# Fostering seamless transitions of care: A novel collaboration between the Rapid Access Unit and the Family Medicine Teaching Clinic at South Health Campus to improve Patient Care at Discharge

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## CONTEXT

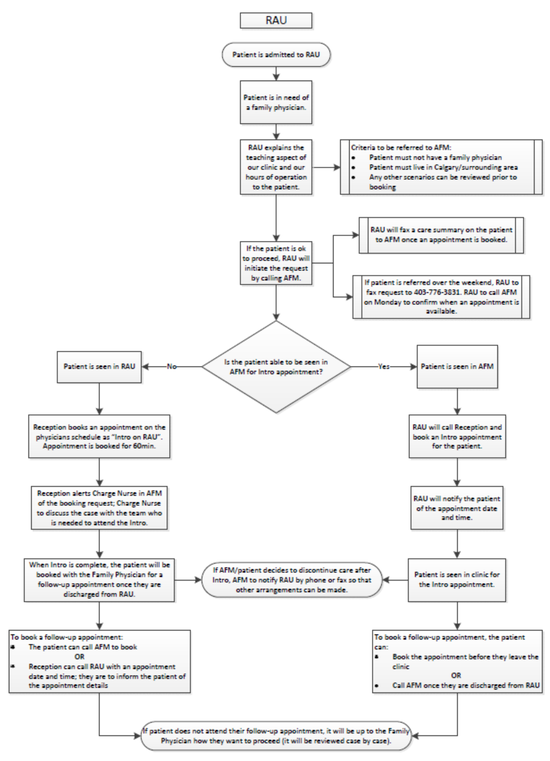
Transitions are known to be one of the highest risk times of a patient's journey through the health care system, and discharge is no exception (1-5). Numerous strategies have been trialed to improve coordination of care and communication with the patient medical home and reduce the likelihood of adverse medical events. (1-5). Our clinic, being located in an acute care facility, is uniquely positioned to be able to collaborate with the acute care team, ideally addressing the barriers that create challenges at discharge.

## OBJECTIVE AND TARGET AUDIENCE

We initiated a pilot collaboration between the Rapid Access Unit at South Health Campus and our Family Medicine clinic, to improve care for patients at discharge. This was done by initiating contact for patients who were in need of a Family Physician/Medical home while they were still admitted, and promoting collaboration and communication between the inpatient and community care teams during the acute care stay.
In this collaboration, we care for patients who are admitted to the Rapid Access Unit (RAU) at South Health Campus, but are preparing for discharge and are in need of a Family Physician/Medical Home.

## DESCRIPTION

Patients who are admitted to RAU and are in need of a Family Physician are asked if they are interested in the clinic here at South Health Campus by the team at RAU. If patients are interested, the RAU team contacts the Family Medicine Clinic and faxes the current patient records to the clinic. A time is scheduled for the Physician and relevant team members including Resident Physicians to go to the Unit to see the patient if most appropriate, or if appropriate for the patient to come to the clinic to meet the team and see the facility. At this visit, history is completed, connection between the inpatient and community team is fostered, and the patient meets the clinic team and ensures they are comfortable with the clinic and processes. This collaboration allows for a "warm handoff" including promoting the further transfer of information ie test results that arrive after the patient is discharged
Feedback was collected via in person or phone interviews. Interviews were completed with all patients who had been seen by our clinic through the pilot. Providers at the Rapid Access Unit were also asked a series of questions about the experience of the pilot.
14 patients have been seen through the pilot, and all are currently being followed through the clinic, though one patient is unsure if they will continue, as they are unsure if it is the right clinic for them due to the teaching environment.




Process Map

## PROVIDER FEEDBACK

**Impact on system resources**

Providers were asked if the pilot impacted system resources. Multiple providers from RAU noted a decreased length of stay as a result of the pilot. "The largest system impact has been decreased length of stay. With appropriate follow up being able to be arranged during a patients admission, certain outstanding tests/assessments can safely be deferred or reviewed after discharge."
"The process has been very easy to incorporate into the discharge process. When we first started this process, often patients who needed a primary care provider were identified at or near discharge. Now these patients are identified early during their admission … and appointments are coordinated prior to discharge. From a referrer/provider it has not added any significant work and actually has decreased stress/workload as there now is an easy and viable option for discharge."

