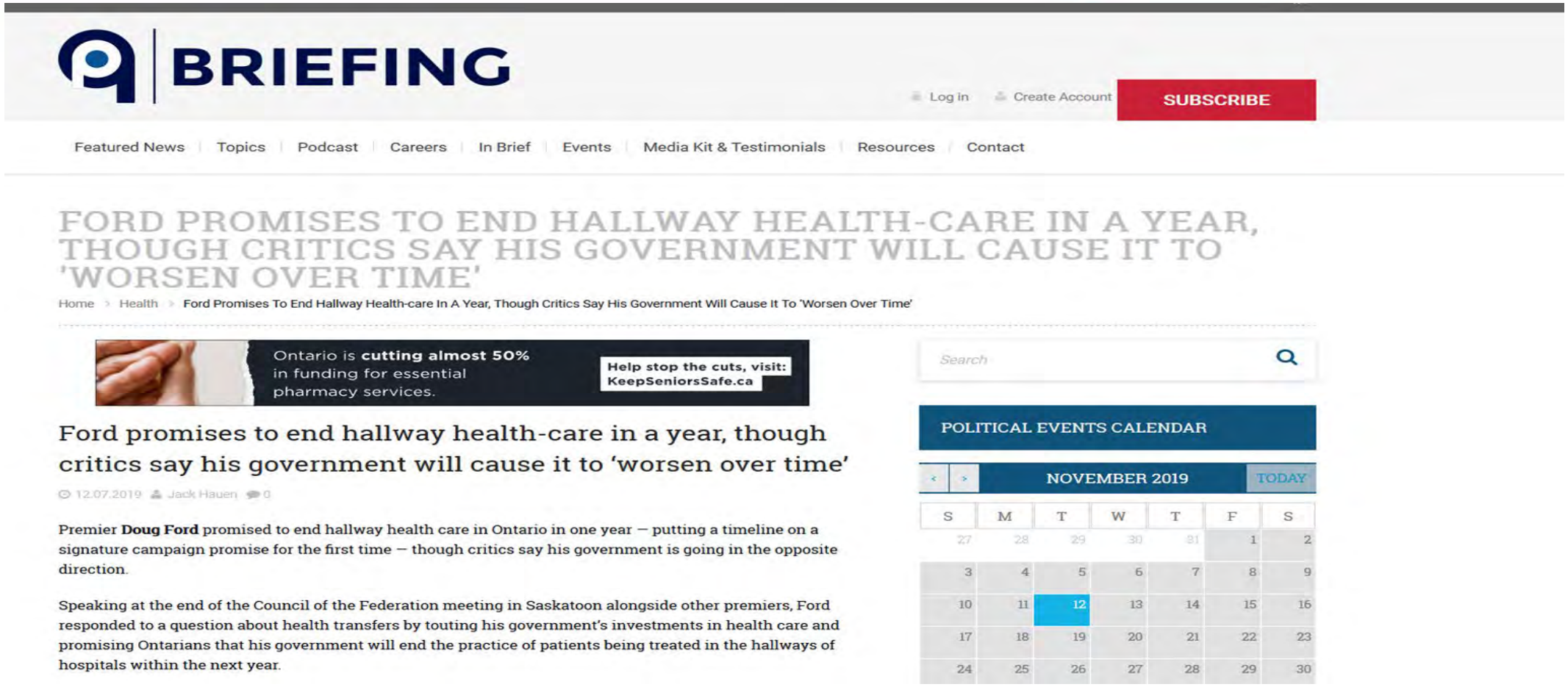
1st Interim Report from the Premier's Council on Improving Healthcare and Ending Hallway Medicine

January 2019

Ontario

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Promises made….



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FORD PROMISES TO END HALLWAY HEALTH-CARE IN A YEAR, THOUGH CRITICS SAY HIS GOVERNMENT WILL CAUSE IT TO 'WORSEN OVER TIME'

Home › Health › Ford Promises To End Hallway Health-care In A Year, Though Critics Say His Government Will Cause It To 'Worsen Over Time'

Ontario is **cutting almost 50%** in funding for essential pharmacy services.

Help stop the cuts, visit: KeepSeniorsSafe.ca

Ford promises to end hallway health-care in a year, though critics say his government will cause it to 'worsen over time'

12.07.2019 Jack Hauen 0

Premier **Doug Ford** promised to end hallway health care in Ontario in one year — putting a timeline on a signature campaign promise for the first time — though critics say his government is going in the opposite direction.

Speaking at the end of the Council of the Federation meeting in Saskatoon alongside other premiers, Ford responded to a question about health transfers by touting his government's investments in health care and promising Ontarians that his government will end the practice of patients being treated in the hallways of hospitals within the next year.

Search

POLITICAL EVENTS CALENDAR

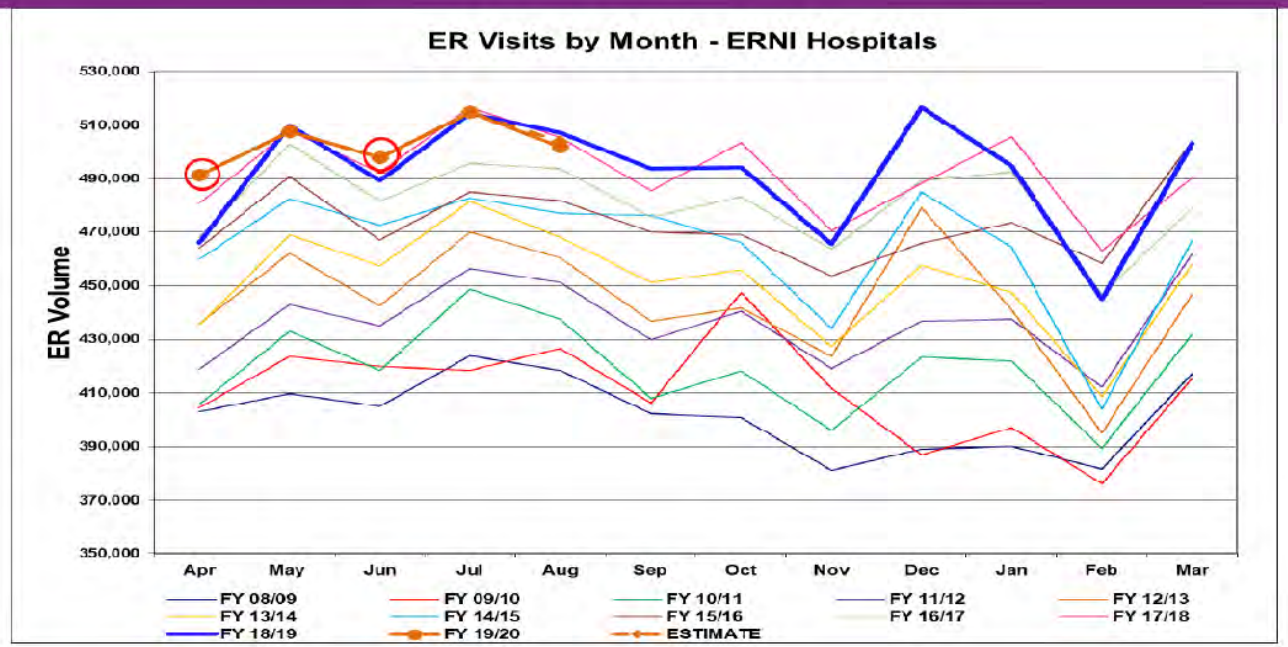
< > NOVEMBER 2019 TODAY

S	M	T	W	T	F	S
27	28	29	30	31	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

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Volume Growth/Pressure has eased

ED Volume Trend: August 2019 (since Baseline April 2008)



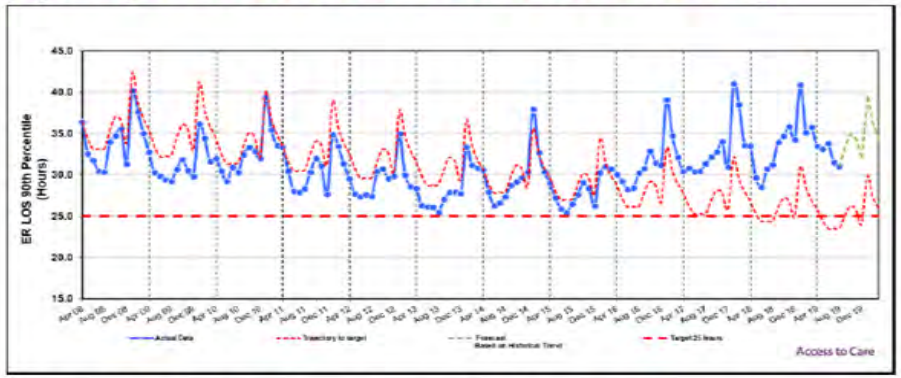
Record high for the month

Note: February 2012 and 2016 were 29 days long (leap year). In order to ensure comparability with previous February data, the volume was adjusted to reflect 28 days of data (i.e., the daily average volume was subtracted from the reported February 2012 volume of 29 days.)

Despite that flow is worsening

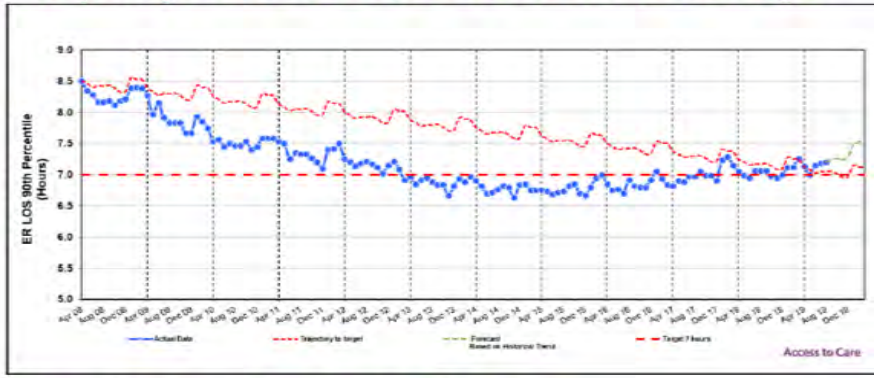
ED LOS Trend and Trajectory Analysis

Admitted ED Visits
Trajectory based on a 25 hour March 2020 internal target

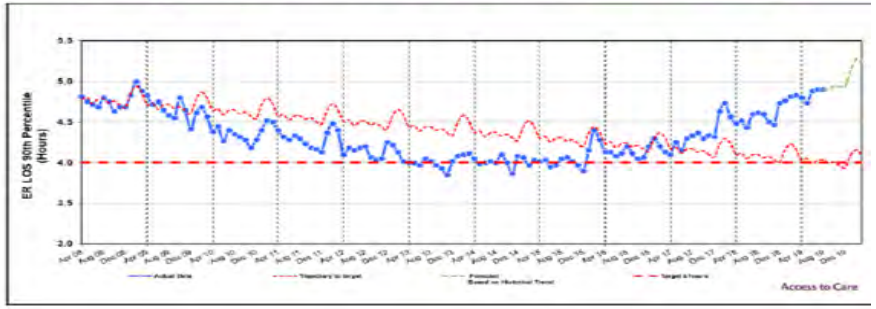


- August 2019 ED LOS for **admitted ED visits** (31.0 hours) decreased by 30 minutes compared to July 2019; August 2019 ED LOS was six hours and one minute above the internal target of 25 hours.
- August 2019 ED LOS for **non-admitted, high acuity ED visits** (7.2 hours) increased by one minute compared to July 2019; August 2019 ED LOS was 12 minutes above the internal target of 7 hours.
- August 2019 ED LOS for **non-admitted, low acuity ED visits** (4.9 hours) remained the same compared to July 2019; August 2019 ED LOS was 54 minutes above the internal target of 4 hours.

Non-Admitted, High Acuity ED Visits
Trajectory based on a 7 hour March 2020 internal target



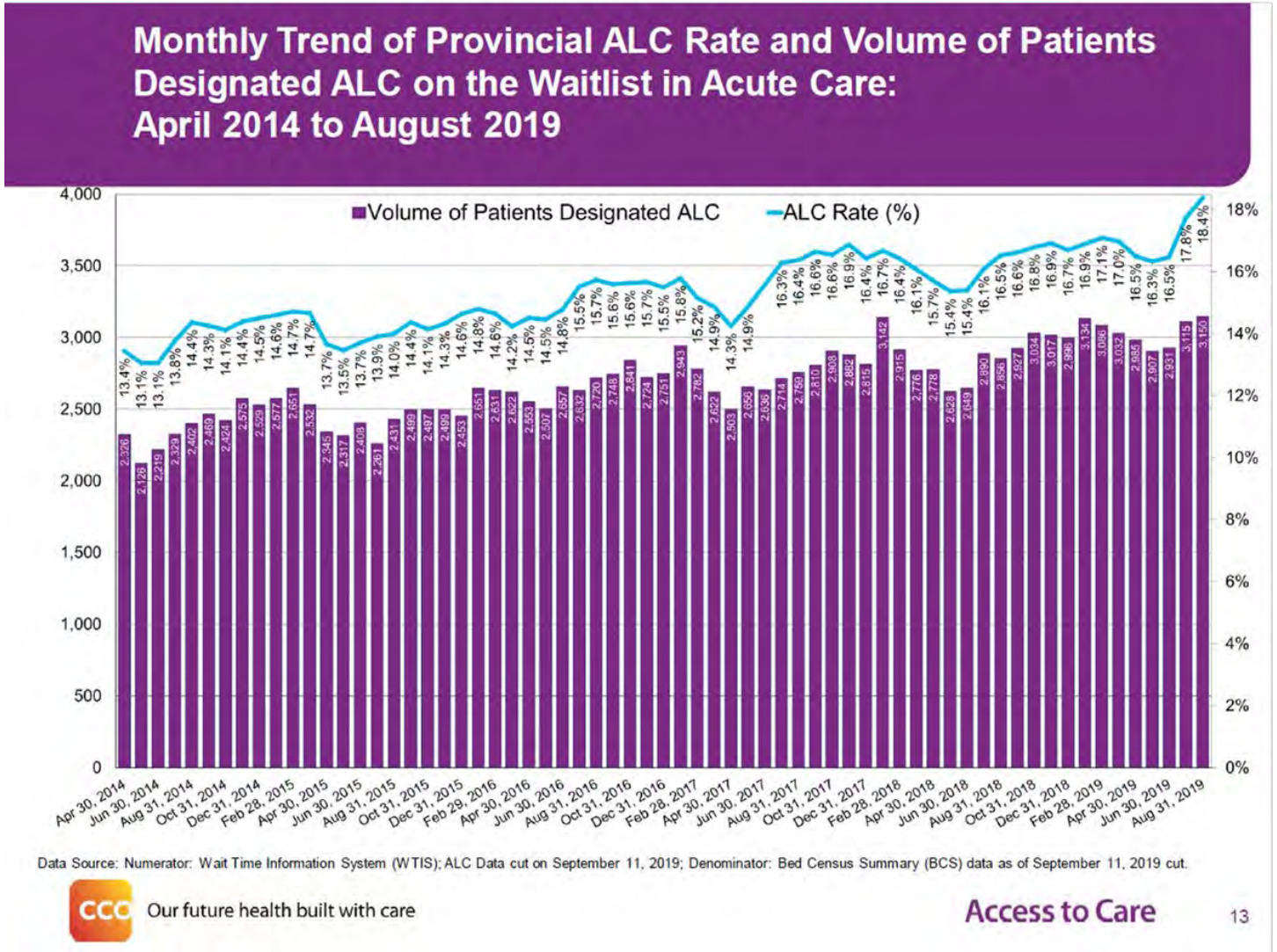
Non-Admitted, Low Acuity ED Visits
Trajectory based on a 4 hour March 2020 internal target



CCO Our future health built with care

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ALC Worsening in Parallel



Promises broken….

Ontario health minister says ending 'hallway health care' will take longer than Ford promised last week



By **Rob Ferguson** Queen's Park Bureau
Mon., July 15, 2019 | 2 min. read



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Flu season could get ugly!

CONTRIBUTORS | OPINION

A contingency plan for preventing certain January emergency room gridlock

By **Bob Bell** Contributor
Mon., Sept. 23, 2019 | 3 min. read



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We’re going from 14 RHA’s to 1 with 5 “zones”



Nova Scotia went from 9 to 1 with 4 in 2015…how are they doing?

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Not so well!

Nova Scotia

Scathing review of Nova Scotia Health Authority, 2 years after merger

Executives respond to concerns that the organization isn't agile enough to respond to local needs

Nina Corfu · CBC News · Posted: May 15, 2017 3:32 PM AT | Last Updated: May 15, 2017



The paper includes seven recommendations, from stopping political interference to creating four zones within the existing framework. (CBC)

28 comments

A paper by a group of medical professionals in Nova Scotia offers a scathing review of the two-year-old Nova Scotia Health Authority, saying the organization isn't agile enough to respond to



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In Other News…

CONTRIBUTORS OPINION

Are Ontario Health Teams designed for failure?

By **Bob Bell** Contributor
Tues., Sept. 3, 2019 | 3 min. read



Given the lack of clear direction coming from the ministry, OHT's seem at risk of creating a fragmented, chaotic approach to provincial health service planning. There are obvious advantages of scale evident in planning health services for 14 million people. At this point, the OHT process of planning at the local level without strong provincial guidelines may seem suspect.

Bob Bell worked in Ontario health care for more than 40 years as a GP, surgeon, hospital CEO and Deputy Minister of Health. Follow him on Twitter: @drbobbell

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eCTAS Matures

ectas



The Electronic Canadian Triage and Acuity Scale (eCTAS) initiative aims to:

1. Improve patient safety and quality of care by establishing an electronic triage decision support tool that standardizes that application of national triage guidelines (CTAS) across Ontario.
2. Enhance accountability through the timely collection and analysis of triage data.

eCTAS by the numbers

120+
participating hospitals

90%
of emergency department patient volumes

~400,000
patients will be triaged with the system per month

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om/article/ectas-improves-patient-care-in-ontario-with-ingenious-solution/398162

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CLOUD PUBLIC SECTOR

eCTAS improves patient care in Ontario with 'Ingenious' solution



Danny Bradbury @dannybradbury
Published: November 9th, 2017

The winner of the Information Technology Association of Canada's Ingenious Award in the Large Public Business category for 2017 brings new efficiencies to primary health care. The electronic Canadian Triage and Acuity Scale (eCTAS) solution from Canada Care Ontario is making emergency room triage more accurate, leading to better patient outcomes.

Triage – the process of sorting patients into levels of urgency – is a difficult challenge for emergency department nurses under pressure. Nurses in Canada use the five-point Canadian Triage and Acuity Scale (CTAS) for making these decisions, but those working at the sharp end of the process must categorize patients under pressure.

Research found an ineffective triage process in which many patients are underserved. In fact, only 37 per cent of patients were appropriately triaged, according to a 2010 Ontario auditor general report on the issue. Of those that were incorrectly categorized, the majority were under-triaged, meaning that they were seen later than they should have been, given their ailments.

See all the awards coverage 2017 Ingenious Awards winners hub – stories, video, and podcasts

Evaluating Public Policy? A novel idea!

GENERAL MEDICINE/ORIGINAL RESEARCH

Interrater Reliability, Accuracy, and Triage Time Pre- and Post-implementation of a Real-Time Electronic Triage Decision-Support Tool

Shelley L. McLeod, PhD(c), MSc*; Joy McCarron, RN, BScN; Tamer Ahmed, MBA, BSc; Keerat Grewal, MD, MSc; Nicole Mittmann, PhD; Steve Scott, MBA, BEngMgt; Howard Ovens, MD; Jason Garay, MHSc; Michael Bullard, MD; Brian H. Rowe, MD, MSc; Jonathan Dreyer, MD; Bjug Borgundvaag, MD, PhD

*Corresponding Author. E-mail: shelley.mcleod@sinaihealthsystem.ca.

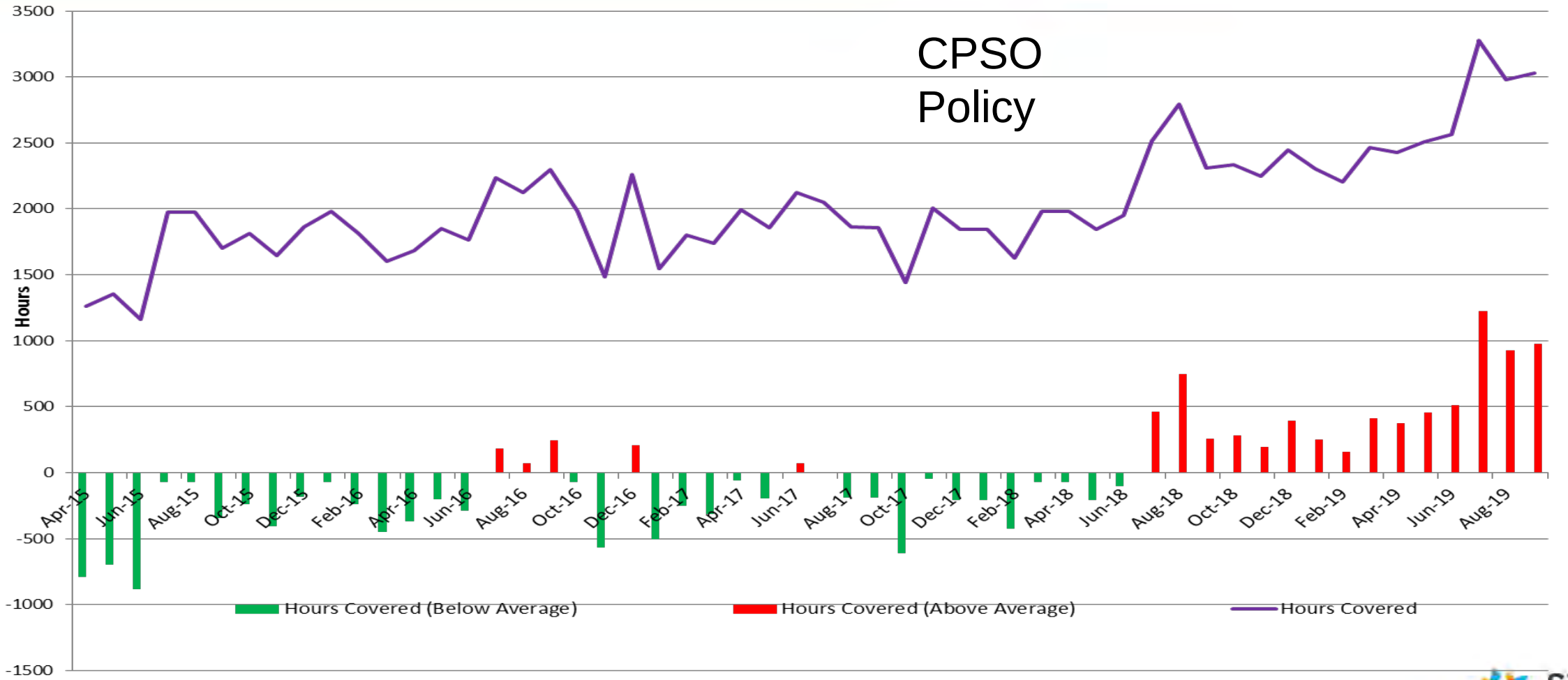
Study objective: The electronic Canadian Triage and Acuity Scale (eCTAS) is a real-time electronic triage decision-support tool designed to improve patient safety and quality of care by standardizing the application of the Canadian Triage and Acuity Scale (CTAS). The objective of this study is to determine interrater agreement of triage scores pre- and post-implementation of eCTAS.

Methods: This was a prospective, observational study conducted in 7 emergency departments (EDs), selected to represent a mix of triage documentation practices, hospital types, and patient volumes. A provincial CTAS auditor observed triage nurses in the ED pre- and post-implementation of eCTAS and assigned an independent CTAS score in real time. Research assistants independently recorded triage time. Interrater agreement was estimated with κ statistics with 95% confidence intervals (CIs).

Results: A total of 1,491 individual triage assessments (752 pre-eCTAS, 739 post-implementation) were audited during 42 7-hour triage shifts (21 pre-eCTAS, 21 post-implementation). Exact modal agreement was achieved for 567 patients (75.4%) pre-eCTAS compared with 685 patients (92.7%) triaged with eCTAS. With the auditor's CTAS score as the reference, eCTAS significantly reduced the number of patients over-triaged (12.0% versus 5.1%; Δ 6.9; 95% CI 4.0 to 9.7) and under-triaged (12.6% versus 2.2%; Δ 10.4; 95% CI 7.9 to 13.2). Interrater agreement was higher with eCTAS (unweighted κ 0.89 versus 0.63; quadratic-weighted κ 0.93 versus 0.79). Median triage time was 312 seconds (n=3,808 patients) pre-eCTAS and 347 seconds (n=3,489

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EDLP- A Barometer of EP Supply



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Crisis in ER Nursing?

HURON PERTH HEALTHCARE ALLIANCE

FOR IMMEDIATE RELEASE
November 8, 2019

HPHA
HURON PERTH HEALTHCARE ALLIANCE

Nursing Shortage at Clinton Public Hospital Emergency Department Results in Temporary Reduction in Hours of Operation Effective December 2, 2019

The Emergency Department (ED) at the Clinton Public Hospital (CPH) site of the Huron Perth Healthcare Alliance (HPHA) will be reducing operating hours due to a nursing staff shortage.

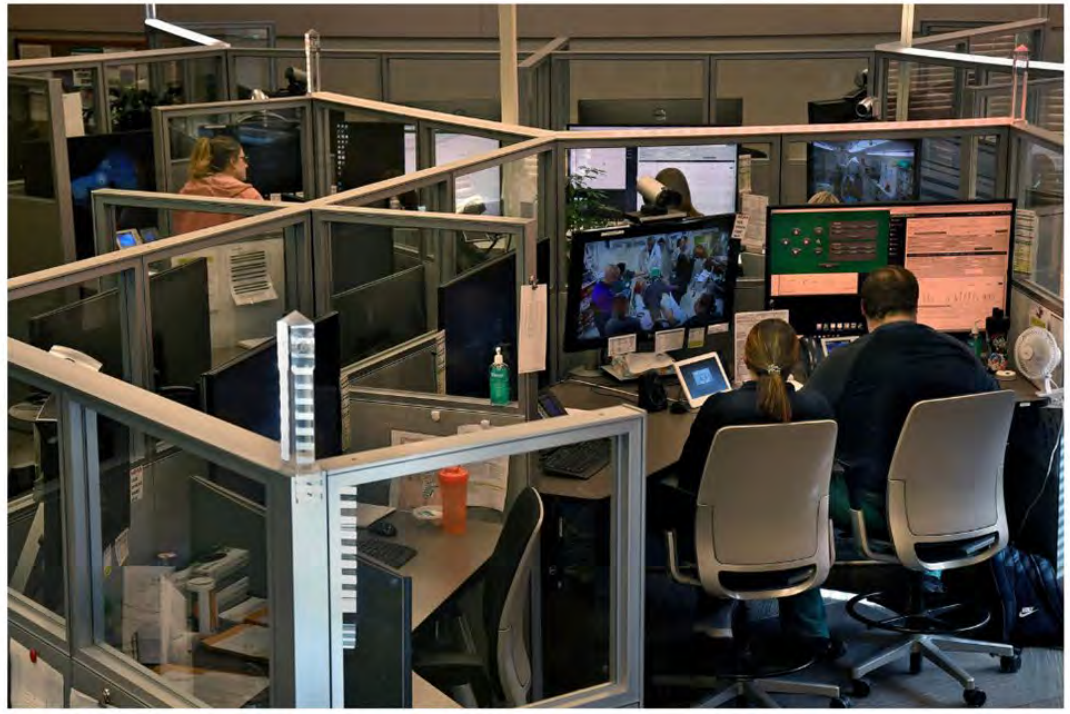
Starting Monday, December 2, 2019, the **CPH ED will be accepting patients from 8:00 AM to 8:00 PM**, and will be closed overnight until 8:00 AM. This reduction in hours will be in effect until further notice.

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In Other News…

National

The most remote emergency room: Life and death in rural America



Avera eCare employees sit at virtual emergency room workstations at a telemedicine center in Sioux Falls, S.D. (Michael S. Williamson/The Washington Post)

By **Eli Saslow**
November 16

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Calgary

Calgary woman left to miscarry in crowded ER waiting room

CBC News · Posted: Jul 26, 2006 9:35 AM MT | Last Updated: July 27, 2006

A Calgary woman is looking for answers after suffering a miscarriage in a hospital waiting room.

Accompanied by her husband, Rick, Rose Lundy went to the emergency room at the Peter Lougheed Centre with abdominal pain last week.

She was three months pregnant with her third child. She says staff told her there was a shortage of beds and she'd have to wait.

"I don't know why it happened that way, but it was wrong," she said.

Woman felt humiliated

"We were letting them know what was going on. As I'm sitting there, I'm losing tissues out of my body and blood is pooling all around me and it was too much."

Lundy said about 30 patients were in the waiting room.

PEI

P.E.I. miscarriage case prompts changes at ER

CBC News · Posted: Sep 08, 2010 4:31 PM AT | Last Updated: September 8, 2010



Charlottetown's Queen Elizabeth Hospital has completed an internal review of the treatment it gave to a woman who suffered a miscarriage. ((CBC))

Charlottetown's Queen Elizabeth Hospital has completed an internal review of a case where a

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We CAN do better!



femінem
FEMALES WORKING IN EMERGENCY MEDICINE

HOME FIX 2020 FIX: NEW ENGLAND WOMEN IN MEDICINE JOBS PODCAST RESEARCH SPEAKERS BUREAU STUFF CART ACCOUNT

Home Blog LEAD We Can Do Better: The Mishandling of Miscarriage in Emergency Medicine

#leadership #pregnancy #patient care

We Can Do Better: The Mishandling of Miscarriage in Emergency Medicine

Kelly Quinley, MD February 21, 2019 7

"Ugh, *another* 'vag' bleeder in room 10, I guess that's mine." His preceding exasperated sigh was not subtle. As a medical student on my emergency medicine rotation, I watched the tired resident slowly will himself out of the chair and shuffle to the room where the

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Posting Estimated Wait Times; Propaganda or Panacea?

Going to the ER? Real-time hospital emergency wait times now online

DH Vancouver Staff | Dec 19 2017, 7:22 am

Going to the ER? Real-time hospital emergency wait times now online

An online tool might make your next hospital emergency admittance wait time shorter and, hopefully, less painful. In an attempt to make the most efficient use of the region's hospital resources and to improve patient flow, local Vancouver health authorities are making their real-time emergency room wait times dashboard publicly accessible online.

The system currently lists the wait times of five of the region's most busiest emergency departments: Downtown Vancouver's St. Paul's Hospital, Vancouver General Hospital, Vancouver's Mount Saint Joseph Hospital, North Vancouver's Lions Gate Hospital, and Richmond Hospital. More regional hospitals will be added to the viewable online system when more funding is made available for the project.

The system was originally designed specifically for paramedic and hospital staff use only. The average wait times listed on the website are based on the wait times of the emergency departments' non-critically ill patients (critically ill patients are always seen immediately). The times are in real-time, updated every five minutes.

On the website, two sets of wait times are given for each hospital emergency room: the first set *"displays the most current average wait time based on the last hour"* and the second set *"displays how long 90% of the people arriving [in the ER] have waited to see a doctor,"* based on the last ten patients. The wait time for an incoming patient is within the range of these two times, although emergency demand can always change quickly

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Health

High-tech solutions not the answer to ER wait times, experts say

Alberta's ER wait time app can change from minutes to hours in blink of an eye

CBC News · Posted: Apr 13, 2013 5:28 AM ET | Last Updated: April 13, 2013



More and more people are checking websites and mobile apps before they go the emergency room to find out how long the wait will be, but experts warn that these tools are not always the best way for patients or hospitals to approach the seemingly intractable problem of long wait times. (iStock)

Checking a mobile app for the latest emergency room wait times before you rush out the door might seem convenient, but the high-tech tool may leave some patients feeling misled.

Alberta Health Services posts real-time wait times on its app for 15 hospitals in Edmonton and

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On posting wait times: an alternate view

Howard Ovens, MD, FCFP(EM)*; Andrew Affleck, MD†; Eric Letovsky, MD‡

We read with both interest and concern the article by Yip and colleagues[1] and the accompanying commentary by Grafstein[2] on reporting of emergency department (ED) wait times and improving patient experience in the ED. The issues they discuss are timely and will likely be the subject of much further discussion and debate. Given the confusing use of terminology in the Yip and colleagues' article, we feel that precision in taxonomy can only help with clarity in the debate around wait times, and placing the reporting of said wait times in a wider context may help us direct our advocacy as a discipline on the issue of ED crowding to where it will be most effective.

Ontario launched its program to reduce ED crowding on April 1, 2008. Ontario requires hospitals to report a broad set of performance metrics monthly, with a selected subset of performance indicators available on a public website.[3] The program provides the 74 larger hospitals in the province with incentive funding to improve their ED performance and a coaching program to help with strategies. Ontario used the same resources to implement and supervise the ED program as they had used to implement the five federally funded programs established to reduce waiting in selected clinical services (hip and knee replacements, cataract surgery, computed tomography/magnetic resonance imaging, radiation oncology, and coronary bypass grafting).

Although ED performance in Ontario is not reported publicly for several months until data quality has been confirmed, many hospitals use their ED Information Systems (EDIS) to capture all or most of their reportable metrics and follow their own performance closely. As Yip and colleagues report in their article, the London Health Sciences Centre (LHSC) chose to post its performance on its hospital website and update it daily with the previous day's performance.[1,4] Yip and colleagues sought to survey a group of patients at one of the hospitals' EDs to see if they were aware of this information and asked them if "given the chance" they would use this information in making a decision about coming to the ED or which ED to go to.

One of the problems in the Yip and colleagues survey and article is the use of the term "wait time."[1] The website they refer to published *length of stay* (LOS) information—the time from arrival at the ED to disposition from the ED to either home or an inpatient unit. Reporting total LOS is an important performance metric but is not the same as a "wait time." Most patients would interpret "wait times" as the time from arrival until they see a doctor (time from arrival to physician initial assessment or time to PIA). US hospitals that report "waiting" times generally also refer to this interval. Ontario collects time to PIA data ("wait times") but does not report it publicly at present. Furthermore, in the Yip and colleagues report, only 9% of respondents were aware of the LHSC website, so the large majority would not have had first-hand knowledge of the information available. The actual question in the survey, "If you were given a chance to see *the ED wait time statistics* before coming, would you base your decision on ED location on the data you saw on the website? [emphasis ours]" is misleading. Although 45% of respondents said "yes," few would have understood from the question that the

From the *Department of Family and Community Medicine, University of Toronto; Toronto Central Local Health Integration Network; and Schwartz/Reisman Emergency Centre, Mount Sinai Hospital, Toronto, ON; †Thunder Bay Regional Health Sciences Centre and North West Local Health Integration Network, Thunder Bay, ON; and ‡Department of Emergency Medicine, Credit Valley Hospital, Mississauga, ON; Department of Family and Community Medicine, University of Toronto, Toronto, ON; and Mississauga Halton Local Health Integration Network, Oakville, ON.

Correspondence to: Dr. Howard Ovens, Schwartz/Reisman Emergency Centre, Mount Sinai Hospital, Toronto; howard.ovens@utoronto.ca.

This article has been peer reviewed.

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QUALITY IMPROVEMENT

Home > Quality Improvement > Quality Improvement in Action > Emergency Department Return Visit Quality Program

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- REGIONAL QUALITY PROGRAM
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  - Rapid Access Clinics for Musculoskeletal Care
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  - Choosing Wisely Ontario
  - Emergency Department Return Visit Quality Program
  - Excellence through Quality Improvement Project (EQIP)
  - Health Links
  - Improving Patient Relations
  - QBP Connect
  - Quality Improvement and Health System Funding

Emergency Department Return Visit Quality Program



Focusing on the quality of care in emergency departments, this program builds a culture of continuous improvement. It is designed to help clinicians and hospitals in Ontario identify, audit and investigate underlying causes of return visits to their emergency departments and take steps to address them.

Supported by Health Quality Ontario, Access to Care and the Ministry of Health and Long-Term Care, the program is guided by an expert working group involved in all stages of its design.

Questions about participating in the Emergency Department Return Visit Quality Program? Contact us at EDQuality@hqontario.ca

WHAT'S NEW?

The 2018 report on the Emergency Department Return Visit Quality Program is now available.

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“Zero Tolerance” – No brainer?



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WTBS 17 Zero-Tolerance Policies in the ED, Part 1: The delicate balance of protecting staff while ensuring patient access



It was busy, so I approached my next patient with the detachment that often brings: He was in custody and cuffed, had been injured during apprehension, was subdued and cooperative, and needed suturing. But as the two police officers talked about him, the story that emerged shattered my detachment

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So…where are we?





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Faculty/Presenter Disclosure

- **Faculty:** n/a
- **Relationships with commercial interests:**
  - None

Disclosure of Commercial Support

- **This program has not received financial or in-kind support from any organization**

- **Potential for conflict(s) of interest:**
  - Not applicable

Mitigating Potential Bias

- **Not applicable**

Patient Reflections on Early Pregnancy Loss in the ED

EDAC: November 26, 2019

Dr. Kristin Blakely, PhD

Chair, Canadian Women's Foundation

Consultative Committee Member, Gender Equality Network Canada

Course Director, Department of Sociology, Glendon College | York University

Instructor, Business & Professional Studies, School of Continuing Studies | University of Toronto

Co-Investigator, Diversity Institute| Ryerson University





Gender Equality Network Canada | Réseau d'égalité des genres Canada











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My First Miscarriage





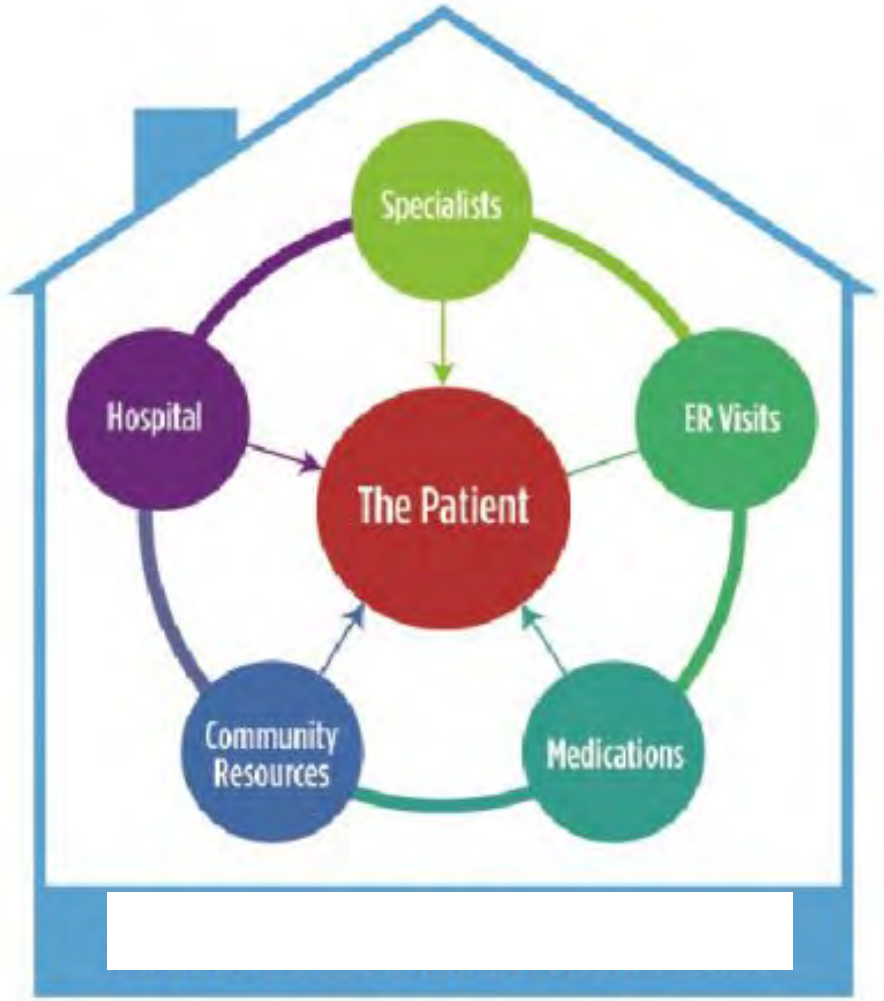
My ED Miscarriage



My Continued Miscarriage Journey



The Medical ‘Home’ for Early Pregnancy Loss?




TIME
FOR
ACTION


Research
& Advocacy

got privilege?

increasing awareness examining privilege cultivating community



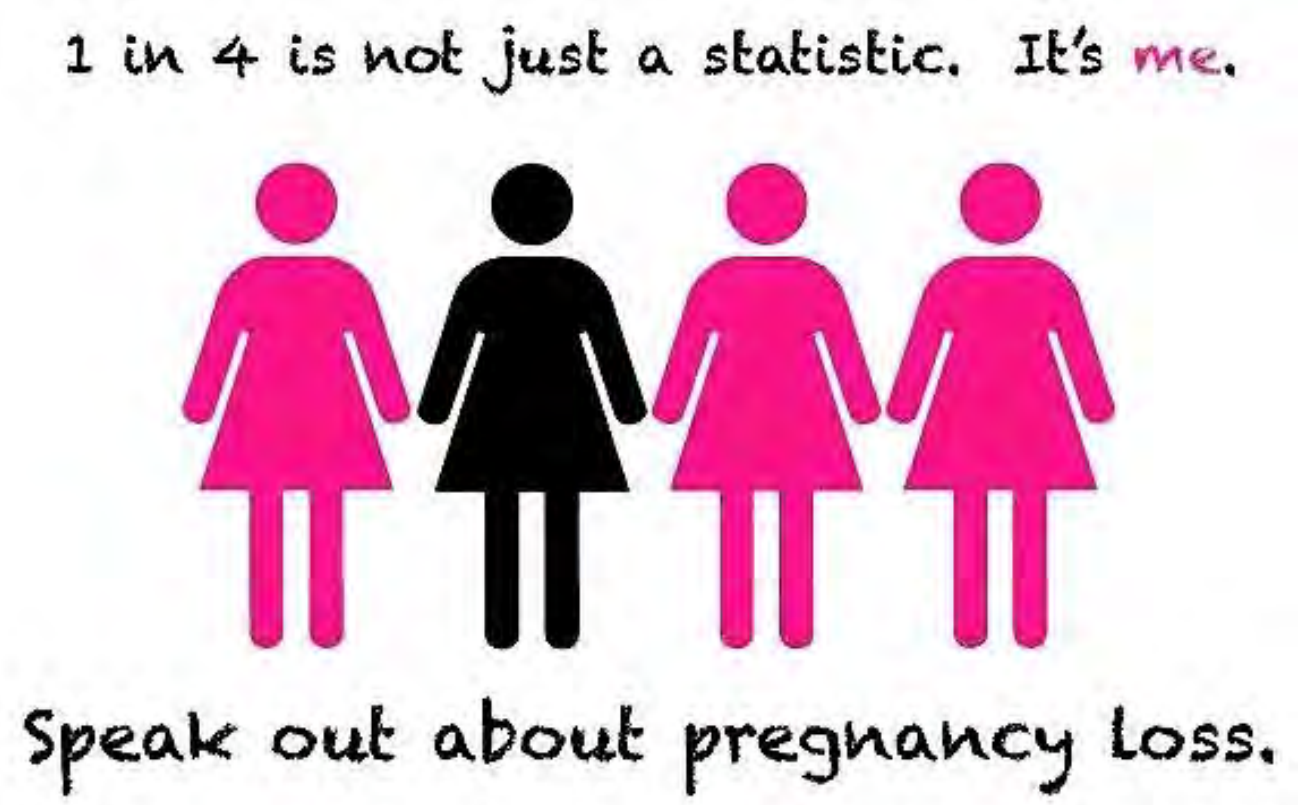







what is privilege?
feministastic.com • privilege 101
We can define privilege as a set of unearned benefits given to people who fit into a specific social group. Society grants privilege to people because of certain aspects of their identity. Aspects of a person's identity can include race, class, gender, sexual orientation, language, geographical location, ability, and religion, to name a few.
by Sian Ferguson via Everyday Feminism

The Current Situation is Bleak….



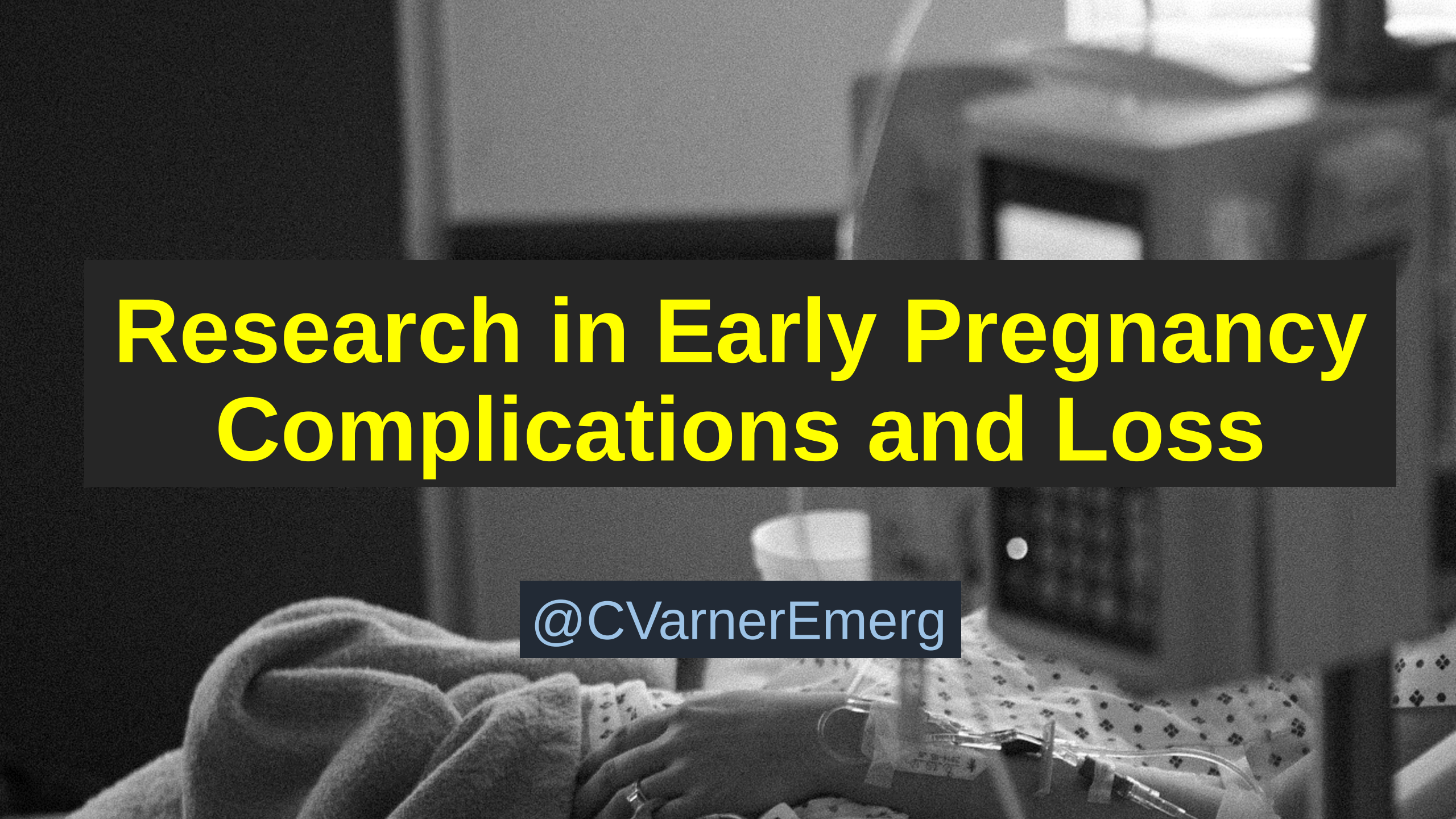
Stigma & Grief








"There is no greater agony than bearing an untold story inside you."
— Maya Angelou,
I Know Why the Caged Bird Sings

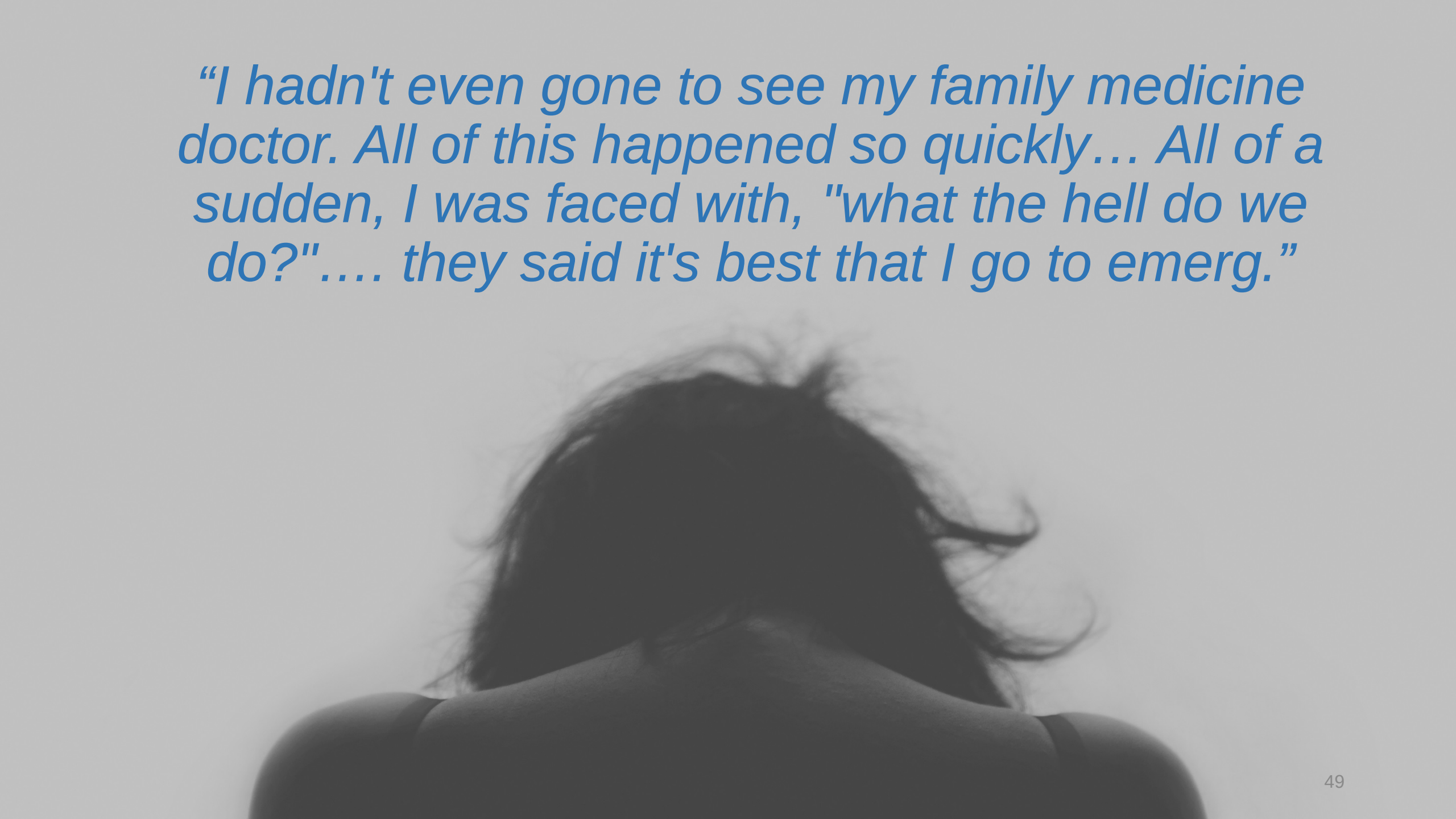


Research in Early Pregnancy Complications and Loss

@CVarnerEmerg



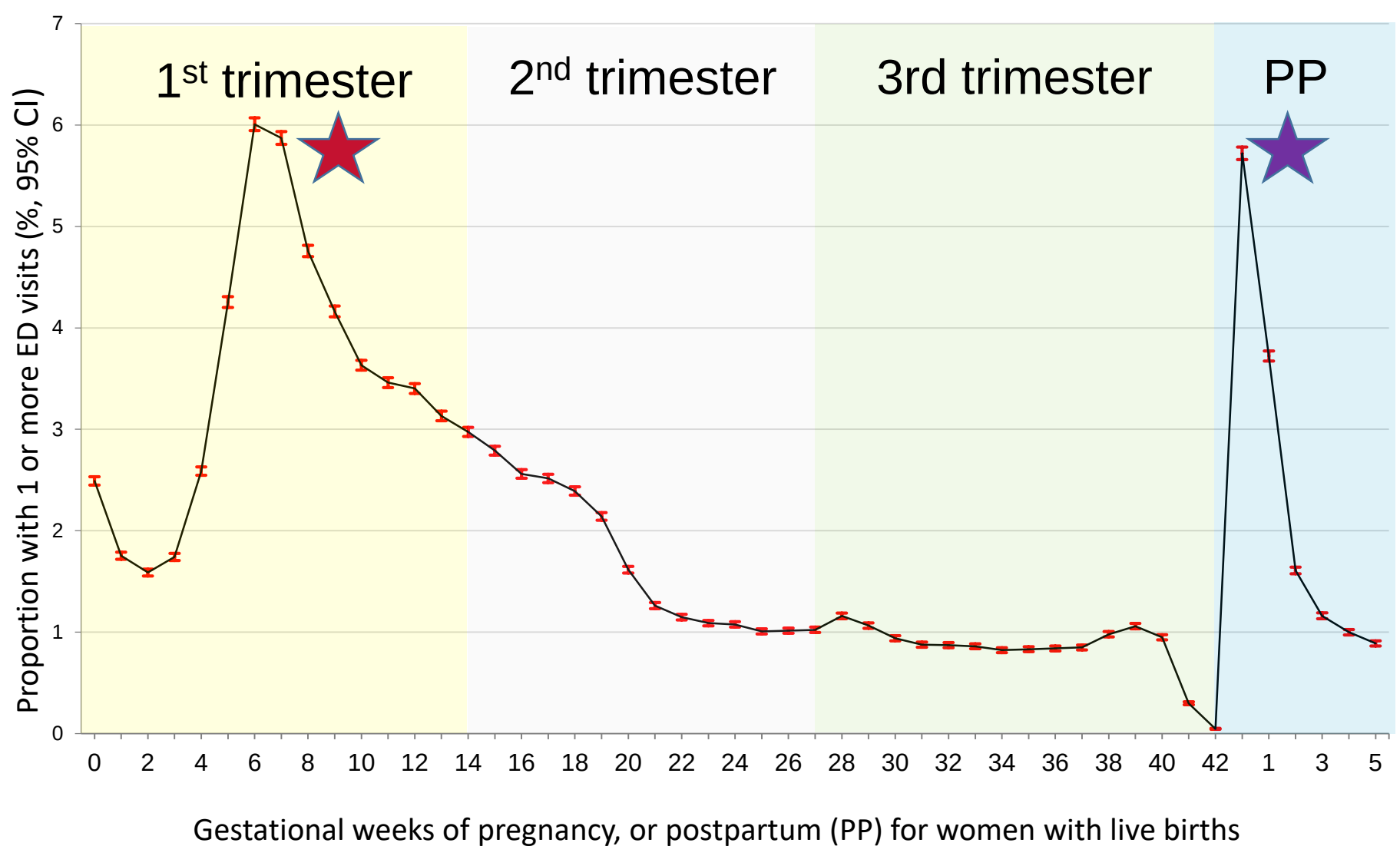
“I hadn't even gone to see my family medicine doctor. All of this happened so quickly… All of a sudden, I was faced with, "what the hell do we do?"…. they said it's best that I go to emerg.”




