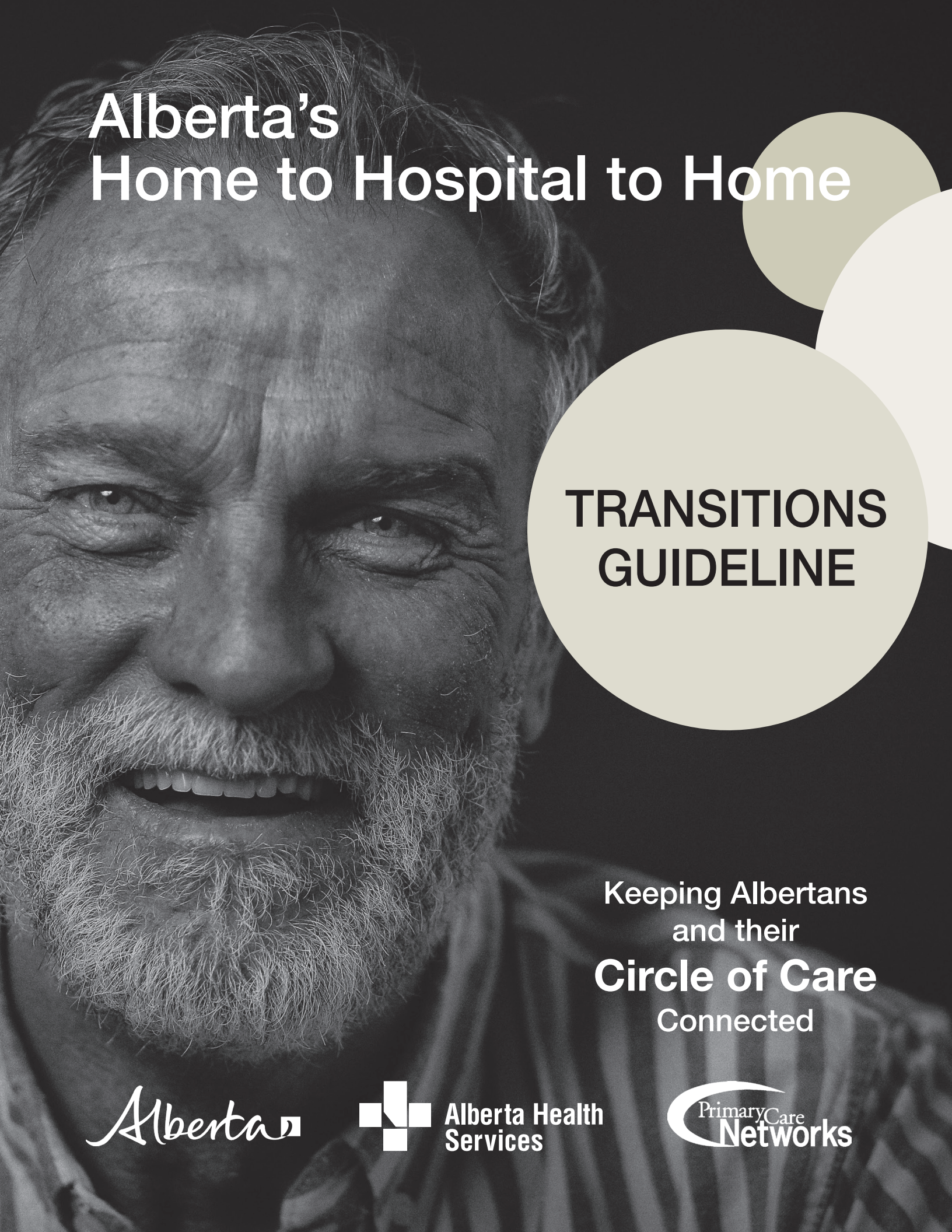


Alberta's Home to Hospital to Home

TRANSITIONS GUIDELINE

Keeping Albertans and their

Circle of Care

Connected

Alberta

Alberta Health Services

Primary Care Networks

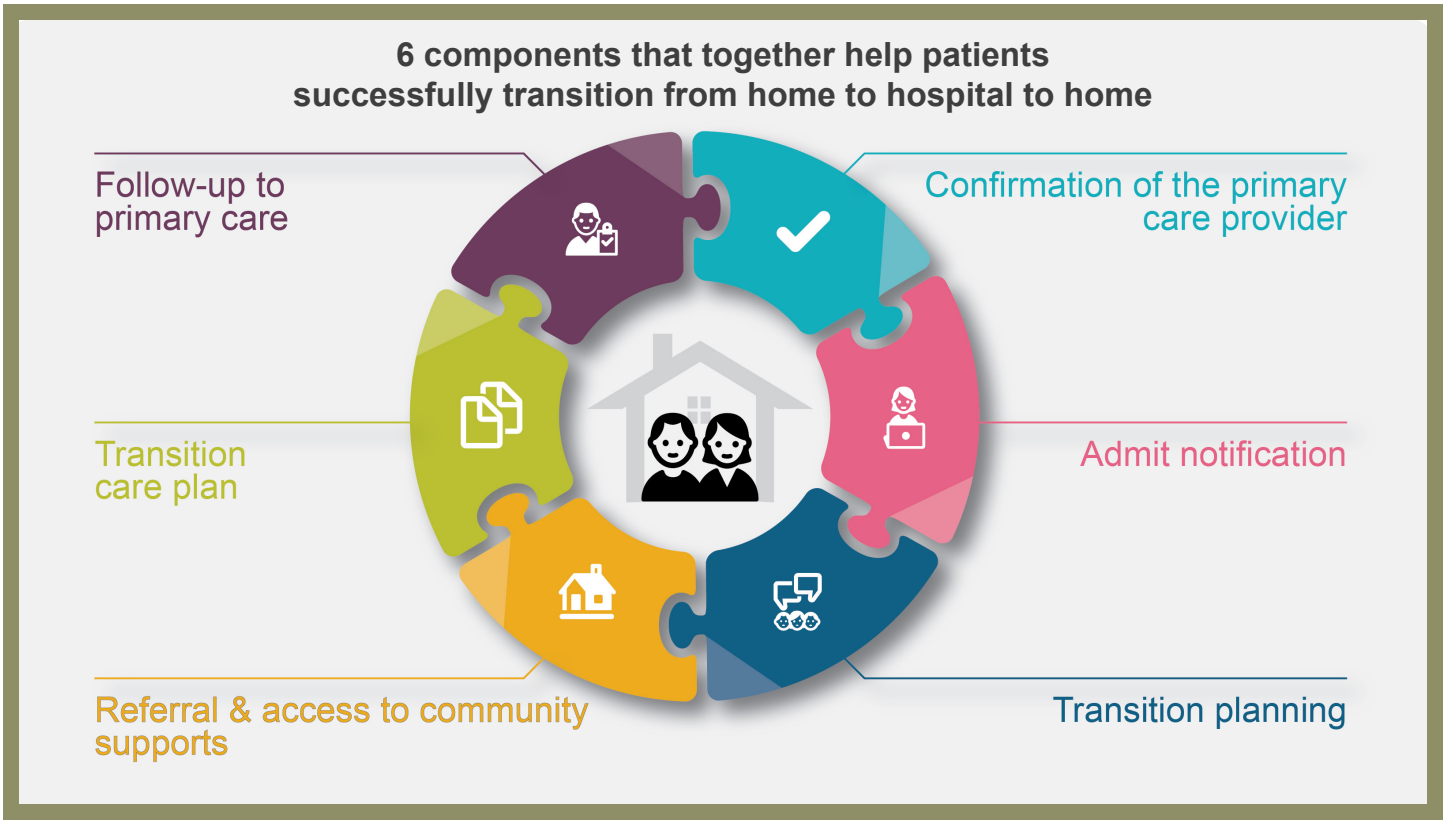
November 2020

This guideline has been prepared by the Primary Health Care Integration Network, Alberta Health Services.

Contact

For more information, questions or comments please contact:

Primary Health Care Integration Network
PHC.IntegrationNetwork@albertahealthservices.ca



> "If there is better planning and better familiarization with the situation (around transitions of care), many of these patients will be able to cope and understand what they are going through, and that will be beneficial to them both in the confidence they have in the outcome of the situation and also in their confidence of the healthcare system in general."
>
> – John, patient/family advisor

Forewords

Alberta Health

Primary health care is the main point of contact for most Albertans with the health care system, and provides connection and coordination with other parts of the health and social system. Primary health care supports continuity, which means patient care is coordinated across settings, information is shared with the patient, and transferred across providers.

Alberta's first Home to Hospital to Home Transitions Guideline will provide a framework for primary health care and acute care to ensure safe, successful transitions between acute, primary and community care providers. Patients and their families should be equal partners in making decisions about their care, and the guideline places an emphasis on the patient as the center of transition planning. I look forward to Primary Care Networks (PCN) and Alberta Health Services (AHS) working together to implement these guidelines.

