Home to Hospital to Home (H2H2H) Transitions

ALBERTA MEDICAL ASSOCIATION | ACTT Accelerating Change Transformation Team

Purpose:

To assist primary care clinics in optimizing processes for paneled patients for effective transitions in care from home to hospital to home (H2H2H).

Aim Statement:

By a specific date, the clinic will offer a follow-up appointment, as appropriate, to a specific number of patients within 14 days post-hospital discharge.

Outcome Measure:

A percentage or number of high-risk patients with a visit within 14 days post-hospital discharge.

Balancing Measure:

Time to third next available (TNA) appointment

Prerequisite Tools

- Change Package Clinic Menu
- Rationale and Evidence - H2H2H
- Measurement Guide - H2H2H

Prerequisite

CII/CPAR participation is strongly recommended. It is a technical enabler for implementing potentially better practices.

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

Search our collection of premium tools in AMA's Resource Centre.

High Impact Changes	Potentially Better Practices (PBPs)	Process Measures	Searchable Tools
1. Improve the patient experience	1.1 Establish a multidisciplinary quality improvement team and consider including a patient with lived experience	Regularly scheduled team meetings	• Sequence to Achieve Change Workbook • Patient Partner Guide • Quality Improvement Team List
	1.2 When appropriate, invite patients to bring a caregiver or family member to a follow-up appointment	Clinic has a pre-visit script and processes to apply.	• Scripting Samples - H2H2H • PDSA Worksheet
2. Identify paneled patients for care improvements	2.1 Upon receipt of admit notification, develop a process to provide hospital team with any relevant patient information	Process is documented for notifying hospital team of relevant patient information	• Panel Processes Change Package Summary • Process Mapping
	2.2 Develop a process to identify patients discharged from the hospital (using CII/CPAR)	Process exists for identifying patients discharged	• CII/CPAR Toolkit for Primary Care (pg. 55)

Continued over

High Impact Changes	Potentially Better Practices (PBPs)	Process Measures	Searchable Tools
2. Identify paneled patients for care improvements (cont.)	2.3 Partner with your PCN when you are accepting new patients to your panel	Process exists for accepting new patients	• AlbertaFindADoctor.ca
3. Optimize care processes	3.1 Develop a process to review patient discharge summary* from hospital *The H2H2H Transitions Guideline uses 'transition care plan' to describe the discharge summary'	Process is documented for reviewing discharge summary	• Roles & Responsibilities - H2H2H • Process Mapping
	3.2 Develop a process to check each discharge summary for a risk of readmission score* (documented in 4.1)	Process is documented for checking risk of readmission score	• LACE Index Scoring Worksheet *LACE is the preferred risk of readmission score at Alberta Health Services
	3.3 If a risk of readmission score has not been provided by acute care, develop a process to determine who your high-risk patients are	A process is documented for determining high-risk patients	• PDSA Worksheet
	3.4 Develop a process to offer and manage follow-up care, as appropriate	A process is documented for offering and managing follow up care.	• Post Discharge Follow-up Process • Virtual Care
	3.5 Create a plan for the patient appointment (e.g., medication reconciliation, review care plan, results and outstanding test follow up)	A plan is documented	• My Next Steps: Getting Ready to Leave the Hospital
4. Standardize documentation	4.1 Standardize entry of admit notifications, discharge notifications and discharge summaries 4.2 Standardize entry of patient risk for hospital readmission in the patient record (Aligns to 3.2)	The number or percentage of discharged patients with risk assessment documented in the patient record	• EMR Guides - H2H2H
5. Coordinate care in the medical home	5.1 Establish clear roles and responsibilities for supporting patients in transitions	Documented roles and responsibilities of team members	• Roles & Responsibilities - H2H2H • Sample Huddle Checklist

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High Impact Changes	Potentially Better Practices (PBPs)	Process Measures
6. Coordinate care in the health neighborhood	6.1 Communicate as needed post-transition with care providers outside of the medical home (e.g., primary care accessing specialist advice and liaising with homecare or other members of the extended healthcare team)	Process in place for contacting specialist advice programs, homecare, and other

Searchable Tools

- Introductions with Intentions
- Specialist Advice Programs:
  - Specialistlink,
  - ConnectMD,
  - RAAPID