ALBERTA MEDICAL ASSOCIATION

Building Blocks to Successful Transitions of Care Webinar

Welcome! Thank you for joining early

Start Time: 5:00 PM promptly

- Your **mic** and **camera** are enabled by default
- Please **mute** yourself
- **To ask questions:**
  - Click **'raise hand'** during presentation; moderator will invite you to unmute during the question period
  - At any time, type questions in the **'chat box'**

Building Blocks to Successful Transitions of Care Webinar

Webinar Series:
Maintaining and Optimizing Your Practice During Times of Rapid Change

We will be starting the session promptly at 5:00 PM

Zoom Instructions

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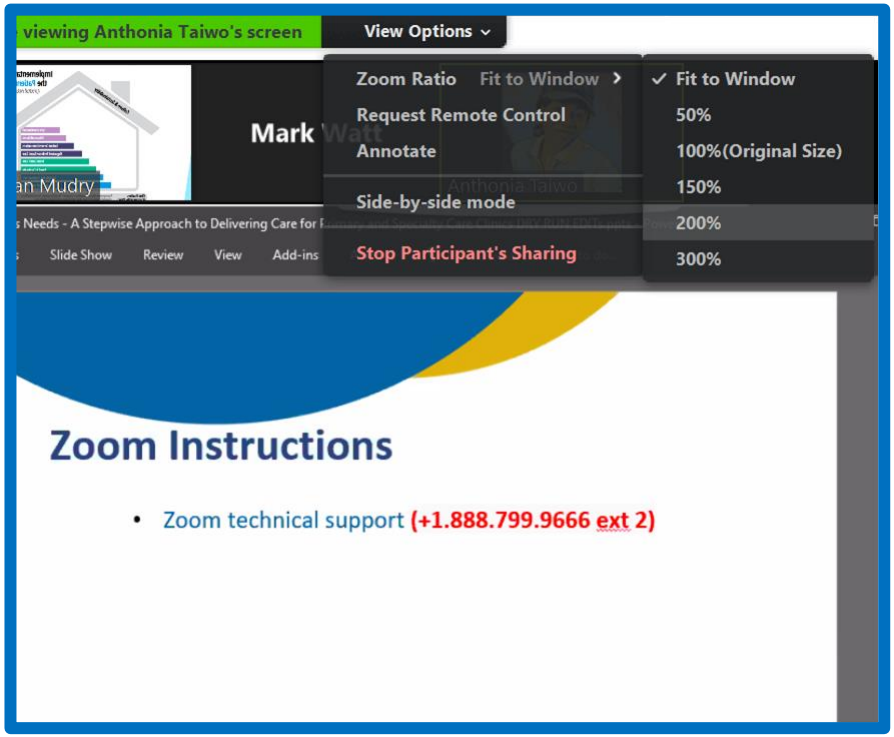
Zoom technical support
(+1.888.799.9666 ext 2)



Live Recording

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- Privacy Statement: Please note that the webinar you are participating in is being recorded. By participating, you understand and consent to the webinar being made publicly available via a link on the AMA website for an undetermined length of time.
- By participating in the chat and live Q&A, your name entered into the Zoom sign-in may be visible to other participants during the webinar and/or in the recording.

Land Acknowledgment

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We would like to recognize that we are webcasting from, and to, many different parts of Alberta today. The province of Alberta is located on Treaty 6, Treaty 7 and Treaty 8 territory and is a traditional meeting ground and home for many Indigenous Peoples.

Disclosure of Financial Support

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This program has not received any financial or in-kind support.

Presenters:

Dr. Brad Bahler
Family Physician, ACTT Medical Director, Alberta Primary Care Alliance Chair

Dr. Joseph Ojedokun
AMA Physician Champion, North Zone

Dr. Heather La Borde
AMA Physician Champion, Provincial

Mona Delisle
AHS Acting Executive Director, Primary Health Care

Barb McCaffrey
AMA ACTT CII/CPAR Project Lead

Moderators:

Michelle Tobias-Pawl
Session Moderator

Sue Peters
Q&A Moderator

Barb McCaffrey
Q&A Moderator

Sheena George
Q&A Moderator

Bonnie Lakusta
Q&A Moderator

Jon Mudry
Q&A Moderator

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Presenter Disclosure

- Dr. Brad Bahler: AMA-physician contractor, CIHR Grant
- Dr. Joseph Ojedokun: AMA-Physician Champion, North Zone
- Dr. Heather La Borde: AMA-Physician Champion, Provincial
- Mona Delisle: AHS- Acting Executive Director, Primary Health Care
- Barb McCaffrey: AMA ACTT CII/CPAR Project Lead

Moderator Disclosure

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- Michelle Tobias-Pawl: AMA employee
- Sue Peters: AMA contractor, IBI Group-contractor, honoraria-HQCA
- Bonnie Lakusta: AMA employee
- Sheena George: AMA employee
- Jon Mudry: AMA employee

Session Overview

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- Patient Story – Gaps in Care
- Closing the Informational Continuity Gap
- A Guideline for Effective Transitions
- CII/CPAR & The Guideline in Action
- Leveraging your Team for Smooth Transitions
- Additional Transitions Webinars & Resources
- Questions and Wrap-Up

Learning Objectives

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At the end of this session participants will be able to:

- Identify where gaps in continuity occur during transitions of care and recognize how the Home to Hospital to Home (H2H2H) Transitions Guideline recommendations may help address gaps in care
- Recognize how CII/CPAR supports continuity and transitions of care
- Describe how primary care teams have improved patients transitions of care

Today's Presenters

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Dr. Brad Bahler
Family Physician, ACTT Medical Director, Alberta Primary Care Alliance Chair