Dean Screpnek
Former Assistant Deputy Minister
Health Workforce Planning and Accountability
and Chair, Provincial Primary Care Network Committee
Alberta Health

Alberta Health Services

Alberta's healthcare facilities provide world-class care, but what happens within the hospital walls is only one piece of a patient's journey. The Home to Hospital to Home Transitions Guideline outlines how to integrate the support a patient receives from primary healthcare, their community and their loved ones, with the care they receive while in the hospital. I am thrilled that Alberta continues to be a world leader in integration by defining how best to manage transitions in care. I am asking all providers and patients from across the province to join me in embracing the processes and partnerships outlined in this guideline because I truly believe this will benefit Albertans.

Dr. Verna Yiu
Former President and Chief Executive Officer
Alberta Health Services

Primary Care Network Physician Leads Executive

As primary care physicians, we know our patients' stories. We understand the nuances of their medical history and have learned what matters most to them and their families. Implementing the Home to Hospital to Home Transitions Guideline aims to facilitate working in partnership and coordinating patient care with AHS providers, throughout a patient's journey. The Provincial PCN Committee was pleased to collaborate on Alberta's first provincial guideline for home to hospital to home transitions. We endorse its use in all primary care practices, PCNs and AHS facilities. We look forward to better, safer transitions for all our patients.

Dr. Ernst Greyvenstein, Calgary Zone
Dr. Fredrykka Rinaldi, South Zone
Dr. Helen Akosile Xulu, North Zone
Dr. Jordan LaRue, Central Zone
Dr. Justin Balko, Edmonton Zone
Primary Care Network Physician Leads Executive

John Hanlon
Patient and Family Advisor

Patients and Families

My passage through Alberta's health system was successful but not quick or entirely smooth. I had suffered a sudden and sharp hearing loss that made even simple communication with others either difficult or nearly impossible. Eventually, though, I returned to the World of Hearing courtesy of hearing aids. Throughout my journey I was impressed by the quality and concern of the healthcare professionals. But the long waits? They were new to me, as I had spent the last 20 years smoothly navigating the healthcare system in Tokyo where I worked as a journalist. There, I routinely visited specialists or underwent MRIs just a week after referral.

I was aware, however, that Alberta Health Service was taking measures to improve the system. So I decided to do whatever I could to help. That's why I became a patient and family advisor and eventually joined this Home to Hospital to Home project.

It aims to help patients by making their transitions to and from home and hospitals safer and more effective. The importance of this goal became painfully clear to me after talking with patients whose transitions hadn't gone well. One tearful mother described her helplessness and anguish over repeated and avoidable failures to get the treatment her daughter needed. Another patient told me his promised homecare didn't materialize. Quelling what he called a panicky feeling, he realized he would have to change his own dressing. But first he had to learn how.

Now, with this guideline, we have an opportunity to help patients avoid situations like these by making hospital and home transitions better and, yes, safer. The recommendations you will read are the result of more than a year of intensive collaboration among patients, healthcare providers, health system leaders and physicians. There will be challenges in implementing these recommendations, but I'm encouraged by the passion and commitment of the many healthcare providers and Alberta Health Services staff whom I've come across during the project. If they're an indication of the overall enthusiasm to implement safer transitions, patients have good reason to be optimistic.

I would like to thank Alberta Health Services staff who went to great lengths to ensure that patients took part in the guideline initiative. To ensure patients have the tools they need to be equal partners in the transition process, they formed the Patients Transitions Resources team that I and other patient and family advisors served on. I praise my teammates for their insight, dedication and passion while serving so effectively as the voice of Alberta patients. I am proud to have worked with them.

John Hanlon
Patient and Family Advisor
Alberta Health Services

Acknowledgement

With input from over 750 stakeholders, including more than 15 patient and family advisors, this Home to Hospital to Home Transitions Guideline initiative is a critical resource to enable system integration.

Providers from acute, primary and community care united alongside patients and researchers to design Alberta's first provincial guideline on how to support patients as they transition from their community, into hospital and back home again. The input of so many stakeholders helped ensure the guideline reflects leading evidence, best practice and the real needs of Albertans.

Integration and team-based care, where providers across the system collaborate with each other and with patients and families, is the future of healthcare. The diverse groups of people who sat down together during this initiative — from patient advisors to family physicians, allied healthcare providers to hospital physicians and administrators — demonstrate that future is already coming to life in our province.

> "Input from over 750 stakeholders, including more than 15 patient/family advisors."

To every person, team and organization who set aside traditional roles and organizational boundaries to work on this guideline, thank you for making the guideline reflective of a patient's full continuum of care. The publication of the Home to Hospital to Home Transitions Guideline marks a major milestone in our province's journey towards complete system integration. Because of your willingness to come together and collaborate, the future is now!

> "Perspectives from patient/family advisors helped ensure this guideline reflects the needs of Albertans from Lethbridge to Sexsmith, from Foremost to Sylvan Lake."

To our patient and family advisors who generously volunteered hundreds of hours and courageously shared their stories, thank you for being our partners. Hearing what matters to you transformed the way we approached this initiative. You are the reason each section of the guideline outlines the important role patients, families and caregivers play in successful and safe transitions. Your stories illustrated what evidence tells us — that equal partnerships with patients and their loved ones are critical to wellness and recovery. We can't thank you enough for walking beside us each step of the way on this Home to Hospital to Home initiative. Perspectives from patient and family advisors helped ensure this guideline reflects the needs of Albertans from Lethbridge to Sexsmith, from Foremost to Sylvan Lake.

"Alone we can do so little; together we can do so much." These words from Helen Keller capture perfectly the collaboration required to create safe, reliable and effective transitions in care. Whether you were involved in the guideline initiative or, most importantly, are embracing it in your day-to-day work, thank you. Together we can and are making a difference in the lives of Albertans.

Rob Skrypnek
Senior Program Officer, Primary Health Care
Senior Provincial Director, Primary Health Care Integration Network
Alberta Health Services

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Introduction

Albertans often access multiple providers and services on their journey from community, to hospital and then back home. If we, as providers, can dissolve the organizational boundaries between these services, we can help ensure Albertans have the support they need to stay well in their community — on their terms. Alberta's first province-wide Home to Hospital to Home Transitions Guideline for adult patients will help healthcare providers and teams in acute, primary and community care operate as a singular entity with patients and their loved ones as equal partners — where people and communities, not diseases, are at the centre of the system.

> "Albertans consistently identify transitions in care as a critically important issue."

Transitions in care are defined as a set of actions designed to ensure the safe and effective coordination and continuity of care as patients experience a change in health status, care needs, healthcare providers or location (within, between or across settings, including home).[1] High quality, seamless transitions improve relational, informational and management continuity.[2]

Albertans consistently identify transitions in care as a critically important issue, particularly for patients with chronic conditions and complex care needs, as they are the highest users of the health system and have the most frequent transitions.[2,3]

To provide the best quality care and keep patients safe, their information needs to be transferred between providers, they need appropriate follow-up after leaving hospital and they need coordination across the continuum of care, both pre- and post-hospitalization.

By implementing this guideline into your quality improvement initiatives, you can help integrate Alberta's system and continue to improve care and outcomes for patients.

Call to Action

In 2017, improving patient transitions was set as a priority in Alberta through the new Primary Care Network Governance Framework. In mid-2018, the Alberta Health Services' Quality, Safety and Outcomes Improvement Executive Committee and the Provincial Primary Care Network Committee asked for a province-wide transitions guideline, which would outline what ideal transitions would entail. The Primary Health Care Integration Network (PHCIN) led the co-design of this guideline in an effort to build on existing improvement initiatives across the province.

Solution

Improvement initiatives that simultaneously implement several components of a transition across the patient journey[4,5] (i.e., timely follow-up with primary care, transition-planning processes involving the patient and care team) have been reported to have the most positive outcomes, such as reduction in readmission, length of stay and emergency department encounters.[4]

The PHCIN augmented this evidence with an environmental scan, literature review, a co-design collaborative, stakeholder interviews and a panel of experts to finalize content (modified Delphi methodology). They worked with hundreds of partners including primary care providers; community health service providers; specialists; and patients, family and caregivers to identify key processes that will be effective in Alberta.

To assist providers and teams within Alberta, this guideline presents leading operational practices, change management, tools and resources, and additional information for the following sections:

- Confirmation of the Primary Care Provider
- Admit Notification
- Transition Planning
- Referral and Access to Community Supports
- Transition Care Plan
- Follow-Up to Primary Care

How to Use this Document

This guideline bridges the connections between hospitals, primary care and community services, with patients, families and caregivers at the center. Transitions in care require a coordinated approach as many factors may contribute to high quality care transitions.

