

# Stronger Together

Family Physicians and Hospitals Inspiring New Ways of Caring





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Patients expect to access care when they need it most, and they trust that it will be both safe and well-coordinated. They also trust that the family physician they rely on in the community will be well-connected to the hospital they go to at their sickest. That's why family physicians and hospitals are working together to think of new, innovative ways to meet every patient's expectations: timely, high-quality and seamless care.



# Introduction

## Stronger Together: Family Physicians and Hospitals Inspiring New Ways of Caring

High-quality health care across the system requires strong relationships between hospitals and family physicians. For this reason, the Ontario College of Family Physicians (OCFP) and the Ontario Hospital Association (OHA) have collaborated on this new Ideabook to showcase the valuable work that hospitals and family physicians are undertaking on behalf of their patients.

Family physicians and other health care providers are well aware of the challenges patients face when they transition from one care setting to another. As the population ages and more people are living longer with multiple chronic illnesses, the benefits of collaboration to ensure safe and effective care have become more widely recognized across the system. This has encouraged family physicians and other health care providers to take a more proactive role in strengthening partnerships with the hospital sector with the goal of providing better, more coordinated care. Improved communication and greater collaboration among providers are key ingredients to enhancing the patient experience and optimizing health outcomes, especially as patients transition between different health care settings.

To this end, many hospitals and family physicians across the province are actively working together to jointly address common challenges and to identify opportunities for advancing the delivery of more seamless, high-quality patient care.

As organizations, both the OCFP and the OHA are committed to supporting these efforts. This resource was developed to highlight the successes that have been achieved and to share critical learnings among peers. Some stories feature small and rural communities that are faced with distinct challenges, such as long distances between health care providers and fewer resources. Other stories focus on urban communities that are looking for ways to make more effective use of local specialist resources to better serve patients, especially those with chronic conditions. Although each story is unique, all of them are a testament to the great work being done in Ontario, with hospitals, family physician leaders, community team-based models and community services working together towards a common goal. We hope that this Ideabook can serve to help spread good ideas to those seeking new strategies for improving care in their local context.

We hope that you will enjoy reading about these successes and find value in the efforts of your colleagues. We truly believe that working as a system for patients, we are stronger together.

Sincerely,

Dr. Glenn Brown  
President  
Ontario College of Family Physicians

Anthony Dale  
President and CEO  
Ontario Hospital Association

# Faster Access, Better Care: The Champlain BASE™ eConsult Service

The Champlain BASE™ eConsult service is a secure online platform that allows family physicians and nurse practitioners to pose questions about patients' care directly to specialists.

## Who was involved

Champlain Local Health Integration Network (LHIN), Winchester District Memorial Hospital (WDMH), Bruyère Research Institute (Bruyère), and The Ottawa Hospital (TOH)

## The challenge

In 2009, Drs. Clare Liddy and Erin Keely sat down together for a cup of coffee to discuss a common frustration: the long wait times that their patients experienced when seeking specialist care. Dr. Liddy, a family physician, witnessed patient after patient waiting months for the appointments to which she'd referred them, their frustration and anxiety growing in the interim. On the other end was Dr. Keely, an endocrinologist, who saw wait times increasing for her patients, many of whose visits could easily have been



avoided by providing some direction or guidance to the family physician or nurse practitioner. The two physicians felt there had to be a better way to improve access for patients by enabling family physicians or nurse practitioners to safely determine whether a face-to-face specialist visit was really needed.

## The solution

Their solution was to create the Champlain BASE™ (Building Access to Specialists through eConsultation) eConsult service, a secure online platform that allows family physicians and nurse practitioners to pose questions about patients' care directly to specialists.

Drs. Liddy and Keely partnered with the Champlain LHIN, WDMH, Bruyère, and TOH to obtain the necessary infrastructure and technical expertise. Together, they developed a working model of the service, which they tested in an initial proof-of-concept study.

“ I cannot imagine not having this service now and in the future as this has been one of the top two most positive things for my patient's care since I started to use an EMR 15 years ago. ”

– Primary Care Provider



To use the eConsult service, family physicians and nurse practitioners log onto the secure portal and write out their question in a text field. Users can attach any files they feel might be useful to the specialist in assessing the case – such as pictures of dermatological problems, test results, or patient histories. Once submitted, the eConsult is assigned to an available specialist from the chosen specialty, who is automatically notified by email that a new case is pending review and requires a response within one week. This response could be advice for the family physician or nurse practitioner on how to treat the patient, a recommendation that the patient should be referred, or a request for more information. Discussion can continue back and forth until the family physician or nurse practitioner decides they're ready to close the case.

## The impact

Response to the eConsult service was immediate and positive. Originally intended for endocrinology cases only, the number of specialties quickly expanded to five in the initial proof-of-concept stage, and is currently over 100. Since 2011, eConsult has enrolled over 1,000 family physicians and nurse practitioners and completed over 20,000 cases, two-thirds of which were resolved without the patient requiring a face-to-face visit with a specialist. This translates to over 8,000 cases where patients have avoided attending an unnecessary specialist visit.<sup>(1)</sup>

The average specialist response time is only two days, and the service has received nearly unanimous praise from patients, family physicians, nurse practitioners, and specialists alike. Users rate the service as having high or very high value in over 90% of cases, citing the speed and quality of its responses as well as its educational value.<sup>(2)</sup> A survey of specialists revealed that 94% believed the service improves their communication with family physicians and nurse practitioners,<sup>(3)</sup> while interviews with patients found nearly unanimous support for the service as a method for receiving quick access to specialist advice.<sup>(4)</sup>

## Advice and key elements for success

- When designing a health care innovation, engage users early and often. Without an active and enthusiastic user base, even the best innovation won't succeed.
- Partnerships with stakeholders and clinicians are also key. Enthusiastic physicians serve as important champions for the service and can help spread the service among their peers, while regional partners help provide the legislative and infrastructural backbone that a new innovation needs to thrive. On a larger scale, partnerships can help expand the innovation to new populations or jurisdictions. For instance, the eConsult team has engaged with groups from several provinces across Canada, as well as a number of national organizations dedicated to improving access to care. As a result, a new eConsult service is now up and running in the province of Newfoundland and Labrador, while Champlain BASE™ is serving as one of two innovations available from a national quality improvement collaborative.<sup>(5)</sup>
- Once the service is implemented, it is important to continue engaging with partners to ensure the innovation meets their needs and find ways in which it can be improved. Incorporating a method of evaluation analysis into the system itself allows innovators to collect usage data and feedback in real-time. For instance, the eConsult service uses a brief closeout survey, which primary care providers must complete at the conclusion of each case. Questions include the outcome of the eConsult, whether a referral was originally considered/ultimately avoided, and the users' perceived value of the eConsult to their patients and themselves. Users can also leave optional free-text comments, which provide insight into the service's benefits, highlight areas that need improvement, and serve as an outlet for users to show their appreciation to specialists whom they found especially helpful.

Building on the success of the Champlain LHIN BASE™ eConsult Service, the Ontario Ministry of Health has announced plans to expand the service province-wide in 2017-18. The expansion is an important component of the province's efforts to strengthen health care for all Ontarians, and will be supported with a \$20 million investment.

## Final reflection

In developing the service, the eConsult team remained focused on the problem it was meant to address: long wait times for specialist appointments. Many health care innovations adopt a technology-first approach to problem solving, relying on a pre-chosen product and attempting to tailor it to the situation at hand.

“ [eConsult] saves me having to take a day off work to sit around a waiting room all day just to find out that there was really no point in coming here. ”

- Patient

In contrast, the eConsult team remained “technology agnostic” and open to whatever solution would best help patients get better access to specialist advice while ensuring the privacy of their personal health information and remaining cost-effective. This decision enabled the team to adopt the best tool to suit their needs, and to adjust course when an initial decision proved ineffective (for instance, an original choice to use email was abandoned, as the medium failed to meet provincial privacy requirements). It also allows the service to adapt in response to user needs.

## Contributing authors

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# SCOPE: Seamless Care Optimizing the Patient Experience

**SCOPE is a partnership among the Toronto Central CCAC, UHN and WCH, which provides a virtual interdisciplinary health team to solo family physicians working in the community.**

## Who was involved

University Health Network (UHN), Women's College Hospital (WCH), the Toronto Central Community Care Access Centre (CCAC) and 134 community family physicians

## The challenge

The population is aging and living longer with multiple chronic conditions. Family physicians are finding it increasingly difficult to care for patients with multiple comorbidities, especially when they work in isolation, without access to an interdisciplinary team, specialists, and the infrastructure to navigate hospital and community resources. This often leads to uncoordinated patient care that can negatively impact patient outcomes and experience.

Qualitative interviews with family physicians showed that they wanted the following supports:

- A single point of access to services rather than multiple referral forms or numbers to call
- Quick and easy responsiveness to their medical questions by a specialist with the option to have a semi-urgent patient seen in a timely manner
- Services to support frail, homebound patients
- Ready access to hospital reports

## The solution

SCOPE (Seamless Care Optimizing the Patient Experience), a partnership among the Toronto Central CCAC, UHN and WCH, provides a virtual interdisciplinary health team to solo family physicians in the community.

Community-based family physicians can now call a single SCOPE phone number to access:

- Assistance from a resource nurse navigator and a CCAC coordinator through a navigation hub, in order to facilitate timely access to appointments with specialists as well as hospital and community resources.
- A general internal medicine (GIM) specialist on-call for an expedited phone consultation and/or referrals to a short-stay medical unit (WCH's Acute Ambulatory Care Unit) for urgent assessment of medical problems or management of exacerbations of chronic conditions, within a 24-hour timeframe.
- A diagnostic imaging consultant on-call for advice on interpreting imaging results, for appropriateness consultation and for urgent imaging and reporting. This intervention is based on evidence that hospital-based imaging has traditionally been designed to serve in-patients and specialists. Impeded by long wait times, these family physicians resorted to using overcrowded emergency departments (EDs) to expedite imaging for patients.

Connecting Ontario and access to e-consultations are also available to SCOPE family physicians who can view real-time hospital and lab reports and connect with other specific sub-specialties.

Consultations to develop and implement the SCOPE model initially involved community-based family physicians along the Toronto Western Hospital (TWH) corridor, whose practices were using the TWH in large numbers; senior management from the key hospitals and CCAC; clinical leaders of services such as the UHN Emergency Department; the chiefs of family medicine, medicine, psychiatry, and general internal medicine at UHN and WCH. Over time, as the program was offered to more family physicians in the community, further consultations were conducted. A 14-member Physician Advisory Group also meets regularly to provide feedback and advise on iterative changes to the program.

This grassroots co-design and ownership depended on in-kind contributions by all three partners: CCAC, UHN and WCH, such as funding for the nurse navigator, a dedicated CCAC coordinator, a primary care physician lead, administrative overhead and project manager, and stipends to the general internist staff. Furthermore, through various research funds, an evaluation and quality improvement process for the program has been developed.

