



Improving Emergency Consultation

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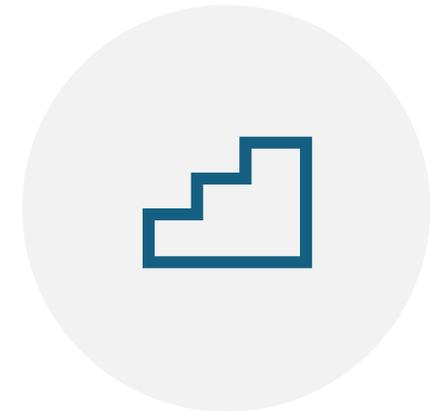
Agenda



LITERATURE REVIEW



FOCUS GROUP – CLINICAL
RESOURCE COMMITTEE



NEXT STEPS

The Critical Role of Consultation



Consultations determine patient disposition, access to interventions, and multidisciplinary coordination



The Problem:
Undefined workflows & misaligned expectations



The Risks/Consequences:
Treatment delays, increased Length of Stay (LOS), adverse patient outcomes.



The Goal: consider the development of a general, pragmatic tool

Currently using seizure and status epilepticus as “proof of concept”

Current Challenges & Friction Points

Systemic Pressures: High patient volumes vs. specialist competing demands and variable coverage.

EP Perspective: Perception of consultants as unresponsive or rigid in admission criteria.

Consultant Perspective: Perception of EP requests as premature, incomplete, or insufficiently justified.

The Result: A "cycle of negativity" that erodes collegiality and reinforces future communication breakdowns.

Existing Frameworks: Strengths and Limits

Conceptual Models: 5Cs, PIQUED, and CONSULT focus on context and articulating the clinical question.

The "One-Size-Fits-All" Flaw eg. Differences between Surgery vs. Medicine

Barriers to Adoption:

Rigid checklists create "operational friction" under time stress.

Clinicians often abandon structured tools in favor of speed.

The Gap in BC Healthcare

01

CONTEXT MATTERS:
BC FACES UNIQUE
CHALLENGES IN
RURAL-URBAN
DISTRIBUTION AND
VARIABLE SPECIALIST
AVAILABILITY.

02

THE MISSING LINK: NO
PUBLISHED CONSULTATION
TOOLS ARE CURRENTLY
TAILORED SPECIFICALLY TO
THE BC HEALTH SYSTEM OR
THE "ART" OF THE
CONSULTATION ITSELF.

03

INVISIBLE WORK:
VALUABLE REGIONAL
WORK (RTVS, CCON) MAY
EXIST BUT REMAINS
LARGELY UNPUBLISHED
AND PUBLICLY
INACCESSIBLE.

Proof of
Concept:
Seizure & Status
Epilepticus (SE)



"Time is Brain"



Complex Handoffs



Specific Pain Points

Focus Group Questions

Problems in consultations/transfers

Specific clinical difficulties and system-level pressures

Communication tools and frameworks

BC Healthcare and its unique environment

Disposition

Theme #1: Availability and Responsiveness



Inconsistent availability sets negative tone



There is a perceived loss of "mocap levels" or standards



EPs report on consultants expressing frustration at being paged



Delays in responsiveness lead to patient adverse outcomes, including treatment delays and increased length of stay.

Theme #2: Lack of Referral Clarity and Efficiency



"Unilateral" consultant decisions and call responsibilities



"Expectation Pain" in Handovers



EPs as "Residents"



Time wasted on the transferring manual demographic data (PHN, name)

Theme #3: Lack of Disposition Clarity and Ownership

Services often unwilling to take ownership

MRP Disputes eg. Internal Medicine vs. Hospitalists

Mediation Benefit to prevent as a "go-between".

Theme #4: Utility of a Tool



Standardization vs. Peculiarity



The "Ask" First



Evidence-Based Language

Proposed Solution & Project Goals

Co-Development: Creating condition-specific tools alongside both EPs and Specialists.

Pragmatic Design: Moving away from static scripts toward context-sensitive frameworks that reflect ED realities

1. Clarify expectations for both parties

2. Reduce variability in care

3. Enhance interprofessional collegiality

Strengthening the consultation interface is a critical target for clinical, operational, and educational quality improvement.

The Vision: A shared framework that improves BC healthcare for consultation



Analyze responses and data from focus group further



Hope to generate focus group or interview questions for subject matter experts in Seizure and Status Epilepticus (proof-of-concept framework in progress)

Next Steps





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