**QI Project:** Optimizing Transitions of Care for Medical Patients at St. Thomas Elgin General Hospital (STEGH) from Hospital to Primary Care

**Health Theme:** Appropriate Resources, Effectiveness, Efficiency, Patient-Centredness, Safety  
**Location:** Ontario - South West LHIN  
**Health Sector:** Acute Care, Primary Care  
**Project Uploaded:** Jun 2015

**Summary**

Variation exists in the discharge process and lack of transition links between hospital and primary care in Elgin County leads to inconsistent and inadequate follow-up for patients. As a result, primary care providers receive only ~41% of discharge dictations within 48 hours and STEGH experiences higher than expected readmission rates for selected CMGs (~20% actual vs. ~16% expected).

**Approach**

**Aim**

High Level Aim: to optimize transitions of care for Acute Medical patients following discharge (hospital to primary care) to ultimately decrease the readmission rate at STEGH. Sub Aim: to increase the proportion of Acute Medical patients with select Case Mix Groups (CMGs) discharged from STEGH seeing their primary care provider within 7 days of discharge from 23% to 30% by March 31, 2015. Sub Aim: to increase the proportion of discharge summaries sent within 48 hours from STEGH to primary care or community provider for Acute Medical patients from 41% to 80% by March 31st, 2015.

**Change Ideas**

1. Physicians dictate their discharge summaries within 48 hours of discharge. Scorecard developed to track percentage of dictations done within 48 hours by physician (anonymous) and posted in physician office. Transcription was outsourced (planned prior to IDEAS project) and an auto send process was initiated to eliminate the authentication process that was contributing to a delay in sending. 2. At time of discharge, ward clerks are scheduling follow up appointments with patient’s family doctor (goal: within 7 days of discharge). Data from HQO shows that follow up with primary care within 7 days of discharge contributes to readmission avoidance. Multiple cycles were tested to determine how to best identify patients in the selected CMG category. In order to capture 100% of that population and reduce the time it takes to search for information, we determined that 100% of patients discharged (except those to LTC or another inpatient facility) will receive an appointment.

**Measures**

<table>
<thead>
<tr>
<th>Type</th>
<th>What Measure</th>
<th>How are you measuring?</th>
<th>Goal</th>
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<tbody>
<tr>
<td>Outcome</td>
<td>Readmission rate within 30 days for selected CMGs</td>
<td>Using integrated decision support system, and 7 and 28 day internal hospital data as a more timely proxy</td>
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<tr>
<td>Process</td>
<td>Discharge summary dictation</td>
<td>% of discharge summaries sent to primary care within 48 hours of patient discharge</td>
<td>80%</td>
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<td></td>
<td>Follow up appointments</td>
<td>% of patients discharged with a scheduled follow up appointment with their primary care provider</td>
<td>100%</td>
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<td>Balance</td>
<td>Post discharge ED visits</td>
<td>Looking at high users to determine if process measures were followed</td>
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*IDEAS (Improving & Driving Excellence Across Sectors), is a province-wide learning initiative to advance Ontario’s health system priorities by building capacity in quality improvement, leadership and change management across all health care sectors. Participants apply IDEAS quality improvement program learnings to applied projects from their own organization or local health systems over the course of the five-month Advanced Learning Program*
Results and Learnings

Documented results of the implementation of a QI project's change ideas that include key learnings, experience and insights. These contribute valuable information to others and contribute to overall QI knowledge to support sustainability and spread.

Data Highlights

The key process and outcome results of the project

The percentage of discharge summaries sent within 48 hrs is now above 85%. Transcription turn around times have been reduced from 24 to 2 hrs, and the auto send process has eliminated the time to authenticate resulting in a substantial improvement in getting discharge summaries to primary care. Consistently, 100% of patients discharged are having follow up appointments scheduled. Using our readmission proxy indicator (due to data lags), internal 7- and 28- day readmission rates have shown a nearly 50% month over month decrease for the past 5 months.

Sustainability

What has been done to sustain improvements since the initial QI project end cycle, or why and how the initial project plan has evolved over time

Monitoring has now been incorporated into our Leadership Scorecard and that is reviewed weekly by the Leadership Team. Key measures are also part of our 2015/2016 QIP and reported to the Board monthly. The measures are also reviewed during daily huddles by both Acute Medicine floors. The physician scorecard has been maintained and have further incorporated the discharge summaries dictated within 48 hours by all providers and this is reviewed monthly by the Medical Advisory Committee. Booking follow up appointments is now part of the ward clerk’s standard daily work.

Spread

The degree to which the project improvements and learnings have been adopted and adapted by others within the same setting and/or by other settings, or to identify the main target audience for potential spread

We are committed to spreading this project to the remaining appropriate patient populations at STEGH. The Pharmacists on the medicine units have increased their involvement with discharge medication reconciliation and patient education. We have also created a partnership with the Central Community Health Center to refer "unattached" patients for follow up if they do not have a family doctor.

Setting

The most valuable setting-specific learnings, insights, experiences from the project that will be relevant to the spread to other settings

Resources

This project did not require a significant amount of resources beyond the cost of the team to participate, as it was more about increasing efficiency of the discharge process we already have. Resources we developed were a follow up appointment sheet attached to our census sheet used by the ward clerks to help them stay organized with booking the appointments - especially around the weekends and holidays. We also developed appointment cards to give to patients as a reminder. Commitment to the process and frequent communication with staff is what is necessary to spread/sustain this initiative.

People

Inherent in the culture at STEGH, the Board and Leadership team are engaged, involved and ensure accountability for improvement through monitoring, implementation of standards and staff engagement in change. Commitment from leadership was a key factor in the success of this project and will be a key driver in its sustainability. Our IDEAS team was able to leverage the process improvement skills present throughout the organization, senior leadership and the LHIN to help enable success of the project.

Organizational Enablers

A major factor in our success was the fact that we had excellent organizational support. Key enablers include organizational governance, structure and culture. A key leader on this project was VP and Chief of Staff, Dr. Whitmore. Her influence with physicians helped motivate them to meet the goals of the project. STEGH has been on a journey over the past 5 years and has worked hard to develop a LEAN culture of continuous improvement throughout the hospital and that helped to enable movement forward with the changes necessary to reach and achieve project objectives.

System Factors

Key environmental factors that contributed to success were transitioning to a new transcription/dictation
system in December (during the project) and initiating the auto-send process. These enabled improved measurement, helped to reduce transcription times and eliminated a process step previously required for physicians to authenticate. In order to enable spread, engagement and community partnerships were key. The LHIN was critical in supporting system partnerships in order to increase engagement with key tables and community organizations.
Lessons Learned

We learned that a little friendly competition goes a long way! Much of our success with the dictation times can be contributed to competition between the physicians and them trying to be the first to reach 100%. There was also informal competition between our two medicine floors and the ward clerks wanting to reach 100% of follow up appointments scheduled before the other floor. We also learned that change is much easier with frequent communication and early input from our stakeholders and partnerships.

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