

# HOMETOHOSPITALTOHOMETRANSITIONS MONITORING MEASURES **JULY 2024**

Key monitoring indicators can help teams assess and plan their transitions in care work:

**80%** of Alberta patients were able to give the name of their primary care provider (PCP) during their hospital stay.



This ensures the PCP receives their patients' hospital-visit information, enabling them to plan follow-up care.



**90%**



of discharge summaries are completed by acute care teams within 24 hours, then sent to the patient's PCP, so they can plan follow up care. **Only 4% of discharge summaries include a LACE index\*.**

**59%** of moderate- and high-risk patients with a documented PCP get follow-up care within recommended timeframes.



**37%** of patients without a documented PCP get follow-up care within recommended timeframes.

**16%** of high-risk patients with a PCP who get follow-up care within recommended timeframes are readmitted within 30 days.



**27%** of patients who did not receive any follow-up care were readmitted.

\*LACE index for readmission risk

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