## The impact

The impact of SCOPE was analyzed across the following categories:

### I: Implementation

- 134 physicians registered in downtown Toronto with no one dropping out since inception in 2012
- Active 14-member Physician Advisory Group
- Over 12,000 calls to SCOPE since inception in 2012. 45% serve older adults and persons affected by mental health and addictions

“ The SCOPE program has been very eagerly received and utilized by all of my colleagues because it is driven by the philosophy of collaboration and rapid access. ”

– Community-Based Family Physician

- 98% provider satisfaction regarding relevance of SCOPE services
- Ranked as priority project to scale across the Toronto Central Local Health Integration Network (LHIN) sub-regions – first expansion site in west Toronto to integrate community-based family physicians with St. Joseph’s Health Centre launched in January 2017

### II: Improved Patient Outcomes

Specific services evaluated the impact of the SCOPE intervention on perceived ED diversions:

- Internist on-call: Respondents note 42% of calls averted an ED visit
- Navigation nurse: Respondents note 31% of calls averted an ED visit
- Radiologist on-call: Respondents estimate 39% of calls averted an ED visit
  - In a study of 103 urgent image calls conducted between May 2014 and March 2015 with 60 family physicians, it was reported that 40 ED visits were avoided and an additional 40 appropriateness consultations were provided to help determine the most appropriate imaging.
  - A post-call survey to 42 separate callers revealed 100% of respondents were satisfied with the service and would recommend the call centre to their colleagues.

### III: Qualitative Results Pertaining to PCP Satisfaction

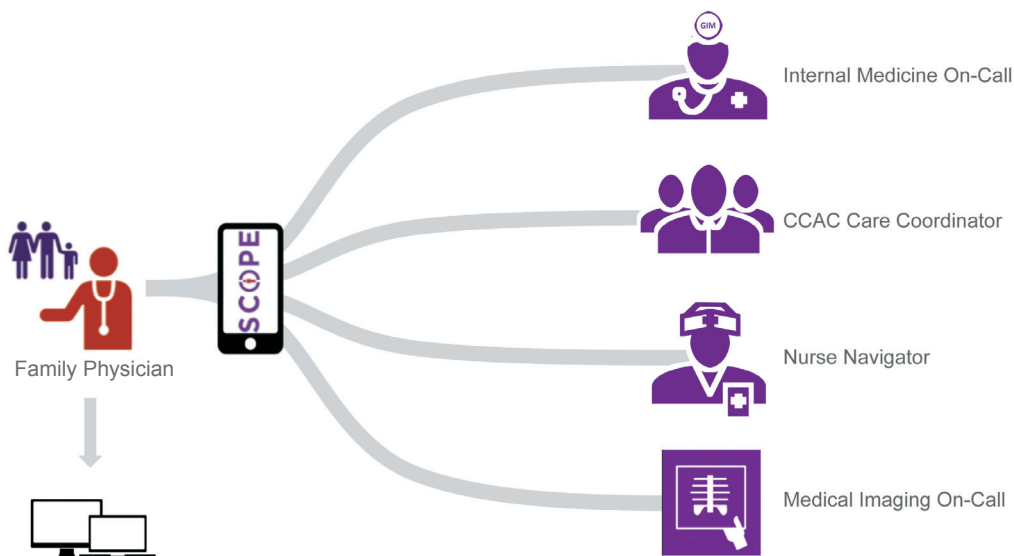
- 27 in-depth, semi-structured interviews conducted with SCOPE family physicians and 12 patient interviews demonstrated that SCOPE improved the quality and coordination of care community-based family physicians provided to their patients (Lockhart, 2016).
- SCOPE helped family physicians overcome isolation, heightened awareness of available services, enabled better provision of care, and demonstrated an enhanced ability for family physicians to practice shared care for their complex patients.

### IV: Hospital Benefits and Unintended Consequences

- SCOPE identifies service gaps in hospitals and the community for the most high-needs patients.
- SCOPE is a valuable platform that matches primary care needs with hospital and community services.
- SCOPE has created a community which did not previously exist, for both the family physicians, who for the most part work in solo practices, and

for the hospital that can turn to an informed family physician coalition to obtain advice on best integration practices and trial improvements to accessing hospital resources and specialist consultation.

- These more integrated relationships have enabled better use of Health Link strategies such as coordinated care planning for high users of acute care services.
- A number of sub-specialties are considering how to improve referral appropriateness and have collaborated with SCOPE physicians to offer more streamlined services such as: mental health and addictions services, general gynecology, neurology, general surgery, oncology, hematology and neurosurgery.
- SCOPE now logs over 300 calls a month which, given that a significant number of these calls divert complex patients from the ED, is more cost-effective than the usual care and also results in cost savings for the system.



## Final reflection

To date, the SCOPE intervention has focused on supporting community-based family physicians and their patients. However, there are many patients who bypass their family practice office and go directly to the ED. This is a group that the SCOPE program is now addressing by flagging visits to the ED and following up with these patients and their providers.

## Contributing authors

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## Advice and key elements for success

- Grassroots planning and co-design that respected family physician input and adapted the intervention to meet their needs was important.
- Applying a quality improvement framework allows for continuous improvements to the interventions.
- Interventions need to be both patient-centered and provider-enhanced.
- Reduce fragmentation with a single point of access and seamless feedback loops.
- Practice ongoing communications (SCOPE newsletter, e-blasts on SCOPE programs, engagement events, website) to keep physicians informed and also facilitate change from usual practice.

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# Connecting Our Hospital to Our Community Doctors

**The challenge was to find a solution that would enable pharmacists and physicians (both in the ER and the most responsible family physician (MRP) caring for the patient) to access outpatient charts from the hospital.**

## Who was involved

Collingwood General and Marine Hospital and Georgian Bay Family Health Team (FHT)

## The challenge

When patients presented to the emergency department (ED) and/or were admitted to the hospital, there was no way for the hospital to access the patient's reports and test results from the community provider. This often led to uncoordinated care plans and duplication of services. The challenge was to find a solution that would enable pharmacists and physicians (both in the ED and the most responsible family physician (MRP) caring for the patient) to access outpatient charts from the hospital.

## The solution

The solution was to connect the FHTs' electronic medical record (EMR) to the hospital-based EMR. As such, ED physicians and pharmacists at the hospital now have read-only access to the EMR. External access to the EMR allows the hospital to access information that is necessary to provide high-quality patient care.

There were a number of factors that made this solution possible, including:

1. The existing connectivity of community-based family physicians
  - At the time when Family Health Groups were being introduced, a group of early EMR adopters encouraged all family physicians in the Georgian Bay region to use the same EMR and all agreed.
2. All physicians were already working on a single server
  - This came about when one of the family physicians in the FHT sought out a solution to enable ePrescribing, which was another initiative felt to be a priority for the physicians in the group.
3. Family physicians maintain hospital admitting privileges
  - As part of the Family Health Organization governance structure, all members are strongly encouraged to maintain hospital admitting privileges. This enables family physicians to be the MRP for their patients in hospital and further enables continuity of care.

## The impact

The outpatient EMR is accessed by inpatient MRPs on a regular basis. The ability to see previous consultations, imaging, lab results, current and previous medication lists and past medical history greatly enhances the patient's context, reduces duplication, and helps in planning and delivering high-quality patient care.

The ED physicians access the EMR less consistently as the log-in process can slow down a busy work flow. Nonetheless, those who do utilize the EMR indicate the value of the information in improving the accuracy of diagnoses and creating a more patient-centered care plan. Pharmacists have also seen the value of having access to the outpatient EMR and they use it regularly to create the most accurate admitting medication list, as part of the medication reconciliation process.

## Contributing authors

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## Advice and key elements for success

- Have a champion with vision, patience and commitment. Physician champions who also have an IT interest were instrumental to the success of this project. They were committed to achieving better work flow and better patient care, and were patient in dealing with setbacks throughout the process.
- Foster a culture of collaboration among peers and with community partners. This project would not have been possible without the support of the hospital's Chief Executive Officer and IT department, who recognize that primary care is part of the hospital's "core business".
- Change needs to fit within current workflows to enhance uptake. A piece of advice to other communities considering a similar solution is to create "one button" to enable access to the community EMR from the hospital EMR. This would likely enhance uptake.
- Encourage family physicians to remain connected to their local hospitals by caring for their own patients when hospitalized.

“ Connecting primary and secondary care increases our ability to talk to each other, access information about patients and ultimately provide better patient care. ”

– Dr. James Lane, Georgian Bay Family Health Team



# Acute Care-Primary Care Interface Group

**A dedicated group of leaders from both primary and acute care were brought together for the common goal of creating a united team focused on addressing the most pressing issues impacting patient-centered care.**

## Who was involved

Hamilton Health Sciences (HHS) and St. Joseph's Health Care Hamilton (SJHH); primary care medical and administrative leadership from the two Hamilton Family Health Teams (FHTs); frontline primary care physicians; Public Health officials; and the Medical Director of the Hamilton Niagara Haldimand Brant Community Care Access Centre.

## The challenge

Hamilton is a city of approximately 550,000 residents, served by two tertiary care hospital systems: HHS and SJHH. The city is also served by two large, primary care FHTs.

Increasingly, given the complexity and specialization of health care, these acute and primary care providers recognized that needless duplication and inefficiency exist within the local health care system. This was particularly evident during patient transitions between primary and acute care, which were becoming more challenging and patients were receiving less than optimal care.

## The solution

A dedicated group of leaders from both primary and acute care were brought together for the common goal of creating a united team focused on addressing the most pressing issues impacting patient-centered care. The group's objective was to create a forum dedicated to solving the issues that were inhibiting patient-centered transitions along the continuum of care.

The working group's membership evolved to include: medical and administrative leaders from the two hospital corporations – HHS and SJHH; primary care medical and administrative leadership from the two Hamilton FHTs; frontline family physicians; Public Health officials; and the Medical Director of the Hamilton Niagara Haldimand Brant Community Care Access Centre.

In the spring of 2016, a decision was made to perform a needs survey under the leadership of Dr. Mangin from the Department of Family Medicine, McMaster University in Hamilton. Family physicians within the community were asked to reflect on their practices, as well as their patients' recent emergency admissions to hospital, in order to identify what supports may have been better used to care for patients in the community, rather than in the hospital. Dr. Mangin presented her work, along with a literature review of hospital avoidance initiatives, to the working group in November, 2016.





Several broad themes were identified:

1. Access: Need for rapid access to diagnostics (CX-ray/EKG/blood work) without referring the patient to the emergency department and access to timely nursing and social services.
2. Integration: Reliable processes for accessing specialty advice; addressing the challenges associated with communicating between family physicians and inpatient physicians caring for the patient; integrated discharge planning; the inclusion of mental health services.
3. Comprehensiveness: Treatment in the community (intravenous fluids, intravenous antibiotics first start, transfusions); medical care in long-term care; rapid streamline, secondary care appointments (i.e., flexibility in triaging appointments).
4. Challenges navigating referral pathways: Communication between providers.

