Improving Access to Quality Care for Emergency Department Patients in British Columbia

Report of the Expert Panel on ED Decongestion

Submitted to the Health Operations Committee by the ED Decongestion Expert Panel

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Executive Summary

Every day, thousands of patients arrive in emergency departments (EDs) at hospitals across British Columbia – approximately 1.9 million visits each year – and many must wait for care due to ED congestion and overcrowding.[1] Addressing these issues is a complex task requiring multifaceted approaches, supported by strong leadership and the comprehensive engagement of practitioners and administrators across the health care system.

The primary goal of reducing ED congestion and overcrowding is to improve the quality of care provided in the system. It means *promoting a cultural shift* with respect to the role of the ED – rather than a default care space for full-capacity hospitals, health authorities need to operate as a network to ensure that all patients are moved to the most appropriate care spaces quickly (out of EDs or Acute Care spaces when an order to discharge is received).

The Expert Panel on Emergency Department Decongestion identified four key principles that must underpin future actions in order for BC to effectively address ED congestion and overcrowding:

- Quality emergency care is a core service for British Columbians and it is essential that the public have timely access.
- There must be a shared understanding about the root causes of congestion and overcrowding, and a collective commitment to solutions from senior leadership and all levels of the health care system.
- Both health authorities and the Ministry have the responsibility to develop and implement solutions to ED congestion and overcrowding, and to resource effective initiatives in the near, medium and long term.
- Sustainable system improvements will require dedicated funding for change management, and must be adequately resourced to be sustained.

With these principles in mind, the Panel discussed existing system-wide barriers, identified areas for improvement, and highlighted eight (8) key areas for action:

1. Focus on system flow and capacity as the lead organizational priority

This is essential to address ED congestion. Overcrowding was identified by the Panel as *the key cause of congestion in EDs*. In order to reduce overcrowding, system-wide patient flow must improve. To achieve this health authorities and the Ministry should: keep Emergency Departments for emergency patients by "protecting" emergency

[1] "Congestion" in EDs occurs when there are more patients than can be seen in a timely fashion by the staff in the department. "Overcrowding" occurs when ED resources (e.g., stretchers, staff time) are utilized to care for admitted patients who have not yet been transferred to an inpatient unit.

stretchers (i.e. ensuring that admitted patients are moved out of the ED upon the order to admit); reduce visits to EDs; and continue to improve ED efficiency using innovative practices supported by appropriate timelines.

2. Allocate Resources based on Technical Planning and Health System Modelling

In order to allocate resources in an effective and sustainable way, modelling of the health system should be continued and expanded. Modelling allows effective operational planning and evidence-based resource allocation, and can be used to assess optimal staffing models, required acute care capacity, and determine the optimal number of emergency stretchers to protect in order to achieve optimal flow.

3. Strengthen Accountability

This is an essential part of achieving the goals of ED decongestion. The Ministry, in partnership with the heath authorities, must clearly articulate performance-based expectations, and any associated incentives and consequences. Clear performance based expectations related to improving patient flow, as well as incentives and consequences, should be in place. Responsibility for addressing ED congestion and overcrowding should be understood as a *health authority flow* issue that must be addressed from a system perspective.

4. Standardize measures and data, clinical information and decision support tools

Provincially comparable performance indicators relevant to different levels of decision-making should be developed. These indicators should be regularly scrutinized for data quality, and shared across the health authorities and with the Ministry on as close to a real-time-basis as can be established. Indicators should be sensitive enough to capture incremental improvements towards targets, not just whether the targets were met. Information Management and Information Technology investments are needed to improve electronic access to clinical decision support tools and patient records in EDs, and ultimately improve patient care and patient flow.

5. Explore new funding approaches

EDs require sufficient resources to meet the fluctuating demand for emergency and after hours care, and well-developed connections with the rest of the health care system to effectively support their patients. The use of hospitalists and other alternate care providers in the health care system should be explored. Alternative funding approaches might include providing financial incentives/disincentives to program areas to “pull” their patients out of ED within established target times. This type of funding model would shift accountability for ED congestion from ED leadership (where congestion due to admitted patients in largely out of their control), to the program areas. Funding models may also need to be adjusted to ensure greater access to specialist and primary health care services.

6. Ensure effective change management support

Effective change management is essential to ensuring success in addressing ED congestion and overcrowding. Dedicated resources are required to promote, facilitate and sustain change. Change Management teams and Champions-of-Change are essential to this process.

7. Apply an "ED Lens" to health planning and policy

Planning for new initiatives across the health care system should consider the impact of any proposed changes on the flow and functioning of EDs. At the same time, planned changes in ED processes need to be reviewed to assess potential impacts on other parts of the health care system.

8. Establish a Provincial ED Services Advisory Council

A provincial ED Services Advisory Council of similar make up to this Expert Panel should be established to provide guidance on how to implement the advice of the Panel. The Council would advance system-wide flow perspectives on ED congestion and overcrowding by forging links with groups in other sectors of the health care system (i.e. the Provincial Home and Community Care Council, the Provincial Mental Health Council, Health Operations Committee, the Physicians Services Committee, the Medical Services Commission, BC Ambulance Service, the BCMA, the General Practice Services Committee, the Specialist Services Committee, etc.) and would report back to government on progress.

The Report of the Emergency Department Decongestion Expert Panel will be presented for consideration to the Health Operations Committee – a Ministry/health authority collaborative forum chaired by the Assistant Deputy Minister of the Health Authorities Division, in July 2009.

~ For a Detailed version of this Executive Summary, please see Summary and Conclusions (Page 27) ~

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Background

Highlights of this section

- Emergency departments (EDs) are used by thousands of British Columbians every day, and congestion and overcrowding are barriers to timely access to quality care.
- ED performance provides a window into the functioning of the entire health care system.
- Monitoring ED performance provides information linking care received before and after hospital visits, as well as the flow within hospitals.
- Government values the grounded feedback that experts in the field can provide on the strengths and weaknesses of government's approach to ED decongestion.
- The Panel's mandate is to "bring together recognized experts in the field of emergency medicine and health system reorganization to build on previous and current strategies, share expert knowledge, and provide advice on how to improve access to quality care for ED patients in British Columbia."

Every day, thousands of patients arrive in emergency departments (EDs) at hospitals across British Columbia – approximately 1.9 million visits each year. ED congestion and overcrowding has been an ongoing issue and area of concern in British Columbia for a number of years. "Congestion" in EDs occurs when there are more patients than can be seen in a timely fashion by the staff in the department. "Overcrowding" occurs when ED resources (e.g., stretchers and staff time) are utilized to care for admitted patients who have not yet been transferred to an inpatient unit.

ED congestion and overcrowding affects the quality of care patients receive in EDs, can compromise patient safety, and increase the risks and stress for those who are working in this environment every day.

EDs act as a window into the functioning of the entire health care system. Monitoring ED performance provides information to assess whether there is:

- healthy flow of patients within the hospital;
- an appropriately sized acute inpatient bed base;
- timely access to community and residential care services; and
- effective links to primary health care, home and community support, and residential care for patients before and after visiting the hospital.

One of the key goals of reducing congestion and overcrowding in EDs is to ensure that patients receive effective and timely treatment and services. Government appreciates the need to invest in improving the flow and functioning of EDs. One-time funding was provided to the health authorities for small scale changes in 2006 via ActionNow. This was followed by Health Innovation Funding (HIF) in 2007 which encouraged health authorities to find new and innovative approaches to addressing ED congestion.

Experts in the field can provide grounded and valuable feedback on the strengths and weaknesses of government's approach to ED decongestion to date. The use of Expert Panels comprised of healthcare leaders has been an important component of British Columbia's provincial strategies, with Panels providing valuable guidance to inform government's direction for system improvement.

The ED Decongestion Expert Panel

The Ministry of Health Services (the Ministry) convened an Expert Panel on ED Decongestion (the Panel) in April 2009. Nominations for Panel participants to represent each of the province's six health authorities were put forward by members of the Health Operations Committee (HOC) – a Ministry/health authority collaborative forum chaired by the Assistant Deputy Minister of the Health Authorities Division. A representative was also appointed by the British Columbia Medical Association's Board from the Section of Emergency Medicine to participate as an ex-officio member.

