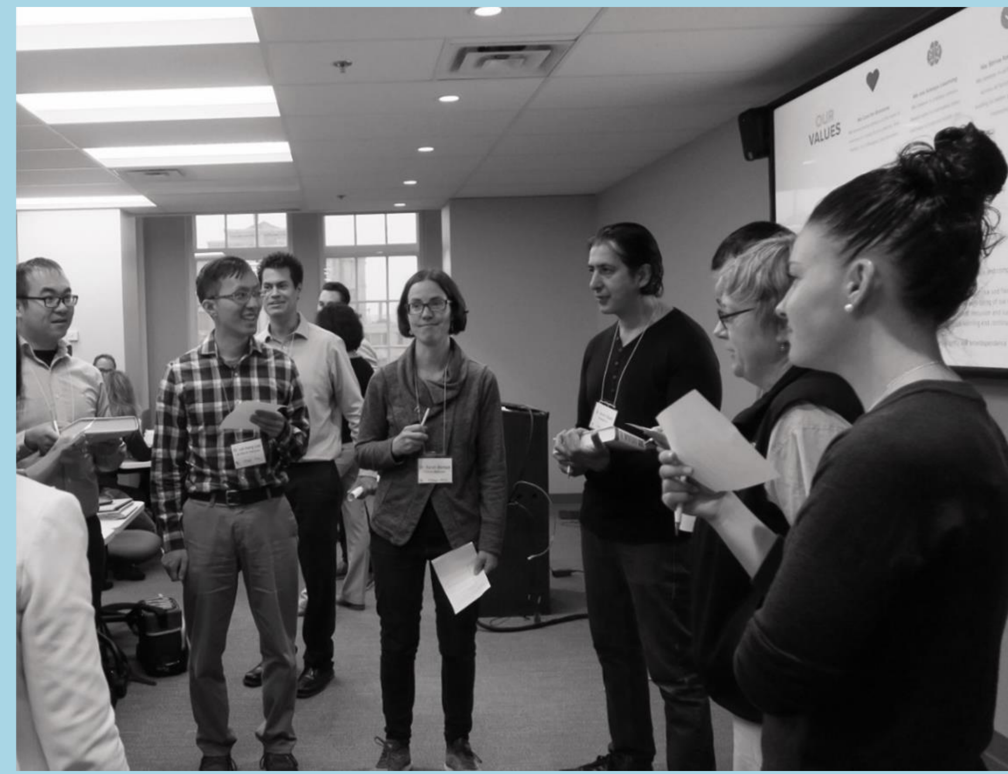


Physician Quality Improvement: Examples and Opportunities

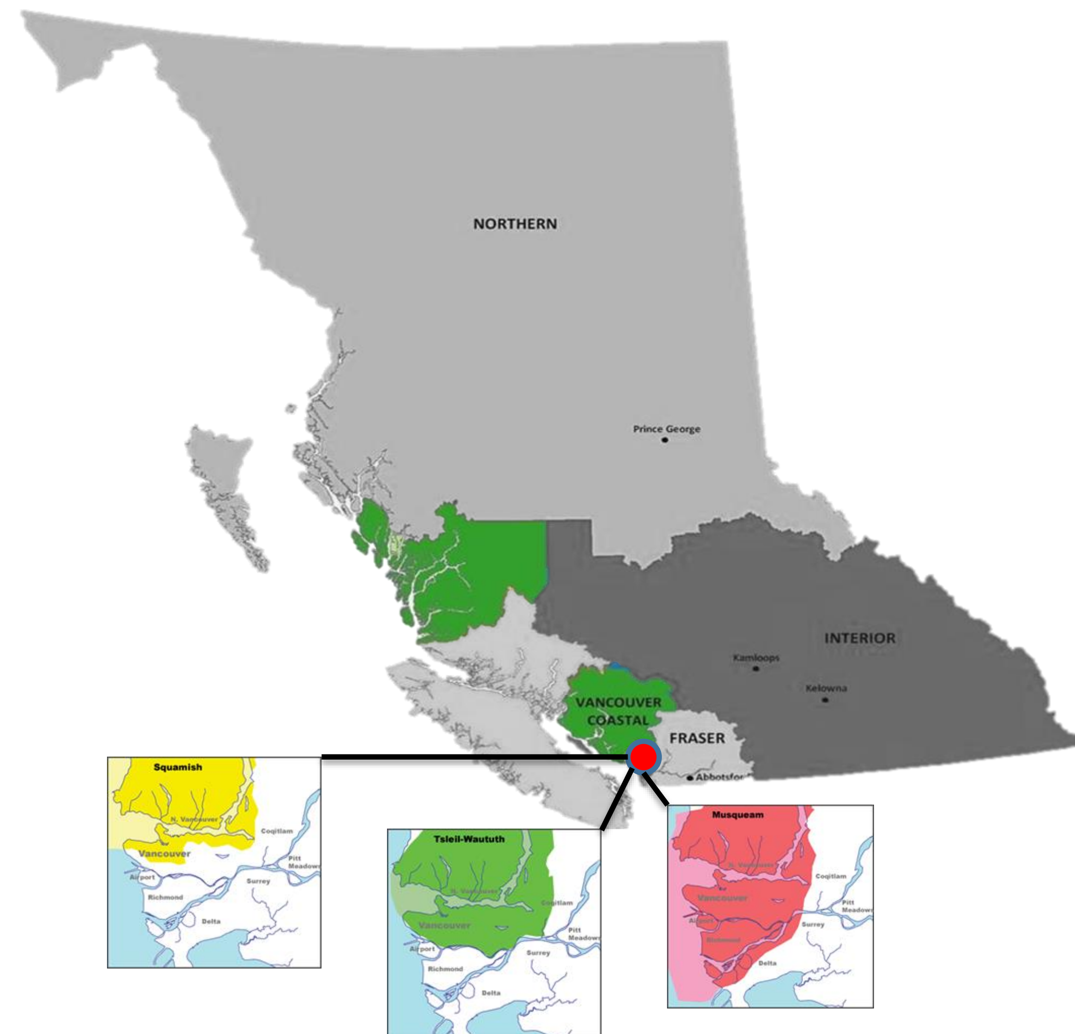
Dr. Amrish Joshi, Dr. Vandad Yousefi, Enrique Fernandez

Providence
Health Care
How you want to be treated.

Territory Honouring

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

Vancouver Coastal Health is committed to delivering exceptional care to 1.2 million people, including the First Nations, Métis and Inuit in our region, within the traditional territories of the Heiltsuk, Kitasoo-Xai'xais, Lil'wat, Musqueam, N'Quatqua, Nuxalk, Samahquam, shíshálh, Skatin, Squamish, Tla'amin, Tsleil-Waututh, Wuikinuxv, and Xa'xtsa.



Indigenous Health | Vancouver CoastalHealth

A bit about us

Dr. Vandad Yousefi

Department Head, Family and Community Practice

Dr. Amrish Joshi

Palliative MD, Richmond Integrated Palliative Care Program.

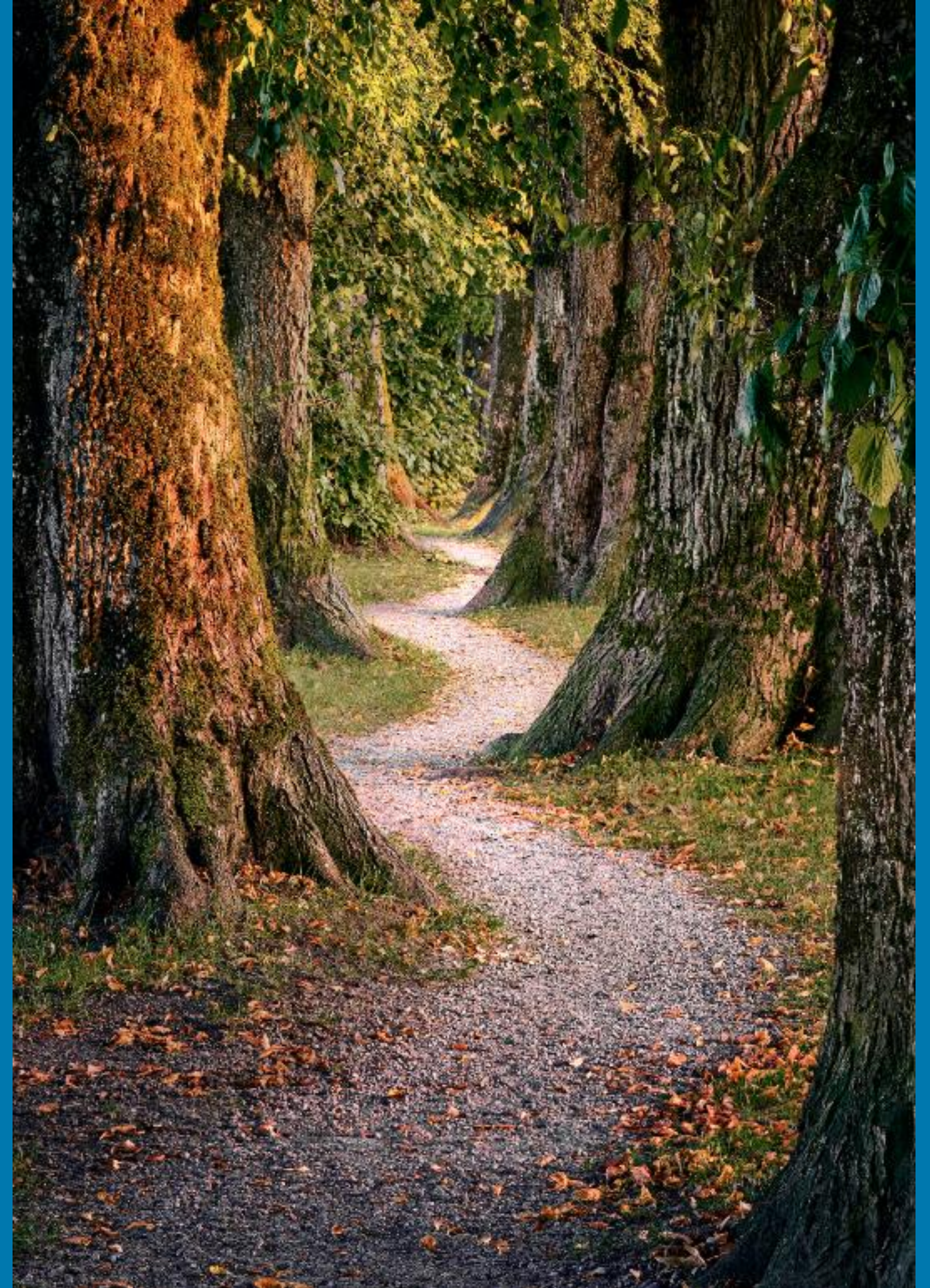
Medical QI Lead for Richmond CoC.

