Introduction

My On the Road travels continued in March at the gracious invitation of Lena Cuthbertson, the Provincial Director, Patient-Centered Performance Measurement & Improvement, Clinical Care and Patient Safety Branch, Ministry of Health, British Columbia (BC) and Co-Chair of the BC Patient Satisfaction Steering Committee. The long trip to the Northwest region of the continent was matched by an extensive journey across the province by road and by phone that provided a powerful overview of what BC has been focused on in driving patient experience, namely in the Emergency Department (ED).

So why the ED specifically? This is an area on which BC and their extensive measurement efforts related to patient experience of care have been fundamentally focused since 2007 through a continuous surveying effort. This focus also allowed us to get a sense of what was happening across the province versus simply one facility. It provided a means to look for patterns of success and opportunities for improvement that drive patient satisfaction and experience at what many say is the “front door” to any hospital, the emergency department.

Interestingly enough, while not the same as the acute care setting, I would suggest that the ED environment may be an even tougher place to deliver on the patient experience. Already an environment of potential crises and organized chaos, there needs to be a much clearer intention to effective process and sustained behaviors in order to deliver on the expectations our patients and families bring with them.

What I saw through my visits and conversations was a collective effort to meet the needs of communities and citizens, no different from what you would see in any hospital in any country. The same struggles exist there, that I hear about from colleagues or Institute members in the U.S., the U.K., Australia and elsewhere; the ED is the place of ultimate need and significant expectation. It hinges on the issues of flow and communication, is driven by process and throughput and is collectively focused on the best outcomes for patients. Through my experiences and observations I hope to tell the story of an effort committed to the ultimate in patient and family experience, informed by data, driven by action and committed to care.

A Brief Primer of Patient Satisfaction Surveying in BC

While BC has conducted coordinated, province-wide sector surveying on patient satisfaction and experience since 2002, it has varied its target from the acute setting to residential long-term care, from outpatient cancer care to short stay mental health and addictions. With a critical focus on experience in the ED not only in Canada, but expanding globally, the BC Patient Satisfaction Steering Committee implemented continuous surveying in the ED, targeting feedback at the point of care. Working in partnership with their survey vendor, the province now surveys a target of 65,000 ED visitors annually across the province’s 110 EDs to gauge the nature of their visit and their experience.

While the Committee is not directly responsible for how the data is acted upon, it has worked to refine reporting to make it more timely, more user-friendly, and more focused on what is important to patients by trending key items at the facility level that are highly correlated to overall satisfaction and below a threshold of performance. By highlighting potential slips and gains in scores, frontline ED leaders and clinicians can make the appropriate assessment on actions needed and identify the efforts that have been either successful in supporting or perhaps impediments to driving a positive patient experience. Lena Cuthbertson talked about the ongoing efforts to support the process of moving into action through the provision of an ED Tool Kit for addressing and acting upon the data and more specific commentary on where opportunities based on the data exist. “While the data is crucial to the overall improvement of patient experience,” she added, “it is how the data is used that is central to improving satisfaction and experience overall.”

During my travels across the province, Lena and a number of players involved from ED Leaders, regional directors and supporting organizations showed how the integration of data and action can and should be used overall to drive patient experience success and where work still needs to be done.
An Overview of the Visit

My two days spent across the BC system afforded me a chance to interact with each of the six regional health authorities and supporting organizations that support experience, quality and safety across the province. My intention here is not to share my visits in sequence, but rather to talk about the key supporting themes I experienced in my travels, from tours of three specific EDs to conversations with regional leaders. While I may not have the space to cover every conversation or identify every individual I spoke with during my visit, each and every one of the over 30 people I had the chance to meet helped shaped this story.

Through my visits to the emergency departments at Royal Columbian Hospital, Surrey Memorial Hospital and Lions Gate Hospital, current and emerging practices in support of experience success were highlighted. Through my conversations with other key leaders and supporting organizations a number of improvement efforts were shared. Aside from common practices that have been implemented to drive experience in the ED, I will also touch on some broader initiatives that help pull the picture together.

Core Practices, Key Programs and Overall Success Themes

In sharing common practices to improve patient experience in the ED setting I look to the efforts of three very different settings, the EDs at Royal Columbian, Surrey and Lions Gate. While each location had its own unique challenges I believe they face the same challenges any hospital in any country faces - namely growing and changing populations, physical space constraints, rapidly increasing ED volumes, etc.; they also seemed focused on a set of core processes that helped support better experiences in the ED. In looking at these examples we see common practices not only found in BC, but rather central to effective emergency care overall.