Subsequent to this review, the following initiatives were prioritized for action: 1) Implementation of “ask the expert” rounds, designed to build relationships between family and consultant physicians; 2) Creation of a working group to develop a pilot program for access to laboratory diagnostics through hospital (HHS and SJHH) Urgent Care Centers; 3) Encouraging enrollment of specialists (particularly Benign Hematology, Gastroenterology, Nephrology) in the eConsult initiative, as well as the development of guidelines/algorithms for a more effective work-up by family physicians referring to these clinics; 4) Creation of a working group to solicit reliable, direct contact information from family and consultant physicians through the hospital paging systems.

Additional areas of focus for future exploration have also been identified and include: standardized intake processes for outpatient clinics, further expansion of diagnostic access, and ambulatory delivery of blood products.

“ This group is a great step forward for our community. The two surveys that have been sent out to the primary care physicians have had overwhelming responses, demonstrating that primary care physicians are committed to making health care better in our community. Acute care has shown similar dedication by supporting this committee. It is very helpful to be able to go back to my primary care colleagues and tell them that there is a venue where their voice is being heard and that there is a willingness to make changes to enhance their work in the community.

I believe that both Hamilton Health Sciences and St. Joseph’s Healthcare Hamilton are demonstrating great leadership to other hospitals in terms of their support to improving health care in general for the community of Hamilton. ”

- M. De Benedetti, Lead Physician,  
Hamilton Family Health Team

## The impact

Together, an engaged working group of health care practitioners has been created, spanning acute and community care. Tangible, simple actions that are having a positive impact on patient care have been identified.

A key outcome has been the improved relationships and connections between the hospitals and primary care providers in Hamilton. The working group unanimously recognized that it was important to focus on projects that address the immediate needs of primary care in order to foster trust, repair relationships and solve some of the urgent concerns



impacting their ability to deliver care to their patients by improving discharge planning, communication with specialists and the referral practice. This work has also been effectively tied to Health Links, which can have a positive impact on emergency department visits, and possibly, admissions and readmissions.

The crucial early win for the community was the establishment of a credible body that, to a degree, mirrors existing structures at the hospital and LHIN level, and has enabled a connection with a key element of their health system (primary care).

## Contributing authors

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## Advice and key elements for success

- This work takes time; be patient.
- Identify problems that will have tangible benefits for patients, family physicians and hospitals. Don't proceed with preconceived ideas of what you want fixed.
- Leadership from the hospital and community must be prepared to devote time and energy to a project such as this.
- It is not necessary to have a large group; it is better to involve few who are engaged than many who are not.
- It is important to have practitioners who are regarded as credible to carry messages.



# Community to Hospital and Back – COPD Care as a Circle of Care

**A partnership was established between the Georgian Bay FHT, Collingwood General and Marine Hospital and the local YMCA to deliver an outpatient pulmonary rehabilitation program.**

## Who was involved

Collingwood General and Marine Hospital, the Georgian Bay Family Health Team (FHT) and the Collingwood YMCA

## The challenge

Chronic Obstructive Pulmonary Disorder (COPD) is a chronic disease whose exacerbations can lead to frequent hospital admissions. Evidence has shown that pulmonary rehabilitation can improve quality of life, and reduce admissions and readmissions after a hospitalization for an exacerbation. However, Collingwood General and Marine Hospital did not have the resources to fund all the personnel, nor the space to house pulmonary rehabilitation for patients who presented in the emergency room with COPD exacerbations, or who were re-admitted for this reason.

“ [This program] has done a lot for me. [It] has taught me how to breathe right, and the exercise is good too. I have found a big improvement in my body, and I have really enjoyed this. ”

- Patient

## The solution

A partnership was established between the Georgian Bay FHT, Collingwood General and Marine Hospital and the local YMCA. The FHT already had a respiratory educator and a relationship with the local YMCA for health promotion activities. This existing relationship was leveraged by the hospital to establish a partnership between the three organizations, to deliver an outpatient pulmonary rehabilitation program. The YMCA offered the space, the FHT offered the respiratory educator and the hospital offered the physiotherapy and dietary supports.

## The impact

Although it is still too early to show a measurable effect on readmission rates, many of the program participants have reported improved quality of life. Data collection is analyzed every six months and the second set of data is expected to provide more information on the hospital visit impact.

One surprise was how many individuals were not interested in the idea of pulmonary rehabilitation, shying away from the thought of an “exercise program”. Re-framing it as a program to “help their breathing muscles” encouraged more participation.

All parties benefitted: patients took more control of their health, a community organization focused on health promotion was able to connect with these patients and their families, family physicians have anecdotally reported a reduction in emergency room visits and hospitalizations for some of their patients, and frontline workers were able to see the fruits of their efforts.





## Advice and key elements for success

- Have a vision, and continue to seek solutions even when the hospital may have competing priorities.
- Align education and messages with feedback from frontline professionals.
- Start slow, and make improvements nimbly as you go along, knowing that you won't get it all right the first time.
- It is important to have frontline workers who believe in the project and want to make it happen.

“ I used to have to go to a nurse to get my toenails cut, but I don't have to do this anymore. I can now get down to my feet to do my own nails! ”

– Patient

## Final reflection

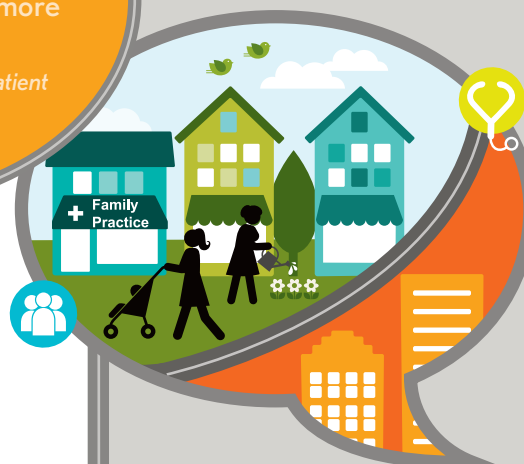
Connecting community, primary care and the hospital has been a great experience, and it will serve as a model for future collaborations.

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“ I feel more confident about the level I can exercise at, which has allowed me to exercise more often. ”

– Patient



# Partnering to Help Frail Seniors Live at Home Longer

**Providence saw an opportunity to bring together four health care sectors in their catchment area – hospitals, CCACs, primary care providers and community services – to create a solution that would support frail seniors living in the community.**

## Who was involved

Lead hospital Providence Healthcare (Providence) works in partnership with Michael Garron Hospital, The Scarborough Academic Family Health Team, Toronto Central Community Care Access Centre (CCAC), Central East CCAC, community-based family physicians, nurse practitioners and community services.

## The challenge

Despite the fact that the Ontario government has made it a priority to help frail seniors avoid hospital admission, there is still a lack of referral options available to these individuals who present in emergency departments. As well, primary care providers continue to search for solutions and resources for frail seniors who visit their offices. Care coordinators and nurse practitioners at CCACs also face limited options for clients who require more care than can be provided in the home, yet who are not appropriate for admission to an acute care facility.

## The solution

To address this issue, the Fast Access for Seniors to Community Assess and Restore Services project was established. A catalyst for the project was a request for proposals issued by the Toronto Central Local Health Integration Network (LHIN) for Assess and Restore funding. Providence saw an opportunity to bring together four health care sectors in their catchment area – hospitals, CCACs, primary care providers and community services – to create a solution that would support frail seniors living in the community.

The project targeted a specific population: complex, vulnerable patients and frail seniors living at home who are at risk of hospitalization or admission into a long-term care home, and who have restorative potential that could delay the need for institutional care.

The proposal built on the significant work already undertaken to meet the goals in existing Assess and Restore guidelines. It leveraged the existing Frailty Intervention Team (FIT) at Providence and created a new standardized, expedited care pathway that enables direct admission to Assess and Restore inpatient and outpatient programs for use by emergency departments, primary care providers and community services.





The collaborative development of the program began in May 2015. Once funding was obtained in September 2015, the rollout commenced, which included the following steps:

- Development of a Steering Committee with all partners represented and processes in place to promote regular communication and feedback
- Creation, implementation, design and testing of a Community Referral Pathway
- Expansion of Providence’s existing FIT to support a projected increase in the number and complexity of referred patients, including adding geriatricians and family physicians specializing in caring for the elderly, and providing mental health training for the FIT team
- Creation and implementation of a Community Health Navigator to follow patients admitted from the community to be seen by the FIT, identify the baseline status of patients, and provide ongoing monitoring at regular intervals in collaboration with the family physician

- Analysis of patient outcomes from baseline to three months
- Identification of indicators and performance measures to monitor progress and success
- Development of a one-page community referral checklist to provide partners with a quick and simple tool for referring patients
- The promotion of the project to all hospitals, primary care providers, CCACs and community agencies working with the target population in Providence’s geographic area. This step involved the development and distribution of branded, clear, concise and compelling printed materials. Presentations and introductory phone calls were also made to these audiences
- Development of a satisfaction survey aligned with the Telemedicine Impact Plus satisfaction survey to enable measurement against a similar program
- Education and promotion of the use of coordinated care plans with patients, families, referral sources, partner organizations and primary care providers

## The impact

From April 1 to December 31, 2016, 85 patients were admitted directly from the community to Providence through the Community Referral Pathway.

From the fall of 2015 to December 2016, 196 patients received assessments from the FIT. These patients were monitored at baseline (just prior to the patient’s appointment with the team), then after two weeks, one month and three months. The review involved four areas: Identifying if the patient had a completed Coordinated Care Plan, and scoring the Reintegration to Normal Living Index, Caregiver Strain Index, and Depression Screening Questionnaire (PHQ2).

The results of this review are as follows:

**Coordinated Care Plan:** Between April 1, 2016, and December 31, 2016, a total of 143 of the 144 patients assessed by the FIT had coordinated care plans generated by the team at Providence. The remaining patient came to the assessment with an existing coordinated care plan that was then updated by the FIT.

**Reintegration to Normal Living Index:** Between April 1, 2016, and December 31, 2016, the average Reintegration to Normal Living Index Score improved from 62.8 at baseline to 77.5 at three months (higher is better).

**Modified Caregiver Strain Index (M-CSI):** Between April 1, 2016, and December 31, 2016, the average Modified Caregiver Strain Index score improved from 10.5 at the baseline assessment to 7.8 at three months (lower is better).

**Depression Screening Questionnaire (PHQ-2):** Between April 1, 2016, and December 31, 2016, the average Depression Screening Questionnaire score improved from 2.0 at baseline to 1.1 at three months (lower is better).

Through the collaborative work inherent in the community referral pathway, frail and vulnerable patients who may have ended up in the emergency department and in long-term care have received care to enable them to remain at home for an extended time.

