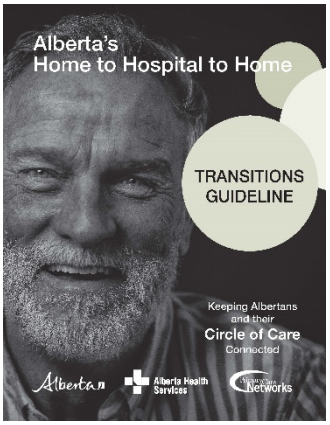
Home to Hospital to Home Transitions
| Frequently Asked Questions

In late 2020, Alberta launched the Home to Hospital to Home Transitions Guideline. It is Alberta's first provincial guideline on how patients can best transition from their communities, to hospitals and then back home again.

This FAQ will help healthcare workers understand more about the guideline and how it is being implemented in both primary and acute care.

For more information, visit:
ahs.ca/hhhguideline



About the Home to Hospital to Home Transitions Guideline

What is the Home to Hospital to Home Transitions Guideline?

- The Home to Hospital to Home Transitions Guideline is a unique, province-wide initiative that merges acute, primary and community care under one guideline. The guideline outlines what support Albertans need to safely transition from their communities, to hospitals and then back home again.

Who is the guideline for?

- The guideline is for use by providers in acute, primary and community care. It outlines the role of each group in care transitions.
- The guideline is for adult transitions from a patient's community, to hospital and then back home again. Transitions for other services and demographics may be added to the guideline in the future.

Why do we need a provincial guideline for transitions in care?

- Transitions are a critical point in the patient journey and represent times when patients are most at risk and vulnerable. When care transitions are not well managed, this can lead to negative outcomes for patients, families and caregivers as well as undue burden on the healthcare system such as:
  - Negative patient, family and caregiver experiences
  - Avoidable emergency department visits and hospitalizations
  - Increased healthcare costs

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- A standard approach to transitions as set out in the guideline will:
    - Create positive patient, family and caregiver experiences
    - Improve continuity
    - Reduce practice variability
    - Create common understanding of processes for everyone involved in a transition
    - Improve patient outcomes, experience and satisfaction
    - Improve provider satisfaction
    - Enable a collaborative team approach to provide patient-centred care
    - Develop a shared understanding or a common language around transitions in care in Alberta
    - Enable healthcare professionals to understand their roles and responsibilities across care settings

What is included in the guideline?

- The Home to Hospital to Home Transitions Guideline covers multiple points on a patient's journey — from checking if patients have a family doctor when they come to a hospital and are admitted, through referral and access to community supports when they are discharged.
- The guideline includes recommendations for how to partner with patients, families and caregivers.
- When planning transition initiatives, use the guideline to understand what processes and partnerships need to be in place to create safe, reliable and effective transitions.

Who has approved the guideline for use in Alberta?

- The guideline has been endorsed by the Alberta Health Services Executive LeadershipTeam, Alberta Health and the Provincial Primary Care Network Committee.

What health-system priorities will integrate the guideline into their work?

- The guideline is being integrated into the implementation of priorities such as the Alberta Health Services (AHS) Review, Alberta Surgical Initiative, Connect Care and improving continuity of care.

Who wrote the guideline?

- The guideline was written in collaboration with stakeholders from across the system, including AHS, Alberta Medical Association (AMA), Primary Care Networks (PCNs) and Alberta Health.
- The guideline initiative combines evidence from around the world with best practices and perspectives from over 750 stakeholders, who live right here in Alberta.
- Perspectives from more than 15 patient/family advisors helped ensure the guideline reflects the needs of Albertans from Lethbridge to Sexsmith, from Foremost to Sylvan Lake.

