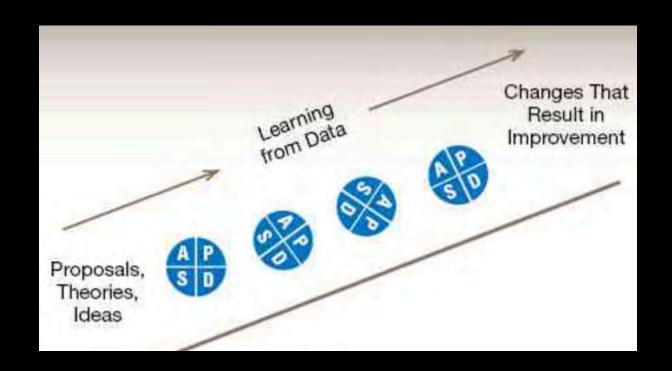


What's Next for Quality Improvement?

10 Ideas for QI 2.0

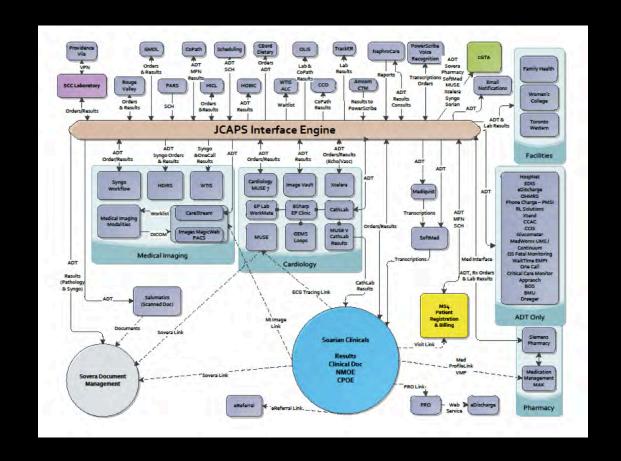
Twitter: @drjoshuatepper

Driving Change... Driven by Change



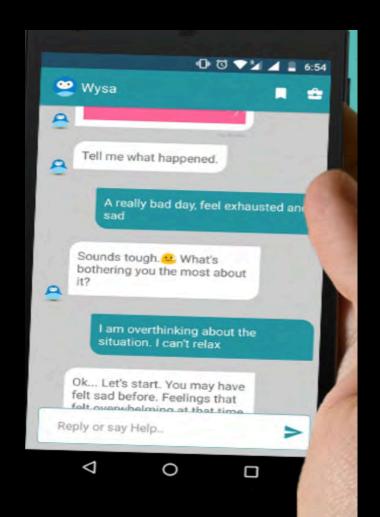


1) New Data

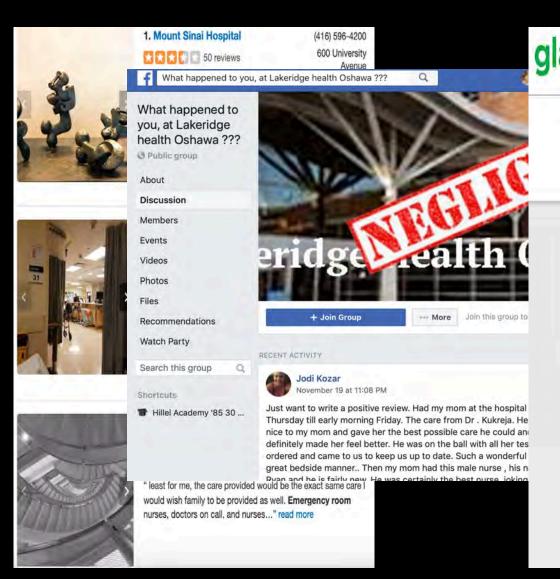


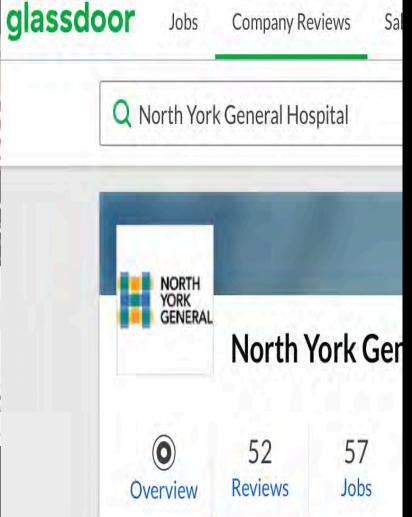
















HEALTH AFFAIRS > VOL. 35, NO. 4: PATIENTS' & CONSUMERS' USE OF EVIDENCE

Yelp Reviews Of Hospital Care Can Supplement And Inform Traditional Surveys Of The Patient Experience Of Care

Benjamin L. Ranard, Rachel M. Werner, Tadas Antanavicius, ... See all authors

AFFILIATIONS V

PUBLISHED: APRIL 2016

https://doi.org/10.1377/hlthaff.2015.1030

BMJ Qual Saf. 2016 Jun;25(6):404-13. doi: 10.1136/bmjqs-2015-004309. Epub 2015 Oct 13.

Measuring patient-perceived quality of care in US hospitals using Twitter.

Hawkins JB¹, Brownstein JS², Tuli G³, Runels T⁴, Broecker K⁴, Nsoesie EO⁵, McIver DJ⁴, Rozenblum R⁶, Wright A⁶, Bourgeois FT⁷, Greaves F⁸.



2) New Transparency

ER Inspector

Find and Evaluate Every Emergency Room Near You

By Lena V. Groeger, ProPublica. Updated September 19, 2019.

To get the best care possible, your choice of emergency room matters. Look up hospitals ahead of time so you can evaluate where to go in an emergency. Get data on hospital quality measures, such as wait times, patient ratings and citations for emergency room violations. How We've Updated ER Inspector | Download ProPublica's Emergency Room Planning Toolkit | About This Data

Find Emergency Rooms Near You

Q Look up an address of up social

Search

Search

Use my current location

For example: 874 State Street CT. 11210

ER Wait Times & Violations by State

For each state, we chart the average amount of time that patients wait in emergency rooms before they get sent home or are admitted to the hospital. We also include the percentage of hospitals that have been cited for at least one ER-related violation, as identified during the investigation of a complaint, since 2015. For every measure, lower numbers are better. Experts caution that very small differences between hospitals for a given measure are unlikely to correspond to noticeable differences in the real world.

- State

† Time Until Sent Home

* Time Before Admission

* Violations





Average time, in hours, patients spend in the emergency room before being sent home (if not admitted)



Average time, in hours, patients spend in the emergency room before being admitted to the hospital



Percentage of hospitals in the state with at least one ERrelated violation since 2015



LIQUID EXPECTATIONS

TRANSCEND TRADITIONAL BOUNDARIES

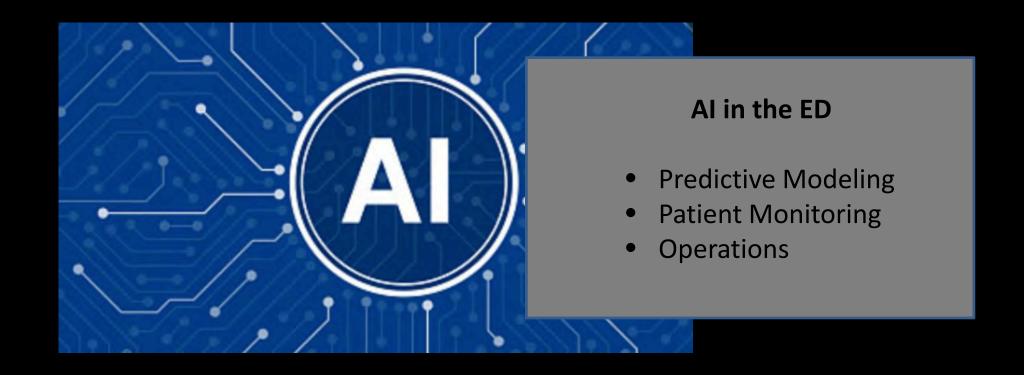
why can't checking in/ out of my hotel be as easy as using Uber? why can't my cell phone bill be as easy to read as Mint.com? why can't everything be as easy to find as it is on Google?







3) Artifical Intelligence





Artificial intelligence in emergency Medicine, Journal of Emergency and Critical Care Medicine
Nan Liu et al , October 2018

4) Focus on Equity

Patient A:

Chest Pain

- 55 YO
- White Male
- Successful self employed sales person
- Type 2 DM, long standing poor control
- New Onset exertional CP, radiating left shoulder
- Progressive symptoms
- Now symptomatic in the Office

Patient B:

Cough

- 2 YO
- Non English speaking
- Refugee
- Living in womens shelter
- Single mom
- Febrile (40)
- Non rousable
- Decreased fluid intake and U/O



Safe Effective Patient-Centred Timely Efficient Equitable

Institute of Medicine



5) Focus on Wellness

Patient A: Chest Pain

- 55 YO
- White Male
- Successful self employed sales person
- Type 2 DM, long standing poor control
- New Onset exertional CP, radiating left shoulder
- Progressive symptoms

Patient B: Cough

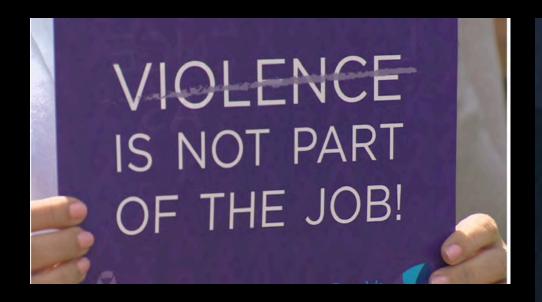
- 2 YO
- Non English speaking
- Refugee
- Living in womens shelter
- Single mom
- Febrile (40)
- Non rousable
- Decreased fluid intake and U/O

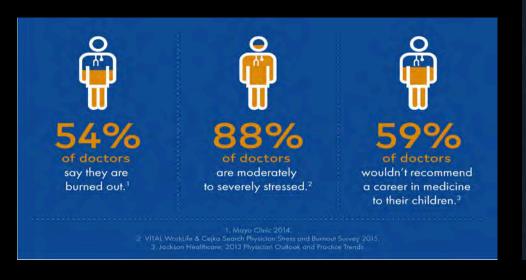
Patient C: Headache

- 50yo female
- 3/52 new h/a
- Fell 3/52
- No PMH
- Lower SES

CT: 15+ solid lesions









Wellness and Quality

Burnout Impacts:

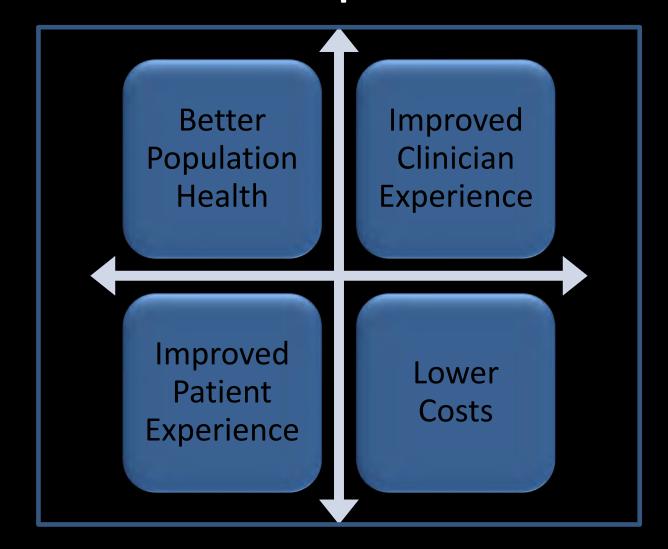
- Safety
- Patient Centeredness
 - Empathy, Patient Satisfaction
- Effectiveness
 - Adherence to guidelines, protocols & care standards
 - Mortality (ICU)
- Efficiency
 - High MD turnover
- Timely
 - Admissions, elective surgeries



TNA (SC)		
February 14, 2018		
	28	
	1	
	8	
	6	
	26	
	34	
	19	
	1	
	6	
	2	
	6	
	8	
	2	
	19	
	27	
SC Top 90 th Percentile	1	
FHT Top 90 th Percentile	1	



Quadruple Aim





6) Remember Joy

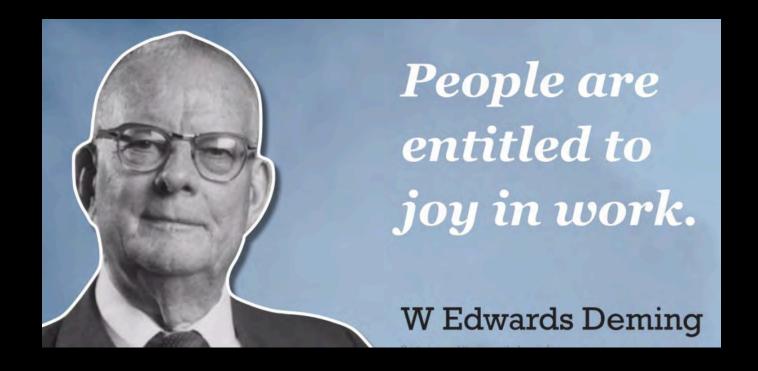


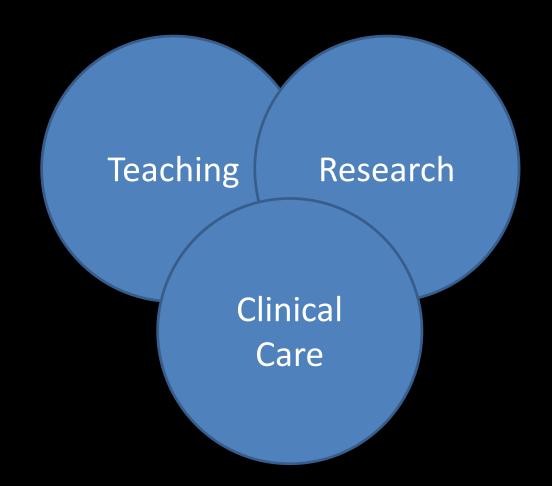


Figure 2. IHI Framework for Improving Joy in Work

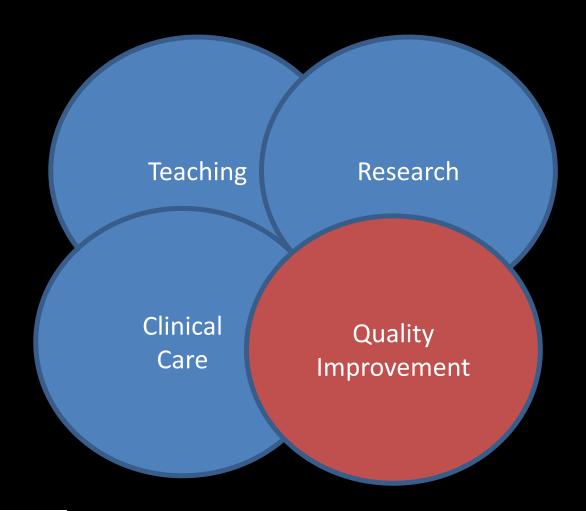




7) A Career in Quality









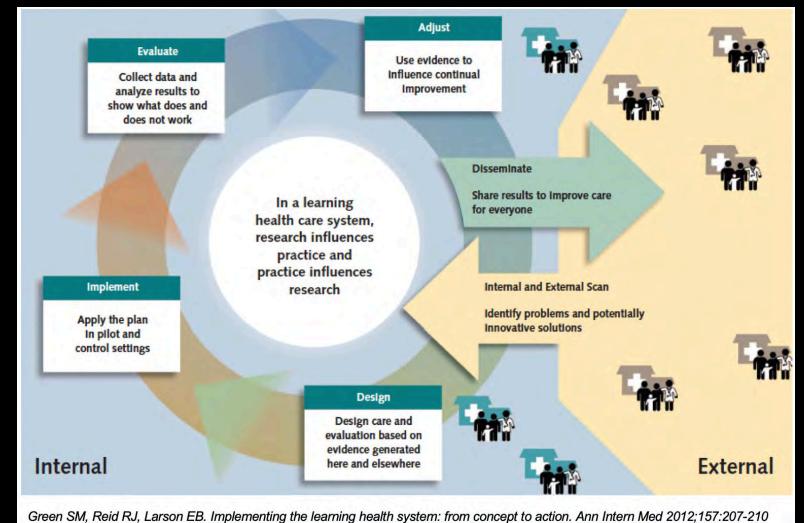


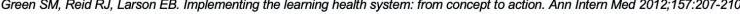


8) "Meta" QI

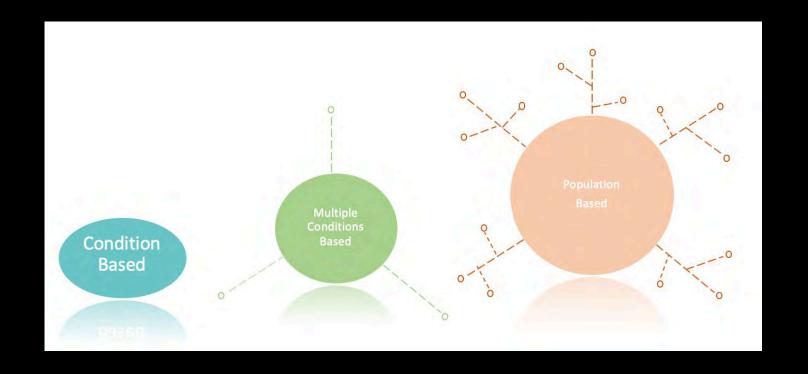






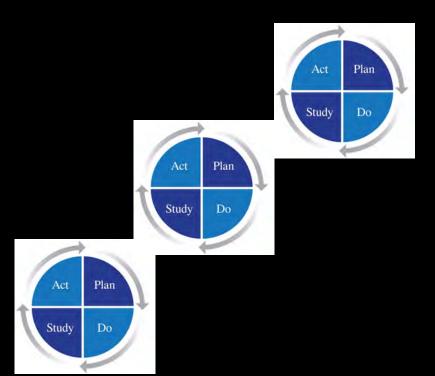






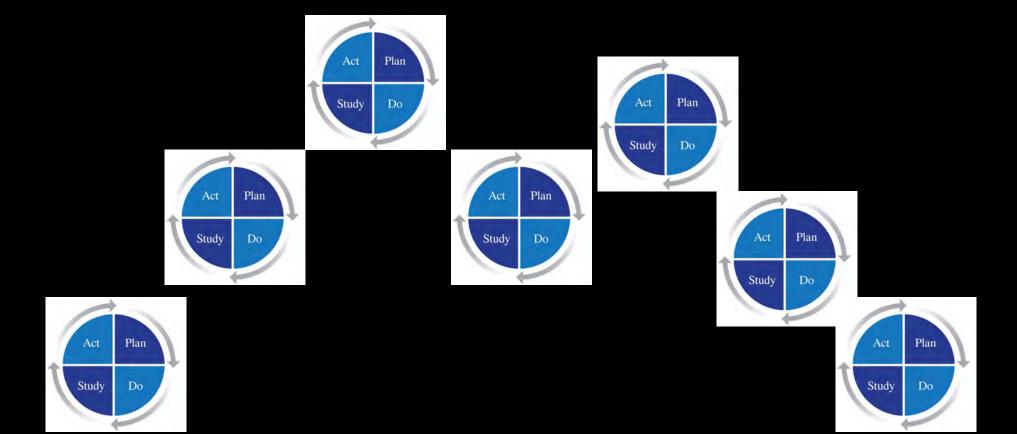


9) Intentional Disruption





10) Build Psychologically Safe Team



"Psychological safety is a shared belief that the team is safe for interpersonal risk taking."