Although the sections below are listed separately, the transition activities listed within will happen simultaneously and likely overlap. Each section is foundational in the patient journey and builds upon one another to facilitate high-quality transitions.

INTENDED AUDIENCE

- Healthcare providers and teams working in hospital, primary care and community settings. To be used in partnership with patients, families and caregivers.

INTENDED USE

- For adult patient populations, particularly those living with chronic disease.
- This guideline is not a policy; it is a collection of high-level recommendations around how primary care, community and specialists can work together and with patients, families and caregivers to provide better care for Albertans.
- This guideline is not a one-size solution for everything; it is a starting point for teams to work together on patient shared care planning across transition points.

PATIENT INVOLVEMENT

- **A unique, dedicated group of patients provided recommendations on existing patient resource tools to inform healthcare providers about patient and family perspectives on transitions in care.** Find out more by following this link: **www.ahs.ca/hhhguideline**

It is recognized that locally, each zone/facility/Primary Care Network will be at differing stages of readiness in terms of implementation. Teams will be working within their own context to address key aspects in the guideline which will be prioritized differently across zones. The leading operational practices are meant to highlight key processes that teams can work towards during their implementation journey.

Various aspects of implementing this guideline are dependent on initiatives such as Connect Care and other supporting technological infrastructure (i.e., Central Patient Attachment Registry) to be in place. The goal is to work towards preparing for the future state when patients have one seamless electronic health record which tracks their journey and care plan across care settings.

Confirmation of the Primary Care Provider

Background

Confirming the attachment relationship between a primary care provider and a patient is a crucial step in ensuring bidirectional flow of information between primary care providers and hospitals. Confirmation needs to occur as early as possible in the admission process. This step ensures the hospital admit notification and subsequent transition care plan are sent to and received by the correct primary care provider. Additionally, the primary care provider will be able to provide key information to assist with the patient's hospital care and their transition from hospital to home. Without this step, the patient and hospital team may assume the primary care provider is still practicing in Alberta (i.e., has not retired or moved to another area to practice) and agrees to accept responsibility for the care of this patient upon discharge.

> "Confirmation needs to occur as early as possible in the admission process."

During this step, three types of attachment will be identified:

1. **Current attachment**
   – a patient's attachment to a primary care provider is confirmed
2. **Previous attachment**
   – a patient's attachment to a primary care provider is not confirmed
3. **No attachment**
   – a patient has no attachment to a primary care provider (i.e., unattached)

When the attachment relationship is not confirmed and the patient would like to be connected to a primary care provider, the hospital team will work collaboratively with the appropriate Primary Care Network (PCN) to facilitate a connection with a primary care provider who has capacity to care for the patient. Patients who are currently unattached may also request to be connected with a primary care provider upon discharge, whereas other patients may not want to pursue this connection.

Leading Operational Practices

Hospital Team

- Ask the patient, family and caregivers for the **name of the primary care provider▲** or clinic **they attend most regularly** who could assist with the patient's care in hospital and support their transition from hospital to home
- Contact the primary care provider to confirm the attachment as soon as possible
- If attachment is not confirmed, collaboratively work with the appropriate PCN to connect a patient to a primary care provider prior to discharge, when applicable

CHANGE MANAGEMENT TIP
Document primary care provider name and/or affiliated clinic in patient chart

Patient, Family and Caregivers

- Identify the name of the primary care provider or clinic they attend most regularly, when applicable
- If a regular primary care provider or clinic is not known, identify any other providers seen on a regular basis (i.e., walk-in clinic)

Primary Care Provider/Team

- Agree or disagree the attachment relationship is correct upon receipt and communicate the decision with hospital
- **Agree to accept the responsibility▲** for the care of the unattached patient, when applicable

CHANGE MANAGEMENT TIP
Primary care provider confirms attachment relationship with hospital

Community Supportive Care Teams

- Be aware and document patient's primary care provider in medical record or patient chart, when applicable

Potential Benefits

Improved informational and management continuity across care settings.

Additional Information

When both Connect Care and the Central Patient Attachment Registry (CPAR) are established in Alberta, confirming the attachment relationship will be seamless, allowing for the bi-directional flow of information between primary care providers and hospital.

Some patients may only identify a clinic rather than the name of a primary care provider. Processes will need to be developed to confirm this type of attachment.

For patients with no current attachment, the process of connecting them to a primary care provider will be beneficial to managing their care (for example with follow-up appointments and prescriptions).

In Alberta, the term attachment is widely used in primary care; it may need to be introduced to other care providers in the health system.

> "Everybody's responsible for their own health, but . . . I think the family physician needs to be the quarterback."
>
> – D'Arcy, patient/family advisor

Tools and Resources

Primary Care Networks "Alberta Find a Doctor" Website – Managed by a committee of executive directors, physicians and communicators from the Primary Care Networks, this site is a tool to that allows patients to key in an address, postal code or community to find out which PCN family doctors are accepting new patients in their area.

Continuity of Care and Establishing the Physician-Patient Relationship: CPSA Standards – *College of Physicians and Surgeons of Alberta* outlines the minimum standards of professional behaviour and ethical conduct expected of all physicians registered in Alberta.

Community Information Integration (CII)/Central Patient Attachment Registry (CPAR) – Managed by the *Alberta Medical Association's Accelerating Change Transformation Team*, this site provides a detailed overview of this attachment and continuity initiative for both patients and providers.

Confirming Attachment with a Family Physician – Managed by the *Alberta Medical Association's Accelerating Change Transformation Team*, this document provides a script for 'Confirming Patient Attachment to a Family Physician/Consent if No Family Physician.'

Communicating with Patients about why Attachment Matters – Managed by the *Alberta Medical Association's Accelerating Change Transformation Team*, these are posters that can be presented in a family physician office that reinforce the importance of continuity of care with a patient's attached physician. The messages in the posters reflect what patients care about in language they understand, represented by diverse images of real people.

Admit Notification

Background

Admission to hospital is a transition point that requires organized and prompt communication between a patient's identified circle of care and the hospital.[6] Awareness of an admission presents the opportunity for bidirectional flow of information between a patient's circle of care and the hospital (i.e., informational and management continuity). The patient's circle of care can contact the hospital team (e.g., attending physician) to convey vital information, such as a patient's history, care plan, medications and any social or family dynamics that may affect care.[7-9]

It is important to note the confirmation of the primary care provider should have already occurred and supports the implementation of this section of the guideline.

> "Admission to hospital is a transition point that requires organized and prompt communication between a patient's identified circle of care and the hospital."

Leading Operational Practices

Hospital Team

- Notify the patient's identified circle of care, including the attached primary care provider and/or community supportive care team members, of hospital admission immediately through eNotification (i.e., sent directly to Electronic Medical Record)
- Request any recipient of an admit notification to send a confirmation that notification was opened and read
- **Request and receive relevant patient information▲** from the patient's identified circle of care as soon as possible, when applicable

CHANGE MANAGEMENT TIP

Incorporating patient information from care teams outside of the hospital provides the opportunity to collaborate to enhance patient care

Patient, Family and Caregivers

- Share with the hospital team the identified circle of care (e.g., specialists, mental health practitioners)
- Share a comprehensive list of medications including prescriptions and supplements (e.g., green sleeve with medication list, goals of care plan with medication list) with the hospital team
- Share current life circumstances ("what matters to you"). This could include current living situation, what life looked like prior to hospital admission (e.g., walking, mobility), social supports, etc.

Primary Care Provider/Team

- Open and read the admit notification▲ as soon as possible (i.e., read receipt to hospital)
- Provide the hospital team with any relevant patient information

CHANGE MANAGEMENT TIP

The action of notifying and relaying a patient's admit notification is the basis for the bidirectional flow of information between the patient's circle of care (e.g., primary care and supportive care teams) and hospital

Community Supportive Care Teams

- Open and read the admit notification as soon as possible
- Provide the hospital team with any relevant patient information

Potential Benefits

Improved informational and management continuity across care settings.

Additional Information

Some patients may have a larger circle of care involving other healthcare professionals in addition to the primary care provider (e.g., continuing care, rehabilitation, emergency medical services, pharmacy, addiction and mental health, etc.). Processes will need to be developed for notifying these professionals. Privacy and increased demand on hospital teams to accommodate additional notifications to a patient's circle of care will need to be taken into consideration.

eNotification is a real-time (or near real-time) electronic message that notifies heathcare providers when their patients are admitted to hospital. eNotification methods may be dependent on organizations' or providers' abilities to build on existing processes, partnerships and technologies. In cases where eNotifications are not possible, another method will be used (e.g., telephone call, email, fax). This alternative method should resemble real-time as much as possible (i.e., prior to the end of a hospital shift). A process will need to be developed to ensure the admit notification is sent in a timely fashion. In the absence of eNotification, the patient's circle of care will be notified within 48 hours of hospital admission.

