#QS18 – Transformation through Innovation Abstracts

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A JOURNEY OF 1000 MILES BEGINS HERE!   BUILDING A COALITION TO LEAD IMPROVEMENTS IN QUALITY AND SAFETY EDUCATION IN ALBERTA

The IDEA: Healthcare safety and quality outcomes matter to patients and families in our care system! Why? The Canadian Adverse Events Study has shown that adverse events in our healthcare system occur in 7.5% of hospital admissions, accounting for significant patient harm and excess healthcare costs. In Alberta, the rate of patient safety incidents in 2015-16 was 14%. Clearly a greater emphasis on care systems and processes is critically needed.Education in healthcare quality and safety (HQS) improvement has been shown to reduce errors and improve outcomes. Currently, there are only two Masters programs in Eastern Canada. With regard to offerings in Alberta, several education and training programs that promote facets of HQS are spread throughout the province, yet they are not well integrated with each other.

The JOURNEY: In order to identify provincial education needs and better integrate existing HQS training/education, the need to engage multi-disciplinary stakeholders from across the province in a 'gap analysis' of HQS education is essential.Our project brought together over two dozen stakeholders from across the province and included representation from major universities, professional associations, the provincial healthcare system, and healthcare professionals including physicians, nurses, EMS, allied health, HQS experts, and patient/family representatives.

The IMPACT: Over the course of a 1-day meeting and 1-1 interviews, we succeeded in identifying the common 'gaps' in Alberta HQS education, the overarching education need, and the vision for what HQS education in Alberta could be. We then wrote a white paper derived from the coalition's input that both provided a means by which these provincial voices could be heard and creates a compelling case for new HQS education to be developed pan-provincially.

LESSONS LEARNED: Coalition team building and consensus gathering around a common need has succeeded in laying a foundation for HQS education in Alberta. Greater synergy and collaboration in HQS education in Alberta will optimally generate a platform for further in-depth dialogue on developing a more comprehensive education program in quality improvement and patient safety and ultimately, improve health outcomes for all Albertans.

Alberta Health Services

A MATRIX FOR THE SPINE PATIENT POPULATION; MANAGING DEMAND THROUGH INNOVATION

The demand for spine beds at Foothills Medical Centre (FMC) is approximately 30 patients per day, whereas the spine unit (101) only has 19 beds. Most capacity discussions had centered around more beds for unit 101 and/or decreasing the demand. However, with no budget for increased resources and a long wait-list for spine surgery, the spine team needed to look at other methods to ensure the best care was delivered to their patients. Given the complexity of spine surgery, it is often quite difficult to determine which patients should have priority placement on unit 101 on a consistent basis. The stakeholders identified were surgeons, nurse practitioners, site managers, inpatient unit managers, educators, nurse clinicians, staff nurses, and allied health.The improvement initiative selected was a spine matrix as a decision making tool. This document was implemented November 7, 2016. It is a living document that changes based on increased capacity from partner units. Changes are made through stakeholder communication, with the provision of real-time feedback and course corrections when necessary. A survey was sent out the stakeholders after a year of implementation. The majority of survey respondents that the matrix improved the flow at FMC (100%), decreased transfers (97%), ensured that the right patient was placed in the right care area (93%), enabled the staff to become competent in care (94%), and helped avoid placing a patient in a care area unprepared (97%). A consequence of the matrix was an increase in length of stay (LOS) from a mean 3.4 to 4.2 days. With no changes to the nursing model on unit 101, LOS and acuity should be reviewed to ensure that the unit 101 funding and worked hours are matched within the context for the 'new' patient population. It was difficult to formally evaluate this improvement initiative as the measurement of spine patients being on the right unit the first time is not well understood. Potential metrics would be non-101 unit spine patient LOS; the number of transfers per patient; which units were transferring patients and to where; the reasons for transfers, and patient outcome data.

Alberta Health Services

ADAPTING COGNITIVE TASK ANALYSIS TO PRIMARY CARE: A TRANSFORMATION THROUGH INNOVATION

Changing health care means going out to see what people who work in and use the health care system need. Having the right people at the table from the start is important. To do this, the EnACt team (University of Alberta) and Improvement Advisors from Toward Optimized Practice (TOP, Alberta Medical Association), have been the first to adapt a type of research called Cognitive Task Analysis (CTA) to primary care. CTA digs deeper into how people really do their work, rather than how they think they do their work. Using this new approach, we were able to find real, practical solutions that health care teams can use to improve patient care. Connecting with Primary Care Networks, researchers, and the Patient & Community Engagement Research program, we used CTA to gather local evidence in primary care. We found the issues brought to us were different from what was happening, and what solutions were needed. The following examples highlight our findings. 1) A national organization believed over ordering tests for low back pain was because physicians weren't aware of the rules, our findings showed other reasons were pressuring physicians to over order; 2) A research team wanted to create a risk calculator for knee osteoarthritis but physicians/patients wanted an app that would assist with communication and self-management; 3) Discovering how care teams manage change differently helped find customized practical solutions and supports; and 4) Knowing the characteristics of someone who can inspire change allows us to look for those traits when choosing people to help bring about change.Using CTA and keeping it practical led to an overall impact of real, practical solutions that could be used. Talking to the people who are doing the work, and including patients allows us to question 'are we building practices and systems that suit their needs, not just ours?' Our next step is to create a CTA training program designed for a range of experienced health care workers and researchers so we can bring about change by engaging and understanding those who work in and use the health care system.

AIW LEADERSHIP SYSTEM IMPLEMENTATION AND CAPACITY INCREASE AT THE STRATHCONA COMMUNITY HOSPITAL

By the implementation of the AIW Leardership System we accomplished not just an increase of 25% number of ambulatory care appointments but also increased staff and patient satisfaction

Alberta Health Services

AN INNOVATIVE WAY TO MEET THE NEEDS OF PATIENTS SUFFERING FROM MS FATIGUE.

YOUR IDEA:Up to 95% of people who have Multiple Sclerosis (MS) experience fatigue. Forty percent of people who have fatigue report that it is their most debilitating symptom. Because of this, the OPTIMUS (Out-Patient in Treatment for MS) Program at Foothills Medical Centre receives many referrals to provide intervention to patients whose fatigue limits their activities of daily living.In our multidisciplinary program, each discipline addresses fatigue from their own lens, and thus a large amount of clinic time is spent addressing fatigue directly or indirectly.In 2016, the team discussed that a MS Fatigue Group should be created to: address clinic efficiencies provide innovative ways to meet patient needs; increase therapists' time for patients who require individualized service; reduce redundancy of information provided by therapists, and received by patients; build an informal support for patients; reduce patient wait times.

SHARE YOUR JOURNEYWe looked at the National MS Society's, Fatigue: Take Control as a resource to develop our 7-session Fatigue Group, which is tailored to tackle the effects of fatigue from all angles.Once developed, we recruited the MS Clinic to advertise. OPTIMUS also promoted the group through discussions when meeting with patients, and we received positive feedback about the proposed group. We had no issues with recruitment.

POTENTIAL or ACTUAL IMPACTIn 2017, the group went live! Data collected showed promising results in patient satisfaction. The feedback from the patient experience survey regarding the Fatigue Group was positive showing that the group was valued and helpful. Significant pre-post differences were found for fatigue and depression. The Fatigue Group has assisted patients to access OPTIMUS services quicker, and receive comprehensive care for their debilitating symptoms.

LESSONS LEARNEDBased on therapist and patient feedback, each session of Fatigue Group has been refined to better meet patient needs. Lessons learned were: how to identify appropriate group members using Telehealth to other sites in Alberta;the need for more time to discuss and learn from other group members would be beneficial; a need for education regarding MS fatigue for families, co-workers and friends.

Alberta Health Services

ASSESSING THE CURRENT STATE OF PATIENT SAFETY TO INFORM FUTURE STRATEGY

In 2017, AHS refreshed its patient safety strategy with a focus on becoming a 'High Reliability Organization' (HRO). HROs operate in complex systems without catastrophic failures. To become a HRO, AHS needs to understand the current state of patient harm and patient safety activities in the organization, and measure these against future states. Led by a working group of quality and safety stakeholders and a patient representative, a current state assessment was completed to understand the current burden of patient harm and patient safety activities in AHS. Patient harm was measured according to frequency, severity, and trends in patient safety data sources. Patient safety activities were measured by structured interviews with a sample of quality and safety leaders. Key findings and lessons learned include:(1) The top three areas of harm were suicide, incomplete / inadequate treatment, and wrong site for a procedure /treatment/intervention (2) Our understanding of patient harm is limited to what is currently measured in disparate data sources . (3) There is a lot of patient safety activity in AHS. The top three reported activities involve safety culture (95%), patient and family engagement (91%), and collaborative practice (89%). Interviewees reported an average of 26 activities, and much activity is not coordinated provincially.(4) There is limited reported measurement of the impact of patient safety activity. Specifically, 35% of reported patient safety activity had 'anecdotal' or 'no' measurement.The current state assessment findings led to several recommendations for the AHS patient safety strategy:(1) Develop a patient safety measurement framework(2) Gain a better understanding of the linkage between specific types of harm and patient safety activities.(3) Increase resources and tools to proactively mitigate patient safety risks(4) Continue improving patient safety culture(5) Improve coordination efforts and improve shared learnings within and outside of AHSIn the short term, the future strategy will provide the basis for identifying specific tactics to transform AHS into one of the safest healthcare systems in Canada. Longer term, the strategy charts the course for AHS to become a HRO.

Alberta Health Services

AUTISM, SURGERY AND A ROBOTSUPPORTING CHILDREN WITH AUTISM SPECTRUM DISORDER (ASD) SCHEDULED FOR SURGERY WITH HELP FROM MEDI ROBOT.

IDEA: Imagine a child with autism, arriving in a busy surgical unit, challenging the healthcare team to think outside the box, change the way a standard surgical day looks and ask a robot for some extra support. These are all little pieces of a puzzle we have been working on in Child Life at the Alberta Children's Hospital. How could we help support families on surgery day when it is often difficult for them to even get their child to walk through the front doors of the hospital? What could we do differently and how could we help make the day less stressful for both families and the health care team?

JOURNEY: Our initial goal for this project was to better engage with families and create a collaborative approach to minimize stress and unnecessary stimulation for the child and family with the aim to provide a safe and positive hospital visit. We developed a communication tool that is used to gather information about the unique needs of each child and share it with everyone involved before the child arrives at the hospital. Then we asked that same team to 'throw out the rule book' consider reducing the wait time, not checking their blood pressure or even allowing Child Life to bring a robot into the operating room with coping strategies.

IMPACT: Both families and the health care team have realized the impact of this initiative. Families recognize we are listening and making changes to address the unique needs of their child. The Surgical team is better prepared, having more successful interactions with these children, and avoiding triggers that escalate anxiety related behaviors.

LESSSONS: Although unexpected changes are impossible to predict, eliminating some of the more obvious challenges for a child with ASD can increase the chances of a successful visit to the operating room for both the patient and provider. Accepting that things may never be perfect and convincing the team that small changes can have great impact is an ongoing challenge. Adding a robot to the mix demands we are prepared for unexpected technical issues and staff wariness.

Alberta Health Services

BARIATRIC FRIENDLY HOSPITAL INITIATIVE: IMPROVING CARE FOR PATIENTS LIVING WITH OBESITY.

In Alberta, 35% of hospitalized patients are living with obesity and are staying in hospital approximately two times longer. Patients with obesity in health care settings are at significantly higher risk for injury and complications due to inadequate facility design, equipment, and/or staff competencies in their care. Creating a bariatric friendly hospital that addresses these issues will reduce risk, increase safety, decrease stigma, and improve patient experience.Building on previous research findings on bariatric care in acute care settings, the Diabetes, Obesity and Nutrition Strategic Clinical Network partnered with the Medicine Hat Regional Hospital (MHRH), the University of Alberta Faculty of Rehabilitation Medicine, the Canadian Obesity Network and patient advisors to identify and address gaps in care for hospital patients living with obesity. Using a novel approach capturing input from staff and patients across all inpatient units and departments, the patient's journey from initial contact through discharge from MHRH was mapped in detail. The mapping exercise identified bariatric care gaps and enablers across the care continuum and highlighted that bariatric care begin with EMS transportation to hospital. This map informed the subsequent development of standards and guidelines for appropriate and safe bariatric care in the hospital setting. These standards will support health care providers to work effectively and compassionately with patients with obesity; develop competencies in patient and staff safety; and delineate processes for patient transitions between hospital units and across care settings.Aligned with AHS Patient First and Our People Strategies that promote patient and family-centered care and empowering staff; care pathways will be designed that address the health care needs of patients with obesity and resources will be developed to increase health professional knowledge on the complexity of obesity and risk of weight bias. Next steps involve: development of staff educational modules to improve staff knowledge and competencies on appropriate and safe bariatric care; and identify processes and actions required to implement bariatric care standards at a demonstration site (e.g. MHRH) to inform requirements for future implementation at all Alberta hospitals.

Alberta Health Services

BETTER TOGETHER: NEW WAYS OF IMPROVING AND INNOVATING IN CENTRAL ZONE

As Einstein said 'The definition of insanity is doing the same thing over and over again and expecting different results'. With new Technology and a rapidly changing, increasingly complex healthcare system we knew we needed to try something different. Design Thinking, Sprints, Human Centered Design, Scrums and Liberating Structures looks to change that, and the IQM team in Central Zone is embracing these styles of working and are on an innovative journey. With support and inspiration from the AHS Design Lab we jumped in with both feet. We gained support from our zone senior leaders to create an inspiring IQM team space. We have been connecting with like-minded innovative individuals inside and outside of AHS. We joined the world of Twitter. There is a lot of power in social media connection, especially in this type of work. Opportunities that we have taken to try our new way of working include:Improving Dementia Care in the Community with the Senior's SCN. Using Human Centered Design with a mix of Liberating Structures we were able to organize 120 people to come up with 8 amazing ideas on improving the care we deliver. A zone physician leader with a small background on Sprints suggested we completely change how we provide Cardiac Rehab. A design day was created using ideologies from IDEO's human centered design, we started with empathy. We then pushed the team members, from RNs, OT, PT, physicians and a patient advisor to begin illustrating how they would deliver cardiac rehab to patients within Central Zone. Physician Innovation: It was not innovative from the ideas to the application process. Physicians would sit down at a desk and fill out a long boring written proposal, submit it, and wait to hear if they were selected to receive funding. This year we opted for a 'Dragon's Den' style pitch event. We ended up with 14 innovative proposals and more collaborative process.Innovation and Design days are a blend of attendees feeling engaged with both the process and the outcomes, as well as achieve innovative, groundbreaking solutions to system issues within healthcare.

BREAKING THE NEWS PROPERLY: USING PHYSICIAN REPORT CARDS TO FACILITATE SURGEON/NSQIP ENGAGEMENT

The implementation of NSQIP in 2015 at a 625 bed medical and surgical hospital, has been focused on benchmarking surgical outcomes at a surgical specialty level.The NSQIP team recognized the need to share data at a surgeon level to foster awareness, facilitate engagement, and improve specific surgeon outcomes. Therefore a strategy to develop individual surgeon report cards was established and is unique to the sites NSQIP program.The 2016 NSQIP surgical cases captured at the site provided sufficient data to identify areas for improvement when stratified down to a surgeon level. A working group consisting of the NSQIP site champions, site physicians and the SCR developed a template to report post-operative occurrences at a physician specific level, site specialty specific level, collaborative specialty specific level and NSQIP specialty specific level.Physicians with 25 cases or greater, over a one year period, were included in this initial report distribution. Forty-five Physician reports, using the agreed upon template, were prepared by the SCR and sent confidentially to each surgeon. They also received a description of the data elements and NSQIP variables for reference. Ongoing feedback from surgeons will be valuable to help evolve the reporting tool to meet their needs.The NSQIP physician report cards represent the evolution of the use of NSQIP data to serve as the foundation for continual quality improvement. It is hoped this will lead to an increased level of physician engagement, increased quality of patient care, and a tool to track individual surgical outcomes going forward.

BREAKING THE RULES FOR BETTER CARE: AN AHS EXECUTIVE EDUCATION ACTION LEARNING PROJECT TEAM JOURNEY

Ever wonder what would happen if you could 'break the rules' to enhance patient care? AHS Executives endorsed an Action and Learning Project as part of the AHS Executive Education program in 2018 to explore what happens when we ask staff and clinicians. Sometimes we inadvertently create or follow processes or ways of working that prevent us from delivering optimal care to Albertans. Building on the work done by the Institute for Health Care Improvement, we will show how we applied the 'Breaking the Rules for Better Care' campaign within AHS.

The aim of this project was to challenge staff to view the existing system through a new lens, to start to understand the barriers that may inhibit the best patient care and enhanced experience, and create a culture of empowerment of frontline staff.

Leaders from the Peter Lougheed Hospital Emergency Department-Mental Health Program area and the Northern Lights Health Centre came forward to test this idea. With the assistance of the AHS Design Lab, front-line staff and leaders at each site came together to design the campaign at their sites. They helped identify best ways to engage all staff and encourage open participation for this campaign. Each site then launched efforts to solicit input from staff, helped identify which rules could be eliminated, adjusted and/or clarified. The ALP group helped connect both sites to the Design team directly when rules emerged from design sessions that needed work immediately to ensure momentum with this project.

This project embraces the principle of empowerment. These efforts will be tough, but inspiring, insightful and one step closer to transforming Alberta Health Services.Aim: Create a space/tool/process for leaders to empower frontline employees to make decisions within their direct sphere of influence that can be replicated across the system

Methodology:

1.   Focus group/co-design
2.   Initiate campaign
3.   Make change/co-design
4.   Evaluate

At time of submission this group is currently in the co-design process with both sites. If selected, a full description of lessons learned including an evaluation summary and understanding of what protocol or processes would be put in place within AHS by October.