"vulnerability is the birthplace of innovation, creativity and change"

-Brene Brown



10Things That Should Change QI in ED

- 1. New Data
- 2. New Transparency
- 3. A focus on equity
- 4. Al
- 5. Systems Application
- 6. QI As a fully rounded Career Path
- 7. Burnout/quadruple AIM
- 8. Focus on Joy
- 9. Intentional Disruption
- 10. Build psychologically safe teams



Thank You



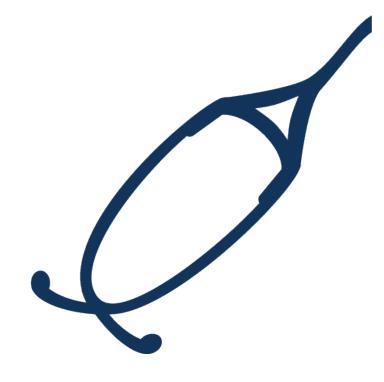
Audit and Feedback:

The CPD of the Future

Shawn Dowling, MD, FRCPC Assistant Dean, Physician Learning Program/CPD QI Scientist, University of Calgary

Christopher Rice, BComm, MDes (i.p) Knowledge Translation Design Specialist, Physician Learning Program, University of Calgary

@skdowling@DesigningRice







Faculty/Presenter Disclosure- Dowling



Relationships with Financial Interests		
Grants/Research Support	CIHR	
Speakers Bureau/Honoraria	None	
Consulting Fees	None	
Patents	None	
Other	University of Calgary employee (Physician Learning Program), AHS	





Faculty/Presenter Disclosure - Rice



Relationships with Financial Interests		
Grants/Research Support		
Speakers Bureau/Honoraria	None	
Consulting Fees	None	
Patents	None	
Other	University of Calgary employee (Physician Learning Program)	



Take Home Points

- 1. Audit & Feedback (A&F) will be a key part of CPD in the future
- 2. Providing data is not the GOAL. Actionable information is.
- 3. How you develop, deliver and support the A&F will impact the effectiveness of the A&F





CME Outcomes Measurements



Source: Adapted from Moore's 7 Levels of CME Outcomes Measurements. Moore DE, et al. J Contin Educ Health Prof 2009; 29: 1-15



What is Audit and Feedback?

Definition:

A summary of clinical performance provided over a specified period of time, which aims to improve healthcare quality.

Synonyms:

- Physician practice improvement (PPI)
- Report cards
- Physician performance reports
- Dashboards

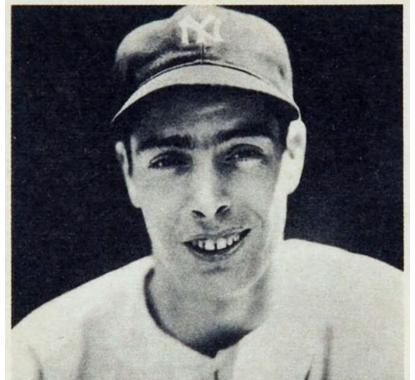




Data ≠ information









We do not learn from experience...we learn from reflecting on experience.

— John Dewey —

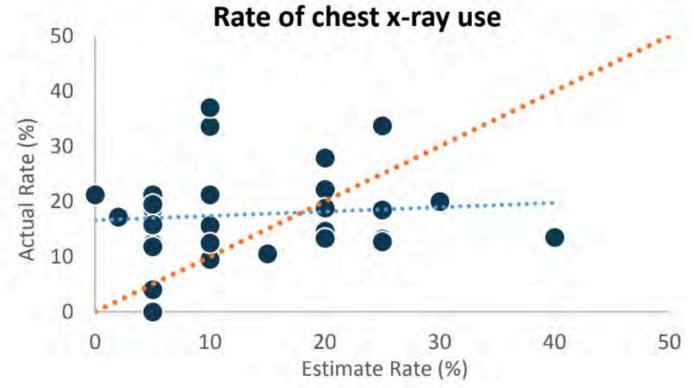
AZ QUOTES





Bronchiolitis Project

Self-predicted vs. actual practice







Future Vision for CPD in Canada





Source: www.fmec-cpd.ca





Supports Regulatory Requirements for Practice Improvement

9. All physicians will be expected to participate in a continuous cycle of practice improvement that is supported by understandable, relevant, and trusted individual or aggregate practice data with facilitated feedback for the benefit of patients.



Adapted from Physician Practice Improvement, http://fmrac.ca/wp-content/uploads/2016/04/PPI-System_ENG.pdf





Does Audit and Feedback Work?





- 140 Clinical Trials
- A&F improves compliance with desired professional behavior by 4% (IQR 0.5-16%)
- A&F is more effective when . . .
 - The source is a respected colleague
 - It is delivered both verbally and in written form
 - It is provided more than once
 - It includes explicit targets and an action plan

Source: Ivers N, et al. Cochrane Database of Systematic Reviews 2012; 6: CD000259.





Evidence Informed Feedback Model

Annals of Internal Medicine

ACADEMIA AND THE PROFESSION

Practice Feedback Interventions: 15 Suggestions for Optimizing Effectiveness

Jamie C. Brehaut, PhD; Heather L. Colquhoun, PhD; Kevin W. Eva, PhD; Kelly Carroll, MA; Anne Sales, PhD; Susan Michie, PhD; Noah Ivers, MD, PhD; and Jeremy M. Grimshaw, MD, PhD

Ann Intern Med. 2016;164:435-441. doi:10.7326/M15-2248 www.annals.org

The Calgary Audit and Feedback
Framework: a practical, evidence-informed approach for the design and implementation of socially constructed learning interventions using audit and group feedback

Lara J. Cooke¹ Diane Duncan², Laura Rivera², Shawn K. Dowling³, Christopher Symonds⁴ and Heather Armson⁵

Implement Sci 2018; 13(1):136.



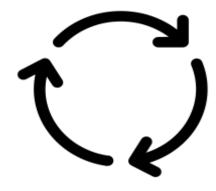




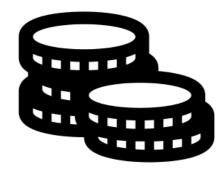
Key ingredients for A&F and CPD



- Access to data
- The right metrics
- Sustainability



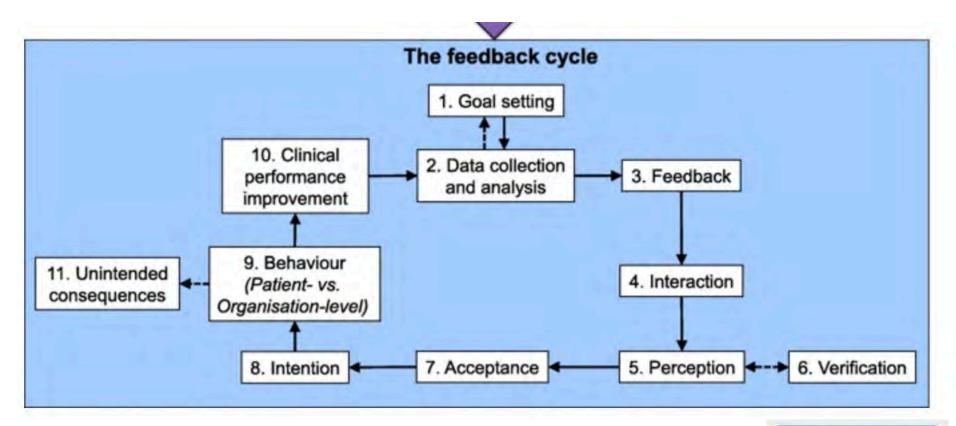
 Most efficient & effective process for delivering A&F



 Resources to develop, implement & sustain A&F initiatives













The drive to be the best, and to do well by patients, is "ingrained in the medical profession."









Physician Engagement







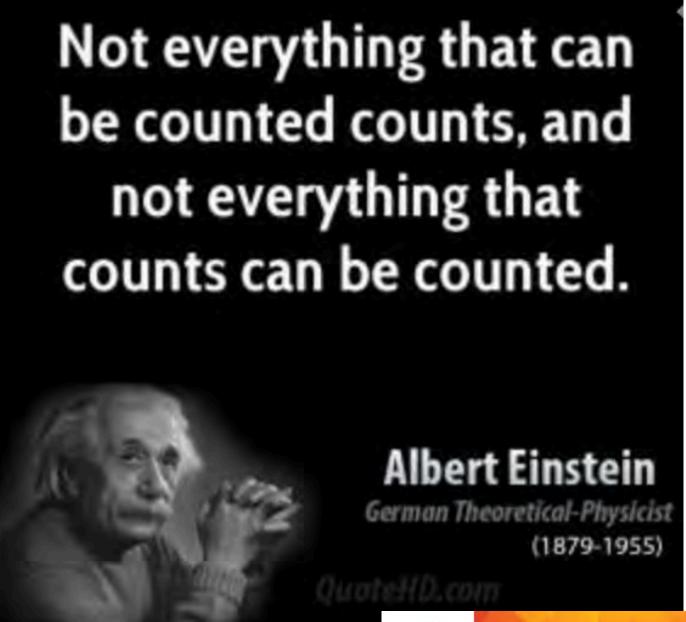
Relationship Building

- Co-design A&F project/metrics
- Identify local champions
- Socialize the process
- Logistical and technical support













Choice Metrics



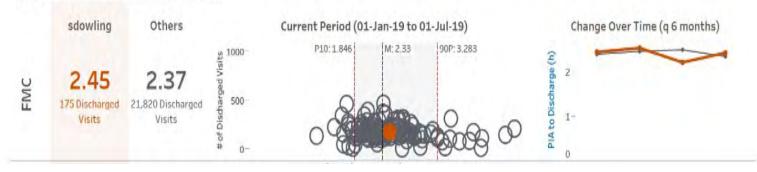




Flow metrics

MEASURE 4: MEDIAN PIA TO DISCHARGE TIME

The <u>median number of hours</u> from physician initial assessment (PIA) to discharge time. This measure is calculated only for <u>discharged visits</u> triaged with a <u>CTAS of 2 or 3</u>, and only those with a <u>single ED MD provider</u> (i.e., visits are excluded if there was a handover). This measure is a reflection of a physician's time reach a discharge decision.







Quality of Care

MEASURE 6: TRANSFUSION VISIT LIST

This view shows RBC transfusions when the <u>HGB was >= 70</u>. A recent quality improvement project has suggested the <u>over-utilization of packed red cells</u> both in terms of the number of units transfused and in lieu of IV iron for hemodynamically stable patients with a likely profile of iron deficiency anemia. This is an exploratory form of individualized physician level feedback identifying those instances when blood products might have been avoided.

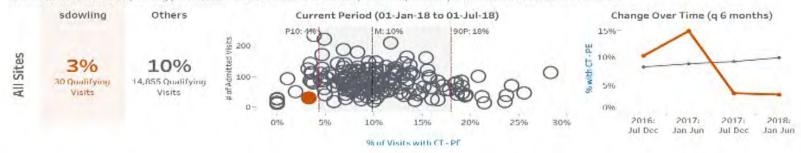
Encounter	Age	Facility	Disposition	Presenting Complaint	Diagnosis	Transfusion Time	Transfused	HGB
100045285199	84	FMC	Admitted	Shortness of Breath	CHF, GI BLEED	02-Nov-17 14:56	1 unit(s)	82
100044063664	86	FMC	Admitted	Blood in Stool / Rectal Bleeding	${\sf GIBNYD/SYMPTOMATICANEMIAANDHYP}$	23-Feb-17 16:00	1 unit(s)	71
100042705393	68	FMC	Admitted	General Weakness	ENDEMETRIAL CANCER	24-Apr-16 17:42	1 unit(s)	74
100042109073	68	FMC	Discharged	Altered Level Of Consciousness	ANEMIA/ AFIB	04-Dec-15 22:40	1 unit(s)	79
						04-Dec-15 21:20	1 unit(s)	79



• Resource Stewardship

MEASURE 10: CT FOR PE

The <u>percentage of PE visits</u> with a <u>CT Chest for Pulmonary Embolus Study</u> order. 'Query PE' visits are identified as visits with a presenting complaint of 'Shortness of Breath', 'Chest Pain (Non Cardiac Features)', or 'Chest Pain (Cardiac Features)'. Physician's seeing fewer than 10 PE visits OR having no CT orders in the current reporting period have been excluded from the peer comparison plot. Measure shown for all sites.





Balancing Measures

MEASURE 5: % CONSULTS ADMITTED

The % of visits with an <u>ED MD Consult for admission</u> order that were <u>actually admitted</u>. This measure includes only <u>Internal Medicine</u>, <u>General Surgery</u>, <u>Hospitalist and CCU/Cardiology</u> consult services. It is limited to these services because it is recognized that the 'Reason for Consult' field is not often changed to 'Request for Treatment advice/followup', and consults to other services are often for this reason. 5 admit minnimum for inclusion in plots.

	sdowling	Others	Current Period (01-Jul-18 to 01-Jan-19)			Change Over Time (q 6 months)		
			150 -	P10: 76.1%	M: 85.9%	P90: 96.1%	80%-	
FMC	86%	85% # Admitted: 2,943	≥ 100-		0		89 60%-	
	# Admitted: 14		Visits	8	000000000000000000000000000000000000000	00	40%-	
			b # 0-	900	عاد المحادث	0 9	3 20%- 8 0%	





PLP Calgary's feedback report design maxims:

- 1. Be a minimalist
 Take extra steps not to overwhelm the reader.
- 2. Group content into 'chunks' Birds of a feather flock together
- 3. Keep a consistent information 'map' Don't make your reader guess where things are.
- * Effective data visualization
 Remember ABR: Always Be Reflecting.





1 Da a minimalist

Parameters	Distribution of all physicians			My Patients (n=##)	All patients (n = 3655)
Any Respiratory Viral Test	Admitted 100% 80% 60% 40% 20% 0% Lowest 10th percentile	52% Me	65% Median	## (%%)	512 (63.9%)
	100% 80% 60% 40% 20% 5% Lowest 10th percentile	25% Me	21% Median	## (%%)	670 (23.5%)





2. Group content into 'chunks'

- Information that's related / trying to make the same point should be close together on a page.
- Clear labelling and spacing are the easiest way to create 'chunks' on the page.



3. Keep a consistent information 'map'

- Each page should have a designated space for the title, main content, and types of supporting content.
- Consistent information maps help readers quickly find and take in information.









My Patients All patients Distribution of all physicians (n = 3655)**Parameters** (n=##)Admitted Any 100% Respiratory 80% 65% Viral Test 52% 60% ## (%%) 38% 512 (63.9%) 40% 20% 0% Lowest 10th percentile Median Me Discharged 100% 80% 60% ## (%%) 670 (23.5%) 40% 25% 21% 20% 5% 0%

Me

physicians you don't often work with.

