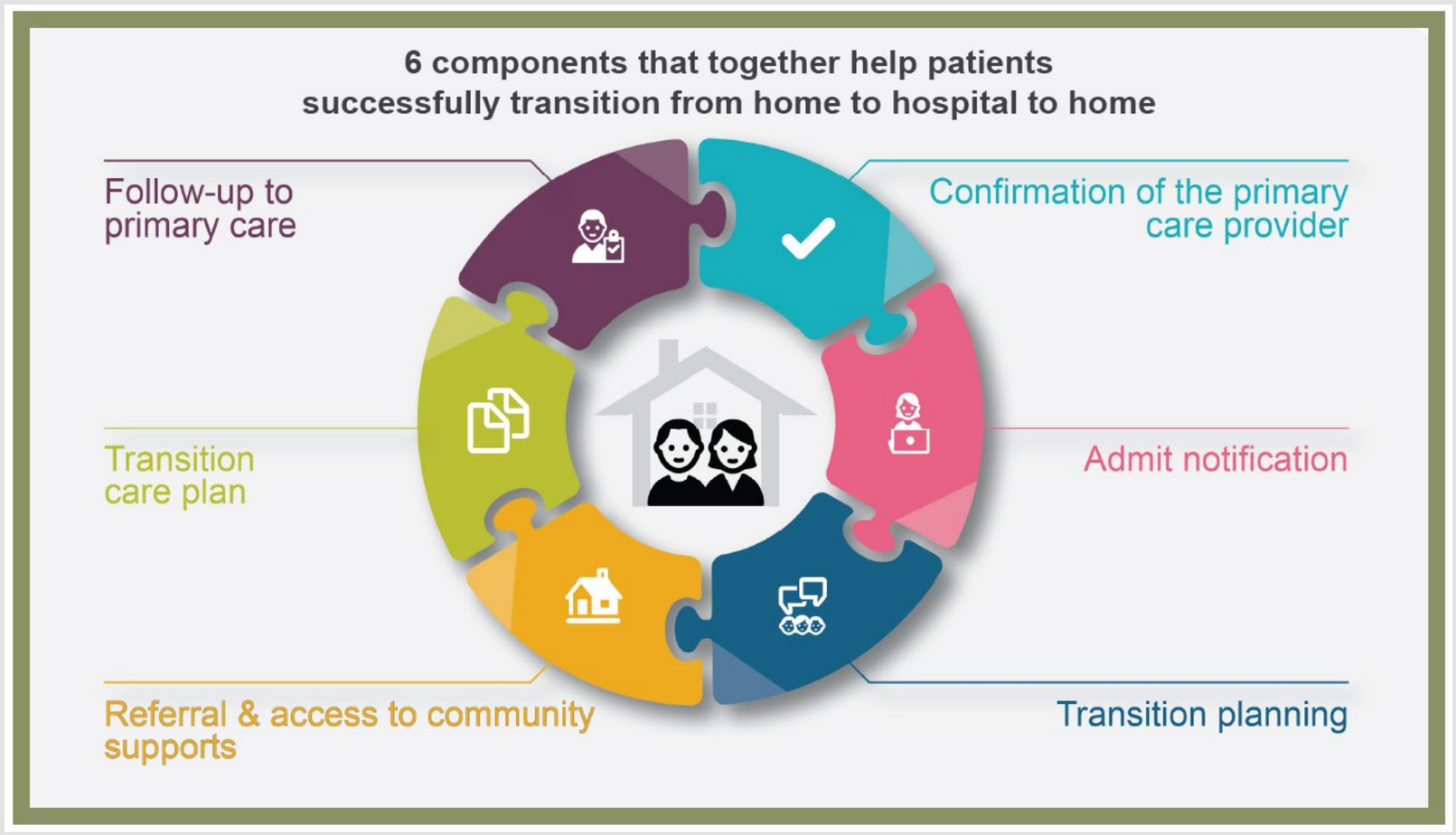
HOME TO HOSPITAL TO HOME (H2H2H) TRANSITIONS MEASURES REPORT

July 2024

Alberta Health Services
Primary Health Care

This report provides provincial and zone-level retrospective data for the Home to Hospital to Home (H2H2H) Transition measures, focusing on transition activities in acute care and primary care.



This report includes data gathered from all adult Albertans (18 years and older) who were discharged from the hospital to home or home with support. Only acute care sites where Connect Care (CC) has been implemented as of May 2023 (CC launch 6) are represented in this report. These sites comprise 13 in the Calgary Zone, 20 in the Central Zone, 10 in the Edmonton Zone, and 12 in the North Zone. The report showcases the current state of select H2H2H Transitions measures based on CC data (up until March 31, 2024) and administrative data (up until December 31, 2023).

For detailed information on each metric please refer to the February 2024 report.

This report has been prepared by Applied Research & Evaluation Services, Primary Health Care

For more information, please contact:
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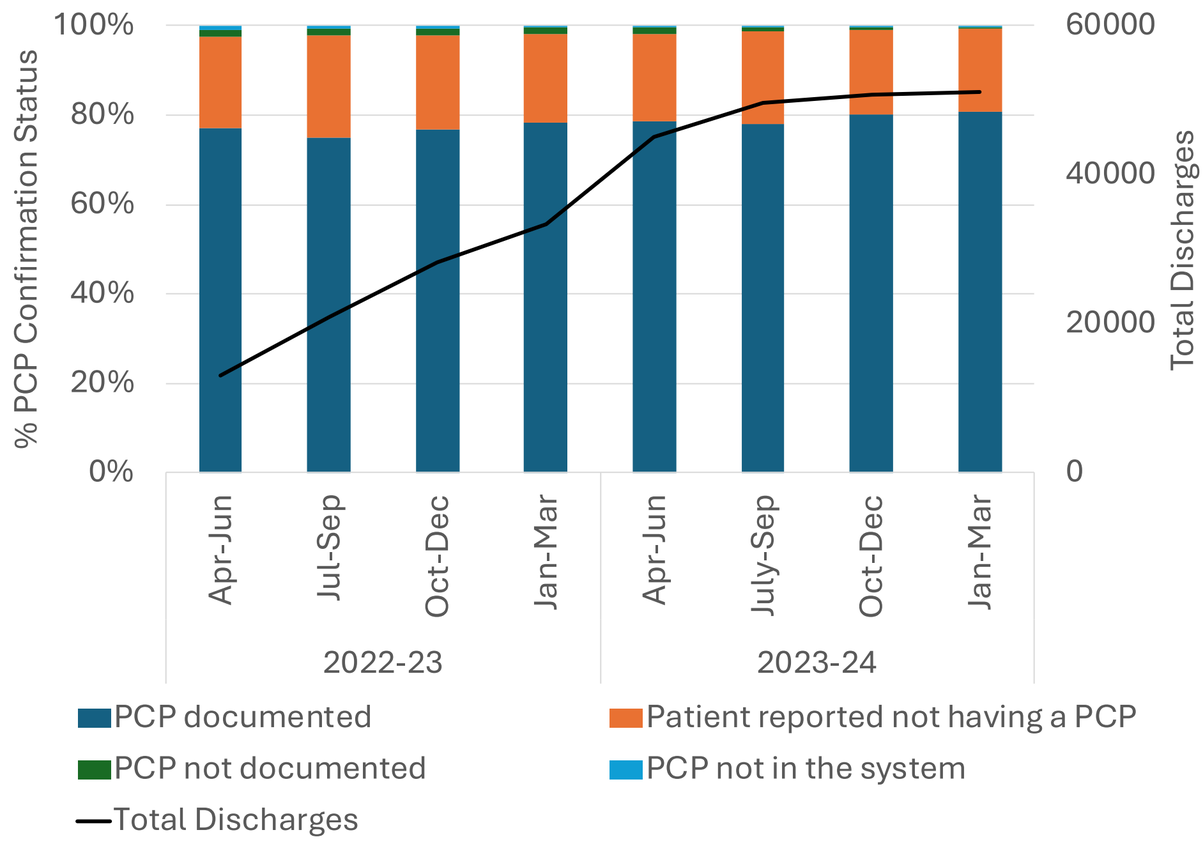
HOME TO HOSPITAL TO HOME (H2H2H) TRANSITIONS MEASURES REPORT PROVINCIAL DATA

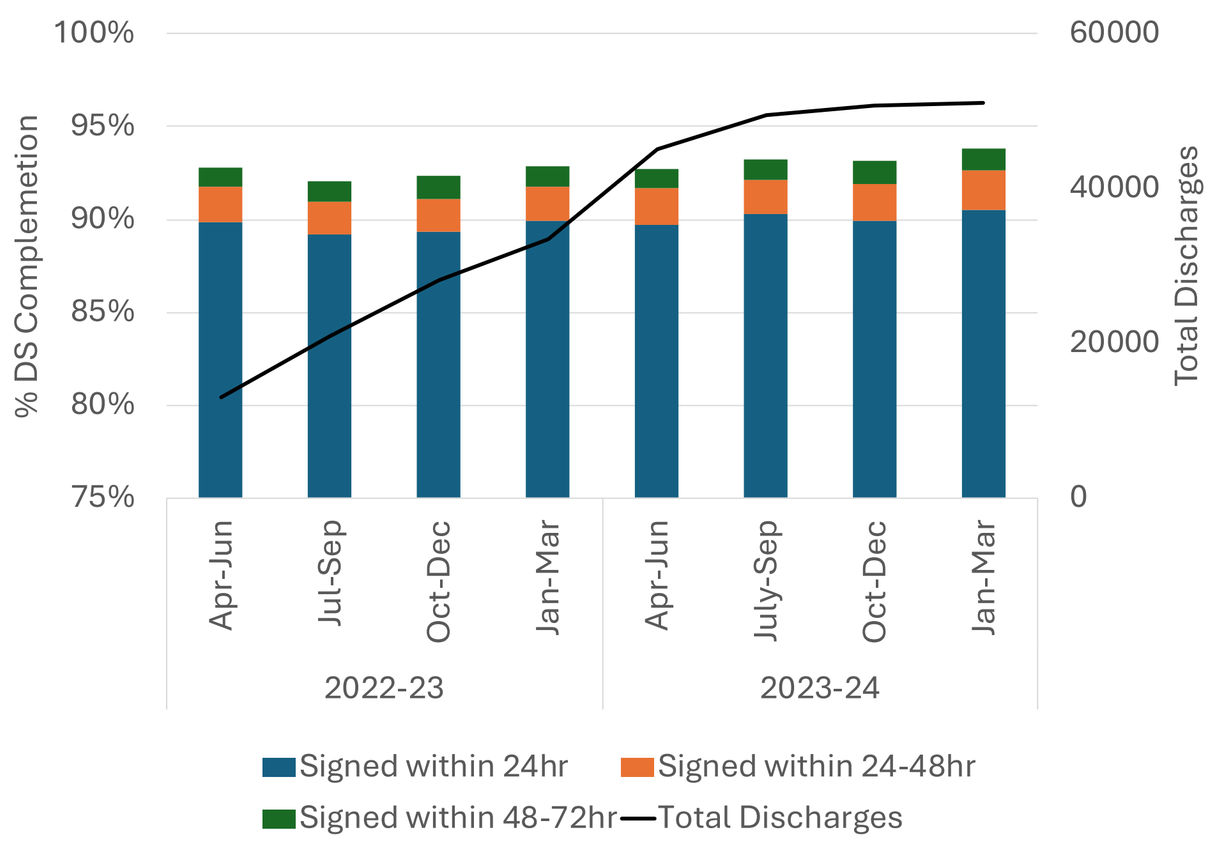
Strategic Measures within Acute Care

Confirmation of the Primary Care Physician (PCP) during hospital stay



In the last two quarters, patients reporting having a PCP increased by 3% compared to previous quarters.

Timeliness of discharge summary (DS) completion



In the last two quarters, the proportion of DS completion within 24 hours remained consistent at 90%, compared to previous quarters.

LACE Index included in discharge summaries

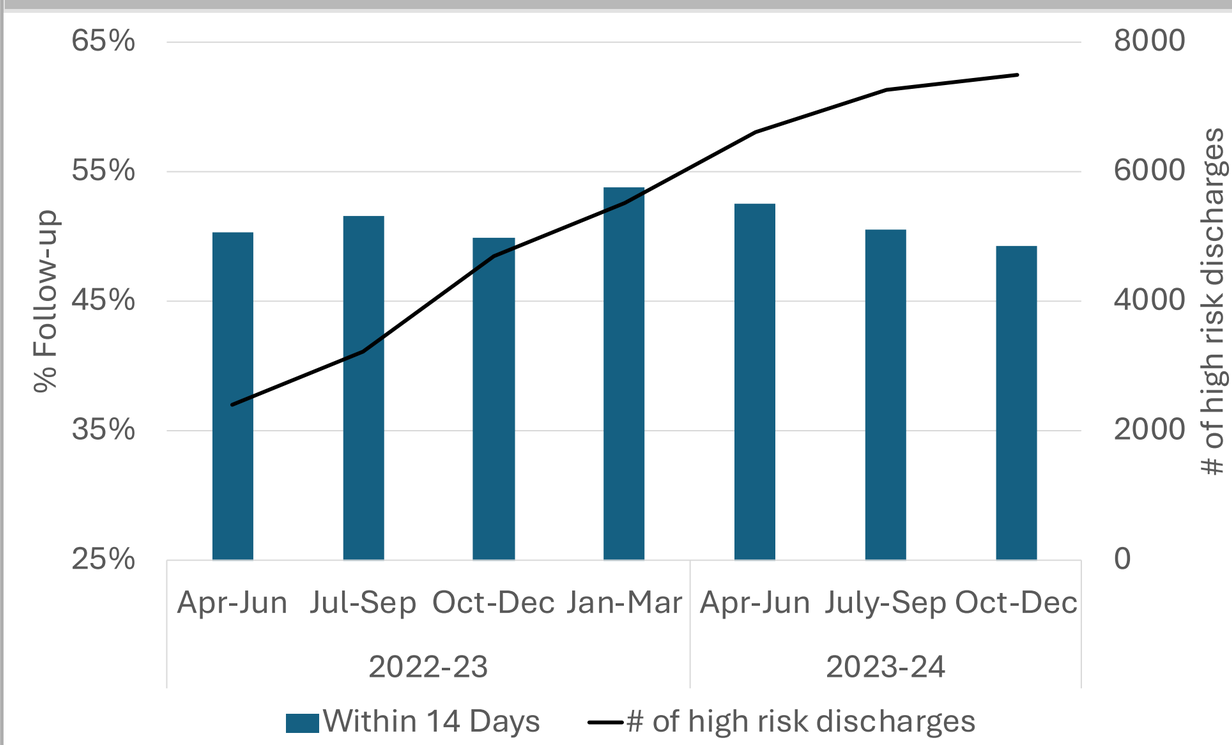
4% of discharges summaries included a LACE Index.

Utilization of provincial standard discharge summaries

5% of discharges used one of the provincial standard discharge summary templates.

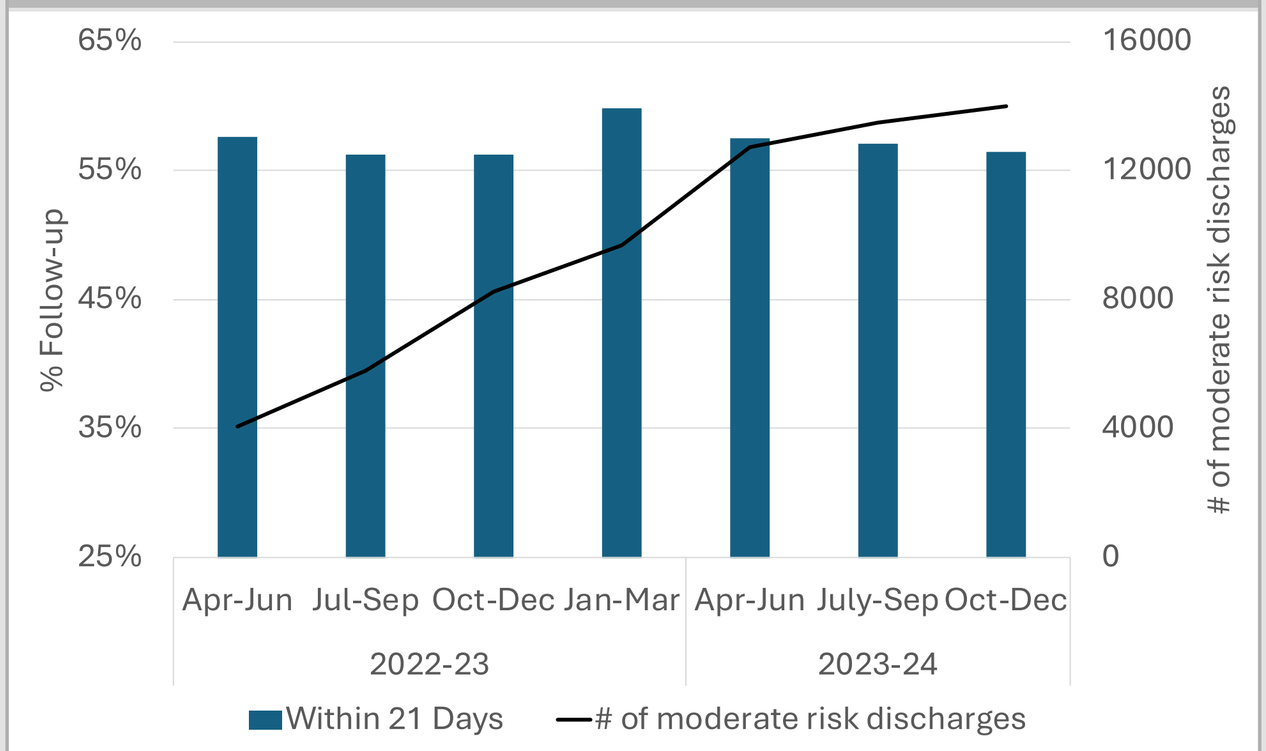
Strategic Measures within Primary Care

Post discharge PCP follow-up within 14-days among patients at high-risk of readmission



In the last two quarters, the percent of high-risk patients receiving PCP follow-up within 14 decreased by 2%, compared previous quarters.

Post discharge PCP follow-up within 21-days among patients at moderate-risk of readmission



In the last two quarters, the percent of moderate-risk patients receiving PCP follow-up within 21-days remained stable, compared to previous quarters.

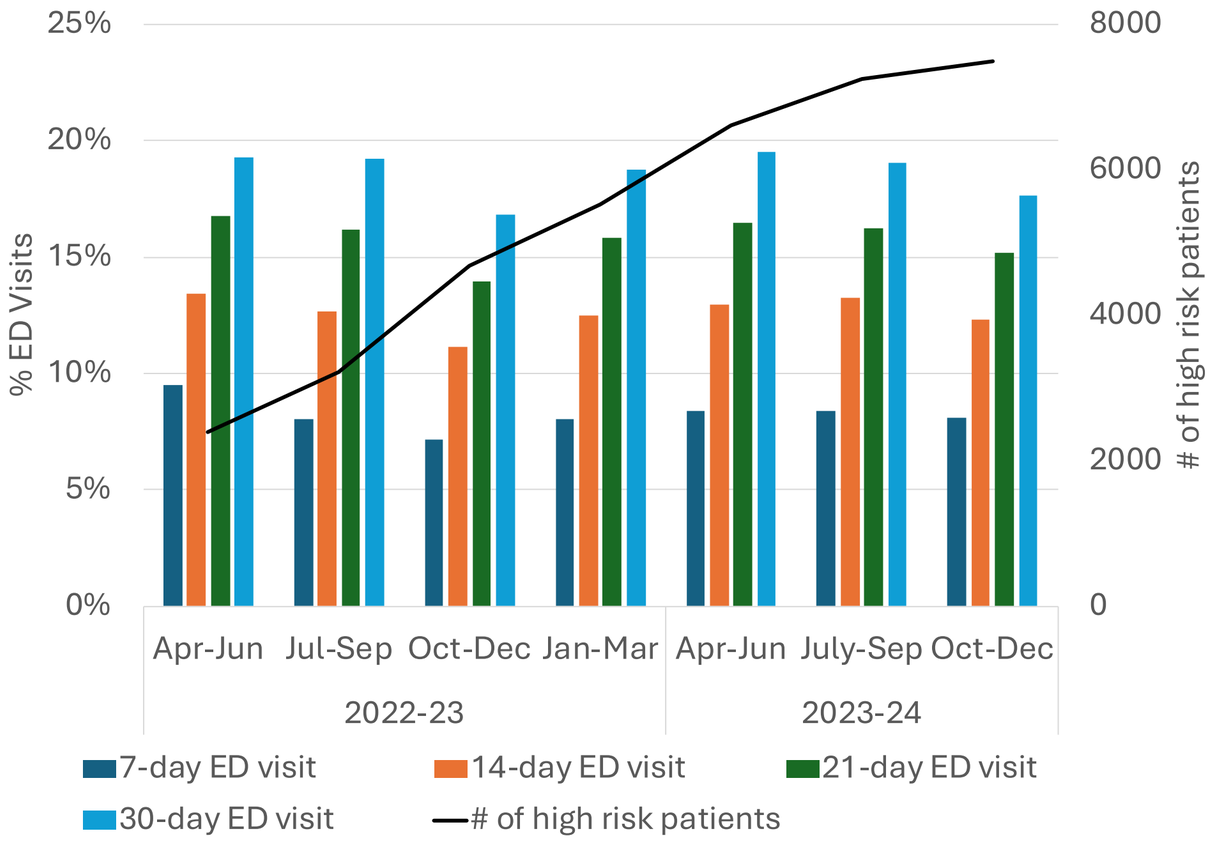
PCP follow-up for patients who reported having PCP compared to those who did not

55% of high-risk patients were followed-up within 14-days.	**PCP Documented**	62% of moderate-risk patients were followed-up within 21-days.
33% of high-risk patients were followed up within 14-days.	**Patient reported no PCP**	38% of moderate-risk patients were followed up within 21-days.

HOME TO HOSPITAL TO HOME (H2H2H) TRANSITIONS MEASURES REPORT
PROVINCIAL DATA

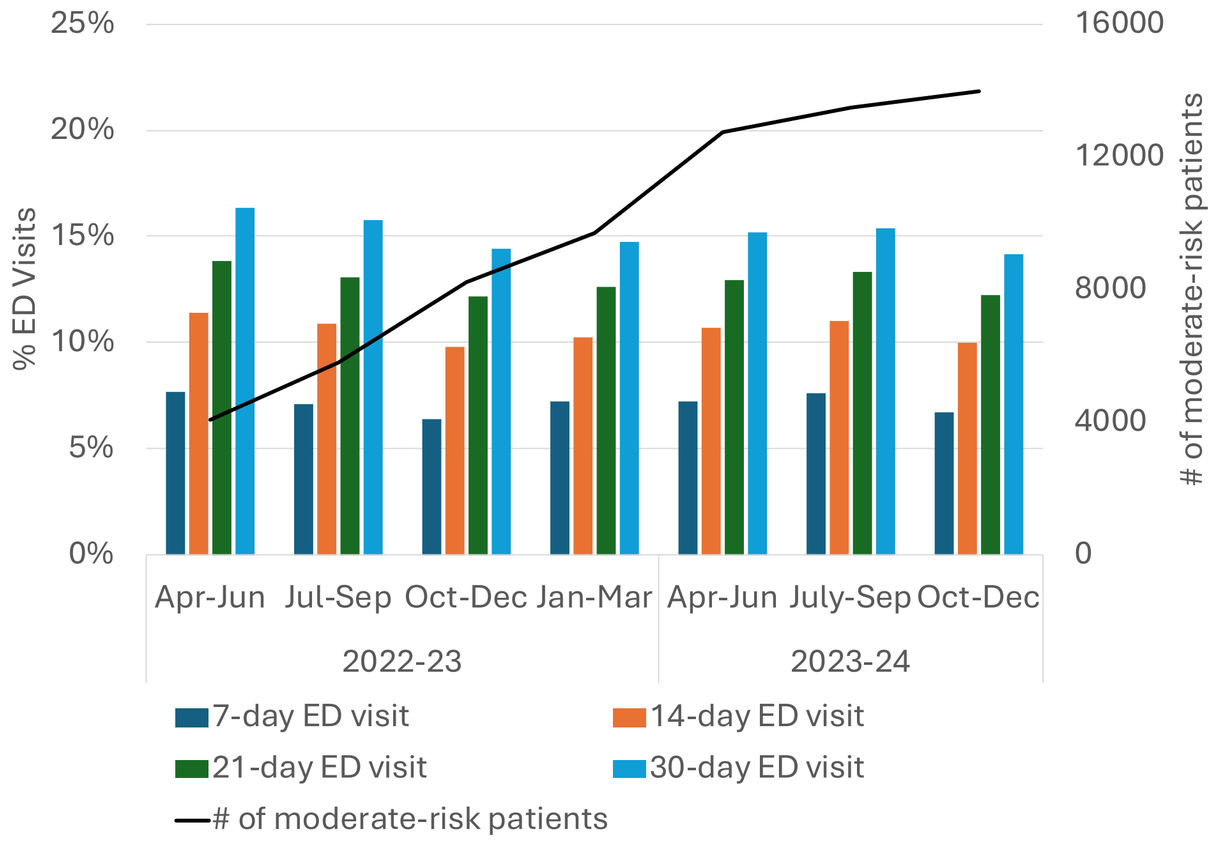
Outcome Measure - Emergency Department (ED) visit post hospital discharge

ED visit among high-risk patients



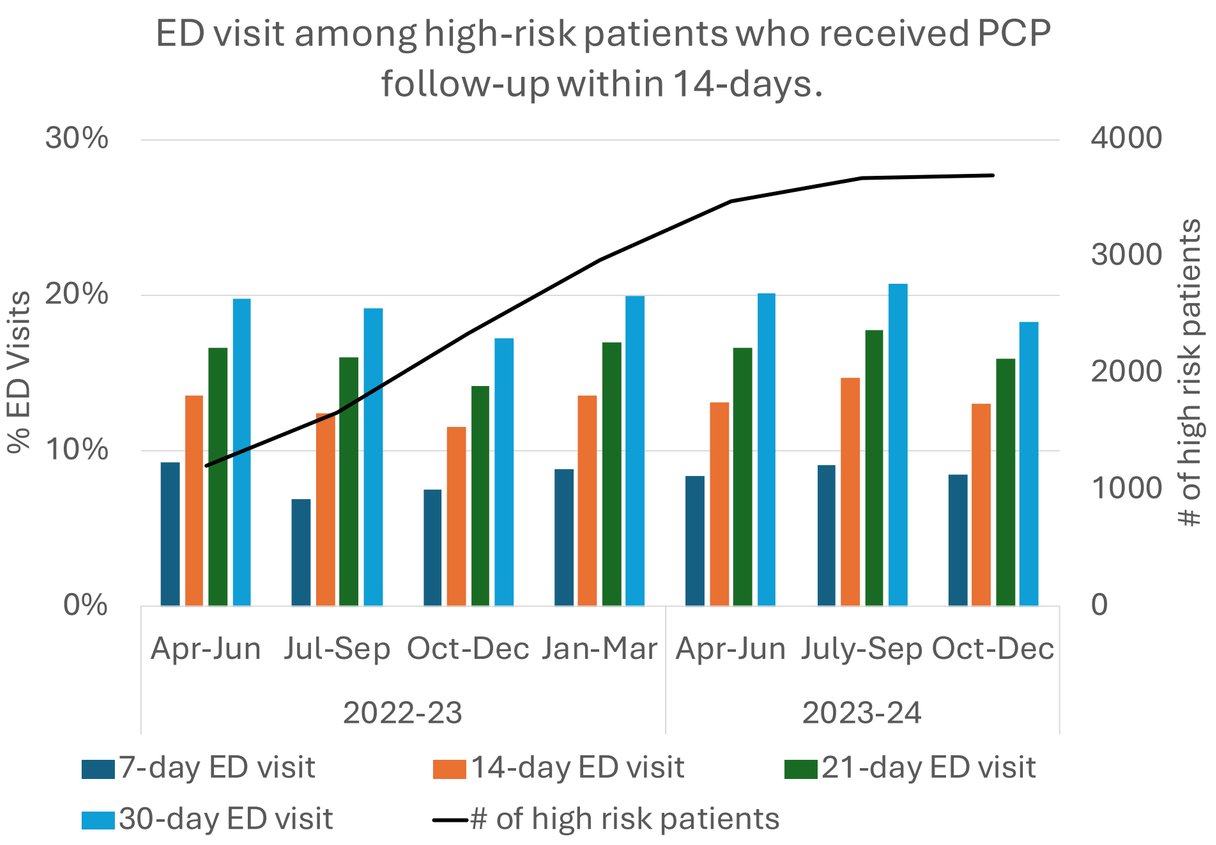
In the last two quarters, the percent of patients experiencing a 30-day ED visit decreased by 1% compared to previous quarters.

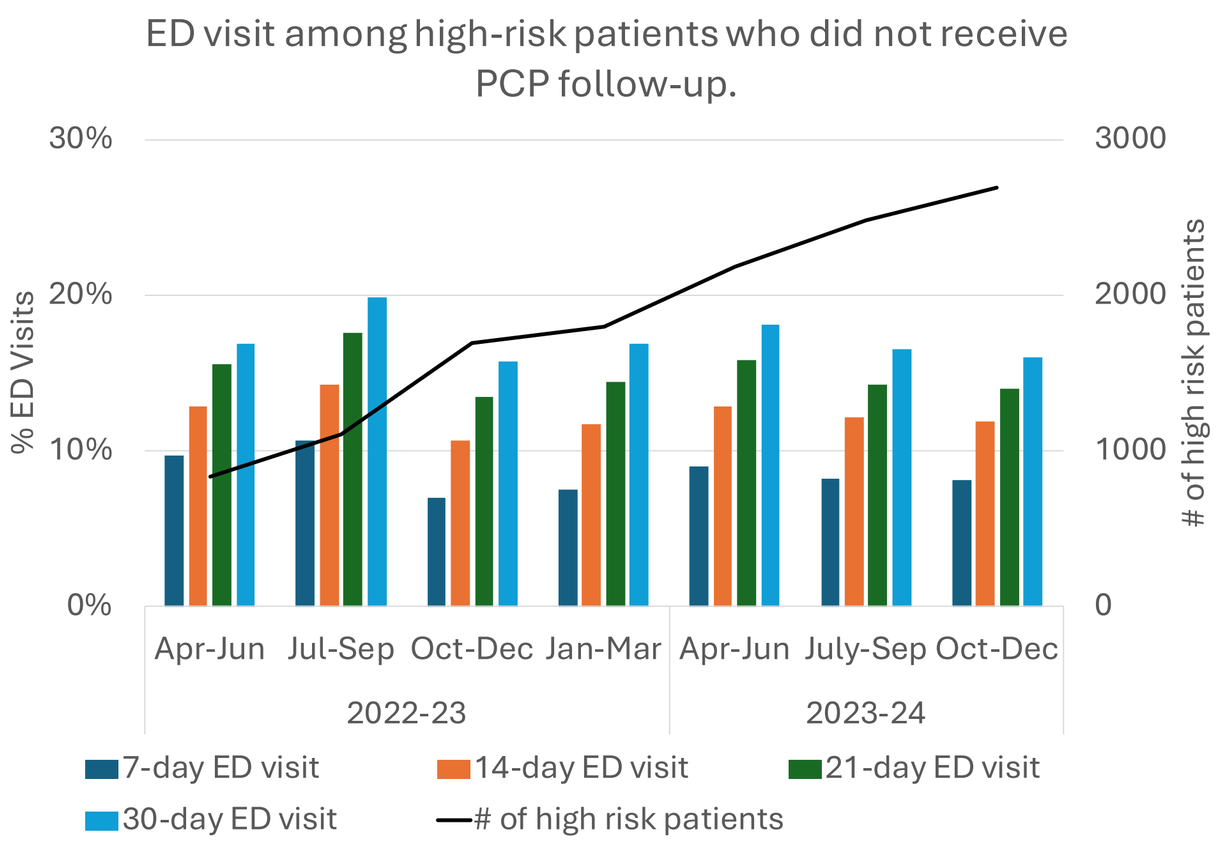
ED visit among moderate-risk patients



In the last two quarters, the percent of patients experiencing a 30-day ED visit remained stable at 15% compared to previous quarters.

