AIMing for Improvement at GIMRAC

Quality Improvement Project on the Rate of Appropriate Emergency Department Referrals for the General Internal Medicine Clinic at St. Catharines Hospital

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Conflict Disclosures

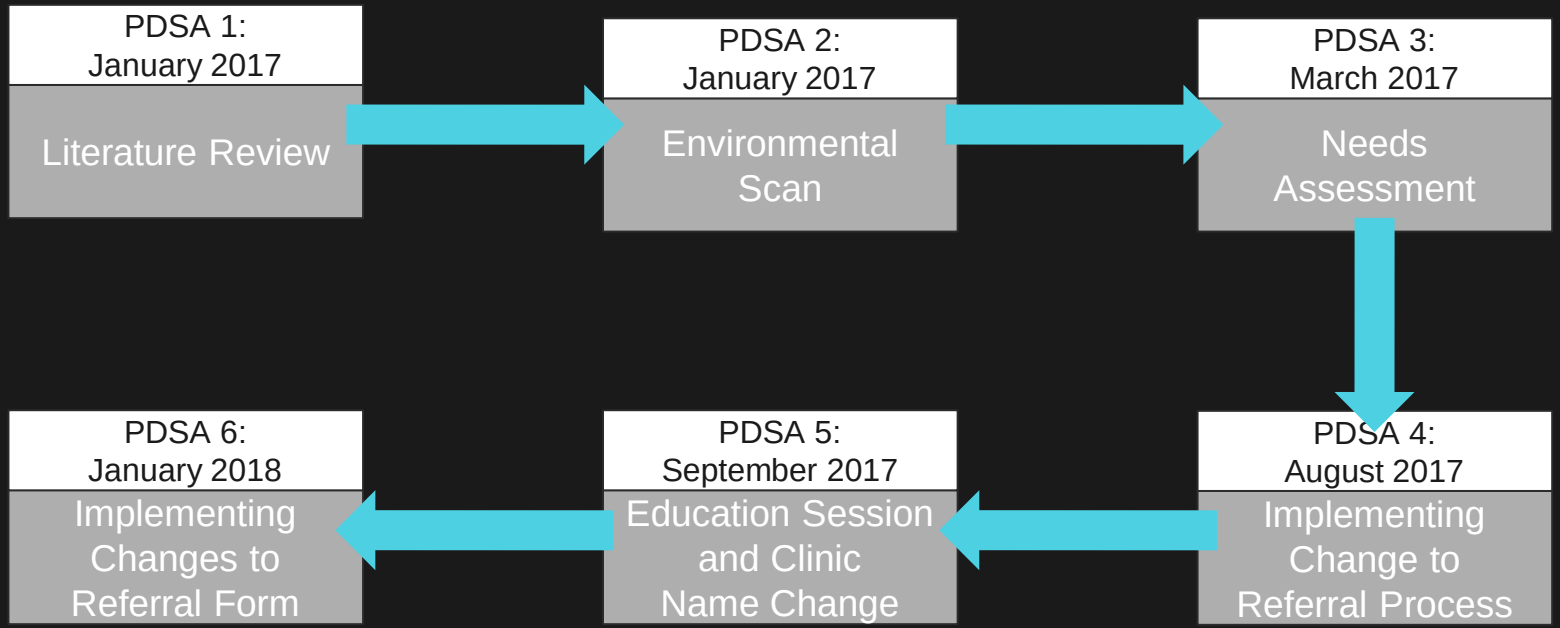
The authors do not have any conflicts to disclose.

Background

- What is the General Internal Medicine Rapid Assessment Clinic (GIMRAC)?

