Fraser Northwest
Division of Family Practice
An FPSC initiative

SharedCare
Partners for Patients

EMERGENCY DEPARTMENT AND HOSPITAL IN-PATIENT DISCHARGE FOR COMMUNITY FOLLOW UP

Shared Care Project

Project Overview

Project Aim: Strengthen communication, collaboration and coordination for patients discharged from the hospital, through the development of the discharge referral program

Project Leads: Dr. Jennifer Yun (FP), Dr. Ali Okhowat (FP), Dr. Joseph Ip (Specialist Lead), Dr. Jerusha Millar (Specialist Lead)

Project Activities

April 2020 - March 2021 — The Virtual Assessment Clinic
1453 patients referred to clinic
170 providers referred

Oct 2020 — Acute Discharge: Town Hall
45 Family Physicians in Attendance

March 2021 — Transition to Urgent and Primary Care Clinic (UPCC)

July 2023 — Discharge Case Conference (Division & FHA Home Health)

CLINIC STATS

172 Referring acute care providers

121 Average referrals per month

5.5 days — Average wait time from referral to appointment

REFERRAL

Acute care providers and hospitalists may refer both attached and unattached patients to the Acute Discharge Program to ensure follow-up after discharge from hospital. *Referrals may also be made for the purpose of attachment to a primary care provider.*

BOOKING

Patients will be contacted by the clinic MOA to schedule an appointment for the follow-up period identified.

APPOINTMENT

Patients will be contacted virtually by a Fraser Northwest Virtual Care Hub physician at the time of their scheduled appointment to conduct their follow-up visit. If physical assessment is required, an in-person appointment will be scheduled.

ATTACHMENT

If requested, the patient will be added to the Attachment Hub Waitlist for attachment to a primary care provider.

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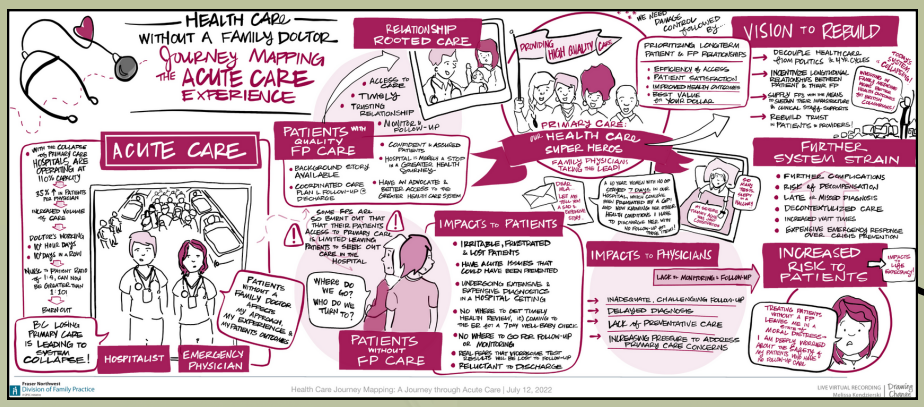
Project Activities: Overview



Journey Map - Acute Care Discharge Experience, July 2022

Click here for full resolution image for the Journey Map

Lessons Learned: What worked well?

Collaboration and shared goal/purpose among stakeholders, resulting in improved care coordination between acute care and the community

Data collection and analysis processes - results showed a 41% follow up rate and 24% of patients returned to the ED

Multiple channels to disseminate information on discharge follow up processes were established to increase awareness and utilization of service

Transitioning operations to FHA UPCC

Responsive to gaps in delivery of care resulting from Pandemic

Challenges & Gaps

- Ongoing collaboration to address gaps, communication + coordination of care
- Attachment to longitudinal primary care provider
- Patient compliance in follow up
- Avoiding multiple changes (i.e. referral form)
- Lack of established mechanisms to track referrals and share data with FHA data system

Next Steps

- Ensuring ongoing communication is established between acute care providers and PCP's to ensure longevity of services and to build trust
- Establishing continue engagement & information sharing with acute care providers
- Implementing discharge case conferences for families and PCP's
- Conducting ongoing analysis from "familiar faces"

Click here for the full Acute Discharge Shared Care report