Shared Care Final Project Report

Project Title	Acute Discharge Shared Care "Emergency Department and Hospital In-Patient Discharge for Community Follow Up" (SCC4544)
Physician leads	Dr. Jennifer Yun, Family Physician Lead Dr. Ali Okhowat, Family Physician Lead *(Apr. 2020 — Jan. 2021)* Dr. Joseph Ip, Emergency Medicine, Specialist Lead *(Apr. 2020 – Nov. 2022)* Dr. Jerusha Millar, Emergency Medicine, Specialist Lead (*Nov. 2022-Present)*
Project lead	Cindy Young
Date of Submission	August 28, 2023

EXECUTIVE SUMMARY

Background / Overview

The Fraser Northwest (FNW) Acute Discharge Shared Care project was initiated in April 2020 in response to the challenges posed by the COVID-19 pandemic. The project aimed to address the reduction of in-person primary care visits, leading to patients being discharged from hospitals without adequate follow-up care. Furthermore, with approximately 30% of patients being unattached to a primary care provider, there was a pressing need to strengthen the coordination and communication of care for discharged patients.

The project's central objective was to establish a Virtual Assessment Clinic that would serve as a referral follow up program for discharged patients from Eagle Ridge Hospital (ERH) and Royal Columbian Hospital (RCH). Patients without a primary care provider or those whose providers were unable to offer follow-up care could be referred to this clinic. The clinic would facilitate virtual telehealth assessments with a local family physician, with the option of in-person visits when necessary.

Project Outcomes

The implementation of the FNW Acute Discharge Shared Care project yielded several positive outcomes, benefiting patients, providers and the healthcare system.

Improved provider relationships	● Improved family physician and specialist satisfaction in knowing that patients received a timely follow up appointment with a primary care provider upon discharge ● Improved coordination of care among family physicians and acute care providers
Improved patient care	● Improved patient outcomes and experience after discharge ● Improved access to primary care and outpatient services
Effect on system costs	● Decrease in return ER visits for patients who received a follow up appointment at the Virtual Assessment Clinic after discharge

Conclusion

The FNW Acute Discharge Shared Care project successfully addressed the challenges posed by the COVID-19 pandemic in accessing primary care and coordinating discharge planning. Through the establishment of the Virtual Assessment Clinic, the project improved the coordination of patient care across health settings and strengthened communication and collaboration among healthcare professionals. The project's positive impact on the healthcare system reinforces the significance of sustained efforts in ensuring timely and quality follow-up care for discharged patients. The lessons

learned from this project will contribute to the continued improvement of patient outcomes and experience in the Fraser Northwest region and beyond.

INTRODUCTION

The Fraser Northwest Division of Family Practice (FNW DoFP) encompasses family physicians in New Westminster, Coquitlam, Port Coquitlam, Port Moody, Anmore and Belcarra representing the traditional catchment area of the Royal Columbian and Eagle Ridge Hospitals. Together, members and division staff work to improve patient access to local primary care, increase local physicians' influence on health care delivery and policy, and provide professional support for physicians.

During the COVID-19 pandemic, there was decreased access to primary care and a reduction of in-person visits. Patients were being discharged from the hospital earlier due to concerns of COVID-19 transmission. Family members were not able to be present during hospital discharge and patients required follow up on their care. It was unclear who coordinates discharge planning for patients in an acute setting and much of the process depended on sick patients who were in a vulnerable state. Additionally, we know that approximately 30% of patients are unattached to a primary care provider. To address this concern, the FNW Acute Discharge Shared Care committee was formed in April 2020 to develop a solution to ensure patients being discharged receive timely follow up care.

Problem Statement:	**Aim Statement:**
Difficulty accessing primary care for patients due to the COVID-19 crisis resulting in patients being discharged from the hospital with no follow up plan.	This project centers around strengthening communication, collaboration and coordination of care for patients discharged from the hospital, including the development and sustainment of the discharge referral program.

With the rise of telemedicine, it was deemed that a Virtual Assessment Clinic was the solution. The FNW Division of Family Practice worked with several local primary care providers, emergency medicine physicians, hospitalists, midwives, maternity, and home health to develop this clinic.

PROJECT OBJECTIVES

The objectives of the FNW Acute Discharge Shared Care project were to:

1. Pilot a discharge follow up clinic run by local family physicians to ensure patients referred to the program will have access to virtual care appointments for timely follow up care.
2. Ensure all discharged patients from ERH and RCH who require follow up are referred to the clinic to receive a virtual assessment by a family physician within the specified timeframe of the referring provider.
3. Coordinate a process for unattached patients who are referred to this program to be attached to a longitudinal primary care provider.
4. Weekly and monthly referral data tracking to evaluate and monitor impact of the discharge clinic

5. Develop the hospital discharge clinic into a sustainable program and look for partnership for sustainment and continuation of operations once the project and/or pandemic is over.

TARGET POPULATION

The target population for this project includes primary care providers, hospitalists, emergency medicine physicians, internal medicine physicians and patients being discharged from the Royal Columbian Hospital (RCH) and Eagle Ridge Hospital (ERH) in the Fraser Northwest community, which includes New Westminster, Port Moody, Coquitlam, Port Coquitlam, Anmore and Belcarra.

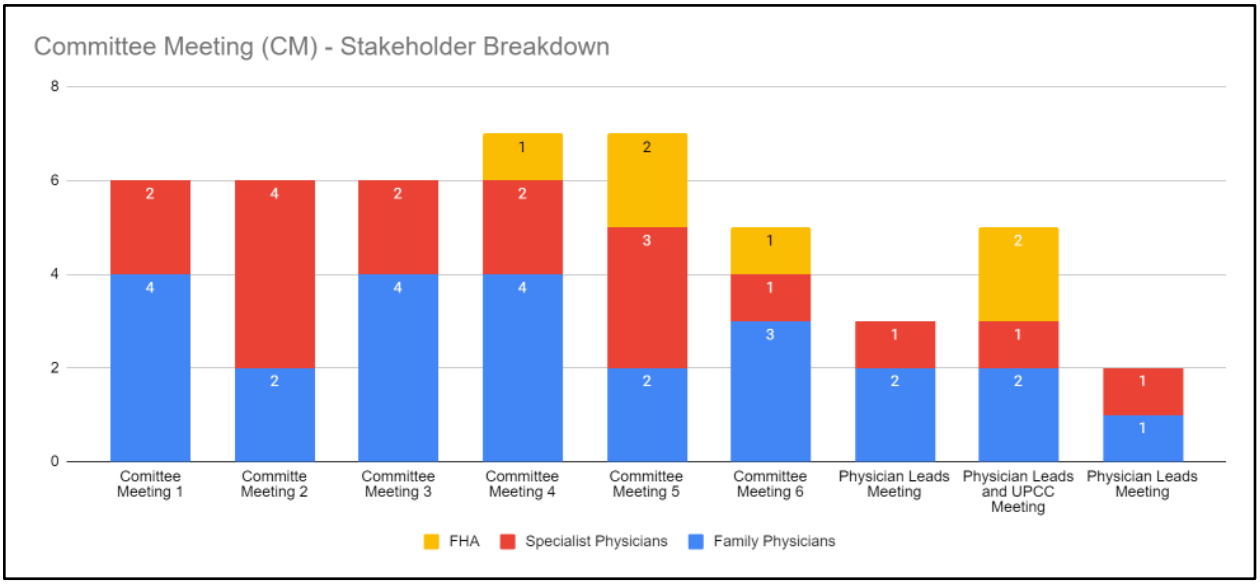
ENGAGEMENT STRATEGY

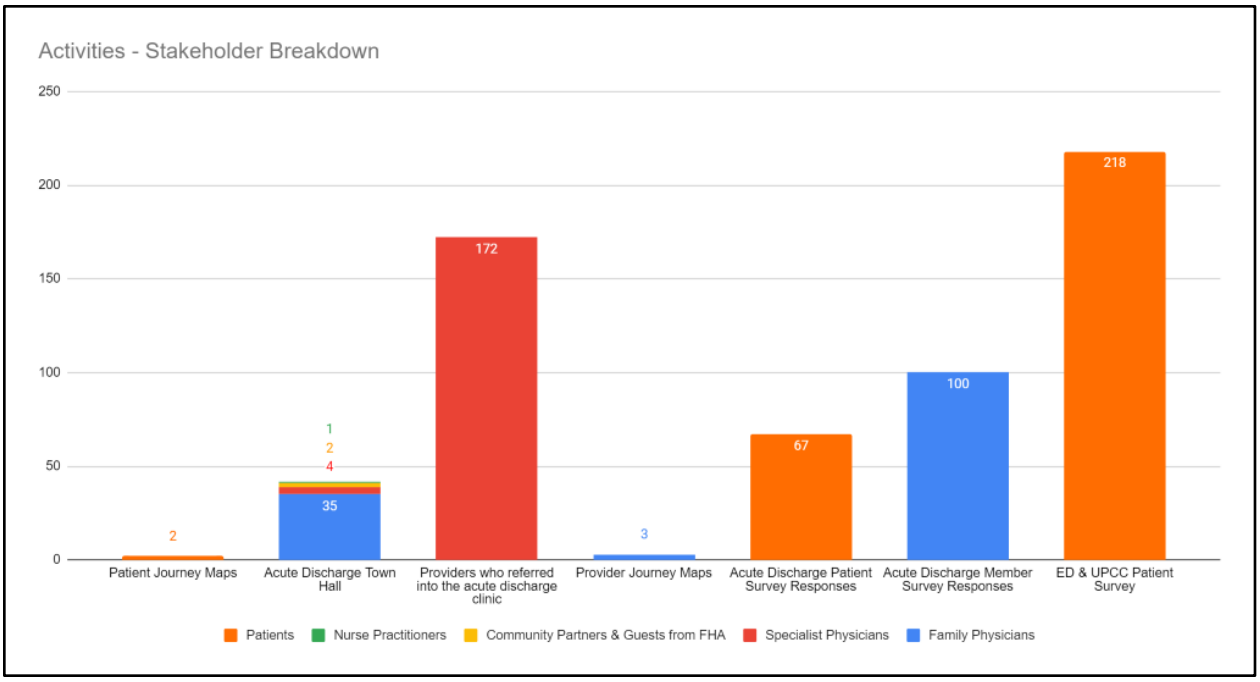
Physicians that showed interest in participating and driving this project were selected to participate as stakeholders to contribute to the planning and implementation of the project. Additional non-physician stakeholder partnerships were identified to be crucial in supporting the collection and analysis of data and for continued project sustainability and spread.