1 in 3 pregnant women in Ontario attended the ED during the perinatal period

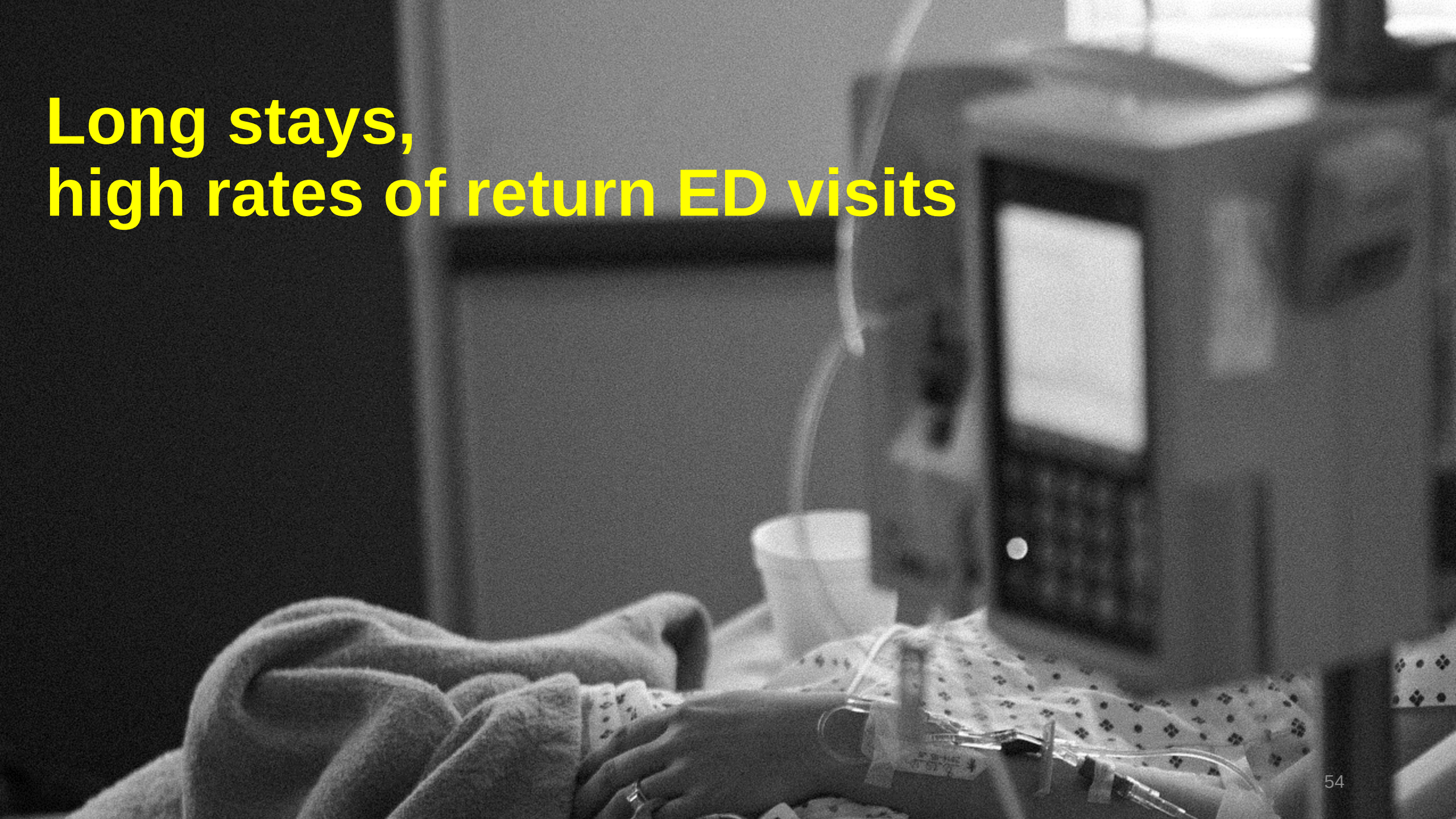

1 in 4 pregnant women attending the ED had
3 or more unscheduled return visits

Pregnant women attended the ED when obstetrical care was ***not*** available



4 in 5 women with early pregnancy loss attended the ED




Long stays,
high rates of return ED visits

Pregnancy of Unknown Location

Methotrexate Failure



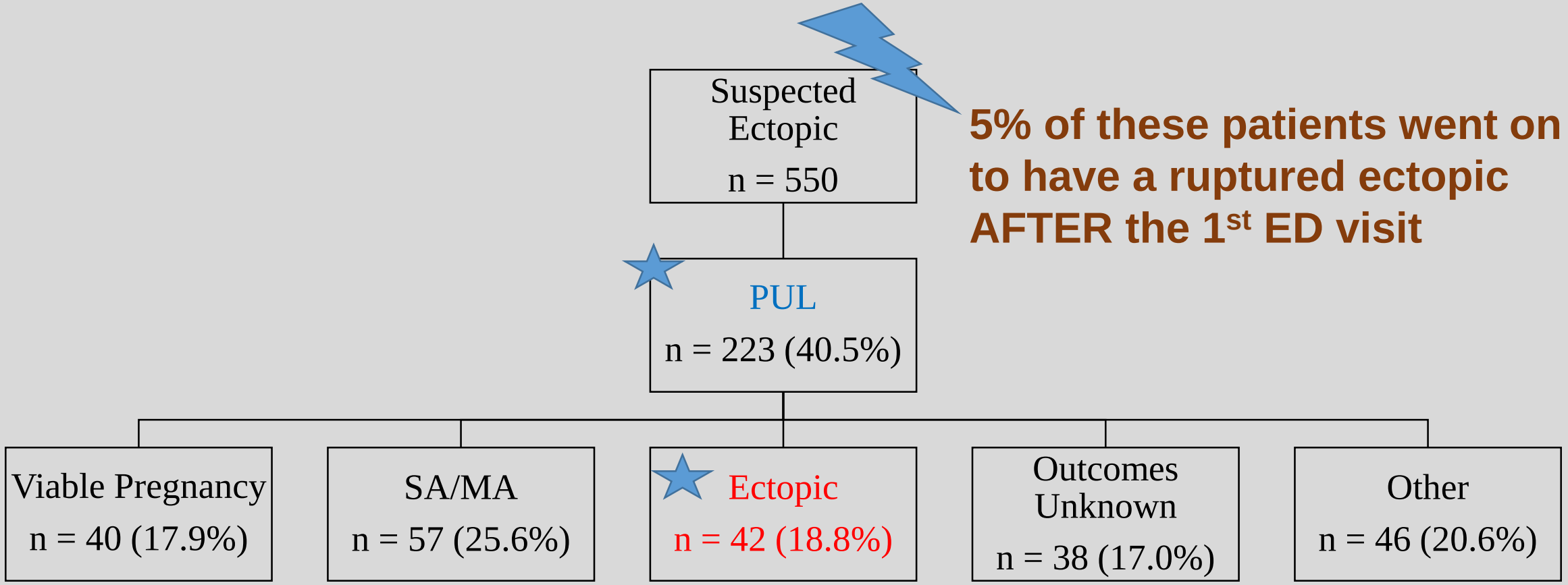
Negative Patient Experience

“I want to say like 500 to 300, so at that point they diagnosed it as a miscarriage, but they still weren't able to see anything in the tubes or in the uterus.”

[Patient went on to rupture 11 days later]



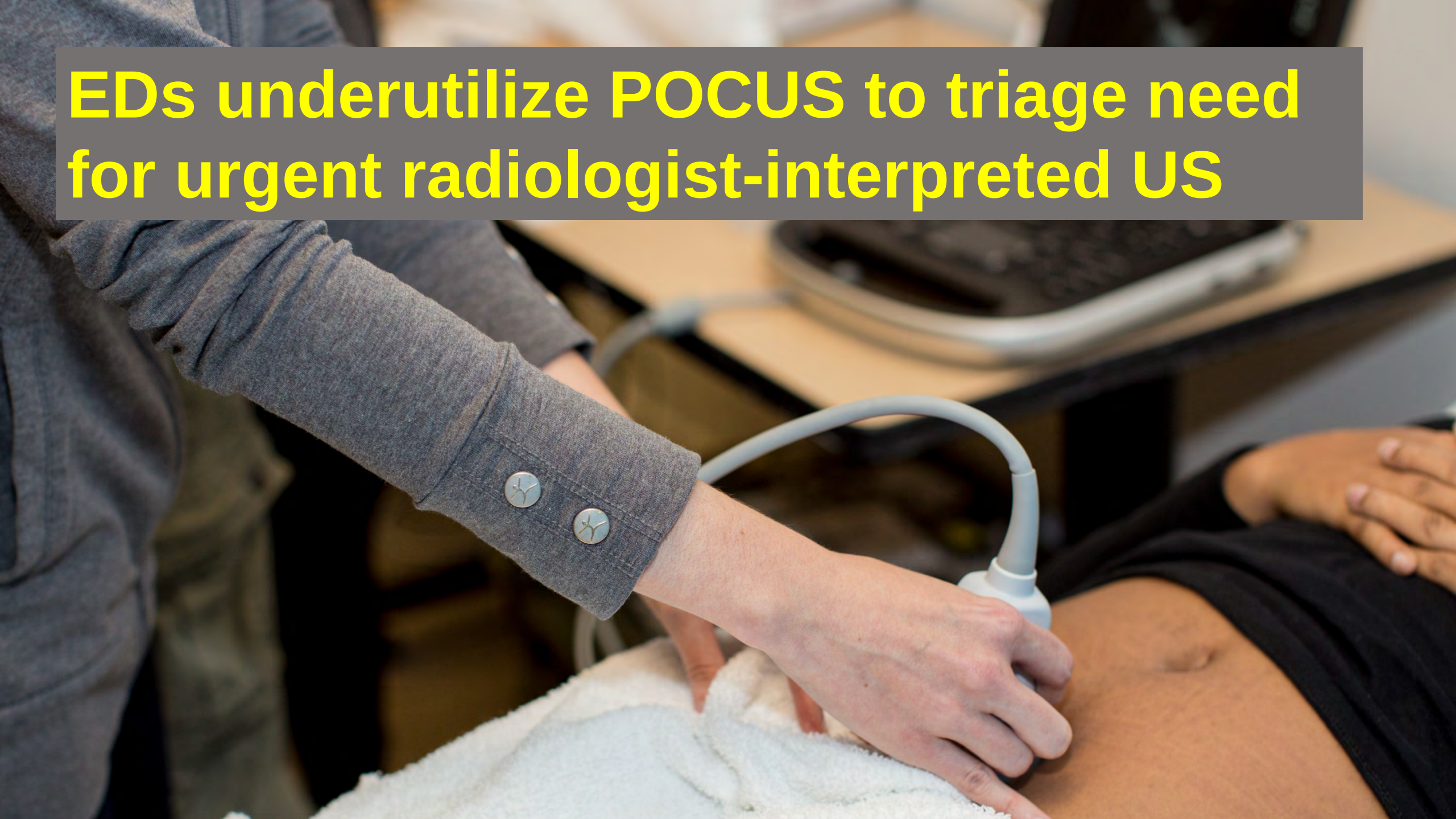
20% with PUL will have ectopic pregnancy



5% of these patients went on to have a ruptured ectopic AFTER the 1st ED visit

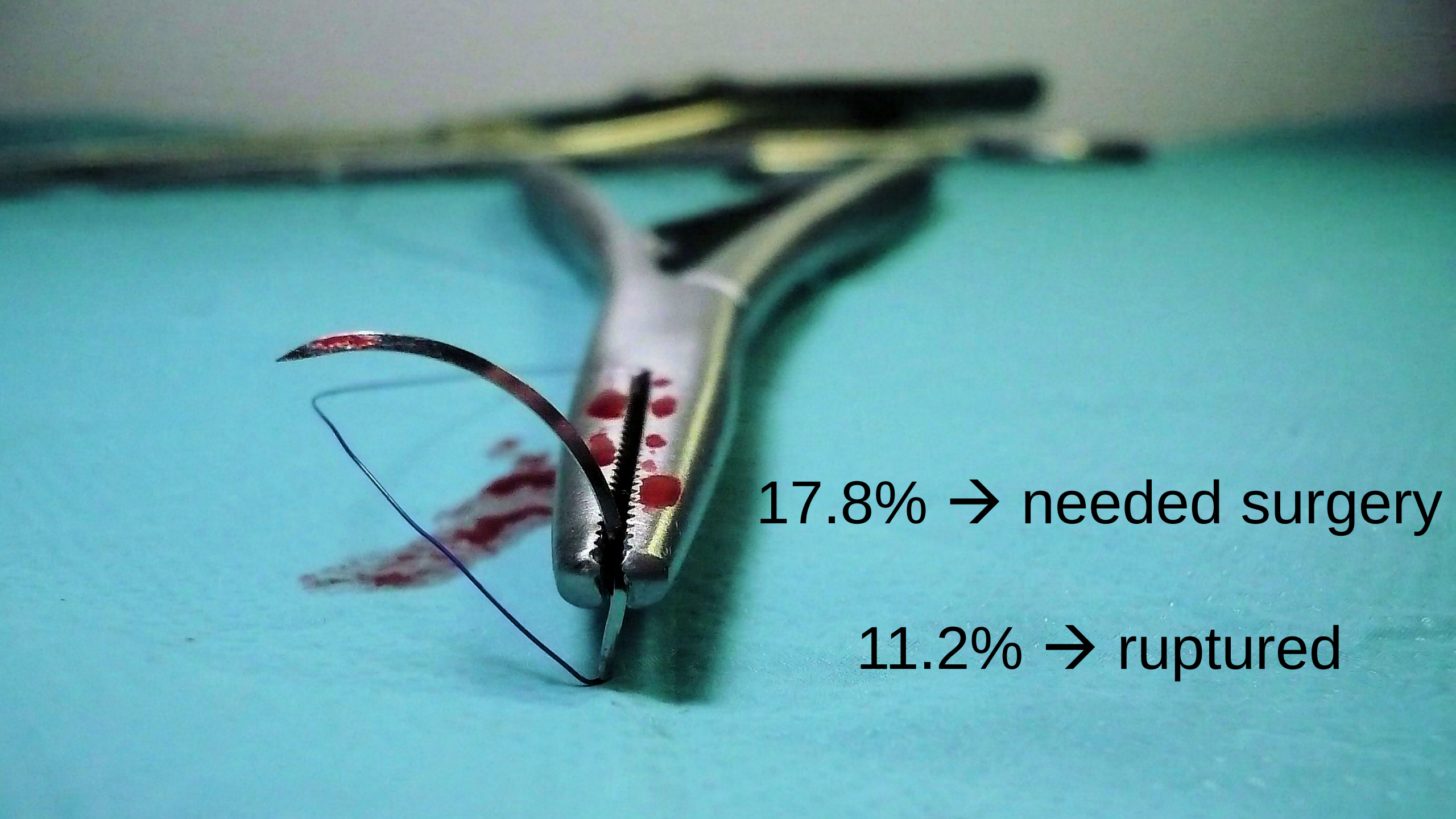
SREMI SCHWARTZ/REISMAN EMERGENCY MEDICINE INSTITUTE | Mount Sinai Hospital Sinai Health System | NORTH YORK GENERAL Making a World of Difference

Hawrylyshyn K, McLeod SL, Thomas J, Varner C. *Canadian Journal of Emergency Medicine*. 2018 Mar 4:1-4.

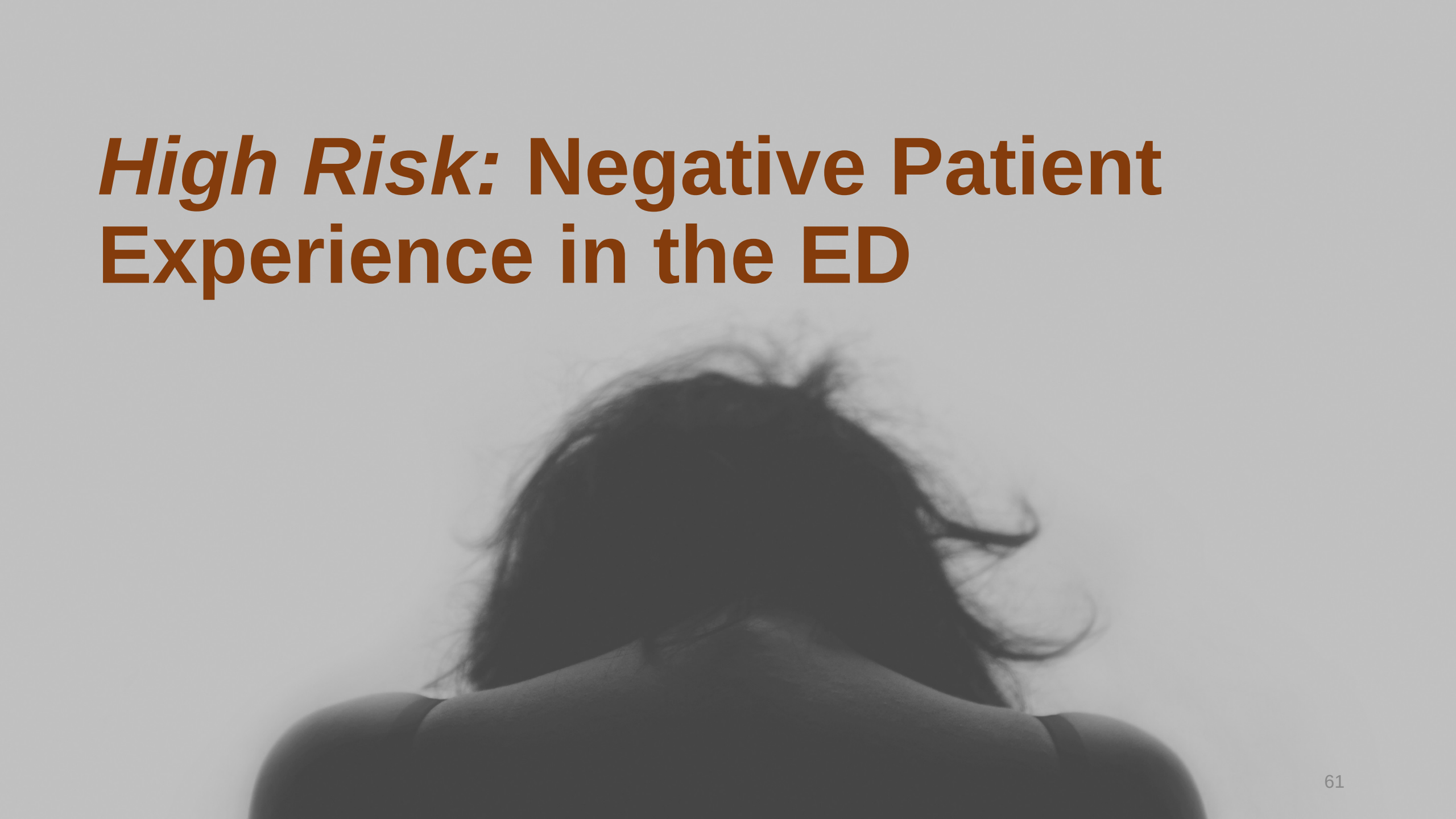

EDs underutilize POCUS to triage need for urgent radiologist-interpreted US

High Risk: Methotrexate Treatment Failure in Ectopic Pregnancy



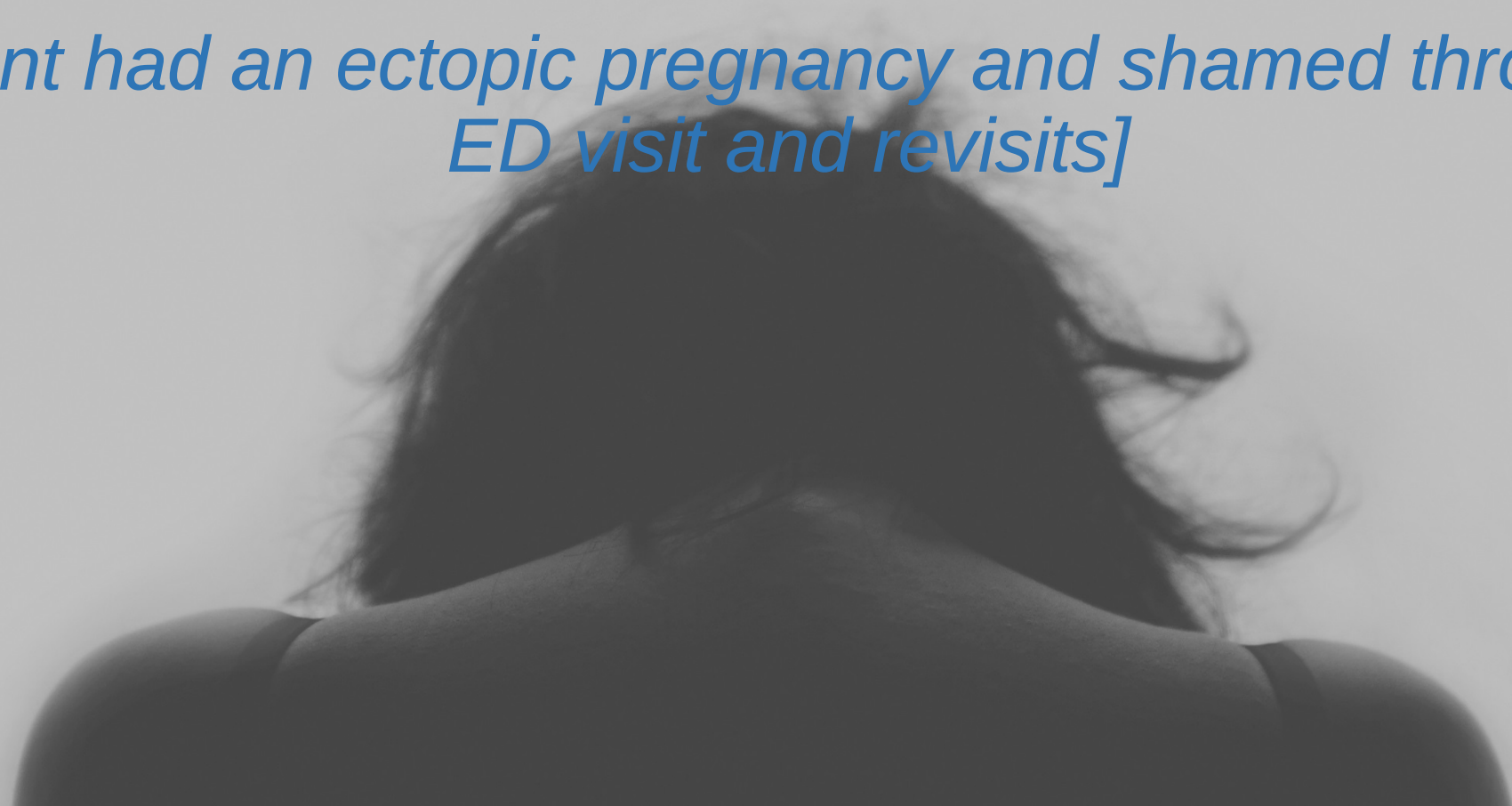

17.8% → needed surgery
11.2% → ruptured

High Risk: Negative Patient Experience in the ED



So, when I first went [to the ED] I told her what I just told you - I'm here because I just did this test and it was positive and my doctor told me to do this. And she giggled and she said, he said that to you? And I said, yes.

[Patient had an ectopic pregnancy and shamed throughout ED visit and revisits]



I already felt like I was wasting everybody's time… [hospital staff] pointing out that this is happening and it's not an emergency… I'm following direction that my doctor gave me. I was already feeling like I shouldn't have been there. Like I was wasting resources.



I was apparently one of five or six ectopic pregnancies that happened to have gone down that evening. We were all waiting together in the rapid assessment zone. And there was a woman in there that had a newborn baby. And that was hard. I know it's difficult in any space, but for someone who's now having to terminate a pregnancy sitting next to someone who's just given birth to a baby…



Then, [the] resident comes, I get put back in a room … Then, I'm put back in the seating area … Being thrown back and forth between sitting with my elbows rubbing up against a stranger while I bawl my eyes out, to then have to revisit the conversation all over again. I understand the concept of it, and that it makes the emerg flow better … That, I didn't like, but fine. I sucked it up. It is what it is. I dealt with it.



The ER visits were really stressful – I'm assuming first trimester complications are lower priority for care because the fetus isn't viable yet … this was very apparent to us and caused a lot of emotional distress.



Quality Standards

Early Pregnancy Complications and Loss

Guiding evidence-based care for people experiencing early pregnancy complications (such as pain and vaginal bleeding) and/or loss in the first trimester of pregnancy



Health Quality Ontario

Let's make our health system healthier

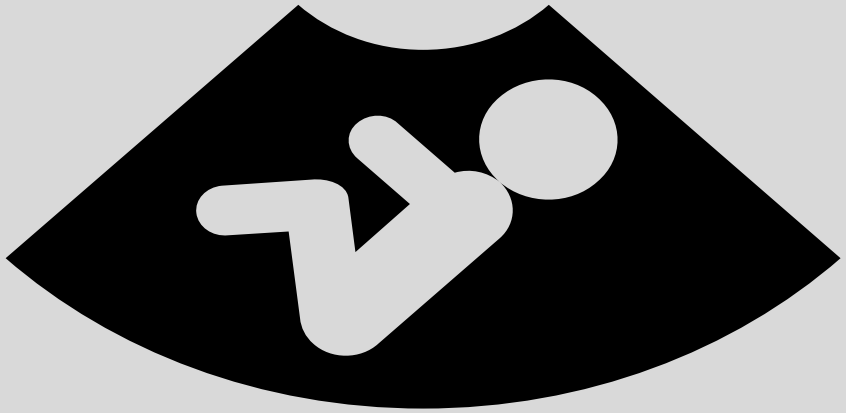
Sunnybrook

PREGNANCY AND INFANT LOSS NETWORK

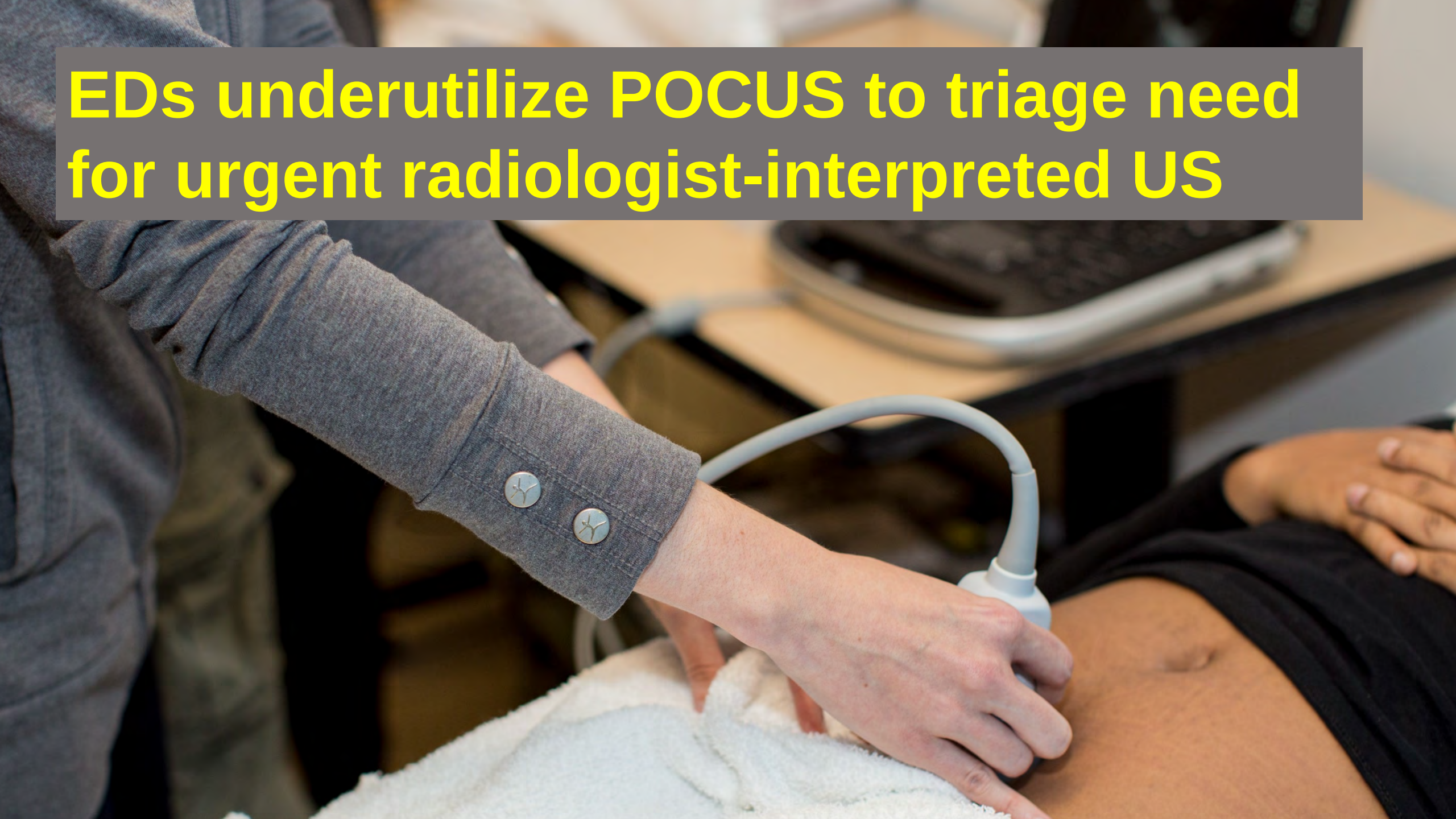
Quality Statement 1:
Comprehensive Assessment

People with signs or symptoms of early pregnancy complications receive a comprehensive assessment that includes a transvaginal ultrasound and serum beta-hCG measurement.

In Ontario, **24/7 radiologist interpreted ultrasound** was available to only **22 (36%) of 63** hospital sites with EDs > 30,000 visits/year.



Source: Glicksman R, McLeod S, Thomas J, Varner C. Services for emergency department patients experiencing early pregnancy complications: a survey of Ontario hospitals. CJEM. 2019 Sep;21(5):653-658.


EDs underutilize POCUS to triage need for urgent radiologist-interpreted US

Quality Statement 2:
Early Pregnancy Assessment Services

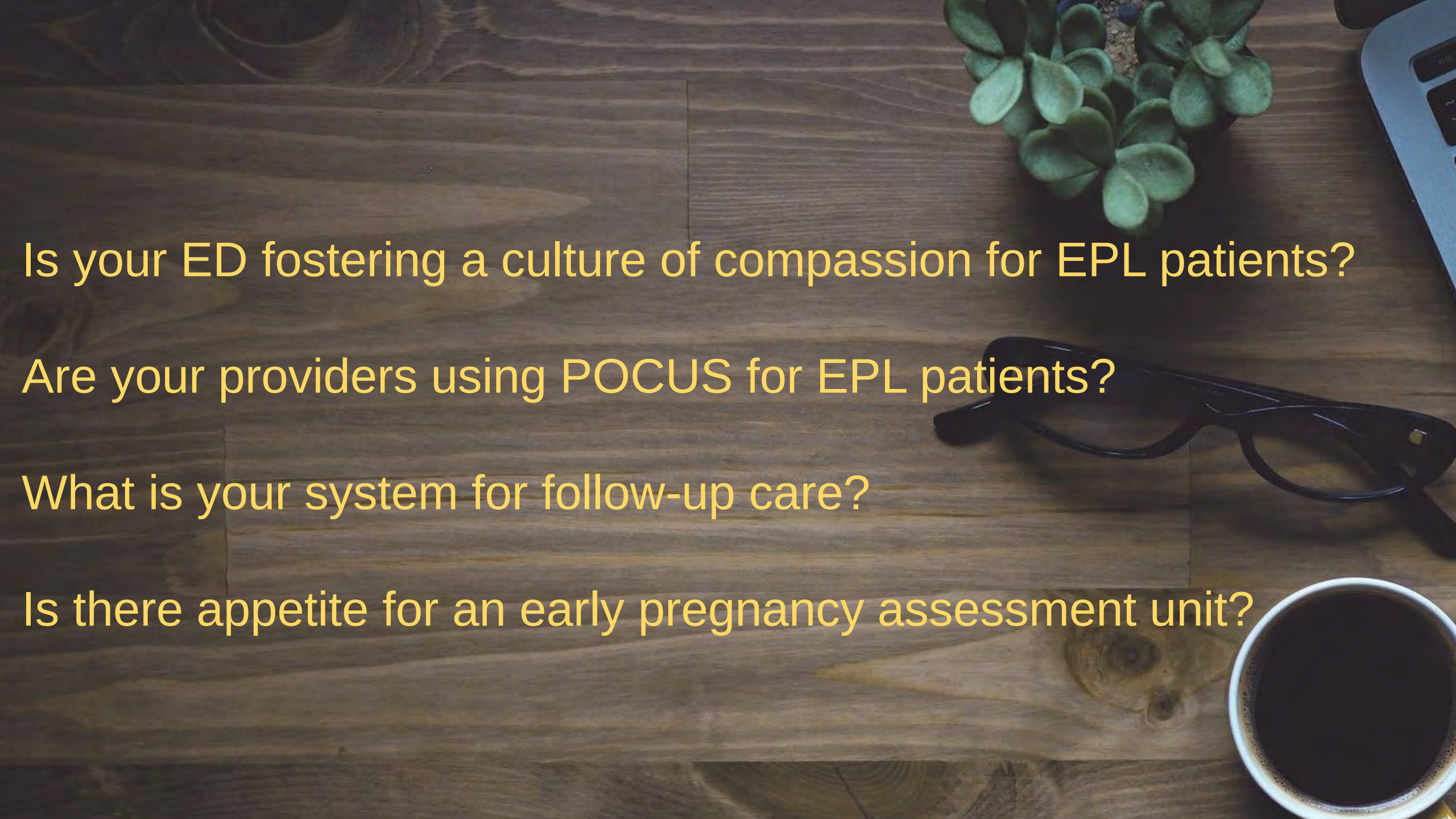
People experiencing early pregnancy complications and loss have access to early pregnancy assessment services.

In the same survey, only **29 (46%) EDs** reported access to early pregnancy assessment units for follow-up.



Source: Glicksman R, McLeod S, Thomas J, Varner C. LO40: Services for emergency department patients experiencing early pregnancy complications: a survey of Ontario hospitals. CJEM. 2019 Sep;21(5):653-658.




Is your ED fostering a culture of compassion for EPL patients?
Are your providers using POCUS for EPL patients?
What is your system for follow-up care?
Is there appetite for an early pregnancy assessment unit?

Acknowledgements:

Vanessa Rojas-Luengas
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Modupe Tunde-Byass
Kristin Blakely
Katie Dainty
Joel Ray
Alison Park



NORTH YORK GENERAL

Making a World of Difference

The management of Early Pregnancy Loss and complications. An Alternate Pathway to Care through The Early Pregnancy Assessment Clinic (EPAC). The North York General Hospital Experience.

Modupe Tunde-Byass FRCOG (UK), FRCS ©
Staff Obstetrician and Gynaecologist, Physician Lead EPAC

Disclosure

Commercial Support

- This program has not received financial or in-kind support from any organization.
- Potential for conflict(s) of interest : Not applicable

Mitigating Potential Bias

- Not applicable

Expert Panel member developing Quality Standards for Early pregnancy complications and loss

(HQO/PCMCH/PAIL initiatives)

Objectives

- To describe clinical presentations of Early pregnancy complications
- Overview of the NICE guidelines
- Alternate pathways to the management of Early pregnancy complications and Loss
- Early pregnancy Assessment units (EPAUs)– UK experience
- Early pregnancy Assessment Clinics (EPAC) – NYGH experience

Scenario 1

- 25yo G2P1 presented to the ER at 12 weeks gestation with significant bleeding and pain.
- USS 2 weeks prior revealed a live IUP compatible with 10 weeks gestation.
- She was hypotension 80/49, Pulse 130. HB 90
- VE Profuse bleeding, Os open,
- Fluid resuscitated
- Gynaecology team called.
- Urgent D and C . Patient discharged home

Scenario 2

- 26yo G1P0 was referred by her GP to the ER at 10 weeks gestation with painless vagina spotting and an USS report of a missed miscarriage. Her vital signs was stable.
- Patient very anxious and didn't trust the USS report and wanted a repeat USS.
- Blood work – HCG 5000, Hb 120.
- USS (next day) revealed confirmed the diagnosis.
- 6pm Seen/examined by Gyne. Management options discussed. She wanted surgical option- D &C.
- OR booked on the white list but remained on the ER bed. Case bumped by ruptured Appx and incarcerated hernia. 4am – Pt. stable case cancelled (Day 3).
- D & C back on the white list – surgery completed at 7pm (day 3).
- Discharged home at 10pm.

Scenario 3

- 22yo G1P0 presented to the ER at 7 weeks gestation with Left sided pain and vagina spotting. Her vital signs stable.
- Seen by the Dr. A, the ER Physician. Baseline Blood work – HCG 3000, Hb 120.
- USS – L ectopic pregnancy.
- She was a candidate for medical management. She received IM Methotrexate IM after counselling. Follow up arranged through the ER.
- On Day 4. Had Blood work. Seen 4hrs later by Dr. B another ER Physician. Serum HCG was 1500. FU Day 7 for repeat serum HCG.
- Day 7, Patient returned with her 2 toddlers. Met Nurse C whom she recognized. Had blood taken ….. Saw Dr. D from the ER after 4 hrs.
- Serum HCG 500. FU weekly.
- The patient's journey continued …… for 2 more visits until HCG <5

Appropriate level of care??

- Scenario 1 Yes or No?- Yes – active resuscitation
- Scenario 2 Yes or No? - No

❖Delay with USS, Re-traumatization, Waiting time for D and C

- Scenario 3 Yes or No? – No

❖Poor follow up process, delay accessing good quality of care, inconsistency in care, significant safety issue.

Why do we need an alternate pathway for managing miscarriages?

- Common problem- 4.4million pregnancy/year in US

  900,000 to 1 million end in losses

  US Dept of Health and Human Services

- Affects everyone
- Long lasting emotional and psychological trauma- 20% of women have moderate to severe post traumatic symptoms 9 months after miscarriage
- Current state –fragmented care from multiple providers, lack of clear discharge instructions, education, follow up.
- Gaps in care
- Women feel marginalized

Why do we need an alternate pathway for managing miscarriages?

- Ensure Consistency in care
- Better access
- Ensure adequate follow up – to discuss patients' feelings and questions
- Improved patient satisfaction after follow up *(Brier et al, Obstet Gyne 1999)*

Impact of EPCL on people's lives

- The emotional and psychological impacts of early pregnancy loss can be serious. For some people, the emotional distress can result in clinical depression, post-traumatic stress disorder, and/or anxiety.
- Ontario families experiencing early pregnancy loss have reported a lack of kindness and respect from health care professionals, that they felt less supported, and that they experienced more stigma at the time of their loss, compared with people whose loss occurred later in the pregnancy.

Sources:
National Institute for Health and Care Excellence. Ectopic pregnancy and miscarriage: diagnosis and initial management [Internet]. London: The Institute; 2019 [cited 2019 May]. Available from: https://www.nice.org.uk/guidance/ng126
Watson J, Simmonds A, La Fontaine M, Fockler ME. Pregnancy and infant loss: a survey of families' experiences in Ontario Canada. BMC Pregnancy Childbirth. 2019;19(1):129.

Adapted from HQO-EPCL QS

Care in the ER

- In Canada, The ER remains the first contact for women with EPC.
- The ER is not suitable for all women with EPC.
- HCP and ED staff may not be experienced providing emotional and bereavement needs.
- 2017 Task force developed recommendations around compassionate care in the ED for HCP and staff.
- Provincial Council for Maternal and Child Health [Internet]. Toronto: The Council; c2017 [cited 2017 June 12]. Early Pregnancy Loss in the Emergency Department. Available from: https://www.pcmch.on.ca/health-care-providers/maternity-care/pcmch-strategies-and-initiatives/early-pregnancy-loss-emergency-department/

Quality Standards

Early Pregnancy Complications and Loss

Guiding evidence-based care for people experiencing early pregnancy complications (such as pain and vaginal bleeding) and/or loss in the first trimester of pregnancy



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Let's make our health system healthier

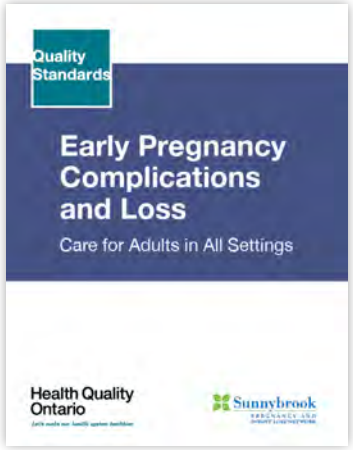
Sunnybrook
PREGNANCY AND INFANT LOSS NETWORK

Quality Standards

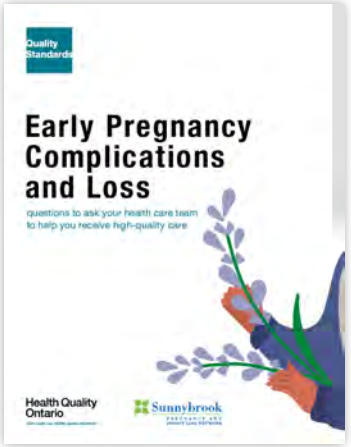
- Inform clinicians and patients what quality care looks like
- Focus on conditions where there are large variations in how care is delivered, or where there are gaps between the care provided in Ontario and the care patients should receive
- Are grounded in the best available evidence



Quality Standards Resources



Quality Standard



Patient Conversation Guide



Getting Started Guide



Recommendations for Adoption



Measurement Guide



Data Tables

Find these resources here:
https://www.hqontario.ca/evidence-to-improve-care/quality-standards/view-all-quality-standards/early-pregnancy-complications-and-loss

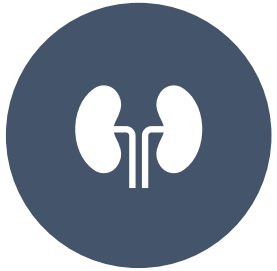
National Institute of Clinical Excellence (NICE) Recommendations on Early pregnancy assessment services (https:www.nice.org.uk/guidance/cg 154/chapter/1-recommendations)



AVAILABLE 7 DAYS A WEEK, WHERE SCANNING IS AVAILABLE AND DECISIONS ABOUT MANAGEMENT MADE.



BE A DEDICATED SERVICE PROVIDED BY HEALTH CARE PROFESSIONALS COMPETENT TO DIAGNOSE AND CARE FOR WOMEN WITH PAIN AND/OR BLEEDING IN EARLY PREGNANCY **AND** OFFER USS AND SERUM BHCG **AND** BE STAFFED BY HC PROFESSIONAL WITH TRAINING IN SENSITIVE COMMUNICATION AND BREAKING BAD NEWS.



SHOULD ACCEPT SELF-REFERRALS FROM WOMEN WHO HAVE HAD RECURRENT MISCARRIAGE, PREVIOUS ECTOPIC OR MOLAR PREGNANCY. OTHERS SHOULD BE ASSESSED BY OTHER HCP EG GP, ER, MW OR RN.



ENSURE ASSESSMENT WITHIN 24 HOURS OF REFERRAL OR AN ALTERNATIVE FACILITY E.G GYNE. WARD, A&E SERVICE WITH GYNE SUPPORT.

UK experience



EPAU model after NICE recommendations



Alternate **daily** access to Early pregnancy complications.



24/7/365

Early pregnancy Assessment Clinic at North York General Hospital.

- Started 2005 to fill the gap and provide a streamlined approach to care for EPCL
- A **one-stop** assessment clinic.
- A **team** of dedicated Physicians, a dedicated RN (perinatal and Bereavement) and an administrative assistance.
- All early pregnancy complications **up to 20 weeks** gestation (PCMCH website).
- **Collaboration** with Lab services, OR and DI (back up and PACs) .
- Documentation, **same day letter** to referring HCP/GP.
- Offer **Management options** – Conservative, Medical and Surgical.
- Counselling / Support (New service- referral to PAIL)
- **Dedicated** D & C list

Early pregnancy Assessment Clinic at North York General Hospital.

- All Miscarriages
- Hyperemesis gravidarum – arrange CCAC/ Home care
- Administration of Rhogam
- FU Ectopic pregnancy
- FU Molar pregnancy
- Recurrent pregnancy losses (out of scope – we arrange referral)
- Pregnancy termination (out of scope- we refer)

10 year retrospective study of the sustained value of EPAC at NYGH (2006 to 2015).

Aim:

- To determine if EPAC has a had a sustained impact to the management of Early pregnancy complications and
- on the number of ER assessments and reassessments of early pregnancy complications.

J Obstet Gynaecol Can 2018; 40(8): 1017-1023.

Results: Jan. 2006 to Dec. 2015

- Total # new referrals 11,349
- Total # follow –up visits 10,764

Sources of referrals.

- ER 44.7%
- Family MD 26.6%
- OBGYNs 18.9%
- Midwives 2.1%
- Other sources 7.7%

Table 2. ER assessments and reassessments data for three early pregnancy complications

Year	Total ER Assessments	Miscarriage		Ectopic pregnancy		Hemorrhage	
		Assessments	Reassessments	Assessments	Reassessments	Assessments	Reassessments
2004	61 155	466	90	54	15	924	286
2005	65 385	433	72	64	24	973	313
2006	67 932	438	55	58	14	963	285
2007	70 509	462	78	62	9	1079	297
2008	72 440	550	85	114	28	1171	292
2009	78 650	589	104	187	53	1166	225
2010	80 291	707	126	163	34	1267	245
2011	85 331	602	97	137	33	967	251
2012	91 770	625	106	144	31	959	300
2013	96 476	654	112	175	45	888	275
2014	101 250	598	92	170	30	875	233
2015	105 402	593	80	203	58	927	207

ER: emergency room.

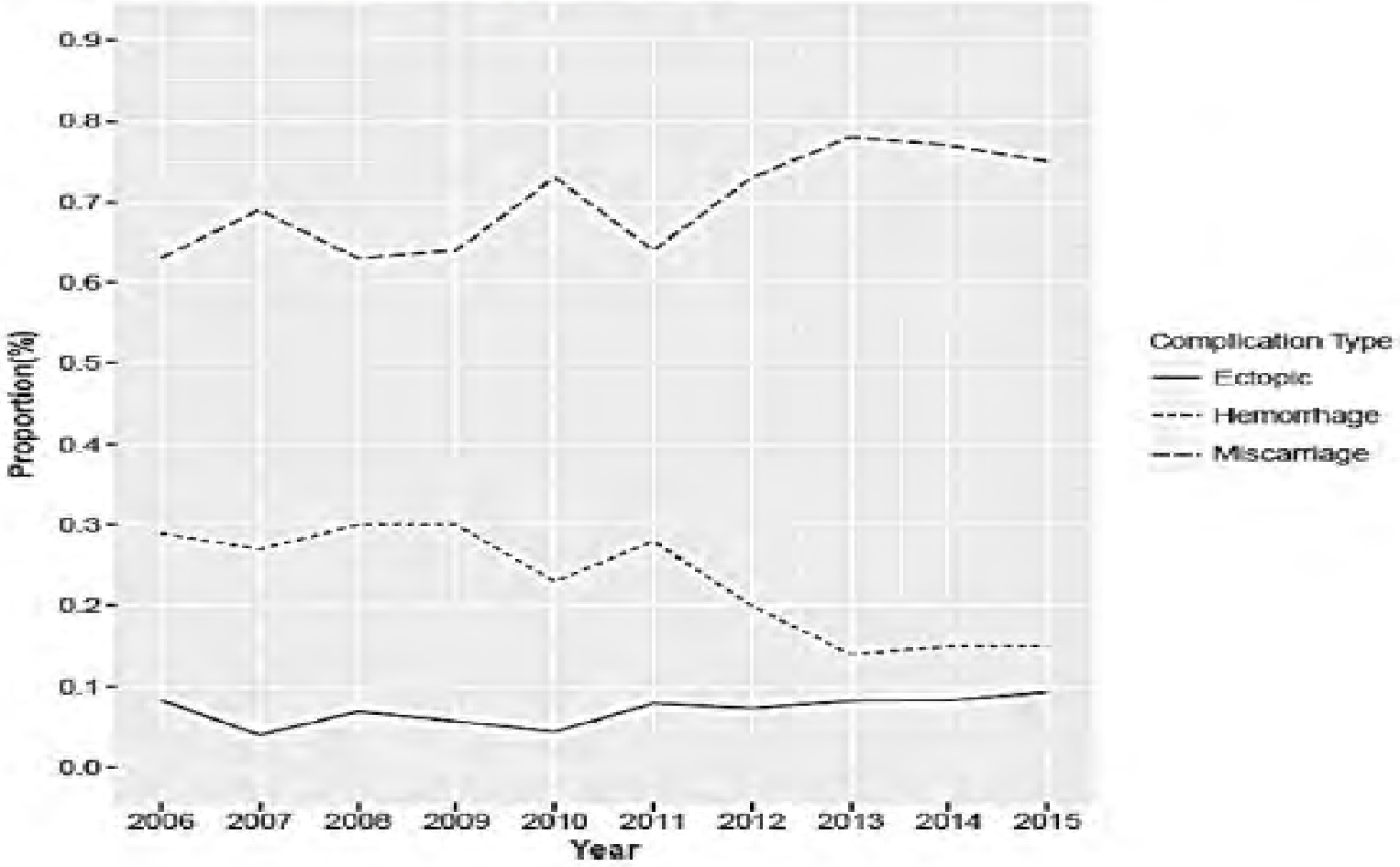
Total ER visits (2004 year -1, 2005 year 0) was 126, 540. ER assessments 2,917. ER reassessments 800
Total ER visits (2006- 2015) 850, 051, ER assessments was 17489, ER reassessments 3800

NORTH YORK GENERAL

Results

- Significant increase in the post EPAC rate compared with pre EPAC rate for ER assessments for miscarriage and ectopic pregnancy but no significant change with reassessments.
- No significant change for assessment of hemorrhage and a significant decrease in the rate of post EPAC re-assessments for hemorrhage.
- The increase in EPAC visits for miscarriage and ectopic pregnancy mirrored the ER findings.

Figure. Trend in early pregnancy assessment clinic visits for miscarriage, hemorrhage, and ectopic pregnancy.



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EPAC at NYGH

- The EPAC continues to manage patients based on population trends and needs
- Restricted access- same opening hours – 3-half days a week (12 hours/ week)- RCOG/NICE recommends daily access to make a change in ER assessments and reassessments.
- Appointment within 24 hours of referral not always possible
- Referral based / no walk ins
- Patient accessing EPAC through the ER

Setting up Early Pregnancy Assessment Clinics as an Alternate care for the management of Early pregnancy complications.

- A recommendation for all hospitals
- Simplified approach- Physician or RN led
- Ideally Daily access
- Collaborative approach
- **Appropriate Location**

EPAC impact analysis

Operational

- Daily or Half day
- Volume
- Staffing – RN 0.5/ 1.0 FTE (from L & D if existing or a new position)

-Admin clerk- 0.5 FTE for appointment and visit scheduling. From existing budget or new position.