The Panel's mandate was to "bring together recognized experts in the field of emergency medicine and health system reorganization to build on previous and current strategies, share expert knowledge, and provide advice on how to improve access to quality care for ED patients in British Columbia" (see Appendix One).

Membership of the Panel (see Appendix Two) represents a broad array of expertise, and consists of administrators, researchers, clinicians and physicians with knowledge and experience in emergency services, decongestion strategies and organizational redesign.

The members were selected to provide a range of perspectives from across the system. Recognizing their key role in the management of care delivery, administrators were drawn from among senior staff of the health authorities.

A small secretariat was established within the Health Authorities Division of the Ministry to provide support to the Panel during its deliberations. The secretariat was responsible for arranging meetings, providing background information, developing supporting materials, establishing a reference library via a SharePoint site, recording Panel meeting discussions, and authoring the final report of Panel deliberations for submission to the Health Operations Committee.

It was decided at the outset that all Panel members would participate as equals and no chair would be appointed. An external independent facilitator was retained to lead the discussion, work with the members to define agendas, and ensure productive meetings in accordance with the Panel's mandate.

Advice of the Expert Panel

The focus of the Panel is on ED decongestion and overcrowding from the vantage point of EDs itself, looking both upstream and downstream at patient flow through the rest of the health care system.

The Panel's advice to the Ministry and Health Operations Committee begins with a statement of five principles to guide actions associated with reducing ED congestion and overcrowding. These principles address issues of quality, universality, effectiveness and efficiency and should be reflected in all subsequent action. They form an interdependent whole, and describe the multi-focused approach that is needed to achieve efficient patient flow in health authorities while focusing on providing high quality care.

The Principles

A considerable amount of work has already been undertaken around the province to address ED congestion and overcrowding. Work to date has borne promising but limited results. Thus, a need remains for continued attention to this issue and a conscious effort to focus on the problem from the system level.

The Expert Panel on Emergency Department Decongestion identified a number of key principles that must underpin future actions in order for BC to more effectively address ED congestion and overcrowding:

1. Quality emergency care is a core service for British Columbians and it is essential that the public have timely access.
2. ED overcrowding is a system-wide patient flow issue, and as such its solution demands a systems approach.
3. In order for congestion and overcrowding issues to be resolved, there must be a shared understanding about its root causes as well as a commitment to solutions from senior leadership and all levels of the health care system.
4. Both health authorities and the Ministry have a responsibility to develop and implement solutions to ED congestion and overcrowding and to resource effective initiatives in the near, medium and long term.
5. Sustainable system improvements will require dedicated funded resources for change management, and must be adequately resourced to be sustained.

Addressing ED Issues – Advice for the Health Operations Committee

The Panel identified a number of systemic barriers and areas for improvement in order for British Columbia to effectively address ED congestion and overcrowding. The Panel highlighted eight (8) key areas for change:

1. Focus on system flow and capacity as the lead organizational priority
2. Allocate resources based on technical planning and health system modelling
3. Strengthen accountability
4. Standardize measures and data, clinical information and decision support tools
5. Explore new funding approaches
6. Ensure effective change management support
7. Apply an "ED Lens" to health planning and policy
8. Establish a Provincial ED Services Advisory Council

1. Focus on System Flow and Capacity as the Lead Organizational Priority

Highlights of this section

- Overcrowding (admitted patients remaining in ED stretchers while waiting for inpatient beds) was identified by the Panel as *the key cause of congestion in EDs*.
- Improving the flow of patients through the system, using focused capacity recovery and flow management strategies, should be the most pressing organizational priority for health authorities and the Ministry.
- Addressing the issue of overcrowding is a complex issue requiring multifaceted approaches, which requires support of strong leaders and comprehensive engagement of practitioners and administrators.
- Wherever possible, new capacity may also be needed in the short term so that existing workloads can be managed while the Ministry and the health authorities contemplate and implement necessary longer term changes.
- As a key indicator of patient flow through the system, ED congestion and overcrowding cannot be solved within the ED.

It is the advice of the Panel that the Ministry and health authorities make improving system-wide patient flow and capacity recovery their most pressing organizational priorities. The Panel emphasized the need to look at how patients are moving through the continuum of health care services – a theme repeated in sections Two, Three and Four below.

Continuing process improvements in EDs is expected to improve timely patient access to emergency services; however, *the* key issue identified by the Panel is admitted patients remaining in ED stretchers while waiting for inpatient beds (see also the "Keep emergency departments for emergency patients" section below). Caring for these patients in the ED is considered the primary obstacle to the effective performance of EDs.

Focusing on system-wide patient flow is essential for understanding potential impacts of process and system changes, and improving access while maintaining quality of care. Further, as a key indicator of patient flow through the system, addressing ED overcrowding requires a system wide approach. It cannot be solved within the ED.

Understanding that ED congestion and overcrowding are hospital flow issues not isolated to EDs further supports and empowers health care practitioners and leaders to find real solutions to these issues. Leadership at the health authority and Ministry level is essential to ensuring this approach takes root.

In order to secure system-wide patient flow as the lead organizational priority, health authorities and the Ministry should focus on the following components: Keep emergency departments for emergency patients; Continue to invest in improving the efficiency of emergency departments; and Reduce visits to EDs.

1.1 Keep Emergency Departments for Emergency Patients

Collaboration with program areas in hospitals and the Home and Community care sector will help create a culture that ensures patients are cared for in the most appropriate care space. Community, residential and hospital program areas should recognize the impact on quality of care, length of hospital stay, and patient health outcomes that can result from extended time spent in EDs[2].

Addressing ED overcrowding requires multifaceted approaches, supported by strong leadership and comprehensive engagement of practitioners and administrators across the health care system. It requires *a shift in thinking* about how EDs are used within the care

[2] One example of a program area that moves patients as quickly as possible out of the ED is Perinatal Services; these practitioners consistently act to pull patients out of the ED and in to inpatient units. Capacity is managed through episodic increases for staffing, discharge planning and community supports.

continuum. Rather than EDs being a default care space for sites that run at full capacity, health authorities may need to organize their capacity to work as a network to ensure patients are moved to the most appropriate care spaces as quickly as possible.

The Panel advises that a proportion of ED stretcher spaces be "protected" for emergency patients[3]. This means capping the number of ED stretchers that can be occupied by admitted patients, which would need to be supported by mechanisms to promote patient flow and effective accountabilities around providing the best care in a timely fashion (see also "Exploring New Funding Approaches", below). The Ministry, care providers and administrators, would need to work together to facilitate implementation of this initiative.

ED congestion is a symptom of delayed access to inpatient beds, which is often a symptom of delayed access to post-hospital care - therefore strategic investments to expand functional capacity and improve the coordination between sectors is needed.

Discharge planning (i.e. follow-up care plans) should begin when patients are admitted to hospital to ensure that resources are in place as soon as the patient is safe to discharge. A significant impediment to patient flow within hospitals is what are termed "alternate level of care" (ALC) patients. These patients remain in the hospital due to unavailability of follow-up care that is required for safe discharge. In particular for the frail elderly, prolonged stays in hospital lead to declining health. Strategies to provide transitional care, home support and sufficient residential care resources are needed to affect ED congestion and overcrowding.

Continued capacity building in the Home and Community Care sector can be complimented with more robust linkages with acute care sites. Individual facilities or health authorities can work to develop grass-roots solutions to forge these links. Overall, best practice guidelines for admission management and discharge planning would improve sites' ability to provide the most appropriate care in the most appropriate setting.

1.2 Continue to Invest in Improving the Efficiency of EDs

As the 24 hour care center for British Columbians 365 days of the year, EDs are an essential part of the health care system. In recent years, through a variety of innovation initiatives (such as the Health Innovation Fund in 2007) the Ministry has funded the development and testing of new operational models for increasing the efficiency of EDs. In October 2008 the Ministry and the BC Medical Association (BCMA) Section of Emergency Medicine (SEM) formed the Emergency Department Overcrowding Solutions

[3] The optimal number of stretchers to be protected in each ED would be determined by modelling work to calculate what would create the optimal flow of patients through EDs (potentially, based on the estimates of one site, this could be in the range of 30 - 40% of ED stretchers).