Lowest 10th percentile





Median

Bronchiolitis Project

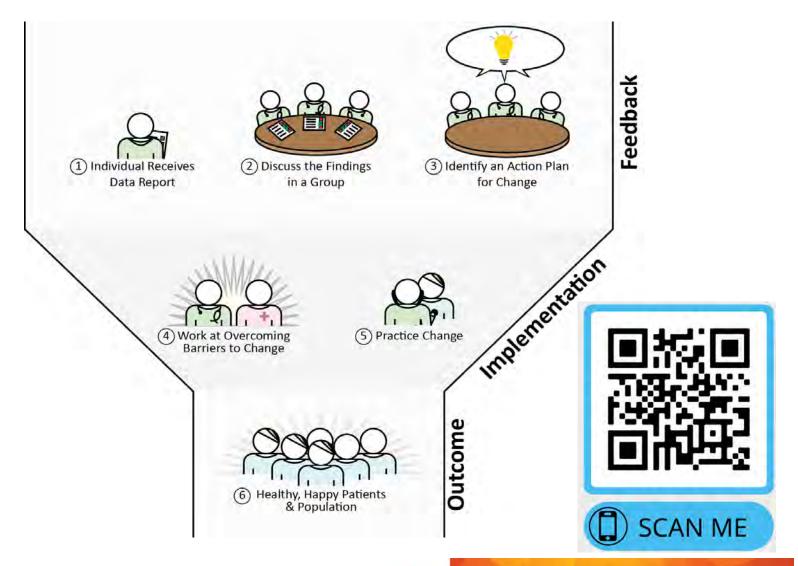
	All Patients (n=4658)					
	Pre-Feedback (n=3884)	Post-Feedback (n=774)	% Absolute Change	% Relative Change		
Tests Ordered						
Chest X-Ray	805 (21%)	136 (18%)	↓ 3 %	↓ 14%		
Respiratory Viral Tests	1240 (32%)	163 (21%)	↓ 11%	↓ 34%		
Treatments ordered						
Steroids	493 (13%)	42 (5%)	↓ 8%	↓ 62%		
Salbutamol	843 (22%)	94 (12%)	↓ 10%	45 %		

Follow along on your report: page 3





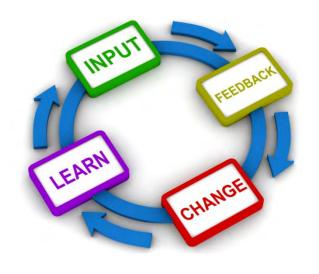
Audit & Feedback Interventions







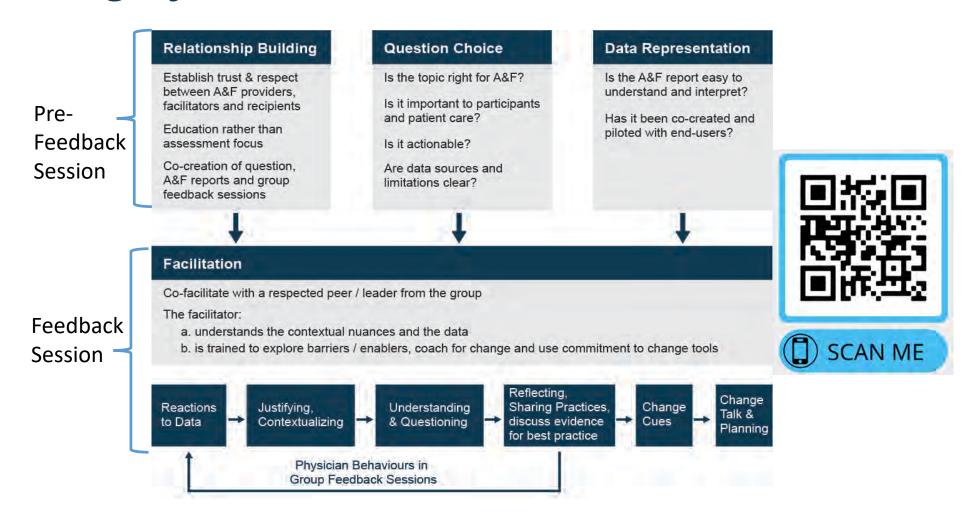
Ground Rules



- Acknowledge data limitations
- Normalize reactions to data
- Safe learning environment
- Focus on what is within our control



Calgary Audit & Feedback Framework (CAFF)



Source: Cooke LC, et al. Implement Sci 2018; 13: 136





Action Planning - Feedback Session

Identify

- Keys to success
- Opportunities for improvement
- Potential barriers
- Discuss data in context of patients

Action Plans

- Assign ownership of action items
- Support action plans by logic models
- Circle of influence
- Commitment to Change form





Activity!

Bronchiolitis Management by Emergency Physicians

Sample report

Chest X-Ray - Discharged patients



Canadian Pediatric Society Recommendations

Routine chest radiograph (CXR) is not supported by current evidence or guidelines (CPS 2018). It should be considered when the diagnosis of bronchiolitis is unclear, the rate of improvement is not as expected or the severity of disease raises other diagnostic possibilities such as bacterial pneumonia.

CXR of infants with bronchiolitis often reveals non-specific, patchy hyperinflation and areas of atelectasis, which may be misinterpreted as consolidation. This can lead to an increased and inappropriate use of antibiotics. In infants, with typical bronchitis, a recent prospective study found CXR findings inconsistent with bronchiolitis in only two of 265 infants, and in no case did the results change acute management (Schuh, J Pediatrics 2007).

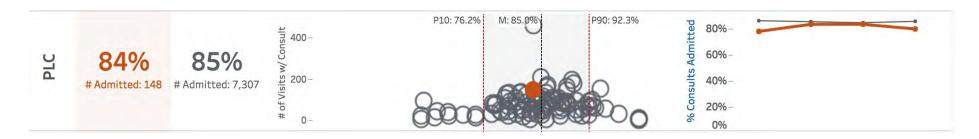
- Write down a few thoughts about your reaction to your data.
- What can you do to change your practice?
- What would be some barriers/enablers of change?
- Turn to your partner and share your thoughts.



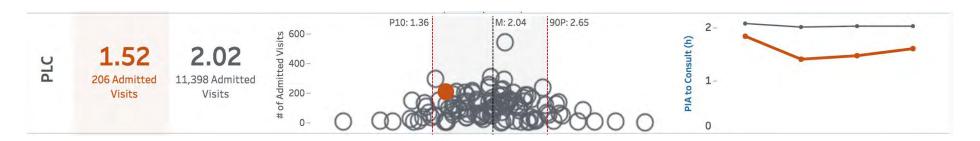


October 2016 to October 2017

% Consults Admitted

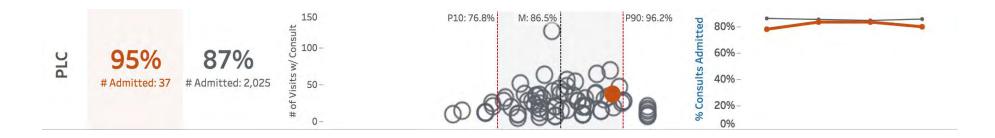


PIA to Consult

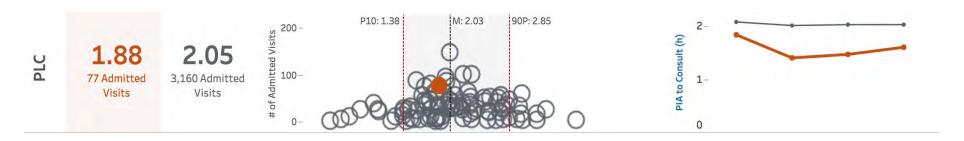


November 1, 2017 to Feb 28, 2017

Consults Admitted



PIA to Consult



Balance

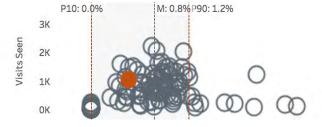
Oct 2016 - Oct 2017

S/C

0.5% # returned: 5 # seen: 1,056

0.9%# returned: 646
seen: 74,789

5



Readmission Rate

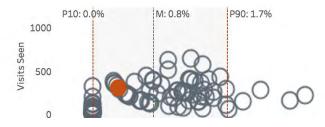


Nov. 1 2017 - Feb 28 2018

PLC C 0.3% # returned: 1

returned: 1 # seen: 310 1.0% # returned: 196

returned: 196 # seen: 19,702





Summary

- A&F can effectively change practice
 - But not all A&F is created equally
- Choosing the right metrics is vital
- Actively engage physicians in the process
 - o CAFF does this at all stages
- The end goal is not providing DATA, it's improving care we deliver
 - o A&F it's limitations
 - Develop a process to deliver the feedback in a self-reflective manner
 - Deliberate and evidence informed







Limitations

- Limited data
- ?Pay for performance
- Dashboards vs Reports
- Frequency of report delivery, minimum # of cases
- Who delivers the reports



Questions?

Shawn Dowling

Shawn.dowling@ucalgary.ca



@skdowling

Chris Rice

Christopher.rice@ucalgary.ca



y @DesigningRice



"Above all else, remember that you, as a medical provider, are entrusted with a profound responsibility to do no harm to those under your care"
- Gwen Benaway

Equity: the forgotten dimension of quality?

Holly Smith - Robin Lennox - Nadia Primiani

EDAC November 27, 2019

Disclosure

HOLLY SMITH

Relationships with commercial interests: None

ROBIN LENNOX

Relationships with commercial interests: None

NADIA PRIMIANI

Relationships with commercial interests: None

Disclosure of Commercial Support

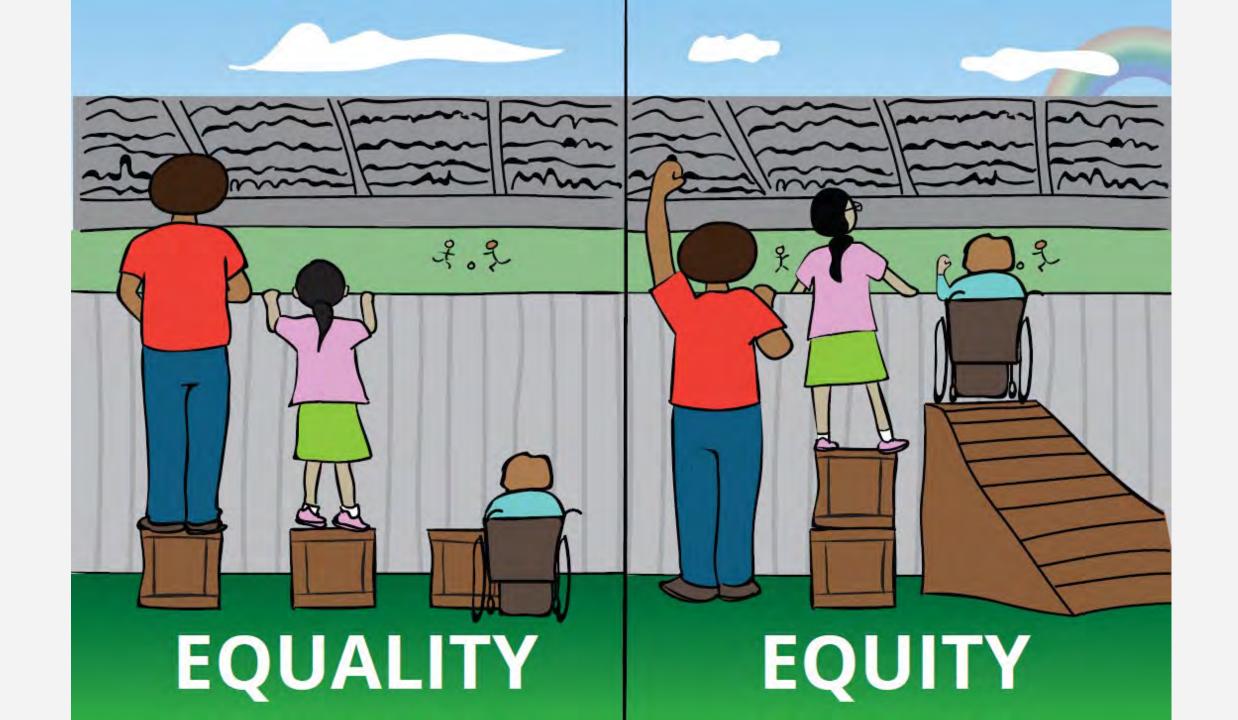
This program has not received financial or in-kind support from any organization

Potential for conflict(s) of interest:

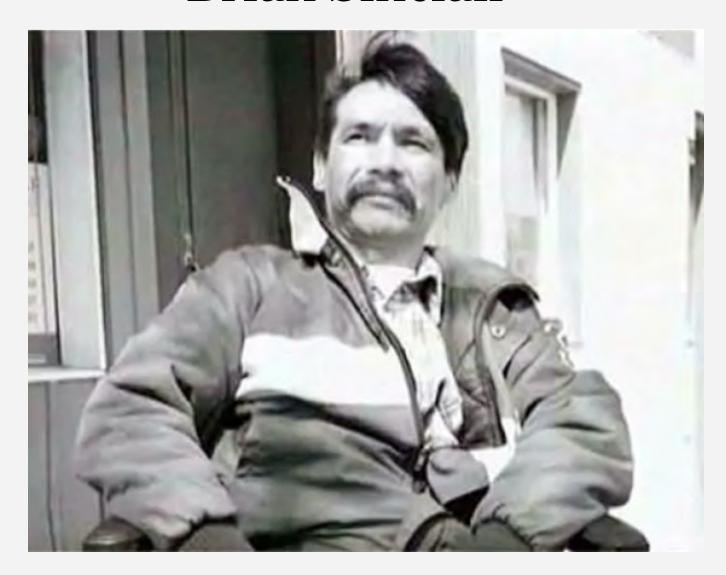
- Not applicable

Mitigating Potential Bias

- Not applicable



Brian Sinclair



Intergenerational Trauma Informed Care

"When the school is on the reserve the child lives with its parents, who are savages; he is surrounded by savages, and though he may learn to read and write his habits, and training and mode of thought are Indian. He is simply a savage who can read and write. It has been strongly pressed on myself, as head of the Department, that Indian children should be withdrawn as much as possible from the parental influences, and the only way to do that would be to put them in central training industrial schools where they will acquire the habits and modes of thought of white men."

Sir John A. MacDonald, 1883

Intergenerational Trauma Informed Care

"It is readily acknowledged that Indian children lose their natural resistance to illness by habitating so closely in these schools, and that they die at a much higher rate than in their villages. But this alone does not justify a change in the policy of this Department, which is being geared towards the final solution of our Indian Problem."

Duncan Campbell Scott, 1910

Intergenerational Trauma Informed Care

School's electric chair haunts natives

The Globe and Mail Fort Albany Parst Nation, Ont.

THE homemade electric chair that was used for years to punish abortginal children at St. Anne's Residential School has disappeared, but its memory

Humbreds of children who survived the harrors of the school have bitter memories of the chair that was used first for entertainment but eventually as a means of forcing them to bend to the will of the Roman Catholic missionaries who ran the school.

First it was used for entertainment, then for punishment for aboriginal children.

chair as a form of punishment," Mary Anne Makogne Davis, 41, who attended St. Anne's between Grades 1 and 6, said in an interview. "They would put children in it if they were had. The nuns used it as a Weapon.

It was done to me on more than one occasion. They would strap your arms to the metal arm rests, and it would jott you and go

what I did that was bad enough to have that done to me.*

Edmund Metatawabin, 49, a former chief of the Fort Albany First Nation, said he remembers he and his class being forced to take turns sitting in the chair and receiving painful jolts of electricity to entertain visiting dignitaries.

"I was six years old," he said "There was no sense of voluntary-

by the brother to do it and there was never any question of not doing it.

"Once the thing was cronked up, I could feel the current going through me, mainly through my arms. Your legs are jumping up, and everyone was laughing."

St Anne's operated as a residential school from 1904 to 1973 in this isolated Cree community of 1.400 people on the west coast of James Bay, 1,000 kilometres north

The federal government faced Cree and Olibwa children to leave their families and live at the school for 10 months of the year --Please see Electric (A4



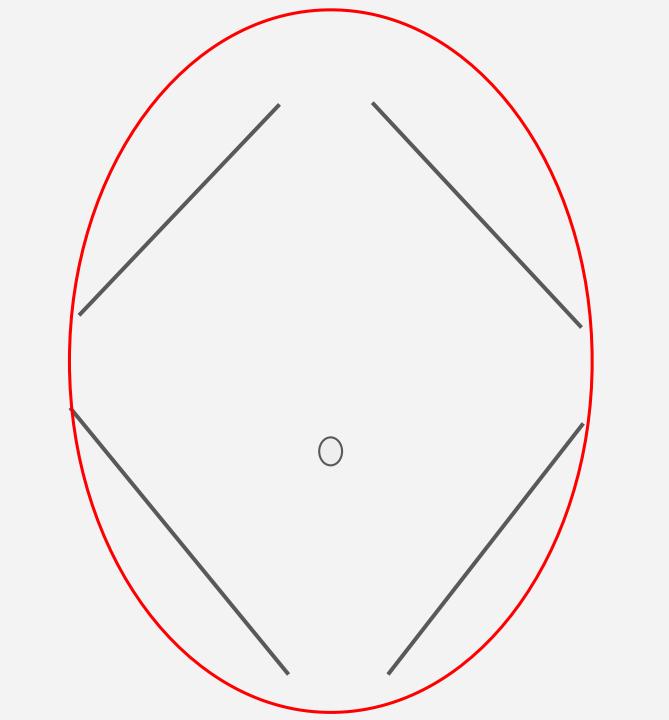


people who use drugs are our patients

7X ED visits ~8X Hospital admissions

Case - Lisa





Unconscious Bias

unconscious attitudes we have towards a group of people, either positive or negative



Like, it's a stereotype, the way some of the doctors and nurses will treat you. They have their own diagnosis of you, and if there's drugs involved, your diagnosis is done. They do not need to look further, that's it; that's all. (P-42)

... I'd be afraid to go [to a specific hospital] if I could not breathe with my asthma. They'll think it was something else, I do not know, and I'd probably die, so ... I think they suspect that people are drug seeking right? And then they do not bother seeing if you are okay. (P-27)

Chan Carusone, S., Guta, A., Robinson, S. *et al.* "Maybe if I stop the drugs, then maybe they'd care?"—hospital care experiences of people who use drugs. $Harm\ Reduct\ J\ 16$, 16 (2019) doi:10.1186/s12954-019-0285-7



When it comes to health care, transphobia persists

I suppose I should have predicted that transphobia would follow me into every aspect of my life, but I naively assumed that having the correct name and gender on my health card would protect me

GWEN BENAWAY

CONTRIBUTED TO THE GLOBE AND MAIL PUBLISHED JULY 18, 2018





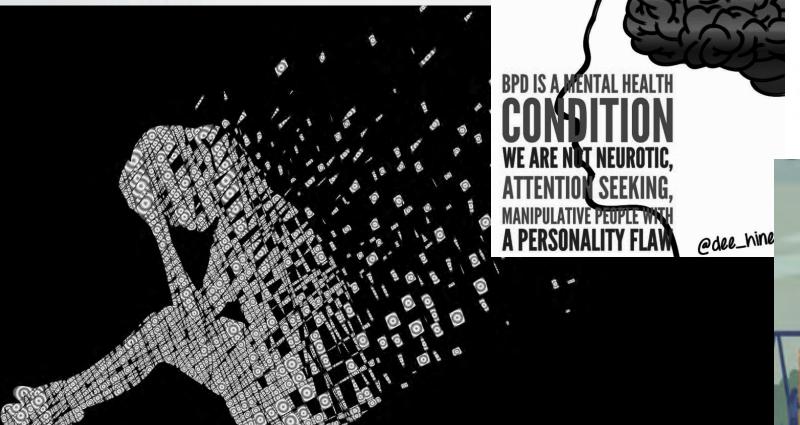
Gwen Benaway's third collection of poetry, Holy Wild, will be published in October.





