Reconnecting HealthLinks Patients from Hospital to Primary Care

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Aim/Objectives

- Within the Central West Health Links, it was identified that there was an inconsistent exchange of information and follow up support for existing Health Link patients as they transitioned from one care provider to another. Specifically, in the Dufferin Area Health Link this problem was evident in the transition from hospital to primary care provider (PCP).

Aim: 20% increase in the number of existing Dufferin Area Family Health Team (DAFHT) Health Link patients that were reconnecting in-person with their primary care provider within 7 calendar days of discharge from Headwaters Health Care Centre (HHCC).

- We felt this was an opportunity for improvement since this issue had an impact on Health Link patients that are often part of the complex patient population that are in and out of the hospital and also because there were multiple health service providers involved in providing care. Relationships between care providers are being developed and strengthened via Health Links so working on this issue together would facilitate more of that relationship building.

Intervention/Change Ideas

1. Use of HHCC brochure inserts and having hospital care coordinators educate and remind patients of the importance of reconnecting with their PCP. DAFHT communication reminding PCPs of the evidence to support reconnecting with patients upon discharge. Patients to be part of transition process.
2. DAFHT Patient Services Coordinator (PSC), RN phoning patients post discharge to do an assessment and book reconnect appointments if patients have not done so already, includes answer patient questions and assessment.
3. PCPs reminded to use E080 billing code for post discharge follow up appointments within 14 days. Encouraged PCPs to connect with their patients being discharged.

Evaluation/Measures & Results

Process Measure: % of existing DAFHT Health Link patients who had an in-person follow up visit booked within 7 and/or 14 calendar days of discharge

Baseline: 10% within 7 days and 17% within 14 days

Results: 32% within 7 days and 45% within 14 days

Outcome Measure: % reduction in 30 day readmissions to HHCC for existing DAFHT Health Link patients

Baseline: 12%

Results: 8%

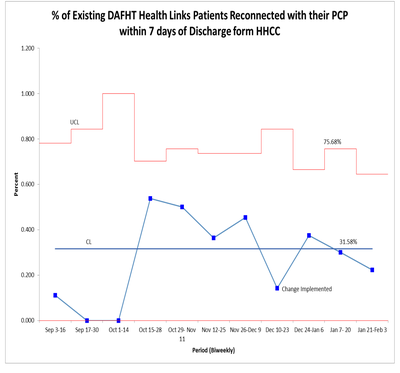
Evaluation/Measures & Results continued

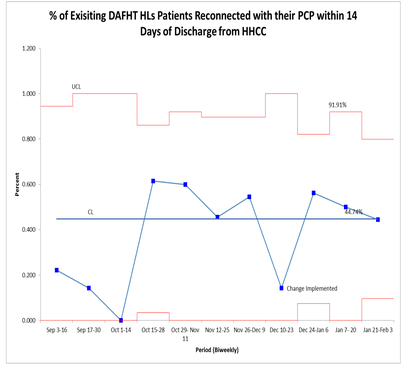
Patient Experience: DAFHT PSC doing follow up calls and assessments with patients was well received by patients. Perception from patients that PCPs see them in hospital, some patients expressed disappointment that PCP did not visit them in hospital. Follow up calls make patients feel that this is how their PCP is following up so the call was welcomed.

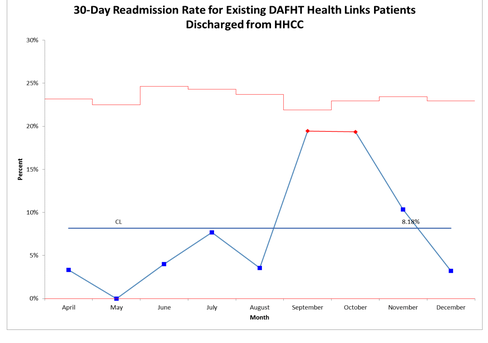
Efficiency: Calls improved efficiency because before PSC would attempt to connect with patients in hospital but they were often not available, sleeping or not well. Many patients would decline to book reconnect appointments while in hospital but once home they have access to their schedule and can commit to an appointment.

Productivity & Effectiveness: Better use of nursing time, connecting with more patients, able to perform medication reconciliation, assessments and triage. Also provides patients with an opportunity to speak with a nurse and ask questions.

Charts







Organizational Enablers

- Success was dependent on the de-politicization of resources. Since multiple care providers were involved in the patients' journey, the interventions could not rely solely on one organization or resource. Required the providers to work as part of a broader regional Health Links team.

- Also critical was engaging stakeholders, specifically front line staff, early in the planning process. All potential change ideas were discussed with the stakeholders and feedback was incorporated to prioritize interventions and implement them appropriately.

Sustainability & Spread

- PSC no longer a resource available at DAFHT. This has resulted in sustainability challenges. Although not all of the change ideas were dependent on this role, we now have to look carefully at the data to determine whether we can continue to expect similar results without this intervention. Upon preliminary analysis, we believe that patients were often booking their reconnect appointments prior to receiving a call from the PSC. Therefore, there may be an opportunity to change this intervention to yield greater results (for example, utilizing another role to connect with patients and doing so earlier – maybe during hospital stay instead of post discharge).

- Spread to PCPs outside of the DAFHT and to the rest of the Central West Health Links is planned however, the change ideas need to be tested further. Need to ensure that only the interventions that have been tested and proven effective are being spread.

Next Steps/Lessons Learned

- The data is promising but also points to the need to scale up Health Link identification and collect more data for Health Link and non-Health Link patient reconnects effected by the change ideas.

- We need to continue to collect and analyze data for change ideas underway and share that learning with DAFHT, HHCC, Health LInks and other stakeholders. Need to determine the effectiveness of specific interventions and identify improvement tasks that are not exclusive to roles or organizations to facilitate spread.

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