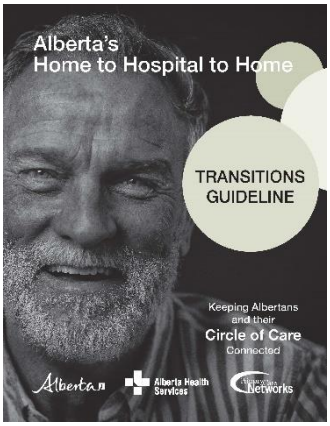
Home to Hospital to Home Transitions

How Connect Care improves transitions in care

You've probably heard about Connect Care—a new way of using and sharing health information supported by a common clinical information system. It provides a more complete patient health history and creates consistency in care, no matter where you are in the province. AHS is putting it in place in acute care sites across Alberta.

But what does Connect Care have to do with primary care? And how can it help primary care providers improve transitions in care, particularly if they don't work in an AHS facility?



Here's the answer in a nutshell: Connect Care helps patient information flow between primary care providers and hospital teams—and it standardizes this flow of information across the province. This informational continuity leads to smoother transitions as patients move between home, hospital and their medical home.

And smooth transitions are what the Home to Hospital to Home Transitions Guideline is all about. To ensure patients are safe and well during transitions in care, the guideline relies on information technology (IT) systems like Connect Care.

Building digital bridges

Here's how Connect Care helps patient information flow between care providers in hospitals and community clinics:

Automatic delivery of key patient documents four times daily

You may already be using eDelivery to get patient results in your EMR, but eDelivery has now been enhanced to send patient information from hospital teams who use Connect Care to primary care providers' electronic medical records (EMRs).

> **Did you know?**
> Alberta Medical Association (AMA) and AMA Section of Family Practice representatives helped develop the eDelivery process for sending patient information to primary care.

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Through eDelivery, Connect Care provides the following summative documents to the primary care provider listed in Connect Care:

- Admitting history and physical
- Specialty consult findings and recommendations
- Discharge summary
- Emergency department providers' notes
- Post-operative notes
- Labour and delivery notes

Discharge summaries

Connect Care helps primary care providers get a standardized discharge summary much more quickly. Primary care providers helped develop this discharge summary to ensure best practices are applied, such as:

- Digital format, making it legible and comprehensive
- Quick turnaround
- Consistency between facilities

Joint discharge planning

Being able to communicate with primary care providers means hospital teams can work collaboratively with the patient's primary care team while the patient is still in the hospital—and the primary care team has the information they need to provide excellent follow-up care. This is the longer term goal of the Home to Hospital to Home Transitions team.

Primary care provider identification

Connect Care, along with eDelivery, helps ensure the primary care provider gets information on their patients' hospital stays. Connect Care charting has a field specifically for the name of the patient's primary care provider, which the hospital team fills out. eDelivery then sends patient information to that provider. This process is facilitated when the patient's primary care provider participates in CII/CPAR.

CII/CPAR

When the primary care provider participates in the Community Information Integration/Central Patient Attachment Registry (CII/CPAR), their name is automatically linked to their patients in Netcare—so hospital teams know how to get in touch with that patient's primary care provider.

LACE scores

Based on care providers' clinical assessments, Connect Care automatically calculates a LACE score for each patient—which categorizes them as low, moderate or high risk for early readmission.

The LACE score considers the patient's length of stay, admission type, comorbidities and frequency of emergency room visits. The use of a prediction model like LACE to quantify a patient's risk of readmission may help primary care providers plan early interventions for patients who will benefit from them the most.

AHS is working to ensure the LACE score is included in all discharge summaries, so the primary care provider will receive the score when their patient is discharged. This would support primary care providers' conversations with patients, help them plan timely follow-up care for higher-risk patients, and prevent readmissions. Note that this process is new and will be constantly optimized by acute care teams.

Trouble-shooting

A systems launch the size of Connect Care will have its glitches, so AHS continues to improve the trouble-shooting process for community providers—for example, if they've been incorrectly identified as the patient's primary care provider. Support options include:

- AHS Solutions Centre: 1-877-311-4300
- Chief Medical Information Office: cmio@ahs.ca
- Connect Care Provider Bridge: ccproviderbridge@ahs.ca

Transitions in care resources: Connect Care and beyond

Did you know that you can find helpful resources online to support your work on the Home to Hospital to Home Transitions Guideline? You might want to bookmark the Home to Hospital to Home Transitions Guideline web page because that's where we post resources. But here are some direct links to key materials:

Connect Care information for healthcare providers: this is where you can find practical information on Connect Care, all geared toward community providers.

Summative documents: learn more about the patient documents that are sent through eDelivery to electronic medical records (EMRs).

eDelivery information: find out more about eDelivery and how to sign up for it.

Home to Hospital to Home Transitions Guideline: read the guideline for background and details on the initiative, or check out this overview webinar. Find out about measuring transitions here, or check out the measures webinar. You can also find information on patient recommendations for the guideline, along with a webinar on co-designing with patients.

FAQs: this frequently asked questions document lets you scan the most commonly asked questions about the Home to Hospital to Home Transitions Guideline.

IT enablers map: get a high-level look at the three IT systems that facilitate transitions in care: Connect Care, Netcare, and the Community Information Integration/Central Patient Registry (CII/CPAR). You'll get information on the Community Encounter Digest, links to video tutorials, and details on patient information flow.

IT enablers video: get more detail on the three IT systems that help patient information flow smoothly between acute and primary care providers. You'll find out how eNotifications help primary care providers find out when their patients have been admitted to, or discharged from, the hospital.

Technology of Transitions webinar: this hour-long webinar explains why IT enablers like CII/CPAR are so vital to the success of transitions in care work. You'll also get some background on the Home to Hospital to Home Transitions Guideline initiative, and where the implentation stands.

Change package: this resource from the Alberta Medical Association Accelerating Change Transformation Team (AMA ACTT) helps primary care physicians and team members implement practice changes related to the guideline.

For more information: PCA@primarycarealberta.ca.