North York Family Health Team

7- Day Follow-Up Post-Hospital Discharge for High-Risk Patients

October is audit month for 7-Day Follow-Up again. A number of physicians identified themselves as volunteers to collect this data. We will email you in the next week to remind you.

Everyone, please continue to strive to see high-risk patients within 7 days of hospital discharge. The list of high-risk conditions and information posters are attached to this newsletter. Patient information encouraging follow-up within 7 days is also on our website. Please consider adding www.nyfht.com to the bottom of your office email signature, if you email patients.

Although 7-Day Follow-Up is technically the "integration" measure for our QI Plan, many people view it as a proxy measure for access. In the last few years, changes in both preventive care guidelines and fee schedule have allowed us to re-purpose our time. Let's ensure we have sufficient same day / next day spots in our schedules to be able to provide prompt follow-up to some of our sickest patients.

Eye See… Eye Learn®

Eye See…Eye Learn®, a free program administered by the Ontario Association of Optometrists (OAO) designed to detect, diagnose and treat children with vision problems, is available across Ontario. This initiative is based on a need- children are not being tested and fall behind in school.

- Children starting Junior Kindergarten are eligible for one complimentary pair of glasses with their annual OHIP eye exam, if prescribed, through participating optometrists.
- Every child (under 19 years) in Ontario is entitled to an annual OHIP-insured eye exam by an optometrist.

For more information on this program and list of participating optometrists, visit www.EyeSeeEyeLearn.ca

Poverty Screening at NYFHT

Poverty is a major social issue and is considered to be one of the strongest mediating factors influencing the health of individuals. As it can be difficult to identify patients who are living in poverty, screening practices may allow providers to consider a patient's socioeconomic status in their care plan.

Earlier this year, NYFHT ran a Poverty Screening Pilot led by Kimberly Wintemute and Amanda Hodges. In this initiative, we selectively screened for poverty, and provided a case work referral to help individuals maximize their income. The results of this pilot suggested that patients were **comfortable** with the screening questions; and reported that the referral was very **acceptable** and **useful**. Patients also reported the referral to be **informative** and **supportive**. *Thank you to the Poverty Working Group and all the pilot sites for your contribution.*

This project has received this year's *College of Family Physicians of Canada (CFPC)'s Patient's Medical Home 60/20 Caring and Compassion Grant* – totalling **$4000**. Funds will be used to expand this as a FHT-wide initiative. Please stay tuned!

Please contact Amanda Hodges (ahodges@nyfht.com) or Joyce Lo (jlo@nyfht.com) if you would like to learn more about supporting patients in need.

North York
Family Health Team

North York Family Health Team Management Office

240 Duncan Mill Road, Suite 301
Toronto ON M3B 3S6

Tel: 647-260-1433 Fax: 416-623-7425

North York
Family Health Team

Have you just been discharged from hospital?

If so, you need to see your family doctor within 7 days if you were admitted for any of these reasons:

- Stroke
- COPD
- Pneumonia
- Congestive Heart Failure
- Diabetes
- Heart Attack or Angina
- Stomach and/or Bowel Problems (see our website at www.nyfht.com for a list of specific stomach/ bowel problems)

North York
Family Health Team

Follow-Up within 7 Days Post Hospital Discharge for Selected Patients

Certain patients are at high risk of readmission within 30 days of hospital discharge.

The ability for these patients to be seen by their primary care provider within 7 days of discharge is a quality measure being monitored within primary care organizations. It is a mandatory measure on our QI Plan. It is shown to decrease the chance of re-admission.

Attached is a quick reference sheet for physicians and nurse-practitioners, outlining the relevant patient groups.

Please make a special effort to see these patients (either in office or at home) within 7 calendar days of discharge.

If you are a designated NYFHT data collector for this project, please track these patients in the attached table. We require patient name or chart number so that we may look back in a QI (not research) audit, to identify barriers to prompt post-discharge visits.

The Institute for Clinical Evaluative Studies (ICES) tracks the date of patient visits after hospital discharge by physician billing data.

Thanks again for participating.

Dr. Kimberly Wintemute - kwintemute@nyfht.com
Marjan Moeinedin - mmoeinedin@nyfht.com