

# 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



Zoom technical support  
**(+1.888.799.9666 ext 2)**

The screenshot shows a Zoom meeting interface. At the top, it says "viewing Anthonia Taiwo's screen". A "View Options" dropdown menu is open, showing the following settings:

Zoom Ratio	Fit to Window	✓ Fit to Window
Request Remote Control		50%
Annotate		100%(Original Size)
Side-by-side mode		150%
		200%
Stop Participant's Sharing		300%

Below the menu, the main content area displays "Zoom Instructions" and a bullet point: "Zoom technical support (+1.888.799.9666 ext 2)".

- 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



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

**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

- 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

- 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



-  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



## 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



**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

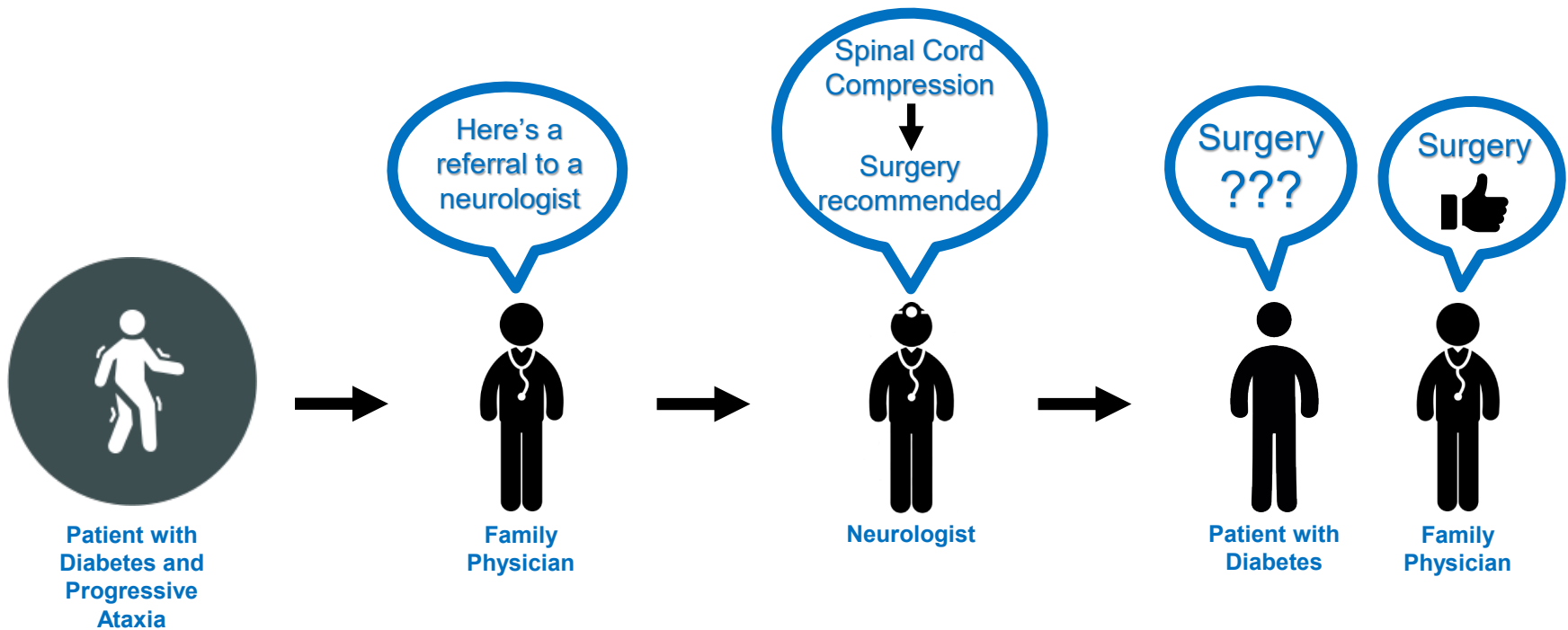


# Patient Story Gaps in Care

Dr. Joseph Ojedokun  
AMA Physician Champion,  
North Zone

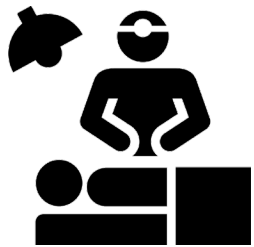
# A Patient Story

## A North Zone Physician Champion's Perspective



# A Patient Story

## 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



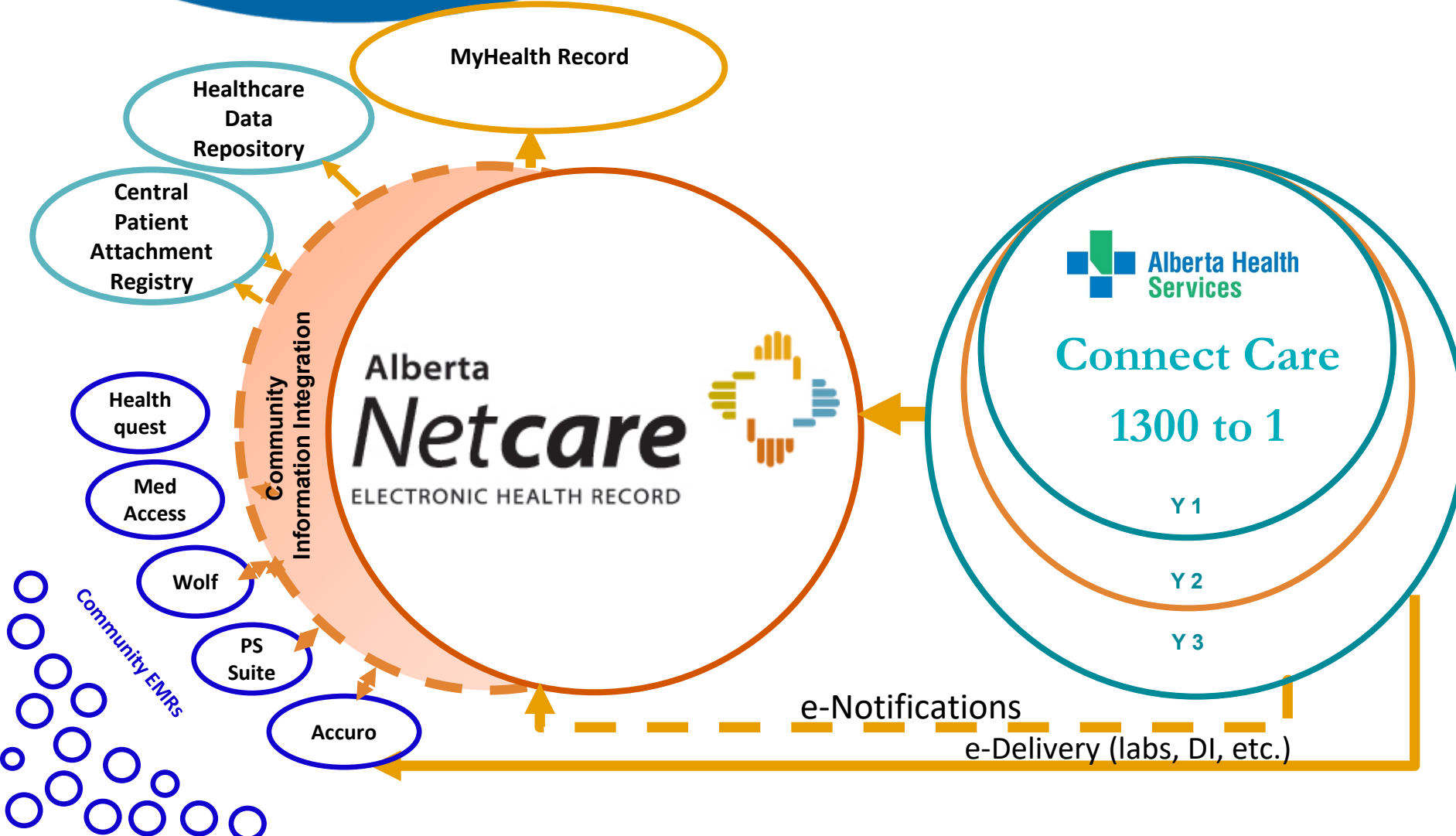
# Closing the Informational Continuity Gap

