

# A WestView Story:

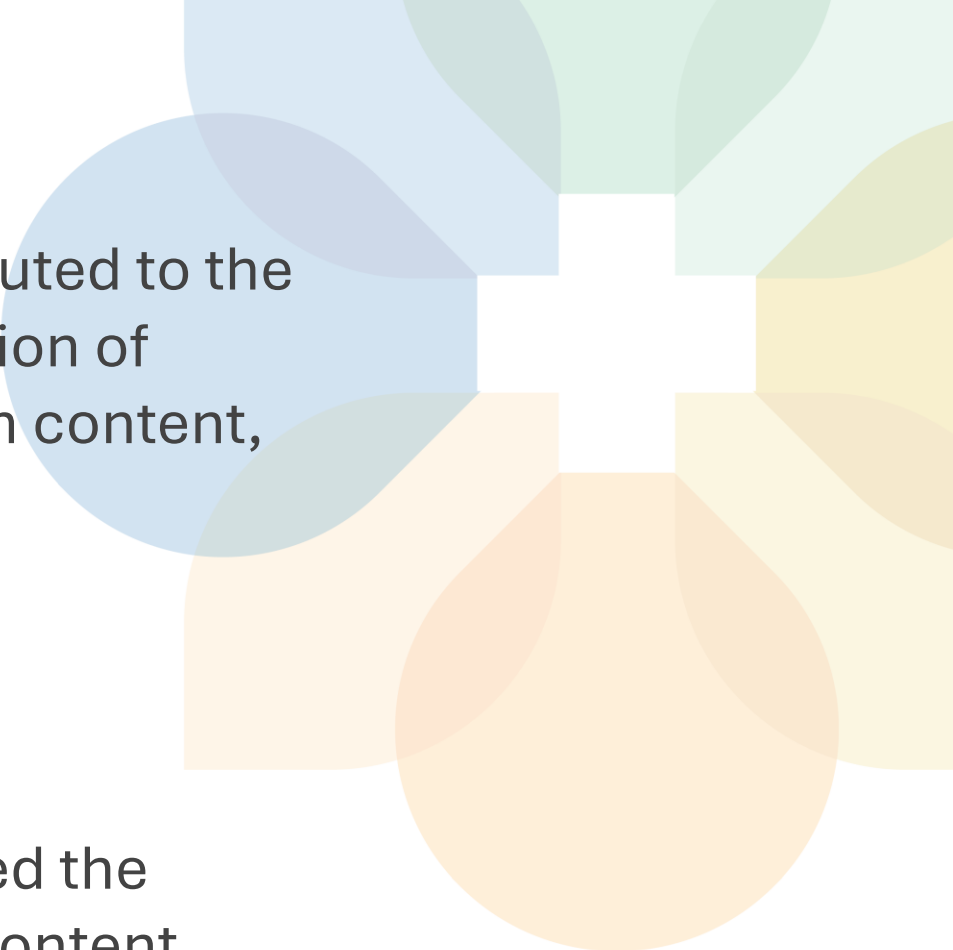
## Supporting Safe Transitions from Hospital to the Medical Home

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May 1-3, 2025



**Primary Care  
Strategic Forum**  
*The Path Ahead*



• The scientific planning committee has contributed to the consideration of learning needs, the determination of learning objectives, the development of program content, and the choice of speakers or presenters.

• No sponsorship funds have been received.

• The scientific planning committee has reviewed the content of the presentations and ensured that content presented is evidence-based and free of undue influence.



# Disclosure of Financial Support

- This program has received in-kind support from Westview Primary Care Network (WVPCN), Westview Health Centre (WHC), and A Disease-inclusive Pathway for Transitions in Care (ADAPT) /Primary Care Alberta (PCA) in the form of program services and research/evaluation support.

# Faculty/ Presenter Disclosure

- **Presenters:**

Dr. Suzanne Squires & Dr. Carla Laidlaw

**Relationships with financial sponsors:** none

**Grants/research support:** none

**Speakers Bureau/Honoraria:** none

**Consulting Fees:** none

**Other:** Board Chair & Medical Director WVPCN

# Disclaimer

Information requested by: Westview Health Care Centre

Description of information: Data to support presentation at PCN Strategic Forum 2025 (Edmonton, May 1-2)

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**Alberta Health's Practitioner Claims data** were used for data analysis and aggregation. The disclosure of aggregated Practitioner Claims data for the above noted project to Third Party executed per AH consent to AHS' disclosure of the data. AH Letter of Approval (Approval Letter 06680)

This data is being disclosed to you as authorized under section 32(1) of the Health Information Act.

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This report is based in part on data provided by Alberta Health. The interpretation and conclusions herein are those of the evaluators and do not necessarily represent the views of the Government of Alberta. Neither the Government of Alberta nor Alberta Health express any opinion in relation to this analysis.

# Learning Objectives

- Why implement H2H2H (Home 2 Hospital 2 Home) in your region?
- How did WVPCN implement H2H2H in their region?
- How could you implement H2H2H in your region?

Disjointed transitions in care result in poor health outcomes, reduced quality of life, and unsustainable health system costs.