Alberta Health Services

BRINGING THE PATIENT VOICE TO LIFE AND ACTION AT ROCKYVIEW HOSPITAL

In 2016 our group of six individual Patient Advisor at Rockyview General Hospital came together. Collectively we have a diverse experience, a desire to contribute, and a passion to improve our health care system. Since forming, the team has worked to define the role, build trust, get a seat and be heard at decision making forums. Our mission is to bring the voice of the patient to where the work of the hospital is being done and decisions are made. By participating on various committees, unit councils, working groups and other forums, we present a balance to a system or medical perspective by adding the patient perspective. 2017 was a year of letting people know who we are, gaining acceptance and learning ways to influence in an effort to contribute to the goals of Rockyview to enhance the patient and family focus and creating exceptional patient experiences. The concept of ensuring the patient has a voice is transformational. We have found that many within the health care system reflect the systems or medical perspective of care and don't think about how the patient experiences the numerous and varied interactions involved along the way - from diagnosis, admission, treatment and discharge. We would like to speak about our journey; how we ensure the patient's voice is heard (what matters to patients matters to us); where we have been able to contribute, our learnings, what has worked, as well as other opportunities we see going forward. Examples of what we would discuss would be: gathering input via patient rounding/interviews, participation on committees (Management Retreat, PFCC, Heart Failure, Elder Friendly, Ethics, etc.) and our involvement with various medical units, department, and quality improvement projects. Our goal is to bring recognition to our collective activities as they are frequently a beginning and can precipitate and inform significant opportunities for Quality Improvement initiatives. Secondly, we hope that this exposure will increase the awareness of the benefits for areas that want to hear 'the voice of the patient'.

Alberta Health Services

BUILDING ORGANIZATIONAL CAPACITY FOR CLINICAL QUALITY IMPROVEMENT IN AN INTEGRATED ACADEMIC AND LARGE HEALTH SYSTEM

INTRODUCTION: University of Alberta (U of A) Department of Medicine (DoM) and Alberta Health Services (AHS) Zone Medicine Program had overlapping strategic priorities to develop a clinical quality improvement agenda and improve outcomes for medicine patients in the Edmonton Zone (EZ). As a result, the EZ Medicine Quality Council-Strategic Clinical Improvement Committee (SCIC) was formed (2016) in alignment with the DoM strategic plan and the AHS quality management framework (QMF) supported by a DoM funded strategic clinical improvement consultant.   The primary mandate of the SCIC is to build organizational capacity for clinical quality improvement (CQI) within the DoM at the U of A and within the EZ Medicine Programs at five Hospitals.

METHODS: Analysis of the strengths, weaknesses, opportunities and threats including an environmental scan was undertaken. Revealing key strengths and opportunities within both organizations that could be leveraged in a collaborative approach to move joint agendas forward. Formation of the SCIC committee enabled forming key partnerships across the U of A and AHS to support the committee's QI activities.

RESULTS:SCIC meets monthly with a 75% attendance rate of its 40 active Physician members who are recognized as CQI leads within their divisions/sections and sites. DoM individual sections and site business meetings are expected to include a CQI updates from SCIC representatives. Collaboration of AHS- EPIQ (Evidenced-based Practice of Improving Quality) accredited physician quality improvement educational stream has trained over 280 physicians, residents, students and AHS leaders. Educational workshops are planned to take place every 2-3 months. 2017, 15 QI projects were completed and showcased at the first annual AHS-UA QI collaborative day on Oct 13, 2017 with over 175 attendees. 2018, 22 QI projects either underway, scoped or pending directly linked with SCIC. SCIC has secured over $150,000 in funding to complete these projects. In addition, a complex (3-year) DoM CQI project related to centralized triage and referral management is ongoing with nearly 65% completion.

CONCLUSIONS: This project outlines an innovative approach to building organizational capacity for CQI within an academic department by building partnerships and engaging various stakeholders at key strategic points.

CHASING HEALTH EQUITY: TARGETED HEALTHY BEGINNINGS VISITS

Public Health in the North Zone was largely treating new families with equality as opposed to addressing health equity. Public Health Nurses spend more than 5,400 hours per year doing Healthy Beginnings Visits. The idea was to look at moving from a system where all families with a new baby get a home visit to one where the program uses a scalable response based on client needs and social determinants of health. We looked at other provinces such as British Columbia, Ontario, and Nova Scotia and identified that the targeted system seemed to be working well for them. We also performed a literature review and identified multiple outcomes that had been studied and realized that for the general population, the home visit had little impact on those outcomes. This supported the idea that providing services on a sliding scale from phone visit only to multiple home visits made sense.We designed a system using tools from other provinces and then brought it to all managers and the staff in 3 Public Health Centres who would be involved in testing it. We had designed a pilot project to measure the impact of the pilot process on the client and on the staff. We tested the system by doing the standard method in May 2017 and the new method in June 2017. In total 256 infants and 252 mothers were included in the test.The system worked as designed. There were cost savings related to decreased travel and less clinician time per client being used. After pulling 30 days of follow-up data for the moms and babies we found no statistically significant difference in preventable ER visit rate or admissions or Health Link calls for babies. We found no significant difference in ER visits or admissions for mothers.Everything went greatâ€¦ except we forgot to engage the front line staff early in the process. They weren't happy with the tools or the process. We are now working on developing a tool and process they are comfortable with and testing again with more robust change management in place.

Alberta Health Services

COMPLEX CARE CLINIC FOR GENERAL NEUROLOGY PATIENTS WITH COMPLEX NEUROLOGICAL CONDITIONS

Our Idea: Transforming care for complex general neurology (GN) patients through a patient centered multidisciplinary team approach in a way that has never been done in GN clinics before.

Share Your Journey: In 2012 when South Health Campus opened in Calgary there was a culture of finding innovative ways to deliver care. Patients in GN clinic often have complex medical issues with multidisciplinary care needs. As the treating team we quickly realized the inefficiencies of the system we were working in. There was a requirement for patients to travel to the hospital repeatedly for their many multidisciplinary care provider appointments. We began brainstorming amongst ourselves and with our patients how to make the process more patient focused, efficient, and effective which lead to the development of the Complex Care Clinic.

Potential or Actual Impact: Patients with complex neurological conditions, most predominantly Parkinsonian syndromes, are now able to have their needs met in a 'one stop shop' environment. The entire multidisciplinary team is able to see these patients and their families in one clinic visit. Physiotherapy, Occupational therapy, nursing, neurologist, speech language pathology, and social work services are offered at each clinic visit with the opportunity to refer to additional services (eg, pharmacy) if required. Sharing of outcomes on the clinic day allows for care plans to be made quickly and for services to be coordinated in their delivery. Sharing of knowledge and learning's amongst team members has helped with a continuous learning environment that transcends GN clinics and into other patient populations for all care providers involved helping to improve the care provider experience.

Lessons Learned: The journey to our current Complex Care Clinic structure and environment has involved much learning, failures, and successes. We had to learn to prioritize which disciplines will have the most impact for patients and their families. Our pre appointment team huddle allows us to optimize efficiency and ensure that all aspects of care are addressed. We have adopted a culture of ongoing learning and openness through an informal Plan-Do-Study-Act (PDSA) cycle approach allowing us to continually improve. Testimonials from patients have been exuberant!

Alberta Health Services

CONSERVATIVE KIDNEY MANAGEMENT: QUALITY IMPROVEMENT AND PATIENT ENGAGEMENT USING TECHNOLOGY AND SOCIAL MEDIA WITH AN ELDERLY POPULATION

Patients over 75 years are the most rapidly growing group starting dialysis. However, for older patients who have higher levels of co-morbidity and poorer functional status, there may be no survival or quality of life advantage to dialysis. These patients tend to experience functional and cognitive decline after starting dialysis. The last months of their lives are often characterized by high rates of hospitalization, ICU admissions, and intensive procedures. In contrast, frail, elderly patients with multiple co-morbidities treated conservatively (no dialysis) may preserve their functional status, maintain a better overall quality of life, and have fewer hospital admissions. Conservative Kidney Management (CKM) is a treatment option for certain patients with category 5 chronic kidney disease (CKD) that emphasizes active symptom management and advance care planning. It includes interventions to delay the progression of kidney disease, but it does not include dialysis. Funded by Alberta Innovates through a PRIHS grant, the Kidney Supportive Care Research Group launched a provincial CKM pathway in September 2016 to improve and standardize care for CKM patients. It was successfully piloted by 4 outpatient kidney clinics in Northern and Central Alberta. We developed and implemented a 'mobile first', interactive clinical pathway and patient decision aid tool (www.CKMcare.com) to empower patients, families and clinicians with individualized care plans and facilitate shared decision-making. We also use social media to engage patients, families and clinicians.The project involved stakeholders from across Alberta including across the continuum of care, patients and families. An IHI Collaborative model and a balanced scorecard was used to track performance and target improvement over 14 months. Quantitative and qualitative data were collected across the 6 dimensions of quality and early results show that the pathway is empowering patients to make informed decisions about their care, improving access to information and resources, reducing symptom burden, and preserving physical function and quality of life. The project has won multiple awards, featured at an AHS Innovation Market Fair, placed 1st in the CIHR Rewarding Success business development competition, and has been awarded another CIHR grant to expand the program to Alberta primary care, and develop a national toolkit.

Alberta Health Services

CREATING A PATIENT-CENTRED MINDSET IN GROUP EDUCATION DESIGN

We believe that patient-centred care is important. However, across our healthcare system we do not have a common understanding of how to provide care that is truly patient-centred. One area where we struggle with this is group education sessions. Our challenge was to create a process that makes it easy for providers to be patient-centred in designing and delivering group education and to establish a partnership with patients. We believe that by following our process, patients can make informed decisions about their health and be more likely to take action to improve their lives. By request, we created the HealthChangeGroup Application Workshop. The goal of this workshop was to 1) give providers a clear process to embed patient-centred care into the design and delivery of group education, and 2) model to the providers how this looks and sounds in practice (aka, we walked the talk). To make this workshop very practical, we asked each provider attending to come prepared to modify or develop their own group education program.   We have delivered this workshop twice, and provided 3-month follow up support. Our biggest success is that everyone who attended the workshop has used the course content to change how their group education is delivered. Providers told us they notice 'more discussion and interaction with patients,' 'feel more energized running the group [education], and feel a partnership with the patients.' Providers highlighted some challenges: 1) lack of support from colleagues to make changes, 2) creating consistent practice across providers leading group education, 3) involving patients in the group design process, and 4) assessing the impact for patients. The success stories from providers attending our workshop, the high level of engagement from the providers, and continued interest from a variety of programs/providers to attend our workshop gives us an indication that our workshop is valuable. As next steps, we intend to involve patients in our process, both in a patient advisor role to look at the design of group education and as part of an evaluation to tell us their experience in a revised group education session.

Alberta Health Services

CREATING HEALTH EQUITY IN CANCER SCREENING (CHECS) PROGRAM

Idea Despite efforts to increase cancer screening, participation rates are below performance targets for Alberta Health Services' Screening Programs. In order to reach provincial targets, there is a need to better understand socioeconomic, demographic, and spatial barriers to cancer screening. This pilot program uses a health equity lens to develop a systematic approach to identify underscreened communities in Calgary and to collaborate with stakeholders to develop community tailored interventions to increase breast, cervical, and/or colorectal cancer screening.

Journey: This program uses a community engagement approach and consists of three phases. The first phase includes developing a systematic approach to identify target communities in Calgary using the Pampalon Index. The Pampalon Index quantifies material and social deprivation factors, which are useful in health services and delivery planning. A partnership with AHS Research and Innovation was established to conduct the data analysis. The second phase consists of community engagement, utilizing best practices from the International Association of Public Participation (IAP2). Robust engagement plans will be developed in partnership with community organizations and healthcare providers working with underserved communities. Multi-sectoral evidenced-based interventions will be identified for implementation. Phase three will focus on implementation and evaluation of collaborative interventions, carried out in target communities.

Potential or Actual Impact: The CHECS program has conducted a data analysis to measure the influence of social and material deprivation factors on cancer screening, which has helped to identify target communities. Overall, areas with higher material and social deprivation have slightly lower screening rates, confirming our initial assumptions. The program has engaged key stakeholders in Calgary to begin program planning. If successful, this approach will be used across Alberta to identify tailored interventions that could inform and drive equitable cancer screening services.

Lessons LearnedThe Pampalon Index helps affirm the anecdotal observations often made by community stakeholders who are eager to help their communities. With this tool, Screening Programs can evaluate interventions for impact on cancer screening for underserved communities and assess feasibility to expand this approach across Alberta. The evaluation framework will be developed with stakeholders, using a common set of evaluation criteria.

Alberta Health Services

DEVELOPING AND SPREADING A BIG IDEA

Our Idea:Our Big Idea, was to spread the concept of the Health Home, a different way of delivering healthcare in Alberta. In just five â€" 1 hour sessions we developed and spread this idea to our provincial primary healthcare team, and beyond. Our process for developing a Big Idea has the potential to help teams build upon concepts, inspire uptake, and spread new ideas across organizations.

Share your Journey:Our approach influenced teams outwards and upwards. We used a variety of tools, focusing on the why, what and how of the Big Idea, to develop our concept and strategies for spread. This resulted in the creation of resources such as our sales pitch and our process for developing and spreading a Big Idea. Once our team refined the concept and developed resources we reached out to other teams, formally and informally, to share our idea with them.

Potential or Actual Impact:We have shown how innovation can start at the front-line and organically spread excitement to others from all levels of the organization so that the concept continues to grow and evolve. Our Big Idea moved beyond the people we directly connected with, was refined and shared back with us â€" beyond our expectations. We believe that our idea has been embraced so fully that it is now influencing strategic planning on our team. As a next test we would like to spread our process for others to apply and refine it in their practice and share with us what worked and did not work for them.

Lessons Learned:We believed that our process worked well; however, we learned that we need to be flexible and at times modify our approach on the fly. Some of the challenges we faced were: keeping our team engaged; being resilient; and welcoming all feedback whether positive or negative. However, the constructive feedback we received helped us consider opportunities and threats we faced and improved the likelihood that our Big Idea would be adopted and spread.

Alberta Health Services

DEVELOPING PATIENT-ORIENTED MIGRAINE EDUCATIONAL MATERIAL

Background: Written migraine educational material has a positive effect on patient outcomes. At the Calgary Headache Assessment and Management Program (CHAMP) there is a lack of migraine patient handouts to provide to patients. The use of patient-oriented research to engage patients as partners can improve patient understanding and satisfaction with care.

Purpose: This study proposes a patient-oriented approach to develop migraine patient handouts to capture topics that are valued by patients and clinicians and to measure patient and clinician-directed outcomes following implementation.

Method: This qualitative study will use participatory action methodology through the creation of an advisory team (CHAMP clinicians, allied health members and patients). Surveys will be developed and distributed to all CHAMP clinicians and approximately 20% of the CHAMP migraine population. Clinician surveys will also address potential enablers and barriers to implementation so these can be addressed early. From the surveys, the advisory team will develop patient handouts displaying information valued by patients and clinicians. Ongoing feedback through interviews and surveys will be conducted as well as a usability test to ensure accessibility. Once handouts are completed, phase two of the study will examine implementation and evaluation of patient and clinician-directed outcomes.

Conclusion: By codesigning migraine educational material with patients and clinicians and distributing them at initial migraine assessments at the CHAMP clinic, we suspect there will be an increase in patient understanding, satisfaction and engagement in care.

DISCHARGE PLANNING QUALITY IMPROVEMENT PROJECT (DPQIP) HELPS TO SHORTEN HOSPITAL STAY

Assessment of length of NICU stay is commonly used as a basic index of health economics. This data is confounded by multiple internal and external factors.After targeted literature search using EMBASE, MEDLINE and PubMed databases, 22 articles related to readiness for discharge and length of hospital stay in preterm infants, including guidelines on discharge of preterm/high-risk neonates (AAP and CPS guidelines), instruments for assessment of infant morbidity/mortality risk, predictors of length of stay, and other reports/assessments of criteria for discharge. This search identified two types of factors influencing reediness for discharge: physical factors (sustained weight gain, oral feeding to support growth, ability to maintain normal body temperature in an open crib, cardiorespiratory stability) and non-physical factors (eg, parental readiness, home environment, local health care policies/services).When physical factors are difficult to change, non-physical factors could be easily modified. Judicious review of the routine practice of discharge preparation may provide with valuable information about possible ways to improve this process. So far, there is no uniform written policy regarding discharge planning for preterm infantsObjective:This quality improvement project aims to assess current standards of discharge preparation and identify if proposed new algorithm will be more efficient than existing practice. Standardized protocol will help to avoid unnecessary delays, decrease time stressors for personnel, decrease health costs to the system, and improve parental satisfaction.

Methods - Phase 1.A. In pre-intervention phase, current discharge preparation will be assessed by special questionnaire.B. Intervention algorithm: 1. On admission: include expected length of stay in admission notes 2. Discuss expected length of stay during the first meeting with parents 3. Discuss disposition in the daily round starting from 35 weeks of CGA and weight of 1.7 kg or 1.25 kg (stable ELGA)4. Start parental teaching from 36 weeks of CGA5. Discharge examination 24 Hours pre-discharge 6. Medications/ prescriptions within 24 Hours pre-discharge 7. Discharge complete checklist Phase 2 In post-intervention phase, readiness for discharge will be assessed by using the same measurable as in phase 1. We hope that proposed algorithm will help improve parental readiness for discharge, minimize the time required for completion of discharge documents. As a result, we expect to

DO WE MEASURE UP?