A unique aspect of emergency care in Canada is the use of a common triage coding system across the country - The Canadian Triage & Acuity Scale (CTAS, see overview below) - which makes both addressing care needs and reporting on acuity and outcomes more consistent than elsewhere. For example in the US, there is still variability between a 3, 4, or 5 level system, though the trends are now towards a five-level system such as CTAS (source: Agency for Healthcare Research and Quality, Emergency Severity Index, Version 4, www.ahrq.gov/research/esi/esi2.htm.) It is through this system of acuity that many decisions are made and processes are based.

Jackie Askew, the ED Manager at Royal Columbian, first introduced me to the CTAS system. In sharing with me the critical process of intake and triage, we discussed the importance of supporting the most effective flow through the department. One of her goals in managing the ED was to ensure speed to care and she talked about the processes she undertook in engaging staff on what changes would be most beneficial to how they operated in the department. A key idea mentioned was the implementation of streaming, a process that enables patients to be seen via the most effective care stream and related to their CTAS rating.

For lower acuity cases, primarily CTAS 4 and 5, they were registered, quickly triaged and moved to a minor care unit (or what others referred to as Super Fast Track) within the department. This quickly moved the patients through the waiting process. These patients follow a green line of arrows on a floor to a secondary waiting area where they were attended to by medical personnel. Part of this process redesign, according to Jackie, was motivated by the participation in the province’s Pay for Performance program (P4P) which incentivizes participating EDs for moving patients through within certain target times. For lower acuity patients, such as mentioned above, the target time from registration to discharge is 2 hours.

“Being able to move people effectively through the ED is a team effort,” Jackie noted. “We must be willing to communicate with each other, have the right systems in place and then work to execute effectively.” This was exemplified recently when the ED at Royal Columbian was swamped with a mass of patients one evening (over 100 arrived and the unit has 48 total beds.) To ensure both the best outcomes and honor patient privacy, the team quickly took over use of the adjoining café area - a Tim Horton’s Coffee Shop - turning it into additional triage space (it was officially closed for the night.) The team quickly identified and addressed high acuity patients, managed triage in a private and effective way without having to care for patients in hallways or other open areas. Using teamwork, effective triage, extensive communication with patients and families and streaming based on acuity, the staff was able to manage the flow, care for these patients and even had the café available and ready to go when it opened again at 6 a.m. the next morning.

Our next visit was with Surrey Memorial. We were greeted by Marianne Southwell, Quality Improvement and Patient Safety Consultant, Christine Predy, ED Manager, Lesley Young, Clinical Nurse Educator and ED Physician, Dr. Craig Murray. Surrey is challenged with having one of
the highest volume EDs in the province, while also facing significant physical restrictions. It was evident in our visit that the team was working to address care and experience to the best of their ability while operating under these constraints. Also a participant in the province’s pay for performance program, the ED team at Surrey was working hard to ensure time to discharge targets were met. They too added a “Super Fast Track” process for low CTAS patients and had an expanded area – a Rapid Assessment Zone (RAZ) for those patients at a CTAS Level 3 in need of urgent, but not critical care.

Christine and Dr. Murray talked about the processes being implemented to change the language and focus of staff members, for instance shifting from the use of “minor treatment” to “Fast Track.” “We do not want any of our patients to think we see their care or treatment as ‘minor,’ Christine said, “We are working on changing the way we work so that each patient knows they are important.” With the challenges I observed at Surrey, it was critical that this positive focus be central to the leadership effort. With a consistent flow in volume, the team added a Clinical Flow Clinician to help move patients more swiftly through the process. This individual could monitor patient flow and ensure as smooth a process as possible for patients whether on a path to discharge or admission to the hospital.

Also due to space constraints and back up for beds, the team implemented a plan to use Emergency Room Attendants (ERAs), who were former paramedics and other care providers. These ERAs were able to transition patients from ambulance care to ED care even before a bed space was available. Acknowledging their desire to provide top quality care for every patient every time, the team stressed the importance of these improvement efforts to begin to address the overall patient experience.

