Consider foundational change packages before implementing

H2H2H TRANSITIONS

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 x date x clinic will offer a follow-up appointment, as appropriate, to x patients within 14 days post-hospital discharge
Outcome Measure: % (#) of high-risk patients with a visit within 14 days post hospital discharge
Balancing Measure: Time to third next available (TNA) appointment

Key documents: *Change Package Menu and Clinic Journey, Evidence Summary, Measurement Guide*

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 transitions of care.

High Impact Changes	Potentially Better Practices (PBPs)	Process Measures	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 it	H2H2H Pre-Visit Script 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 Process Map Guide
	2.2 Develop a process to identify patients discharged from the hospital (using CII/CPAR)	Process exists for identifying patients discharged	CII/CPAR Team Toolkit (pg. 55)
	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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H2H2H TRANSITIONS CHANGE PACKAGE

High Impact Changes	Potentially Better Practices (PBPs)	Process Measures	Tools
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	H2H2H Roles & Responsibilities Guide Process Map Guide
	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 Map (Sample) Virtual care tools
	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)	#/% of discharged patients with risk assessment documented in the patient record	EMR Guides
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	H2H2H Roles & Responsibilities Guide Sample Huddle Checklist
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	Warm Hand Offs Specialist Advice Programs: Specialistlink, ConnectMD, RAAPID (coming soon)