

**Innovative**  
**Post-Discharge Solutions:**  
**Nurse Practitioner Clinic**  
**Supporting Post-Hospital Care**  
**for Unattached Patients**

Sherwood Park – Strathcona County Primary Care Network

# The panel



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# Conflict of Interest and Financial Support Disclosure

There are no Conflict of Interests to declare  
for any of the speakers today

This pilot is support by PCN funding and has  
not received any financial or in-kind support

## Mitigating Potential Bias

- ▶ The scientific planning committee has contributed to the consideration of learning needs, the determination of learning objectives, the development of program content, and the choice of speakers or presenters
- ▶ No sponsorship funds have been received
- ▶ The scientific planning committee has reviewed the content of the presentations and ensured that content presented is evidence-based and free of undue influence

# Land Acknowledgement

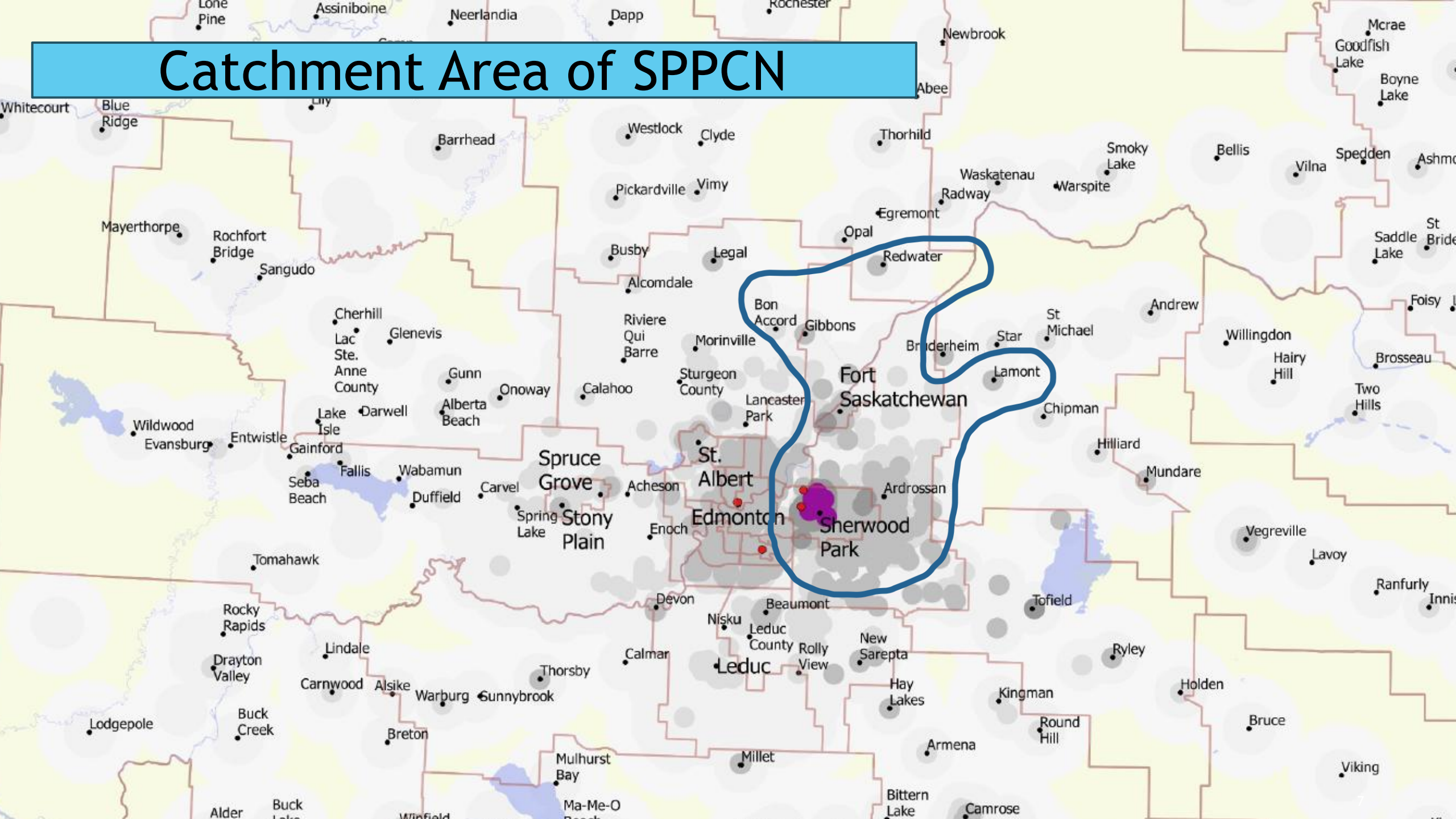
From coast to coast, we acknowledge the ancestral and unceded territory of all the Inuit, Metis, and First Nations people that call this land home.