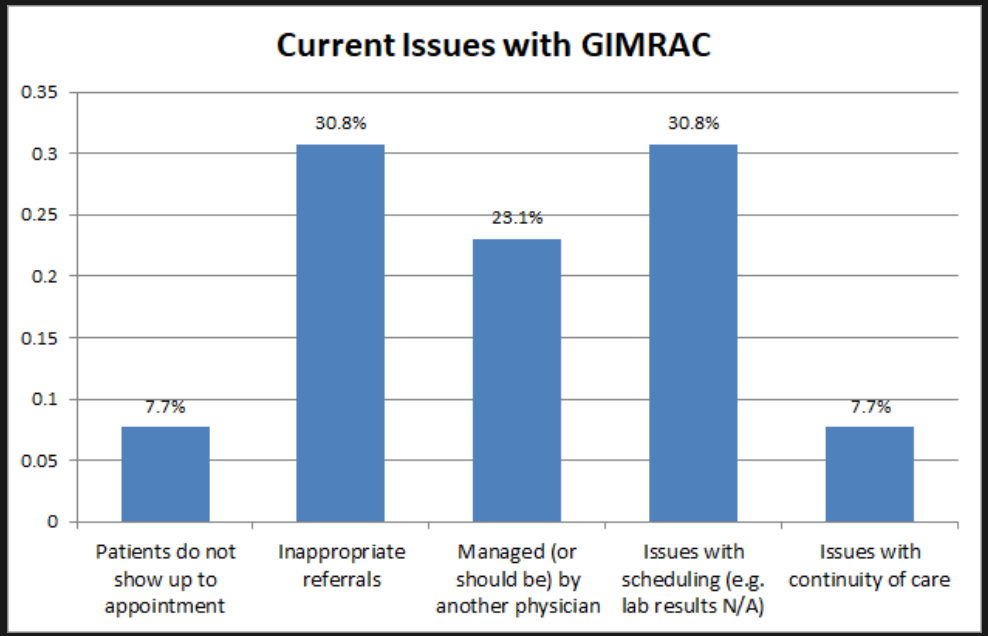
- What are the goals of GIMRAC?
  - Taking consultations from both the emergency department (ED) and the internal medicine ward for patients post-discharge
  - Reducing rate of new hospitalizations and hospital readmissions
  - Not intended to replace GP or manage chronic issues

Overview


PDSA 1:
January 2017
Literature Review
PDSA 2:
January 2017
Environmental Scan
PDSA 3:
March 2017
Needs Assessment
PDSA 4:
August 2017
Implementing Change to Referral Process
PDSA 5:
September 2017