Name	Role	Primary Practice Location
Physician Engagements		
Dr. Ali Okhowat	Family Physician Lead (Apr. 2020 — Jan. 2021)	Coquitlam
Dr. Jennifer Yun	Hospitalist, Family Physician Lead	Coquitlam
Dr. Joseph Ip	Specialist Lead, (Apr. 2020 – Nov. 2022)	New Westminster
Dr. Jerusha Millar	Specialist Lead (Aug. 2022 - Present)	New Westminster
Dr. Vincent Wong	Family Physician	Fraser Northwest
Dr. Mahsa Mackie	Family Physician	Port Moody
Dr. Doug Brown	Emergency Medicine Physician	New Westminster
Dr. Jonathan Braunstein	Emergency Medicine Physician	New Westminster
Dr. Carllin Man	Family Physician	Burnaby
Dr. Ali Abdalvand	Emergency Medicine Physician	New Westminster
Dr. Nimeera Kassam	Family Physician	Port Moody
Dr. Amelia Nuhn	Hospitalist, Family Physician	New Westminster
Dr. Josh Koczerginski	Emergency Medicine Physician	New Westminster

Dr. Josee Poulin	Hospitalist, Family Physician	New Westminster
Dr. Meghan Ho	Internal Medicine Physician	New Westminster
Dr. Cori Gabana	Internal Medicine Physician	New Westminster
Non-Physician Engagements		
Vesna Ivkov	Research Assistant	Fraser Health Authority (FHA)
Ross Howell	UPCC Clinical Operations Manager	FHA
Sanda Dreischner	Director of Clinical Operations Primary Care	FHA
Scott Brolin	Executive Director Community & Eagle Ridge Hospital	FHA

A breakdown of the stakeholder engagement and involvement in committee meetings and project activities are graphed below. The committee meetings were integral in providing a collaborative space for family physicians, hospitalists, emergency medicine physicians and internal medicine physicians to work on the planning of the discharge follow up processes. Together, the group identified challenges and opportunities to increase efficiencies in workflows, brainstormed strategies to increase follow up rate and awareness of the program and analyzed all levels of data of patients referred to this program to monitor the effectiveness of the clinic. Throughout the project's duration, a total of 6 committee meetings and 3 physician lead meetings were held.





DATA COLLECTION ACTIVITIES

The evaluation approach was conducted through a mixed-methods design (i.e. collection of both qualitative and quantitative data). Quantitative data was collected from FHA analytic data and program administrative records. Qualitative data was collected from surveys and interviews with physicians, specialists, stakeholders, patients, and program administrators. The data collected has a developmental lens that focuses on continuous quality improvement and links back to the overall Shared Care goals.

RESULTS / DATA MATRIX

The purpose of this evaluation was to align and support the overall Shared Care goal which is to provide coordinated, continuous and comprehensive patient care in a way that fits the local context and community needs specific to the FNW. The evaluation objectives and questions link directly back to the overall FNW project aim statement. Implementing evaluation measures throughout this initiative supports real-time data collection and clear identification of when progress markers have been attained or when adjustments need to be made to existing measures. The evaluation program's main purpose is to support the cyclical quality improvement processes focusing on the PDSA cycle which supports the implementation, identifies opportunities for improvement, and allows for ongoing feedback between and amongst PCN stakeholders.

The work of this project and its subsequent evaluation are to focus and improve the following key attributes:

- Shared Care project goals
- PMH Attributes
- PCN Attributes

- Quadruple Aim

The evaluation has two main objectives and their subsequent evaluation questions below:

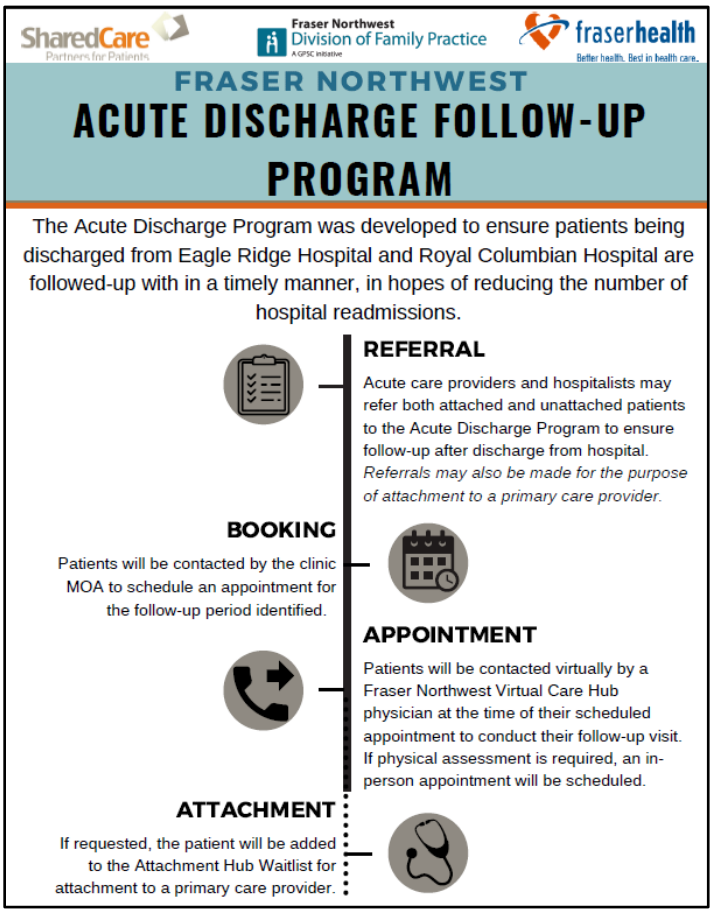
1. **To evaluate the effectiveness of the Acute Discharge Shared Care Initiative in the Fraser Northwest community**
    a. To what extent does the program contribute to increased communication flow among family physicians and acute care physicians?
    b. To what extent does the program contribute to improved patient care?
    c. To what extent did the program contribute to a change in health care utilization and what effect did it have on system costs?
2. **To identify areas for quality improvement and document lessons learned**
    a. What were the unanticipated outcomes of the proposed strategies?

PROJECT ACTIVITIES & DELIVERABLES

The Discharge Follow Up Process:

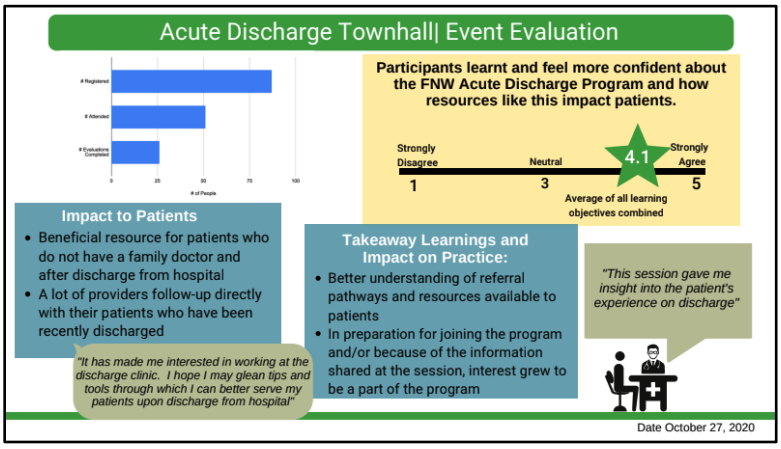
The FNW Acute Discharge Shared Care project was able to quickly address the decrease in follow up care in the community during the pandemic for patients being discharged from ERH and RCH. The Virtual Assessment Clinic was piloted in April 2020 and continued on until March 2021. Acute care providers could make a referral to the Virtual Assessment Clinic for patients who did not have a primary care provider or their provider was unable to provide follow-up upon discharge from the hospital. Patients were connected with a physician at the clinic for virtual telehealth assessments, with the option of an in person visit if necessary.

The referral form (see appendix 1) was disseminated and shared with the acute care providers. With the assistance of committee members and FHA partners, multiple communication and promotion mechanisms were utilized to increase awareness and usage of the clinic. Posters and a referral contest were promoted at ERH and RCH to further increase engagement and outreach.



Referrals were tracked on an ongoing basis and the information from the referrals were analyzed on a monthly basis. The clinic received an average of 121 referrals a month, with 172 unique acute care providers referring to the program. The average wait time from referral to an appointment was 5.5 days. For more information, please see the evaluation framework and data matrix section below.

To ensure primary care providers were kept in the loop, a Town Hall event on October 27, 2020 (see appendix 2) was hosted virtually to provide an overview of the program, the process and next steps for sustainability. Initial data around referral volumes and the impact of the pilot was also shared with primary care providers. Additionally, an overview of the patient experience and journey accessing the clinic was also shared. Nearly 60 community family physicians registered with approximately 45 in attendance. The visual below provides a snapshot overview of the feedback collected at this event.



The Transition

The clinic continued until March 2021, where the operations were transferred to the Urgent and Primary Care Centre (UPCC) in Port Moody for continuation and sustainability. Throughout this transition, the UPCC provided the committee with quarterly updates around what's working well for them and what are their challenges. Some challenges noted were lack of human resources, staff turnover, incorrect or lack of information on referral forms and capacity to attach patients. The UPCC continues to receive referrals from acute providers to follow up with discharged unattached patients. The referral form has been adopted regionally across FHA and is currently available on Form Fast or on Pathways here.

Other Opportunities

After the transition of the discharge follow up process, challenges and opportunities around communication and improving transitions between acute and community were identified. Based on primary care provider feedback, there was a need to ensure that primary care providers are aware of what referrals and recommendations were made for the patient upon discharge to prevent duplication

of work, decrease inefficiencies in the referral processes, and provide coordinated care and support for the patient.

The division, with input from a family physician, worked with the FHA SLP (Speech-Language Pathology) team to clear up restrictions around sharing of inpatient reports with primary care providers. The division also advocated to reduce the burden of requiring community primary care providers to sign off on orders and referrals for SLP assessments originally started in the hospital to increase efficiencies in the referral process.