Part of the improvement process was grounded in the Surrey team’s involvement in the Evidence to Excellence program (E2E, described further below) and also the recognition for the needs of great communication with patients and even between staff. This sparked the team’s engagement in a communications program I heard about many times during my visit - Strangers in Crisis (also described further below). In fact during our visit with the team at Royal Columbian, they were actually kicking off their first staff class that day. In the face of great challenges the Surrey team also exemplified some of the processes and practices central to driving positive experience in the ED. (It should be noted that right after our visit, the team at Surrey officially broke ground on a new state of the art facility expansion that will include new ED facilities to care for this growing population.)

Our third ED visit was with the team at Lions Gate Hospital, led by ED Manager Cynthia Startup and Anita Sanghara, Patient Flow Coordinator. In speaking with Cynthia, she portrayed the story of a journey of improvement, one both proven in data and borne of action. While many of the same practices that we learned of before to impact patient experience were either in place or being implemented, such as establishing a RAZ, participating in P4P, or implementing a flow coordinator role. It was the how things were done at Lions Gate that stood out as similar to exemplar patient experience performance I have seen in other facilities.

First, it was evident that there was clear leadership support for the experience priorities in the ED and with that also came performance expectations. What was powerful was the way in which Cynthia translated these efforts. She was clear in saying that the data from the survey was helpful to her success, but her role was “to help make the information understandable to her team.” She talked about making the language of their efforts “palatable to staff at the front line and helping them realize it is about the (bigger picture) processes, finances, quality and ultimately the patient experience.”

Cynthia and her team used the data from Lions Gate surveys to begin to chart a path to improvement. She posts the data in the staff lounge so they can read, absorb and own what it says. “It is important that the staff is aware of their impact,” she added, reinforcing, “We all come to work wanting to do a good job. We just need to be aware of what and how we do things that impacts others - our patients and their families.”

In addition to the leadership and staff efforts, Lions Gate implemented some process efforts as well. Using capacity planning software to help staff appropriately and anticipate patient flows and initiating iCare, a rounding process was implemented that engaged admitted patients still in the ED, but not yet moved to...
an inpatient floor. They also thought systemically in engaging the community and system of care outside the hospital, building connections with clinics, primary care physicians, long term care centers and others to ensure people were receiving care in the most appropriate venues versus simply the ED. This was a progressive way to address flow issues before they even emerged.

These proactive efforts also led to the support of high volume ED users, who might present themselves to the unit 10 or more times over the course of the year. By working with these patients on care plans and engaging family physicians and other facets of the system, the ability to reduce repeat ED visits and therefore managing volume, while ensuring the best care outcomes for these patients was perhaps the ultimate in providing a positive patient experience. If we look at the patient experience based on The Beryl Institute’s definition – the sum of all interactions, shaped by an organization’s culture, that influence patient perceptions across the continuum of care – these efforts rest squarely on those words, as they managed interactions based on the culture of their organization and considered the full continuum of care, not just within the walls of their ED, but across the system.

Cynthia was clear in adding that the staff was responsible for creating and supporting this vision, “They wanted to make it a great place to work and a great place to receive quality care.” The patient experience data results at Lions Gate would indicate they are now consistently achieving this objective. (You can see their scores in the sample report above).

### Broader Efforts in Support of Success

While the examples shared above provide just a sample, but offer a significant view of what is taking place across BC, there were some large-scale efforts that represent broader quality and patient experience efforts under way.

**Fraser Valley ED Change Initiative**

As part of our visits we had the chance to speak with Leanne Heppell, Executive Director of the Fraser Health Authority Emergency Health Program. She described a major initiative under way for 2011 focused on improving the patient and family experience in the ED. The process began by engaging 200 staff from all levels, front line, executives, physicians, etc. and bringing them together to discuss what was important and central to addressing the patient experience. What was significant in what Leanne shared was the opportunity to focus on what can be controlled versus what cannot.

“Congestion has been our focus and had distracted us from action,” Leanne said. This is not to say patient flow is not an important aspect of care delivery, but represented a realization that patients are going to come. What was clear was that there was the recognition about the impact that processes and behaviors could have on overall patient experiences.

The first meeting led to a long list of positive initiatives from simple actions to complex efforts. The power behind it was that it included voices across roles and levels from all parts of the health authority. It was a true systemic solution process. The next steps include a follow-up meeting that will engage half of the original group, plus a new group of 100. This will continue to expand the ownership and involvement of leaders at all levels as the effort continues. The second session will begin to identify priorities, build out shared action plans and assign accountabilities in moving the improvement process forward.