Education Session and Clinic Name Change
PDSA 6:
January 2018
Implementing Changes to Referral Form

PDSA 1: Literature Review

- Discussion among internists at SCH regarding the state of GIMRAC



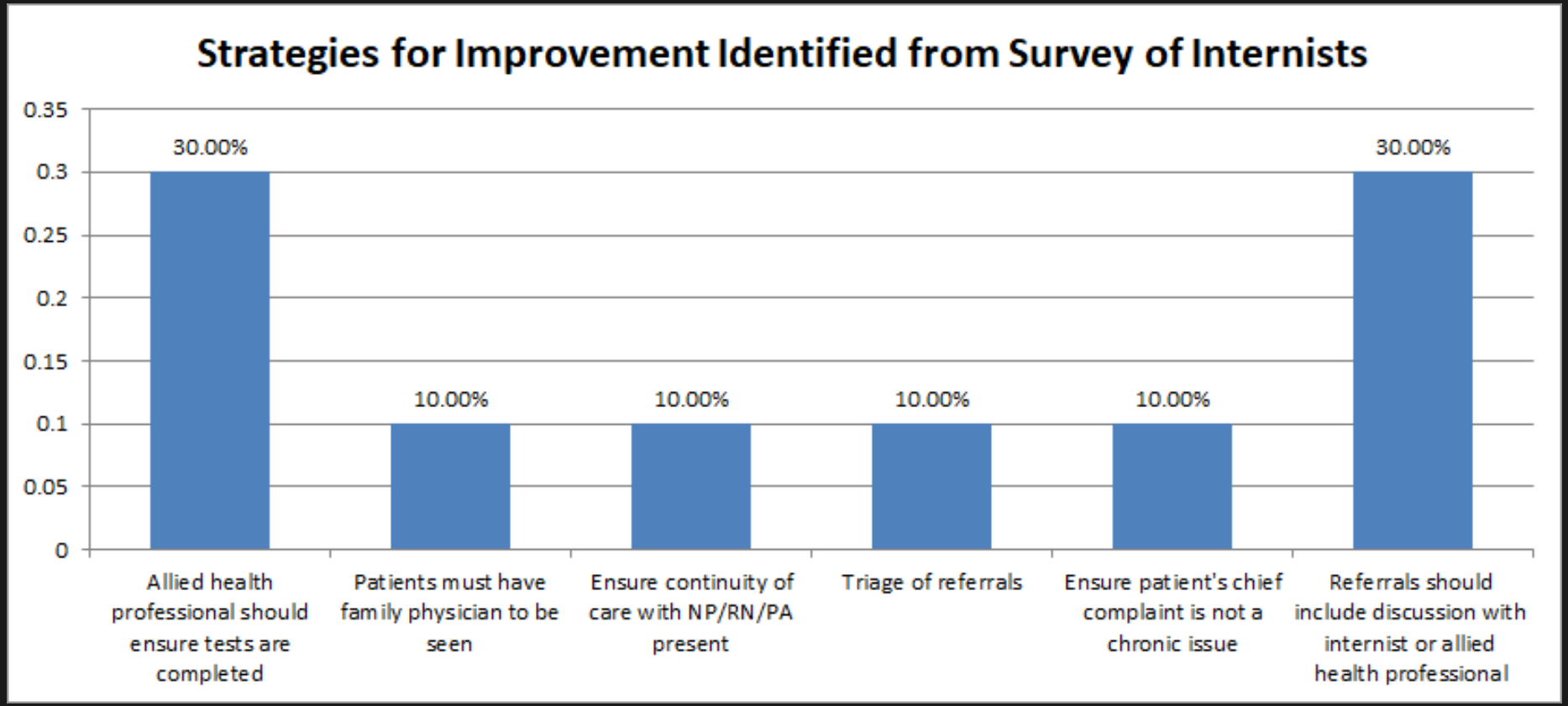
- Search of existing literature on quality improvement for general internal medicine outpatient clinics
  - Educating referring physicians improved appropriateness of referrals
  - In-person teaching sessions and handout resources were both effective
  - Specific guidelines on referral forms were effective

