Insights Following the Implementation of a Family Medicine Based Virtual Ward

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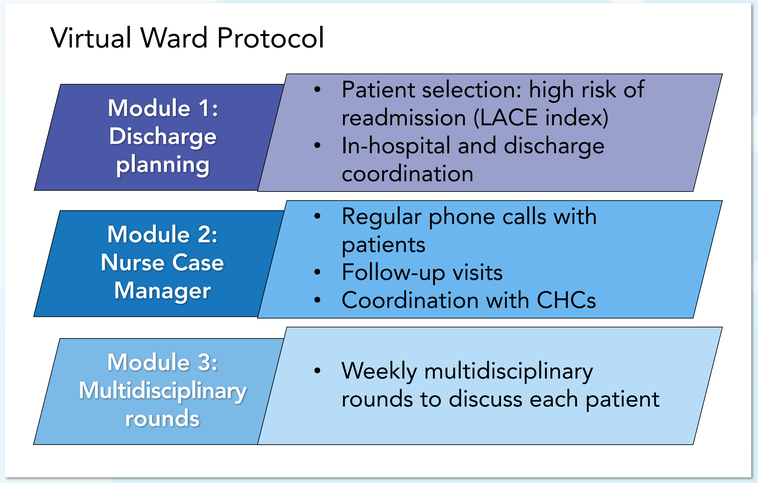
CONTEXT

- The *Virtual Ward* (VW) is a patient-centered transitional care intervention that aims to improve care coordination between hospitals, family physicians, community health centres (CHC), and patients and their families
- This intervention is expected to reduce readmission, length of stay, and risk of death following hospital discharge



OBJECTIVES

1. Describe the VW implementation process
2. Identify barriers faced by the multidisciplinary team
3. Identify strategies for overcoming these challenges

METHODS

- Study design: Qualitative descriptive design using a participatory research approach (researchers, clinicians, patient partners)
- Data collection: Focus groups with the VW team and two potential implementation sites
- Analysis: hybrid thematic analysis of favorable conditions, challenges and recommendations (Diffusion of innovation framework combined with emergent themes)

RESULTS

Implementation process

1. Developed Virtual Ward protocol through literature review
2. Secured funding for full-time nurse case manager
3. Established roles of hospital and CHC staff
4. Developed communication procedures (CHCs, Family physicians, patients and caregivers)
5. Continuously reflected upon and revised processes

Facilitators

Internal characteristics (VW team)
- Built on established home care program
- Multidisciplinary team already established
- Dedicated and passionate Virtual Ward Family Physician

Institutional characteristics (hospital)
- Hospital-based Family Medicine Unit
- Support from hospital Director
- Improving care of frequent users is a priority
- Pilot funding provided

Barriers

Difficulty recruiting Family Physicians
- Government pressure to increase patient volume
- Few incentives for home care
- Few incentives for Family Physicians to improve hospital outcomes

Difficulty working with CHCs
- Limited resources to follow discharge plan
- Home care services overburdened
- Lines of communication not established

Nurse: *"I think people who already know the patient need to be involved across the continuum [...] it saves the wasting of time gathering information that has already been gathered, somewhere else by someone before."*

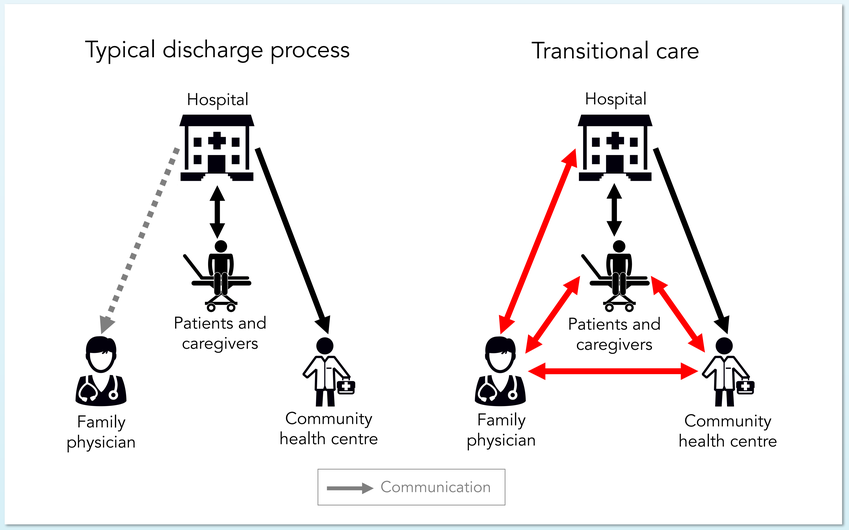
IMPLEMENTATION STRATEGY

Recommended first steps

1. Identify a Virtual Ward champion for each site
2. Identify dedicated case manager
3. Establish coordination processes around a single patient
4. Establish lines of communication first with the more frequently used CHCs
5. Develop process for identifying and notifying Family Physician upon hospital admission
6. Develop process for involving Family Physician and CHCs in rounds
7. Standardize information collection
8. Work to incentivize home care and care coordination for Family Physicians

Adapting the intervention to different contexts

- This intervention addresses the limited communication and coordination between hospitals, family physicians and CHCs and patients and their families.
- Modules may be used separately, according to the needs and capacities of different settings such as where better systems of communication are already in place (i.e. fully integrated electronic medical record systems, tightly knit communities) or where more comprehensive home care is provided.



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