# Optimizing Hospital -Primary Care Continuity for Underserved Populations

A QUALITY IMPROVEMENT WORKSHOP
ACCELERATING PRIMARY CARE CONFERENCE NOV 30, 2018

# Presenter Disclosure

- **Presenter:** Dr. Jessica Kirkwood

**Relationships that may introduce potential bias and/or conflict of interest:**

- **Grants/Research Support:** N/A
- **Speakers Bureau/Honoraria:** Alberta College of Family Physicians
- **Consulting Fees:** N/A
- **Other:** Alberta Health Services, Family Physician, Boyle McCauley Health Centre

# Disclosure of Commercial Support

- **This program has received financial support from in the form of an education grant from:**
  - Merck Canada, University of Calgary Department of Medicine, Alberta Health Services, Alberta Innovates, Alberta Netcare, College of Licensed Practical Nurses of Alberta, BrightSquid,, Health Quality Council of Alberta, Boehringer-Ingelheim, and the Institute of Health Economics.

- **This program has received NO COMMERCIAL in-kind support.**

- **Potential for conflict(s) of interest:**
  - **Dr. Jessica Kirkwood** has not received payment from the APCC planning committee. Funds from sponsors are pooled to off-set conference costs.

# Mitigating Potential Bias

- The planning committee developed the conference objectives which do not include the discussion of our sponsor's products or services.
- Sponsorship funds are pooled and are evenly distributed throughout the conference. They do not fund specific speakers.
- The committee has reviewed the content of the presentations and ensured that content presented is evidence-based and free of undue influence.

# Presenter Disclosure

**Presenter:** Shanell Twan

Melanie Garrison

**Relationships that may introduce potential bias and/or conflict of interest:**

- **No relationships to declare.**

# Team Members and Acknowledgements

**Project Team:**

- Ginetta Salvalaggio (Assoc. Scientific Director – ICHWP)
- Karine Meador (Asst. Director ICHWP)
- Elaine Hyshka (Scientific Director ICHWP)
- Tracy Borrelli (Research Coordinator/Program Eval BMHC)
- Karen Frederickson (Clinic Coordinator, BMHC)
- Jess Kirkwood (Physician BMHC)
- Melanie Garrison (RA)

**Key Liaisons :**

- Shanell Twan (Community)
- Community Advisory Group
- Natalie Scorah (Team Lead, BMHC)
- Kim Carter (Team Lead, BMHC)
- Tally Mogus (Physician, BMHC)
- Chris Cardinal (Peer Support Worker, ARCH)
- Robert Gurney (Peer Support Worker, ARCH)
- Beatrix Massee (Peer Support Worker, ARCH)
- Michael Lee (Nurse Practitioner, ARCH )