Patients with complex health needs who may have not had access to an interprofessional assessment team were seen by the FIT, which provided them with a one-stop, comprehensive assessment.

Results from the patient experience survey include:

- 99% of respondents agreed - I am confident that my/the patient's care will be better managed as a result of the Frailty Intervention Team assessment.
- 97% of respondents agreed - I am satisfied with the recommendations developed during the assessment.
- 94% of respondents agreed - I am hopeful that my/the patient's condition will improve as a result of the assessment.



## Final reflection

Without this collaboration, the Community Referral Pathway and direct referrals to the FIT would not have been possible. The team feels extreme satisfaction knowing that it has helped a vulnerable population at risk of falling through the cracks get access to the health services they need, and in a timely manner.

In the near future, Providence and its community partners plan to continue working together to identify innovative ways of supporting people waiting in the community for long-term care.

## Contributing authors

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## Advice and key elements for success

- Above all, regular, two-way communication is essential when collaborating with partners.
- From the outset, confirm that each partner organization supports the project at the senior leadership level. Understand your partners' needs as well as the needs of their patients.
- If there is a committee leading the development of the project, establish terms of reference and stipulate that attendance by all members is mandatory at each meeting.
- Regularly communicate with each partner at least monthly to identify and resolve issues unique to each partner.
- Provide partners with branded materials describing the program with clear, concise and consistent messaging. Also use phone calls and face-to-face meetings to introduce the program to partners and sustain awareness.
- Provide partners with feedback to help them understand the positive outcome of their referral and encourage continued participation.
- Monitor, assess and revise the project, as required; have dedicated staff working as part of the project to ensure that it is properly resourced.





# Improving Outcomes for COPD Patients Through Program Integrations

Readmission rates for patients with COPD at GGH were some of the highest in the area. In response, a cross-sector COPD Steering Committee was established to oversee an improvement initiative which involved testing a number of ideas.

## Who was involved

Guelph General Hospital (GGH), the Guelph Family Health Team (FHT), St. Joseph's Health Centre Guelph, the Guelph Community Health Centre (CHC), and the Waterloo Wellington CCAC

## The challenge

Readmission rates for patients with Chronic Obstructive Pulmonary Disease (COPD) at GGH were some of the highest in the area. In addition, patients reported that their experience of care was not optimal – they often left hospital feeling like they didn't know what was going to happen next, or whom to call if symptoms worsened.

## The solution

A cross-sector COPD Steering Committee was established in Guelph to oversee an improvement initiative which involved testing a number of ideas:

“ Our COPD initiative has resulted in not only positive outcomes for our patients, but has also strengthened our relationship with family physicians within our Family Health Team and other community providers. We have built the foundation to truly put the patient first. ”

– Marianne Walker, President and CEO,  
Guelph General Hospital

1. GGH created a dedicated unit within the hospital because grouping similar patients on a single unit allows staff to develop expertise in providing standard care to patients diagnosed with COPD. Education is standardized, oxygen is weaned more quickly, and early ambulation is encouraged.
2. GGH, the Guelph FHT and the Guelph CHC created standard discharge follow-up and communication processes with the primary care provider.
3. Before leaving the hospital, patients have, in hand, a scheduled, follow-up appointment with their family physician within one week of discharge. Transfer of accountability is faxed to the family physician for tests and procedures, and immunizations administered.
4. After leaving the hospital, patients are supported by the Community Care Access Centre Rapid Response Nurse (CCAC-RRN). Transfer of accountability from the CCAC-RRN is also provided to the family physician.



- The hospital shared a list of admissions and emergency department visits (for patients presenting with COPD or related conditions) over a period of six months with the primary care teams. The list was assessed and patients with COPD at high-risk for further hospital visits were identified so the primary care team could reach out to offer proactive management to avoid future hospital visits.
- Primary care teams are working on standardizing the care pathway in the community to ensure earlier diagnosis and access to education and self-management supports for patients.

### The impact

These initiatives have improved the quality of care for COPD patients, and have resulted in lowering the COPD readmission rate to the hospital by over

40% over the past 12 months (see Figure 1)! While there was a spike in December rates, the overall year-to-date rate is still 40% lower than it was over the previous 12 months. The COPD Steering Committee in Guelph is seeing the spike in December rates as an opportunity for exploration, investigation and further improvement.

Certain physician groups have targeted efforts around increasing the percentage of patients who are being referred for spirometry in order to get a confirmed diagnosis of COPD as soon as possible (see Figure 2). Other changes primary care teams have been testing include: smoking cessation support, patient education and self-management support, and vaccination for pneumonia. These improvements have also contributed to reduced readmission rates.

**Figure 1: COPD Readmission Rates at Guelph General Hospital  
April 2016 – March 2017**

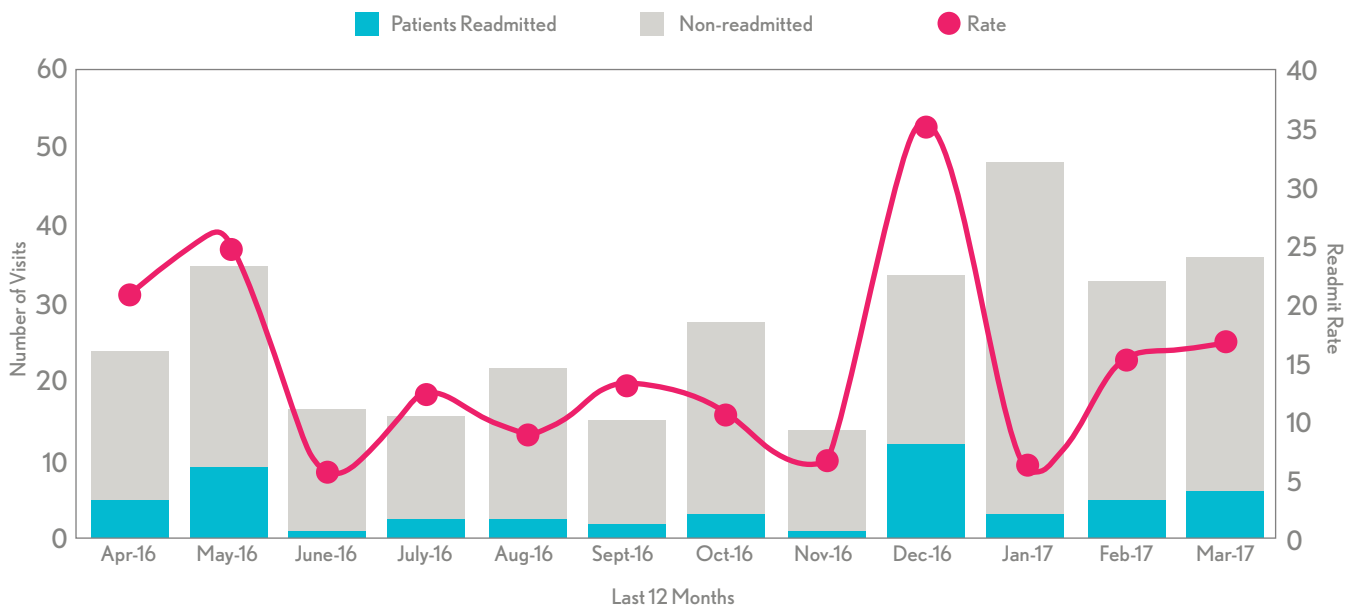
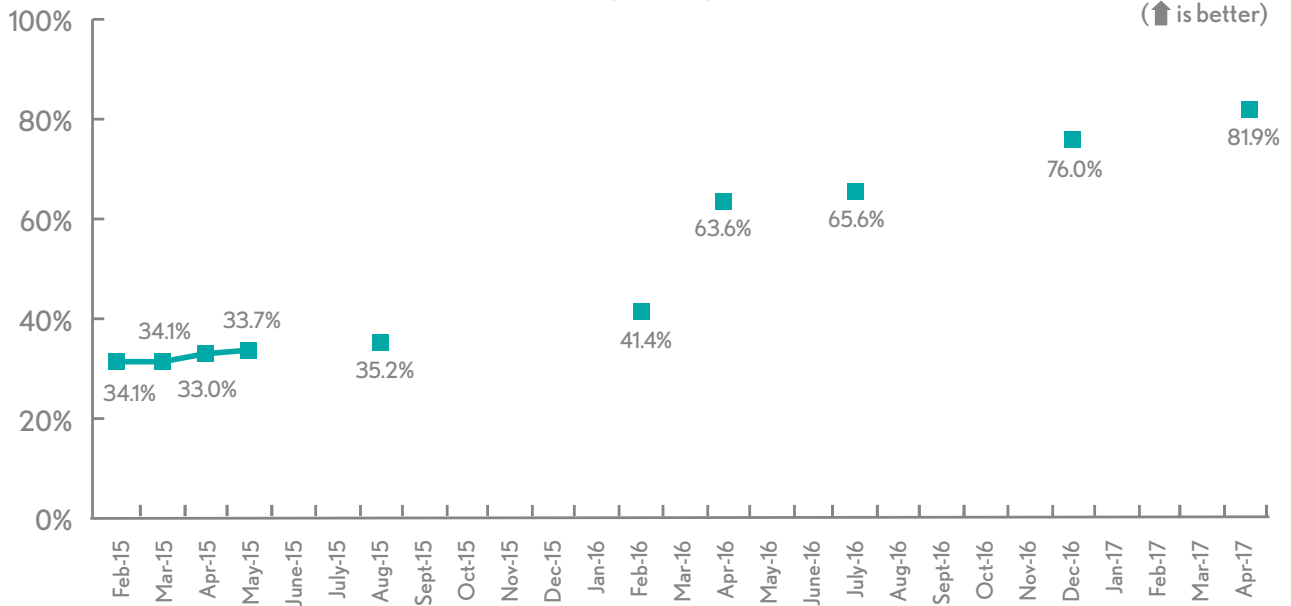


Figure 2: % of COPD Patients with Spirometry (n=105)



### Final reflection

One challenge identified by the group was the idea of spreading local improvements to have broader reach. For example, a few family practices chose to work on improving spirometry rate and experimented with different improvements that were successful. Spreading these improvements to more family practices is challenging with almost 100 family physicians in Guelph with different priorities and different office environments. Through the leadership of the Guelph FHT and the Guelph CHC, family physicians that are interested in pursuing these improvements and working to support their efforts are being identified.

The partners believe that much of the work that has been completed will be relevant for other chronic conditions, including Congestive Heart Failure (CHF). The community has identified this as a next step and will be working in 2017/18 to develop a community-wide improvement plan for CHF based on the success of the COPD initiative.