Barb McCaffrey

AMA ACTT CII/CPAR Project Lead



# Simple View of eHealth in Alberta



# CII/CPAR Participants: Share, Receive & Enhance

## 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)*



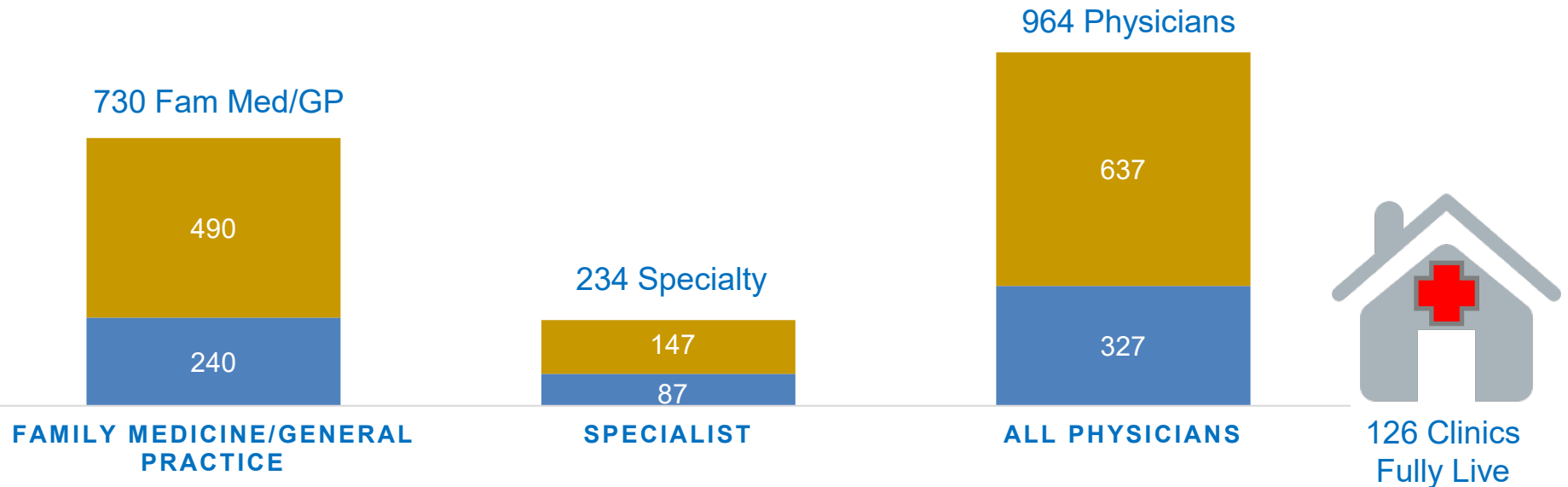
\*Consults from Specialists and Primary Care providers providing consultative services.