The Sherwood Park-Strathcona County PCN is on Treaty 6 territory, a traditional meeting grounds, gathering place, and travelling route to the Cree, Saulteaux, Blackfoot, Metis, Dene, and Nakota Sioux.

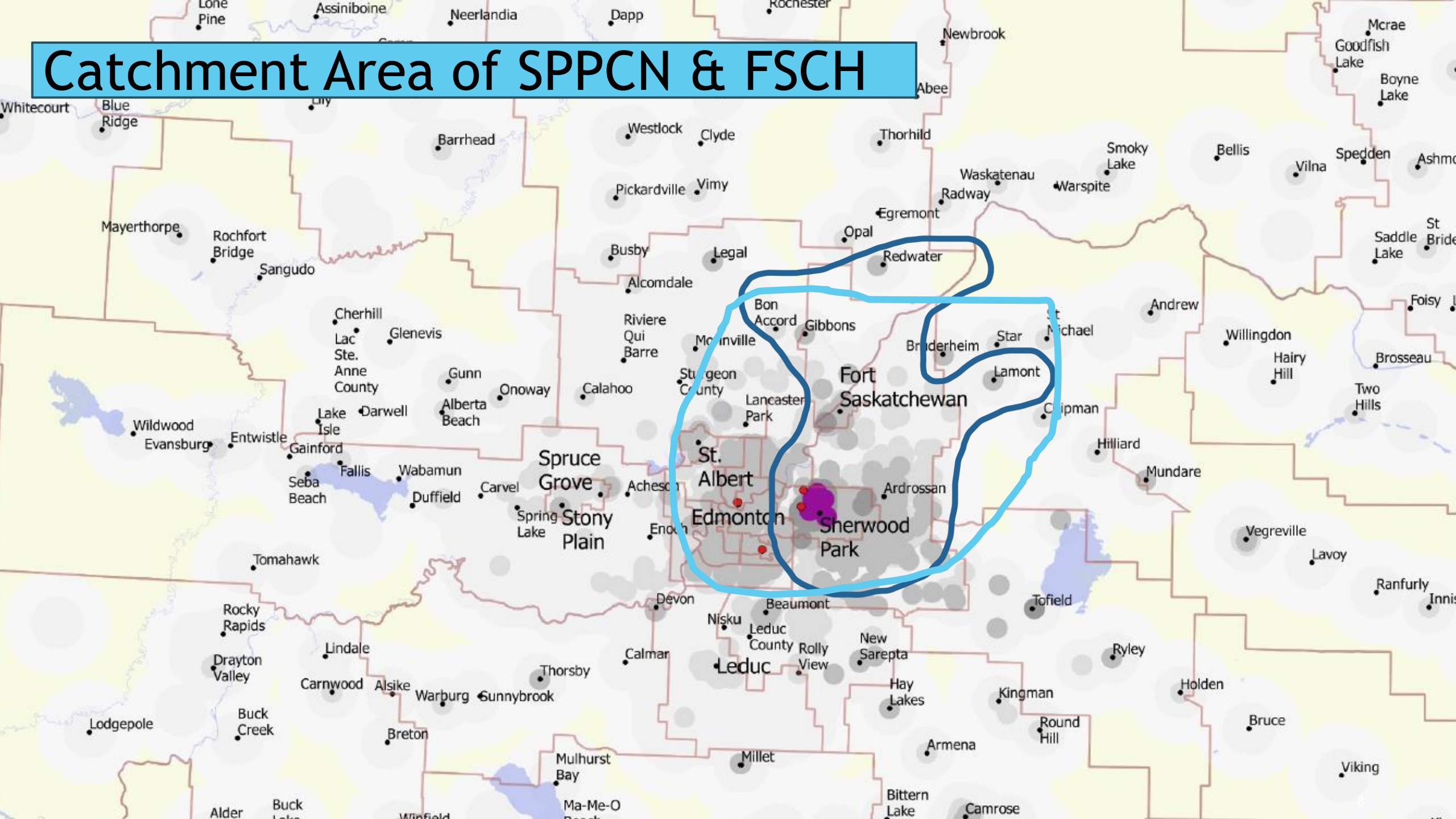
# Objectives

- ▶ Review background information on clinic planning & implementation
- ▶ Demonstrate importance of partner relationship building during clinic implementation & long-term patient attachment
- ▶ Share evaluation metrics & lessons learned

# Catchment Area of SPPCN



# Catchment Area of SPPCN & FSCH



Where did the clinic  
idea come from?

# Background

- ▶ Unattached patient population numbers unacceptably high across the province
- ▶ Home to Hospital to Home guidelines provided a roadmap
- ▶ In conversations with our partners at the Fort Saskatchewan Hospital, the idea of the clinic came to life

What problems were  
we trying to solve  
with this clinic?

## Problems we are Addressing

- ▶ Increased levels of family physicians retiring or leaving the profession
- ▶ Lack of consistent primary care for unattached patients increasing risk of hospital admission and re-admission
- ▶ Lack of patient knowledge of services available post hospital discharge
- ▶ Current practicing family physicians not accepting new patients

Planning Phase:  
What were key factors to  
success with clinic set up?

# Success Factors

- ▶ Building and leaning into partnerships
  - ▶ Hospital and member physician connections
- ▶ Experienced Primary Care Nurse Practitioner provider