- Physician (OBGYNS) OHIP billing/ FFS
- Supplies

Capital (Facilities/space, renovations, equipment, technology)

- Space- existing or new.

- reception, Nurse, consultation
- Equipment USS- TV probe, exam table

Stakeholders/Customers

Partnerships & Alliances

- Partnerships with Medical Imaging.
- ?Consider partnerships with other LHIN to provider care if residual capacity

Risk (e.g regulatory/legal, political, reputational etc)

- Potential increased risk with increase volume and complex cases.

Patient Care (e.g quality, access, etc.)

- Increased patient satisfaction- improved continuity of care and follow up

Impact on other Health Care Providers

- Improved communication amongst all care givers involved through prompt response.
- Improved access to lab and test results, all results are available in a timely fashion.

Internal Service Processes

Clinical

- Surgery – OR time for D & Cs
- Family & Community Medicine – access to clinic will improve access to appropriate care
- ER – guaranteed referral to clinic and decrease volume of first trimester complications, F/U s
- Maternal Newborn- ↑access to care, OB volume, prenatal classes

Clinical support

- Medical imaging
- Labs – Nurses will draw blood, increase cost to lab to process routine blood that would have been done in the community

Non clinical

- Environmental/ Portering – for OR
- IT- install/maintain computer and phone/ PACs .
- Linen- increased
- Health records
- Volunteers

Learning & Growth

Human resources

- Recruit staff –RN, secretary

Professional Practice (Skills. Training)

- Increase demands for orientation and recertification

Academic /Teaching

- Increased opportunity for teaching-Nurses, Medical students, residents, Fellows

Research

- Great opportunities for research

are several reasons why this Clinic provides superb patient care and an excellent learning opportunity for medical students and residents.

As you know, I have recently completed residency at the University of Toronto in Obstetrics and Gynecology. Prior to this, I was a medical student at the University of Toronto. In my training, I have spent a total of 5 clinical rotations at NYGH: one as a clinical clerk and 4 as a resident. In total in residency, I spent 10 months rotating at NYGH. During all of these rotations, I spent time working in EPAC. Now, as a Clinical Associate at NYGH, I also work shifts in EPAC and occasionally supervise learners there.

This clinic is a unique entity in the city of Toronto, in which point of care ultrasound, laboratory investigations, consultation and management are all done in one patient visit. I have never come across another clinic like this in our city in my clinical work. Certainly this provides a continuous, streamlined experience for patients, which is highly advantageous to other models, where patients have separate ultrasound, blood work and clinician visits which can sometimes involve long wait times, multiple visits or emergency room assessments. In addition, it allows the learner to participate in gynecology ultrasound, which is a skill that is otherwise challenging to find the opportunity to learn in our training in Toronto. Most helpful in my opinion, however, it allows the learner to develop the skills to synthesize investigations and clinical consultation into a comprehensive management plan. The application of clinical information in these visits is a superb learning opportunity and has significantly impacted my development as a resident in early pregnancy care.

As a supervising physician, I have particularly noticed the benefit to training our family medicine residents in EPAC, where they can gain knowledge and comfort in managing early pregnancy complications, which ultimately equips them to provide more comprehensive patient care in their future roles as primary care physicians.

I would not hesitate to encourage other hospitals to model their clinic after NYGH.

Sincerely,

Summary

- Early pregnancy loss and complications affects 25% of all pregnancies
- It results in emotional and psychological trauma.
- The ER is the first contact for women with early pregnancy complications.
- There are recommendations by the PCMCH /HQO on compassionate care in the ED.
- An alternative care through the early pregnancy assessment clinics will ensure a compassionate and comprehensive approach to care.
- **This should be our goal !!!!**

Acknowledgements

- EPAC Physician Group at NYGH
- RN Tempest
- Admin- Jolanta Klimach
- NYGH Foundation/ Dr. Sheila Cohen Foundation

Thank You.

- Questions Feedback.

Contact : modupe.tunde-byass@nygh.on.ca

The University Of Sheffield.

School Of Health And Related Research.

Faculty/Presenter Disclosure

- **Faculty:** SUZANNE MASON

- **Relationships with commercial interests:**
  - None

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- **This program <u>has not</u> received financial or in-kind support from any organization**

- **Potential for conflict(s) of interest:**
  - Not applicable

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Mitigating Potential Bias

- **Not applicable**

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Using data to understand demand in urgent & emergency care systems

Suzanne Mason
Professor of Emergency Medicine
ScHARR, Sheffield
Barnsley Hospital NHS Foundation Trust

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The UEC Patient Journey

ISSUES

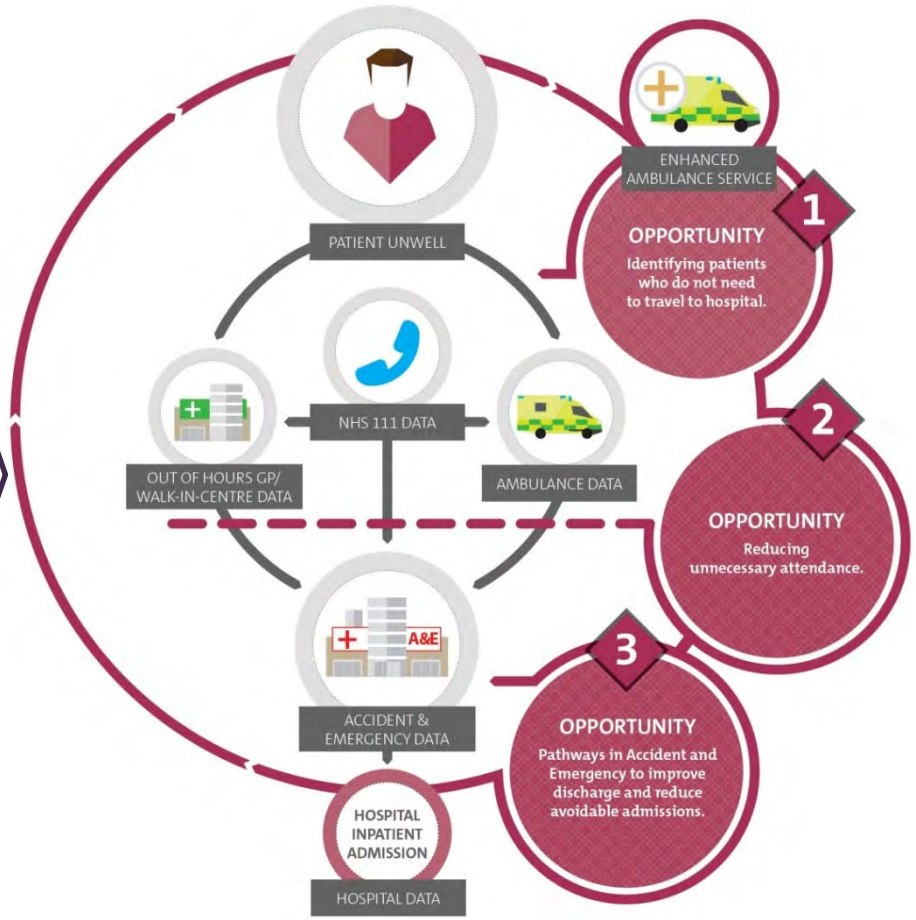
Increased demand on emergency systems

↓

Performance compromised

↓

Patient care/outcomes sub-optimum



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Studying the living eco-system in UEC



- Population of 5.5 million
- Mixed rural / urban
- 1 Ambulance Service

(999 and NHS 111 services)

- 13 acute hospital trusts
  - 19 EDs (≈10% of England)

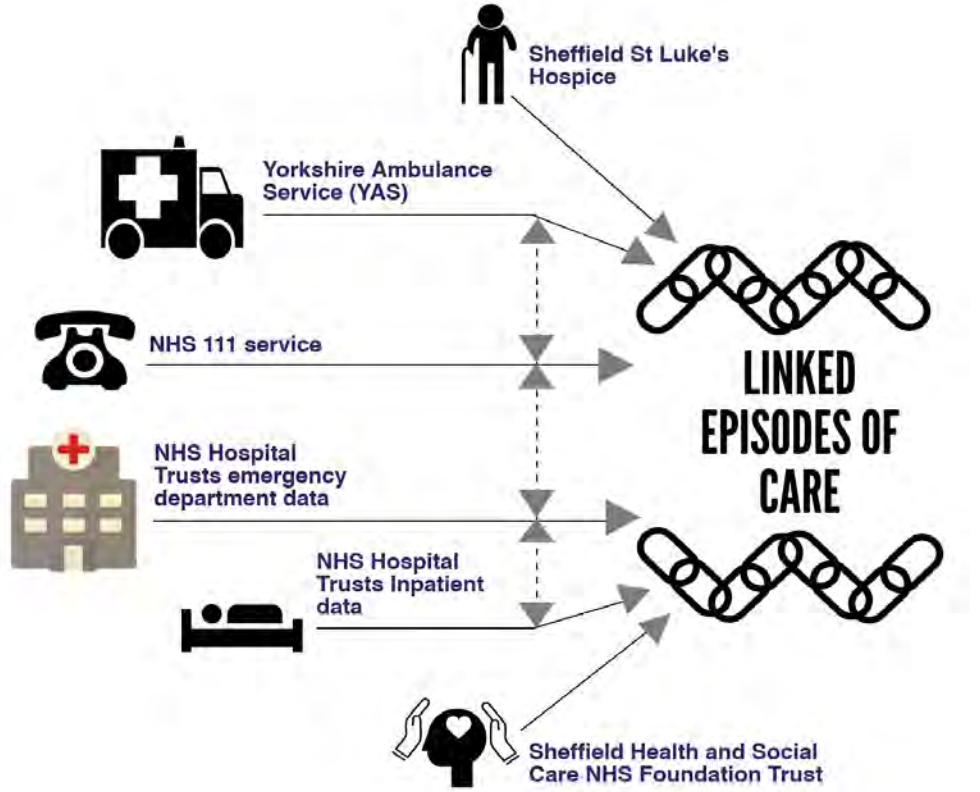
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Data linkage of urgent care data

- Understand the system, patient use, flows and outcomes
- Focus on specifics:
  - Low Acuity patients
  - Elderly
  - Mental Health
  - Short stay admissions
  - Flow / performance
- Public / healthcare staff perspectives on Urgent & Emergency care system
- Model the system to identify success factors
- Link with other datasets: EOLC, MH



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Accessing the system

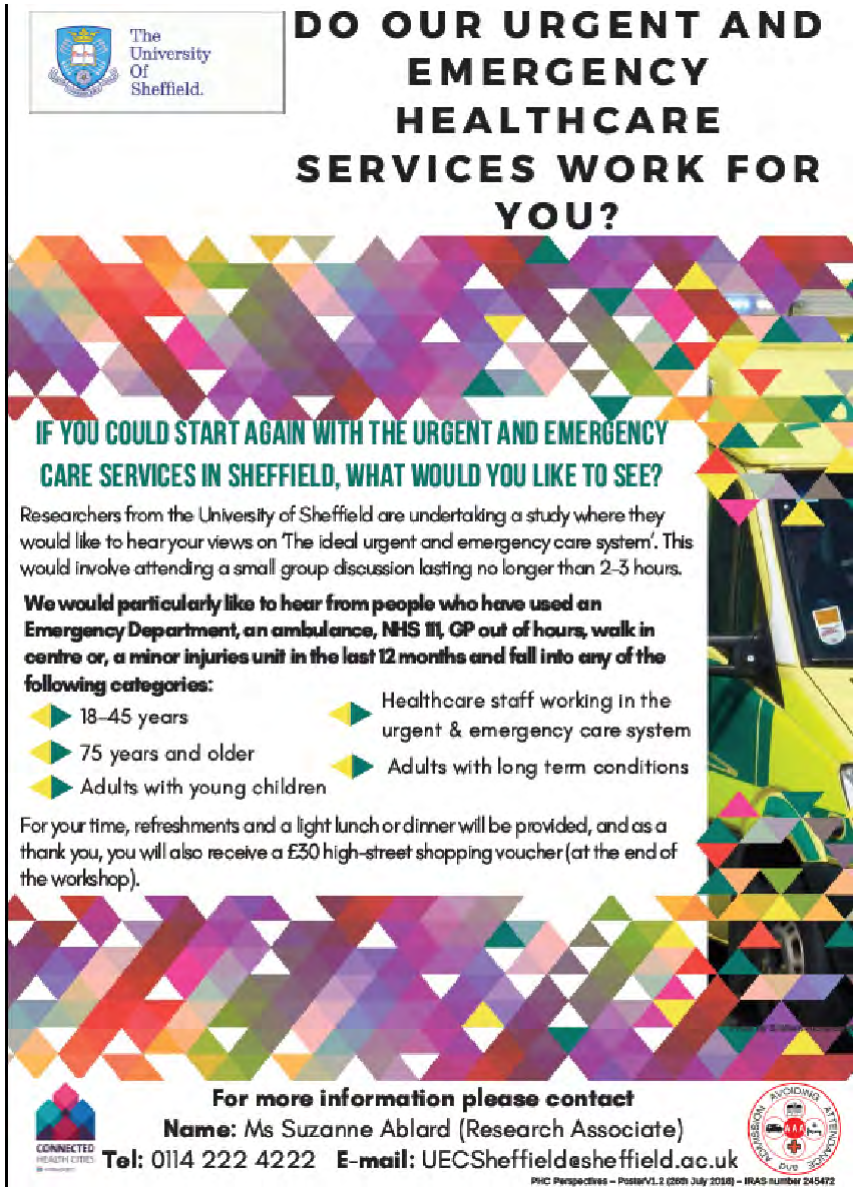


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Patient behaviour



- Simplify the system
- Communicate with each other
- Share our records

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Reasons for attendance

I wanted to see a doctor ASAP **(19.6%)**

Advised to attend by someone else **(44.9%)**

I need reassuring that it is not serious **(20.4%)**

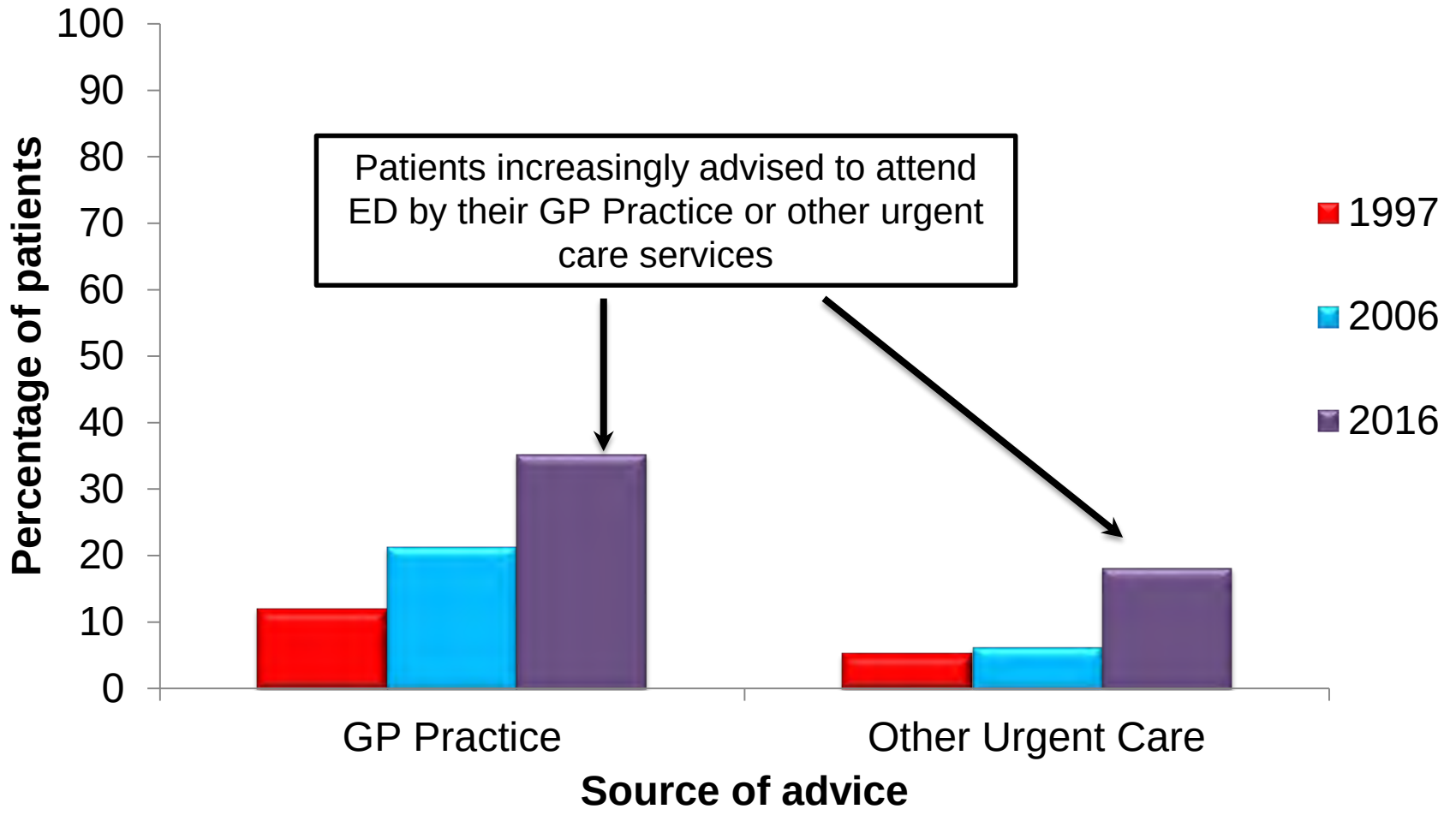
I thought I needed an x-ray **(28.6%)**

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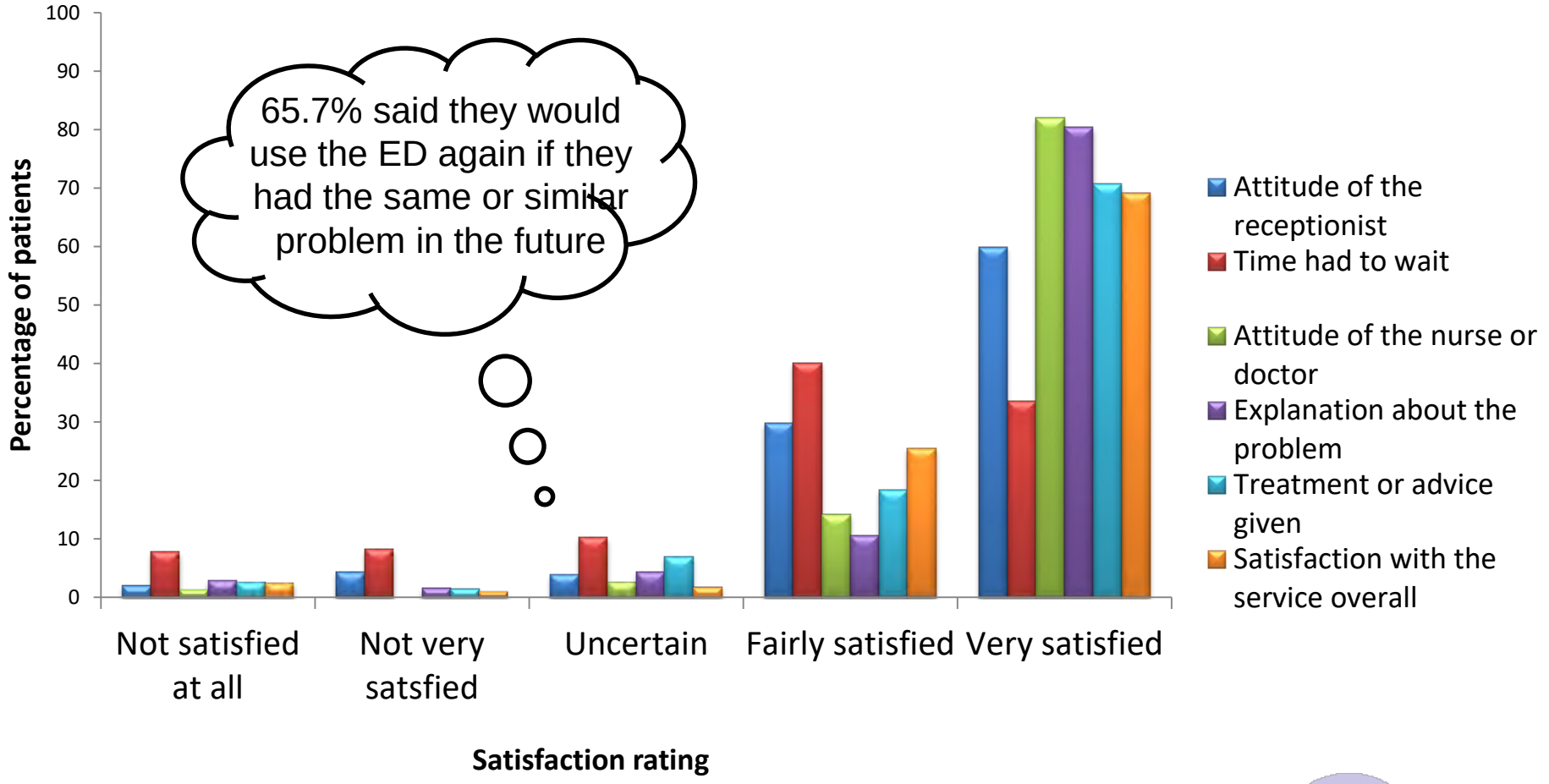


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Satisfaction with ED



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Who needs to come?

Defining non-urgent attendance

- **"First attendance with some recorded treatments or investigations all of which may have been reasonably provided by a GP, followed by discharge home or to GP care."**

  - Not investigated in ED (except urinalysis, pregnancy test or dental investigation)

  - Not treated in ED (except prescription, recording vital signs, dental treatment or guidance/advice)

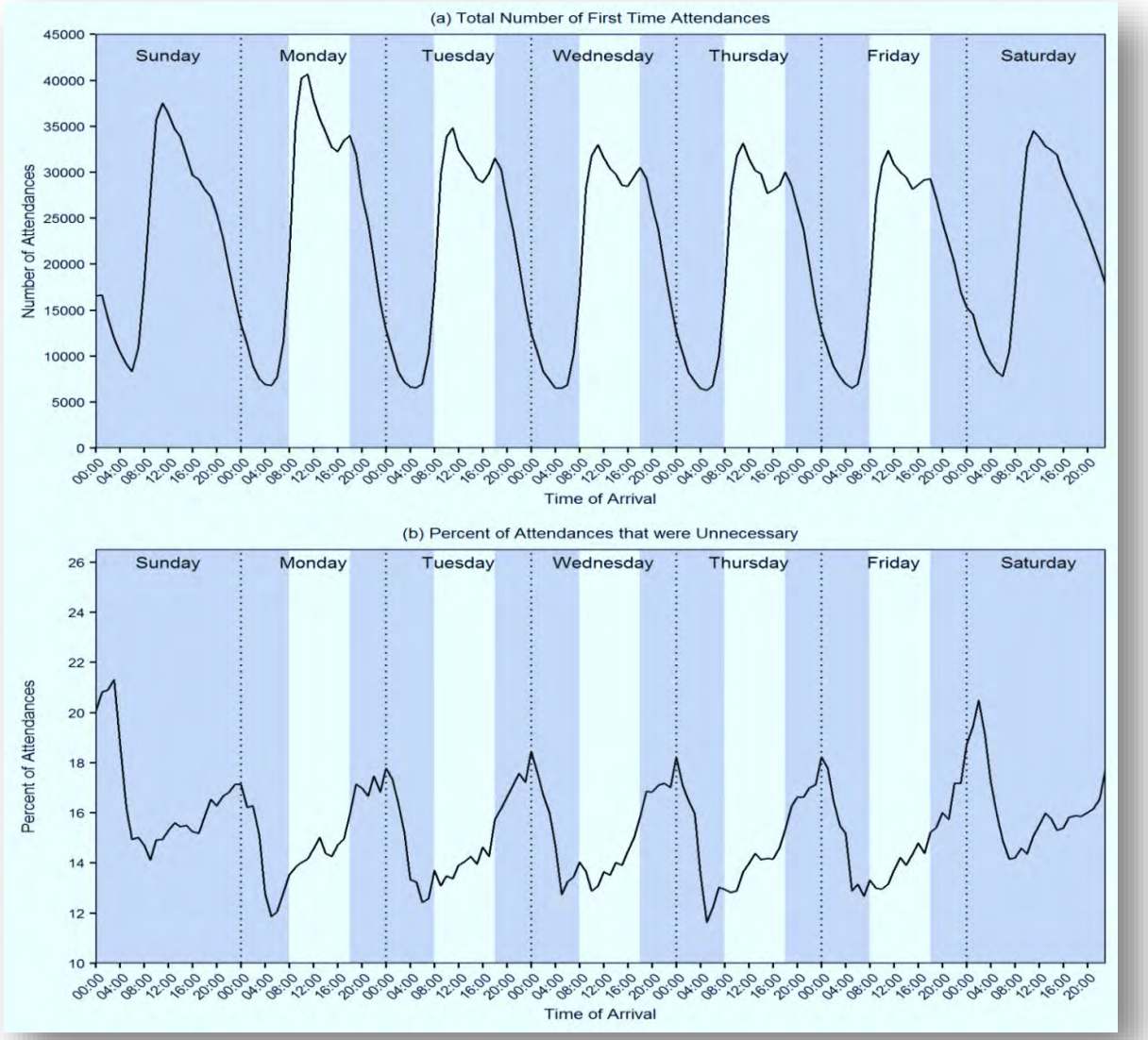
  - Discharged completely from care in ED or referred to their GP

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Pattern of attendances



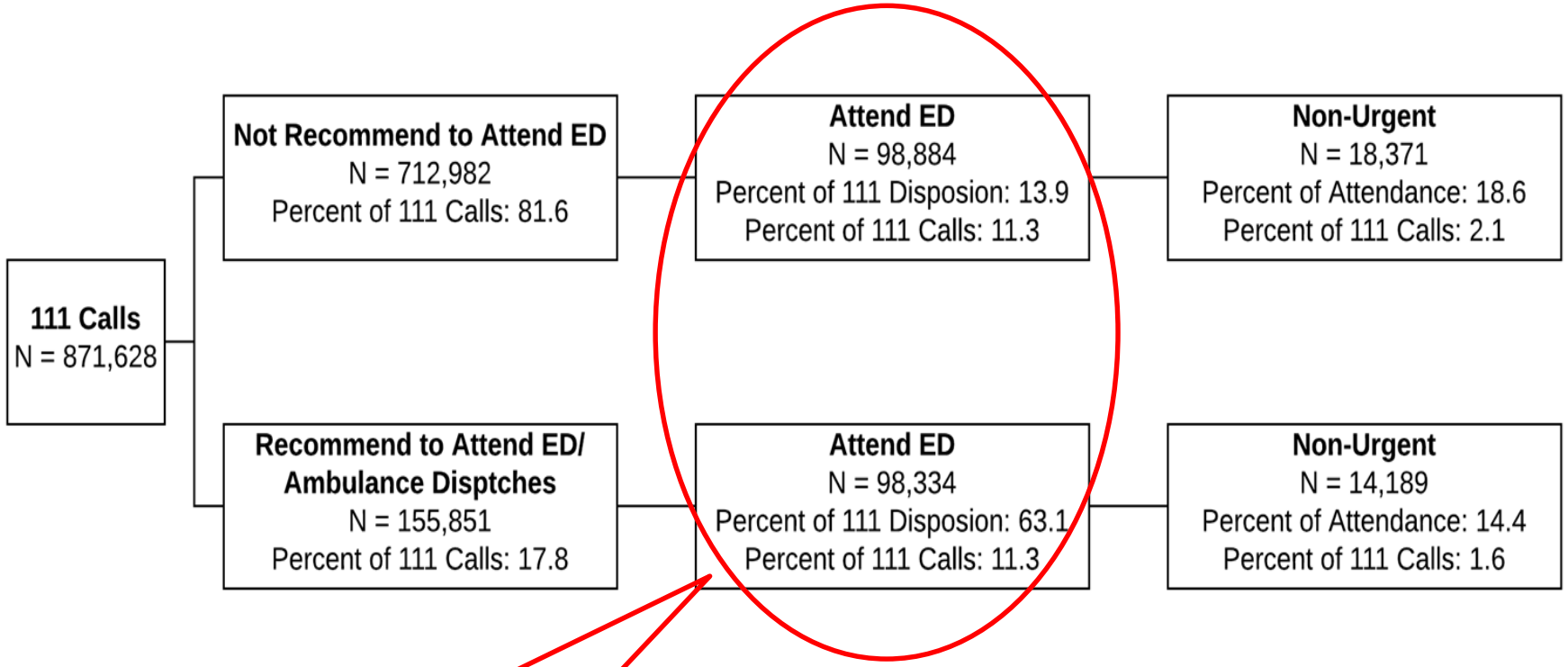
- 23% adults & 31% children
- attend avoidably
- Tend to be <45y
- Attend more OOH

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Other Provider behaviour



22% of all ED attendances
23% of all 111 calls
Half advised **not** to attend

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Avoidable ambulance conveyances

- **404,348 ambulance conveyances analysed for 1 year**
- **65,360 patients** transported to ED with a low acuity problem
- **16.2%** of all ambulance conveyances

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Total avoidable conveyances n=65,360

Proportion of avoidable conveyances n=65,360

	16-35	35-54	55-74	75+		16-34	35-54	55-74	75+
Abdominal Pains/Problems	194	90	74	42		21.7	12.2	11.9	5.8
Allergies (reactions) / Envenomations	202	98	54	26		47.5	34.9	26.0	17.2
Assault / Sexual Assault	511	250	22	9		38.8	41.1	22.0	29.0
Back Pain (non-traumatic or non-recent trauma)	35	49	36	13		36.1	33.6	27.7	7.9
Breathing Problems	1020	743	612	498		33.3	20.3	8.0	4.9
Chest Pains (non-traumatic)	1165	1272	834	493		26.7	16.8	8.6	4.7
Convulsions / Fitting	1016	674	227	113		28.0	23.0	12.8	8.2
Diabetic Problems	56	61	62	46		15.1	14.3	11.0	7.1
Falls	913	899	976	2489		28.2	23.4	13.8	10.9
Headache	78	49	16	17		44.8	29.3	17.2	19.3
Heart Problems	191	134	106	64		32.0	21.1	10.3	7.4
Haemorrhage / Lacerations	460	329	294	398		27.3	19.2	13.8	10.5
Overdose / Poisoning (ingestion)	916	485	78	10		26.4	19.5	14.1	6.1
Pregnancy / Childbirth / Miscarriage	233	33	1	0		25.2	16.8	100.0	0.0
Psychiatric / Abnormal behaviour / Suicide attempt	1061	1040	267	36		48.6	50.1	42.3	13.4
Sick Person (Sepcific Diagnosis)	616	465	337	367		40.7	27.3	12.4	6.5
Stroke (CVA)	204	285	281	299		33.0	20.5	9.3	5.3
Traffic / Transportation Accidents	443	237	106	40		31.0	27.8	24.3	22.0
Traumatic Injuries (Specific)	638	348	187	186		30.5	29.2	21.5	15.6
Unconscious / Fainting (Near)	1520	619	369	360		39.7	23.3	10.7	6.3
Unknown Problem (Collapse 3rd Party)	24	24	16	12		31.6	25.0	13.3	3.7
HCP (Health-Care Practitioner) Referral	647	949	998	1389		22.9	16.2	8.6	6.4
111	3858	2572	1594	1413		30.6	22.8	12.4	7.6

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- 1:6 ambulance journeys
- 1:3 patients aged 16-35y
- Potential Targets
  - Minor illness
  - Alcohol intoxication
  - Head injury
  - Mental Health
  - Chest Pain

Solutions:

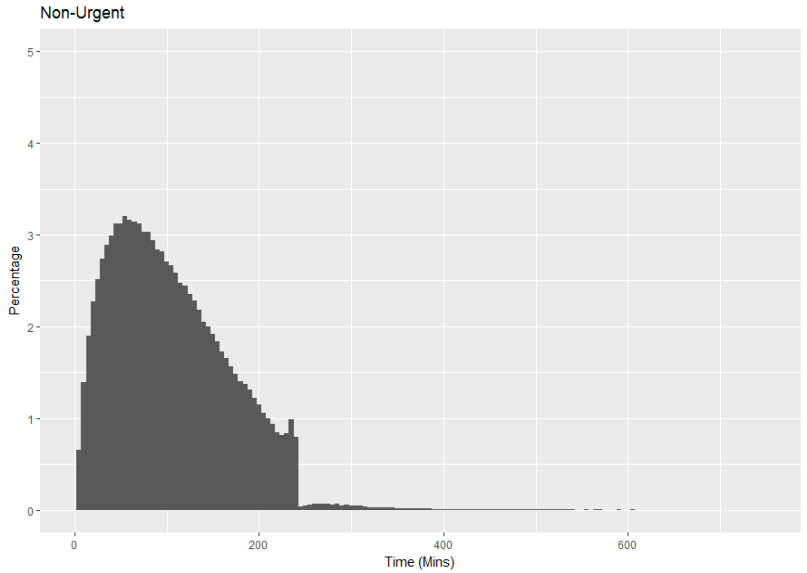
- **Empower services**
- **Care Pathways**
- **Paramedic Ed.**

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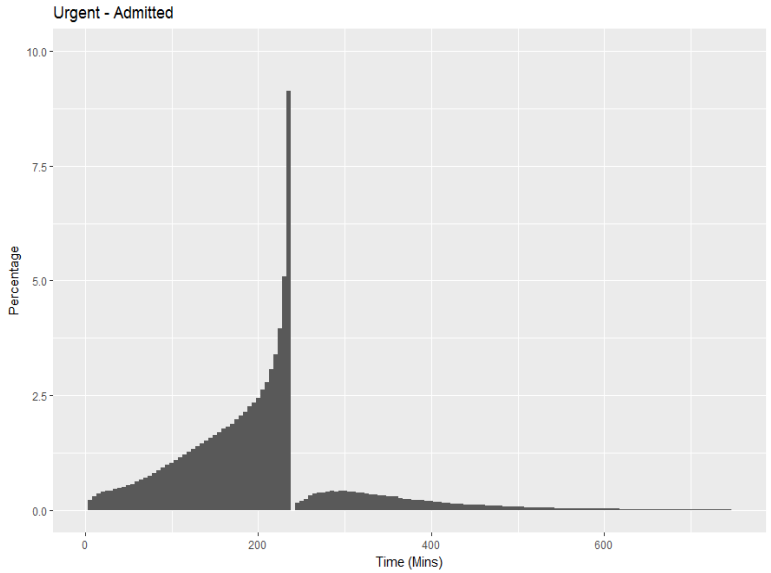
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Is the 4HT a good thing?

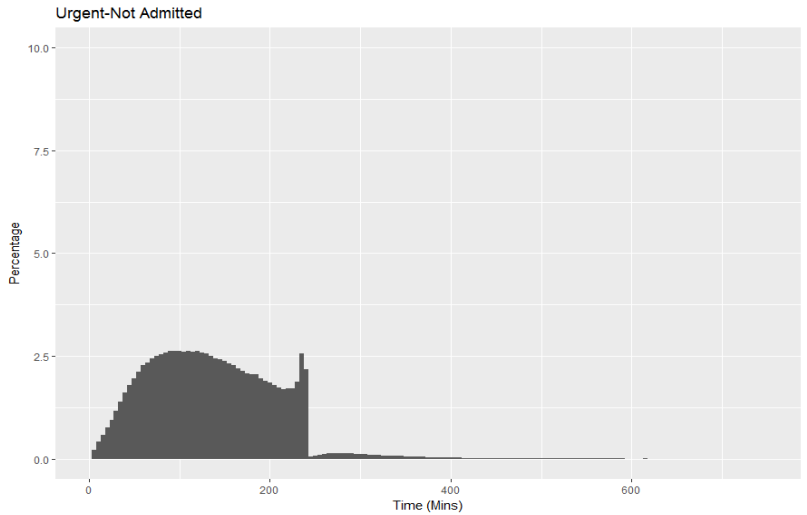
Non-urgent attenders



Urgent – admitted



Urgent – not admitted



	Median Total Time (IQR)
Non-urgent	110 (64 – 169)
Urgent – not admitted	149 (94 – 209)
Urgent - admitted	230 (166 – 312)

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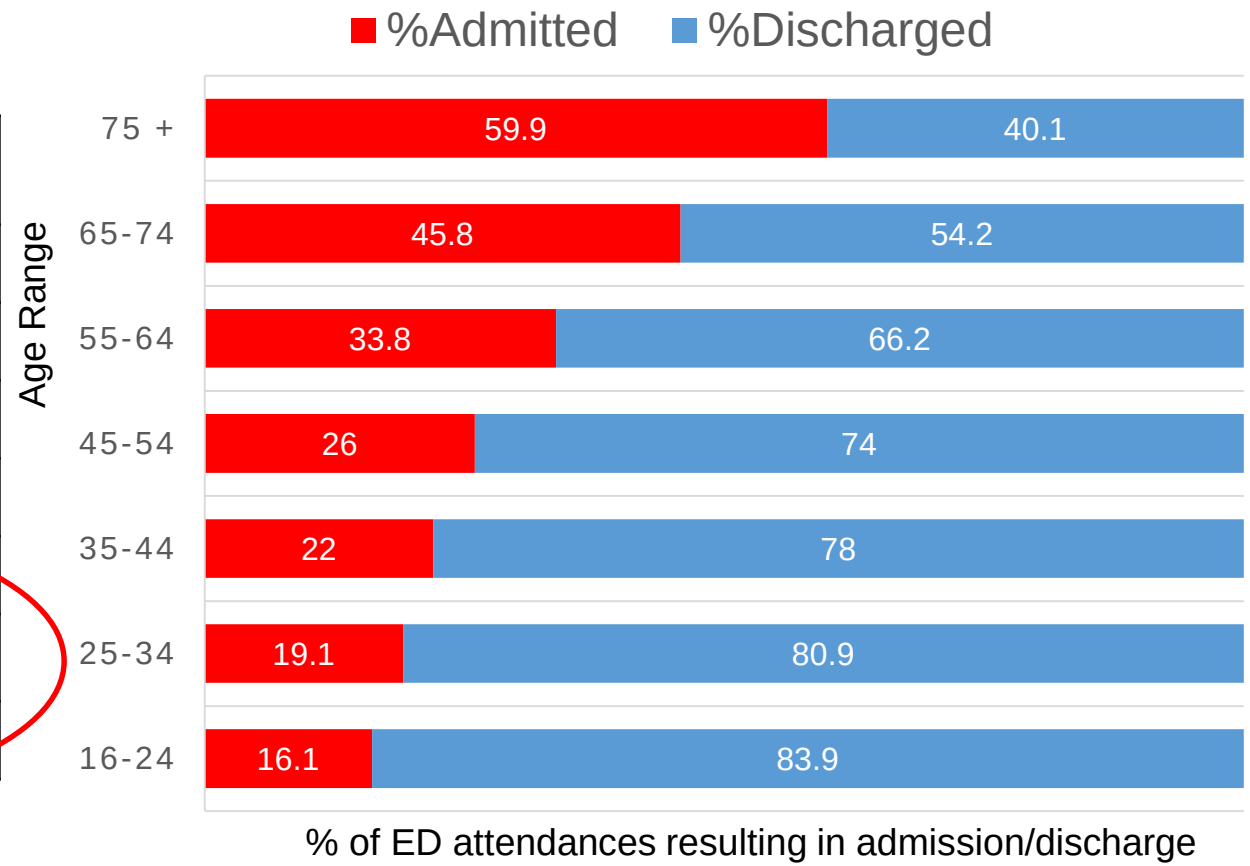
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Hospital Admission

Age Range (Years)	Number Admissions
75+	379,876
65-74	162,124
55-64	130,791
45-54	133,853
35-44	120,623
25-34	124,453
16-24	116,462

361,538 = 31%

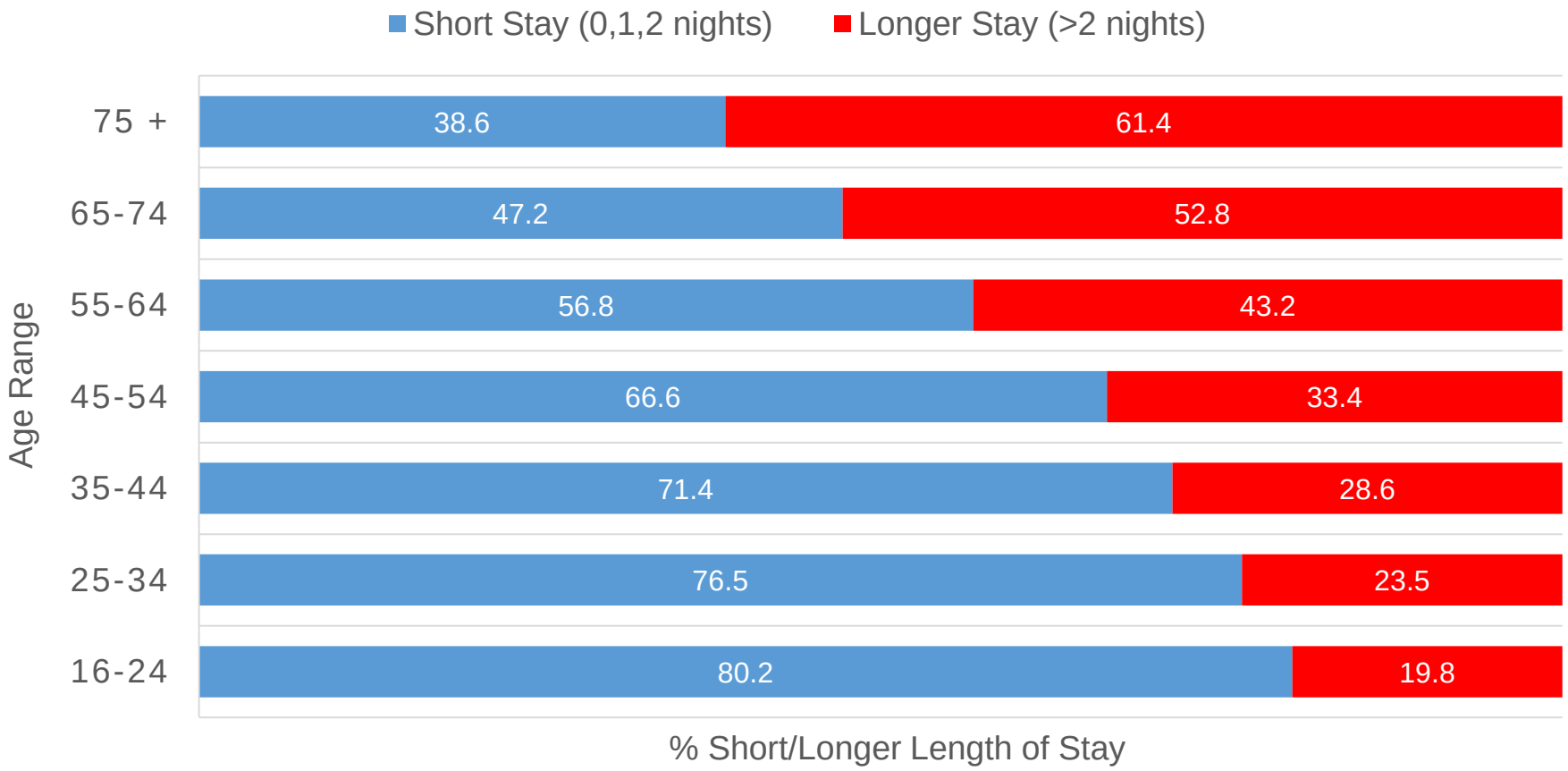


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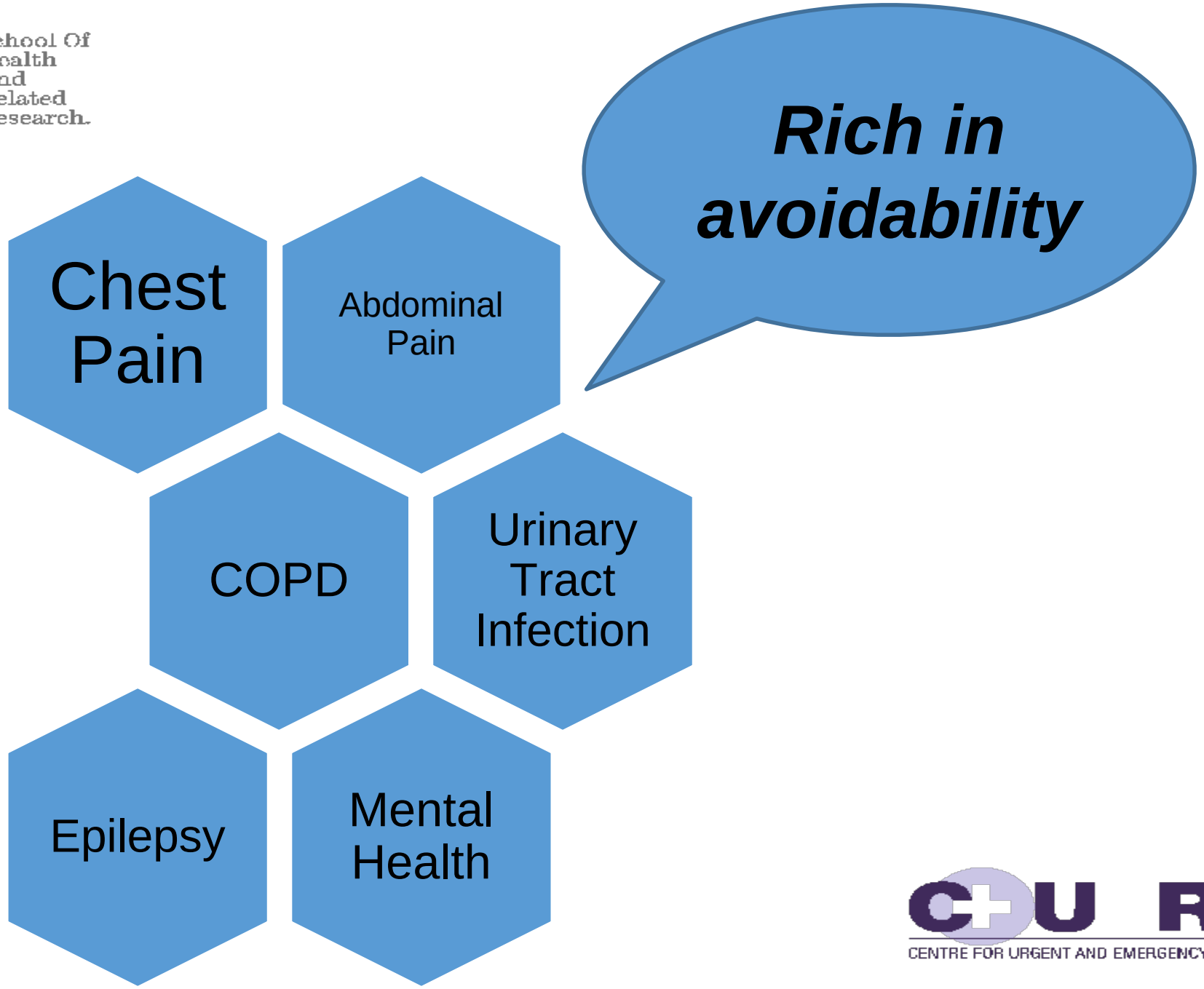
Length of Stay



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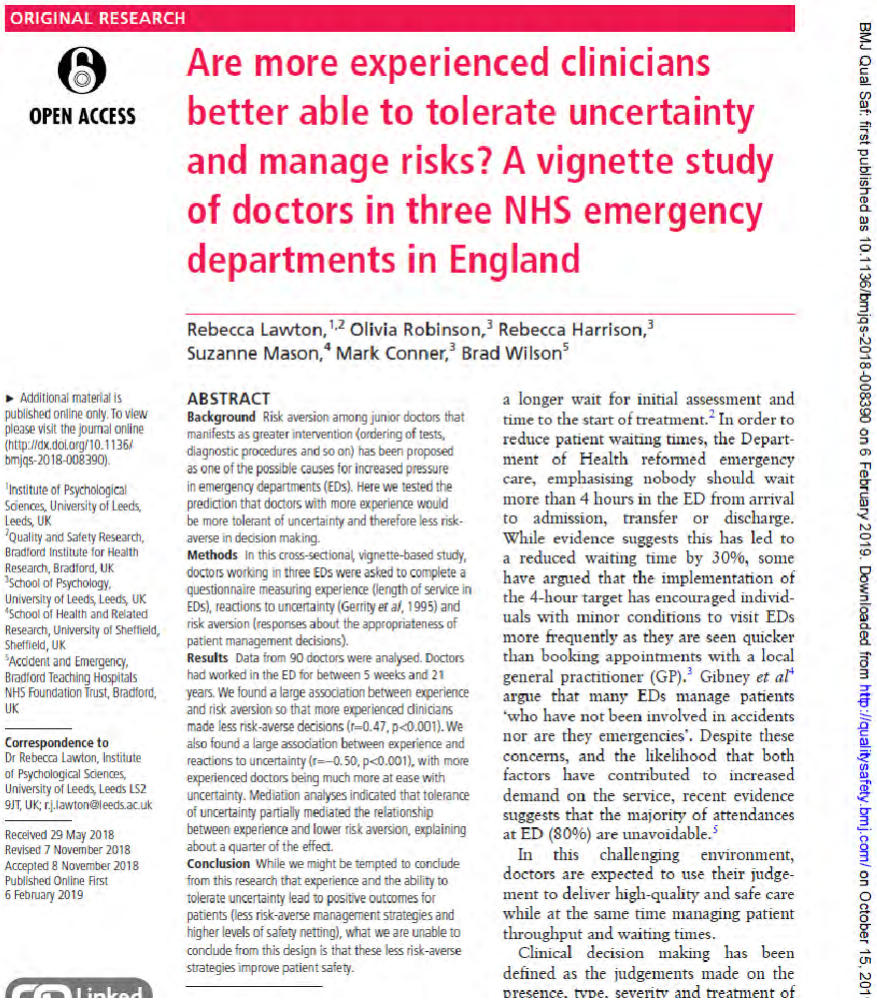


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Tolerance of uncertainty



ORIGINAL RESEARCH

OPEN ACCESS

Are more experienced clinicians better able to tolerate uncertainty and manage risks? A vignette study of doctors in three NHS emergency departments in England

Rebecca Lawton,[1,2] Olivia Robinson,[3] Rebecca Harrison,[3] Suzanne Mason,[4] Mark Conner,[3] Brad Wilson[5]

► Additional material is published online only. To view please visit the journal online (http://dx.doi.org/10.1136/bmjqs-2018-008390).

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[2]Quality and Safety Research, Bradford Institute for Health Research, Bradford, UK
[3]School of Psychology, University of Leeds, Leeds, UK
[4]School of Health and Related Research, University of Sheffield, Sheffield, UK
[5]Accident and Emergency, Bradford Teaching Hospitals NHS Foundation Trust, Bradford, UK

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ABSTRACT

Background Risk aversion among junior doctors that manifests as greater intervention (ordering of tests, diagnostic procedures and so on) has been proposed as one of the possible causes for increased pressure in emergency departments (EDs). Here we tested the prediction that doctors with more experience would be more tolerant of uncertainty and therefore less risk-averse in decision making.

Methods In this cross-sectional, vignette-based study, doctors working in three EDs were asked to complete a questionnaire measuring experience (length of service in EDs), reactions to uncertainty (Gerrity *et al*, 1995) and risk aversion (responses about the appropriateness of patient management decisions).

Results Data from 90 doctors were analysed. Doctors had worked in the ED for between 5 weeks and 21 years. We found a large association between experience and risk aversion so that more experienced clinicians made less risk-averse decisions ($r=0.47$, $p<0.001$). We also found a large association between experience and reactions to uncertainty ($r=-0.50$, $p<0.001$), with more experienced doctors being much more at ease with uncertainty. Mediation analyses indicated that tolerance of uncertainty partially mediated the relationship between experience and lower risk aversion, explaining about a quarter of the effect.

Conclusion While we might be tempted to conclude from this research that experience and the ability to tolerate uncertainty lead to positive outcomes for patients (less risk-averse management strategies and higher levels of safety netting), what we are unable to conclude from this design is that these less risk-averse strategies improve patient safety.

a longer wait for initial assessment and time to the start of treatment.[2] In order to reduce patient waiting times, the Department of Health reformed emergency care, emphasising nobody should wait more than 4 hours in the ED from arrival to admission, transfer or discharge. While evidence suggests this has led to a reduced waiting time by 30%, some have argued that the implementation of the 4-hour target has encouraged individuals with minor conditions to visit EDs more frequently as they are seen quicker than booking appointments with a local general practitioner (GP).[3] Gibney *et al*[4] argue that many EDs manage patients 'who have not been involved in accidents nor are they emergencies'. Despite these concerns, and the likelihood that both factors have contributed to increased demand on the service, recent evidence suggests that the majority of attendances at ED (80%) are unavoidable.[5]

In this challenging environment, doctors are expected to use their judgement to deliver high-quality and safe care while at the same time managing patient throughput and waiting times.