Allied Health departments are eager to identify and implement practice and process improvements. So eager, that the previous year there had been 27 goals for an Acute Care Allied Health Department. The lesson learned was simple: 27 goals is too many goals. To move forward in a meaningful way it was identified that a Quality Management Framework needed to be developed to determine the priorities, projects, and gaps to move the department forward and ensure practices and processes were meeting the needs of patients and staff. Establishing a Quality Management Framework (QMF) creates a foundation to understand how clinical and supporting processes interrelate and to identify the indicators that ensure patients are provided with safe quality care. Supporting processes include staff focus, patient/family involvement, knowledge management, leadership development, and patient safety.Initial engagement was with the Allied Health Manager to sponsor the QMF followed by Allied Health Discipline Clinical Leaders. To develop the QMF, the stakeholders were brought together on several occasions over several months to define the processes, identify missing components, and to choose the key performance indicators. Group sessions were facilitated to create space for innovation, challenge the status quo, and to inspire consensus building.Creating a QMF for an Allied Health Department proved challenging in many ways. The QMF needed to encompass all of the AH disciplines, teams, as well as the areas and patient populations served by the department. One of the challenges was figuring out a way to make the QMF easy to understand by frontline staff to support understanding and engagement. To achieve this, an infographic design was created, after many iterations, to show how all the pieces fit together from supporting and clinical processes, through to serving Albertans. Having a QMF will support the creation of an Allied Health Department strategic plan, including goals for the department, in addition to the ability to measure, monitor, and report on performance of the department over time. The QMF promotes accountability, and answers the question, do we measure up?

EARLY EFFECTS OF A PATIENT PORTAL ON PATIENT SATISFACTION AND HEALTH SYSTEM USAGE

Introduction: Despite good evidence that Canadians want self-access to their health information, and proven benefits of Patient Portals (PP) in other jurisdictions, the ability to access health information, manage appointments, or securely message care providers is still uncommon. Web-based and mobile PP use is expected to rapidly expand in the future. We report early experience with over 2500 patients using a PP called eCLINICIAN MyChart (MyChart) tethered to an Electronic Medical Record called eCLINICIAN (Epic systems corporation) being used in the Edmonton Zone of Alberta Health Services.

Development: Allowing patient access to MyChart required extensive policy work and multi-disciplinary engagement. Current features include: viewing laboratory and diagnostic imaging reports self-scheduling and management of appointments, pre-visit questionnaires, tracking blood pressure and glucose, secure messaging, proxy access for family members (e.g. a child's results), immunizations and health summaries. Since February 2016, over 2500 patients have accessed MyChart, with a high degree of usability and general satisfaction: 96% of respondents said MyChart was easy to use, 83% answered it made communication more convenient. Users of MyChart had fewer missed or no-show appointments. Over 1,102,779 visits using the eCLINICIAN Electronic Medical Record, the baseline no-show rate in clinics not using MyChart was 12.7% (range: 12.0%-13.7%). Amongst MyChart users there were 12,436 visits and a no-show rate of 7.4% (range: 5.7%-8.7%), a 42% relative reduction.

Conclusion: Early experience with an EMR-tethered PP showed good usability and patient satisfaction, and decreased no-show rates for appointments. Implications on the expanded use of PPs for medical professionalism require more study in Alberta Health Services.

Alberta Health Services

EDMONTON ZONE, DEPARTMENT OF MEDICINE ACCESS PARTNERSHIP PROJECT (APP)

BACKGROUND: The Edmonton Zone Medicine Strategic Clinical Improvement Committee (SCIC) was formed as a collaboration between the Department of Medicine (DoM) and Alberta Health Services (AHS) Medicine Operations as a Medicine EZ Quality Council. One of the major priorities of the SCIC is to work toward optimizing referral access and central triaging for patients and care providers in order to improve care delivery. The foundation for this work is built on the AHS Level 1 policy (approved September 3, 2013) Wait Time Measurement, Management and Reporting of Scheduled Health Services.

METHODS: Project was segmented into 5 phases. Phase 1 involved the development of draft referral guidelines for 12 sub-specialties that will be uploaded into the Alberta Referral Directory (ARD) with links to the appropriate physician profiles. The goal is to standardize the process of referral for specialists and primary care physicians and decrease the number of incomplete and inappropriate referrals. Phase 2 and 3 incorporated the use of quality improvement methodology to develop and analyze the current referral processes, close gaps, develop a future state process and develop a referral source engagement strategy. The aforementioned supported the development of an action plan and streamlined referral measurement to reflect similar operational processes within all divisions of the DoM.

RESULTS: 12 of 12 divisions have completed a current state analysis which identified one future state referral process resulting in: The development of 65 of standard operating procedures that incorporate existing IT scheduling system and salient referral management practices. The Support of 100% of divisions submitting completed referral guidelines with access targets to the Alberta Referral Directory. 75% of the divisions are actively improving processes to increase patient access and reduce wait times. The engagement and leadership of physicians to standardize triage, scheduling and patient outcome communication.

CONCLUSIONS: Referral management standardization for the 12 Divisions within the DoM has be achieved. Standardized referral processes identified require further refinements and integration with the new clinical information system to be completed within each individual division prior to the development of a DoM centralized access and triage referral process which is the ultimate Phase 5 goal.

EDUCATING SEXUAL HEALTH CHAMPIONS IN ONCOLOGY

Background: Sexual health has been a topic that many staff express as a gap in their professional knowledge and, therefore, specialized services are often sought. To improve the availability of sexual health resources, we proposed to facilitate oncology-specific sexual health care training to a geographically dispersed and multidisciplinary group of oncology health care providers. Goals included improving knowledge of front-line staff, and expanding a network for the delivery of sexual health care to patients.

The Journey: Key stakeholders in this quality improvement project were the AHS Quality Improvement program which provided grant funding, and partners at the De Souza Institute who coordinated courses in Sexual Health in Oncology specifically for Albertan participants.We also engaged with the AHS Director of Professional Practice and Education for support. The opportunity to apply for this training was communicated widely through Cancer Control Alberta.ImpactA full complement of multidisciplinary oncology health care professionals enrolled in Sexual Health in Cancer virtual courses. Geographical representation included tertiary, regional, and community cancer centres throughout the province. Disciplines included: Radiation therapy/oncology, Social Work, Rehabilitation Medicine, Nursing, Psychology, and Pharmacy.

The results surpassed expectations with respect to the willingness of the participants to champion sexual health care as part of their current scope of practice. In addition to supporting patient education modules by telehealth, participants have created new local initiatives, and aided many patients in obtaining sexual health information, education, and support directly. Furthermore, an ongoing Community of Practice has emerged for sexual health care in oncology.LessonsA significant challenge was coordinating and completing a sexual health quality improvement project without dedicated time, personnel, or funding for sexual health in oncology. The original proposal had specified a role for a sexual health consultant, but no funding was acquired for such a position.

The keys to success of the project have been staff who have stepped up as champions for sexual health care in oncology.

Our next steps are to support the momentum of the community of practice for sexual health in oncology, and to share knowledge and resources through a virtual list-serve.

EMPOWERING PATIENTS (AND THEIR FAMILIES) AS PARTNERS IN DECISION-MAKING IN THE CONTEXT OF SERIOUS ILLNESS

Background: Recent studies continue to describe significant deficiencies in the quality and quantity of communication and decision-making during serious illness. A root cause analysis documented that doctors and nurses infrequently engage in such conversations with seriously ill patients and families because, they believe, the patients and families are ill-prepared to have such conversations. Rather than wait for clinicians to engage in this topic with their patients, we developed a patient- (and family-) centered decision-support intervention to help patients clarify their authentic values, educate them regarding the different treatment options available in the context of serious illness, and give them to tools to approach their doctor to engage in a 'Goals of Care Designation' conversation.

Methods: We reviewed the literature and conducted several one-on-one interviews and focus groups with health care professionals, patients, and their family members to develop and revise the content for a novel decision aid. Subsequently, we evaluated the final version to assess the feasibility, acceptability and clinical sensibility from the perspective of lay patient advisors.

Results: Initial versions of the decision aid were iteratively piloted and revised with input from 23 patients in a primary care clinic in Lethbridge, Alberta. Forty-two health care professionals provided additional feedback that improved the clarity and comprehensiveness of the decision aid. Eighteen lay people participated in the evaluation of the subsequent version. Overall, on a scale of 1=poor and 5=very good, participants rated the tool a median of 5 (range 3-5). The majority found the language clear and understandable, that it was easy to work through, felt the amount of information was 'just right', and thought the decision aid would be very helpful to patients with serious illness. When asked if they would use it if recommended by their doctor, the median response was 'definitely would use it.' In addition, the majority also responded that they would recommend it to others.

Conclusions: This novel decision aid seems to be acceptable to lay persons and has the potential to aid patients (and their families) to engage primary care clinicians in goals of care conversations. Further evaluation in the clinical context is warranted.

ENGAGEMENT OF PHYSICIANS AND IMPROVEMENT OF PATIENT EXPERIENCE IN MEDICAL ASSISTANCE IN DYING

Medical Assistance in Dying (MAID) is an end of life option for Canadians. AHS MAID Care Coordination Service (CCS) teams serve as point of contact for patients, families, and health care teams, and recruit physicians to assess eligibility and administer MAID.

Questions:

1. Why do south zone physicians decline to participate in MAID? 9 physicians provided 29 MAID provisions in 2016-17. There is a belief that many physicians may object due to religious / moral reasons, but perhaps other potentially modifiable factors are contributing (inexperience, emotional burdensomeness, medicolegal concerns, time constraints)

2. Is patient/family experience different if MAID is provided by a patient's own family physician or other known physician versus a physician met for the first time on date of provision? It seems that having a familiar face would improve experience, but does it? Should we be encouraging specialization of a small number of providers who travel to patients, or supporting many physicians to be involved with a small number of their own patients?

Methods: Surveys will be sent to physicians who have had a patient request MAID and have declined to participate. The survey will examine the reason(s) for declining to participate, including religious/moral objection and other intrinsic and extrinsic factors.Semi-structured interviews will be completed with family members regarding overall experience, and perceived impact on patient and family of the providing doctor being the patient's family physician versus meeting for the first time at MAID provision.

Preliminary Results:7 family member interviews have been completed to date. 1 patient had MAID provided by her family physician and her daughter felt it impacted the experience positively; 'I think she felt quite comfortable having him there; 6 patients had MAID provided by a previously unknown physician and none felt this impacted the experience; 'I don't think he cared one wit who was doing it'.Implications:The results of the physician survey will determine what types of resources would be expected to increase the number of physicians willing to participate in MAID. The family interviews will help develop strategy on physician recruitment and improve patient and family experience.

Alberta Health Services

EXOSKELETAL ROBOTIC WALKING GETS PATIENTS BACK ON THEIR FEET AT FOOTHILLS MEDICAL CENTRE

Idea: To implement Exoskeletal Assisted Walking (EAW) as an adjunctive therapy for patients with neurological conditions at Foothills Medical Center. EAW is the use of a robotic, external orthosis to allow patients with spinal cord injury, brain injury and stroke to stand and walk. To date no prior use or established protocol exists for EAW in the Calgary zone. Standard gait training therapies exhibit limitations including resource intensiveness (multiple staff required) and safety considerations for patients/staff.

Share your journey: An Ekso GT Exoskeleton was generously donated through Calgary Health Trust. A working group was established to develop a protocol for clinical implementation of the device. Demonstrations of Exoskeleton provided onsite to engage staff and patients with use of device.

Telehealth conferences with external Canadian sites who had established use of EAW including Edmonton Glenrose Rehabilitation Hospital and London Parkwood Institute. Series of meetings with several drafts of protocols.

Working group consulted physicians, allied health management, rehabilitation therapists and patients/existing users of Exoskeleton. Dissemination of protocol to occupational therapy, physiotherapy, physicians, recreation therapy and speech language pathology.Exoskeleton used prior to protocol development and anticipate to trial full protocol by May 2018.

Potential or actual impact: EAW offers the opportunity to provide intensive, over ground, real world walking that previously was not available. EAW offers full physical support to the patient reducing stress and strain on therapists with the potential impact to reduce staff injuries. Patients are able to walk further, longer and more frequently with low levels of exertion to patients and therapists. Exoskeleton users have reported psychological benefits, improvements in gait, endurance and emotional well-being.

Lessons learned: Anticipate challenges with respect to equitable use of EAW among patients. There are aspects of the protocol to specifically address this. Adding to current physiotherapy workloads was prohibitive, so a system was designed to offload exoskeleton trained physiotherapists.A future plan was identified to train additional staff. We believe we can achieve improved mobility and health outcomes for patients, reduction in staff injury and improved efficiency/effectiveness of physiotherapy interventions.

Alberta Health Services

EXPLORING HOME AUTOMATION TECHNOLOGY IN THE HOSPITAL SETTING TO PREPARE PATIENTS FOR INDEPENDENCE AT HOME

Your Idea: We have been working with individuals at Foothills Medical Centre with spinal cord injuries who have limited upper extremity function resulting in decreased independence. This population is dependent on others to do things as simple as change the channel. We want to provide education to patients so they can make informed decisions about home modifications that will increase their independence; we let patients trial wheelchairs, so why not this technology? Our project has focused on allowing patients to trial home automation equipment in hospital to decide what will work for them at home.

Share your Journey: With a grant from Craig H. Nielsen, we purchased a control hub, tablets, fans, mounting equipment, and access switches. The technology interfaces with the hospital TVs, elevators, and anything else that has a remote control. We have collaborated with current and past patients, Allied Health and nursing staff, AHS IT, community partners (i.e., ALS Society), vendors (i.e., Home Medical Solutions). Together, we have researched and trialed different options and worked through barriers. We are working with patients along their journey through the ICU, the acute care units, and the neuro-rehabilitation unit.

Potential or Actual Impact: We have received positive responses from patients and staff. One patient noted 'I'm so happy that I don't have to call my nurse for something as small as changing the channel. I have some control over what I want to do.' Patients and their families are figuring it out faster than we are, finding new tools and ways to use the technology. Our goal is to increase independence, which leads to better quality of life, improvements in mood, engagement in rehabilitation, and better long term outcomes!

Lessons Learned:Some challenges identified include not having enough mounting options and unreliable internet access. We will continue researching, connecting with vendors, and working with IT to find solutions. Our next steps include:- Purchasing more equipment to increase accessibility and functionality- Expanding to brain injury and stroke populations- Educating staff and developing resources so staff can work with patients without the project lead

Alberta Health Services

FALLING THROUGH THE CRACKS: BUILDING THE CASE FOR ENHANCED HEALTHCARE TEAMWORK RESULTING IN BETTER PATIENT/FAMILY OUTCOMES

The Idea: When patients experience breaks in their continuity of care, bad things happen. A stunning film was developed about Greg Price's experiences of discontinuity in his care and its tragic ending. To use a film about a patient's journey through the healthcare system to transform the way people in healthcare think and how they act is a unique and innovative way to respond to an adverse event.

The Journey:Producing a film that allows the audience to know the protagonist of the story and to experience the profound sense of loss that his family went through is a daunting project to successfully achieve. An engaged team of award winning film producers, writers and director, in combination with a very insightful family and a group of healthcare providers and educators allowed us to develop a shared vision to use that experience to inspire positive change in the health system.

Impact:The initial screening of the film was with first year medical students; it had a profound impact on them. This highlighted that the film was special in many ways and that it has applications not only for education but also to inspire the desire for change in all audience members regardless of how they were associated with the health system. The film is currently being screened for different types of audiences and facilitation guides are being written in order to develop teamwork skills for care providers and for patients and family members so they can become more effective team players on their own healthcare team.

Lessons Learned: While it is challenging to use healthcare tragedies to transform the way people think, this is what this film accomplishes. The film does not point fingers; it challenges people to think about how healthcare is structured and what we all can do to improve patients' continuity of care.The film has and will continue to inspire a desire for change in how healthcare is delivered and how care providers might serve as champions of this change. It will also provide an opportunity for patients to learn the important parts of teamwork to make their own healthcare journeys more reliable and less likely to end poorly.

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FUNCTIONAL NEUROLOGICAL DISORDERS WORKING GROUP/CLINIC FOR PATIENTS IN THE NEUROLOGY CLINICS AT SOUTH HEALTH CAMPUS, CALGARY

Your idea:Providing an interdisciplinary intensive treatment program for adults with Functional Neurological Disorders which currently does not exist in Alberta. The clinic would help quickly diagnose, assess readiness for treatment, educate and rehabilitate Albertans with somatization disorders. Currently there is no formal treatment program for the 30% of adult neurological patients who have this disorder.

Share your Journey:The working group began in December 2017 after a physiotherapist returned from a Functional Movement Disorders conference where successful multidisciplinary team rehabilitation approaches were shared. Recognizing the potential for developing a similar team at South Health Campus due to access to neurology and Allied Health, the working group has begun mapping out the process to develop a Functional Neurological Disorders Clinic.

Potential or Actual Impact:Patients with Functional Neurological Disorders represent 30% of all patients seen in neurology clinics. This large population to date has not had access to comprehensive rehabilitation. By providing the appropriate care for patients we hope to decrease the burden on the health care system by decreasing emergency department visits and reducing unnecessary referrals for both diagnostic imaging and specialists.

Lessons Learned:As this area of practice is largely unknown and no similar program exists in our area, it is predicted there may be some potential challenges stemming from hesitancy or acceptance of this program in the early stages. To help mediate this risk the goal will be to educate staff, patients and their families about the intentions of this program. Furthermore, as there is limited research to specifically describe treatment interventions and parameters for treating Functional Neurological Disorders, we acknowledge that our proposed methods will likely require ongoing modifications and adaptations throughout our program development phase.