  - ▶ Clinic set up and supply needs
- ▶ Communication channels
  - ▶ Regular partner meetings
  - ▶ Patient communication cards



# Success Factors

- ▶ Innovative attachment avenues
  - ▶ Personalize conversations
- ▶ PCN support
  - ▶ Clinical team
  - ▶ Funding
  - ▶ Organizational structure

# Implementation Phase: What is the PCN Hospital Transition Clinic all about?

# Key Components of the Clinic

- ▶ NP led clinic, with admin and new addition of an LPN
- ▶ Patients to be seen within 7-14 days of hospital release
- ▶ Currently same day/same week availability for appointments
- ▶ New intake focus:
  - ▶ Deal with medical issues post discharge to reduce risk of re-hospitalization/ER visit
  - ▶ Coordination of care
- ▶ Follow up appointments booked at first visit
  - ▶ Ongoing primary care medical needs
  - ▶ Initiate routine screening/ASAP Screening





## Key Components of the Clinic

- ▶ Accept the entire immediate family for wrap-around primary care in family unit
- ▶ Uninsured services available at no charge to the patient
- ▶ Evening clinic hours available once a week
- ▶ When possible, home visits within Fort Saskatchewan



# The Clinic Team

Core Team:

NP

LPN

Clinical Admin

# The Clinic Team

- ▶ **Support Team:**
  - ▶ Physician Liaison
  - ▶ Specialty Referral Coordinator
  - ▶ SPPCN Clinical staff, involved as needed:
    - ▶ Dietitian
    - ▶ Behavioural Health Consultant
    - ▶ Pharmacist
    - ▶ CDM Registered Nurse
    - ▶ Exercise Specialist

How do hospital staff  
decide who to  
recommend to the clinic?