Additionally, the division worked with the FHA Home Health team to pilot a discharge case conference between a hospitalist, family physician, caregiver and the Community Health Nurse that is attached to the patient and family physician. The caregiver and provider journey maps are shared in the evaluation section of this report. The group also worked on a process to book an appointment with the patients primary care provider before discharge to ensure timely follow up. Please see the evaluation section below for more details.

LESSONS LEARNED

What worked well?	Challenges and Gaps
Collaboration among stakeholders - family physicians, acute care providers, the division and health authority had a shared goal and purpose	Continued collaboration among community primary care providers and acute care providers to address gaps, improve communication and improve transitions and coordination of care.
Being quick to respond to the gaps from the pandemic. Establishing the Virtual Assessment Clinic with the help of local family physicians and doing PDSA cycles with providers involved which provided relief for the emergency department knowing that patients would receive appropriate timely follow-up care.	Attachment to a longitudinal primary care provider was an initial goal voiced by the physicians but this was not feasible due to the ongoing primary care crisis in limited provider capacity.
Various communication and promotion mechanisms to share information about the discharge follow up process were tried to increase awareness and utilization of the service.	Patient compliance in follow up - one of the main reasons for loss of follow up was having the incorrect phone number or patients not answering their phones. A suggestion was to collect patient emails to improve response rate.
Transitioning the operations and the discharge follow up process to the FHA UPCC partners for sustainment. The project highlighted the importance of follow up for discharge unattached patients even after the COVID-19 pandemic is over, as this issue has been an ongoing problem in the community. The referral form has been	Avoid making too many changes to the process (such as changes to the referral form) as physicians are inundated with many changes on a daily basis. If possible, physicians recommended designating someone like a unit clerk or manager to keep track and stay informed of changes and

integrated into the FHA Form Fast system and the discharge follow up process is now adopted regionally across all UPCCs in FHA.

Ongoing data collection and analysis to evaluate usage and impact of the pilot clinic.

be the one communicating information to the appropriate parties.

After the transition, there was a lack of established mechanism to track referrals and share data with the FHA data system. To keep referring providers informed, a recommendation from physicians was to explore ways to report back to referring providers with a high level overview of how many patients were referred or helped so they have the confidence and reassurance to know their patients have been helped. Improved connections and communication across the FHA services is needed (UPCC to hospital).

NEXT STEPS

Through the leadership of local healthcare providers and stakeholders, a creative and innovative solution to pilot a Virtual Assessment Clinic was possible. By starting the process at a local level and refining the implementation, it became clear that there was a demand to sustain this process at a higher level. During this collaborative process, the local FHA UPCC team committed to sustaining the operations of this process for unattached patients.

Physician leads of the project emphasized that consistent reminders and the service's longevity are important in establishing trust and encouraging more utilization of services. Given the complexities of the healthcare system, continued engagement and information sharing opportunities with acute care providers is needed to spread awareness about this service further, especially for those who may have forgotten about this process and for new providers who join the community. By ensuring these strategies are top of mind for healthcare providers and leadership teams, the efforts started from this project can reach more patients across the region and improve their access to timely follow up care and coordination of care across care settings.

Additionally, other opportunities worth exploring more include the discharge case conferences to ensure families and their primary care provider are aware of the care plan. Also, more analysis is needed to look into what solutions and supports are available for patients who frequently present to the ER, also known as “familiar faces”, as they may not have primary care providers and face socioeconomic barriers. Through this project, the division has identified the priority and commitment to continue working with FHA partners and stakeholders to ensure that there is improved coordination of care for patients discharged from the hospital to the community setting. Further work on improving communication between acute care providers and community primary care providers is also needed to prevent gaps in care.

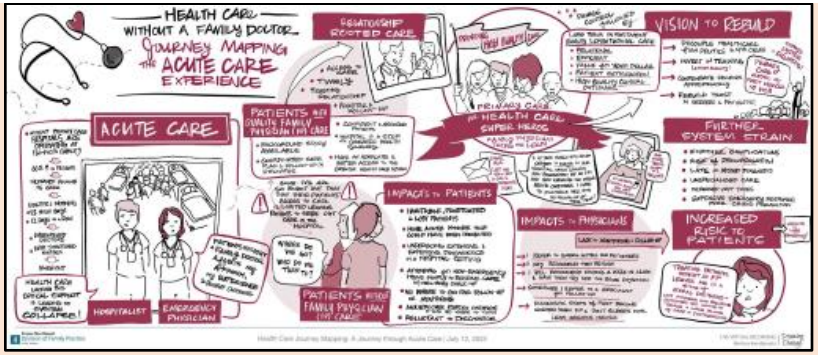
EVALUATION FRAMEWORK & DATA MATRIX

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
Provider Experience: To what extent does the program contribute to increased communication flow among family physicians and acute care providers?	Improved family physician and specialist satisfaction in knowing that patients received a timely follow up appointment upon discharge Improved coordination of care among family physicians and acute care providers	Program documentation Family physician satisfaction survey Specialists satisfaction survey FHA ER data	As mentioned above, this project was developed to ensure patients being discharged from Eagle Ridge Hospital and Royal Columbian Hospital are followed-up within a timely manner, in hopes of reducing the number of hospital readmissions and repeat emergency room visits. A total of 172 acute care providers made one or more referral to the Virtual Assessment Clinic for follow up. Anecdotal feedback from a provider who made a referral to this program said, *"The program is so great and I want to encourage others to keep doing it. I can't explain how much better my life is telling patients someone will call to follow up with you for this complicated issue compared to the old days of saying well good luck finding a GP or a walk in clinic."* Initial program impacts around re-referral rate will be further examined in the following sections. Additionally, understanding the complexities of the provider experience can typically be best understood through story telling. In Fall 2022, two stories were shared by a family physician and a Hospitalist detailing the understanding of a patient's journey through the acute system and into the community upon discharge. These stories were interconnected and woven together through a combined journey maps that identified the journey in the acute system and the second image notes the journey upon discharge into the community.

(See appendix 3)

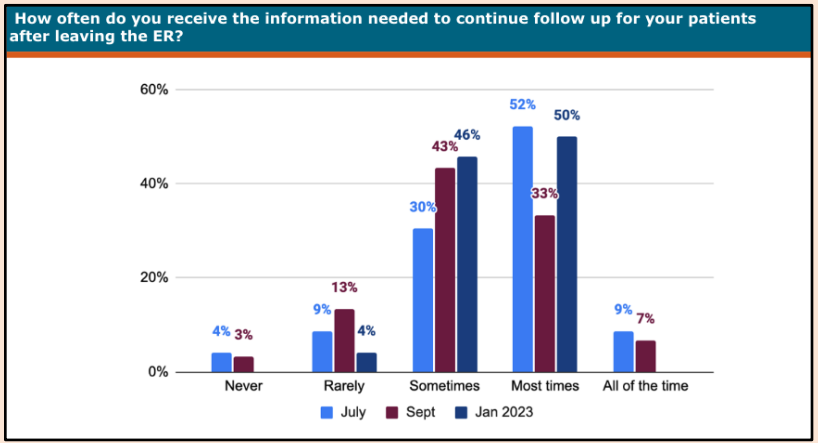
(see appendix 4)

The impact for patients who are unattached and do not have a regular primary care provider also poses significant risks and impacts upon the acute system. In summer 2022, a local Hospitalist and Emergency Room physician spoke around the impacts within acute care when patients require support and do not have a primary care provider:



(see appendix 5)

Opportunities continue to exist within the transitions in care between acute and into community. Division member feedback provided through member surveys (July 2022, September 2022, January 2023) identified continued opportunity for further support around discharges and coordinated follow up care between acute and community providers:



How can this process be improved?

Themed Responses:

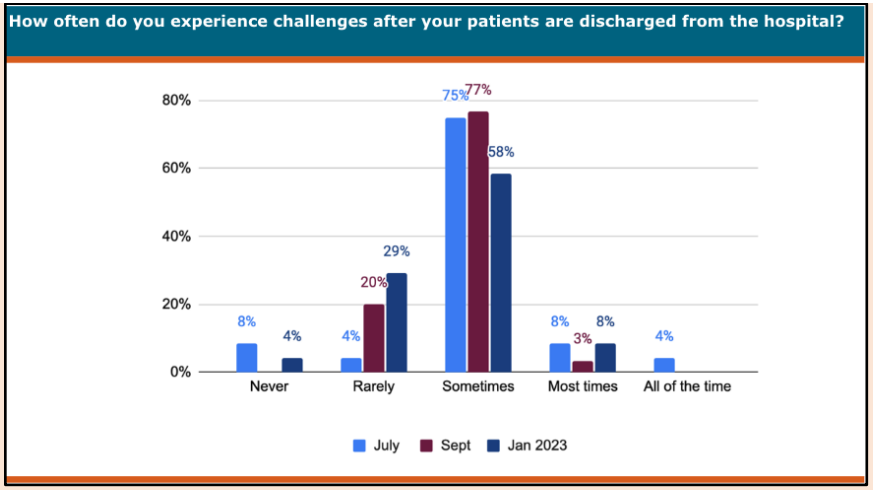
- **Clear communication on referred services** and tests including who is responsible for follow up, contact numbers to book appointments with specialists (sent to **both FP** and **patient** as some are **unattached**)
  - Would be nice if hospital completed the follow up on the referrals they initiated - many report these **referrals are lost/not received** when inquiring with the referred specialist office
- **Dictated reports** (many are illegible)
- Receiving **timely** and **legible** intake sheets
  - Stop sending **multiple** duplicate notices
  - Ensure **correct MRP** is included (including NPs)
- Download ER notes into the EMR automatically
- Ensure patient is told to **follow up with MRP**

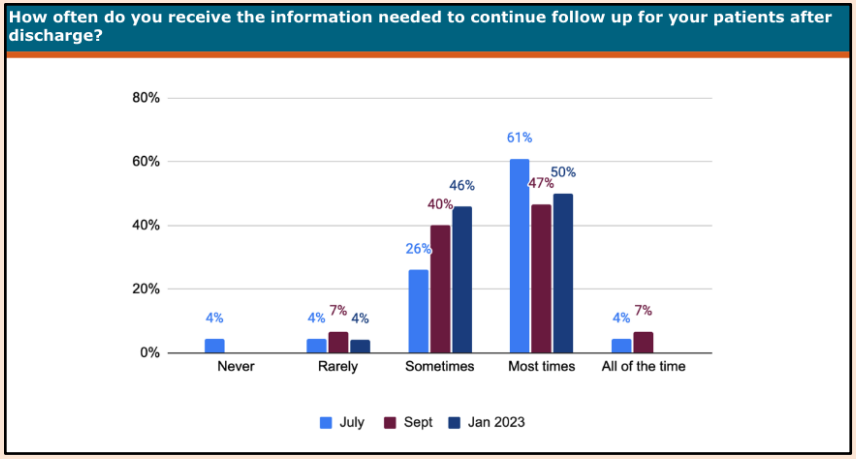
*"For referrals by ER physicians to be received by the specialist's office quickly. I had a patient waiting 20 days for an **urgent referral** to a specialist (initiated by the ER physician), only for us to find out that the specialist **never received the referral**."*