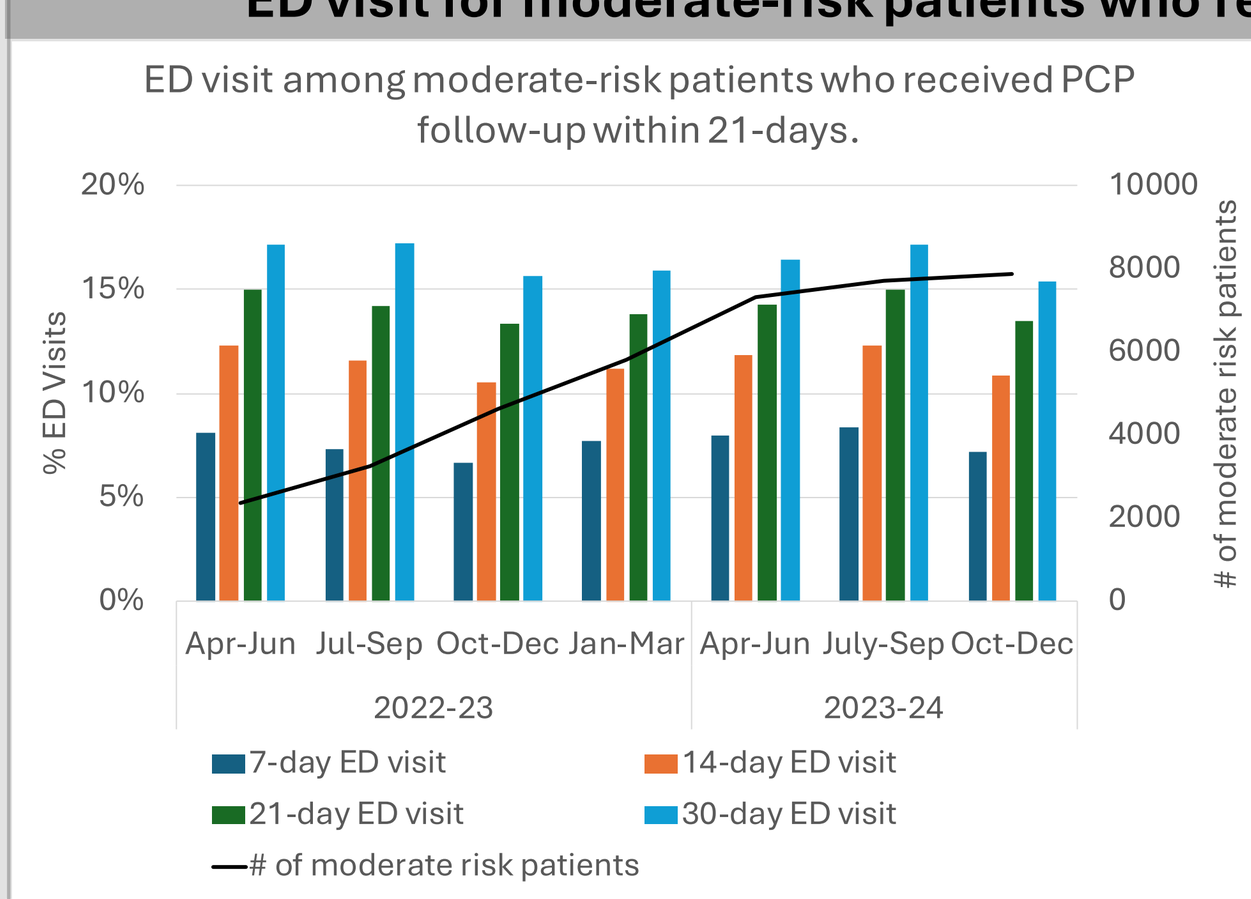
ED visit among high-risk patients who received PCP follow-up vs. no PCP follow-up

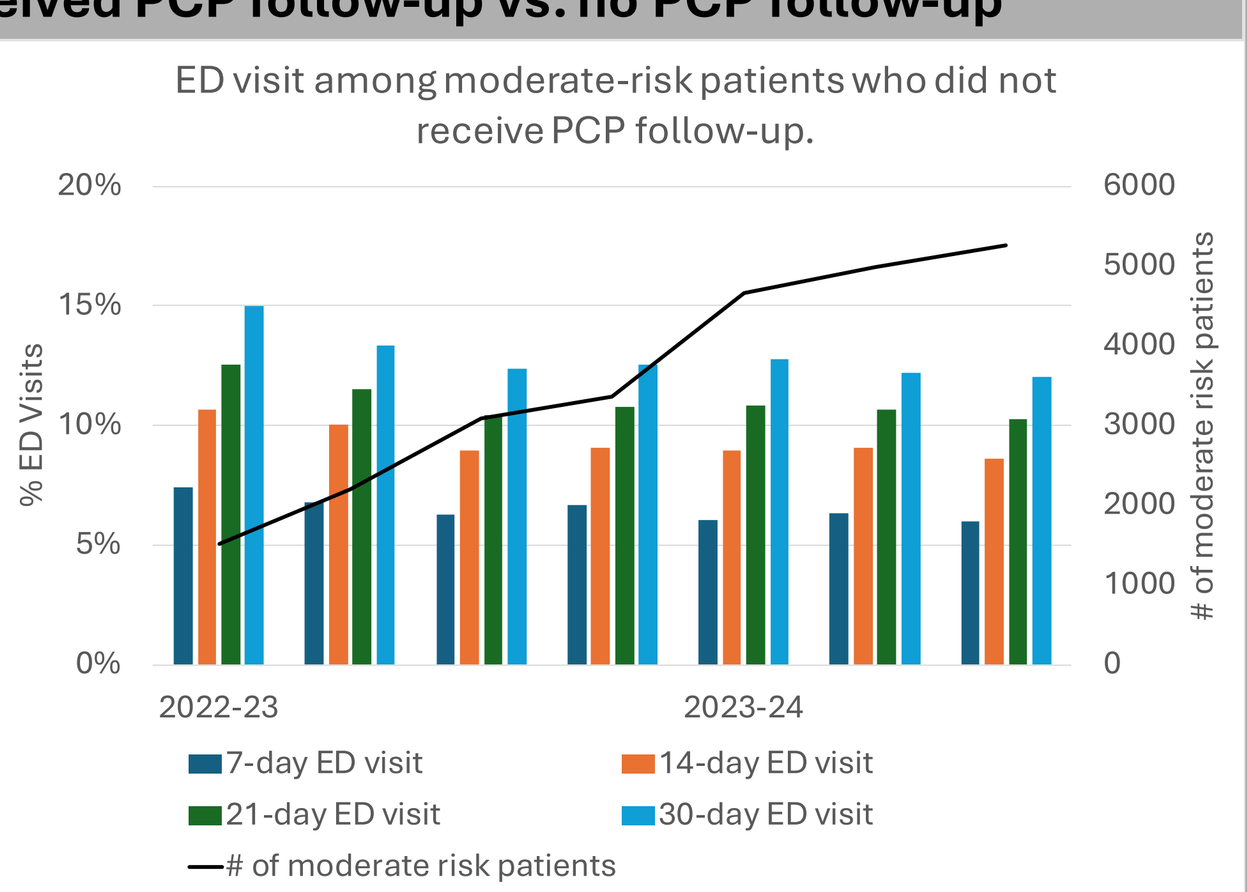




Overall, 19% of high-risk patients who had PCP follow-up within 14 days visited the ED within 30 days, compared to 17% of those who did not receive PCP follow-up.

ED visit for moderate-risk patients who received PCP follow-up vs. no PCP follow-up



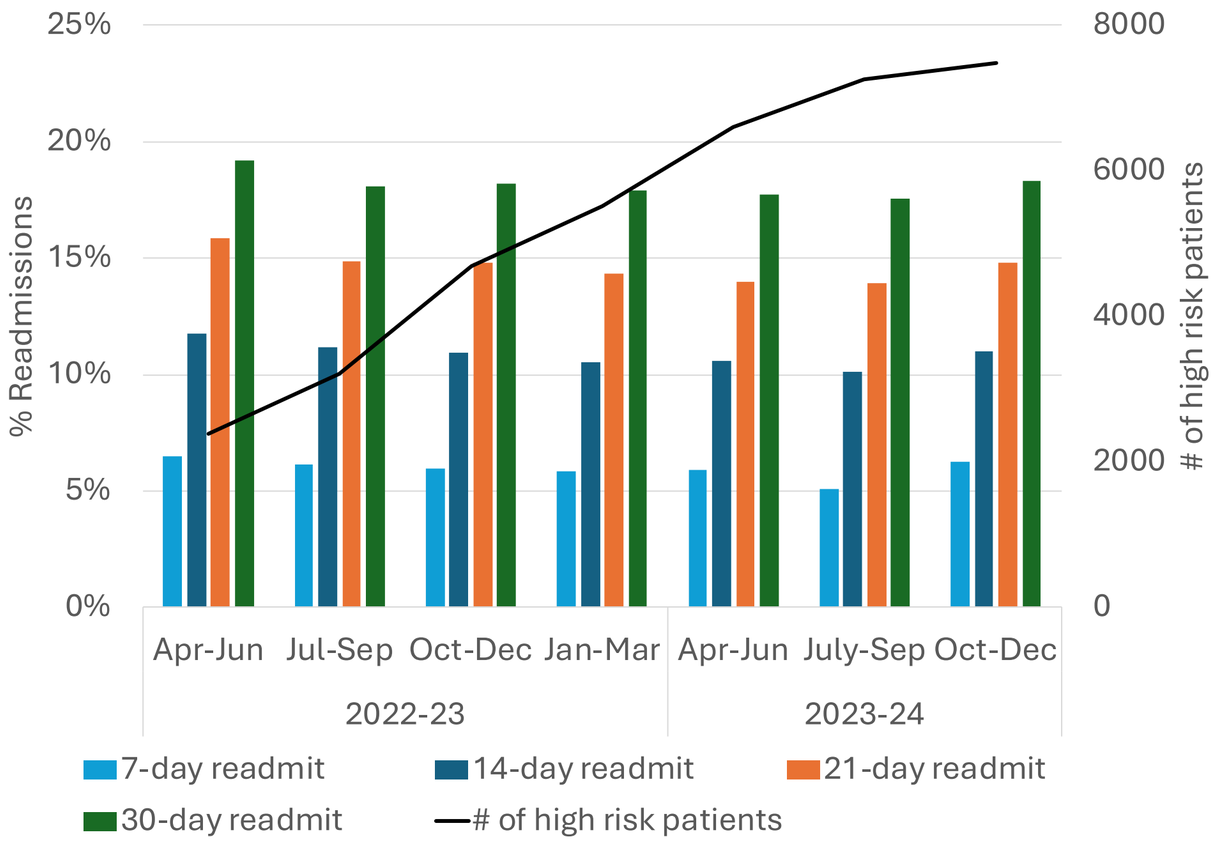


Overall, 17% of moderate-risk patients who had PCP follow-up within 21 days visited the ED within 30 days, compared to 13% of those who did not receive such follow-up.

HOME TO HOSPITAL TO HOME (H2H2H) TRANSITIONS MEASURES REPORT
PROVINCIAL DATA

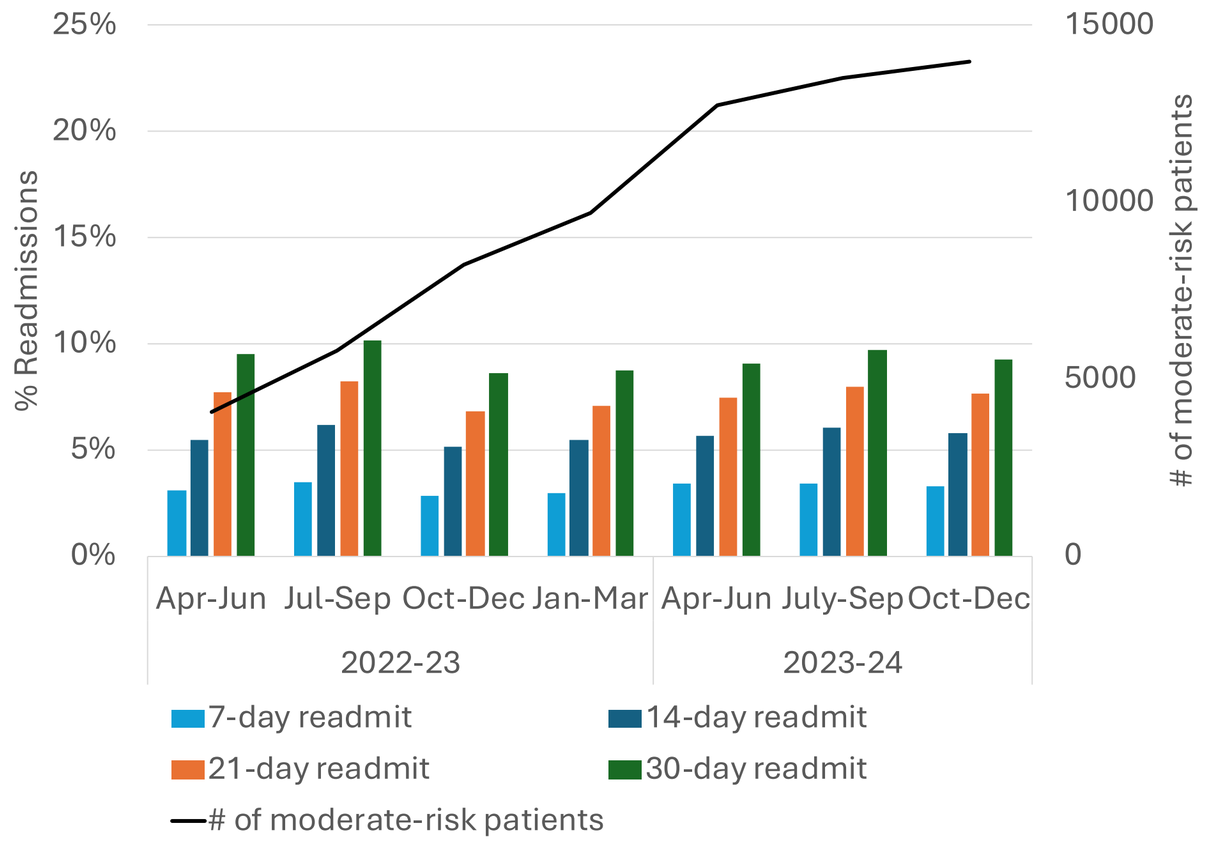
Outcome Measure – Unplanned readmission post hospital discharge

Unplanned readmission among high-risk patients



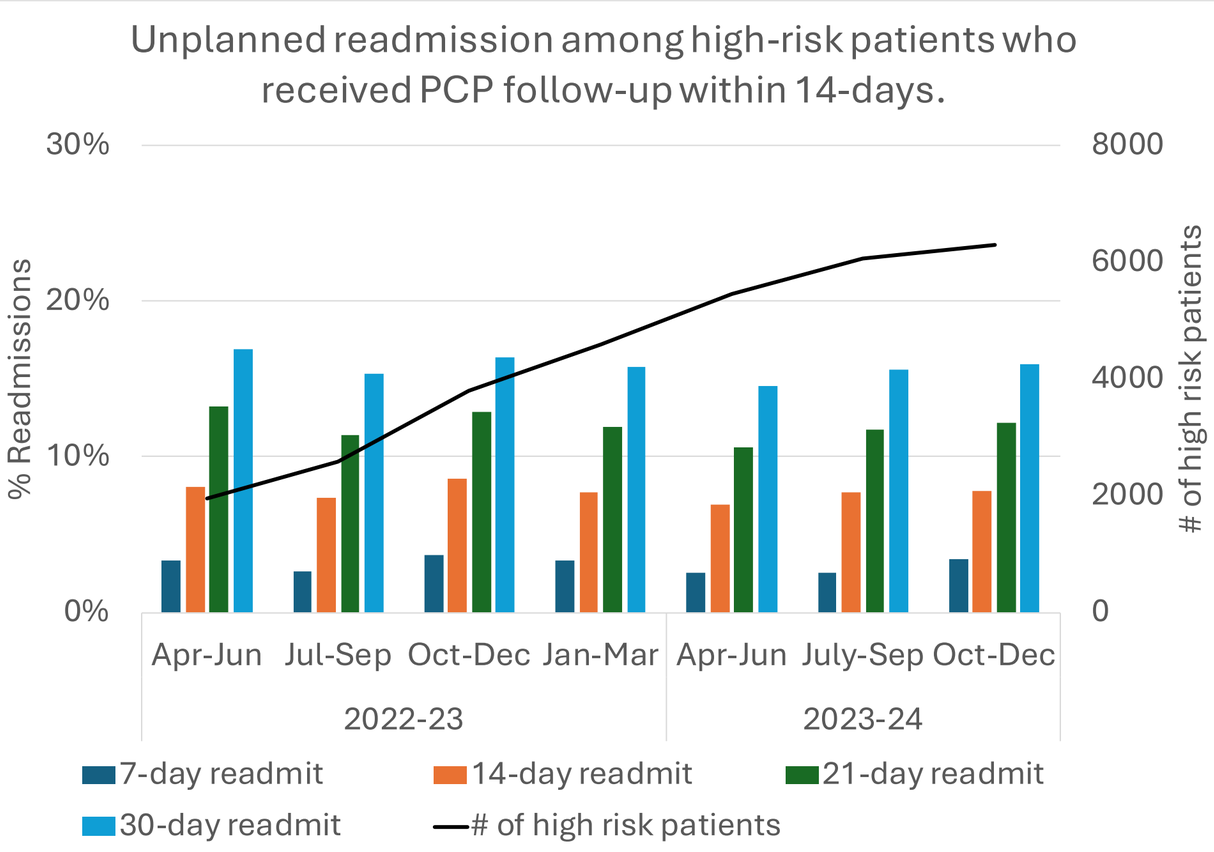
In the last two quarters, the percent of patients experiencing a 30-day readmission remained stable at 18% compared to previous quarters.

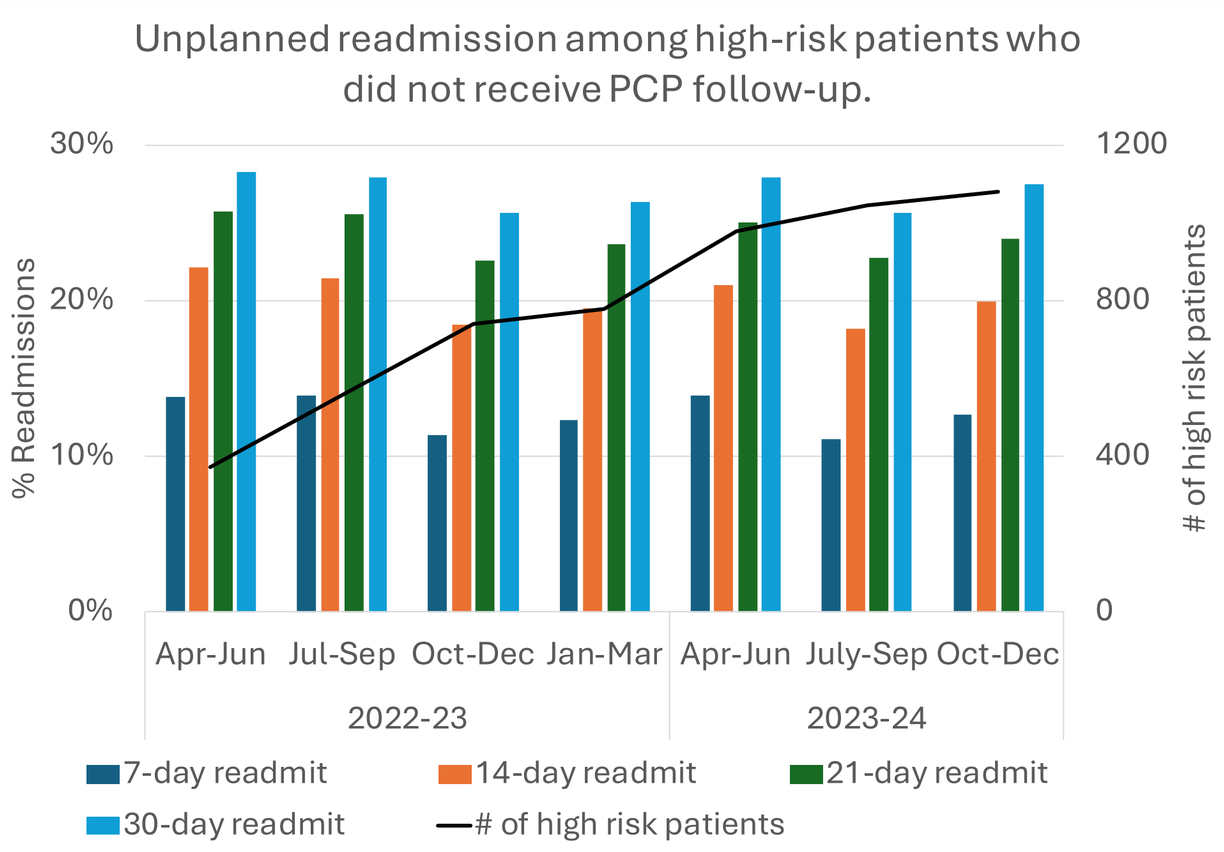
Unplanned readmission among mod-risk patients



In the last two quarters, the percent of patients experiencing a 30-day readmission remained stable at 9% compared to previous quarters.

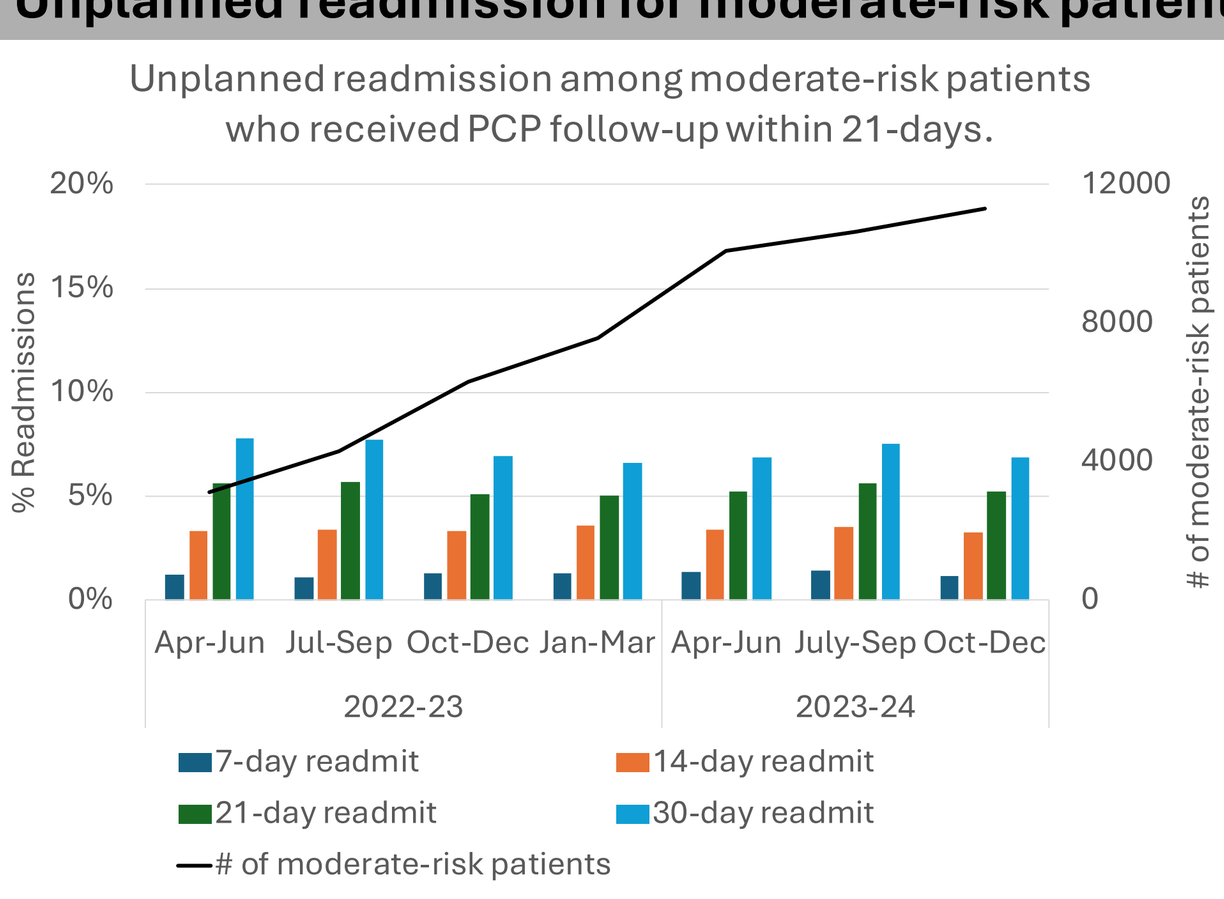
Unplanned readmission among high-risk patients who received PCP follow-up vs. no PCP follow-up

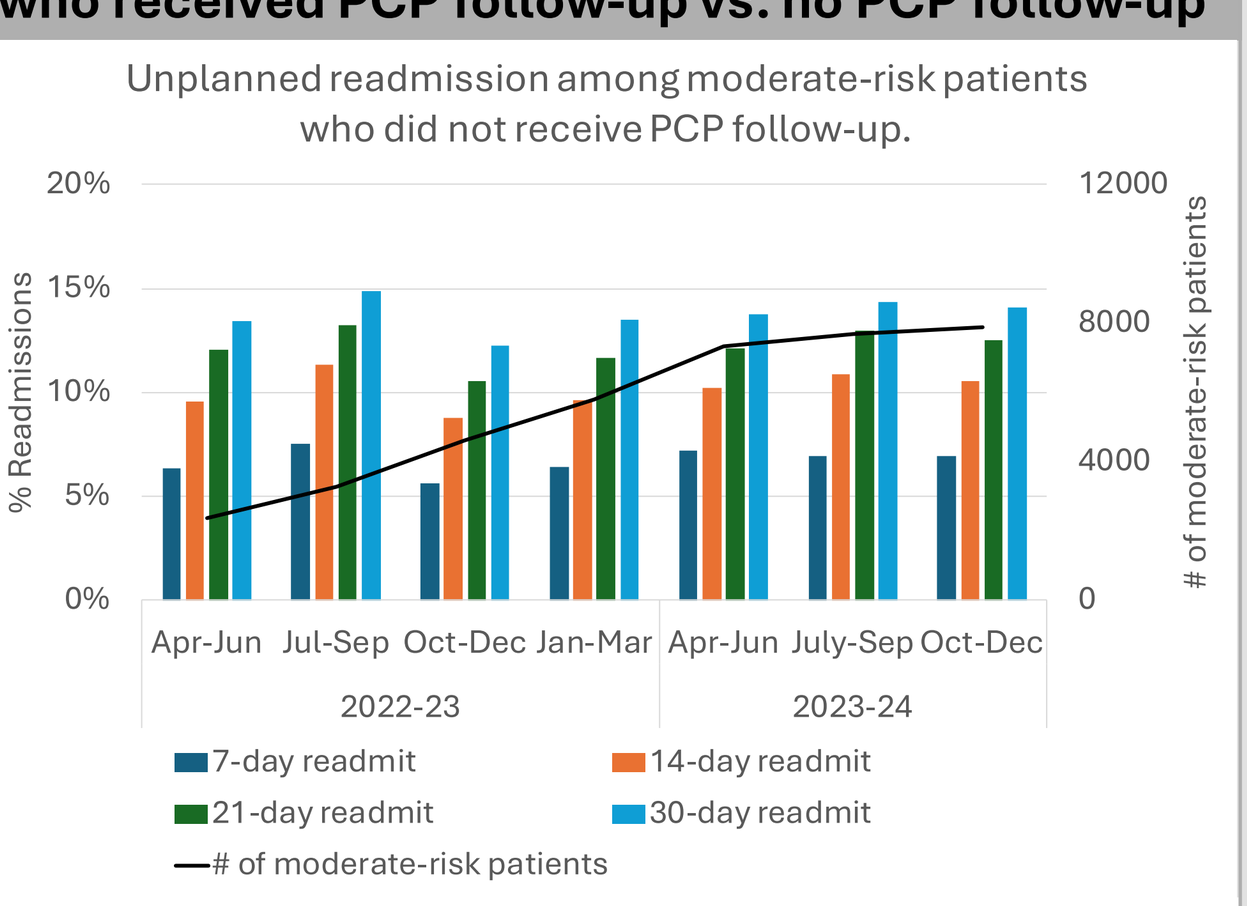




Overall, 16% of high-risk patients who had PCP follow-up within 14 days had an unplanned readmission within 30 days, compared to 27% of those who did not receive such follow-up.

Unplanned readmission for moderate-risk patients who received PCP follow-up vs. no PCP follow-up



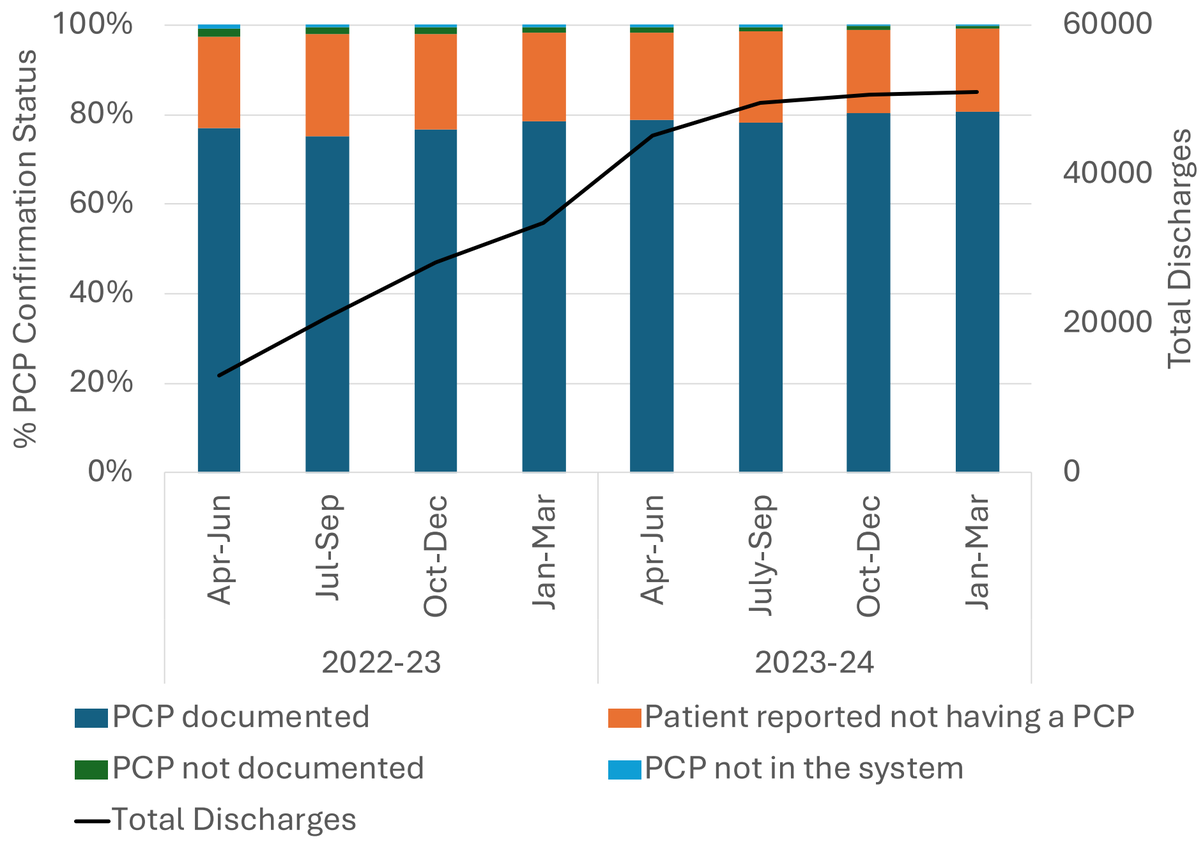


Overall, 10% of moderate-risk patients who had PCP follow-up within 21 days had an unplanned readmission within 30 days, compared to 14% of those who did not receive such follow-up.

HOME TO HOSPITAL TO HOME (H2H2H) TRANSITIONS MEASURES REPORT
CALGARY ZONE

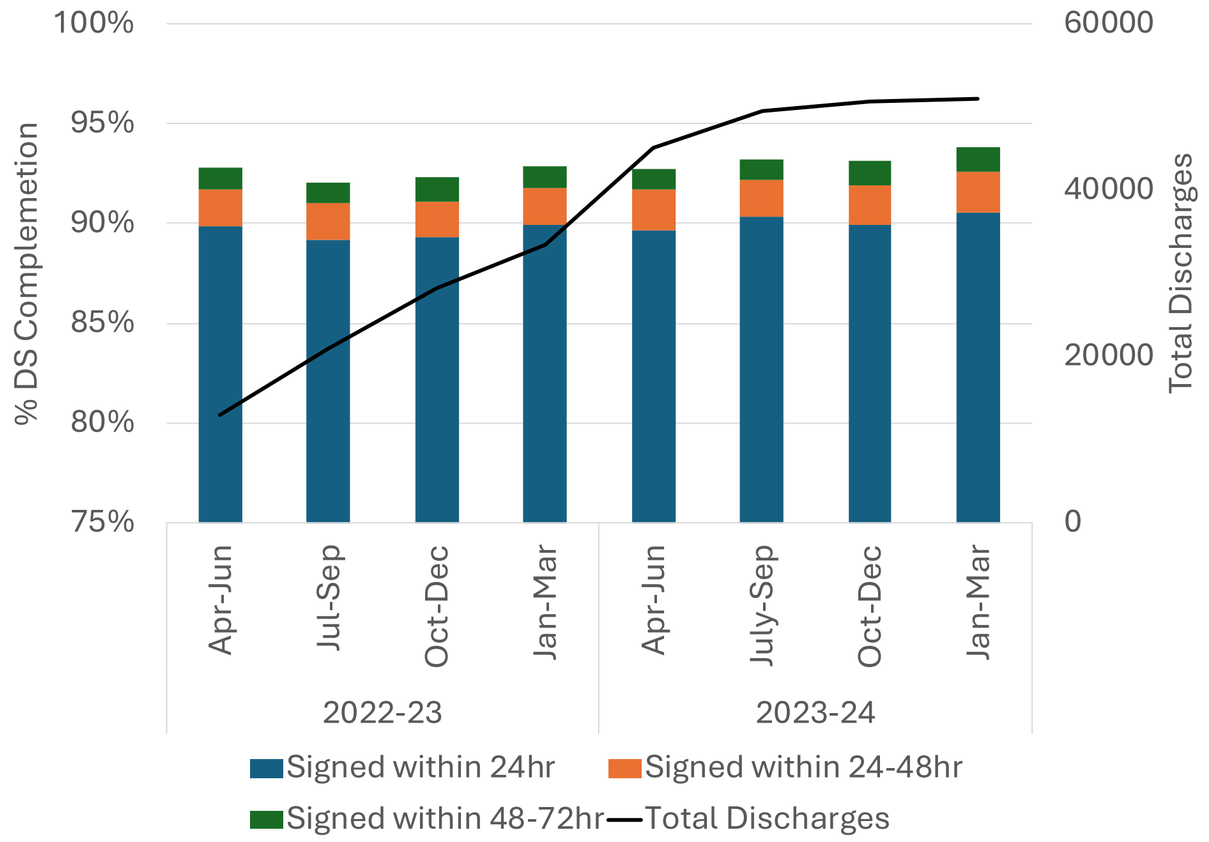
Strategic Measures within Acute Care

Confirmation of the Primary Care Physician (PCP) during hospital stay



In the last two quarters, proportion of patients reporting having a PCP increased by 1% compared to previous quarters.

Timeliness of discharge summary (DS) completion



In the last two quarters, the proportion of DS completion within 24 hours remained consistent at 91%, compared to previous quarters.

LACE Index included in discharge summaries

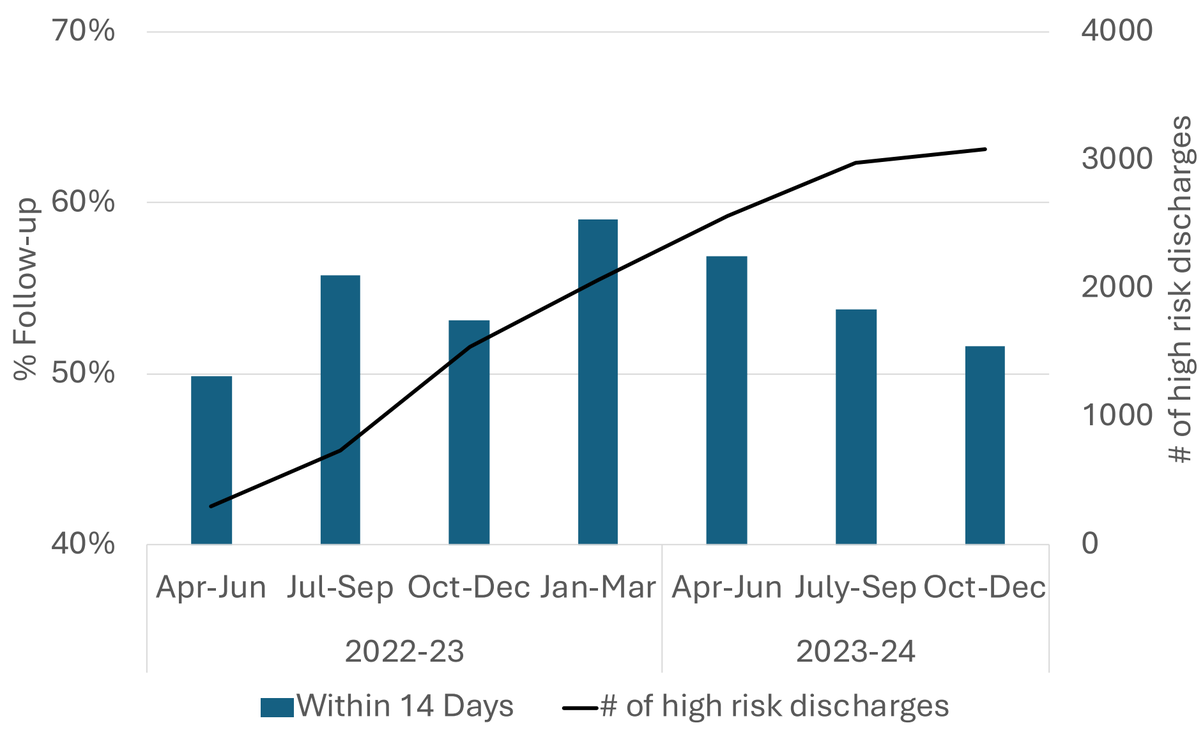
4% of discharge summaries included a LACE Index.