PDSA 2: Environmental Scan

- Fracture Clinic
  - Patients booked for appointment at time of visit as opposed to at a later time
  - No consultation with on-call orthopedics prior to making referral

- Cardiac Rapid Assessment Clinic (CRAC)
  - Provided information package to ED physicians on appropriate vs. inappropriate referrals
  - No consultation with on-call cardiology prior to making referral

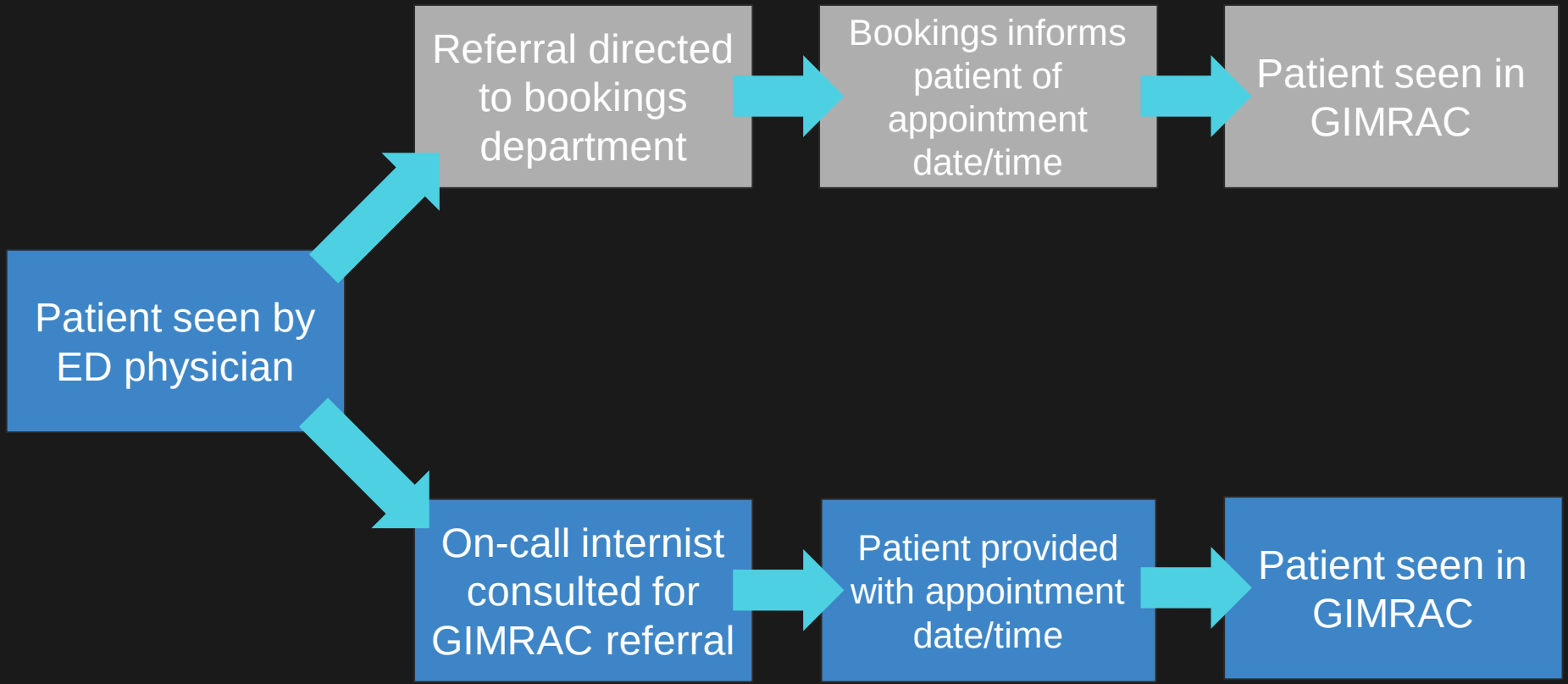
PDSA 3: Needs Assessment



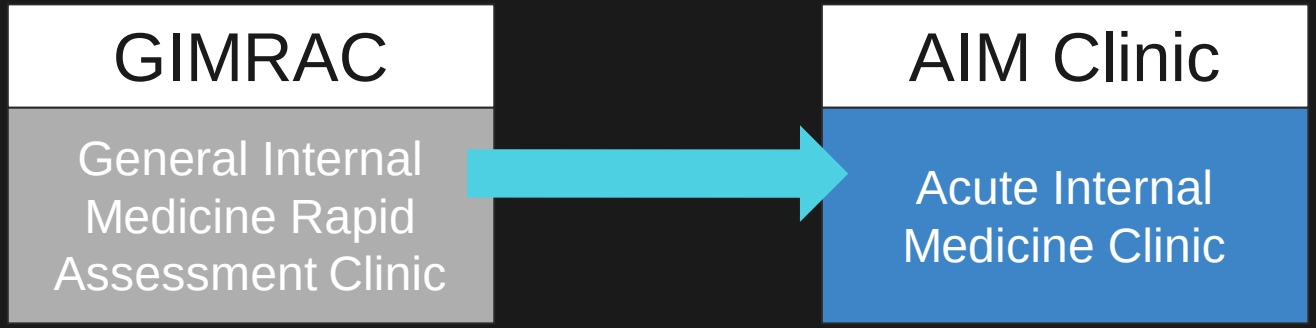
Aim Statement

Making changes to the referral process and facilitating cross-specialty communication between ED physicians and internists to reduce the proportion of inappropriate referrals to the clinic by 50% within two years of starting this project.

PDSA 4: Implementing Change to Referral Process



PDSA 5: Education Session and Clinic Name Change



- Attended quarterly ED physician meeting to communicate proposed changes to GIMRAC and review the aims of the clinic

Assessing PDSA 4 and 5

Outcome Measures	Process Measures	Balancing Measures
Rate of internist-rated appropriate referrals	Reason that referrals were inappropriate Follow-up for patients post-clinic Understanding of changes by ED physicians	Number of referrals from the ED Duration of wait-times to be seen in clinic Rate of patient no-show