Collaboration in order to meaningfully engage the SEM and BCMA in addressing ED overcrowding and decongestion in the province. A final report on this work was completed in April 2009 recommending a nine-point framework to reduce ED overcrowding, and improve patient care (please see Appendix Six). This work was further validated through the deliberations of the Expert Panel, with strong parallels between the areas highlighted for improvement by each group.

In addition, information sharing and cooperative venues such as the Evidence to Excellence (or E2E)[4] forum and ED Working Group[5], have allowed operational details of successful pilots to be shared and integrated into other EDs across the province. This information sharing has been pivotal to the progress that has been made on ED congestion in recent years.

Government should continue to provide innovation funding and opportunities for health authorities to try innovative practices, which should be supported with appropriate timelines. Panel members recommend innovation funding packages be extended to up to three years (rather than single-year funding) to allow greater time to implement, evaluate and redesign promising practices. Successful initiatives should be shared and implemented where appropriate across the province. Recognizing that patient flow in the ED is affected most by the boarding of admitted patients, innovation should encourage the expansion of linkages between services and improved quality of patient care.

Improving the flow and functioning of EDs will not be sufficient to address the core issues of ED congestion and overcrowding. Wherever possible, new capacity may also be needed in the short term so that existing workloads can be managed while the Ministry and the health authorities contemplate and implement necessary longer term changes.

1.3 Reduce Visits to EDs

Although the primary cause of ED congestion is admitted patients waiting in the ED for transfer to an inpatient bed, some gains in timely access to emergency care can be achieved by reducing demand for services.

Access to regular medical care is a key factor in the prevention and management of chronic disease or other health problems. Overall strengthening of Primary Health Care services would likely result in fewer ED visits, particularly for chronic disease patients.

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[4] Evidence to Excellence (E2E) is a provincial community of multidisciplinary Emergency staff that aspires to implement and streamline best operational and clinical practices.

[5] EDWG is a Ministry of Health Services/health authority collaborative forum to review opportunities, issues and challenges related to the congestion of EDs, and provide advice and leadership on addressing these matters. Member ship consists of administrative representatives from each health authority.

Initiatives such as asthma action plans, advanced access models, physician support programs, and Integrated Health Networks should continue to be developed. These programs help to ensure that appropriate, non-emergency care is provided outside of EDs, and that patients with complex care needs are effectively and efficiently served outside of the ED. ED visits can be further reduced through health promotion programs, such as influenza vaccinations and falls prevention strategies.

Another strategy is to ensure that all British Columbians who wish to have a primary care provider have one. Outreach and resources for "unattached" or "orphaned" patients assisting them to find a GP in their region could increase the number of British Columbians with a family doctor, and could decrease visits to EDs.[6]

For elderly and residential care patients, EDs must not become primary care substitutes. Strategies to provide in-home support for seniors can be complemented by increasing the treatment capacity of staff in residential care facilities, changing funding models to encourage family practitioners to see patients in their residences, and the development of nursing outreach teams for the residential care sector would ensure that fewer elderly patients visit the ED. Advanced care directives and "Do Not Resuscitate" orders, developed with the participation and informed consent of patients, may also have an impact on ED visits and overall patient flow.

Public education about appropriate use of EDs, such as during the recent H1N1 influenza education campaign, could also help reduce visits to EDs. Increased utilization of NurseLine and 8-1-1 services may also assist, but would need to be supported with timely access to in-person consultation and access to diagnostic facilities (such as x-ray, blood tests, CT scans, etc.) to ensure visits to EDs can be reduced.

Finally, technological solutions that provide the public with system-wide information about the congestion level of EDs could be developed. These solutions would give patients and emergency transport workers more information to make informed decisions about which site to visit.[7]

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[6] A program run in the Northern Health Authority has linked up a group of family practitioners with patients who do not have a primary health care provider. These patients are monitored and provided advice over a period of time, thus raising the level of continuity of care.

[7] Note – this approach would have more impact for high population areas than for smaller communities with fewer alternatives to their local ED.

Putting ideas and best practices into operation:

Focus on system flow and capacity

- Use modelling to identify and "protect" an optimum number of ED stretchers
- Promote program-area responsibility for admitted patients who remain in the ED after a target period of time
- Strengthen primary care in community and residential settings
- Focus on flow of patients in mid- to high-acuity levels: these patients have the longest waits and the highest resource requirements
- Promote emergency services outreach to residential care
- Re-introduce low level, fee-based home support
- Focus on discharge planning: use discharge planners, Home and Community Care planners, and/or social workers to assist the acute care team to plan for timely discharges
- Remove operational and policy barriers that impede patient flow: reduce the amount of time patients wait for a consulting specialist; review discharge and admitting privileges; increase family practitioner rounds to earlier in the day and more than once a day; and enhance and increase the use of hospitalists in urban centers

2. Allocate Resources Based on Technical Planning and Health System Modelling

Modelling involves the analysis of current and long term social dynamics that will affect capacity requirements for the health care system. It includes analysis of: expected changes to the population's size and age structure; projected future health status of the population; trends in service delivery models; and trends in patterns of service utilization.

Modelling in health care supports effective operational planning from the perspective of physical space requirements, adjacencies, staffing levels and staffing scope. Work initiated on modelling that supports evidence based decision making for resource allocation in the health care system should be continued and expanded.

In particular, modelling work in individual emergency departments is needed to determine the optimal number of emergency stretchers needed to provide timely care for emergency patients (see Keep emergency departments for emergency patients, above). Modelling is also used to understand the acute care capacity of the hospital.

Putting ideas and best practices into operation:

Allocate resources using technical planning and modelling

- Identify specific questions for the models to address – changing demand and acuity distribution, or the impact of a particular project
- Do not attempt to model everything - manage the scope
- Establish baseline markers and input those into the model
- Only use accurate and representative data that has been validated
- Understand the system before it is modeled:
  - identify 'contributors to delays' or 'contributors to congestion'
  - examine the use of non-traditional care spaces
  - consider the hours of operation
- Use models to determine the optimum number of protected ED stretchers
- Model the hospital to determine the functional capacity needed to ensure flow, based on the site's catchment population
- Identify system resource and capacity needs, and restructure or reconfigure service delivery accordingly

3. Strengthen Accountability

ED congestion and overcrowding must be understood as a health authority flow issue that can only be addressed using a system perspective. It is essential that the Ministry, in partnership with the health authorities, strengthen and broaden the accountability for addressing ED congestion and overcrowding. Understanding that overcrowding (or "boarding" admitted patients) is t*he key cause of congestion* in EDs, responsibility for ensuring optimal ED functioning and flow goes beyond the Department, and accountabilities need to be adjusted to reflect this.

Accountabilities should relate to improving patient flow through the health system, which will require receiving program areas proactively transferring patients. For example, admitted patients need to be 'pulled' out of the ED by inpatient units; ALC patients need to be 'pulled' out of the inpatient units by residential and community care programs.

Performance-based expectations – such as time limits for how long a patient will stay in a service area waiting to be 'pulled' out by the receiving program area – should be clearly communicated, and have associated incentives and consequences. This begins with leadership from government, but health authorities also have a responsibility to ensure that clear accountabilities exist within their governance structures.

Well-defined performance expectations should be tied not only to health authority funding, but to assessing the performance of hospital or regional management staff. Accountability frameworks that break down the positional responsibilities of the Ministry, health authority and care providers to address ED congestion and overcrowding should be implemented. These frameworks can provide detail on key deliverables, actions or remedies for correcting performance, and any consequences or incentives. A broad engagement of stakeholders to develop these frameworks is recommended.