Enrique Fernandez Ruiz

Program Advisor, VCH/PHC Physician Quality Improvement (PQI)

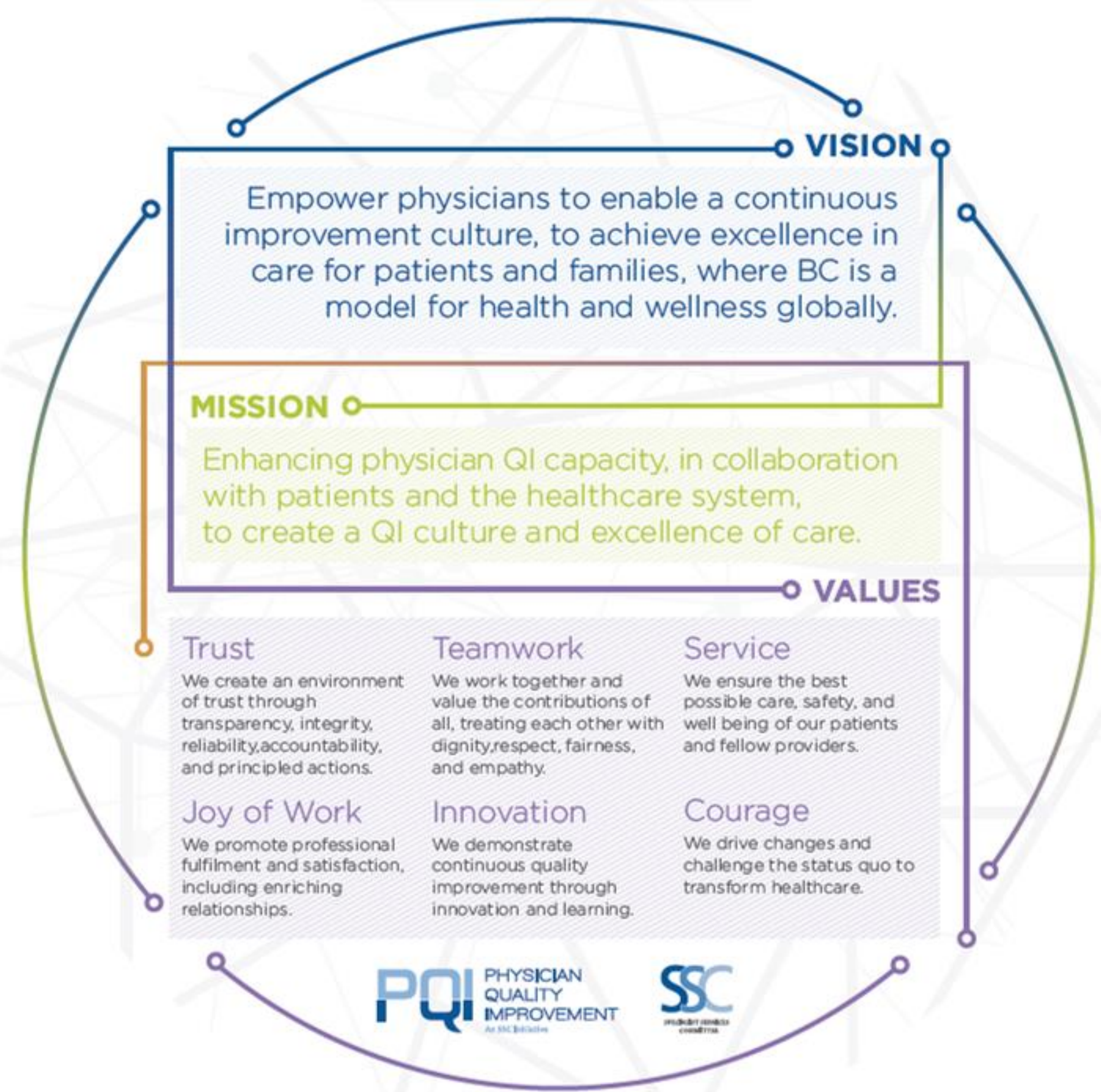
Why are we here today?

- Define Quality Improvement
- Share two physicians' journeys in Quality Improvement Training
- PQI Funding opportunities for you



What is Physician Quality Improvement?

Physician Quality Improvement (PQI) is an SSC (Specialist Services Committee) initiative addressing gaps in quality structures relating to physician participation in QI activities and ensures those physicians have adequate dedicated technical supports (i.e. data analysts, quality improvement advisors, etc.).



POLL

Have you heard about Physician Quality Improvement (PQI)?

(Annotate with a stamp using Zoom / enter response in the Chat)

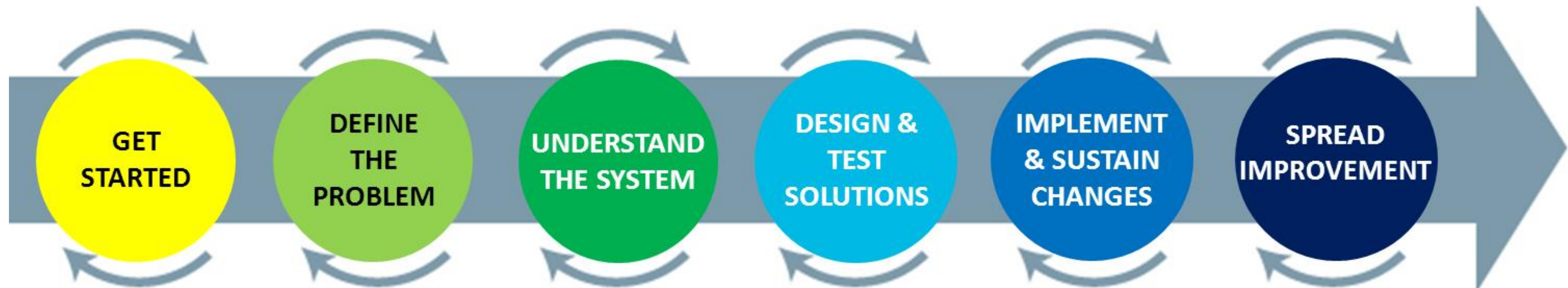
Yes, I have!

Sounds familiar...

No idea!

What is Quality Improvement?

- The **systematic approach** to making changes that create **better** outcomes, experiences and processes
- In health care, QI is focused on achieving better **patient* outcomes** and **system performance***



Providence Health Care & Health Quality Ontario

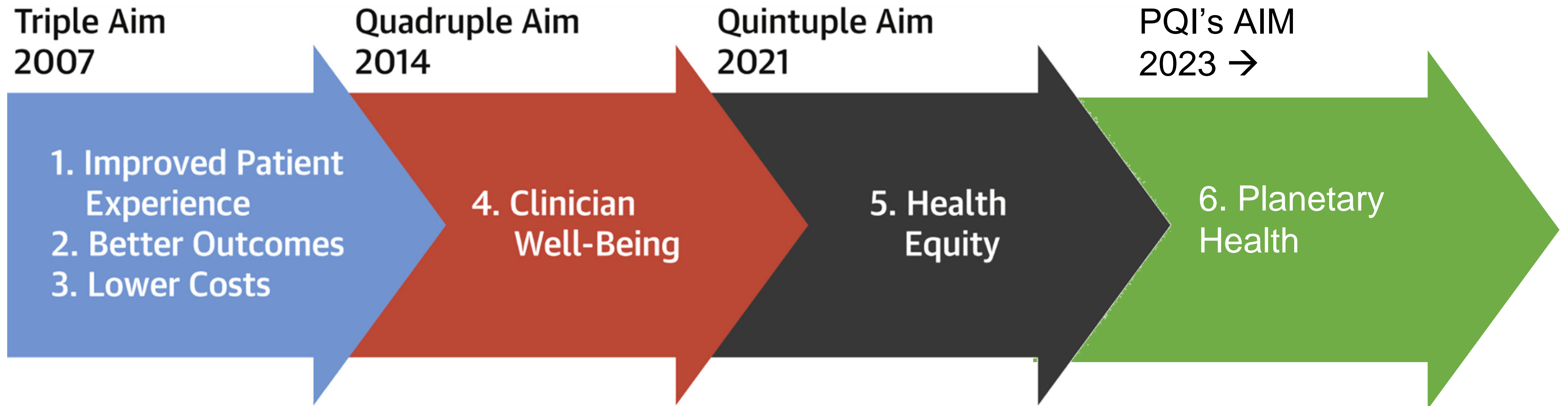
The “Know-Do” Gap

12
10
8
6
4
2
0

What we know
What we do

Yesterday
Today
Tomorrow

These are the domains that we want to make a difference



Adapted from: https://www.jacc.org/doi/10.1016/j.jacc.2021.10.018

Framework for Planetary Healthcare

Net zero healthcare: a call for clinician action

Health professionals are well positioned to effect change by reshaping individual practice, influencing healthcare organisations, and setting clinical standards, argue **Jodi Sherman and colleagues**

Achieving net zero emissions in healthcare will be possible only with radical and immediate engagement of the clinical community. The covid-19 pandemic has served as a wake-up call for high income health systems that resources are finite and globally interdependent, vulnerable to massive surges in demands and simultaneous infrastructure disruption, and that inequities in access to care threaten health and wellbeing for everyone.

During the first months of the pandemic, the medical community united at a historic pace, rapidly sharing information, redesigning models of care, conserving and innovating resources, and moving towards a circular economy. In comparison, the task of transforming healthcare culture and practice to halve healthcare emissions by 2030 as recommended by the Intergovernmental Panel on Climate Change[1] seems entirely feasible.

health and wellbeing depend.[2] This planetary health lens acknowledges crucial links between ecological change, human health, and our ability to thrive.[2]

Planetary accountability encompasses actions taken by individual health professionals within the clinical setting, collective actions of clinicians in healthcare organisations with the communities they serve, and interactions of individuals and collectives in professional societies with regulatory and oversight bodies.

For clinicians, this means recognising that healthcare consumes finite resources and produces harmful pollution, accepting that environmental stewardship is integral to our fundamental duty of care, and that we are quickly approaching a climate tipping point.

Healthcare is one of the largest polluting industries, responsible for nearly 5% of total global greenhouse gases.[3] Like all industries, healthcare must rapidly and substantially reduce its greenhouse gas

strands of action: reducing emissions from healthcare services, matching supply and demand, and reducing demand for healthcare.[4] Here we provide practical suggestions to help clinicians enact that framework (table 1).