Mona Delisle
AHS Acting Executive Director, Primary Health Care

Dr. Joseph Ojedokun
AMA Physician Champion, North Zone
Family Medicine

Dr. Heather La Borde
AMA Physician Champion, Provincial
Family Medicine

Patient Story
Gaps in Care

Dr. Joseph Ojedokun
AMA Physician Champion,
North Zone

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A Patient Story

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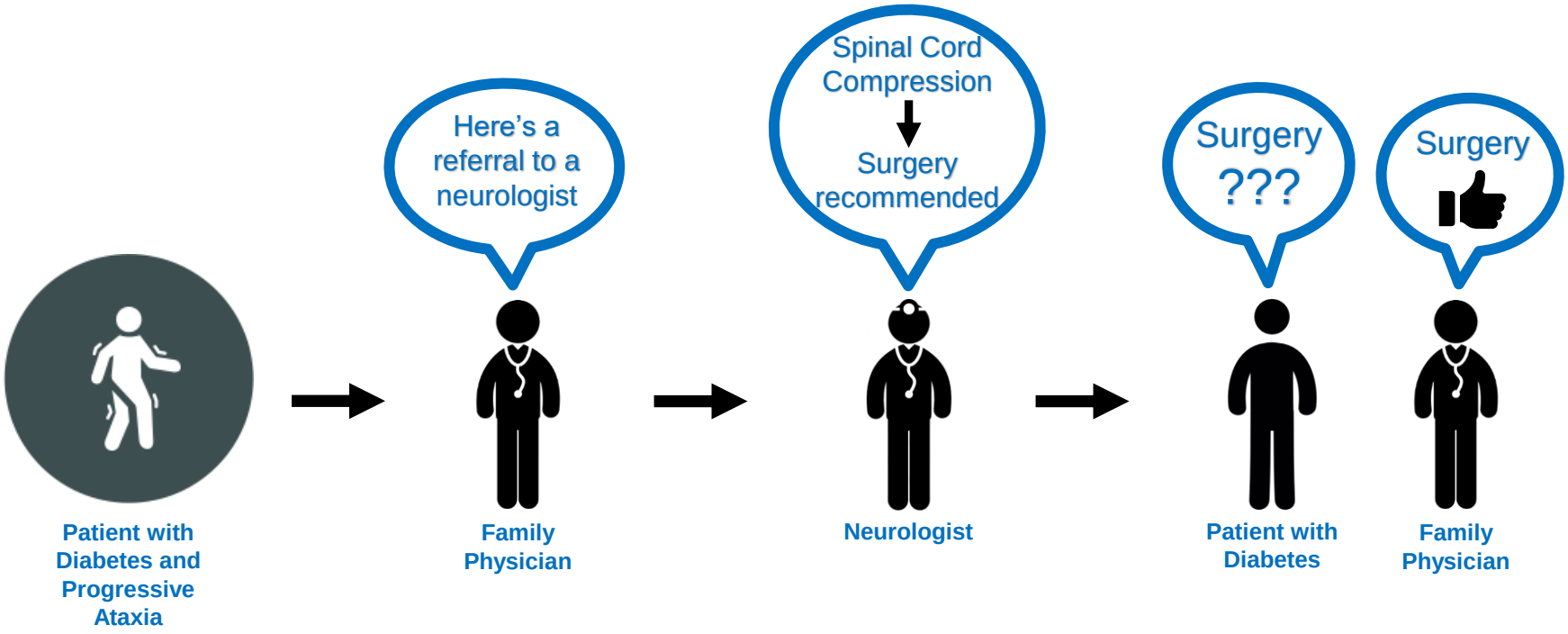
A North Zone Physician Champion's Perspective



A Patient Story

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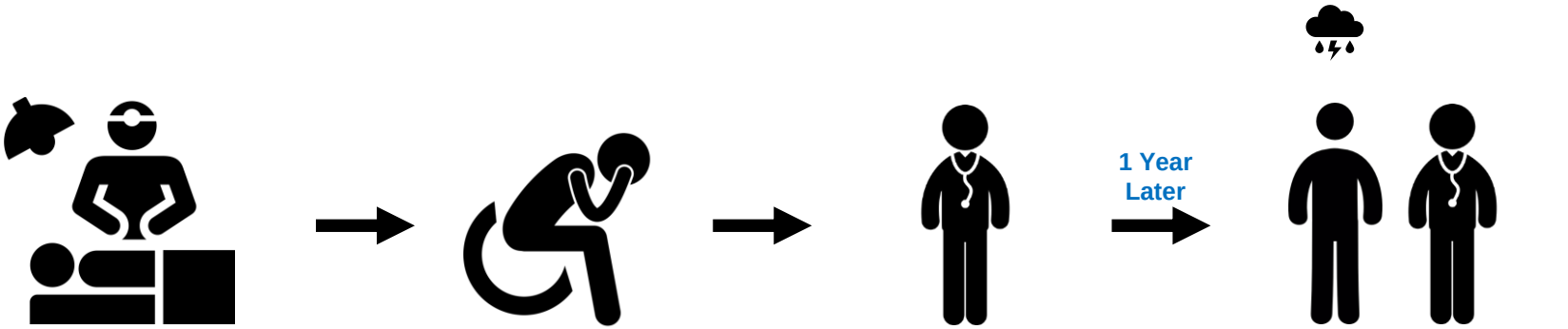
A North Zone Physician Champion's Perspective



Patient Undergoes Surgery

Post-Op Complications Leave Patient Wheelchair Bound

The patient's family physician is unaware of the patient's situation

By the time the patient finally visits his family physician, he is severely depressed

Closing the Informational Continuity Gap

Barb McCaffrey
AMA ACTT CII/CPAR Project Lead

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Simple View of eHealth in Alberta

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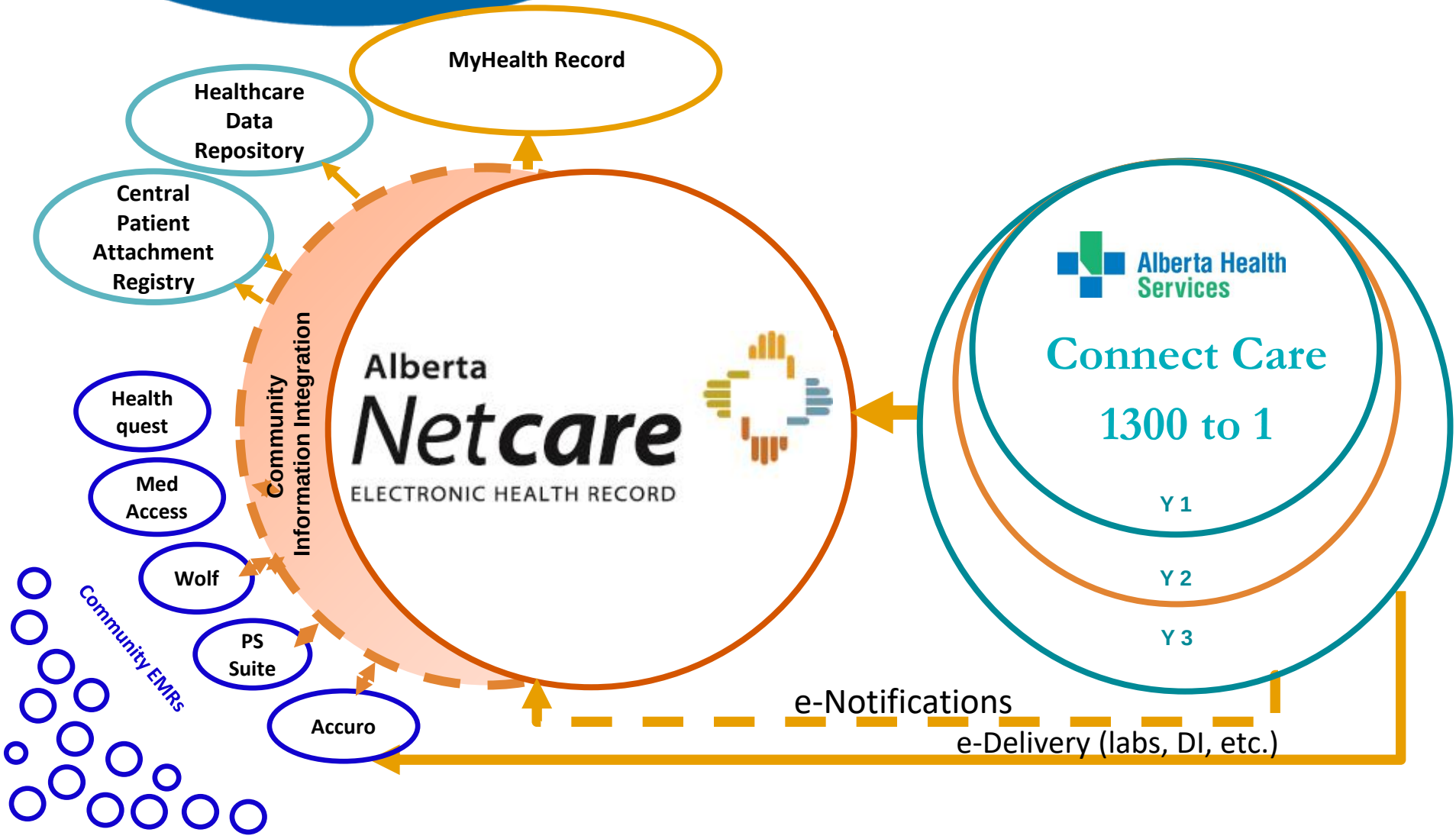