Utilization of provincial standard discharge summaries

4% of discharges used one of the provincial standard discharge summary templates.

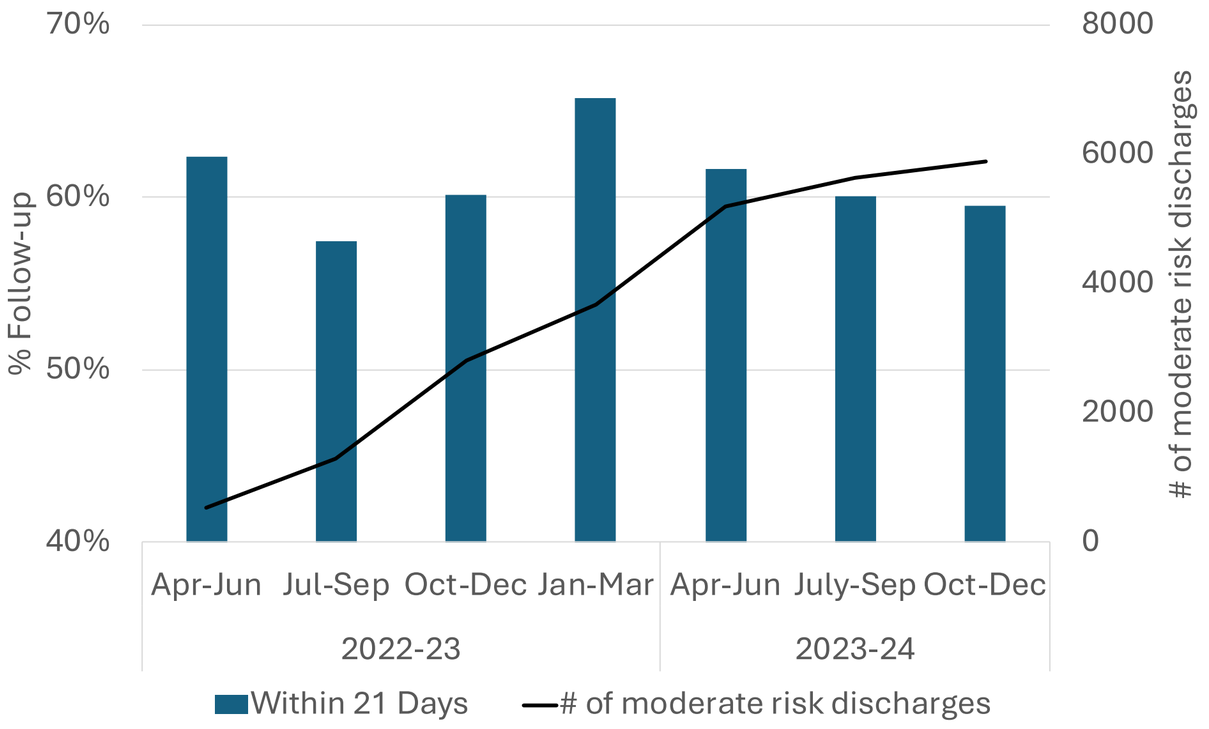
Strategic Measures within Primary Care

Post discharge PCP follow-up within 14-days among high-risk patients



In the last two quarters, the percent of high-risk patients receiving PCP follow-up within 14 decreased by 3%, compared previous quarters.

Post discharge PCP follow-up within 21-days among moderate-risk patients



In the last two quarters, the percent of moderate-risk patients receiving PCP follow-up within 21-days decreased by 1%, compared previous quarters.

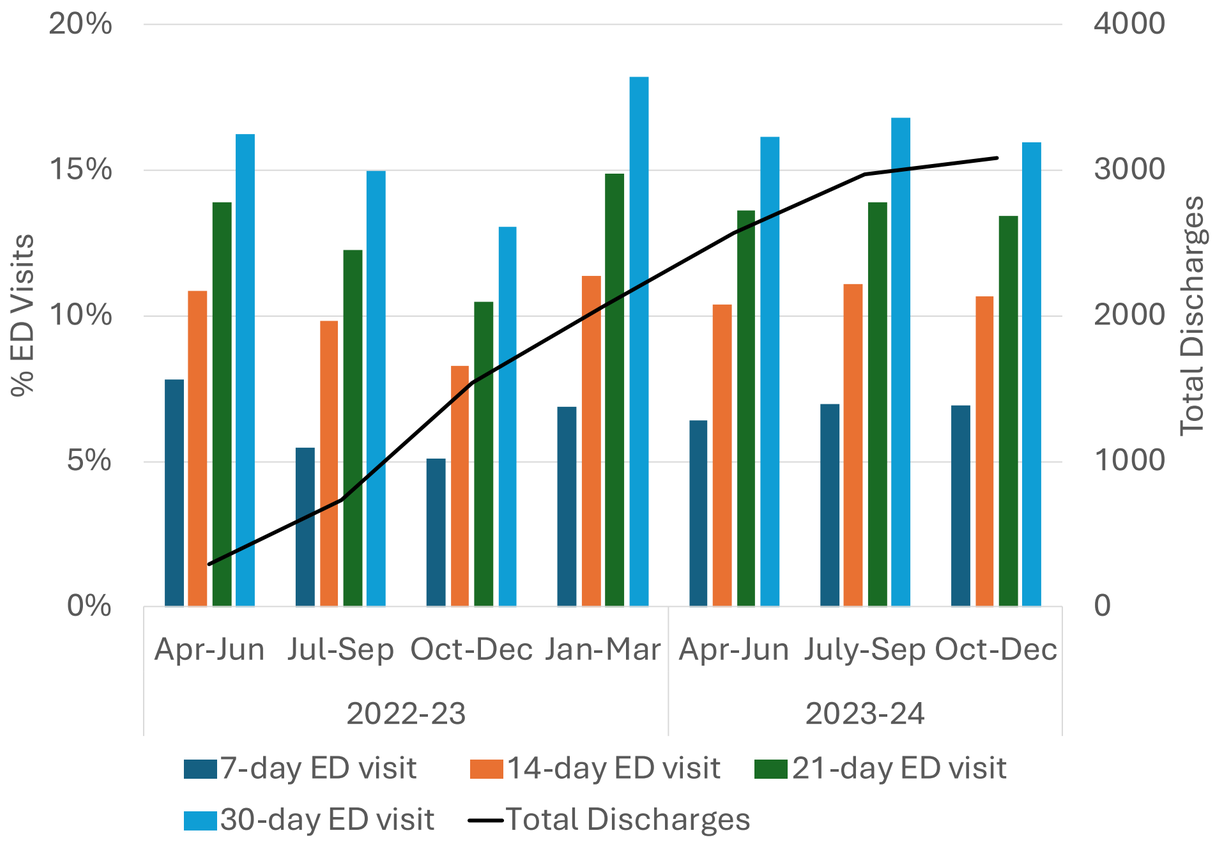
PCP follow-up for patients who reported having PCP compared to those who did not

57% of high-risk patients were followed-up within 14-days.	**PCP Documented**	65% of moderate-risk patients were followed-up within 21-days.
41% of high-risk patients were followed up within 14-days.	**Patient reported no PCP**	46% of moderate-risk patients were followed up within 21-days.

HOME TO HOSPITAL TO HOME (H2H2H) TRANSITIONS MEASURES REPORT
CALGARY ZONE

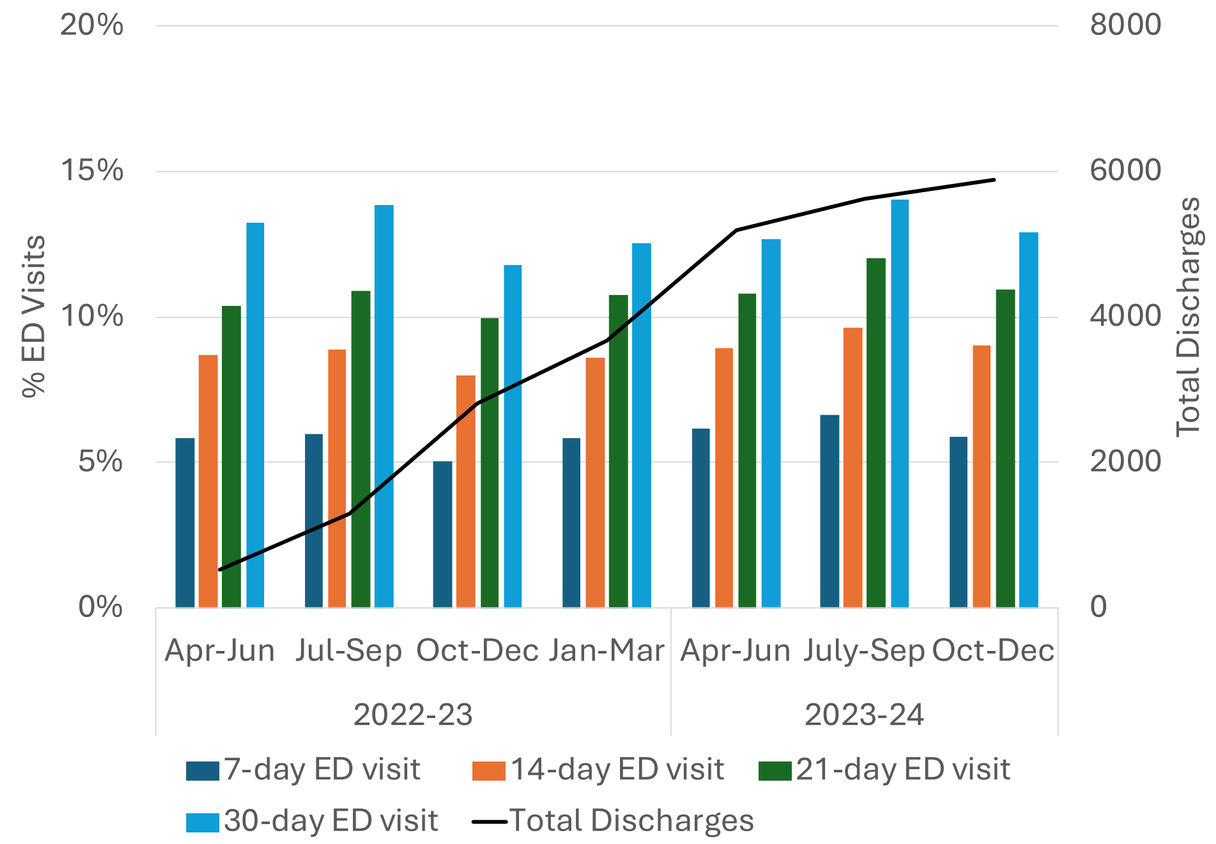
Outcome Measure - Emergency Department (ED) visit post hospital discharge

ED visit among high-risk patients



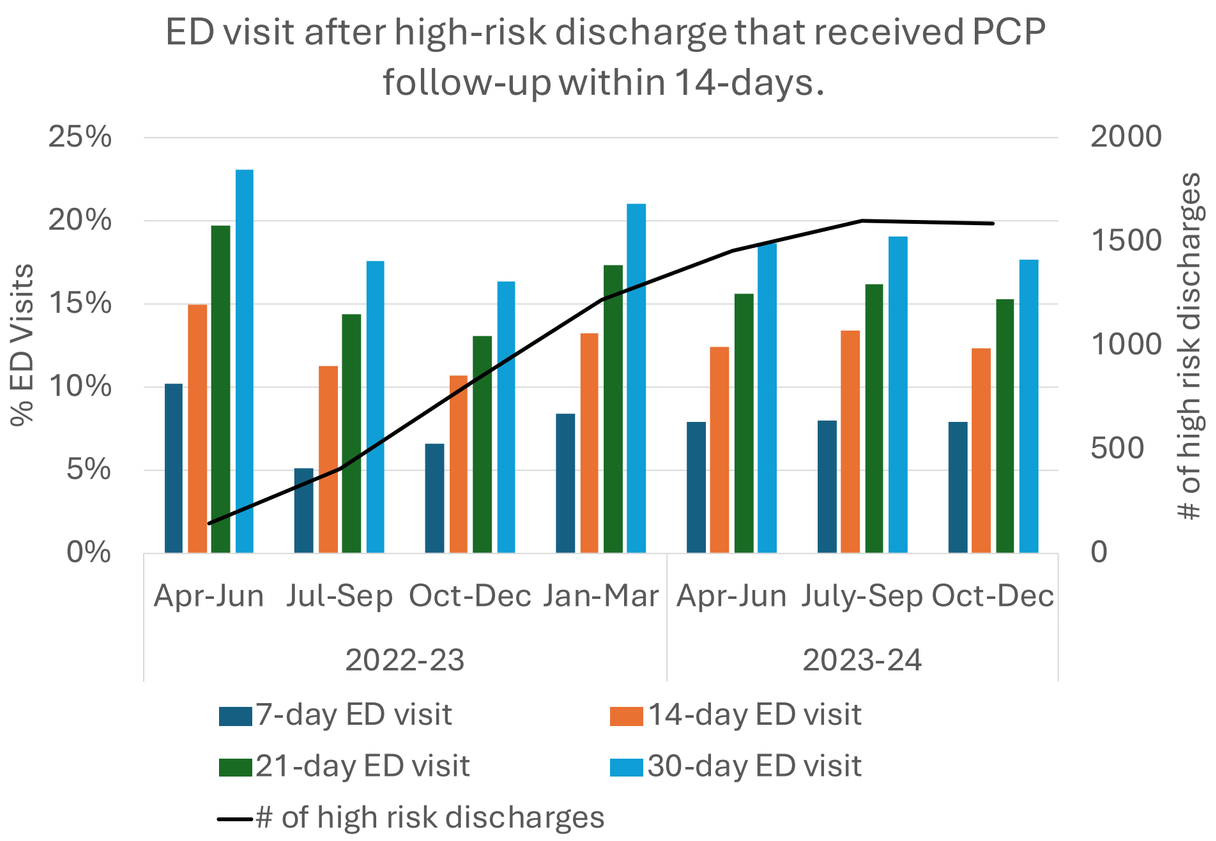
In the last two quarters, the percent of patients experiencing a 30-day ED visit remained stable at 16% compared to previous quarters.

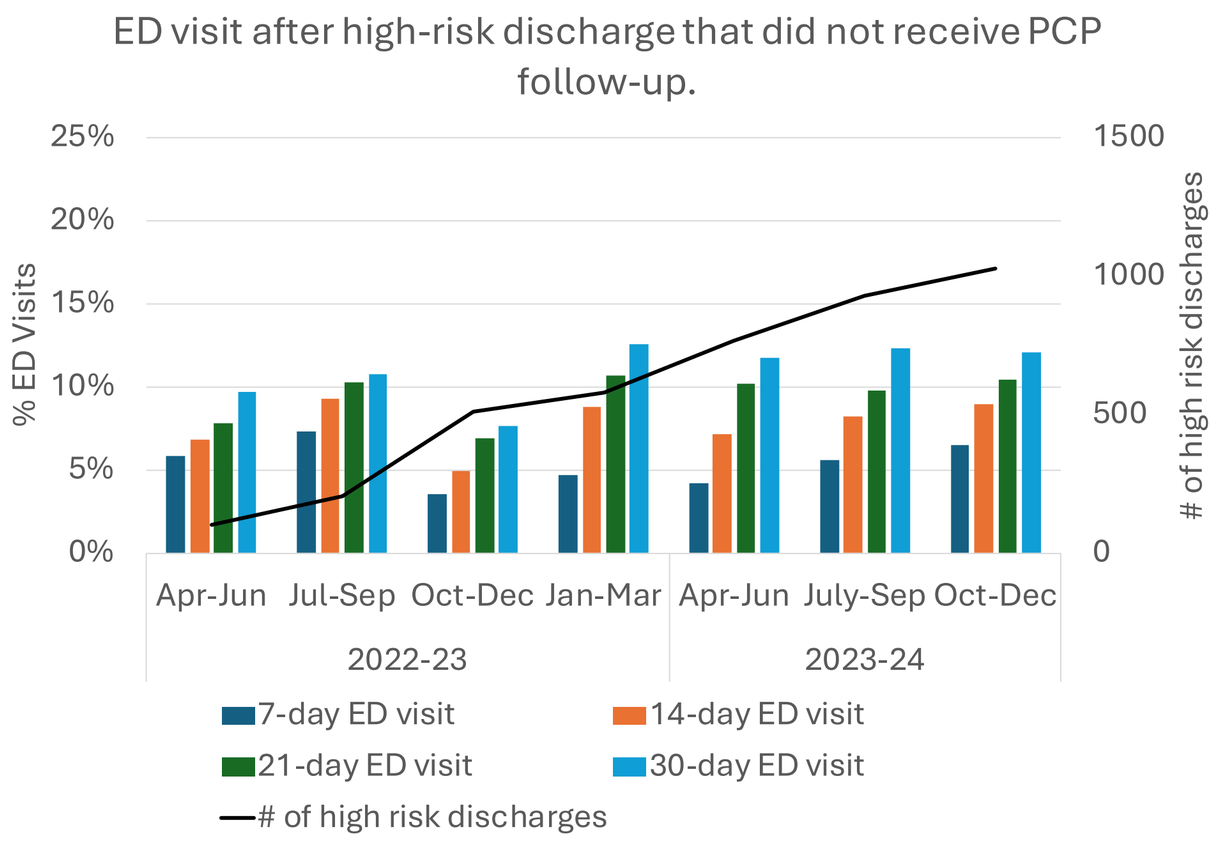
ED visit among moderate-risk patients



In the last two quarters, the percent of patients experiencing a 30-day ED visit remained stable at 13% compared to previous quarters.

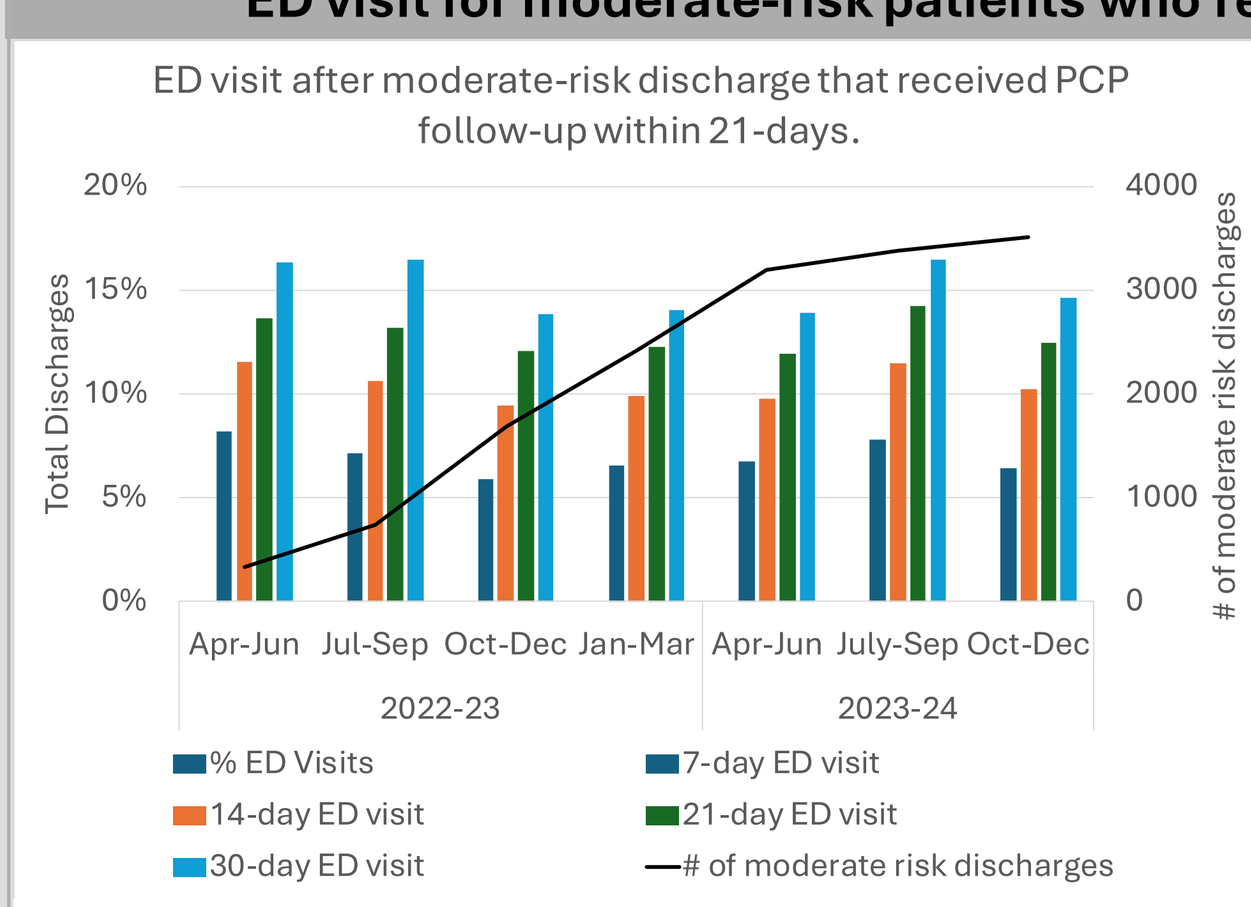
ED visit among high-risk patients who received PCP follow-up vs. no PCP follow-up

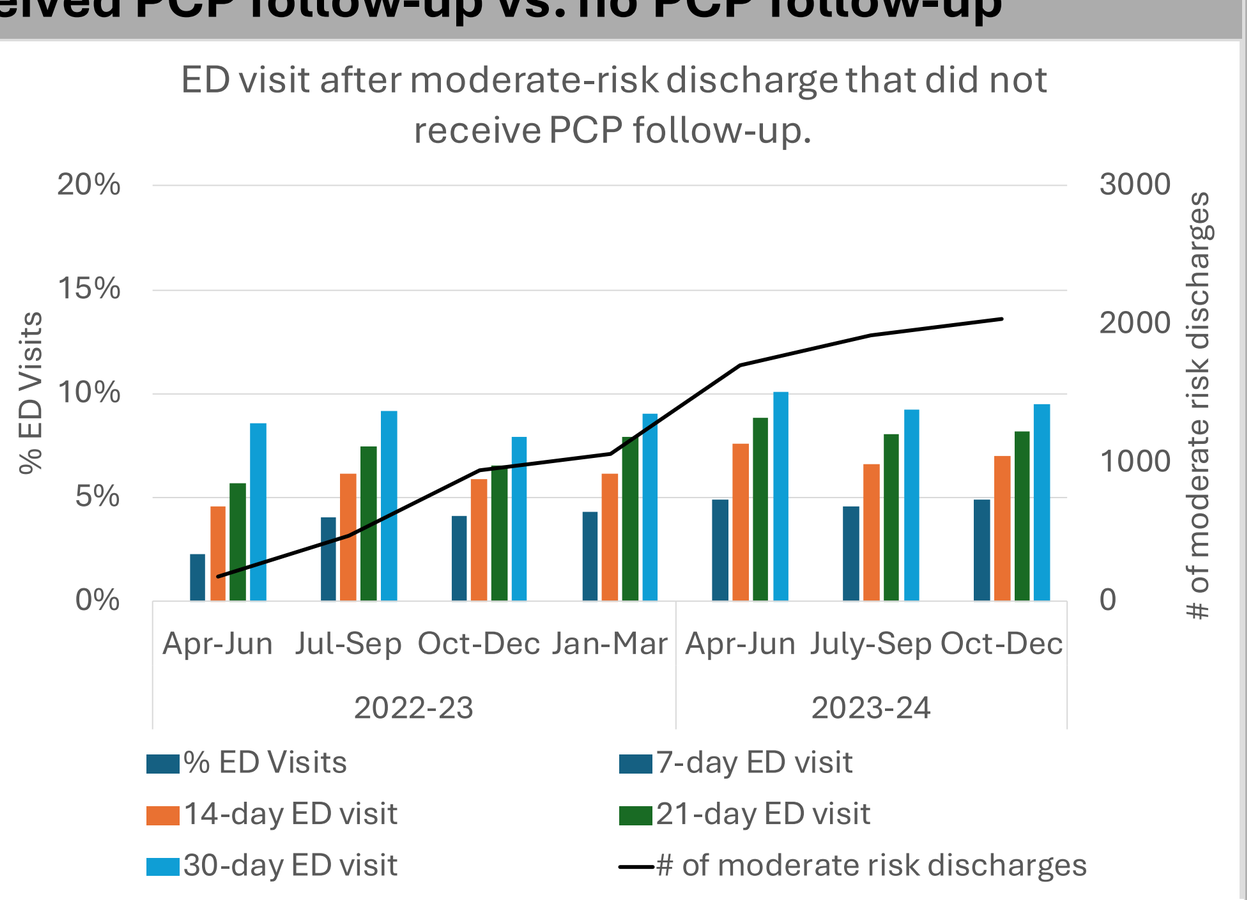




Overall, 19% of high-risk patients who had PCP follow-up within 14 days visited the ED within 30 days, compared to 11% of those who did not receive PCP follow-up.

ED visit for moderate-risk patients who received PCP follow-up vs. no PCP follow-up



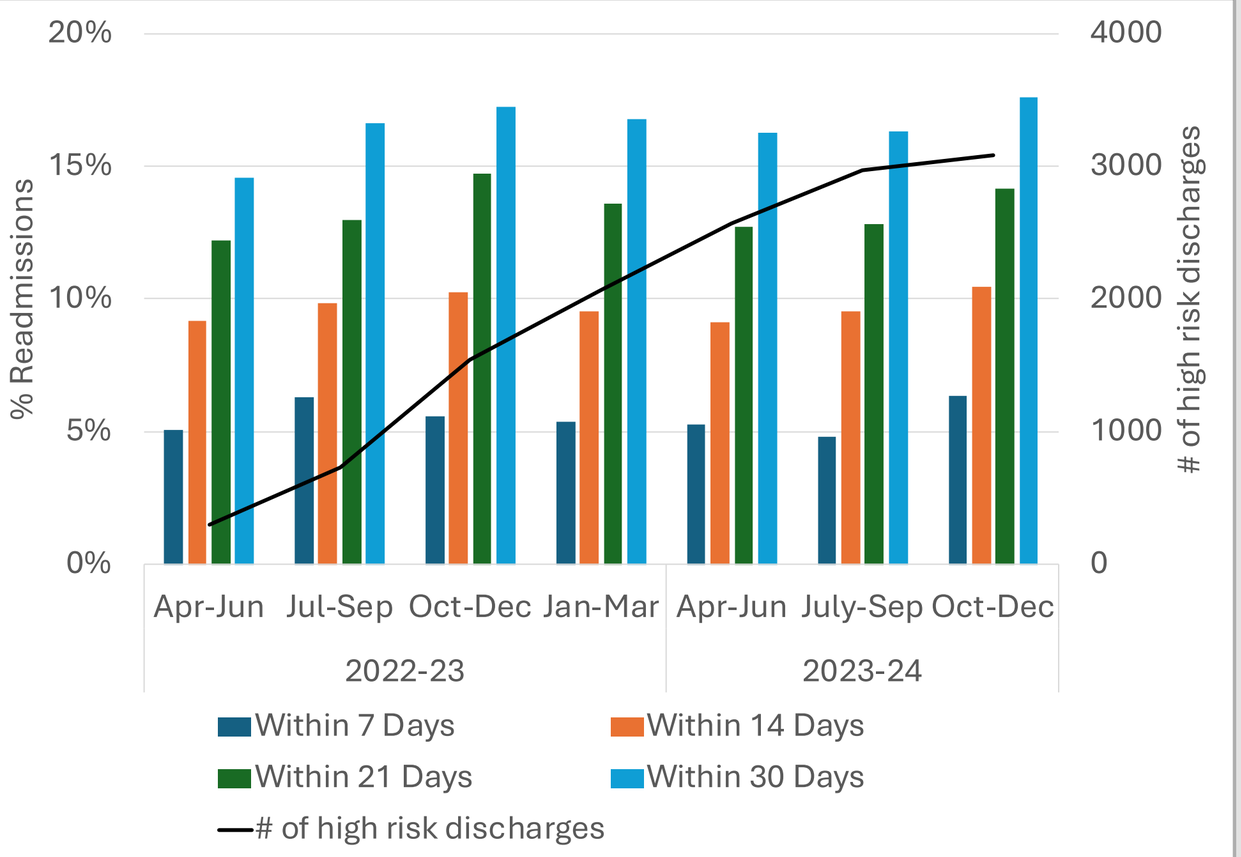


Overall, 15% of moderate-risk patients who had PCP follow-up within 21 days visited the ED within 30 days, compared to 9% of those who did not receive such follow-up.

HOME TO HOSPITAL TO HOME (H2H2H) TRANSITIONS MEASURES REPORT
CALGARY ZONE

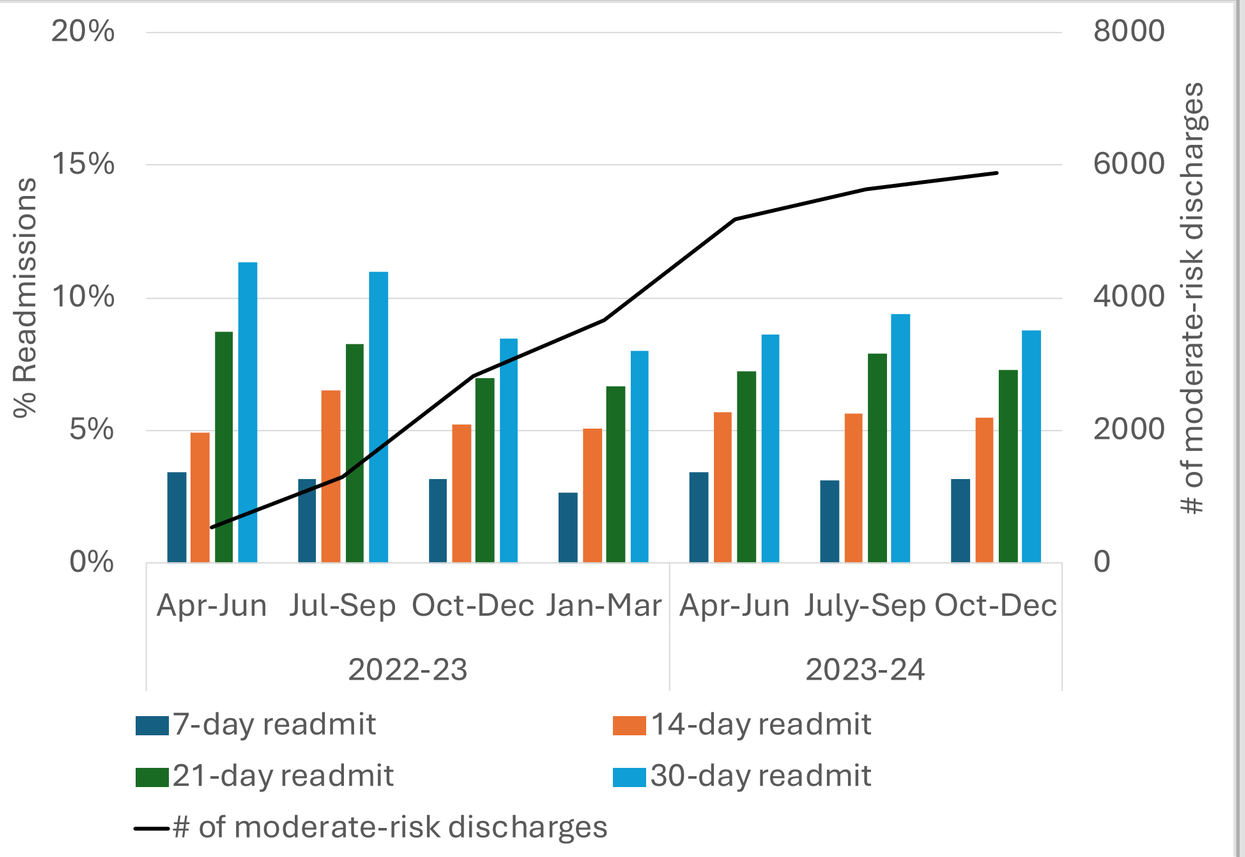
Outcome Measure – Unplanned readmission post hospital discharge

Unplanned readmission among high-risk patients



In the last two quarters, the percent of patients experiencing a 30-day readmission remained stable at 17% compared previous quarters.