GETTING TO 1+1=3: DECREASED COGNITION + INCREASED AGGRESSION SHOULD NOT EQUAL UNTREATED PAIN

Traditional pain assessments rely on verbal reporting to describe pain in continuing care residents with moderate to severe dementia. Our team is encouraging a radical shift in thinking to transform the patient experience. By proposing a common communication platform for discussing pain amongst care providers, we will improve the quality of life for continuing care residents with dementia. Using a common language supports staff to accurately represent the experience of pain for residents with dementia, and helps continuing care teams advocate for appropriate pain management. Dementia is a cognitive and emotional burden on residents and their families. Failing to recognize and appropriately manage their pain adds unnecessary physical suffering to an already vulnerable population. This journey began in 2017 when we noticed a trend in reported serious harm incidents of resident-to-resident aggression. A review of the literature indicated that a primary contributing factor to resident-to-resident aggression is undertreated pain, which is difficult to assess in residents with moderate to severe dementia. We then reviewed Calgary zone data, which showed that as residents' level of cognitive impairment increases, incidence of aggressive behaviour increases; yet pain scores decline. Taken together, this information suggests that pain in continuing care residents with advanced dementia exists, but may be poorly recognized and treated. Consultation with key stakeholders, including physicians and operational leaders, uncovered a gap in communication between nursing and physicians related to describing the pain experience of residents with dementia. Namely, the severity of pain, its quality, and other factors which would inform treatment options can be difficult to obtain due to the resident's limited ability to self-report.Currently our innovative idea is to spark the conversation around accurately capturing the patient experience of pain. One of the lessons learned to date was to effectively present the issue to appeal to a variety of stakeholders with competing interests. We were able to reframe the conversation to fit the priorities of each, resulting in improved engagement. We would love to see this conversation grow at the 2018 Quality Summit.

Alberta Health Services

HOW DO YOU KEEP PATIENTS SAFE? : MOVING AHS TOWARDS A PROACTIVE PATIENT SAFETY MODEL

The aviation and nuclear industry have long had bragging rights for being 'High reliability organizations' (HROs). Provincial Patient Safety has boldly asserted that AHS can also achieve this status, and has set us on this direction with the new AHS Patient Safety Strategy. While drafting this strategy, Provincial Patient Safety felt it was imperative to connect with the frontlines to understand how they achieve safety in their everyday work. We hypothesized that there were already pockets of high reliability behaviors living on the frontlines.   We just had to find them. So we set out on a road trip across the province, with a coffee cart, to ask 800 individuals in diverse roles, 'How do YOU keep patients safe?'Very few had difficulty answering. Even a locksmith had a line of sight to how he helped keep patients safe. The majority gave us responses that echoed policies and accreditation standards (essentially doing what they are told to do). However, as hypothesized, some were clearly practicing HRO behaviors.When we set out with our coffee cart, we really didn't know what we would find. We just had to have faith that our outreach would result in something of value to inform the AHS Patient Safety Strategy. It wasn't until analyzing our data that we realized we had struck gold. It became clear that our greatest resource as an organization to achieve HRO status is our own people.   Despite being patient safety experts, we could never have advised the proactive practices we heard about (i.e. a protective services staff who rock climbs with adolescent mental health patients because it's easier to de-escalate a situation if he has a rapport with the patients). Facilitated empathy mapping with patient advisors also helped us understand what make patients feel safe in our care.From this work, the branding of the AHS strategy was born, 'Everyday HeRO', defined as an individual who exhibits high reliability behaviors in their everyday work.   These stories will be incorporated into our communication plan to help everyone understand 'high reliability', and inspire others to be bold innovators, proactively keeping our patients safe.

Alberta Health Services

IMPROVING DECISION-MAKING IN GAIT ANALYSIS: USING OPEN-SOURCED SOFTWARE TO MODEL MUSCLES DURING WALKING

Background: Use of gait analysis to make clinical decisions is limited by the complexity of data, lack of general clinician expertise and difficulty in communicating gait analysis results. Evaluating specific muscles during walking and understanding the relationships between muscles at rest and muscles during walking is especially difficult. Clear communication of this complex information amongst clinicians and to families and community colleagues is challenging. As shared decision-making is a hallmark of family-centred care, effective communication of complex gait information is necessary when partnering with colleagues, community practitioners and engaging in shared decision-making with families.   Open-sourced software (Open Sim biomechanical modeling) has been used in research to model and simulate muscle activity while walking but use of this technology for clinical planning and communication is novel. Using muscle modeling (muscle tendon length and velocity) can help clinicians more easily understand and share information on muscle activity during walking.

Project Description: Using the Alberta Health Services Improvement Way (Design Effort stream), the Movement Assessment Centre explored 'How does the addition of muscle modeling affect clinical gait analysis at Alberta Children's Hospital'? Project planning steps included programming systems to utilize available Open Sim software, developing reporting for the muscle models, educating clinicians and physicians in interpretation of muscle models, implementing muscle models into clinical practice and evaluating the impact of muscle model usage.Impact: For most clinicians, the addition of muscle modeling provided clear benefits when considering interventions to lengthen muscles in children with cerebral palsy.

Lessons Learned: Lack of experience and expertise with muscle models limited value for some clinicians. It was recommended to continue to use muscle modeling, although additional education sessions would help to improve clinicians' understanding of muscle models and gait analysis. Exploration of the use of muscle models in additional patient groups and clinical questions is warranted. Evaluation of children's and families' experiences with muscle modeling and gait analysis would help to determine future directions.

Alberta Health Services

LESS IS MORE: A PHYSICIAN LEARNING PROGRAM AND SENIORS HEALTH SCN PARTNERSHIP TO ADVANCE THE APPROPRIATE USE OF ANTIPSYCHOTICS.

The Physician Learning Program (PLP) and Seniors Health SCN co-delivered an interdisciplinary workshop on Appropriate Use of Antipsychotics (AUA) for six Calgary Supportive Living sites attended by 33 care providers. Teams crafted a vision statement, brainstormed improvement ideas, and developed an action plan empowering them to implement changes immediately. Both organizations have led successful antipsychotic reductions initiatives and this workshop was the ideal opportunity to trial a new kind of partnership to enhance AUA in Supportive Living. Experimenting with paired facilitation gave us the advantage of sharing our complementary skills and expertise with the teams.

Innovative approaches: - Sites identified unmet resident needs and recruited people from different roles most responsible for meeting their needs, rather than working with pre-defined QI teams. - Participants shared their ideas with each other, stimulating the spread of innovative ideas without a passive, didactic educational component. - Teams were encouraged to generate and prioritize their own improvement ideas. There were no prescribed solutions to implement, running counter to top-down models that mandate specific solutions. - Site-level comparative data was shared as a baseline for improvement and to stimulate friendly competition.Impact:29 participants completed a post-workshop evaluation rating the session on a 5-point Likert scale: - 100% would recommend the workshop to their colleagues; - 92.9% were confident they could change the way they provided care; - 89.7% felt they could provide a higher quality of care for their patients Post-program data shows a reduction in antipsychotic prescribing rates at all participating sites.   Challenges: - Recruiting interdisciplinary teams rather than individuals. - Designing a team-based workshop meeting the needs of individuals in different roles. - Developing metrics comparable between sites and useful for evaluating change over time.

Lessons Learned: - Interdisciplinary workshops for site-based teams are effective in engaging physicians. - Shared vision setting helps teams build trust and collaborate effectively on complex projects. - Freedom to locally prioritize and plan improvements increases buy-in and raises the chance of successful change implementation.We are planning additional AUA workshops in the Central Zone. Our workshop approach is adaptable with potential to scale this model provincially and to other priority patient populations.

Alberta Health Services

LIVER HEALTH ASSESSMENT AND TRIAGE- AN INNOVATIVE MODEL FOR SERVICE DELIVERY AND IMPROVEMENT OF LIVER HEALTH AT THE UNIVERSITY HOSPITAL

Fatty liver is the commonest cause of liver disease in Canada and the incidence is continuing to rise. A subsequent increase in referrals to Hepatology for abnormal liver enzymes, which are typically caused by fatty liver, has led to physician bottlenecks. Referrals for mildly elevated liver enzymes are often declined review by a specialist or put on lengthy wait lists. Frequently, patients with progressive liver disease are not identified in time for effective intervention.

A nursing triage clinic was developed to provide earlier identification of patients with advanced liver disease, timelier access to specialist care, and ongoing monitoring of those in the early stages of liver disease. Evidence-based triage algorithms were developed, tested and modified to ensure patients with advanced fibrosis were accurately identified and hepatologist time was used most appropriately. Primary Care Networks were contacted to facilitate delivery of in-services on fatty liver disease and the value of fibrosis assessment to physicians in their networks. Patient and physician feedback was formally solicited with questionnaires and incorporated into clinic development.

A significant improvement in quality was observed after the first year. The RN provided earlier advanced assessment of fibrosis and determined that 80% of patients did not need to see the hepatologist. All patients with fatty liver received brief lifestyle counselling by the RN and follow-up assessment was booked. The triage process successfully identified advanced liver disease and wait times to see the hepatologist decreased from 349 to 147 days. The majority of patients were satisfied with the care they received (93%) and were comfortable not seeing a doctor (89%). Ninety-one percent of referring physicians felt nursing triage was of benefit to their patients.

Major challenges have been resistance to the alternative approach to care delivery and limited material and operational resources. Initial success has improved acceptance of the model and in-depth analysis of quality data will be used to further refine the model and secure long-term funding to operationalize the program. Anticipated changes to the model include the addition of community-level screening using readily available blood tests and community-based fibrosis assessment.

Alberta Health
Services

MAKING HOME CARE WORK FOR JOYCE

The Calgary Zone Home Care (HC) leadership team was challenged with numerous competing priorities to best adapt the program's design to meet client needs. Although traditional project approaches were put forward, no clear path was identified; the context of HC within the local healthcare environment is complex and there is limited best practice guidelines on how to design a HC program. Taking a step back, the team realized an important first step was to directly involve program stakeholders; innovative approaches were used to engage clients, frontline staff and leadership in identifying program goals and designing changes to meet them. Firstly, 81 HC clients were interviewed to identify program strengths and areas for improvement. Secondly, 1300 HC staff suggestions for improvement were collected and themed. Building on these themes, a Design Day with 5 client representatives, 16 clinical staff, 21 managers and 2 system partners was held to set the foundation for future HC design. A persona with the name 'Joyce' was used to create empathy to ensure clients were central in all discussions.Stakeholders identified four program goals to support 'Joyce': (1) Partner with 'Joyce's' Primary Care Team (PCNs).(2) Ensure 'Joyce' receives quality support service options.(3) Enable staff to provide 'Joyce' with only value added services.(4) Build stable care teams with the Case Manager as specialist for 'Joyce'.Progressing on these goals and maintaining momentum has been a challenge; in addition to the program's primary focus on daily operations, HC has over 80 projects underway at any given time. HC ensures focus is maintained by prioritizing projects and measuring program performance against these goals. Program leaders are also assigned to each goal; notable initial specific improvement initiatives include a World Cafe with vendor service providers to refine how we provide Joyce with quality service options. Another innovative initiative completed was an environmental scan of Collaborative efforts with Primary Care Teams to identify best practices and next steps. As important as these initial activities, the Design Day shifted the leadership's view of meaningful engagement and has set the stage for making HC work for Joyce.

MEETING PHYSICIANS WHERE THEY'RE AT: A GROUND-UP APPROACH TO ESTABLISHING PATIENT MEDICAL HOMES

Calgary West Central Primary Care Network (CWC PCN) has a novel, ground-up approach to achieve the provincial objective of supporting family physicians to establish their patient medical homes by 'meeting physicians where they're at.' Rather than focusing on where we think physicians should start, the Patient Medical Home (PMH) team, which consists of patient care team and patient information team members, ask physicians what matters to them in terms of ensuring patient care and improving practices. This approach allows physicians to work on areas of need specific to their practice. The value in this approach has been demonstrated both through an increase in physician engagement, and through improved patient health outcomes. To date, the team has engaged 72 unique primary care clinics and over 120 family physicians with multiple quality improvement goals. The majority of goals relate to process improvement (e.g., access), screening and prevention (e.g., cancer screening and vaccinations), complex care and chronic disease management (e.g., diabetes and chronic kidney disease), and targeted specific populations (e.g., seniors care). In terms of improved health outcomes, the team has worked to improve: access to services by reducing no-show rates and improving time to third next available, patient attachment by implementing process improvements and electronic medical record standardizations, screening and vaccination rates through patient and provider awareness, and complex care planning and chronic disease management by focusing on population health and lifestyle modifications. Additionally, the team has supported improved care for targeted and specific patient populations by creating enhanced process administration. For example, implementing a standard approach for assessing mental health conditions, and implementing a standard approach for managing patients who are taking opioids (e.g., use of opioid agreements and pain assessment tools). Key elements to the success of this work have included the interdisciplinary team of content experts, (i.e., quality improvement, measurement and evaluation, primary care, and behavioural health), leveraging other PCN programs and services, using electronic medical record data to inform decision making, and maintaining a culture of constant innovation. Next, the team plans to formally evaluate the approach while continuing to work with member physicians on selected improvement goals.

Alberta Health Services

NEONATAL ENHANCED RECOVERY AFTER SURGERY (ERAS): A NEW FRONTIER

The Idea: Neonates suffer high rates of adverse events after surgery. Variability in perioperative care likely contributes to these events. A standardized approach to neonatal surgery may decrease this variability and offers the potential to bridge the gap between best evidence and actual practice. Enhanced Recovery After Surgery (ERAS) guidelines have been used in select adult procedures to optimize patient recovery through the standardization of the perioperative care pathway. Few attempts have been made to develop pediatric ERAS guidelines. None have been designed for neonates. Our research team aims to develop an ERAS guideline specifically tailored for neonatal patients undergoing intestinal resection. Our project will produce the first pediatric ERAS guideline endorsed by the International ERAS Society.

The Journey: The priorities and approach for this study were generated through collaboration between the research team and stakeholder input. A multidisciplinary panel of clinicians involved in the surgical care of neonates was assembled to form an International Guideline Committee (IGC). IGC members participated in a consensus-based process to determine guideline scope. These elements were expanded and refined through parental stakeholder review. Each element identified for inclusion was assigned an IGC member who completed a rapid review of the literature to draft recommendations. A variety of experts have been engaged to provide feedback on the recommendations including dieticians, physiotherapists/occupational therapists, enterostomal care specialists, and parents.

Potential Impact: The holistic approach of ERAS guidelines has been shown to positively affect health outcomes in a number of adult surgeries by decreasing complications and length of stay; translating to a reduction in health-care costs. Our ERAS guideline aims to enhance overall quality, efficiency, and safety of care for neonates undergoing intestinal resection. Furthermore, this guideline has the potential to decrease the burden on the health-care system, and increase parent and staff satisfaction.Potential

Lessons Learned: IGC members will participate in another consensus-based process to determine the necessity, clarity, and ambiguity of each recommendation. A tailored implementation strategy will be developed and the final guideline will be piloted at the Alberta Children's Hospital. This pilot study will identify feasibility, acceptability and barriers to implementation.

Alberta Health Services

NEW WAYS TO USE CLINIC DATA: BETTER INFORMATION MEANS BETTER INTERACTIONS

Your idea: Patient registries (clinical information databases) are becoming increasingly common as clinics collect comprehensive data about the patients they see. In this project (awarded Calgary Zone CMO QI funding 2018-2019), the University of Calgary Spine Triage and Assessment Clinic is using registry data to improve referral processes and the quality of the physician encounter with an innovative approach to patient engagement and data collection. We are developing electronic survey forms that patients complete after they are referred to the clinic but before they are triaged, providing clinicians with an accurate and comprehensive picture of the patient's situation. This allows for more appropriate clinical prioritization, scheduling and more time dedicated to patient priorities, rather than history taking, at the clinic visit.

Share your journey: As we developed our idea of electronic patient forms and data collection, we immediately involved Calgary Zone Patient and Family Centered Care to ensure solutions were co-designed by patients and providers. Moreover, patient voices were represented not as consultants but as team members and contributors to the project. AHS stakeholders are engaged and see the benefit of the potential impact on wait times and access to appropriate services; as well as the improvements for patients and physicians in the physician encounter.

Potential or Actual Impact This project demonstrates how we can improve the efficiency and effective use of routinely collected patient data for improved service delivery by allowing more time in the appointment for discussion of personalized treatment options informed by patient-provided information. Patients and physicians will also complete surveys to determine satisfaction and experiences with the new tools and the quality of the clinic visit.

Lessons Learned: Collecting and using patient data in these new ways means navigating ethical risks to managing this data, and the discussion will touch on the use of ARECCI in QI to mitigate these risks. Having a patient advisor as a team member has been invaluable for capturing the voice of the end user, as we try to fully understand what concerns may arise from a patient perspective while considering all the ethical implications of the work we are implementing.

Alberta Health
Services

NORTHERN LIGHTS AMBULATORY CARE SERVICES: TRANSFORMATION OF OUTPATIENT SPECIALIST SERVICES TO CENTRAL INTAKE

BACKGROUND: The Northern Lights Regional Health Centre recognized an opportunity to improve their scheduling processes for all patients in the Ambulatory Care department. The department multiple processes being used for physicians creating unequal access and wait times for service for patients. A major priority of the work was to optimize access and to reduce wait times for all patients. The foundation for this work is built on the AHS Level 1 policy Wait Time Measurement, Management and Reporting of Scheduled Health Services approved in 2013.

METHODS: The project began with a large process mapping session involving all the key stakeholders for patient access to services. Project demonstrated a need for improvement in the referral and scheduling processes to ensure patients receive timely care. The recognized gaps in the current state of the process were prioritized based on patient access and the amount of impact to the system. A future state plan for a standardized referral process based on increased appointment capacity without resultant increases in costs was developed and implemented.