END THE BAN!

It's time for science, not stigma.



Don't ask me to snap out of it.









CISgender: anatomy/sex assigned at birth CONgruent with gender identity

TRANSgender: anatomy/sex assigned at birth INcongruent with gender identity

2S - Two Spirit

L - Lesbian

G - Gay

B - Bisexual

T - Trans

Q - Queer

I - Intersex

Cultural Safety

Analysis and self-reflection of power and privilege, institutional discrimination, colonization and colonial relationships

PWUD: person who uses drugs

PWID: person who injects drugs

Anti-Racism

Where racism is confronted and human rights are defended

Substance use disorder

Top 3 things

Mandatory Cultural Safety Training for all ED staff members

- Seek out cultural safety training

Organizational leadership commitments to address anti-racism strategies

Policy and procedures to uphold accountability

Indigenous representation in ED and organizational leadership

- Indigenous patient navigators
- Community consultants
- Indigenous Elders

Policy statement on language

Listen to what you hear in your dept & then draft a policy for distribution re: language

Naloxone Kits & Acute Opioid Withdrawal Orderset

Adopt

policy of distributing naloxone kits from ER

If not

already available, develop an order set for acute opioid withdrawal and buprenorphine initiation.

Addiction Medicine Support for your ER

Develop permanent or semi-permanent addiction medicine support, peer support worker in ER, addiction counsellor in ER or addiction med specialist who can support your ER (people access it the most often)







Jo	nai Health System	Health System th & Wolf Lebovic Health Complex WARTZ/RIIISMAN			ergency cord niversity Avenue o, Ontario, Canada X5 1 (Rev. 10.2019)	Clearly imprint patient identification card			to BACK	Mount Sinai Hospital Stel Heath Synur Joseph A Wolf Lebrer Heath Conclex SCHWARTZ/REISMAH EMBREGENCY CENTRE		Emergency Record 600 University Avenue Toronto, Ontario, Canada MSG 1XS MS 410 (Rev. 10.2019) Paga 2 of 5	Clearly imprint patient identification card		
ALLERGIES	s			Page 1	of 6	PROC October				FOLD HERE	Time Seen (***Max)	Physician/NP/PA			
	INITIAL ORD	DER	RS			ADDITIONAL ORDE	RS								
MD Order	Circle Order	No.	RN Order	Collected	MD Order	Write and Sign Order	20	RN Ore	ser Collected					Chosen Name:	ž
Time	Order	Ø	Time	RN Initials	Time	Order	Ø	Time	RN Initials					Pronouns:	
1	CBC			100										Medication Hx:	See ODB None Reviewed
	Lytes, Cr. Glucose				4 - 4										
+	Troponin								1					400	
	hCG														

System changes with targeted equity training

Consider making training mandatory for all employees of the hospital



Resources

Rainbow Health Ontario - https://www.rainbowhealthontario.ca



Human Rights Campaign - https://www.hrc.org/resources/



References

- 1. Stella R. Quah, Health-Related Stigma, International Encyclopedia of Public Health (Second Edition), 2017
- 2. P. Goddu, A., O'Conor, K.J., Lanzkron, S. et al. Do Words Matter? Stigmatizing Language and the Transmission of Bias in the Medical Record, J GEN INTERN MED (2018) 33: 685. https://doi-org.myaccess.library.utoronto.ca/10.1007/s11606-017-4289-2
- 3. Winter S, Diamond M, Green J, Karasic D, Reed T, Whittle S, et al. Transgender people: health at the margins of society. The Lancet 388:10042; 390-400 July 23, 2016
- 4. Mark A. Schuster, M.D., Ph.D., Sari L. Reisner, Sc.D., Sarah E. Onorato, B.A.Beyond Bathrooms Meeting the Health Needs of Transgender People. N Engl J Med 2016; 375:101-103, DOI: 10.1056/NEJMp1605912
- 5. Chan Carusone, S., Guta, A., Robinson, S. *et al.* "Maybe if I stop the drugs, then maybe they'd care?"—hospital care experiences of people who use drugs. *Harm Reduct J* 16, 16 (2019) doi:10.1186/s12954-019-0285-7

LGBTQ Welcoming Environment Checklist

Below is a list of eight environmental changes your clinic can make to communicate that it is welcoming to LGBTQ patients. Use this checklist to assess your clinic's environment. For each element listed below, mark the box indicating whether the element is in place, in process, needs attention or isn't relevant/appropriate to your clinic.

1.	A rainbow of the door.	r another equali	ty symbol indicating th	at LGBTQ patients are welcome is posted on								
	☐ In place	☐ In process	☐ Needs attention	☐ Not relevant/appropriate								
2.	Photos of LGBTQ people and families are posted along with photos of other families.											
	☐ In place	☐ In process	☐ Needs attention	☐ Not relevant/appropriate								
3.	Posters or of posted.	ther artwork foc	using on LGBTQ people	e or issues of concern to this population are								
	☐ In place ☐ In process		☐ Needs attention	☐ Not relevant/appropriate								
4.	LGBTQ frien	dly brochures ar	e included with patien	t education information.								
	☐ In place	☐ In process	☐ Needs attention	☐ Not relevant/appropriate								
5.	At least one publication designed for LGBTQ readers is included with periodicals for patients to read in the waiting room.											
	☐ In place	☐ In process	☐ Needs attention	☐ Not relevant/appropriate								
6.	Books about	LGBTQ families	are included with child	dren's books in the waiting room								
	☐ In place	☐ In process	☐ Needs attention	☐ Not relevant/appropriate								
7.	Single-stall b	athrooms are m	arked as gender neutr	ral (unisex).								
	☐ In place	☐ In process	☐ Needs attention	☐ Not relevant/appropriate								
8.		n-discrimination e waiting room.	policy that includes so	exual orientation and gender identity is								
	☐ In place	☐ In process	□ Needs attention	☐ Not relevant/appropriate								

10TIPS for improving services for transgender people

Transgender Law Center recognizes that many health care providers are eager to provide a safe, welcoming treatment environment for members of the transgender community, yet may not have had the opportunity to access information about the needs and experiences of this marginalized population. With this barrier in mind, we have created this pamphlet to work in partnership with providers to improve quality of care and provider-patient outcomes.

- 1. WELCOME TRANSGENDER PEOPLE BY GETTING THE WORD OUT ABOUT YOUR SERVICES AND DISPLAYING TRANSGENDER-POSITIVE CUES IN YOUR OFFICE. You can use LGBT community centers, services, newspapers, and Internet resources to advertise your services. Posters, buttons, stickers, and literature about transgender people can demonstrate that you are transgender-friendly. You can rewrite your intake form to include "chosen name" in addition to "legal name," as well as a third, blank option for "sex/gender" where someone can more accurately describe their gender. And single-use restrooms are a welcome option for many, including transgender people.
- 2. TREAT TRANSGENDER INDIVIDUALS AS YOU WOULD WANT TO BE TREATED. You can show respect by being relaxed and courteous, avoiding negative facial reactions, and by speaking to transgender clients as you would any other patient or client.

- 3. REMEMBER TO ALWAYS REFER TO TRANSGENDER PEOPLE BY THE NAME AND PRONOUN THAT CORRESPONDS WITH THEIR GENDER IDENTITY. Use "she" for transgender women and "he" for transgender men, even if you are not in the patient's presence,
- 4. IF YOU ARE UNSURE ABOUT A PERSON'S GENDER IDENTITY, OR HOW THEY WISH TO BE ADDRESSED, ASK POLITELY FOR CLARIFICATION. It can be uncomfortable to be confused about someone's gender. It can also feel awkward to ask someone what their gender is. However, if you let the person know that you are only trying to be respectful, your question will usually be appreciated. For instance, you can ask, "How would you like to be addressed?" or "What name would you like to be called?" In order to facilitate a good provider-patient relationship, it is important not to make assumptions about the identity, beliefs, concerns, or sexual orientation of transgender and gender non-conforming patients.
- 5. ESTABLISH AN EFFECTIVE POLICY FOR
 ADDRESSING DISCRIMINATORY COMMENTS AND
 BEHAVIOR IN YOUR OFFICE OR ORGANIZATION. Ensure
 that all staff in your office or organization receive
 transgender cultural competency training and that
 there is a system for addressing inappropriate
 conduct.
- 6. REMEMBER TO KEEP THE FOCUS ON CARE RATHER THAN INDUCTING IN QUESTIONS OUT OF CURIOSITY. In some health care situations, information about biological sex and/or hormone levels is important for assessing risk and/or drug interactions. But in many health care situations, gender identity is irrelevant. Asking questions about a person's transgender status, if the motivation for the question is only your own curiosity and is unrelated to care, is inappropriate and can quickly create a discriminatory environment.
- 7. KEEP IN MIND THAT THE PRESENCE OF A TRANS-GENDER PERSON IN YOUR TREATMENT ROOM IS NOT ALWAYS AN APPROPRIATE "TRAINING OPPORTUNITY" FOR OTHER HEALTH CARE PROVIDERS. Many transgender people have had providers call in others to observe their bodies and the interactions between a patient and health care provider, often out of an impulse to train residents or interns. However, like in other situations where a patient has a rare or unusual

finding, asking a patient's permission is a necessary first step before inviting in a colleague or trainee. Many transgender patients wish to maintain control over who sees them unclothed. When patients are observed without first asking their permission, it can quickly feel like an invasion of privacy and creates a barrier to respectful, competent health care.

- **8.** IT IS INAPPROPRIATE TO ASK TRANSGENDER PATIENTS ABOUT THEIR GENITAL STATUS IF IT IS UNRELATED TO THEIR CARE. A person's genital status—whether one has had surgery or not—does not determine that person's gender for the purposes of social behavior, service provision, or legal status.
- 9. NEVER DISCLOSE A PERSON'S TRANSGENDER STA-TUS TO ANYONE WHO DOES NOT EXPLICITLY NEED THE INFORMATION FOR CARE. Just as you would not needlessly disclose a person's HIV status, a person's gender identity is not an item for gossip. Having it known that one is transgender can result in ridicule and possible violence towards that individual. If disclosure is relevant to care, use discretion and inform the patient whenever possible.
- 10. BECOME KNOWLEDGEABLE ABOUT TRANSGENDER HEALTH CARE ISSUES. Get training, stay up to date on transgender issues, and find out where to access resources. For free, confidential provider-to-provider information, visit www.project-health.org/transline.



For more information or to get help, please contact Transgender Law Center at www.transgenderlawcenter.org.

Using simulation to turn your ED upside down... for patient safety



Andrew Petrosoniak, MD, MSc, FRCPC
Emergency Physician & Trauma Team Leader
St. Michael's Hospital
Assistant Professor, University of Toronto
Associate Scientist, LKS Knowledge Institute
@petrosoniak

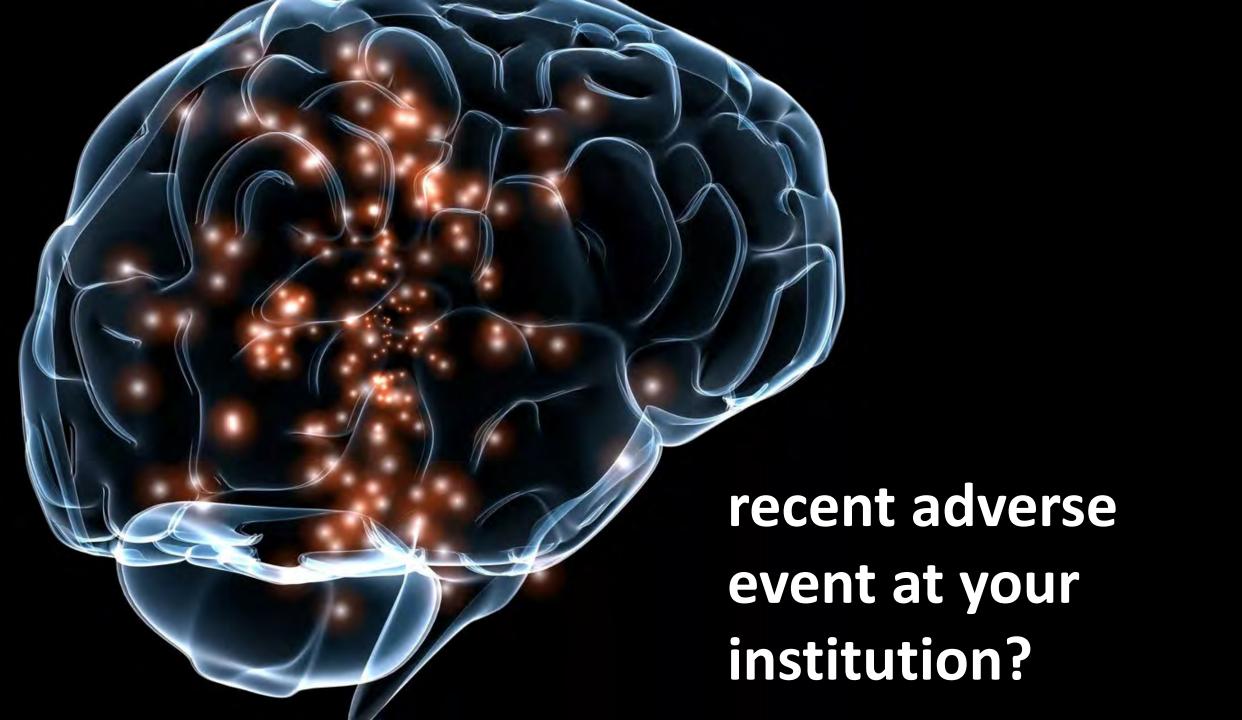
Kari White, RRT, FCSRT, MScCH (c)
CLM- Respiratory Therapy
Unity Health Toronto – St. Michael's Hospital
@karilynwhite

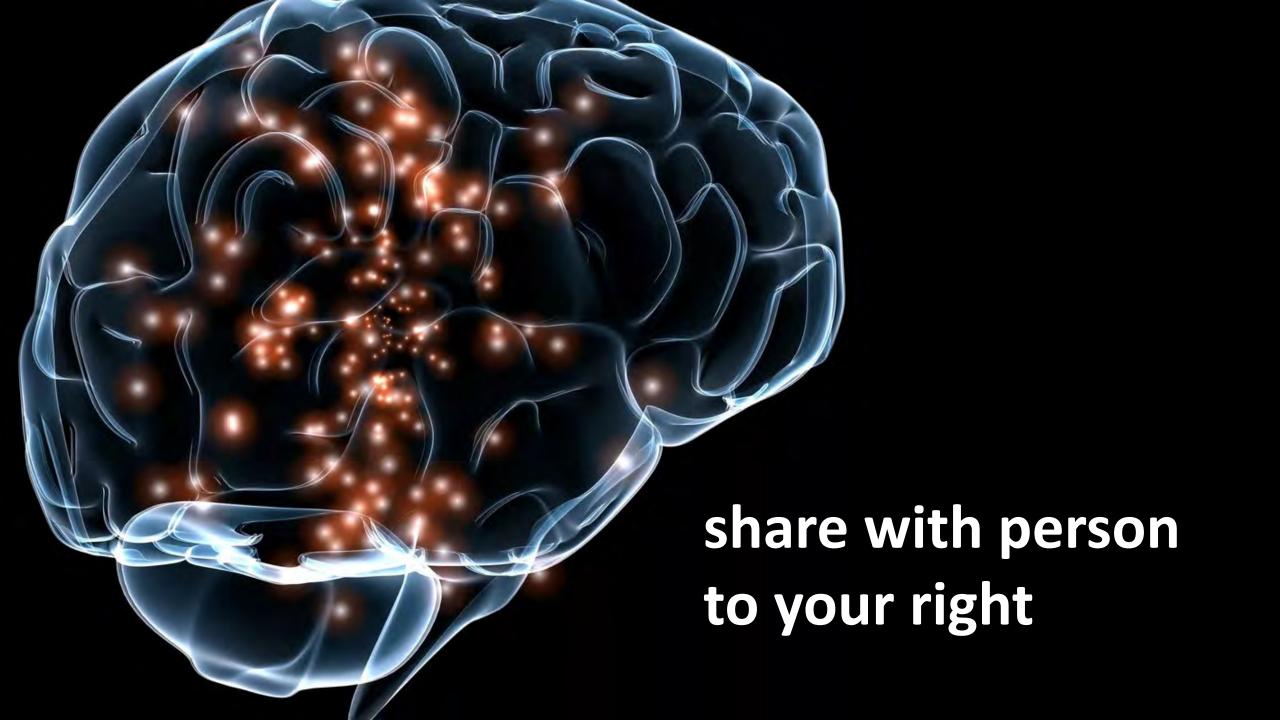


no disclosures

objectives

- 1. Role of simulation in patient safety & QI
- 2. Practical considerations for simulation + patient safety
- 3. Test case for simulation + PSQI