CII/CPAR Participants: Share, Receive & Enhance

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Information shared

- ✓ Confirmed Panel
- ✓ Patient Encounter Data
- ✓ Consult Reports*

Information received

- eNotifications
  ED discharge, in- patient admit, discharge and same day surgery
- Panel conflict reports
- Demographic mismatch reports

Enhance Continuity (Info in Netcare)

- Community Encounter Digests
- Consult Reports

Future:

- *Display primary provider (June 2021)*
- *Patient Summary (2021)*

**Consults from Specialists and Primary Care providers providing consultative services.*

Physician Deployment in Alberta (Jan 6, 2020)

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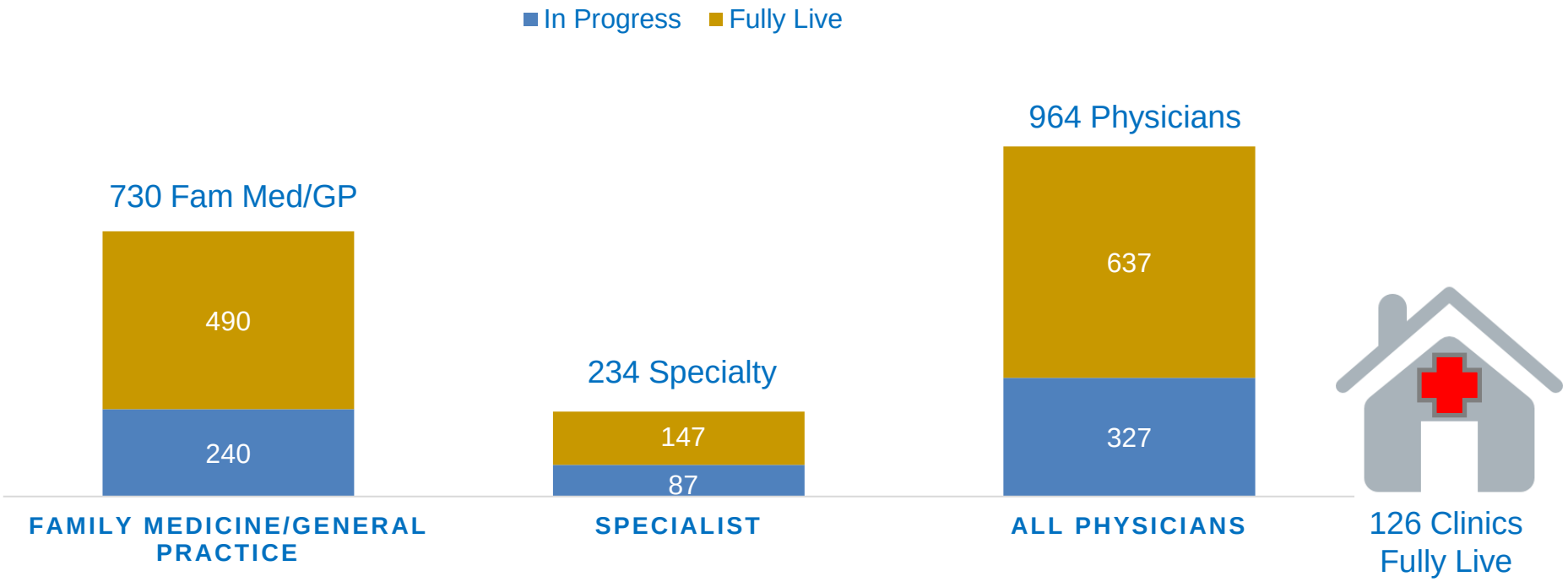
CII/CPAR PHYSICIAN DEPLOYMENT