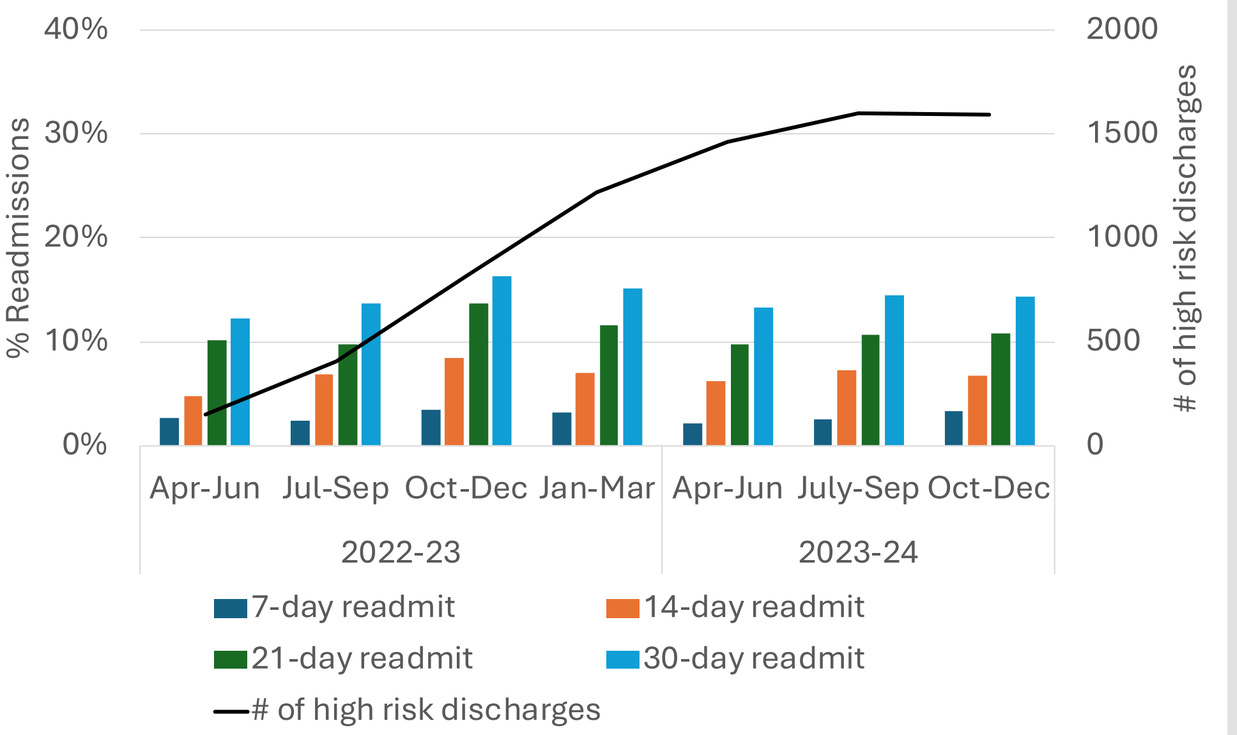
Unplanned readmission among mod-risk patients



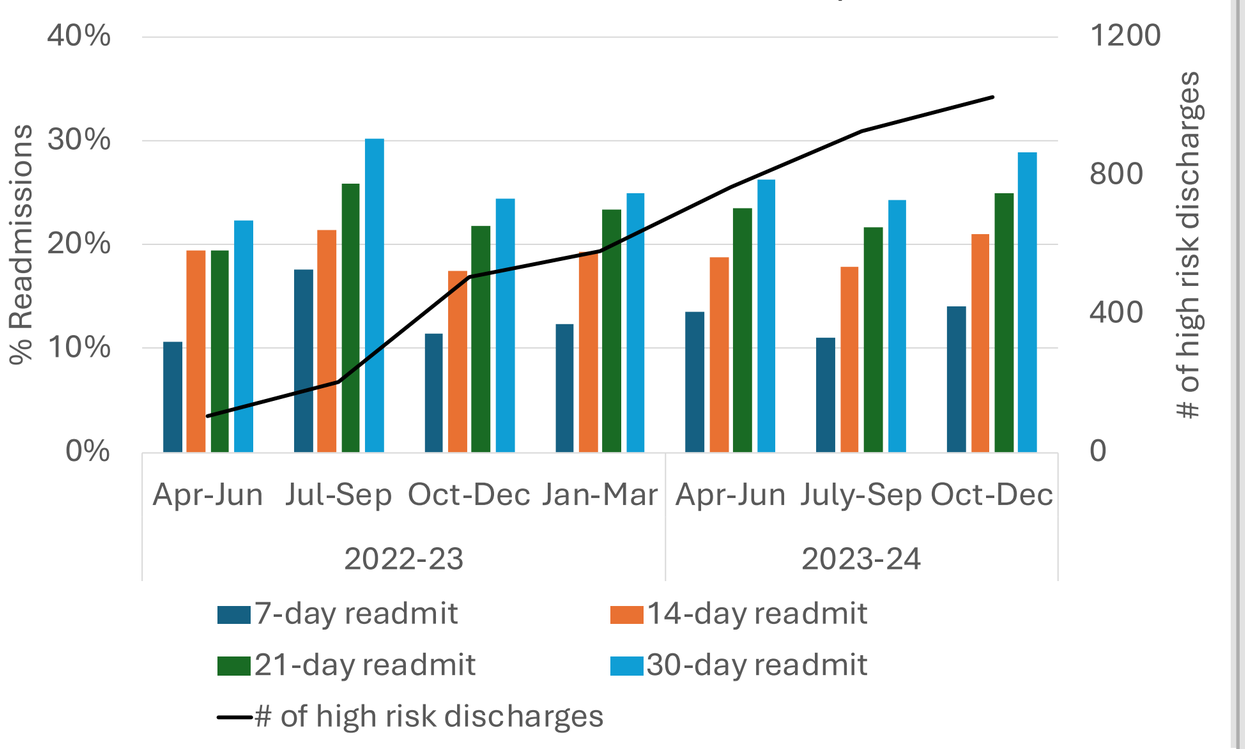
In the last two quarters, the percent of patients experiencing a 30-day readmission remained stable at 9% compared to previous quarters.

Unplanned readmission among high-risk patients who received PCP follow-up vs. no PCP follow-up

Unplanned readmission after high-risk discharge that received PCP follow-up within 14-days.



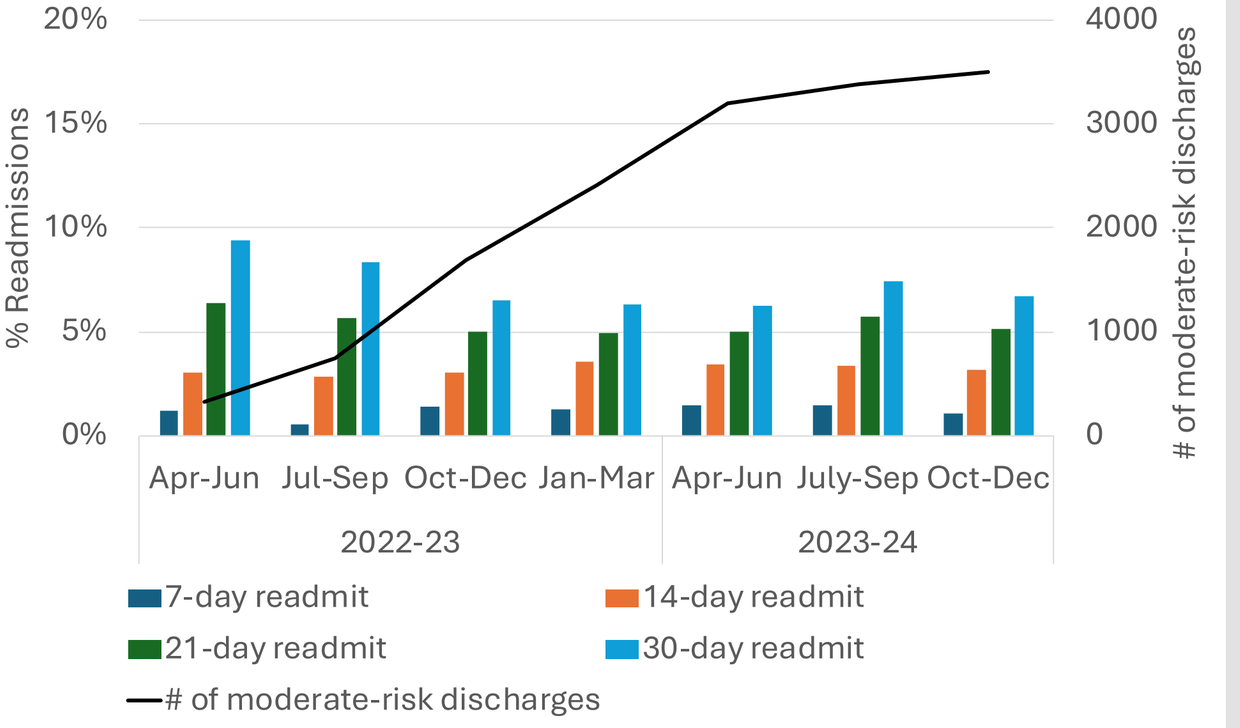
Unplanned readmission after high-risk discharge that did not receive PCP follow-up.



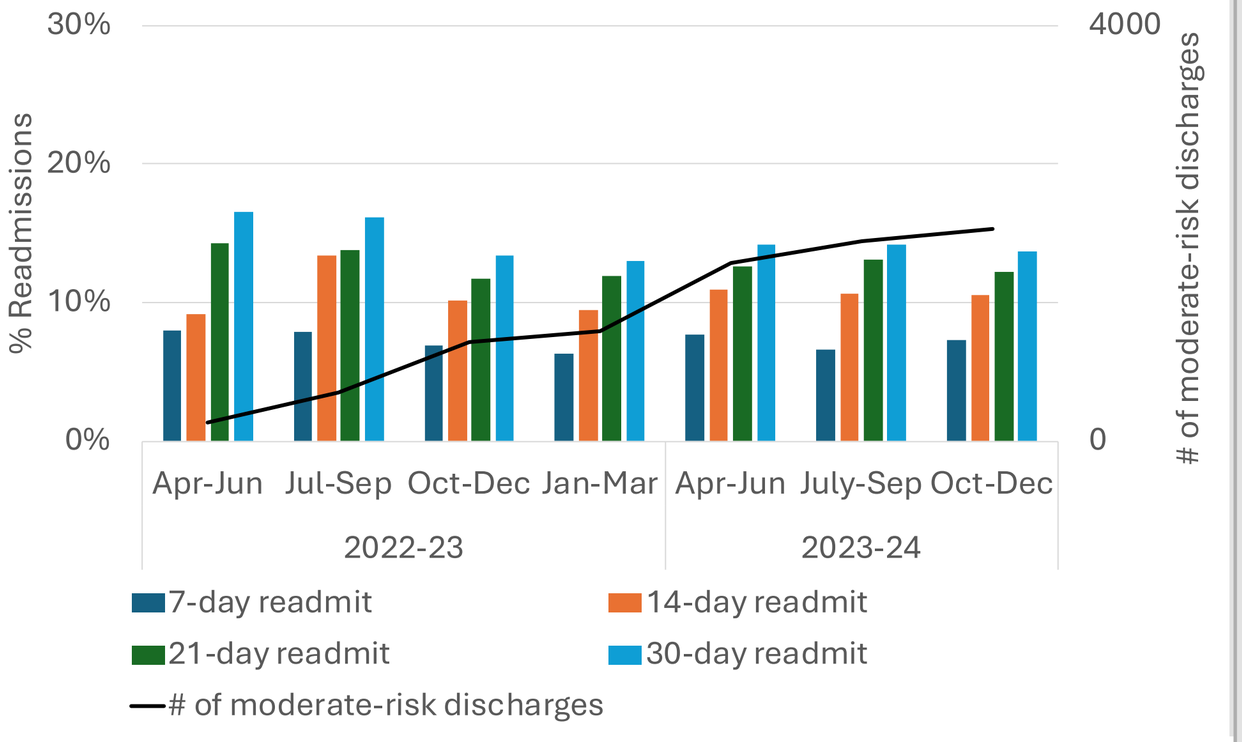
Overall, 14% of high-risk patients who had PCP follow-up within 14 days had an unplanned readmission within 30 days, compared to 26% of those who did not receive such follow-up.

Unplanned readmission for moderate-risk patients who received PCP follow-up vs. no PCP follow-up

Unplanned readmission after moderate-risk discharge that received PCP follow-up within 21-days.



Unplanned readmission after moderate-risk discharge that did not receive PCP follow-up.

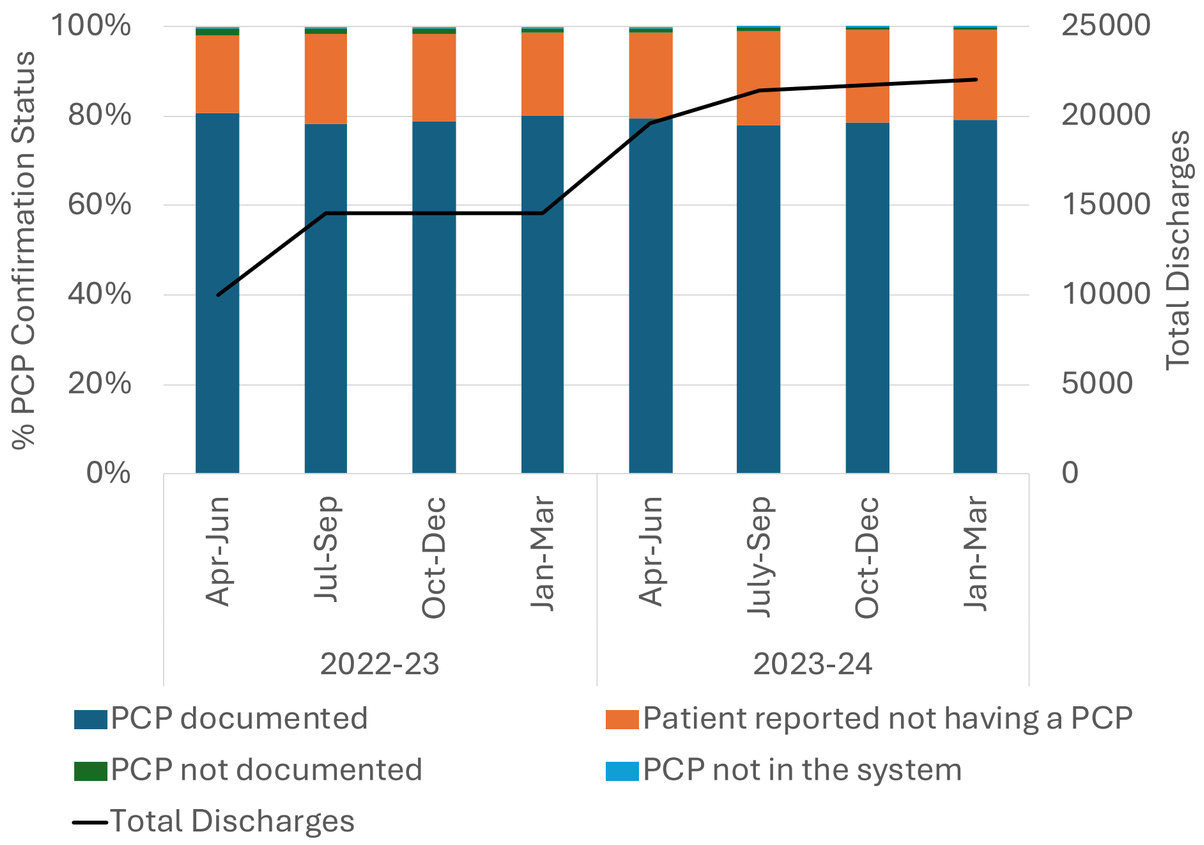


Overall, 7% of moderate-risk patients who had PCP follow-up within 21 days had an unplanned readmission within 30 days, compared to 14% of those who did not receive such follow-up.

HOME TO HOSPITAL TO HOME (H2H2H) TRANSITIONS MEASURES REPORT
EDMONTON ZONE

Strategic Measures within Acute Care

Confirmation of the Primary Care Physician (PCP) during hospital stay



In the last two quarters, proportion of patients reporting having a PCP remained stable at 79% compared to previous quarters.

Timeliness of discharge summary (DS) completion

In the last two quarters, the proportion of DS completion within 24 hours remained stable at 90% compared to previous quarters.

LACE Index included in discharge summaries

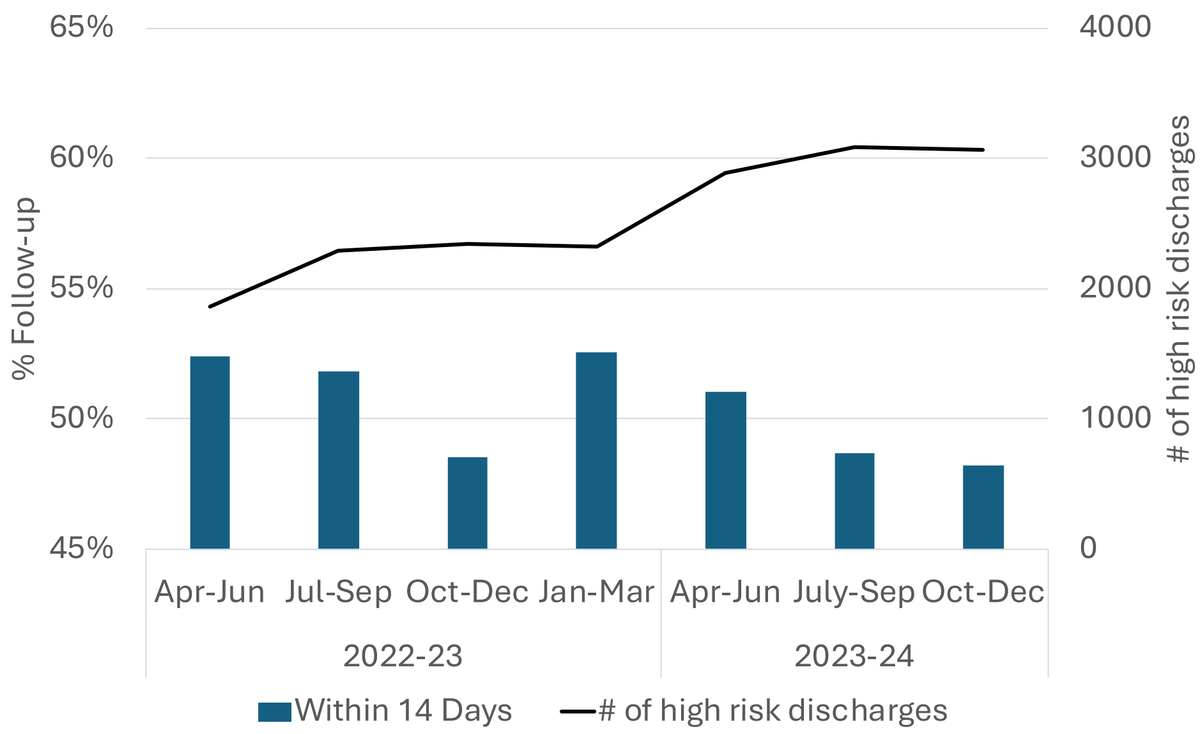
5% of discharge summaries included a LACE Index.

Utilization of provincial standard discharge summaries

5% of discharges used one of the provincial standard discharge summary templates.

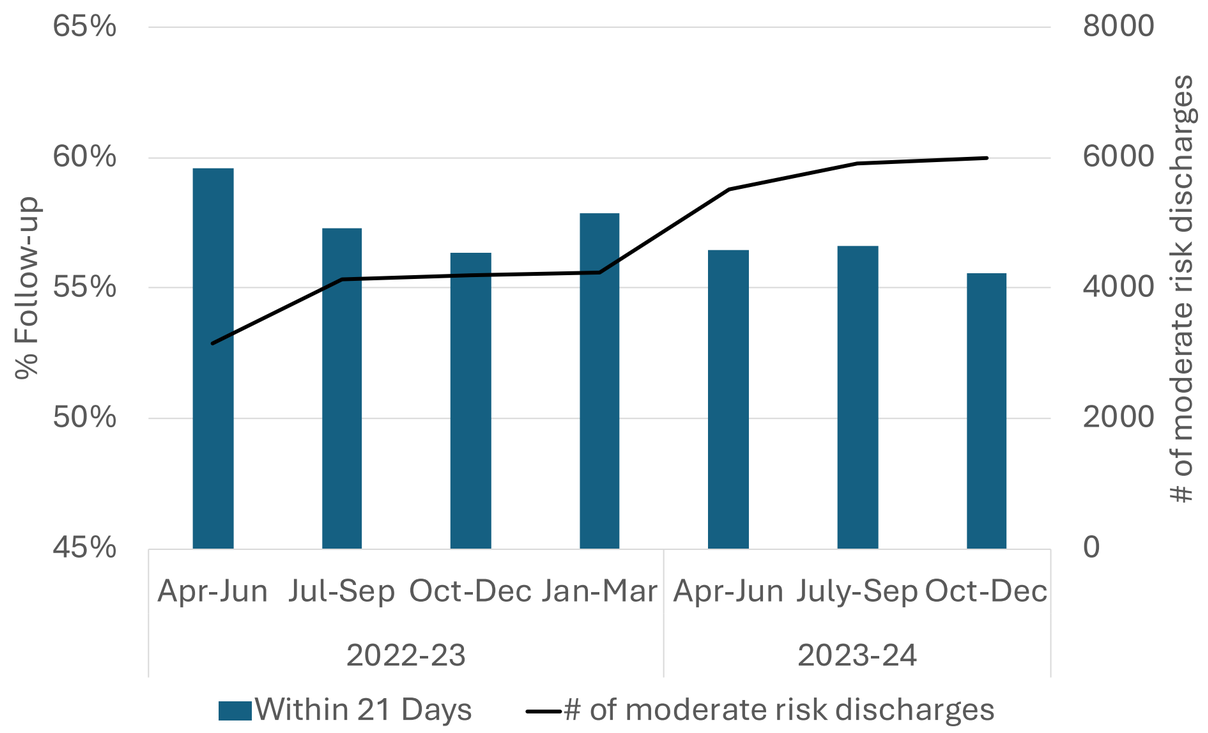
Strategic Measures within Primary Care

Post discharge PCP follow-up within 14-days among high-risk patients



In the last two quarters, the percent of high-risk patients receiving PCP follow-up within 14 decreased by 2%, compared previous quarters.

Post discharge PCP follow-up within 21-days among moderate-risk patients



In the last two quarters, the percent of moderate-risk patients receiving PCP follow-up within 21-days decreased by 1%, compared previous quarters.

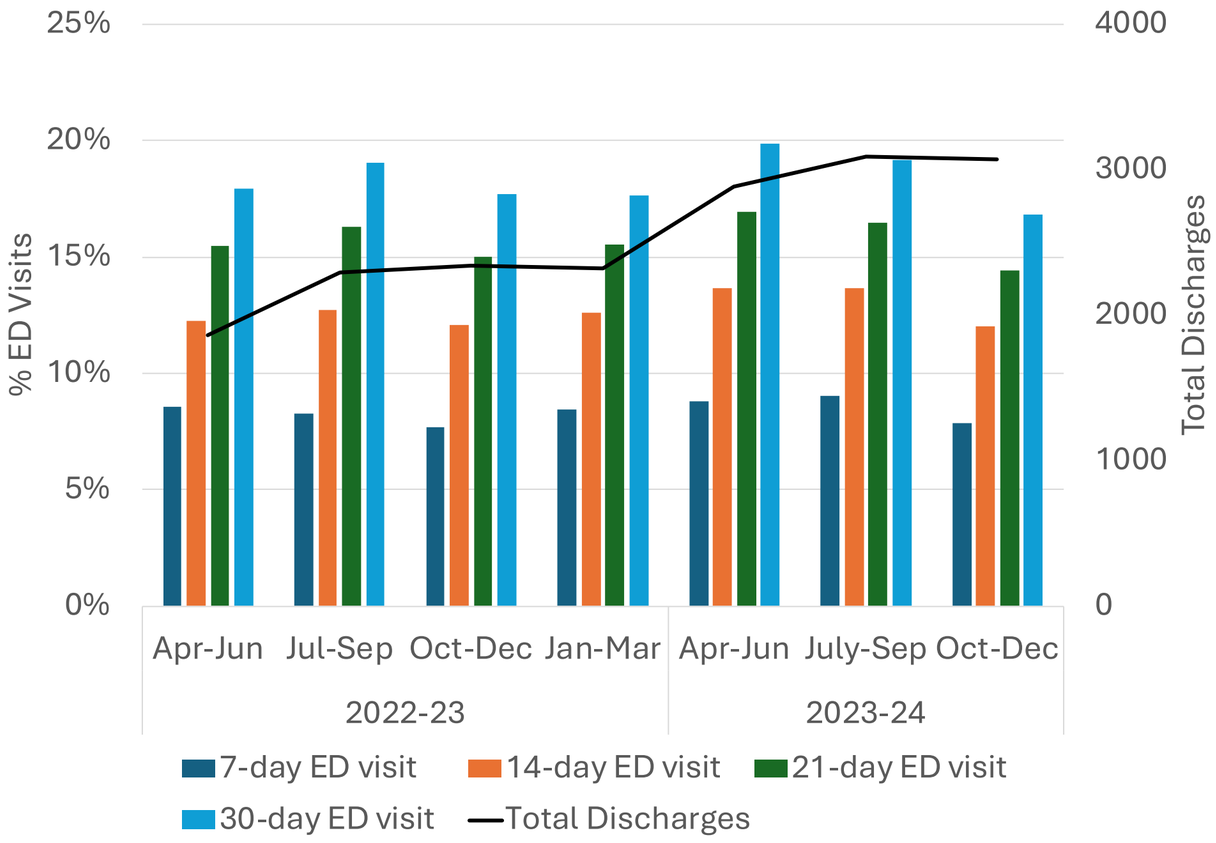
PCP follow-up for patients who reported having PCP compared to those who did not

54% of high-risk patients were followed-up within 14-days.	**PCP Documented**	62% of moderate-risk patients were followed-up within 21-days.
28% of high-risk patients were followed up within 14-days.	**Patient reported no PCP**	36% of moderate-risk patients were followed up within 21-days.

HOME TO HOSPITAL TO HOME (H2H2H) TRANSITIONS MEASURES REPORT
EDMONTON ZONE

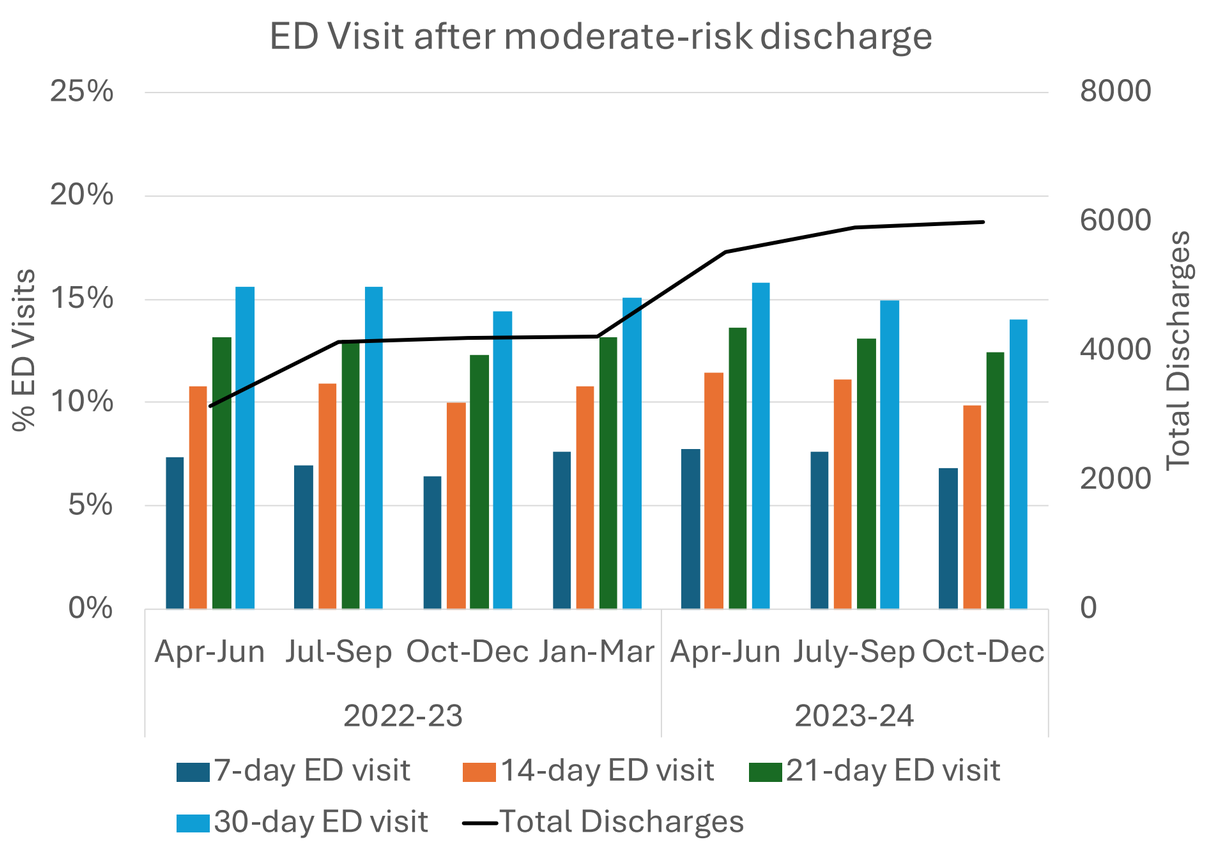
Outcome Measure - Emergency Department (ED) visit post hospital discharge

ED visit among high-risk patients



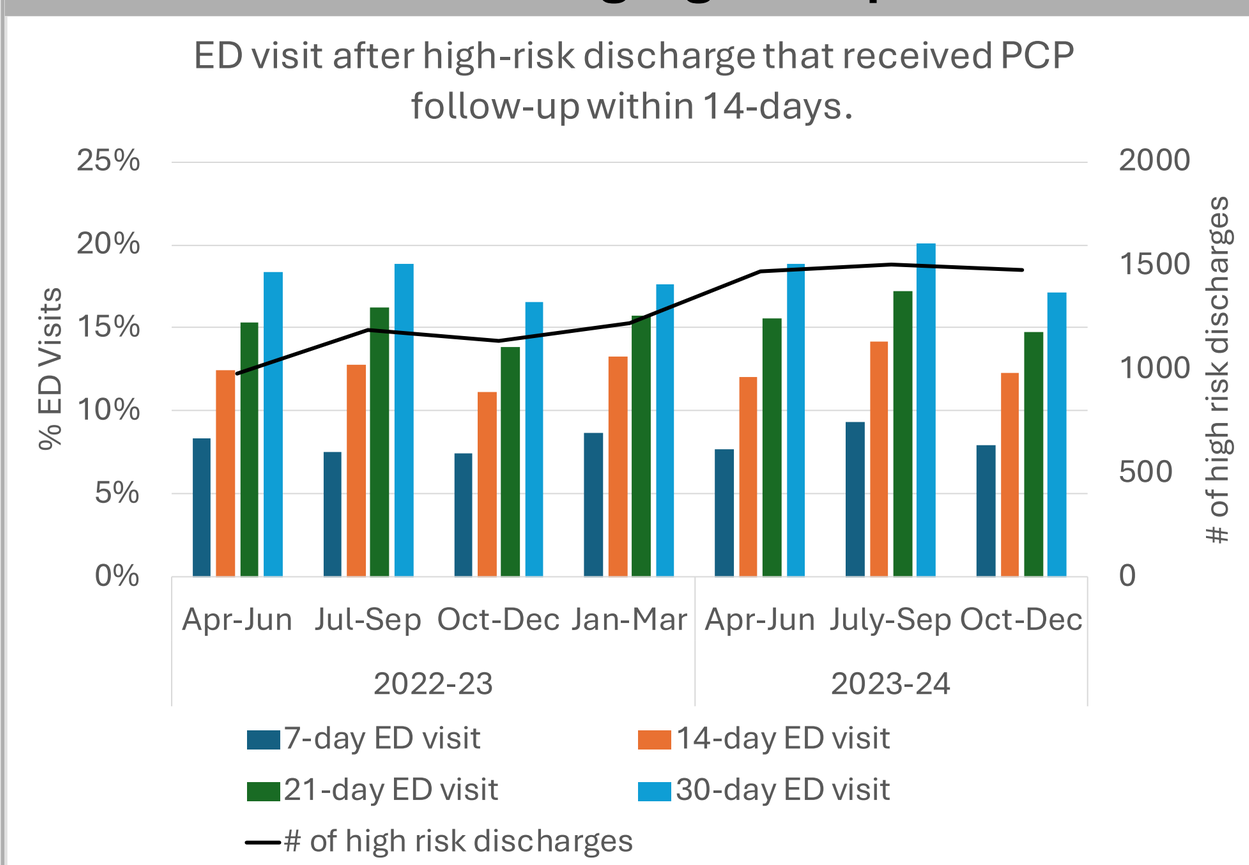
In the last two quarters, the percent of patients experiencing a 30-day ED visit decreased by 1% compared to previous quarters.

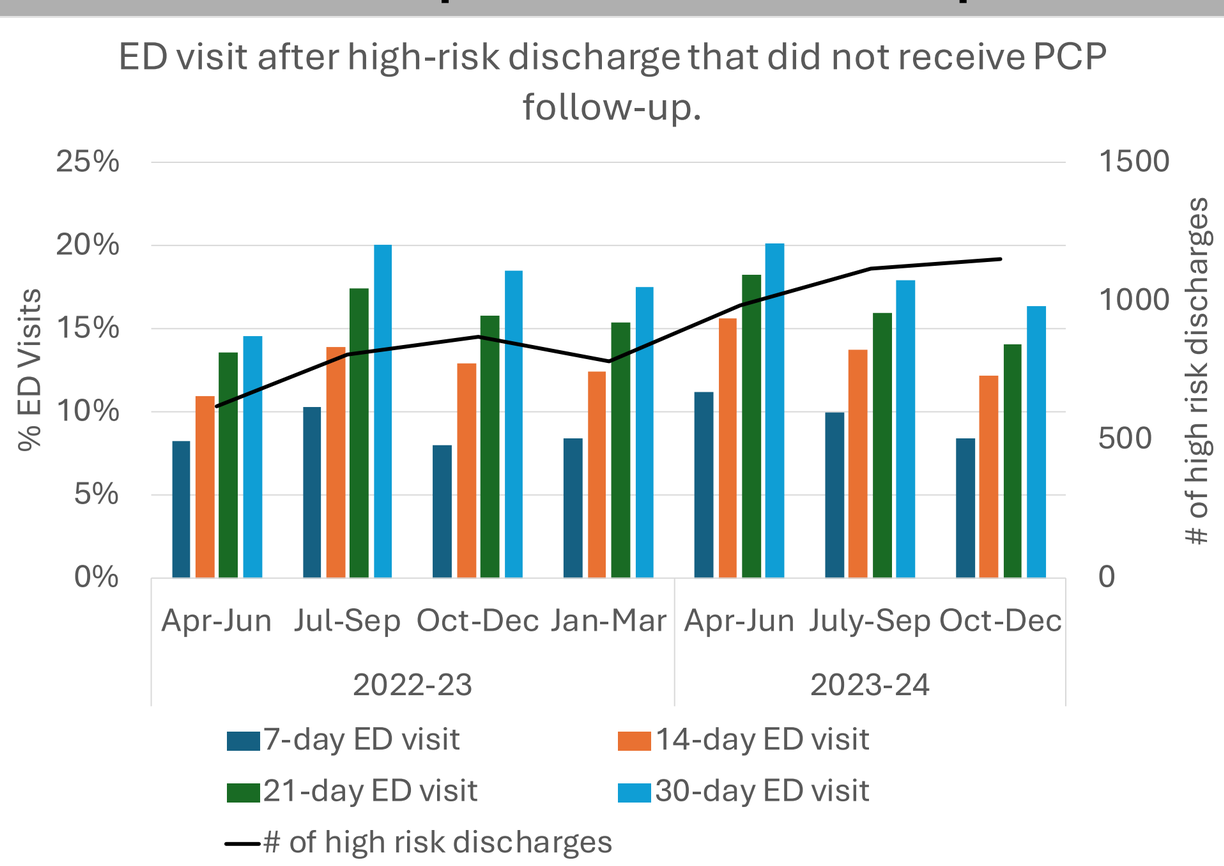
ED visit among moderate-risk patients



In the last two quarters, the percent of patients experiencing a 30-day ED visit remained stable at 15% compared to previous quarters.