Putting ideas and best practices into operations:

Strengthen Accountability

- Use performance and accountability to reinforce commitment to patient flow as the organization's lead priority
- Use standardized decision support tools, such as guidelines for admitting and discharging patients
- Build frameworks to outline the structure of accountability and relationships in health organizations
- Define performance-base expectations in accountability documents

between government and health authorities, and within health authorities

- Explore options for linking performance expectations with incentive funding or funding recovery

4. Standardize Measures and Data, Clinical Information and Decision Support Tools

4.1 Data and Measures

The Panel advises that addressing ED congestion and overcrowding in BC would be improved through the development of a larger suite of provincially-defined performance targets, with funding incentives and/or funding recovery initiatives attached (see also Strengthening Accountability, above).

Recent piloting of pay-for-performance projects to improve the flow and functioning of EDs included regular monitoring of transit times for patients, and directly linked rewards to improved performance. Next day reporting to front line staff on established target times enabled understanding of successes and challenges, linking daily work with progress towards greater efficiency. The Panel felt that well-developed communication of consistent performance indicators, in addition to robust change management and decision support practices, were important lessons of the pay-for-performance projects.

Standardized outcome measures of quality of patient care, patient satisfaction, flow into and out of EDs, as well as the flow out of hospitals, would provide a better basis for understanding and addressing the issues of ED congestion and overcrowding. Being able to paint a better profile of the types of patients using EDs in British Columbia - their chief complaints, reason for attending, and what type of community services they are accessing - would provide a strong base for designing and assessing ED improvement initiatives. In particular, indicators are needed that can measure the progress on building or strengthening links between information systems across sectors, improving patient transitions between sectors, and, ultimately, increasing timely access to appropriate care.

Provincially comparable performance indicators with clearly defined data elements relevant to different levels of decision-making need to be established. These indicators should be regularly scrutinized for data quality, reportable in as close to a real time basis as possible, and shared across the health authorities and with the Ministry. Development of these indicators should build on and link into other Canadian and North American measures. Provincial and national comparisons of the quality and timeliness of patient care will provide a sound foundation for assessing the impact of change initiatives.

Comparable performance indicators should be evaluated every two years in order to ensure their validity, reliability, and applicability based on population and geographic location. Further, when assessing performance, it is important that indicators are sensitive enough to capture incremental improvements towards targets, not just whether the targets were met.

It is also important to expand the tracking of these performance indicators for all EDs with a significant patient volume, and hence an increased potential for patient flow problems. In order to improve the ability of stakeholders to assess the impact of change initiatives and of performance in EDs and the hospital, further investment in information management and information technology (IM/IT) would be required.

Implementation of real time passive tracking systems in EDs will facilitate tracking in the hospital (i.e., the location of porters or other resources, beds vacated by individuals with resistant organisms, etc.) thereby improving process efficiency. Tracking systems can also be used to measure performance - for example, time from triage to first physician consultation in EDs. This would help to develop more accurate workload models and identify bottle necks as sources of congestion, creating a sound basis for consistent and comparable provincial performance monitoring. Finally, a provincial approach to ED technology development would support the ability of systems to communicate with each other, thus increasing transparency and accountability across British Columbia.

4.2 Access to Clinical Decision Support Tools in the ED

IM/IT investments to improve electronic access in EDs to health records that capture a patient's history - including residential care, mental health services, etc. - will improve the ability of practitioners to provide quality care as well as improve patient flow. At minimum, the Panel suggests electronic access to the following items:

- Past encounters with residential care, mental health and addictions, primary care
- Laboratory results
- Diagnostic imaging reports
- Inpatient and outpatient drug history

In addition, clinical decision support tools such as protocols and guidelines for specific health issues support best practices and facilitate timely and appropriate care for patients.

4.3 Some Potential Measures for Consideration

The Panel suggests the following with regard to current and future indicators:

<u>Current indicators</u>

- Continue to monitor the percentage of ED patients admitted to the facility where the time between decision to admit and leaving the ED to an inpatient bed meets targets
- Revise current GLE time from triage to physician measure to reflect incremental improvements resulting from changes in practice

- Monitor the performance of all EDs with visits of >20,000 with specific indicators, not just the 15 highest-volume sites currently being monitored
- Follow the leadership of the National Working Group on ED Indicators[8] and develop indicators reflecting clinical, systems and process improvements

Future Indicators

The Ministry should consider developing measures around the following categories:

- Timeliness of care: Consistent metrics for the ratio of visits to stretchers, the percentage of ED patients discharged home in greater than four hours; and total length of stay (LOS) for admitted patients compared to expected LOS
- Reasons for ED visit: reason for encounter; and reasons to seek care in an ED
- Treatments Provided: the clinical needs of patients entering EDs
- Quality of Care: discharge diagnosis in ED information systems using agreed-upon standard sets of diagnoses; track select diagnoses to monitor quality of care; and number of ED visits per patient

Putting ideas and best practices into operation:

Measures and Data, Clinical Information and Decision Support Tools

- Make strategic investments in IM/IT in the Ministry and health authorities
- Establish a manageable number of measures that reflect meaningful measurement of the system
- Measures need to be understandable and patient centric
- Track "frequent users" of EDs to determine who uses the ED as their primary source of health care
- Develop specific indicators targeting "pull" measures
- Use broad engagement of stakeholders to develop ED measures

[8] Run by the Institute for Clinical Evaluative Sciences (ICES)

5. Explore New Funding Approaches

Faced with fluctuating demand for emergency and after hours care, EDs require sufficient resources to effectively support their patients. A significant proportion of ED stretchers are consistently occupied by inpatients. These admitted or "boarding" patients are cared for by ED personnel who are also caring for emergency patients. ED staff have two separate care requirements, which contributes to high levels of staff frustration and exacerbates recruitment and retention issues.

To balance off the responsibility to care for admitted patients in the ED, care providers (registered, limited practice, or speciality nurses) could be re-assigned from inpatient areas to work in the ED. Health authority or facility budgets should be reallocated to create a "boarding budget" for supporting adequate ED staffing levels.

The Ministry and health authorities should also consider the use of incentives and disincentives – i.e., activity based funding and funding recovery mechanisms. Extensive consultation would be required in designing these new arrangements; however, they are likely to act as levers for achieving the results and change needed in the system. Funding and managing the EDs like other program areas and the use of incentives or funding recovery could be linked to stronger accountability and the organizational focus on increased patient flow.

In addition, the funding models to employ hospitalists, physician extenders and other alternate care providers such as Nurse Practitioners, Physicians Assistants, and Patient Care Aides in the health care system also need to be explored.

As mentioned in the 'Reduce visits to EDs' section, changing funding models for family practitioners providing care to elders living in residential care may decrease transfers to EDs for episodic care. This would require that funding models in the Home and Community Care sector be reviewed.

Putting ideas and best practices into operation:

Explore new funding models

- Assign medical, surgical, or mental health nursing staff to care for admitted patients in the ED during the first 24-48 hours of admission
- Determine the 'boarding budget' by counting the number of patients at midnight on census
- Government and the health authorities should provide ongoing

innovative funding to allow trialling of ideas

- Explore how funding models can be used as levers with health care Practitioners to affect desired change (i.e. bring into better alignment work with the Specialist Services Committee and other relevant bodies to encourage changes in practice and culture to meet the objectives of improved patient flow).

6. Ensure Effective Change Management Support

Effective change management in large and complex organizations is essential to ensuring success in addressing ED congestion and overcrowding, and requires dedicated change management resources to promote, facilitate and sustain change.

At the local level, engagement of staff is pivotal to ensuring that proposed changes are based in the operating environments where they will be implemented.

At the health authority level, strong support from senior management is needed to promote real change in the near and long term. And at the provincial level, government has a strong role to play in establishing ED congestion and overcrowding as a key priority for regions.

Engaging all of these levels of expertise in change management is positive for the morale of staff, and they feel that they are better able to provide appropriate care to patients.

One effective approach is to form a Strategic Performance Support Team (see text box). The diagram to the right outlines the three key areas required to achieve transformational system change: Effective Leadership, Strategy and Performance Support. In order to achieve the level of system transformation required to decongest EDs, and to a larger extent the health network, all areas must be aligned and in place.

