Care Transitions Backgrounder 2025

History

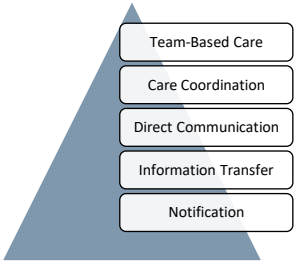
In 2013, VDFP undertook an extensive engagement process with its members; one area of concern identified was a lack of communication between hospital and community settings. Two physician leads, Drs. Laura Phillips and Lisa Veres, applied for funding from the Shared Care Committee to develop a QI project. This funding enabled the hiring of a project lead, Kristin Atwood (now Director of Care Innovations), in September 2013, and the establishment of the Care Transitions Committee

Goals, Approach, and Linkages to Divisions Strategic Plans

Care Transition's mission is to *improve transitions in care for our patients by engaging professionals across the health care system and strengthening ties between them*.

Our approach emphasizes provider-to-provider communication, which affects the quality of transitions and overall patient outcomes[i]. Our theory of change model is described in Appendix.

Care Transitions views communication as a pyramid: the foundations must be present in order for higher communication to occur. At the base, notifications alert providers who share responsibility for a patient's care to what the other is doing. At an intermediate level, information exchange provides clinical details essential for quality care. Alerted to a changing situation and equipped with the necessary clinical information, providers can communicate effectively.



Taking a collaborative approach is essential in order to build positive, trusting relationships. A high level of collegiality increases provider satisfaction and confidence that patient safety will be maintained and contributes to a sense of 'being on the same team' for patient-centred care. A QI approach allows Care Transitions to develop, pilot, and implement solutions that can be sustained long-term.

Areas of Focus

Care Transitions has been operational for nearly a decade, and it would be challenging to list every QI project that has been explored in that time. Therefore, the areas of focus described below focus on general directions and key accomplishments and are not meant to be exhaustive (projects may also cross categories).

Notification

Care Transitions' work began with basic notifications from hospital to family physicians in 2013, including notification of admission, death in hospital and deaths in ED without an admission; and discharges. Care Transitions partnered with hospitalists, to improve timeliness of discharge summaries and supported EDPs in moving to dictation to improve the quality of ED encounters. Work on the eNotification project was published in 2021[ii].

Information Exchange

Care Transitions has worked with Island Health's Health Information Management team to promote improved data quality in the health authority's information system, so that hospital workers have access to correct contact information for FPs. Work also included improved reports distribution through automation, digitization, and increasing the types of documents that community physicians can receive.

A key accomplishment is the patient summaries work, which enables the flow of information from FPs into the hospital to support an admission, or proactively for patients at risk. Having information flow *from* community *to* hospital is something that very few communities have achieved. This ground-breaking work has been recognized by the Ministry of Health, who recruited the Care Transitions physician leads into leadership positions in provincial efforts associated with its Digital Health Strategy.

Other information exchange work has included supporting Island Health's efforts to clearly identify patients transitioning from long-term care into the ED and improving discharge information flowing from nursing to community for patients admitted for heart failure.

Care Transitions has also been involved in information exchange projects where the goal is to produce written documentation to increase the knowledge of one health care setting among providers in another. Examples include our Tips and Tricks from the ED; a database of long-term care facilities that will assist EDPs in knowing where patients are transitioning from; and the addition and flagging of heart failure and caregiver resources in Pathways.

Direct Communication

A key project facilitating direct communication has been Care Transitions' Familiar Faces work, which identified high volume users of the ED and engages FPs in collaborative care conferences with EDPs, who then create care plans to help improve continuity for the patients when they present.

Care Transitions also ran a substantial pilot project of secure messaging, enabling brief communications between hospital and community clinicians via a smart-phone application that enabled encryption on providers' personal devices. This work was published in BMJ Innovations in 2020[iii].

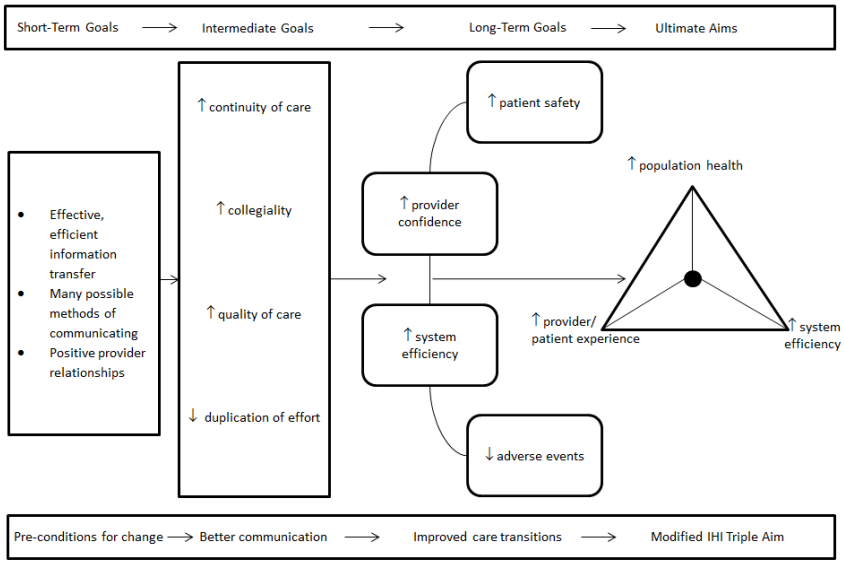
Care Coordination

As the Committee's capacity has increased, we have been able to take on more complex work that enables care coordination. Specifically, our Specialist Referrals project aims to build collegiality between FPs and SPs while improving referral processes so that the transition to and from specialist care is safe and seamless. As well, our Opioid Using Patients project coordinates care for substance use patients between the ED, the Rapid Access Addictions Clinic, and longitudinal follow-up care.

Most recently, Care Transitions has initiated work to improve referral pathways for patients with skin health issues needing referral to dermatology and/or plastics; and for patients who could benefit from social prescribing to community agencies.

For more information, please contact Kristin Atwood, Project Lead, at katwood@victoriadivision.ca.

Appendix: Theory of Change Model



[i] See Jeffs, L. Lyons, R. F., Merkley, J. and Bell, C.M. (2013). Clinicians' view on improving inter-organizational care transitions. *BMC Health Services Research 13*, 289-296. See also Van Walraven, C. et al (2008). Information exchange among physicians caring for the same patient in the community. *Canadian Medical Association Journal 179* (1), 1013 – 1018.

[ii] Atwood, K. (2021). Using Institutional Ethnography to Bridge the Gap and Develop eHealth Communications for Patient Transitions in British Columbia. *Journal of Applied Social Science 15* (2); 226-240.

[iii] Spina, S.P, Atwood, K.M., and Loewen, P.S. (2020). Evaluation of Secure Mobile and Clinical Communication Solution (SMaCCS) across Acute and Community Practice Settings. *BMJ Innovations 0*:1–8. doi:10.1136/bmjinnov-2020-000436.