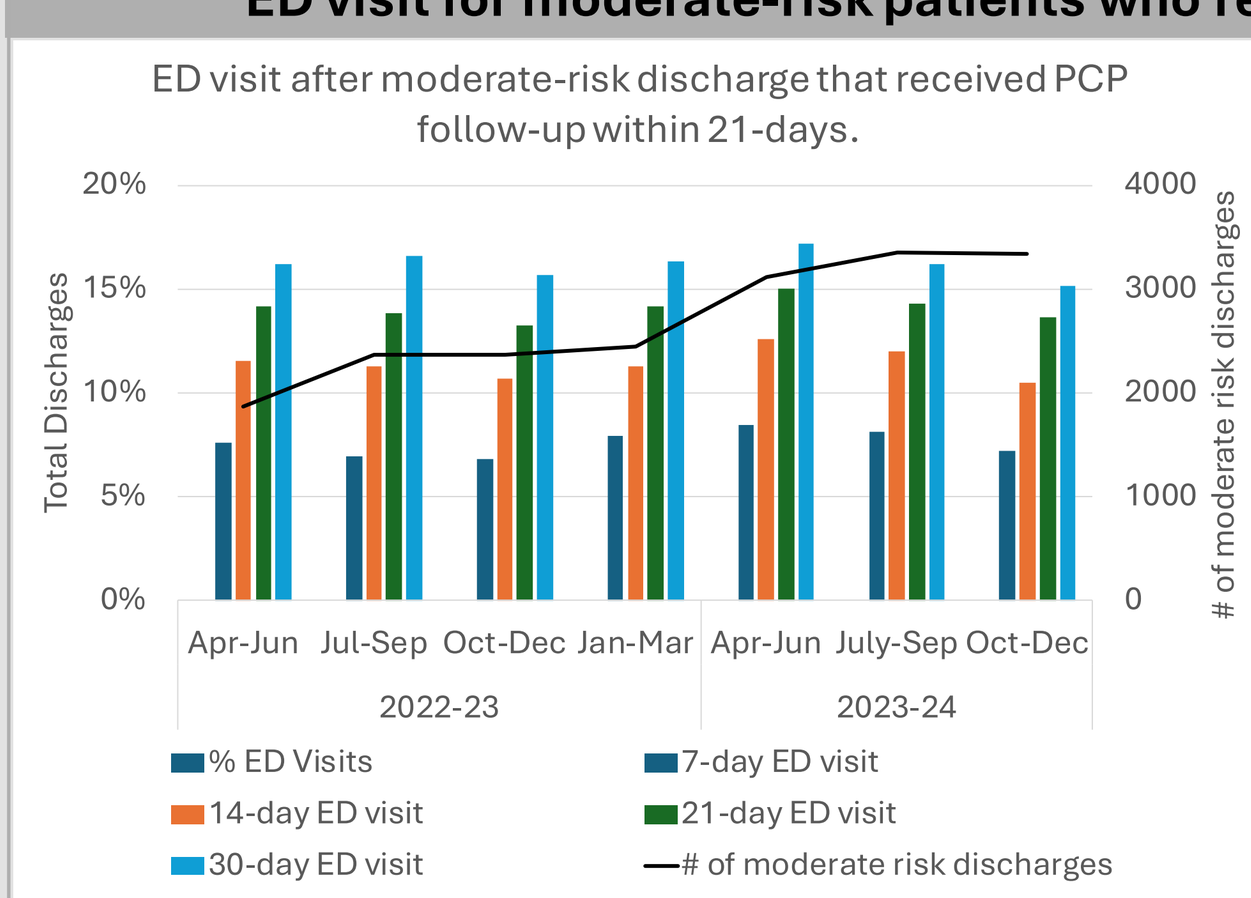
ED visit among high-risk patients who received PCP follow-up vs. no PCP follow-up

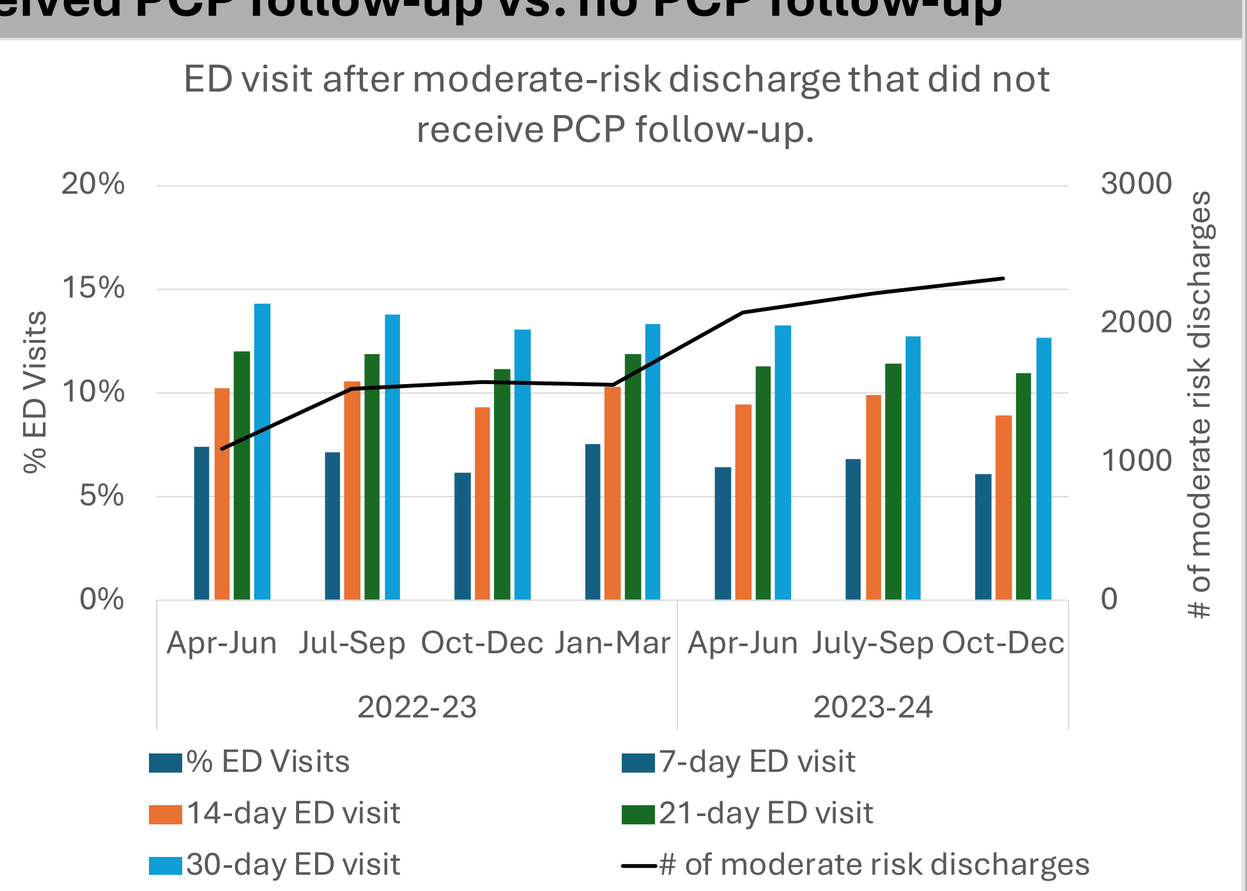




Overall, 18% of high-risk patients visited the ED within 30 days regardless if they have a PCP follow-up within 14-days or not.

ED visit for moderate-risk patients who received PCP follow-up vs. no PCP follow-up



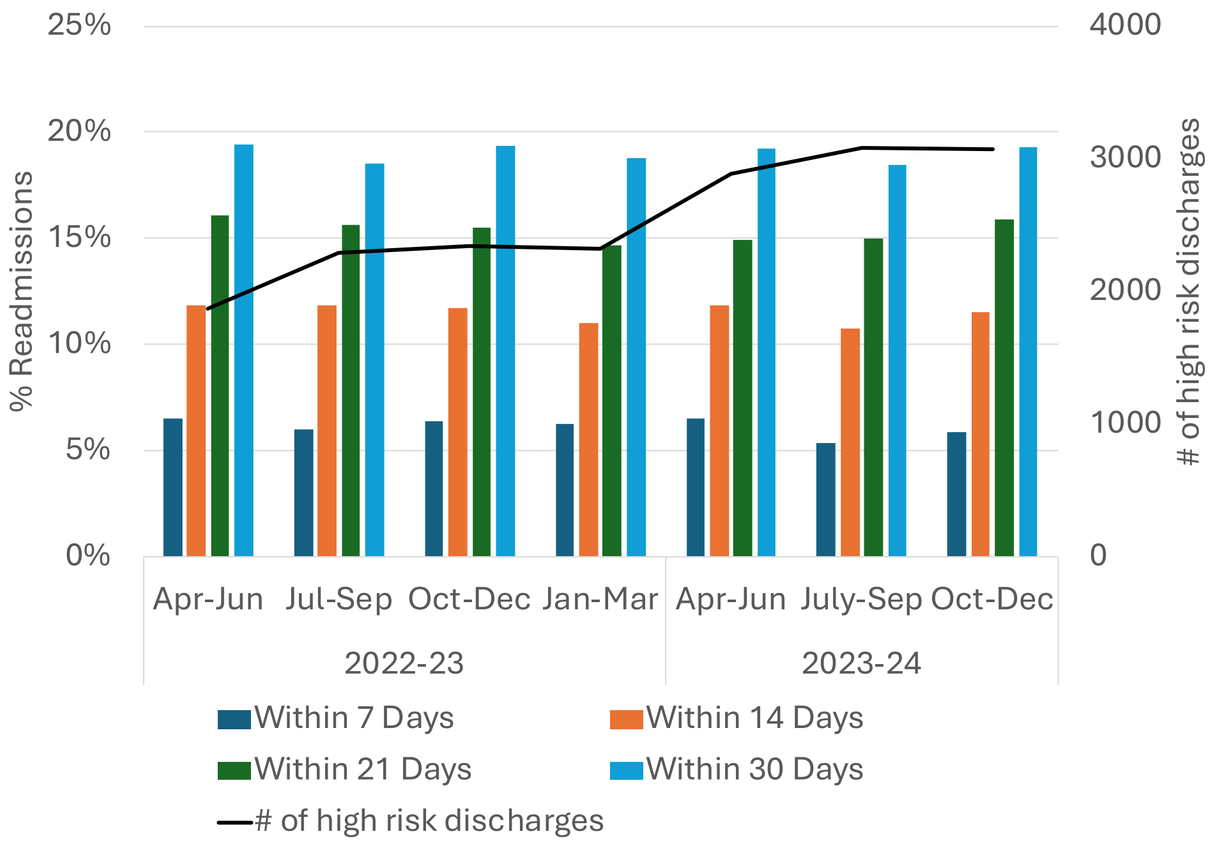


Overall, 16% of moderate-risk patients who had PCP follow-up within 21 days visited the ED within 30 days, compared to 13% of those who did not receive such follow-up.

HOME TO HOSPITAL TO HOME (H2H2H) TRANSITIONS MEASURES REPORT
EDMONTON ZONE

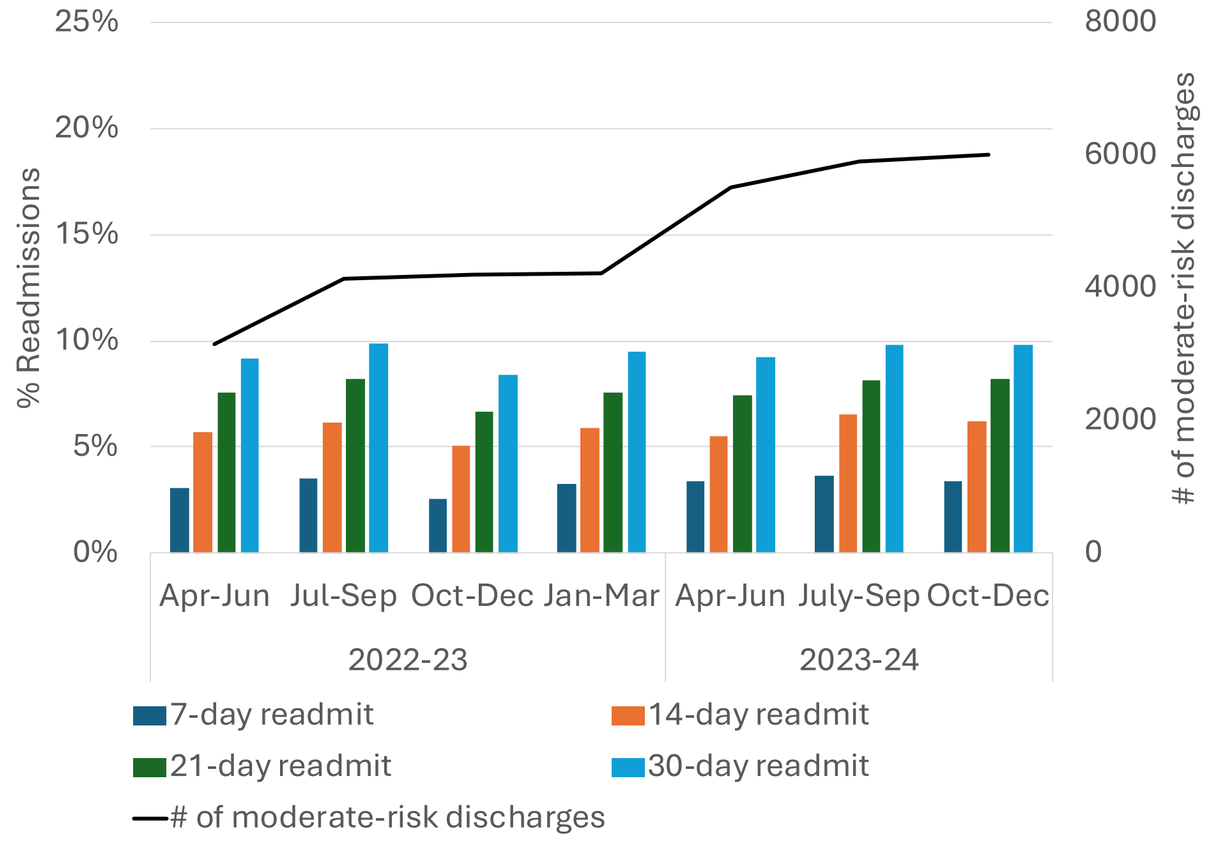
Outcome Measure – Unplanned readmission post hospital discharge

Unplanned readmission among high-risk patients



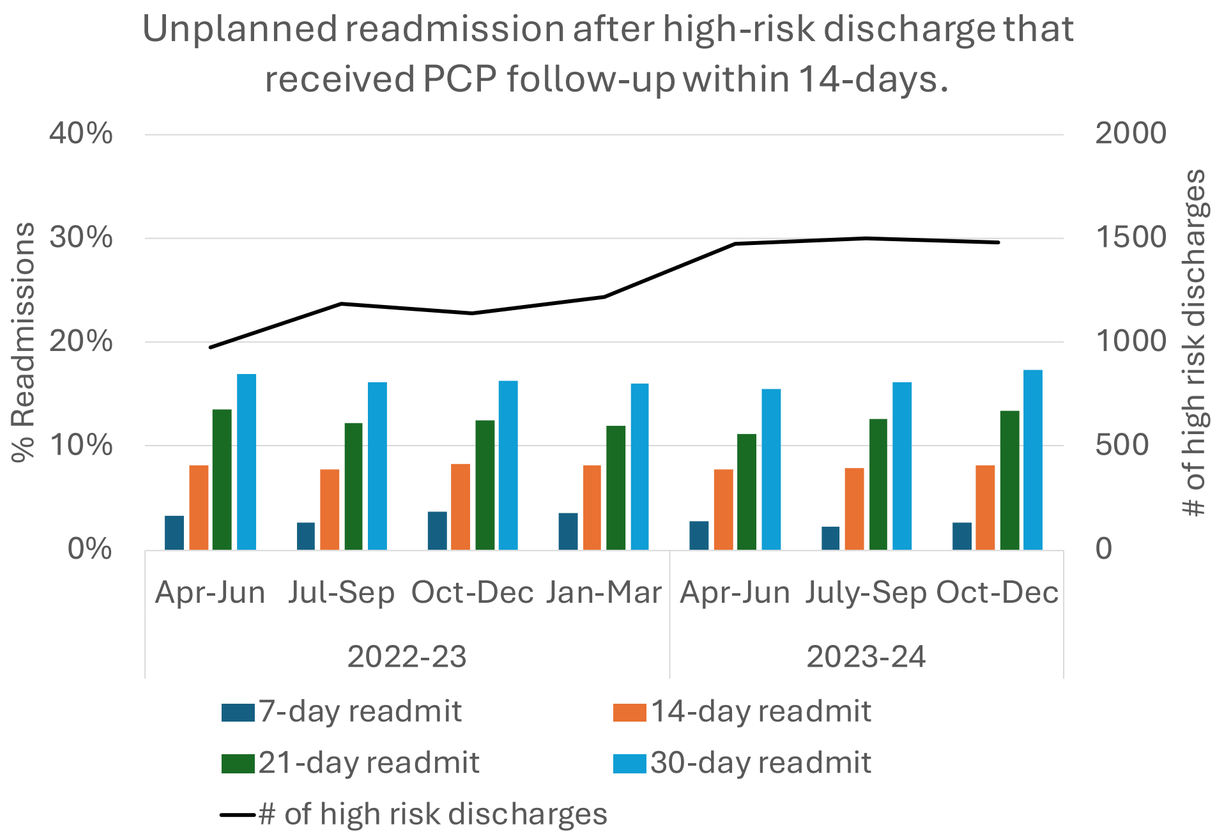
In the last two quarters, the percent of patients experiencing a 30-day readmission remained stable at 19% compared previous quarters.

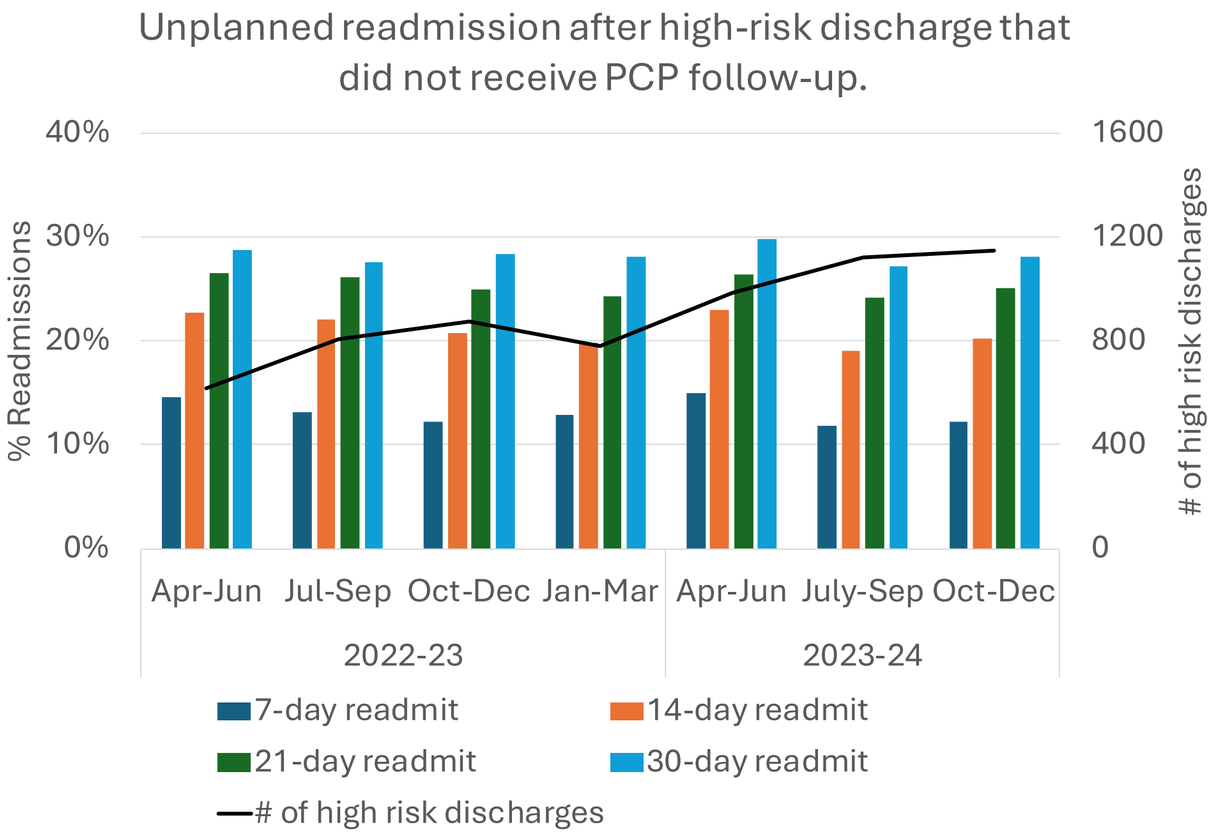
Unplanned readmission among mod-risk patients



In the last two quarters, the percent of patients experiencing a 30-day readmission increased by 1% compared to previous quarters.

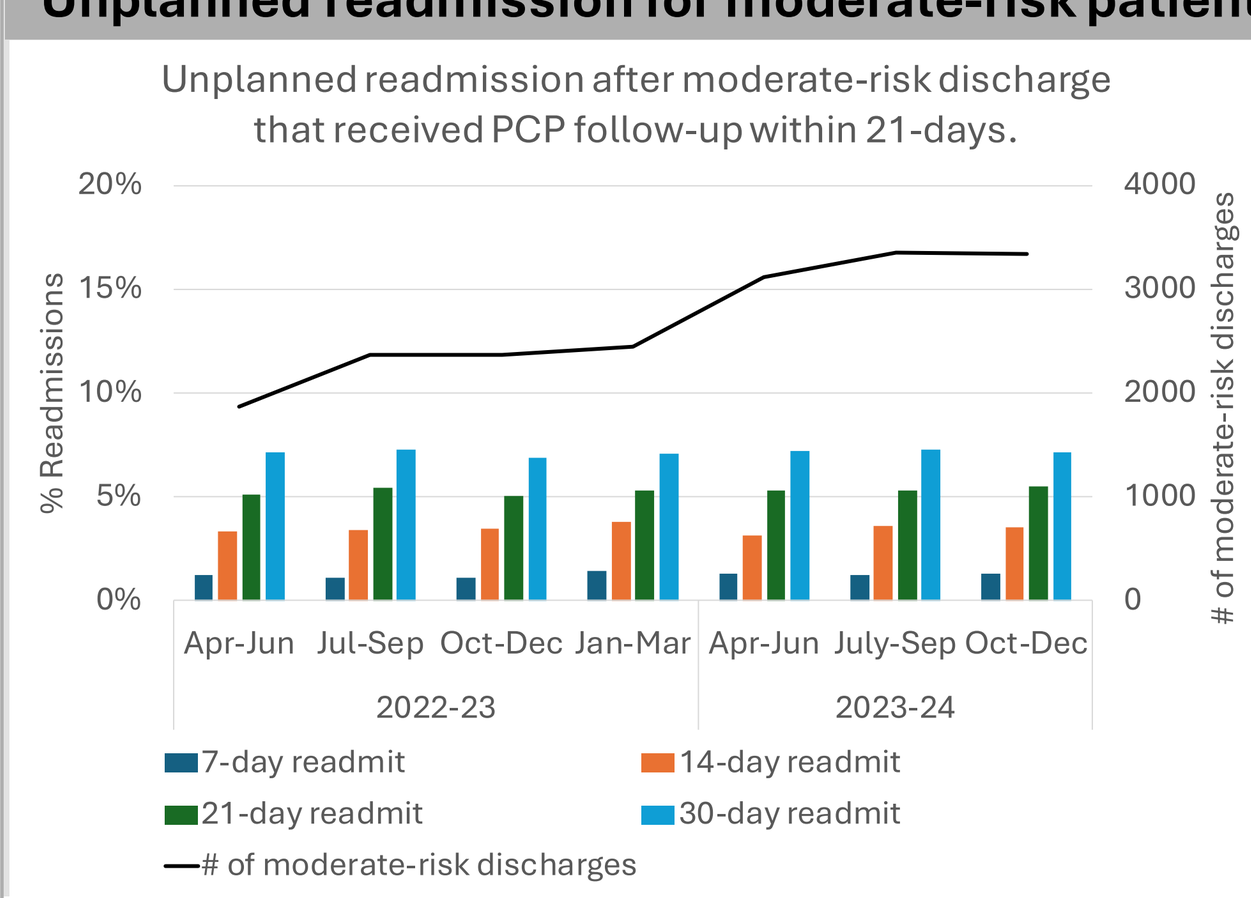
Unplanned readmission among high-risk patients who received PCP follow-up vs. no PCP follow-up

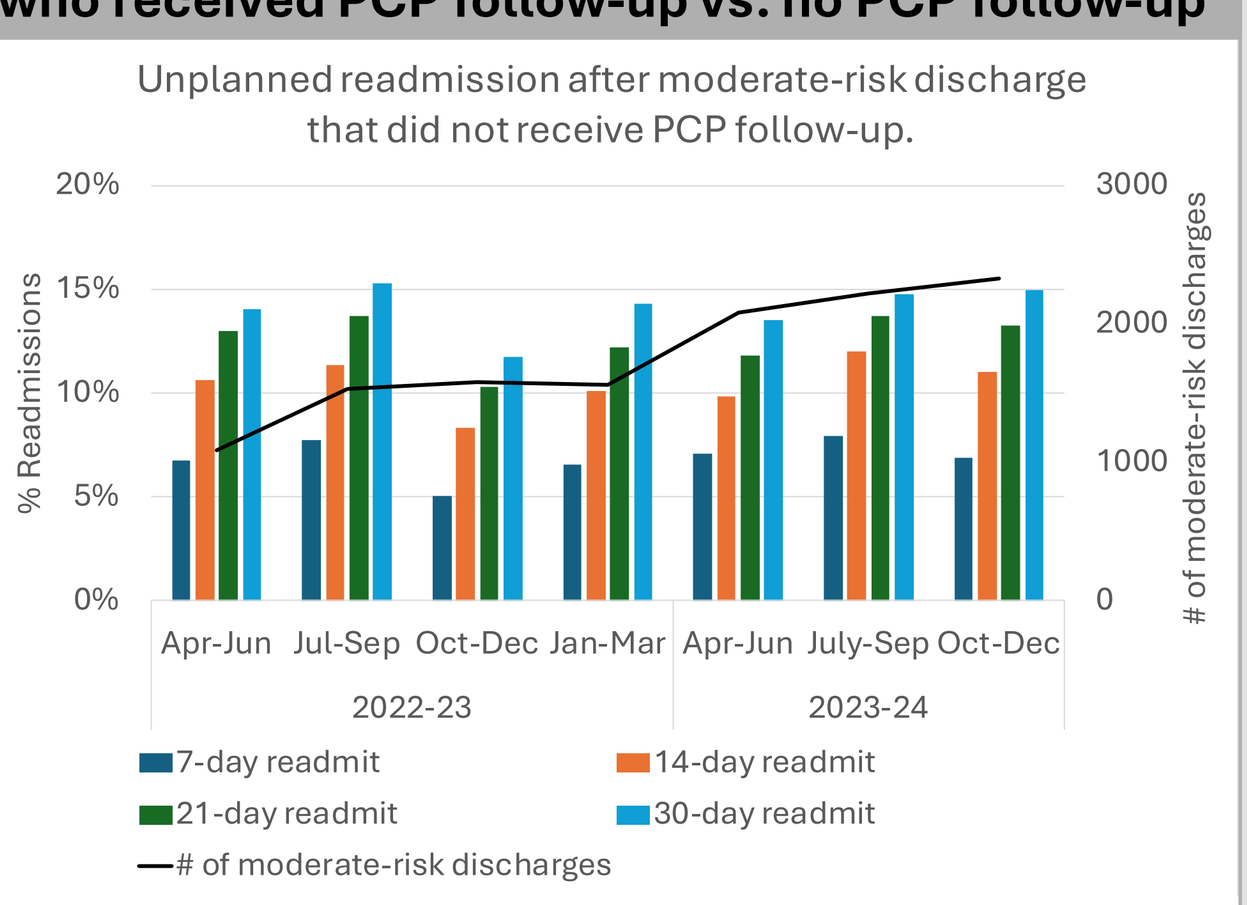




Overall, 16% of high-risk patients who had PCP follow-up within 14 days had an unplanned readmission within 30 days, compared to 28% of those who did not receive such follow-up.

Unplanned readmission for moderate-risk patients who received PCP follow-up vs. no PCP follow-up



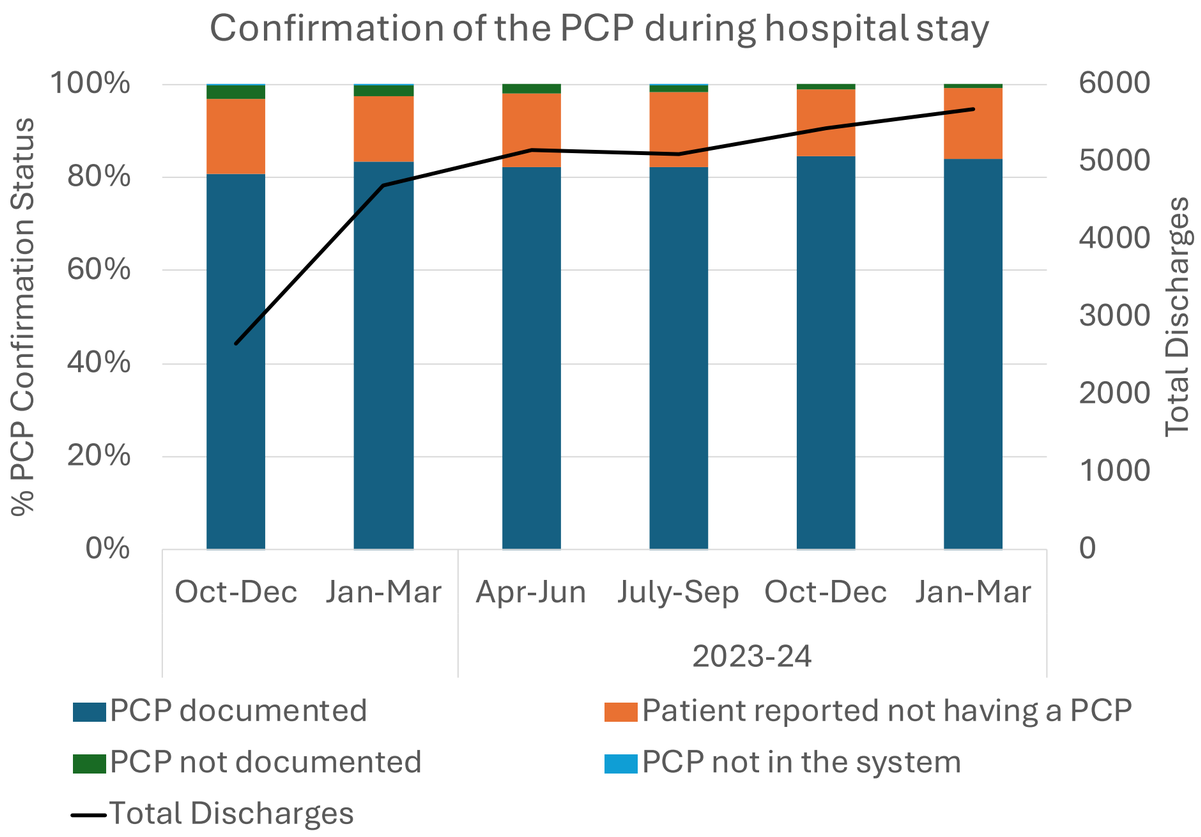


Overall, 10% of moderate-risk patients who had PCP follow-up within 21 days had an unplanned readmission within 30 days, compared to 14% of those who did not receive such follow-up.

HOME TO HOSPITAL TO HOME (H2H2H) TRANSITIONS MEASURES REPORT CENTRAL ZONE

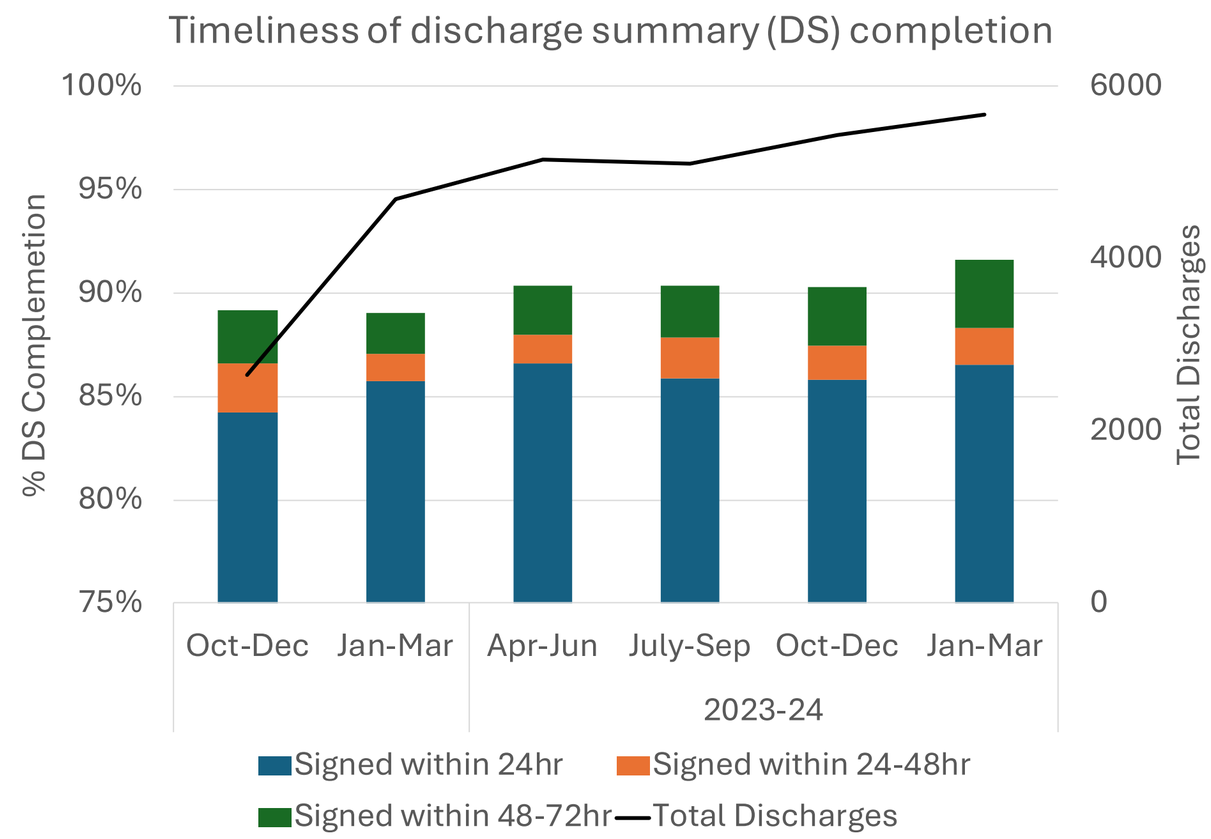
Strategic Measures within Acute Care

Confirmation of the Primary Care Physician (PCP) during hospital stay



In the last two quarters, proportion of patients reporting having a PCP remained stable at 83% compared to previous quarters.