Reducing emissions from supply of health services

Reducing emissions from healthcare services encompasses all activities that consume materials and energy. Most healthcare sustainability initiatives focus on large scale facility operations, such as improving hospital energy performance and sourcing renewable electricity, which typically are not under the control of clinicians. However, clinicians influence building use through decisions on care settings—for example, whether to administer monitoring or treatment in the home, clinic, or hospital (which has the highest resource and emissions intensity).[5] Virtual care for patient-provider interactions that do not

Reduce Demand for Health Services

Social Determinants of Health

Health Promotion

Disease Prevention

Chronic Disease Management

Match Supply of Health Services to Demand

Primary and Community Care Services

Ensure Appropriateness of Care

Stewardship Programs

Reduce Emissions from Supply of Health Services

Green Infrastructure and Operations

Decarbonised Transport

Circular Economy in Supply Chains

Coordinated Care Delivery

Integrated Technology Systems

Virtual Care

MacNeill A, McGain F and Sherman J.
Planetary Health Care: A Framework for Sustainable Health Systems, Lancet Planetary Health 2021

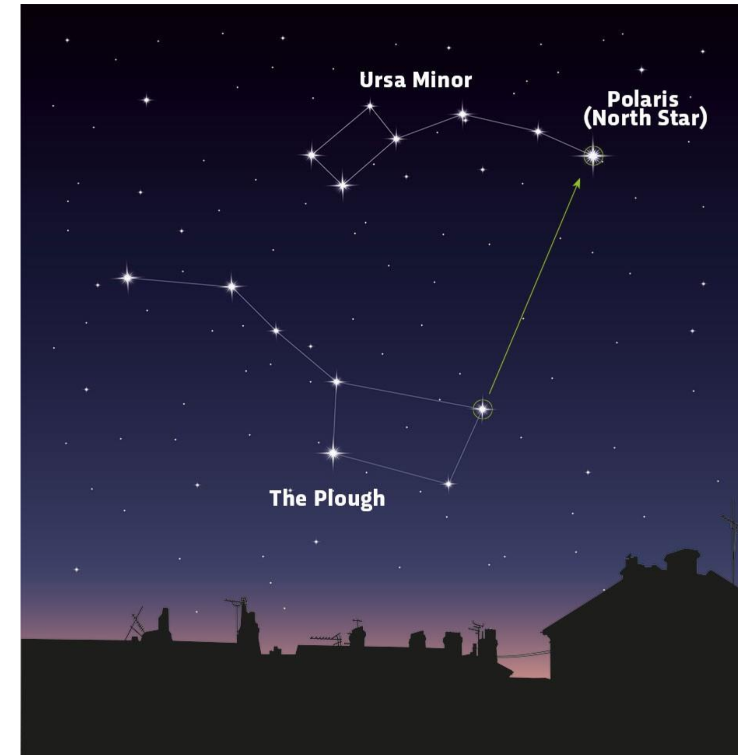
DIMENSIONS OF QUALITY

Quality is made up of multiple Dimensions of Quality. Five dimensions focus on the individual experience from both a person and population perspective: *Respect, Safety, Accessibility, Appropriateness* and *Effectiveness.* Two dimensions focus on the performance of the systems in which health and wellness services are delivered: *Equity* and *Efficiency.*

How do others define Quality Improvement?

BC PATIENT SAFETY
& QUALITY COUNCIL
Working Together. Accelerating Improvement.

"In essence, when used in a health care setting, a common definition involves how well the **right care is delivered to the right patient at the right time**."



https://www.sciencefocus.com/space/how-do-i-find-the-north-star/

Research VS Quality Improvement

	Research	QI
Purpose	Generate new knowledge	Generate change
Starting point	Hypothesis or question	Aim statement (goal)
Tools	Established methods, Statistical analysis	Established methods, Tools, Statistical analysis (SPC)
Data	Rigorous, “just in case”, pre-established N	“Just enough”, evolving N
Scope	Generalizable	Specific to environment
Time frame	Months – years	Weeks – months
Dissemination	Posters, Publication (ethics)	Rounds, Storyboards, Posters, Publication
Audience	Scientific community	Local stakeholders, Agency
End Point	Study N achieved, or saturation (qualitative)	When change occurs!

One of my QI Journeys

Research Review

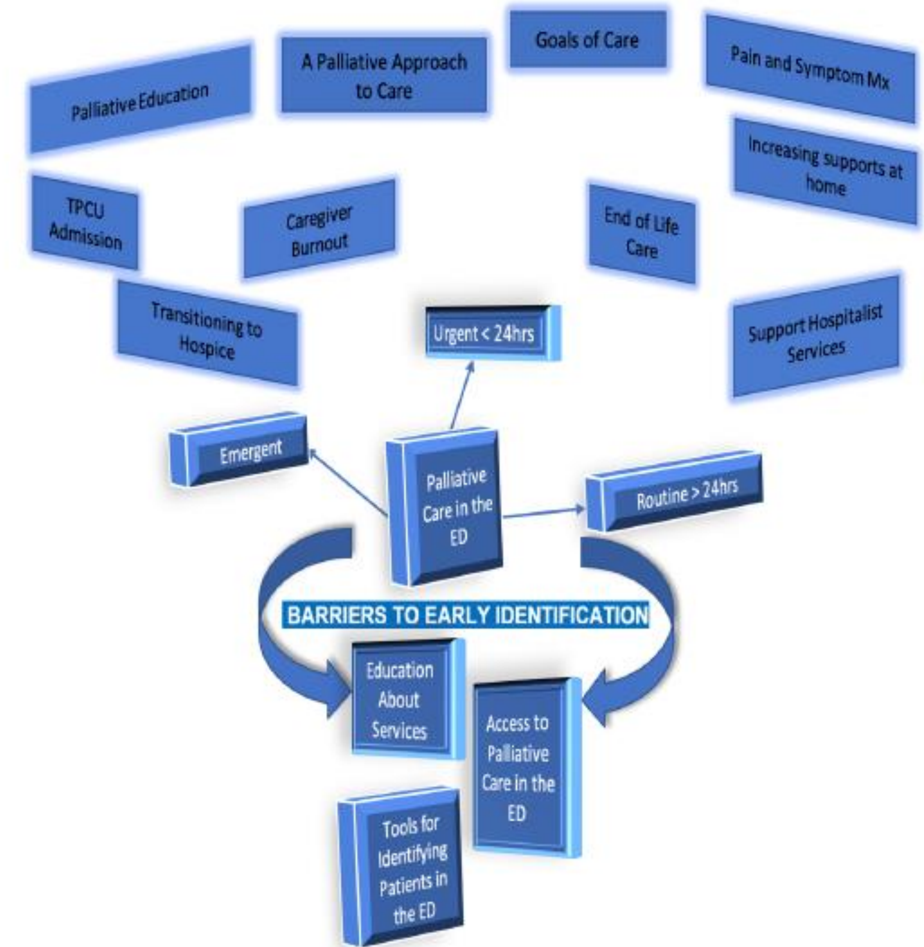
Palliative Care at the ‘Doors’ of the Hospital

Background

Recently, the Palliative Care Team has been re-evaluating the services provided by the Tertiary Palliative Care Unit (TPCU) within the acute care setting. Anecdotally, the team was noticing challenges with referrals: Late referrals for patients who were already admitted to hospital; lack of clarity on what services were provided by the palliative care team; and when to refer for an admission to the TPCU. A recent survey done with the team of palliative doctors over a the past few months-reasons for a consult-confirmed the concerns of the team; and highlighted possible reasons for contrasting services that ‘palliative care’ patients were receiving.

A recent Richmond Hospital cohort of Interdisciplinary Learning Reviews (ILRs) has looked at patient journeys from the doors of the hospital (Emergency Department) to a medical unit or the TPCU-generating several Opportunities for Improvement (OFI). The system challenges and the benefits of early palliative care involvement have been highlighted: access to palliative care services at the entrance to the hospital cannot be understated.

Figure 3. Overview of Palliative Care at the Doors (Loffredo et al. 2021; Wang et al. 2017; Malloy et al. 2022; Bayuo et al. 2022).



Let's P.A.U.S.E
A Moment

P.A.U.S.E.

.....and think **Palliative Care** if

one or more of the following apply:-

P - Palliative care requested by patient or family, or, previously known to palliative care services.

A - Advanced care planning: assistance desired with decision making around goals of care, e.g. resus status, withdrawal of treatment.

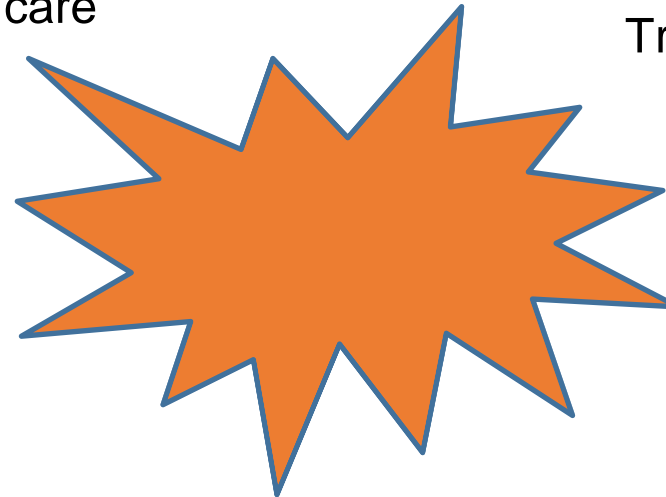
U - Uncontrolled symptoms – e.g. physical / psychological / declining performance status

S - Surprise Question – Do you think the patient will die in this admission or within the next 12 months?

E - ED repeat attendances over recent months.

ACP
Values
Family/TSDM
Healthcare Teams
Goals of care

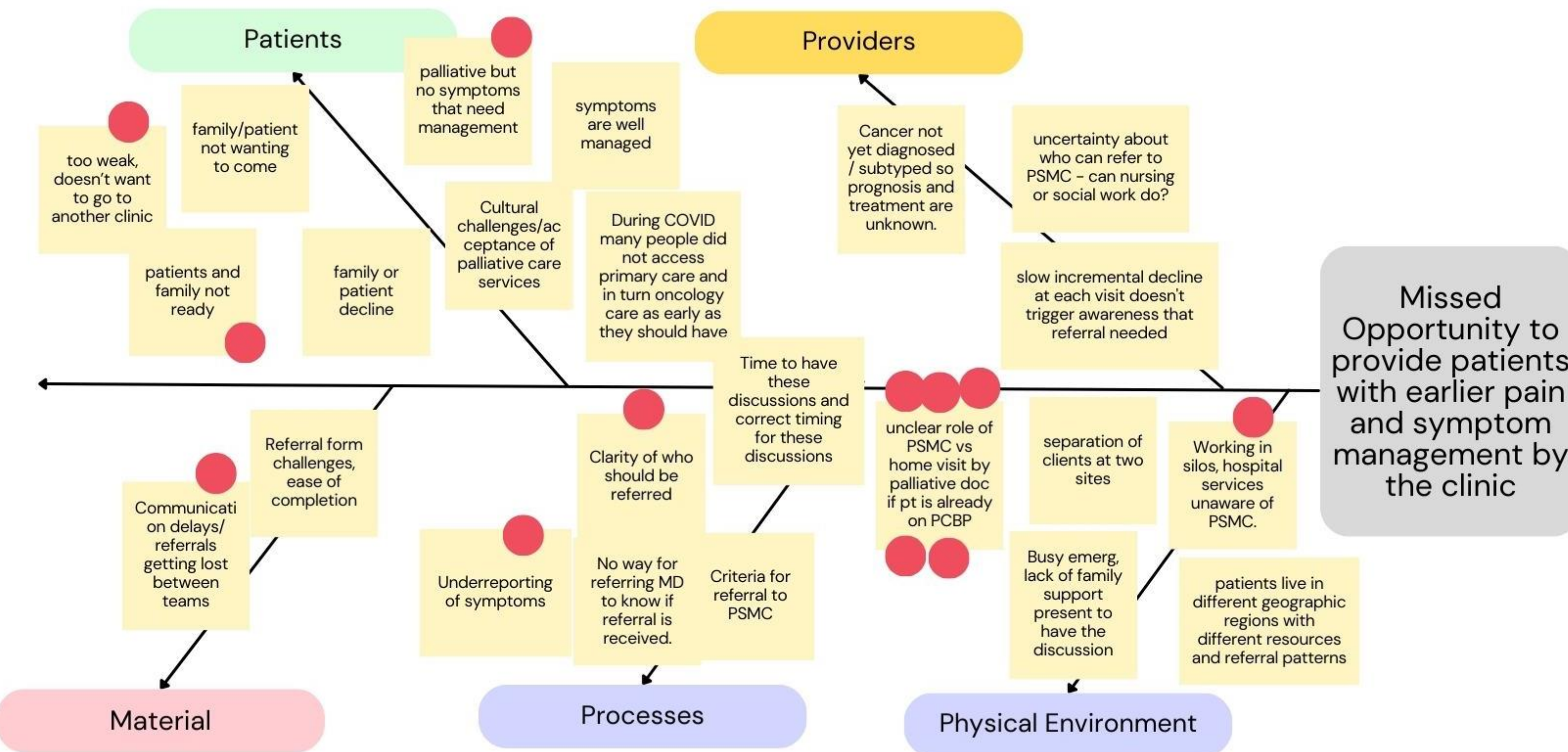
Outcomes
Symptom Management
Quality of Life
Transitions