Clinical decision making has been defined as the judgements made on the presence, type, severity and treatment of

BMJ Qual Saf: first published as 10.1136/bmjqs-2018-008390 on 6 February 2019. Downloaded from http://qualitysafety.bmj.com/ on October 15, 201

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Lawton, R., Robinson, O., Harrison, R., Mason, S., Conner, M., & Wilson, B. (2019).. *BMJ Quality & Safety*. doi:10.1136/bmjqs-2018-008390

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Primary Care Colocation

Primary care services located with EDs: a review of effectiveness

Shammi Ramlakhan,[1,2,3] Suzanne Mason,[2,3] Colin O'Keeffe,[2] Alicia Ramtahal,[4] Suzanne Ablard[2]

ABSTRACT

Background Primary care focused unscheduled care centres (UCC) co-located with major EDs have been proposed as a solution to the rise in ED attendances. They aim to reduce the burden of primary care patients attending the ED, hence reducing crowding, waits and cost.

This review analysed available literature in the context of the impact of general practitioner (GP) delivered, hospital-based (adjacent or within the ED) unscheduled care services on process outcomes, cost-effectiveness and patient satisfaction.

Methods A narrative literature review of studies published between 1980 and 2015 was undertaken. All study types were reviewed and included if they reported a service model using hospital-based primary care clinicians with a control consisting of standard ED clinician-delivered care.

Results The electronic searches yielded 7544 citations, with 20 records used in the review. These were grouped into three main themes: process outcomes, cost-effectiveness and satisfaction. A paradoxical increase in attendances has been described, which is likely to be attributable to provider-induced demand, and the evidence for improved throughput is poor. Marginal savings may be realised per patient, but this is likely to be overshadowed by the overall cost of introducing a new service.

Conclusions There is little evidence to support the implementation of co-located UCC models. A robust evaluation of proposed models is needed to inform future policy.

unscheduled care services on process outcomes, cost-effectiveness and patient satisfaction.

METHODS

In order to explore the evidence supporting a hospital-based urgent care model, we undertook a literature review of existing research. The search strategy was based on the variables upon which the theoretical benefits of an UCC are premised.

A search strategy was designed with the following three-part question based on the study objectives.

For patients presenting to an ED with non-urgent problems (population) and managed by hospital-based primary care professionals (intervention) or emergency physicians (control), are there systematic differences in cost-effectiveness, process outcomes and patient satisfaction (outcomes)?

We searched for specific process outcomes related to the time from arrival to first diagnostic contact with a clinician (waiting time (WT)), time to treatment or intervention (treatment time (TT)) and total time in the ED (length of stay (LOS)).

We searched the following databases for articles between 1980 and February 2015: Business Source Premier, CINAHL, Cochrane Library, DARE, EMBASE, HTA, MEDLINE, NHS Evidence, NHS EED, PsycINFO and SCOPUS. We chose the lower date limit as the concept of ED patients being better suited for primary care only became topical around the mid-1980s. This was supported by a PubMed 'Results by Year' keyword scoping search, which demonstrated a low annual publication rate

- Currently little evidence
- Risk of supplier-induced demand
- Staffing an issue
- Cost an issue
- More evidence needed

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Senior Front Door Triage

The impact of senior doctor assessment at triage on emergency department performance measures: systematic review and meta-analysis of comparative studies

Maysam Ali Abdulwahid, Andrew Booth, Maxine Kuczawski, Suzanne M Mason

ABSTRACT

Study question To determine if placing a senior doctor at triage versus standard single nurse in a hospital emergency department (ED) improves ED performance by reviewing evidence from comparative design studies using several quality indicators.

Design Systematic review.

Data sources Cochrane Library, MEDLINE, EMBASE, CINAHL, Cochrane Effective Practice and Organisation of Care (EPOC), Web of Science, Clinical Trials Registry website. In addition, references from included studies and citation searches were used to identify relevant studies.

Review methods Databases were searched for comparative studies examining the role of senior doctor triage (SDT), published from 1994 to 2014. Senior doctor was defined as a qualified medical doctor who completed high specialty training in emergency medicine. Articles with a primary aim to investigate the effect of SDT on ED quality indicators such as waiting time (WT), length of stay (LOS), left without being seen (LWBS) and left without treatment complete (LWTC) were included. Articles examining the adverse events and cost associated with SDT were also included. Only studies with a control group, either in a randomised controlled trial (RCT) or in an observational study with historical controls, were included. The systematic literature search was followed by assessment of relevance and risk of bias in each individual study fulfilling the inclusion criteria using the Effective Public Health Practice Project (EPHPP) bias tool. Data extraction was based on a form designed and piloted by the authors for dichotomous and continuous data.

Conclusions This review demonstrates that SDT can be an effective measure to enhance ED performance, although cost versus benefit analysis is needed. The potential high risk of bias in the evidence identified, however, mandates more robust multicentred studies to confirm these findings.

INTRODUCTION

Emergency department (ED) crowding occurs when demand for emergency services exceeds the capacity to provide care within a reasonable time frame.[1] This problem is international in scope and affects governments, hospitals, service providers and service users[2–4] ED crowding is important because it is associated with long waiting times (WTs) and increased length of stay (LOS) of patients in the ED.[2] This is often reflected in risks to patient safety and reduced patient satisfaction.[3]

It is helpful to break down the causes of crowding into input, throughput and output factors.[4] Trying to control input or output is largely beyond the capability of ED staff and managers. Often such action requires a multilevel approach and collaborative involvement, including numerous hospital and out-of-hospital interventions.[1]

On the other hand, several interventions have been implemented to improve throughput or patient flow.

Nurse triage is currently the standard triage model in the majority of hospitals throughout the world.[5] Nonetheless, there seems to be a rising concern among policy makers as to whether or not this older model is effective enough in the face of

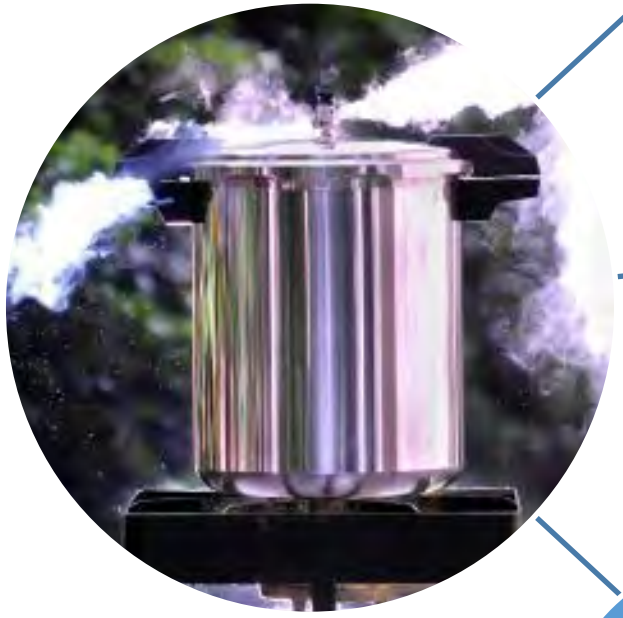
- Some impact on total WT and LOS
- No impact on admissions / patient satisfaction
- Staffing / sustainability
- No analysis of cost-effectiveness
- Larger multi-centre studies needed

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ED

- Size
- Casemix

Staff

- Sickness
- Strain
- Autonomy

Culture

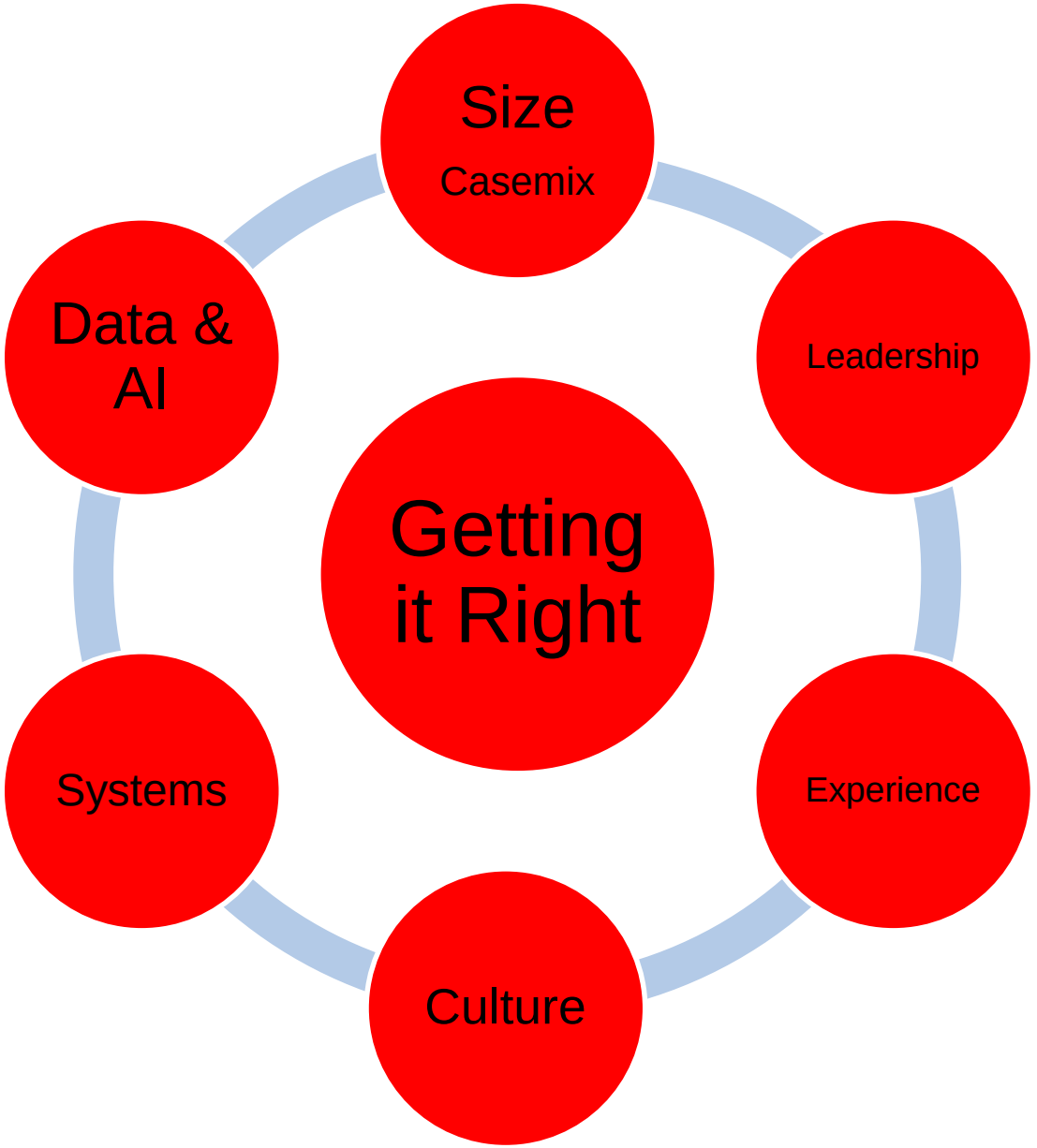
- Leadership
- Ownership
- Boundary spanning

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Thankyou

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@ProfSueMason

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Washington University in St.Louis

The ACA Impact in the United States

Christopher Carpenter, MD, MSc, FACEP, AGSF
Washington University School of Medicine
Barnes-Jewish Hospital

November 26, 2019
ED Administration Conference

Faculty/Presenter Disclosure

- **Faculty:** Christopher Carpenter

- **Relationships with commercial interests:**
  - None

Disclosure of Commercial Support

- **This program <u>has not</u> received financial or in-kind support from any organization**

- **Potential for conflict(s) of interest:**
  - Not applicable

Mitigating Potential Bias

- Deputy Editor-in-Chief
  - *Academic Emergency Medicine*
- Editorial Board
  - *ACP Journal Club*
  - *Journal of the American Geriatrics Society*
- SAEM Board of Directors
- ACEP Clinical Policy Committee
- Speaker: BEEM and EM Abstracts

Objectives

- Briefly review roots of the Accountable Care Act
- Explore the post-Obama evolution of US healthcare unintended consequences & alternative funding structures
- Opine on the future



History – Pre-Obama

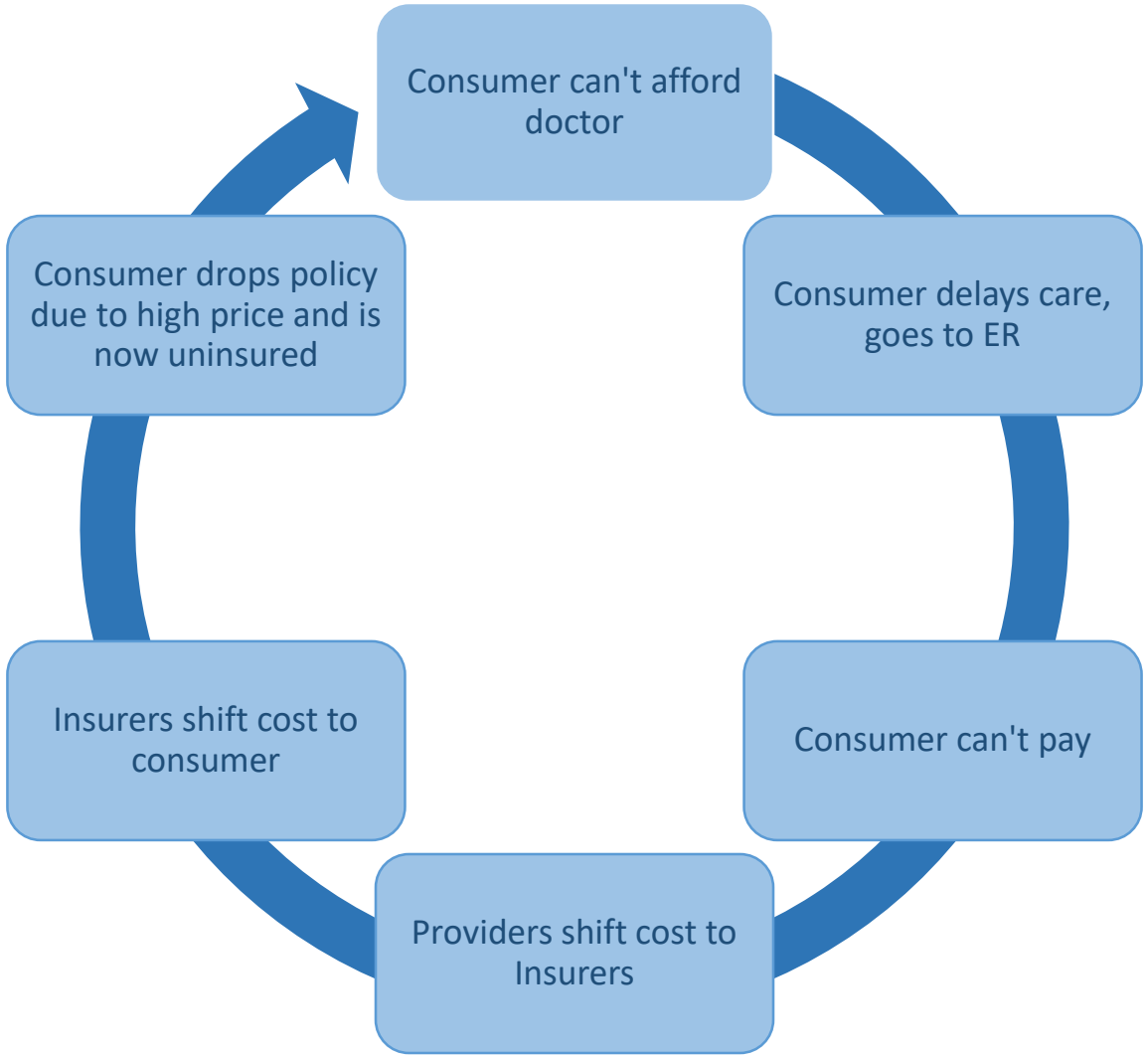
- 1945: President Harry Truman proposed voluntary national insurance program
- 1965: President Lyndon Johnson pushed Medicare
- 1974: President Richard Nixon proposed mandatory employer health coverage
- 1993: President Bill Clinton again proposed mandatory employer health coverage
- 2005: President George W. Bush added prescription benefits to Medicare

Obama Era - The ACA

- Patient Protection & Affordable Care Act
  - Affordable Care Act
  - Health Care Reform Law
  - “Obamacare”



After 100+ years, why ACA now?



Post-Obama Tinkering
(AKA: The Alphabet Soup Era)

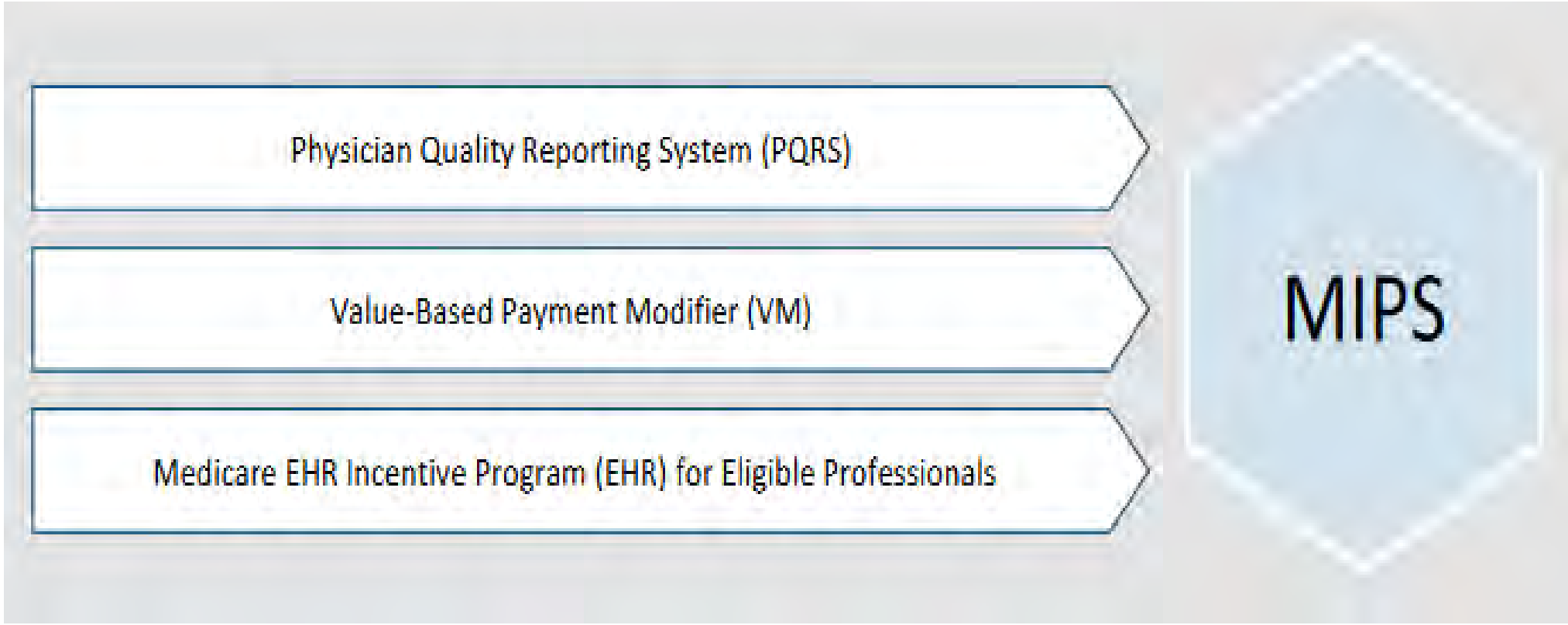


- Patient Protection & Affordable Care Act
  - Affordable Care Act
  - Health Care Reform Law
  - “Obamacare”



MIPS- combines legacy programs

- “single, improved program”



MIPS & APM's – Financial Impact

Incentives/penalties range **(on all paid Medicare Part B claims):**



BPCI Hospital Medicine Bundles

- Chronic obstructive pulmonary disease, bronchitis, asthma
- Cellulitis
- Sepsis
- Urinary tract infection
- Stroke
- Gastrointestinal hemorrhage
- Cardiac arrhythmia
- Congestive heart failure
- Acute myocardial infarction
- Gastrointestinal obstruction
- Simple pneumonia and respiratory infections
- Hip and femur procedures except major joint
- Major joint replacement of the lower extremity
- Renal failure
- Pacemaker



Alternative Payment Models (APMs)

- Syncope, Chest Pain, Abdominal Pain, Altered Mental Status
  - Initial APMs
  - High variability across the U.S. in managing.

- Goals
  - Reduce cost, variability, readmissions
  - 25% pts enrolled now
  - 75% pts enrolled 2023-2024
  - ED responsible during a 30 day window

ED Care Process

Discharge Patient to Home?

No → Patient sent to Observation

Yes →
- Shared Decision-Making
- Contact:
  - Specialist
  - PCP

→ Monitor/Manage 30 days Post-ED Visit:



- Telemedicine
- Home Visit/Care
- Transitional Care
- (or no use of waivers)

Current Process

Targeted Process

It's No Longer About Accelerating Throughput - But Optimizing the Quality of the output

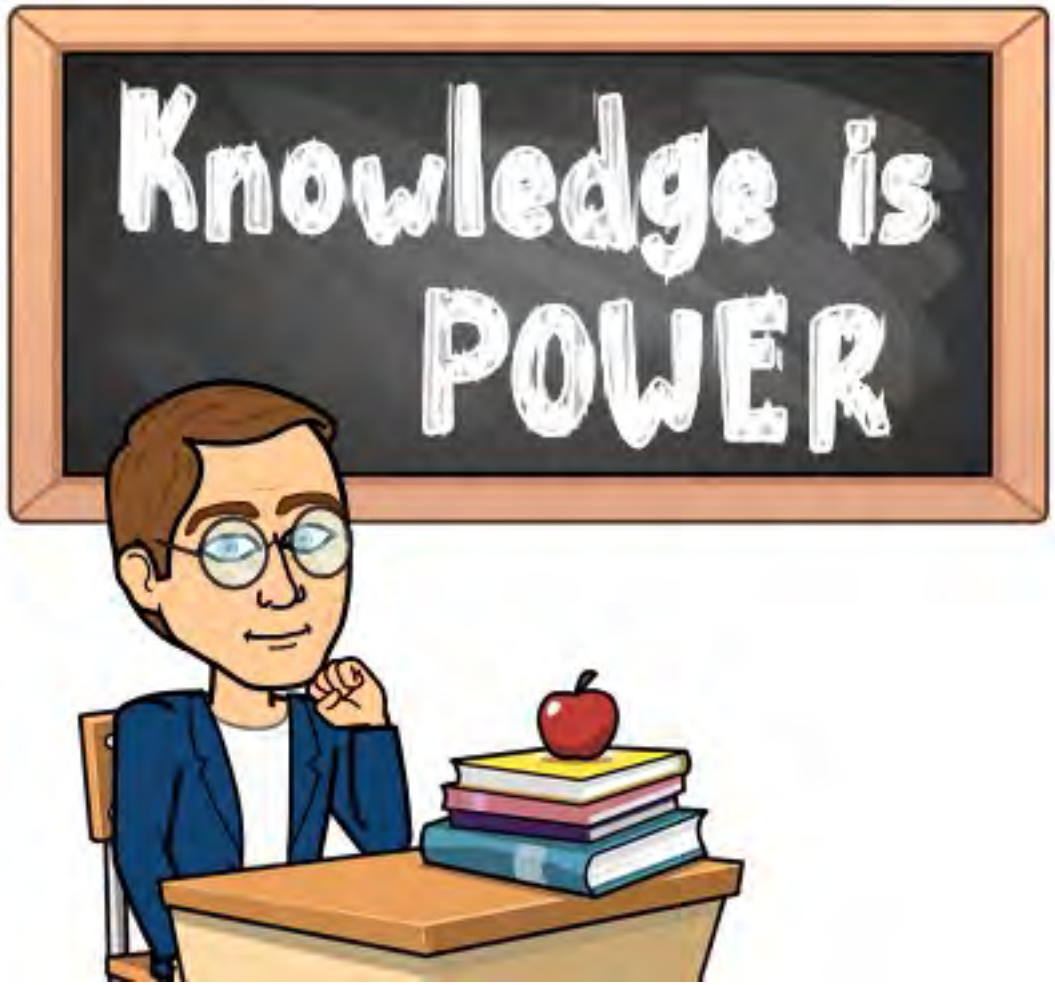


The best admission is one that is admitted quickly

The best admission is the admission that was avoided

Two parting thoughts & opinions

- The Mark Twain paradox
- Contemplating “The Cure”



The Mark Twain Paradox

Nonspecific Symptoms Lack Diagnostic Accuracy for Infection in Older Patients in the Emergency Department

Jeffrey M. Caterino, MD, MPH, David M. Kline, PhD,† Robert Leininger, MD,‡ Lauren T. Southerland, MD,* Christopher R. Carpenter, MD, MsC,§ Christopher W. Baugh, MD, MBA,¶ Daniel J. Pallin, MD, MPH,¶ Katherine M. Hunold, MD,* and Kurt B. Stevenson, MD, MPH‖*

30-Day Emergency Department Revisit Rates among Older Adults with Documented Dementia

Tyler Kent, BS, Adriane Lesser, MS,* Juhi Israni, MS,* Ula Hwang, MD, MPH,† Christopher Carpenter, MD, MS,‡ and Kelly J. Ko, PhD**

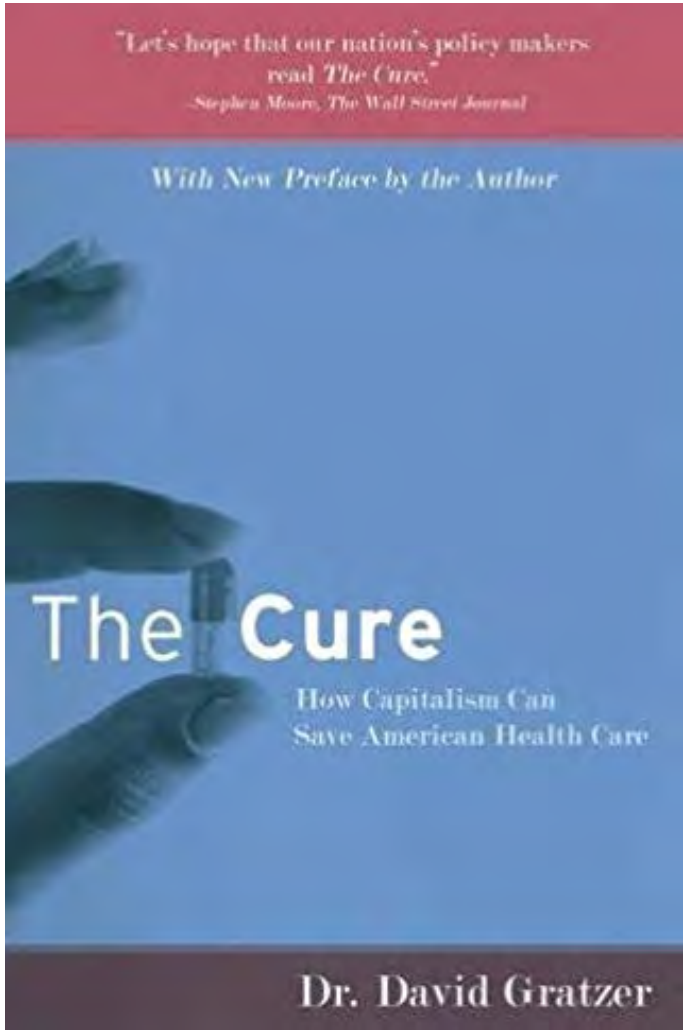
Instruments in Eme A Diagnostic Meta-

Christopher R. Carpenter, MD, MSc,
Debra Eagles, MD, MSc, Linda Schnitk
Susan Fowler, MLIS, and Michael A. La

Shared Decision Making to Improve the Emergency Care of Older Adults: A Research Agenda

Teresita M. Hogan, MD, Natalie L. Richmond, BA, Christopher R. Carpenter, MD, Kevin Biese, MD, Ula Hwang, MD, Manish N. Shah, MD, MPH, Marcus Escobedo, MPA, Amy Berman, BSN, Joshua S. Broder, MD, and Timothy F. Platts-Mills, MD, MSc

The Cure – How Capitalism Can Save American Health Care





Summary

- US healthcare funding ideas are in constant state of flux
- American College of Emergency Physician's is working with Congress to identify feasible alternatives for emergency medicine
- Challenging times are ahead

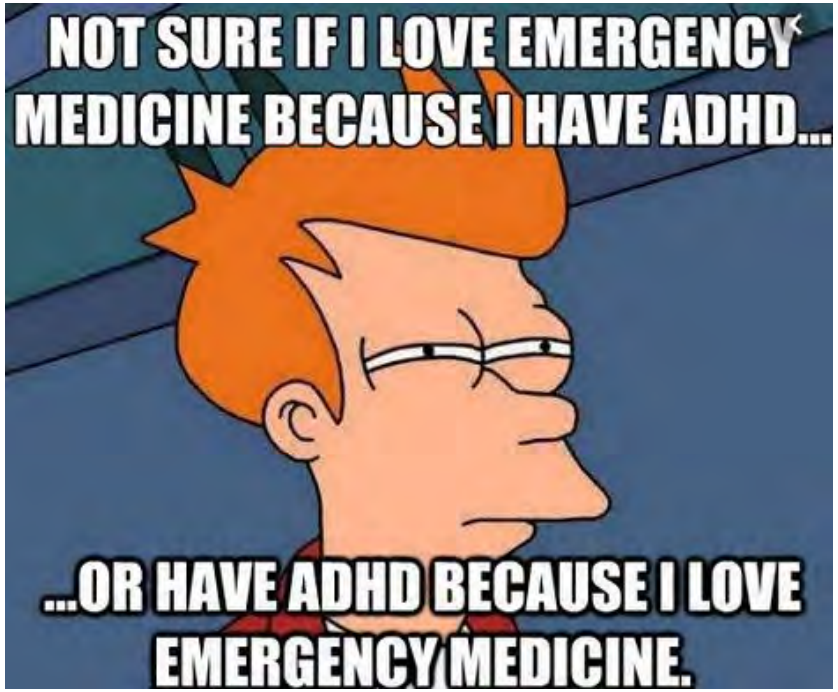




Questions?



"It's our new method for determining who we should treat first. We take people in order of how loud they scream."



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Journal Club website: http://emed.wustl.edu/Journal-Club
Twitter1 @GeriatricEDNews Twitter2 @SAEMEBM

Impacts Of The Affordable Care Act

- **Changes to private insurance, e.g.,**
  - Kids can't be denied health coverage if they are sick
  - Young adults on parents' policies to age 26
  - Prohibit lifetime monetary caps
  - Minimum medical loss ratio
- **Closes the Medicare prescription "doughnut hole"**
- **Expands coverage + imposes individual mandate in 2014**
  - Expands Medicaid to 138%* of FPL
  - Exchanges

*ACA 133% = 138% due to across the board income disregards

Pay For Performance Programs

- E-Prescribing program (eRx)
- Physician Quality Reporting System (PQRS)
- Meaningful Use (aka EHR Incentive Program)
- Value-based Modifier program (VM)

- Each program ended in 2016, and 2017 saw the first year of MIPS

MACRA

- The Medicare Access & CHIP Reauthorization Act of 2015 required CMS to develop a value based incentive program-- QPP

Quality Payment Program

QPP

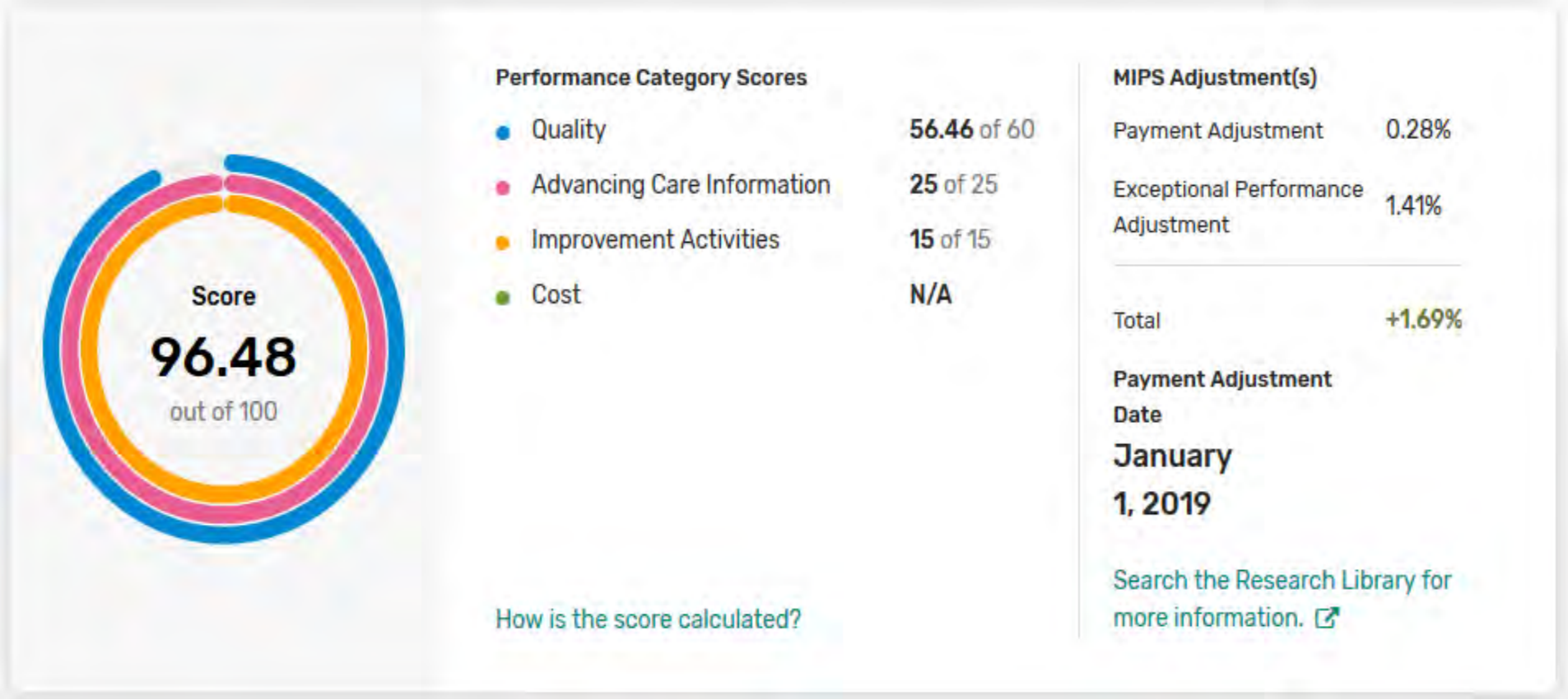
- Improve beneficiary outcomes
- Reduce burden on clinicians
- Maximize participation
- Improve data and information sharing

MIPS / APM

- Merit Based Incentive Payment System (categories of value reported individually or by group)
- Advanced Alternative Payment Models (limited # of risk based models)

MIPS Scorecard

2017 Data impacting 2019 reimbursement



Final 2018 score published July 2019 impacts 2020 payments

THE NHS APPROACH TO PREDICTIVE ANALYSIS

MATTHEW COOKE

CHIEF CLINICAL OFFICER, CAPGEMINI
RETIRED EMERGENCY PHYSICIAN

Faculty / Presenter Disclosure

- **Faculty:** Matthew Cooke

- **Relationships with commercial interests:**
  - Employee of Capgemini PLC

- **Mitigating Potential Bias**
  - The approaches discussed are widely available

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Digital First for Health. November 2019

- Data integration and predictive analytics: Providers will face fewer barriers to integrating and using secure health information to manage health resources and improve patient care. This could lead to improvements such as earlier intervention and better management of chronic disease. assessment.



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What is predictive analytics

- The practice of extracting information from existing data sets in order to determine patterns and predict future outcomes and trends.
- It does not tell you what will happen in the future.
- It forecasts what might happen in the future with an acceptable level of reliability and includes what-if scenarios and risk assessment.



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Some lateral thinking

Other sectors use a lot of predictive analysis
How could this be used in emergency care?

- **Supermarkets** **attendances**
- **Google** **how busy now**
- **Metropolitan Police.** **rostering**
- **Passport Office** **risk profiling**
- **Amazon** **logistics and purchasing**
- **Facebook** **purchase predictions**

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The applications in ED

Many applications already use some predictive analytics

Does complexity and sophistication add usefullness?

- **Predicting ED arrivals**
- **Smoothing demand**
- **Rostering**
- **Predicting high frequency users**
- **Predicting clinical decisions**
- **Predicting bed needs**
- **Developing control systems**

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The challenges

The techniques of predictive analytics are well established

The challenge is the human belief and local circumstances

- **A different approach exclusion not inclusion of variables**
- **Data quality**
- **Merging datasets**
- **Computing capacity and expertise**

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Artificial Intelligence

No discussion about digital healthcare is complete without mentioning

Artificial Intelligence



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Predictive analytics

New Statesman Healthcare

October 2019

Join the conversations on LinkedIN

ns-healthcare.com

Can predictive analytics make healthcare more efficient in the use of limited resources?

By Matthew Cooke, Capgemini 17 Oct 2019

FACILITIES ASSET MANAGEMENT

An industry expert says analysing previous trends in how, when and where emergency care is needed could change the way the healthcare industry uses resources to deliver better outcomes for patients



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THE NHS APPROACH TO PREDICTIVE ANALYSIS

MATTHEW COOKE

CHIEF CLINICAL OFFICER, CAPGEMINI
RETIRED EMERGENCY PHYSICIAN

MATTHEW.W.COOKE@CAPGEMINI.COM



The Use of Real Time Data in ED Management

The SickKids® Experience

Dr. Tania Principi

Faculty/Presenter Disclosure

- **Faculty:** Tania Principi
- **Relationships with commercial interests:**
  - None

Disclosure of Commercial Support

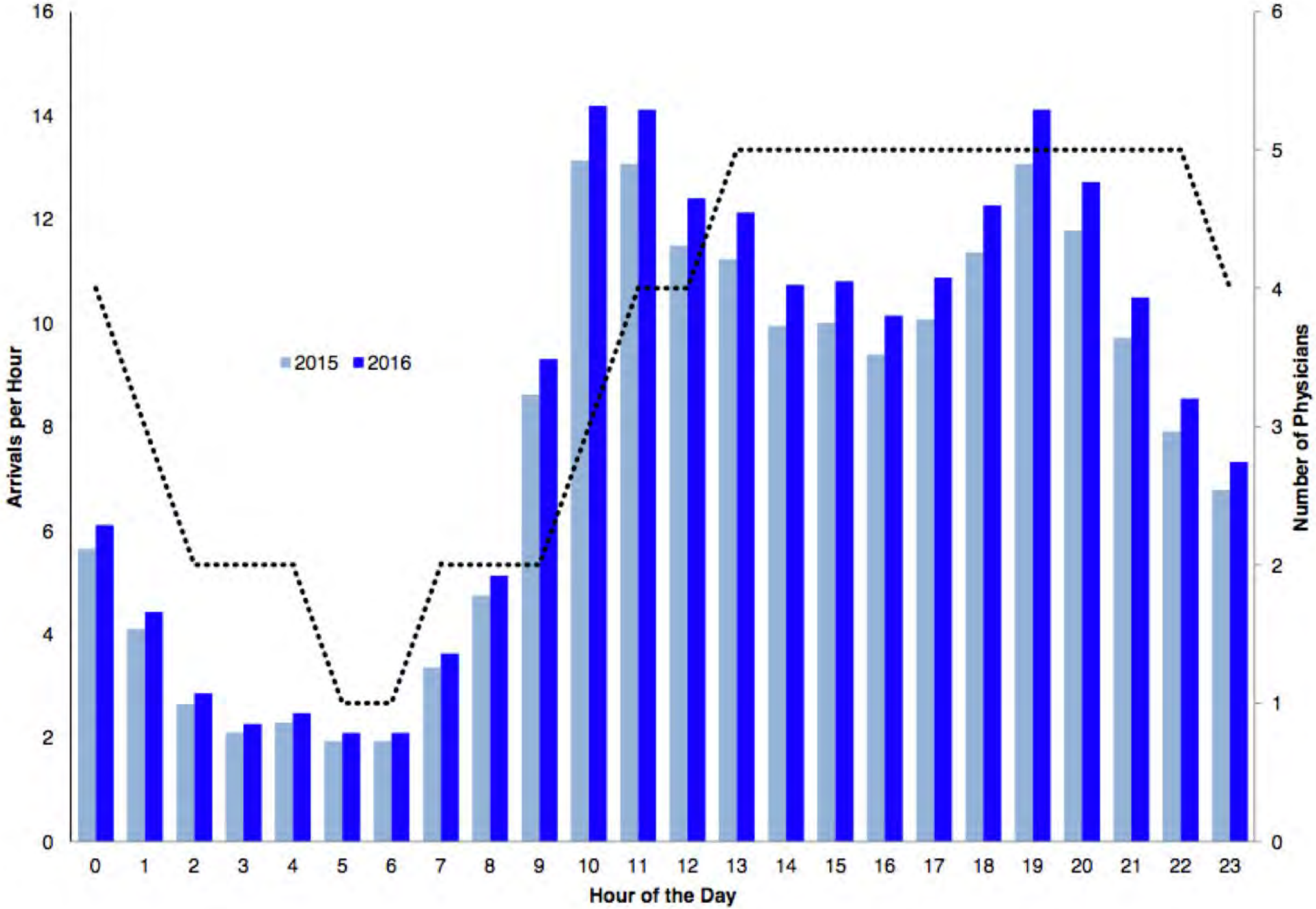
- **This program <u>has not</u> received financial or in-kind support from any organization**
- **Potential for conflict(s) of interest:**
  - Not applicable

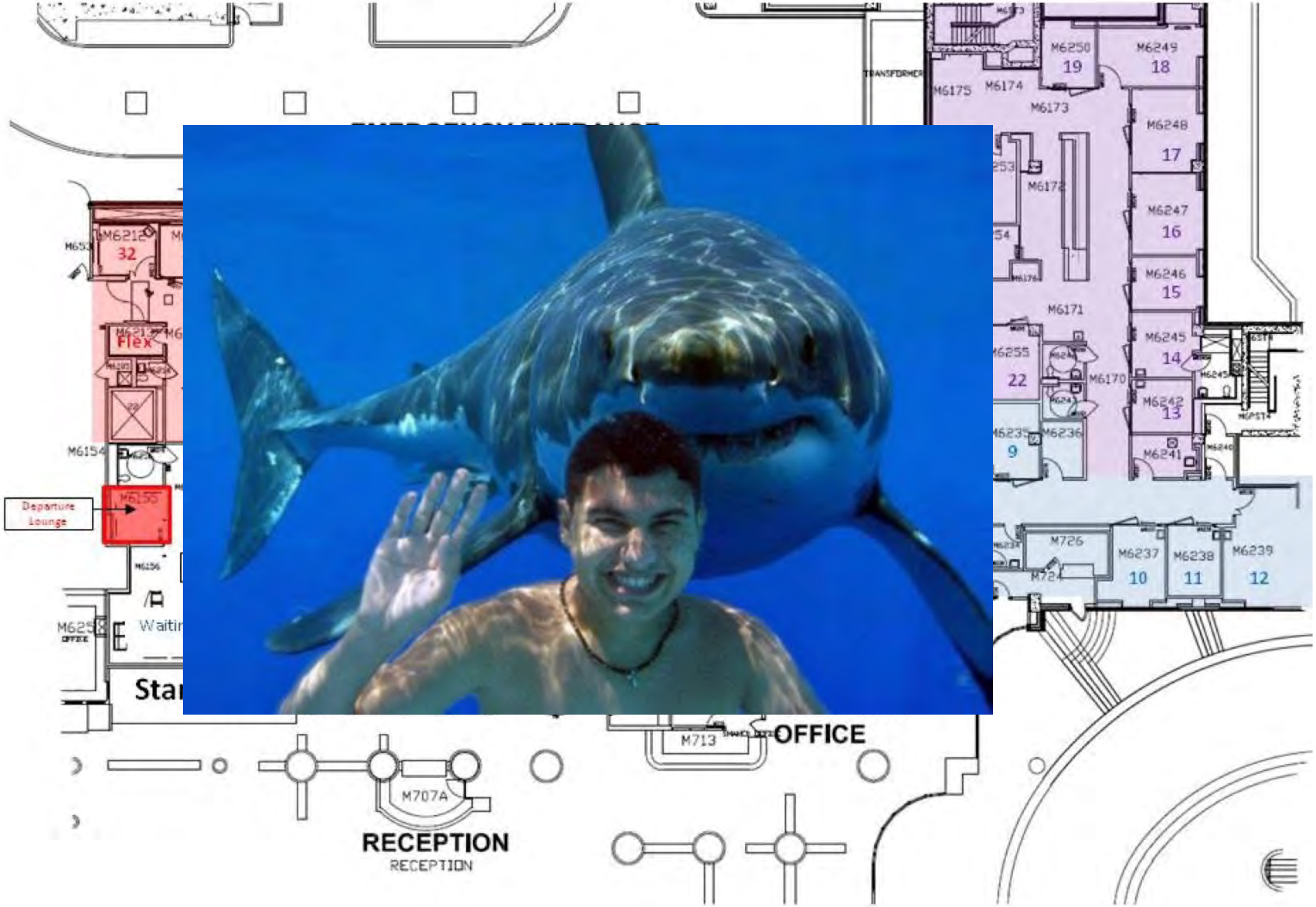
Mitigating Potential Bias

- **Not applicable**



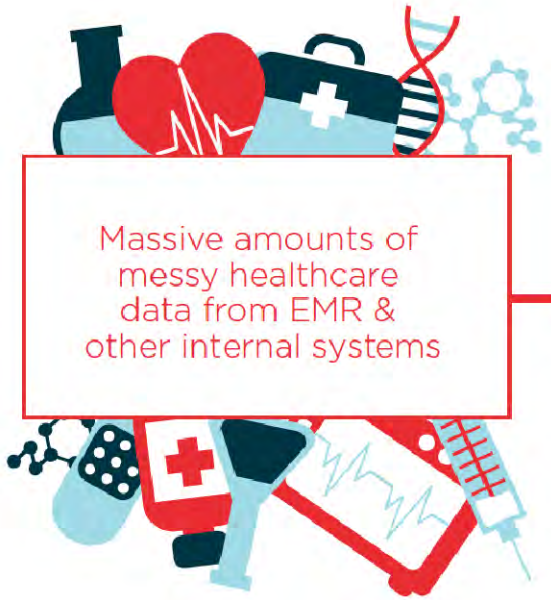

BUSINESS
INNOVATION!
MEDIA
IDEA!!!
OUTDOORS
TV
Radio
press
INTERNET
INFORMATION
real estate +10%
MARKET
X+Y=2 ?! 2
25%


Arrivals per Hour
Number of Physicians
2015
2016
Hour of the Day
0
1
2
3
4
5
6
7
8
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M6239
12
M726
M724
M6175
M6174
M6173
M6172
M713
OFFICE
M707A
RECEPTION
RECEPTION


AI

The Qventus Platform



Massive amounts of messy healthcare data from EMR & other internal systems

Data Science

Machine Learning

Behavior Science

Predict

Identifies issues before they occur

Prescribe

Recommends immediate course-corrections based on cost, benefit and constraints

Persuade

Engages right team member at right moment

Higher Utilization of Services

Increased Patient Satisfaction

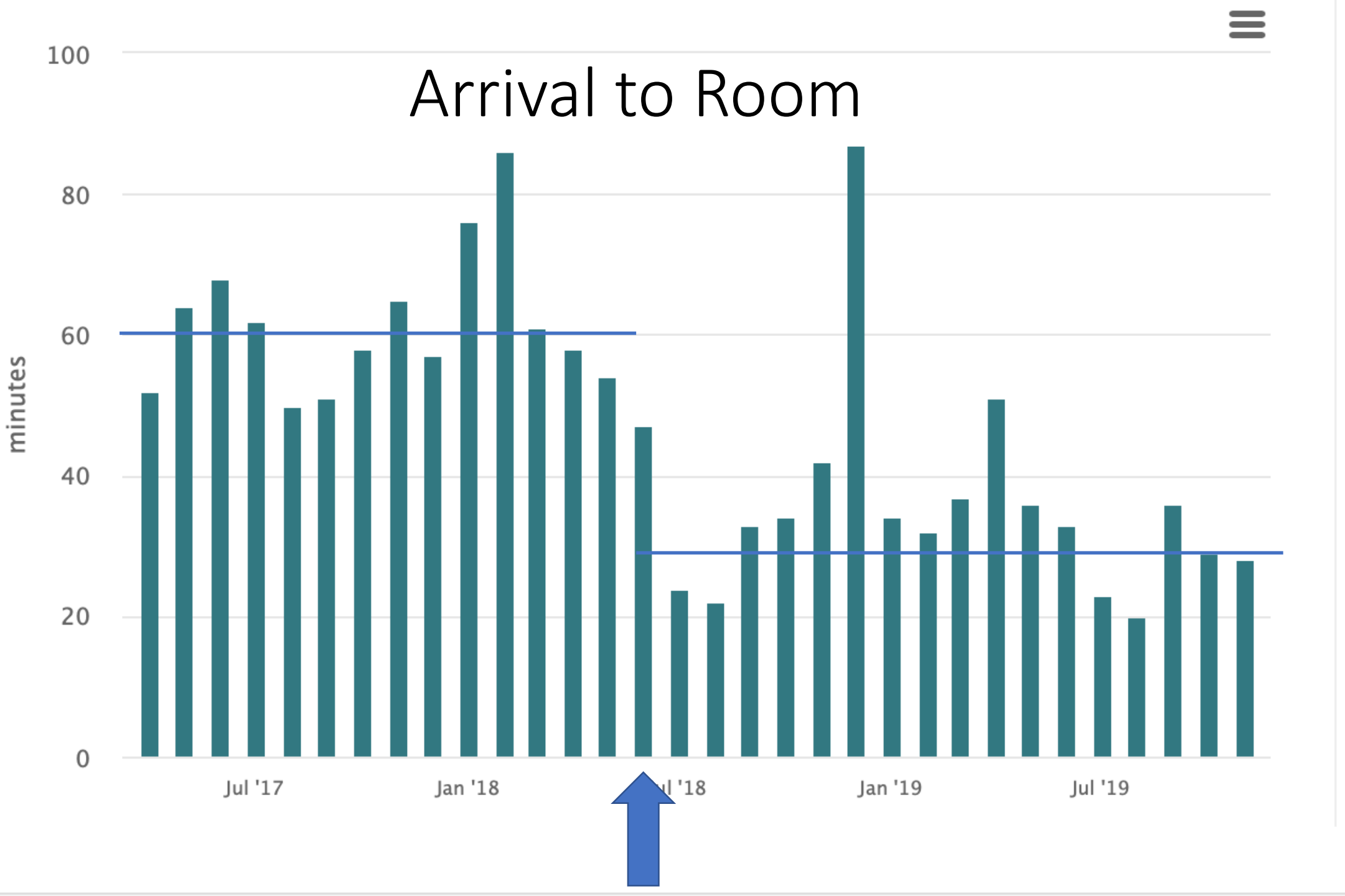
Improved Financial Performance

Computers continuously learn from data and adapt with minimal programming

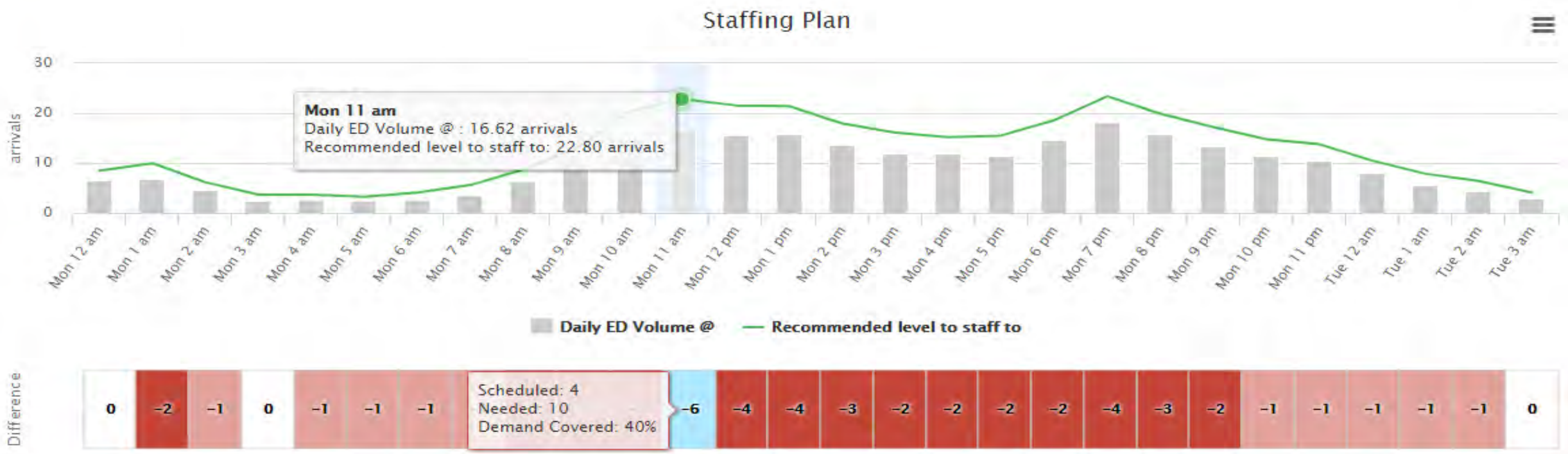
Metrics - Deep Dive



Arrival to Room

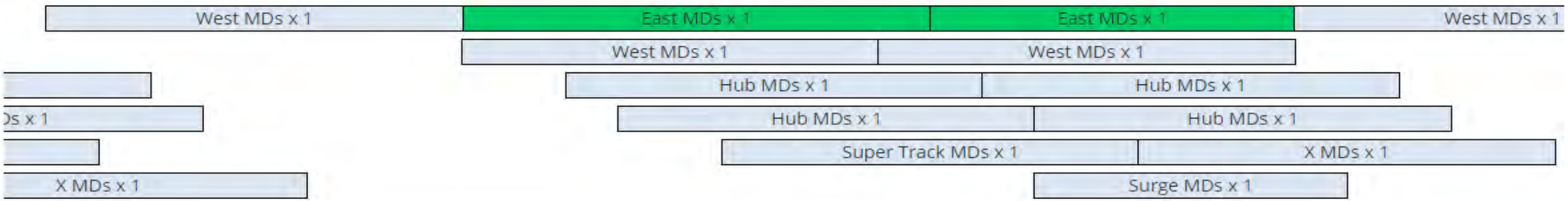


Expected Workload (Mondays in November)



Staffing Plan

Click a cell above to add a new shift or double click one of the scheduled shifts below if you would like to modify it.