**Research/Evaluation Support:**

- Klaudia Dmitrienko
- Karine Laverngne

# Objectives

1. Review our QI Project
2. Share lessons learned
3. Discuss how you might apply strategies

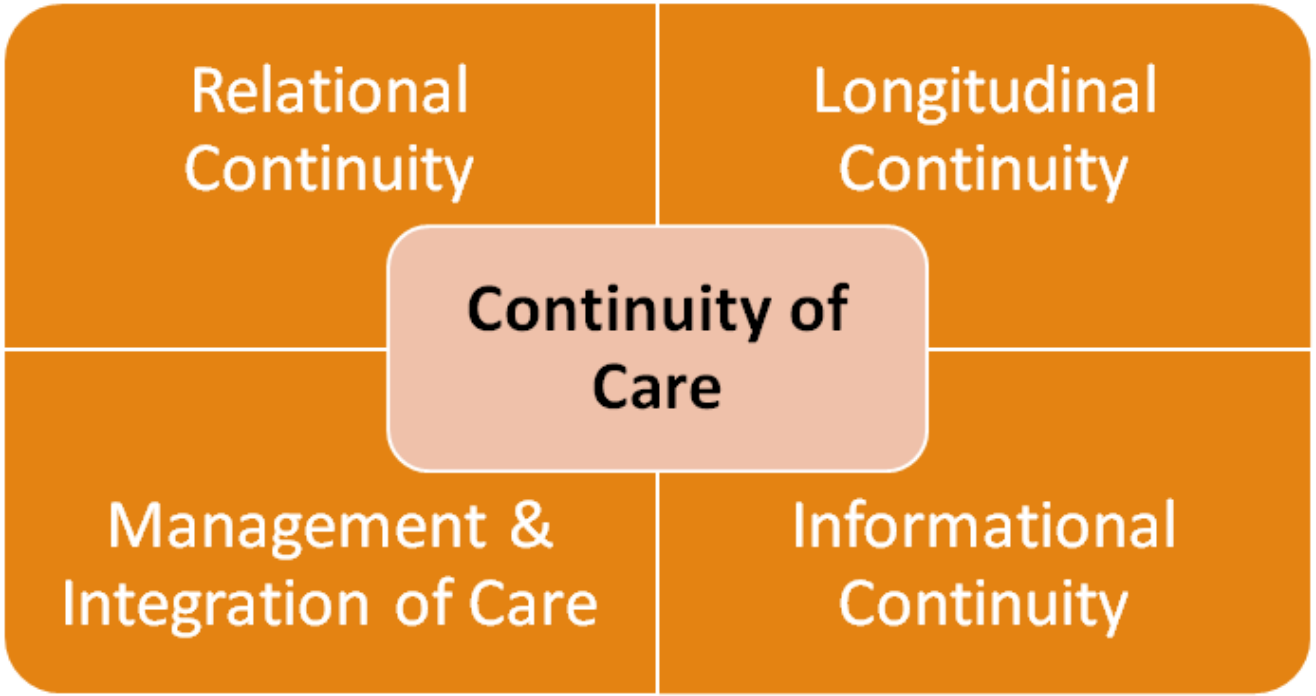
# What did we do?

1. **Identification of key hospital-primary care health care team processes** that facilitate inner city continuity of care

2. **Refining processes** for shared hospital-primary care patients in alignment with identified best practice.

# What are the biggest challenges with continuity for underserved patients?

# Continuity


Relational Continuity
Longitudinal Continuity
Continuity of Care
Management & Integration of Care
Informational Continuity

# Continuity

Patient Perspective

Clinician Perspective

# Health Care Teams


# Community Advisory Group (CAG) & AAWEAR Members

Community members with lived experience supported:

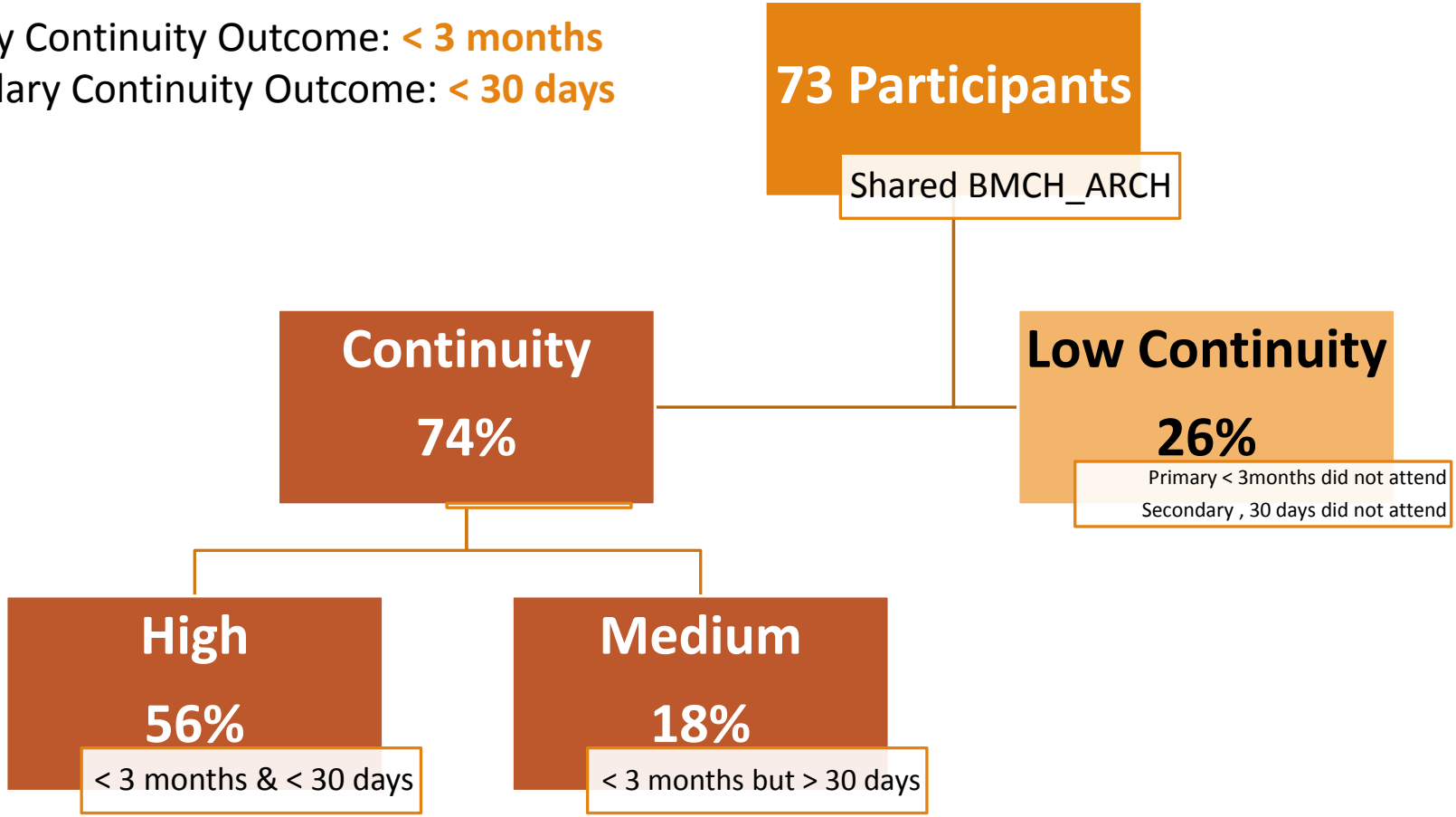
- Informing continuity outcomes
- Research methods
- Research interpretation
- Knowledge translation

# Identification of key ARCH-BMHC health care team processes

# Framing Continuity in an Inner City Context

| | |
|---|---|
| **Primary Continuity Outcome** | **Time to completed appointment at the BMHC after a hospital admission, where <3 months = high continuity** |
| **Secondary Continuity Outcome** | **Time to ANY CONTACT with the BMHC after a hospital admission (via phone, outreach worker, etc.), where <30 days = high continuity** |

Primary Continuity Outcome: **< 3 months**
Secondary Continuity Outcome: **< 30 days**



# What Team Processes Improved Continuity?

**BMHC chart review:**

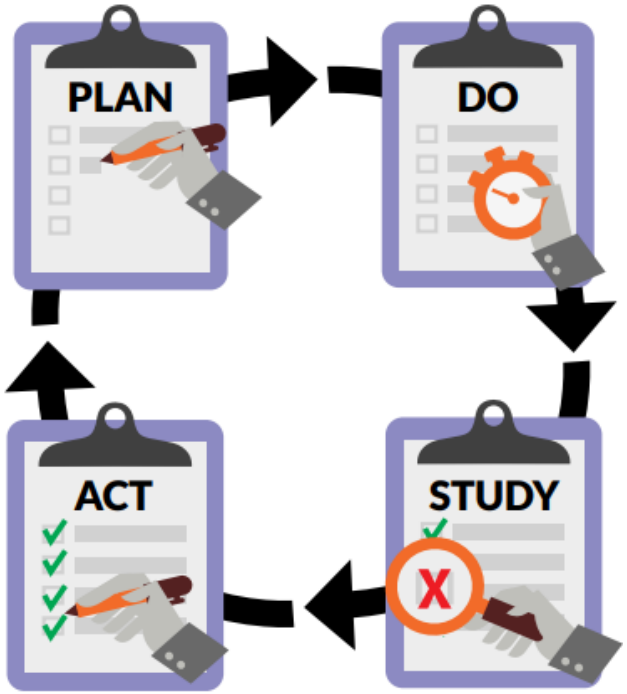
- Verbal communication
- Written communication
- Transportation
- Prescription Continuation/Coordination
- Navigation supports
- Accessing Netcare