30s or less

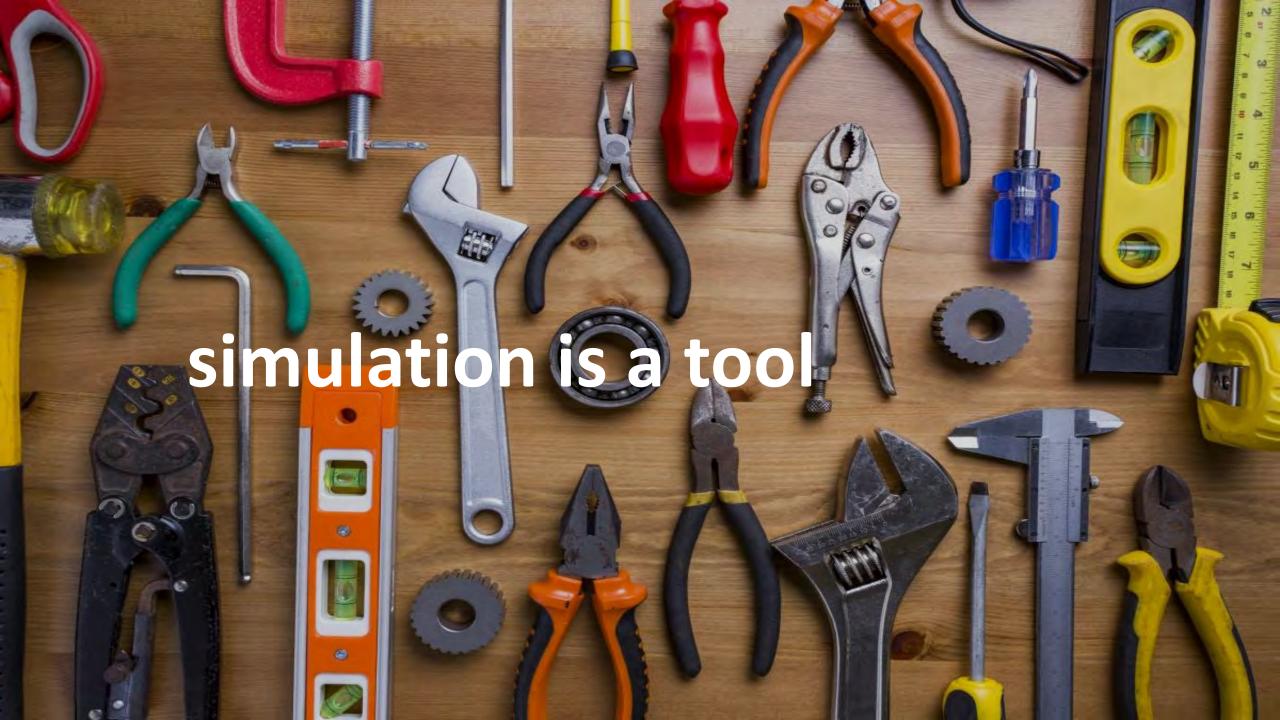








we should NO longer tolerate the notion of a RARE event



translational simulation

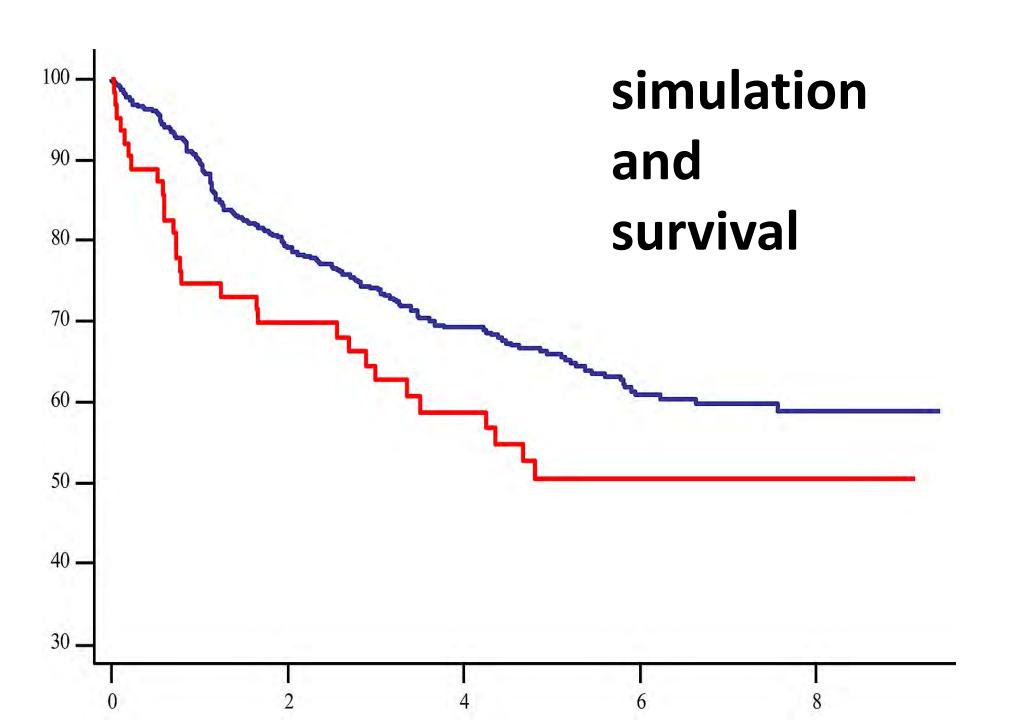
health service priorities

patient outcomes













TRUST.

clarity of plan stakeholder engagement confidentiality role of leadership follow through







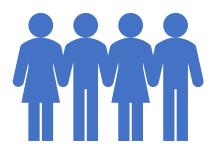
interprofessional simulation

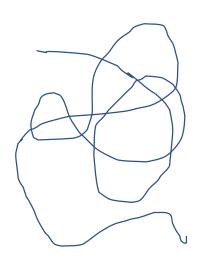


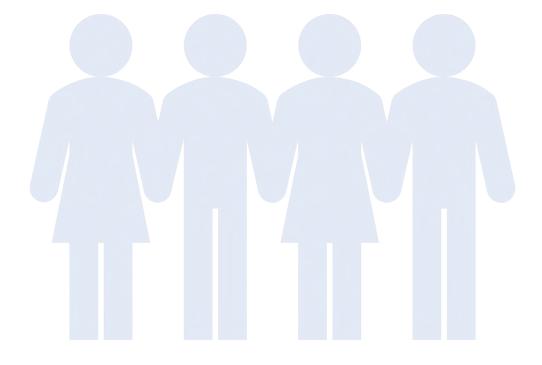
relationships

process

culture

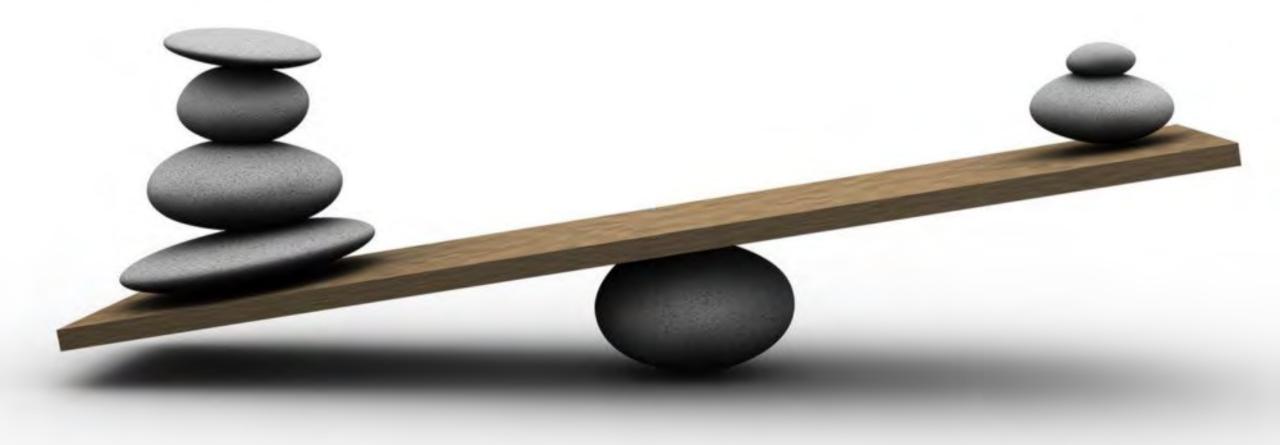






SIMULATION





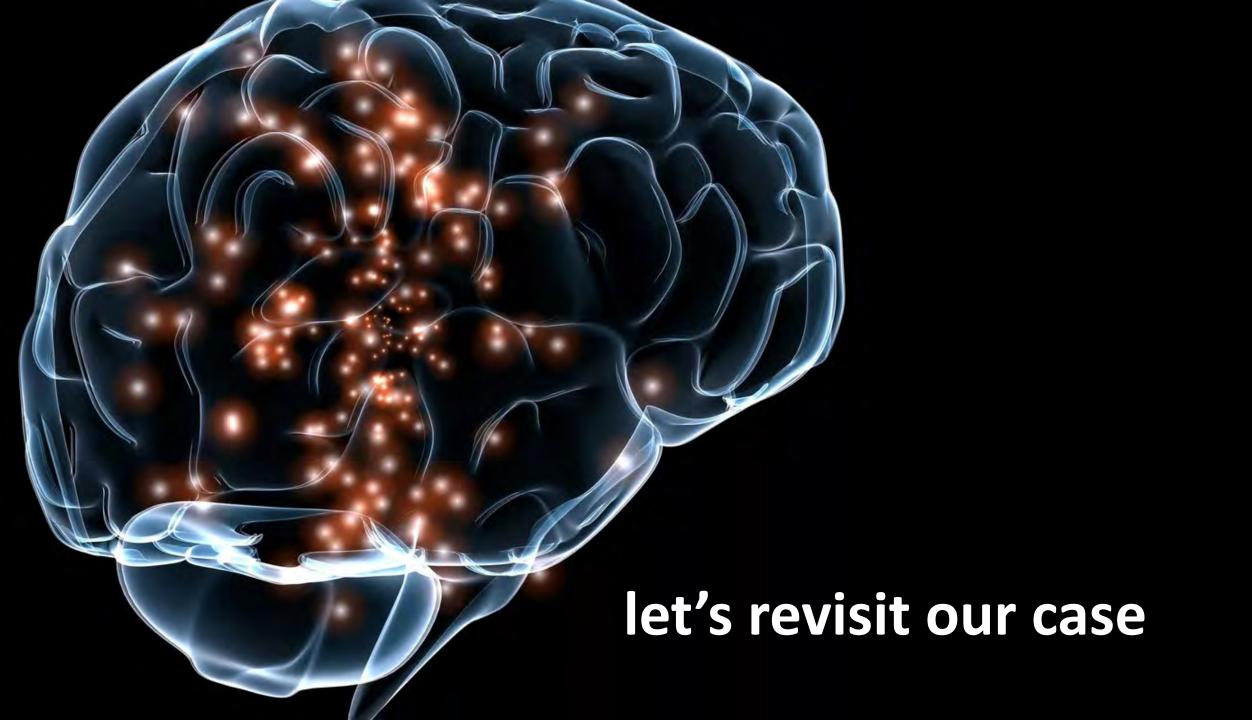
leverage: QI & safety







motivation barriers



translational simulation

adjust debriefings

interprofessional

simulation shapes culture

making it happen



THE END

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Improving Outcomes Patients Care About

Samuel Vaillancourt Emergency Physician

Cathie Hofstetter Patient advisor

EDAC Nov 27, 2019





Faculty/ Presenter Disclosure

Faculty: Samuel Vaillancourt

Relationships with commercial interest:

• none

Faculty: Cathie Hofstetter

Relationships with commercial interest:

none



Disclosure of Commercial Support

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Potential for conflict(s) of interest: Not applicable



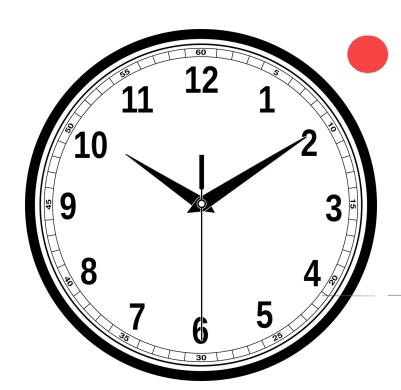
Mitigating Potential Bias

Not applicable

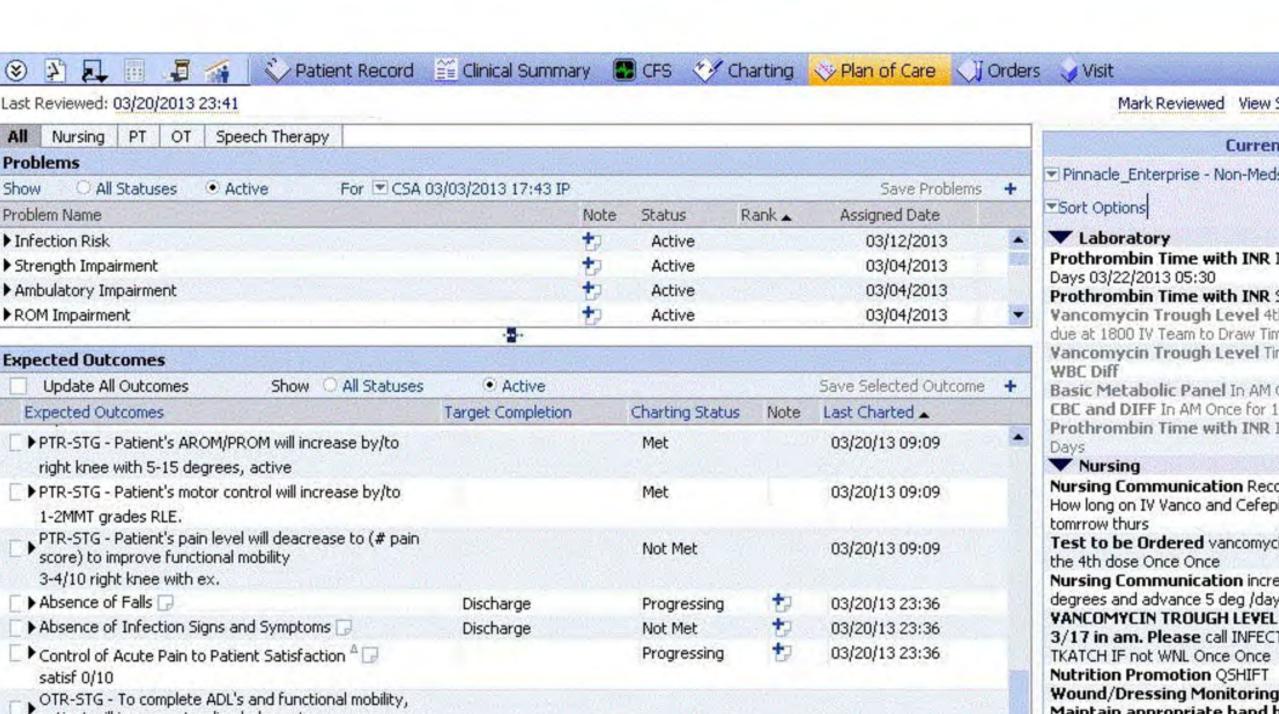


What are we trying to accomplish?





"Do you remember that patient you saw?"











What patients think?

The patient experience





What outcomes matter?

Cathie Hofstetter

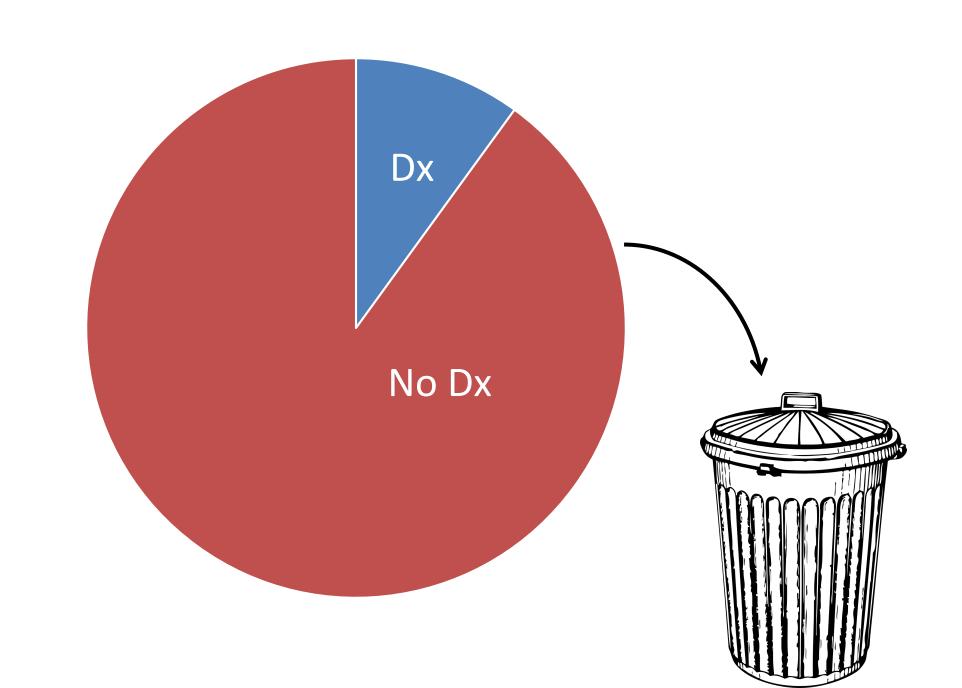


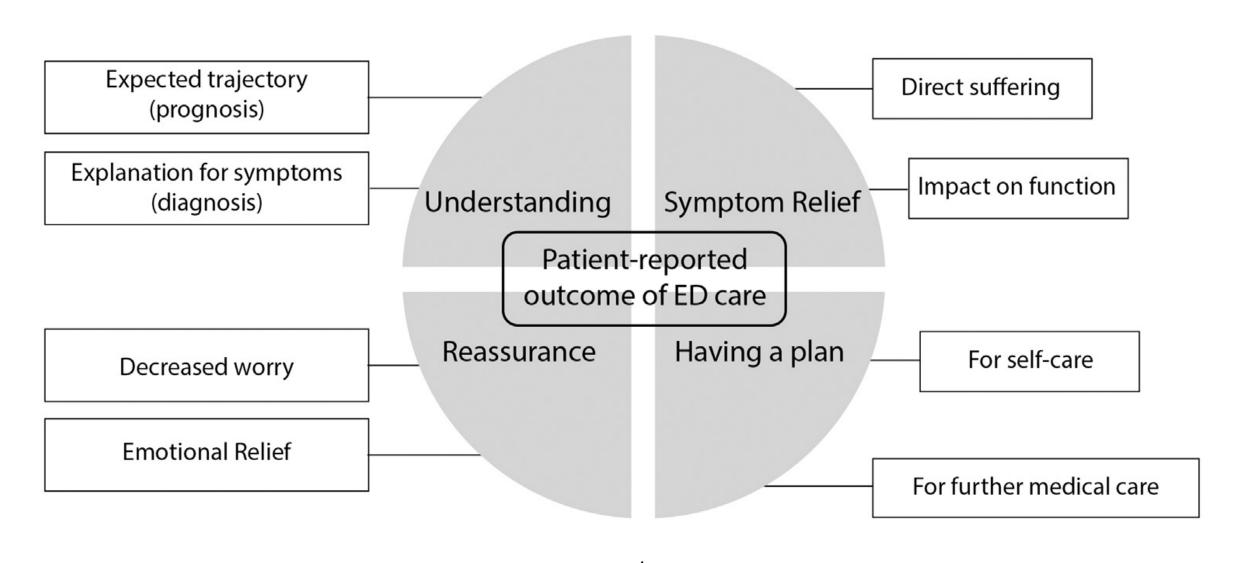
Measuring Outcomes of **Emergency Department Care**

Outcomes **Emergency Department** Care hospital admission 10% of patients

• 90% of patients go home.