## Contributing authors

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**Marianne Walker**, President and CEO, Guelph General Hospital

**Tricia Wilkerson**, Director, Quality Improvement and Evaluation, Guelph Family Health Team

**Melissa Kwiatkowski**, Director, Strategy and Risk Management, Guelph General Hospital

“ This initiative clearly shows how real collaboration between primary care and acute care can make a big difference for patients. Guelph Family Health Team and Guelph General Hospital have demonstrated how collective work within a region can result in significant system improvement. ”

– Ross Kirkconnell, Executive Director,  
Guelph Family Health Team

## Advice and key elements for success

- Engage a diverse group early on so that each person can see other parts of the system and understand what is happening from the patient’s perspective as they move between providers. Allow the group time to build a common understanding of the challenges that exist across the continuum of care, to brainstorm potential solutions and vote on which ones they want to tackle first. In this case, this was done through early engagement of senior leaders for commitment to the team’s plan, weekly touch bases with middle management and monthly meetings with a Steering Committee.
- Create a sense of shared leadership between organizations for the success of the project.
- Incorporate the patient perspective in the group’s work; patients were interviewed prior to the meeting and their feelings and experiences were then incorporated into the process map. A client value statement was also created as the first team exercise, which really grounded the group in a shared purpose.



# A Regional Approach to CHF Management

**A group of health care providers identified opportunities for improving outcomes for patients with CHF. They agreed to use a standardized education tool so patient education initiated in hospital would be reinforced upon discharge by all organizations providing follow-up care.**

## Who was involved

Pembroke Regional Hospital (PRH) and Petawawa Centennial Family Health Centre (PCFHC)

## The challenge

PRH delivers a broad range of acute, post-acute, outpatient and diagnostic services to a mixed urban and rural population of approximately 55,000 residents. Twenty minutes' drive west, the Petawawa Centennial Family Health Centre (PCFHC) delivers team-based primary care to the 20,000 residents of the Town of Petawawa and area. Both organizations are major partners within the North Renfrew County Health Link, with PRH serving as the Health Link's lead.

However, the lack of communication between the hospital, family physicians and patients; standardization of Congestive Heart Failure (CHF) care; and patient support in the region, have led to a high proportion of emergency department visits and hospital readmissions within 30 days of discharge. PRH readmission rates range from 23% to 50%, and only a low percentage of discharged patients access their family physician within seven days of discharge.

“ I had a client encounter over the phone, three days post-hospital visit. The client had seen the Congestive Heart Failure team at Pembroke Regional Hospital during their stay [and] was provided with the GAP Tool and the Heart Failure Patient Guide.

The client showed clear knowledge [of their] CHF condition and was extremely grateful for the assistance, knowing that the goal was to keep them healthy and in their own environment.

[It was a] shining example. As a provider, I was pleased in the knowledge that this client was fully supported by the whole team, [including] the Paramedics, our CHF team, and the CHF team at PRH. It was pleasant to hear the client describe their knowledge and realize it was a consistent message from all the supports involved. ”

– Steve Coulas, Pharmacist, Petawawa Centennial Family Health Centre

## The solution

PCFHC facilitated a workshop with regional service providers delivering care to patients diagnosed with CHF. Participants included the Community Care Access Centre (CCAC), community paramedicine, Heart Function Clinic Nurses, the regional Vascular Health Program coordinator, the PRH clinical educator, the PRH pharmacist, the North Renfrew County Health Link project manager, and the PCFHC CHF team consisting of a nurse practitioner and pharmacist.

Using process mapping techniques, the group identified opportunities for improving patient outcomes. They agreed to use a standardized education tool, the “Guide for Patients and Family” developed by the University of Ottawa Heart Institute, so that the patient education initiated in hospital would be reinforced upon discharge by all organizations providing follow-up care. The guidance tool, which is provided to patients on admission, has been provided electronically to the CCAC home care nurses, community paramedics, and the primary care providers and the pharmacist attached to the PCFHC. Furthermore, PRH utilizes a GAP tool to document critical information regarding a patient’s condition and treatment. This tool has proven to be extremely valuable when providing follow-up care by all parties, and is now available to other organizations through the clinical educator upon patient discharge from PRH.

Subsequently, PCFHC was granted access to PRH electronic records. With this access, PCFHC reviews emergency department visits, as well as admission and discharges of its rostered patients daily. This daily review allows PCFHC administrative staff to schedule follow-up appointments within a seven-day period.

## The impact

All service providers were made aware of the GAP tool that had been developed and implemented within PRH. Initially, the tool had been developed internally without consideration about its potential use beyond the hospital. Upon further review, it was evident that the information contained within the tool would allow for a smoother transition of care to community and primary care providers.

In addition, all parties were interested in making sure that the patient education was reinforced and consistent throughout the spectrum of care. The use of a standardized teaching document has enabled this consistency and has demonstrated a stable and collective approach to the patient.

## Final reflection

In rural areas, relationships between service providers are usually strong, given shared professional history and the small number of service providers. The Regional Vascular Health Program’s early successes helped with regional planning when the Health Link was being developed. PCFHC became an early adopter of the dispersed model of Health Link care coordination, with clinical staff identifying high-cost, high-use patients, and then leading the coordination of the services, not just provided by their own organization, but across sectors.

Since the initiation of the CHF project, PRH has leveraged the successes and lessons learned to establish similar quality improvement processes for patients admitted with Chronic Obstructive Pulmonary Disorder (COPD), diabetes, and for mental health and addiction issues. Additional indicators and benchmarks have been developed within each group which will be tracked and reported monthly for the 2017-2018 hospital drivers. For patients admitted with diabetes, PRH will measure the percentage of patients who receive diabetes education prior to discharge along with the percentage who are referred to the outpatient diabetes clinic. Furthermore, PCFHC was invited to be part of a hospital working group on unplanned readmissions, which was a result of the interest generated by this initiative.

## Contributing authors

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## Advice and key elements for success

It is likely that siloes are created because individual organizations have been so focused on trying to address their own service challenges that they haven't had the time to think about the broader impact to the local health care system. However, it is important to remember that all providers share the same goal: providing high-quality care to patients. With this in mind, providers should be encouraged to reach out to one another for support in order to improve care for patients.

# Telemedicine Impact Plus: TIP

**TIP Clinics were created and embedded in each TC LHIN Sub-Region. These clinics share the goal of coordinating care planning and identifying solutions for addressing patients' medical and psychosocial needs.**

## Who was involved

Toronto Central Local Health Integration Network (TC LHIN) Sub-Regions, Ontario Telemedicine Network (OTN), St. Elizabeth Health Care, Home and Community Care of the TC LHIN

## The challenge

Family physicians do not always have access to an interprofessional team that can provide advice and strategies on how to manage patients' increasingly complex care needs. The population is aging and the number of patients with multiple and complex needs is increasing steadily. Without adequate supports to help family physicians care for these patients, patient outcomes and experience as well as physician satisfaction are negatively affected.

## The solution

With funding support from the TC LHIN, Telemedicine Impact Plus (TIP) Clinics have been created and expanded to each sub-region within the TC LHIN. These clinics share the goal of coordinating care planning and identifying solutions for addressing patients' medical and psychosocial needs. In the TC

LHIN, participating hospitals include Michael Garron Hospital, Sinai Health System, St. Michael's Hospital, Sunnybrook Health Sciences Centre, and Women's College Hospital.

Once an eligible patient has been referred, a TIP clinic nurse from St. Elizabeth Health Care works with the patient, caregiver, family physician and other providers within the circle of care to identify what is most important to the patient and the family physician, and also to summarize all relevant information regarding the patient's health and situation. Using this information, an interprofessional team speaks to the patient/caregiver and the family physician during a one-hour video-conference consultation, set up in the patient's home or the family physician's office, via OTN. The TIP nurse compiles the recommendations of the interprofessional team into a coordinated care plan and helps the family physician to implement the plan for up to six months after the clinic consultation.

This interprofessional team is organized by the TIP nurse based on the needs of the patient. The team's core membership includes a psychiatrist, internist, pharmacist, social worker, home and community care coordinator and dietitian, and can also consist of Family Health Teams and rehabilitation or other specialist teams depending on the patient's needs. Specialists such as geriatricians, geriatric psychiatrists, and endocrinologists may also be consulted.

With TIP, the patient, caregiver and family physician are better able to navigate health and community resources to address more complex health problems, using the expertise of a broadly skilled team.





## The impact

The results of TIP have been very positive to date:

- 89% of patients and caregivers rated TIP as “excellent” or “very good”.
- 100% of family physicians “agreed” or “strongly agreed” that TIP improved their access to interprofessional resources.
- 88% of family physicians felt increased confidence in managing patients with chronic conditions as a result of TIP.
- 95% of patients and caregivers felt increased hope that their care will be better managed, as a result of TIP.

It is evident that TIP has had a positive impact on patient outcomes, patient experience, and physician satisfaction. Since many of the referrals are for high users of hospital emergency departments (EDs) and acute inpatient services, data has shown a reduction in ED visits following TIP consultations for these complex patients. A 2015 evaluation found that patients who participated in a TIP consultation experienced a 40% reduction in hospital and ED visits over the 12 months following the consultation. TIP was also chosen as part of a national randomized control trial, *Patient-Centred Innovations for Persons with Multimorbidity (PACE in MM)*, as the chronic disease model in Ontario that will be evaluated. Initial qualitative data reinforces the value of TIP to all participants. Quantitative data collection for the evaluation is being completed in 2017.

## Contributing authors

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## Advice and key elements for success

- Working together with other health care providers along the continuum of care requires additional effort with respect to communication and coordination. Patients benefit from having all care providers and consultants problem solving together with the patient and family. Other benefits include the enhanced working relationships among members of the health care team and an expanded knowledge base by learning from each team member.
- Solutions to complex problems are easier to identify in real time, and the stress of managing patients with complex needs is reduced with the broad expertise of the team.
- A key success factor is the dedicated TIP nurse in each sub-region who is involved before, during and after the consultation session. Having the support of the TIP nurse is especially invaluable to the family physician and helps to expedite the implementation of recommendations identified during the consultation session.
- TIP is a model of care developed with physicians and the ongoing involvement of physician champions through the planning, development, implementation and evaluation phases is crucial for physician engagement and buy-in.
- The use of telemedicine technology is an innovation that enables family physicians or remote specialists to participate in the consultation virtually, and patient/caregivers appreciate not having to travel for the consultation. The TIP nurse sets up the video-conference right in the patient’s home.

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# Integrating Mental Health and Addiction Services into Primary Care

**A solution was co-developed by CMH, Langs CHC and local family care providers, who came together to discuss the existing and emerging mental health challenges facing the community.**

## Who was involved

Cambridge Memorial Hospital (CMH), Langs Community Health Centre (CHC) and community-based family physicians

## The challenge

The Waterloo Wellington Local Health Integration Network (LHIN) developed objectives to help integrate mental health and addiction services into primary care, in order to reduce wait times for access to mental health services. Three sub-regions and their needs were identified. Specifically, the Cambridge and North Dumfries sub-region was identified as having inadequate community-based psychiatry services and low utilization of Ontario Telehealth Network (OTN) psychiatry consults.