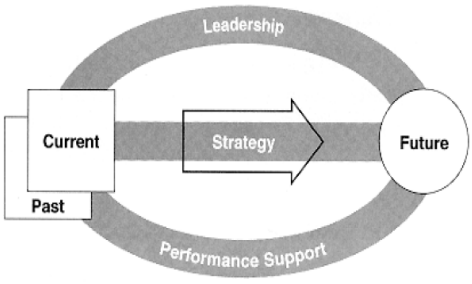


Figure 1. The Enterprise Development Template

A Strategic Performance Support Team may have the following 3 main components:

1. Transformation Support
   Core Competencies:
   - Coordination and Project Management
   - Change Management
   - Organizational Systems Design Innovation
   - Facilitating Engagement, Collaboration and Participation
   - Catching Breakdowns
   - Branding and Visibility
2. Process and Workflow Improvement Support
   Core Competencies:
   - Process Analysis
   - Lean Management
   - System/Process Redesign
   - Quality Improvement
   - Total Quality Management
3. Clinical Intelligence Support
   Core Competencies:
   - Analytics
   - Performance Management

A significant cultural shift is needed to support health care providers in addressing overcrowding: working with all sectors of the health care system so that EDs do not become the "catch-all" default care space, and that patients are provided with appropriate care in an appropriate setting – be that to inpatient wards or out of the hospital into community-based services.

For the most part health authorities have the core leadership capacities in place and can develop strategies; however, they lack resources in the area of change management support. As the Ministry continues to partner with the health authorities to develop performance expectations and accountabilities, the health authority's leadership will need to implement comprehensive change management strategies in order to achieve the system transformation that is required to decongest the health network.

Identifying 'Champions for Change' and ensuring dedicated resources are available for Change Management raises the commitment level of front-line staff to any particular initiative, and creates a sound foundation for integrating change into hospital processes.

Putting ideas and best practices into operation:

Effective Change Management Support

Change management requires investments at different points in the system to be successful:

- Invest in standardized technological support in all BC EDs (e.g. passive tracking systems and radio communication devices)
- Support innovative quality improvement initiatives and provincial level collaboratives (e.g. E2E)
- Establish common data sets and share across all health authorities to better inform system transformation decisions
- Create Strategic Performance Support Team (see text box) and Change Management plans

7. Apply an "ED Lens" to Health Planning and Policy

The Panel advises that in implementing initiatives at different points throughout the care continuum (e.g. the implementation of High-Risk Stroke/TIA Guidelines), consideration should be given to the impact of proposed changes on patient flow. This consideration would be applied for planned changes in EDs, as well as practice changes in services areas outside of the ED.

Traditionally, hospitals, residential and community services have relied on 24/7 access to EDs to provide the "safety net" in situations when demand exceeds service availability (e.g. access to community resources on evenings and weekends), or when service reductions are made for budgetary or human resource reasons.

In an effort to decrease further default use of EDs, consideration of impact on EDs – determined by applying the 'ED lens' - is necessary prior to implementation of new initiatives or further service reductions. Significant discussion and consultation with other program areas that may be affected should occur well in advance of new projects or programs being introduced.

The Panel also proposes an Advisory Council (see "8. Establish a Provincial ED Services Advisory Council", below) to provide guidance on how to operationalize this and other pieces of advice of the Panel.

Putting ideas and best practices into operation

Apply an "ED Lens" to Health Planning and Policy

- Use policy to promote an outward looking consideration of the impact of any policy, practice, infrastructural, or other changes being planned.
- Start consultations early in the planning stage, and maintain strong communication links.

8. Establish a Provincial ED Services Advisory Council

In order to ensure that the advice of the Panel is taken forward and operationalized effectively in the near term, and that this momentum is continued in the long term, the Panel advices that a Provincial ED Services Advisory Council be established (proposed Terms of Reference attached, see appendix Four).

The mandate of this Advisory Council would be to provide guidance to government, health authorities and facilities on how to implement the advice of the Panel. The Council would advance the system-wide flow perspective on ED congestion and overcrowding by forging links with groups in other sectors of the health care system (i.e. the Provincial Home and Community Care Council, the Provincial Mental Health Council, Health Operations Committee, the Physicians Services Committee, the Medical Services Commission, BC Ambulance Service, the BCMA, the General Practice Services Committee, the Specialist Services Committee, etc.).

The Council would form a tripartite table, bringing together physicians and managers from the health authorities, the BCMA, and the Ministry (similar to the make-up of the Expert Panel). It would be an ideal vehicle for knowledge sharing and monitoring province wide progress on patient flow, discussing innovative ideas and working to ensure that effective links between EDs and other sectors of the health care system are created and maintained.

Forming this Council would provide an excellent opportunity to unify and bring into alignment efforts currently underway in government, health authorities and by members of the BCMA to address ED and system-wide patient flow issues. The Council would serve to prevent duplication of effort and increase efficient and cost effective health care management in the province (please see Appendix Five).

A continued focus on local adaptations of best practices is vital to ensuring success, as is the involvement of a broad range of health care practitioners and managers in innovation and change. The Council would provide an ideal vehicle to ensure that all stakeholders are engaged, and that real solutions to improving ED access can be achieved.

Putting ideas and best practices into operation:

ED Services Advisory Council

- Establish a provincial level roundtable for bringing forward to action the operational details arising from this report.

Summary and Conclusions *(Detailed Executive Summary)*

Monitoring ED performance provides a window into the functioning of the entire health care system. The primary reason to focus on improving access to care in the ED is to ensure that patients are receiving effective and timely access to the best available treatment and services throughout the system. EDs provide information on the flow within the hospital, the appropriateness of the acute inpatient bed base, access to community and residential care services, and links between primary health care and residential care.

Every day, thousands of patients arrive in emergency departments (EDs) at hospitals across British Columbia. Congestion and overcrowding in EDs is an ongoing issue that affects the quality of care patients receive in EDs. "Overcrowding" occurs when ED resources (stretchers, staff time) are used to care for admitted patients who have not been transferred to an inpatient unit. "Congestion" in EDs occurs when there are more patients than can be seen in a timely fashion by the staff in the department.

Addressing overcrowding and congestion is a complex task requiring multifaceted approaches supported by strong leadership and comprehensive engagement of practitioners and administrators across the health care system. It means *promoting a cultural shift* where, rather than EDs being used as the default care space for full capacity sites, health authorities work as a network to ensure that patients are moved to the most appropriate care spaces quickly.

The Expert Panel on ED Decongestion (the Panel) brought together recognized experts in the field of emergency medicine and health system reorganization from each of the six health authorities in British Columbia. A representative was also appointed by the BCMA Board from their Section of Emergency Medicine as an ex-officio member.

The Panel identified a number of principles that must be reflected in any strategies to address overcrowding and congestion:

- Quality emergency care is a core service for British Columbians and it is essential that the public have timely access.
- There must be a shared understanding about the root causes of congestion and overcrowding, and a collective commitment to solutions from senior leadership and all levels of the health care system.
- Both health authorities and the Ministry have the responsibility to develop and implement solutions to ED congestion and overcrowding, and to resource effective initiatives in the near, medium and long term.
- Sustainable system improvements will require dedicated funding for change management, and must be adequately resourced to be sustained.

With these principles in mind, the Panel discussed systemic barriers and areas for improvement, and highlighted eight (8) key areas for change:

1. Focus On System Flow and Capacity as the Lead Organizational Priority

It is essential that the Ministry and health authorities make improving system-wide patient flow and capacity recovery their most pressing organizational priority. As a key indicator of patient flow through the system, ED overcrowding and congestion require a system wide approach. It cannot be solved within the ED.

In order to improve system-wide patient flow health authorities and the Ministry should focus on the following three components:

- Keep Emergency Departments for Emergency Patients.

  Overcrowding is *the key cause of congestion in EDs* identified by the Panel. It is the advice of the Panel that a certain number of emergency stretcher spaces should be "protected" for emergency patients. This would mean keeping a cap on the number of stretchers that can at any time remain occupied by admitted patients. It also means working with the other departments of the hospital and sectors of the health care system to *promote a cultural shift* in which other departments would view those patients with orders to admit as a key priority, and work to ensure that they can move the patient to the appropriate care space upon the decision to admit.