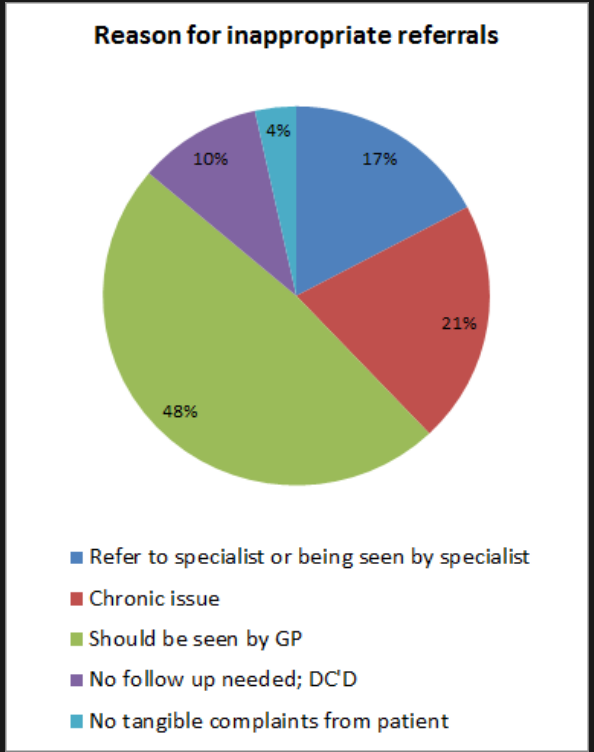
Assessing PDSA 4 and 5

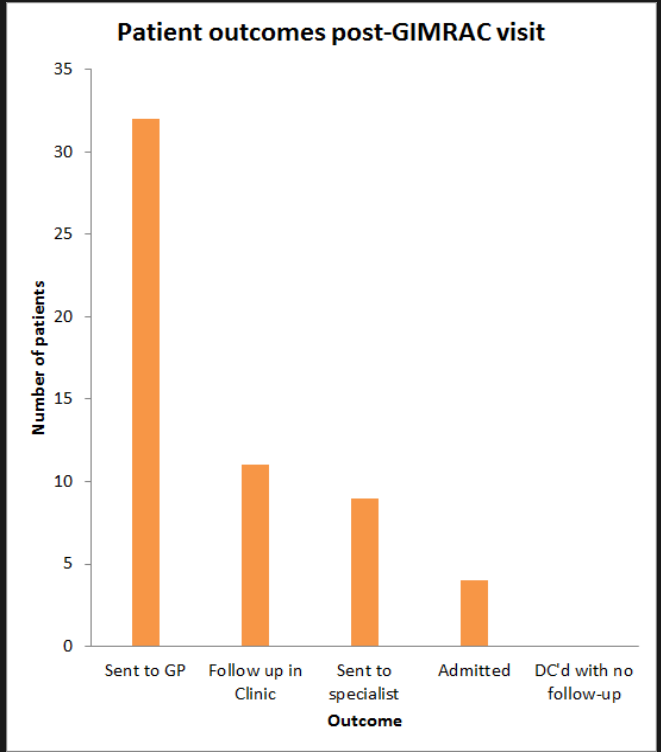
Process Measures

Reason that referrals were inappropriate

Follow-up for patients post-clinic

Understanding of changes by ED physicians