Due to years of recruitment challenges, there was also limited consultation and mentorship support from Mental Health and Addiction (MHA) specialists. Primary care providers, even Family Health Teams in the area, had few resources to support ongoing care management of patients with complex mental health issues. CMH has struggled with medical retention due to the high acuity of emergency care which has further exacerbated wait lists. CMH lost three psychiatrists

to neighbouring LHINs in 2016, prompting stronger negative feedback from frustrated family physicians and community concern, which led to primary care referring patients outside of CMH's catchment area for these services.

## The solution

The goal was to increase system capacity through three methods:

1. Extend hours and add weekend psychiatry days;
2. Adopt a tiered model of care and rapidly identify patients who could be cared for by primary care providers;
3. Re-design the intake model by integrating with primary care providers.

Adding to the number of hours in a work day and adding Saturday clinics compensated for the lost psychiatrists, but had no impact on the waitlists that were continuing to grow. Meaningful capacity was generated only by transferring medically stable patients back to family care providers (through rapidly identifying where patients fit in the tiered model of mental health care). Finally, patients were brought directly into the mental health orientation session under the care of their credentialed family physician (which involves brief individual assessments by social workers and mental health nurses) prior to seeing a psychiatrist.

This solution was co-developed by CMH, Langs CHC and community-based family physicians, who came together to discuss the existing and emerging mental health challenges facing the community. Through a facilitated and consultative process, clinicians

proposed ideas that would optimize services in an environment of scarce hospital and human power resources.

Family physicians with privileges at the hospital, agreed to maintain medical care for stable patients until such a time that the patient could be assessed by a psychiatrist. Until then, they would be the “most responsible physician” for their patients. To support family physicians, the hospital offered protected and dedicated time with a psychiatrist, where family

“ In this day and age when family physicians are more office-based than ever, it is especially important for the hospital to find ways to remain engaged with area primary care providers. I am happy to say that the hospital leadership has kept this a priority and the hospital and specialists work well with the family physicians in Cambridge to improve access and care for our patients.

By meeting with family physicians and obtaining feedback prior to making changes, the hospital has obtained buy-in and truly been able to collaborate on improving available mental health services. Together, we have been able to reduce psychiatry wait lists and times significantly. Although there is plenty of work that still needs to be done by all, I am optimistic that we will be able to provide excellent care to our patients because of the established trust and working relationships between the hospital, specialists and family physicians.”

– Anil Maheshwari, Chief of Family Medicine, Cambridge Memorial Hospital

physicians could call in to ask questions and get telephone advice or an urgent consultation. A ‘learning needs assessment’ was conducted, resulting in a five-part lecture series covering common illnesses that was developed and delivered by CMH Psychiatrists.

## The impact

- Psychiatric services at the hospital have been maintained despite the loss of three psychiatrists. Some local family physicians are resuming care of patients with stable psychiatric conditions (i.e., low self-harm risk or no medication changes in six or more months), which has mitigated rising wait times.
- There has been a 25% decrease in the waitlist for consults and urgent assessments are occurring within two weeks.
- Over 25 family physicians, nurse practitioners and a handful of community social workers attended the learning sessions and feedback averaged 4.5 out of 5 points.



- These early successes have had three secondary impacts: 1. Positive feedback from primary care with respect to access and quality; 2. Improved reputation as suggested by the number of new job applicants to the Outpatient Mental Health team; 3. Improved staff morale and satisfaction as evidenced in the department huddles.

## Final reflection

Like many things in health care, people have a tendency to wait until they need to react. The health care providers said that if they had to choose to do this project again, they would have started sooner. That said, the hospital was able to recruit four new psychiatrists, all of whom were on boarded by June 2017. The Saturday clinics were stopped once the hospital's capacity to see mental health outpatients increased. Many of the other tactics remain, like the dedicated call-in times for family physicians, and are now part of the mental health program's practice. The tiered model approach to identifying patients that could be served by primary care providers is now in the process of being implemented throughout the Waterloo Wellington LHIN.

## Contributing authors

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## Advice and key elements for success

- Open, honest communication and a readiness to collaborate with peers are important.
- The primary enabler is the collaborative relationship between CMH, Langs CHC and primary care providers. Furthermore, the hospital fosters a positive relationship with local family physicians by providing resources to their on-call schedule and offering credentialed family physicians a suite of opportunities to work in hospital programs (e.g., rehabilitation, hospital medicine, mental health, surgical assist, etc.).
- CMH has a strong Medical Advisory Committee with an engaged Chief of Family Medicine. All chiefs at the hospital recognize the important role of local care providers and are active in maintaining a strong relationship with them.



# Leveraging Education to Build Long-Lasting Relationships

**The Chief of Community and Family Medicine at HRH wanted to establish a relationship between community-based family physicians and the hospital to support the delivery of high-quality patient care across the continuum.**

## Who was involved

Dr. Art Kushner, Chief of Family and Community Medicine, Humber River Hospital (HRH)

## The challenge

Many family physicians who practice in large communities work in isolation. They often lack opportunities to socialize with their peers and to share their practice challenges and successes. The Chief of Community and Family Medicine at HRH wanted to establish a relationship between community-based family physicians and the hospital to support the delivery of high-quality patient care, across the continuum.

## The solution

The solution was for HRH to leverage education as a way to build long-lasting relationships with local family physicians.

The College of Physicians and Surgeons of Ontario requires physicians to participate in a number of continuing professional development (CPD) activities throughout the year. In light of this requirement, the Department of Family and Community Medicine (Department) at HRH in collaboration with family physicians, designed and developed a CPD program tailored to meet the needs and interests of local family physicians. In 2017, the Department is planning to utilize the onsite Simulation Lab to provide learning opportunities in various clinical areas. Since April 2016, dedicated clerical support has been assigned to the Department along with designated office space where the Chief can meet with local family physicians. A welcome effect of this program is that it also brings solo practitioners together to share practice challenges and successes and helps establish a constructive relationship with the hospital that is beneficial for patients when they are admitted or transition across the continuum of care.

## The impact

As of February 2017, over 300 family physicians have participated in the CPD program at HRH. Family practice rounds occur two to three times per month and up to 50 community providers attend each time.

By engaging with peers in a shared space, physicians report being better able to identify gaps in their knowledge and skills. Family physicians have also said they bring back the learnings to their practices in the community, which can result in improved patient care, and ultimately, better patient outcomes.

## Final reflection

Long-lasting relationships are built by sharing resources and creating environments that promote collaboration and professional growth amongst peers. The CPD program at HRH is inclusive of all; pharmacists and other community health practitioners have also attended the events.

## Contributing author

**Art Kushner**, MD, MCFP, Chief, Family and Community Medicine, Humber River Hospital Lead Physician, Humber River Family Health Team

### Advice and key elements for success

- Leverage education and the need for continued professional development to engage physicians with local hospitals. In most cases, education is the most straightforward and inclusive approach to connecting physicians in the community with the hospital.
- By offering resources and support, physicians are better engaged, help identify opportunities to improve care delivery both in hospitals and the community, and implement key learnings within their own practice.

“ I am impressed by the quality of speakers and the information that is disseminated; it’s practical and helps improve my practice and patient care. ”

– Family Physician

# Physician Engagement: Partners in Excellence

Senior leadership at the DRHC has committed to implementing and using evidence-based programs and tactics to improve communication, increase recognition and acknowledgement, standardize respectful behaviour, promote effective leadership training and encourage accountability among physicians working at the organization.

## Who was involved

Dryden Regional Health Centre (DRHC) and the Dryden Physician Community

“ I feel the DRHC has really embraced the idea of improving physician engagement. Chuck Schmitt (Physician Recruitment/ Fundraising) is an excellent front man for the hospital when dealing with physicians. We see that he is genuine, enthusiastic in his work and cares deeply for DRHC and Dryden as a community. Physicians here count on him for safe/effective dialogue with the hospital. ”

- Dr. Stephen Viherjoki, Chief of Staff,  
Dryden Regional Health Centre

## The challenge

Not unlike other small, rural hospitals, physicians providing medical leadership and overseeing hospital inpatient and emergency room care are also working independently in primary care clinic settings outside the hospital. At times, effective communication and meaningful engagement with physicians can be challenging due to the physical dynamic and multi-faceted nature of these relationships.

However, employee, physician and patient engagement are the driving force behind a healthy and positive workplace that delivers high-quality health care. Engaged employees and physicians have a more positive, supportive and satisfying work environment, connection to meaningful work and purpose, and dedicated focus on the delivery of high-quality, compassionate care.

## The solution

Senior leadership has committed to implementing and using evidence-based programs and tactics to improve communication, increase recognition and acknowledgement, standardize respectful behaviour, promote effective leadership training and encourage accountability among physicians working at the DRHC. The DRHC focuses on physician engagement as well as employee engagement, and has been able to effectively address identified challenges and areas of concern with strategic projects, tools, and planned resources.

Focused tactics include a multi-channel approach to physician communication including physician rounding, Medical Staff Stoplight reports, emails, and dedicated questions at the end of organizational meetings specifically focused on what needs to be communicated to the Medical Staff.

- **Rounding with Physicians:** This is an opportunity for administration to regularly connect with physicians, both on a personal basis and then with a work-related focus. It links their work to the mission, vision and values of the organization and empowers physicians to think strategically and identify areas and processes that can be improved upon. Welcoming feedback demonstrates value for the physician experience, knowledge of their work space and processes as well as organization-wide systems, and supports strong, positive relationships.
- **Medical Staff Stoplight reports:** Strategic relationships are fostered between Senior Leaders and the Medical Chiefs of Service during weekly organizational performance and service reviews, including planning and process improvements.
- **Development of action plans:** Medical staff teams thoroughly review and analyze physician engagement survey results. From these discussions, action plans are developed targeting at least one of the top three priorities where improvement can be made. Action plans are communicated and rolled up into an organization-wide plan for improvement.

- **Leadership Development Institutes:** These quarterly professional development sessions help foster leadership, and are customized for the organization and build high-performing health care teams.

DRHC also ensures organizational information is shared through department Huddle Boards, rounding with physicians, general staff meetings, newsletters, daily rounds, orientation, department meetings, focus groups, leadership meetings, safety inspections, celebrations, training, casual coffee breaks with the CEO and through the organizational intranet.

Physician representation is solicited during project development and implementation and strategic planning so that initiatives are responsive to need, practical in application, supported and successful.

Physician partners are included in all organizational workplace wellness and staff-led Staff4Staff events and initiatives. Recognition of service milestones and key achievements are integrated within an annual, formal organization-wide Recognition Event.

