Frequently-Asked Questions for
A DiseAse-inclusive Pathway for Transitions in Care (ADAPT)

How does ADAPT align with the Home to Hospital to Home Transitions Initiative? How do they differ?

ADAPT is a grant-funded implementation initiative for the Home to Hospital to Home (H2H2H) Transitions Guideline.

- The ADAPT study and the H2H2H initiative share very similar expected outcomes (e.g., reduction of 30-day all-cause hospital readmission rate).
- ADAPT and H2H2H will have a joint advisory committee.
- ADAPT and H2H2H will continue to collaboratively engage and consult with key project stakeholders and partners.

Guideline Elements

- The ADAPT study will support implementation of 3 of the 6 H2H2H Transitions Guideline elements (Admit Notification, Transition Planning, and Follow-Up to Primary Care) across 5 acute care sites and interested Primary Care Networks in Alberta.
- The H2H2H initiative aims to implement all 6 Guideline elements in all acute care and Primary Care Network sites across the province.

Patient Populations

- The ADAPT study concentrates on transitions in care for adult Albertans with the 5 following complex chronic conditions: heart failure, chronic obstructive pulmonary disease, cirrhosis, end-stage kidney disease and/or stage 3-4 cancers.
- H2H2H focuses on transitions in care for all adult Albertans and is not disease specific.

How is ADAPT Unique?

- The ADAPT study is grant funded - ADAPT can provide both participating acute care and Primary Care Network sites with additional resources and capacity to implement the selected 3 elements of the H2H2H Transitions Guideline.
- As part of ADAPT, provincial stakeholders will participate in co-designing the disease-inclusive transitions in care pathway.

How/where does ADAPT fit with other transitions initiatives taking place across the province?

Pathway Initiatives

- The ADAPT study will involve co-developing and implementing a comprehensive, evidence-based disease-inclusive pathway for transitions in care. To do this, the ADAPT study team is working with disease-specific pathway groups across the province who are also working to better support patients with heart failure, chronic obstructive pulmonary disease, cirrhosis, end-stage kidney disease and/or stage 3-4 cancers.

- The ADAPT pathway will be created by refining and re-aligning components from these pre-existing disease-specific pathways, taking into consideration the common pathway elements, primary care and community care, to establish a single, disease-inclusive pathway.

One:carepath

- The ADAPT study is closely aligned with the grant-funded care planning initiative known as one:carepath.
- ADAPT and one:carepath both aim to improve care planning and patient outcomes but target different components of the illness trajectory. While ADAPT focuses on patient transitions from hospital to home, one:carepath aims to keep patients in their medical home after they have transitioned out of hospital.
- The ADAPT and one:carepath initiatives are well integrated: they both focus on the same 5 chronic conditions; stakeholder engagement will be a shared endeavor when appropriate; they will leverage each other's results; their knowledge translation strategy is integrated; and both initiatives are involved in H2H2H engagement and planning sessions.

Provincial information technology (IT) work

- ADAPT is aligned with multiple provincial information technology initiatives/projects taking place across Alberta: Connect Care and Community Information Integration & Central Patient Attachment Registry (CII/CPAR).
- The rollout of Connect Care and CII/CPAR will support aspects of automation that will promote adoption of the H2H2H Transitions Guideline, the ADAPT pathway (e.g., automatic notification of hospital admission and discharge, secure messaging between patients and providers, etc.) and one:carepath.

AHS Sustainability Program Office

- Improving transitions in care was identified as a priority in the Ernst and Young review of Alberta Health Services (AHS).
- The AHS Sustainability Office is currently leading the development of a detailed implementation plan for the AHS review recommendations. The H2H2H Transitions Guideline (and therefore the 3 elements of focus for ADAPT) will be an important consideration incorporated into this plan.

Alberta Surgical Initiative

- The Alberta Surgical Initiative recommends implementing the H2H2H Transitions Guideline as a component of their specialty access bundle aimed at improving the care and experiences of patients.