**Benefits of the pilot**

"One of the biggest developments with this project has been the development of increased awareness of both the RAU and AFM (Academic Family Medicine) clinic of one another. The RAU now easily can describe the AFM clinic and providers at the AFM clinic seem willing to refer their patients directly to the RAU if admission is required. The personal-professional relationships are very beneficial as verbal hand-off tends to occur between AFM and RAU providers."

**Barriers/suggestions for improvement**

Providers were generally very happy with the process but noted that a shared EMR would improve communication.

## PATIENT FEEDBACK

Patients were asked about their previous care and about the knowledge of the benefits of a continuous relationship with a primary care provider or team prior to coming to our clinic.

Prior to accessing care at our clinic, care was being provided in a number of ways, some by walk in clinics, some by discontinuous relationships with family physicians, and in many cases with no significant care.

**Benefits of continuity of care**

Most patients described being aware of the benefits of continuity of care. One stated that they were healthy so weren't sure of the benefit of continuity, but most patients stated they now saw the benefit of "having a family physician that listens and does not send them for unnecessary tests" Another stated they now "like to come to the doctor more often."

**Frequency of visits**

Patients were asked about frequency of previous visits, and this varied according to conditions as expected, but one patient stated they were "seeking frequent care from walk in clinics as the patient has multiple health concerns and they would only address one problem at a time"

**Being part of a clinic/team to address needs and improve health**

Patients were asked if there are benefits to being part of a clinic like ours with a team to look after them and if this changes their views of this model, and if there are health benefits they foresee from being part of this type of model.

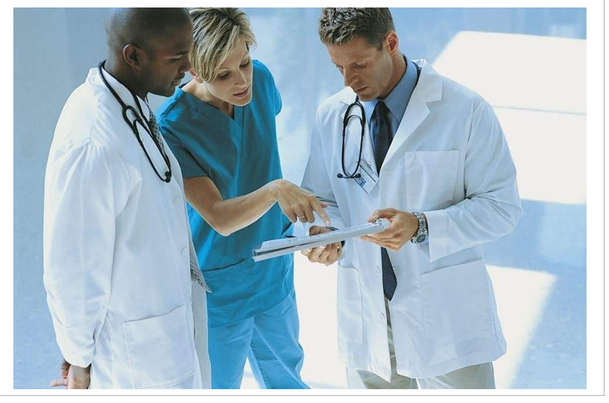
There was a consistent theme in the answer to this question in the patient now seeing the benefit of the relationship with the physician and team to improve their health. One patient relayed an experience since they have been a patient at our clinic where they were referred to hospital and feels this "saved their life." Another states that now … they can say they have a family physician. They have developed a relationship with their physician and trust them. They will come to see their physician instead of going to the ER. Another patient said that they are very happy now that they attend our clinic. It has changed their view of a medical team as they can come in and discuss multiple concerns, and be heard by the physician. Patient states that now that they are apart of our clinic, they like that they've built a good relationship with their physician and that they can come in and "no question is a dumb question".

**Alternatives**

Patients were asked where they would have been cared for if they had not agreed to be part of the pilot. Most stated they would have returned to what they were doing before, and some stated they would have looked for a new family physician, either via the internet or recommendations.

**Experience and Improvement**

Patients were asked about their experience of being seen during their admission and then care continued at our clinic. All experiences were positive, with the only question being one person who was still getting used to the presence of the learners. Patients were also asked about ways to improve the initiative, and none had any suggestions, with one stating, "how can you improve something that is perfect?"



## CONCLUSIONS

This project is currently in the pilot phase and initial feedback has been very positive from patients and providers.
Long term plans once adequate numbers of patients are included are to review administrative data to assess ER visits and hospital readmissions of patients involved in the project.
This novel pilot collaboration between the SHC RAU and Family Medicine clinic has fostered collaboration and initial feedback suggests patient care has been improved at discharge.

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