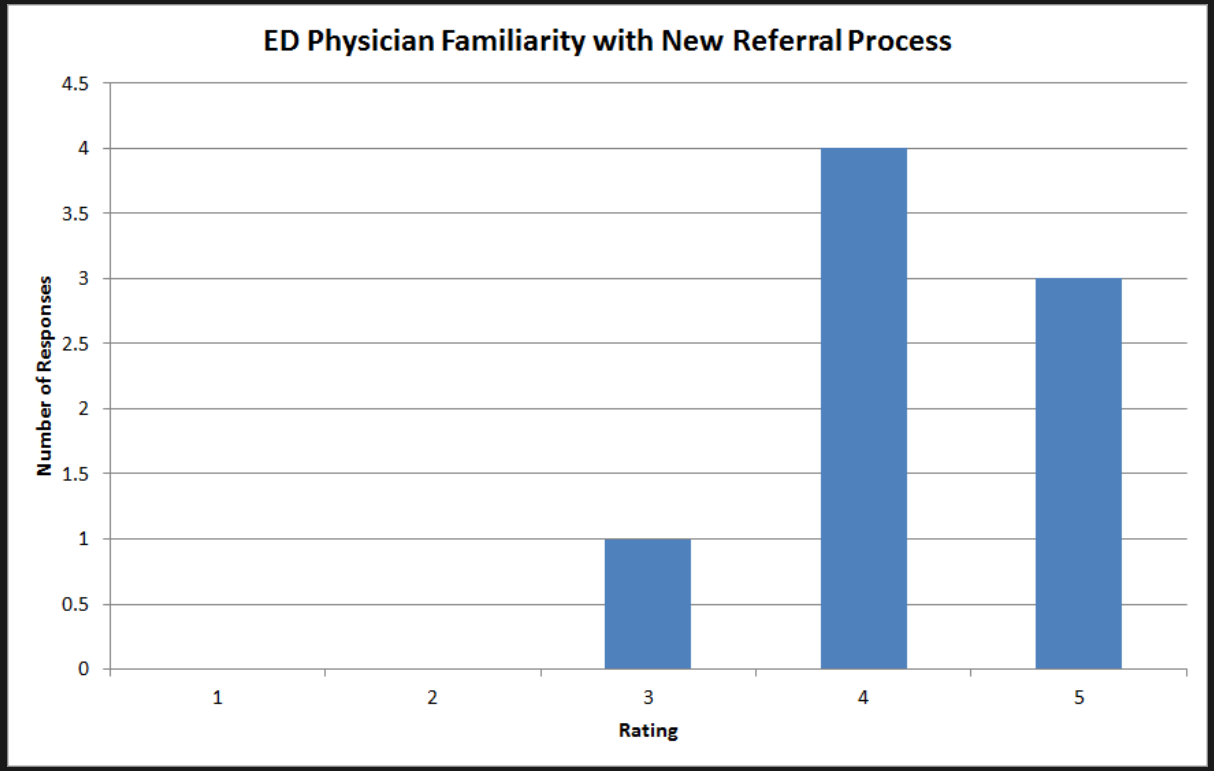
Assessing PDSA 4 and 5

Process Measures

Reason that referrals were inappropriate

Follow-up for patients post-clinic

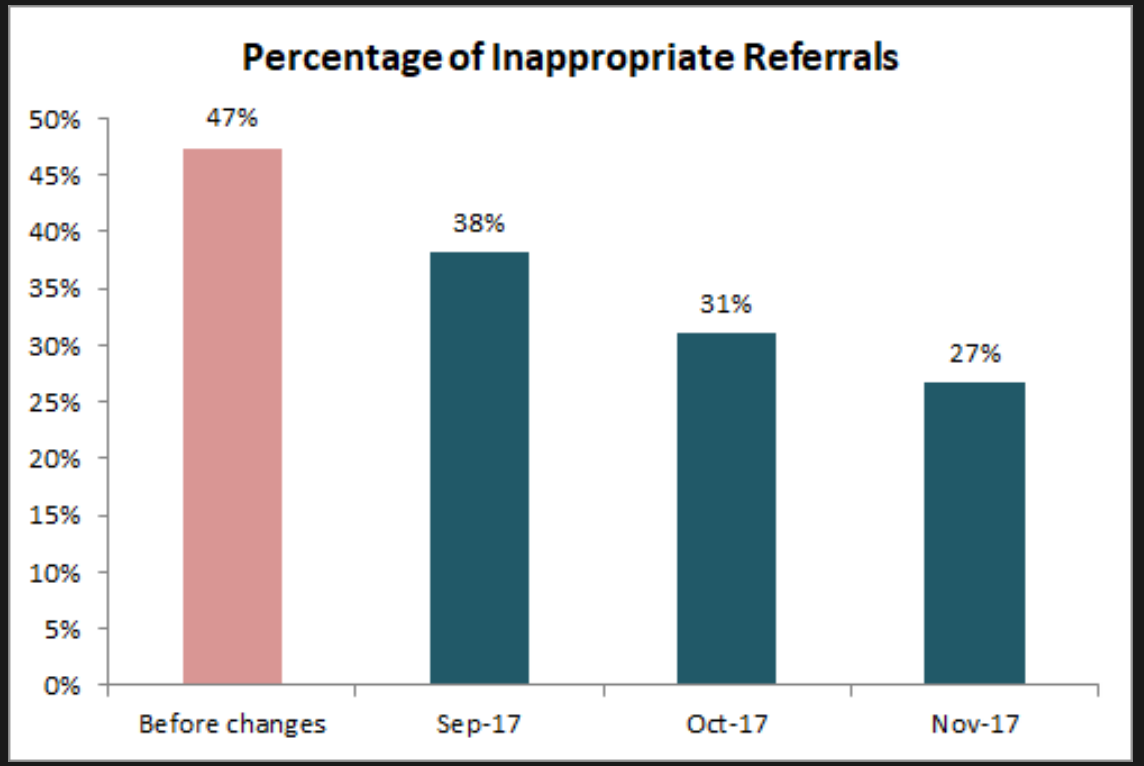
Understanding of changes by ED physicians