- Continue to Invest in Improving the Efficiency of EDs.

  Support for EDs to pilot new operational models to increase the efficiency of services within the ED and other opportunities for innovation should continue to be fostered, and successful initiatives should be shared and rolled out across the Province.

- Reduce Visits To EDs.

  Public education about appropriate use of EDs could help reduce visits to EDs. In order to successfully reduce visits however, patients must have access to alternate care options. Increasing the utilization of services such as NurseLine and 8-1-1 may assist; however, visits to EDs may not be affected by these initiatives unless patients can also have timely access to in-person consultation and to diagnostic facilities (such as x-ray, blood tests, CT scans, etc.).

2. Allocate Resources Based on Technical Planning and Health System Modelling

Modelling involves the analysis of current and long term social dynamics that may affect capacity requirements for the health care system. Modelling supports effective operational planning, and can also be used to assess optimal staffing models. The modelling work that has been initiated to support effective evidence-based resource allocation in the health care system should be continued and expanded.

In particular, modelling work is needed to determine the optimal number of emergency stretchers needed to provide timely care for emergency patients (i.e. protected stretchers) in individual EDs, as well as the acute care capacity requirements of the hospitals within which EDs function.

3. Strengthen Accountability

Strengthening accountability related to ED and health system congestion is an essential part of achieving the goals of ED decongestion. Clear performance-based expectations as well as incentives and consequences should be in place, with responsibility for addressing ED congestion and overcrowding being understood as a *health authority flow* issue that must be addressed from a system perspective.

Accountabilities should relate to improving patient flow throughout the health system, which will require more active movement of patients on behalf of the receiving program areas. Admitted patients need to be 'pulled' out of the ED by inpatient units; ALC[9] patients need to be 'pulled' out of the inpatient units by residential and community care programs.

Performance-based expectations – such as time limits for how long a patient will stay in a service area waiting to be 'pulled' out by the receiving program area – should be clearly communicated, and have associated incentives and consequences.

At the health authority level, strong support from senior management is needed to promote real change in the near and long term. At the provincial level, government has a strong role to play in establishing ED congestion and overcrowding as a key priority for regions.

Well-defined performance expectations should be tied to health authority funding, and to the performance assessments of hospital or regional management staff. Accountability frameworks developed by a broad engagement of stakeholders that detail positional responsibilities, key deliverables, actions or remedies for correcting performance, and any consequences or incentives should be implemented.

4. Standardize Measures and Data, Clinical Information and Decision Support Tools

- <u>Data and Measures</u>

  There is a need for provincially comparable performance indicators relevant to different levels of decision-making. These indicators should be regularly scrutinized

[9] Alternate Level of Care patients – those who remain in a higher acuity care space awaiting necessary home or community supports to be safely discharged.

for data quality, and shared across the health authorities and with the Ministry on as close to a real-time-basis as can be established. Standardized and timely outcome measures that look at the quality of care for patients, patient satisfaction, flow in EDs, and flow out of EDs and out of hospital care are needed. This would provide a better basis for understanding and addressing the issues of ED congestion and overcrowding.

Indicators should be developed by building on and linking with other current Canadian and North American indicator development work. Comparable performance indicators should be evaluated every two years in order to ensure their validity and reliability. Finally, in assessing performance, it is important that indicators are sensitive enough to capture incremental improvements towards targets, not just whether the targets were met.

- Access to Clinical Decision Support Tools in the ED

  Information Management and Information Technology investments are needed to improve electronic access to patient records in EDs, and ultimately improve patient care and patient flow. In addition, clinical decision support tools such as protocols and guidelines for specific health issues support best practices and facilitate timely and appropriate care for patients.

- Potential work on measures

  The Panel proposed that the indicators currently being tracked by the Ministry require further work to refine and specify the data elements for each indicator. In addition, the Panel suggested that the following be areas of focus for monitoring EDs in British Columbia:

  - Timeliness of care
  - Reasons for ED visit
  - Treatments Provided
  - Quality of Care

5. Explore New Funding Approaches

In order to meet the fluctuating demand for emergency and after hours care, EDs require sufficient resources and well-developed connections with the rest of the health care system.

Recognizing that a significant proportion of ED stretchers are consistently occupied by inpatients, health authority and/or facility budgets should be reallocated to provide staffing levels in EDs similar to inpatient units (i.e. a “boarding budget" – explained on page 21).

A suggested best practice would be for patients to have medical, surgical or mental health nursing staff assigned to care for them in the ED if the patients cannot be

moved immediately to inpatient wards. This practice would improve the level of care that patients receive in their first 24-48 hours of admission.

Funding models in the Home and Community and Primary Health Care sectors may also need to be adjusted to ensure that more care can be provided in an individual's place of residence or in the community itself. Changing funding models for family practitioners providing care to elders living in residential care would likely decrease transfers to EDs for episodic care.

The use of hospitalists, physician extenders and other alternate care providers such as Nurse Practitioners, Physicians Assistants, and Patient Care Aides in EDs should be explored as a way to maximize the utility of human resources.

6. Ensure Effective Change Management Support

Effective change management is essential in order to achieve the level of system transformation required to improve patient flow in the health system and decongest EDs. However, dedicated resources are required to promote, facilitate and sustain change.

Engagement of staff at the local level is pivotal to ensuring that proposed changes are based in the operating environments where they will be implemented, as well as for the morale of staff during periods of organizational change.

At the same time, effective change management in large and complex organizations requires leadership and accountability at the senior levels, supported by effective Champions-for-Change and dedicated Change Management personnel.

7. Apply an "ED Lens" to Health Planning and Policy

It is the advice of the Panel that planning for new initiatives across the health care system should consider the impact of any proposed changes on the flow and functioning of EDs. At the same time, planned changes in ED processes need to be reviewed to assess potential impacts on other parts of the health care system.

In an effort to decrease further default use of EDs, consideration of potential impacts on EDs is necessary prior to implementation of new initiatives or further service reductions. Traditionally, hospitals, residential and community services have relied on EDs as a 24/7 default care space when they are at full capacity. Health authorities may need to organize their capacity to work as a network to ensure patients are moved to the most appropriate care spaces as quickly as possible.

8. Establish a Provincial ED Services Advisory Council

In order to ensure that the advice of the Panel is taken forward and put into operation effectively, it is the advice of the Panel that a Provincial ED Services Advisory Council be established (proposed Terms of Reference attached, see appendix Four).

The mandate would be to provide guidance to Government, health authorities and facilities on how to implement the advice of the Panel.

The Council would work to advance the system-wide flow perspective on ED congestion and overcrowding by forging links with groups in other sectors of the health care system (i.e. the Provincial Home and Community Care Council, the Provincial Mental Health Council, Health Operations Committee, the Physicians Services Committee, the Medical Services Commission, BC Ambulance Service, the BCMA, the General Practice Services Committee, the Specialist Services Committee, etc.).

The Council would form a tripartite table, bringing together physicians and managers from the health authorities, the BCMA, and the Ministry. The establishment of a Council would bring into alignment all of the efforts currently underway around the province that are dedicated to addressing ED and system-wide patient flow issues.

The Report of this Panel will be presented to the Health Operations Committee – a Ministry/health authority collaborative forum chaired by the Assistant Deputy Minister of the Health Authorities Division in July 2009.

The Emergency Department Decongestion team, on behalf of the Ministry of Health Services would like to thank the Panel members for their valuable time, expertise and active participation in this process. We and the Panel members would also like to recognize the outstanding contributions of the facilitator, Lillian Bayne.

Appendix One – Expert Panel on ED Decongestion Terms of Reference

Congestion in Emergency Departments (EDs) is an ongoing issue that has been an area of concern at the facility and health authority level for a number of years. Government introduced the Emergency Department Decongestion Strategy (the Strategy) as a priority project in 2007 to provide provincial level oversight and direction for work targeting the problem of congestion.