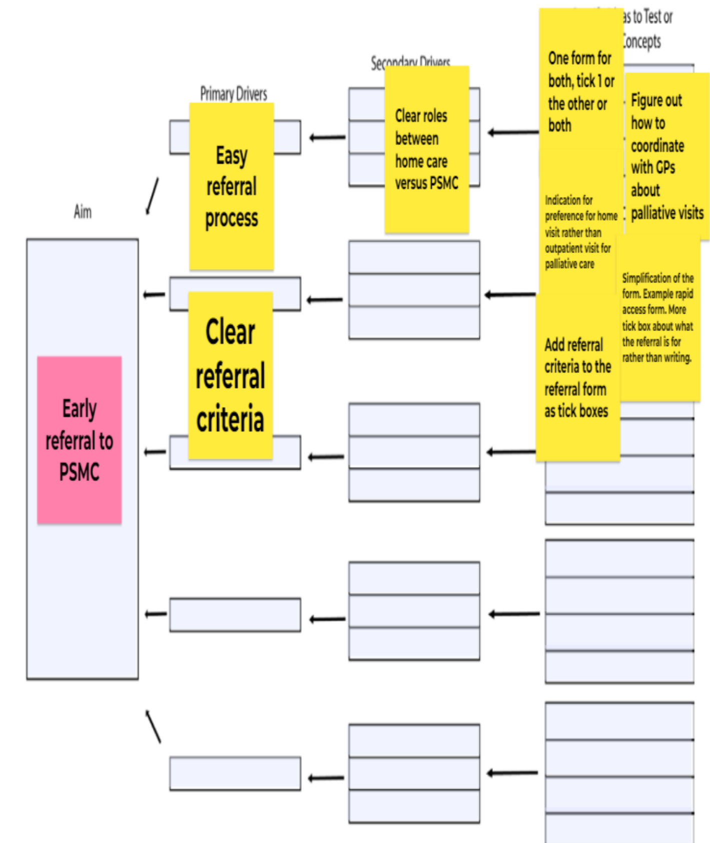


Length of Stay
3-10 days
Care they want
Reduced Costs

Treatment
Comfort vs aggressive Rx

DELIVERY OF QUALITY CARE
Oncology and Palliative Team





Where are we in our PDSA?

Vancouver CoastalHealth | Richmond Integrated Hospice Palliative Care | Patient Label

RICHMOND INTEGRATED HOSPICE-PALLIATIVE CARE
INPATIENT AND OUTPATIENT CONSULTATION REQUEST FORM

Date of referral: ______
Referring clinician: ______ Clinician contact: ______

Client details (attach patient demographic label above or complete spaces below):

Name: ______ PHN/MRN: ______
DOB: ______ Age: ______ Gender: ◻ Male ◻ Female ◻ Other
Address: ______
Preferred contact: ______ Telephone #: ______
Interpreter required ______

Send additional documentation with completed consultation request form: MOST, community DNR, BC Palliative Care Benefits, and consultation notes.

Referral algorithm (tick boxes as appropriate)

Does the patient have a life-limiting illness?

- ◻ Advanced dementia or CNS disease
- ◻ Local or advanced cancer
- ◻ End-stage renal or liver disease
- ◻ Advanced COPD or CHF
- ◻ Provider discretion: high chance of accelerated death (hip fracture, >80 years of age, major trauma in the elderly, intracranial bleed)

If NO, then patient is not eligible for a referral to the Richmond Palliative Care team.
If YES, then continue screening for referral to the Richmond Palliative Care team with the next question.

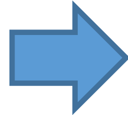
PAUSE: Does the patient have ONE OR MORE of the following palliative care needs?

- ◻ Palliative care requested by the patient and/or family
- ◻ Advanced care planning assistance
- ◻ Uncontrolled symptoms and/or functional decline
- ◻ Surprise question: do you think the patient will die in this admission or within the next 6-12 months?
- ◻ Emergency/hospital admissions over the recent months

If NO, then patient is not eligible for a referral to the Richmond Palliative Care team.
If YES, then identify primary concern(s) below and pick the most appropriate palliative consult option.

Primary concern(s):

INPATIENT PALLIATIVE CONSULT		OUTPATIENT PALLIATIVE CONSULT
URGENT WITHIN 24-48 HOURS Referring clinician to phone on-call palliative physician.	NON-URGENT WITHIN 48-72 HOURS Fax completed consultation request form and additional documents to 604-244-5264	Fax completed form to 604-297-9926. ◻ Ambulatory patients will be seen at the Richmond Pain and Symptom Management Clinic within 1-2 weeks. ◻ Home-based patients need to be known to the Richmond Home Health team. Connect with the Patient Care …



Vancouver CoastalHealth | Richmond Integrated Hospice Palliative Care | Patient Label

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Date of referral: ______
Referring clinician: ______ Clinician contact: ______

Client details:

Name: ______ PHN/MRN: ______
DOB: ______ Age: ______ Gender: ◻ Male ◻ Female ◻ Other
Address: ______
Preferred contact: ______ Telephone #: ______
Interpreter required ______

*** Include MOST, community DNR, BC Palliative Care Benefits, and consultation notes, if available. ***

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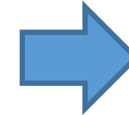
- ◻ Emergency/hospital admissions over the recent months

If NO, then patient is not eligible for a referral to the Richmond Palliative Care team. You may discuss with on-call palliative physician/clinician (see below).
If YES, then identify primary concern(s) below and pick the most appropriate palliative consult option.

Primary concern(s): ______

INPATIENT palliative consult		OUTPATIENT palliative consult
URGENT WITHIN 24-48 HOURS *0800-1600:* Check VCH On-Call Scheduling System *1600-0800:* Phone 604-836-7255	NON-URGENT WITHIN 48-72 HOURS Fax completed consultation request form and additional documents to 604-244-5264.	Fax completed form to 604-297-9926. ◻ Ambulatory patients will be seen at the Richmond Pain and Symptom Management Clinic within 1-2 weeks. ◻ Refer home-based patients to the Richmond Home Health team, if not already known. Connect with the Patient Care Coordinator and/or Transition Nurse regarding this referral.



Vancouver CoastalHealth | Richmond Integrated Hospice Palliative Care | Patient Label

RICHMOND INTEGRATED HOSPICE-PALLIATIVE CARE
INPATIENT AND OUTPATIENT CONSULTATION REQUEST FORM

Date of referral: ______
Referring clinician: ______ Clinician contact: ______

Client details:

Name: ______ PHN/MRN: ______
DOB: ______ Age: ______ Gender: ◻ Male ◻ Female ◻ Other
Address: ______
Preferred contact: ______ Telephone #: ______
Interpreter required ______

INCLUDE MOST, COMMUNITY DNR, BC PALLIATIVE CARE BENEFITS, AND CONSULTATION NOTES, IF AVAILABLE

Referral algorithm (tick boxes as appropriate)

Does the patient have a life-limiting illness?

- ◻ Advanced dementia or CNS disease
- ◻ Early or advanced cancer
- ◻ End-stage renal or liver disease
- ◻ Advanced COPD or CHF
- ◻ Provider discretion: high chance of accelerated death (hip fracture, >80 years of age, major trauma in the elderly, intracranial bleed, etc.)

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- ◻ Emergency/hospital admissions over the recent months