Growing potential for smoother transitions of care provincially

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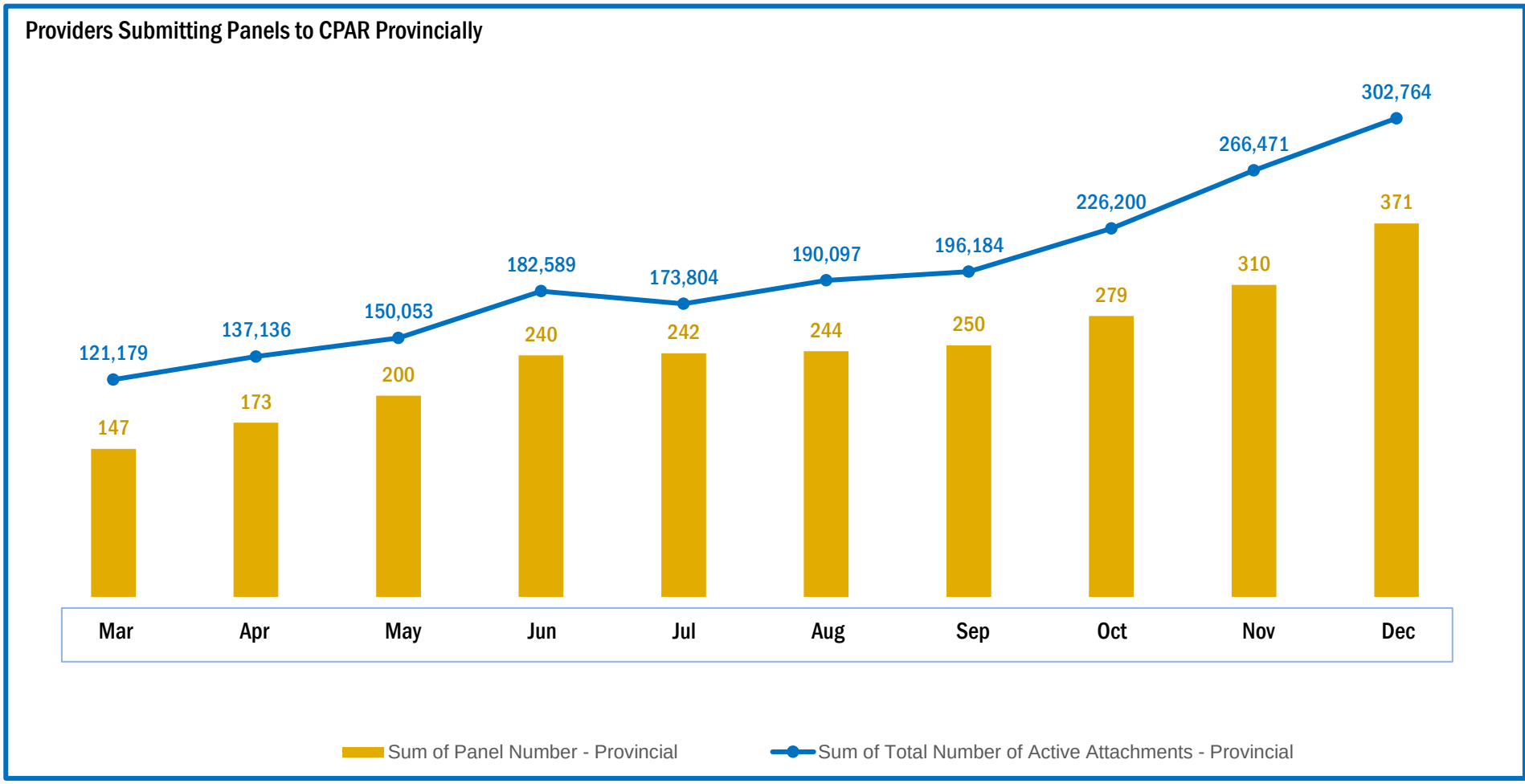

Growing potential for smoother transitions of care provincially

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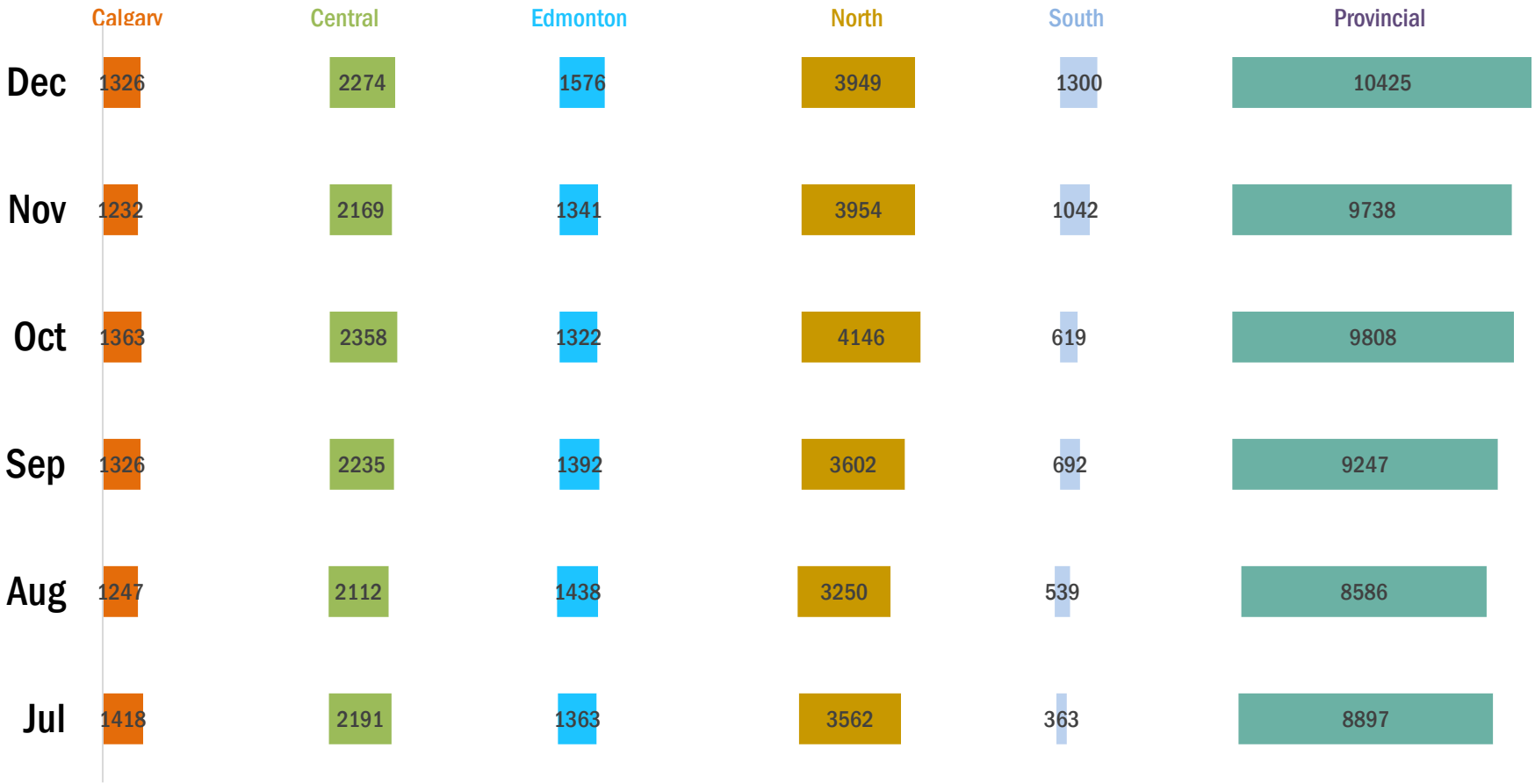
10,000+ notices in December 2020

Sent eNotification – Zonal (Jul-Dec 2020)



Benefits of CII/CPAR

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Over **82,523** Consult Reports have been submitted to Alberta Netcare.

Encounter data from over **237,869** unique patients has been shared and uploaded into Alberta Netcare Portal as a Community Encounter Digest (CED) report.