RESULTS: Improved patient access and decreased wait timesStandardized scripts for booking appointments and follow upsMissed appointment and cancellation standards documentedImprovement in the Confirmation Call process lead to a No-show (Missed Appointment) rate that went from 43% to less than 5% Referral forms reduced from 13 to 2 standardized forms.Standardized wait list and wait times management processesWait Lists reduced from 24€36 months to 3 months or no wait listsTriaging time for all referral less than 14 days Scheduling by access targets, reason for referral and priority.Referring sources and patients being notified of appointment details or wait list status within 14 daysDevelopment of Referral Guidelines in the Alberta Referral Directory reduced incomplete referrals from 52% to 10%. Optimization of the IT scheduling system supports reporting as per AHS policy standards and measurements.

CONCLUSIONS: The standardized referral processes implemented will allow us to expand to additional services and programs within Ambulatory Care. The process implemented will continue to be refined to achieve a central intake and triage model integrated within ConnectCare.

OPERATING ROOM NURSE ORIENTATION: A PERSON-CENTERED APPROACH TO PREPARE NURSES TO WORK IN THE OR

A partnership between Alberta Health Services (AHS) and MacEwan University started in 2014 provides a creative approach to perioperative training for newly hired Registered Nurses and Licensed Practical Nurses. The goal of this program is to prepare nurses to work in the challenging operating room environment. The innovations in this program are the ongoing support and mentorship nurses receive from the Clinical Education Coordinator, grouping students so that they go through the entire program together and integrate with OR staff as colleagues. To see if the program is working, Alberta Health Services in partnership with Grant MacEwan surveys managers and learners. Early findings: learners and their managers feel that after taking the program, nurses are ready to practice in the OR; both managers and learners feel new staff are able to provide safe care; learners and managers feel learners are bringing standards into practice and managers and learners feel learning together in a group helps them be successful in the OR. A key learning from this work is that spending time on building and maintaining relationships, communicating with everyone involved and exploring better ways to do things together are key to building a successful perioperative nurse orientation program with long-lasting results.   The next steps for the Perioperative Orientation Program are to continue to measure how the program is doing, to continue to support and promote teaching learners in groups in partnership with MacEwan and to seek out new ways to improve perioperative education in the province. **Special Note: The value of this abstract is in the presentation. The presentation will be a visual interpretation of relationship building and the impact AHS has on the employees that go through the perioperative program through the use of pictures taken in the field through the eyes for the person who teaches and supports the learners through the entire process â€" the Perioperative Education Coordinator (who is also a professional artist).There will be impactful stories and quotes from healthcare providers and about patients and families shared throughout the presentation.

OPERATION INNOVATION: ZONE PATIENT FLOW, WITH A NEW WAY OF WORKING

In Central Zone, operations leaders and physicians have been trying to 'solve' how to better utilize our beds and improve the care we provide to our patients. Many traditional quality improvement approaches have been taken over the years to tackle this wicked problem. After focus group meetings with zone physicians, operations was interested in finding a new way to tackle this issue. The task was to pull together physicians and operations staff from throughout the zone in one place, in person, to work towards one goal; A zone-wide patient flow team that would work together to improve patient repatriations and transfers. We knew that some sites sat filled to the brim all while other sites within the zone had patient beds available, but how were we to utilize those beds? And how could we make this safe for the patient and a positive experience for the patient and family?By utilizing Central Zone IQM and their expertise in liberating structures and human centered design an evening was created to pull on the collaborative intelligence of everyone in the room. We were able to collectively create the building blocks that would become zone patient flow, while focusing on the patients and their lived experience. It was from idea generation focused around risk mitigation to the organization, operations, physicians, patients and EMS from this day that guided our way forward. Each task was themed into a group: 1. Criteria for Transfer 2. CNZ Patient Flow Coordinators 3. Hand-offs Provider Communication 4. Patient Facing Communication 5. Alternative Level of Care 6. Transportation 7. Centers of Excellence In partnership with operations and the quality team, each group was tasked with planning their work moving forward, and were given decision making ability to quickly execute their piece of the puzzle. This work is currently ongoing but an early big win has been the creation of positive relationships between rural and tertiary hospitals as we begin to move this work, collaboratively and with agility.

Alberta Health Services

OTHERWORLDLY IMMERSION: USING VR TO EASE ANXIETY AND PAIN IN COMPLEX WOUND CARE

Rockyview General Hospital (RGH) is the first hospital in Canada to use Virtual Reality (VR) to help patients manage pain and anxiety during complex wound care. VR transports patients to environments like a virtual lakeside campground, observing dinosaurs or swimming with dolphins.Patients report that wound care treatments are painful and provoke anxiety. Studies from Dr. Spiegel at Cedars-Sinai show the effectiveness of using VR for pain reduction in various health settings. The Telehealth team at the RGH recognized these exciting results as an opportunity to introduce VR to patients and clinicians. After reviewing the research and receiving approval from site leadership, the team engaged the Allied Health Wound Care team to trial VR. Patients were asked to rate their level of discomfort and overall experience using surveys administered before and after VR (using a scale from 0-10). Measures of patient discomfort include ratings of pain, nausea and anxiety. Measures of patient experience include ratings of feelings about future treatments and overall experience. Initial results were extremely encouraging. Patient surveys showed a 75% reduction in patient discomfort and a 31% improvement in overall patient experience. No side effects were reported and 100% of patients who used VR found it helpful. To our surprise, wound care staff described lower levels of distress while they delivered treatment; they attribute this to increased patient comfort during their procedure.Determining the Infection Prevention and Control (IP&C) guidelines was the biggest hurdle. Telehealth, IP&C, RGH Site leadership, management, and mobility services were important allies in supporting this project. All teams worked closely to develop recommendations for using VR. Telehealth and the Wound Care Team maintained ongoing communication regarding training, VR troubleshooting and headset maintenance. Given the success of this project, the expansion of VR to the Cardiac Care Unit (CCU) and the Intensive Care Unit (ICU) at the RGH will begin in April 2018. In this department, we will be studying anxiety reduction and relaxation for patients while using VR. Our team is also investigating new VR technology with a focus on cost reduction and ease of use for both clinicians and patients.

Alberta Health Services

OUR PEOPLE SURVEY - ONLY ONE THING, BUT ALWAYS ONE THING

We care about our people and want them to be excited about coming to work each day. For us to continue to provide quality and safe care to our patients and families, we need to ensure we are caring for AHS staff, physicians and volunteers. Driven by Our People Strategy, AHS launched Our People Survey in 2016 to measure our peoples' engagement and patient safety culture. A first of its kind in Canada, Our People Survey is unique in that it combines engagement and patient safety culture as an intentional link to ensure we are creating an environment that is supportive to our People, patients and families.To guide us, we adopted the Gallup methodology. More than 46,150 told us what was needed to make AHS an even better place to work. We learned AHS must focus on ways to continuously improve communication and staff engagement, as well as our patient safety scores, that while encouraging there is room for improvement.Since the 2016 survey, there has been a concerted effort to embrace local level (grass root) action planning. This is a radical departure from the more top-down directive we had used in the past. In 2017 we did a temperature check through 'Our People Pulse Survey'. Results indicated that many of 22,149 staff agreed that the new methodology was useful and to-date 513 local action plans have been developed through leaders sharing survey results, holding conversations with their teams which resulted in action.To support this organization wide transformation, the Talent Engagement and Learning Solution team is taking a learner centric approach, creating opportunities for social learning and using storytelling to ensure connections are made. We are also increasing our visibility within the organization through Our People Survey Street Team; the hearts and hands in supporting teams through large scale adoption. This team, at the frontline, gives leaders ideas on how to have inspiring conversations and develop innovative actions with their teams. Most specifically, this team are the change agents who empower leaders and teams so they provide the best care possible with the goal of better patient experiences.

Alberta Health Services

PARTNERING WITH FAMILY AT THE BEDSIDE AND BEYOND: FAMILY-ADMINISTERED DELIRIUM DETECTION IN THE INTENSIVE CARE UNIT (ICU)

Our idea: Few conditions are as common in hospital as delirium, which affects over 60% of intensive care unit (ICU) patients. Patients with ICU delirium are less likely to survive and more likely to suffer long-term consequences after their stay. In Alberta ICU delirium is routinely assessed by registered nurses. Family caregivers are frequently at the bedside and may be the first to notice changes in their loved ones. We are studying the use of family-administered delirium detection in the ICU, in conjunction with routine delirium assessment. This could fundamentally shift how healthcare services are delivered by directly engaging family members in the detection of delirium.

Our journey: Following a stakeholder engagement meeting, we involved former-ICU patients/family members, decision-makers, physicians, world-renowned ICU delirium researchers, and ICU nurses in the design and conduct of the Family ICU Delirium Detection Study (FIDDS). We sought to meaningfully engage former ICU patients/family members as co-investigators in this project. These team members are engaged in activities they identified as meaningful, from reviewing documents to recruiting participants. Our project is innovative in that it moves patient/family engagement towards partnership in both healthcare and research.

Our impact: The protocol was successfully designed with patient/family co-investigators. Consecutive, eligible patients and family members were recruited from the Foothills Medical Centre ICU for FIDDS. No participating family caregivers indicated the study was a burden or withdrew once enrolled. Patient/family co-investigators on the research team expressed enjoyment in their roles, though reported frustration with the constraints of the research process. We found that it is feasible and beneficial to include former patients/family members as co-investigators for patient-oriented research.

Lessons learned: Family caregivers are often overwhelmed when faced with the critical illness of a loved one. Having a former-ICU patient/family member with lived experience is invaluable when approaching patients/family caregivers for participation in a research study. Training and supervision of patient/family co-investigators must be a priority for the research team. The FIDDS paradigm of patient and family partnership can be extended to other areas in the ICU (e.g., early mobility) and hospital settings where delirium is common.

Alberta Health Services

PATH TO CARE: TRANSFORMING REFERRAL MANAGEMENT IN SCHEDULED HEALTH SERVICES

Our healthcare system is complex. Unclear referral processes result in uncertainty, increased wait times and frustration for our patients, their families and health providers. Path to Care (P2C) aims to improve care coordination and communication across providers to improve the patient's experience and decrease wait times. Identi-fying where delays occur and making efforts to improve is crucial to ensuring that all patients receive the Right Care, at the Right Place and at the Right Time.P2C is a provincial program that is Transforming Access by standardizing optimal referral, wait list and wait time management processes across scheduled health services. The Wait Time Measurement, Management, and Reporting of Scheduled Health Services Policy defines the leading access practices and standards of the P2C program.Referral Management is the initial step focused on standardizing referral business processes, referral guidelines and referral communication practices. Referral Management includes the following practices and standards:

Communicate referral received within 7 days to referral source.

Communicate referral accepted and appointment details within 14 days to both patient and referral source.

Communicate referral decline within 14 days to referral source.

Communicate wait list status every 90 days to patient and referral source.

Communicate outcome of initial appointment within 30 days to referral source.

Establish communication processes for declined and incomplete referrals.

Develop referral guidelines by reason for referral.

Maintain information in the Alberta Referral Directory (ARD) and Inform Alberta (IA)

Of the 2911 schedule services, 2222 are actively engaged in improving their referral management practices. 1201 of these services are working to fully integrating these practices and standards. 82% of scheduled services listed in the ARD are considered complete for use by health care providers.P2C creates a consistent referral experience no matter where is in the province. Referral Management improves: patient safety, patient and provider experience, communication with referring sources and patients, provider collaboration, transparency, patient health outcomes, work load burden and appointment outcomes. Sustaining the efforts of a practice change, such standardized referral management ensures patients receive the Right Care, Right Place, Right Time.

Alberta Health Services

PATH TO CARE: ALBERTA REFERRAL DIRECTORY.CA

Context The Path to Care program aims to standardize and transform access to scheduled health services within AHS. Supporting Referral Management practices is a cornerstone of the initiative, a recognition of the need for better information sharing between referral sources and scheduled services across Alberta. A resource in this goal is the referral directory.The Alberta Referral Directory (ARD) seeks to be a transformative product by centralizing referral information for consulting physicians and scheduled health services, avoiding the need to publish information in multiple places. Having all referral information in a single, online source makes finding and selecting the right consultant/service easier. This means less delays and frustration for all. A complete and appropriate referral is facilitated by reasons for referral outlined by each receiving consultant/service, allowing them to process the referral within the communication targets as outlined in the Referral Consultation Standards of the College of Physicians and Surgeons of Alberta.Since the ARD is web-based, it avoids paper-based directory safety issues as information is updated in real time. An added feature is the ability to provide the patient with relevant service details.

Methods: The ARD team worked with and continues to liaise with specialists/consultants to create and manage their profile information. Service profiles are updated at point of care by designated individuals within the service. Promotion of directory benefits and clear explanation increase understanding of new enhancements, and help grow guideline development and communication.

Outcomes: The ARD contains extensive service representation due to our consultation with existing directories and services. The need for this resource is supported by the doubling of ARD viewership over the last 6 months with usage continuing to improve. The ARD contributes to the improvement of information sharing, supports effective referral management practices, and ultimately improves Albertans access to scheduled health services.

Lessons Learned: Services required more consultation then was originally assumed to complete their ARD profile; however, by offering an increased level of support service transformation occurred beyond the originally targeted areas. Building a review cycle that is sensitive to content and application usability has allowed better response to users' needs.

Alberta Health Services

PATH TO CARE: MANUAL TRACKING TOOL

Path to Care is a provincial program that is Transforming Access by standardizing optimal referral, wait list and wait time management processes across scheduled health services. The Alberta Health Services Wait Time Measurement, Management, and Reporting of Scheduled Health Services Policy defines the leading access practices. An environmental scan revealed that many scheduled services do not utilize technology and are unable to identify opportunities for improving access to care. The Manual Tracking Tool is an excel workbook designed to be used by scheduled services / clinics that do not currently use an electronic scheduling system or that wish to collect additional data not found in their existing systems. The main entry worksheet tracks the patient journey from the time the referral is received to when the patient attends their initial appointment. The referral information entered by the scheduling staff automatically generates dashboards and reports. This information is used to identify gaps and opportunities to drive continuous quality improvement as it relates to patient access and wait times. The Manual Tracking Tool measures, manages, reports and monitor your patient wait times tracks referral volume, complete or incomplete referrals and if referrals are appropriate acts as a scheduler, tracks appointment outcomes (no shows, cancellations) reduces workload while optimizing efficient via a single entry worksheet measures each step in the patient path from receipt of referral to attended appointment auto-populates reports and dashboards for real time snapshot of program key performance indicatorsclearly identifies gaps and inefficiencies that can inform decision making and opportunities for process quality improvement to decrease wait times supports an easy seamless transition to Connect Care which is designed based on Path to Care standard business flow. Reports and Dashboards provide a graphical representation of the business processes that are addressed within the policy. Leadership will be able to measure, in real time, their performance targets, progress and identify process improvement changes to support policy implementation.   Adopting this workflow will allow your service/clinic to track policy requirements, optimize business processes and reveal improvement opportunities relating to access to care and wait times.

Alberta Health Services

PERSON TO PERSON CONNECTIONS: THE NEUROTRANSMITTERS OF INNOVATION

How can we develop a culture of innovation in AHS that is organic and responsive versus cumbersome and policy-driven? The answer is counterintuitive: Rapid, large scale improvement requires many person-to-person connections! Collaborate person-to-person, with individuals from other SCNs, Patient Engagement, Policy, Accreditation, HPSP, CoACT, WebComm and Communications. Collaborate with all levels of formal and informal operational leaders. Always look for the win:win! Connect change teams in face to face Innovation Collaborative Workshops. Participants say, 'We loved hearing other people's ideas! Keep the conversations going: Involve Patient Advisors in resource development; Share innovative ideas: in articles, workshops, Skype meetings, conferences and websites; Work together to solve tough cases in Curbside Consultations: monthly phone-in sessions with Health Care Aides, Nurses, Educators, Nurse Practitioners, Occupational and Recreation Therapists and Geriatricians.

Once care teams are inspired by innovative ideas and empowered to develop their own solutions, a quality improvement culture develops. Success fuels success. The stories surprise and delight us: The aggressive dementia patient destined for a lengthy hospital stay, discharged in 30 day; A 100 year old patient with delirium - walking within 6 days;The resident who regained abilities to walk, talk and feed himself .The driving force for quality improvement is often one memorable patient outcome. When care teams see the benefit for one, they're motivated to innovate for all. Ideas from empowered units spark possibility thinking in other units. A movement is born! The Appropriate Use of Antipsychotics project impacted approximately 25,000 of Alberta's 37,000 beds. The Elder Friendly Care (EFC) project has been implemented in approximately 1000 beds, with another 100 hospitals to go. Improved outcomes for individual patients add up to more efficient use of scarce resources.Care teams want to improve, but often don't know how to begin. We now guide teams to identify priorities, set up working groups, and try small test (PDSA) cycles. We brag about their achievements and encourage them to share their successes with the world. We maintain momentum by providing web-based QI resources to support an appetite and aptitude for quality improvement. Next steps: provincial spread of EFC!

Alberta Health Services

PHYSICIAN INNOVATION: FROM LABORIOUS AND BORING PAPER PROPOSALS TO INNOVATIVE PITCHES BUILT WITH COLLABORATIVE INTELLIGENCE.

In Central Zone, we have been looking for ways to work more collaboratively and innovatively with physicians, patients and families and frontline staff. It was through this innovative mindset that we have been looking for opportunities to take this pioneering approach to our work. Since 2014, the Chief Medical Office (CMO) has provided funding and support to physicians to complete quality improvement and innovation projects throughout the province. Historically, physician innovation ideas were submitted via a tedious and boring paper proposal system where physicians were unable to provide input into each other's projects and lacked innovative thinking. This led us to question how can we do this differently?Enter our innovative approach for 2017-Physician Innovation Event-'Dragon's Den style'. An idea was crafted to hold a physician innovation event where physicians were able to propose their idea in 3 minutes and receive immediate feedback from both the selection committee (the 'Dragon's) and their peers. This method made the idea pitches richer, patient centered and engaging for both the physician pitchers and the selection committee. One of the biggest things that kept us up at night was if anyone would show up to pitch. To our delight we had a total of 14 pitches presented via a 3 minute pitch either in person or through a video pitch which was supported in person by their project team. What was highlighted in the evaluation post-event was how engaged physicians were. Quotes from evaluations included: 'Seeing how engaged physicians were about making a difference to patients, and how IQM could facilitate these improvements in zone.; 'Allowed us to learn about challenge opportunities and innovations in other areas; 'Also planted the seeds for physicians in the future to consider innovation opportunities'Evaluation of the event showed 13/14 Participants agreed that the event was valuable and would like to see this approach continue bigger and better with involvement from operational dyads, patient and family advisors and medical residents.

