

Abstract 16 Figure 2 Heat map of selected health equity quality report measures stratified by race and ethnicity

(EDI) which, in part, outlined a commitment to develop and track metrics related to EDI. This increased focus on EDI amplified challenges posed by the complexity of the patient demographic data as well as variations in methodologic approaches for identifying significant disparities in care and outcomes. Additionally, our institution did not have a regular, accountable process for assessing our highest priority safety and quality measures.

Objectives To develop institutional standard methods and tools for use by analysts across the organization to allow for standardized assessment of equity of care and to apply these methods to a board-level Health Equity Quality Report (HEQR).

Methods We developed an institutional standard operating procedure (SOP), which provides a common methodology for assessing the equity of care based on patient social determinants of health. The SOP specifies how to combine patients into broad categories based on race and ethnicity, language, and payor; and how to measure differences in performance between groups. We identified significant differences using criteria based upon both the magnitude of the difference and the p-value of the statistical test of comparison. We developed an annual Health Equity Quality Report that applies these methods to enterprise-wide quality measures as well as high priority local clinical quality measures (figure 1).

Results The SOP was distributed widely across the hospital through presentations at quality and analyst forums. The HEQR identified disparities in several measures (figure 2). Additional analyses are underway to understand drivers of these differences and design improvement interventions.

Conclusions These resources greatly standardized our institution's approach to measuring health disparities by lowering barriers to analysis. Application of the methods will drive improvements in care for our patients and families.

experiences, and in appreciation of the need for depth of information from which to advance improvement, a qualitative approach is essential.

Objectives 1) Describe the experiences of providers caring for residents with disabilities during a COVID-19 outbreak; 2) critically examine the enablers/challenges regarding their emotional well-being during the outbreak; and 3) develop context-specific strategies for change, and determining disaster preparedness.

Methods Providers from a group home for adults with developmental and physical disabilities were recruited for this arts-based case study; in spring 2020 they had a COVID-19 outbreak and six residents died. Participants are making art (e.g., painting, poems) to express their experience, which is further explored in interviews/focus groups.

Results Eleven providers have volunteered. They describe the outbreak as life-altering. A repeated descriptor is 'war zone'; participants were not sure they would survive it. Unwillingness to leave residents-viewed as family-made for feelings of guilt when providers finally relented to going home despite having worked a 16-hour shift. Additional results will be shared.

Conclusions One participant stated, 'I think what we went through will be informative to others and I would hope to experience some healing through it as well.' Meaningful, sustained improvement will not occur unless we systematically, respectfully document the words and unpack the complexities of what it was like for those who provided care during the crisis of COVID-19; only then can we build anew.

18 JOY AT WORK: NSQIP IN TIMES OF COVID

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Background Surgical Clinical Reviewers (SCR's) are the heart of this program. They collect data and use critical thinking and clinical experiences as nurses to analyze, interpret and present data to the teams and stakeholders working to improve surgical outcomes. In 2019, a restructuring of the program in our health authority led to a reduction in staff and resources. The COVID pandemic in 2020 brought on an even greater sense of isolation and disintegration. Our already reduced staff was redeployed, which resulted in further feelings of overwhelm and loss of value amongst the SCR's. The Joy at Work project was conceptualized in Mar 2021 to address these issues.

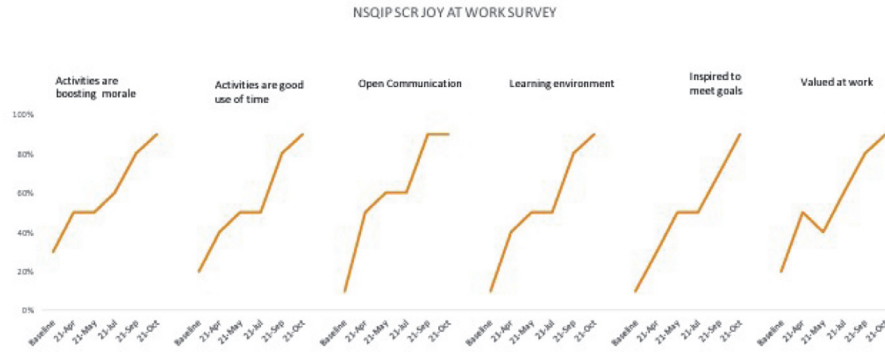
Objectives The objective was to improve SCR's Joy at Work measures by March of 2022.