# Hospital Decision Making

- ▶ NP looks for any, and all patients that are without a primary provider in the community
  - ▶ Inpatient discharges
  - ▶ Newborns and moms
  - ▶ IV therapy patients
  - ▶ Emergency lab result pool
- ▶ Patients who are attached, but experience long waits to get in to see their provider
- ▶ Patients can be identified upon admission, discharge planning or in the moment of discharge
- ▶ Unique situations: provider on extended sabbatical

Once a patient is identified  
by hospital staff, what is  
the communication flow?

# Communication Flow

- ▶ Communicate with patient about the clinic and gain permission to send info to the PCN
- ▶ PCN Recommendation note is created and messaged to unit clerk
- ▶ Working around lack of Connect Care access



## You have been recommended to the Primary Care Transition Clinic.



### LOCATION

#206, 9821-108 St  
Fort Saskatchewan, AB  
T8L 2J2



### PHONE

780-410-8000 Ext. 4



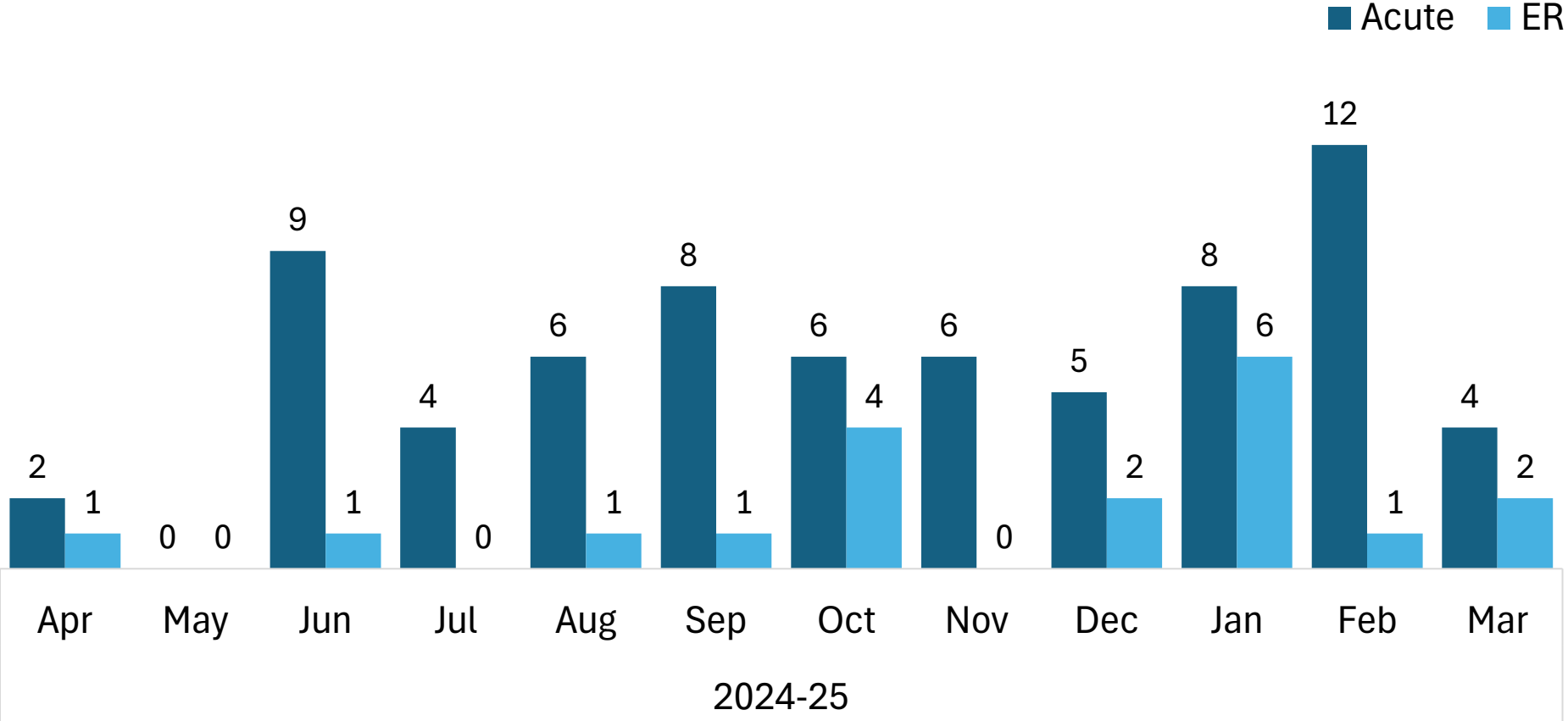
**They will contact you within the first week of your discharge to discuss a follow-up appointment date and time**



