Transitions and Care Planning in the Patients Medical Home

Background: ADAPT and **one:care**path are leading a coordinated approach to integrate, spread, and scale current disease-specific pathways work into a **disease-inclusive approach to be used in primary care**. Through combined engagement, primary care providers will participate in co-development activities to inform content, processes, and tool development for ADAPT and **one:care**path. This work will focus on optimizing care for Albertans with five chronic diseases: **heart failure, chronic obstructive pulmonary disease, cirrhosis, end-stage kidney disease, and stage 3/4 cancers**.

The Initiatives:

Working towards the same key outcomes, these initiatives focus on discrete aspects of the patients' journey through the health system

ADAPT focuses on **optimizing transitions from hospital to home.** ADAPT will implement 3 of 6 elements of the Home to Hospital to Home Transitions Guideline (admit notification, transition planning, and primary care follow-up). Implementation will be tested in five acute care sites and associated Primary Care Network (PCN) clinics across the province. $**1.2 million in funding** will provide support for current state analysis; change management; development of local leaders/champions; evaluation; implementation science; and facilitation between acute, primary care and other key stakeholders.

one:carepath focuses on enhanced support for patients with **advanced stage diseases within their medical home**. one:carepath will implement standardized processes and tools to support ongoing care planning through an interactive digital decision support tool for healthcare providers & patients/family caregivers. Elements will include risk stratification, disease and symptom management guidelines, crisis planning, decision aids, and shared care plans. one:carepath will identify and transition patients to more palliative approaches to care as appropriate. Implementation will target **350 physicians** aligned with participating PCNs. **$4.8M of funding** will provide supports as above for ADAPT. Over **$2 million will go directly to primary care** to fund co-development and implementation activities.

Co-Development Opportunities

Post discharge process in primary care: Determine what constitutes a successful follow-up visit in primary care after patients' transition from hospital.

Integration of foundational and disease-specific components into ADAPT: Iterative, consensus building workshops to provide input on admit notification, transition planning, and follow-up to primary care processes.

To participate in these transitions planning activities contact pamela.sterling@ahs.ca

Shared-care planning: Determine content requirements and information needs of primary care for ongoing patient centered shared-care planning and documentation.

Interactive digital decision support tool: Provide input on the one:carepath interactive healthcare provider Web Platform (e.g., content, navigation, clinic process integration).

To participate in the care planning or the digital decision support tool activities, contact kirby.scott@ahs.ca

Time Commitment & Compensation

For each co-development opportunity, the time commitment may be a **1-hour** interviews and/or a **2-hour** consensus building workshop (both virtual). We will compensate participating primary care physicians at an hourly rate of $189.

Please consider sharing your time and experience to help improve transitions and the care of Albertans with chronic diseases in their Medical Home.

Alberta Health Services Inspiring solutions. Together.
Primary Health Care Integration Network

UNIVERSITY OF ALBERTA

UofA Ethics ID: ADAPT Pro00101674, one:carepath Pro00110585

Version 4.0, Last Updated 18 June 2021