# What can you do to improve transitions in care?

Alberta Health Services
Primary Health Care

Improving transitions in care helps bridge the gaps between care providers, increasing continuity of care.

## What can primary care teams do?

1. Join CII/CPAR and confirm your patient panel
2. Ensure patients know the name of their family physician or nurse practitioner (NP)
4. Review admit notifications
7. View patients' discharge summaries
8. Provide appropriate follow-up care & refer patients to community supports

## What can acute care teams do?

3. Confirm name of patient's family physician or NP in Connect Care
4. Give patients transition resources
5. Use discharge summary templates co-designed by primary care teams
6. Complete discharge summaries 24-48 hours after patient is discharged

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# Focus on follow-up

When family physicians follow up with patients who have been in the hospital, those patients are less likely to be readmitted—and continuity and quality of care improve.

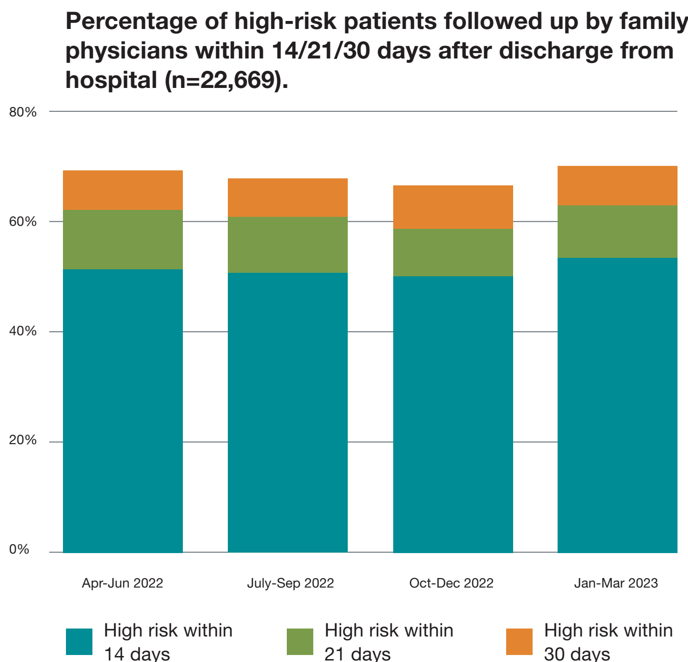
Through CII/CPAR notifications and the delivery of AHS documents like discharge summaries direct to primary care EMRs, we can facilitate effective follow-up care.

**CII/CPAR:** In early 2024 Connect Care will display patients' family physicians as listed in CPAR, making it easier for hospital teams to send you information on your patients' hospital visits.

**61% of PCN family physicians with conformed EMRs are now on CII/CPAR. The goal is 80%.**

**Timely follow-up care:** Just over half of patients who have a high risk of hospital readmission are now getting follow-up care within the recommended time of 14 days after discharge from hospital.

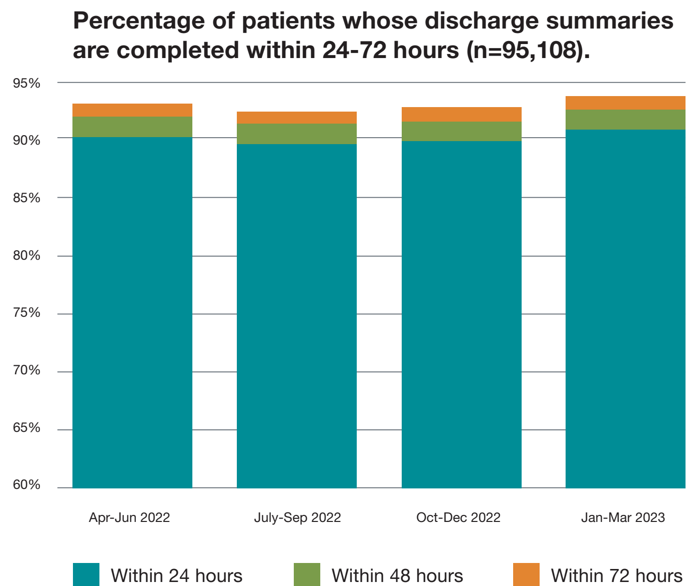
**Percentage of high-risk patients followed up by family physicians within 14/21/30 days after discharge from hospital (n=22,669).**




**Discharge summaries:** The sooner hospital physicians complete a patient's discharge summary, the sooner family physicians can get it in their EMR and start planning follow-up care—thus helping prevent readmission.

**Now, about 90% of all discharge summaries are being completed within 24 hours after a patient is discharged from hospital.**

**Percentage of patients whose discharge summaries are completed within 24-72 hours (n=95,108).**




Continued improvements in CII/CPAR adoption and discharge summary processes support identification of patients who need follow-up care after a hospital stay.

**A note on the data:** With the exception of the CII/CPAR item above, this data is drawn from acute care hospitals that were live on Connect Care as of March 31, 2023. This data is based on discharges for adult (18 years and older) Albertans who were discharged to home or home with support between April 1, 2022, and March 31, 2023. Only those acute care sites where Connect Care is implemented are represented here. This includes 11 sites in Calgary Zone, 16 sites in Central Zone, 8 sites in Edmonton Zone and 12 sites in North Zone.