Timeliness of discharge summary (DS) completion



In the last two quarters, the proportion of DS completion within 24 hours remained stable at 86% compared to previous quarters.

LACE Index included in discharge summaries

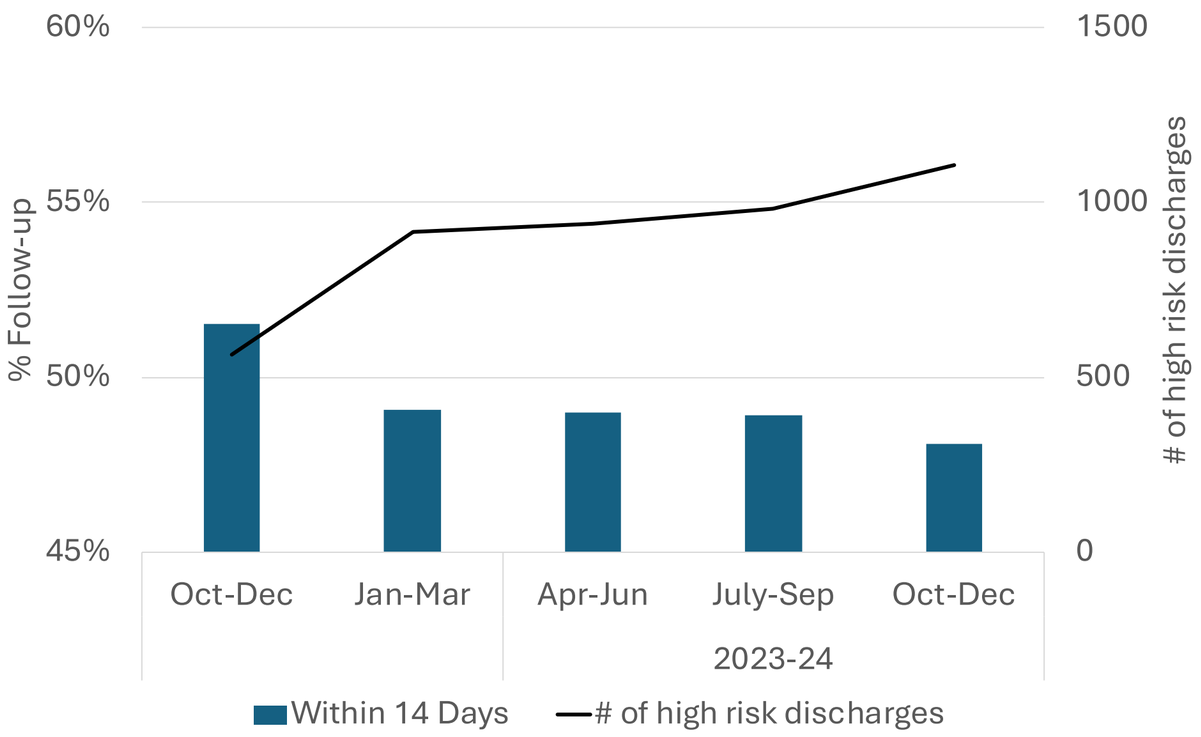
6% of discharge summaries included a LACE Index.

Utilization of provincial standard discharge summaries

5% of discharges used one of the provincial standard discharge summary templates.

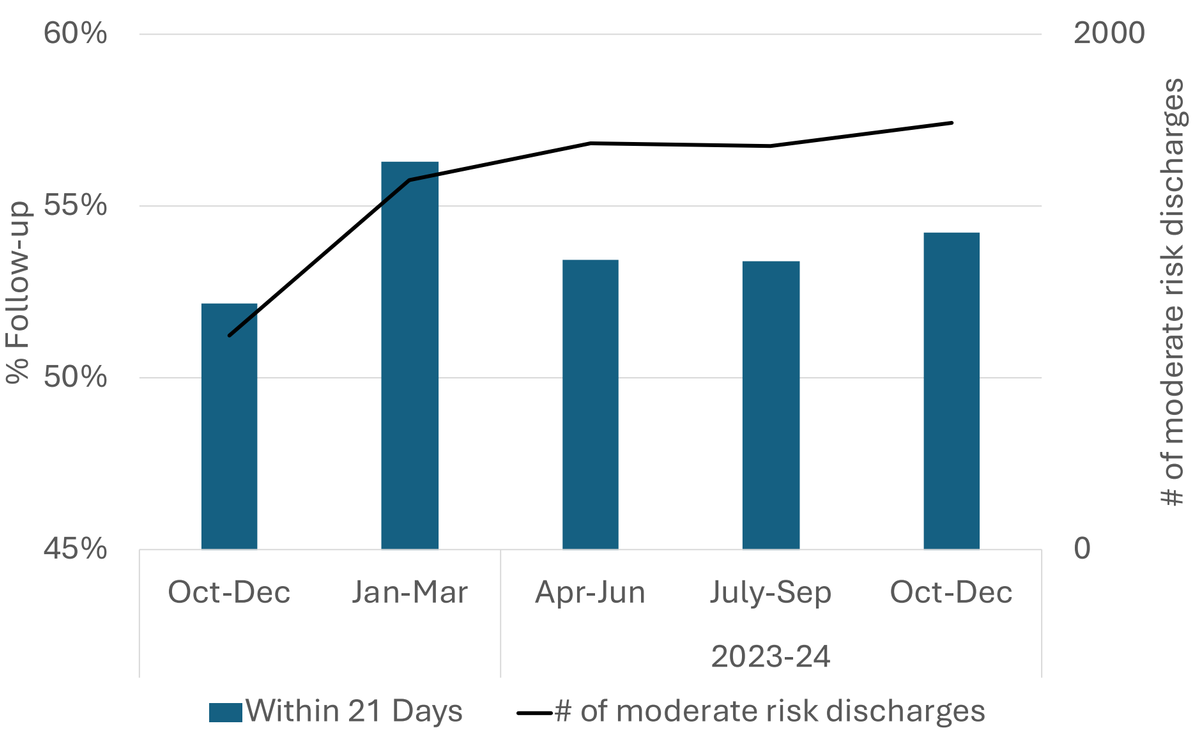
Strategic Measures within Primary Care

Post discharge PCP follow-up within 14-days among high-risk patients



In the last two quarters, the percent of high-risk patients receiving PCP follow-up within 14 decreased by 2%, compared previous quarters.

Post discharge PCP follow-up within 21-days among moderate-risk patients



In the last two quarters, the percent of moderate-risk patients receiving PCP follow-up within 21-days remained stable at 54% compared to previous quarters.

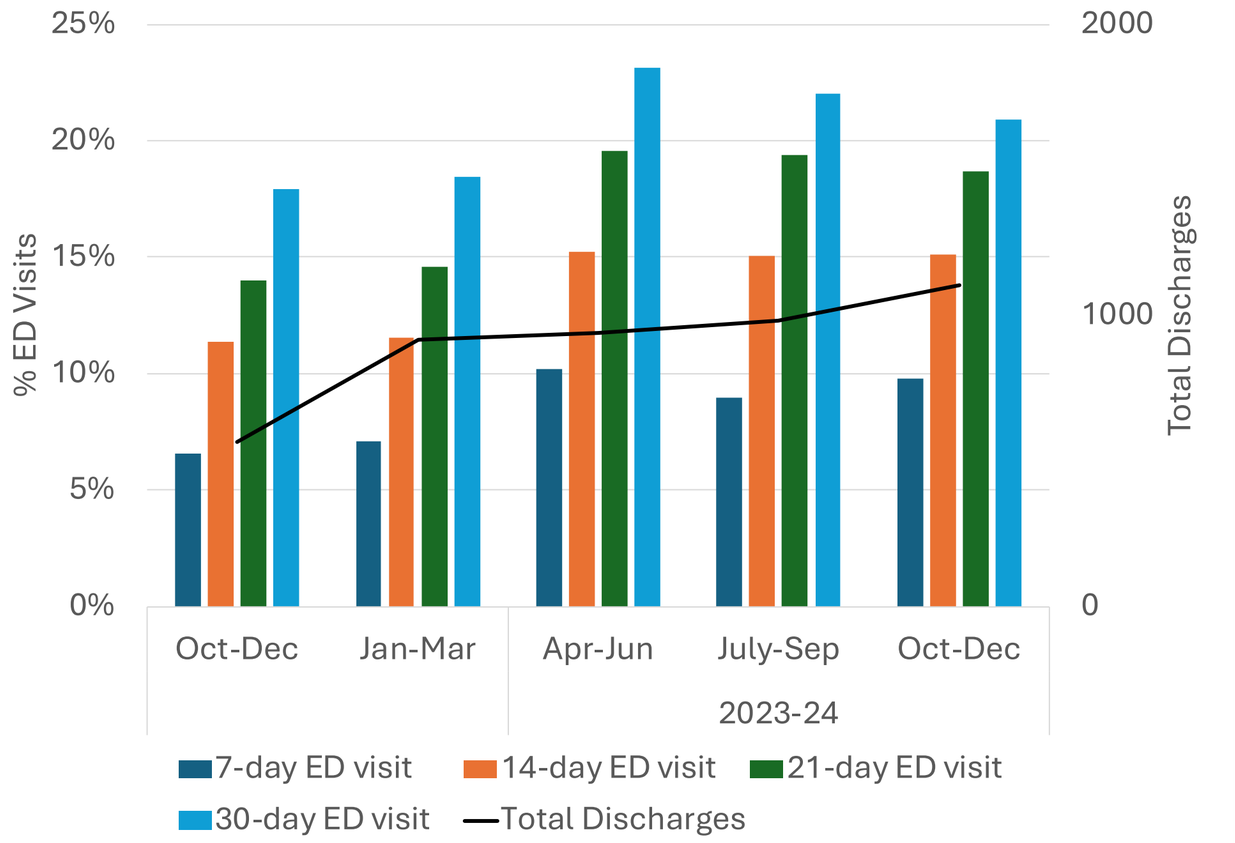
PCP follow-up for patients who reported having PCP compared to those who did not

53% of high-risk patients were followed-up within 14-days.	**PCP Documented**	48% of moderate-risk patients were followed-up within 21-days.
27% of high-risk patients were followed up within 14-days.	**Patient reported no PCP**	30% of moderate-risk patients were followed up within 21-days.

HOME TO HOSPITAL TO HOME (H2H2H) TRANSITIONS MEASURES REPORT
CENTRAL ZONE

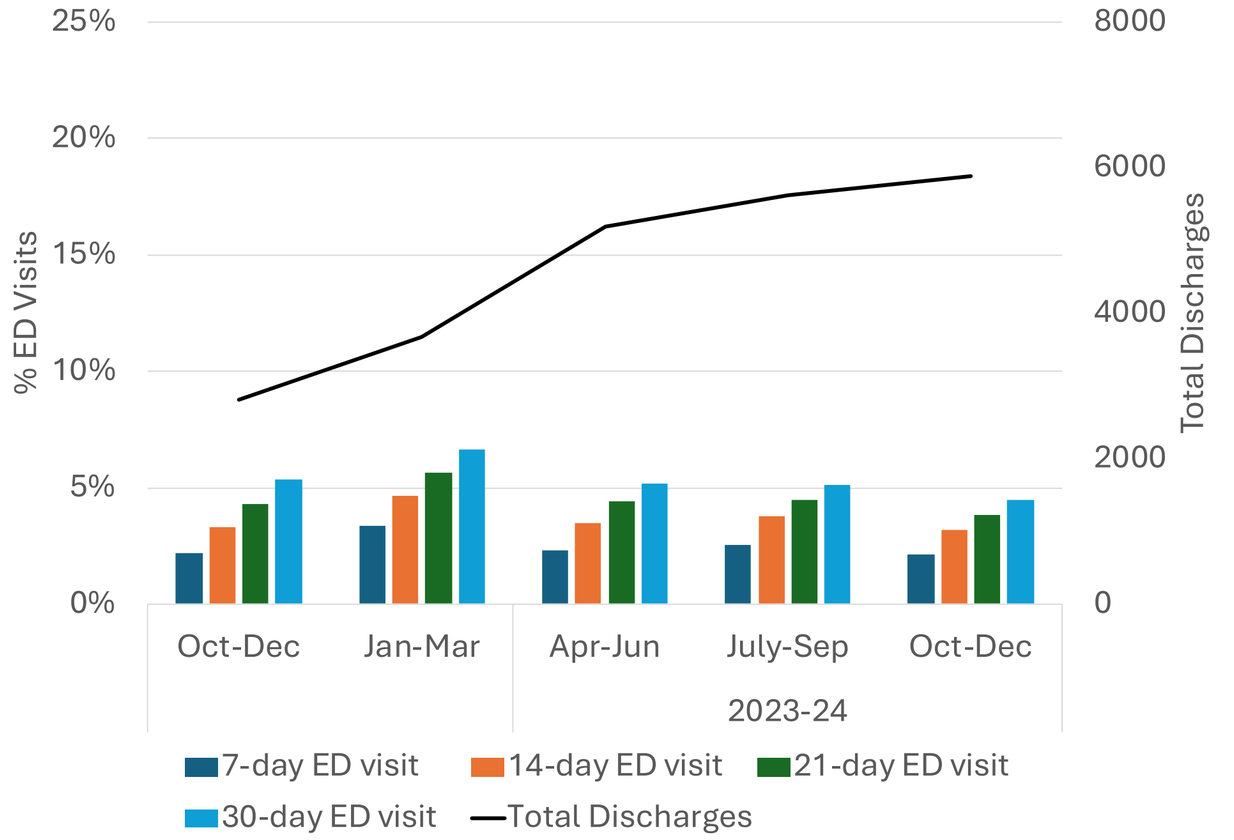
Outcome Measure - Emergency Department (ED) visit post hospital discharge

ED visit among high-risk patients



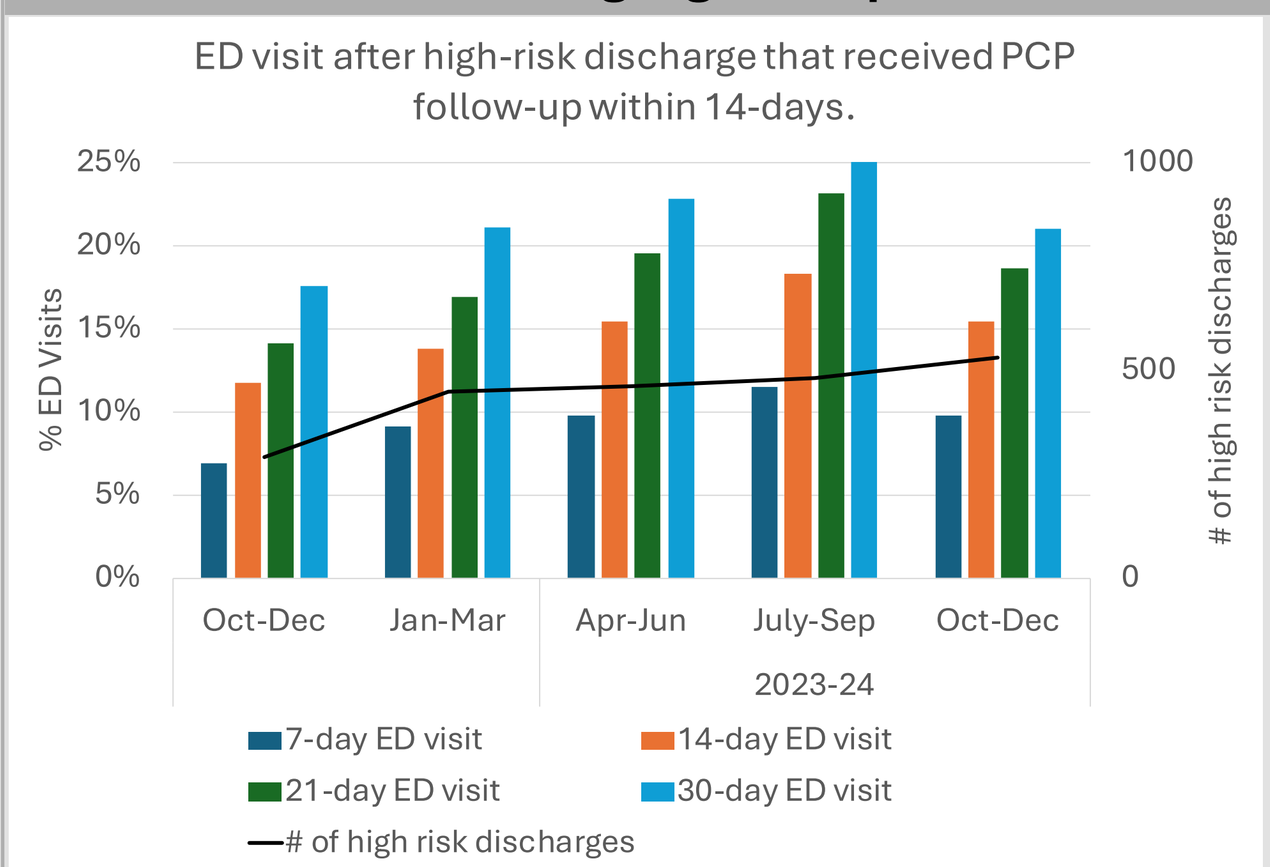
In the last two quarters, the percent of patients experiencing a 30-day ED visit increased by 1% compared to previous quarters.

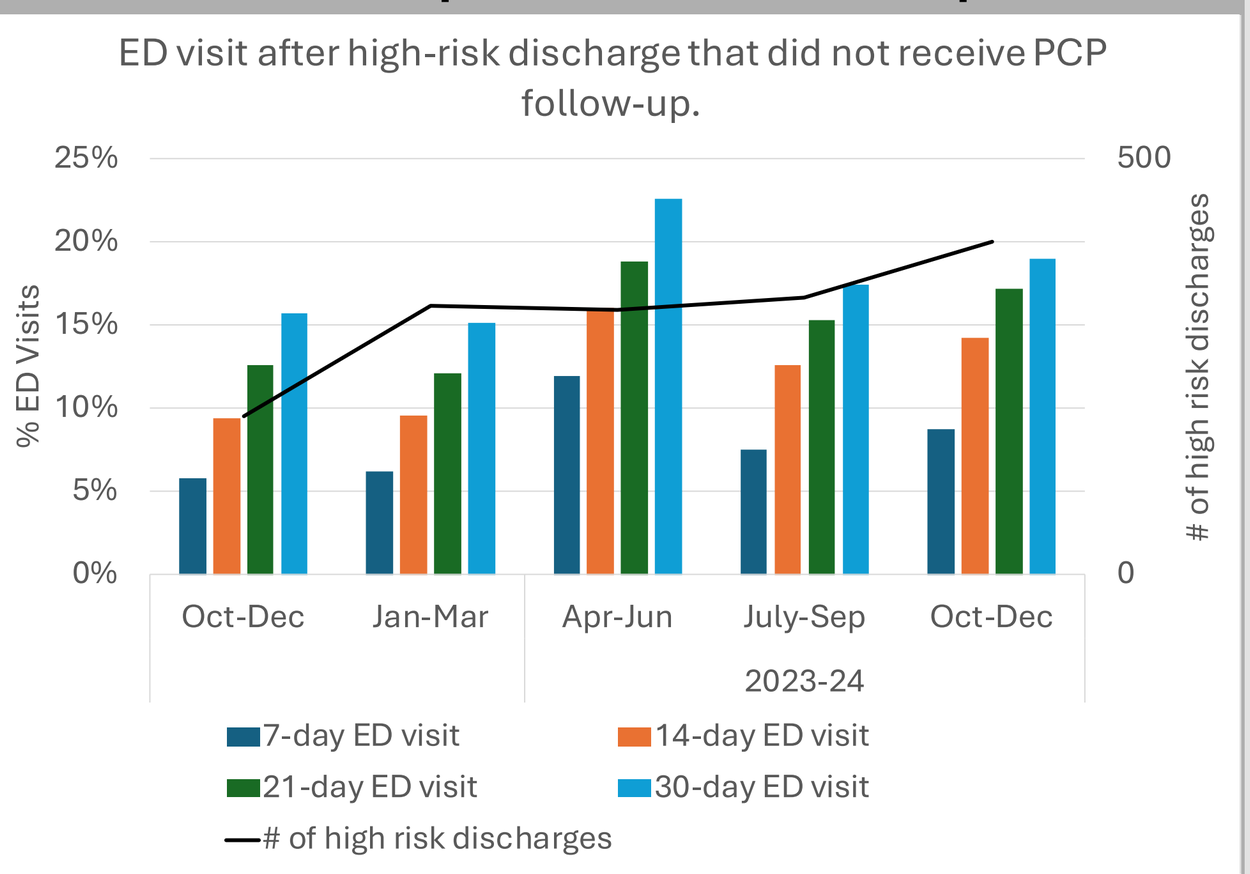
ED visit among moderate-risk patients



In the last two quarters, the percent of patients experiencing a 30-day ED visit decreased by 1% compared to previous quarters.

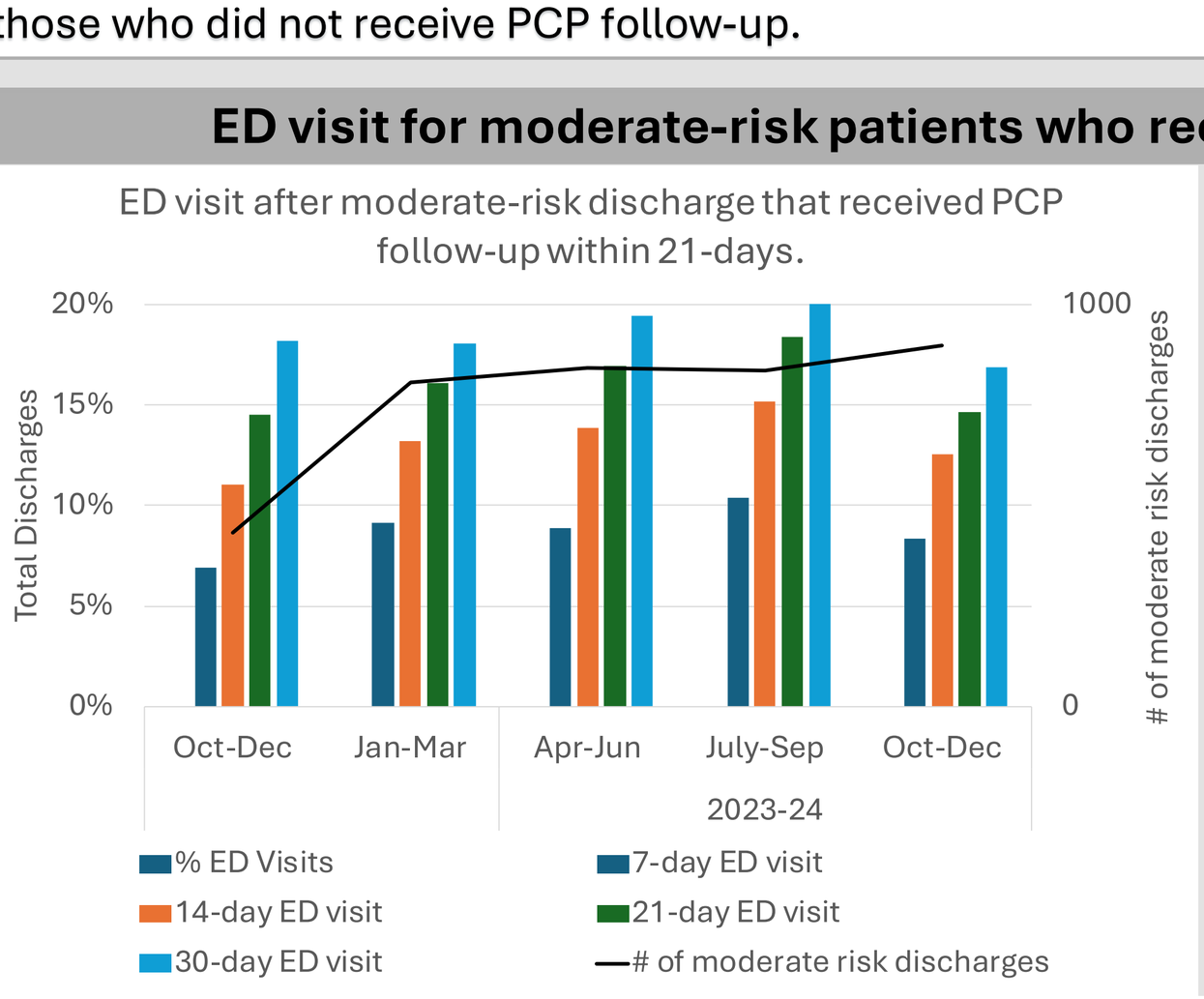
ED visit among high-risk patients who received PCP follow-up vs. no PCP follow-up

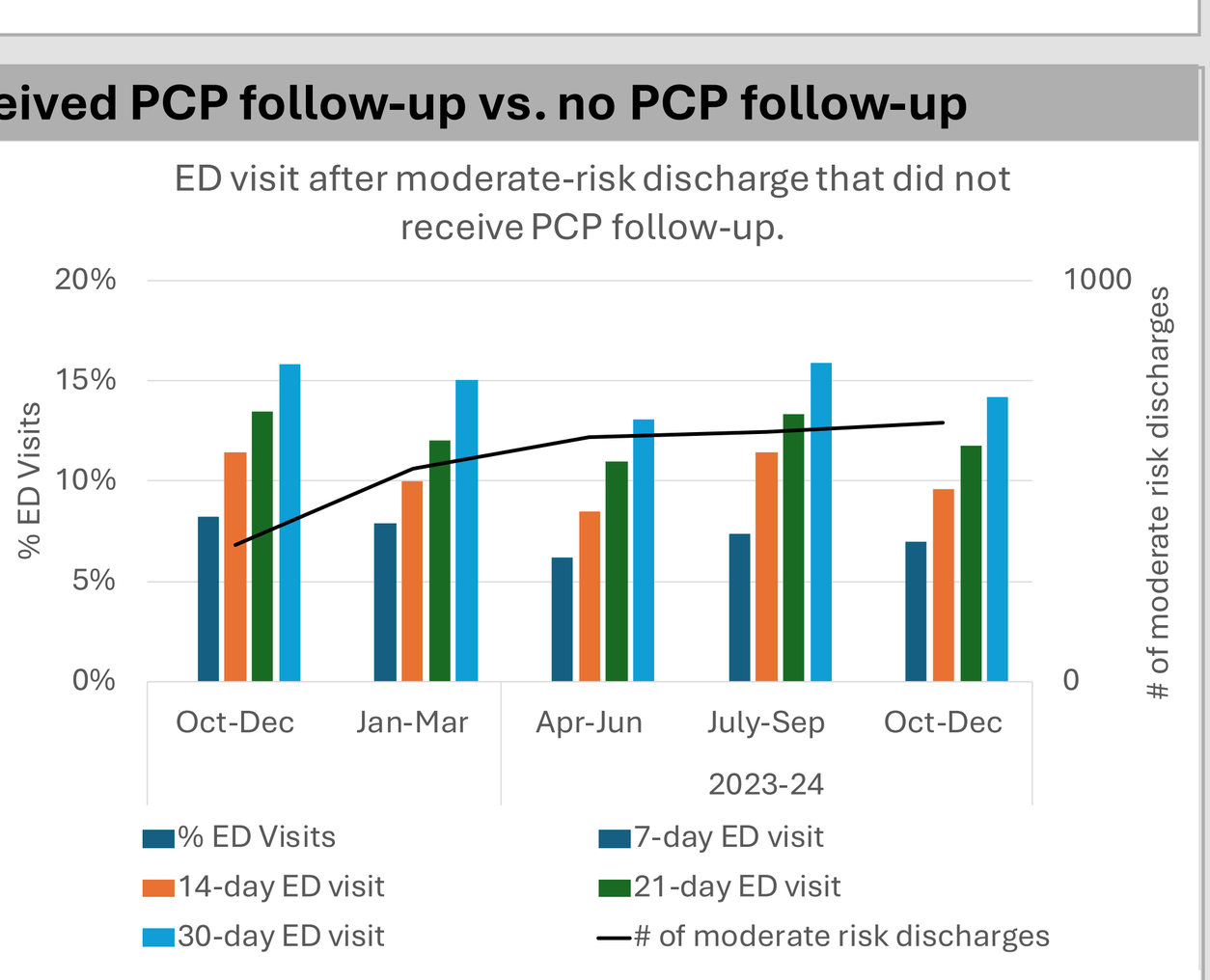




Overall, 22% of high-risk patients who had PCP follow-up within 14 days visited the ED within 30 days, compared to 18% of those who did not receive PCP follow-up.

ED visit for moderate-risk patients who received PCP follow-up vs. no PCP follow-up



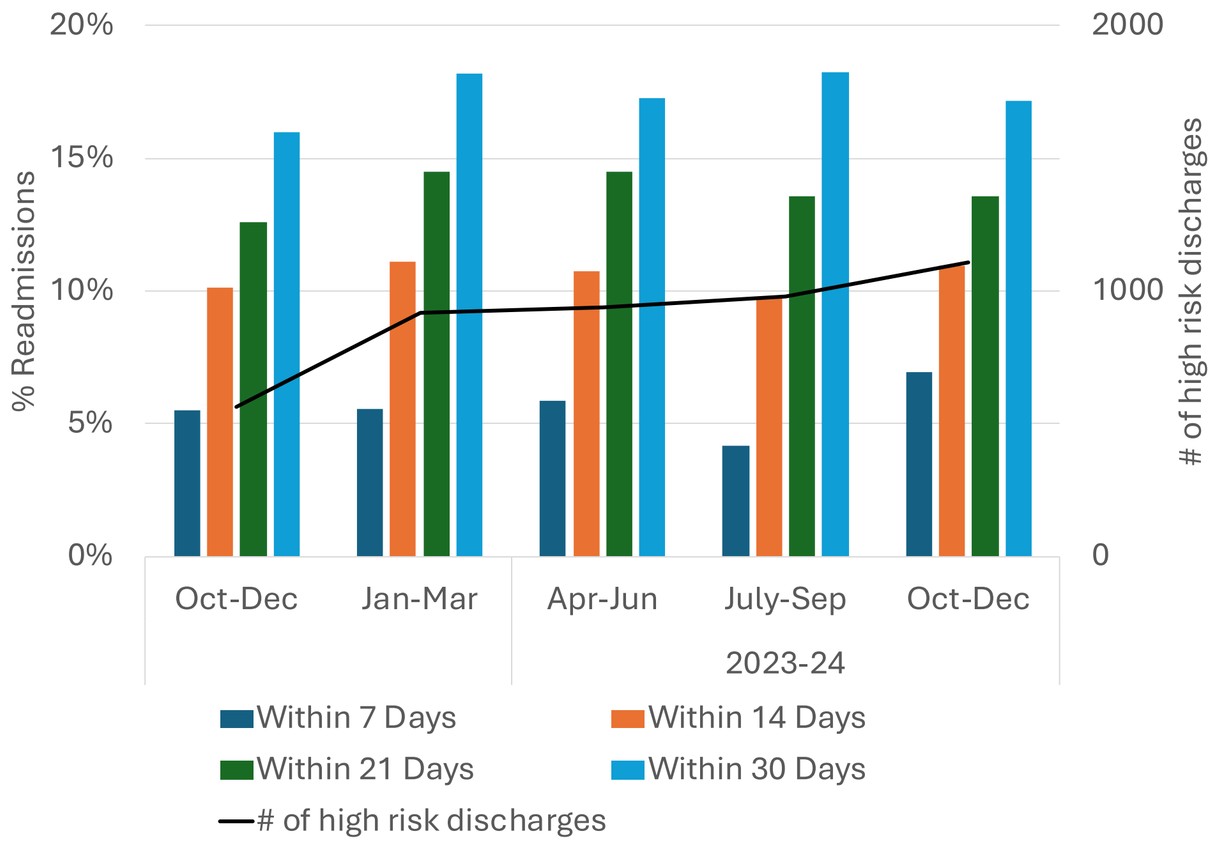


Overall, 19% of moderate-risk patients who had PCP follow-up within 21 days visited the ED within 30 days, compared to 15% of those who did not receive such follow-up.