Care Area ▾ status at sickkids

Showing the state on October 29 at 10:00 PM ▾



Total Census



Length of stay of discharges in the last 60 minutes



Expected patients will be discharged in the next hour



Expected patients will be admitted in the next hour

Status Counts

Waiting Room (2)

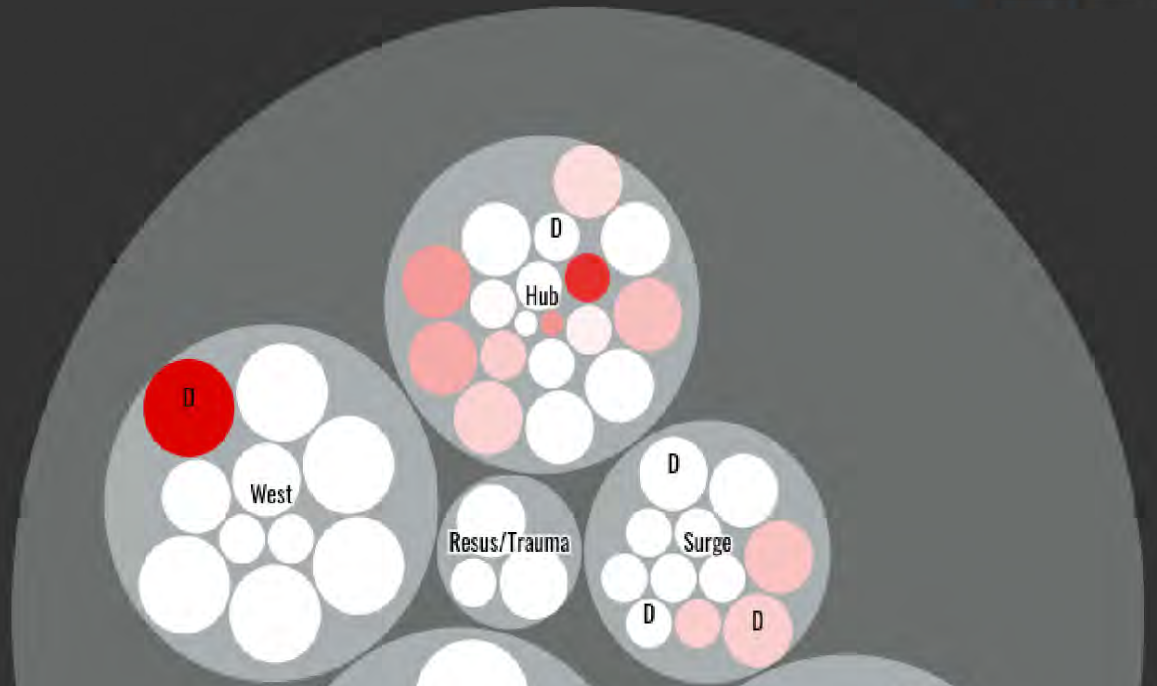
Triaged (19)

Roomed (35)

Pending Discharges (7)

Pending Admits (2)

ON

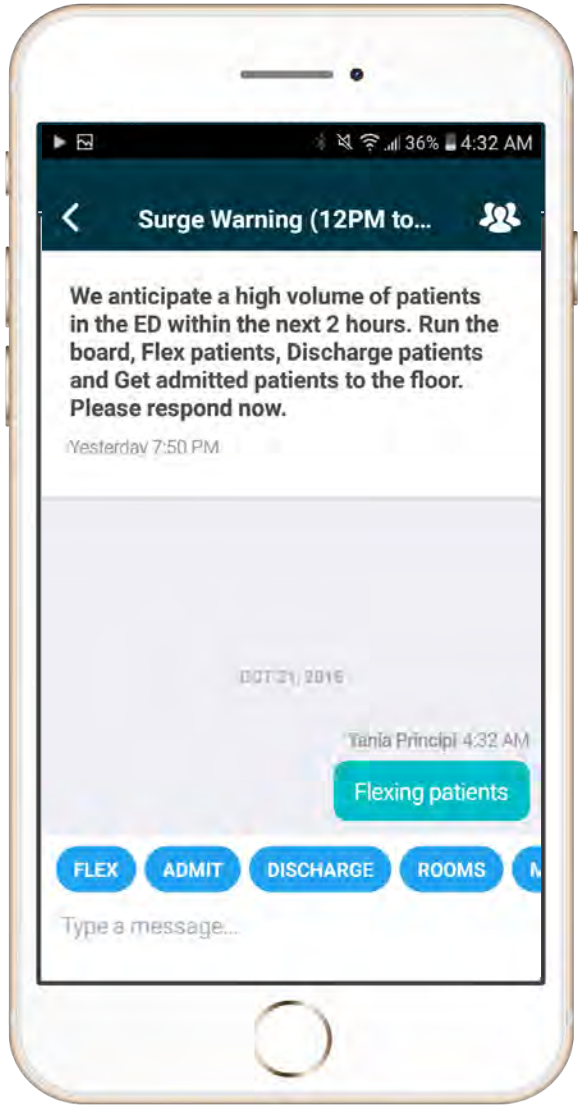


Decision Recipes

Help Target Actions in the Moment

ED Surge Warning

- Anticipates periods of high census in the Emergency Department up to 2 hours in advance



Care Area ▾ status at sickkids

Showing the state on October 29 at 10:00 PM ▾

powered by Qventus

65 Total Census

281.6 Length of stay of discharges in the last 60 minutes

15.4 Expected patients will be discharged in the next hour

4.1 Expected patients will be admitted in the next hour

Status Counts

Waiting Room (2)

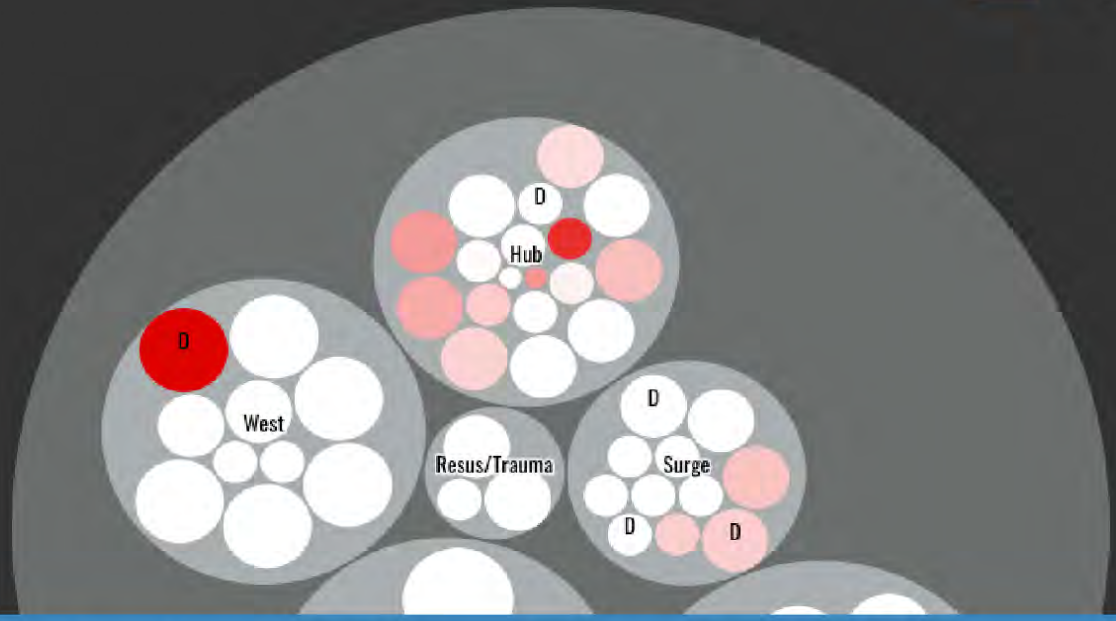
Triaged (19)

Roomed (35)

Pending Discharges (7)

Pending Admits (2)

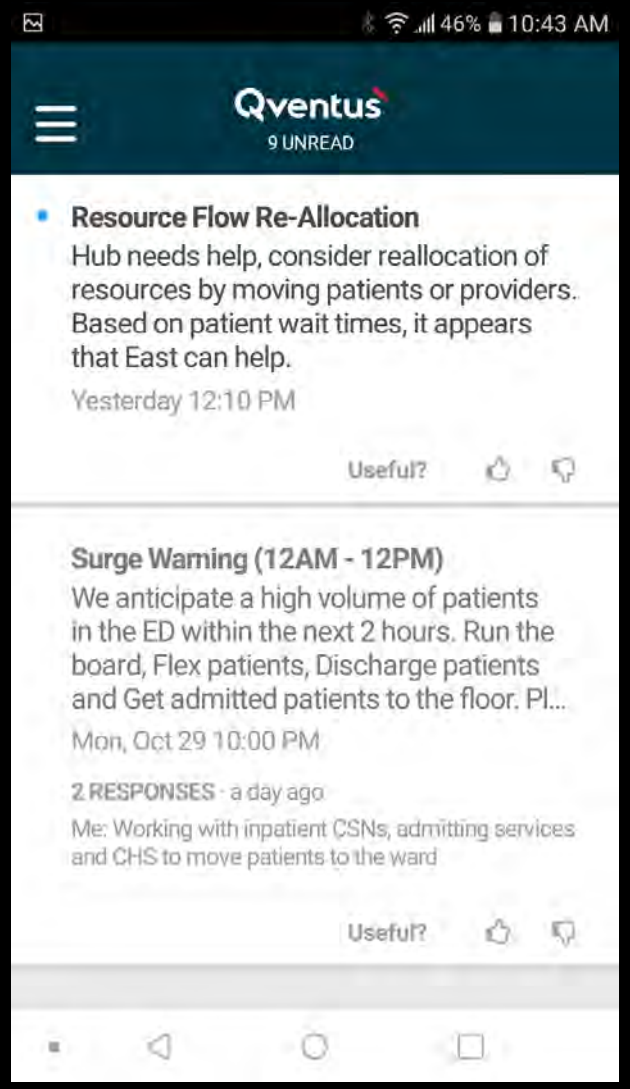
ON

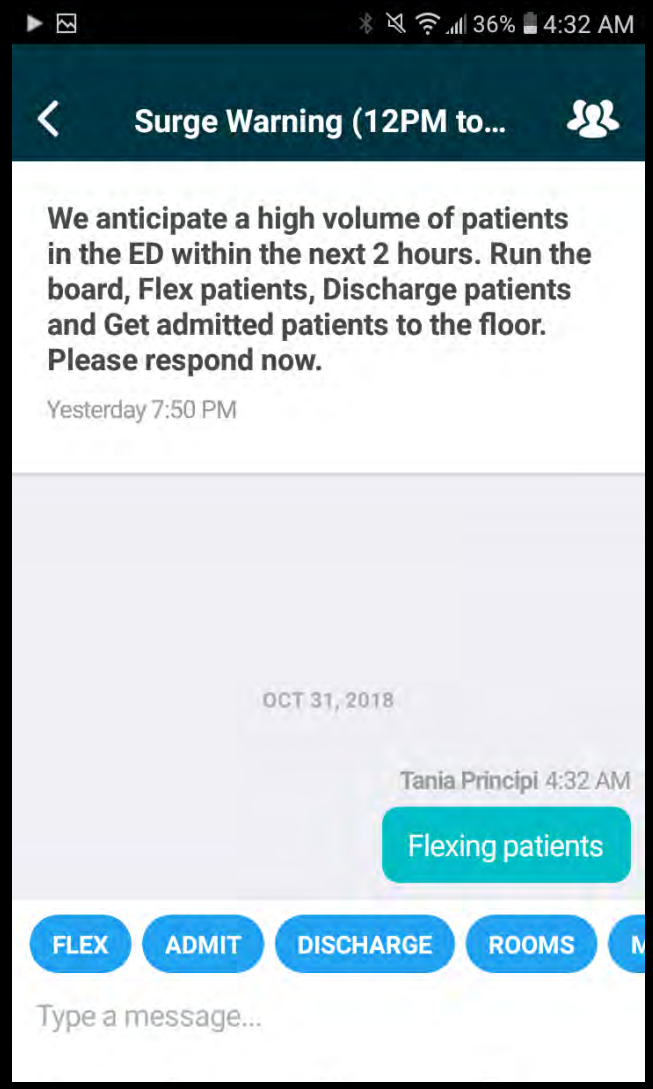


Recommendations

We anticipate a high volume of patients in the ED within the next 2 hours. Run the board, Flex patients, Discharge patie...

Questions?


46% 10:43 AM
Qventus
9 UNREAD
Resource Flow Re-Allocation
Hub needs help, consider reallocation of resources by moving patients or providers. Based on patient wait times, it appears that East can help.
Yesterday 12:10 PM
Useful?
Surge Warning (12AM - 12PM)
We anticipate a high volume of patients in the ED within the next 2 hours. Run the board, Flex patients, Discharge patients and Get admitted patients to the floor. Pl...
Mon, Oct 29 10:00 PM
2 RESPONSES · a day ago
Me: Working with inpatient CSNs, admitting services and CHS to move patients to the ward
Useful?


36% 4:32 AM
Surge Warning (12PM to...
We anticipate a high volume of patients in the ED within the next 2 hours. Run the board, Flex patients, Discharge patients and Get admitted patients to the floor. Please respond now.
Yesterday 7:50 PM
OCT 31, 2018
Tania Principi 4:32 AM
Flexing patients
FLEX
ADMIT
DISCHARGE
ROOMS
Type a message...

SICKKIDS EMERGENCY DEPARTMENT ⇌ ⤭

LAST UPDATED: [redacted]

Qventus

No recent nudges to review at the moment

TOTAL NUMBER OF PATIENTS IN THE EMERGENCY DEPARTMENT



43

PATIENTS

NUMBER OF PATIENTS WAITING TO SEE A DOCTOR



14

PATIENTS

NUMBER OF PATIENTS RECEIVING TREATMENT BY A DOCTOR



29

PATIENTS

LONGEST WAIT TIME TO SEE A DOCTOR

2.8

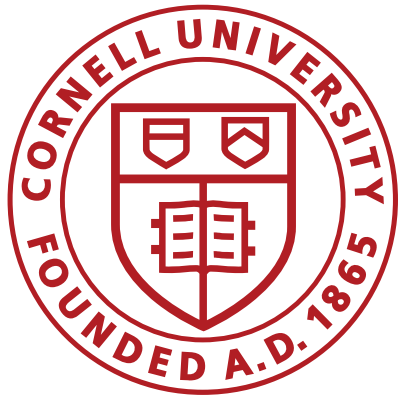
HOUR(S)






elve group
The2112Group.com


100
300
500
50
10
20
7.100,00
2,00,00
1100,00
75%





Does Posting ED Wait Times Online Affect Patient Choice and Composition Mix?

Stephenson Strobel
Department of Policy Analysis and Management

EDAC 2019

Faculty/Presenter Disclosure

- **Faculty:** Cornell University, University of Manitoba, Niagara Health

- **Relationships with commercial interests:**
  - None

Disclosure of Commercial Support

- **This program has not received financial or in-kind support from any organization**

- **Potential for conflict(s) of interest:**
  - Not applicable

Mitigating Potential Bias

- **Not applicable**

Where I started working…



The wait time tracker



Why might we implement wait time trackers?

1. Patient satisfaction and expectation setting
2. Emergency system efficiency

Oculys sheds light on ER wait times

Dave Pink, Special to The Record

Easing one of Canada's biggest health-care dilemmas may be a simple matter of mathematics.

also equips patients with information they can use to avoid long line-ups or at least know what they're in for at any given time.

"He dissected the emergency department. He put in hours and

might be discouraged from going to the hospital if they know the wait times, but Hivert says emergency room visits by people with high-priority needs were up slightly over the same period.

Hivert is confident that within a year the technology will be in use in 10 to 15 hospitals. It will be tailored to meet their individual needs. "Each emergency room is different," he says. "We respect that."

Windsor Regional Hospital unveiled a new online wait-time tracker on Wednesday that lets patients know how long it will be before they get to see a doctor in the emergency department.

Accessible through the hospital's website at wrh.on.ca, the feature allows people considering a trip to the emergency department to see how crowded the waiting rooms are at both the Metropolitan and Ouellette campuses. In addition to showing the estimated wait times, the tracker shows how many people are currently in treatment and how many are waiting for treatment. With information updated every 10 minutes, patients can also see whether times will get better or worse over the next six hours.

"You can make the decision of when to go into the ED," said Jeff Theriault, program manager of the emergency department at the Ouellette campus.

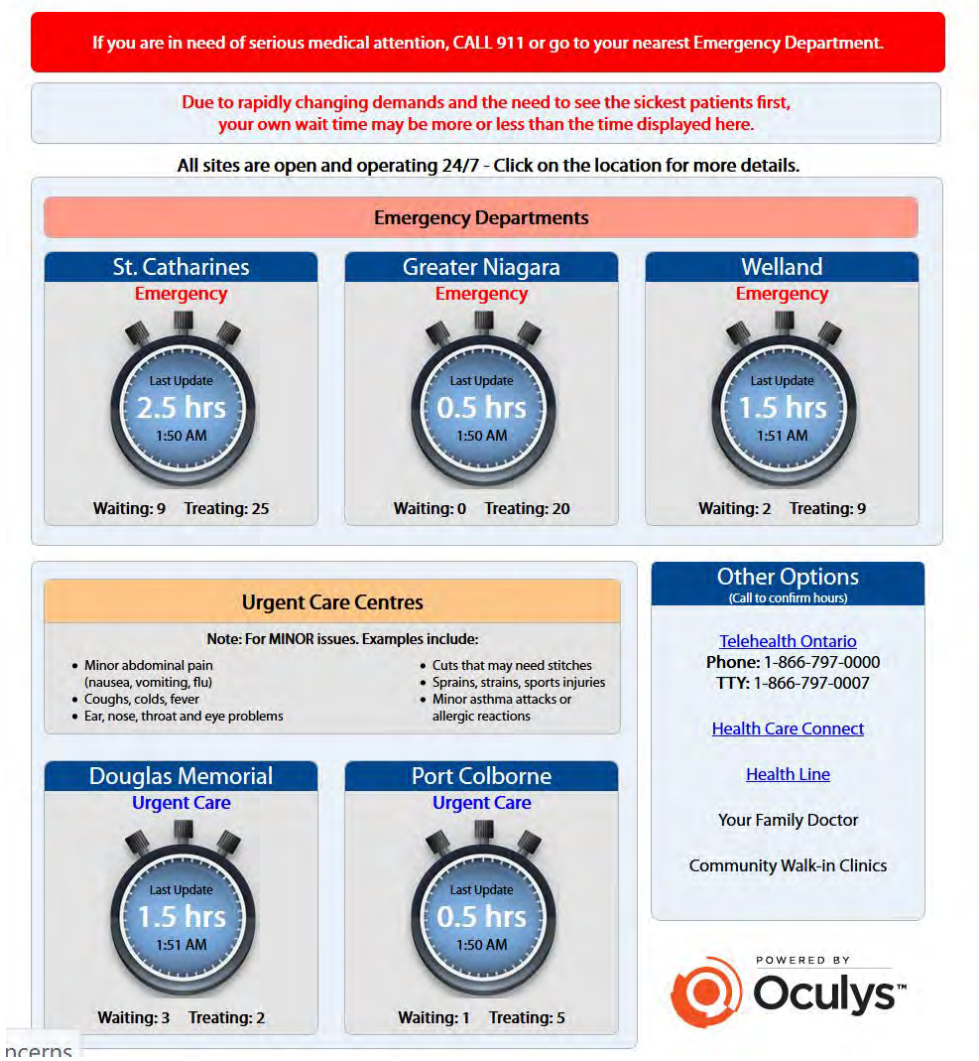
> *We don't want to discourage people from coming to the emergency department*

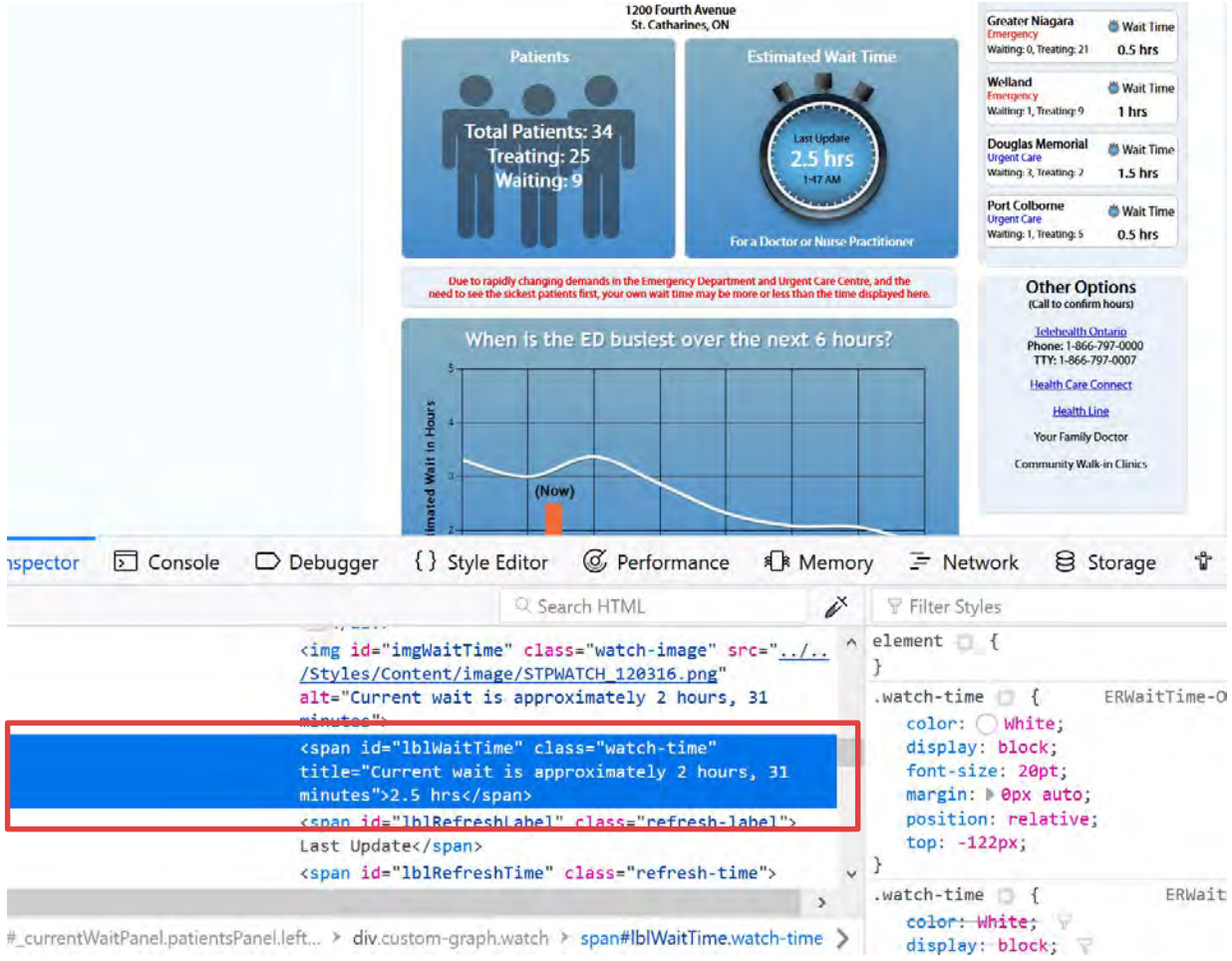
Research Question

- How do wait time trackers affect the choice and patient mix of patients presenting to EDs in Niagara?

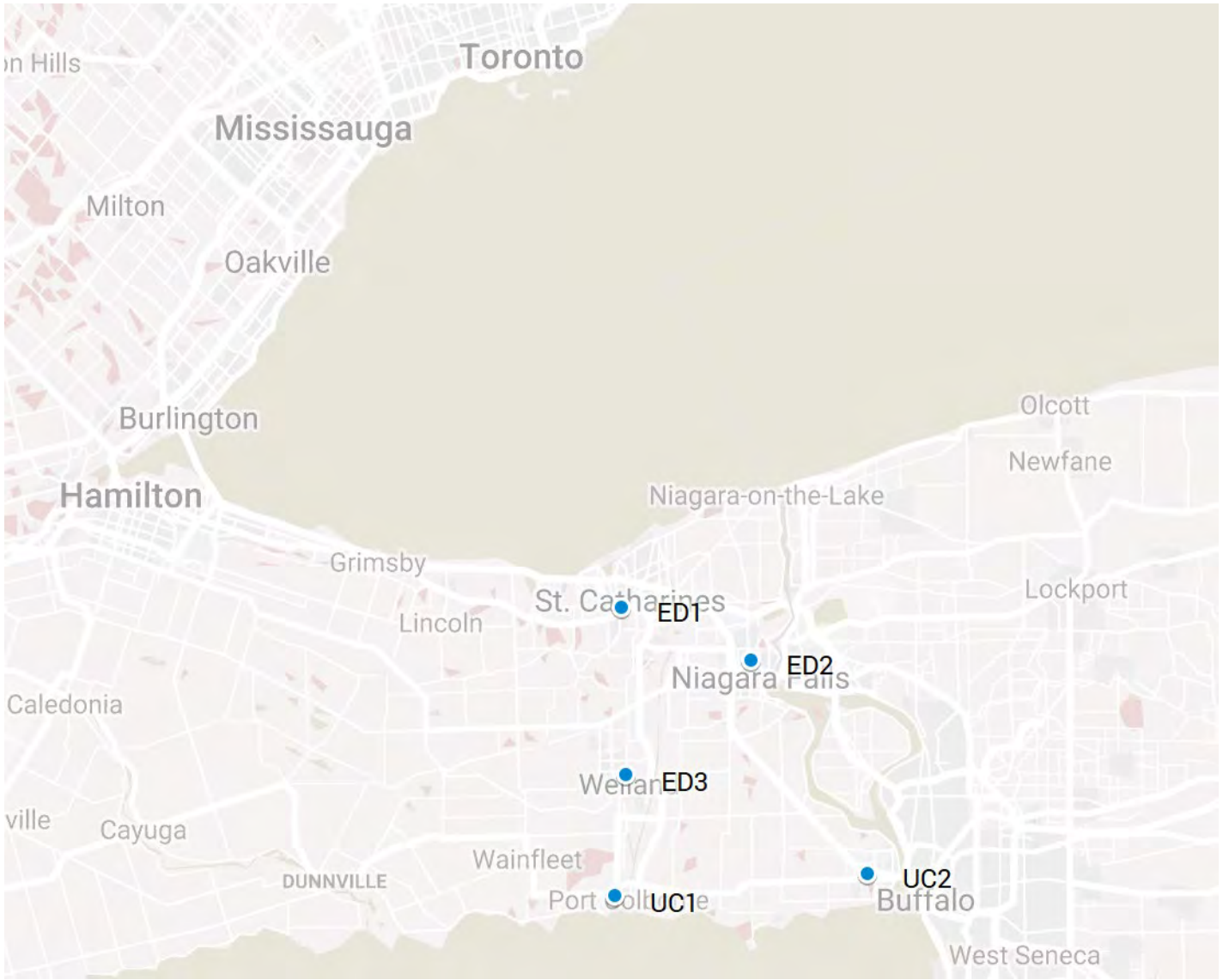
1. Observably similar EDs which differ in wait time lead to fewer waiting patients in an ED with the higher wait time
2. Patients tend to visit lower resourced settings as a result
3. The composition mix of patients visiting Niagara Health settings changes as a result.

How do we find observably similar EDs?





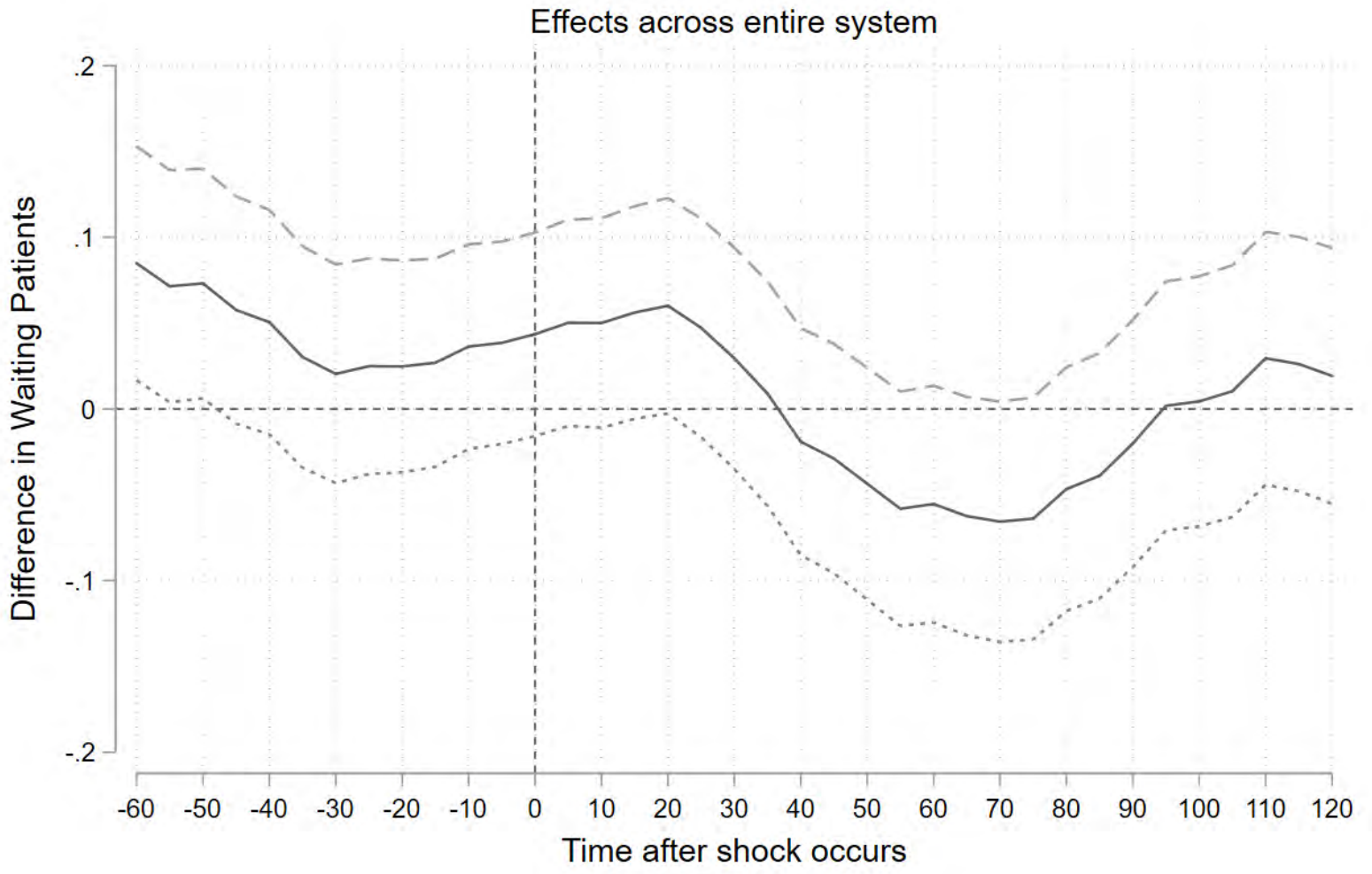
Niagara Health System Geography



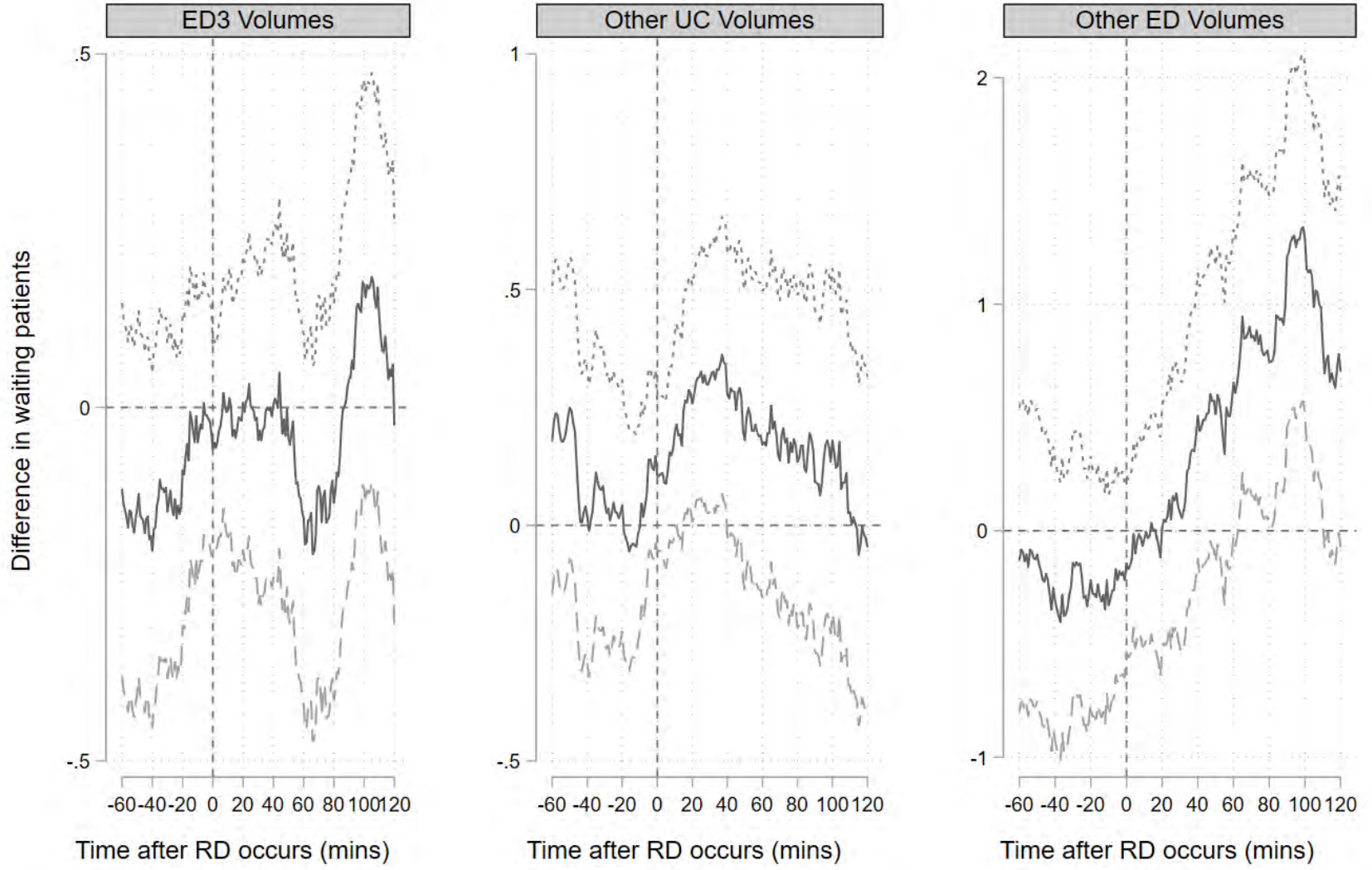
Data

- Hospital-minute level data (n=5.4 million)
  - Data runs from January 2017-April 2019, aggregated from patient visit data
  - Outcomes are waiting patient volumes, average CTAS scores of all patients, volumes of “high” CTAS scores
- Oculys Predict data (partially scraped, partially provided by Oculys)
  - Predicted wait times at the minute level (90^{th} percentile)
  - Updated approximately every 2-5 minutes at each site
  - Treatment within 3 minutes of the cut off
  - About 136,000 “shocks”
  - Some gaps in this data

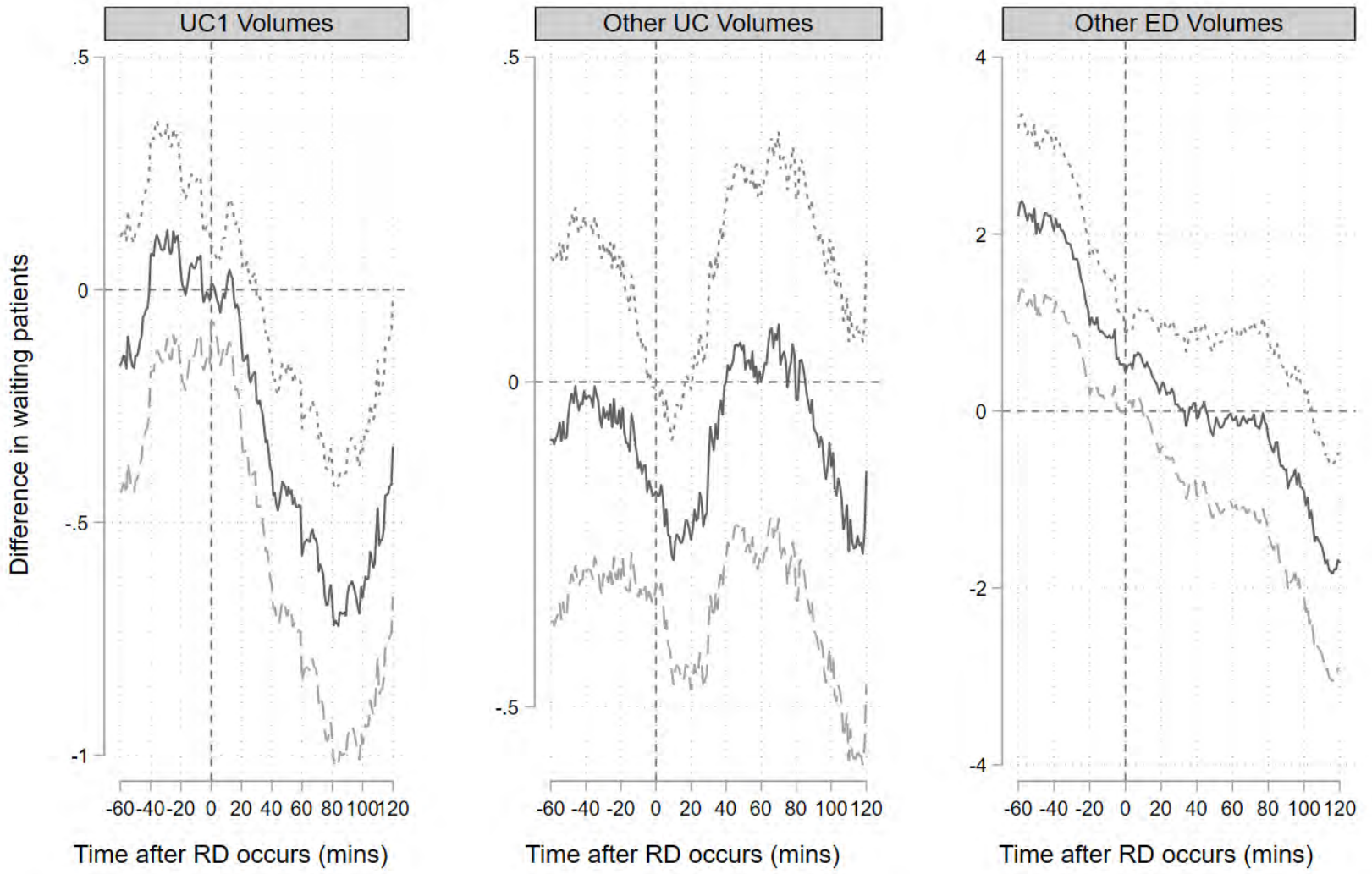
Are there fewer patients after a wait time shock?



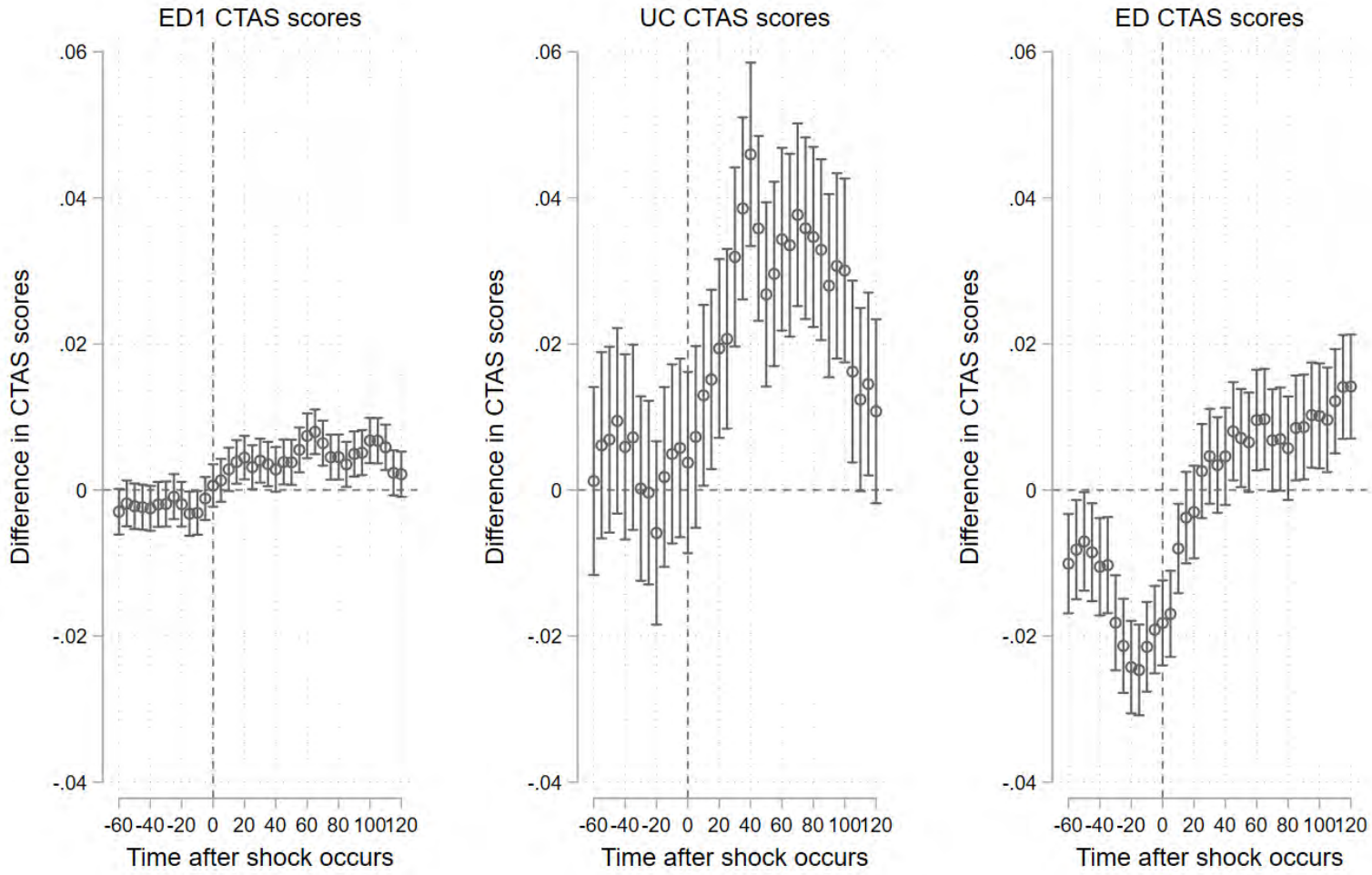
Effects and spillover effects at EDs



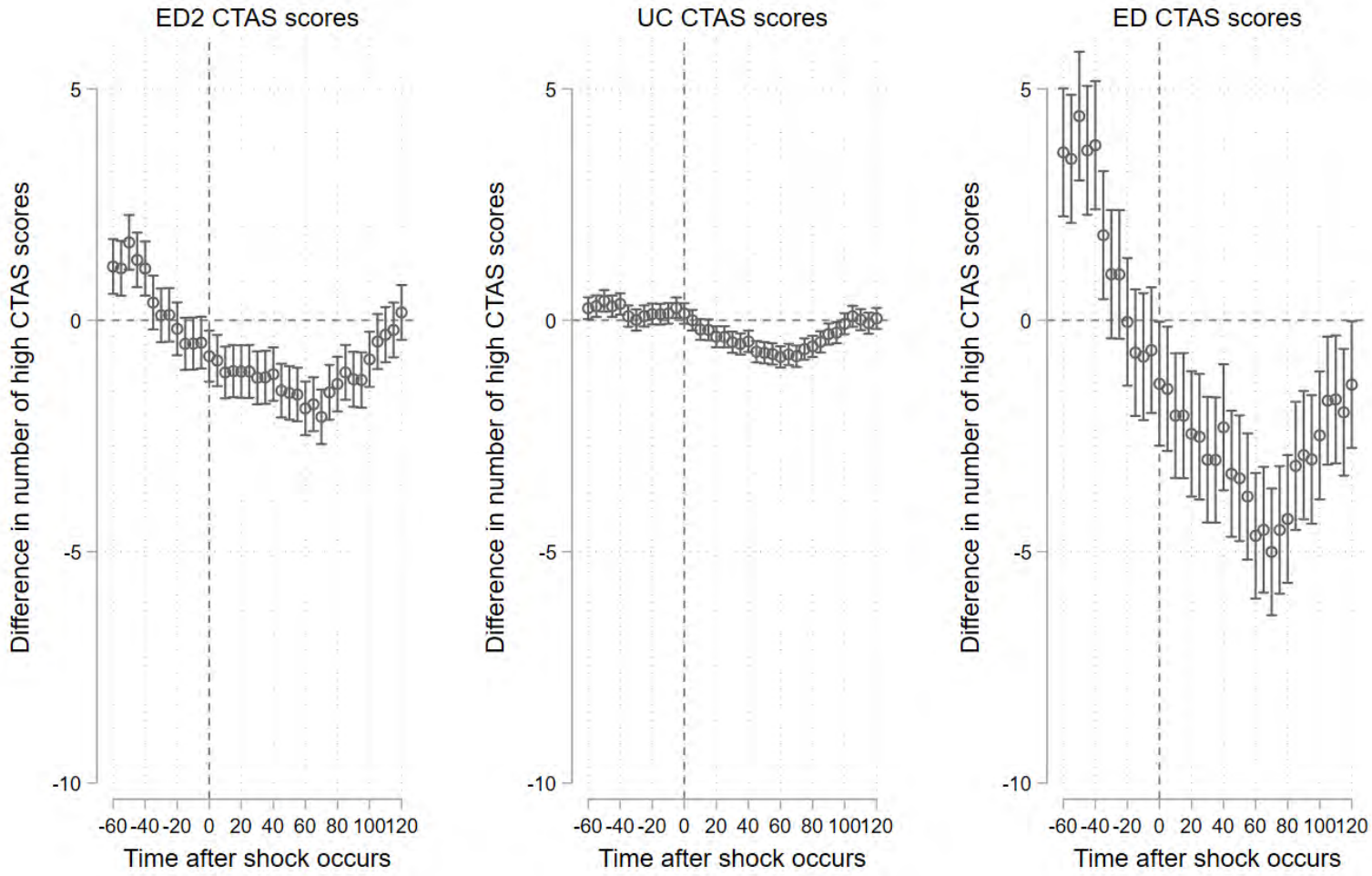
Effects and spillover effects at UCs



Effect on average CTAS Scores



Effect on high CTAS scores



Are these estimates a lower bound?

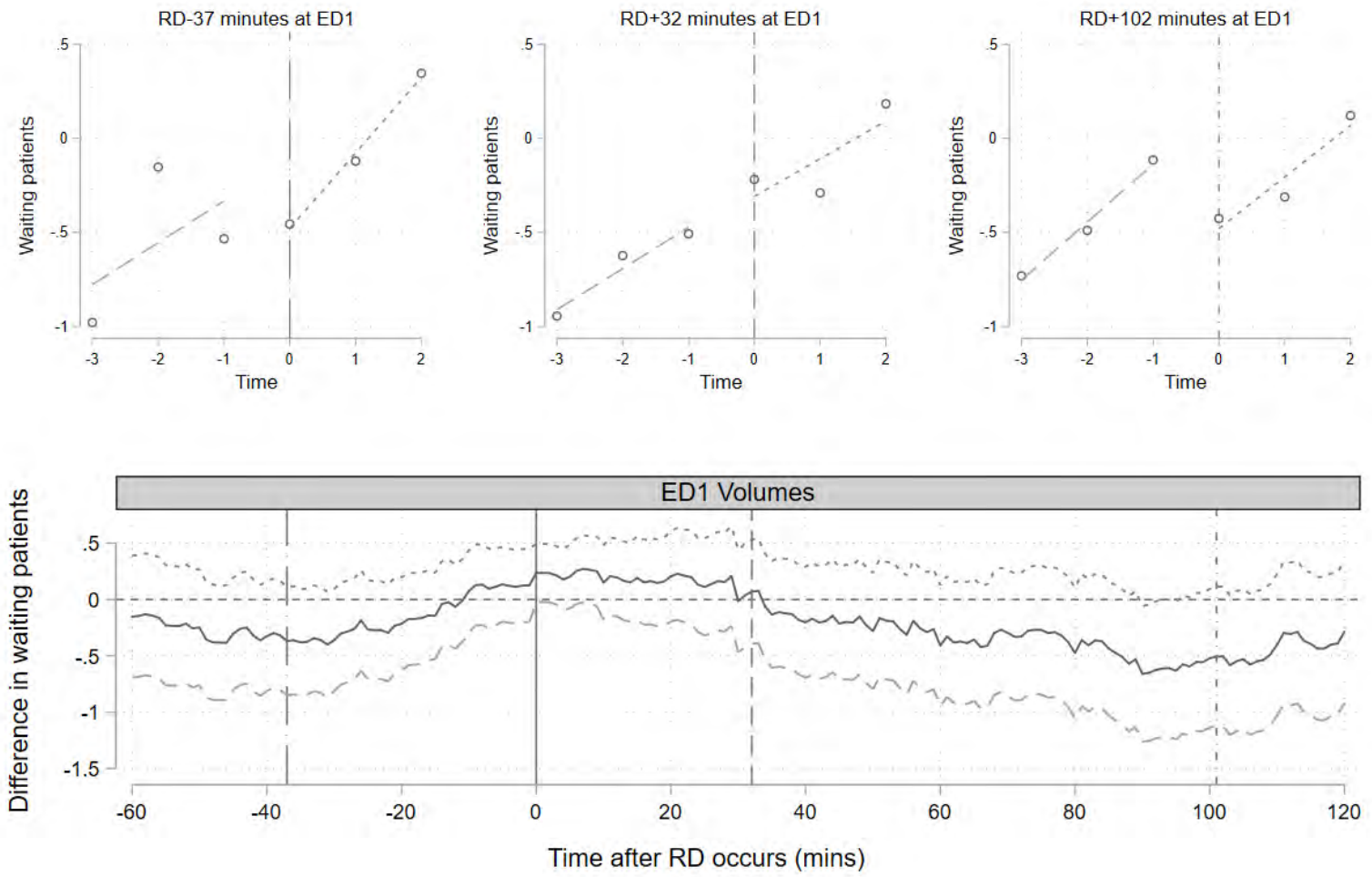
- Rough back of the envelope calculation suggests that these shocks alone move about 1-2% of patient visits
- These are only 30-minute shocks
- These shocks are relatively rare events
- Below average internet and cell phone penetration
- Rural area with large costs to move between areas

Summary

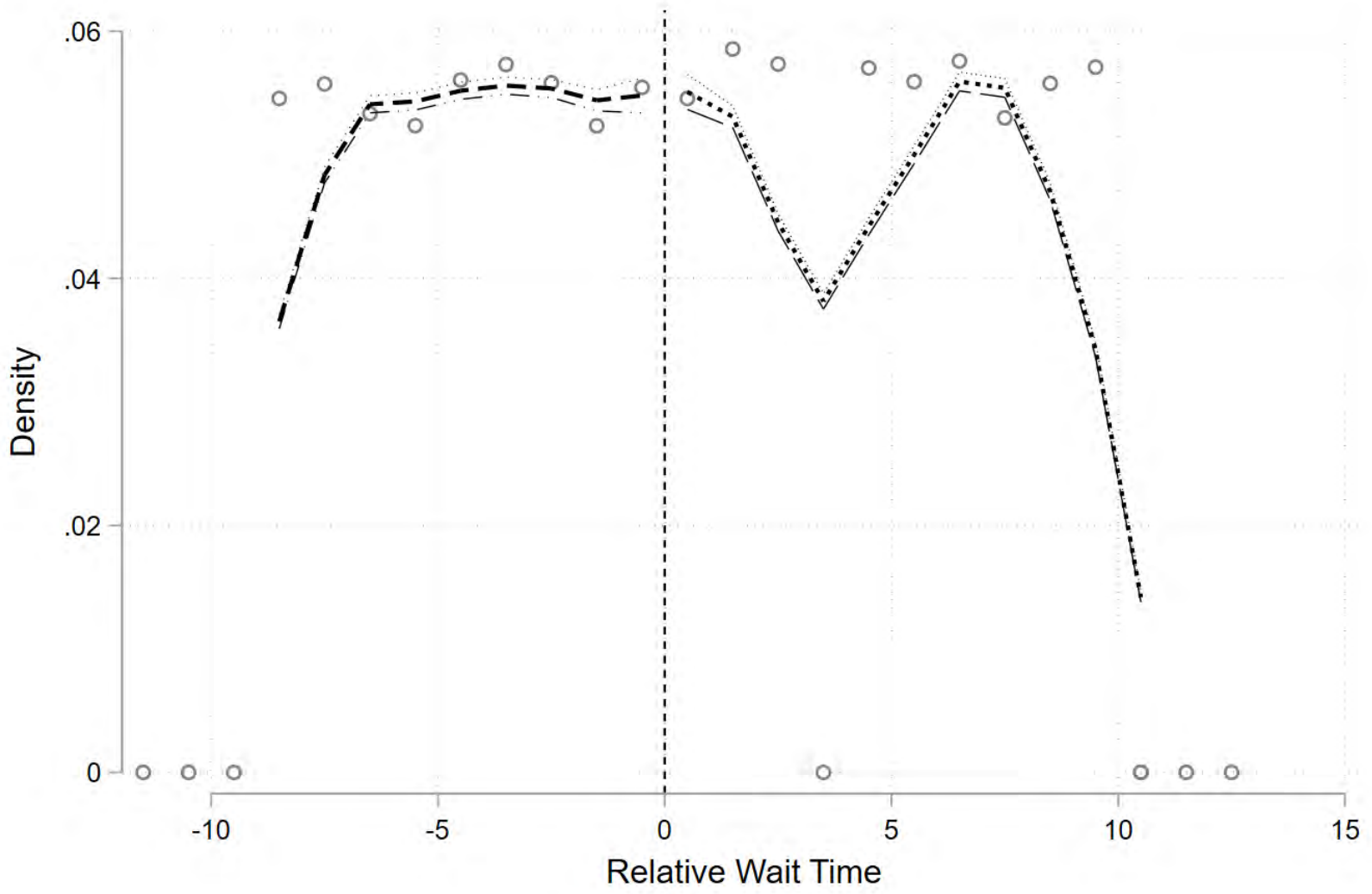
- Patients use wait time trackers to choose alternate EDs
- Patients move towards lower resourced settings when shocks occur
- CTAS scores change appreciably when shocks occur

Questions

How do shocks change patient volumes over time?