As of January 1, 2020

A Guideline for Effective Transitions

Mona Delisle
AHS Acting Executive Director,
Primary Health Care

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Home to Hospital to Home (H2H2H) Transitions Guideline

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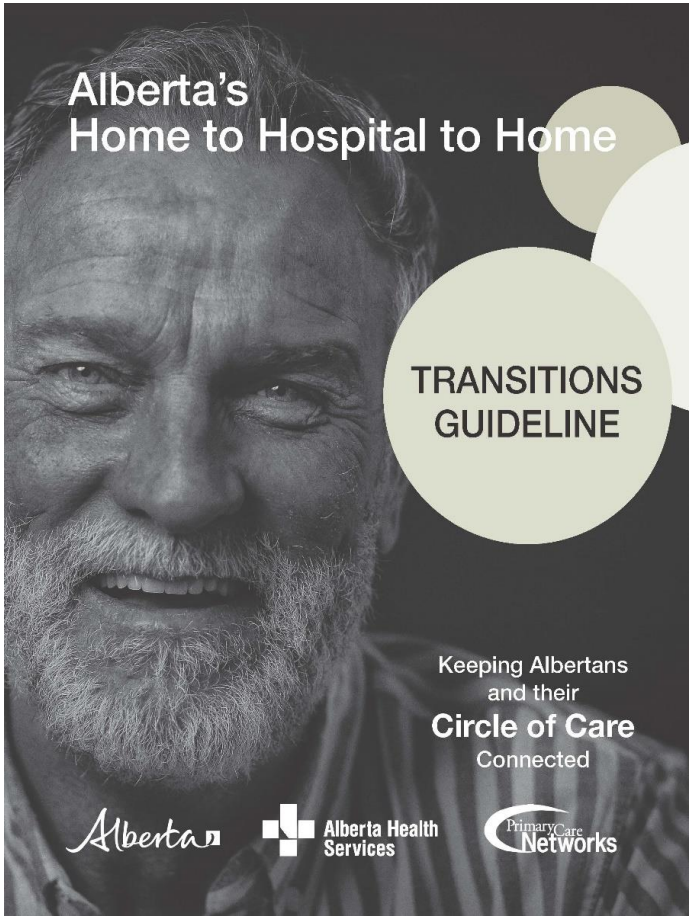

Potential Benefits:

- Reduce practice variability
- Improved informational and management continuity
- Create understanding of processes from sender and receiver
- Improve patient outcomes, experience and satisfaction
- Increase provider satisfaction

Guideline Components

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6 pieces that together help patients successfully transition from home to hospital to home

Alberta Health Services Inspiring solutions. Together.
Primary Health Care Integration Network

Guideline Components and CII/CPAR

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Guideline Section		Providers live on CII/CPAR, for your PANELED Patients
	Confirmation of the Primary Care Provider	• Receive **ADMIT eNotification** automatically into EM lab report/task area • Patient encounter information is shared in the form of a **Community Encounter Digest (CED)** in Netcare
	Admit Notification	
	Transition Planning	• PCPs and practices can collaboratively work with the hospital teams to ensure appropriate clinical and nonclinical post discharge community supports are arranged
	Referral and Access to Community Supports	
	Transition Care Plan	• Receive **DISCHARGE eNotification** (In-patient & Emerg) automatically into EMR lab report/task area
	Follow-up to Primary Care	• **Timely Access** to a follow-up appointment requires PCPs and practices to understand and balance the demand and supply of appointment

Implementation of the Guideline

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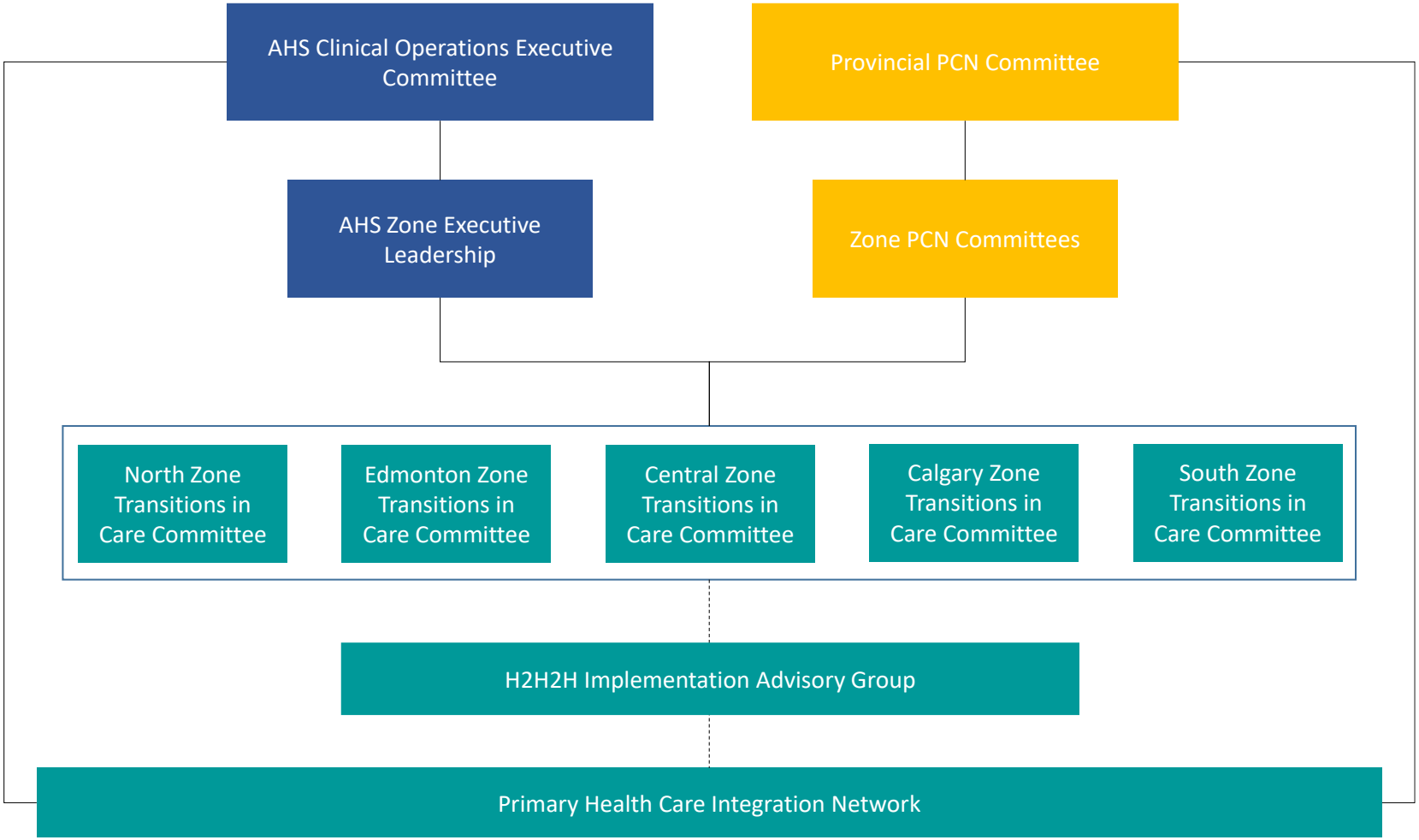

CII/CPAR & The Guideline In Action

Dr. Joseph Ojedokun
AMA Physician Champion,
North Zone

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The Biggest Benefits of CII/CPAR

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Dr. Ojedokun - A North Zone Physician Champion's Perspective

Studies have shown that, ***continuity of care is the single most important intervention*** *that, when offered to patients through timely access, can reduce mortality by up to 50%.*