*"Each ER visit creates far **too many electronic message** to EMR.*

1. *Triage notification*
2. *ER admission notification*
3. *scanned ER clinical record (handwritten). Sometimes this is blank, directing to...*
4. *... sometimes electronic ER physician report*
5. *Discharge notification (sometimes twice)"*

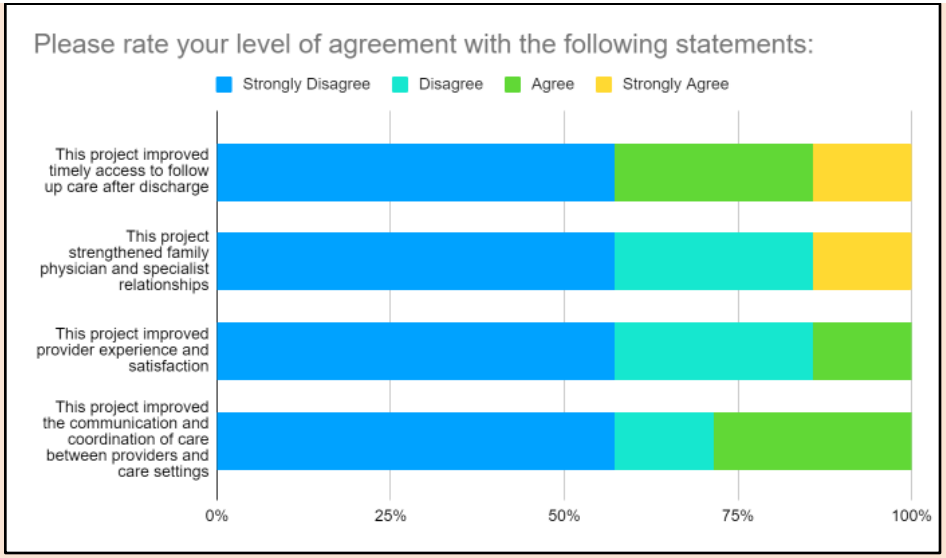
*"Clear **communication** with pt for **referred services** and recommendations including **contact numbers** for booking appt with specialists"*





The above graph does indicate a positive trend towards communication of follow up care once primary care providers' patients have been discharged from the acute system. Feedback from these providers indicated the following opportunities for improvement in future:

			1. **Phone call** to MRP about **high priority items** would be appreciated 2. Clear discharge summary sent in a **timely manner** 3. Ensure that **referrals and appointments are successfully followed** through or made in the ER When providers were asked around factors that may impede on their ability to follow up with their patients upon discharge, the following themes were identified: 1. Lack of capacity 2. Delayed notices from the hospital, lack of communication with family doctor *"From hospital, there is often a lack of ability to communicate with family doctors. Often calls are not returned from the hospital. Lack of availability of offices on Fridays and weekends."* 3. Sometimes patients are not able to come in to the office or don't want to follow up 4. Improperly identified MRP in hospital records Committee members provided feedback at the close of this project regarding the identified project objectives:

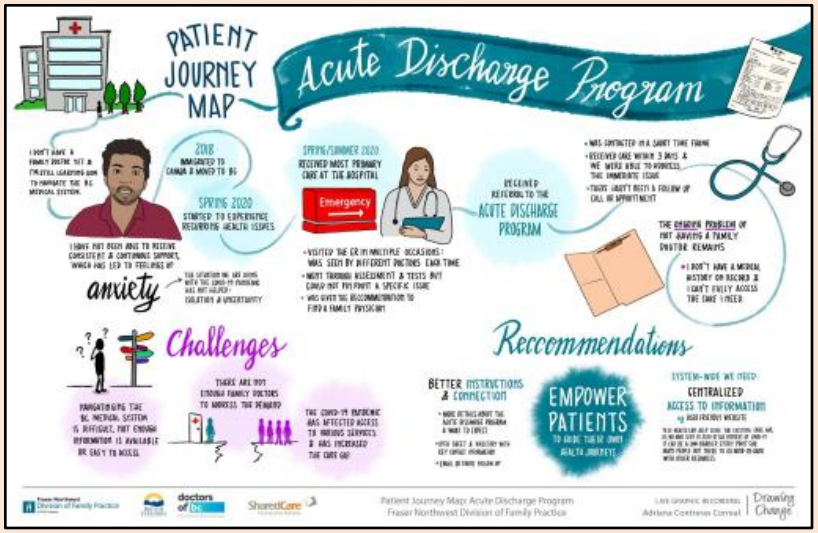


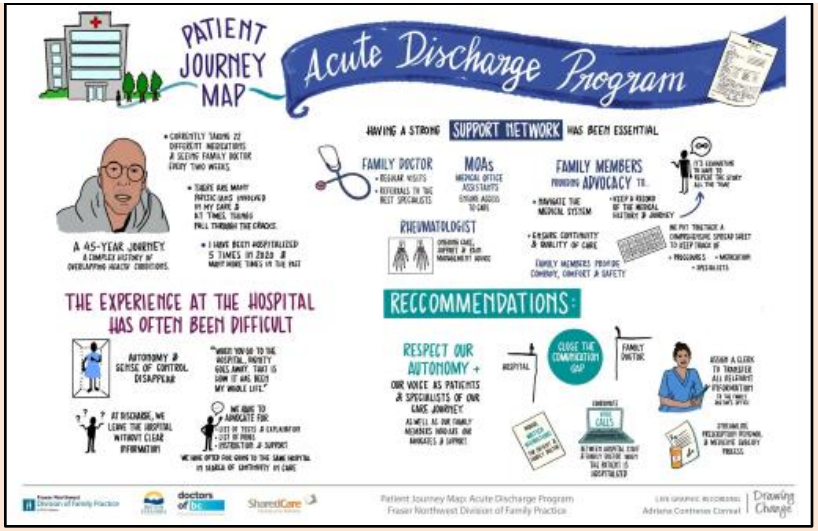
(see appendix 6 for breakdown)

When asked around whether the project met it's identified objectives, one physician noted that *"the idea was great but the implementation was quite variable"*

Another comment by a physician noted that the successes of this project *"allowed us to pursue and operationalize the ideal of having discharged patients seen."*

Beyond this project close date, there continues to be opportunities that exist in supporting the coordination and collaboration of care between the acute and community providers and teams.

Patient Experience: To what extent does the program contribute to improved patient care?	Improved access to primary care and outpatient services Improved patient outcomes and experience after discharge Increase in patient attachment	Patient satisfaction surveys FHA ER data Program documentation	Similarly in understanding the provider experience, understanding the patient experience can be best articulated through story telling. One patient shared their experiences accessing the project's discharge follow up process through the Virtual Assessment Clinic after being discharged from the hospital as an unattached patient. They also noted the complexities and challenges of navigating the acute system without a family doctor:  (see appendix 7) A second story was shared by a patient who has spent over 45 years navigating the healthcare system and has developed a strong network of support by multiple physicians. This experience details the importance of a cohesive and coordination team of providers wrapping around and supporting patients as they navigate their healthcare journey regardless of whether it's in acute or the community.

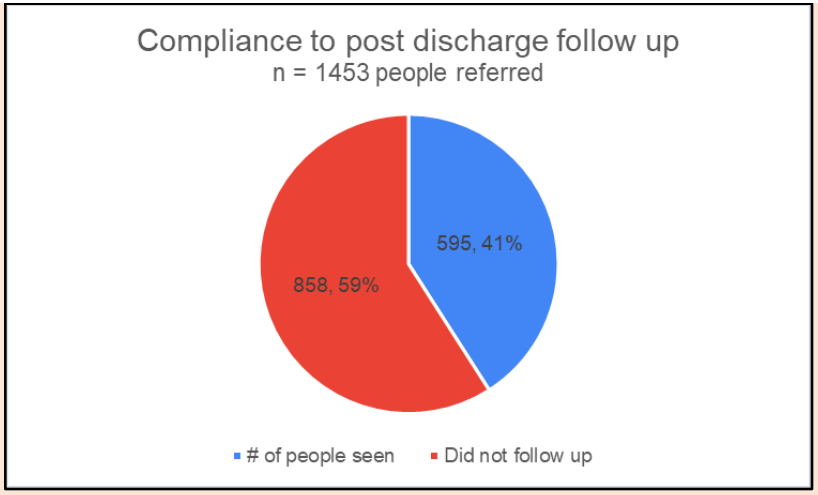


(see appendix 8)

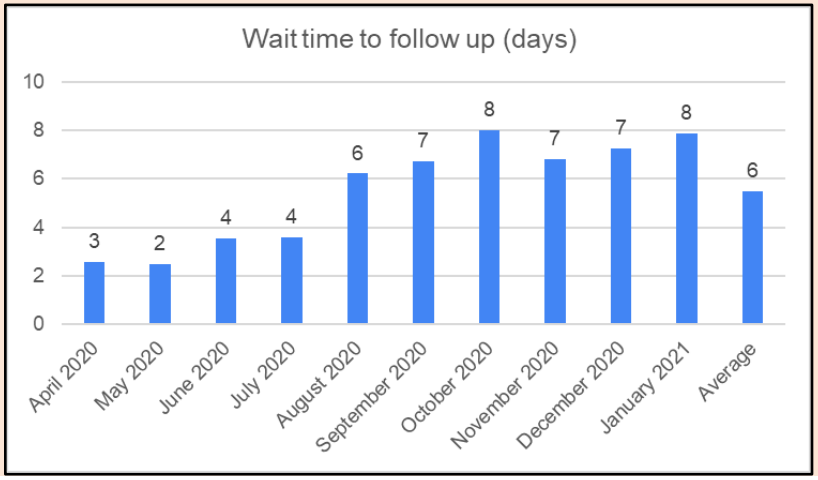
Through 2020 and early 2021, collaborative work between the local hospital emergency departments and the FNW Virtual Assessment clinic was done to analyze the referrals received:

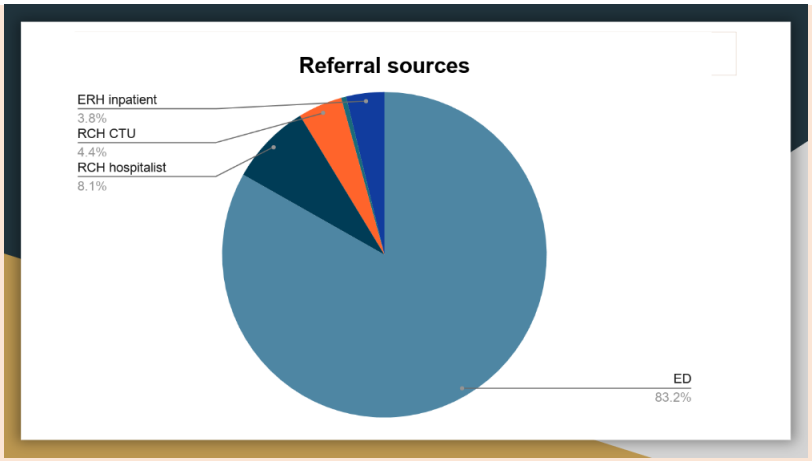
- April 1, 2020 to March 15, 2021
- Patients were referred from Emergency Departments and Inpatient units (hospitalist, CTU, Cardiology) at RCH and ERH
- The Virtual Assessment Clinic provided follow up to patients referred from both hospitals

Out of 1453 patients that were referred to the FNW Assessment Clinic, the follow up rate was 41%



Upon discharge from the acute sites, patients had to wait for follow up at an average of 5.5 days across 10 months:



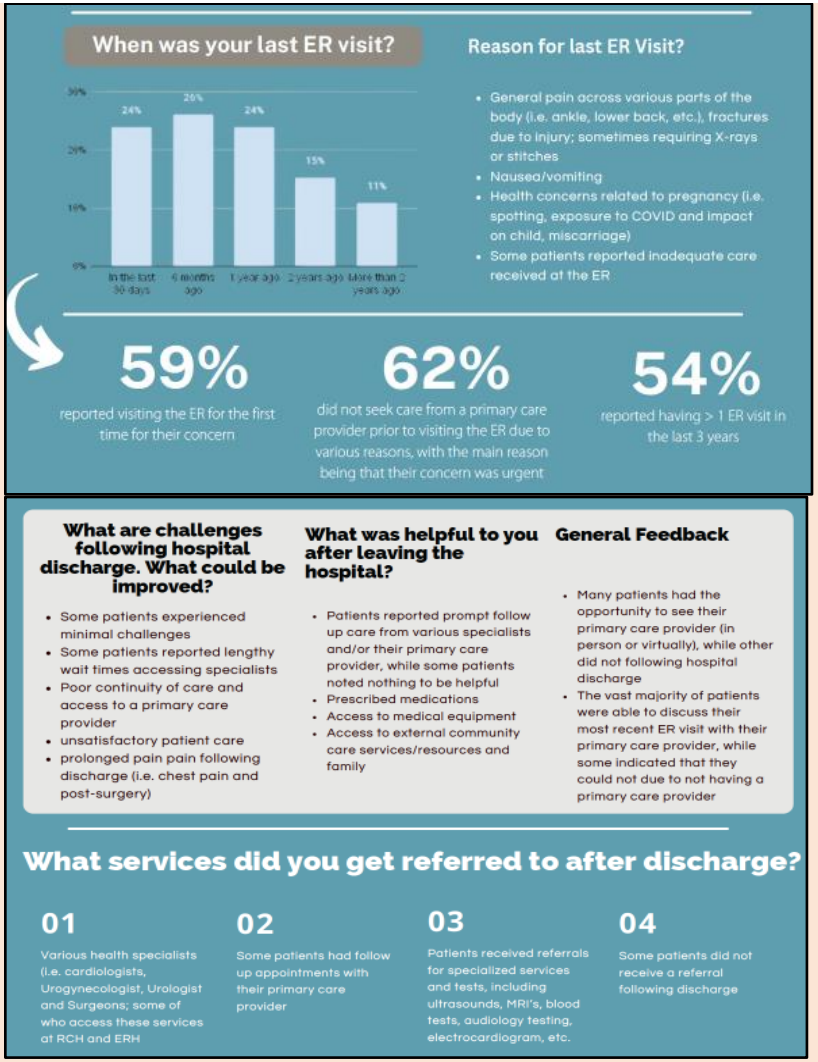


The referral sources noted above indicate the importance of having timely follow up care available for providers and staff working within the emergency departments. Additional analysis around the readmission rates into acute are reviewed in the following sections.

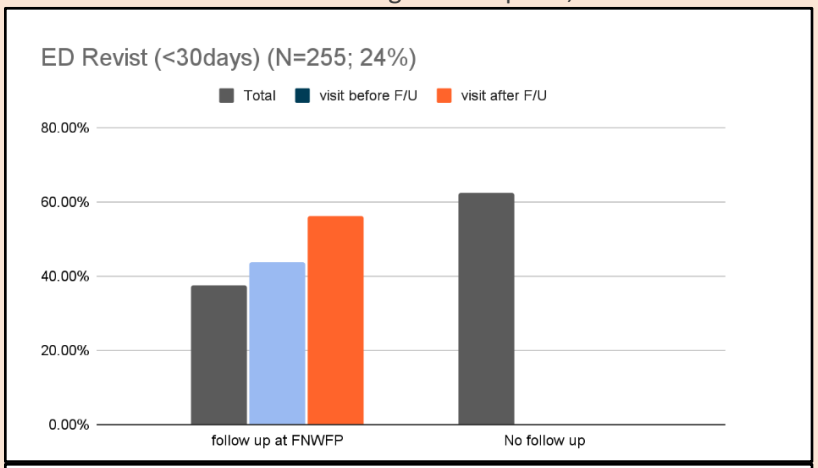
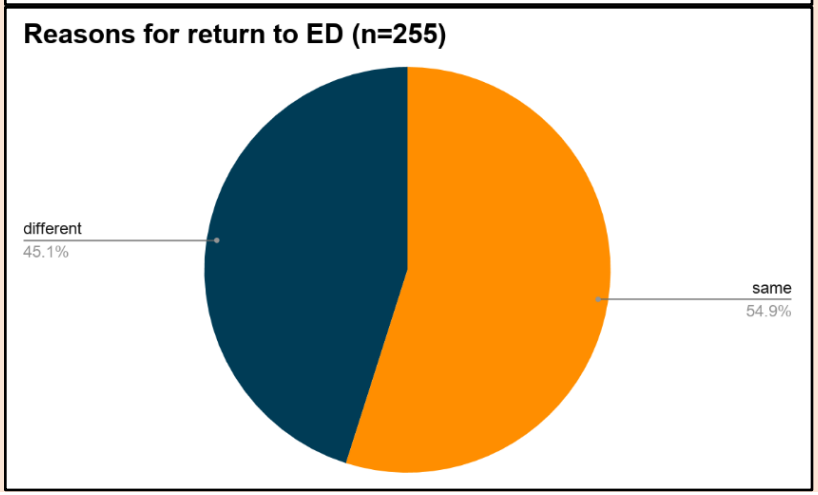
Another outcome of the project was to increase attachment to primary care providers. Unattached patients were added to the waitlist to find a primary care provider, however, due to the limited capacity of providers at that time, only 23 patients were attached.

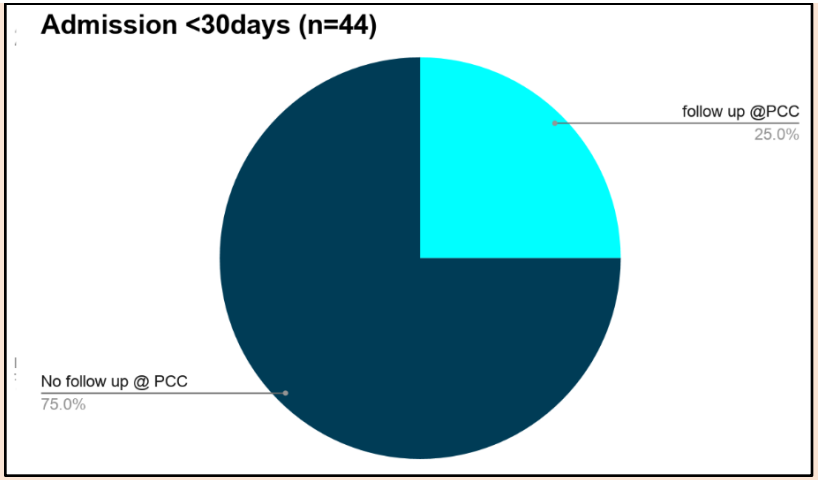
In Summer 2022, a patient survey was launched to better understand the health care experiences of patients who visit the emergency room and the transition between acute and primary care in the FNW. Patients provided feedback around challenges, success and what services patients were referred to after discharge.

The snapshots below provides an overview of the feedback collected from respondents in Fall 2022. A total of 67 people responded to the survey.



(see appendix 9)

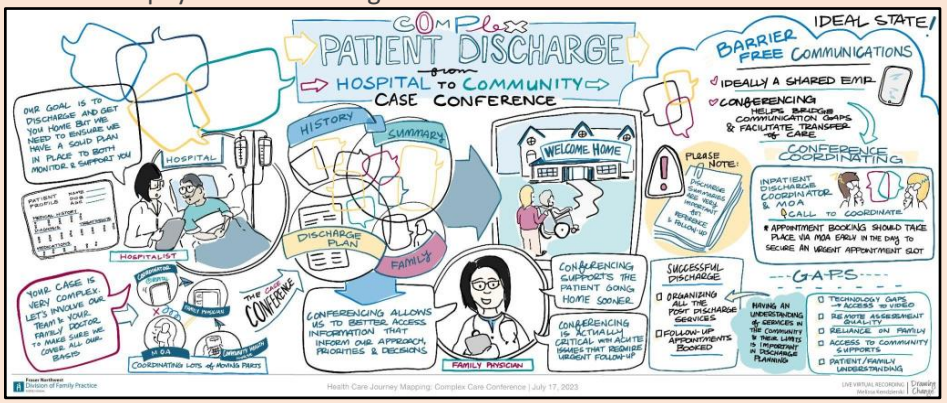
Health Outcomes: To what extent did the program contribute to a change in health care utilization and what effect did it have on system costs?	Decrease in return ER visits for patients	Program data FHA ER data Patient survey and/or interview	The following visuals reflect the analysis completed with regards to ED readmissions after initial discharge from April 1, 2020 to December 31, 2020.  