Vaillancourt S, et al. Patients' Perspectives on Outcomes of Care After Discharge From the Emergency Department: A Qualitative Study.

Annals of Emergency Medicine. 2017.

S ymptom Relief
U nderstanding

R eassurance

F ollow up plan

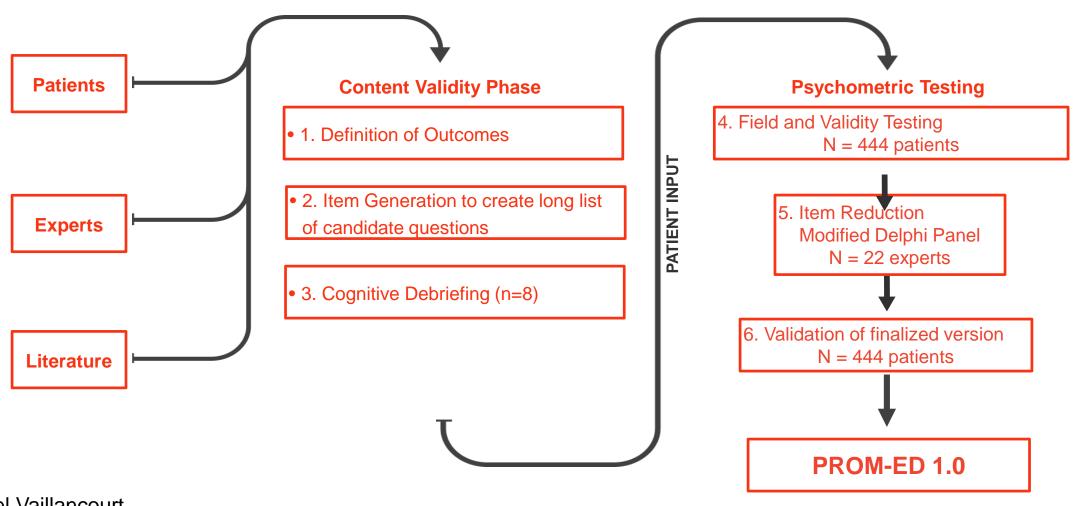


Patient-reported Outcome Measures

PROM



METHODS - Developing a new PROM



Samuel Vaillancourt & PROM-ED team

PROM-ED

Patient-reported outcome measure for emergency department patients





Instructions

You are receiving this questionnaire because you received care recently in the emergency department.

This questionnaire asks about how you are doing **today** with regard to the health concern that brought you to the emergency department.

Try to answer all questions that apply.

By contributing information on how you are doing now, you can help improve the care provided in the emergency department.

Authors: Samuel Vaillancourt, John D Cullen, Katie N Dainty, Taucha Inrig, Andreas Laupacis, Denise Linton, Stéphanie Malherbe, Alies Maybee, Michael J Schull, M Bianca Seaton, Dorcas E Beaton.

- And our website www.prom-ed.org



PROM-ED_V1.0_PAGE 1 OF 4

1- SYMPTOM RELIEF

In this	s section we	ask you at	oout the dis	scomfort o	r symptom	related to th	ne reason yo	u went to	the emer	gency dep	artment.
	Did you hav or example, Yes No	discomfor	rt or sympt	tom can b	e: pain, fe	eling sick,	-	eathing,	nausea, e		
Pleas	se consider	this disco	mfort or sy	ymptom w	when you a	nswer the f	ollowing qu	estions.			
1.2.	How wou emergence No discomfort/ symptom			ensity or s	severity of	your disc	omfort or	sympton	n when y	ou went t	Discomforti symptom as bad as it can be
	0	1	2	3	4	5	6	7	8	9	10
1.3.					severity of and now)?	your disc	omfort or s	sympton	n in the p	oast 24	Discomfort/ symptom as bad as it can be
	0	1	2	3	4	5	6	7	8	9	10
	In the pas) how mu								
	discomfor	t or symp	otom			Never	Rarely	Somet	imes Ve	ry Often	Always
1.4.	interfere w (including	ith your us	sual activit		ome)?	Never	Rarely		imes Ve	ory Often	Always
	interfere w	ith your us both outsi	sual activit	side the h	iome)?				_		_
1.5.	interfere w	ith your us both outsi ole tasks h to you feel eck one)	sual activit ide and ins ard to con	mplete? ecovering		□。	nr that brou] ₂ to the em		□ ₄
1.5.	interfere w (including) make simple s	ith your us both outsi ble tasks h lo you feel eck one) better tement be eck one) better, an better. I	sual activitide and installed	side the h mplete? covering roved S [libes you in the common of the	from the he	oved No	trn that brou	□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □] ₂] ₂ to the em Expression of the em Use of	ay and no	epartment



PROM-ED_V1.0_PAGE 2 OF 4

Vaillancourt S, et al. PROM-ED: Development and Testing of a Patient Reported Outcome Measure for Emergency Department Patients Who Are Discharged Home. Annals of Emergency Medicine. 2019 In press.

Workshop 1

Find as many ideas for improving the outcome you have been assigned

15 minutes

Workshop 1.1

Take a vote on the potentially most impactful idea

1 minute

Experience

Value =

Wait times

Outcomes

Cost

 Differentiate patient reported satisfaction, experience and outcomes

- Whether you measure them or not, focus on outcomes from the perspective of patients
- Measure and find new ways to improve









Morbidity & Mortality Rounds: Making a Century-Old Idea New Again

Edmund Kwok, MD MHA MSc FRCPC

Assistant Professor, University of Ottawa Clinician Investigator, The Ottawa Hospital Research Institute

Kindra Lewis, RSW MSW

Social Worker, The Ottawa Hospital



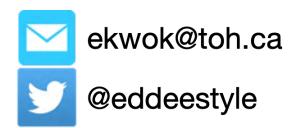




Faculty/Presenter Disclosure

Faculty: Edmund Kwok, MD MHA MSc FRCPC

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





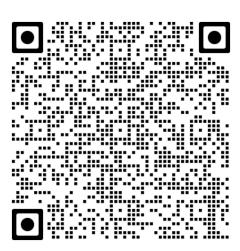


Mitigating Potential Bias

Co-lead for the development of

The Ottawa Morbidity & Mortality Model (OM3)

























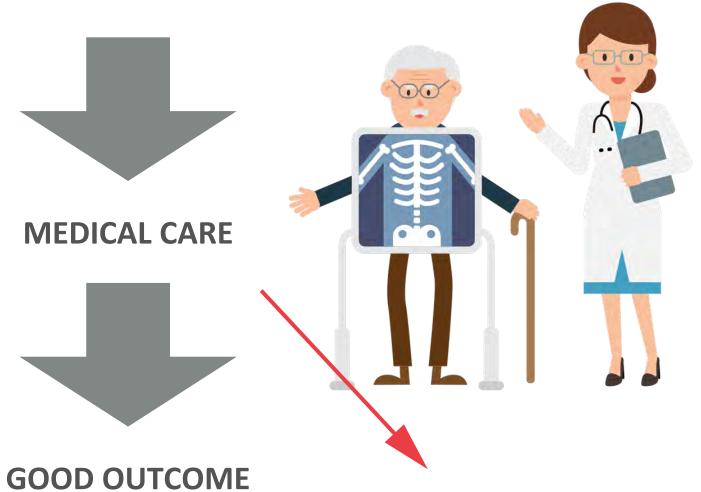


Why do we do M&M rounds?





PATIENT ARRIVES



ADVERSE OUTCOME

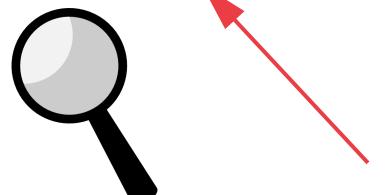




PATIENT ARRIVES



MEDICAL CARE



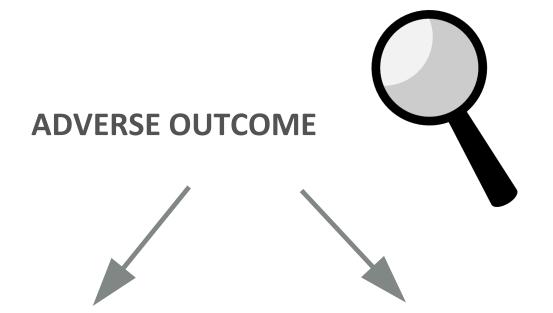
LESSONS?

AREAS FOR IMPROVEMENT?

HOW TO PREVENT FUTURE ONES?

ADVERSE OUTCOME







PROSPECTIVE

Active Screening

Trigger Tools

RETROSPECTIVE

Complaints

Medicolegal

M&M rounds

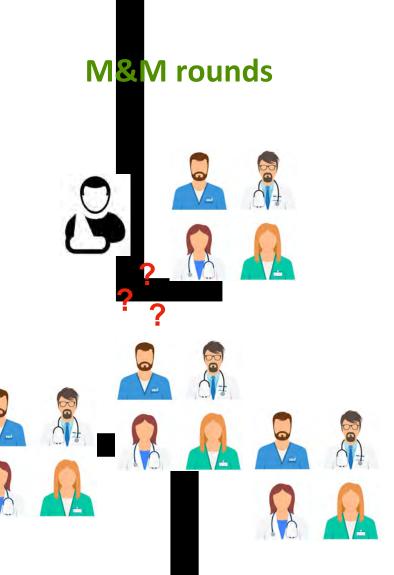
Critical Incident Review





Complaints









How many of you hold/attend regular M&M rounds in your ED?

(1hr / month) x (12months / yr) = 12hrs/yr



Most of this has been wasted time.







Born

30 December 1869

Boston, Massachusetts

Died

23 November 1940 (aged 70)

Ponkapog, Massachusetts

Nationality United States

Fields Medicine, Surgery

Institutions Massachusetts General Hospital

Harvard University

Alma mater Harvard University

Known for Establishing end results based

medical care.

"End Results System"

Errors in Diagnosis Lack of Physician Knowledge Unconquerable Disease **Unavoidable Calamities**





"The lost sponge in the abdomen is a glaring error, obviously preventable, and obviously a proof of wretched carelessness..."

"...a follow-up system...will do much toward weeding out the lazy and ill-trained surgeons of your community..."

"...if the house officers should see these results, it would be very **instructive** for them..."





The Journal of the American Medical Association

Published Under the Auspices of the Board of Trustees

Vot., 135, No. 14

CHICAGO, ILLINOIS COPPRISON, 1947, BY AMERICAN MEDICAL ASSOCIATION

ANESTHESIA STUDY

Findings of Eleven Yea

HENRY S. RUTH, Hoverford, Pa.

FREDERICK P. HAUGE

D. DWIGHT GROVE, M.D.

Death from anesthesia is an ever present factor in the compilation of statistics on surgical mortality. The importance of this factor has increased as the years ave passed since its introduction in 1846. Generally speaking, improvement in the management of the mesthesia period has not kept pace with improvement in the management of the surgical period. Many hospitals in this country and abroad are using methods of anesthesia rather similar to those employed one hundred years ago. In many surgical amphitheaters, attempts to employ newer methods of anesthesia by poorly qualified personnel have resulted in an even greater incidence of death.

Accreditation Council for Graduate Medical Education

> nours of the induction of at hospitals and physicians Philadelphia. The cases offered on a voluntary ba the meetings reads the mor-

disclosing the origin of the case. Free discussions take place from the floor by anesthesiologists as well is representatives of other specialties. After the list (us ion, a vote is recorded by the majority pinion or whether the fatality appears to be preventable or nonpreventable. The probable cause of death and the factors contributing to it are also decided. Recommendations are made as to what the commission feels would be better management, but no attempt is made to transmit the recommendations to those involved unless this is requested. Interest in this commission has increased greatly since its beginning. At this time









November 2016 Volume 42 Number 11

The Joint Commission Journal on Quality and Patient Safety

Methods, Tools, and Strategies

Morbidity and Mortality Conferences: A Narrative Review of Strategies to Prioritize Quality Improvement

Vanessa Giesbrecht; Selena Au, MD, FRCPC, MSc





	Table 1. Reviewed	Literature Desc	ribing Morbidity and	Mortality Conference (MM)	C) Structure and Rep	orted Outcomes	
eviewed Paper	Summary	Setting	Preexisting MMC Structure	Revised MMC Structure	Outcomes	Author Comment on Study Quality	

32 papers

Large variability in structure (if any)

Inconsistent Outcomes

Small Sample

Kwok et al.	Implemented
(2016) ³³	modified MM
437.9	hospitalwide

a using the "Ottawa M&M Model"

Hospitalwide study including multiple specialties within an academic hospital

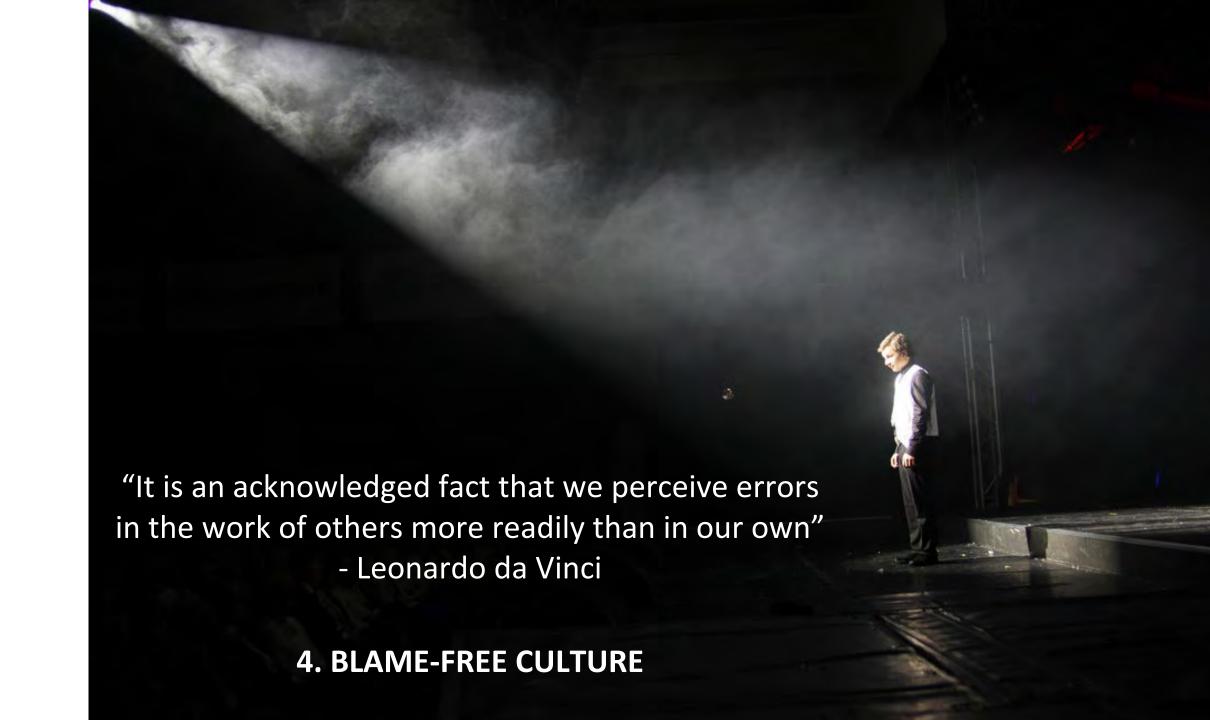
Largest evaluation of a revised MMC. Pre-post intervention design.





WHAT MAKES M&M ROUNDS EFFECTIVE?

- 1. CLEAR PURPOSE & GOALS
 - 2. FORMAL STRUCTURE
- 3. MECHANISM FOR ACTION







Strategies to Maximize Potential of M&M Rounds





STEP 1: Define Goal





Goal of M&M Rounds:

DISCUSS CASES OF ADVERSE OUTCOMES
THAT PROVIDE LESSONS IN TERMS OF
COGNITIVE/SYSTEM ISSUES...

ULTIMATELY, TO IMPROVE QUALITY OF CARE.