As enablers of continuity of care,
CII, CPAR, and eNotifications are, in my opinion, the best things that have happened to Primary Care in Alberta*."*

Dr. Joseph Ojedokun,
MRPCN, Whitecourt

A Patient Story

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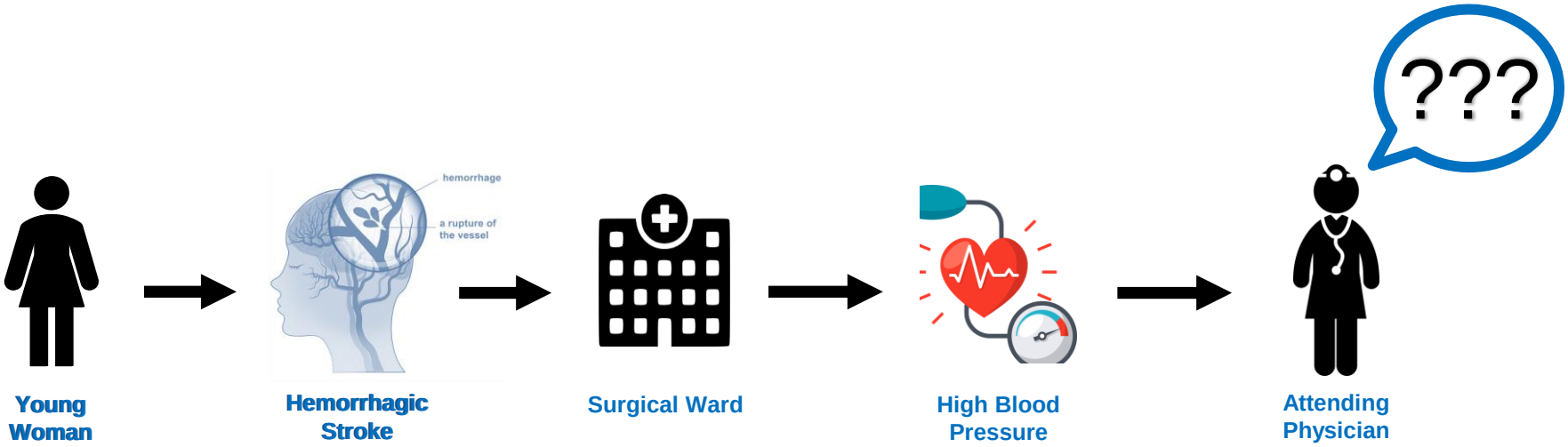

A Patient Story

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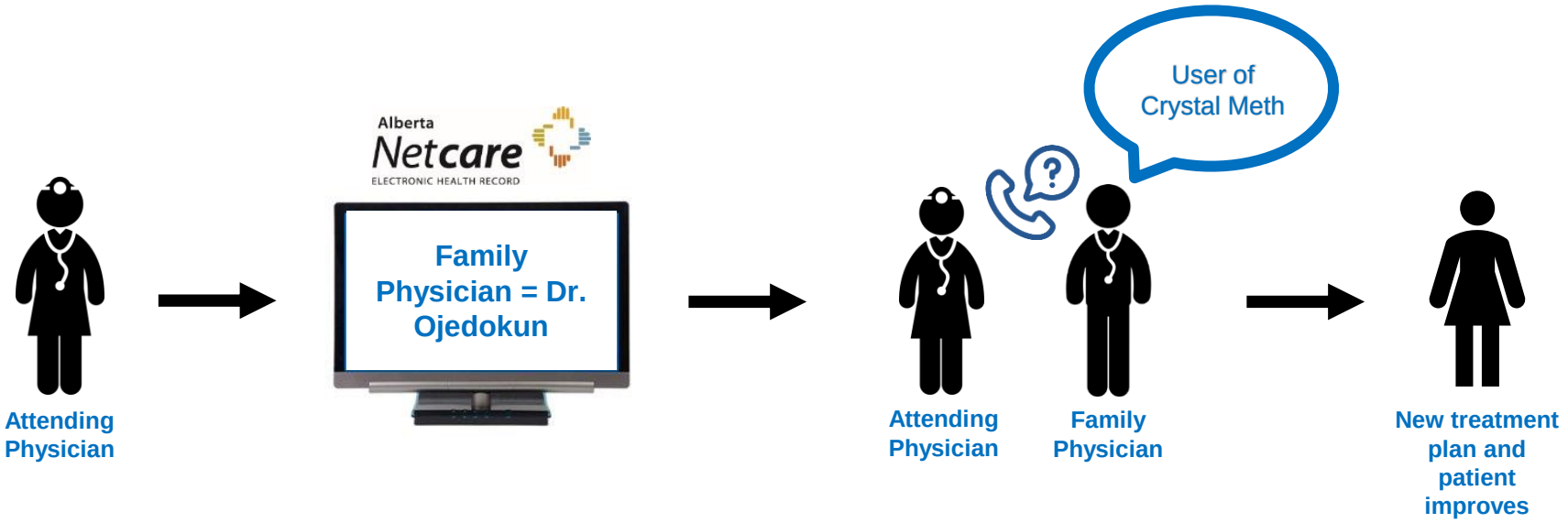

The Biggest Benefits of CII/CPAR

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Dr. Ojedokun - A North Zone Physician Champion's Perspective

"CII/CPAR promotes:

1. *Patient safety*
2. *Timely, efficient, and effective patient-centered care"*

Dr. Joseph Ojedokun, MRPCN, Whitecourt

Leveraging your Team for Smooth Transitions

Dr. Heather La Borde
AMA Physician Champion,
Provincial

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My clinic took the COVID pandemic as an opportunity to go live with CII/CPAR. It is especially important during these times to know when my patients are admitted to hospital or in the ED so I am well positioned to care for them.