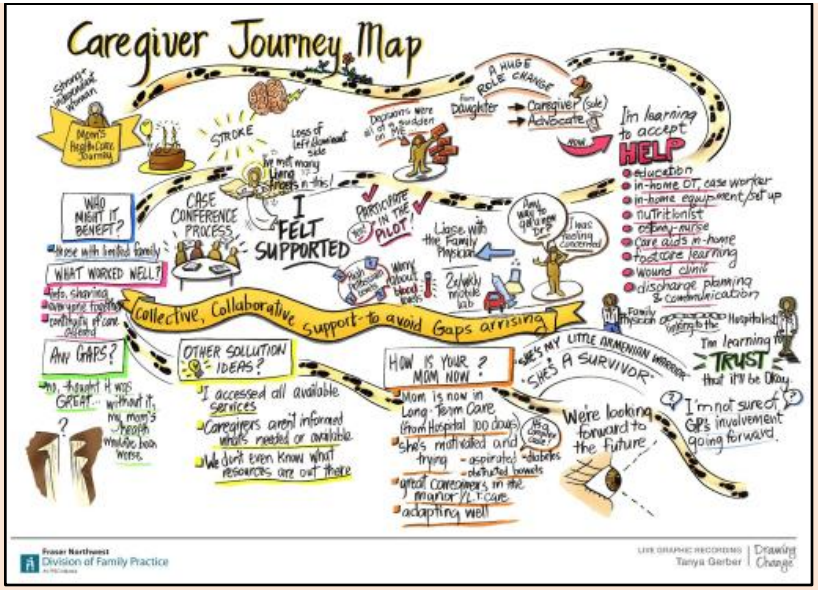


Synopsis (N=1059)

- 41.3% (n=437) of referred patients followed up at FNWFP
- Majority (83%) of referrals were initiated in ED At RCH and ERH
- Approximately 2.8% of those referred were positive
  - 20% of those screened were positive
- 17.5% of referred patients are attached to a family doctor; 82.5% did not have a family doctor
  - Of those who are not attached to a family doctor, 53% followed up with FNWFP and 47% did not follow up
- 24% (n=255) of referred patients returned to ED within 30 days after discharge from ED/ inpatient units
  - 38% (96/255) of those returned to ED had follow up visit at FNWFP
  - 62% (159/255) of those returned to ED did not have follow up arrangement at FMWFP
  - Average # of return ED visits = 1.6 visits
  - 55% (140/255) returned with same reasons/ complaints
- 17% (44/255) of those who had repeat ED visits require admission
  - 25% of those admitted had follow up at FNWFP
  - 75% of those admitted did not have follow up at FNWFP
- 7/1059 (0.66%) died within 30 days after discharge from ED/ inpatient units

This data report does indicate a decrease in return ED visits for patients who have proactive follow up care within the community compared to those who

			did not receive follow up care. Further opportunities can be explored to continue to support these transitions in care between acute and primary care.
Sustainability and Spread: What were the unanticipated outcomes of the proposed strategies?	Improved family physician and specialist satisfaction Sustainability of the program	Program documentation Survey/ interview feedback (patient, family physician, specialist)	The sustainability of a key aspect of this project was built into the discharge follow up process from acute sites within the communities to ensure follow up care for unattached patients is accessible and coordinated with the UPCC. An additional key aspect of the project that indicates sustainability is the increased relationship building and opportunities for immediate identification, discussion and implementation of solutions when challenges or opportunities for improvement arise. Two key examples reflecting this include: 1. Piloting a discharge case conference process between the Hospitalist, family physician, patient and caregiver to ensure a coordinated follow up plan was established before the patient left the hospital. A provider and patient journey map were conducted with the physician and caregiver and have been included below:  (see appendix 10)



(see appendix 11)

2. Working with the Speech and Language Pathology team around inefficiencies in acute care assessments and to identify solutions for reducing the burden on community primary care providers to sign off on follow up assessments where these assessments have arisen within the acute site.

2 physicians part of the committee noted a gap in this project did exist with regards to patient engagement and a suggestion for future projects requiring better *"planning and follow-up measures available before implementation. I feel that this may have relieved the acute setting but simply left it to the community for follow-up. Many times there are patient barriers/attitudes towards longitudinal care that is a barrier for community-based access rather than simply the availability of resources."*

			As part of the close out activities for this project, the Division team conducted close out interviews with the physician leads and were asked about successes, challenges, remaining gaps, and proudest moments. Focusing in this section specifically around the successes and remaining gaps, feedback noted: **Successes:** ● *"The success that anyone was referred to and how fast anyone was seen. Patients fell through the cracks mostly because of wrong contact info. This project was efficient with the amount of people seen and the timeline seen."* ● *"This was a relief for the emergency department, knowing patients would be followed up with."* ● *"It highlighted how important it is that when we discharge patients, how important this process really is due to the fact that there are so many unattached patients in BC."* ● *"Connection between physicians in the community and emergency physicians was a highlight for this project in providing a continuation of care."* ● *"Difficult to get physician funding but having COVID allowed this clinic to be operational, it was amazing and remarkable."* ● *"Sustainability moving to UPCC has gone FH wide - a process from anywhere (whether people use it or not) where any unattached patient who needs follow up."* **Remaining Gaps** ● *"Glaring gap is getting people attached. We were not very successful in this. It would be nice if I can improve how patients get attached."* ● *"Best way to communicate with physicians about changes and referral processes- doctors are emailed and info's out. Probably someone like a unit clerk is the best person. So we can offload this knowledge on them. Having someone else who knows these details and changes. With the ability to complete the referral form."*

			• *"More education needed for the community. Patients need to understand that instead of an emergency. Patients can be seen in a quicker fashion using UPCC's. "* • *"Gatherings between community physicians and emergency physicians are needed in order to collaborate on understanding, education, and communication in order to address the gaps."* **Sustainability** • *"Getting a good recipe and keeping it the same. As long as the referral process stays the same, it percolates down to all the doctors and keeps things tidy and straightforward. Minimizing changes. The longer something is around, the more physicians will know about it and be willing to use it."* • *"Needs to make sure FH is involved and create capacity (booking appt before patient is discharged). Making sure these processes are not just physician dependent. Ideal - If family physician can come into hospital, in person or virtually."* Future iterations of this work should explore increased patient and public engagement to support the developing understanding of follow up care after discharge. A second opportunity for future exploration that was not explored from the project activities are related to solutions for "familiar faces" presenting in the ER.

**Shared Measures* were not implemented at the time of this project creation/implementation

APPENDICES

- Appendices of relevant documents that would be helpful for the audience.
- Provider testimonials, patient impact stories, and quotations including the Physician Lead End of Project Survey
- Include PDF copies and links to all resources created during the project.

Appendix 1: Please note that the referral form was updated to this current version which is available on Form Fast or Pathways

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PRIMARY CARE ACUTE SITE DISCHARGE (ED OR HOSPITAL) PROGRAM REFERRAL

A physician will connect with the patient by phone or telehealth following discharge to provide follow-up assessment and connection to community supports, if needed. Any questions can be directed to Erin Carey at erin.carey@fnwdivision.ca.

Phone Number: 778-801-3521 **Fax Number: 778-623-2006**

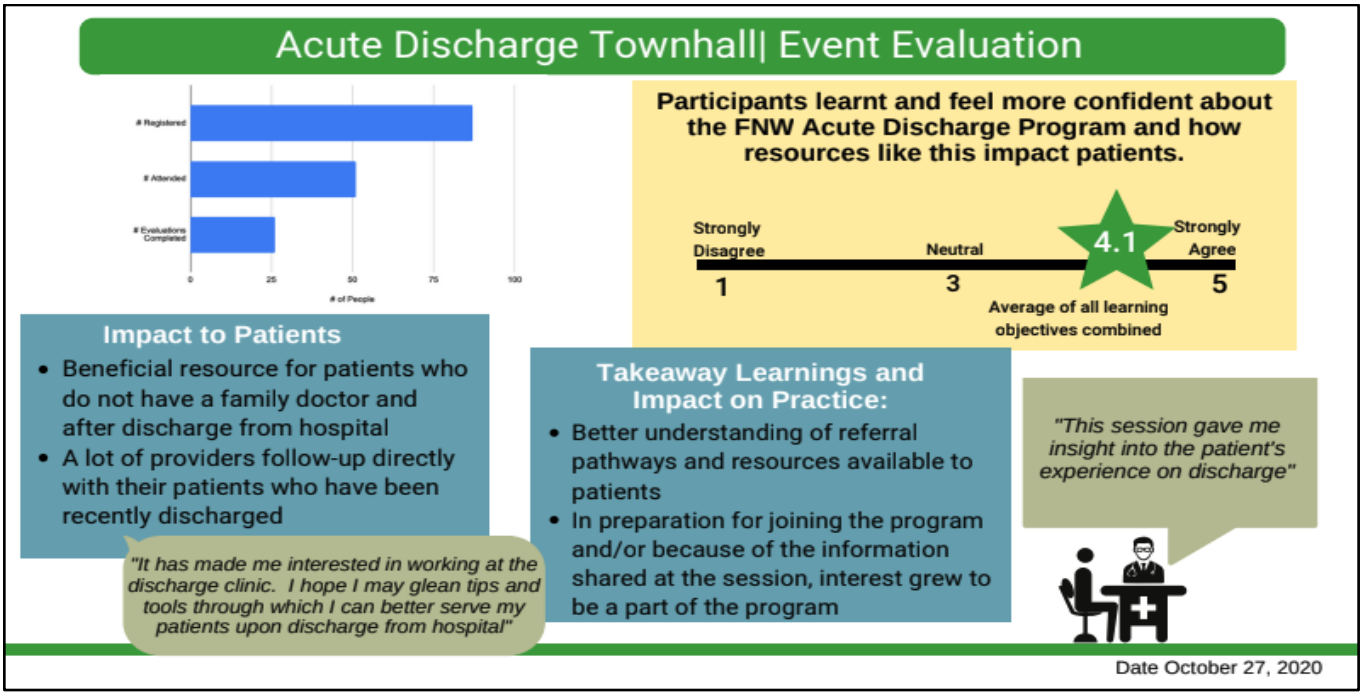
REFERRAL DETAILS			
Referral Date:		Patient Label:	
Referring Institution:	☐ RCH ☐ ERH ☐ Other: _____		
Referring Department:		Patient Phone Number:	
Referring Provider:		Patient E-mail:	