An Expert Panel has been identified as an opportunity to engage a larger group of subject matter experts to contribute knowledge to government's approach to decongestion. The use of Expert Panels consisting of acknowledged clinical, management and research leaders has been a component of many provincial strategies focused on improving access to quality care.

Mandate

The Expert Panel on ED Decongestion (the Panel) will bring together recognized experts in the field of emergency medicine and health system reorganization to build on previous and current strategies, share expert knowledge, and provide advice on how to improve access to quality care for ED patients in British Columbia.

Scope and Deliverables

The Panel is to provide guidance on how British Columbia's health system should go about improving access to emergency services. Work will include, but is not limited to, discussing existing barriers and current initiatives, identifying opportunities to improve access to quality care and patient flow, exploring performance measurement and monitoring, and reviewing the approach that government has taken in the past in its oversight role.

Through this work, the Panel will provide input and advice for a report to be authored by the Panel's Secretariat. The report will identify system-wide, comprehensive, and long term options for achieving and maintaining improved access to quality care and reduced wait times.

Out of Scope

The Panel's work will exclude:

- Negotiation of compensation or elements of collective agreements; and
- Budgetary issues or funding requirements for health authorities.

Membership

Nominees were put forward by the Health Operations Committee (the Committee) and confirmed by the Ministry. The Panel includes representation from each of the province's six health authorities and consists of administrators, researchers, clinicians and physicians with knowledge and experience in emergency services, decongestion strategies and organizational redesign that will provide the required system perspective. Also participating in an ex-officio capacity is an appointee from the British Columbia Medical Association Section of Emergency Medicine. The Panel may grant observer status to additional members.

Governance & Accountability

The Panel will be established by and accountable to the Ministry and health authorities through the Health Operations Committee (the Committee). The Terms of Reference for the Panel will be submitted to the Committee for approval. Panel members will volunteer their time in both preparation for, and participation in the meetings. The Ministry will cover travel and meeting costs and offer an honorarium to non-salaried Panel participants.

Conduct of Meetings

All Panel members will participate as equals. An external independent facilitator will work with the members to define agendas and ensure productive meetings in accordance with the Panel's mandate. The Ministry will act as the liaison between Leadership Council, Health Authority Chief Financial Officers Committee, Health Operations Committee, Collaboration Committee, the Panel and the ED Working Group as appropriate.

Timelines

The Panel is time-limited. It will meet until the deliverables are achieved; this work is anticipated to be complete in a maximum of four months. The final product will be a report from the Panel that will be submitted to the Ministry by way of the Committee.

Project Management & Secretariat

A small Secretariat, housed in the Ministry, has been established with responsibility for providing support to the Panel.

Appendix Two – Membership of the Panel

Fraser Health Authority

Dr. Rob Street – Emergency Physician and Department Head, Royal Columbia Hospital

Martha Cloutier – Director, Surrey Emergency

Laura Case – Director, Systems Improvement

Vancouver Coastal

Dr. Eric Grafstein – Department Head, Emergency, St. Pauls Hospital

Dr. Jeff Coleman – Vice President Regional Programs and Service Integration, Richmond Hospital

Interior Health Authority

Sue Carpenter – Corporate Director of Emergency Services

Dr. Mike Ertel – Emergency Room Physician, Kelowna General Hospital

Vancouver Island Health Authority

Brenda Uhrynuk – Executive Director Medicine, Community Hospitals, and Staff Scheduling

Leighanne MacKenzie – Director, Emergency Services, Trauma Care & Neurosciences

Northern Health Authority

Jim Fitzpatrick – Manager, Critical Care Services, Prince George Regional Hospital

Michael McMillan – Chief Operating Officer, Northern Interior Health Service Delivery Area

Bill Clifford – Chief Medical Informatics Officer

Provincial Health Services Authority

Dr. Ran Goldman – Division Head and Medical Director, BC Children's Hospital

Elaine Allchurch – Senior RN and ED Manager, BC Children's Hospital

Vicky Crompton – Program Manager, Emergency Department, BC Children's Hospital

British Columbia Medical Association Section of Emergency Medicine (SEM) Appointee

Dr. William Cunningham – Emergency Physician, Cowichan District Hospital and Co-Chair of the Ministry/BCMA Emergency Department Overcrowding Solutions Collaboration.

Secretariat

Morag Mochan – A/Director, ED Decongestion Strategy

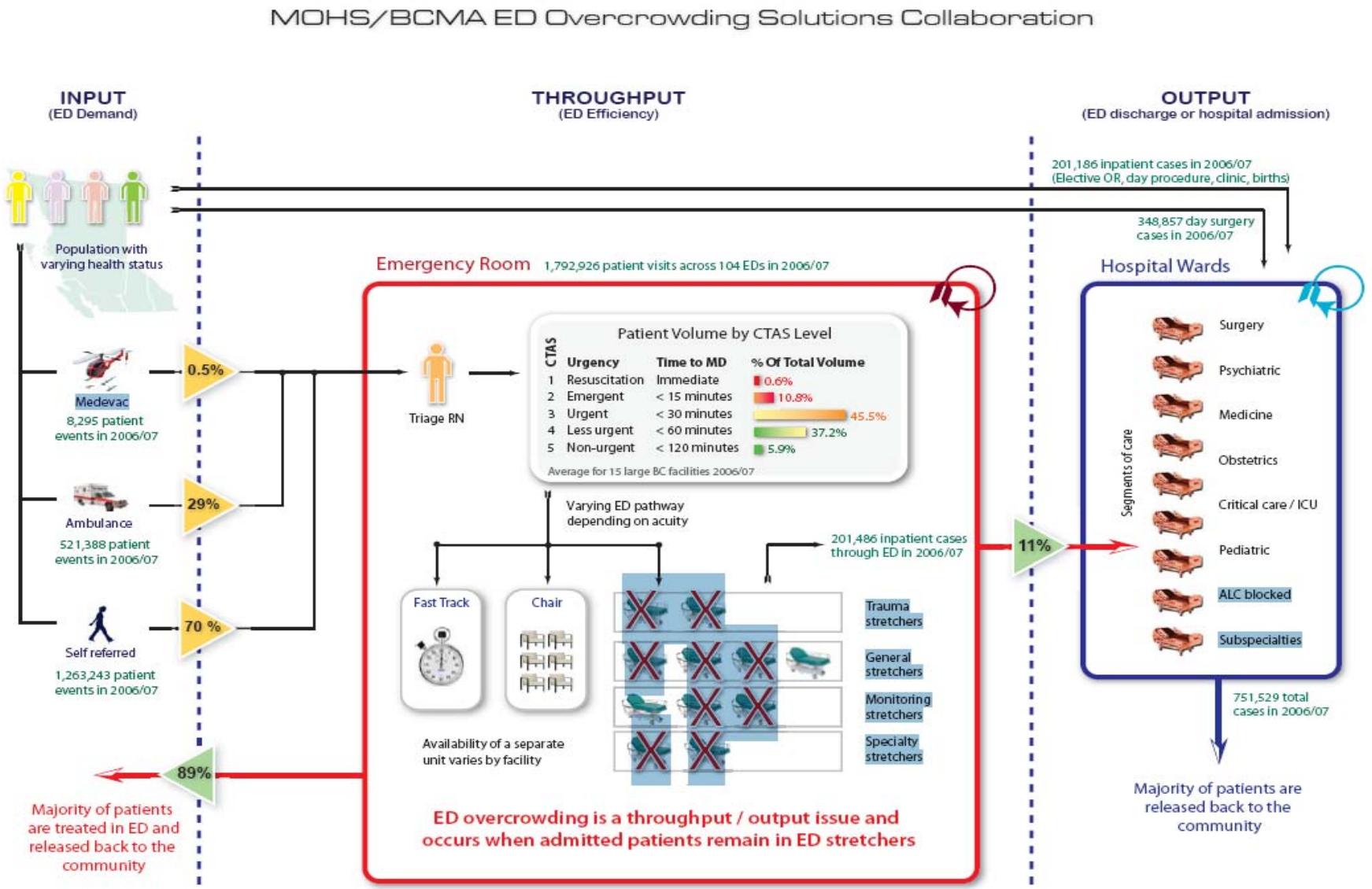
Carmon McColl – Project Manager, ED Decongestion Strategy

Máire McAdams – Team Lead, Acute Care Policy and Planning

Alison Millar – Director, Access/Wait Times Strategy

Lillian Bayne – Facilitator

Appendix Three – Input, Throughput and Output: A Matrix of Issues



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Appendix Four – Proposed Terms of Reference for a Provincial ED Services Advisory Council

PROVINCIAL EMERGENCY SERVICES ADVISORY COUNCIL

PROPOSED TERMS OF REFERENCE

Purpose:

The goal of a Provincial Emergency Services Advisory Council (PESAC) would be to improve the access, utilization, effectiveness, and sustainability of the Emergency Services system in BC. PESAC would serve to advise government and health authority executive on issues that occur across the health care system related to emergency department access and performance. Its advice would be focused on problem solving and sharing knowledge and best practices.