Through this simple act of engaging individuals, focusing on what can be changed, and prioritizing for action, the potential for a positive impact on patient and family experience is clear. It will require follow-through and sustained commitment to ensure it is successful, but creating ownership in this way and taking on a systemic perspective is supportive of positive outcomes. As Leanne suggested, “Shifting from managing waits to excellent experience is energizing.” This process and the opportunities it creates should be exciting to see.

### Strangers in Crisis Program

A program that was shared at many stops on our journey and came up in a number of conversations we had was the communications-focused learning program, Strangers in Crisis. Offered by the Institute for Healthcare Communication, based both in the U.S. and Canada (www.healthcarecomm.org), the program offers a core set of ideas in communication most effective with patients and families in an ED setting. We had a chance to stop in on the first class being held at Royal Columbian and also speak with Jill Breker, Darin Abbey, and Ev Pollock from the Vancouver Island Health Authority on their leading the implementation of the program in BC.

While I am not one to suggest a training program as a sole solution to improvement efforts, a focused program such as Strangers in Crisis layered on process improvement and organization change efforts can be very successful. The program as described is grounded in evidence-based practices and focuses on four components of communication in an ED setting – engagement, empathy, education and enlistment. I will not attempt to outline the entire program here, but rather will share the passion with which the individuals delivering and participating in the program speak to its value.

An interesting component of the program is its specific customization for hospitals in BC. The customization is based on a 2009 study conducted by the University of British Columbia’s Centre for Health Policy and Research (CHSPR) titled, “In Pursuit of Quality: Opportunities to Improve Patient Experiences in British Columbian Emergency Departments.” The study found something interesting that courtesy, above teamwork, availability or even wait times was the most important influencing factor in patient feedback. The study showed that in examining all the influencing factors of quality and experience, the most important factor for those who said their overall quality of care was excellent was the degree to which they considered staff to be courteous. Interestingly enough, similar to those who reported positive experiences, those who
reported negative ratings cited staff courtesy as the most important factor as well. The full report is available at www.chspr.ubc.ca/research/patterns/emerg.

Darin touched on this very point in emphasizing a core premise and important point of the program. It is not only that communication matters, as depicted by the findings on courtesy, but also that communication is a procedure like any other conducted in the ED setting. He was clear in supporting the idea that as staff in the ED follow clinical process, they too need to be aware of the processes of communication they follow that can impact patient and family experience. He added, “We need to be patient-centered, but it is equally important that we understand ourselves (as care providers).”

Jill added that the program offers an important lesson for ED staff, while recognizing their unique nature. “It is important we recognize that patients don’t come to our emergency department, we work in theirs,” she said. “At the same time we must remember in delivering the program that ED nurses get bored easily, they are used to action, so the course must keep moving.”

In my visit to UCLA on last month’s On the Road Dr. Feinberg and Dr. Rosenthal suggested that cultures of patient experience were not necessarily based on change, but rather on unearthing and reviving the passion people bring to their work in healthcare. It was evident through our conversation the passion that these individuals brought to and gained from the program. Also, while not yet directly linked to survey outcomes, the interest in the program has spread rapidly across the province as a tool to reignite the passion and communication skills of all staff, from leadership to the front line.

**Quality Academy and Evidence to Excellence (E2E)**

My visits also led me to the offices of the BC Patient Safety and Quality Council (BCPSQC) and an enriching conversation with Katie Procter, a Quality Leader, and Anna Needs, Project Coordinator, on two core efforts, while not initially designed for this purpose, have the potential to impact patient and family experience, the Quality Academy and the Evidence to Excellence Collaboratives (which sits outside BCPSQC). As described on their website (www.bcpqsc.ca), the BC Patient Safety and Quality Council provides advice to the Minister of Health on issues of patient safety and quality of care, and brings health system stakeholders together in a collaborative partnership to promote and inform a provincially coordinated, innovative and patient-centered approach to patient safety and quality improvement.

While the BCPSQC has a broad mandate to support quality and safety efforts, it has developed and supported a number of comprehensive and focused programs to support clinical outcomes and by extension impact patient and family experience overall. Through its support to initiatives like E2E, for example, ideas mentioned above such as the RAZ, Fast Track and DTU have been able to spread to other facilities around BC impacting on the patient experience in receiving their care in the ED. Other basic improvement methodologies were shared via E2E but a broader and deeper exposure to Quality Improvement needed to occur in healthcare in BC.