CLINICAL INFORMATION	
Patient requires follow up within: (NB: must phone for <24hr follow up) ☐ < 24 hours ☐ 1-2 days ☐ 3-5 days ☐ Other: _____	Reason for follow up: Presenting ER Diagnosis & Hospital Admission: _____ *Select one or more of the following:* ☐ Follow up new acute condition ☐ Follow up of chronic condition ☐ Follow up of COVID-19 swab/symptoms ☐ Other: _____ ☐ Patient does not require clinical follow up, but needs attachment to a Family Practitioner Notes:
Is the patient attached to a Family Practitioner? ☐ Yes, FP Name: _____ _____ ☐ No, please connect with FNW Attachment Hub	

Checklist of additional notes to include: *(* = required)*		
☐ ER Face Sheet*	☐ Hospital discharge report* ☐ Medication Reconciliation* ☐ In-hospital consultation*	☐ Labs/Imaging done in hospital* ☐ Pending tests and consultations*

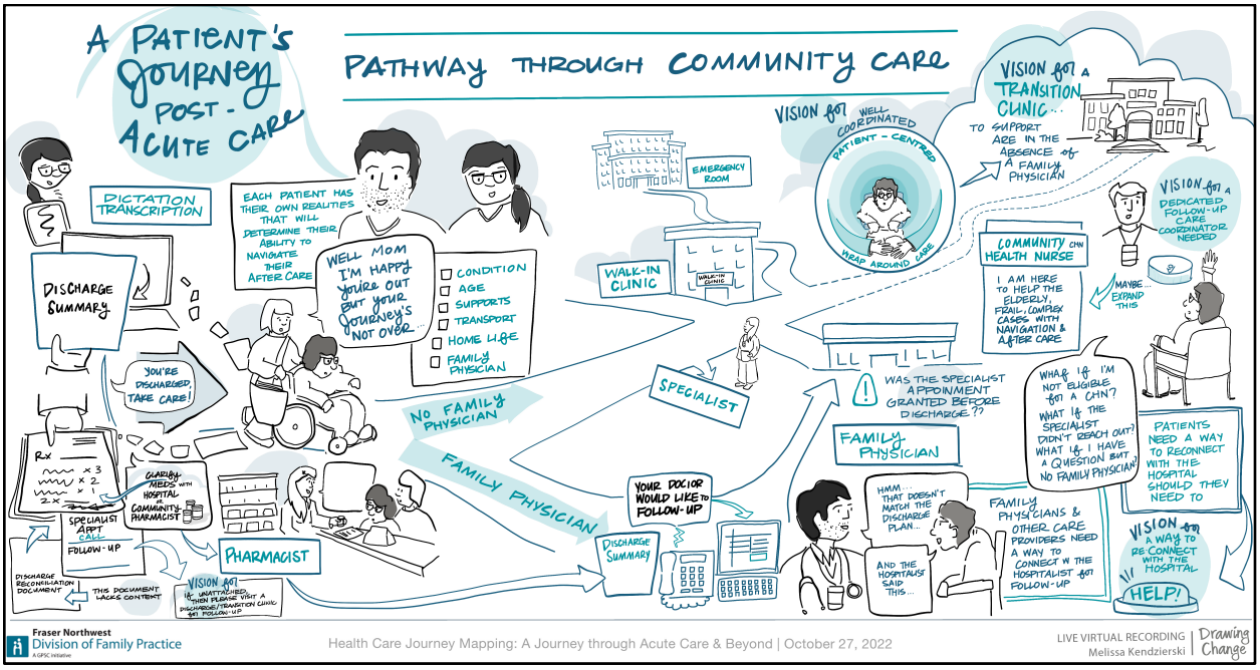
Please ensure the above-mentioned documentation is included, as clinic physicians do not have access to patient records.