Assessing PDSA 4 and 5

Outcome Measures

Rate of internist-rated appropriate referrals



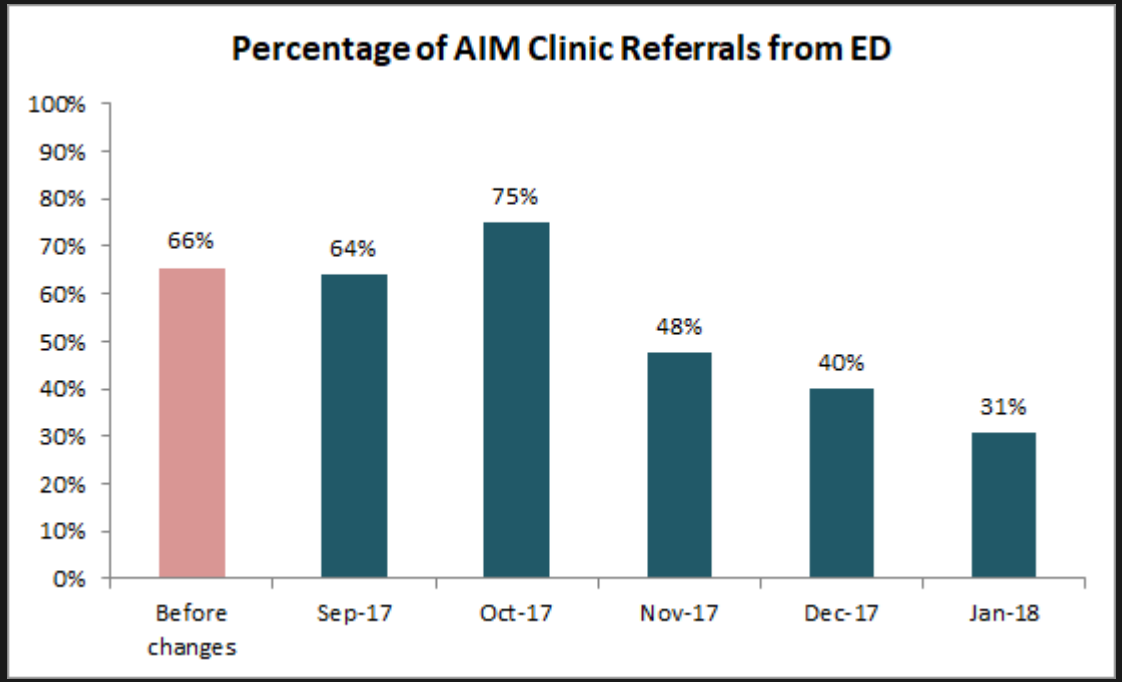
Assessing PDSA 4 and 5

Balancing Measures

Number of referrals from the ED

Duration of wait-times to be seen in clinic

Rate of patient no-show

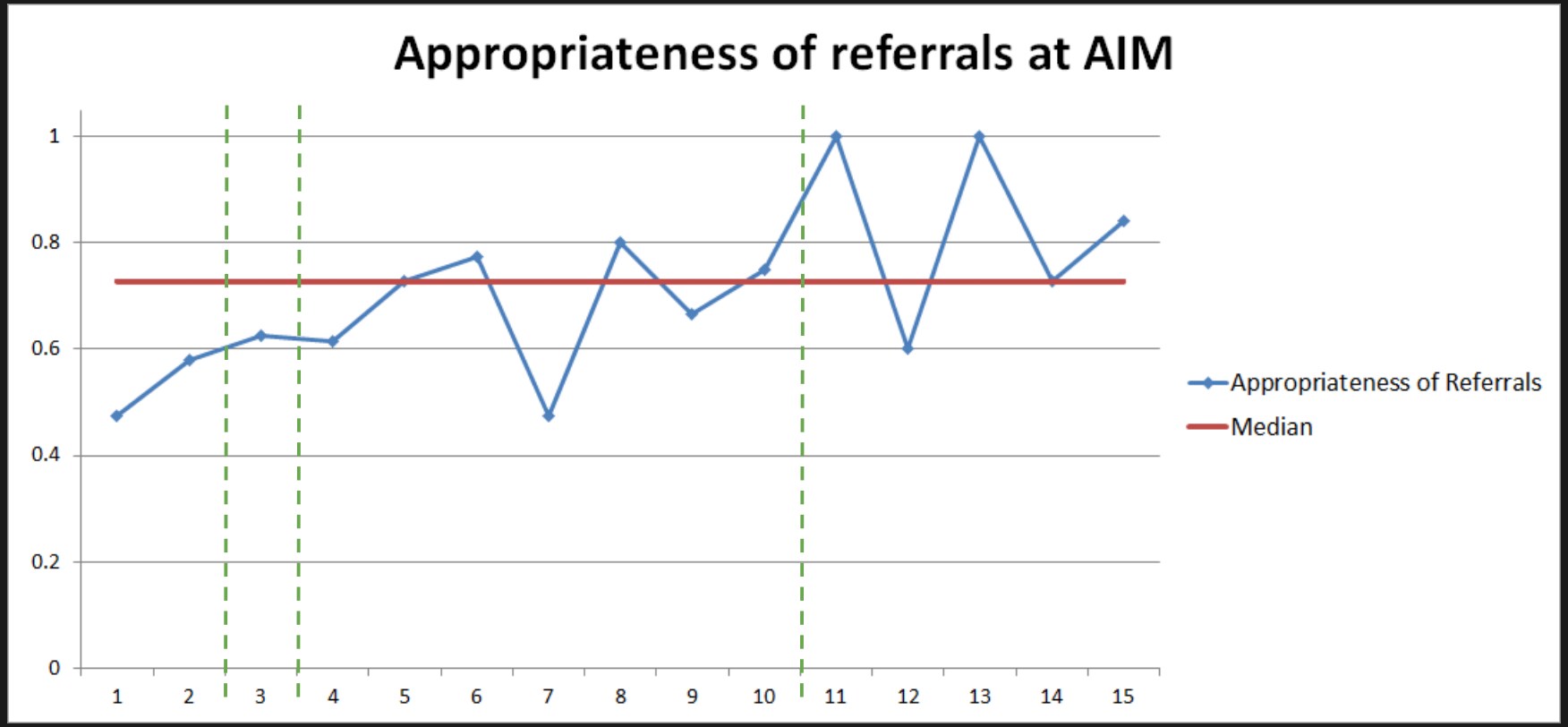


PDSA 6: Implementing Changes to Referral Form

☐ Heart failure ☐ Hypertension ☐ COPD (new diagnosis/exacerbation)
☐ Pneumonia ☐ Syncope ☐ Liver disease (cirrhosis/hepatitis/jaundice)
☐ Cellulitis ☐ New onset DM ☐ Electrolyte abnormalities
☐ Autoimmune disease/inflammatory arthritis/polyarthritis/gout ☐ Other

- Discussion with internists to generate list of most common issues to be seen at AIM clinic
- Change to referral form to include a structured checklist
- Reverting some previous changes to better streamline referral process

PDSA 6: Implementing Changes to Referral Form



Conclusions

1. Communication between internists and ED physicians was crucial in ensuring the goals of the clinic were well understood to all parties.
2. Changing the referral process to include consultation of the on-call internist led to more appropriate referrals but created a barrier for referral, resulting in decreased AIM consults from the ED overall.
3. Changing the referral form to include a structured checklist maintained the improvement in appropriateness of consults while reducing the barrier for referrals.

Limitations

- Lack of stakeholder engagement with ED physicians prior to implementing changes to the referral process

- Did not attain 100% participation from internists on recording AIM Clinic data

- The reduction in the proportion of ED referrals we observed may have been confounded by the simultaneous increase in post-discharge referrals from the internal medicine ward