The admit notification will include the following:

- Patient's identification (full name, personal health number, address, phone number, date of birth)
- Contact information for admitting physician (full name, telephone number, fax number)
- Hospital (name and location)
- Reason for hospital admission
- Date/time of admission
- Approximate discharge date or hospital length of stay, if possible

Tools and Resources

Community Information Integration (CII)/Central Patient Attachment Registry (CPAR) – Managed by the *Alberta Medical Association's Accelerating Change Transformation Team*, this site provides a detailed overview of this attachment and continuity initiative for both patients and providers.

Notify Community Providers of Patient Admission to Hospital – Managed by *Health Quality Ontario*, this document illustrates some suggested processes involved when notifying community healthcare providers after a patient's admission to hospital. Real-world examples are provided by different practices in Ontario, along with further tools, resources and considerations.

> "(My family doctor) is in the loop with everything that is going on, and that has been a key factor in my care. I always have that person who is looking out."
>
> – Karon, patient/family advisor

Transition Planning

Background

Preparing patients, family and caregivers for their recovery at home is at the heart of transition planning. This process should occur as early as possible after admission for all patients. Successful planning requires the active participation and involvement of patients, family and caregivers and the circle of care team.[10] This step can help the patient navigate many of the challenges associated with transitions in care.

There are a number of different factors required for effective transition planning, including an individually tailored, easy-to-understand transition care plan. This plan provides a comprehensive set of resources that will support a safe transition in care.

> "Successful planning requires the active participation and involvement of patients, family and caregivers and the circle of care team."

Key challenges related to transition planning include:

1. lack of informational continuity between hospital and patients' circle of care;
2. discrepancies in medication lists before and after discharge;
3. inadequate preparation with patients, family and caregivers prior to discharge.[10-11]

These challenges can increase the burden of care; confuse patients, family and caregivers; and lead to undesirable outcomes (e.g., hospital readmissions, emergency department visit, etc.).

Leading Operational Practices

Hospital Team

- Complete medication reconciliation upon admission and before discharge with patient
- Develop a transition care plan that incorporates input of all members of the care team, including the patient, family and caregivers
- Use a **risk assessment tool**▲ and **clinical judgement** to identify patients who are at high risk for hospital readmission and plan supports for the patient
- Use a standardized discharge safety checklist
- Arrange a post-discharge follow-up visit (in person or virtual, if appropriate) with their primary care provider and/or specialist
- Arrange any procedures, diagnostic imaging and referrals that need to occur post-discharge and Cc primary care provider on all requisitions/requests
- Send discharge notification and copy of the transition care plan to the primary care provider and patient, family and caregivers that includes after hours contact information if urgent issues arise

CHANGE MANAGEMENT TIP

The risk stratification of patients should be considered a potential foundational element of transition planning

Patient, Family and Caregivers

- Collaboratively develop the transition care plan with the hospital team
- Ensure that the care plan is easy-to-understand and makes sense
- Ask the hospital team questions like: **"What happens if I leave hospital and an urgent issue comes up"?** and **"Who can I contact for follow-up questions and emergencies?"**

Primary Care Provider/Team

- **Provide any information**▲ required to actively assist with the transition planning process

CHANGE MANAGEMENT TIP

Primary care should be able to provide additional information (i.e., social issues) that may be crucial for developing and adjusting a patient's care plan

Community Supportive Care Teams

- Collaboratively work with the hospital team to identify and arrange post-discharge community supports with the patient, family and caregivers, when applicable
- Communicate any arrangement to the attached primary care provider and the patient's circle of care

Potential Benefits

Improved informational and management continuity across care settings.

Improved patient safety through the reduction of hospital readmissions post-discharge[4] and other adverse events[3,4] (i.e., medication errors).

Improved provider, patient, family and caregivers experience.[11,4]

Additional Information

All patients have unique life histories and environments that make individualized, patient-centred transition planning important. Consideration of patients' post-discharge healthcare needs, along with their functional and social supports, should be assessed. The choice of a risk assessment tool should consider these factors.

Direct measurement of risk assessment, using a standardized tool, will help build the transition care plan that will accompany the patient home and be sent to the primary care provider and community supportive care teams.

Patient education is a critical component of transition planning. Patients need to know what to do and whom to contact if they have questions or need assistance. The information should be provided verbally and in a clearly written format to the patient, family and caregivers (e.g., instructions about wound care, new medical equipment and any medication changes).

Specific risk assessment tools which can be used include, but are not limited to:

- 8P Screening Tool (leveraged in Connect Care)
- LACE Index Scoring Tool for Risk Assessment (Length of Stay, Acuity, Comorbidities, Emergency Department Visits)
- Blaylock Risk Assessment Screening Score (BRASS)
- Frailty assessment tools
- International Classification of Functioning, Disability and Health (ICF) checklist

Patients' medication should be reviewed upon admission, during the stay and at discharge for reconciliation, adherence and optimization. This supports the education of the patient, family and caregivers around medication management and avoids potential related adverse events.

Post-discharge **follow-up with the primary care provider** will be based upon the patient's transition care plan.

- It is the **primary responsibility of the hospital staff** to book all follow-up appointments required prior to discharge from hospital.
- In the event that a follow-up appointment in primary care cannot be arranged before the patient is discharged, this will be communicated in the transition care plan. It is the **shared responsibility of both the primary care provider and patient, family and caregivers** to ensure the appointment is arranged in a timely manner.

All post-discharge **follow-up appointments with specialists** will be arranged by the hospital team.

Based on patients' needs, arrangements for clinical support services (e.g., home care, supportive living, long-term care, physiotherapy, occupational therapy, nutritional services and/or medical equipment) and non-clinical support services (e.g., transportation assistance, meal support) should be completed as soon as possible after admission. The approach to residential continuing care is evolving across the province with a shift to assessments being provided outside of acute care settings. Wherever possible, the assessment for residential continuing care should occur post-discharge while the patient is in their pre-hospital home. The need for this assessment should be identified during the transition plan.

eNotification is a real-time (or near real-time) electronic message that notifies primary care and other providers of the patient's requirements in their transition care plan. eNotification methods may be dependent on organizations'/providers' abilities to build on existing processes, partnerships and technologies. In cases where eNotifications are not possible, another method will be used (e.g., telephone call, email, fax). This alternative method should resemble real-time as much as possible (i.e., prior to the end of a hospital shift). A process will need to be developed to ensure the transition care plan is sent in a timely fashion.

Tools and Resources

CoACT Suite of Tools for Integrated Care Process – Managed by *Alberta Health Services*, this page describes the purpose of the CoACT program and what patients and families might experience through this collaborative care program (e.g., bedside shift reports, comfort rounds, etc.).

Access to a Designated Living Option Policy – Managed by *Alberta Health Services*, this page describes the key changes made to the continuing care services for identifying designated living options for Albertans.

Health Change Methodology – Managed by *Alberta Health Services*, this pages describes the purpose of Health Change Methodology and how conversations and approaches can lead to the development of a successful shared care plan that is understandable to the patient, family and caregivers.

Family Presence and Visitation Policy – Managed by *Alberta Health Services*, this page describes the family presence and visitation policy within all AHS settings. It includes detailed information of appeal procedures, tools and resources.

Medication Reconciliation Policy – Managed by *Alberta Health Services*, this document describes the provincial policy for medication reconciliation and outlines responsibilities and steps that should be undertaken (e.g., generating a Best Possible Medication History).

Medication Reconciliation at Care Transitions – Managed by *The Institute for Safe Medication Practices Canada*, this site contains a number of organizational recommendations for conducting medication reconciliation at care transitions. It includes detailed guideline steps, tools and resources.

Referral and Access to Specialty Services

This version of the guideline is limited in addressing referral and access to specialty services. A provincial Wait Time and Access Strategy is currently under development, which is focused on seven key services areas within Alberta Heath Services: Acute Care Flow, Addiction and Mental Health, Cancer, Continuing Care, Diagnostic Imaging, Specialty Access and Surgery. The strategy will be used to inform the referral process from primary care to specialty and from specialty to specialty, as it pertains to transitions, with particular focus on leading operational practices. The Home to Hospital to Home Transitions Guideline implementation will be part of this work and we are anticipating an updated version of the guideline in and around the two-year mark after launch.

> “What matters most to me about improving transitions in care for patients and families is communication and detailed planning of discharge requirements…Patients should have the opportunity to be part of the care plan.”
>
> – Debbie, patient/family advisor

Photo courtesy of Chris Roach (copyright 2019)

Referral and Access to Community Supports

Background

Timely and appropriate access to community supports are essential for patients transitioning from hospital to home.[27] The patient's functional, social, cognitive and mental health needs must be assessed in order to determine what community supports are required after they leave hospital. Assessing need and arranging these services should **occur as early in the hospital admission as possible** to ensure that the appropriate services, such as rehabilitation and home care, will be ready for the patient post-discharge. The assessment of supportive care services should, wherever possible, occur post-discharge while the patient is in their pre-hospital home. This step ensures the patient is accurately assessed and is not placed in a long term care facility when their care needs could be met in the community.