HOME TO HOSPITAL TO HOME (H2H2H) TRANSITIONS MEASURES REPORT
CENTRAL ZONE

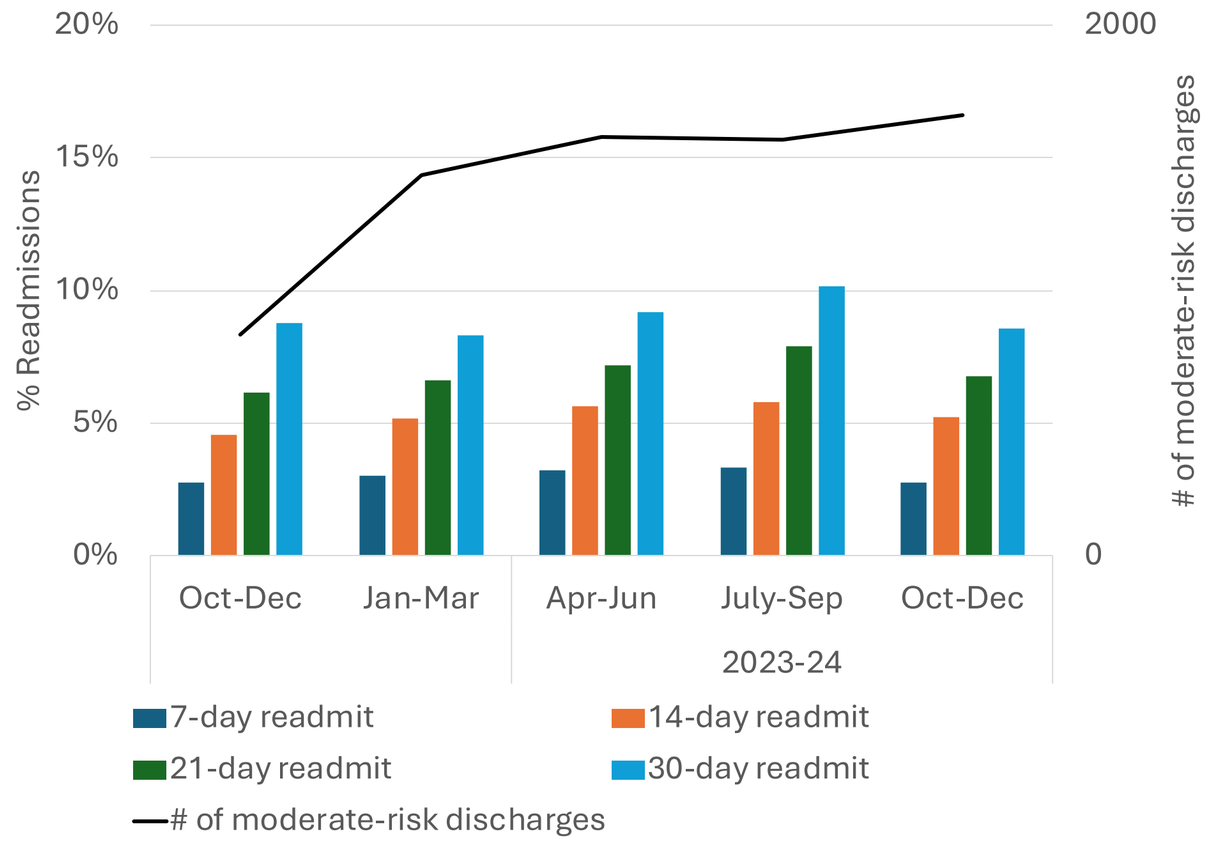
Outcome Measure – Unplanned readmission post hospital discharge

Unplanned readmission among high-risk patients



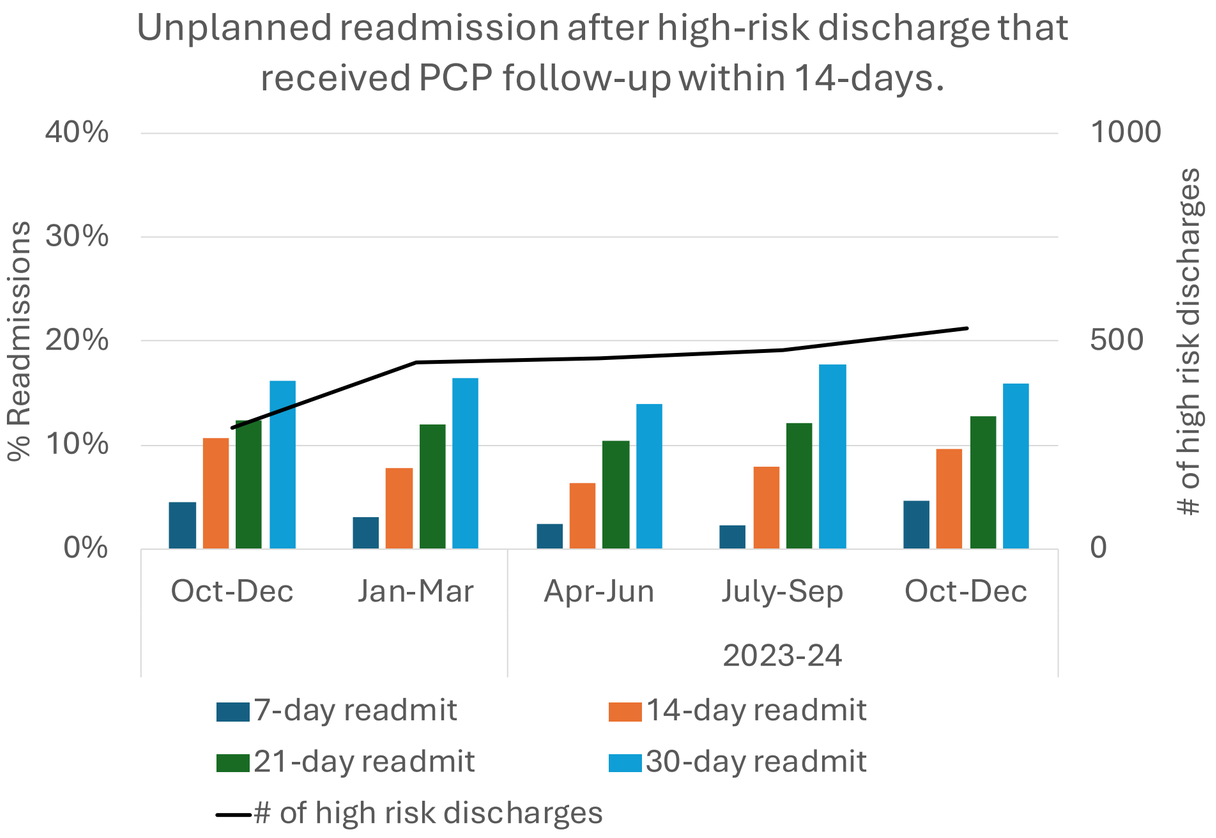
In the last two quarters, the percent of patients experiencing a 30-day readmission increased by 1% compared to previous quarters.

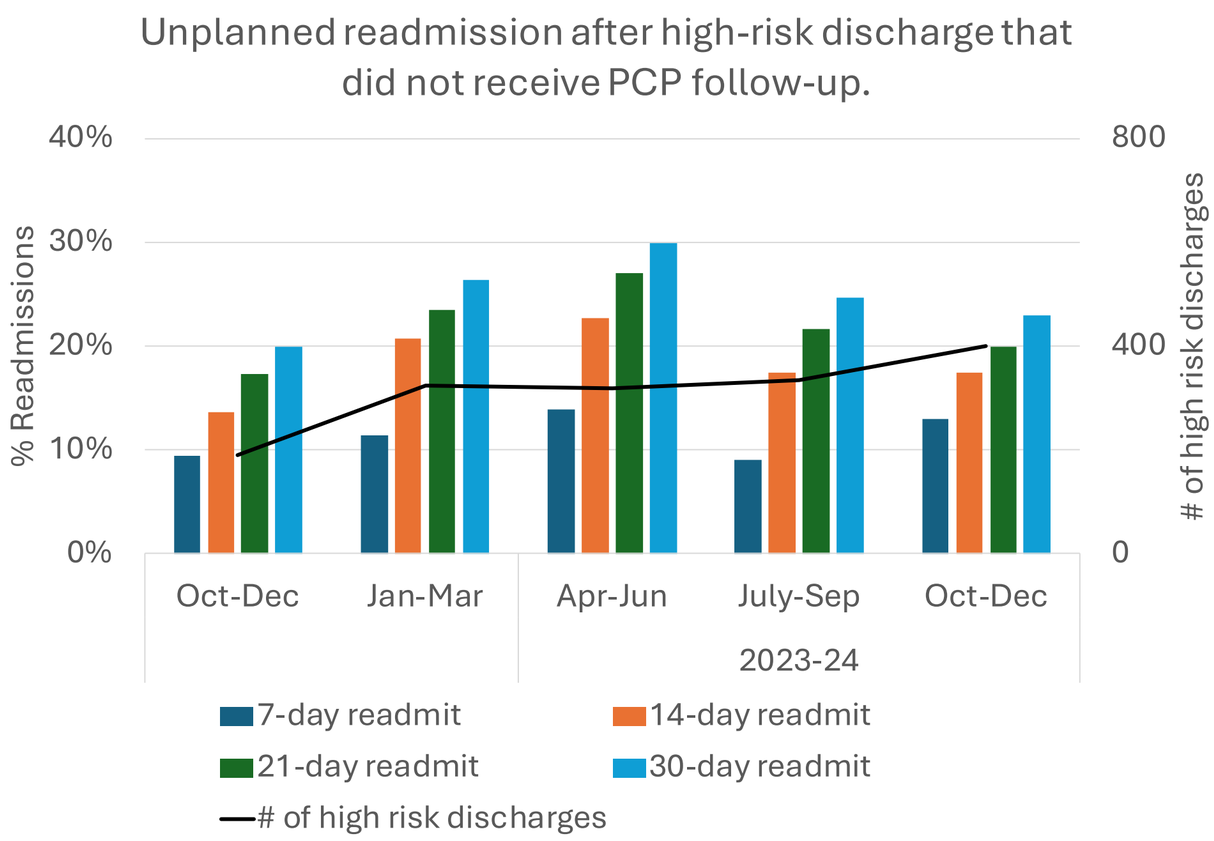
Unplanned readmission among mod-risk patients



In the last two quarters, the percent of patients experiencing a 30-day readmission remained stable at 9%, compared to previous quarters.

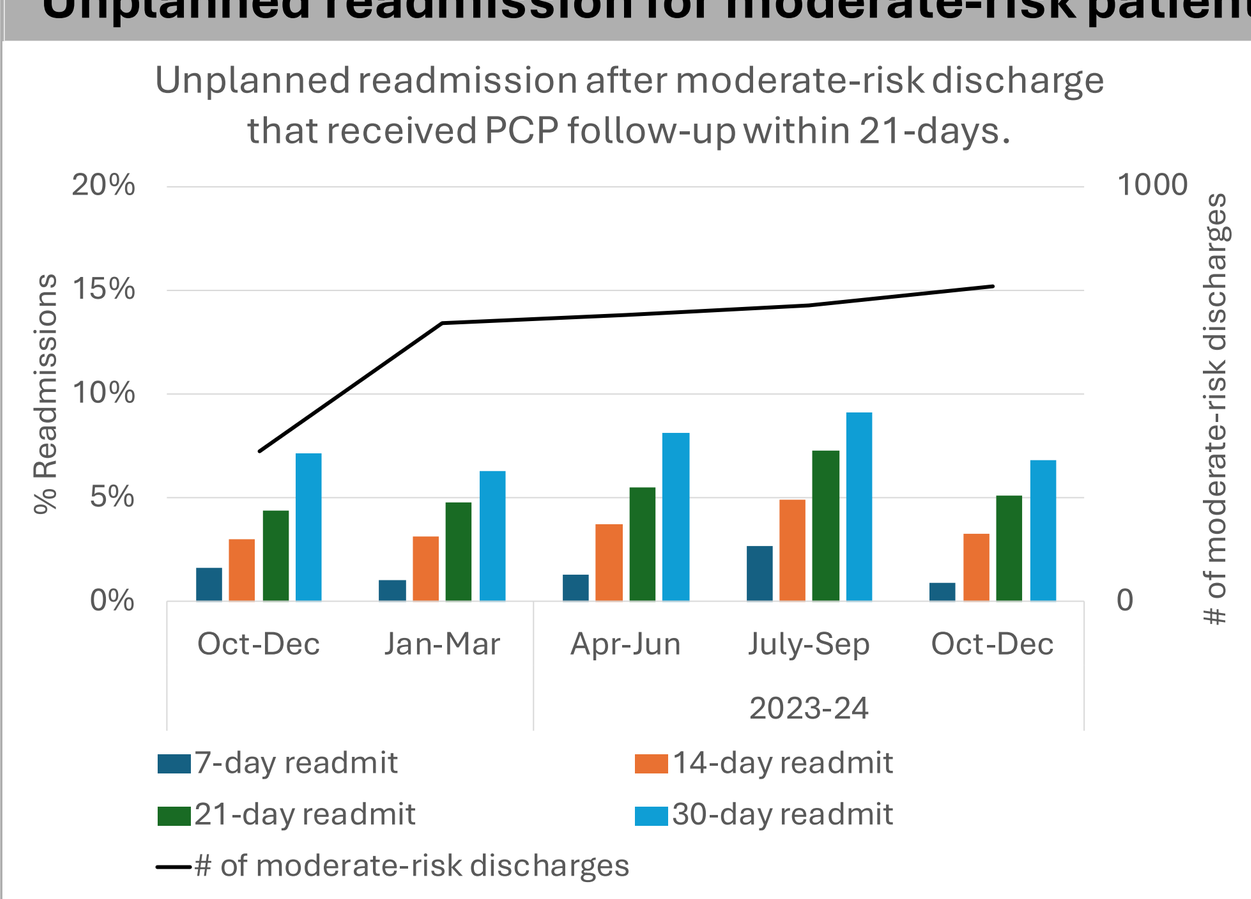
Unplanned readmission among high-risk patients who received PCP follow-up vs. no PCP follow-up

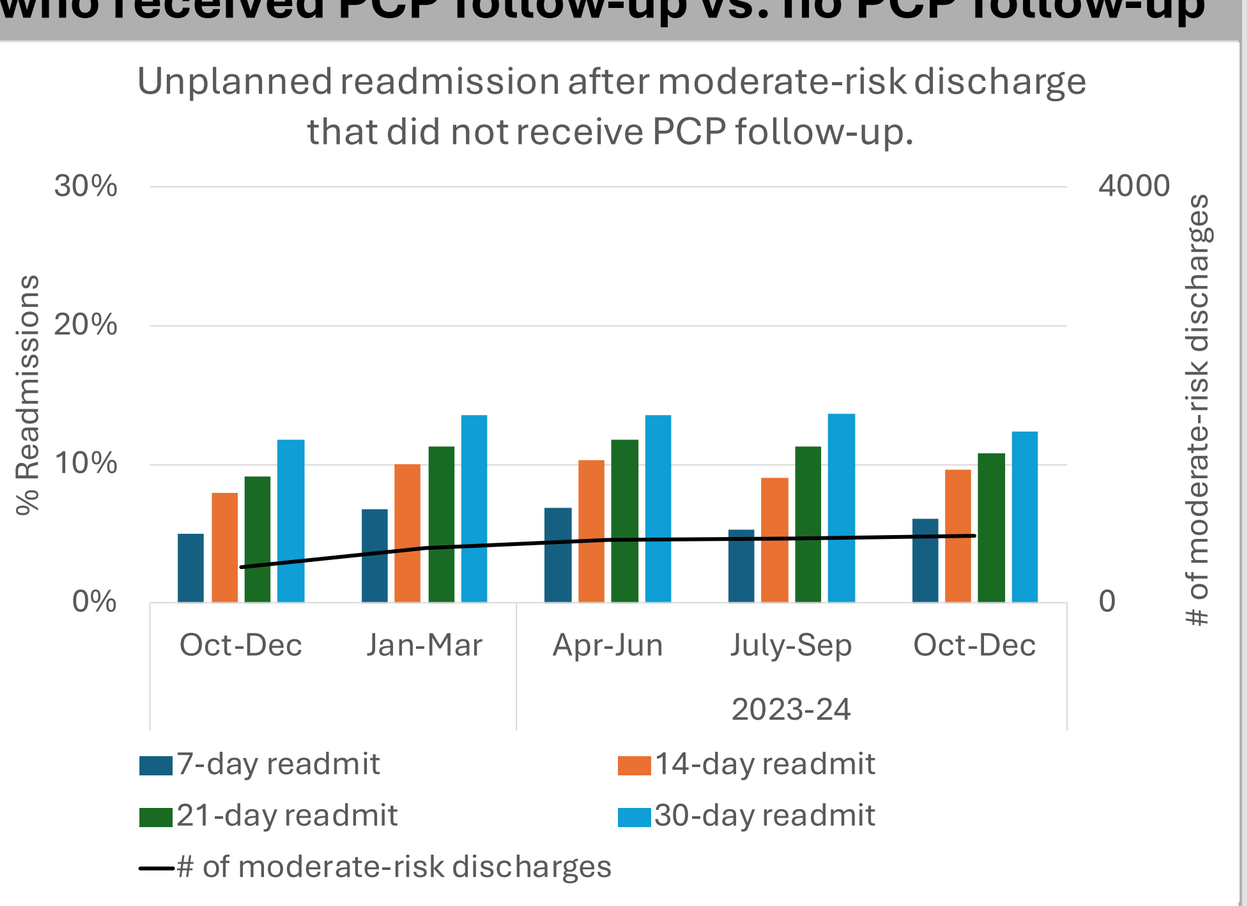




Overall, 16% of high-risk patients who had PCP follow-up within 14 days had an unplanned readmission within 30 days, compared to 25% of those who did not receive such follow-up.

Unplanned readmission for moderate-risk patients who received PCP follow-up vs. no PCP follow-up



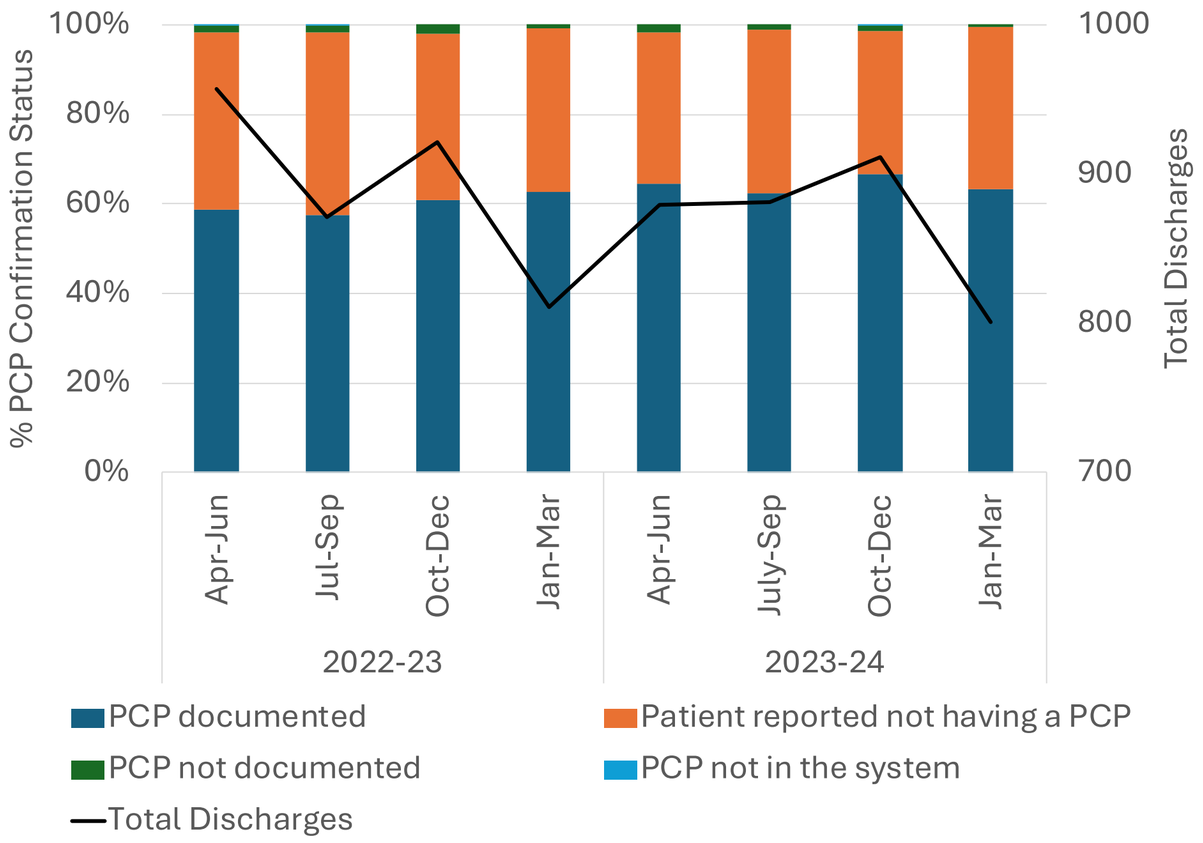


Overall, 8% of moderate-risk patients who had PCP follow-up within 21 days had an unplanned readmission within 30 days, compared to 13% of those who did not receive such follow-up.

HOME TO HOSPITAL TO HOME (H2H2H) TRANSITIONS MEASURES REPORT NORTH ZONE

Strategic Measures within Acute Care

Confirmation of the Primary Care Physician (PCP) during hospital stay



In the last two quarters, the proportion of patients reporting having a PCP remained stable at 62% compared to previous quarters.

Timeliness of discharge summary (DS) completion

In the last two quarters, the proportion of DS completion within 24 hours increased by 2% compared to previous quarters.

LACE Index included in discharge summaries

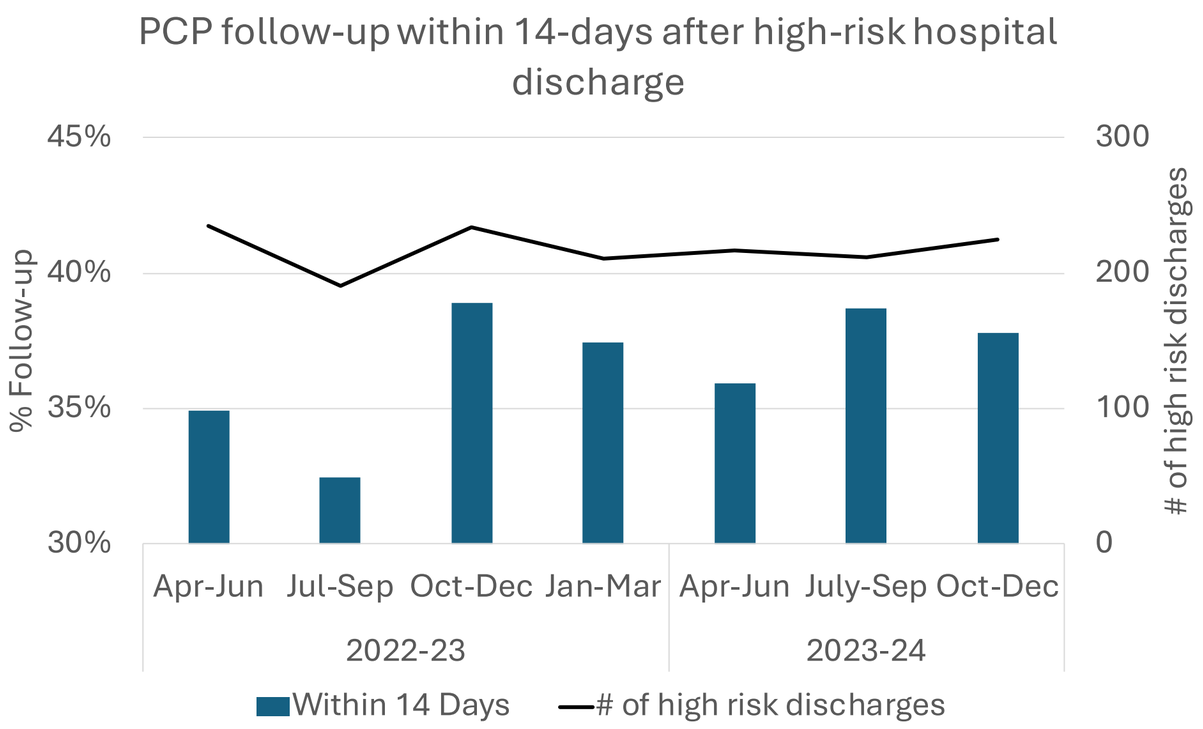
5% of discharge summaries included a LACE Index.

Utilization of provincial standard discharge summaries

5% of discharges used one of the provincial standard discharge summary templates.

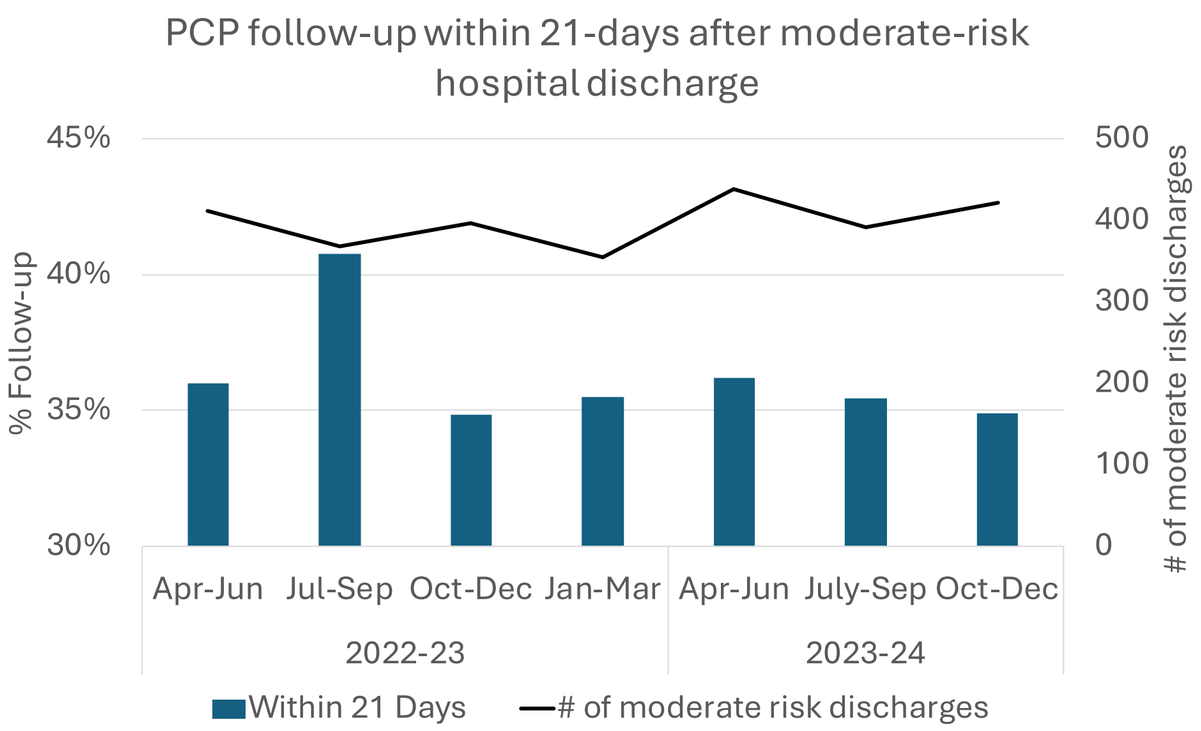
Strategic Measures within Primary Care

Post discharge PCP follow-up within 14-days among high-risk patients



In the last two quarters, the percent of high-risk patients receiving PCP follow-up within 14 increased by 2%, compared previous quarters.

Post discharge PCP follow-up within 21-days among moderate-risk patients



In the last two quarters, the percent of moderate-risk patients receiving PCP follow-up within 21-days decreased by 2%, compared previous quarters.

PCP follow-up for patients who reported having PCP compared to those who did not

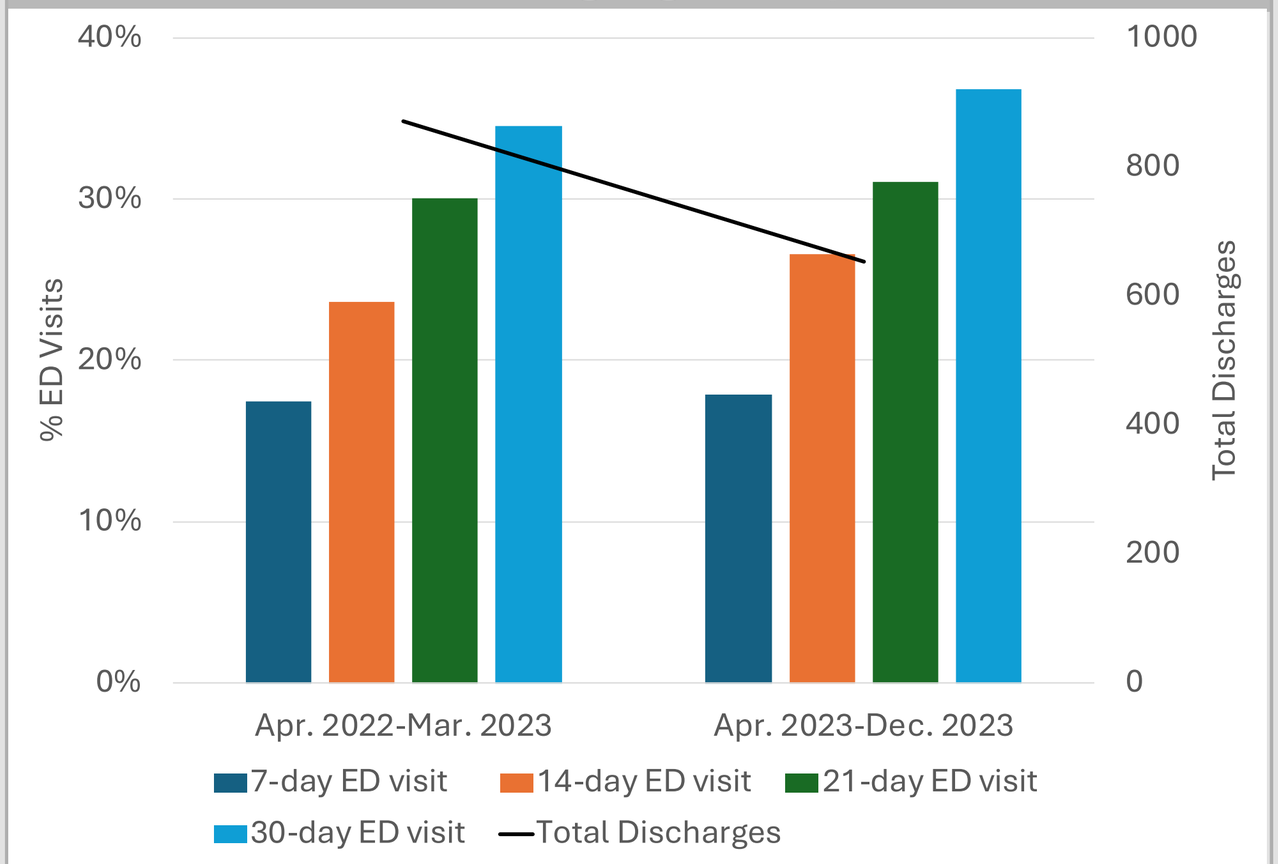
40% of high-risk patients were followed-up within 14-days.	**PCP documented**	43% of moderate-risk patients were followed-up within 21-days.
27% of high-risk patients were followed up within 14-days.	**Patient reported no PCP**	27% of moderate-risk patients were followed up within 21-days.

HOME TO HOSPITAL TO HOME (H2H2H) TRANSITIONS MEASURES REPORT NORTH ZONE

Data presented at fiscal year level due to the small number of discharges

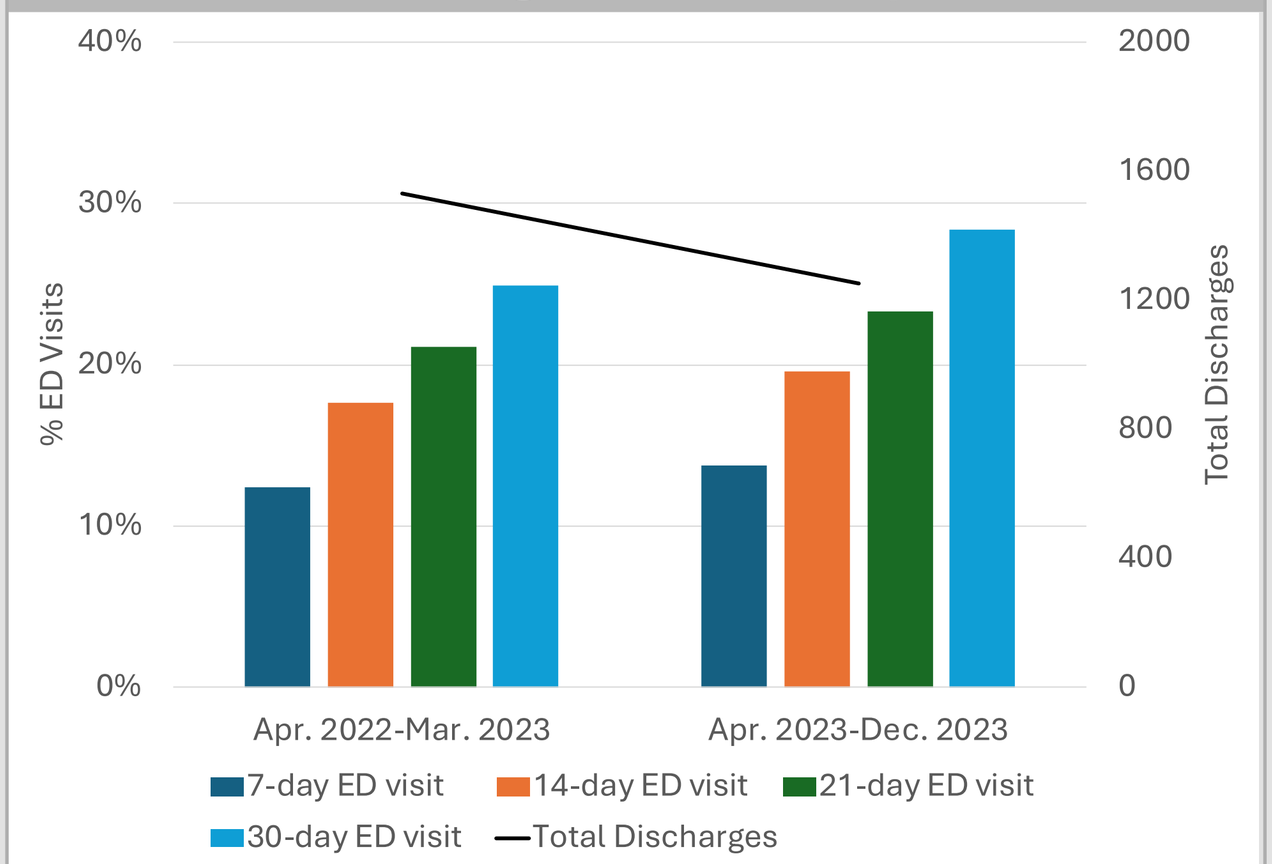
Outcome Measure - Emergency Department (ED) visit post hospital discharge

ED visit among high-risk patients



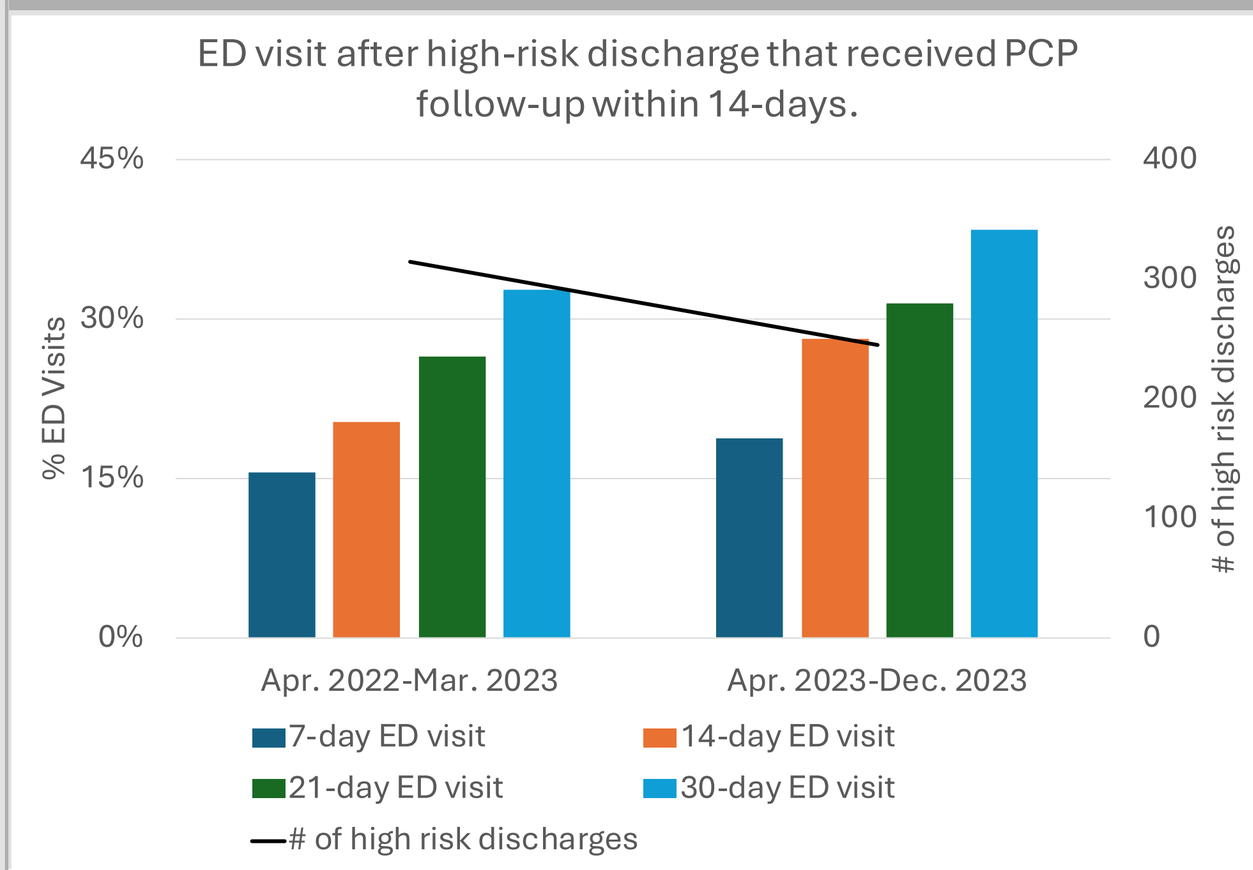
The percent of patients experiencing a 30-day ED visit increased by 2% in 2023/24 compared to the previous fiscal year.