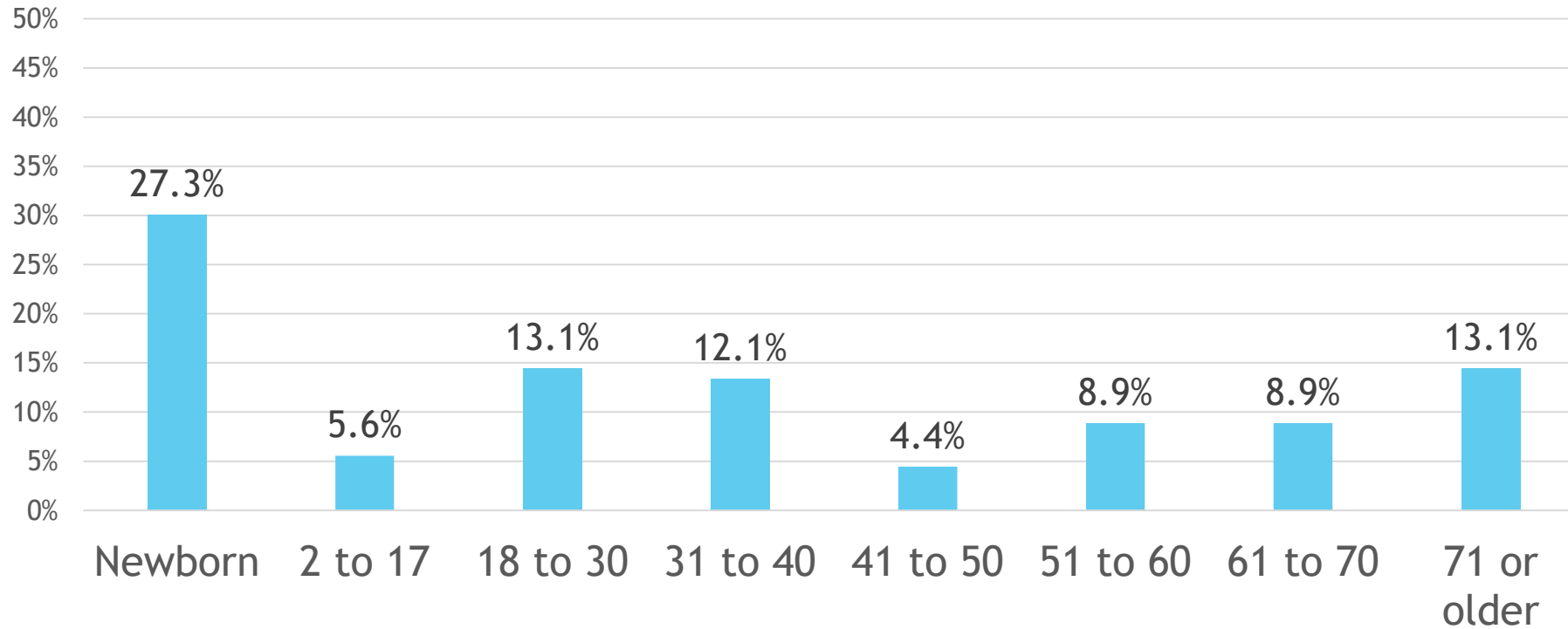
Who are the patients  
being recommended to  
the clinic?