Dr. Heather La Borde, *CFPCN, Calgary*

CII/CPAR - Timely Admit/Discharge Notifications

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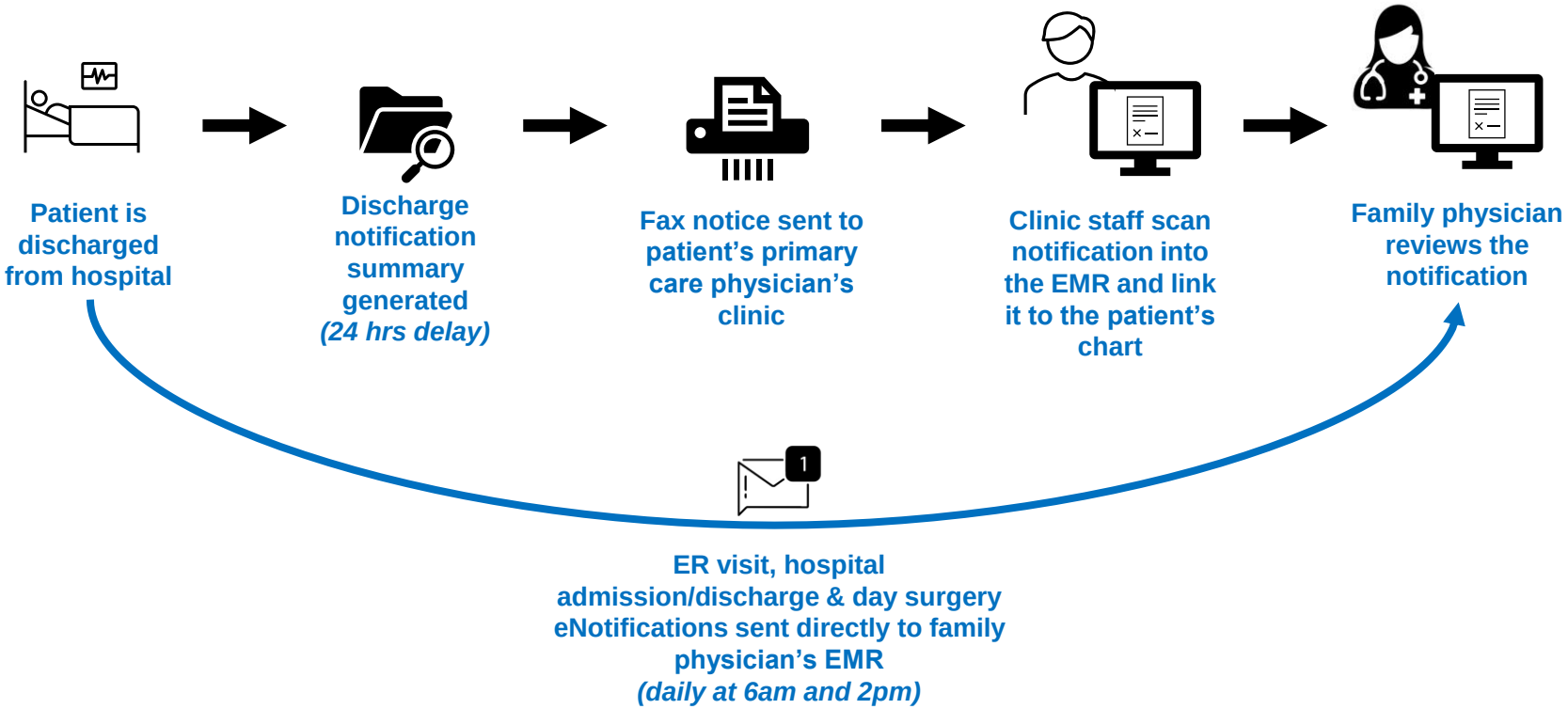
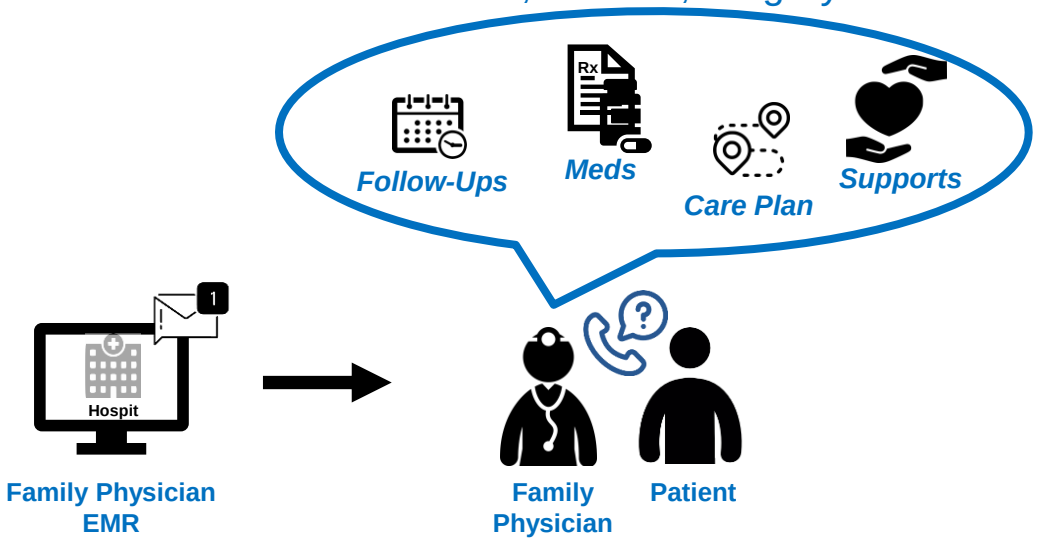


"Each discharge eNotification is an opportunity to check in with the patient to make sure that they have a clear understanding of their care path and identify those patients who may be at higher risk for readmission."

Dr. Heather La Borde, CFPCN, Calgary



What Benefits have I Seen?

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Measureable Improvement In:

- Patient Safety
- Patient Outcomes
- Patient and Provider Satisfaction

Patient Safety

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"A pilot project – LACE & medication reconciliation - identifies patients at higher risk."

"This helps my team identify which patients need to be seen post hospital discharge and for medication reconciliation. The process has improved our clinic efficiency and allows me more time to focus on clinical care".

Dr. Heather La Borde, CFPCN, Calgary

Patient Outcomes

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"CII/CPAR is supporting transitions of care work by saving staff time, streamlining processes, and increasing information accuracy."

" We've measured hospital re-admission rates and ED visit rates and can see the improvement in patient outcomes."

Dr. Heather La Borde, CFPCN, Calgary

Healthcare System Outcomes

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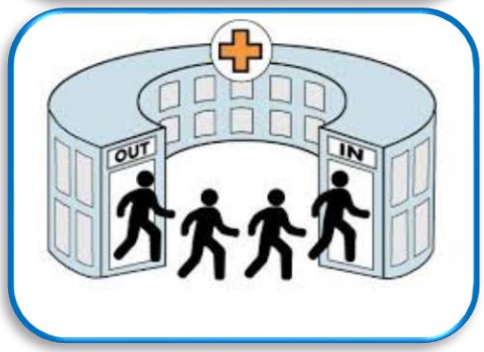
30-day re-admission rates:
67%



7-day ED visit rates:
67%

Post-discharge follow-up appointment wait-time:
12 days *(high risk group)*

Patient Satisfaction

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"When I call a patient after receiving an eNotification, they often think that I'm going above and beyond and are so grateful for that."

"Patients feel their care is quarterbacked and seamless throughout their journey of care."