# Physician Deployment in Alberta (Jan 6, 2020)



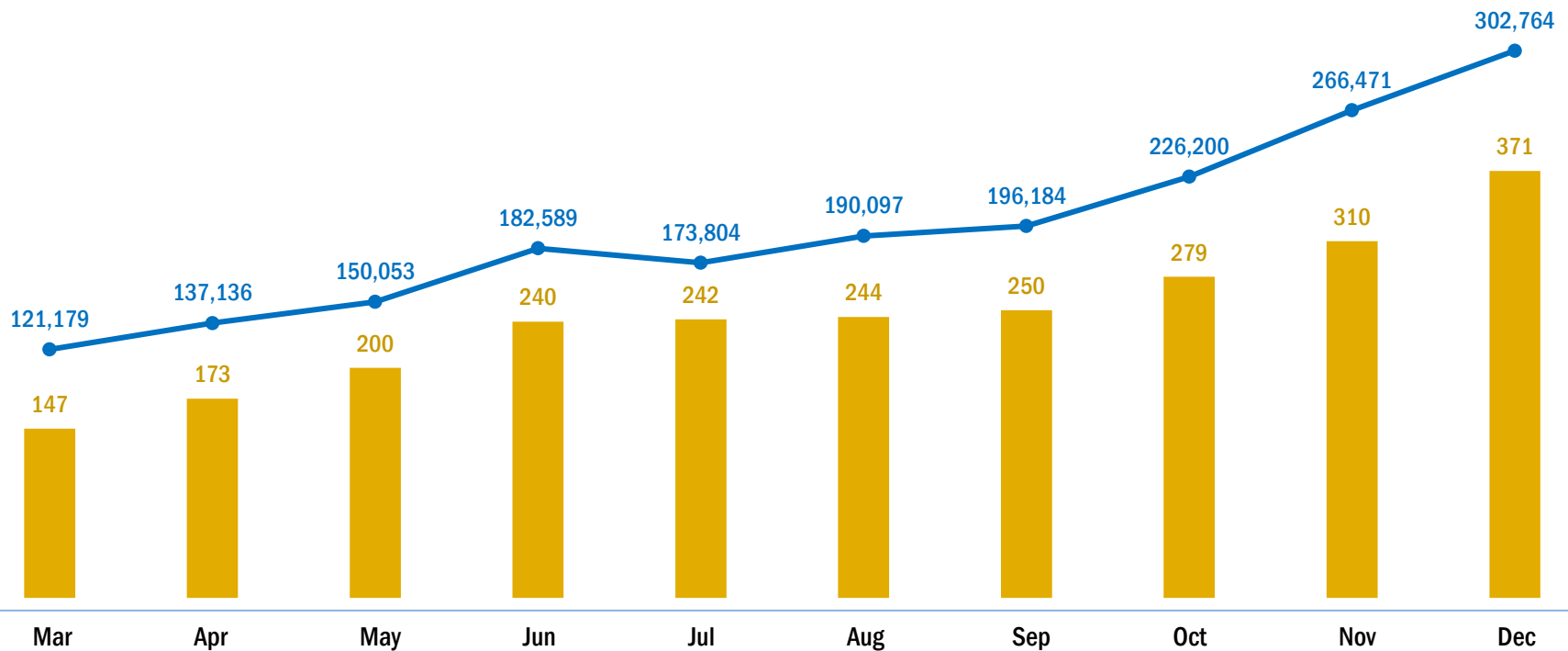
## CII/CPAR PHYSICIAN DEPLOYMENT

■ In Progress ■ Fully Live



# Growing potential for smoother transitions of care provincially

## Providers Submitting Panels to CPAR Provincially



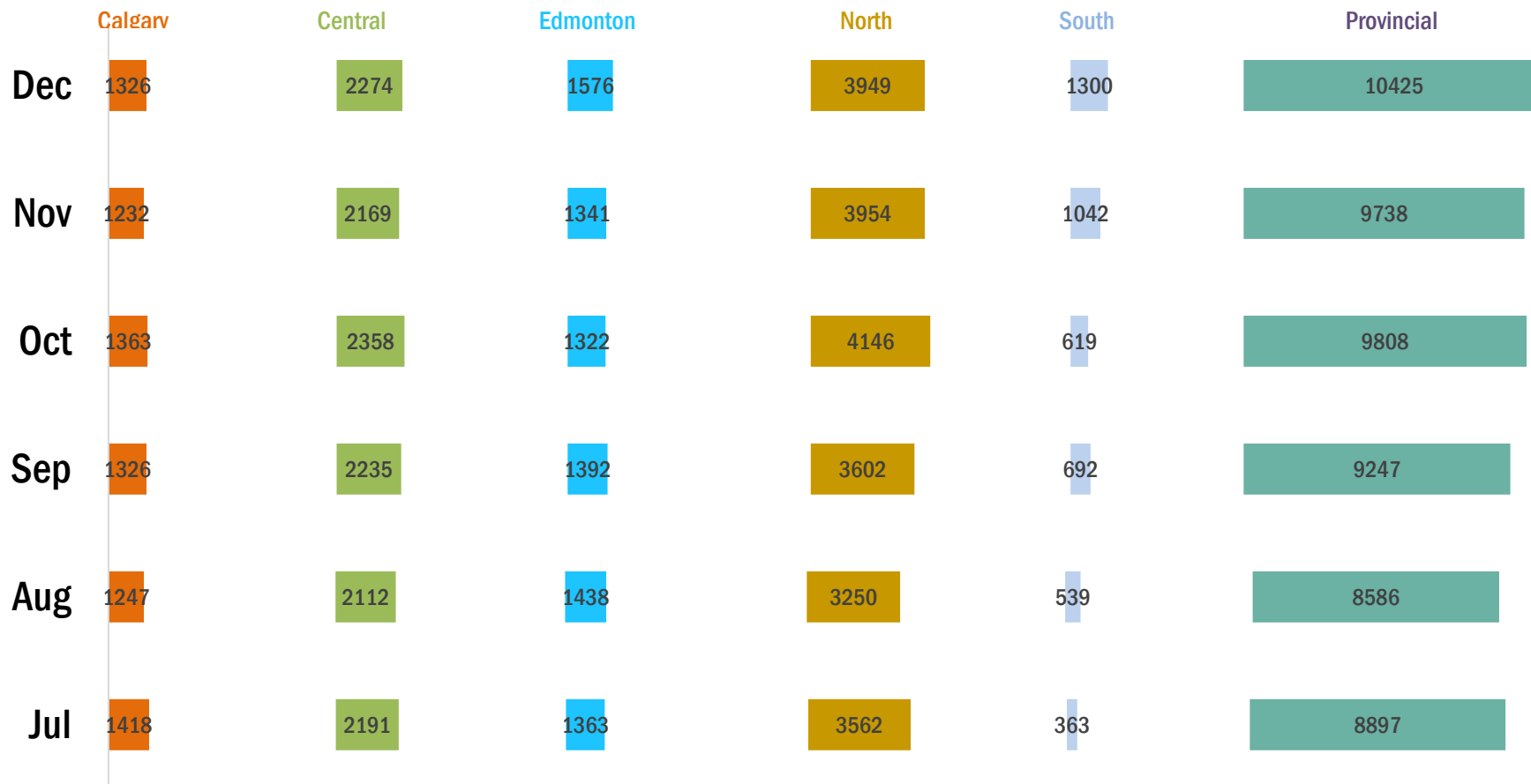
Sum of Panel Number - Provincial

Sum of Total Number of Active Attachments - Provincial

