Alberta Health Services
Primary Health Care

HOME TO HOSPITAL TO HOME TRANSITIONS MONITORING MEASURES JULY 2024

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

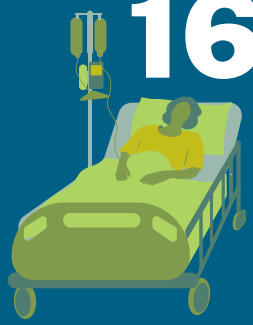
80% of Alberta patients were able to give the name of their primary care provider (PCP) during their hospital stay.

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

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

Posted: **September 2024**