Connected Care: How a Health Science Centre Is Using Evidence to Improve Patient Transitions from Primary to Secondary Care

Soins interreliés : un centre des sciences de la santé utilise des données probantes pour aider les patients à faire la transition des services de santé de première ligne aux services de santé de deuxième ligne

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Abstract

The department of emergency medicine at Queen Elizabeth II Health Sciences Centre in Nova Scotia's Capital Health District is developing pathways to strengthen the ability of family physicians to manage their patients and improve the primary–secondary care transition. This diagnostic pathway initiative improves patient and caregiver satisfaction and also provides system benefits. This innovative initiative was recently featured in *Promising Practices in Research Use*, a series produced by the Canadian Health Services Research Foundation highlighting organizations that have invested their time, energy and resources to improve their ability to use research in the delivery of health services. Tell the Foundation your own stories and visit the *Promising Practices in Research Use* inventory at http://www.chsrf.ca/promising/index_e.php.

Résumé

Le Service de médecine d'urgence au Queen Elizabeth II Health Sciences Centre du Capital Health District de la Nouvelle-Écosse élabore un programme d'accès au diag-

nostic pour renforcer la capacité des médecins de famille à gérer les dossiers de leurs patients et améliorer la transition des services de première ligne à ceux de deuxième ligne. Le programme d'accès au diagnostic accroît la satisfaction des patients et du personnel soignant et se traduit par des avantages systémiques. Cette initiative novatrice a fait l'objet d'un article dans *Pratiques prometteuses dans l'utilisation de la recherche*, une publication de la Fondation canadienne de la recherche sur les services de santé, qui présente des organismes ayant investi temps, énergie et ressources pour améliorer leurs capacités à utiliser la recherche dans la prestation des services de santé. Vous pouvez nous suggérer des idées d'article et consulter la liste des numéros de *Pratiques prometteuses dans l'utilisation de la recherche* au http://www.chsrf.ca/pratiques/index_f.php.

KEY MESSAGES

- Building patient-centred pathways to ease the transition from primary to secondary care can improve patient and caregiver satisfaction and provide system benefits.
- Three important elements of building successful pathways are:
  - seeking input on the new process from all stakeholders, paying particular attention to those with objections;
  - ensuring that the new process has advantages for all stakeholders and that they are aware of the advantages; and
  - asking for stakeholder feedback on improvements and visibly incorporating improvements into the process.

Making the transition between primary and secondary healthcare can be like driving between cellphone coverage areas – disconnects happen. These disconnects are frustrating for everyone involved, especially patients and caregivers, and can be costly to healthcare systems. Nova Scotia's Capital Health District is improving the transition from primary to secondary care, starting with a project on deep vein thrombosis (DVT).

DVT is the formation of a blood clot – commonly in leg veins – that can break off and cause severe complications. It's a serious condition, but suspected cases often have more simple underlying causes. To investigate each case, family physicians follow various methods involving several medical disciplines, which adds to the potential for gaps in care and communication. Moreover, because doctors don't want to take chances, they often refer patients directly to emergency departments, although this is frequently unnecessary.

"It's been a chaotic process," says Dr. Sam Campbell, Director of continuous

quality improvement in the department of emergency medicine at Queen Elizabeth II Health Sciences Centre and a fellow of the Executive Training for Research Application (EXTRA) program. As part of EXTRA, Dr. Campbell investigated DVT referrals. "I wanted to help strengthen the capacity of family physicians to manage their patients and make care management easier for all caregivers. But I also wanted to take practitioners out of their primary or secondary care silos and put them in the patient's silo, organizing care with the patient as the focus."

The project adapted a scoring tool, based on new evidence-based protocols for DVT diagnosis and treatment, to allow family physicians to determine a patient's clinical probability of disease and the appropriate diagnostic strategy. With this step-by-step process, most patients can be diagnosed and treated by their family doctors as outpatients. For those whose diagnosis requires referral to the emergency department, Dr. Campbell's team developed a diagnostic pathway involving advanced care paramedics to avoid taking resources from other emergency cases.

Research evidence guided the development of the investigation and treatment protocol, as well as the strategy to introduce the new process. Dr. Campbell's review of the literature on change management and quality improvement revealed several useful strategies. One was the discovery of the "productivity of resistance" concept, which suggests that resistance can be used constructively. "Resistance is usually viewed as preventing change," says Dr. Campbell, "but the resisters pointed out problems and we adjusted the process accordingly. It was hugely valuable."

Dr. Campbell's multidisciplinary team, which included not only healthcare providers and decision-makers, but also an industrial process engineer, believed that a pathway designed to improve care and make life easier for caregivers would have a better chance of success than one focused solely on improving patient care. With this in mind, they sought input from each stakeholder group on how the process should work.

"We wanted something that would be easier to follow than to ignore," says Dr. Campbell. "That meant we needed a 'win' in it for everyone – patients, family and emergency physicians, advanced care paramedics, and radiology and haematology staff."

The team was careful not to be prescriptive or defensive about the process. "We had no sacred cows to defend," says Dr. Campbell. "We stressed that physicians could override the protocol if they felt it necessary and acknowledged that problems with the process itself might emerge once it was in use."

The team also decided that user feedback was needed to improve the process, and it gathered and used this feedback in a very visible way. For example, since many found the progression of care confusing, a poster was hung in the emergency department to spell it out. The team encouraged staff to write their suggestions directly on the poster.

"This was a master stroke," says Dr. Campbell. "It not only helped us clarify the process, but also, by visibly incorporating people's suggestions via new versions of the poster, the caregivers began to own the project, which really fostered buy-in."

After one year, family physicians who had used the pathway rated it 8.99 out of 10, and 95% of emergency physicians were satisfied or very satisfied with it, as were 89% of the advanced care paramedics. In addition, 95% of patients contacted were satisfied or very satisfied with their experience. Patients referred to emergency saw their length of stay decrease by more than an hour and a half.

The pathway is now considered the standard of care for DVT. "But more importantly," says Dr. Campbell, "we are now developing similar approaches in other areas, such as anticoagulation management, where the processes and primary-to-secondary interfaces are not well defined."

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