> "The patient's functional, social, cognitive and mental health needs must be assessed in order to determine what community supports are required after they leave hospital."

Leading Operational Practices

Hospital Team

- Work with the supportive care teams (i.e., rehabilitation services) and primary care provider/team **as early in the hospital admission as possible** to coordinate areas of functioning through patient screening and assessment for the development on an individualized transition care plan
- Work with the patient, family and caregivers to arrange post-discharge community supports
  - Clinical support services, such as home care, physiotherapy, occupational therapy, nutritional services and/or medical equipment, when applicable
  - Nonclinical support services, such as transportation assistance and meal supports, when applicable
- Document the assessment and arrangements for post-discharge community supports within the transition care plan

Patient, Family and Caregivers

- Share goals for recovery (**"what matters to you"**) with the supportive care team. This should include obstacles and barriers potentially experienced once home or in the community (e.g., lack of a family member or caregiver who can provide support at home)

Primary Care Provider/Team

- Collaboratively work with the hospital team and provide any relevant information needed to ensure appropriate clinical and nonclinical post-discharge community supports are arranged (e.g., transportation, food assistance, social assistance) for patients, families and caregivers before they leave hospital

Community Supportive Care Teams

- **As early in the hospital admission** as possible, supportive care teams should work collaboratively with the hospital team to complete a transition care plan that incorporates the following assessments:
  - Cognitive functioning
  - Functional mobility
  - Medication management
  - Nutrition and hydration
  - Pain management
- Collaboratively work with the hospital team and provide any relevant information needed to ensure appropriate clinical and nonclinical post-discharge community supports are arranged (e.g., medical equipment, home care services) for patients, family and caregivers before they leave hospital

> "Transitions are the fuzzy grey space between when one service stops and one service begins…I usually live in those grey spaces all by myself."
>
> – Sandi, patient/family advisor

Potential Benefits

Improved informational and management continuity across care settings.

Improved patient safety through reduction of hospital readmissions post-discharge[4] and other adverse events[3,4] (i.e., medication errors).

Improved provider, patient, family and caregivers satisfaction and experience.[11,4]

Additional Information

Assigning a **Home and Community Care Coordinator** who works with the hospital team and the patient, family and caregivers to arrange and coordinate access to timely and appropriate home care and post-discharge community supports has been shown to be effective in other transition initiatives both across Alberta and nationally.

A collaborative and interdisciplinary team approach to transition planning brings together programs such as primary care, home care, mental health, nutrition and public health and links outpatient services and other community supports to ensure Albertans get the best care possible. Linking services across sectors helps address patients' social determinants of health. Connect Care has an embedded tool to assist with assessing social determinants of health needs.

In Alberta, there are varying policies and processes which effect the access of securing aid and support in the community (e.g., home care may have a waitlist, lack of resources in rural/remote areas). This barrier highlights the importance of hospital-community/social-based partnerships to align and share resources. These partnerships may be different in each community depending on the needs of the population, but there are many examples of programs and services that are effectively working across communities (e.g., Pan-Edmonton Group Addressing Social Isolation of Seniors).

Tools and Resources

Pan-Edmonton Group Addressing Social Isolation of Seniors (PEGASIS) – Managed by the *Edmonton Seniors Coordinating Council*, this site describes the background of this project and provides detailed resources for healthcare providers to help keep seniors more connected within their community.

Destination Home Initiative – Managed by *Alberta Health Services*, this pages describes a philosophy that home is the best place for patients to recover following a stay in hospital and to be assessed, if appropriate, for a higher level of ongoing care.

Enhancing Care in the Community – Managed by *Alberta Health Services*, this page describes the purpose of the initiative and current programs (e.g., Virtual Hospital, Complex Care Hub, Community Paramedic Program) that are focused on meeting the health and social needs of Albertans to improve their wellness, independence, and quality of life.

Creating Effective Hospital Community Partnerships – *The Health Research and Educational Trust* is an affiliate of the American Hospital Association. This document describes interviews with hospital and health system providers that resulted in lessons learned and best practices for identifying community health needs, potential partners and recommendations for overcoming challenges when building partnerships.

Community Partnerships Resource Guide for Family Health Teams – Managed by *Health Quality Ontario*, this resource guide was developed to assist primary care providers and their teams in establishing effective partnerships with other community organizations. It contains real-world examples, along with further suggestions for tools and resources.

Social Determinant of Health Assessment Tools:

- **Social Determinants Screening Tool (Access Health Spartanburg)**
- **Self-Sufficiency Outcomes Matrix (OneCare Vermont)**
- **PRAPARE Tool (Redwood Community Health Coalition)**
- **Community Paramedicine Pilot Health Assessment (Theda Care)**
- **Social Needs Assessment (Virginia Commonwealth University Health System)**

Community Health Improvement Navigator (CHI) – Managed by the *Centers for Disease Control and Prevention (CDC)*, this site is a "one-stop shop" of different tools and resources for healthcare providers who work in hospitals, health systems, public health and other community agencies. It will help guide different organizations that wish to develop effective collaborations.

Transition Care Plan

Background

A timely and complete discharge summary is a good metric of care coordination for an organization.[13] It is an important document that serves both as a permanent record of a patient's visit to hospital and as a critical communication method to transfer information back to primary care.[12] Unfortunately, because of this dual purpose, it is often delayed or incomplete when sent to primary care as the completion of the health record is given priority over the patient's continuity of care.

> "Nearly half of adverse events that occur during the transition from hospital to home are shown to be preventable though improved communication among providers."

Providers in Alberta have reported the negative impact on their ability to provide timely comprehensive follow-up care when they receive incomplete or delayed discharge summaries.[15] Nearly half of adverse events that occur during the transition from hospital to home are shown to be preventable though improved communication among providers.[14]

Due to the challenges associated with delivering the discharge summary to primary care, a solution is to create an individually-tailored transition care plan; one copy is sent to the primary care provider/team and the other accompanies the patient when they transition back to their home. This plan is not an exhaustive and complete synopsis of every activity the patient experienced while admitted, but rather a synthesis of the most important points to facilitate good care coordination and management continuity for the primary care provider/team. The patient's transition care plan must be plain language and constructed to support their self-management.

Leading Operational Practices

Hospital Team

- Develop the transition care plan with the patient and send to their primary care provider through eNotification on the day of the patient's discharge▲
- Provide a "patient-oriented" version of the transition care plan to the patient, family and caregivers
- Evaluate and provide supports for patients to access medications until they have a follow-up visit in primary care
- The transition care plan sent to the primary care provider will include:
  - Main diagnosis (admission and discharge)
  - Pertinent physical findings
  - Results of procedures and laboratory tests
  - Discharge medications with reasons for any changes to the previous medication regimen
  - Details of follow-up appointments made to primary care, specialty care and other post-discharge community supports, if applicable
  - Outstanding investigations
  - Patient goals
  - Any other specific follow-up concerns

Patient, Family and Caregivers

- Ensure the care plan includes **all relevant follow-up appointments and instructions for care when at home** (i.e., prescriptions for medication and when and how to take them)
- If the follow-up appointment in primary care hasn't been arranged, contact the clinic and book an appointment
- Make sure to have a paper copy of the care plan that can be shared with family or caregivers

Primary Care Provider/Team

- **Confirm the receipt of the transition care plan▲** with the hospital (i.e., read receipt to hospital)
- Book or arrange any outstanding tests or procedures needed to be done post-discharge
- Verify if a follow-up appointment was scheduled and if not, contact patient to arrange an appointment

CHANGE MANAGEMENT TIP

It is important that the transition care plan is sent to the primary care and supportive care teams within 24-48 hours post-discharge. This is a critical step to support informational and management continuity for all patients

Community Supportive Care Teams

- Confirm the receipt of the transition care plan with the hospital (i.e., read receipt to hospital)
- Review the transition care plan, identify any specific follow-up concerns and contact the hospital and primary care provider to discuss any concerns/issues with the plan

> "Post-recovery had many frustrating moments. There seemed to be a constant need to provide my contact information, family history, medication history and more, and to multiple care givers."
>
> – Alan, patient/family advisor

Potential Benefits

Improved informational and management continuity across care settings.

Improved patient safety through reduction of hospital readmissions post-discharge[4] and other adverse events[3,4] (i.e., medication errors).

Improved provider, patient, family and caregivers experience.[4,11]

Additional Information

The hospital team will remain responsible for the transition care plan until they receive a confirmation of receipt from the primary care provider/team. By receiving the confirmation, the sender can confirm whether the notification was sent to the appropriate provider and ensure the communication loop closes.