# Recommendations Received

Total of 89 patient recommendations;  
70 from acute care, 19 from the emergency department

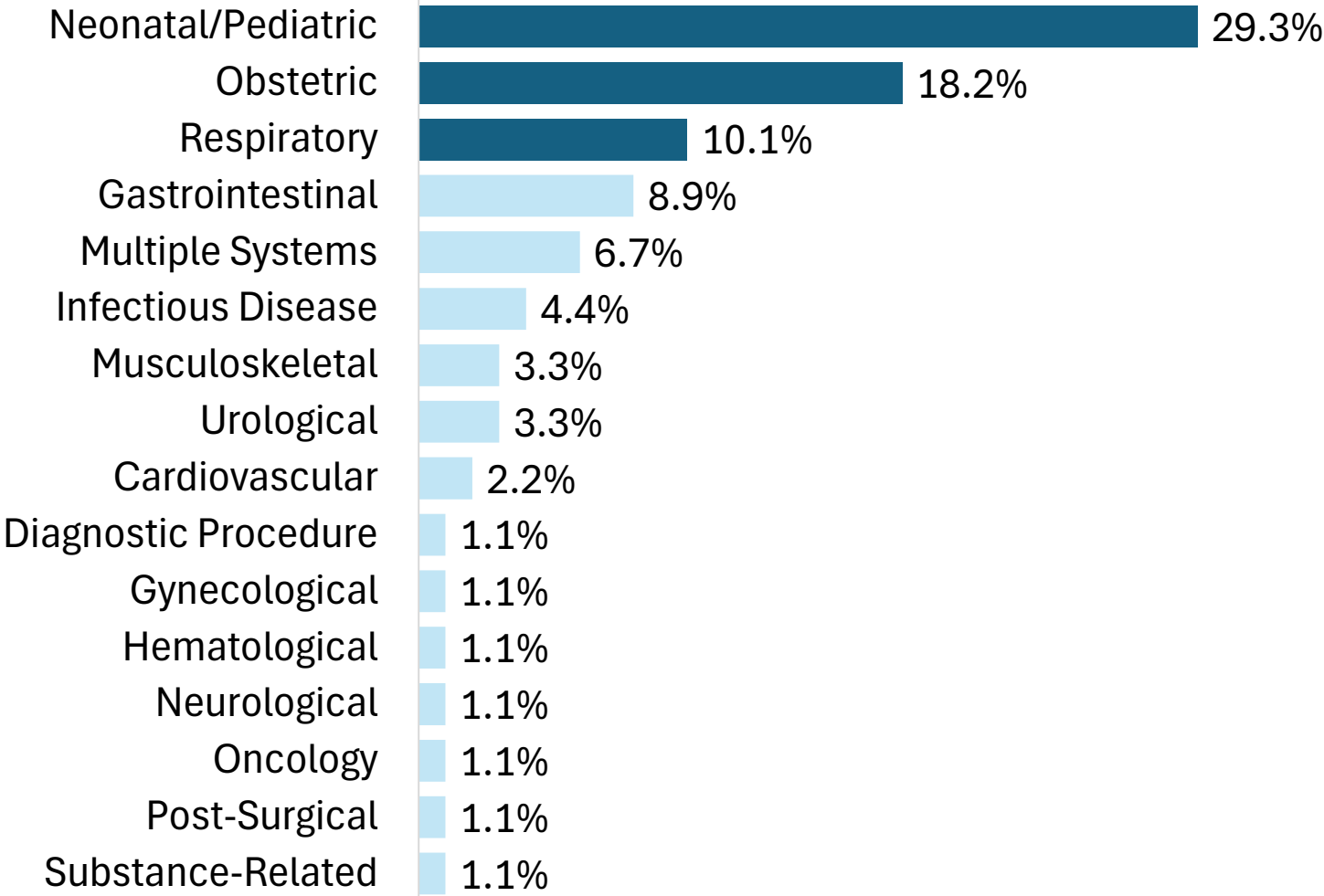


# Age Demographics



n=90

# Reason for Hospitalization



n=90

How are we managing  
long-term attachment for  
these patients?



# Patient Attachment

- ▶ The goal for the clinic includes:
  - ▶ To see the transition of patients from hospital
  - ▶ Meet primary care needs for the short term
  - ▶ Get screening up-to-date and referrals made
  - ▶ Hand off to primary provider for longitudinal care
- ▶ Patient aware our clinic is a short-term transition
- ▶ Board Chair & Medical Director are connecting with physician members

What evaluation measures  
are we looking at?

# PCN staff & Partner Experience

- ▶ Pre-established relationships facilitated a smooth planning and implementation
- ▶ Effective communication and collaboration has allowed prompt resolution of any barriers faced
- ▶ Slower patient flow allowed for process refinement
- ▶ Technology, operations and staffing have been the biggest challenges to overcome

# Patient Experience

- ▶ Patient satisfaction surveys sent out after 8 weeks with the clinic
- ▶ Most patients fully understood why they were being referred to the clinic and understood its purpose
- ▶ 100% were very satisfied or satisfied with the ability to book an appointment in a timely manner
- ▶ 92% were very satisfied or satisfied with the time between leaving the hospital and being contacted for an appointment with the NP
- ▶ 100% were very satisfied or satisfied with the service received from the NP