# Growing potential for smoother transitions of care provincially

10,000+ notices in December 2020

## Sent eNotification – Zonal (Jul-Dec 2020)



# Benefits of CII/CPAR



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



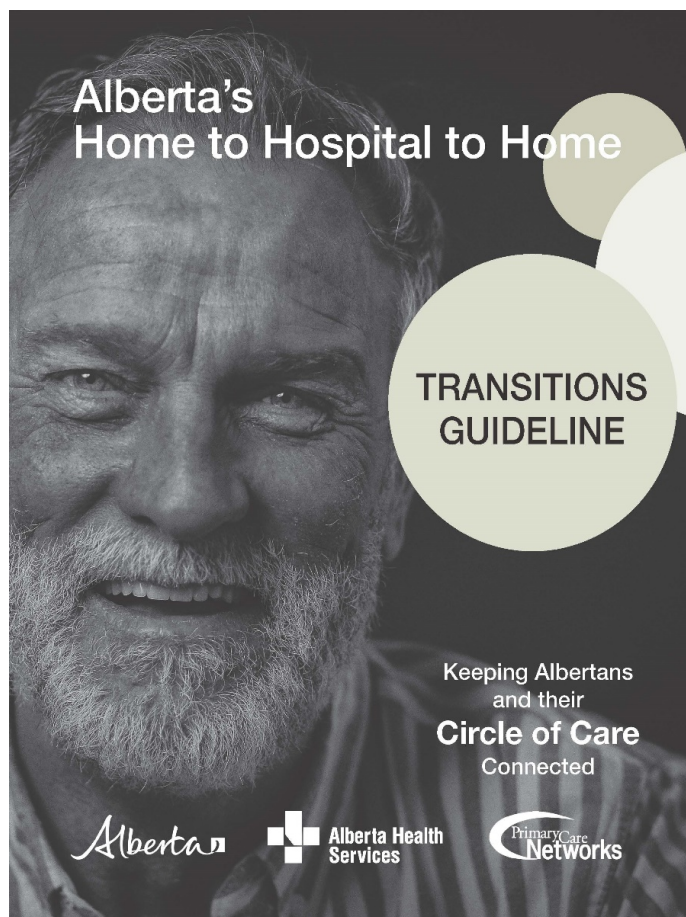
Encounter data from over **237,869** unique patients has been shared and uploaded into Alberta Netcare Portal as a Community Encounter Digest (CED) report.