It is best practice for community pharmacies to manage outpatient medications. For legal reasons, hospital pharmacies are not able to dispense medications for outpatient use. There are logistic concerns such as labeling/packaging of medications, provision of opioid medications and resources available to package medications. There are also safety concerns because medications provided by an inpatient facility are not uploaded into the Netcare medication profile that would be accessible to community pharmacy.

However, there are circumstances that allow for bridging medications to be supplied. Alberta Health Services current policy allows for the following: *A bridge supply of medication shall only be dispensed to patients discharged from an AHS setting in extraordinary circumstances, where the patient does not have a medication supply at home and does not have adequate, timely access to the medication(s) from a community or specialty pharmacy. A bridge supply of medication shall be the minimum amount of medication needed for the patient's health, safety and ongoing treatment requirements, but shall not exceed 72 hours supply.*

While the transition care plan is an important tool for communication between providers in the post-discharge period, it does not replace the need for direct communication. Alberta Health Services CoACT Collaborative Care initiative supports the need for a warm hand-off for complex, clinical situations during transitions. Alberta Health Services also provides **Green Sleeves** for patients, families and caregivers for advanced care planning. In an emergency or a visit to any healthcare setting, medical providers can view the patient's healthcare needs and plans.

Tools and Resources

CoACT Collaborative Care Resource Guide – Managed by *Alberta Health Services*, this toolkit is designed to help introduce and implement Collaborative Care in different settings. It presents the background to the initiative, and the tools and resources needed for healthcare providers, as well as an overview of key implementation strategies.

Advance Care Planning: Green Sleeve – Managed by *Alberta Health Services*, this site describes the importance of advance care planning for patients (Your Personal Directive, Goals of Care Designation) and how to go about getting a Green Sleeve.

Medication Supply: Bridging Discharged Patients to Community – Managed by *Alberta Health Services*, this document describes the procedure required in extraordinary circumstances when a bridge supply of medication is provided to patients discharged from an AHS setting.

Clinical Ethics Services – Managed by *Alberta Health Services*, this site describes the confidential services available in Alberta that help patients, families, healthcare providers and administrators identify and resolve ethical issues they may encounter.

Re-Engineered Discharge (RED) Process Checklist – Managed by the *Boston University School of Medicine*, the RED is an evidence-based strategy to improve the hospital discharge process in a way that promotes patient safety and reduces rehospitalization rates. The RED intervention is founded on 12 discrete, mutually reinforcing components and yields high rates of patient satisfaction.

Patient Oriented Discharge Summary (PODS) – PODS is a simple tool and set of process changes that was co-created with over 50 patients and caregivers, including those with limited health literacy and language barriers, to ensure it met their needs, as well as with healthcare providers to ensure its usability and feasibility. It was developed by *The Patient Oriented Discharge Summary Implementation Group*.

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Follow-up to Primary Care

Background

Prompt patient follow-up with a primary care provider has been promoted as a key strategy to reduce hospital readmissions and emergency department utilization post-hospital discharge.[16-24] This reduction has been noted specifically in high-risk patients (i.e., those with multiple conditions and complex needs).[16] A collaborative approach between the hospital team and primary care ensures appropriate sharing of information to enhance management and informational continuity. Although patient follow-up to the primary care provider post-discharge may reduce further acute care utilization, it is important to note that some encounters may not be preventable.

> "I am hoping that, looking at transitions, everybody (all providers) talk to one another, so I don't always have to be that conduit between people."
>
> – Sandi, patient/family advisor

Leading Operational Practices

Hospital Team

- Use clinical judgement and risk assessment tools to determine whether the patient requires a **follow-up▲** with a primary care provider and the timeline as to when the appointment should occur (i.e., seven days post hospital discharge)
- Work collaboratively with the patient, family and caregivers in the arrangement and planning for their follow-up appointment with a primary care provider
- Work collaboratively with the primary care provider/team to book appropriate follow-up appointment prior to patient discharge, when applicable

CHANGE MANAGEMENT TIP

Follow-up based on patient risk assessment, (follow-up with primary care, specialist and/or both)

Patient, Family and Caregivers

- Attend any follow-up appointments scheduled with the primary care provider/team
- **Bring a complete list of prescriptions** currently taken (e.g., Green Sleeve with medication list, goals of care plan) and updated with any medications received while in hospital
- Come prepared with the care plan to discuss any **questions or concerns** with the primary care provider/team

Primary Care Provider/Team

- Work collaboratively with the hospital team to provide a **timely follow-up appointment**
- Review the patient's transition care plan and clarify any outstanding questions with the hospital team (i.e., attending hospital physician)
- At the follow-up appointment: perform medication reconciliation, ask the patient to explain their goals, follow-up on test results and order any outstanding tests

CHANGE MANAGEMENT TIP

If primary care is unable to arrange a post-discharge appointment in a timely fashion, then it is the clinic's responsibility to engage in quality improvement strategies

Community Supportive Care Teams

- Work collaboratively with the patient, family and caregivers in the arrangement of their **follow-up appointment** with relevant community supportive care teams
- At the follow-up appointment: perform medication reconciliation, ask the patient to explain their goals, follow-up on test results and order any outstanding tests

Potential Benefits

Improved informational and management continuity across care settings.

Reduced hospital readmissions post-discharge[4] and other adverse events[3,4] (i.e., medication errors).

Additional Information

Follow-up appointments should be in place prior to the patient being discharged. Patient, family and caregivers should be consulted as to what appointment time and date works for them. Consideration for the patient's health and social needs when scheduling the follow-up appointment is a necessary step in the transition process.

In cases where the hospital team are unable to book a follow-up appointment with the primary care provider prior to discharge, the hospital team will be accountable for ensuring that primary care is informed, via the transition care plan, that the patient requires a timely follow-up appointment. The patient, family and caregivers will also be informed that they should connect with their primary care provider for a follow-up appointment.

Effective transitions across the patient journey are part of everyone's core business regardless of their place in the healthcare system. In cases where team members (hospital, primary care or community support teams) encounter access or efficiency challenges limiting their ability to achieve the guideline leading operational practices, there is a responsibility to engage in quality improvement strategies. If assistance is required, consider contacting the local improvement/change consultant(s) or program(s) for support. If not aware of these resources, contact the **Primary Health Care Integration Network office via email** to help inform on potential connections or visit the **Primary Health Care Integration Network website**

Based on clinical judgement and risk assessment tools, the hospital team may not recommend immediate or prompt follow-up with the primary care provider. Alternative methods of follow-up may be recommended in these cases (virtual care, such as video conference or phone call).[25,26]

Tools and Resources

Schedule a Primary Care Visit before Leaving Hospital – Managed by *Health Quality Ontario*, this document illustrates some suggested processes involved when arranging a post-discharge follow-up visit in primary care. Real-world examples are provided by different practices in Ontario (e.g., Standard Operating Procedure for Pre-Booking Primary Care Visits), along with further tools, resources and considerations.

AIM Alberta – Managed by *Alberta Health Services*, this site provides tools, resources and information about primary care and specialty care access improvement.

Patient's Medical Home – Managed by *Alberta Medical Association*, this site provides information about the patient's medical home, along with tools and resources to implement the model in Alberta.

How to Conduct a Post-Discharge Follow-up Phone Call – Managed by the *Agency for Healthcare Research and Quality*, this site provides information on the component Re-Engineered Discharge (RED) Toolkit that describes the steps recommended (e.g., Review Health history and Discharge Plan; Check Accuracy and Safety of Medicine Lists) for conducting a post-discharge touchbase with patients over the phone.

List of Contributors

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- Enhancing Care in the Community
- Emergency Medical Services – Mobile Integrated Healthcare
- Medical Affairs
- Nutrition Services
- Path to Care
- Pharmacy
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Glossary of Terms

The definitions compiled below reflect the most accepted and common understanding of the terms in the medical and scientific literature. Following each term is a number that designates where the term is most often used; (1) Common within the Alberta context (2) Common within the Canadian context and (3) Common within the international context.

Admission: A formal documented acceptance by a healthcare facility of a patient who is to be provided with continuous nursing service and a hospital bed where a patient usually stays overnight.[1]

Alberta Netcare: This is the provincial electronic health record that is accessible to health professionals and contains Albertans' personal health information. Alberta Netcare is not a single database, but rather a network of data repositories and information systems. Clinical data is collected through point-of-service systems (in hospitals, laboratories, testing facilities, pharmacies and clinics) and is sent through secure messaging to the provincial repositories and information systems. When a health professional logs on to the Alberta Netcare and searches for a patient record, the portal retrieves all of the available information from the provincial systems and presents it as a unified patient record.[1]

Attachment: The informal agreement between a patient and a primary care provider where both agree the primary care provider is the most responsible provider for the continuous and longitudinal care of the patient.[1]

i) **Confirmation:** The attachment relationship is confirmed within the primary care physician's electronic medical record (EMR) and is accompanied by a date stamp indicating the day the patient agreed the primary care provider is responsible for his/her continuous and longitudinal care. The attachment relationship should be reconfirmed at least once every 36 months or during each clinic visit. This was also once known as validation.

ii) **Verification:** The attachment relationship is verified in the Central Patient Attachment Registry. Situations where patients appear on the panel of more than one primary care provider are referred to as 'panel conflicts.' The primary care provider and their team will work with the patient to resolve those conflicts and ensure those patients are only represented on one panel. At this point, the attachment will be verified.