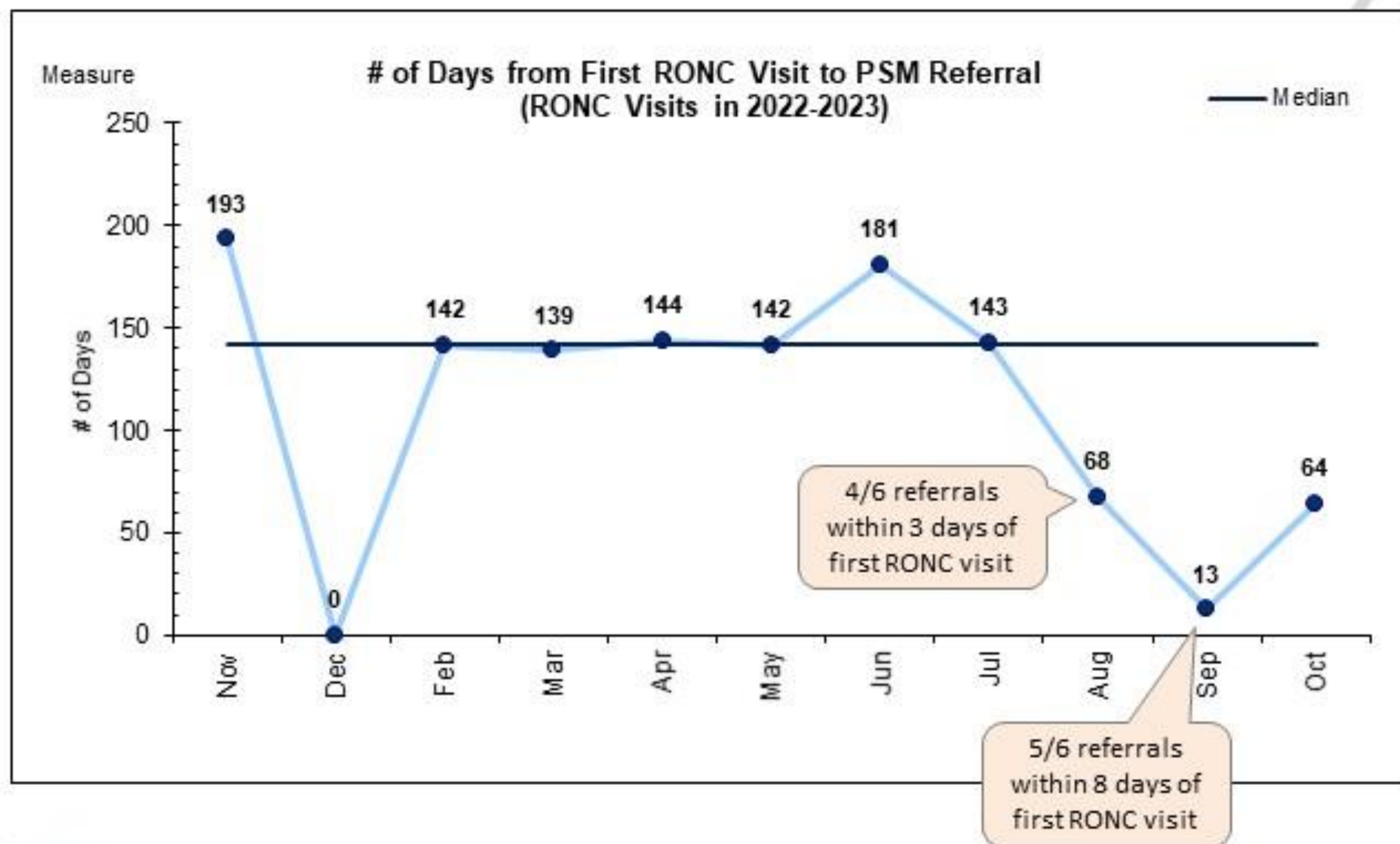
If NO, then patient is not eligible for a referral to the Richmond Palliative Care team. You may discuss with on-call palliative physician/clinician (see below).
If YES, then identify primary concern(s) below and pick the most appropriate palliative consult option.

Primary concern(s): ______ ◻Routine ◻Urgent

INPATIENT palliative consult		OUTPATIENT palliative consult
URGENT WITHIN 24-48 HOURS *0800-1600:* Fax referral form to 604-244-5264 AND phone palliative consult physician (check VCH On-Call Scheduling System) *1600-0800:* Phone 604-836-7255	ROUTINE WITHIN 48-72 HOURS Fax completed consultation request form and additional documents to 604-244-5264.	Fax completed form to 604-297-9926. ◻ Ambulatory patients will be seen at the Richmond Pain and Symptom Management Clinic within 1-2 weeks. ◻ Refer home-based patients to the Richmond Home Health team, if not already known. Connect with the Patient Care Coordinator and/or Transition Nurse regarding this referral.

V1.4 230718

Average # of Days from First RONC Visit to PSM Referral



DRAFT

Lessons Learned

- Not jumping to conclusions – what’s the root cause
- Trusting the process – it works!
- Building a team – collaboration
- Buy in from other members and help spread versus Siloing
- Operations involvement – funds, support, connections
- It can be fun!

Another Example of a QI Project

Collaborative Medication Review in High Risk Elderly Patients

A Vancouver General Hospitalist -Pharmacy Patient Safety Collaboration

Polypharmacy in the Elderly

- Polypharmacy is generally defined as the concurrent use of 5 or more medications
  - Various definitions, appropriate vs. inappropriate polypharmacy (MAI, Beers' Criteria, STOPP/START)
- It is associated with higher rates of adverse events
  - Eg. Higher CV death in patients with atrial fibrillation (data from AFFIRM Trial): adjusted RR 1.3 (95% CI 1.03-1.64)*

Polypharmacy and major adverse events in atrial fibrillation - observations from the AFFIRM trial. Clin Res Cariol. 2015

Polypharmacy in the Elderly

- Polypharmacy is an even more important issue in the elderly because:
  - Increasing prevalence of chronic conditions in the elderly
  - Physiological changes associated with aging
    - Increase in body fat
    - Decreased first-pass metabolism
    - Decreased excretion
    - Decrease in number of receptors

Polypharmacy: optimizing medication use in the elderly patients. Pharmacy Practice 2013

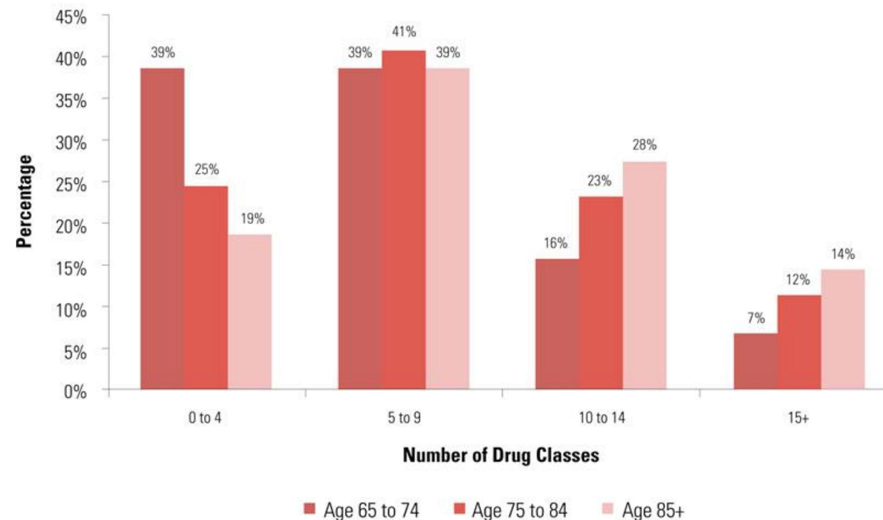
Prevalence of Polypharmacy

- A 2008 Statistics Canada telephone survey (Canadian Survey of Experiences with Primary Health Care) revealed 27% of seniors were taking 5 or more medications regularly

The impact of polypharmacy on the health of Canadian seniors. Family Practice 2012; 29:427–432

Prevalence of Polypharmacy

- Other studies suggest higher levels of polypharmacy:
  - CIHI study of National Prescription Drug Utilization Information System (NPDUIS) suggests 69% of Seniors take ≥ 5 drugs



Medication Use among Canadian Seniors. Healthcare Quarterly, 2012: 15(4)

Prevalence of Polypharmacy

- Study of seniors admitted to hospitals with Community Acquired Pneumonia in Edmonton showed:
  - ↑ in polypharmacy after hospitalization at 1 yr
    - 45% before, 74% within 90 days after discharge, 72%
  - Large number of medication changes in the transition period
    - 80% started at least 1 new medication, 74% stopped at least 1 med
  - Mean number of drug changes:
    - New meds started:3.3 +/- 2.7, meds stopped: 2.4 +/- 2.6

Medications transitions and polypharmacy in older adults following acute care Therapeutics & Clinical Risk Management 2014; 10: 189-196.

QI Project

- In 2014, hospitalists at VGH decided to undertake a QI project based on the principles of CWC
    - Reached out to a number of stakeholders (Medicine, nursing leadership, QI/PS)
    - Review of 5 relevant recommendation lists, narrowed down systematically

QI Project

- The American Geriatrics Society has 10 recommendations including:

“Don’t prescribe a medication without conducting a drug regimen review”

QI Project

Multidisciplinary collaboration including

- Hospitalists
- Pharmacists
- Nursing
- Family physicians (Vancouver Division)
- VCH Quality and Safety
- VCH Physician Quality

QI Project

- Aim:
  - To conduct a comprehensive medication review on all patients admitted to the hospitalist program at VGH within 12 months

Intervention

- **Design**:
  - Quality improvement initiative
  - Model for Improvement approach
  - Patients have a comprehensive medication review performed within 48 hrs of admission
  - Collaborative discussion between hospitalist, family physician, and clinical pharmacist

Intervention

Pt admitted to CP8A/B

- RRAS ≥ 10
- Able to communicate
- Admission > 2 days
- Not palliative

Comprehensive medication review performed by clinical pharmacist

Family physician invited to participate in med review meeting w/ pharmacist & hospitalist

- Comprehensive medication review and meeting documented in Access database

Patient discharged from hospital

- Pharmacist counsels pt & gives medication calendar
- Copies of documentation faxed to family physician

Readmission Risk Assessment Report

Readmission Risk Report for 02/05/2017

Patients on Nursing Unit

Census Date	MRN	Nursing Unit Code	Patient Service Description	Readmission Risk Flag	Admission Date	LOS
Feb 5 2017		C7E	Hospice (before 25May16: ALC 3)	High	Jan 29 2017	7
Feb 5 2017		C7E	Family Practice	High	Jan 28 2017	8
Feb 5 2017		C7E	Family Practice	High	Jan 27 2017	9
Feb 5 2017		C7E	Home Health (before 25May16: ALC 4)	High	Jan 13 2017	23
Feb 5 2017		C7E	Family Practice	Moderate	Feb 01 2017	4
Feb 5 2017		C7E	Family Practice	Moderate	Jan 31 2017	5
Feb 5 2017		C7E	Family Practice	Moderate	Jan 31 2017	5
Feb 5 2017		C7E	Family Practice	Moderate	Jan 22 2017	14

HISTORY SHEET

Site:

CHOOSING WISELY Initiative

Date 11/2/2015

MRN 999999999 | Hospital SPH

Patient Name Patient Name | Program/Ward Medicin

Date of Birth 4/7/2016 | Most Responsible Physician Doctor.n

Pharmacist Medication Review

Patient Identification and Relevant History

Notes on patient history

Medication Review and Recommendations

Obtained From:

PharmaNet · Patient · Caregiver · Family · Physician · Ot

Drug	Regimen	Indication	Recommendation
Piperacillin/Tazobactam	BDDD	Could also type free text	Change duration to:1
Atenolol		Other: Cdiff	Change formulation to:2
Baclofen		T2DM	Change regimen to:3

Comments

Comments here

Compliance Recommendations

Medication Calenda · Blister Packing · Medication Dosettes

Patient/Caregiver Counselling · Medication Management (via community nursing or pharmacy)

Communication of Care

		Date	Time
Discussed with Hospitalist	Dr..	11/18/2015	15:30
Discussed with Family Physician	Dr..	11/18/2015	15:45
Faxed to Family Physician		11/18/2015	16:00
Faxed to Community Pharmacy	Community Pharmacy Ph (604) 991-7624 Fax 1(888) 912-9248	4/7/2016	

Addendum

Date 11/19/2015 Time

More Notes Here

Please Contact | Phone | Signature

CHOOSING WISELY

Choosing Wisely is a patient quality and safety initiative of the American Board of Internal Medicine (ABIM) that aims to promote health care supported by evidence, not duplicative, free from harm and necessary. The Choosing Wisely Initiative at Vancouver General Hospital represents a collaborative project between clinical pharmacists, hospitalists and family physicians to implement the American Geriatrics Society's recommendation to complete a medication review for patients prior to prescribing any medications.