Katie shared the efforts of their new learning program, Quality Academy. This program developed as a result of the recognition of the huge need for professional development in leadership of quality and safety initiatives and of the question, “How can we teach this and how can we bring quality to the front line in a meaningful way?” said Katie. The program runs over a six-month period with 5 residency sessions plus webinars and mentor support. The Quality Academy includes a comprehensive curriculum that includes the core components of quality improvement including: process and systems thinking; personal and organizational development. Involving patients, users, careers, staff and the public, making improvement a habit: initiating, sustaining and spreading change, delivering on cost and quality, problem solving/internal consultancy skills, and Innovation for improvement. Participants will demonstrate what they have learned by working on an improvement project that relates to the need of the organization they come from. “The key to the program is that it not only provides learning for the participants, but it prepares them to go back and teach others,” she noted, adding, “It is important to point out the this program is built on the core of patient-centeredness.”

The second significant effort discussed during our visit to BCPSQC was the implementation of a “built in BC” adaptation of the Institute for Health Care Improvement’s Breakthrough Series Collaborative Approach. The process supports an electronic/virtual “Community of Practice (eCoP)” combined with the IHI collaborative model, using facility-based cross-functional teams to address critical improvement issues. The program, Evidence to Excellence or E2E, has been used to drive improvement efforts in hospitals around BC and in particular (as we are exploring ED patient experience) was born from a conversation on ED improvement. One current collaborative effort is focused on the issues surrounding ED Flow. Believing in the importance of health services and academic partnership, E2E worked with the Ministry of Health Services, UBC eHealth Strategy Office, and the BCPSQC to implement its quality improvement work.

As Anna Needs of BCPSQC explained, the program was established in 2007 in response to feedback from members of the BC ED community who were looking for a means for effective networking, support, and demonstrable outcomes for emergency departments and who were wanting to foster an inter-professional

---

For more “On the Road” stories, visit www.theberlinstitute.org
community of clinicians and administrators in solving ED issues. Following the IHI Collaborative Model of learning sessions bridged by action periods following a Plan-Do-Study-Act (PDSA) process, the E2E process led to two collaboratives of 36-38 different teams over two years addressing the critical issue of ED flow (including triage) and sepsis from a quality, change and patient-centered perspective. The very improvements and processes we described above that drove the successful improvements at Lions Gate Hospital were a result of their committed participation in this process.

The E2E process and Quality Academy are leading systemic processes that exemplify the very best in collaboration and the sharing of ideas for driving better overall patient and family experience. While in the space here I cannot do these programs full justice, the impact they have and their effective use by the healthcare facilities involved have led to some significant outcomes. I suggest you explore the E2E site further - www.evidence2excellence.ca - to better understand the process, see the results that can emerge from this type of process...and join the eCoP!

To the point I made in my blog last November, in healthcare we have a great and much needed opportunity to share with and learn from one another. In particular in regions and markets facing similar challenges, we need to look at collaboration and the collaborative learning process as a way to improve care for our communities. To look at potential improvements as shared opportunities rather than competitive advantages and make our ability to execute the means by which people choose our care over others is a brave and bold choice. The E2E collaborative makes the strong case and is building a record of significant results to show shared learning drives better outcomes for all. It can and should be the focus of healthcare improvement and efforts to impact the patient experience in all healthcare settings.

From my facility visits and the exemplar processes and programs I was provided a broad view of the patient experience efforts underway in BC, specifically to the ED sector. I was offered an open and honest perspective on what has been successful and where struggles remain. It is through this balance of perspectives that key success themes and potential opportunities can be framed from which we can all hopefully learn.

**Common Success Themes Uncovered and Potential Opportunities Identified**

Through my conversations with many of the individuals across BC, it was evident that leading practices were shared by many facilities throughout the province. As I closed out my visit I had the honor to spend some time with the BC Patient Satisfaction Steering Committee to talk through some of what I heard and get a sense of if my two days of exploration were in sync with what these individuals experience on a regular basis. I shared both what I saw as consistent themes supporting ED success and offered a few opportunities for continued action.

In reviewing where there was success in ED performance and patient reporting some key themes included:

- A strong and sustained senior leadership commitment to ED improvement.
- A systemic perspective in implementing solutions, i.e. the inclusion of the broader community of healthcare practice in ED improvement efforts from family doctors, to long term care and elsewhere.
- Ownership for outcomes was nurtured and continuously supported at all levels within the ED, from the Director levels to the front line and across roles from leadership to clinical delivery to support functions.
- The understanding, effective translation, and practical use of available survey data to help staff understand the impact of their actions on the patient experience and to focus on the appropriate solutions as they build improvement strategies.
- A willingness to ensure the right people were on board to deliver care and a commitment to ensure the right behaviors were both expected and reinforced.
- Effective and regular communication was evident both from leadership to staff and among staff themselves; this extended into how staff communicated to patients and families as well.
- A team-based approach to planning actions and moving toward outcomes from individual encounters with patients to significant changes in process.