# Patient Identified Benefits & Barriers

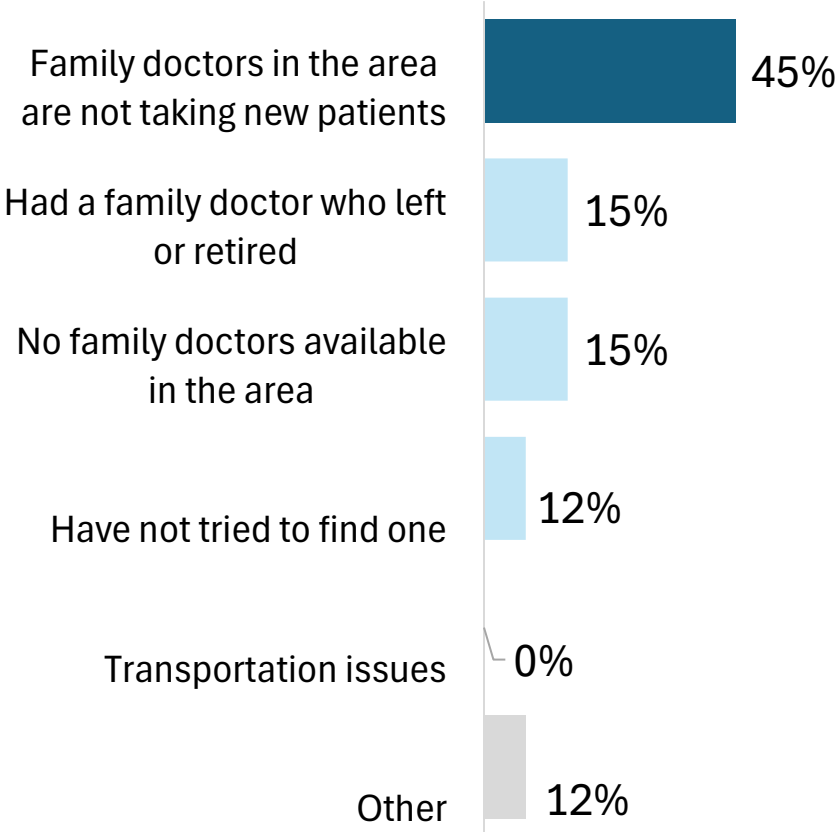
## BENEFITS

- ▶ Access to medical care, including primary care and specialists
- ▶ Friendly and helpful services
- ▶ NP takes extra time, allowing space to talk and clearly explaining topics

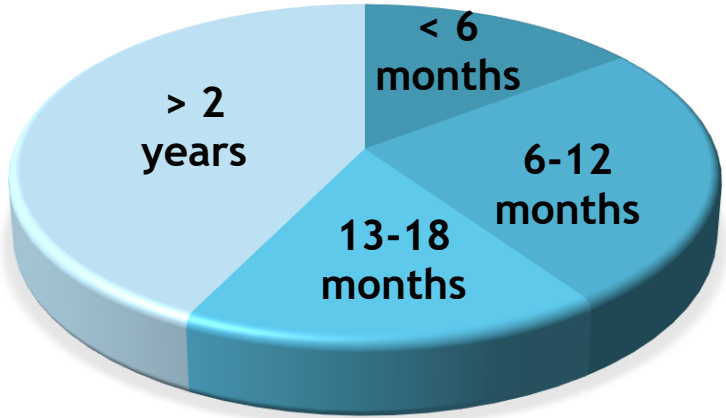
## BARRIERS

- ▶ Clinic location
- ▶ Lack of direct phone number to clinic

# Details on Unattachment



LENGTH OF TIME SEEKING ATTACHEMENT



# Re-admission Rate & Referrals

- ▶ We had a hospital re-admitted rate of 7% within 30 days post discharge
- ▶ 58% of patients were referred to other clinical services within the PCN
- ▶ 67% needed a speciality referral, which was facilitated using our Speciality Referral Coordinators

What were the learnings  
along the way?

# Learnings

- ▶ Uptake slower than expected
- ▶ Important to set out processes for receiving timely hospital recommendations
- ▶ Communication
  - ▶ No access to Connect Care, importance of direct fax
  - ▶ Quarterly partner meetings





# Learnings

- ▶ Day to day clinic versus consult only PCN
- ▶ Initiating WCB process/EMR integration
- ▶ NP coverage requirements

Where are we at  
today and where we  
are going?

# Transition Clinic Today

- ▶ Fort Saskatchewan Community Hospital
  - ▶ Acute care
  - ▶ ER
  - ▶ IV therapy
  - ▶ OR
- ▶ Expanded to Lamont Health Care Centre in December 2024
- ▶ Looking to expand to our other partner hospitals:
  - ▶ Redwater Health Centre
  - ▶ Strathcona Community Hospital
- ▶ Needs expressed from other hospital sites for newborn care

# Transition Clinic Future Plans

- ▶ Transition patients to community providers for longitudinal primary care
- ▶ LPN completing patient phone calls within 72 hours post hospital discharge
- ▶ Expanding quarterly partner meetings
- ▶ Focus on "FLOW" of patients coming in/going out of Transition Clinic
- ▶ Attempt to match patient and provider expertise to increase successful PCP attachment

What are the key  
takeaways from this  
presentation?



# Key Takeaways

- ▶ Relationships, Relationships, Relationships
  - ▶ **Initiate** partnerships with local hospitals
  - ▶ **Engage** with physician members to create list of providers willing to accept patients
- ▶ Build solid internal communication processes
- ▶ Leverage your resources (i.e. experienced primary care providers, PCN services, hospital connections etc.)
- ▶ Embrace innovation in the face of uncertainty

# Thank You



## Fort Saskatchewan Community Hospital



Questions?