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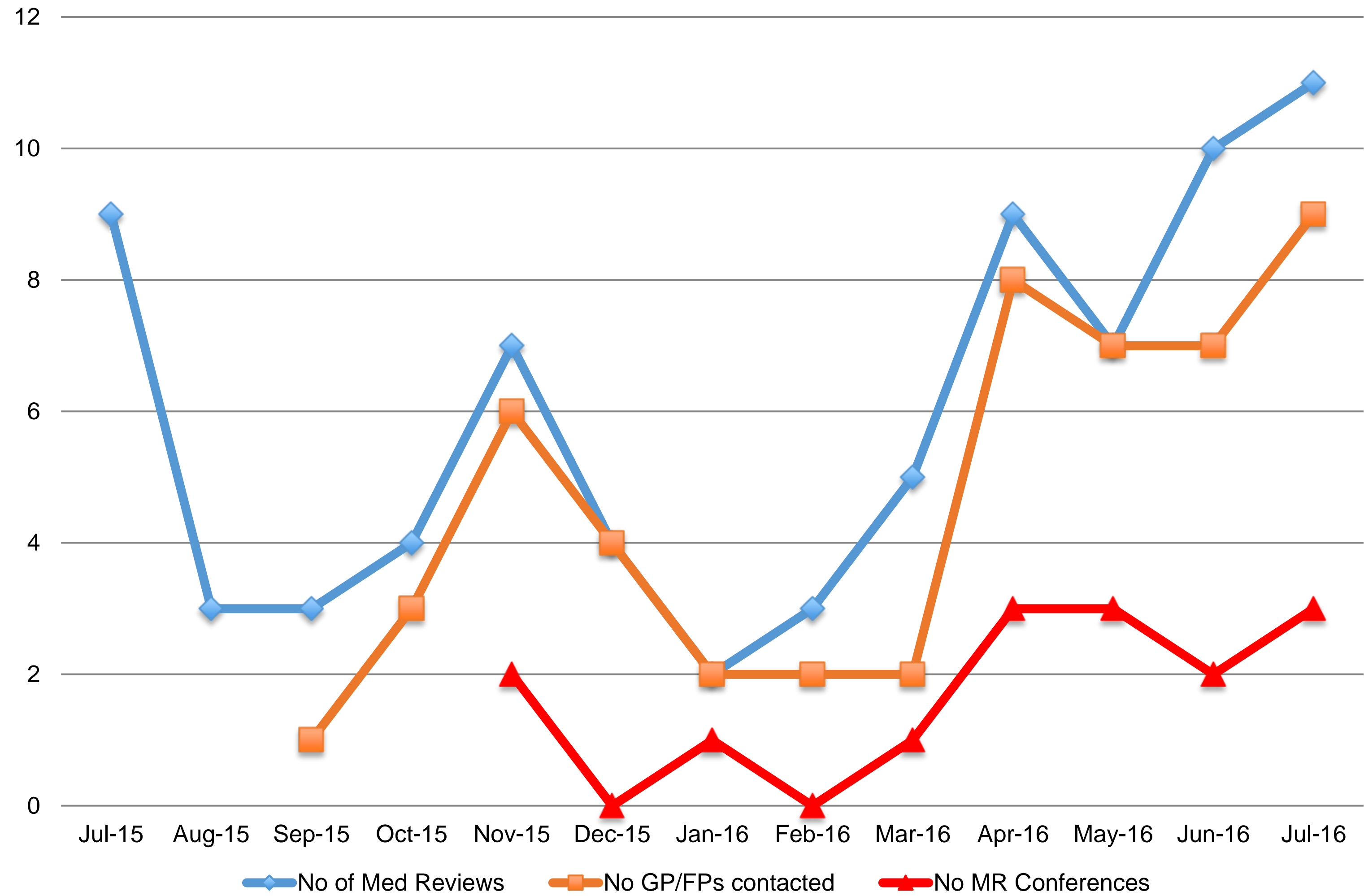
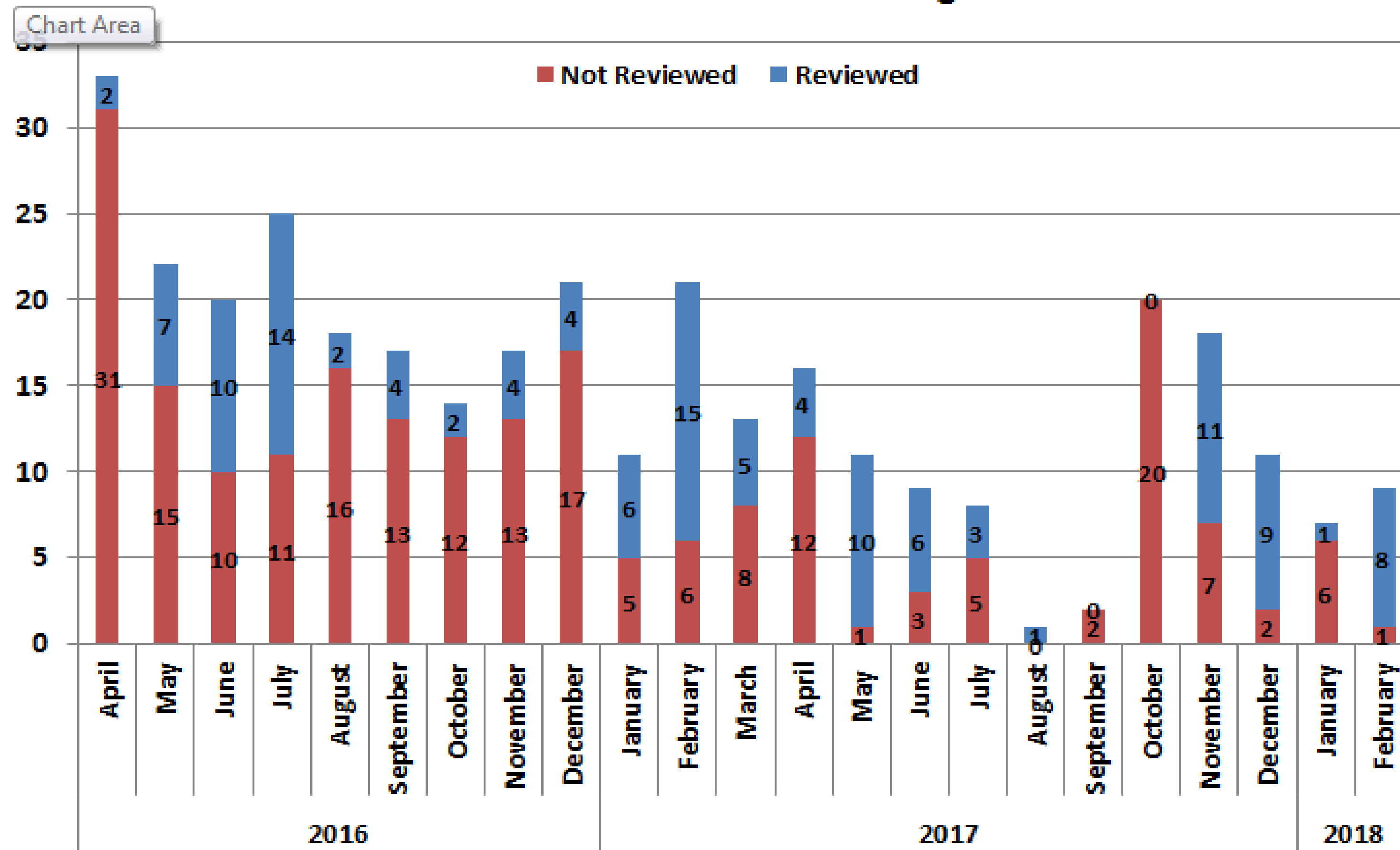
Pharmacist Consult Note

Process Variables

- Number of eligible patients per month/period
- Number of actual reviews per month/period
- Number of case conferences
- Communication with family physician and community pharmacist (# faxes sent/received)
- Estimated time spent by pharmacist

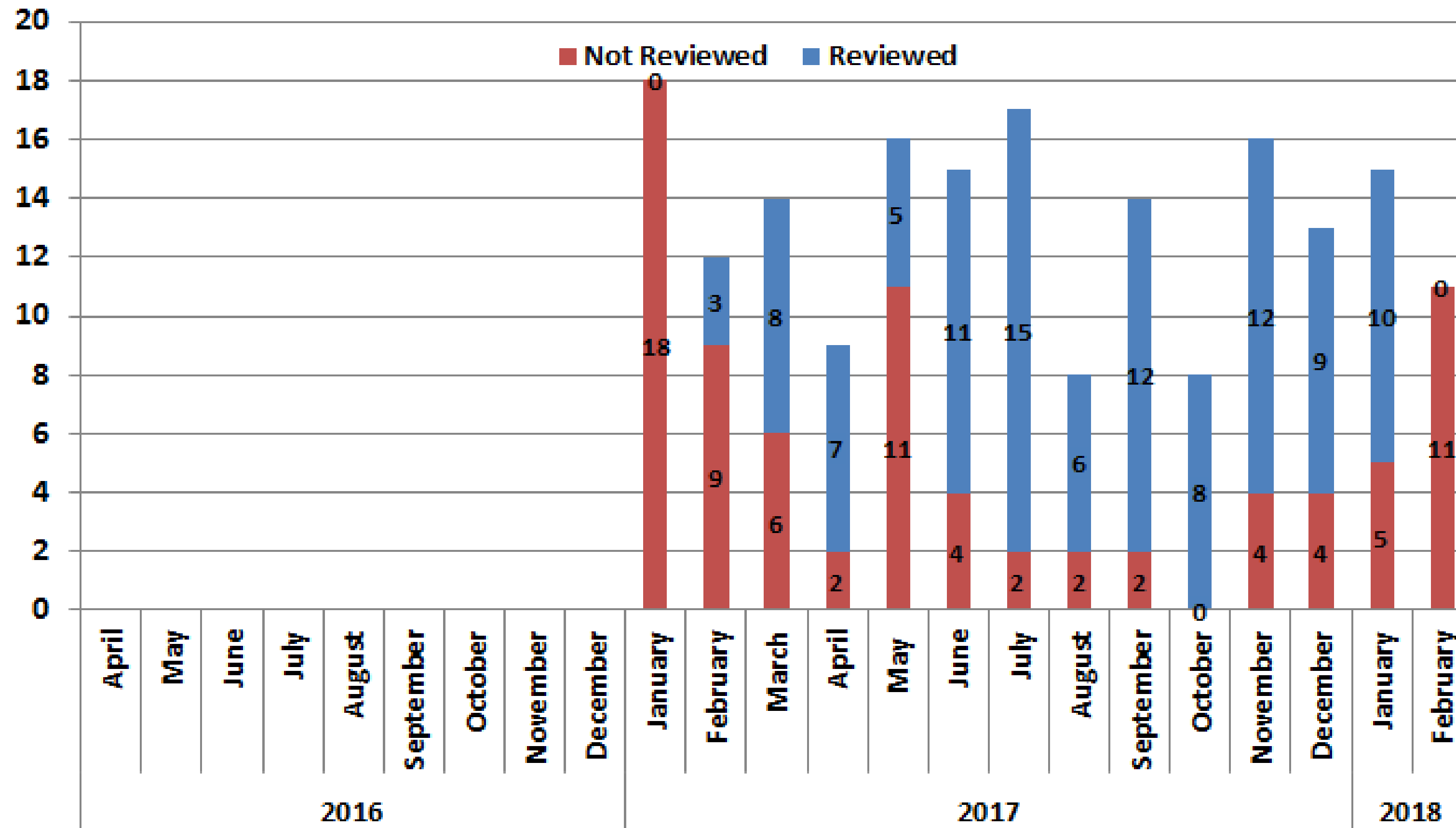

Med Review Project Progress
12
10
8
6
4
2
0
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
No of Med Reviews
No GP/FPs contacted
No MR Conferences