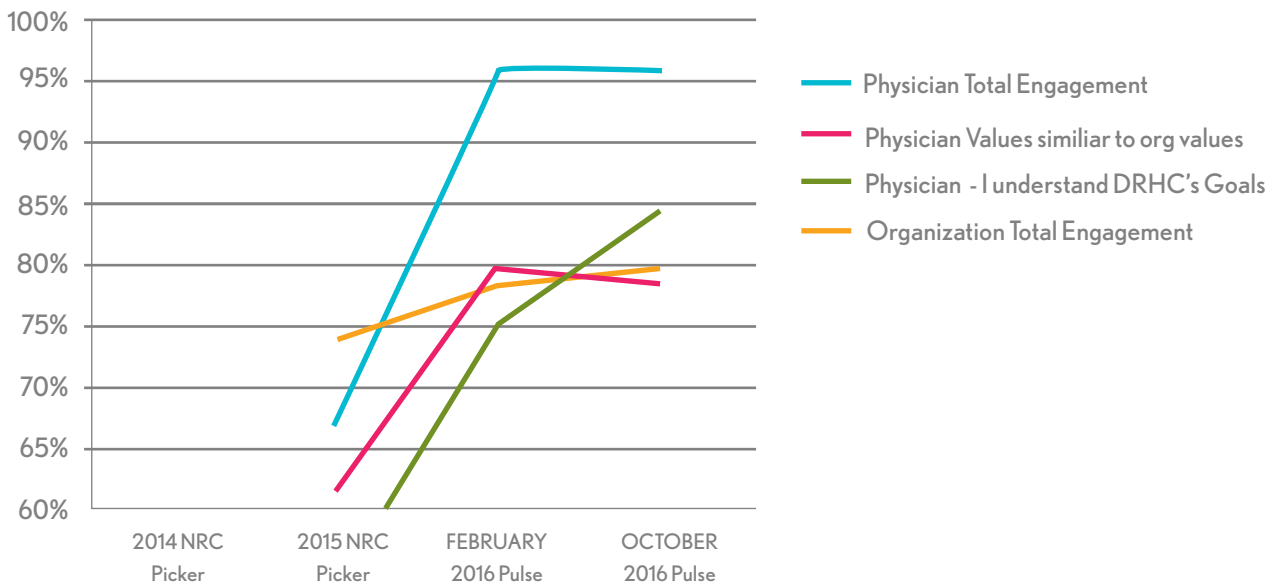


## The impact

Physician engagement is a focused organizational goal and is measured using in-house and NRC Health physician engagement surveys. Annual survey results are communicated widely throughout the organization using face-to-face presentations at medical staff meetings, department and team meetings, written notices, huddle boards and electronic media (email/intranet).

- Positive response to physician engagement survey questions about understanding organizational goals and how they align with the organizational strategy moved from 53.84% strongly agree/agree in 2015 to 84.62% in October 2016.
- Positive response to physician engagement survey question regarding ‘senior management communicates with physicians re: goals’ moved from 38.46% strongly agree/agree in 2015 to 85.71% in October 2016.
- Positive response to physician engagement survey question about ‘senior management acting on physician feedback’ moved from 30.77% strongly agree/agree in 2015 to 71.43% in October 2016.
- Positive response to physician engagement survey question to “I am proud to tell others I am a Part of the Dryden Regional Health Centre” moved from 76.92% strongly agree/agree in 2015 to 100% in October 2016.
- Positive response to physician engagement survey question about how physicians would rate the opportunities their job provides to make suggestions to improve the work of the department moved from 53.85% strongly agree/agree in 2015 to 92.86% in October 2016.

### Physician Engagement - Year to Year Comparison





## Final reflection

Sometimes in our fast-paced, ever-changing health care environments, we may overlook the value of slow, thoughtful planning and the simplicity of respecting all those who partner with us to provide high-quality care to our patients. Respecting the importance of the physician experience and valuing strong, effective and progressive partnerships with family physicians will support organizational health, collaboratively improve the patient experience and support a healthy, safe environment.

## Contributing authors

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## Advice and key elements for success

- Focus on shared common goals.
- Make family physician engagement an organizational priority.
- Focus and consistency in application and use of tactics.
- Have patience: positive results may take time.
- Align efforts with organizational goals, mission, vision, values and strategic initiatives.
- Communication: Never assume your message has been conveyed without concerted effort to communicate it! Finding alternate and multi-faceted ways to share information in ways best suited to your audience will foster and support positive relationships. Simply asking the question ‘what needs to be communicated to our Medical Staff?’ at the end of organizational meetings provides reminder of the valued partnership and the need for ongoing, focused communication.
- Involvement: Empower and encourage family physician representation in projects designed to improve organizational process.



# Optimizing Transitions of Care – Hospital to Community

A target of sending 80% of discharge summaries to primary care providers within 48-hours was set, which has been exceeded (over 93%) and sustained for more than one year.

## Who was involved

St. Thomas Elgin General Hospital (STEGH), Family Physicians of Elgin County, and the Central Community Health Center (CCHC)

## The challenge

A gap in the discharge and transition of care between the hospital and community was identified at St. Thomas Elgin General Hospital (STEGH). Data revealed that only 41% of discharge summaries were being sent to primary care practitioners within 48 hours, and fewer than 25% of patients had a follow-up appointment arranged within seven days of discharge from the hospital. This resulted in care transitions that were inadequate, inefficient and ineffective. Even patients who visited their family physician within seven days of discharge were not receiving optimal care as the physician would likely not have the relevant information including diagnoses, interventions, test results, medication changes, etc.



## The solution

Discharge summary communication was a three-step process at STEGH including dictation, transcription, and manual authentication. The review highlighted that there was a large variation in the average time that it took for discharge summaries to be sent from the hospital to family physicians with many summaries never having been sent at all. As such, the first key change focused on improving dictation turn-around times by the Clinical Associate physicians. The manual authentication process was identified as a large barrier to timely discharge summary communication. This process required physicians to log into the electronic health record after the discharge summary was dictated and transcribed, in order to manually

authenticate the discharge summary prior to it being sent to the final destination. Physicians were “batching” this work which created lengthy delays.

An ‘auto-authentication process’ was developed and tested by physicians, where the discharge summary was sent to primary care practitioners automatically, immediately after it was dictated and transcribed. Robust process planning ensured that physicians, partners, patients, and the Medical Advisory Committee (MAC) were engaged. Ongoing executive leadership support was also a significant asset to the project.

While developing strategies to improve the timeliness of post-discharge communication, the team also identified an opportunity for the hospital to facilitate the scheduling of follow-up appointments for patients as they transitioned back to the community. A process was trialed where post-discharge follow-up appointments were coordinated by the unit ward clerks. Prior to this project, patients were responsible for scheduling their own post-discharge follow-up appointments. In many cases, this did not happen in a timely manner or was not done at all.

After multiple Plan-Do-Study-Act (PDSA) cycles, a target was set to ensure that 100% of patients discharged to their home, a group home or a retirement home, have a follow-up appointment booked within seven days of discharge. Once a pending discharge is confirmed, the ward clerk books an appointment with the patient’s family physician prior to the patient leaving the unit. Patients receive appointment cards as a reminder.

However, approximately 4% of patients admitted to Acute Medical Units (AMUs) do not have a family physician. To address this challenge, a process was developed with the Central Community Health Center (CCHC) to ensure that unattached patients are scheduled to receive a follow-up appointment with a family physician or nurse practitioner at the CCHC.

“ Receiving timely discharge summaries from the hospital ensures that I am aware of my patient’s hospitalization, and therefore, I can note any medication changes that may have occurred. It also ensures I am able to counsel the patient who may not fully understand their illness or what they need to do next to manage their condition following their hospitalization. I can’t ensure adequate follow up when I am not even aware the patient was in hospital or if I don’t know what happened while they were there. Setting up the appointment with our office directly ensures timely follow up and takes the burden off patients or their family who are dealing with an acute or chronic disease. ”

– Dr. Kellie Scott,  
Family Physician

## The impact

A target of sending 80% of discharge summaries to primary care providers within 48-hours was set, and to date, the target has been exceeded and sustained for more than one year at over 93% (Figure 1). A standard policy is now endorsed by the MAC.

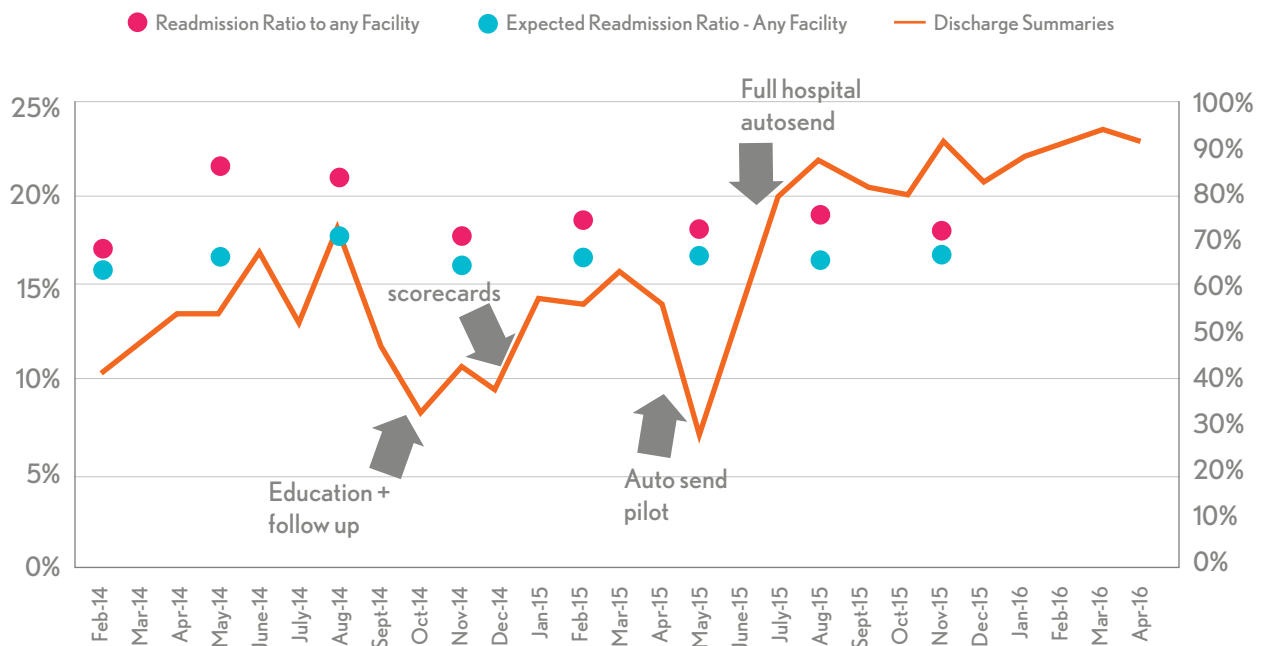
Physicians were originally skeptical about the auto-authentication process as they would not have the opportunity to edit their dictations prior to them being sent to primary care practitioners. However, data shows that the number of addendums being made to discharge summaries is low and primary care practitioners have reported positive feedback on the quality of the summaries they receive. There were many technical glitches with the auto-authentication process at the time of initiation, however, currently, 100% of discharge summaries are successfully auto-authenticated at STEGH.