**ARCH chart review:**

- Appointment booking

# Refining processes for shared ARCH-BMHC patients

# How:  PDSA Cycles



# ARCH PDSA: Discharge Process

**P**

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

**D**

- 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

**S**

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

**A**

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

**Welcome to Boyle McCauley Health Centre**

Inner City Healing Through Health Care

We provide a broad range of medical and support services:

| | | |
|---|---|---|
| Medical clinic | Mental health supports | Optometry |
| Footcare clinic | Health advocacy | Acupuncture |
| Miyowayawin clinic | Streetworks | Chiropractor |
| Dental clinic | Housing supports | Lab services |
| Youth health clinic | Women's health and pregnancy | |

We are equipped to deal with minor emergencies, including stitches, burn treatment, and wound treatment.

**Where:**

**10628 96 Street NW**
Edmonton, AB


| Your BMHC Appointment Information | |
|---|---|
| Date | |
| Time | |
| Provider | |

We look forward to seeing you. **If you are unable to come to this appointment please connect with us by phone at 780-422-7333 or drop by.** We will find a better time for you.

# BMHC PDSA: Pre-discharge Visit

**P**

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

**D**

- 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 Discharge)

**S**

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

**A**

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

# What did we learn?

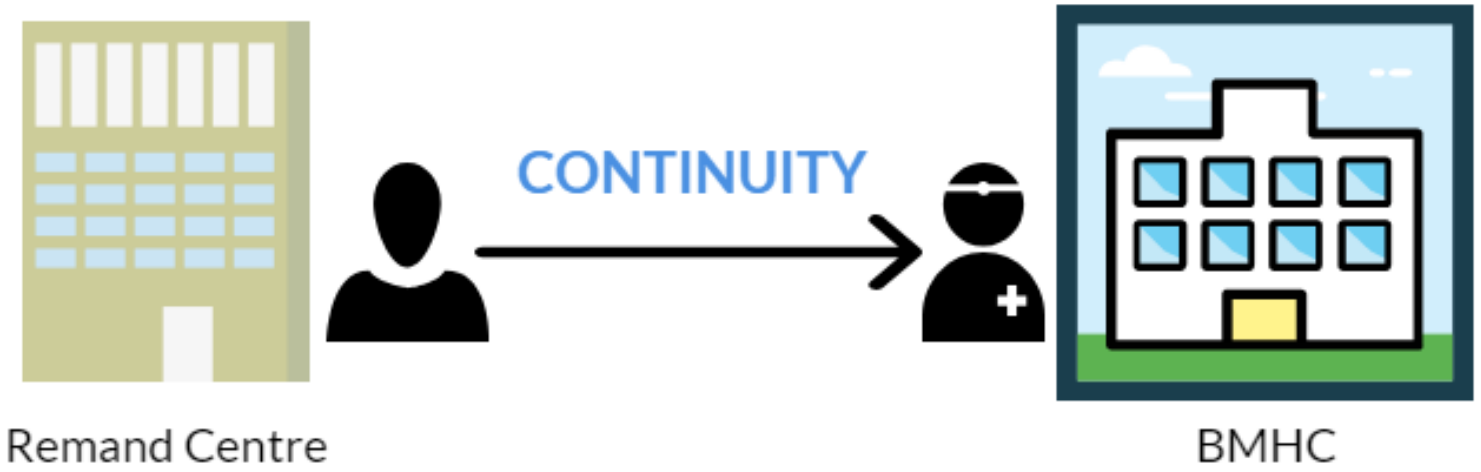
# What did we learn?