Emergency Services are defined as those services which are focused on the inputs, internal processes, and outputs of hospital emergency departments. Urban and rural emergency service issues would also be considered.

Accountability:

In order to meet the mandate of the group, PESAC would need to report to a committee or council that includes representation at a high level from each health authority and the Ministry, and ideally one which has formal linkages with physicians and other key health care stakeholders.

Structure:

Membership

Membership should include balanced representation from all health authorities, the Ministry of Health Services, and the BCMA, with linkages to the UBC Department of Emergency Medicine.

Chair

TBD

Secretariat

It is proposed that the Council Secretariat would be staffed by the Ministry of Health Services, and would be responsible for booking meeting space, distributing agendas, minutes and related information in a timely manner, and maintaining a work plan.

Meetings:

Regular meetings could be held every two months or more frequently if necessary, either in person or by video/teleconference. The Council might also convene subcommittees/working groups to address specific issues as needed.

Funding:

Budget

Funding would potentially be provided by the Ministry of Health Services. The amount is to be determined.

Expenses:

The costs of administrative and clerical support required for the work of PESAC and its working groups, and physician participation (other than those who are employees of the parties) would potentially be paid from funds provided by the Ministry of Health Services to support the work of PESAC.

Reporting:

Minutes:

Minutes would be recorded and disseminated by the Council Secretariat.

Requirements:

The Council would report through its members to their respective parties – in particular senior Ministry, Health Authority and BCMA representatives. In addition, the Council could produce a short, bi-monthly report detailing meeting outcomes and activities that occur between meetings.

Consensus:

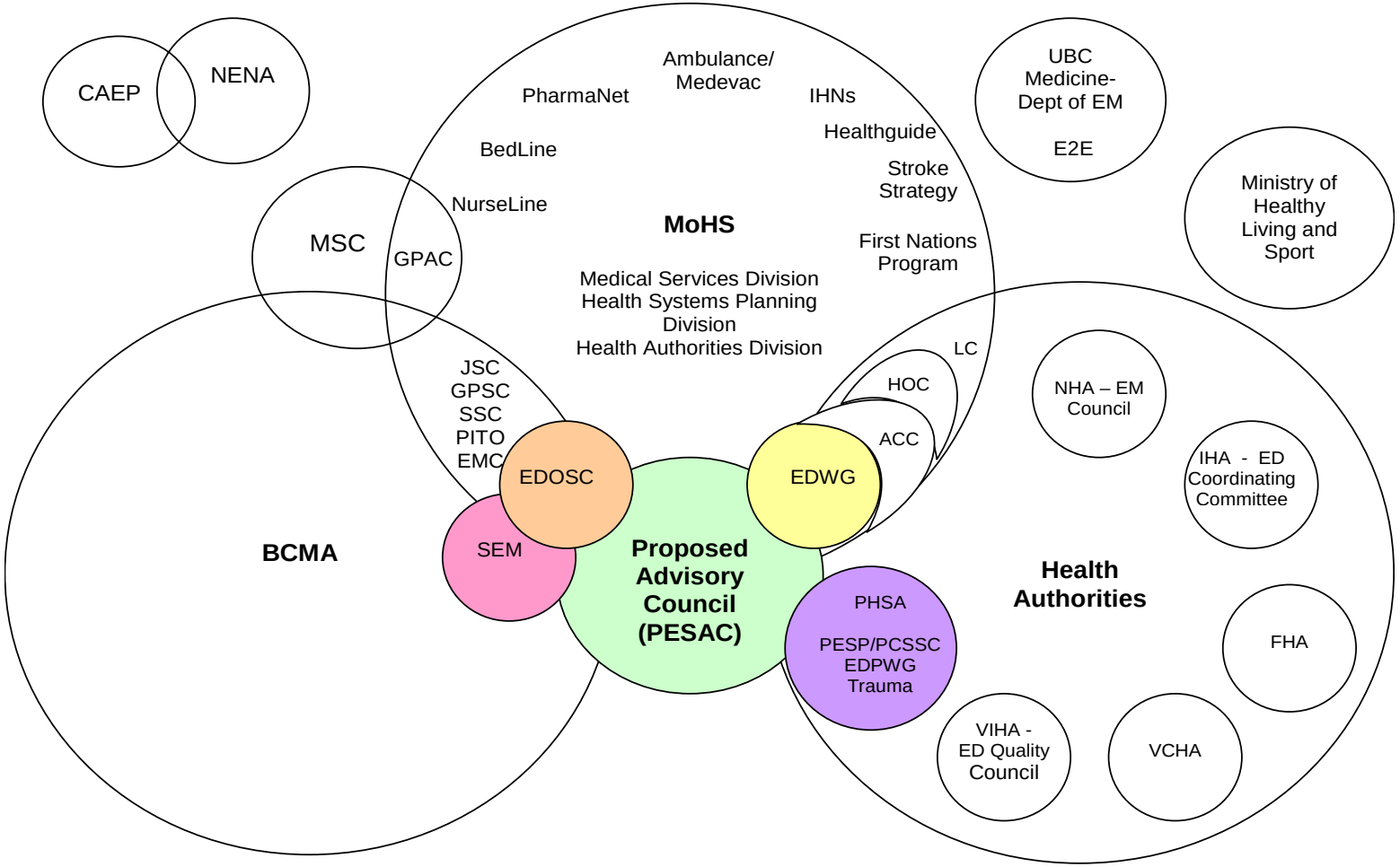
It is proposed that the Council would make decisions and recommendations by consensus. If any parties were to have strong objections to the advice or recommendations going forward from PESAC, a formal process would be set by which these objections would be brought to the attention of the receiving body.

Confidentiality:

A standard Confidentiality agreement would be included in the Terms of Reference (i.e. “From time to time, Council members may possess information or documentation of a confidential nature. Such information will not be disclosed to persons other than members of the Council without consultation of the Council.”)

CAEP = Canadian Assoc. of Emergency Physicians JSC = Joint Standing Committee on Rural Issues NENA = National Emergency Nurses Affiliation GPSC = General Practice Services Committee MSC = Medical Services Commission SSC = Specialist Services Committee GPAC = Guidelines and Protocols Advisory Committee EMC = Emergency Medicine Committee PITO = Physician Information Technology Office SEM = Section of Emergency Medicine	PESAC = Provincial Emergency Services Advisory Council EDOSC = Emergency Department Overcrowding Solutions Collaboration EDWG = Emergency Department Working Group EDPWG = Emergency Department Protocol Working Group PESP = Provincial Emergency Services Project PCSSC = Provincial Critical Services Steering Committee HOC = Health Operations Committee ACC = Acute Care Council LC = Leadership Council E2E = Evidence to Excellence

Appendix Five – Diagram of existing ED working groups



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Appendix Six – Supporting Documentation

Below is a list of studies and other literature that have informed the views of Panel Members:

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3. Hoot, Nathan R, and Dominik Aronsky, "Systematic Review of Emergency Department Crowding: Causes, Effects and Solutions." Annals of Emergency Medicine 52.2, (August 2008).

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