Best Possible Medication History (BPMH): This is a medication history created using 1) a systematic process of interviewing the patient/family, and 2) a review of at least one other reliable source of information to obtain and verify all of a patient's medication use (prescribed and non-prescribed). Complete documentation includes drug name, dosage, route and frequency. The BPMH is more comprehensive than a routine primary medication history which is often a quick preliminary medication history which may not include multiple sources of information. The BPMH is a 'snapshot' of the patient's actual medication use, which may be different from what is contained in their records. This is why patient involvement is vital.[1-3]

Circle of Care: The group of healthcare providers treating a patient who need information to provide that care. The consent to share information with providers in the circle of care is generally implied. A patient who accepts a referral to another healthcare provider implies consent for sharing relevant information. This includes sharing with physicians and other healthcare providers who are caring for the patient, but does not necessarily include others such as family, friends, etc. If the patient's identified circle of care is outside of the traditional medical care (physicians, nurses, supportive care), consent to share relevant patient information may have to be obtained. The patient's circle of care can be defined within Connect Care and the MyHealth Records portal.[1,2]

Clinical Judgement: These are critical decisions made on the basis of scientific or medical observations, with the added skill provided by long experience with similar cases. It is the ability to use discretionary judgement and an ability to integrate information from multiple

systems in order to understand and predicate the potential trajectory of a patient's condition and recovery.[1,2]

Collaborative Care Team: At the individual patient level, the entire care team, including the patient and family, work together daily to pursue high-quality, proactive, integrated care to meet evolving patient care needs to achieve the best possible health outcomes. The care team's composition reflects population health needs, enables and supports optimized professional practice and integrated care processes inclusive of structured communication and quality commitment. Collaborative practice, as a function, includes the development of high performing teams.[2]

Community Information Integration/Central Patient Attachment Registry (CII/CPAR): The chosen vehicle to integrate community EMRs with two-way data flow. Together CII/CPAR enable the health system integration and improved continuity of care that are essential and foundational change elements in the implementation of the Patient's Medical Home. Based on the CPAR patient panel data, electronic notifications (eNotifications) will be transferred directly to the primary care provider whenever a patient is admitted or discharged from the hospital or has an encounter in the emergency department. In late 2019, participating primary care providers will be able to upload patient summaries to Netcare and the patient portal (MyHealth Records).1 It is a joint project between the AMA, Alberta Health and Alberta Health Services.

Community Supportive Care Teams: In the context of the guideline, the members of this team would include providers working in continuing care (home care, supportive living, long-term care), rehabilitation (occupational, physical, recreation therapy), psycho-social or spiritual services, or those who assist patients with more practical day to day services (nutrition, transportation). This service sector will vary from community to community within Alberta.

Complex, High Risk Patient: Often used synonymously as 'patient complexity' or simply a 'complex patient,' there is no current Alberta definition for this category of patient and it is unlikely that any single tool will accurately identify a 'high risk' or 'complex' patient. When physicians are asked about patients who fit this definition, they recognize there are multiple influences that make a patient 'complex.' Those who are complex due to multiple chronic diseases [e.g., heart failure and chronic obstructive pulmonary disease (COPD)] will require a different treatment consideration than a patient who is complex because of their mental health (e.g., bipolar with addiction challenges), or compared to patients who have social deprivation considerations (e.g., homelessness).[2,3]

Complex, Clinical Situation: Often described as a combination of one or more fluctuating patient variables including their clinical issue (e.g., COPD), functional level (e.g., aged or frail) and social situation (e.g., isolated). If a patient expresses concerns or challenges related to the transition, they would benefit from a warm handoff. Situations that involve or require the coordination of multiple services or systems (acute, primary, continuing) also meet the criteria. This could be where funding sources other than Alberta Health (federal, other provincial ministries) are required (e.g., transitioning to non-AHS, private services or facilities) and informational or management continuity is in danger of being broken.[1]

Connect Care: A common clinical information system (CIS) that will allow healthcare providers in Alberta a central access point to patient information, common clinical standards and best healthcare practices. Due to be implemented in 2020, Connect care will be in place everywhere AHS provides healthcare services and where partnerships exist to provide healthcare services, including hospitals, clinics, continuing care facilities, cancer centres, mental health facilities and AHS-run community health sites, as well as at Carewest, CapitalCare, Covenant Health, Calgary Laboratory Services and DynaLIFE. Epic Systems Corporation is the vendor building the CIS for Alberta.[1,2]

Continuing Care: Alberta's continuing care system provides Albertans with a range of health, personal care and accommodation services required to support their independence and quality of life. Continuing Care clients are defined by their need for care, not by their age or diagnosis, or the length of time they may require services. There are three streams of care within Alberta's continuing care system: home care, designated supportive living and long term care.[1]

Continuity: Also referred to as continuity of care. It is how one patient experiences care over time as coherent and linked; the result is good information flow, good personal relationship and good coordination of care. It occurs when separate and discrete elements of care are connected. The three type of continuity are:[1-3]

i) Informational – the transfer of relevant patient information between multiple care providers and locations. Includes accumulated knowledge about the patient's preferences, values and context.

ii) Relational – the ongoing, trusting therapeutic relationship between a patient and a primary care physician and their team, where the patient sees this primary care physician the majority of the time.

iii) Management – the coordination and handoff of care between relevant care providers using a shared care plan in a way that is both consistent and flexible to meet patient needs.

Delphi Method: The method used to obtain a collective view from experts about issues where there is no or little definite evidence and where opinion is important. The experts anonymously reply to questionnaires and subsequently receive feedback in the form of a statistical representation of the 'group response,' after which the process repeats itself. The goal is to reduce the range of responses and arrive at expert consensus. The process can result in group ownership and enable cohesion among individuals with diverse views. The modified Delphi consist of beginning the process with a set of carefully selected items. The modified Delphi typically improves the initial round response rate to the survey and helps maintain rigor when attempting to maintain focus within the group.[3]

Designated Supportive Living: Licensed supportive settings where AHS controls access to a specific number of spaces according to an agreement between the operator and AHS. There are three levels of designated supportive living: 3, 4 and 4-Dementia. Healthcare aides are on site 24/7 in designated supportive living level 3 facilities, and healthcare aides and licensed practical nurses are on site 24/7 in designated supportive living level 4 and 4-Dementia facilities. Professional services are delivered by AHS staff as needed (e.g., registered nurses, rehabilitation). Some designated supportive living sites have arrangements with physicians to see residents on site in the building, while in others residents go the physician's office as they would if living in their own home.[1]

Discharge Summary: This serves as the primary document communicating a patient's transition care plan to the post-hospital care team in the community. Often, the discharge summary is the only form of communication (through email, fax or mail) that accompanies the patient to the next setting of care. Discharge summaries are generally thought to be essential for promoting patient safety during transitions between care settings, particularly during the initial post-hospital period. However, the discharge summary also serves as a health record of the patient's stay in the hospital. This often causes delays in sending the information back to primary care. If a complete discharge summary cannot be sent on the day of discharge, then an interim discharge note should be sent. At minimum, it should include the diagnoses, discharge medications, results of procedures, follow-up needs and pending test results.[2,3]

eNotifications: These are automated messages delivered directly into a physician's Electronic Medical Record (EMR) with information about key healthcare events for paneled patients, such as emergency room visits and hospital admissions or discharges. eNotifications will be sent to the physician or nurse practitioner to whom the patient is paneled in the Central Patient Attachment Registry (CPAR).[1]

eDelivery: A secure service to electronically deliver patient results from a data source (for example, laboratory tests or diagnostic imaging) to a physician's electronic medical record (EMR). eDelivery assists healthcare providers in having the most up-to-date patient information, thus ensuring the highest quality healthcare.[1]

Emergency Department: Part of the acute care system where patients with emergency health needs are assisted anytime, day or night. They provide care for patients with major trauma, cardiac events, injuries and general medical problems. They take care of people who are very sick or injured on a priority basis (i.e., triage level). They stabilize people and get them ready to transport to a higher level of care facility, if needed. Following assessment within the emergency department, the attending physician may decide to admit the patient as an inpatient in the hospital.[1]