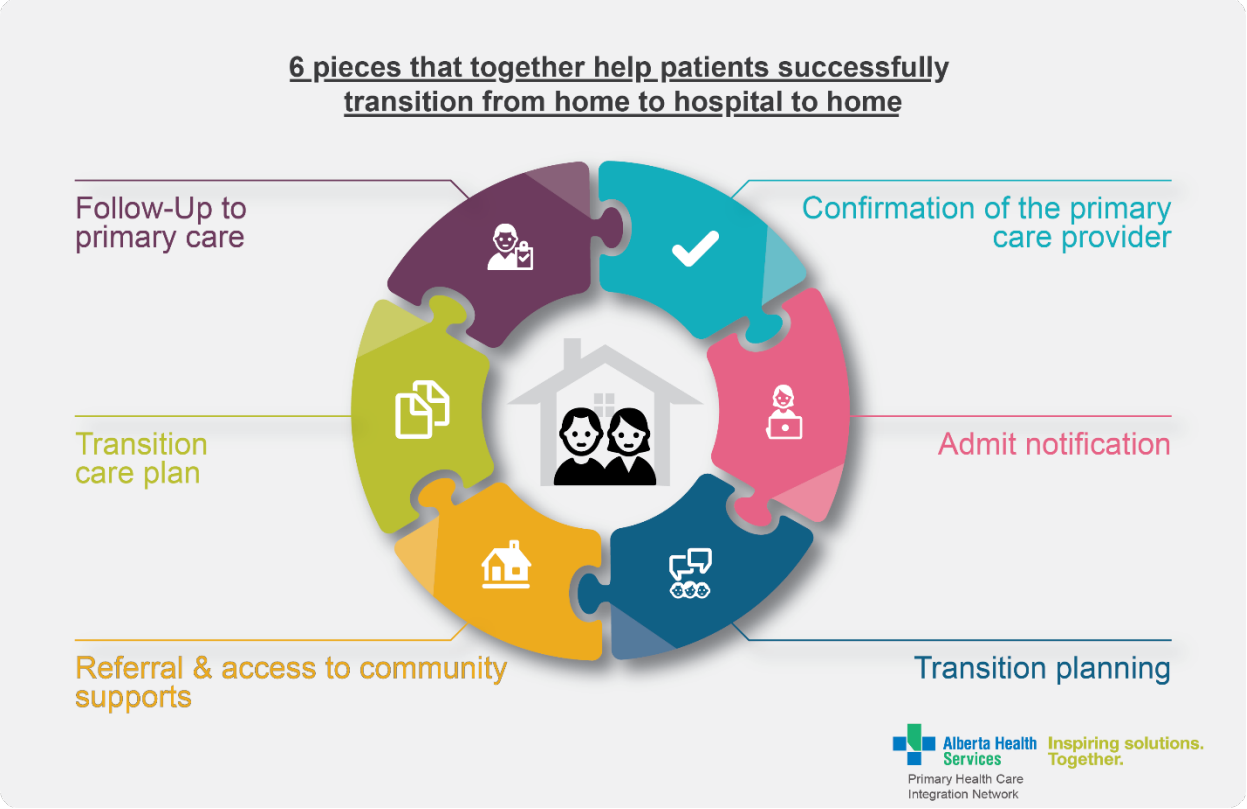
Implementation of the Guideline

Who is implementing the guideline?

- In primary care, Zone PCN Committees are developing implementation plans for the guideline as part of their zone service plans. These plans will be rolled out over three years, starting January 2021 to March 2023.
- Implementation of the guideline in acute care will happen through the AHS Review and the work of the AHS Sustainability Program Office. See the FAQs below for more information on the AHS Sustainability Program Office.
- The Primary Health Care Integration Network (PHCIN), in collaboration with the AMA, is working with partners in both acute care and primary care to support implementation of the guideline.

What supports are available for implementation of the guideline?

- The PHCIN and AMA are supporting full implementation of all six elements in the guideline, which is projected to be implemented by 2023. Please see below for the six elements of the guideline.



- The PHCIN will support zones by providing resources for implementation and accessing initiatives such as Connect Care, the Community Information Integration and Central Patient Attachment Registry (CII/CPAR) and other key technological enablers of high-quality transitions.
- The PHCIN will help zones build awareness for the guideline and will develop education and change management tools to help with local implementation.

How will implementation be measured?

- Monitoring measures have been identified with key stakeholders and experts, and the PHCIN will provide support accessing and interpreting these measures.
- The PHCIN is working with the AHS Documentation Quality Improvement Initiative, Connect Care, CII/CPAR, Collaborative Care (CoACT) and other key initiatives to develop reports to better assess transitions.