# A Guideline for Effective Transitions

**Mona Delisle**  
AHS Acting Executive Director,  
Primary Health Care

# Home to Hospital to Home (H2H2H) Transitions Guideline



## 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

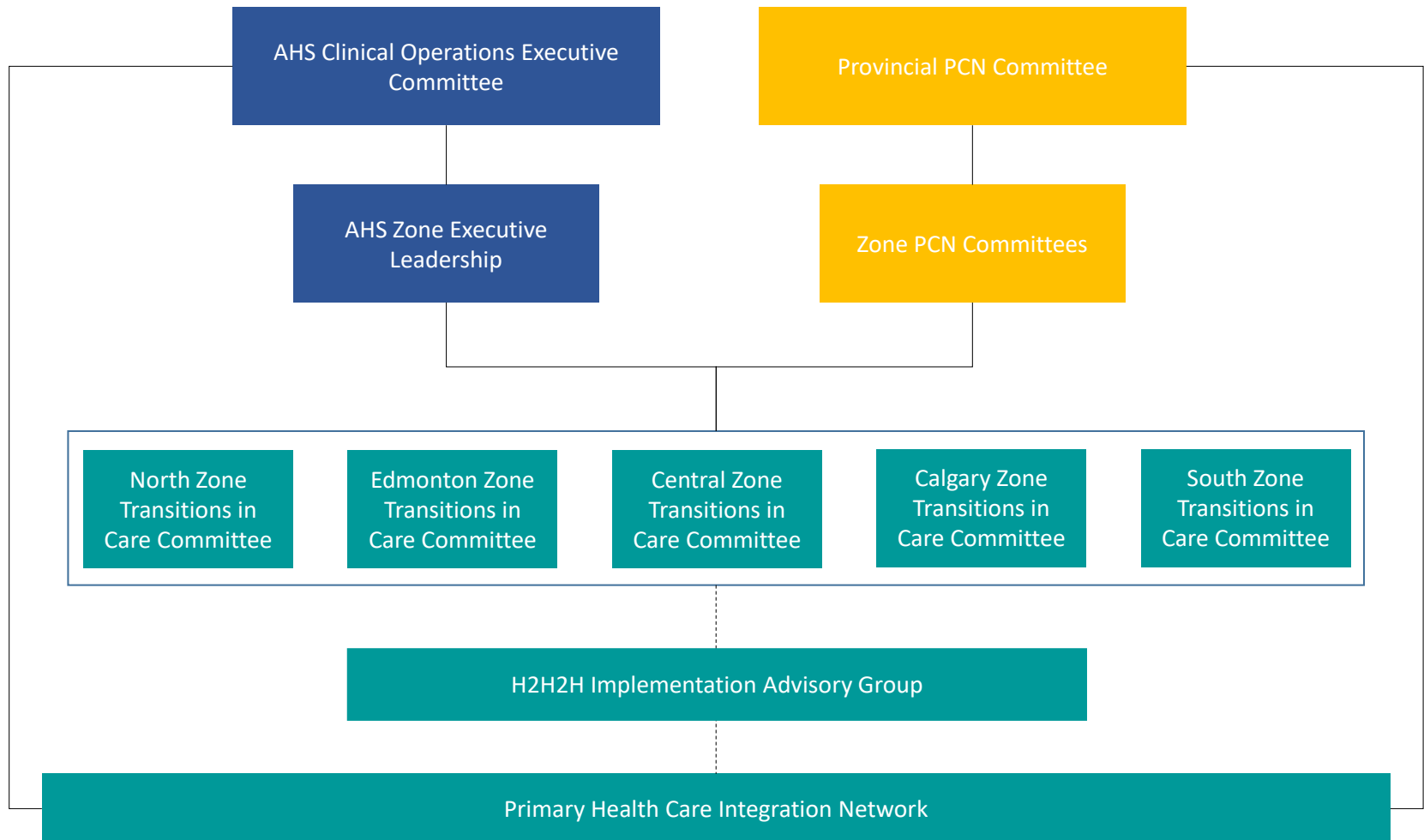
## 6 pieces that together help patients successfully transition from home to hospital to home



# Guideline Components and CII/CPAR

Guideline Section		Providers live on CII/CPAR, for your PANELED Patients
	<b>Confirmation of the Primary Care Provider</b>	<ul style="list-style-type: none"> <li>Receive <b>ADMIT eNotification</b> automatically into EM lab report/task area</li> <li>Patient encounter information is shared in the form of a <b>Community Encounter Digest (CED)</b> in Netcare</li> </ul>
	<b>Admit Notification</b>	
	<b>Transition Planning</b>	<ul style="list-style-type: none"> <li>PCPs and practices can collaboratively work with the hospital teams to ensure appropriate clinical and nonclinical post discharge community supports are arranged</li> </ul>
	<b>Referral and Access to Community Supports</b>	
	<b>Transition Care Plan</b>	<ul style="list-style-type: none"> <li>Receive <b>DISCHARGE eNotification</b> (In-patient &amp; Emerg) automatically into EMR lab report/task area</li> </ul>
	<b>Follow-up to Primary Care</b>	<ul style="list-style-type: none"> <li><b>Timely Access</b> to a follow-up appointment requires PCPs and practices to understand and balance the demand and supply of appointment</li> </ul>