Follow-up appointments are now booked for 100% patients on the AMUs, as well as throughout the organization, with all units booking appointments for 100% of their patients.

A small barrier faced by the team involved two family physicians who have stopped accepting hospital booking follow-up appointments for their patients due to patients not showing up for the scheduled visit. Regrettably, these physicians were reluctant to share their data or patient names, so STEGH has not been able to study this further. However, feedback from other physicians has been positive. They have indicated that they appreciate the appointment bookings as it informs them that their patient has been in hospital and they should be expecting a discharge summary within 48 hours. Patient feedback has also been positive as they appreciate having one less thing to do post-discharge.

Figure 1 – Results Impact

St. Thomas Elgin General Hospital  
Readmission Ratio (actual and expected) & Percent of Discharge Summaries sent from Hospital to Primary Care within 48 hours



## Final reflection

Unfortunately, the partnership with the CCHC was not sustained as they were unable to keep up with the number of patients referred to them due to staffing issues. In the future, there might be a possibility for the general internists to follow up with some of the unattached patients post-discharge. Another possibility is to tap into the Primary Care Network which may be able to match unattached patients with family physicians in the community.

Reflecting on the process, the initiative could be greatly improved by initiating regular check-ins with family physicians to determine alternative methods for patient referrals and to have those at highest risk of readmission matched with a primary care provider.

## Advice and key elements for success

Communicate early and often. Have a face-to-face meeting at the initiation of your project to set goals and standards, and communicate updates frequently. It is important to know what the goals of your stakeholders are, and to check in when change ideas are initiated to see how it has affected them and if there is room for improvement.

The key drivers that made this project a success at STEGH was the support from the Executive Team who played a key role in incorporating this data into a monthly Board Scorecard, and weekly Leadership Scorecard which displayed the Key Performance Indicator on huddle boards throughout the organization.

## Contributing authors

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It was also fortunate to be able to try out the auto-authentication process prior to rolling it out. The ward clerks were already accustomed to booking post-discharge follow ups with specialists, but it had not been considered for family physicians.

Externally, having a primary care representative is important when the hospital is trying to implement changes. The idea of local Primary Care Networks is relatively new and many communities/Local Health Integration Networks do not have them, making it difficult for organizations to communicate with a group of primary care providers to get this kind of input and collaboration. This Network was unique in Elgin and helped facilitate this initiative.

# Closing the Gap with Transitions in Care

**In order to improve continuity of care, the FHT and the hospital explored opportunities to improve identification of FHT patients who were admitted to the hospital. Hospital Report Manager was introduced, which has made it easier to get information about patients' hospital visits.**

## Who was involved

OakMed Family Health Team (FHT) and the Oakville Trafalgar Memorial Hospital

## The challenge

The OakMed FHT physicians were facing a gap in patient information as patients moved through the health care system. They did not know when patients were admitted to the hospital, what happened during a patient's stay, or when patients were discharged, until the patients arrived sometime later to the FHT offices. Follow-up visits were lengthy as patients were tasked with explaining their complicated journeys and post-discharge plans. Patients were frustrated and overwhelmed, while this often left staff, physicians and patients struggling with time management challenges. At times, there would be repeat admissions to the hospital before an office follow-up was made. Other times, the FHT would not know that a patient had died until reaching out for a routine follow up or preventative care screening.

## The solution

In order to improve continuity of care, the FHT and the hospital explored opportunities to improve identification of FHT patients who were admitted to the hospital.

As a result, Hospital Report Manager was introduced, which has made it easier to get information about patients' hospital visits. This solution provides FHT nursing staff with log-in access to the local hospital. Every day, nursing staff retrieve patient lists, and liaise with the hospital when requested by the patient's family physician. This helps alert FHT physicians when a patient is admitted and for what reason. It also provides re-assurance to the FHT that patients seen at the FHT office who are sent home with test requisitions and a plan for office follow up, but who end up receiving care in the hospital, have not fallen through the cracks.

This strategy allows the FHT to share relevant information with the hospital that can aid in the care of the patient, and reduce unnecessary diagnostic tests or consults. Additionally, the FHT is also alerted when a patient is discharged from hospital, thus initiating a cascade of appropriate next steps.

Within 24 hours of hospital discharge, the FHT nurse calls the patient to ensure they are coping well at home, answers questions about medications, and asks for a summary of the hospital stay. The nurse also books a follow-up appointment for the following day or later in the week based on urgency.

## The impact

Statistics collected for the Association of Family Health Teams show that this FHT's readmission rates and emergency department visit rates are amongst the lowest of all FHTs in Ontario, with a less than 10% readmission rate within 30 days of discharge and over 90% of patients who follow up with their family physician within seven days of discharge.

Patients and family members also report worrying less knowing that their family provider who knows them well, is able to touch base, clarify follow-up instructions and medications, which can ultimately help to reduce medication errors and omissions. Connecting with the patient by phone right after discharge also allows the FHT to confirm that needed equipment as well as home and community services are in place. Likewise, the follow-up call provides another opportunity to assess for unanticipated needs from the hospital once the patient is home, such as needing a medication blister pack, or having medications or meals delivered to the home as the patient recovers.

The intervention was simple to implement. This medium-sized practice generates a small number of hospital discharges each day. Although the added workload for the nursing staff is marginal, the time saved on the follow-up visit for the physician and patient is substantial.

While the intent of the initiative was to ensure patient safety and facilitate timely follow-up visits with the family physician, it also fostered a culture of feedback and accountability between the FHT offices and the hospital. Becoming aware of patients who recently visited the FHT office whose out-patient management plan still resulted in a visit to the local hospital provides the FHT with an opportunity to reflect on the care strategies implemented and their appropriateness. The FHT's willingness to share information with the hospital on admitted patients, helped build trust between the FHT's physicians and the hospital-based physician group. These strengthened relationships have also facilitated warm handovers and touch-base points during the hospital stay.

## Final reflection

The project began informally within the FHT's internal office. However, proper engagement with the hospital at the onset of this project should have been done to ensure that the program included consistent warm handovers at both transition times, into and out of hospital, and assurance that the information was being received in a timely manner and by the appropriate people in the hospital.





Broadening this initiative to other groups, particularly solo or small group physician practices, will require full workflow mapping at the hospital and offices, defining quality standards and expectations at transition points, and confirming a fixed method of moving information in the absence of a universal electronic medical record. The improvement in patient and provider satisfaction, and reduced readmission rates support that a simple project can have meaningful impact, and conversations about how to spread this initiative need to be undertaken.

## Contributing author

**Dr. Mira Backo-Shannon**, Physician, OakMed Family Health Team

“ This project has improved transitions from hospital to follow-up at our office for both patients and the doctors. ”

- Family Physician

## Advice and key elements for success

- Recognize that hospital administration, hospital staff and physicians, and family physicians share the same goal. Though each group may play a different role in providing care to patients throughout their journey, collectively, they form a community of care providers responsible for providing high-quality care to their patients.
- Collaborative problem solving allows providers to think about the patient's full health care story, rather than just the particular "chapter" in which each provider plays a role. As such, the approach to care management plans becomes easier to see. Likewise, system failure points and gaps become much more visible, which creates a shared interest for all to contribute to system improvement that can enable better patient care and workflow.

# The BATON Initiative: Improving Discharge Planning

As part of the BATON initiative, a set of practice tools were developed based on examples from other jurisdictions, customized for northwestern Ontario.

## Who was involved

Sioux Lookout Meno-Ya-Win Health Centre and 12 rural hospitals across northwest Ontario

## The challenge

Rural hospitals, like all hospitals, face difficulties in ensuring that patients are discharged in a timely manner, that necessary follow-up with home care and primary care is arranged prior to discharge, and that patients are well-informed about how to manage their health in the community.

“ The BATON project was a great way to experience collaborative learning and improvement across our 13 organizations. We will use this model for future improvement initiatives and planning. I’m proud to share that the tools and processes implemented through BATON are still in place across the region and being used with much success. ”

— Jennifer Lawrance, Former Vice-President  
Quality & Support Services, Sioux Lookout Meno  
Ya Win Health Centre

## The solution

As part of the BATON (Better Admission Transitions in Ontario’s Northwest) initiative, a set of practice tools were developed based on examples from other jurisdictions, and were customized for northern Ontario. These included:

- A risk scoring tool to identify patients at risk for readmission;
- A detailed, written discharge plan for patients at high risk, including contact information, medication instructions, follow-up appointments, warning signs to watch for, home care services and special equipment; and
- An enhanced medication reconciliation form, detailing changes to drugs made in hospital.

Some hospitals adopted additional tools such as discharge checklists, and implemented additional policies including requiring an estimated date of discharge, discharge notes to be dictated within 24 hours, and a warm hand-off policy to ensure that the hospital physician and the receiving physician have a verbal conversation about high-risk patients prior to discharge. Some hospitals also worked with family practices to ensure patients are seen within one week of discharge.

Teams from participating hospitals met face-to-face four times and via teleconference every two weeks to monitor progress with implementation. Family physicians who work both in the community and in hospital reviewed the tools several times and provided feedback. The tools then underwent field-testing before being finalized.



## The impact

All rural hospitals in northwestern Ontario have co-designed and implemented a standard discharge planning template for patients and community providers. All are also using some form of risk assessment.

It was difficult to collect data on patient satisfaction with the discharge process. In the future, it may be helpful to consider incentives for ensuring that these quality monitoring activities take place on a continuous basis.

## Final reflection

Throughout this project, teams in northwestern Ontario took ideas and tools from elsewhere, such as checklists and standard discharge templates, and tested and customized them so that they would work best in a rural context vastly different from other settings like teaching hospitals. “Even though implementing these tools seems basic, making sure they get done consistently is much more challenging than one might think,” says Dr. Ben Chan, medical director for the BATON initiative. “Never underestimate the amount of engagement of health care providers and the level of practical support needed to make these tools stick.”

Ultimately, these best practices for discharge planning should become the standard of care. “Doing a thorough discharge plan takes a lot of time, and that can generate resistance among staff. But in the long term, the up-front investment of time will result in safer care and more efficient use of resources. Our patients expect nothing less.”

## Contributing author

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## Advice and key elements for success

- Obtain buy-in from senior leadership (i.e., CEO and Board).
- Ensure that middle management staff have dedicated a portion of their time to participate in regular quality improvement meetings.
- Engage physicians at the start.
- Encourage strong leadership around change management, to ensure buy-in.
- Test how tasks can be done in the most efficient manner using Plan-Do-Study-Act (PDSA) cycles. For this project, teams were able to figure out the most appropriate team member to complete the different parts of the discharge tools.
- Ensure that teams get adequate support. For example, a team struggling periodically with physician buy-in needed additional mentorship on ideas to increase acceptance of the tools. Often, a change in practice may result in some additional tasks added up front in order to prevent unnecessary work down the road.
- Bring together teams working on the same topic in different sites on a regular basis in order to spread ideas for change.





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