How are patients involved?

- Patient and family advisors were part of the design team who helped develop the Home to Hospital to Home Transition Guideline.
- A team, co-led by patient and family advisors, are spreading awareness of the guideline through various advisory groups.
- A team, co-led by patient and family advisors, also developed a report called "Transitions through Patients Eyes: Recommendations to Support Patients and Families." This document outlines six recommendations for Alberta's health system leaders to use when implementing the Home to Hospital to Home Transitions Guideline.

About the ADAPT Grant

What is ADAPT?

- ADAPT (A DiseAse-Inclusive Pathway for Transitions in Care) is a grant funded initiative that will support implementation of three elements of the Home to Hospital to Home Transitions Guideline: admit notification, transition planning and follow-up to primary care.
- ADAPT is a Partnership for Research and Innovation in the Health System (PRIHS) grant by Alberta Innovates and AHS.

How will ADAPT support Home to Hospital to Home implementation?

- The ADAPT initiative will create a common transitions in care pathway for Albertans with heart failure, COPD, cirrhosis, end-stage kidney disease and stage 3-4 cancers.
- The plan is to develop and implement the ADAPT pathway in five acute care sites and associated PCN clinics between April 2021 and April 2024.

CII/CPAR and Improving Transitions in Care

What is CII/CPAR?

- The Community Information Integration and Central Patient Attachment Registry (CII/CPAR) connects community-based clinics to provincial systems, such as Netcare, to exchange data on patient encounters, patient panels, specialist consult reports and attachment.
- Once a primary care clinic has signed up with CII/CPAR, they will receive automatic notifications about their patients directly to their electronic medical record.
- CII/CPAR enables primary care physicians to confirm their patient attachment relationships allowing them to identify and resolve panel conflicts. This helps ensure all healthcare providers can access accurate information about who a patient's primary care provider is.

How does CII/CPAR affect implementation of the guideline?

- The CII/CPAR initiative will help improve home to hospital to home transitions for patients by improving informational and management continuity. Using CII/CPAR is one of the most important actions that family physicians can take to help implement the guideline.
- CII/CPAR will allow family physicians to know when their patient has been admitted or discharged from the emergency department or hospital. The physician and team can then provide more timely post discharge follow-up.
- Alberta Health and the Provincial PCN Committee have prioritized CII/CPAR implementation.
- Eighty per cent of PCN clinics are projected to register and actively use CII/CPAR by Dec 2023.
- The name of the primary care provider will be displayed in Netcare as of June 2021, so acute care providers will be able to understand who to share patient information with during transitions in care.

AHS Sustainability Program Office and Implementation of the Guideline

What is the AHS Sustainability Program Office?

- The AHS Sustainability Program Office is leading the implementation of key initiatives to improve acute care flow, reduce Actual Length of Stay/Expected Length of Stay (ALOS/ELOS) and to reduce readmissions.
- The key initiatives are: Collaborative Care (CoACT), Home to Hospital to Home Transitions Guideline, Elder Friendly Care, Enhanced Recovery After Surgery and the COPD/Heart Failure Pathways.

How is Home to Hospital to Home involved?

- The Home to Hospital to Home Transitions Guideline will be implemented in AHS tertiary and regional hospitals as part of implementing AHS Review recommendations.
- The Home to Hospital to Home team is engaging with 14 hospitals in Alberta on implementation of the guideline. Site engagement will take place from February 2021 to March 2021.
- Site specific implementation plans will be developed following the engagement period which will help inform implementation practices that can be applied to other acute care sites.
- The AHS Sustainability Program Office and partners will work with the Connect Care team to optimize the electronic medical record to support and enable Home to Hospital to Home implementation.

COVID-19 Response

How did the guideline help the COVID-19 response?

- The principles outlined in the Home to Hospital to Home Transitions Guideline influenced guidance on how to care for COVID-19 patients in the community. The guideline also informed procedures that help ensure continuity of care at hospital discharge for COVID-19 patients. For example, the COVID-19 Safe Discharge Home Checklist (for providers) and the COVID-19: My Discharge Checklist (for patients) integrate components of the guideline.