McCrary Test



WINTER 2020

Emergency Department Administrative Conference

November 2019

Kuldeep Sidhu
Susan Woollard



Disclosures

1

Faculty/Presenter Disclosure

Faculty:

- Kuldeep Sidhu
- Susan Woollard

Relationships with Commercial Interests:

- None

2

Disclosure of Commercial Support

- This program **has not** received financial or in-kind support from any organization
- There are no applicable potential conflict(s) of interest

3

Mitigating Potential Bias

Not applicable

Governance: Access to Care

Committee Membership

- Sub-Committee of both Medical Advisory Committee and Senior Leadership Team
- Chair Medical Advisory Committee
- VP Clinical Programs and Chief Nursing Executive
- VP Finance and Chief Information Officer
- Program and Medical Program Directors – All Clinical Areas
- Director Patient Experience and Quality
- Director Health Information Management, Privacy and Decision Support

Frequency

Monthly

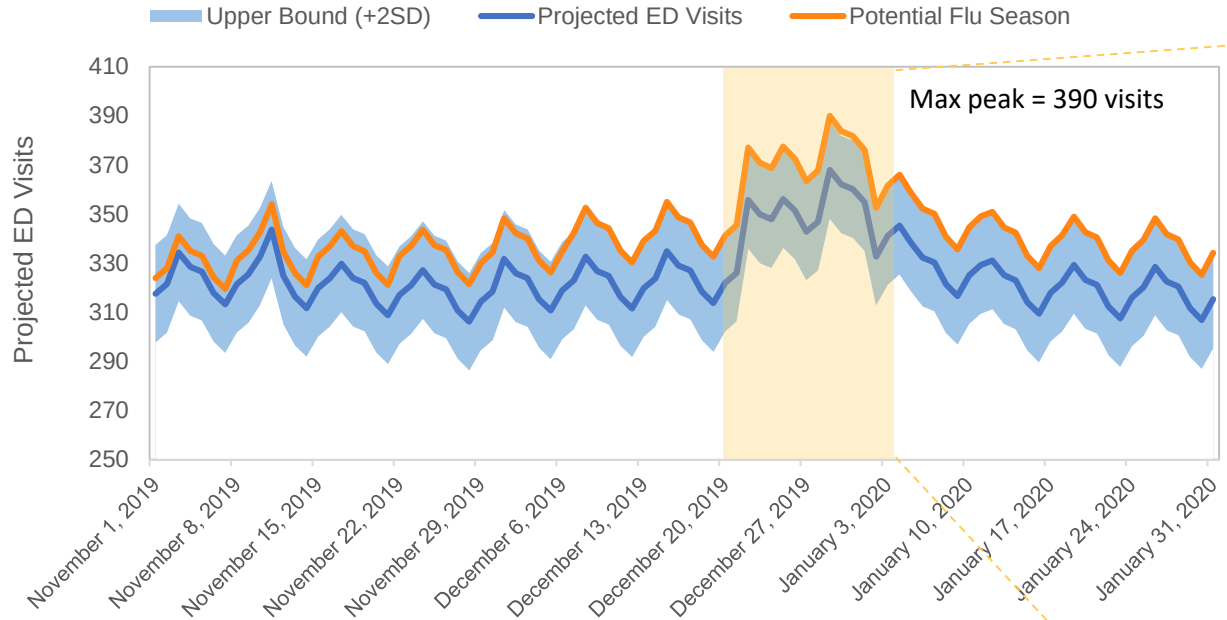
Projects & Key Performance Indicators

Determined Annually

It is important to have this work aligned to your corporate goals & accountabilities

Projected ED Daily Visits: Peak Holiday Period

FY19/20 Projected ED Visits – Prime Holiday Period



Average and Maximum Number Daily Visits

DATE	Projected ED Visits	Upper Range (Max # of Visits)
Sunday, Dec 01, 2019	332	352
Monday, Dec 02, 2019	326	346
Tuesday, Dec 03, 2019	324	344
Wednesday, Dec 04, 2019	315	335
Thursday, Dec 05, 2019	311	331
Friday, Dec 06, 2019	319	339
Saturday, Dec 07, 2019	323	343
Sunday, Dec 08, 2019	333	352
Monday, Dec 09, 2019	327	347
Tuesday, Dec 10, 2019	325	345
Wednesday, Dec 11, 2019	316	336
Thursday, Dec 12, 2019	312	331
Friday, Dec 13, 2019	320	340
Saturday, Dec 14, 2019	324	344
Sunday, Dec 15, 2019	335	355
Monday, Dec 16, 2019	329	349
Tuesday, Dec 17, 2019	327	347
Wednesday, Dec 18, 2019	318	338
Thursday, Dec 19, 2019	314	334
Friday, Dec 20, 2019	322	342
Saturday, Dec 21, 2019	326	346
Sunday, Dec 22, 2019	356	376
Monday, Dec 23, 2019	350	370
Tuesday, Dec 24, 2019	348	368
Wednesday, Dec 25, 2019	356	376
Thursday, Dec 26, 2019	351	371
Friday, Dec 27, 2019	343	363
Saturday, Dec 28, 2019	347	367
Sunday, Dec 29, 2019	368	388
Monday, Dec 30, 2019	362	382
Tuesday, Dec 31, 2019	360	380
Wednesday, Jan 01, 2020	355	375
Thursday, Jan 02, 2020	333	352
Friday, Jan 03, 2020	341	361
Saturday, Jan 04, 2020	345	365
Sunday, Jan 05, 2020	338	358
Monday, Jan 06, 2020	332	352
Tuesday, Jan 07, 2020	330	350
Wednesday, Jan 08, 2020	321	341
Thursday, Jan 09, 2020	317	336
Friday, Jan 10, 2020	325	345
Saturday, Jan 11, 2020	329	349
Sunday, Jan 12, 2020	331	351

Below the daily average

<7% higher than average

Peak days

Summary Findings

- Peak Holiday time defined as December 15-January 12
- On average for the year, we have ~326 daily ED visits
- Around the peak holiday time, we can expect this to increase to ~338 daily ED visits But are peak days will be December 22/23, December 25/26, and December 29-January 1st where it is expected to reach an average of 357

Closer to flu season, we will begin monitoring the flu incidence and the predominant flu strain circulating as this may impact ED volume

Predicted ED Daily Visits

DECEMBER 2019

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1 332	**2** 326	**3** 324	**4** 315	**5** 311	**6** 319	**7** 323
8 333	**9** 327	**10** 325	**11** 316	**12** 312	**13** 320	**14** 324
15 335	**16** 329	**17** 327	**18** 318	**19** 314	**20** 322	**21** 326
22 356	**23** 350	**24** 348	**25** 356	**26** 351	**27** 343	**28** 347
29 368	**30** 362	**31** 360	**1** 355	**2** 333	**3** 341	**4** 345
5 338	**6** 332	**7** 330	**8** 321	**9** 317	**10** 325	**11** 329

JANUARY 2020

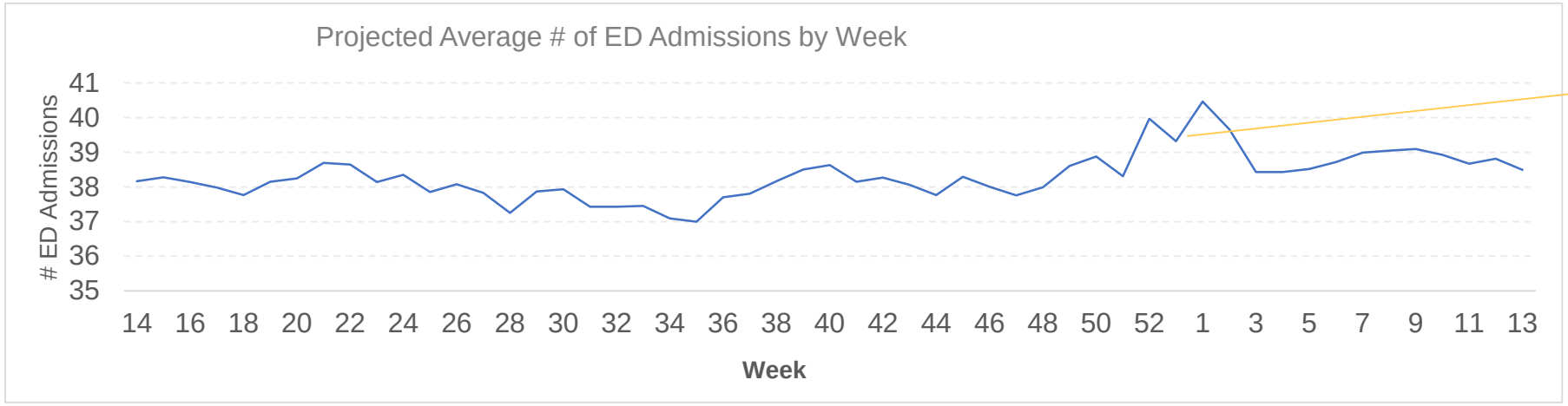
12 331	**13** 325	**14** 323	**15** 314	**16** 309	**17** 318	**18** 322
19 329	**20** 323	**21** 321	**22** 312	**23** 308	**24** 316	**25** 320

Legend:

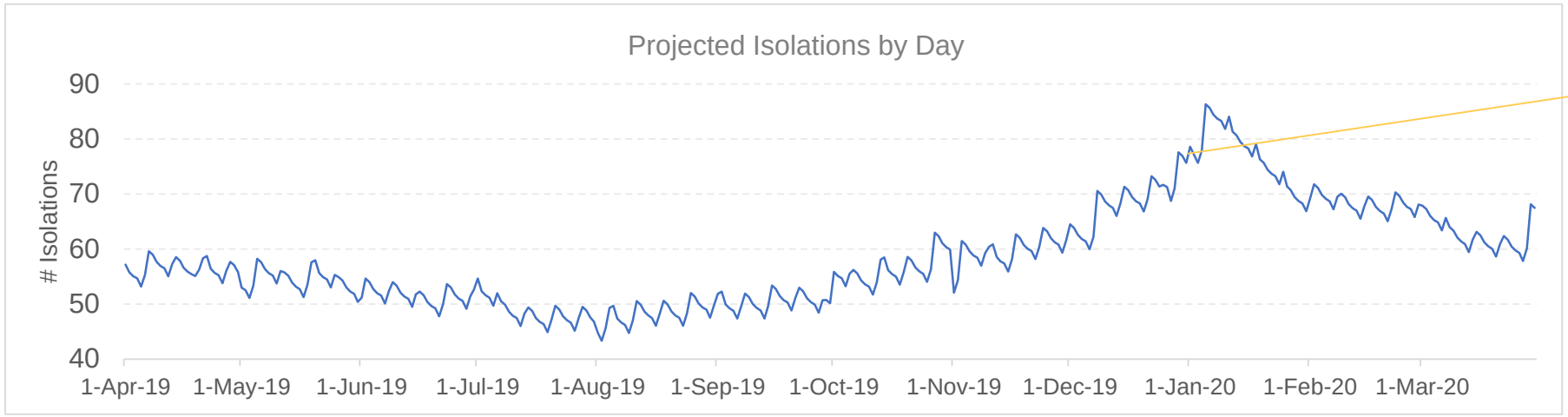
- Indicates predicted precipitation (snow, rain) is likely >=50%
- Indicates predicted ice
- OR closures
- Partial OR closures

ED Admissions and Isolation Forecasts for FY2019-20

The Year in a Snapshot



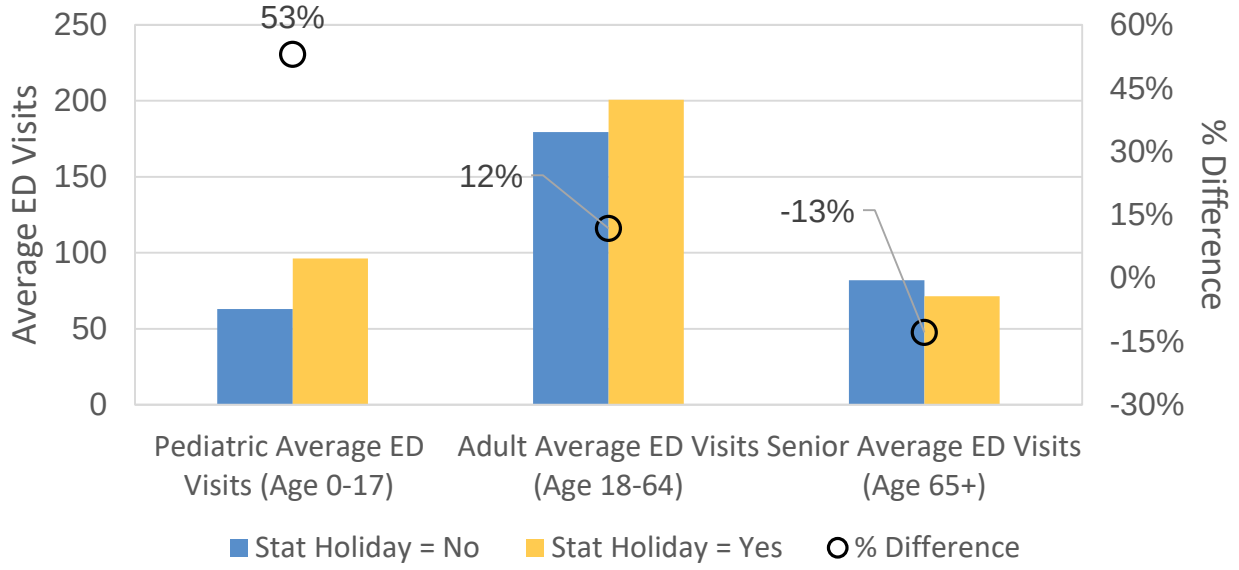
Projected increase on December 24, 2019 by 13% (avg. 38 → 43) and continue high until mid-February

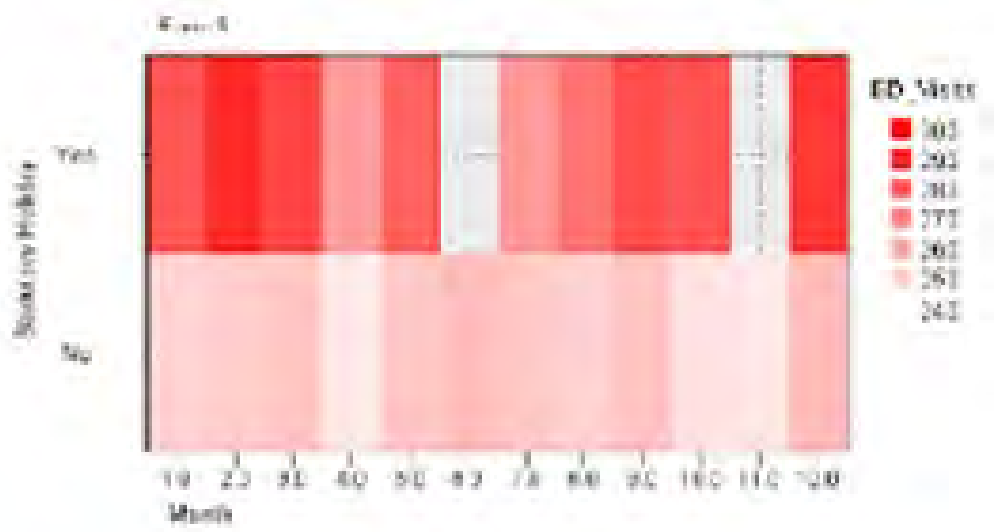


Projected increase on December 15, 2019 by 34% (avg. 53 → 71) and continue high until mid-February

Stat Holidays: The Impact of Christmas and N.Y.D.

Impact of Holiday Season on ED Visits by Age Groups





Summary Findings

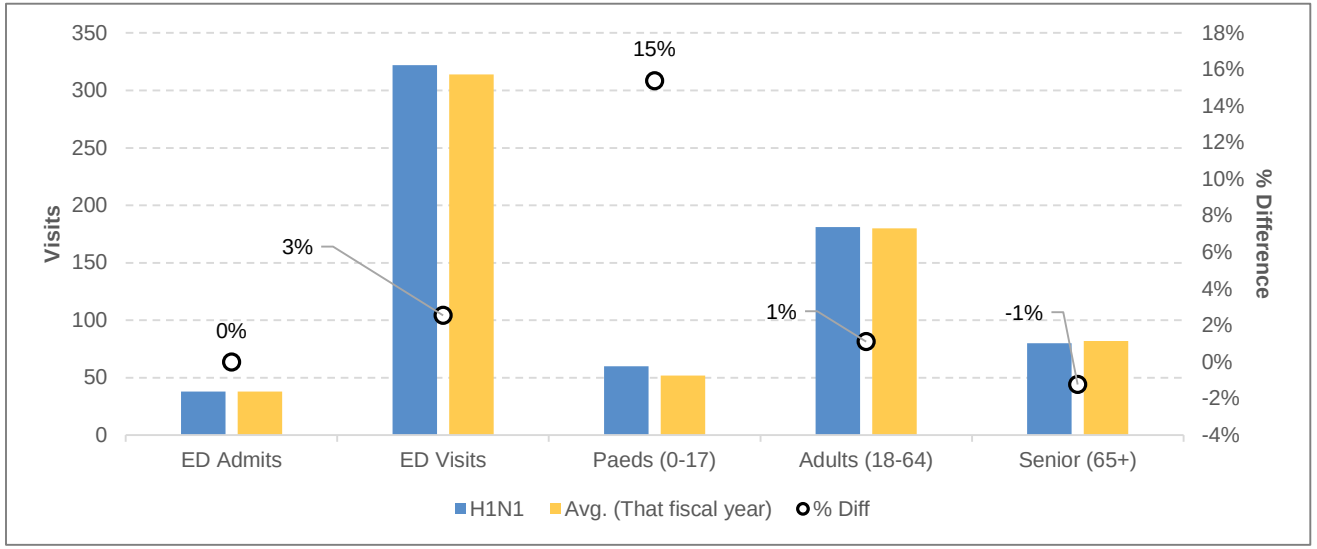
Statutory Holidays, in general, have a direct impact on our ED visits.

There is also an interaction between day of the week and when the statutory holiday occurred. Christmas falls on a Wednesday this year. The events leading up to this date and after will directly affect ED visits. The last time Christmas fell on a Wednesday was December 2013 as a such, we can expect a similar cyclical pattern as that year combined with our annual growth rate.

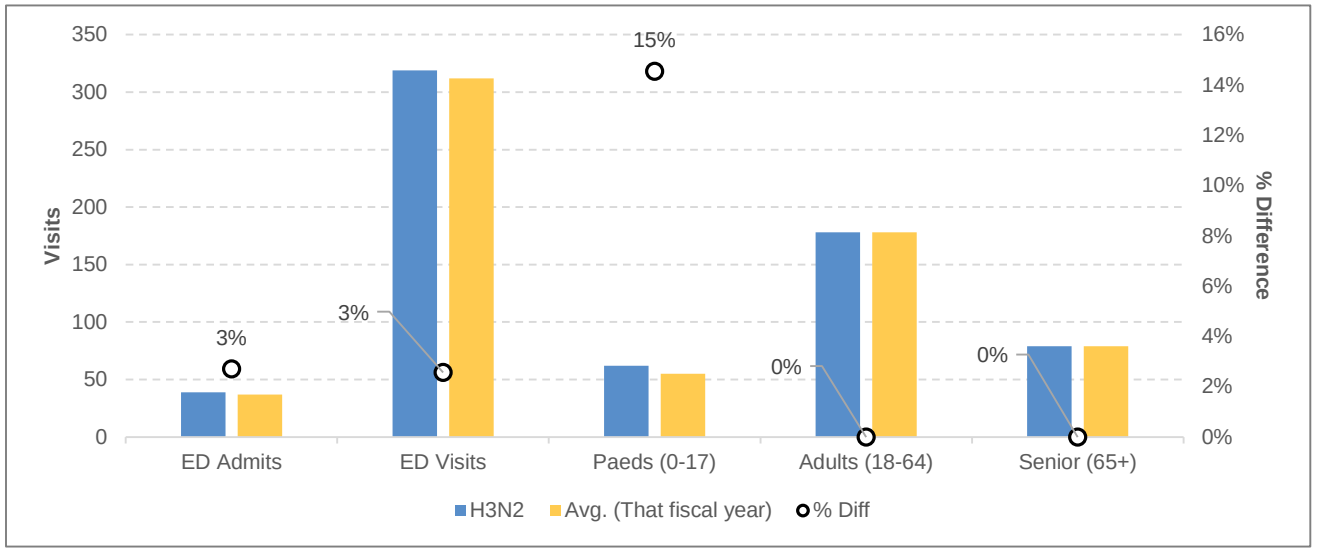
ED Visits during the Holiday Season historically affect different age groups. Measuring last years impact, we saw a 53% increase in Pediatric Visits. This was followed by the 18-64 age group. We can expect a similar pattern this Holiday season depending on the influenza strain.

Flu Incidence: Predominant Flu Strain Review

ED Visits (H1N1 as the Dominant Flu)



ED Visits (H3N2 as the Dominant Flu)

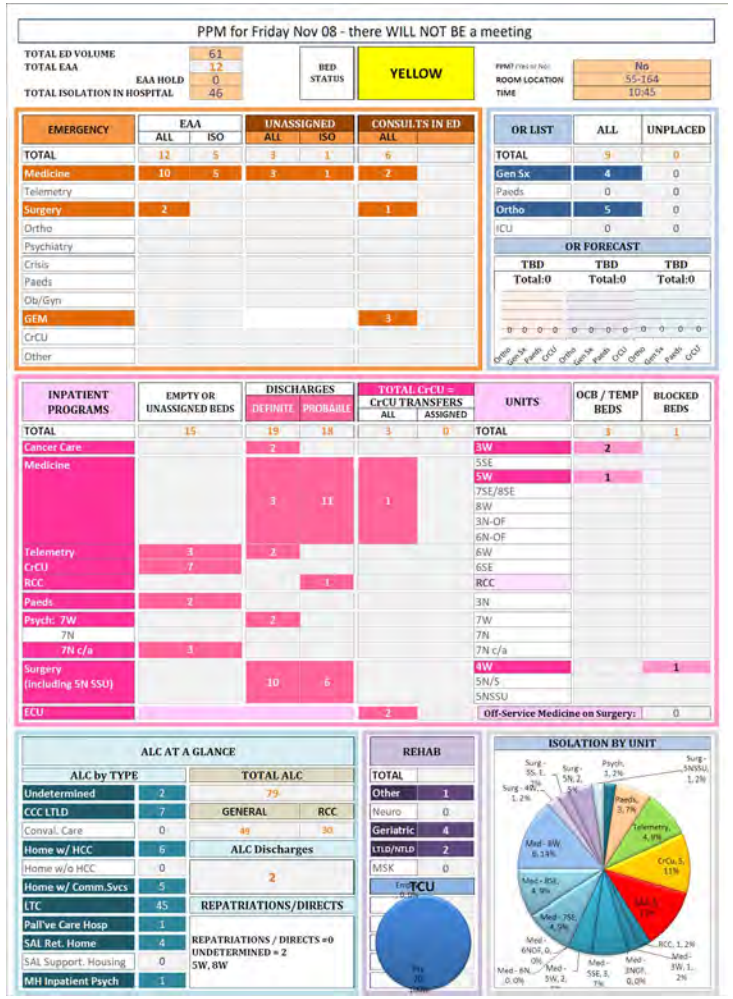


Review of the Dominant Flu Strain

- Historically, the prominent flu strains that impact our ED visits are H1N1, H3N2 and B (but the strains mutant under each of these categories which makes it hard to predict future strains)
- Historically, when H1N1 was the predominant flu strain, we saw an average increase of 8 ED visits daily
- Historically, when H3N2 was the predominant flu strain, we saw an average increase of 10 visits daily and a 3% increase in ED admissions
- This results in an increase in isolation admissions
- During the flu season we see, on-average, a 15% increase in Paeds ED visits
- This information has been taken into consideration when developing the model. Once we know the predominant flu strain for this year, we can update the model inputs accordingly

Overcapacity Protocol

Daily Information



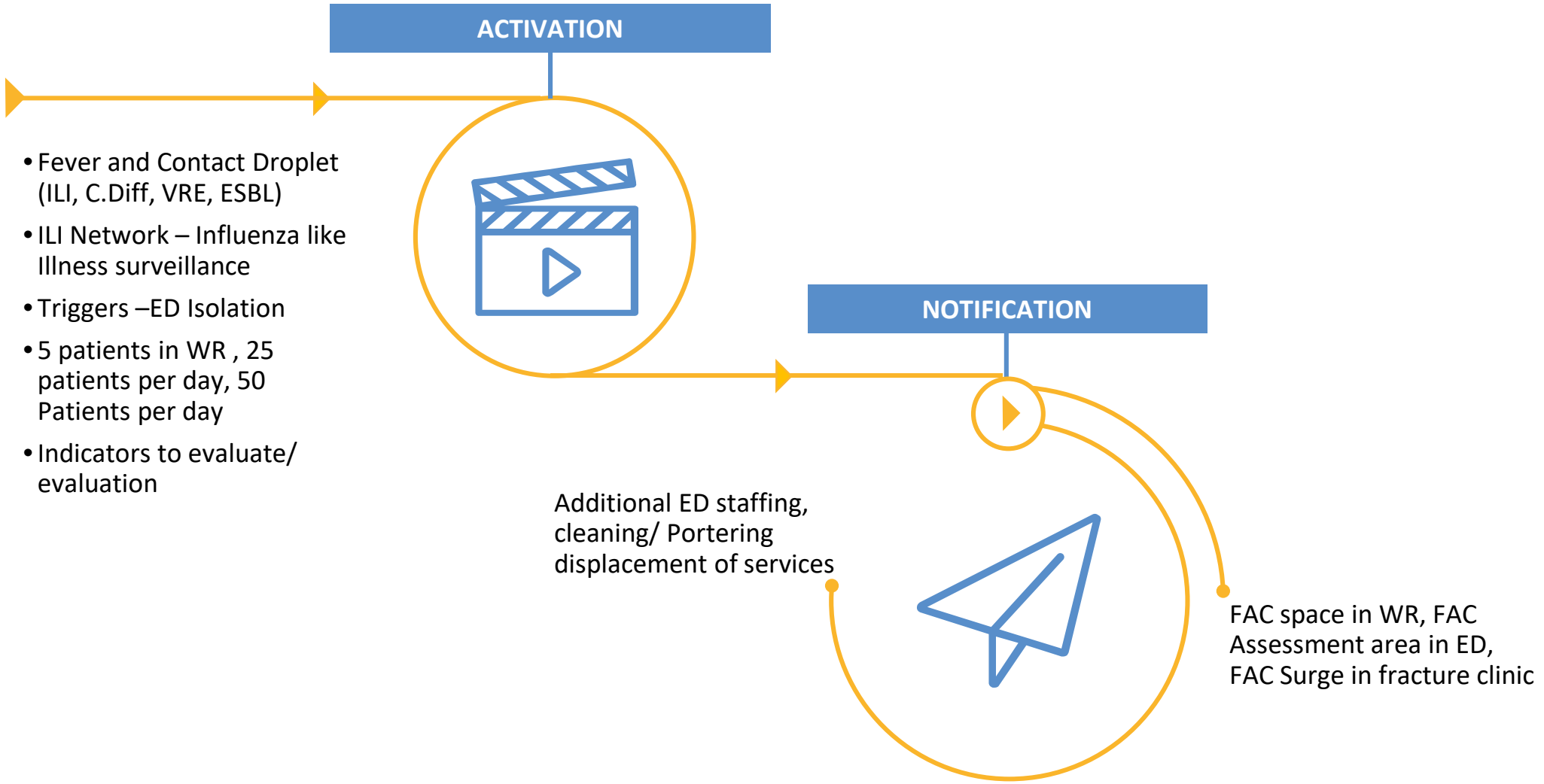
Alternate Space by ED

- Triggers
- Infrastructure
- Notifications
- Implementation
- Evaluation

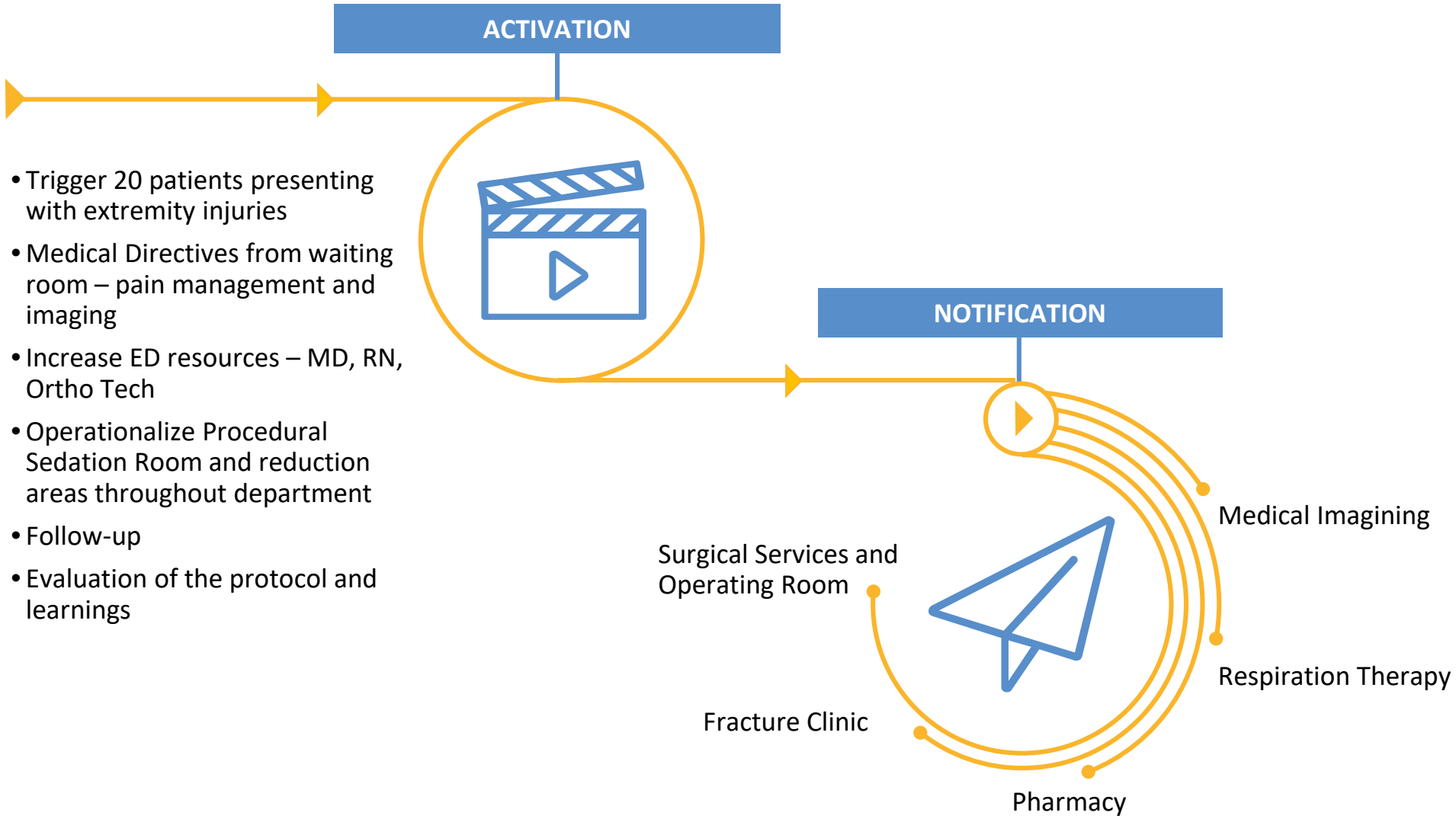
Unit in a Box

- Opening of 8 beds
- Criteria for SLT approval
- Temporary relocation of services
- Review checklist
- Safety walk about
- Implementation
- Decant

Flu Assessment Clinic Surge Planning

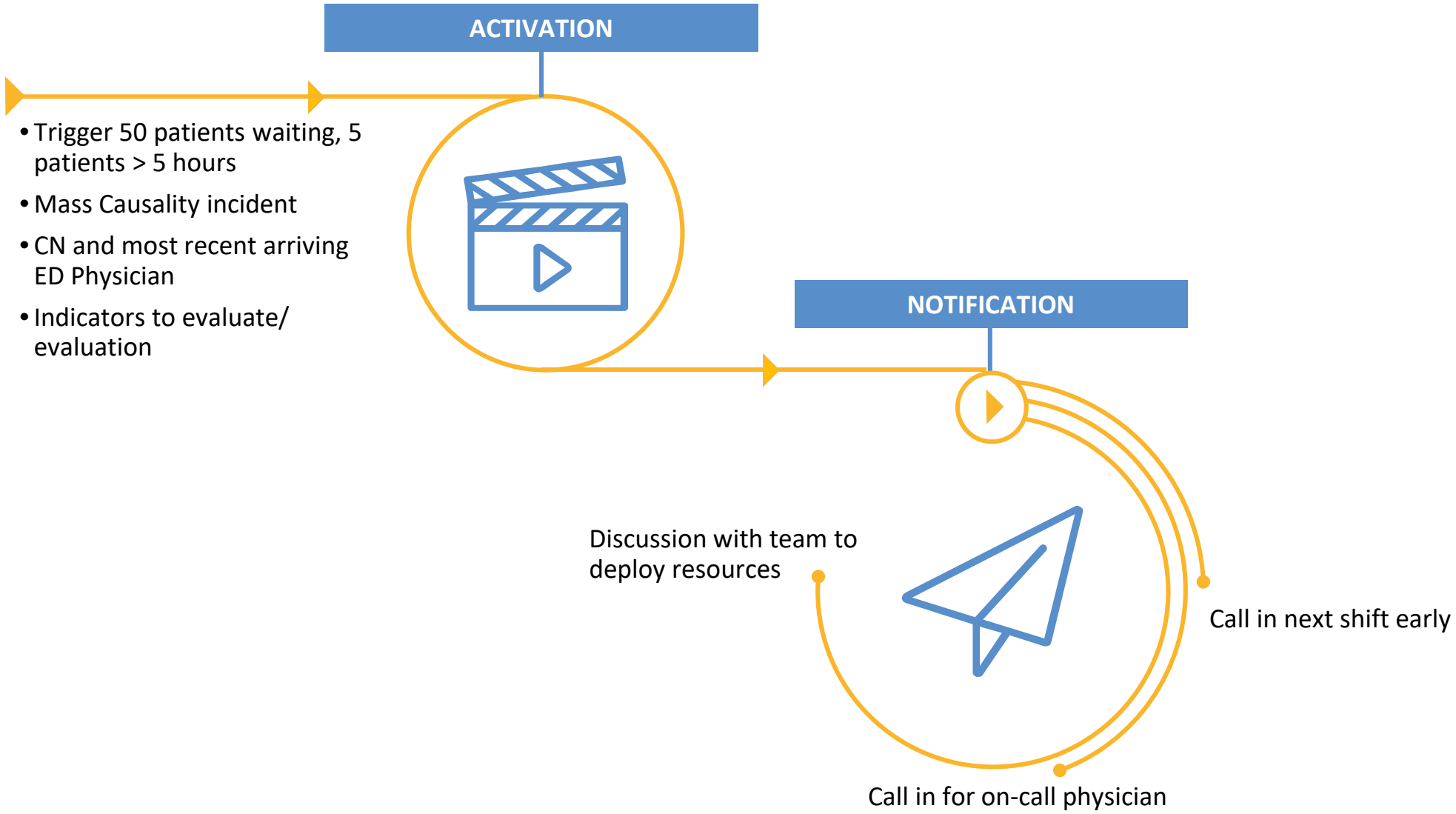


Ice Day Protocol



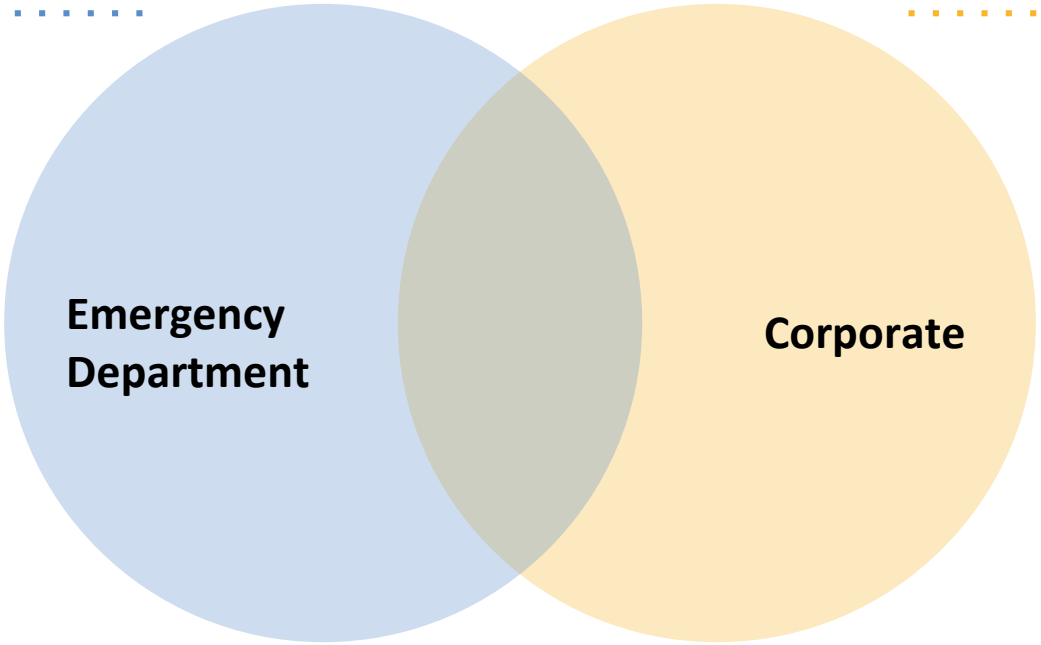
- Trigger 20 patients presenting with extremity injuries
- Medical Directives from waiting room – pain management and imaging
- Increase ED resources – MD, RN, Ortho Tech
- Operationalize Procedural Sedation Room and reduction areas throughout department
- Follow-up
- Evaluation of the protocol and learnings

ED On Call Guidelines



Financial Planning

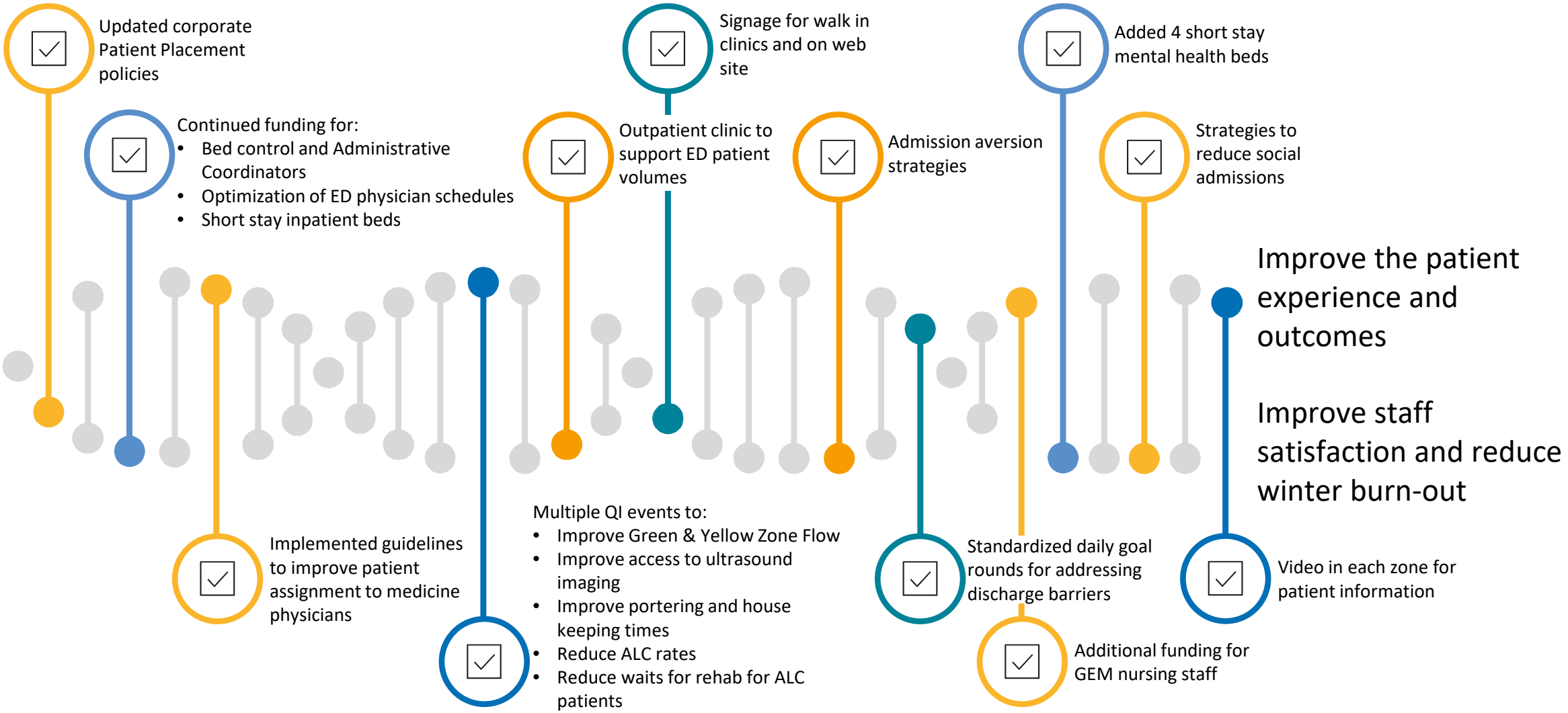
- Enhanced Security
- Trial ED Flow Coordinator (yellow zone)
- Additional housekeeping on nights
- Secretary in yellow zone on nights
- Additional nursing
- Enhanced Team Attendant schedule
- Fracture room space evening/weekends
- Nurse Led Outreach Team (ED diversion)
- Lab Tech for admitted patients



- Paediatric short stay open 24x7
- Enhanced outpatient clinic and endoscopy hours
- Admin Coordinator hours increased
- 6 N beds
- Transitional care bed proposal
- Enhanced allied staffing
- OTN virtual visits
- Reactivation Care Centre
- ALC projects

Communication & Culture

Multiple initiatives have been launched and sustained to improve access and quality in the ED – **We are in this together**





Spring 2020

Evaluate

Idea Generation

Start Planning Cycle Again

Summer 2020



Engaging Future Leaders; Focus on Women

Carolyn Snider MD, MPH, FRCPC

Department Chief, Emergency Medicine
Unity Health Toronto – St. Michael's Hospital

UNITY HEALTH TORONTO | PROVIDENCE Healthcare | ST JOSEPH'S HEALTH CENTRE TORONTO | St. Michael's Inspired Care. Inspiring Science.

UNIVERSITY OF TORONTO FACULTY OF MEDICINE

Faculty/Presenter Disclosure

Relationships with commercial interests:

- None

Mitigating Potential Bias

- Not applicable

Disclosure of Commercial Support

- This program has not received financial or in-kind support from any organization

Potential for conflict(s) of interest:

- Not applicable

Engaging Future Leaders; Focus on Women

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UNIVERSITY OF TORONTO FACULTY OF MEDICINE



Objective

- Leadership Gap
- How to sponsor women to increase leadership diversity throughout the career pathway

JAMA Network | Open

Original Investigation | Health Policy

Association of Physician Characteristics With Perceptions and Experiences of Gender Equity in an Academic Internal Medicine Department

Shannon M. Ruzycki, MD, MPH; Georgina Freeman, MSc; Aleem Bharwani, MD, MPP; Allison Brown, MSc

Abstract

IMPORTANCE empirically und
harassment, dis

Conclusions and Relevance In this study, senior men physicians' perceptions of gender equity were different from lived experiences of gender inequity reported by junior women physicians. This demographic mismatch between perceptions and experiences of gender equity in medicine may explain the lack of action by leaders and decision-makers in medicine to mitigate disparities.

OBJECTIVES To explore how physicians perceive the climate for women physicians and compare perceptions and experiences of gender inequity among physicians based on characteristics including gender, faculty status, parental status, and years in practice.

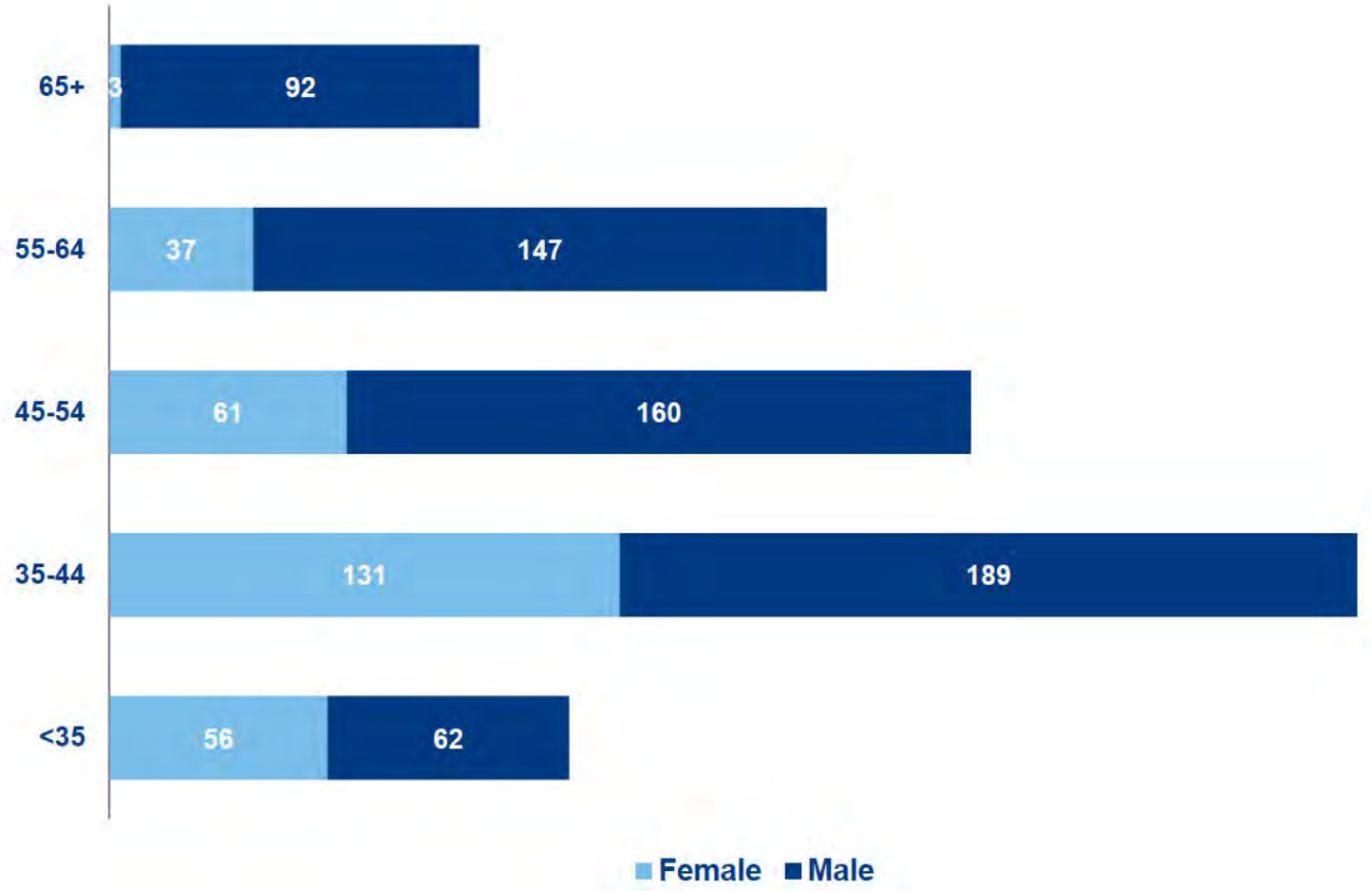
DESIGN, SETTING, AND PARTICIPANTS This sequential, explanatory, mixed-methods qualitative study used the Culture Conducive to Women's Academic Success (CCWAS; range 45-225, with higher scores indicating better perceived culture toward women), followed by individual semistructured interviews with physicians at the Department of Medicine of the University of Calgary. All 389 physician members of the Department of Medicine, including academic and clinical physicians and

r-based and
how
ent of
of Calgary
perceive and experience gender inequity?