Alberta Health Services

PUTTING THE TA IN TJA

Rehabilitation is a key component for the successful recovery of patients following hip and knee total joint arthroplasty (TJA). Bone and Joint Canada implemented a national model of care that supports initiation of post-operative mobilization and exercises for the TJA client within 4 hours after surgery. Increased surgeries performed daily led to patients returning from surgery outside of the Physical Therapist's (PT's) normal work day, which delayed mobilization and exercises until the following day. Delay in mobilization decreased client outcomes and increased length of hospital stay. Attempts to recruit evening PT's were unsuccessful.Our idea was to create a new Therapy Assistant (TA) position with an evening shift. The role of this TA would be to initiate exercises and mobilize patients as per the surgeon approved TJA pathway, prior to a PT assessment. This idea was innovative because it expanded the accepted practice of how TA's deliver health care services. In the traditional assignment model, TA's are excluded from the care team unless assignment and supervision is provided by a therapist, who cannot assign activities without first assessing the client. TA competencies and professional-legal considerations were reviewed prior to receiving operational support for this innovative TA service model. Further engagement was sought from physicians, managers, nursing, PT's, and TA's to determine the realm of activities to occur by the TA as a program role. The TJA care team was educated on the role of the TA and how collaboration with PT and Nursing would occur to ensure patients and their families received the best seamless care possible.There were very few challenges with implementation. Positive impacts on client care and service efficiency were evident by Day 0 mobilization statistics above provincial average, and a decrease in average patient length of hospital stay. The provision of evening service for each TJA client allowed the program to consistently deliver safe, high quality rehabilitation. Our success using this model may support the expansion of the TA clinical role within similar AHS programs, with a goal to achieving improved patient outcomes and improved access to rehabilitation.

Alberta Health Services

QA2QI: THE QUALITY & CLINICAL PERFORMANCE TEAM'S JOURNEY TO IMPROVE CONTINUING CARE CLIENT EXPERIENCE, AND REIMAGINE THEMSELVES IN THE PROCESS.

Our Idea: The Calgary Zone (CZ) Quality and Clinical Performance (QCP) team had its mandate changed from Continuing Care Health Service Standards (CCHSS) auditing of CZ continuing care sites to a quality, safety, and education resource for the CZ portfolio. Our team restructured in early 2018 and has had to reinvent itself with no 'roadmap' for our transformation. 'Our idea' was in truth an intensive reflection on how to use our skills to meaningfully improve quality and safety within AHS and contracted continuing care services! How do we use our collective power to take action?

Our Journey: The QCP team supports a huge portfolio over 175 facilities and 4 main AHS areas; a significant undertaking for our small team; how to start taking bites from the elephant? 1) Be intentional about what kind of team culture we want: non-traditional! We have millennial power, as well as baby boomer and gen x wisdom to harness and inspire. Management directions: be creative, build positive customer relationships and challenge sacred cows! We are here to make a difference! 2) Identify priority areas and plan actions to address using data to support decision making. Data including HQCA resident surveys, RAI assessment performance indicators, patient concerns, and other sources provide us with a rich understanding of areas of opportunity. 3) Build educational partnerships with, and deliver education directly to our CZ facilities to translate the standards and audit outcomes to front line staff and improve the resident care experience.

Potential or Actual Impact: 1) Developing partnerships and building engagement with continuing care services; happening! 2) Direct assistance to sites lacking quality and safety expertise to support process changes related to post audit action plans, safety incidences, or other improvement related work.

Lessons Learned: 1) Trust is earned through action; we have to deliver on our expectations to build credibility. 2) Set boundaries and expectations to meet as much demand as we can; be lean! 3) Talk about change all the time! 4) More to come!

Alberta Health Services

QUERULOUS: A NEW APPROACH TO HEALTH CARE COMPLAINTS

Society demands excellence in health care but unfortunately this expectation is not always met. Having worked in Quality and Health Care Improvement for 11 years as a Patient Relations Consultant, I have been privileged to converse with thousands of patients and families to resolve concerns related to unsatisfactory health care experiences. Unfortunately, I have also engaged with many patients and families, who remain unsatisfied and cannot reach resolution, which I identify as Querulous. Being challenged by querulous complainants prompted me to engage in a PhD to study complaint behavior in health care systems. Health care is politically driven and we consider all concerns in the same way; despite the consequences. My research challenges the current beliefs and processes related to complainant management in a public health care system. We do value all patient and family concerns and feedback to improve our services; however, in the context of Querulous Complainants the intention is to disrupt the organization.Through my research I have identified that there are an estimated 100 Querulous complaint cases per year within Alberta Health Services. Of these 100 cases, resolution cannot be achieved and the total cost to the organization is approximately 25,000,000.00. This amount does not account for the emotional impact of engaging with such complainants on nurses and other health care providers. If we are inviting concerns to improve patient care, we need to be prepared to manage querulous complainants differently. I have developed the Querulous Complainant Pre Identification Tool. This tool will pre-identify if a complainant is likely to be Querulous and will prompt an alternate management process that will eliminate misuse of resources. I have been supported by the leadership within the Office of Patient Relations to conduct my research and this tool will be piloted in the Patient Relations Department in the Fall of 2018. This tool will not only reduce cost, it will provide a process that will appropriately address the concerns of a Querulous Complainant. In addition to the financial benefit, this tool will reduce the emotional and psychological stressors that health care providers face when managing Querulous Complainants.

RECOVERY CARE IN THE CONTEXT OF FORENSIC NURSING

The idea of Recovery Care is widely heralded as the golden standard in psychiatric nursing. However, using a Recovery Care approach in the context of Forensic Nursing has proven to be a contentious and challenging issue because of the need to balance the forensic patient's wants and needs with the safety of the public. To address the question of how we can reconcile Recovery Care and bring it to the forefront of Forensic Nursing care, a literature review was done on three key areas: Recovery in the context of Forensics; Forensic Nursing culture; and Ethnography and Nursing Research. Recovery in the context of Forensics included two subtopics: how forensic patients and offenders experience and perceive Recovery; and the idea of Secure Recovery, or how Recovery Care already exists in Forensics. Some of the literature for Secure Recovery explore how to manage the balance between the dual role of Forensic Nursing and proposed models of how to bring Recovery Care into the realm of Forensic Nursing. This topic allowed me to explore how Recovery is both defined and influenced by this population. The second topic on Forensic Nursing culture explored what delineates Forensic Nursing from other areas of psychiatric nursing, and the unique challenges facing Forensic Nurses, from a multitude of levels, from the micro level of how forensic nurses interact with patients, to macro levels of how forensic nurses reconcile their roles in the Mental Health and Justice systems. Lastly, the topic on Ethnography and Nursing Research provided a lens on how to capture a specific nursing culture, as well as the possibility of changing and influencing nursing culture. This will propel me towards the next steps, which will include a focused or critical ethnographic approach to explore Forensic Nursing and its relationship with Recovery Care and Secure Recovery.

Alberta Health Services

SAFE PEOPLE, SAFE COMMUNITIES - FORM 10 INNOVATION

Background: Alberta Health Services (AHS) Collaborative Urgent Services and Calgary Police Services (CPS) identified concerns related to individuals brought to hospital on a Form 10 under the Mental Health Act. The purpose of the Form 10 is to ensure individuals who encounter police while in a mental health crisis can be safely transported to hospital for further assessment. Concerns identified included: difficulty transitioning care, appropriateness of patients, and frequent presentations resulting in significant financial and time costs to patients, AHS, CPS, and Emergency Medical Services (EMS). We hope to improve patient care by providing appropriate services when required.

Journey: Aligning with the AHS strategic directions of appropriate care in the community, partnering for patient care, and a sustainable healthcare system; our team, including members from AHS and CPS, was formed and began meeting twice monthly since November, 2017. The committee identified and reviewed previous quality improvement initiatives from Edmonton, Ontario, and British Columbia. Key stakeholders were identified, a team charter was created, and an environmental scan completed. The team completed a business process map, obtained legal opinions from CPS and AHS, brainstormed ideas, and established key performance indicators.

Results: Initial data was compiled, previous Form 10's reviewed, and scenarios developed in preparation for the planning day. On April 26, 2018, 80 stakeholders from AHS, CPS, EMS, and various community agencies will meet in a World Cafe format to identify potential solutions for Plan-Do-Study-Act (PDSA) implementation. We will enact six to eight week periods to trial innovations proposed at the planning day, with ongoing communication, and feedback provided.

Conclusions: Challenges included integrating professionals from large scale organizations with divergent mandates and providing sufficient time to gather appropriate data. We successfully planned the day ensuring key stakeholders are informed. We remain mindful of our overarching goals of reducing the number and/or increasing the appropriateness of individuals brought to hospital on a Form 10, and reducing the waiting times for CPS and EMS when transferring care. We look forward to sharing the outcomes of our planning day and our results to date, in October!

Alberta Health Services

SAFER AND WELCOMING CONTINUING CARE FOR LESBIAN, GAY, BISEXUAL, TRANSGENDER AND QUEER+ CLIENTS

Media and patient feedback highlighted that some continuing care clients who identify as Lesbian, Gay, Bisexual, Transgender and Queer+ (LGBTQ+) were choosing to be 'closeted' due to fear of poor care, bullying and unacceptance by healthcare providers, other clients and visitors. To enhance quality of life for this vulnerable population, Alberta Health Services (AHS) developed a Continuing Care LGBTQ+ Toolkit (herein Toolkit). The Toolkit is intended to support staff awareness, confidence, knowledge and skills to create safer and more welcoming continuing care environments.A Task Group was established with representation from the LGBTQ+ community (including continuing care clients and advocacy organizations), researchers, and various AHS portfolios. Personalized contact was made with each member to establish rapport, explain the project goal and personally invite them to join the group. Follow up meetings were facilitated to ensure a positive experience. Clinical professionals who were unable to join the Task Group due to workload were invited to provide feedback on the draft Toolkit later in the process. There has been positive feedback from LGBTQ+ community members and healthcare providers on the initial phase of the project, which saw the development of a webpage. Our team was amazed with the executive leadership support, which helped advance the project timelines. The clinical professionals provided important insights and were impressed with the Toolkit. The Toolkit release is planned for June 2018, accompanied by a web survey for feedback. Updates will be made to the Toolkit as needed to support staff to create safer and more welcoming care. The true successes were establishing a committed Task Group that included several members identifying as LGBTQ+, and having a supportive executive leadership to develop an Alberta website and Toolkit within a 12-month timeframe. An important challenge was ensuring that the voice of LGBTQ+ Albertans was at the forefront in the development of the content. We also realized there would be different opinions on content and the Alberta perspective with every person that participated in the education. Next steps may include client education, advocacy for Toolkit mandatory education, and development of a policy to support care.

Alberta Health Services

SCALING THE EDMONTON ZONE TRIPLE AIM INITIATIVE TO A CROSS-SECTOR, ZONE-WIDE COMMUNITY COLLABORATIVE.

The Edmonton Zone Triple Aim Initiative sought to improve outcomes for complex, high-needs patients (CHNP). System changes included service improvements, policy changes, and resource shifts. Aims of the Initiative aligned with the Quadruple Aim: improved health, enhanced patient experience; enhanced experience of providing care for staff; and reduced cost. Results from an outcome evaluation set the stage for a renewed strategy to build a common agenda with our community partners, align activities toward common goals, enhance collaboration, and improve outcomes for some of our most vulnerable community members.The goal of the renewed strategy is to build stronger cross-sector commitment for closer collaboration, joint innovation, and the integration of services. We believe this work is innovative because it acknowledges and actively confronts the reality that the formal health system does not account for a high proportion of the health and wellbeing needs of vulnerable populations. Continuous communication, including active engagement efforts across organizations and sectors are required to ensure we provide these services in appropriate ways to coordinate around the needs of these individuals: person-centered care. Initial stages of this work consisted of community engagement sessions with diverse stakeholders, which included cross-sector groups that exist in the community and struggle with system barriers. We have brought forward results from these sessions to two cross-sector workshops: 1) a Strategic Senior Leadership Forum, and 2) a Frontline Leaders Forum. These forums are where shared decision-making resulted in goals, strategic priorities, guiding principles, and a roadmap for collective impact. Our community partners have greeted this engagement work with approval. Participants have reflected that the opportunity to collaborate is important for their frontline to see that their work is valued, and their perspectives on the barriers their clients experience are important. Challenges we face relate to the power AHS wields in these conversations. Figuring out how we balance our interest in supporting the development of a common agenda in the community, while limiting the impact our voice has to disproportionately influence the conversation is critical. We will share lessons on our successes and failures in this regard.

SCRUMS - THEY'RE NOT JUST FOR RUGBY!

AHS' privacy team had a problem - frontline staff weren't always sure how to use privacy principles in their work. The privacy team wanted to help but traditions of steering committees, working groups, and lengthy guidance documents got in the way. That changed in February 2018 when the privacy team asked the AHS Design Lab to help us hold our first Design Sprint (a method of defining a problem and identifying and testing solutions over a two-day session).Seeing how effective the Sprint was for 'getting stuff done,' the steering committees and working groups were paused and we looked for a new, more Sprint-like way to work. Enter the Scrum: a method used in the technology industry to break up large project goals into manageable pieces. These smaller pieces are broken down into even smaller clearly defined tasks and assigned to a development team. The team has less than one month to complete the Scrum cycle and create a product. The team holds brief, daily check-ins where members keep each other on track and remove road blocks together. Within three days of our Scrum crash-course we held our first planning meeting with partners from the Information Management Risk team. We identified and ranked projects and each team member chose tasks. Our goal? In three weeks we would have a plan for a privacy & security coaches' network. Training yourself to work in new ways can be messy; our first Scrum cycle was too long, tasks weren't defined well enough, and meeting times had to change. We had to welcome the concept of 'failing fast and failing often'. As a result, we have a better understanding of the process and how we can improve. We are even nearing the end of our first Scrum with a product.What does this mean to the patient? Learning to Sprint and Scrum, is teaching privacy to support staff better by learning to act quickly, involving frontline staff in developing solutions, and promoting a proactive approach to privacy. Patients will see positive impacts on their overall patient experience as staff mature their privacy practices.

SETTING GOALS FOR PROCESS TRANSFORMATION: A SHIFT IN CONTEXT

Goals are foundational for improvement projects, providing direction and motivation for improved process outcomes. Setting goals often includes uncertainty and a pull towards being careful to create achievable goals.Consider the unexamined context of process improvement: changing a process to make it better. This produces great results while what gets missed is that the outcomes of a changed process are limited to what we already know is possible.Changing a process is to alter it, make it more, better or different that before. Transforming a process is bringing something new into existence, causing unpredictable and extraordinary outcomes. While there is nothing inherently wrong with changing processes, there is another world available through process transformation with a profound impact on the future of healthcare.'The electric light did not come from the continuous improvement of candles.' Oren HarariTransformational goals are not:In Order To Goals: What we have to do or are supposed to do, serving to produce a specific (often pre-determined) outcome.Fear of Failure Goals: Created out of a need to avoid failure, a limited method of ensuring project success.Unicorns & Rainbows Goals: Overly optimistic goals too big to be accomplished, lacking a basis in reality, impacting credibility.The first step to creating transformational goals is establishing the process Current State, to get how it works in reality , all the details, limitations and breakdowns. When we're clear on the Current State as the Current State, with nothing to fix and nothing to change, the Current State as it is and as it is not, we are able to set goals for transformation.Goals for transformation are created from nothing, a clearing for innovation and creativity. They're bold and ambitious, clear and measurable, based in reality and consistent with the intention of the improvement initiative. They form the foundation for transformation.Shifting the context from change to transformation is not easy. Lessons learned include a pull back towards changing the process. In process transformations, something is being created not changed. The realigning action is focusing on the fulfillment of the transformational goals, designing actions that make a difference.

SEXUAL & REPRODUCTIVE HEALTH SOCIAL MEDIA ACCOUNTS: PROMOTING HEALTHY SEXUALITY AMONGST YOUTH

With increasing STI rates in Alberta, and public attention on sexual assault and consent, this project focuses on an innovative method to promote healthy sexuality amongst youth. Calgary Sexual & Reproductive Health (SRH) Program has established social media accounts that offer positive evidence-based sexual health messaging and links to clinical services. Through the implementation of social media accounts, we hope to help engage youth in their care to reduce the stigma surrounding STIs, improve knowledge of STIs and contraception, and support healthy relationships.Through client feedback, and clinic attendance trends we found that youth couldn't easily access online information for sexual health resources and services. We were advised by AHS communications that first steps to obtain social media pages for SRH was to develop a landing page for resources and services. A provincial SRH working-group was established consisting of provincial subject matter experts and www.ahs.ca/srh was established. A social media strategy was submitted and approved by Communications & Legal & Privacy. Facebook, Instagram and Twitter accounts (@AHSexualhealth) were launched in the fall of 2017. Early 2018 the Calgary Adolescent and Youth Advisory Council (CAYAC) was consulted. Our goal of having 100 followers for each account was surpassed within a few months. Instagram has over 290 followers, Facebook with 198 and Twitter with 111. Instagram posts had over 1800 unique views, Facebook over 900 and Twitter with 11,200. Visits to the www.ahs.ca/srh has grown to over 1000 visitors a month. Despite many of our posts having a large reach, our primary goal for reaching youth ages 15-29 was only accounting for a small proportion of post views. The consultation with the adolescent and youth advisors was very valuable for ideas on how to reach more youth. The advisors thought that posts were informative and humorous and they suggested we add more videos and use Snapchat to reach more youth. With next steps, we hope to engage a larger youth audience by submitting a proposal to use other social media platforms, dedicate resources to pay to promote posts to youth accounts, as well as exploring functionality to create an anonymous question box.