Dr. Heather La Borde, CFPCN, Calgary

Provider Satisfaction

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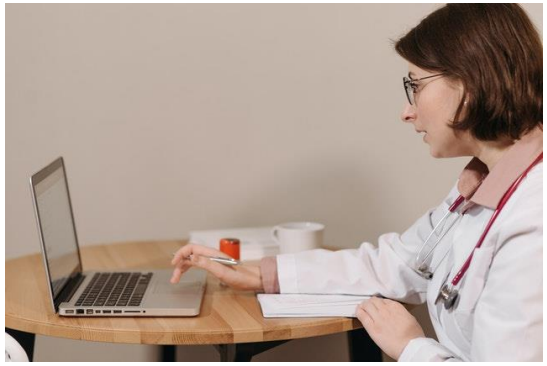
*"Being able to follow-up with patients through eNotifications helps me spend more time with my patients and feel **more connected** to them."*

*"I can **better direct patient care** because now, I get the information, validate it, reach out to the patient, and make sure that they're on the right path."*

Dr. Heather La Borde, CFPCN, Calgary



Q & A

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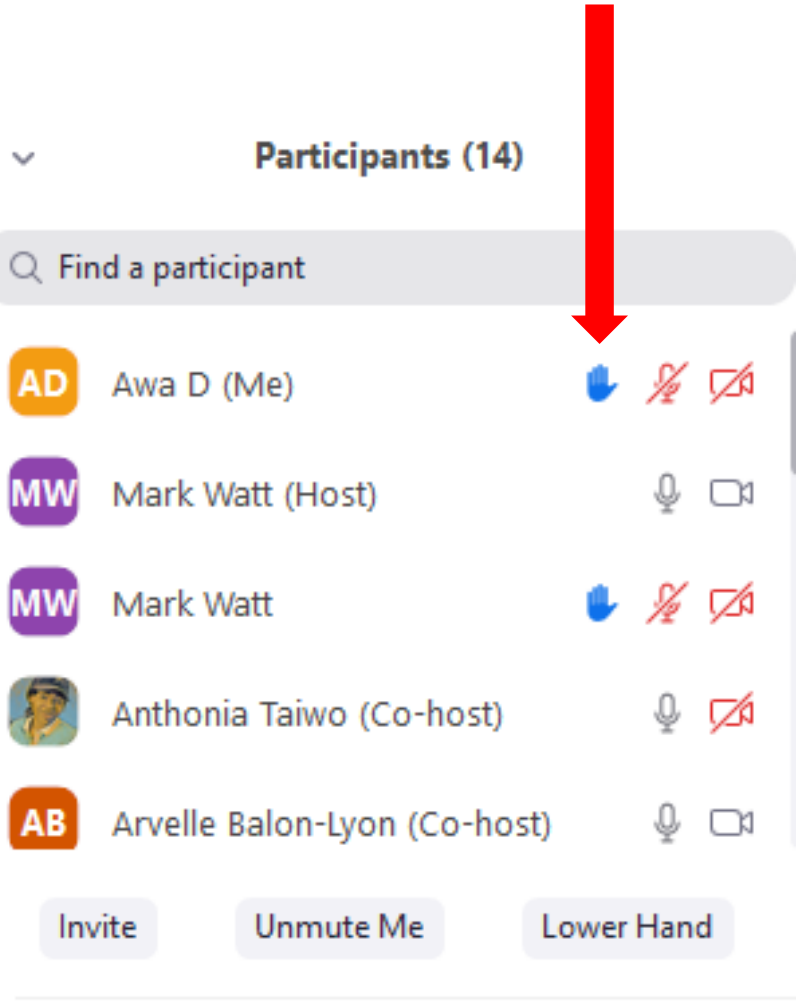
Live Q&A and Polling

- Please put your virtual hand up by using the raise hand function under the ‘participant’ menu

- If using the phone, open the participant menu and scroll down to find the raise hand feature



Additional Transitions Webinars & Resources

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Additional Transitions Webinars & Resources

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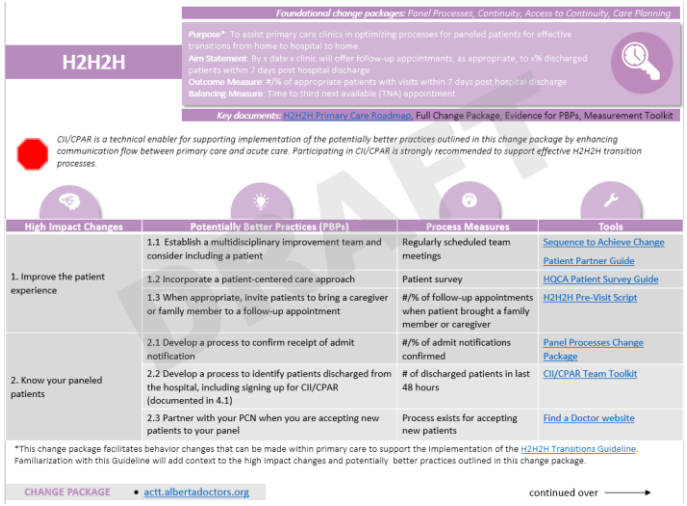
- Recorded Webinars
  - H2H2H Guideline Orientation
  - H2H2H Transitions Measures Orientation
- Resources
  - H2H2H Change Package & PF Training (In development)
  - ACTT H2H2H Transitions Webpage
  - AHS H2H2H Transitions Webpage



H2H2H

Foundational change packages: Panel Processes, Continuity, Access to Continuity, Care Planning

Purpose*: To assist primary care clinics in optimizing processes for paneled patients for effective transitions from home to hospital to home
Aim Statement: By x date x clinic will offer follow-up appointments, as appropriate, to x% discharged patients within 7 days post hospital discharge
Outcome Measure: #/% of appropriate patients with visits within 7 days post hospital discharge
Balancing Measure: Time to third next available (TNA) appointment

Key documents: H2H2H Primary Care Roadmap, Full Change Package, Evidence for PBPs, Measurement Toolkit

CII/CPAR is a technical enabler for supporting implementation of the potentially better practices outlined in this change package by enhancing communication flow between primary care and acute care. Participating in CII/CPAR is strongly recommended to support effective H2H2H transition processes.

High Impact Changes	Potentially Better Practices (PBPs)	Process Measures	Tools
1. Improve the patient experience	1.1 Establish a multidisciplinary improvement team and consider including a patient	Regularly scheduled team meetings	Sequence to Achieve Change Patient Partner Guide
	1.2 Incorporate a patient-centered care approach	Patient survey	HQCA Patient Survey Guide
	1.3 When appropriate, invite patients to bring a caregiver or family member to a follow-up appointment	#/% of follow-up appointments when patient brought a family member or caregiver	H2H2H Pre-Visit Script
2. Know your paneled patients	2.1 Develop a process to confirm receipt of admit notification	#/% of admit notifications confirmed	Panel Processes Change Package
	2.2 Develop a process to identify patients discharged from the hospital, including signing up for CII/CPAR (documented in 4.1)	# of discharged patients in last 48 hours	CII/CPAR Team Toolkit
	2.3 Partner with your PCN when you are accepting new patients to your panel	Process exists for accepting new patients	Find a Doctor website

*This change package facilitates behavior changes that can be made within primary care to support the implementation of the H2H2H Transitions Guideline. Familiarization with this Guideline will add context to the high impact changes and potentially better practices outlined in this change package.

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continued over

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Thank you and please complete the post-session evaluation!

Evaluation

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https://interceptum.com/s/en/RC01212021