17 AN ARTS-BASED APPROACH TO SYSTEM IMPROVEMENT: PROVIDER EXPERIENCES OF COVID-19 IN A GROUP HOME

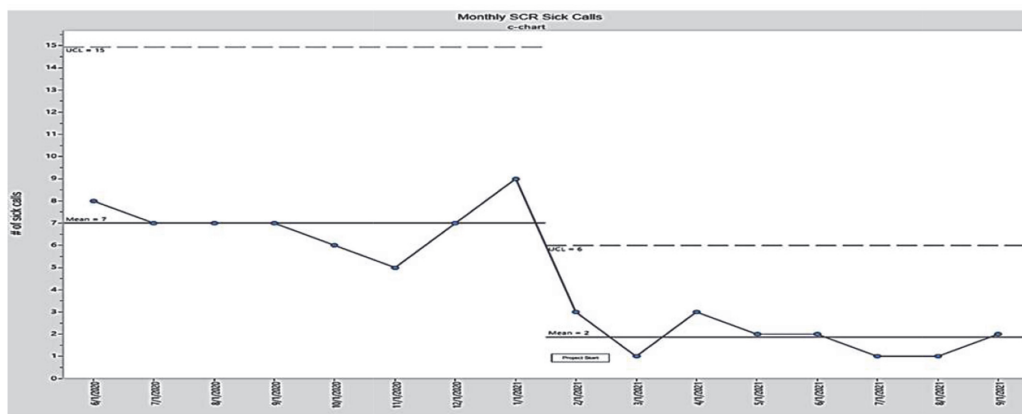
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10.1136/bmjocq-2022-IHI.17

Background The devastating effect of COVID-19 has been felt worldwide. Hospitals garnered significant attention, but the immense vulnerabilities in community settings-including nursing homes and assisted-living facilities-were quickly realized. As the crisis subsides, it is critical we learn from professionals who worked during this time, and generate evidence for informing resilience, particularly in long-term care. In respect of the traumatic, individualized, and sensitive nature of these



Abstract 18 Figure 1 NSQIP SCR joy at work survey



Abstract 18 Figure 2 Monthly SCR sick calls

Methods Several PDSA's were done, testing and refining numerous change ideas including biweekly meetings, targeted education sessions, a WhatsApp group and planned social outings.

Use of staff satisfaction surveys, team member attendance, and meeting participation metrics to measure.

Results Results demonstrated a reduction in sick calls, increased meeting attendance, and greater member participation (figures 1 and 2). We turned the QI lens back onto ourselves, to explore ways to improve our experience of work during this very challenging time.

Conclusions Next steps to take will be to expand this project to our clerks and our Surgeon Champions.

revealed 25% of patients showed markers of financial toxicity (Aviki et al, 2021).

Objectives As healthcare professionals we agree that change is needed to improve health outcomes for our patients, but great ideas, great research and great possibilities become trapped in the quagmire of our own systems. The question to answer in this session is not what the barriers to implementing change are, but to consider how we contribute to their very existence, and how we change these behaviors.

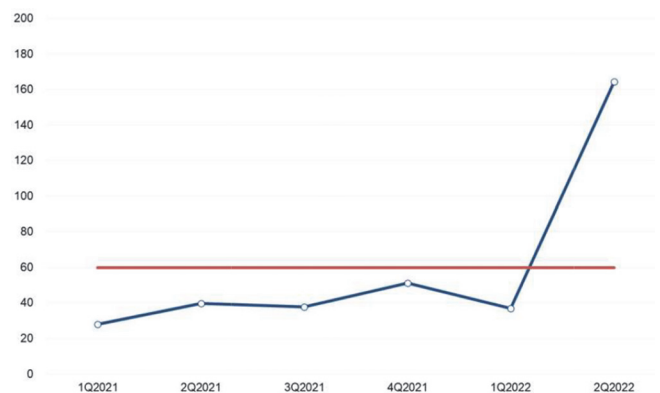
Methods Through multi-professional brainstorming, it was decided to develop and implement an order-set that would

19 **MAKE IT MAKE CENTS: A ROADMAP TO REDUCING PATIENT FINANCIAL TOXICITY BY DECONSTRUCTING SILOS**

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Background From the perspective of oncology patients, the financial burden of paying for cancer care is as concerning as their own potential mortality (ASCO, 2018). Even richly resourced large academic cancer centers are not immune: a review of data at large comprehensive cancer center in 2018



Abstract 19 Figure 1 Clinical referrals to patient financial services