Alberta Health Services

SHARING PATIENTS' HEALTH PERSPECTIVE IN A TIMELY MANNER " PATIENT REPORTED OUTCOMES DASHBOARDS"

Healthcare outcomes improvement projects aim to improve patient outcomes by adopting best clinical practices and care processes. While care processes and clinical outcomes can be monitored using existing electronic data, patient reported outcomes remain difficult to obtain. In AHS, EQ-5D has been endorsed as the tool to measure the patient reported outcome of health related quality of life (HRQoL). EQ-5D findings can be shared with frontline staff, managers, and administrators in a timely, interactive, and user friendly manner. Two cases from acute care will be presented.Working groups including physicians, unit managers, patient/family, and representatives from information technology and analytics were formed to develop and implement the improvement projects. Primary data collection experts were asked to lead and facilitate a sub-group to develop a process to collect EQ-5D data. Work plans were formulated in collaboration with physician project champions and unit managers.Both working groups identified a desire to receive timely feedback on the indicators so improvement targets could be set and progress could be monitored. Tableau dashboards were built with regular data updates; for EQ-5D data, the information is updated biweekly. Interactivity was built into the dashboard to provide unit and site level views. Discussions took place with the intended end users to ensure that the dashboards are meaningful and useful, which resulted in different presentations of the EQ-5D data in the two cases. It is hoped that by viewing a project's measurable differences, staff and physicians will become more aware of the impacts of their outcomes improvement work.While only a small amount of meaningful change in HRQoL was found in the first project, the established processes and learnings were easily translated to the second case. The second case is still in the early stages of data collection and the project's impact on patient outcomes remains to be seen.These two cases demonstrated that patient reported outcomes can be easily collected using EQ-5D and data visualizations can be produced using Tableau dashboards. EQ-5D information can be integrated into any outcomes improvement project to provide patients' perspective and our EQ-5D dashboards can be used as reporting templates or examples.

SOAR - SPIRIT OF ART AND RECONCILIATION

The Idea:AHS is committed to creating a culturally safe and welcoming health care environment to support and build trust with Indigenous (First Nations, Metis, and Inuit) Communities. Chinook Regional Hospital in Lethbridge is situated on traditional Blackfoot territory, home to many Indigenous peoples. The initiative demonstrates intent for reconciliation, enhanced cultural competency among staff & physicians, and develops customized expressive arts for Indigenous patients and families - creating a culture in which everyone feels safe, healthy, and valued, and can reach their full potential. The project demonstrates respect for patient's beliefs, traditions, culture, values, and protocols and builds stronger relationships between patient/family and care providers.

The Journey:Indigenous Health, South Zone partnered with Therapeutic Recreation, the Chinook Regional Hospital Site Leadership, Elders, and several AHS provincial programs including Environmental Services, Facilities, Maintenance & Engineering, and Infection Prevention & Control to create a unique Indigenous Art Project that is improving positive experiences in health care, ultimately transforming care for Indigenous people.The Indigenous Art Project named SOAR - Spirit of Art and Reconciliation is facilitated with a holistic approach, honoring traditional practices to improve wellness and support access to care, while building relationships and respecting beliefs, behaviors and values, creating an environment that is safe and promotes the dignity of all people. There are 6 Components to the project: SOAR: Spirit of Art and Reconciliation Drop in Expressive Arts Group; Creative Comfort Kits; Bedside Art Cart; Art in the Atrium; Mural;   Indigenous Art & Artifacts Display

 The Impact: The initial results have been amazing. The stories, photos, narratives, and comments from patients and staff involved have all been extremely positive. Attendance at events has been overwhelming and people are very engaged while participating. With the patients, there is an early indication of improved mood, decreased stress, increased connection with culture and community.

Lessons Learned:Evaluation of the project is in the early stages, and ongoing. There is interest in other parts of the province to spread this initiative to other areas.

Alberta Health
Services

SQUID¦ GOING TO NEW DEPTHS: TAKING INTERACTIVE REPORTING TO LEVELS NOT YET DISCOVERED IN PRIMARY CARE

1. Our idea: We have reached a point in our existence where data has become a driving force propelling our increasingly connected lives. Here at the Department of Family Medicine (DFM) in Calgary, we have not only embraced this revolution; but believe we have created a tool that has the potential to lead the ever changing informatics landscape not just for DFM but any seeking to advance the patients wellness journey. More than ever we need enhanced capacity and capability to process, interact, and manage this plethora of data into meaningful, sharable, idea provoking information not just for providers but patients, families, and stakeholders alike. We need to observe current trends in interface design and aggressive innovation while making is friendly to all users; and we believe SQuID is on target to bring this vision to reality.

2. Our journeyDuring this journey of development and exploration we have met many challenges. From convincing potential stakeholders of its necessity, to internal setbacks caused by those who struggled to see our vision, to convincing providers to share their data with us. It has been a long journey, and we would like to share it with as many as we can; in the hopes that not only will they be able to learn something from us, but us from them. Yet all of these lessons and tribulations have allowed us to take SQuID to new depths.

3. Potential or actual impactSQuID connects both external stakeholders and internal providers by encouraging the conversation about the data that drives our daily healthcare activities. Improving on the prototype model created in its first year and by listening to user feedback we have created more exciting and engaging interfaces offering some of the most vivid, lush and fresh perspectives with respect to the perception of the data.By connecting both web and mobile application development we believe we have the potential to change the face of informatics in our industry. The real time participation and communication between healthcare providers can lead to faster decisions regarding potential pathways of care while at the same time observing an enhanced awareness and analysis of the data itself. All built on a platform for capacity for all kinds of services to utilize the system.

 4. Lessons learned 1. The more we work together; the better we work. 2. Data, data, data. The more we analyze, the better the decisions we make 3. Don't be afraid to hit new depths

Alberta Health Services

STOP STARVING SURGICAL PATIENTS! " TRANSFORMING PATIENTS' SURGICAL EXPERIENCES THROUGH A PROVINCIAL PRACTICE CHANGE TOOLKIT

Many surgical patients in Alberta are still asked to stop eating and drinking at midnight despite evidence-based Canadian Anesthesia Society minimum fasting guidelines of last solid food at 6 hours and last clear fluids at 2 hours before surgery. Enhanced Recovery After Surgery (ERAS) evidence recommends patients drink high carbohydrate clear juice (carb loading) 2 to 3 hours preoperatively to provide energy for recovery. Uptake of current preoperative fasting guidelines and carb loading practices varies across Alberta Health Services (AHS). Since 2013, ERAS implementation has introduced these practices at 9 sites/8 surgical areas. Decreasing preoperative fasting times and adding carb loading has improved patient comfort with decreased anxiety and postoperative nausea and vomiting. In alignment with the Alberta Surgery Plan, there is a need to standardize preoperative fasting and carb loading practices provincially to avoid prolonged and unnecessary fasting, and improve surgical quality, safety, and experience for all surgical patients. Through engagement with anesthesia, surgeons, nutrition and site operations, the ERASAlberta provincial team developed a comprehensive standardized Preoperative Fasting and Carb Loading Toolkit for surgical sites. The Toolkit provides sites with tools and resources to implement evidence-informed 1) preoperative patient instructions, and 2) clinical practices following minimum fasting guidelines and carb loading recommendations. The Toolkit includes clinical evidence, process improvement, change management, engagement, planning and communication templates and guidance. Patient advisors were involved in redesigning patient education materials. Patients suggested preoperative instructions need to focus on what patients should do instead of what they should not do. The Toolkit is being tested at Red Deer Regional Hospital (RDRH) from Feb to May 2018, with Calgary Zone roll out planned for May to June 2018 with spread to other Zones later in 2018/19. Toolkit evaluation will focus on patient experience, practice change resources utility/acceptability/uptake, and impacts to surgical safety and operations. Findings from the RDRH implementation will inform Toolkit updates before further provincial spread. The Toolkit has the potential to support changes to deeply engrained outdated preoperative fasting beliefs and practices, and contribute to the transformation of surgical care across Alberta.

Alberta Health Services

SUPPORTING THE HOSPITALIST AGAINST MEDICAL ADVICE DISCHARGE

Idea: Patients are not always able to remain in hospital as prescribed by the health care team. Patients leaving prior to completion of care are labelled as discharged against medical advice (AMA). These situations strain the patient-provider relationship. Patients feel their need(s) are not being met in hospital, while providers fear consequences of incomplete treatment. What if the care team had means to support patient autonomy and facilitate successful recovery beyond hospital walls? Whether it is having a prescription available, calling the patient to ask why they left, connecting to community services or arranging follow up appointments, opportunity exists to provide greater integration from hospital to community.

Journey: The Peter Lougheed Centre serves a diverse, complex, inner-city population. The perception exists that Hospitalist AMA discharges affect people with increased vulnerability and determinants of health disparity. Our initial step (in progress) is to evaluate a sample of Hospitalist AMA discharges for medical and social criteria that complicate patients' return to health. With this information, we plan on engaging nursing leadership, Patient and Family Centred Care, Mosaic Primary Care Network and other relevant community organizations to collaborate on building a process for the health care team and a toolbox of resources to provide patients when they are leaving the hospital setting AMA.

Potential Impact: Preliminary findings suggest patients are often suffering from a concomitant addiction, however the active medical issue varies from infections, wound care and management of chronic diseases. Social issues such as housing, lack of identification and income support will require further analysis. Reproduction at Calgary's other hospitals will provide local context to inform potential project spread. It is hoped that having appropriate resources available to provide patients leaving AMA will increase the likelihood of successful treatment and aid providers' unease with respecting patient autonomy.

Lessons Learned:We expect that clinician ability to predict AMA discharges will pose a barrier to providing resources tailored to patient needs. Connecting with patients who have already left the facility will likely pose additional challenges. We hope a multi-stakeholder, collaborative approach will design interventions that meets the needs of both patients and providers.

Alberta Health Services

TEENS - PARTNERS IN CARE AND CO-DEVELOPERS OF HEALTHCARE SERVICES

We believe teens living with a chronic condition can be partners in their care and play an important role in the development of healthcare services. This belief led the Well on Your Way program with the support of the Primary Health Care team to design and deliver Teens Talk Transition, a workshop designed in partnership with and led by teens and young adults living with a chronic condition. Often when teens move from pediatric to adult healthcare, their health gets worse, they don't attend medical appointments, and they are seen more frequently in emergency departments. We wondered what could be done to better support teens during this risky period. When asked what they needed, teens and young adults said: 'coordination of activities that would engage youth and make transition easier'. We recruited a group of teens and young adults to make their request happen.Teens Talk Transition is the solution that our teens came up with; a 4-week program for teens living with a chronic condition that is also led by teens and young adults living with a chronic condition. (No adults allowed!) We were challenged with concerns and safety issues around the idea of teens and young adults leading the workshop without adult supervision. Thus, we developed an education program, a step-by-step document to guide leaders through potentially difficult situations, made available two Alberta Health Services staff to respond to emergent situations, and offered a debrief session each week. This program began in February 2016 and we are happy to report that no negative events have occurred. We continue to have registrants and peers volunteering to lead, and have received positive feedback from everyone involved. Peer leaders say it is rewarding to know that they have 'an influence and impact' and appreciate being involved with a group of peers who 'support [them]'. Although we have been successful recruiting teens, the numbers are small and we know that there are many teens we are not reaching. We are currently working with a group of teens and young adults to learn how to market our program better.

Alberta Health Services

THE 3 QUESTIONS PROJECT IN PEDIATRIC RHEUMATOLOGY- A SELF-MANAGEMENT INITIATIVE FOR YOUTH WITH RHEUMATIC DISEASES

3 Questions' is an exciting self-management support initiative at the Glenrose Rehabilitation Hospital. This initiative focusses on giving youth with chronic illnesses (in this case, rheumatic diseases) a formalized opportunity to address their specific concerns, not their parents', during appointments. Beginning at age 7, youth are offered a list of age-appropriate 'frequently asked questions', and asked to choose up to 3 questions they would like answered during each visit. The questions cover a wide variety of topics ranging from medication side effects to risky behaviours to mental health, and can be answered by different members of the multidisciplinary team, depending on the question(s) selected. Currently, the focus on chronic disease self-management in pediatric rehabilitation at our centre is in involving the youth in decision-making about their health, but has not yet evolved into empowering the youth to take the lead in these conversations, making this an innovative approach. It has only been in recent years that the views of young people with chronic health conditions have been sought. Calls for greater attention to young people's voices coincide with the views of young people themselves, who report they often feel left out during their medical appointments, in which the discussion commonly focuses on parent issues and perspectives. Studies show that from early adolescence, youth with chronic diseases report wanting greater engagement with their health care providers. The 3 Questions Tool will impact these youth by teaching them, from an early age, to engage in the conversation about their health. This initiative also aims to teach and reassure parents that they can continue to maintain their naturally protective role while supporting their child's emerging ability to independently manage their health.Two different versions of this tool were created, for ages 7-12 and 13-17. The questions in both versions differ based on age and reading level. The versions will be piloted on actual patients in clinic, and once launched, we will track which questions are asked most commonly and make adjustments to the tool as needed. Our vision is to spread this initiative to other programs at our pediatric rehabilitation centre.

THE AHS INDIGENOUS PATIENT JOURNEY PROJECTS

The AHS Indigenous Patient Journey projects sought to explore what was working, what was not working and what was missing in Addiction and Mental Health (AMH) services delivered to Indigenous populations of Alberta. Stakeholders agreed the best way to get an accurate representation of service experience and service need was by listening to the voice of lived experience; the indigenous service-users themselves. After a hundred interviews with indigenous high needs and sometimes homeless service-users and another hundred indigenous service-users who were incarcerated, the project team has much to share about the AMH services currently delivered to Indigenous populations. This presentation examines levels of lifetime trauma exposure in these two Indigenous populations and how it influences service needs. the presentation highlights the presence of cycles in those who've received Addiction and Mental Health treatment as well as those who've been incarcerated. Participants will see and recognize the gaps in service delivery that further propagate these cycles. Perhaps most importantly participants will hear actual examples of the service user narrative; testimonials that offer a raw depiction of the Indigenous service-user experience.The presentation concludes with recommendations for AHS Addiction and Mental Health service enhancements that will address gaps in services delivered to Indigenous populations, as well as a brief discussion of current and planned initiatives.

THE COMPLEX CARE HUB: THINKING OUTSIDE HOSPITAL WALLS TO TRANSFORM THE HOW, WHERE AND WHO OF ACUTE CARE DELIVERY

Are older adults safer in hospital? The literature suggests an increased risk of iatrogenic complications, functional decline and mortality for older adults admitted to hospital versus those receiving hospital-at-home services. Despite this, admissions to Internal Medicine are rising, with older adults accounting for greater than 40% of these encounters.The Complex Care Hub program was designed to break down barriers to managing patients with high medical and psychosocial complexity in the community. The CCH bridges acute, community and primary care, providing low-acuity intensive medical care for patients while they sleep at home and resume their usual activities. While it is inspired by national and international hospital-at-home and home-based primary care programs, the CCH is novel in its collaboration between General Internal Medicine (GIM), Community Paramedics and Home Care. It also has extensive technological infrastructure, including a shared electronic health record and telemedicine.The CCH launched in February 2018 at the Rockyview General Hospital (RGH) after 2.5 years of stakeholder engagement to obtain support from Calgary Zone and RGH leadership, and negotiating with various RGH and community services. We utilized tabletop exercises, simulation and upskilling all providers to help stakeholders imagine how their current processes could be adapted to accommodate this new model of care. We have admitted 17 patients to date from the Emergency Department. Continual communication with ED staff on eligibility of patients and examination of the diurnal variation of consults in ED, have begun to improve the volume and quality of consults. With each patient, we are learning how to connect with community partners to provide the services that will help them succeed in the community ; a process we believe will strengthen ties between acute and community care. The CCH is anticipated to reduce cost, impact satisfaction (patients, caregivers and providers) and patient outcomes (morbidity, mortality and functional status). It has potential to spread across Calgary Zone and possibly Alberta. This is the beginning of creating a framework for acute care services that can become integrated with and support patients in their health homes, transforming where and how we deliver care in the community with novel healthcare teams.

Alberta Health Services

THE EDMONTON ZONE VIRTUAL HOSPITAL

Individuals living with chronic, complex health issues are often challenged to navigate our fragmented health system. Forming a system wide team of professionals that can 'knit' a tightly woven support system around these individuals and support their health, social, advocacy and self-management skill development needs is the goal of the Edmonton Zone Virtual Hospital (EZVH). Acknowledging the 'break' in care continuity as patient's transition from acute to community care, and moving forward with a desire to close this gap, a partnership has been formed. Together acute and community care leadership applied to Enhancing Care in the Community and were awarded three years of developmental funding to strengthen 'person centred, community delivered, technology enabled integrated care'. Using the project team to identify patients, system partners, community resources and current processes the work has progressed; through the use of rapid PDSA cycles starting April 23, the operational model will be finalized for scale and spread. In addition to development of an operational model the EZVH project will see the development of an Innovation Lab and an evaluation frame work, based on the quadruple aim, and inclusive of economic impact. Measuring for both processes and outcomes; expected benefits include: - Improved patient, family and caregiver experience - Reduction in readmission to acute and emergency care, reduced Length of Stay - Testing and Integration of new technologies to support home-based care - Overall increase in patient flow from acute to community care with eventual reduction in system utilization and cost. Enhancing care in the community requires integration of teams that have traditionally worked independently; this is hard work. Through many conversations, teams have engaged and are working towards strengthened support for medical and social care for the populations identified. Challenging current communication and information flow, care paradigms and infrastructure at all levels of the organization, often requires conversations and engaging partners one at a time. The EZVH will succeed and pave the way for a new way of delivering care, and more patient-centred care for Albertans. The biggest lesson that we live every day is that change takes time, commitment and communication, communication, communication.