Appendix 2: Acute Discharge Townhall Event Evaluation

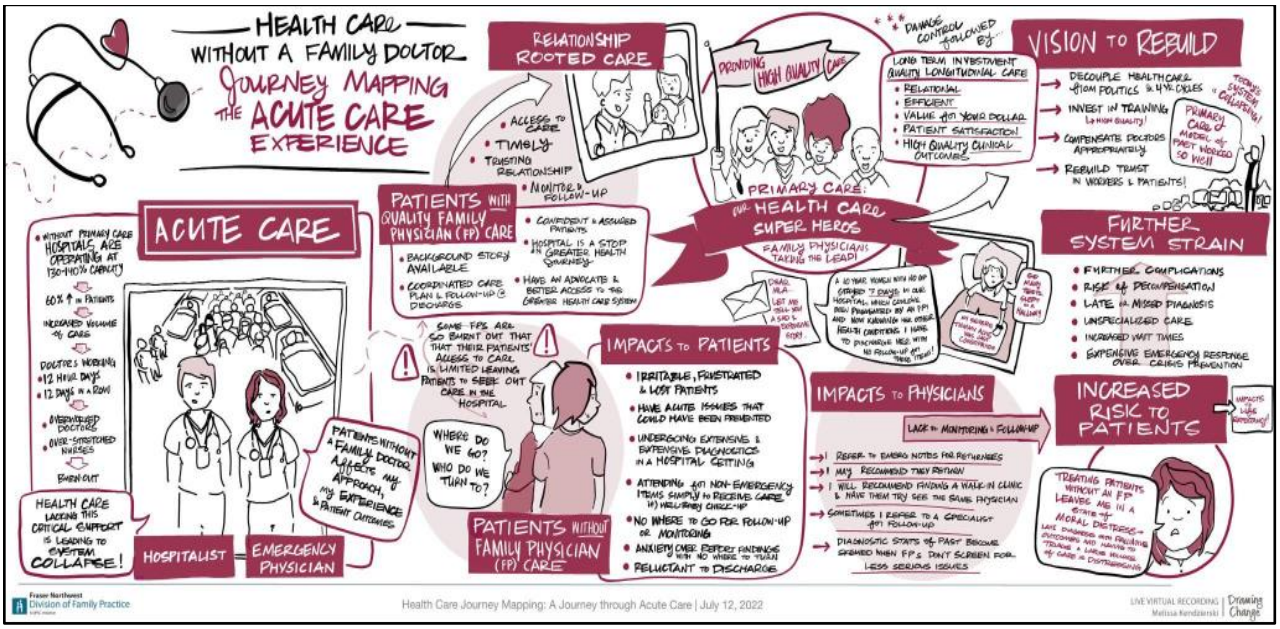


Appendix 3 : Provider Journey Map #1

Appendix 4: Provider Journey Map #2



Appendix 5 : Provider Journey Map #3

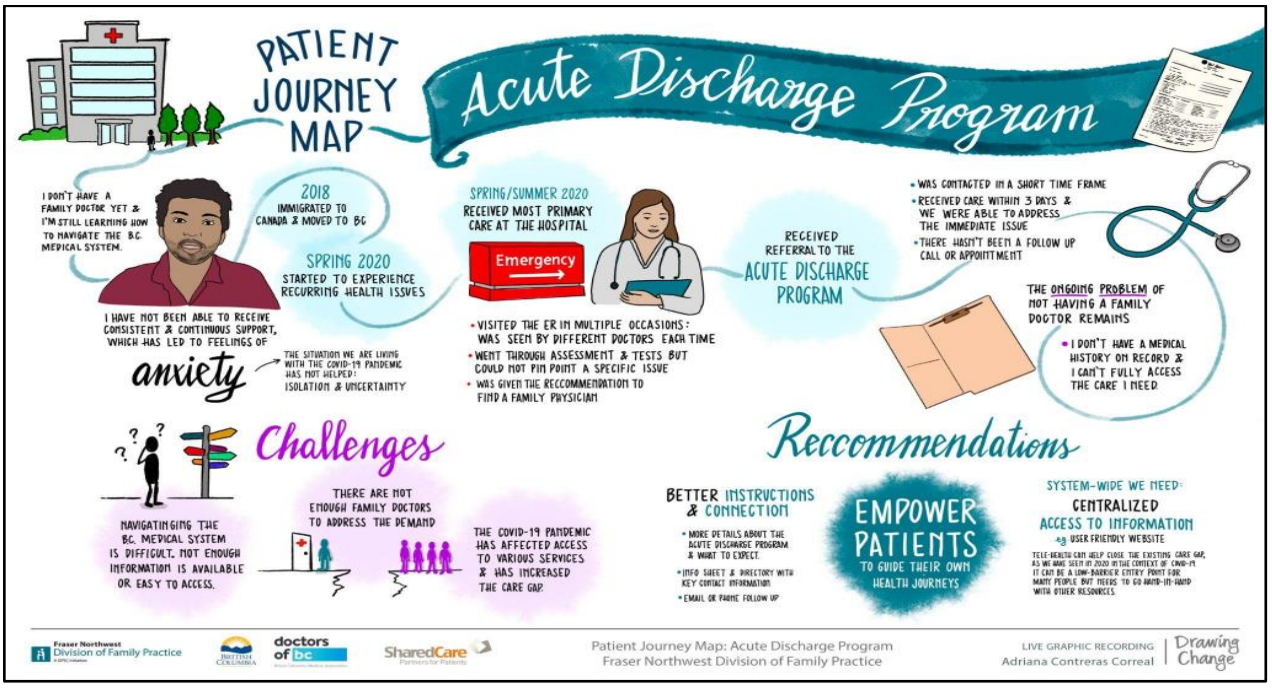


Appendix 6 : Breakdown of committee member feedback at the close of this project

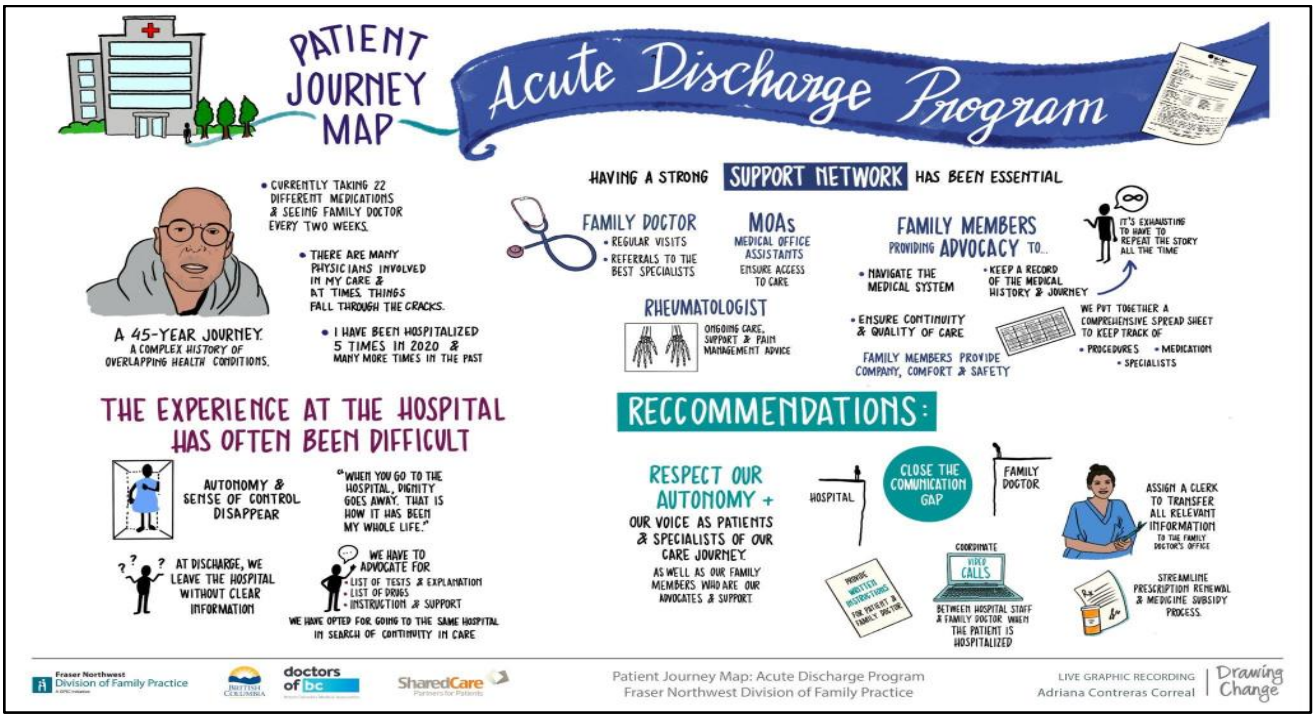
Please rate your level of agreement with the following statements on a scale of 1-4 (1-strongly disagree, 4 - strongly agree):

	Strongly disagree (1)	Disagree (2)	Agree (3)	Strongly agree (4)	**Avg score.**
Improved timely access to follow up care after discharge	4 (57.1%)		2 (28.6%)	1 (14.3%)	**2.0 (50%)**
Strengthened family physician and specialist relationships	4 (57.1%)	2 (28.6%)		1 (14.3%)	**1.7 (43%)**
Improved provider experience and satisfaction	4 (57.1%)	2 (28.6%)	1 (14.3%)		**1.6 (39%)**
Improved the communication and coordination of care between providers and care settings	4 (57.1%)	1 (28.6%)	2 (28.6%)		**1.7 (43%)**

Appendix 7 : Patient Journey Map #1

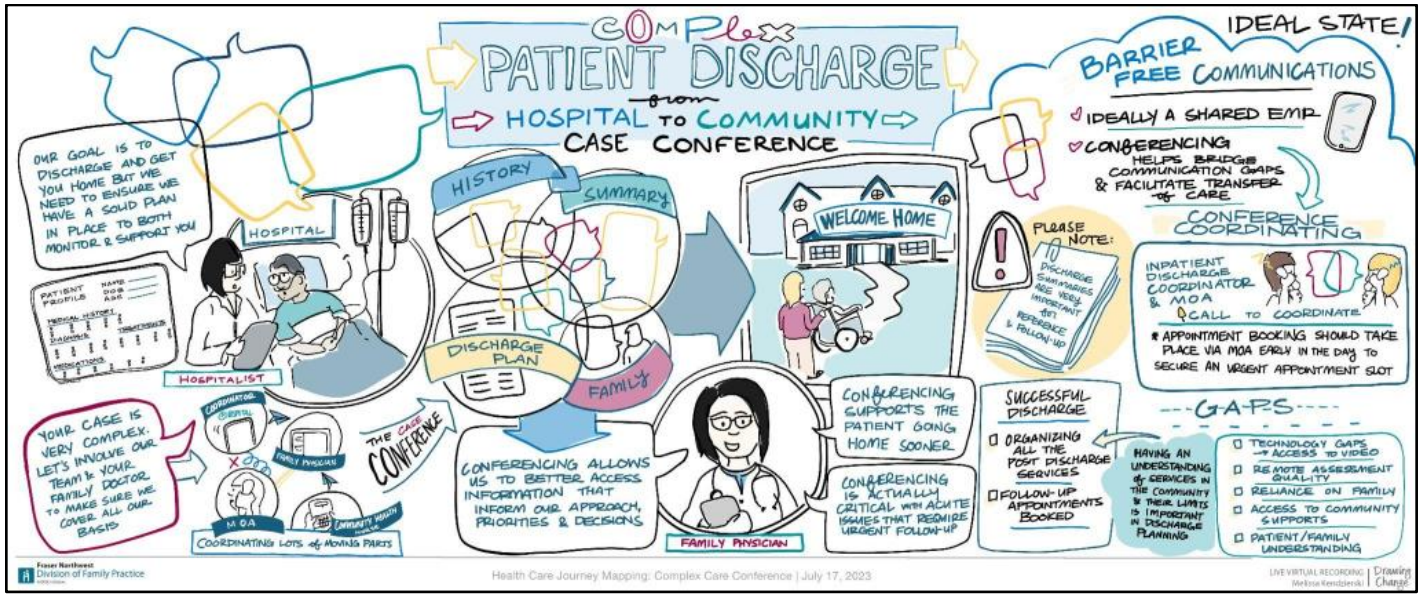


Appendix 8: Patient Journey Map #2

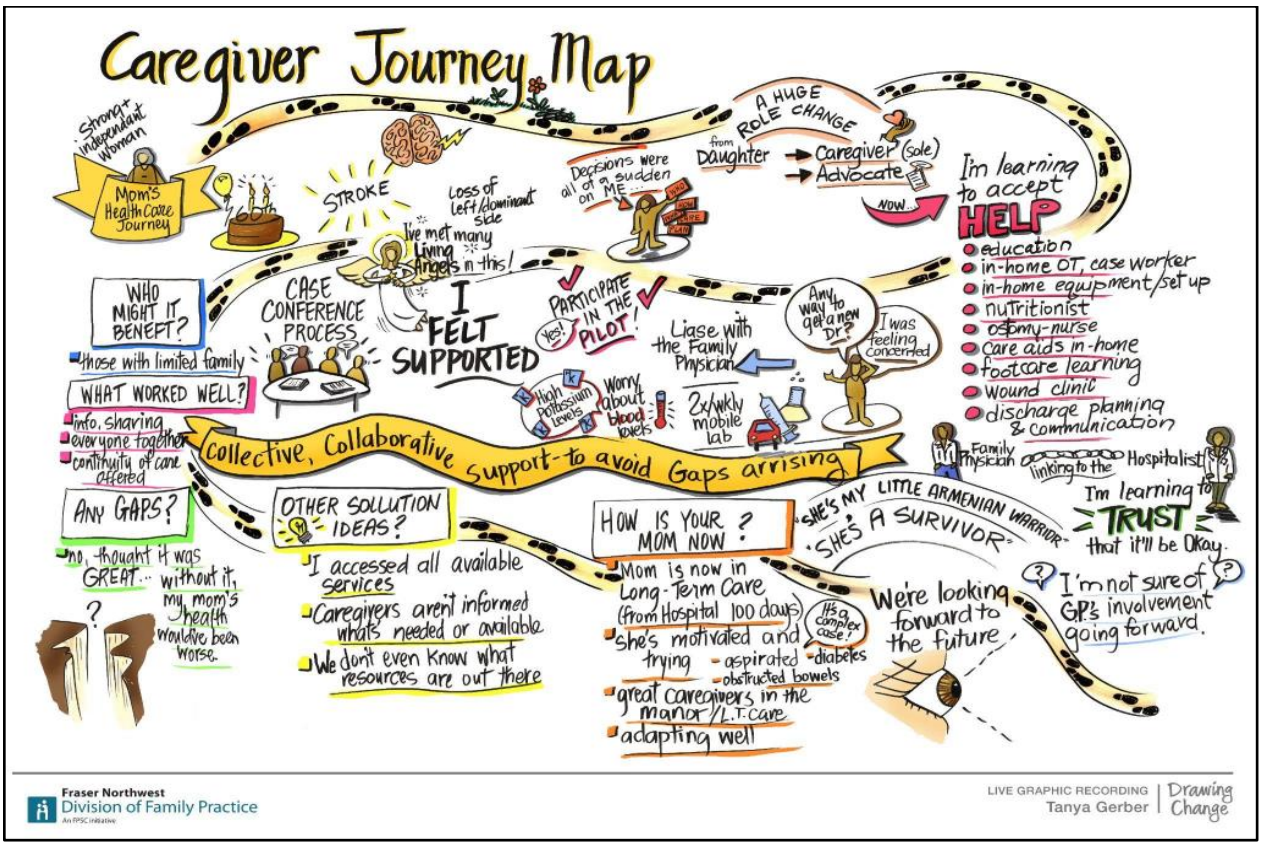


Appendix 9 : Patient feedback breakdown (Fall, 2022)

Appendix 10 : Complex Care Case Conference - Provider Journey Map



Appendix 11 : Complex Care Case Conference - Caregiver Journey Map



Appendix 12: Physician Lead End of Project Survey