# Implementation of the Guideline





# CII/CPAR & The Guideline In Action

Dr. Joseph Ojedokun  
AMA Physician Champion,  
North Zone

# The Biggest Benefits of CII/CPAR



## 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.***"

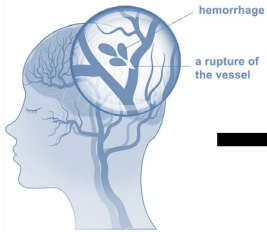


Dr. Joseph Ojedokun,  
MRPCN, Whitecourt

# A Patient Story



**Young  
Woman**



**Hemorrhagic  
Stroke**



**Surgical Ward**



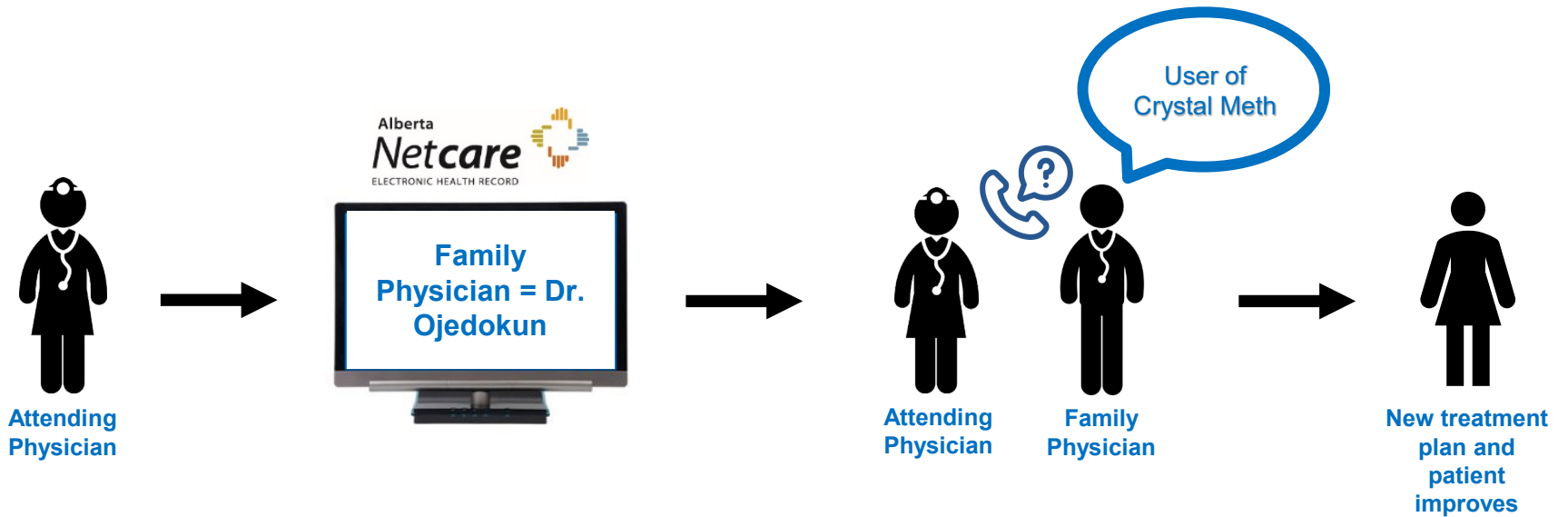
**High Blood  
Pressure**



**Attending  
Physician**



# A Patient Story



# The Biggest Benefits of CII/CPAR

## 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

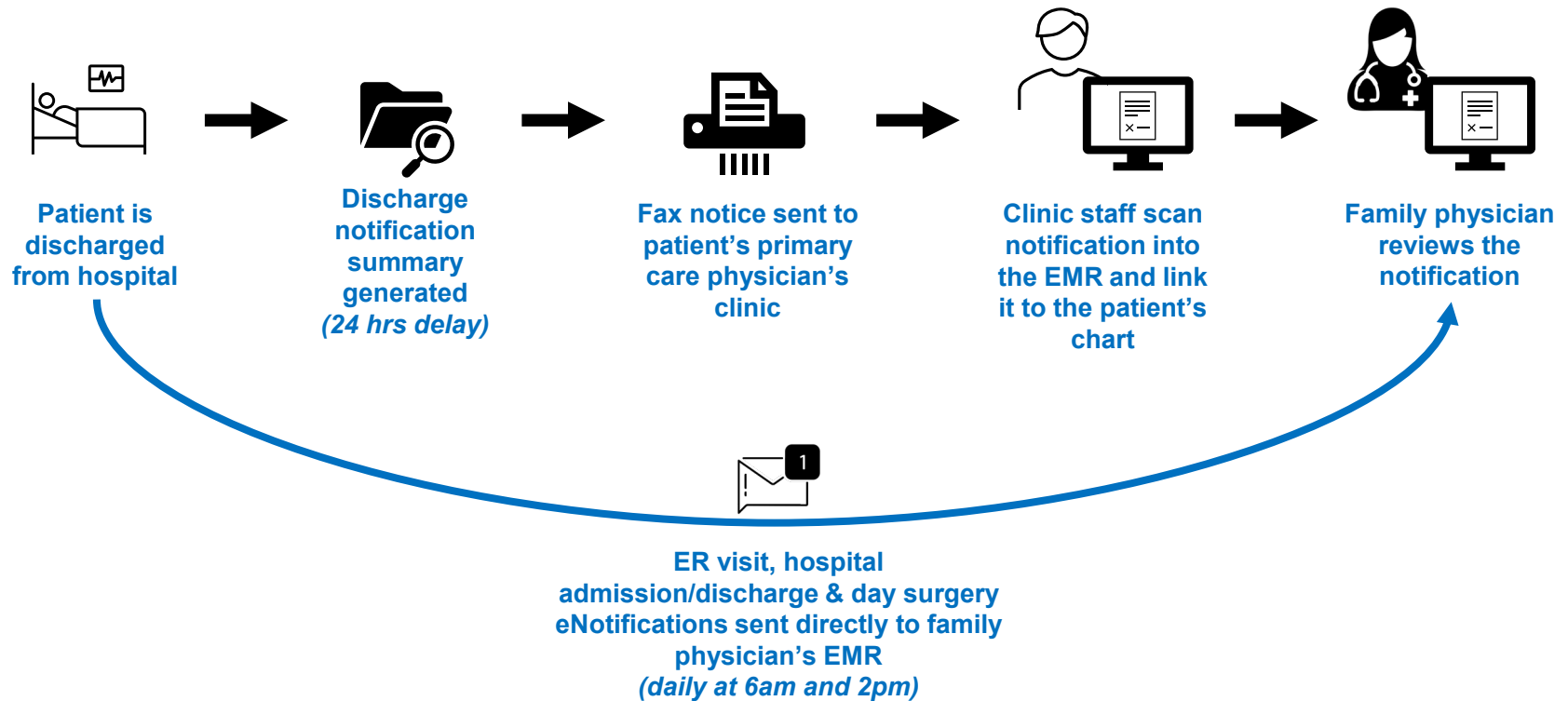
Dr. Heather La Borde  
AMA Physician Champion,  
Provincial