Primary care zone service planning

- Service plans for each of the 5 zones currently identify improving transitions and implementing the H2H2H Transitions Guideline as a priority.

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How are you choosing primary care network and acute care sites for participation in the ADAPT study?

- The ADAPT team will collaborate with Zone leadership, the Provincial Primary Care Network Committee, Primary Care Networks and acute care sites that express interest in participating, to identify sites in each zone best positioned to participate in the ADAPT study.
- Appropriate clinical and administrative support, zone priorities, experience with disease-specific pathways, information technology (IT) infrastructure, representation of chronic diseases, patient volume, and site readiness are examples of considerations that will influence site selection.

What types of support can ADAPT provide?

- Change management and facilitation support for acute and primary care
- Data, analytic and evaluation support
- Communication support
- Knowledge transfer support

How will you scale and spread ADAPT beyond the 5 implementation sites?

- Scale and spread of the ADAPT pathway will occur as acute care and Primary Care Network sites across the province implement the H2H2H Transitions Guideline.
- The H2H2H Transitions Guideline provides foundational elements for successful transitions in care for all patients, while the ADAPT pathway will also incorporate the additional components required to successfully transition patients with 5 specified chronic diseases.

ADAPT focuses on transitions for patients with 5 chronic diseases. How are transitions for other specific patient populations being addressed? Does ADAPT include transitions from the emergency department?

- Within its current 3-year grant, the ADAPT study and its evaluation will focus solely on improving transitions in care for patients with the 5 aforementioned chronic diseases.
- Additional transition points across the continuum of care (e.g., emergency department) and transitions in care for other specific patient populations (e.g., Indigenous, addiction and mental health, etc.) do not fit within the current scope of the ADAPT study.
    - However, learnings from ADAPT will facilitate the scale and spread of the H2H2H Transitions Guideline to these additional patient groups and will be addressed in future projects/initiatives.

How are you engaging community services outside of Alberta Health Services and Primary Care Networks that are required for successful patient transitions?

- Allied health professionals and representatives from community services were engaged during the development of the H2H2H Transitions Guideline.

- The H2H2H Transitions Guideline has specific recommendations for engaging community services. See guideline: Home to Hospital to Home Transitions Guideline (albertahealthservices.ca).

How have patients been involved in the ADAPT study?

- Patients were involved from start to end of the development of the H2H2H Transitions Guideline.
- The ADAPT research team will continue to consult with patient advisors throughout the development and implementation of ADAPT.
- ADAPT will be collecting and incorporating feedback from patients and caregivers during the co-development of the ADAPT primary care follow-up pathway, admission order sets, and discharge order sets (as highlighted below).

How can I get involved in ADAPT?

ADAPT will be engaging Primary Care Networks, community physicians, Strategic Clinical Networks (SCNs), community physicians, community services, acute care, as well as patients and their families, to codesign and implement the ADAPT pathway.

Opportunities exist to participate in ADAPT regardless of Primary Care Network and acute care implementation site choice.

Developing a primary care follow-up pathway:

- ADAPT is currently seeking input from stakeholders to co-develop a primary care follow-up pathway. This will be one component of the ADAPT pathway. If interested in being involved or for more information, please contact the ADAPT study team at ADAPTSTUDY@albertahealthservices.ca

Developing admission and discharge order sets:

- ADAPT will be seeking input from primary care providers, physicians, patients and caregivers to co-develop admission and discharge order sets to be included in the ADAPT pathway. If interested in being involved or for more information, please contact the ADAPT study team at ADAPTSTUDY@albertahealthservices.ca

Partners:

ADAPT is funded by Alberta Innovates through a Partnership for Research and Innovation in the Health System (PRIHS) grant.

The ADAPT Co-lead, Dr. Judy Seidel, is an Associate Professor at the University of Calgary, Cumming School of Medicine.

Contacts:

If you have any questions about ADAPT, please contact the study team at ADAPTSTUDY@albertahealthservices.ca

If you have any questions about one:carepath, please contact Senior Project Manager Kirby Scott at kirby.scott@albertahealthservices.ca