STEP 2: Provide Structure

STEP 1: Define Goal





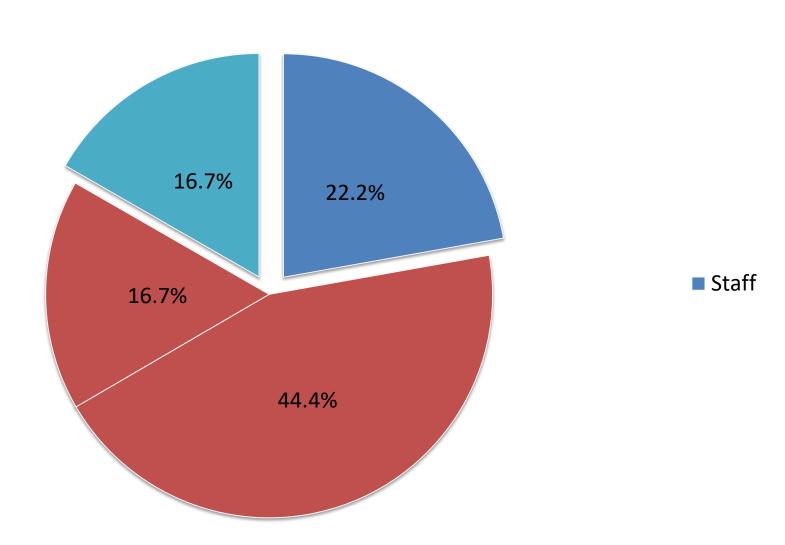
<10% of M&M conferences had structured approach

Improving Quality of Care and Patient Safety Through Morbidity and Mortality Conferences

Bal, Gaëlle; Sellier, Elodie; Tchouda, Sandra D.; François, Patrice











KEY COMPONENTS

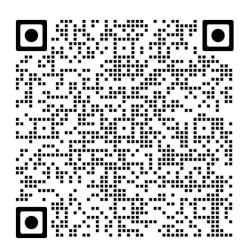
Appropriate Case Selection

Structured Cases Analysis (Cognitive/System Errors)

Creation & Dissemination of Bottom Lines/Summaries

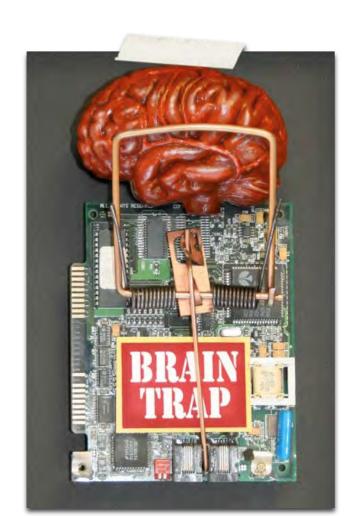
Development of Effector/ Administrative Pathway for Action Items

Encourage Inter-professional & Multidisciplinary Involvement





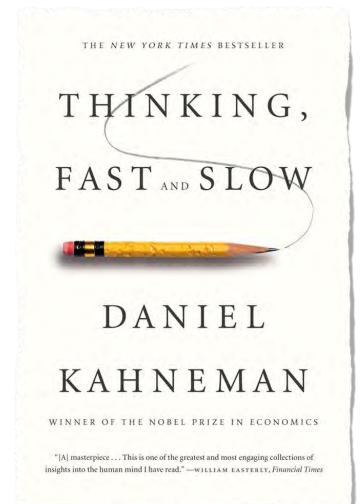




Cognitive Issues



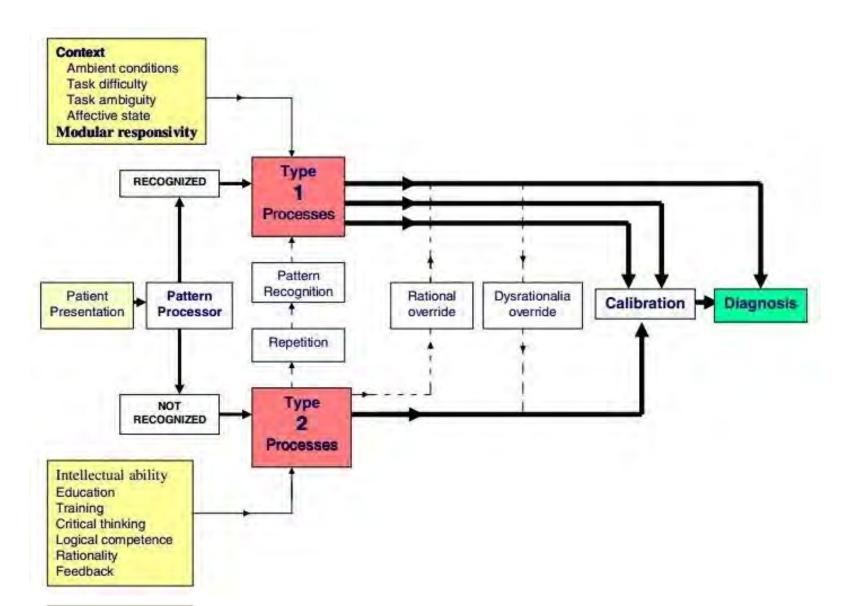












Pick a card.
Really focus on memorizing it.

Write down:

1) the card value

$$K = 13$$

$$Q = 12$$

$$J = 11$$

2) colour of the suit

















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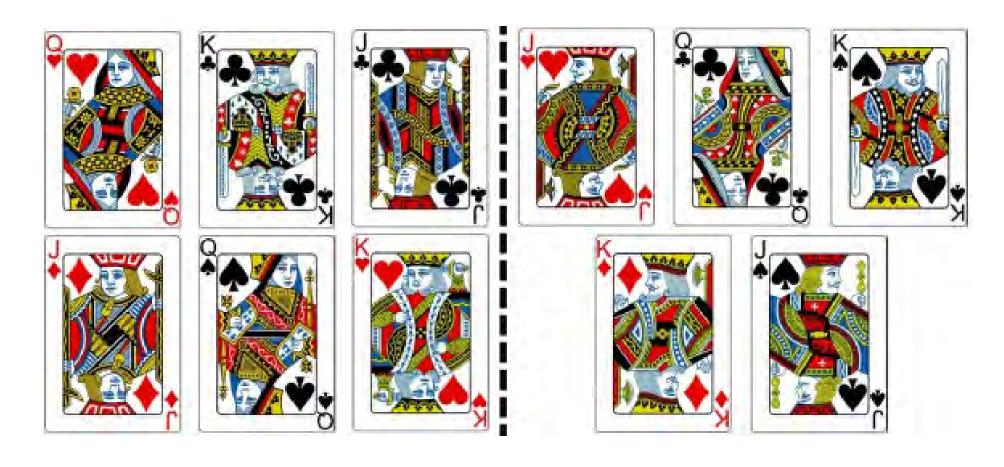




Table 1. Classification Scheme for Cognitive Dispositions to Respond (CDRs)

Error of over-attachment to a particular diagnosis

- Anchoring
- Confirmation bias
- Premature closure

Error due to failure to consider alternative diagnoses

- Multiple alternatives bias
- Representativeness restraints
- Search satisfying

Error due to inheriting someone else's thinking

- Diagnosis momentum
- Framing effect
- Bandwagon effect

Errors in prevalence perception or estimation

- Availability bias
- Base-rate neglect
- Hindsight bias

Errors involving patient characteristics or presentation context

- Fundamental attribution error
- Triage cueing
- Yin-yang out

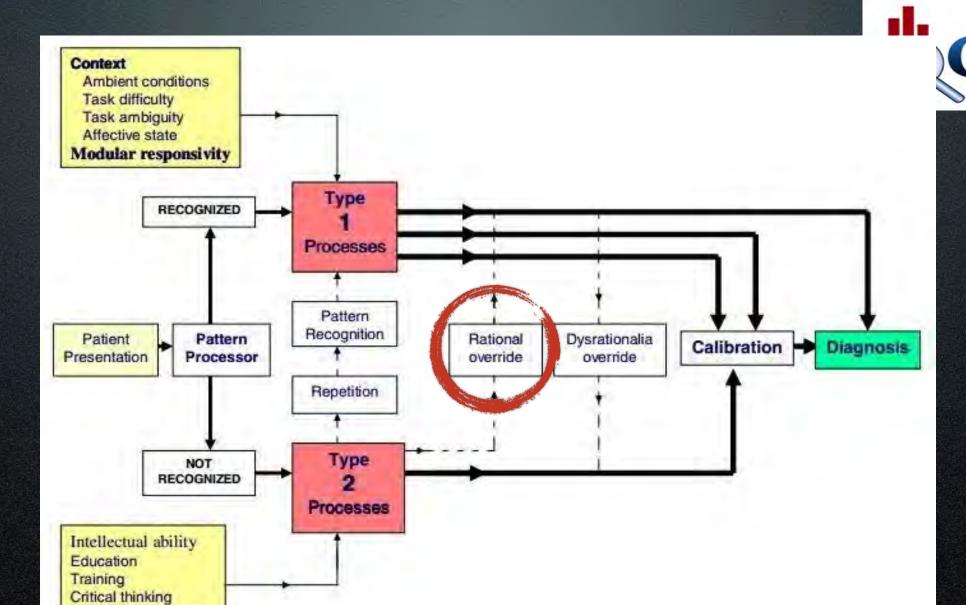
Errors associated with physician affect, personality, or decision style

- Commission bias
- Omission bias
- Outcome bias
- Overconfidence/underconfidence
- Zebra retreat

Adapted from: Campbell SG, Croskerry P, Bond WF. Profiles in patient safety: a "perfect storm" in the emergency department. Acad Emerg Med. 2007; 14:743-749.









Rationality Feedback

Logical competence

























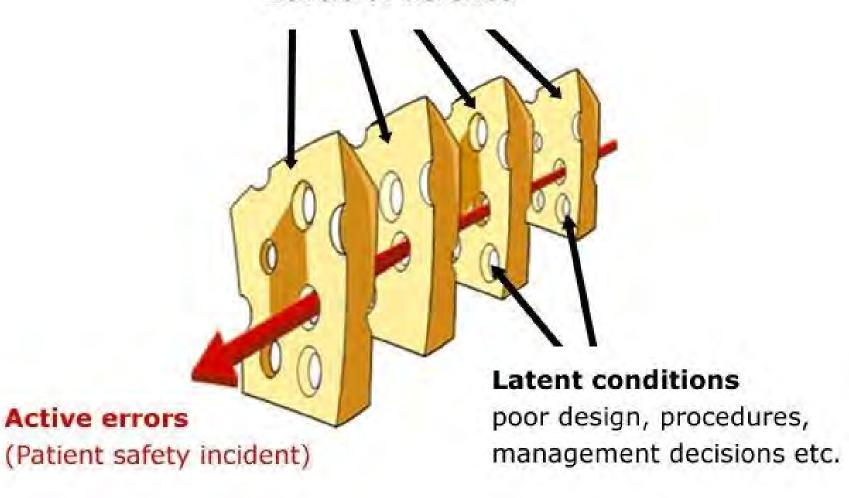






System Issues

Levels of defence









WERE THERE ISSUES RELATED TO:



- I. Communication/care prior to surgical consult?
- 2. Diagnosis?
- 3. Staging Investigations?
- 4. Evaluation of Fitness for Surgery?
- 5. Pre-op Consultations?
- 6. Timing/Prioritizing surgery?
- 7. Other Patient Factors?

- 1. Protocols?
- 2. Choice of surgical approach?
- 3. Teamwork?
- 4. OR leadership?
- 5. Work environment? (e.g. late night, post-call residents, assistance, etc)
- 6. Equipment?

- I. Post-op orders/Pathways?
- 2. Communication with PACU/ ICU?
- 3. Communication within Surgical Team?
- 4. Communication with Consultants?
- 5. Recognition of Adverse Events?
- 6. Treatment of Adverse Events?
- 7. Discharge Instructions?
- 8. Appropriateness of Follow-up care?





Only 22% of M&M leads could articulate mechanism for change

The Joint Commission Journal on Quality and Patient Safety

Volume 43, Issue 1, January 2017, Pages 5-15

Processes for Identifying and Reviewing Adverse Events and Near Misses at an Academic Medical Center





Bottom Lines

- Go beyond simply identifying issues ... suggest possible solutions
- Prepare a brief "bottom line" as the last slide
- Ideally bottom lines are reviewed at a quality committee or by the M&M champion





Dept. of Emergency Medicine

M&M Rounds

BOTTOM LINE

March 2013



Case 1:

- Consider writing out a legible consult note with specific clinical question for every referral you make (for both inpatient/outpatient)
- Remember to provide timely treatment(s) such as antibiotics for referred patients, instead of waiting for consultants to initiate

Action Items:

- Bring forward to QPS/CPC as discussion item re: policy around (mandatory?) filling out consult forms when referring patients +/- mechanism for requesting consultants to touch base with EP after their assessment/plan

Case 2:

- Recognize that Offload Area contains a high-risk population, often mistakenly considered "being taken care of" when necessary care is actually delayed
- Vitals are vital! Remember tympanic temperatures can be highly variable and inaccurate.
- Emergency Physicians (EPs) often not actively made aware of sick patients in different areas of the ER; EPs should consider taking initiative in seeking out sick patients in high-risk geographic areas

Action Items:

- ED flow and surge workgroup to consider protocol for utilizing open beds in Resus/ Emergent for patients triaged to Obs that are stuck in Offload
- Bring forward to QPS/CPC issue of possibly setting "critical lab" cutoffs for CK/ Troponins









Table. Conference Age Topic	nda and Logisti	cs for Quality	Improvement Morbidity and Mortality Conference Brief Description
Introduction	Facilitator	3-5 min	Introduce the conference, describe the agenda, review ground rules and expectations for the conference, emphasizing a culture of safety.
Case narrative	Resident	5-10 min	Chronological description of the events of the case as determined from chart review and interviews.
Process map	Resident	2 min	Concise review of case in the form of a process map.
Systems theory	Facilitator	1-2 min	Brief introduction and review of systems theory.
Quality improvement teaching point	Facilitator	5-7 min	Quality improvement teaching point chosen by facilitator that is relevant to the case being discussed.
Fishbone activity	Facilitator	10-12 min	Review concept of fishbone, then lead interactive discussion of factors that contributed to this error.
Completed fishbone	Resident	1-2 min	Resident displays the completed fishbone and discusses any points not yet covered in the group discussion.
Literature review	Resident	5-7 min	Topic chosen by resident that pertains to error being discussed or possible action plans.
Action plans	Both	7-10 min	Brief review of ranking error-reduction strategies, followed by interactive discussion of proposed action plans as well as suggested plans from audience.
Conclusion	Resident	1-2 min	Brief review of important aspects of case, factors contributing to error, and proposed actions.







STEP 3: Open up the Room

STEP 2: Provide Structure

STEP 1: Define Goal



Open up the Room



• Make rounds multidisc plinary / inter-professional

















Case Examples



Sabrina Natarajan Pharmacist

snatarajan@toh.c a



Kindra Lewis Social Worker

kinlewis@toh.c a





The Ottawa Hospital Social Work Department & M&M Rounds

Kindra Lewis RSW/MSW





Social Work Department



The Ottawa Hospital has over 100 Social Worker (MSW) working at 4 campuses and 3 off- site offices locations.



Most social workers are involved in complex cases daily, yet there is limited collaboration



The idea of case review for our department, began with need for Emergency Department social workers to collaborate, due to limited support and schedules





Why in the Social Work Department?

 THE GOAL: Creating a blamefree environment where each individual in the group feels safe to openly discuss ways to improve quality of care and patient safety

- Limited opportunities within social work to review cases
- There are increasing complexities to address
- More opportunities for feedback and growth





• Enthusiasm and Engagement from the Team • Professional Growth from completing a case analysis What went • Feedback: well... • "I used to go home after a case was difficult and feel shame that maybe I could have done something differently, now I will present these cases and use it as a learning opportunity"











Future Direction Incorporate M&M Rounds into The Ottawa Hospital, Social Work Departments, Clinical Practice Rounds. Two case analysis every quarter.

Began to collaborate with other teams and disciplines for more in depth learning opportunities and interdisciplinary collaboration







STEP 4: Build Processes

STEP 3: Open up the Room

STEP 2: Provide Structure

STEP 1: Define Goal



Hospital Enabling Factors







QUALITY COMMITTEE



M&M and QUALITY = FUNDING







Legislation

Quality of Care Information Protection Act, 2016

The Quality of Care Information Protection Act, 2016 (QCIPA) allows health professionals to have open discussions about critical incidents involving patient care and quality improvement matters in general. The goal of QCIPA is to create a safe space for health professionals to talk openly about quality improvement, including the potential cause of any critical incidents, without fear that the information will be used against them.

QCIPA applies to hospitals, independent health facilities, long-term care homes, licensed medical laboratories and specimen collection centres.

The first version of QCIPA came into force in 2004 (QCIPA, 2004). In July 2014, the Minister of Health and Long-Ferm Care initiated a review of QCIPA to identify areas for improvement. Health Quality Ontario convened a review committee and the committee gave its recommendations to the minister in December 2014. To respond to the committee's recommendations, the minister put forward legislation to repeal QCIPA, 2004 and replace it with QCIPA, 2016. The legislation was passed by the legislature and QCIPA, 2016 came into force on July 1, 2017.