Findings This mixed-methods study demonstrated that men physicians perceive that the culture is more favorable for women than women physicians. Junior women physicians reported experiencing greater bias and discrimination compared with their men

Emergency Medicine

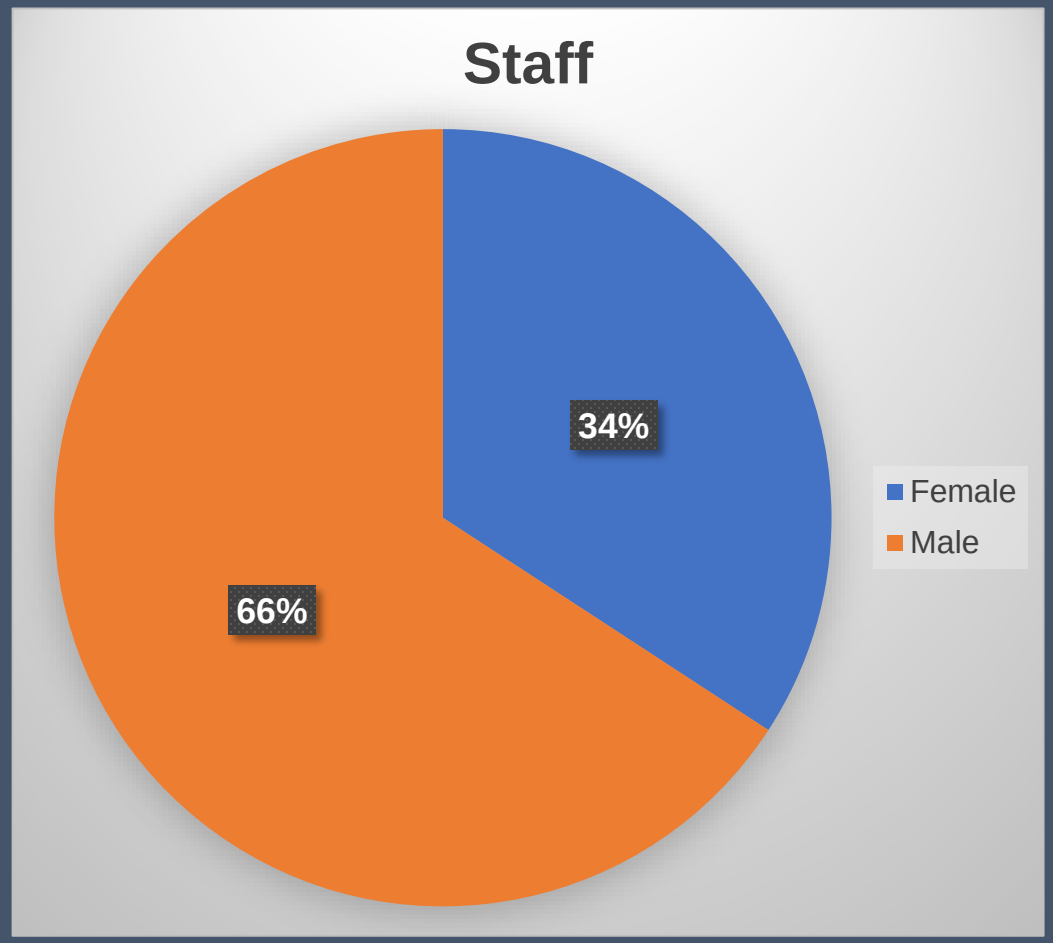
Number by gender & age, 2018

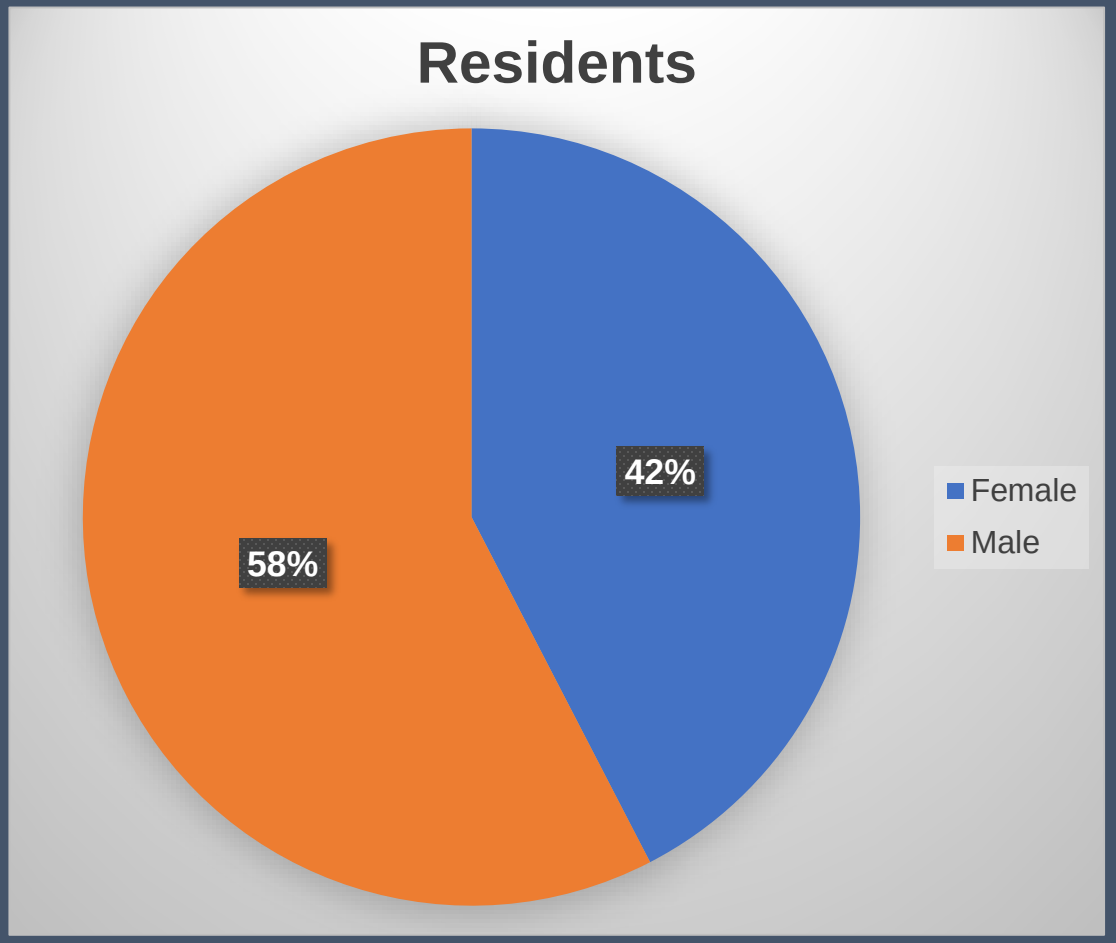


Excludes those where gender or age is unknown.

Source: 2018 CMA Masterfile

From Collaborative Working Group Report





- Department Chairs 21%
- Department Chiefs…
- CAEP Board of Directors - 33% (↑18%)
- Plenary Speakers…

Is it choice or lack of choice?



From the Good Life Family website

Potential vs. Accomplishments

60% vs. 100%



Examining our Implicit Bias

Press "E" for

Bad

or

Black people

Press "I" for

Good

or

White people



Project Implicit

Your data suggest a moderate automatic association for Male with Career and Female with Family.


HIRING

Avoiding gender bias in reference writing

Mention Research and Publications

Don't stop!

Emphasize Accomplishments, not effort

Keep it Professional

Stay away from stereotypes

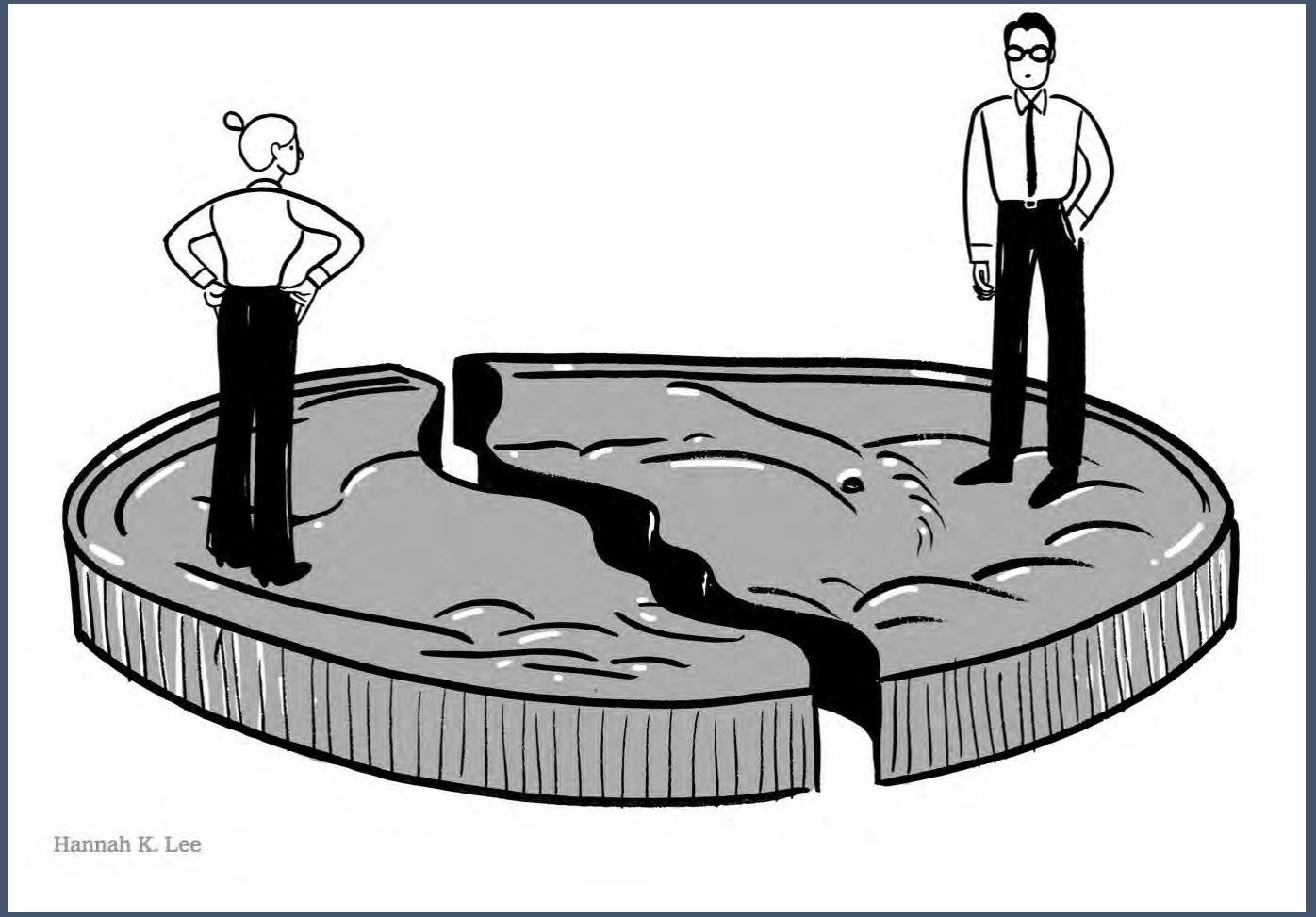
Adjectives to avoid	Adjectives to include
caring	successful
compassionate	excellent
hard-working	accomplished
conscientious	outstanding
dependable	skilled
diligent	knowlegeable
dedicated	insightful
tactful	resourceful
interpersonal	confident
warm	ambitious
helpful	independent
	intellectual

THE UNIVERSITY OF ARIZONA
Commission on the Status of Women

Trix, F & Psenka, C. Exploring the color of glass: Letters of recommendation for female and male medical faculty. Discourse & Society, 2003; and Madera, JM, Hebl, MR, & Martin, RC. Gender and letters of Recommendation for Academia: Agentic and Communal Differences. Journal of Applied Psychology, 2009.

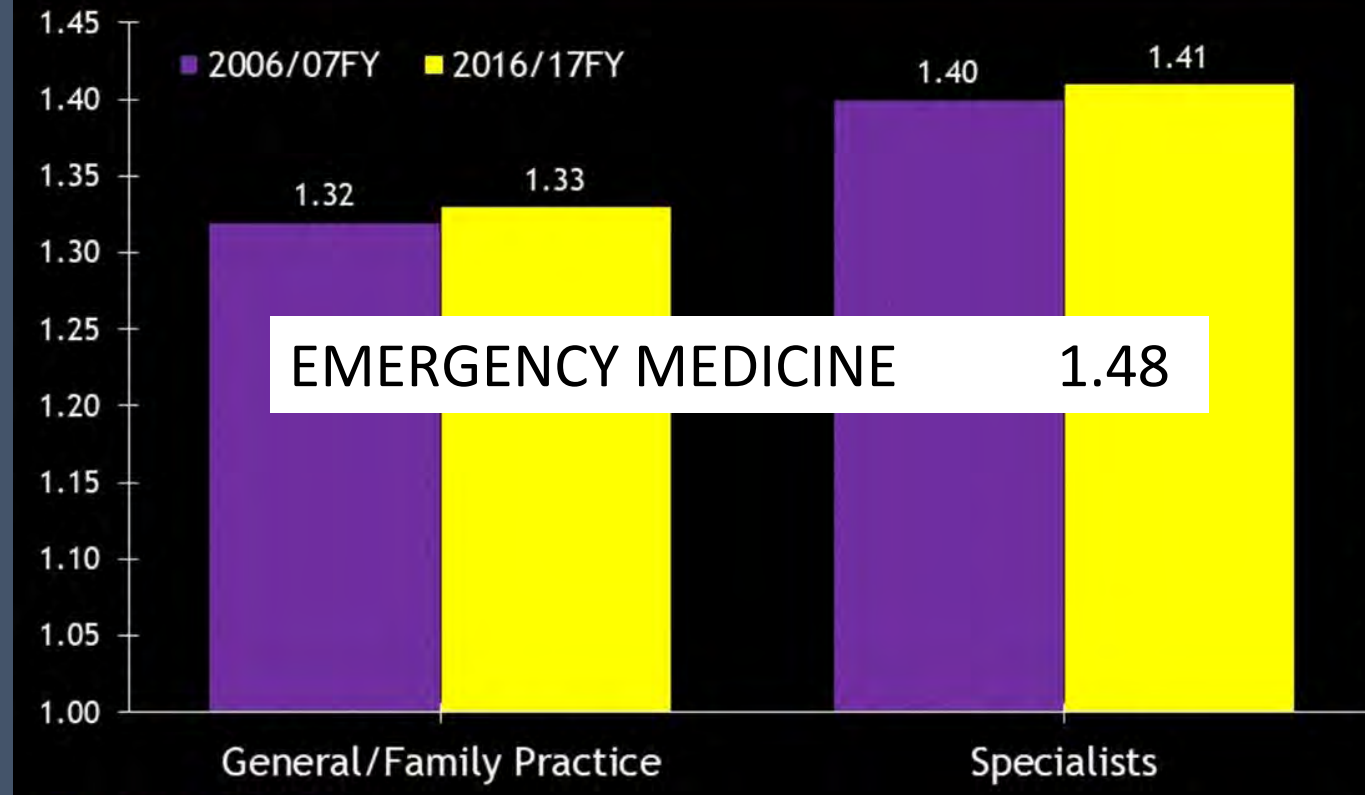
Rx

- Unconscious Bias Training
  - Do the Implicit Assumption Test
- Standardized Review Forms
- Outside members on committee
- Balanced Committee



nytimes.com

Ratio of Average Male to Female MD Payments*: Ontario



EMERGENCY MEDICINE 1.48

PERSPICACITY

* Average Gross Professional FFS Payments>$100,000, Source: OHIP, Calculations by Author

Ratio of Average Male to Female MD Payments*, 2016/17FY

Specialty	Ratio
UROLOGY	1.65
ORTHOPAEDIC SURGERY	1.57
CARDIOLOGY	1.54
GERIATRICS	1.51
ENDOCRINOLOGY	1.50
MEDICAL ONCOLOGY	1.49
EMERGENCY MEDICINE	1.48
OPHTHALMOLOGY	1.44
PAEDIATRICS	1.44
RESPIRATORY DISEASE	1.41
OTOLARYNGOLOGY	1.37
NEPHROLOGY	1.36
NEUROLOGY	1.36
RHEUMATOLOGY	1.35
GENERAL SURGERY	1.34
GENERAL/FAMILY PRACTICE	1.33
DERMATOLOGY	1.33
PHYSICAL MEDICINE	1.31
DIAGNOSTIC RADIOLOGY	1.27
INTERNAL MEDICINE	1.26
PSYCHIATRY	1.26
ANAESTHESIA	1.24
CLINICAL IMMUNOLOGY	1.24
INFECTIOUS DISEASE	1.23
THORACIC SURGERY	1.23
CARDIOTHORACIC SURGERY	1.22
GASTROENTEROLOGY	1.18
OBSTETRICS & GYNAECOLOGY	1.17
NUCLEAR MEDICINE	1.17
PLASTIC SURGERY	1.14
THERAPEUTIC RADIOLOGY	1.07
HAEMATOLOGY	1.03

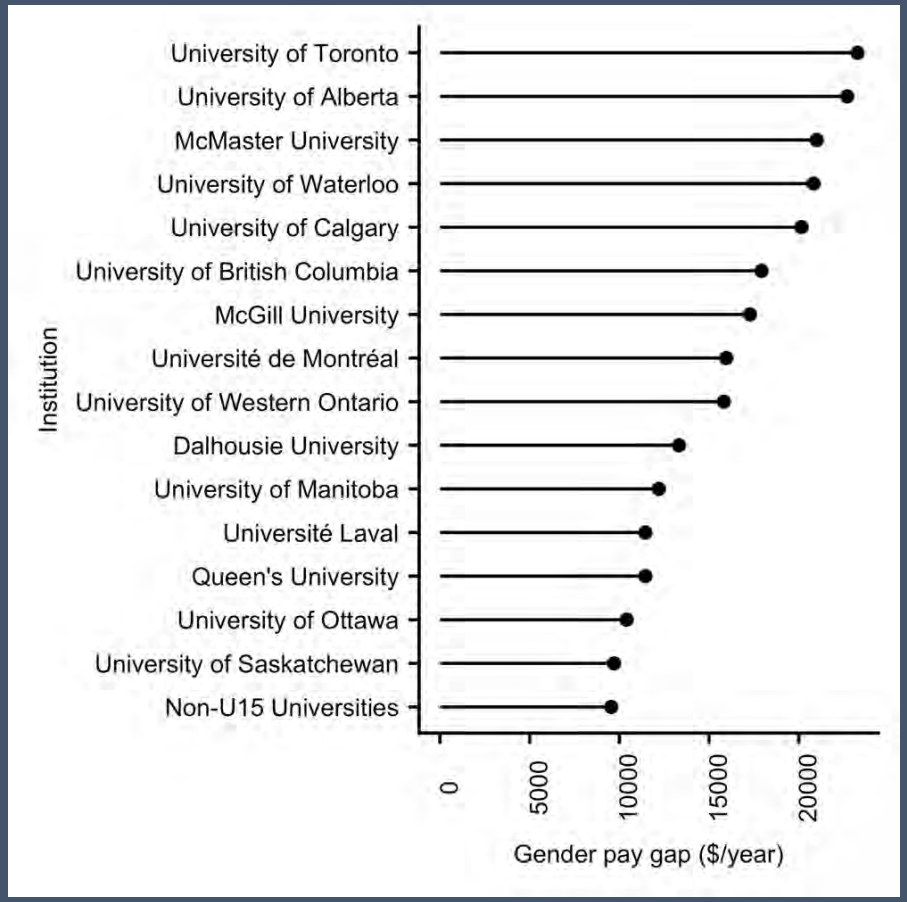
* Average Gross Professional FFS Payments>$100,000

Average Hours worked per week * *FRCPC EM only*

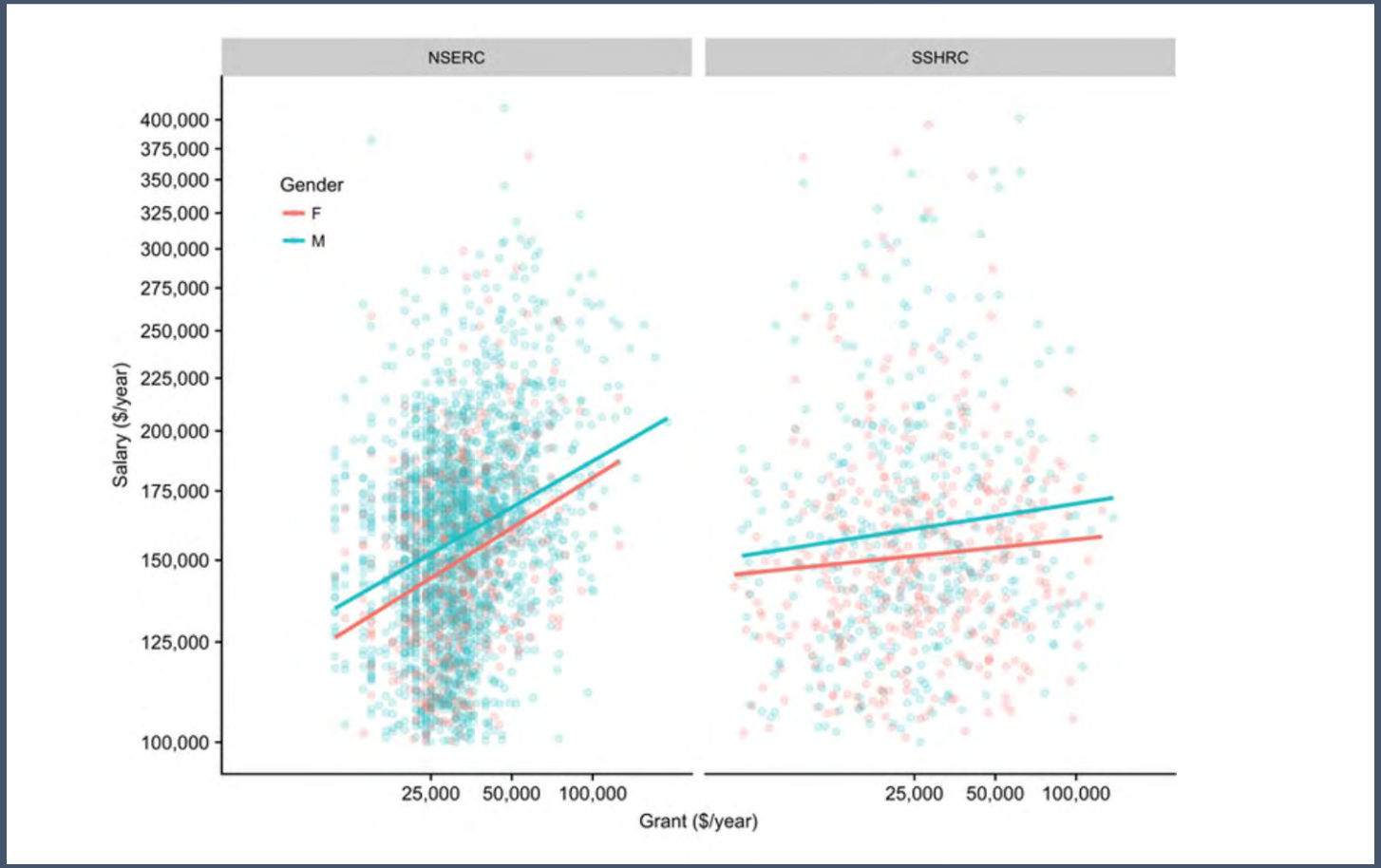
Activity	Gender		
	Female	Male	All
Direct patient care without a teaching component	11.41	11.72	11.61
Direct patient care with a teaching component	18.69	19.20	19.02
Teaching/educating without direct patient care	2.89	2.56	2.67
Indirect patient care	3.51	3.10	3.24
Health facility committees	0.86	1.09	1.01
Administration	4.44	4.77	4.66
Research	2.50	1.37	1.76
Managing practice	0.34	0.54	0.47
CME/CPD	2.83	2.36	2.52
Other activities	0.09	1.08	0.74
TOTAL HOURS PER WEEK	47.56	47.79	47.71
N	359	679	1038
n	38	53	91



Are We Just Slower?



Frederickson, M. **Canadian professors still face a gender pay gap.** ***The Conversation. March 27, 2018***


NSERC
SSHRC
Gender
F
M
400,000
375,000
350,000
325,000
300,000
275,000
250,000
225,000
200,000
175,000
150,000
125,000
100,000
Salary ($/year)
25,000
50,000
100,000
25,000
50,000
100,000
Grant ($/year)

U.S. Academic Medicine

- Difference between Male & Female Academic MDs: $51,315
- Then Adjusted for
  - faculty rank, age, years since residency, specialty,
  - NIH funding,
  - clinical trial participation,
  - Publication count (total as well as first- or last-authored articles),
  - Total Medicare payments
  - graduation from a medical school ranked among the top 20

Difference of $19,878

(Emergency Medicine $6,723) = translates to $700,000+ over a 30-year career

JAMA Intern Med. 2016;176(9):1294-1304.

Rx

- Look for the informal and unpaid leaders on your team
- Remunerate them

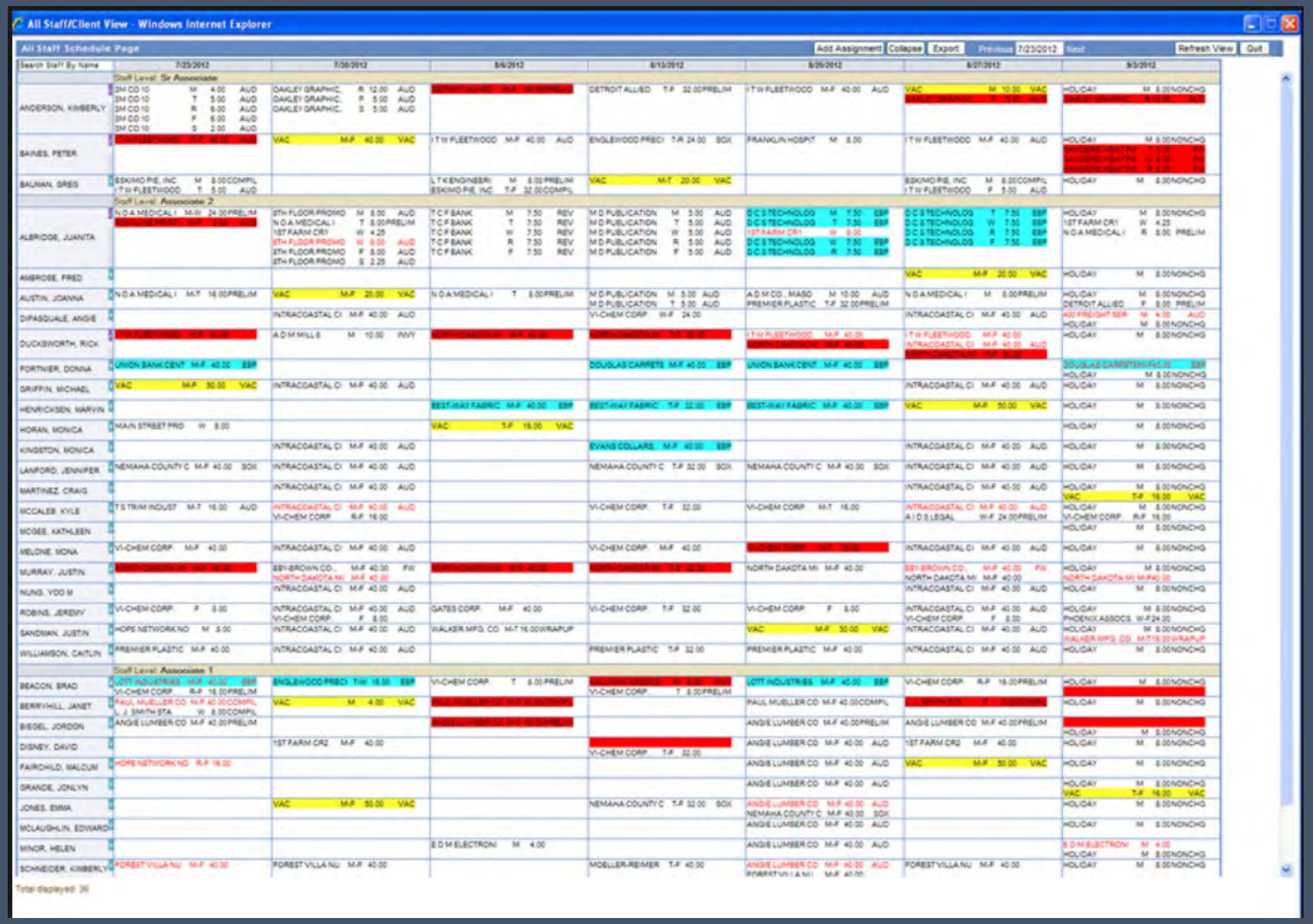
Pattani *et al. BMC Medicine* (2018) 16:48
https://doi.org/10.1186/s12916-018-1032-8

BMC Medicine

CORRESPONDENCE Open Access

The perceived organizational impact of the gender gap across a Canadian department of medicine and proposed strategies to combat it: a qualitative study

Reena Pattani[1,2*], Christine Marquez[3], Camellia Dinyarian[3], Malika Sharma[2,4,5], Julie Bain[3], Julia E. Moore[3] and Sharon E. Straus[2,3,6,7]


All Staff/Client View - Windows Internet Explorer
All Staff Schedule Page
Add Assignment
Collapse
Export
Previous
7/23/2012
Next
Refresh View
Quit
Search Staff By Name
7/23/2012
7/30/2012
8/6/2012
8/13/2012
8/20/2012
8/27/2012
9/3/2012
Staff Level: Sr Associate
ANDERSON, KIMBERLY
BAINES, PETER
BAUMAN, GREG
Staff Level: Associate 2
ALBRIDGE, JUANITA
AMBROSE, FRED
AUSTIN, JOANNA
DIPASQUALE, ANGIE
DUCKSWORTH, RICK
FORTNIER, DONNA
GRIFFIN, MICHAEL
HENRICKSEN, MARVIN
HORAN, MONICA
KINGSTON, MONICA
LANFORD, JENNIFER
MARTINEZ, CRAIG
MCCALEB, KYLE
MCGEE, KATHLEEN
MELONE, MONA
MURRAY, JUSTIN
NUNG, YOO M
ROBINS, JEREMY
SANDMAN, JUSTIN
WILLIAMSON, CAITLIN
Staff Level: Associate 1
BEACON, BRAD
BERRYHILL, JANET
BIEGEL, JORDON
DISNEY, DAVID
FAIRCHILD, MALCUM
GRANDE, JONLYN
JONES, EMMA
MCLAUGHLIN, EDWARD
MINOR, HELEN
SCHNEIDER, KIMBERLY
Total displayed: 36



Timing of Meetings

Bropriations

Mansplaining

The Art of Amplification



- Watch for your implicit biases in:
  - Evaluations of students and residents
  - Resuscitation Dynamics
  - Letters of References
  - Hiring
- Identify informal leaders – label/reward/encourage
- Sponsorship and Mentorship

- Life-Friendly scheduling
- Meeting Dynamics



Creating a Climate for Change

Nov 26, 2019

@phalpherMD

Faculty/Presenter Disclosure

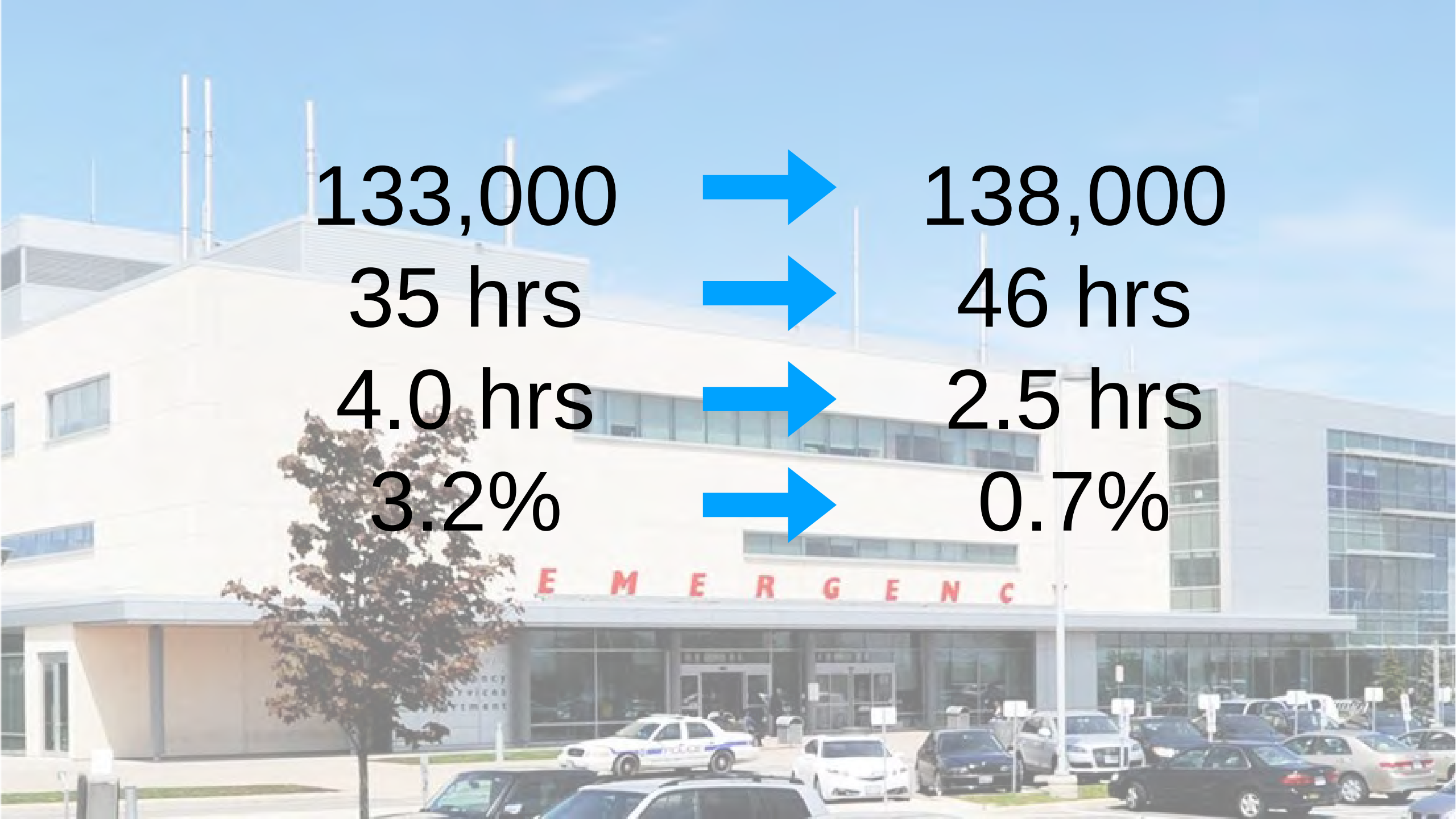
- **Faculty:** Dr. Prashant Phalpher

- **Relationships with commercial interests:**
  - None

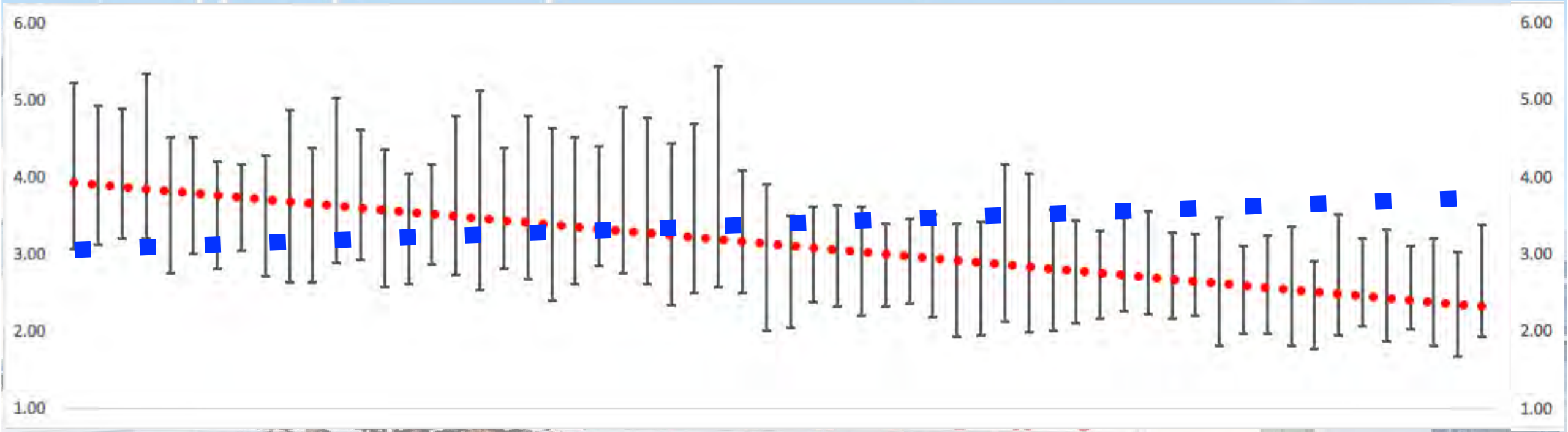
- **This program has not received financial or in-kind support from any organization**

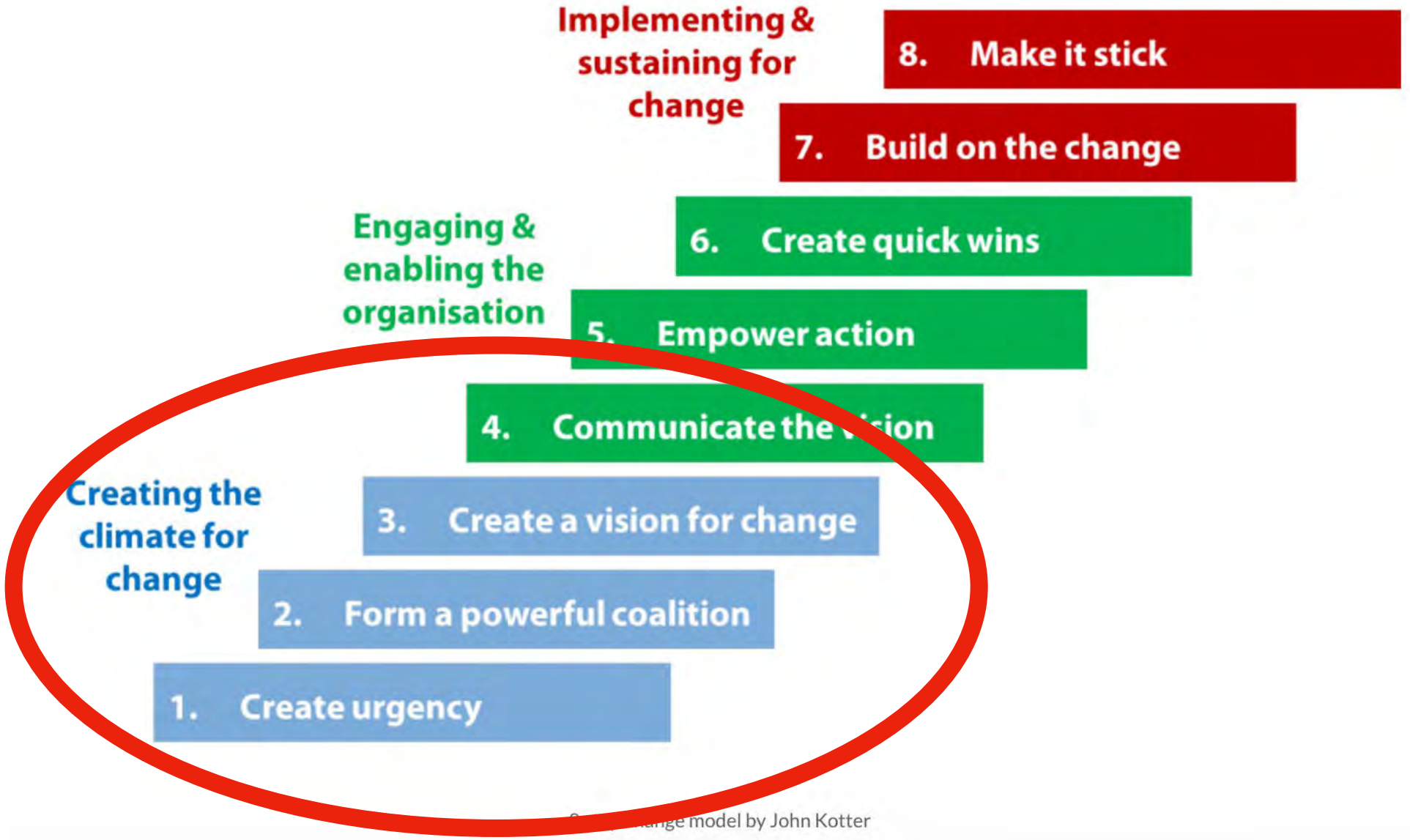
- **Potential for conflict(s) of interest:**
  - Not applicable


133,000
87%
35 hrs
4.0
3.2%

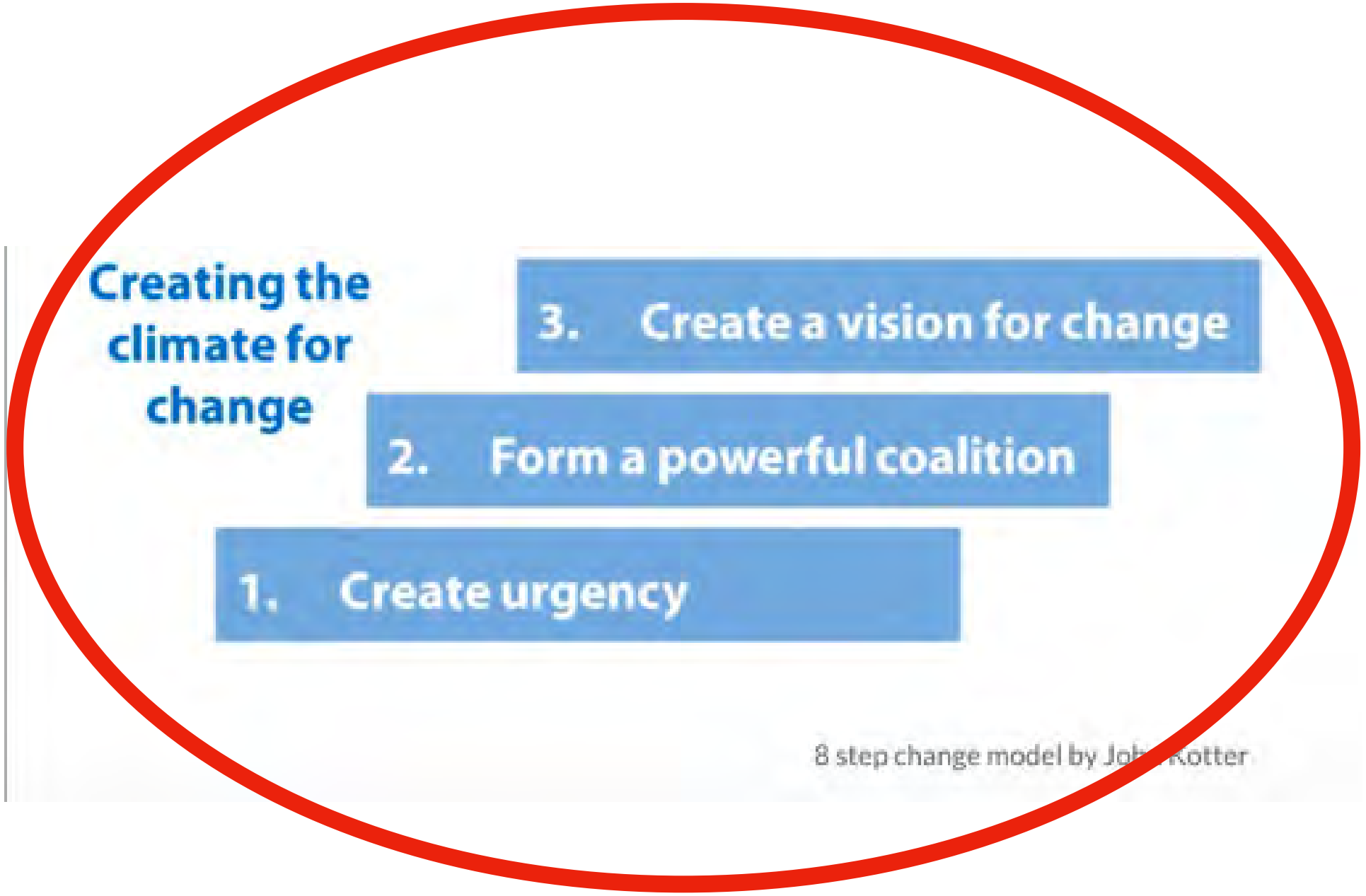

133,000
138,000
35 hrs
46 hrs
4.0 hrs
2.5 hrs
3.2%
0.7%

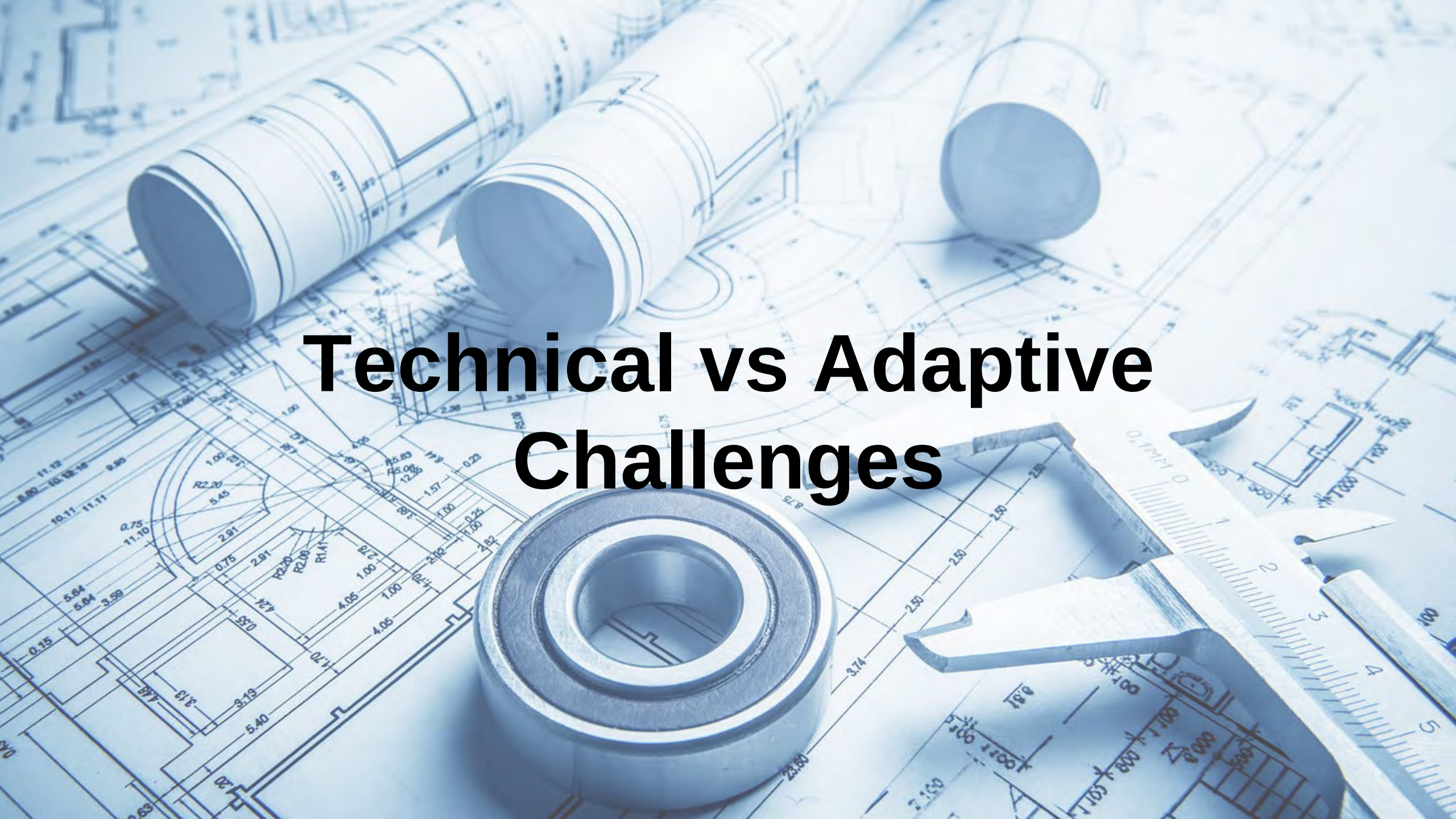
Continuous Improvement: PIA



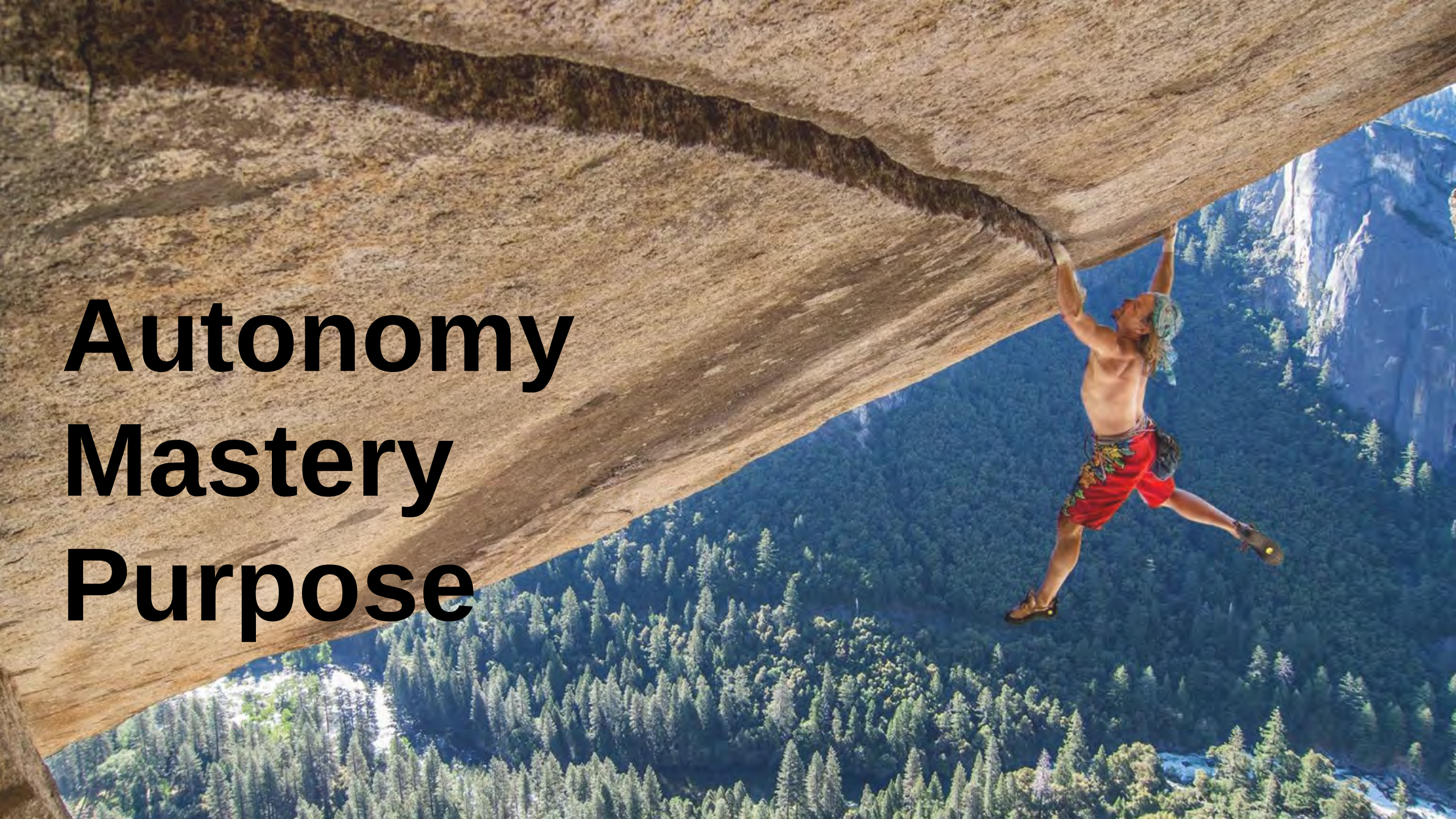


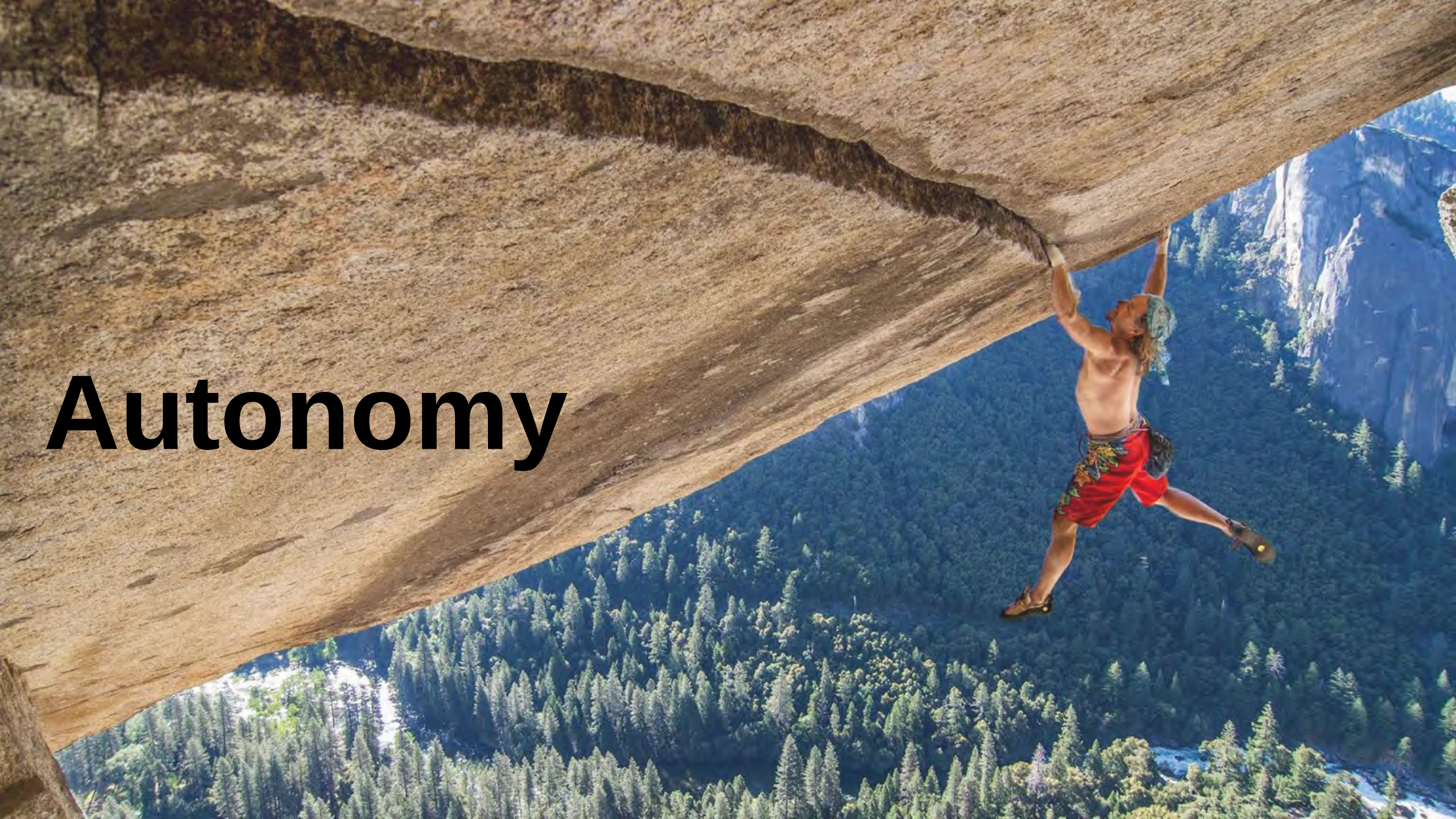
change model by John Kotter


Creating the climate for change
3. Create a vision for change
2. Form a powerful coalition
1. Create urgency
8 step change model by John Kotter



Technical vs Adaptive Challenges


Autonomy
Mastery
Purpose


Autonomy



User Centred Design

Front Line Staff = Most Important User

Acute [BCH]

# WTBS in ED	# WTBS in waiting room	Total patients in ED
7	5	96

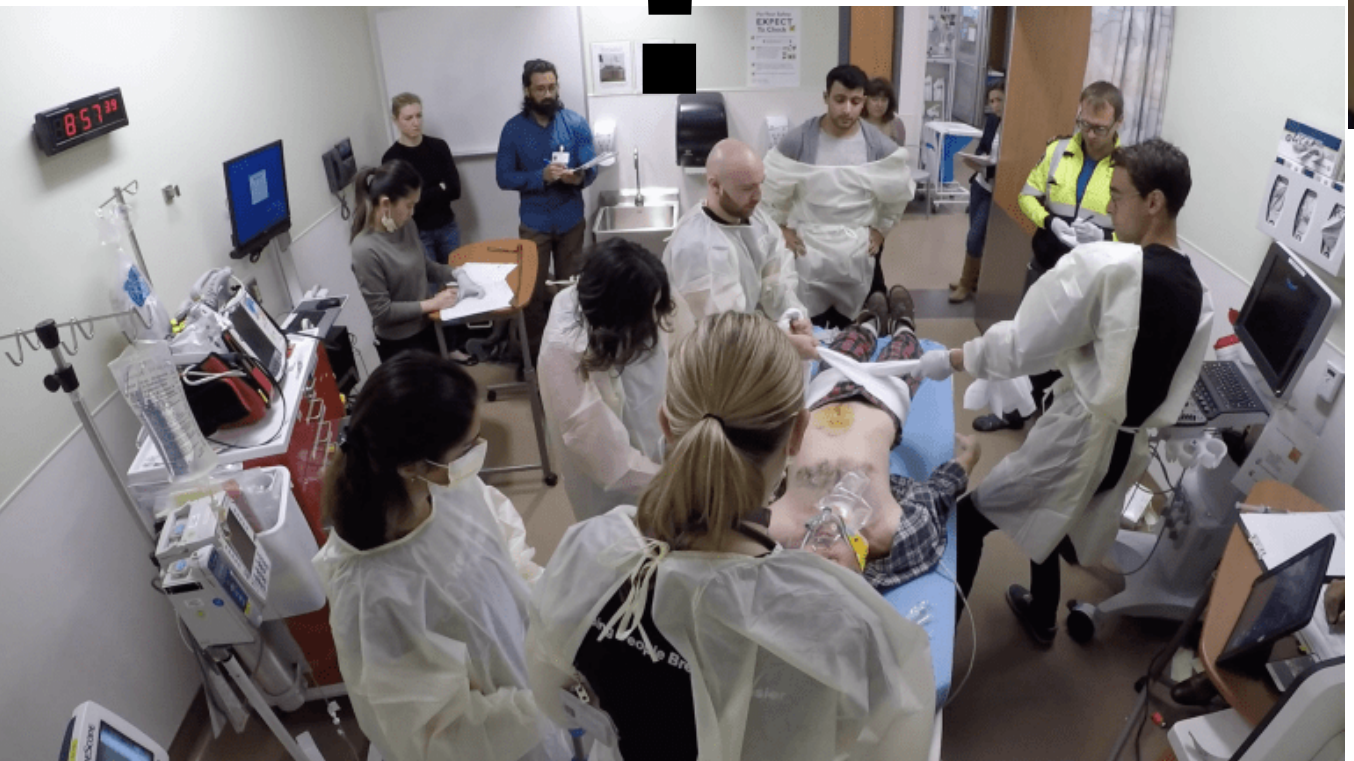
# of patients in Greet BCH	# of resus beds available	# of cubicles available	Total admits in MAU	Total admits in ED
0	1	2	6	20

All Areas (114)
Bed / CTAS
All
AA *R01
AA *R02
AA *R03
AA *R03
AA *R03H
AA *R04
AA A05
AA A05H
AA A06
AA A06H
AA A07
AA A07H
AA A08
AA A09
AA A10
AA A11
AA A11H
AA A12
AA A12H
AA A13
AA A14
AA A15
AA A16

Go M63 Chest pain (cardiac features) [003] ACCU 30:56


Mastery
(Competence)

SIM!!!