During my visit I was also challenged by my hosts to provide feedback on opportunities for continued improvement. So aside from sharing strengths identified across the province, I also collected a few opportunities that I observed could help any of us focused on improving patient experience in the ED. Some of these thoughts complement the strengths shared above and include:

- Address what you know can be changed and don’t be distracted by things you can’t control.
- Find a way to maintain unwavering focus in the face of competing priorities; patient experience is not an initiative to check out, it is a way of being to live.
- Ensure there is clear and expressed support from leadership at all levels – in the case of BC this includes from the Ministry of Health and Health Authority to the facility and department level. This leadership should also ensure accountability for action and results.
- Work towards greater community outreach and engagement of all parts of the healthcare system.
- Be intentional in the use of survey data, including taking time to understand and act on the data with a focus on moving to results.
- In BC in particular it was interesting to see that as ED was the primary sector that received continuous surveying, was this in fact
hampering a greater understanding of the opportunities to improve overall patient experience (and could this be the same challenge with the perspective offered with HCAHPS in the US due to its focus only on the acute care setting?)

While these themes are not all inclusive, they are the most prevalent issues that emerged in my series of conversations and meetings during my visit. The generosity of spirit with which people opened up to share and the desire to learn and improve was evident almost everywhere I went. The hope is some of these ideas either support or inspire continued efforts for improvement.

“Healthcare is as healthcare does...”

To play on a quote from Forest Gump, I thought it poignant to reflect on my visit to BC not about what was different about healthcare in BC or in Canada for that matter, but rather for what was the same. From the very gracious invitation of my host Lena Cuthbertson that started this journey to the shared voices of the caregivers and other healthcare leaders committed to quality and experience, there is one thing that was clear. We all choose this work for a reason.

At the heart of the efforts I saw in BC, be they surveys or quality improvement efforts, be they training programs or change efforts, there was one thing safely resting at the center – the patient (and their family). There is not one country, not one system and not one facility that can claim they care more about the purpose of healthcare. At the core of our actions and our commitments is ensuring the best experience possible for our clients – the patient – be it in safety, quality or satisfaction.

Before I returned to the states I had one quick stop in Toronto and the honor of delivering a speech at the Ontario Hospital Association Conference on Patient Experience in the ED. The audience was full of individuals that tackle the challenges of the ED every day, from physicians to directors to front line caregivers. As I concluded I challenged them to consider the perceptions of the patients in their work to design opportunities in which they could provide for great expectations. I am certain that those in the audience in Toronto and the many amazing people I met in BC are committed, just as you are, to creating unparalleled patient experiences, each and every day.

My special thanks to Lena Cuthbertson for being such a gracious host in our extensive exploration of the patient experience and ED environment in BC. The schedule we followed was rich and full. To the many individuals who provided insights and input in this process, whether named or not here I also express my gratitude. It is your care for this work and your commitment to what you do that provides the voice and platform for an ever growing conversation on the critical nature of patient experience as a vital element in our healthcare systems, regardless of geography or operating model. My deepest appreciation to you all!

To learn more about the BC Patient Experience Efforts you may contact:
Lena Cuthbertson
Provincial Director, Patient-Centered Performance Measurement & Improvement, Clinical Care and Patient Safety Branch, Ministry of Health Services, British Columbia (BC) and Co-Chair of the BC Patient Satisfaction Steering Committee
lcuthbertson@providencehealth.bc.ca

To share your patient experience story, contact The Beryl Institute:
Jason Wolf, Executive Director
jason.wolf@theberylinstitute.org
817-785-5043

More information on The Canadian Triage and Acuity Scale (CTAS) is available in our online version of this article, found at www.theberylinstitute.org.

About The Beryl Institute
The Beryl Institute serves as the professional home for stakeholders who recognize that the patient experience is an essential element in the execution and evaluation of healthcare performance. The Institute defines the patient experience as “the sum of all interactions, shaped by an organization’s culture, that influence patient perceptions across the continuum of care.”