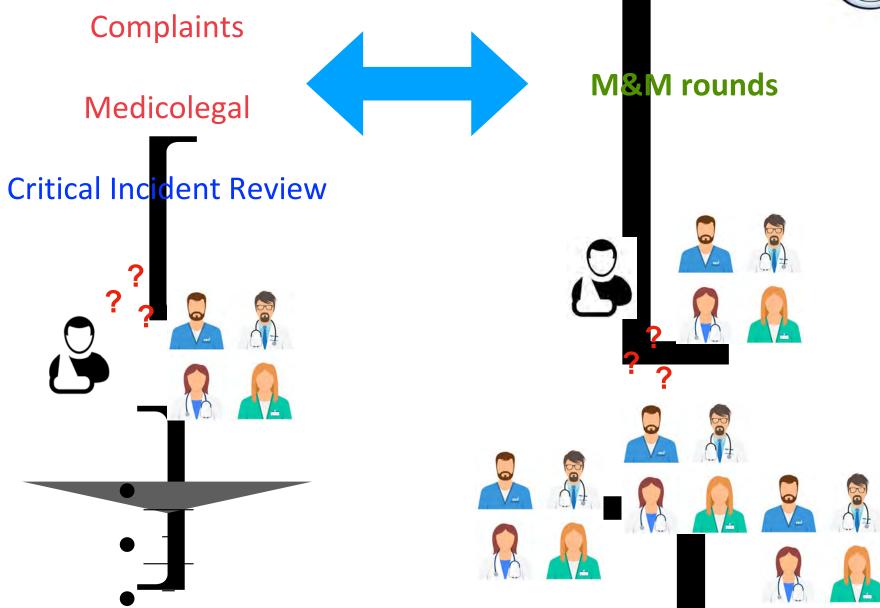
QCIPA, 2016 enables health care providers to have protected quality improvement discussions to help improve patient safety while still ensuring that patients and their authorized representatives have access to the facts about a critical incident. QCIPA, 2016 increases transparency and maintains quality in Ontario's health care system by:

- · Affirming the rights of patients to access information about their own health care
- Clarifying that facts about critical incidents cannot be withheld from affected patients and their families
- Requiring the Minister of Health and Long-Term Care to review QCIPA every five years

http://www.health.gov.on.ca/en/common/legislation/qcipa













STEP 5: Review & Sustain

STEP 4: Build Processes

STEP 3: Open up the Room

STEP 2: Provide Structure

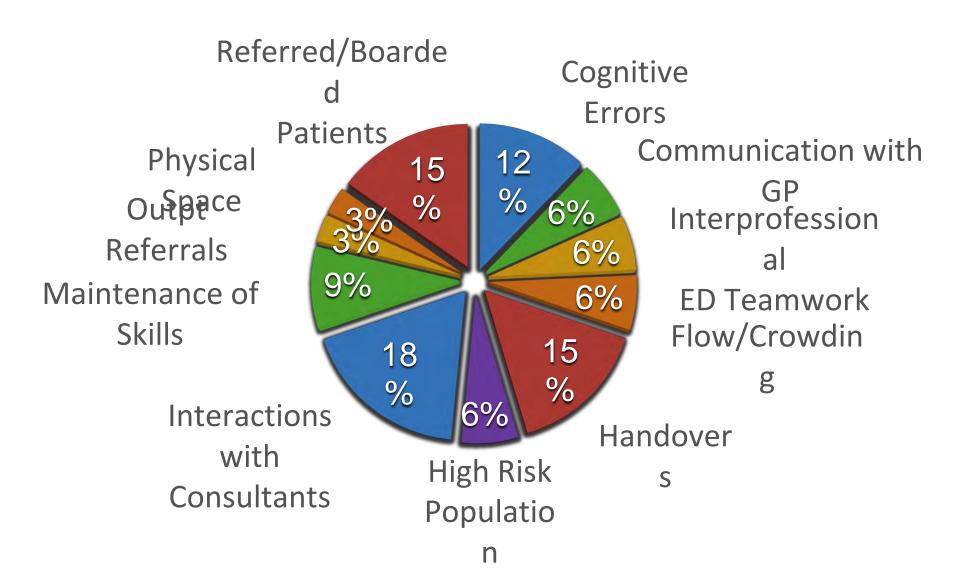
STEP 1: Define Goal





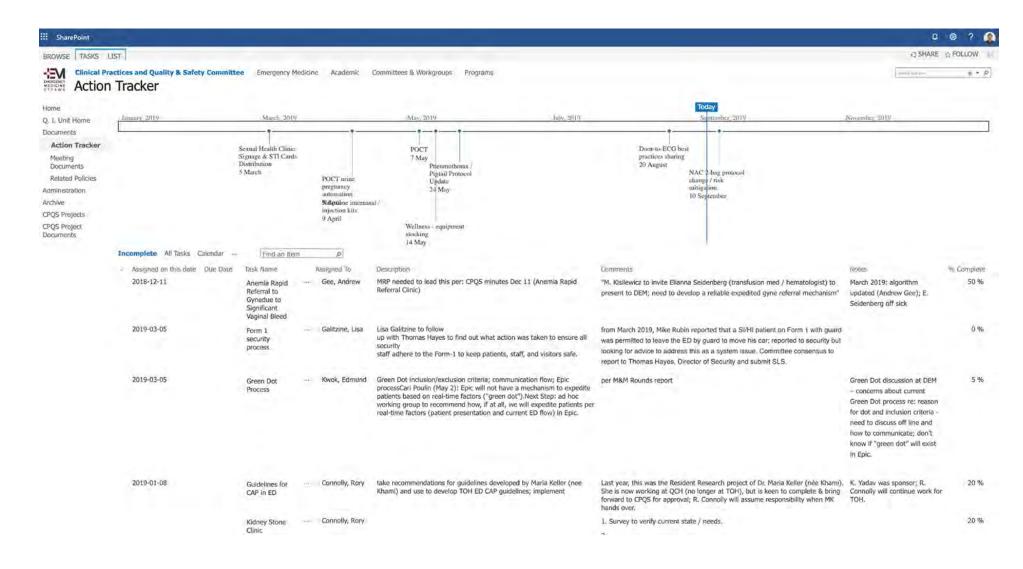
Date	Presenter	Case Summary	Cognitive Issues	System Issues	Recommendations
Sept 8th 2016		27F trauma/shooting victim of partner/sexual abuse. Multiple previous ED visits without SATC being flagged despite CC related to physical abuse, fear for safety etc	•fundamental attribution (blame the patient) •triage cueing •training/knowledge gap of frontline providers •hesitancy in entering D/ C diagnosis that reflects abuse	*patient confidentiality in the ED, especially on large Whiteboards *triage and CTAS modification *triage screening *inter-campus transfers and related logistical challenges	*Remove unnecessary Whiteboards, explore mechanisms to remove/ alter names on Whiteboard *consistent screening at triage and green-dot *review ED "Lockdown" procedures
Nov 3rd 2016		30's M with multiple issues followed by multiple services (Resp, Thromb, Psych). Multiple ER visits for SOB, non-compliance, and ?somatic complaints.	over-reliance on outpatient specialist follow up just because a service "signs off" doesn't mean no issues	 each specialist only views through their own lens lack of a central service/ provider to coordinate care (esp no GP) 	*consider highlighting these patients for "case conference" specific for the ED
		31M fell playing soccer. Severe pain. X-rays normal but in oath F/U found to have compartment and loss of common perineal nerve	*falsely reassured by normal X-rays *anchoring to "just a sports med injury" *fundamental attribution error, ie. "man up, soccer player!"	*triage cueing, U.C. *lack of access to consultants, esp no Ortho after 11pm to get clinical opinion *prompt outpatient F/U is critical *end of shift, picking up "easy ones"	*remember to use Stryker compartment measurement *consider CK in pain out of proportion *re-explore ability to consult Ortho after hours
Dec 1st 2016		50F with CP and hiatal hernia. Seen in UC, tender upper abdom, and US NEG. RTER with incarcerated hiatal hernia requiring paraesophageal hernia repair	knowledge gap around entity triage biased acuity level zebra retreat	*lack of ability to take a "diagnostic pause", too busy, too many interruptions	•consider rare entities when appropriate •lower threshold for using CT vs X-rays
		68M with low back pain seen in UC. Abnormal near finding L1/2, CT prelim normal, pt discharge home. Correct radiology report suggest mod/severe narrowing L1/2, but cant reach patient RTER with	•wrong assumption of "no red flags" - L1 uncommon! •yin-yang out (on 2nd visit, felt everything's	•prelim reports with final corrections •gowning patients for proper exam in UC •access to MRI vs CT	•explore our QA process with radiology •be wary of "red flags" in back pain •avoid feeling barriers to

Major Themes

















No more chicken scratch – new form improves patient safety

atients often leave the Emergency Department with a piece of paper listing (in often-illegible handwriting) some of the diagnostic tests, lab results and specialty consultations they received. Their family doctors may or may not get the paper, so follow-up care can be spotty.

"All this illegible chicken scratch is a patient safety issue," said Dr. Shawn Mondoux, an Emergency Medicine resident in the Civic and General EDs. "We regularly get notes from family physicians saying 'You have to do a better job'."

Dr. Mondoux led the six-month development of a new form that began in March to be automatically faxed to family doctors – patients can't lose it. The form includes a standardized list of tests, results, consultations, medication changes, when the patient should be seen again and more.

"it's the Cole's Notes (or SparkNotes) of what happened in the ED," said Dr. Mondoux, who surveyed 40 family physicians and consulted with 75 ED doctors and 50 residents. "The benefit to patients: we should have a more direct line to the family physicians, who will have a much better idea of what's happened in the ED."

During the first two weeks, about 400 forms (completed by 51 staff physicians) were faxed to family doctors. Some staff members completed the forms 35 times, and will provide valuable feedback to make improvements.





CAEP 2016: Research Poster

TOHAMO: \$20,000 grant

HQT 2017: Panelist, Poster Award







CAEP 2016: Top Moderated Posters









STEP 5: Review & Sustain

STEP 4: Build Processes

STEP 3: Open up the Room

STEP 2: Provide Structure

STEP 1: Define Goal

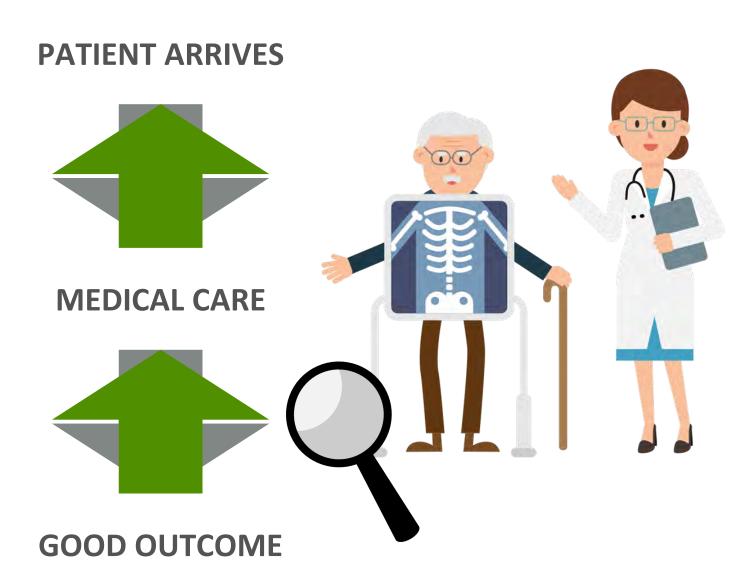
















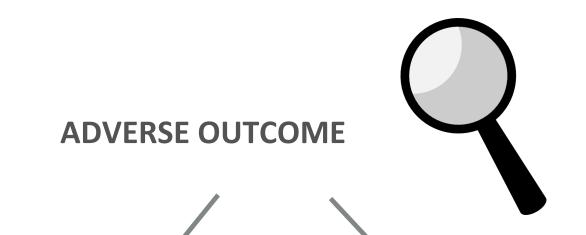
W&W the Ottawa M&M Model:

"What Works"

A Guide to Holding Morbidity & Mortality Rounds

>95% of those surveyed reported learning/incorporating something new







PROSPECTIVE

Screening

Trigger Tools

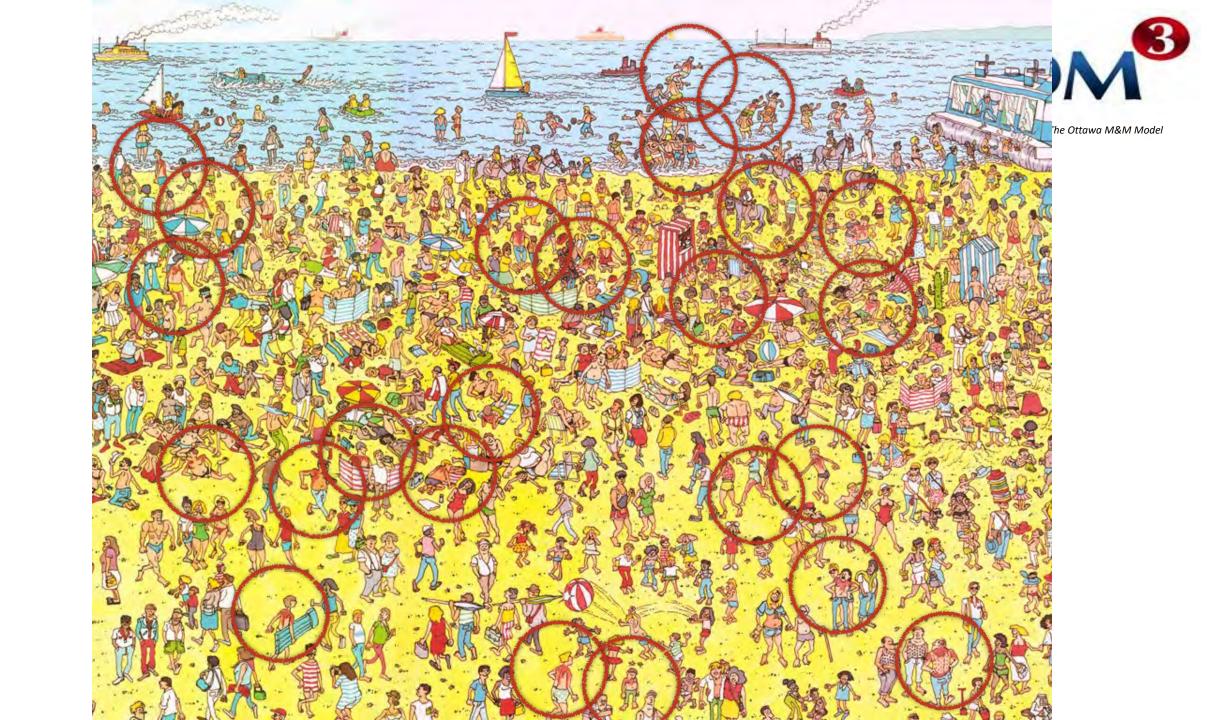
RETROSPECTIVE

Complaints

Medicolegal

M&M rounds

Random Review







ORIGINAL ARTICLE

J Patient Saf • Volume 00, Number 00, Month 2016

Development of an Emergency Department Trigger Tool Using a Systematic Search and Modified Delphi Process

Richard Thomas Griffey, MD, MPH, FACEP,* Ryan M. Schneider, ACNP-BC,* Lee M. Adler, MD,†
Roberta Capp, MD,‡ Christopher R. Carpenter, MD, MSc,* Brenna M. Farmer, MD,§
Kathyrn Y. Groner, MD,// Sheridan Hodkins, RN, MSN,‡ Craig A. McCammon, PharmD, BCPS,¶
Jonathan T. Powell, MD,// Jonathan E. Sather, MD,** Jeremiah D. Schuur, MD, MHS,††
Marc J. Shapiro, MD,** Brian R. Sharp, MD,‡‡ Arjun K. Venkatesh, MD, MBA,**
Marie C. Vrablik, MD,§§ and Jennifer L. Wiler, MD, MBA‡

ORIGINAL ARTICLE

J Patient Saf • Volume 00, Number 00, Month 2018

Multicenter Test of an Emergency Department Trigger Tool for Detecting Adverse Events

Richard T. Griffey, MD, MPH, * Ryan M. Schneider, ACNP, * Brian R. Sharp, MD, † Jeff Pothof, MD, † Marie C. Vrablik, MD, MCR, † Nic Granzella, MD, † Alexandre A. Todorov, PhD, § and Lee Adler, DO//





Patient Involvement





BRIEF REPORT: Hospitalized Patients' Attitudes About and Participation in Error Prevention

Amy D. Waterman, PhD,¹ Thomas H. Gallagher, MD,² Jane Garbutt, MB, ChB,¹ Brian M. Waterman, MPH,³ Victoria Fraser, MD,¹ Thomas E. Burroughs, PhD⁴

¹Washington University School of Medicine, St. Louis, MO, USA; ²University of Washington, General Internal Medicine, Seattle, WA, USA; ³Waterman Research Solutions, St. Louis, MO, USA; ⁴Center for Outcomes Research, Salus Center, St. Louis University, St. Louis, MO, USA.

J GEN INTERN MED 2006; 21:367-370.

2078 patients surveyed

91% thought they could help prevent medical errors in hospitals

98% thought hospitals should educate patients in this regard



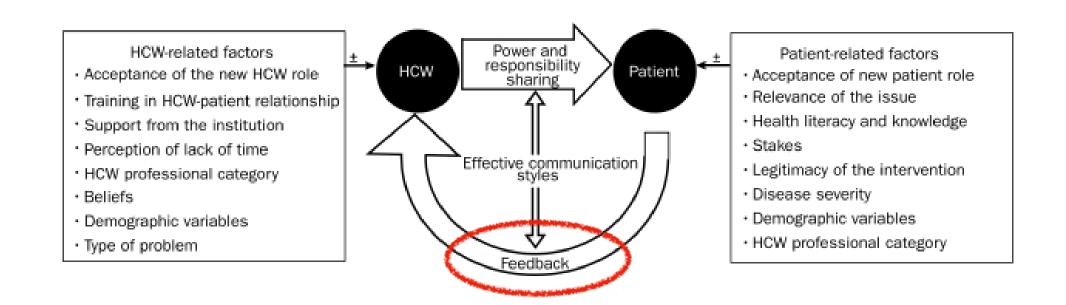


Mayo Clin Proc. 2010;85(1):53-62

SPECIAL ARTICLE

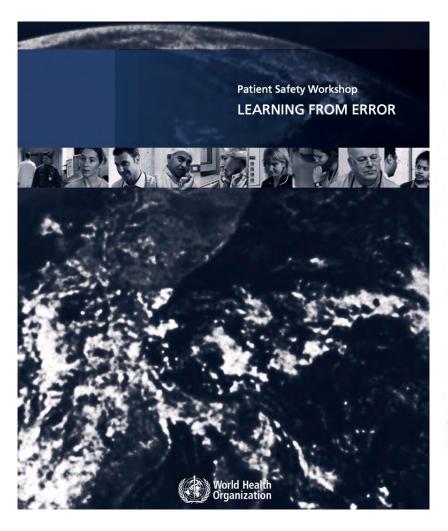
Patient Participation: Current Knowledge and Applicability to Patient Safety

YVES LONGTIN, MD; HUGO SAX, MD; LUCIAN L. LEAPE, MD; SUSAN E. SHERIDAN, MBA; LIAM DONALDSON, MD; AND DIDIER PITTET, MD, MS









Sharing patients' experiences with health-care workers in training encourages a culture where patients are valued and their active participation in the decisions about their treatment is the normal practice. Patients' own stories of unsafe care are an important source of information and insight and can be used effectively to better understand the causes of error and the devastation that can follow.

Barriers to patient participation

Patients are often reluctant to participate because they feel unauthorised to do so.











Please complete the

EDAC 2019 PROGRAM EVALUATION

www.sremi.ca/evaluation