Medication Reviewed by Month at L8A



March 2017 data is only up to the 28th

Medication Reviewed by Month at L7A



March 2017 data is only up to the 28th

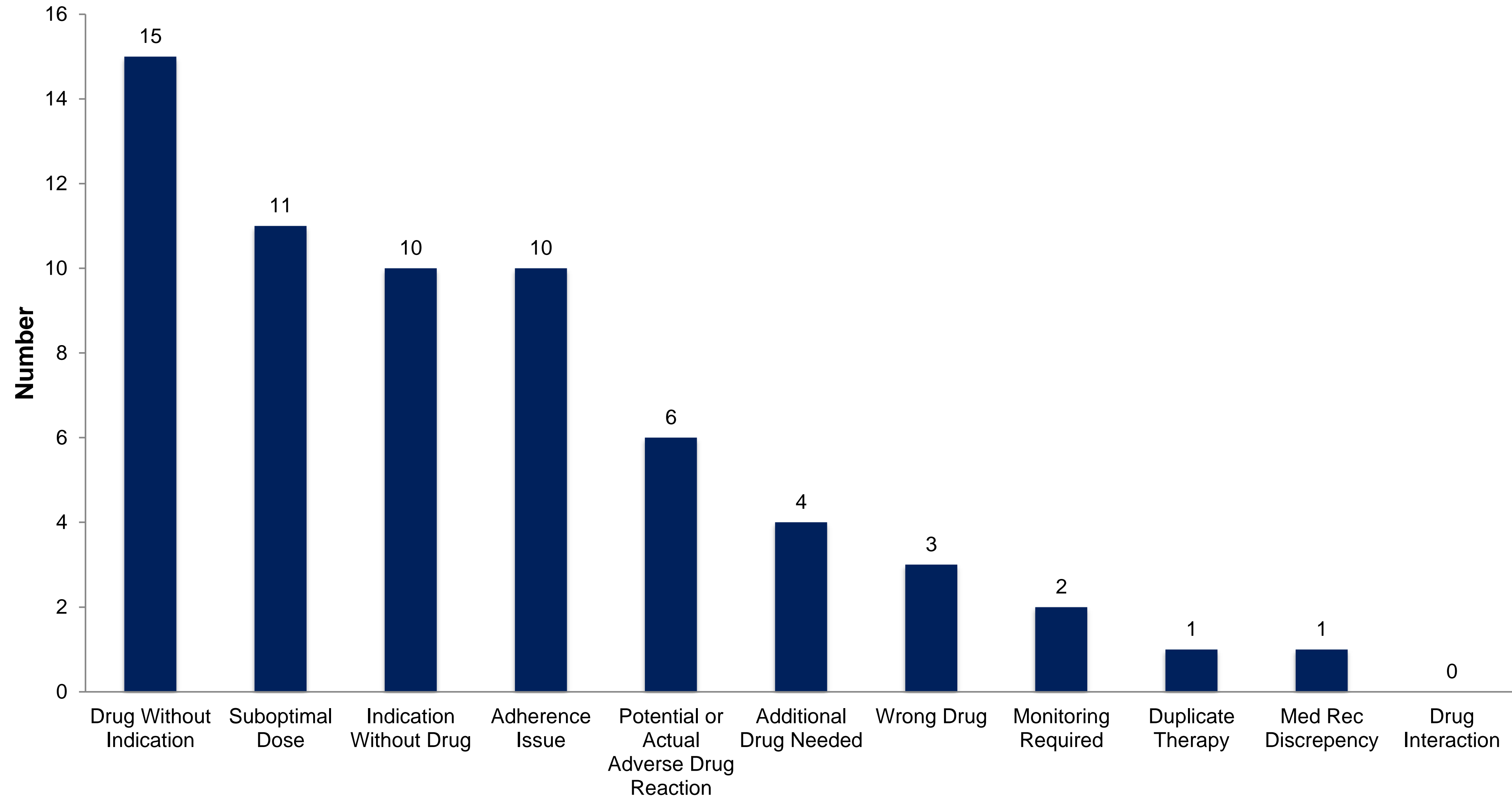
Outcome Variables

- # drug therapy problems
- # interventions (clinical and compliance)
- # meds on admission and discharge
- # Beers list medications on admission and discharge
- Proportion patients taking >5 medications on admission and discharge

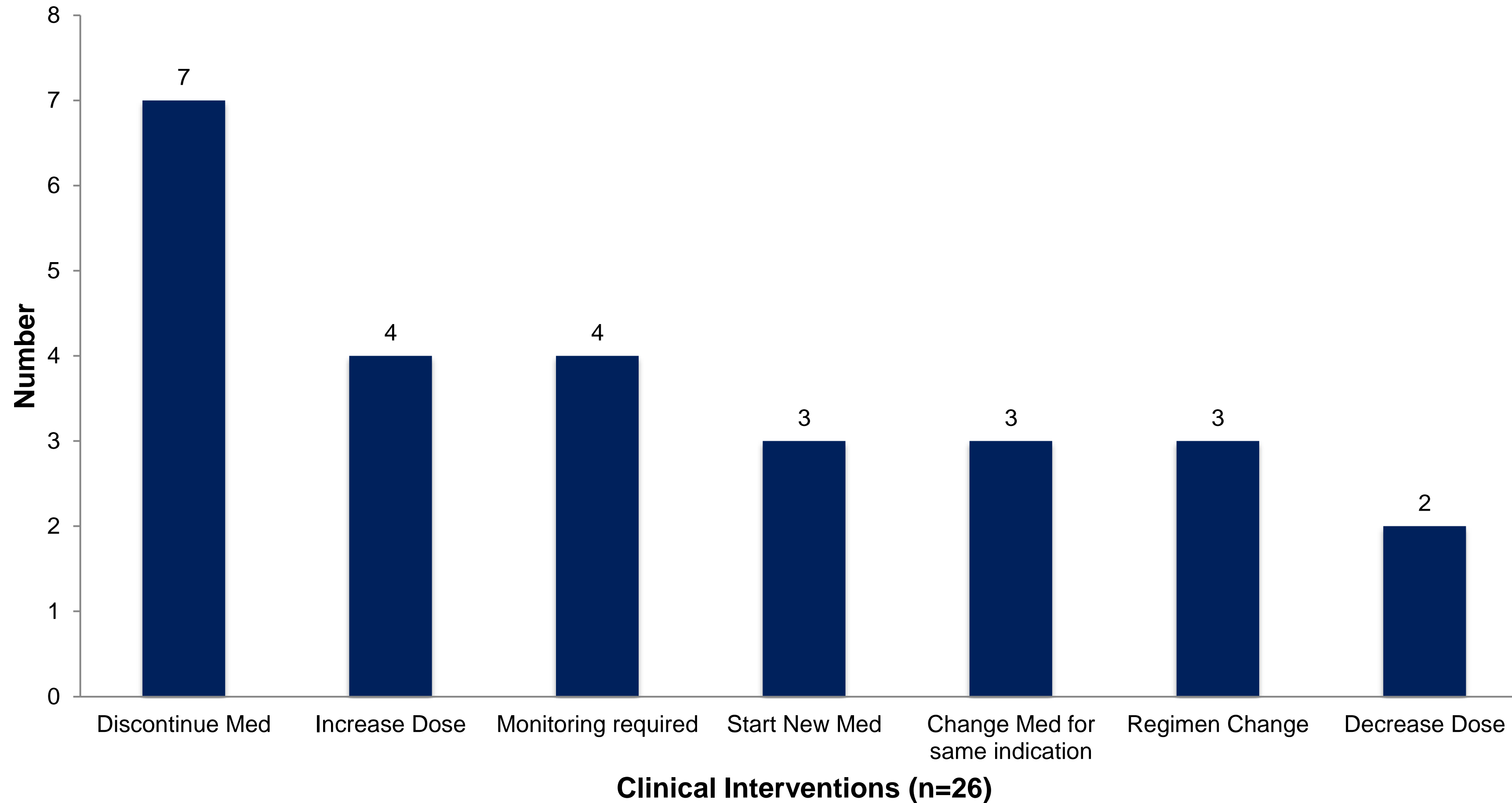
	Baseline (July 2014 – June 2015)	Phase 1 (July 2015 – February 2016)	Phase 2 (March 2016 – January 2017)	Total
Number of cases	77	35	62	97
Percent male	53.25	54.29	45.16	48.45
Age (years)	79.40 +/- 11.90	77.74 +/- 6.79	85.82 +/- 5.73	82.91 +/- 7.24
RRAS	11.90 +/- 1.81	11.69 +/- 1.89	11.58 +/- 1.54	11.62 +/- 1.69
Average Number of Medical Conditions	6.26 +/- 2.78	5.88 +/- 3.71	6.08 +/- 2.39	6.01 +/- 2.91
Length of stay (days)	11.68 +/- 8.96	18.63 +/- 14.03	19.58 +/- 20.28	19.19 +/- 17.88
Readmission within 30 days (% of all cases)	9.09	5.71	11.29	9.28

	Baseline (July 2014 – June 2015)	Project (July 2015 – January 2017)
Total medications reviewed	605	781
Number of Medications Prior to admission	8.07 +/- 3.96	8.40 +/- 3.85
Number of Meds on Discharge	9.08 +/- 3.81	9.62 +/- 3.73
Number of Drug-related problems identified	53	201
Average drug problems per patient	0.69 +/- 1.03	2.14 +/- 1.39

