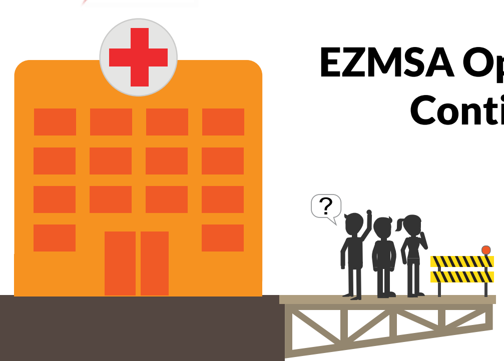
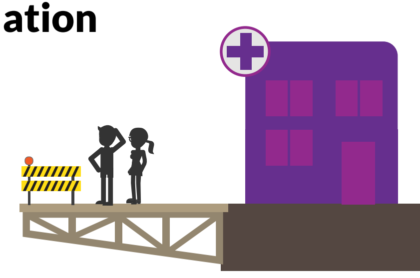
EZMSA Optimization of Hospital to Primary Care Continuity for an Inner-city Population



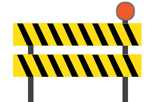


Addiction Recovery and Community Health (ARCH)
ARCH is an interdisciplinary hospital-based consult team that works with people experiencing alcohol or other drug problems, many of whom also have complex social needs.

Boyle McCauley Health Centre (BMHC)
BMHC provides interdisciplinary team based primary care for underserved Edmontonians with complex medical and social needs.

This collaborative quality improvement project aimed to optimize hospital-community continuity processes to support transitions for inner-city patients between hospital and primary care.

People with lived experience of alcohol or drug use, unstable housing, or unstable income may experience poor linkage back to primary care. Our teams wanted to better understand and improve practices that promote hospital-community continuity considering these additional barriers.



As no validated indicators exist to capture continuity during the hospital-community transition period, clinician and patient members of our QI team agreed upon two relevant measures for our patient population:

Primary continuity outcome:

- Time to completed appointment at the primary care clinic after a hospital admission, where <3 months =high continuity

Secondary continuity outcome:

- Time to ANY CONTACT with the primary care clinic after a hospital admission (via phone, outreach worker, etc.), where <30 days =high continuity

Shared ARCH – BMHC patients were separated into high, medium and low continuity groups based on how quickly they connected with BMHC after discharge from hospital. We reviewed charts from both ARCH and BMHC and identified processes that support timely connections to primary care.

Dimensions of Continuity:

- **Relational** - ongoing relationship between patient and his/her mutually agreed upon physician or provider and the patient consistently receive care over time from that physician or provider as opposed to other providers
- **Longitudinal** – indicates that the patient consistently receives care over time in an accessible and familiar environment from an organized team of providers including continuity to a team or to a medical home
- **Management** - care coordinated among several providers using shared management plans or care protocols in a way that is both consistent and flexible to meet patient needs (also care process continuity).
- **Informational** - knowledge of the patient such as preferences , values and personal context as well as their clinical context which is recommunicated and considered by all care providers

Coordinated Approach to Continuity, Attachment and Panel in Primary Care, March 2014

Key Processes Associated with Continuity (Chart Derived Data)	
ARCH	**BMHC**
• Appointment booking prior to discharge	• Verbal communication • Written communication • Transportation provided • Prescription Continuation/Coordination • Navigation supports • Accessing Netcare

Based on 1) chart reviews, 2) community input and 3) their own inner-city knowledge the teams decided on two priority quality improvements and trialed Plan-Do-Study-Act (PDSA) cycles.

PLAN

- Offer new and connecting patients referred to BMHC an information discharge package and a pre-booked post discharge appointment with BMHC

- Arrange a Pre-discharge visit (PDV) with BMHC for all newly referred ARCH patients
- Peer Support worker (PSW) supports transportation/navigation/trust

- 3 pre-booked appts and 4 discussed but not booked within the 6 weeks; 2/3 attended; 1/3 no show but attended within 30 days = 3/3 – 100% high continuity

- There were 5 PDVs booked over 3 months with 3/5 attending with High continuity (a post discharge visit with BMHC within 30 days of DC)

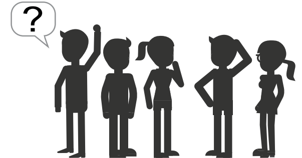
STUDY

- Providing discharge information for BMHC and pre-booking post discharge appts appears to be linked with continuity

- Attendance of PDVs appears to be linked with continuity
- Feedback from Community Advisory Group supported this intentionally warm hand off vs blind referral

- Both teams agree to continue to offer the Discharge process (information package and pre-booked appointments) for new and reconnecting patients with BMHC

- Teams will continue to offer PDVs to any BMHC referred patients who may require support for this transition/connection with primary care.



Patients and clinicians were involved throughout the QI process, including;

- identification of processes appropriate for data abstraction,
- the adoption and refinement of patient-centered processes,
- identification of gaps and insights for QI cycles, and interpretation and dissemination of findings.

Learnings from chart-documented team processes and innovative health care interventions trialed during the PDSAs contribute to continuity of care best practices for marginalized populations and policy development to better bridge the inner-city patient journey between hospital and primary care. Teams caring for underserved populations can use similar approaches to identify continuity processes associated with successful hospital-primary care transition as well as adapt our process improvements to their setting. Hospital and primary care teams, patients, and policy makers need to be involved in this conversation to successfully plan and support best practice spread.

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