



Home to Hospital to Home Transitions: The ADAPT Study

February 2021

Overview of ADAPT

ADAPT is a grant funded (PRIHS 5) implementation initiative for the Home to Hospital to Home Transitions Guideline (H2H2H). This grant, ending September 2024, will provide nearly \$1.2 million to improve transitions in care for Albertans with the following 5 chronic diseases: Heart failure, chronic obstructive pulmonary disease, cirrhosis, end-stage kidney disease and/or stage 3-4 cancers.

ADAPT implementation will focus on 3 of 6 H2H2H Guideline elements (see below). The ADAPT initiative will lead a co-design process to integrate, spread, and scale current disease-specific pathways work across Alberta to establish a disease-inclusive transitions in care pathway for patients with chronic disease.

Implementation of ADAPT will be tested in 5 acute care sites and Primary Care Network (PCN) clinics across the province. ADAPT will also assess whether the disease-inclusive pathway adapted to local settings is an efficient and cost-effective intervention within the Alberta healthcare system.

Implementing 3 Guideline Elements



Admit Notification: Bidirectional flow of information between the patient's circle of care (e.g. primary care & supportive care teams) & hospital



Transition Planning: Create a common platform & standardize patient transitions; integrate primary care & specialist led transitions in care pathways



Follow-up to Primary Care: Strengthen follow-up to primary care & connection to the patient's medical home

Impact

Reduce Clinical Variation

Promote patient self-care & align care with their preferences

Improve Patient Outcomes

Reduce Health System Costs

Support patients at highest risk for poor outcomes post hospitalization

Enhance community capacity & support patient's medical home

Value for Zones

ADAPT will provide additional financial and human resources to help zonal operations (PHC and acute care) implement specific H2H2H Guideline elements & standardize processes and tools to optimize care for patients in their medical home.

Co-Designers Needed

ADAPT is seeking input from stakeholders to co-design a standardized post-discharge follow-up process in primary care for transitioning patients with chronic disease.

This is an opportunity to participate in ADAPT regardless of which 5 acute care sites and PCN clinics are selected to implement ADAPT. Broad perspectives are required to ensure optimal design and usability across the province.

To participate in the co-design of this process, please contact Pam Sterling (email below).

If you have any questions, please contact Pam Sterling, Senior Project Manager, Primary Health Care Integration Network (AHS) at pamela.sterling@ahs.ca