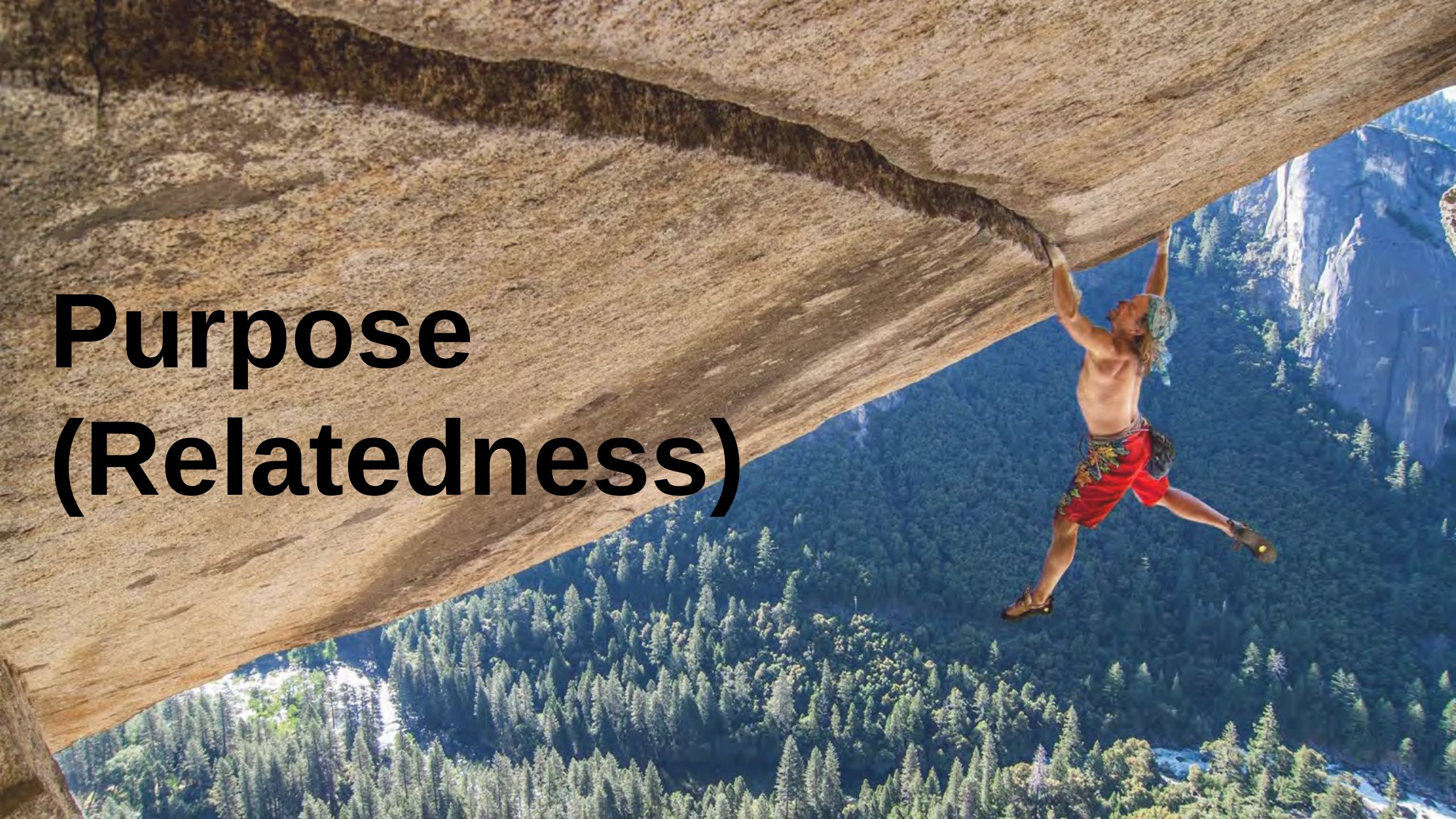
www.oslersim.ca

Mastery ↔ Autonomy

Professional Development ≠ Performance Management

Performance Feedback ≠ Performance Management

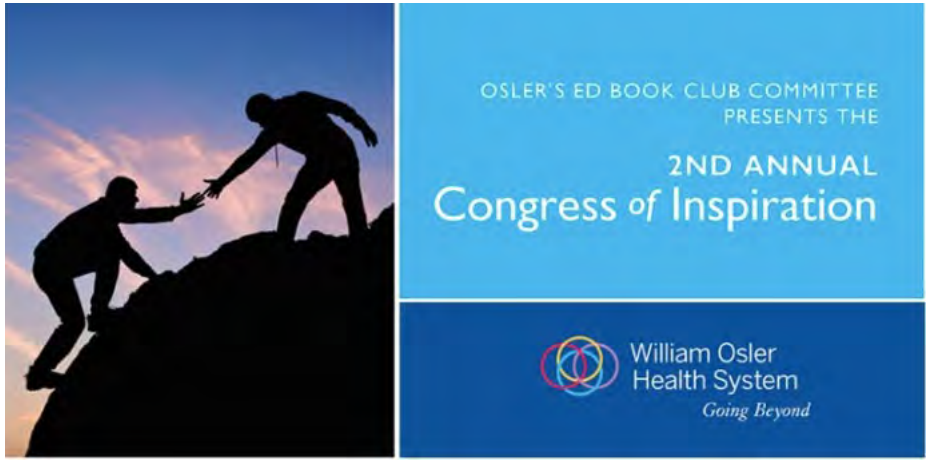
~~Mandatory~~


Purpose
(Relatedness)




NORTH
7
SIAKAM
43





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Going Beyond



Joy at work



Stuff happens

Incident reviews and creating a culture of safety in your ED

Paul Hannam MD CCFP(EM) FCFP
Chief, Department of Emergency Medicine
North York General Hospital

NORTH YORK GENERAL
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SCHWARTZ/REISMAN EMERGENCY MEDICINE INSTITUTE
Mount Sinai Hospital
North York General Hospital

Conflict of interest, Disclosures, Bias

Relationships with commercial interests:

None

Mitigating Potential Bias:

Not applicable

Disclosure of Commercial Support:

This program has not received financial or in-kind support from any organization

Potential for conflict(s) of interest:

None

While you were away..

- Disclosure occurred, except that it was based on incorrect information
- Provider from another service called out one of your staff
- MD or RN was not able to work again after a difficult case



What next?



Key steps following an incident



FIRST RESPONSE

INVESTIGATE

DEFINE

DISCLOSE

MAINTAIN

Messages from today



1. Our response to an incident impacts organizational trust, provider performance, and future outcomes.

2. Respect the emotions.

3. Have a process and make sure each person knows their role.

First response



Process

- Make sure everyone is safe
- Store equipment if at all possible
- Disclose known events only

Emotion

- Apologize for the situation, commit to followup
- Involve the patient/family in the care going forward

Investigate



Process

- Establish which person or group is leading the process
- Gather as much first-hand information as possible

Emotion

- Initiate contact with the patient/family
- Check in with each provider "I'm here, call any time"

JAMA 2003; 289:1001–1007

Define



Process

- Group debriefing of facts
- Define the incident
- Consider interventions in the context of care for others

Emotion

- Individual +/- group support
- Be aware of formal and informal mechanisms to distribute accurate information

Respectful Management of Serious Clinical Adverse Events (Second Edition). IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011

Disclose



Process

- Know the facts
- Ensure everyone in the room is aware of their role

Emotion

- Pay attention to what they value
- Communicate with authenticity
- Make it clear that the relationship is ongoing

Qualitative Health Research 2019, Vol. 29(8) 1096–1108

Maintain



Process

- Ensure patient safety interventions are completed
- Report and followup

Emotion

- Reinforce the idea of a just culture locally
- Be open to continued relationships

Messages from today



1. Our response to an incident impacts organizational trust, provider performance, and future outcomes.

2. Respect the emotions.

3. Have a process and make sure each person knows their role.

Communication and Optimal Resolution (CANDOR)
Agency for Healthcare Research and Quality, Rockville, MD.
https://www.ahrq.gov/patient-safety/capacity/candor/index.html



Thank you

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Workplace Violence in the Small Town Emergency Department

Alan Drummond MDCM

Co-Chair, Public Affairs

Canadian Association of Emergency Physicians

Definition

- Workplace violence is defined as any act in which a person is abused, threatened, intimidated or assaulted in his or her employment

Definition

- **Threatening behaviour** – shaking fists, destroying property or throwing objects
- **Verbal or written threats** – any expression of an intent to inflict harm
- **Harassment** – any behaviour that demeans, embarrasses, humiliates, annoys, alarms or verbally abuses a person and that is known or would be expected to be unwelcome. This includes words, gestures, intimidation, bullying, or other inappropriate activities.
- **Verbal abuse** – swearing, insults or condescending language
- **Physical attacks** – hitting, shoving, pushing or kicking

Violence in the Health Care Sector

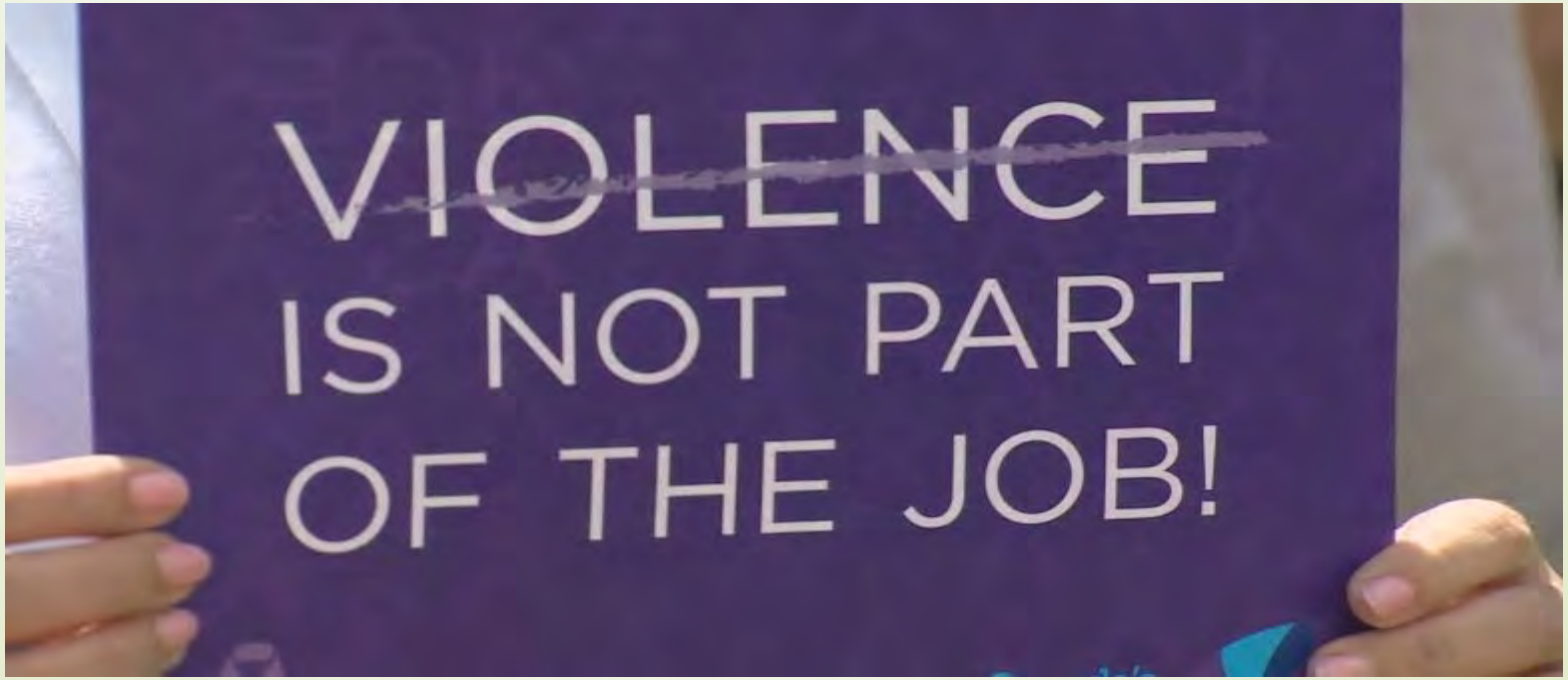
- Health care providers have four-fold higher rate of workplace violence and 50% of all attacks on health care workers occur in the emergency department

Violence in the Health Care: Under-reported

- Only 30% of nurses report incidents of workplace violence
- Among physicians, the reporting rate is 26%
- Inappropriate cultural acceptance
- **“It’s part of the job”**



Violence in the Emergency Department: The Scope of the Problem



'Frustrating and demoralizing': Thunder Bay paramedics encountering increased assaults – CBC Thunder Bay, November 9, 2019

- Paramedics in Thunder Bay are increasingly being exposed to violence while on the job.
- There have been 52 separate reported incidents of physical assaults directed at paramedics from September 2016 to October 2019, according to statistics provided by Superior North EMS.



'Frustrating and demoralizing': Thunder Bay paramedics encountering increased assaults – CBC Thunder Bay, November 9, 2019

- Spitting is the most common type of encounter, representing 33 per cent of the incident reports, but paramedics have also been getting kicked, punched, struck and grabbed

- "As for the violence - both physical and verbal - it is frustrating and demoralizing. I'm just here to make sure you see tomorrow," Sweitzer said.



'Kicked, spat on, bit': Hospital staff take stories of violence on the job to Queen's Park: CBC News, November 05, 2017

Ontario Council of Hospital Unions:

- Sixty-eight per cent (68%) of frontline healthcare staff surveyed were physically assaulted in the past twelve months.
- Eight-six-percent (86%) reported they were subject to verbal violence in the same period.
- Forty-three per cent (43%) reported experiencing sexual harassment or sexual assault in the past twelve months.
- Twenty percent (20%) reported having been physically assaulted more than nine times in the same period.

Nurses are at increased risk

- Gerberich (2011)reported that 79% of emergency department ED nurses experienced workplace violence during a 5-month period
- The Emergency Nurses Association's (ENA's) Violence Surveillance Study (2011) revealed that 54.5% of ED nurses reported exposure to physical or verbal abuse within the previous 7 days
- Gacki-Smith reported (2009) that approximately 25% of emergency nursing respondents reported experiencing physical violence more than 20 times in the past 3 years, and almost 20% reported experiencing verbal abuse more than 200 times during the same period

Emergency Physicians: Pass the Kevlar

- Michigan Survey: 75% had been subject to verbal threats and 28% had been victims of physical assaults
- Behnam (2011) 78% of emergency department physicians reported being targets of workplace violence in the previous 12 months; 75% reported verbal threats, 21% physical assaults, 5% confrontations outside the workplace, and 2% stalking
- ACEP (2018): 47% of emergency physicians polled reported being physically assaulted, with more than 60% of those saying it occurred in the past year.
- 70% of emergency physicians say that ED violence has increased in the past five years, with 25% of them reporting it has increased greatly.

Violence in the Canadian emergency department: Fernandes, CMAJ. 1999 Nov 16; 161(10): 1245–1248.

- Review of 163 emergency department employees in inner city Vancouver
- Fifty-seven percent (57%) were physically assaulted in 1996.
- Most of the respondents felt that violence included witnessing verbal abuse (76%) and witnessing physical threats or assaults (86%).
- 68% reported an increased frequency of violence over time, and 60% reported an increased severity.

Root Causes and Contributing Factors

- **Multifactorial**
- Lie beyond the department itself and are societal and cultural
- Chronic oppression; racism, poverty and social exclusion
- Sexism
- Substance abuse, Alcoholism and the rising use of Crystal Meth
- Mental illness; including dementia and delirium
- Violence in the community with gangs and guns



Root Causes and Contributing Factors

- Overcrowding and increased wait times
- Associated stress of both patients and caregivers
- Insufficient staffing levels and poor communication with patients
- Poor environmental design all contribute to a risk of violence in the ER.



Effects of Violence

- **Multiple studies and reports have shown that exposure to violence in the emergency department has a deleterious and demoralizing effect on staff, most notably nursing staff**
- Occupational strain
- Impaired job performance
- Fear of patients and future assaults
- Decreased feelings of safety
- Reduced job satisfaction
- Absenteeism
- Prematurely shortened careers

Effects of Violence: Institutional Costs

- High staff turnover
- Costs of medical and psychological care
- Costs of increased security
- Increased worker's compensation claims







Is there an impact on patients?

Patients with medical emergencies deserve a place of care that is free of physical dangers and care from staff who are not distracted by patients or visitors with behavioral or substance-induced violent behavior

Workplace abuse comes at steep cost for nurses, taxpayers – Globe and Mail, June 28, 2017

- The cost of violence in Ontario hospitals alone is about $23.8 million annually, making up 10% of hospital lost-time injuries with the majority of these injuries occurred among nurses



Workplace abuse comes at steep cost for nurses, taxpayers – Globe and Mail, June 28, 2017

- In 2014 there were 639 lost-time injuries due to workplace violence in the health-care sector in Ontario, compared with 77 in manufacturing, 10 in construction and one in mining.

- "Nine per cent of nurses are off absent due to their own illness or injury, and just that cost in Canada is close to a billion dollars per year," said CFNU president Linda Silas, adding that the average absenteeism rate across all other occupations in Canada is 5.7 per cent.



Workplace abuse comes at steep cost for nurses, taxpayers – Globe and Mail, June 28, 2017

- "**The key is to improve the occupational health and safety laws and improve internal reporting mechanisms and training, but number one is better risk assessment**," Ms. Silas said. She said that before workers arrive at a construction site, there is a thorough assessment of all possible risks, followed by deliberate measures to mitigate them.



Workplace abuse comes at steep cost for nurses, taxpayers – Globe and Mail, June 28, 2017

- "If your emergency ward is open 24/7, and you know next weekend there's a long-weekend festival just around the corner, chances are you will have more inebriated people in the emergency room," she said. "Maybe you need to increase security, maybe you need to increase staffing; those risk assessments often aren't done in health care."



WA hospitals to issue body armour to doctors, nurses and security guards



- The Health Department has put a tender for the custom manufacture of up to 250 body armour vests, saying the protective clothing was necessary "to improve the safety of workers at risk of injury from increasing levels of violence and aggression".
- A department spokesperson said the vests will cover vital organs and reduce the risk of injury from syringes and knives wielded by aggressive patients.

Man facing assault charges after nurse attacked at Montreal General Hospital

- CBC Montreal, September 4, 2017

- A 25-year-old man is facing assault charges after police say he tried to strangle a nurse in the Montreal General Hospital's emergency room early Saturday.
- The incident occurred in the area of the ER designated for psychiatric emergencies, according to Richard Fahey, director of communications at the MUHC. The patient was "psychotic" at the time, he added.



Montreal General Hospital adds security guard, discovers she lacks training – CTV, September 6, 2017

- Following the first attack, the MUHC changed a job description, turning a security guard from part-time to full time.
- But the first guard installed was not trained for the job.
- "They brought in a security guard from an outside agency. It was their first day as a security guard without any code white training and without any orientation in the hospital," Fernandes said.
- That guard has since been replaced



New details shed light on how mentally ill man was arrested with gun at N.S. hospital –

CBC Nova Scotia, January 20, 2017

- When RCMP officers were called for a second time in less than an hour last October to the hospital in Middleton, N.S., they donned body armour in the parking lot and armed themselves with a C8 carbine assault rifle and a Taser.
- Inside, patients had fled the emergency room waiting area. It was empty, except for one person: a 60-year-old mentally ill man named Mark Baltzer who had left a .22-calibre rifle stashed in a camouflage case at the door.



New details shed light on how mentally ill man was arrested with gun at N.S. hospital – CBC Nova Scotia, January 20, 2017

- Baltzer had earlier that evening walked into the same hospital with an arrow and large hunting knife on his belt — but had been deemed psychiatrically fit by an emergency doctor after refusing treatment for an injured foot.
- He was then escorted out and handed back his weapons.



New details shed light on how mentally ill man was arrested with gun at N.S. hospital – CBC Nova Scotia, January 20, 2017

- Nova Scotia Nurses' Union president Janet Hazelton, a member of the safety working group, said in an interview Thursday the group did not delve into the details of the Middleton incident. But she said one of the 12 recommendations to be made Friday is to draw up lockdown policies for health-care facilities.

- "They may be able to lock the doors or lock the building, but there's no policies," Hazelton said.

- **"When to do it, how to do it, who makes the decisions, when is the decision made, what do we do with visitors."**

Report calls for safety and security assessments of all community ERs; 12 recommendations follow weapons-related incident last October at Middleton hospital – CBC Nova Scotia, 20 Jan 2017

- From January 2016 to November 2016, 61 incidents of violence and threats were reported in emergency departments.

- According to the document, research shows one-third of nurses have been physically assaulted, bullied or injured at work and twice that number have experienced threats or harassment. Nowhere is that risk higher than in emergency departments.



Workplace Safety in Nova Scotia







Leadership and Collaboration

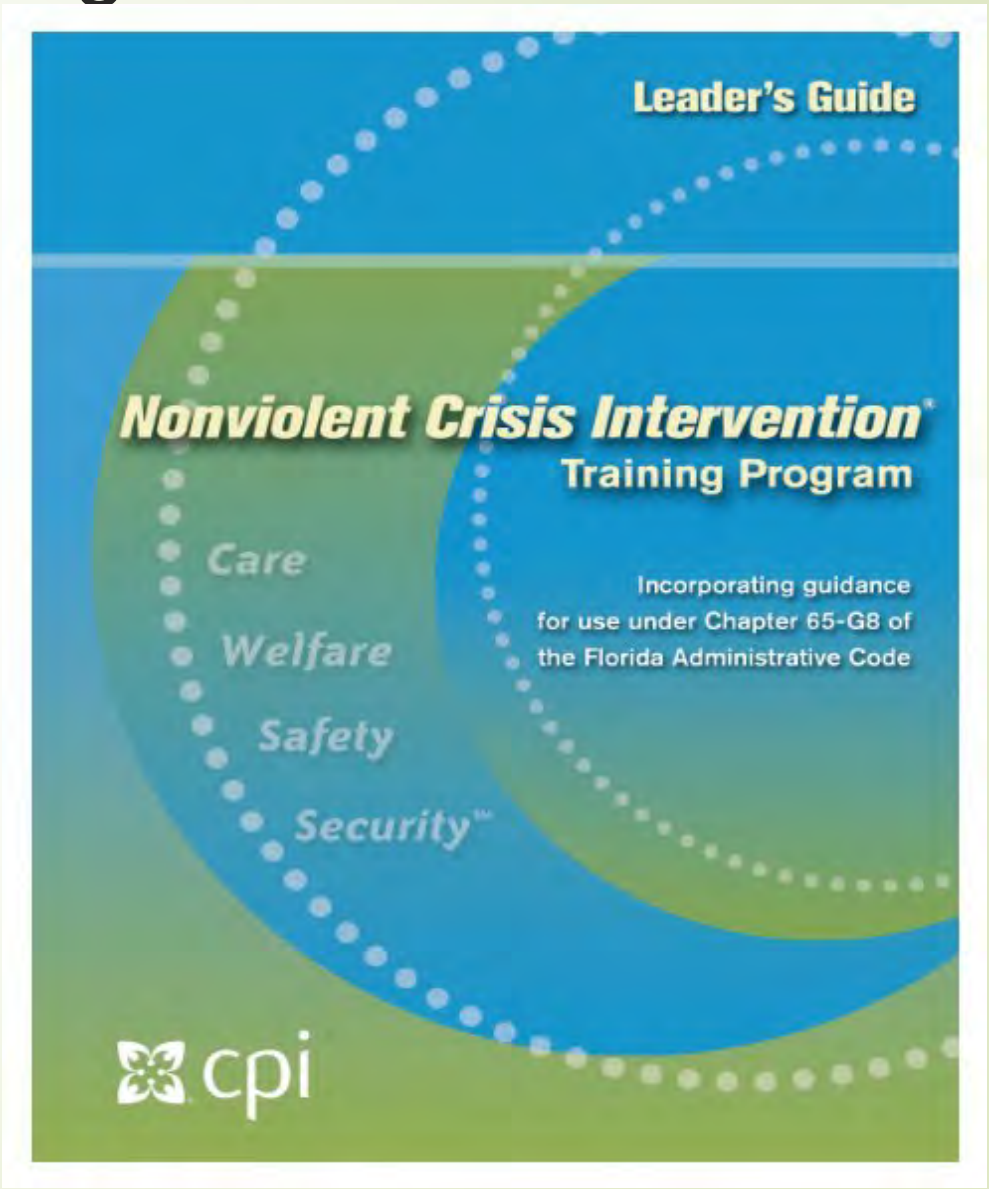
- Leadership: **Hospitals have a duty to provide a safe work environment**
- Collaboration: Unions and employers will work together to prevent workplace violence
  - Create a Joint Occupational Health and Safety Committee
  - Develop a communication strategy so that union partners can be informed when a significant workplace violence incident occurs so staff can receive timely support from both their employer and their union



Education and Training

- To support enhanced Violence in the Workplace education and training needs for NSHA employees, NSHA has adopted the NVCI program.

- Developed by the Crisis Prevention Institute, NVCI focuses on prevention, with proven strategies for safely defusing anxious, hostile or violent behaviour at the earliest possible stage



Single Data Management System

- Incident reports
- WSIB submissions
- Hazard assessments
- Inspection reports
- Injury reports
- Investigation information
- Compliance Reports
- Case management documentation



Workplace Violence Risk Assessment

- A **common risk-assessment tool** will be developed and used for the entire NSHA. All 25 community emergency departments will consult with their local JOHS committees to conduct a violence risk assessment and prevention plan
- **Window tinting** and glazing in some emergency departments (interior and exterior)
- Switchboard/ registration accessibility and use of **shatterproof safety glass**
- Addition of **dedicated safety or quiet rooms** in a number of emergency departments
- Implementation of **panic alarms** for nursing and clerical employees that are linked directly to external security systems as well as the availability of pendant alarms for RNs working at night in some locations.

Security, Safety, Environment and Equipment

- Ensure all health care employees are aware of the role security can play to support the provision of safe and quality health care
- Make security part of the care planning team. Train security with other members of the care team. Give them the guidelines for sharing information in keeping with workplace safety and privacy laws
- Make sure security get consistent training and operate to consistent standards.
- Give security the appropriate equipment as determined by the risk assessment



Emergency Preparedness

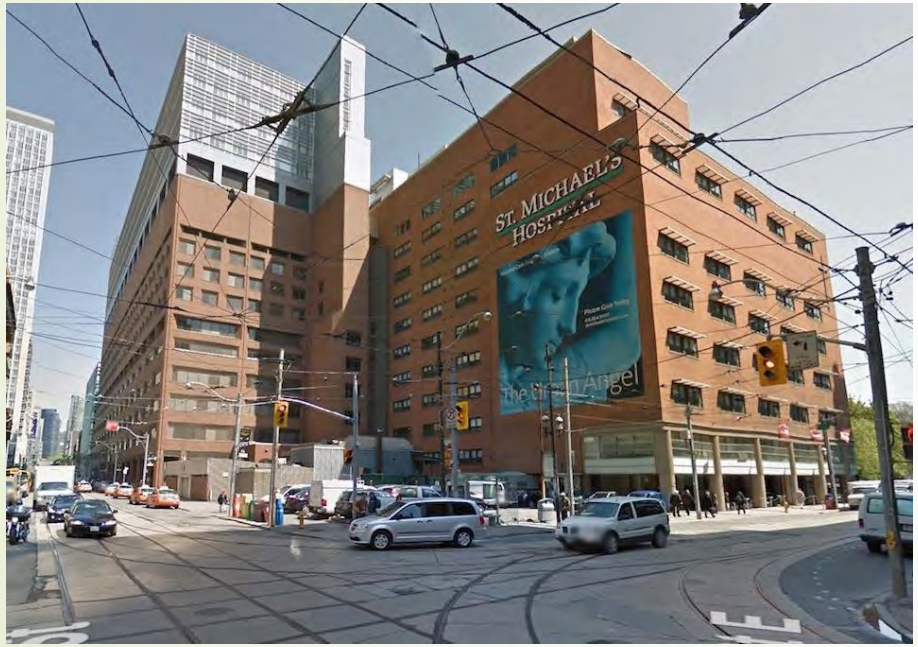
- Code White



- Code Silver



St. Michael's Hospital





Injury Prevention: “Prevention is the Vaccine for the Disease or the Injury”

Haddon Matrix for Prevention of TBI

	Host	Agent	Environment
Primary	• Treatment of ADHD • Education about hazards • Age-appropriate activities	• Teach about infant crying • Monitor play areas • Teach antispearing • Gun safes and trigger locks	• Lower heights of playground slides, etc • Shallower skateboard slopes • Smooth play surfaces • Barriers separating children and hazards
Secondary	• Helmets • Protective clothing • Structures that do not break	• Lower speeds of skateboards and other toys • Lower heights	• Soft play surfaces and wrapping of obstacles
Tertiary	• Appropriate medical care • Parental transport and support	• Avoid further injury	• Pediatric EMS • Rehab services • Schools prepared to help LD students

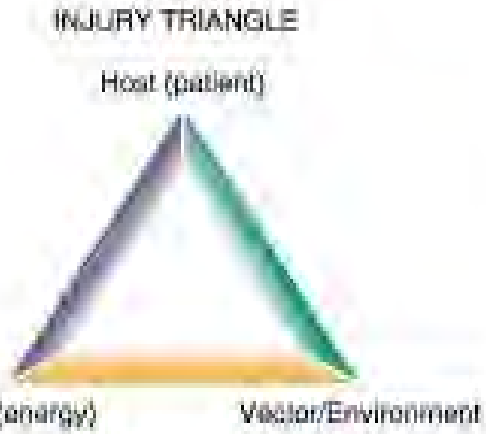


Figure 40-1. The epidemiologic triad can be used as a framework for injury prevention. An injury occurs by the interaction of the host and agent through a vector and an environment that is conducive to injury. Alteration of any of these interactions prevents the injury.[1]

System Factors:

Problems

- Lack of secure/seclusion rooms
- Volume of traffic in care areas
- Nebulous wait times
- Physically and cognitively disorienting journey in Emergency Department
- Specific rooms in ED that are more isolated
- Two safety alarm systems
- Delayed construction and physical barriers

Solutions

- Identification and communication of risk
- Personal alarm use
- Increased Peer Support to assist with meaningful patient engagement and activity
- Improved wayfinding communication
- Monitor to outline average wait times (potential future mobile solutions to provide updated individualized wait-time information)
- Isolated rooms not assignable to patients with identified risk factors for aggression
- Ordering of Pinel restraints to support trauma informed care

Patient Factors

Problems

- Underlying diagnosis – mental health, intoxication, dementia, criminal behaviour
- Response to wait time for care
- Patients may have contraband with them on arrival in ED
- Anxiety, withdrawal, pain, fear

Solutions

- Consistent application of search policy and belongings policy (removal of contraband)
- Earlier nicotine replacement interventions
- Earlier interventions related to anxiety, withdrawal, pain and fear

Provider Factors

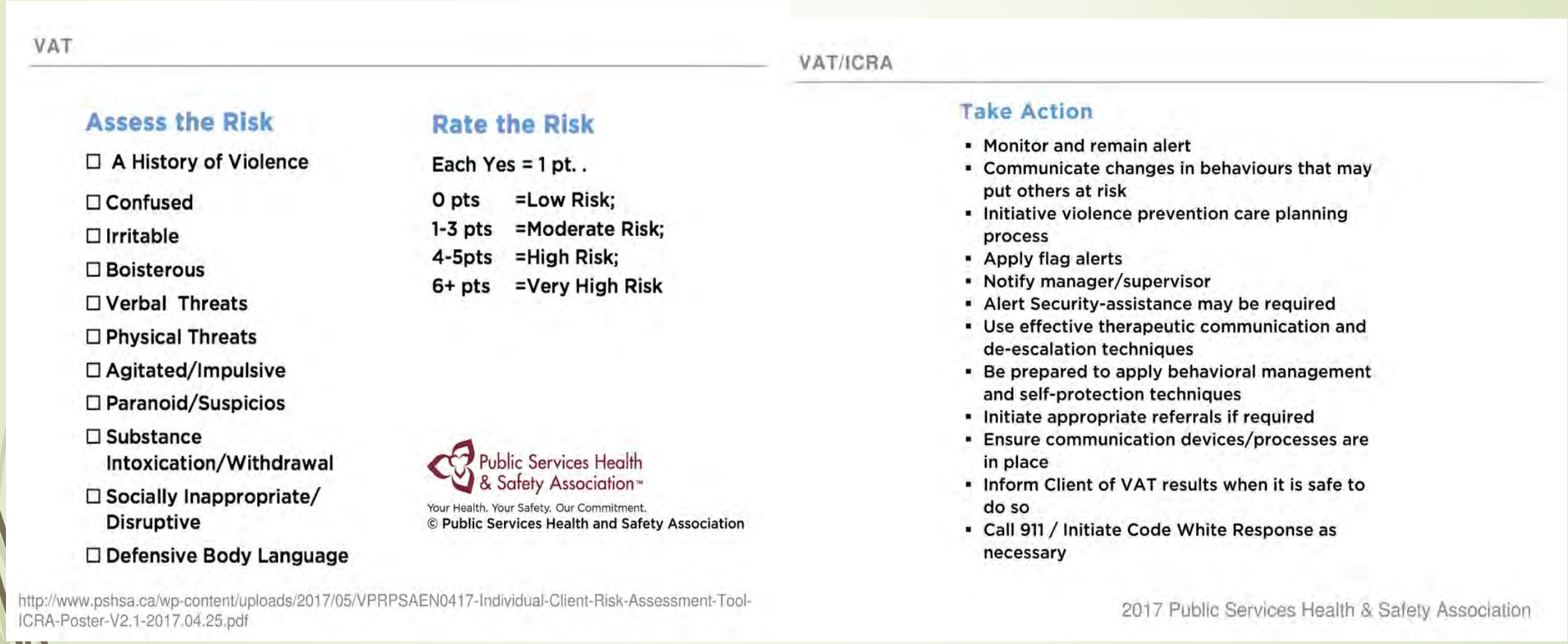
Problems

- Early use of restraints before de-escalation techniques employed
- Lack understanding of withdrawal symptoms from specific psychoactive substances
- Knowledge gaps related to managing responsive behaviours for those living with dementia
- Normalizing violence as part of the job
- Care givers feeling alone/vulnerable to violence when initially trying to de-escalate situations.

Solutions

- Department Stop, Harm and Violence sessions (with security and MDs)
- Understanding of withdrawal symptoms from specific psychoactive substances and related strategies
- Education related to care of seniors
- Earlier involvement of TPS related to violent incidents.
- Adjusting assignments to manage patient need
- Clinical staff to lead de-escalation interventions with delegation to security for additional support as needed

Violence Risk Assessment



VAT

Assess the Risk

- ☐ A History of Violence
- ☐ Confused
- ☐ Irritable
- ☐ Boisterous
- ☐ Verbal Threats
- ☐ Physical Threats
- ☐ Agitated/Impulsive
- ☐ Paranoid/Suspicios
- ☐ Substance Intoxication/Withdrawal
- ☐ Socially Inappropriate/ Disruptive
- ☐ Defensive Body Language

Rate the Risk

Each Yes = 1 pt. .

0 pts	=Low Risk;
1-3 pts	=Moderate Risk;
4-5pts	=High Risk;
6+ pts	=Very High Risk

Public Services Health & Safety Association™

Your Health. Your Safety. Our Commitment.

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VAT/ICRA

Take Action

- Monitor and remain alert
- Communicate changes in behaviours that may put others at risk
- Initiative violence prevention care planning process
- Apply flag alerts
- Notify manager/supervisor
- Alert Security-assistance may be required
- Use effective therapeutic communication and de-escalation techniques
- Be prepared to apply behavioral management and self-protection techniques
- Initiate appropriate referrals if required
- Ensure communication devices/processes are in place
- Inform Client of VAT results when it is safe to do so
- Call 911 / Initiate Code White Response as necessary

http://www.pshsa.ca/wp-content/uploads/2017/05/VPRPSAEN0417-Individual-Client-Risk-Assessment-Tool-ICRA-Poster-V2.1-2017.04.25.pdf

2017 Public Services Health & Safety Association

What about small town Canada?







Small Town Canada

- Rural Canada constitutes 95% of the country's land mass

- Depending on which definition of rural is used, between 19 and 30 % of the Canadian population live in rural areas





The Health of Rural Canadians

- Rural residents of Canada are more likely to be in poorer socio-economic conditions, to have lower educational attainment, to exhibit less healthy behaviours and to have higher overall mortality rates than urban residents
- Disparity in access to mental health services



The Health of Rural Canadians

- Nationally, the rural crime rate was 23 per cent higher than the rate reported by urban police services. The data excludes traffic offences.
- Domestic violence, from threatening to assault to murder, was as much as 4 x higher in rural parts of Canada
- Homicide rate was 45% higher in rural areas than in Canada's urban areas; (2.43 per 100,000 population versus 1.67 per 100,000 population)
- In Alberta, regions with the highest rates of emergency department visits related to opioids or other drug misuse, per capita, are found in the rural north and south



Ottawa man charged after Smiths Falls hospital worker stabbed with scissors – CBC Ottawa, August 24, 2017

- An Ottawa man has been charged with attempted murder after he allegedly stabbed a worker at a Smiths Falls hospital site with blunt-ended scissors.
- Early Thursday, Smiths Falls police brought a man “in crisis” to the Smiths Falls location of the Perth and Smiths Falls District Hospital. There, the man allegedly grabbed a pair of scissors and began stabbing a staff member on site.



Security Before





Security After: The Hospital's Response

A secure patient registration area

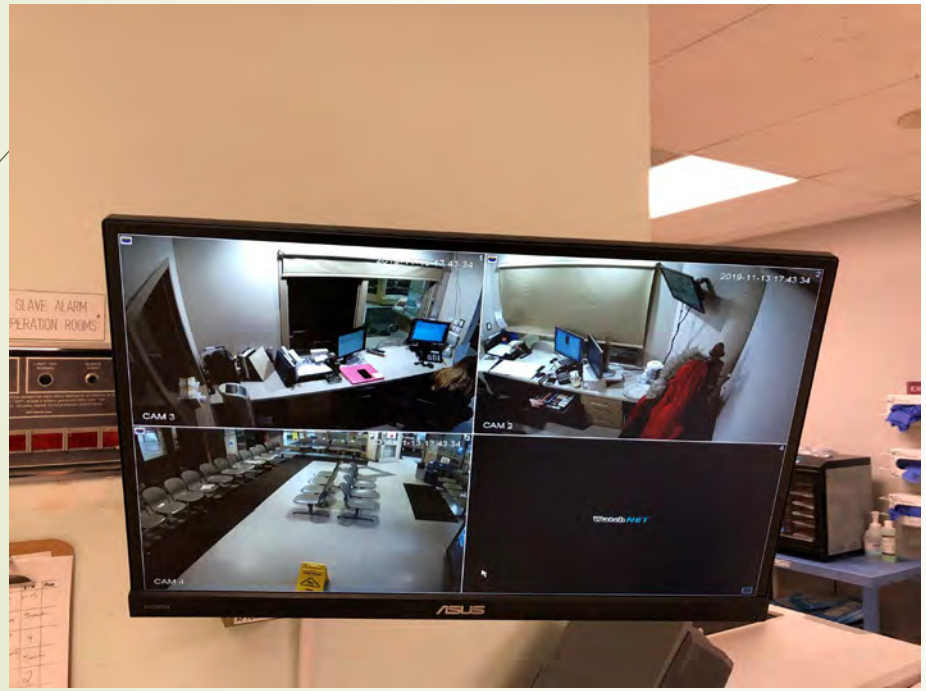


Enhanced security access to the ER



The Hospital's Response

Direct Visual Monitoring



Night Time Security Presence



The Hospital Response

- $250,000 in on-time capital costs
- $250,000 in ongoing operating costs
- Both sites





Elderly couple dead after shooting at Cobourg hospital, SIU investigating

CBC Toronto, October 28, 2017



- Police in Cobourg were initially called to the Northumberland Hills Hospital emergency room for sounds of gunshots at about 11 p.m. ET.
- Linda Davis, hospital president and CEO, confirmed the incident occurred inside the hospital's emergency department and its major trauma room was affected.
- "We did have to go on ambulance redirect from our emergency department. The rest of our hospital functioned as normal. And we were able to, in fact, work through the event," she said.
- Davis said staff and physicians are trained to deal with situations involving weapons and the hospital's employee assistance provider is there to offer support.

City MP, nurses want safety standards for increasingly violent health facilities

Winnipeg Free Press – February 28, 2019

- A Winnipeg MP who spent years working as an emergency room physician is trying to draw attention to health-care violence nationally, tabling a petition Friday that asks Ottawa to tackle an issue in which he has first-hand experience.
- "It's a very serious problem; it's escalating," Doug Eyolfson, Liberal MP for Charleswood-St. James-Assiniboia-Headingley, told the *Free Press*.



City MP, nurses want safety standards for increasingly violent health facilities

Winnipeg Free Press – February 28, 2019





Nurses call for end to workplace violence as attacks mount

CBC New Brunswick, June 4, 2019



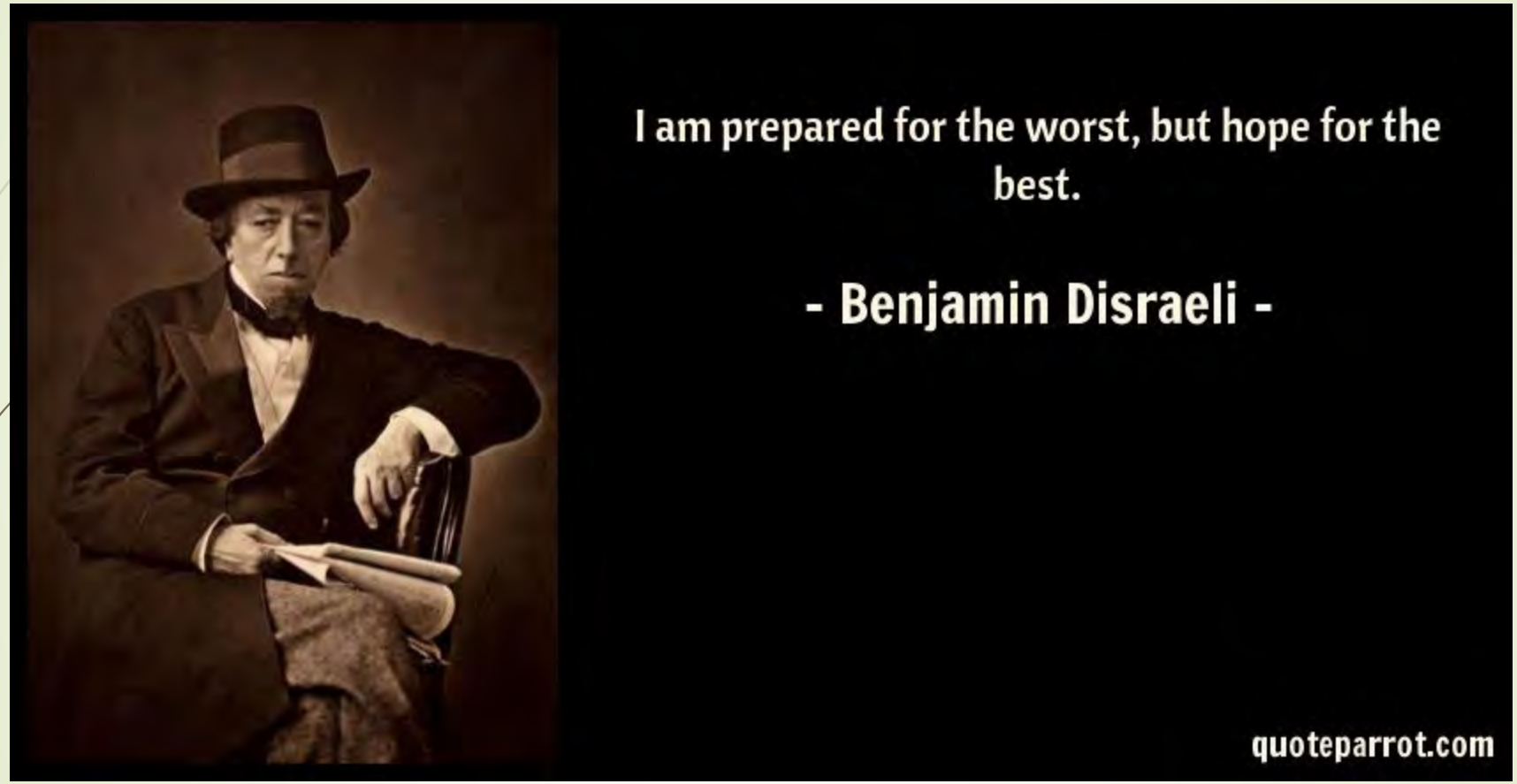
- The nurses are calling for the federal government to pass a private member's bill to make attacking a health-care worker a criminal offence.

Zero Tolerance: The CAEP Position

- We do not believe that the violent patient deserves any less than the optimal care expected by any patient and their individual social and circumstances must be considered in their ultimate care plan.
- Their violence is more often than not a symptom rather than a personality trait and we are not in agreement with any suggestion that patients with a history of violence should at any time be denied access to care.
- We do believe, however, that zero tolerance should be expected of health care institutions and that maximal administrative efforts must be made to provide health care workers and our patients a safe and secure work environment.

VIOLENCE FACING HEALTH CARE WORKERS IN CANADA: Report of the Standing Committee on Health, June 2019

- **A Pan-Canadian Framework for the Prevention of Violence in Health Care Settings**
- **Recommendation 1**
- **That the Government of Canada work with the provinces and territories and health care stakeholders to develop a pan-Canadian framework to prevent violence in health care settings, which would include promoting the adoption of best practices in violence prevention across the country.**
- **Public Awareness**
- **Recommendation 2**
- **That the Government of Canada develop a national public awareness campaign that would raise awareness about the violence faced by health care workers and highlight the valuable role health care professionals play in providing care to Canadians.**
- **Criminal Code**
- **Recommendation 3**
- **That the Government of Canada amend the *Criminal Code* to require a court to consider the fact that the victim of an assault is a health care sector worker to be an aggravating circumstance for the purposes of sentencing.**


I am prepared for the worst, but hope for the best.
- Benjamin Disraeli -
quoteparrot.com

Sinai Health System

Emergency Department Administration Conference, 2019

Mark McCormick, CHPA
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Disclosure of Commercial Support

- **This program has not received financial or in-kind support from any organization**
- **Potential for conflict(s) of interest: None**
- **Mitigating Potential Bias: None**

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Day 1-Setting Expectations

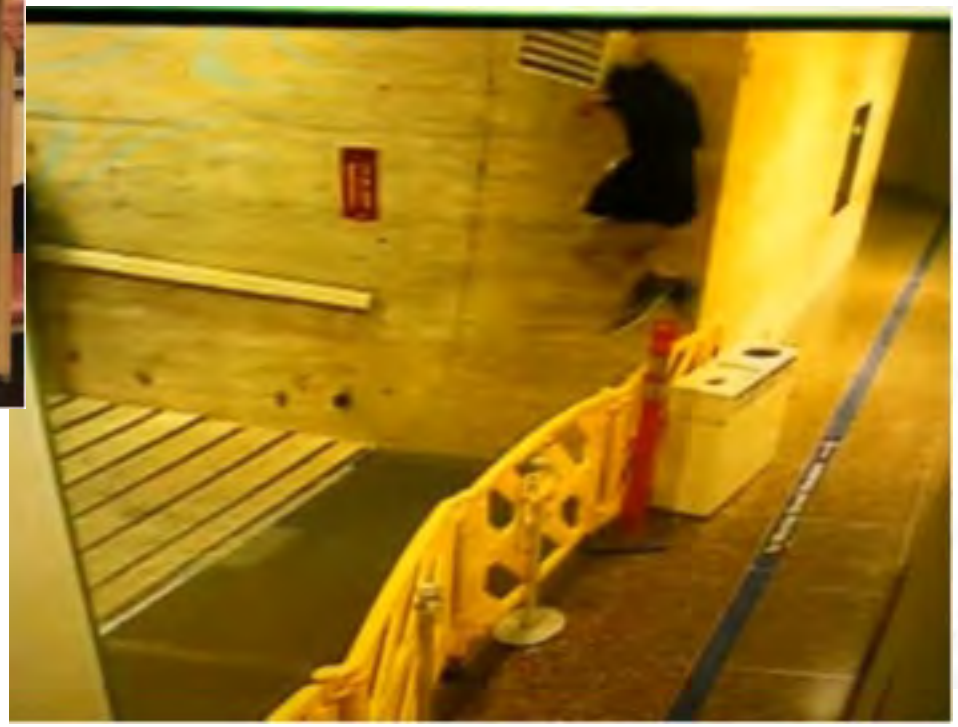
- Interview: best/worst questions
- We’re all the same

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Day 1+ Resetting Reality









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Please complete the

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