*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.*

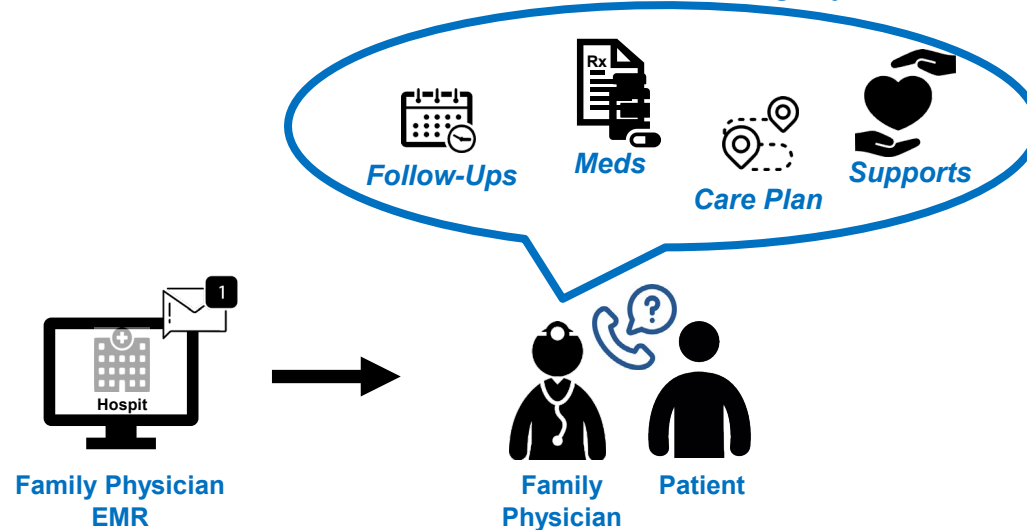
Dr. Heather La Borde, CFPCN, Calgary

# CII/CPAR - Timely Admit/Discharge Notifications



*“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?

## Measurable Improvement In:

- Patient Safety
- Patient Outcomes
- Patient and Provider Satisfaction

# Patient Safety

*“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

*“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



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

*“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

*“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














# 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




Participants (14)

Find a participant

AD	Awa D (Me)			
MW	Mark Watt (Host)			
MW	Mark Watt			
	Anthonia Taiwo (Co-host)			
AB	Arvelle Balon-Lyon (Co-host)			

Invite Unmute Me Lower Hand





# Additional Transitions Webinars & Resources

# Additional Transitions Webinars & Resources



- 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

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

**H2H2H**

**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 (TINA) 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	<a href="#">Sequence to Achieve Change Patient Partner Guide</a>
	1.2 Incorporate a patient-centered care approach	Patient survey	<a href="#">HCQA Patient Survey Guide</a>
	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	<a href="#">H2H2H Pre-Visit Script</a>
2. Know your paneled patients	2.1 Develop a process to confirm receipt of admit notification	#% of admit notifications confirmed	<a href="#">Panel Processes Change Package</a>
	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	<a href="#">CII/CPAR Team Toolkit</a>
	2.3 Partner with your PCN when you are accepting new patients to your panel	Process exists for accepting new patients	<a href="#">Find a Doctor website</a>

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

CHANGE PACKAGE • [actt.albertadoctors.org](http://actt.albertadoctors.org) continued over →

**Thank you and please  
complete the post-  
session evaluation!**

# Evaluation

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