- Assess your resources (e.g. Peer Support Workers)
- Establish and maintain partnerships
- Involve patients/community
- Be aware of potential barriers
- **RELATIONSHIPS MATTER**

# Lessons Learned: iOAT– Dr. Karine Meador

- **a pre-discharge visit was made part of the transfer process**
- ARCH team identifies patient and initiates treatment
- **prior to discharge an appointment is booked** with Edmonton Opioid Dependency Program
- The patient is **assisted in attending the appointment** by the ODP social worker

# Lessons Learned – Continuity Processes for underserved populations



# Could you do this?

- What challenges exist?
- What does this transition in care look like in your setting?
  - Newcomers
  - Rural setting

# Small Group Discussion

1. Discuss possible quality improvements to support continuity
2. Who needs to be involved?
3. How do you build relationships/partnerships?
4. Take stock of resources
5. Negotiate priorities with partners
6. Next steps: PDSA Cycle?

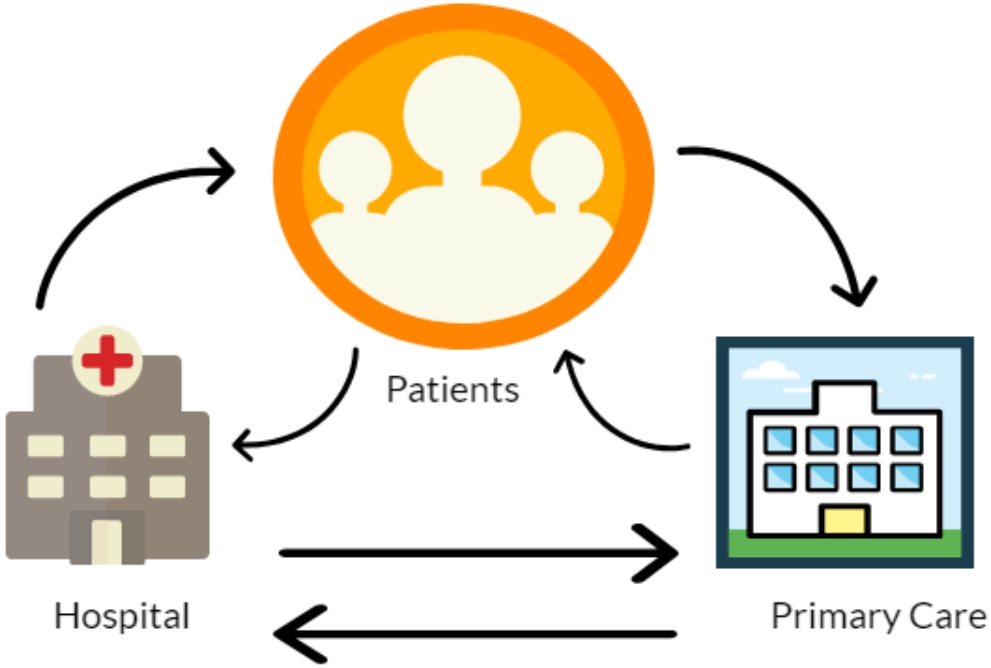
# Measuring Success

# Focus on Patient Outcomes

- Knowing the door is open/community connections
- Commitment to constant caring for patient
- Relationship building/trust (may be appointment # 2 – 3 - 4)
- Success is checking in with patients

# No Shows Happen

# Relationships Matter Most



# Thank you!

@TeamARCH

ginetta@ualberta.ca
@ginettafammed

jek5@ualberta.ca
@BMHC_HealthCare

stwan@boylestreet.org
@AAWEARAlberta

mgarriso@ualberta.ca
@HSERC_UAlberta