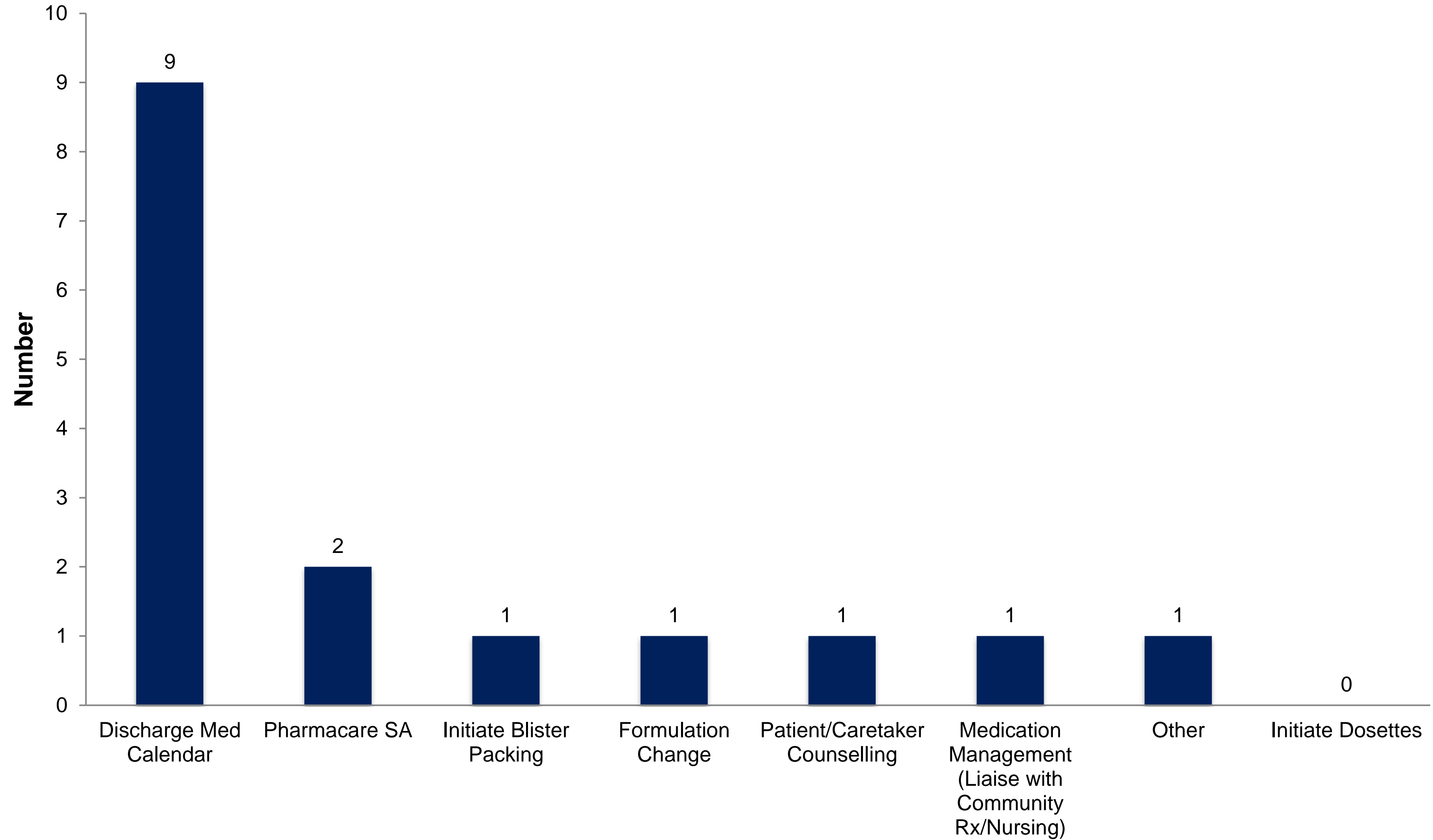
Drug Therapy Problems by Category



Clinical Interventions by Category



Compliance Interventions by Category



Challenges

- Project tool development – bottle necks
- Continue to engage all stakeholders (eg. GPs – hard to reach)
- Pharmacists time constraints and practice variability
- Expansion to remaining hospitalist units
- **Need for a systematic approach to QI – tools, methodologies and knowledge**

How to get involved with PQI?

Alumni have told us that PQI helped

FIND A RENEWED SENSE OF PURPOSE: FEEL EMPOWERED TO SOLVE THE PROBLEMS YOU SEE

BREAK THE MONOTONY: WORK ON A PASSION PROJECT

ACCELERATE CAREER DEVELOPMENT

CONNECT WITH TEAM MEMBERS AND OTHER LIKE-MINDED PHYSICIANS

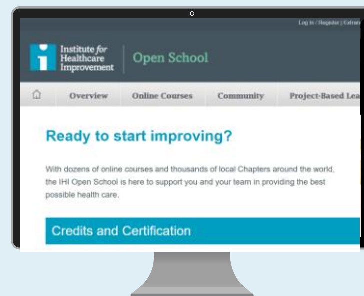
Individual QI Training

QI Coaching

1:1 Ad-hoc, on demand, email us anytime
Sessional funding for coaching time

Level 1

Institute for Healthcare Improvement (IHI)
Online Open School
Learn at your own pace
5 hours sessional funding



Level 2

Two half-days, offered multiple times a year
Interactive zoom-class
7 hours sessional funding

Level 3

Call for applications will open from Dec 8th to Jan 19th

Ten months cohort training from Aug- May
Interactive training days and full project support from QI team and data support
100-150 hours sessional funding

Team QI Training

NEW!

Physician Quality Improvement & Spread (PQI&S)

QUALITY QUEST

Customized QI Workshop for Teams

Are you and your team ready to collaborate and drive change together? The PQI team can work with you to get you started.

Facilitation

PQI has a team of physicians and program advisors trained in QI.

Duration and Location

Depending on the goals of the team, a workshop can range from 1 hour to a half day, at a location that works for you.

We can work with groups of any size, optimal size is from 4 - 15 people (including physicians, residents, fellows, nursing staff, allied health, clerks, etc). **Full-staff physicians are eligible for sessional funding at the JCC rate.**

Topics Include:

- Intro to Quality Improvement and getting started with your project aim
- Process mapping to understand current state
- Identifying change ideas / opportunities for improvement
- Create a data collection plan and measures of improvement

And many more topics customized to your needs!

CONTACT US FOR MORE INFO

MedicalQuality@vch.ca

Visit our website or scan QR code

PQI PHYSICIAN QUALITY IMPROVEMENT Specialist Services Committee

SQI SPREADING QUALITY IMPROVEMENT Specialist Services Committee

Providence Health Care How you want to be treate

Vancouver CoastalHealth

Level 3

Advanced Cohort Training – Apply with a QI project

- Cohort length: **Ten months from August to May annually**
- Interactive training days with lectures and group activities
- **Full project support and mentorship** from PQI coaches & faculty, program advisor, and data analysts
- Project endorsement from VCH/PHC medical and operational leaders
- Access to data, QI resources and templates
- **Sessional funding**: 10 or 15 hours per month

Applications open

Dec 8 – Jan 19, 2024

Check website for more details

What makes a good PQI Project?

An ideal quality improvement project:

- ✓ focuses on advancing system priorities (e.g., Ministry of Health; Health Authority; Department/Division), Planetary health
- ✓ has local, operational support
- ✓ is amenable to a QI approach, where changes are developed and then tested locally with PDSA cycles (the project is not simply an implementation of a single pre-conceived change idea)
- ✓ focuses on a problem that occurs frequently enough for meaningful data to be collected over a 10 month period
- ✓ does not rely on significant investment of new resources (equipment, staff, etc.)

Cancer care

Planetary Health

Addictions care

Equity, Diversity, Inclusion

Surgical Services

Indigenous Cultural Safety

Seniors Care

“The joy in moving to quality improvement is that it opens doors to see and enjoy the benefit of our work in the immediate future, whereas with most traditional research only an exceptional few are lucky enough to see the benefits of their work in their lifetime.”
- Dr. Jane Lea, Otolaryngology
Cohort 2 Physician, Physician Coach

Thanks!

Questions?

Website: https://medicalstaff.vch.ca/working-for-change/vch-phc-plqi/
Email: medicalquality@vch.ca
Call: Allison Chiu at 604-970-1479, or
Enrique Fernandez at 604-652-0890

Over…

550

Physicians trained in **L2 Intermediate training**

140

Physicians trained in **L3 Advanced Cohort training**

Visit our website for more info on past projects & poster booklet

PQI projects funded for Family Medicine

- **Dr. Evelyne Perron** - Improving Accessibility to Prenatal Education at St Paul's Maternity Clinic
- **Dr. Kara Jansen** – Improving Patients' Postpartum Breastfeeding Support at SPH
- **Dr. Jennifer Baxter** – Bringing Joy to the Workplace: Enhancing Physician Wellness in the Emergency Department
- **Dr. Kimberly Merkli** - Optimizing Type 2 Diabetes Mellitus care in the Downtown Eastside
- **Dr. Michael Norbury** - Improving Access to Primary Care for those facing challenges with Social Determinants of Health in Vancouver Community
- **Dr. Nathaniel Winata** - Improving HIV Care at John Ruedy Clinic
- **Dr. Nick Graham** - Goals of Care Documentation at MSJ Family Practice Teaching Service (Acute Medicine)
- **Dr. Olivia Tseng** - Handover communication among physicians
- **Dr. Brian Wang** - Decreasing number of patients in waiting room at the Maternity Clinic in Richmond
- **Dr. Nicholas Lenskyi** – Increasing pneumococcal vaccination at Heatley Integrated Care Team
- **Dr. Olivia Brooks** – Rapid Kadian Titration Optimization in RAAC
- **Dr. Rayna Sivakova** – Decrease Superficial Surgical Site infection Rates at Sechelt Hospital for Post Caesarian Sections
- **Dr. Sarah Bartlett** - Improve Medication Prescribing and Inefficiencies in Team Processes
- **Dr. Jane Donaldson** - Moving Towards Ideal Care for Newborns in the Richmond Community
- **Dr. Jade Koide** – Increasing Rate if Breast & Cervical Cancer Screening at Heatley Community Health Centre
- **Dr. Simona Spassova** – Improve Healthcare Access to Residents at Ocean Falls
- **Dr. Ashley Smith** – Improving Delivery of Care in the Emergency Department for Patients with Substance Use Disorders
- **Dr. Bonnie Law** - Project TED: Reducing readmissions by communicating effectively during transfers to/from ED
- **Dr. Daniel Raff** – Data-driven OAT Outreach
- **Dr. Fiona Duncan** – Improving Joy in Work at a Community Family Practice
- **Dr. Julie Nguyen** - Improving Advance Care Planning on patients >70 at Lotus Medical

And many more!

Some FAQ

- Can we offer a group session on this topic (QI) in your clinic / work area? **Yes, through our Quality Quest initiative (customized QI workshop for teams)**
- Would patient panel clean-up be considered a QI project? **No – a patient panel clean up is a 'just do it' activity, where as QI project looks to tackle a problem that requires investigation of root-causes, testing of change ideas, and implementation of successful change ideas.**
- Is there a way to share successful projects? **Yes, refer to the Exchange database (by SSC) which contains a list of QI projects funded by DoBC in the province.**