H2H2H Glossary & Acronym List

8P Screening Tool: This tool identifies your patient's risk for adverse events after discharge. The 8Ps include:

- Problems with medications
- Psychological
- Principal diagnosis
- Physical limitations
- Poor health literacy
- Patient support
- Prior hospitalization
- Palliative care

ACTT: Accelerating Change Transformation Team (ACTT)

BRASS: The Blaylock Risk Assessment Screening Score (BRASS) is an assessment tool used to identify patients requiring complex discharge planning.

Care Plan: Is a plan to keep everyone on the "same page" as to what matters to the patient (goals, values and preferences). It also helps keep track of what has been planned or being worked on to improve the patient's health and wellbeing.

Change Package: A quality improvement framework that consists of high-impact changes that are expected to occur when the potentially better practices are implemented. Key tools and resources are often linked to support the potentially better practices and suggested measures will track progress made towards the high-impact changes.

CII: Community Information Integration (CII) is a system that transfers select patient information between community Electronic Medical Records (EMRs) and other members of the patient's care team through Alberta Netcare.

Continuity: Continuity of care is how a patient's experiences of care over time are coherent and linked. This includes relational, informational, and management continuity. Relational continuity is the percentage of time a patient sees their own primary care physician vs. others. Relational continuity above 80% is the aim.

CPAR: Central Patient Attachment Registry (CPAR) is a provincial system that captures the confirmed relationship of a primary care provider and their paneled patients.

CPSA: College of Physicians and Surgeons of Alberta (CPSA)

EMR: Electronic Medical Records; the computerized chart in the physician's office

Find A Doctor (AFAD): Alberta Find A Doctor (AFAD) is a website designed to assist patients in finding family physicians.

H2H2H: Home to Hospital to Home (H2H2H)

H2H2H Guideline: This guideline bridges the connections between hospitals, primary care, and community services. Transitions in care require a coordinated approach because many factors may contribute to high-quality care transitions. To assist providers and teams within Alberta, this guideline presents leading operational practices, change management, tools, resources, and additional information for the following elements:

- o Confirmation of the Primary Care Provider
- o Admit Notification
- o Transition Planning
- o Referral and Access to Community Supports
- o Transition Care Plan
- o Follow-Up to Primary Care

HQCA: Health Quality Council of Alberta (HQCA); A provincial agency that brings an objective perspective to Alberta's health system, pursuing opportunities to improve patient safety and health service quality for Albertans.

LACE: The Length of stay, Acuity of admission, Charlson comorbidity index, Emergency department visits in past six months (LACE) index was developed to predict hospital readmissions in Canada.

Panel: A group of patients for whom a primary provider(s) and team is responsible for providing comprehensive and longitudinal care. Paneled patients have a confirmed relationship with their primary care provider.

Patient Representative Guide: This resource is for patients, family members, and/or caregivers, who have been asked to engage and partner with primary care clinics or Primary Care Networks (PCNs) to be part of the Home to Hospital to Home (H2H2H) transitions. It also helps the PCN when including a patient representative in planning new services or approaches.

PCN: Primary Care Network (PCN) is a joint venture between a group of primary care physicians (who form a non-profit corporation) and Alberta Health Services, to coordinate service delivery through a network of physicians and other primary health care providers—such as nurses, dietitians, pharmacists, and social workers—working together to provide primary health care to Albertans.

TNA: Third Next Available (TNA) is a basic measure of access, where clinic scheduling staff are asked to count the number of days to the TNA appointment for all providers within a practice, one-time per week, and record this information for examination over time. The TNA delay measure provides feedback on the amount of time a patient has to wait to see a member of the health professional team and measures the success of backlog reduction.

For more change package definitions, please refer to ACTT Website.