Frail Elderly: With increasing age the risk of frailty increases. While there are several definitions of frailty, it is seen as a multidimensional concept with various indicators such as weight loss, lack of physical activity and lack of strength. Frailty is a multidimensional syndrome that places individuals at risk for adverse health outcomes, including falls, disability, admission to hospital and death.[2]

Green Sleeve: A plastic pocket that holds a copy of a patient's advance care planning forms, such as their personal directive, goals of care designation and a tracking record. In an emergency, AHS medical providers can look at the patient's Green Sleeve and know their healthcare wishes. A personal directive (PD) will list the patient's important healthcare decisions (e.g., where they might want to live or what's important to them), while the goals of care designation (GCD) is a medical order written by a doctor or nurse practitioner. The GCD is made up of a letter and number and helps the healthcare team quickly know the patient's goal of care so they may act on the patient's healthcare wishes.[1]

Guideline: A series of evidence informed statements for health professionals and providers to consider as a recommended course of action. In medicine, guidelines are used to understand the best way to diagnose, treat and prevent diseases and conditions. Guideline recommendations are based on the strongest available scientific evidence and, as a result, the creation of guidelines are a rigorous process.[3]

Home: "Home" is defined by the patient's needs. A safe return home may need to be supported by community-based resources including the patient's primary care providers, community-based rehabilitation resources, family members and primary caregivers, or a residential care facility.[2]

Home Care: Home care is a stream of continuing care

designed to support the wellness and independence of clients within their own home, apartment, condominium or in another independent living option including seniors' residences and lodges. Services are most often provided in a client's residence; however, they are also provided in schools, clinics, lodges, supportive living facilities, adult day programs and even workplaces. Clients are typically individuals living with acute, chronic, palliative or rehabilitative healthcare needs. Home care offers an array of support services including professional healthcare, personal care and home supports to Albertans of all ages as well as respite for their caregivers. Clients may require services only for a short time or on an ongoing basis.[1]

Hospital: An institution operated for the care of diseased, injured, sick or mentally disordered people (Hospital Act of Alberta, 2016). Hospitals in Alberta are operated by AHS.[1]

Hospital Team: In the context of this guideline, this term is inclusive to any member of the care team who is assisting with patient care in hospital from the admission through to the discharge. This could include professionals such as physicians, registered nurses, nurse practitioners, social workers, pharmacists, occupational therapists, physiotherapists, other allied health professionals and administrative staff (i.e., unit clerk). Different specialized providers will be involved in different transitions in care points as required.

Interdisciplinary Team: This team uses and integrates separate discipline approaches into a single consultation. All team members are present during one consultation.[3]

Long Term Care (LTC): A care option that provides services for clients with complex health needs with a 24-hour, on-site Registered Nurse. In addition, professional services may be provided by Licensed Practical Nurses and therapists, recreation staff, dietitians, social workers and others while 24-hour on-site unscheduled and scheduled personal care and support is provided by healthcare aides. Long-term care facilities include nursing homes under the Nursing Homes Act and auxiliary hospitals under the Hospitals Act.[1]

Medication Reconciliation: This is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. Medication reconciliation requires a systematic and comprehensive review of all the medications a patient is taking (known as a Best Possible Medication History) to ensure that medications being added, changed or discontinued are carefully evaluated. It is a component of medication management and will inform and enable prescribers to make the most appropriate prescribing decisions for the patient.[1-3]

Most Responsible Provider (MRP): In Alberta this usually refers to a family physician (although it may be a nurse practitioner) who has overall responsibility for directing and coordinating the care and management of an individual patient at a specific point in time. The identity of who will act as the MRP for a patient should be determined as early as possible. There may be a MRP designated as the attending or admitting physician in the hospital. In primary care, the MRP is typically the provider identified in the patient's attachment relationship.[1,2]

MyHealth Records: An online tool that lets Albertans 14 years of age or older view their health information from Alberta Netcare, the provincial electronic health record. Information includes prescriptions, immunizations and laboratory tests. It allows patients to upload and track information from personal health devices, including blood pressure monitors, blood glucose meters and fitness trackers. This information can be printed out and shared with a patient's circle of care.[1]

Panel: A list of patients derived from the primary care physician's practice indicating the physician has assumed the role as the most responsible provider for these patients. The confirmation date that accompanies the panel indicates the date the patient agreed the primary care physician was the most responsible provider for their continuous and longitudinal needs.[1]

Patient: An individual awaiting or under medical care and treatment.[3]

Post-Discharge Community Supports: These are services that are based outside of the hospital and deliver interventions to maintain or optimize functional capacity and independence, rehabilitation and case-management. [1,2]

Primary Care: Often used to denote the traditional 'family practice' delivery of medical care. It is often referred to as the front door to the healthcare system. In Alberta, primary care services are provided by family physicians, nurse practitioners and Alberta Health Services.[1,2]

Primary Care Network (PCN): The most common model of team-based primary healthcare delivery in Alberta. PCNs are groups of doctors that work together with other health professionals such as nurses, social workers, dieticians and pharmacists to meet the primary healthcare needs of people in their communities. There are 41 PCNs in Alberta. Together they represent more than 3,800 doctors and 1,000 healthcare providers and serve close to 3.6 million Albertans.[1]

Primary Care Provider (PCP): A healthcare practitioner who works with and cares for a person's common medical problems over long periods of time. The PCP is usually a family doctor but could also be a nurse practitioner. In

Alberta PCPs deliver care in many different ways: through primary care networks, family care clinics, community health centres or community mental health clinics.[1-3]

Primary Healthcare: Primary healthcare is a whole-of-society approach to health and well-being centred on the needs and preferences of individuals, families and communities. It addresses the broader determinants of health and focuses on the comprehensive and interrelated aspects of physical, mental and social health and wellbeing. In Alberta primary healthcare includes a wide range of services delivered by teams of providers that can include physicians, nurses, psychologists, pharmacists, dietitians, counsellors, rehabilitation therapists and social workers, among others, depending on the needs of the people with whom they are working. Social and community initiatives such as housing, employment and income supports are part of the programming people can draw on to support their overall health and well-being.[1-3]

Primary Provider: Often used interchangeably with 'primary care provider'; the Central Patient Attachment Registry (CPAR) has used this term to describe either the primary care physician or nurse practitioner.[1]

Risk Assessment/Stratification: In order to deliver true patient-centred care as opposed to a 'one size fits all' approach, those with different needs will require different care plans. Risk stratification is a process carried out to segment or separate patients around their likelihood that they will experience a particular outcome. A successful risk stratification approach will identify and predict which patients are 'high risk' so that their management can be tailored to avoid a potentially poor outcome (hospital readmission, mortality). The approach will usually involve a mixture of standardized tools (e.g., LACE, 8P) and clinical judgement from providers with knowledge of the patient's history.[2,3]

Transition: Transitions in care are defined as a set of actions designed to ensure the safe and effective coordination and continuity of care as patients experience a change in health status, care needs, healthcare providers or location (within, between or across settings, including home).[2]

The types of transitions could include:

Simple – no post-hospital services required; A simple transition is one where the patient returns home with simple or no ongoing health needs which can be met without complex planning.

Routine – one post-hospital service required; this may be a follow-up with the primary care provider.

Complex – two or more post-hospital services required. A complex transition is one where there may be several agencies involved in the transition care plan and arrangements are interdependent, requiring many case conferences or family meetings. This may be due to a 'complex patient.'

Transition Care Plan: Discharge planning involves the development of a **care plan** for each patient who is leaving hospital. The provider discharge summary has previously been the standard for communicating information about a patient's stay back to primary care. However, this is often lacking information that the primary care physician and team require to ensure management continuity is sustained, nor is it delivered in a timely manner. The transition care plan is **not** a replacement for the administrative discharge summary but should be considered more of a **warm handoff** document that is specifically designed to support the transition in care. Further, a patient-oriented transition care plan will also accompany the patient so both patient and their primary care provider have all the necessary information to ensure a seamless transition home.

Transition Notifications: Also referred to as encounter notifications. Transitions of care is defined as the movement of a patient from one setting of care (hospital, primary care practice, long term care, etc.) to another. The notification is defined as each member of the patient's care team is alerted during each movement through the system.[2,3]

Warm Handoff: A form of care transition that involves direct verbal or face-to-face communication between the sending and receiving care teams and provides a higher level of patient/family and receiving care team support during the transition process. These handoff conversations may or may not directly include the patient and/or family dependent upon patient wishes and the clinical circumstances.[1,2]

Warm handoffs include the following elements:

- a mutually agreed upon time to have the conversation
- identification of the topics to be covered in the conversation; including use of a mutually agreed upon standardized communication tool
- confirmation of information received
- review of information sent in order to clarify and ensure understanding by receiving team
- planning for patient-centred delivery of services – i.e. – offering a range of service options required for specialized care needs (physical, emotional, behavioral, social) or to address patient and family preferences