Alberta Health Services

THE EFFECTS OF MUSIC THERAPY ON THE PARENTS AND FAMILIES OF NICU PATIENTS

The impact of the neonatal intensive care unit, however necessary, can have devastating consequences to the patients and families it treats. Young patients who stay in the NICU are susceptible to various forms of physical, neurological and developmental delays in addition to the powerful and long-lasting impact on families and caregivers. Music and music therapists can minimize both the long and short-term consequences through the use of non-pharmacological methods such as singing and the use of the ocean disk.The majority of existing music therapy studies are targeted directly to the NICU patients themselves with some benefits for the parents being seen as a positive secondary result. At the time of writing, there are few, if any, studies or practices of music therapy that directly target the parents/caregivers of the NICU patient. However, the secondary effect of music therapy as shown below offer an optimistic future for parents moving forward from the NICU into their home life.

Alberta Health
Services

THE NUDGE PROJECT: INNOVATIVE ENGAGEMENT SOLUTIONS TO ADDRESS MANAGEMENT OF URINARY TRACT INFECTIONS (UIT) IN A COMMUNITY ER

Our Idea: start a conversation with Strathcona Community Hospital (STCH) staff around the management of Urinary tract infections at their ER. The conversation needed to allow us to understand site processes and concerns, but also inform and inspire the team to change.

Our Journey: In 2016, an audit of antimicrobial prescribing practices for UTI management showed that antibiotics were used inappropriately for the vast majority of presentations. We partnered with site leadership to engage in a dialogue around next steps to ensure appropriate antibiotic prescribing. It was concluded that a Co-Creation Workshop could support this goal.Co-Creation Workshop borrows from the 'Ikea-effect' concept, when a team builds the solution they have a greater commitment for it to succeed. A two-minute video introduced participants to the problem and workshop objectives. The co-creation exercise consisted of 3 activities: 1) The UTI patient journey & our journey, 2) a Five Whys tool, and 3) moving towards change.

Our Impact: There was an enthusiastic response to the Workshop, participants proposed several approaches to address UTI management at the site. Participants felt as part of the solution and project. Several strategies have already been implemented at the site. Preliminary results are positive and an audit to be done shortly will measure the impact of this initiative.

Lessons Learned: The co-creation workshop helped healthcare providers identify their own challenges and opportunities to deliver better patient outcomes regarding UTI management. Engagement of a broad spectrum of the healthcare team has created a group of partners committed to project success.

Alberta Health Services

TRANSFUSING KNOWLEDGE BEFORE BLOOD:CO-CREATING BETTER DECISIONS WITH PATIENTS ABOUT RED CELL TRANSFUSION

The Idea: Red blood cell (RBC) transfusion is often critically necessary, however the criterion for RBC transfusion has become increasingly conservative over the last several years, particularly in the stable non-bleeding patient. Traditionally RBC transfusion has been undertaken based entirely on physician recommendation and assessment of patients' symptomatology coupled with a variable informed consent process. When RBC transfusion is not critically necessary, can we find a simple way to involve patients in the decision process to help avoid potentially unnecessary transfusion and respect patients' unvoiced goals and values?

The Journey: We have developed a decision aide for patients to help them understand the potential risks and benefits of RBC transfusion. This has been vetted by physician and nursing staff and the provincial transfusion committee. The aide is currently under review by a patient/family advisor. We aim to undertake a study of this aides' impact on patient understanding/satisfaction with the consent process using a survey tool We intend to study/survey the impact on nursing and physicians' satisfaction with the decision aide and consent process using a similar survey.

Potential Impact: 1) Improve satisfaction/standardization of consent to RBC transfusion for patients and providers. 2) Co-creation of a decision aide for patients, so that non-life threatening RBC transfusion decisions and discussions can be framed from the patient's perspective. 3) The possiblity that a subset of patients may forgo RBC transfusion and pursue conservative therapy for their anemia based on their values and symptoms, thereby reducing a possibly unnecessary and potentially harmful intervention.

Lessons Learned:Multiple modifications have been made to the decision aid with the likelihood of more iterations to come.Significant concerns by both providers and patients may arise surrounding shared decision making. We will need to address these concerns and find solutions.Next steps will be to translate learnings from this project to extend involvement of patients'/families' voices and values in our routine medical decision-making processes to other areas using similar processes.

Alberta Health Services

UNDERSTANDING THE PATIENTS' PERSPECTIVE: COLLABORATIVE INNOVATION TO IMPROVE THE EXPERIENCE OF ADRENAL INSUFFICIENCY (AI) PATIENTS.

Our Idea: The Division of Endocrinology at the University of Alberta is applying a human-centred design approach to improve the patient experience of people living with Adrenal Insufficiency.

Our Journey: We recently developed an informal online survey for endocrinologists treating patients with primary adrenal insufficiency (aka Addison's disease) in Edmonton. The survey was completed by 15 endocrinologists and identified practice variations in terms of the information provided to patients regarding the need for stress dosing, as well as in the provision of an emergency letter and wallet card. Partnering with the Physician Learning Program, we applied a human-centred design approach to improve and standardize care that fulfills patient-identified needs. We used ethnographic probes in the form of patient diaries. The probes showed how patients experience low cortisol levels, what helps them in management, and what they would have liked to have known at the time of diagnosis. A co-design workshop that included patients and physicians confirmed that patients are experts in living with this condition and that every patient experience is unique.

Our Impact: Patients were grateful to be consulted. Through listening and acknowledging the patients' experience, we have identified five possible ways to improve the delivery of care for patients living with adrenal insufficiency: 1. Ensuring patients have written information on existing resources 2. Ensuring patients have an emergency card 3. Involve the family as part of the care team when appropriate 4. Consider group medical appointments to help build peer support 5. Develop a shared decision making tool to facilitate disease management. The knowledge will inform the care we provide to ensure it is built around patients' needs, expectations, capabilities, and skills and ultimately makes sense for each individual's circumstances.

Lessons Learned: We learned the power of listening and partnership in order to create common ground to improve care for those living with adrenal insufficiency. We learned that flexibility, openness, and collaboration are key to innovation: we must understand the perspectives of our patients to re-shape their experience. Finally, we learned the value of engaging with patients outside of the traditional confines of clinical practice.

USING A MIXED-METHODS APPROACH TO CAPTURE THE CHILD AND YOUTH PATIENT VOICE

The Patient and Family Centred Care (PFCC) Evaluation Committee at Alberta Children's Hospital (ACH) has spent the last two years primarily focused on innovatively capturing direct feedback from child and youth patients. In paediatric settings, PFCC and experience data is most often gathered from adult parents and care providers. Collecting information about experiences of care directly from children and youth is imperative, yet presents unique challenges and unexpected process issues. In this case, we may learn as much or more from the effort, as from the data collected.

Traditional methods of collecting data required adaptation to accommodate this relatively young patient population and the ACH environment. We consulted with the Child and Youth Advisory Council, family representatives, and staff and physician experts throughout AHS in order to develop our data collection procedures and tools, which include simpler language and more attractive designs.

We piloted different versions of surveys in the ambulatory and inpatient areas with different age groups using iPad and paper-based surveys, and we conducted art project focus groups with the general patient population and mental health unit patient population. All of these methods and modes have pros and cons, resulting in shareable learnings for others within AHS who would like to collect process improvement and evaluation data with children. We will provide examples of all methods and modes within the proposed poster.

Recruitment of participants has been our biggest challenge, especially with the inpatient population. We had expected the iPad survey, offered at the bedside, to be the most popular mode and provided paper copies of the survey as an alternate option. Surprisingly, patients often chose the traditional mode of a paper survey. We are considering mailing out the next wave of the child/youth survey as an accompanying piece to our parent/guardian survey. While we have had success with the design of our data collection tools, our data collection procedures have required much discussion and some revision by our evaluation committee. That being said, we have collected rich data over the last couple of years which has facilitated improvement at ACH.

Alberta Health Services

USING DIGITAL PATIENT REPORTED OUTCOME (PRO) REPORTS IN AMBULATORY ONCOLOGY CARE: ESTABLISHING WHAT IS MEANINGFUL

Traditionally, wide scale collection and use of PROs to inform care delivery has been slow due to technological and operational barriers (Wagle, 2016). Recently, CancerControl Alberta (CCA) developed a clinical process for the electronic capturing and reporting of PROs through four new digital PRO reports: an individual trended dashboard, a clinic list report, a symptom cluster report and an aggregate dashboard. We wanted to understand how these reports could be meaningfully integrated into routine ambulatory care processes at one regional cancer centre. We believed utilizing these reports would have a positive impact on patient experience, clinical efficiencies, interdisciplinary collaboration, and contribute to advancing the culture of patient and family centred cancer care. To establish the most meaningful ways to use these PRO reports, a Proof of Concept (POC) was undertaken with a Physician, three Nurse Practitioners, the Allied Health Care Team, clerks, Registered Nurses and patients. Reports were tested in the pre clinic, in-clinic and post-clinic environments. A robust pre-post patient evaluation was conducted to understand how patients felt these reports influenced their care and impacted their experience.Findings suggest these reports were meaningful to the health care team in each phase of the clinical process. Patients felt the reports contributed to an improvement in symptom management and communication between them and their care team. One surprising finding was clinicians found these reports improved interdisciplinary collaboration and communication. The next iteration of this work is the scale and spread of these reports to all the provincial cancer centres over the next four years.The biggest success was working with a site manager who supported our project teams change management efforts contributing to the success of this project. The biggest challenge was that using these reports depends on clinician's competencies in managing a broad range of symptoms, having time in the clinic visit and which symptoms the patient wants support with. Thus the practice change is much larger than simply introducing a new report. As we scale and spread this work to all other cancer facilities provincially, our clinicians will require support to take a person centred approach to clinical encounters.

Alberta Health Services

USING FACILITATED AUDIT AND FEEDBACK SESSIONS AND PHYSICIAN REPORTS TO HELP EMERGENCY PHYSICIANS IDENTIFY OPPORTUNITIES FOR PRACTICE IMPROVEMENT

Thousands of dashboards have been created within AHS to provide clinicians and administrators access to rich and powerful administrative data. But the full potential of these dashboards has not been fully realized. No where is this more evident than in the emergency departments (ED) in Calgary, where we have been providing physician with their metrics for a number of years. Although our reports are robust, they have been disseminated passively and without a clear strategy to support clinicians on self-reflection or on how to change their practice.

Our Journey: Optimizing ED physician metrics has been a multi-year process, culminating with a survey last year that allowed us to better understand how physicians interacted with and used their data. We used the results to finalize a robust, evidence informed individualized Physician Report that incorporate the best Audit and Feedback (A&F) evidence. But clinicians also told us in their surveys and at annual reviews, that the reports were not enough; they wanted concrete strategies to improve their practice.

Impact: The first of a number of planned facilitated A&F session was conducted with a group of 19 physicians who volunteered to attend a session to review and self-reflect on their individual data reports and discuss opportunities for practice change. Physicians present all agreed/strongly agreed that the session helped them identify learning opportunities and helped them identify strategies for change in their practice. Because of the success of this first session, funding has been secured to scale these sessions up to all ED's in the Calgary zone. This project has the potential to decrease variability in care provided and reduce low value care in the ED. Future plans include developing peer to peer mentorship and a coaching for practice improvement model.

Lessons LearnedOur experience is that many physicians want to use their individualized physician reports as a tool to identify perceived and unperceived learning needs. Facilitated A&F sessions are a novel CME tool that have been shown to be an effective tool to engage physicians, socialize the process of reviewing one's individual data and an opportunity to discuss strategies and barriers to practice improvement.

Alberta Health Services

WE CAN'T GIVE AWAY WHAT WE DON'T HAVE:COMMUNITY ENGAGEMENT THROUGH INDIGENOUS WAYS OF KNOWING

Learning Objectives:

1. Participants will be able to state the importance of a Talking Circle format to engage Indigenous children, families and communities to take charge of their own health.
2. Participants will be able to identify strategies to empower patients to heal.
3. Participants will be able to apply through protocol a Talking Circle in their area of practice. ActivitiesPlease join or panel to experience a fish bowl Talking Circle as we create a safe place to learn about the effects of Residential school and the healing journey with one of our Elders. Observers will be given an opportunity to participate in the Talking Circle and debrief session.

Intention (Methods): The purpose of the 'community engagement through Indigenous ways of knowing' presentation is to provide health care professionals a unique example of how Talking Circles can provide a safe environment to engage Indigenous communities in their own healing and health goals. This concept is one way of honouring and implementing the Truth and Reconciliation Commission of Canada: Calls to Action, especially #19 'to consult Indigenous peoples, to establish measureable goals to identify and close the gaps to health outcomes.Relationships (Innovations)Stollery Awasisak Indigenous Health team hosted a 'Vision Day' to talk about what is the best care for children and their families at the Stollery.

Decolonizing (Outcomes): Talking Circles and community engagement is implemented with Stollery Awasisak (Cree for children) Indigenous Health an innovative process for a large children's hospital to include families and communities in developing priorities to promote health equity and enhance strategies to reduce health disparities for Indigenous children in central to northern Alberta.

Results: A Talking Circle Report developed by Alberta Health Services Evaluation Department and the set priorities from the report implemented by the Stollery Awasisak Team.

Transformation (Conclusion): Talking Circles were initiated in 7 communities with the involvement of 28 communities and 95 participants throughout central to northern Alberta to share their hopes, visions and dreams for better access to health services for their children. The continuation of community engagement and staff shapes the foundation for successful Indigenous relationship building.

Alberta Health Services

WHAT IF CITIZENS...?

What if citizens co-designed a way to help Albertans be ready participants in their own healthcare and active participants in redesigning healthcare? What if we started answering common questions like 'what's the difference between Alberta Health and Alberta Health Services' so that instead of waiting to be told where to go, citizens could easily find their way? What if multiple organizations saw the same kind of need and came together using citizen power, virtual conversations, and strategic in-kind organizational resources? Healthcare 101 is our audacious dream-to-taskforce project that has resulted in citizens agreeing to be task force partners, content co-creators and literal guardians of the process and materials. Patients, families and users of health care systems shared challenges, frustrations, and then brainstormed and developed what a solution may look like. Content development was cross-referenced using Alberta's Quality Matrix for Health four domains â€" Being Healthy, Getting Better, Living with Illness or Disability and End of Life. A prototype was launched with a just-do-it mentality to learn and improve, with subsequent launch of Healthcare Basics for Albertans* on MyHealth Alberta Spring 2018. The next three themes will be Finding my Way, Being My Own Advocate and My Rights.Led by IMAGINE Citizens Collaborating for Health and Alberta's Strategic Clinical Networksâ„¢, the content resides on MyHealth Alberta (MHA). MHA's crucial support is joined with leadership and resources from Health Quality Council of Alberta, W21c, ActionDignity, Integrative Health Institute, Alberta's SPOR " Patient Engagement Platform, Alberta's Health Advocates, Patient and Community Engagement Research and several departments within Alberta Health Services (Engagement & Patient Experience as well as Communications). Additionally, business students at the University of Lethbridge developed a social media campaign and co-created materials with our project in order to help us to start promoting the content. Our definition of success? Co-design with the collective partnership and ownership by the voice of the audience, maintain an eagle's overview of the health systems, test with citizens, address sustainability, and target all populations across their life span. Why pick us? We need a wise crowd's help to properly build our second theme, Finding my Way.*https://myhealth.alberta.ca/HealthTopics/healthcare101

WHAT'S APP DOC? TRANSFORMING THE CONSULT EXPERIENCE FOR PATIENTS AND FAMILIES WITH AN AHS CONSULT RECORDING APP

Specialist consultations can be very overwhelming for patients and families. Research has found that audio-recorded consults can improve information recall, retention and patient experience. As a result Alberta Health Services (AHS) and Alberta Cancer Foundation (ACF) have partnered to develop an innovative free audio recording smartphone application ('App') for patients who are having a consult within CancerControl Alberta (CCA). A patient controlled app minimizes information privacy concerns while setting the context for appropriate patient recording behavior including alerting the physician to the recording, not recording in public spaces, and discouraging sharing of the recording on social media. Several other patient centric features have been incorporated including a notes feature for saving patient notes and a question/reminder function.

To ensure alignment with best practices, AHS Legal, Privacy and Communications, the Alberta College of Surgeons and Physicians, and the Canadian Medical Protective Society have been consulted. Stakeholder recommendations have been incorporated into the design and functionality of the app. After the initial design phase, direct patient feedback was sought via a Cancer Patient Advisor network survey and hands on user testing, with AHS Human Factor team assisting. Based on this feedback, modifications were made to the app.

Once the app is built and accessible, the launch and testing of the app will occur in a multi phased approach with a targeted physician change management strategy. We believe having the ability to re-listen to the consult and share it with family members will improve information recall, decrease follow up phone calls for clarification and result in patients who are empowered to participate in decision making.

Our key lessons include that patient feedback through user testing resulted in several modifications to improve utility. Second, the change management strategy for physician practice was pivotal in securing physician support. To address concerns from the AMA we worked to ensure the app's audio recordings were not modifiable. This provided an important protection for physicians.

We believe that this app will be of benefit beyond CCA and as such we have kept the cancer specific content minimal. Broader AHS use will be explored subsequent to CCA implementation.

Alberta Health Services