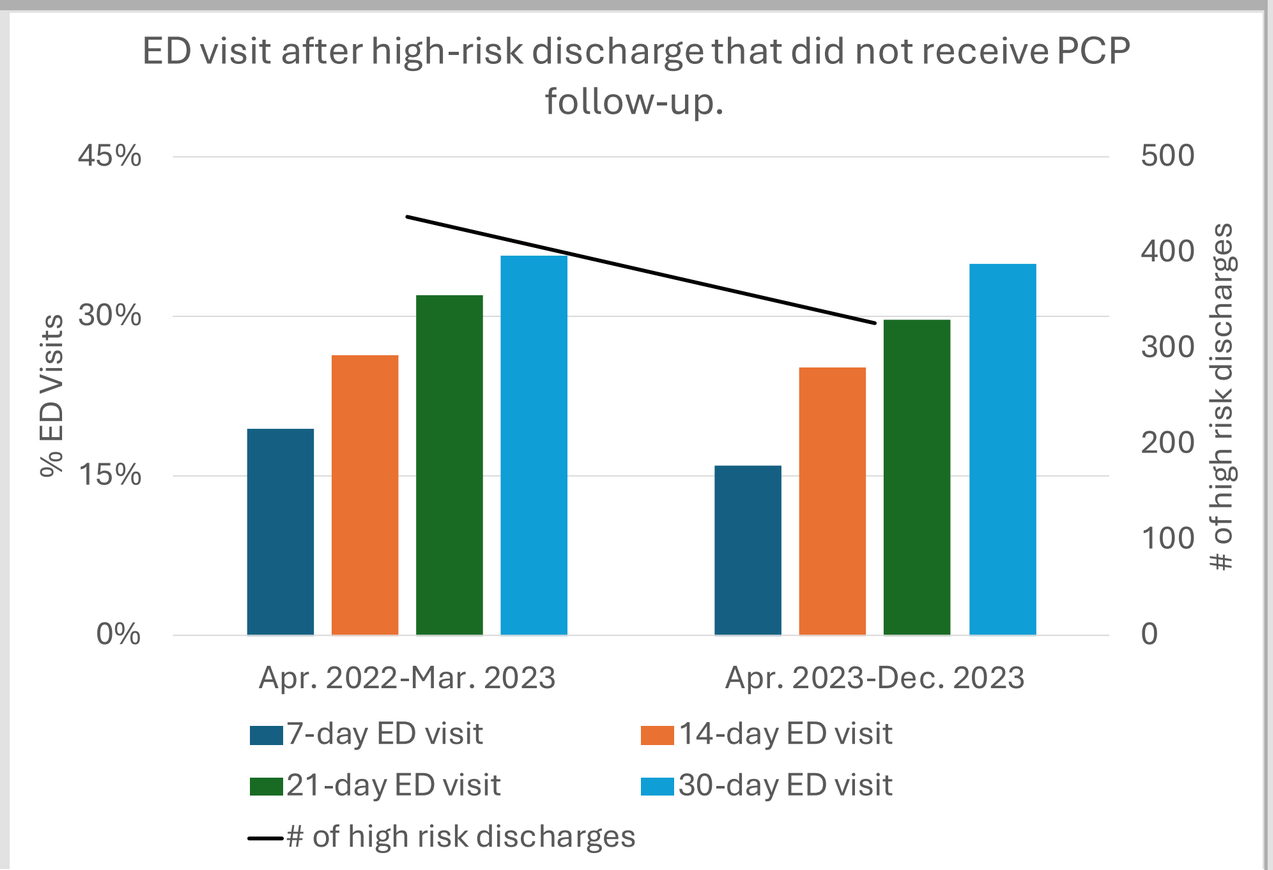
ED visit among moderate-risk patients



The percent of patients experiencing a 30-day ED visit increased by 3% in 2023/24 compared to the previous fiscal year.

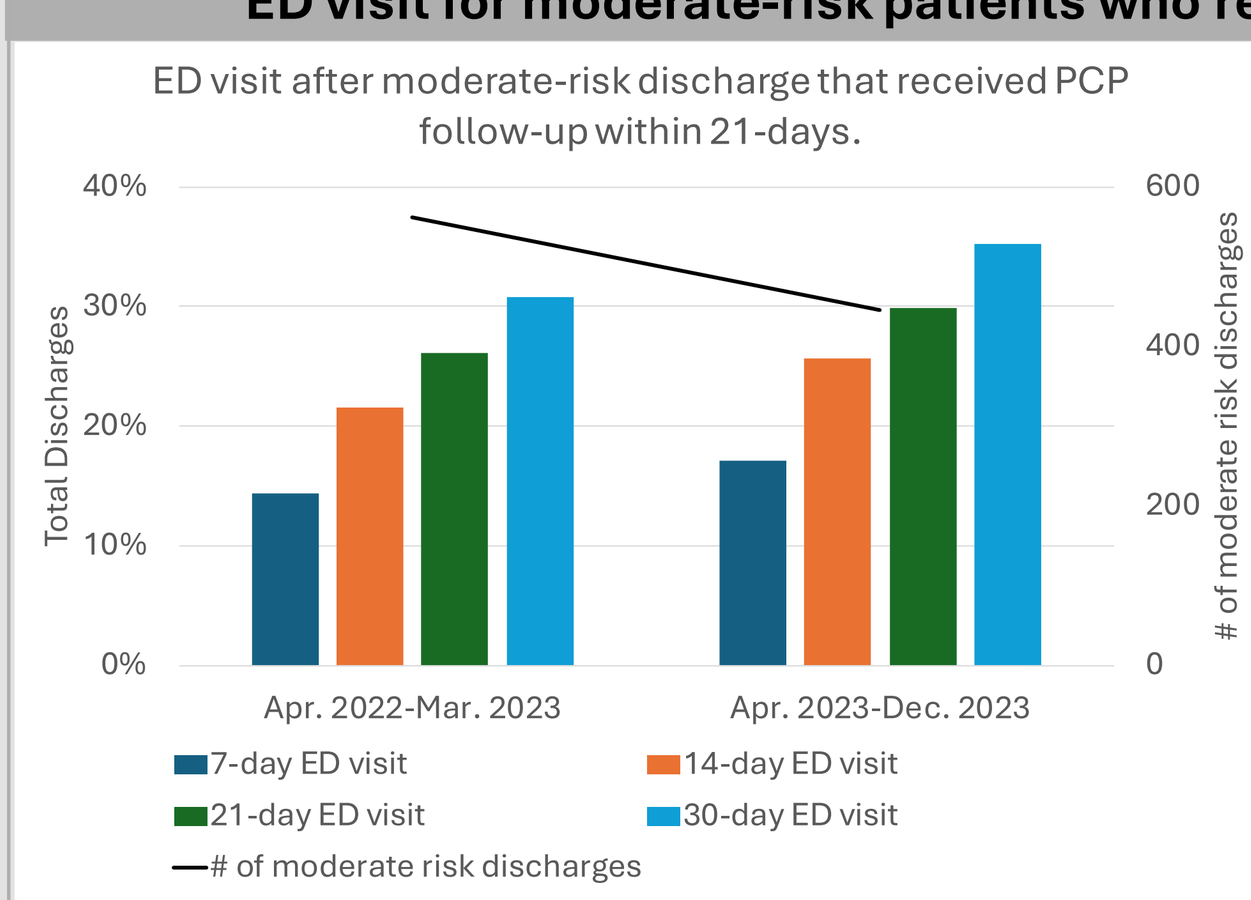
ED visit among high-risk patients who received PCP follow-up vs. no PCP follow-up

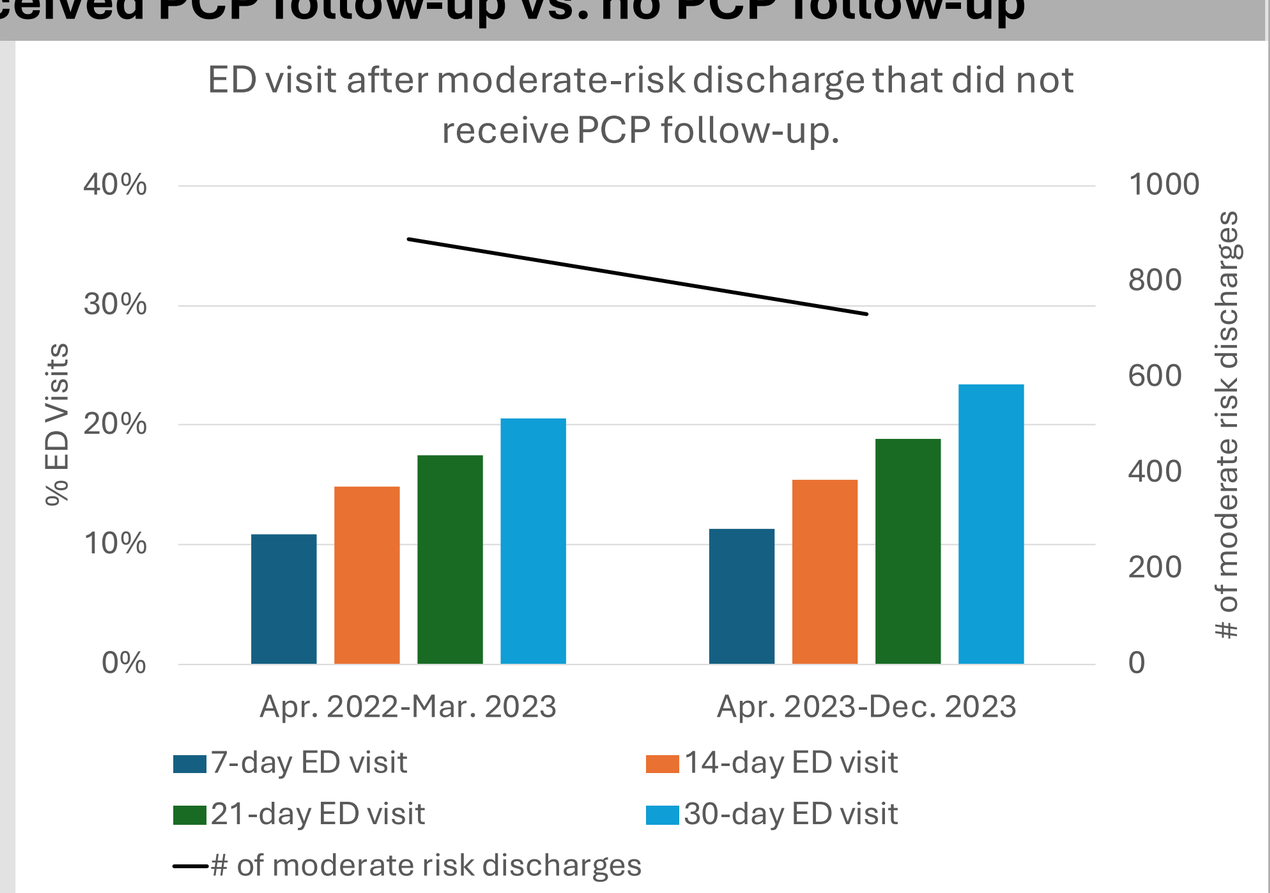




Overall, 35% of high-risk patients visited the ED within 30 days regardless if they had a PCP follow-up within 14-days or not.

ED visit for moderate-risk patients who received PCP follow-up vs. no PCP follow-up





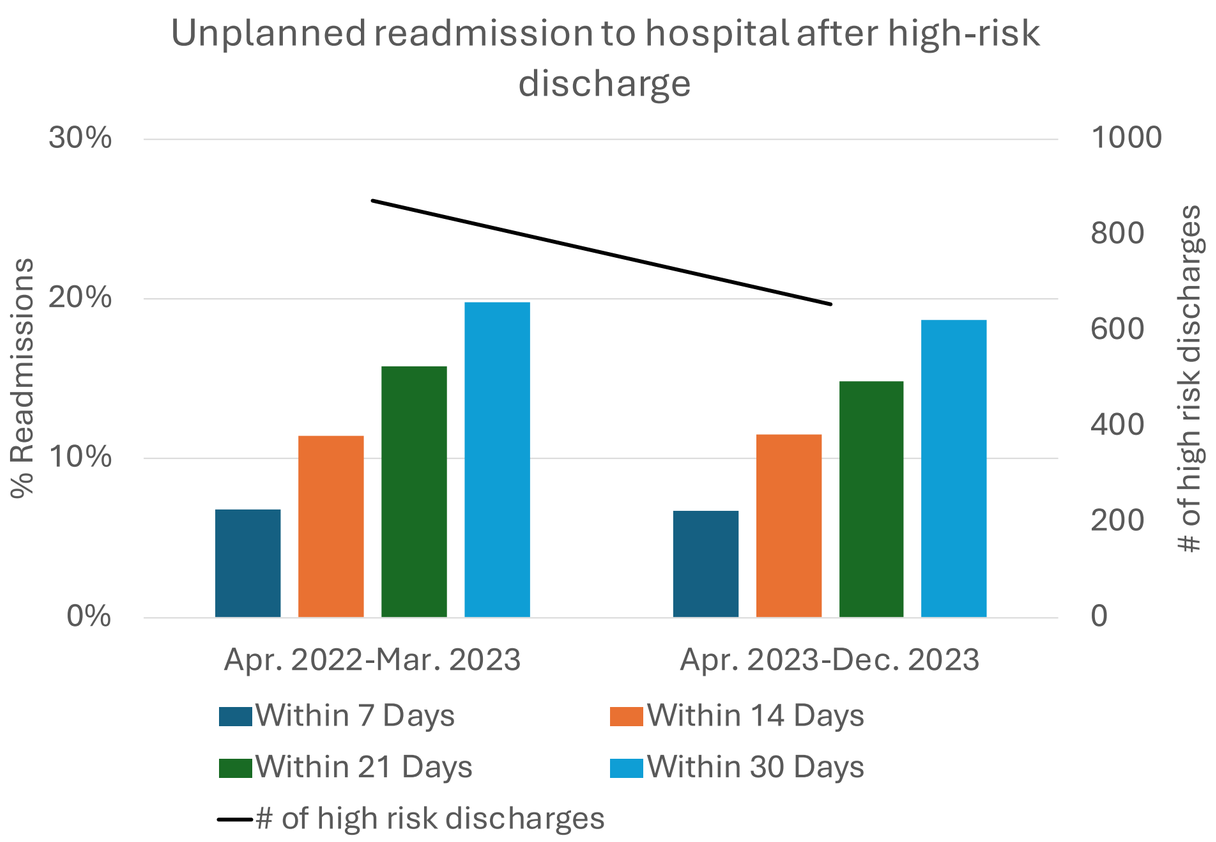
Overall, 33% of moderate-risk patients who had PCP follow-up within 21 days visited the ED within 30 days, compared to 22% of those who did not receive such follow-up.

HOME TO HOSPITAL TO HOME (H2H2H) TRANSITIONS MEASURES REPORT NORTH ZONE

Data presented at fiscal year level due to the small number of discharges

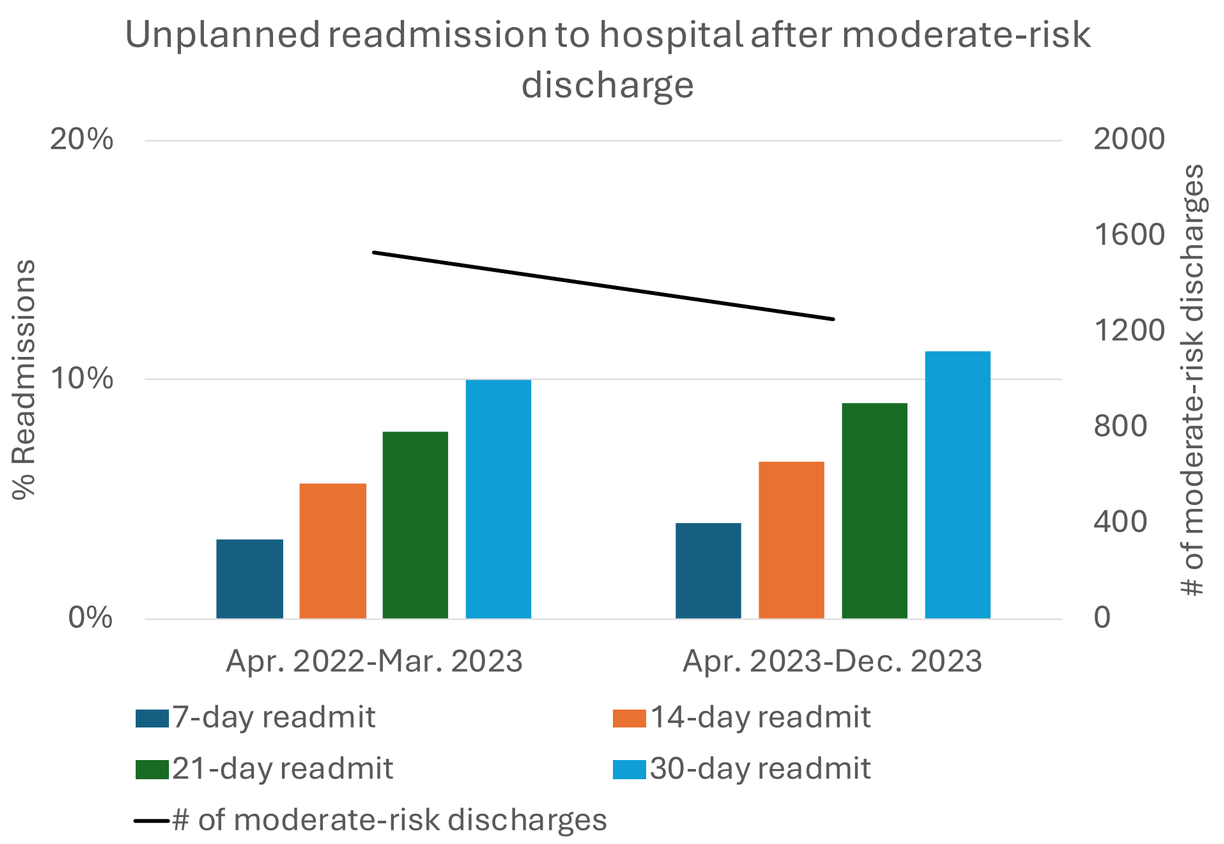
Outcome Measure – Unplanned readmission post hospital discharge

Unplanned readmission among high-risk patients



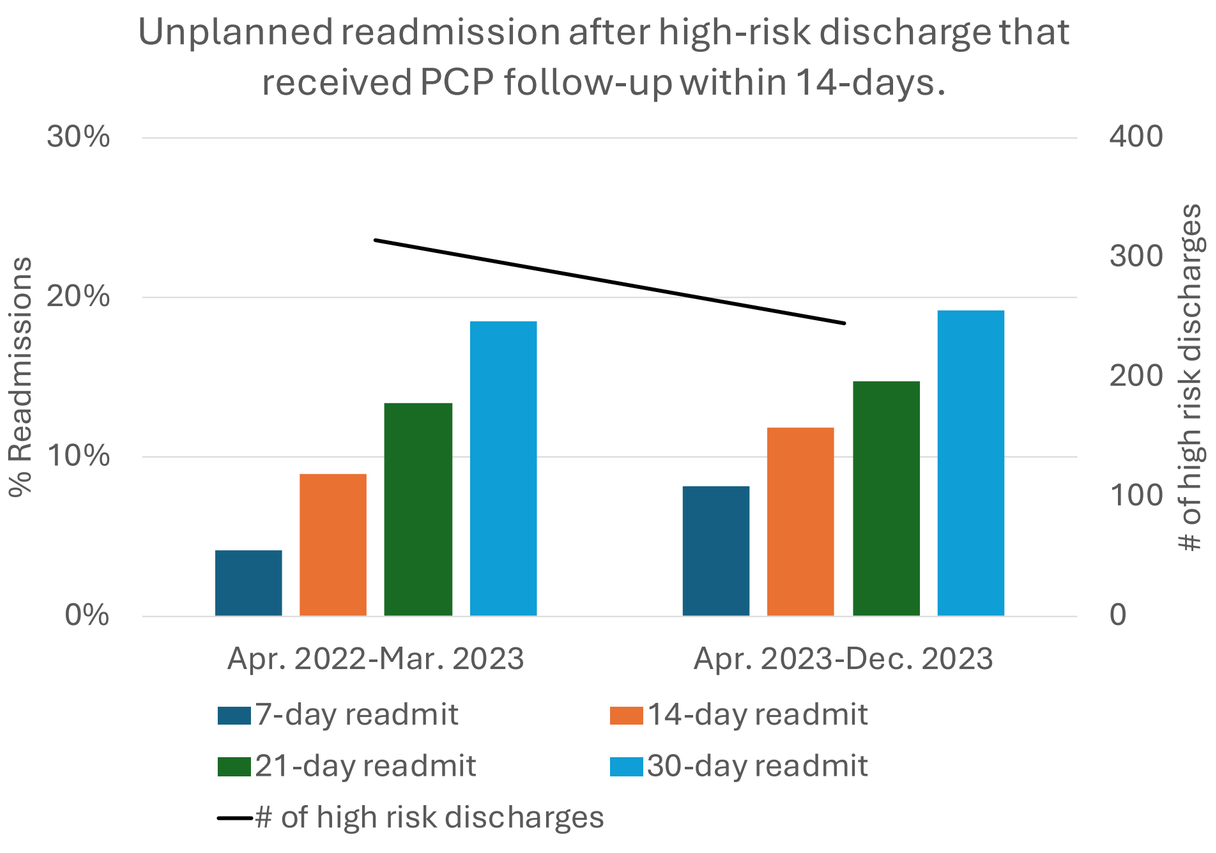
The percent of patients experiencing a 30-day readmission decreased by 1% in 2023/24 compared to the previous fiscal year.

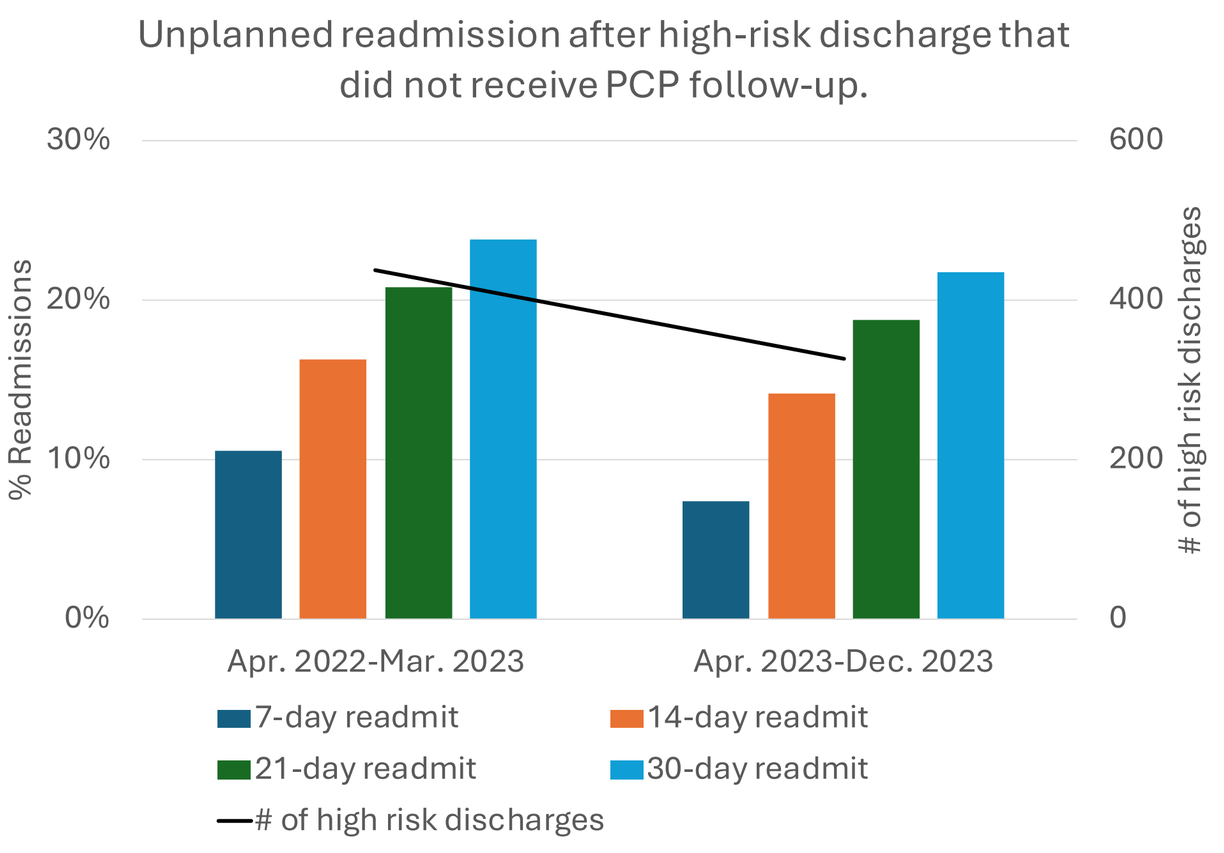
Unplanned readmission among mod-risk patients



The percent of patients experiencing a 30-day readmission increased by 1% in 2023/24 compared to the previous fiscal year.

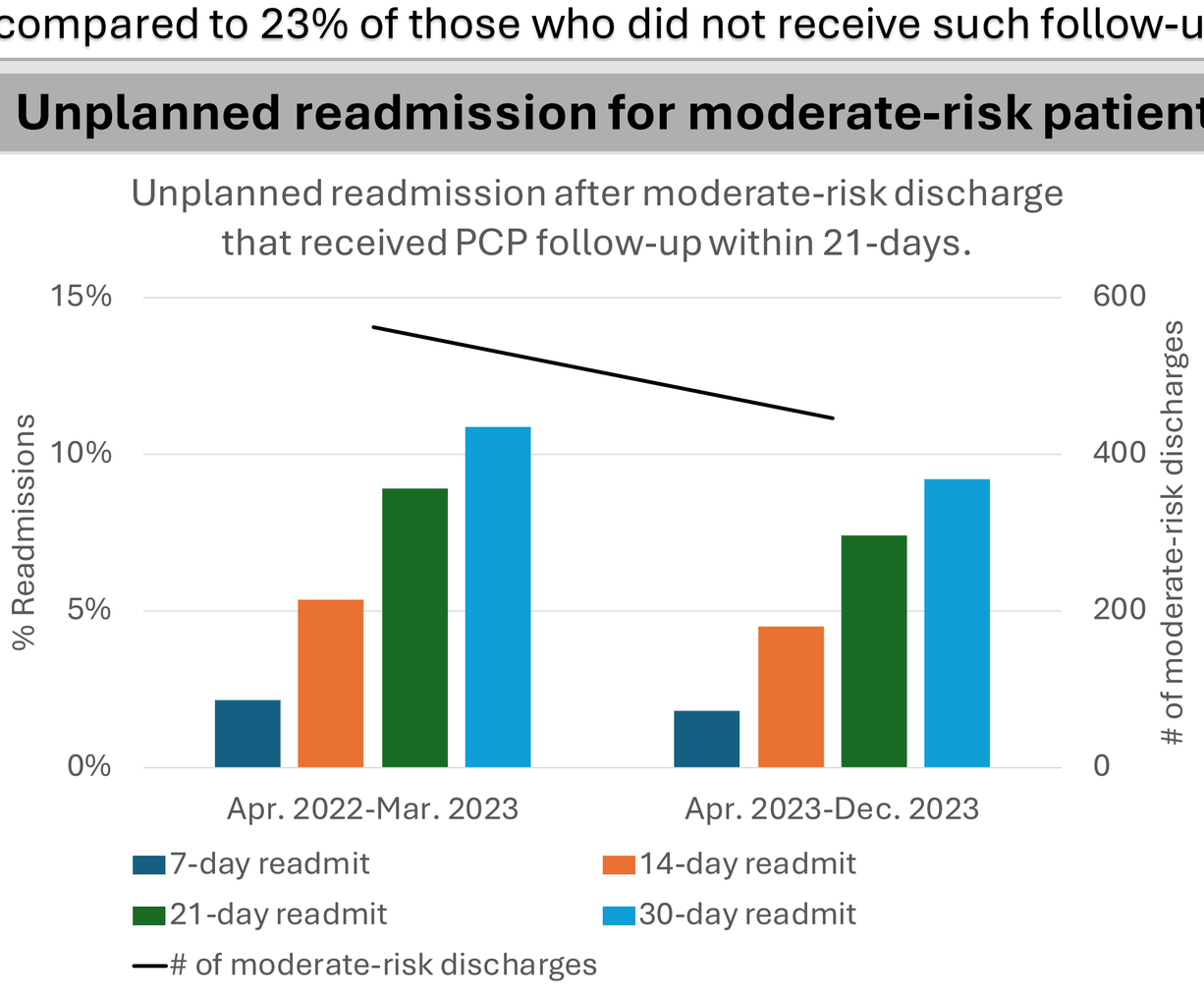
Unplanned readmission among high-risk patients who received PCP follow-up vs. no PCP follow-up

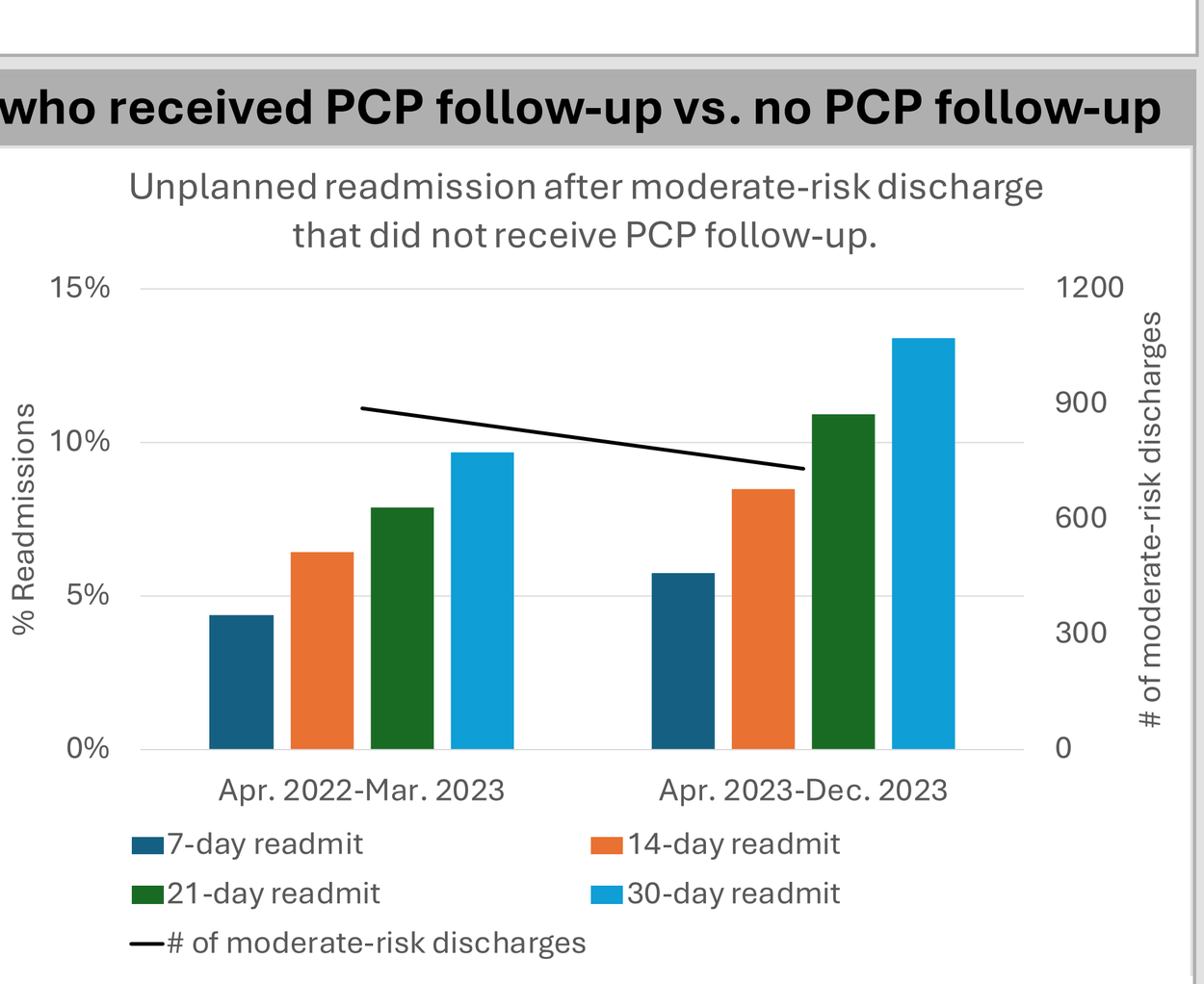




Overall, 19% of high-risk patients who had PCP follow-up within 14 days had an unplanned readmission within 30 days, compared to 23% of those who did not receive such follow-up.

Unplanned readmission for moderate-risk patients who received PCP follow-up vs. no PCP follow-up





Overall, 10% of moderate-risk patients who had PCP follow-up within 21 days had an unplanned readmission within 30 days, compared to 11% of those who did not receive such follow-up.