**232,000+**

adult Albertans had a diagnosis of one or more of HF, COPD, cirrhosis, ESKD or advanced stage cancer

**Highest**

users of the health system with the poorest outcomes

**68,805+**  
**hospital discharges**  
**in Alberta**

**\$1.34 billion**  
Annual cost of hospital discharges in Alberta

**15.9%**

average 30-day all-cause readmission rate (costing \$131M)

Sources: Primary Health Care Integration Network, 2020; Wodchis et al., 2016

## VERY Simple Project

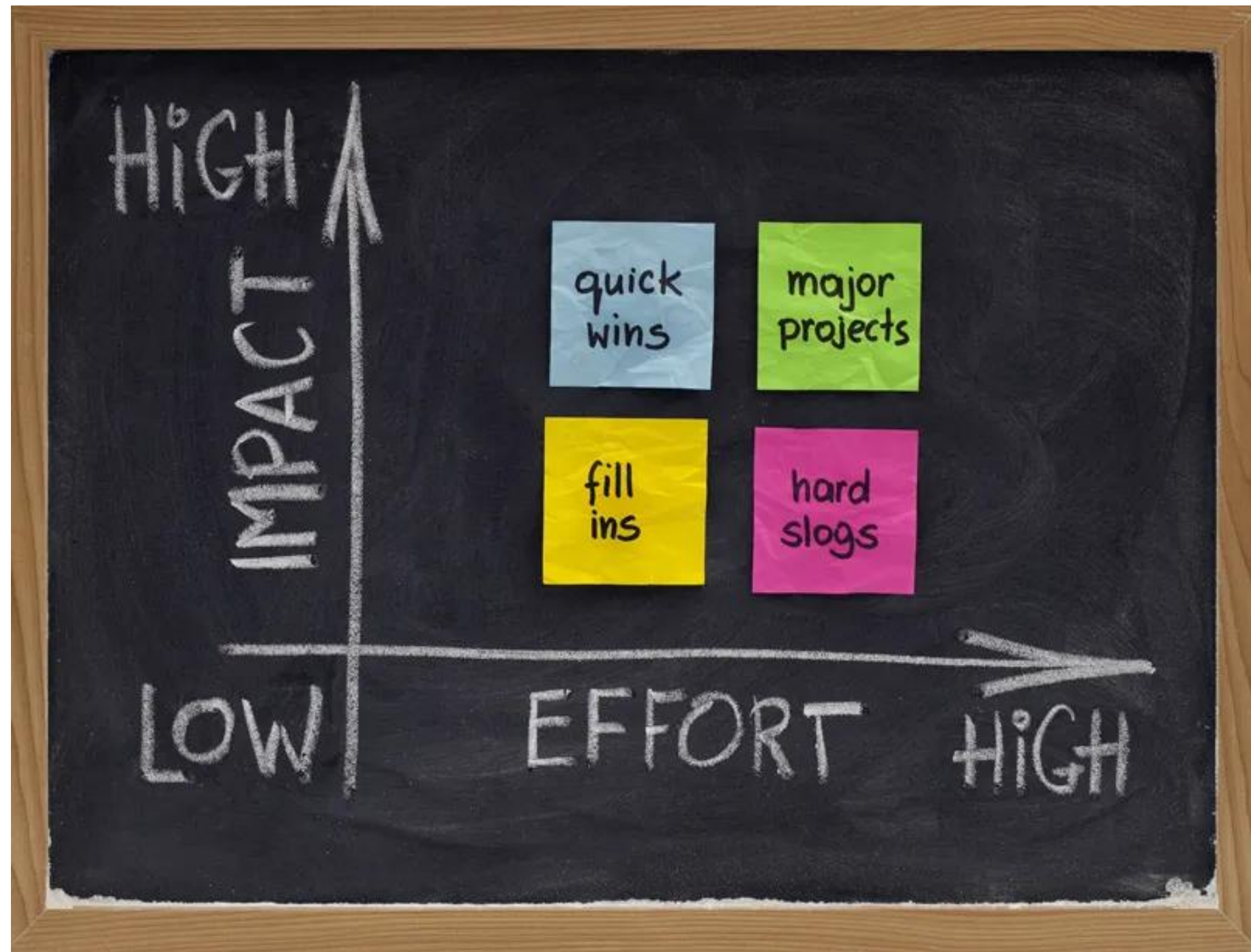
When a patient is discharged from the WestView Health Centre, the unit clerk calls their family doctor's/NP's office to book a follow-up appointment.



Very effective  
in improving  
patient care



Why you should do this project



# Where it Began



# Background

- March 2023: **Edmonton Zone TOC subcommittee** invited WHC and WVPCN to participate in TOC pilot
- **Provincial Transition in Care team (PCA)** provided an orientation to WHC and WVPCN team re: ADAPT, H2H2H, and alignment with Acute Care Bundle Improvement (ACBI)
- June 2023: Initiated collaborative transition improvement project to **lower hospital readmission rates and improve effective and timely follow up care with primary care physician.**



# Foundations for Success

87% WestView Primary Care Network physicians  
on CII/CPAR at start of project

Strong working relationships between Westview  
Health Centre and WestView PCN (several  
physicians on Hospital Care Team are in WVPCN)

Multidisciplinary team on acute care actively  
engages in discharge planning

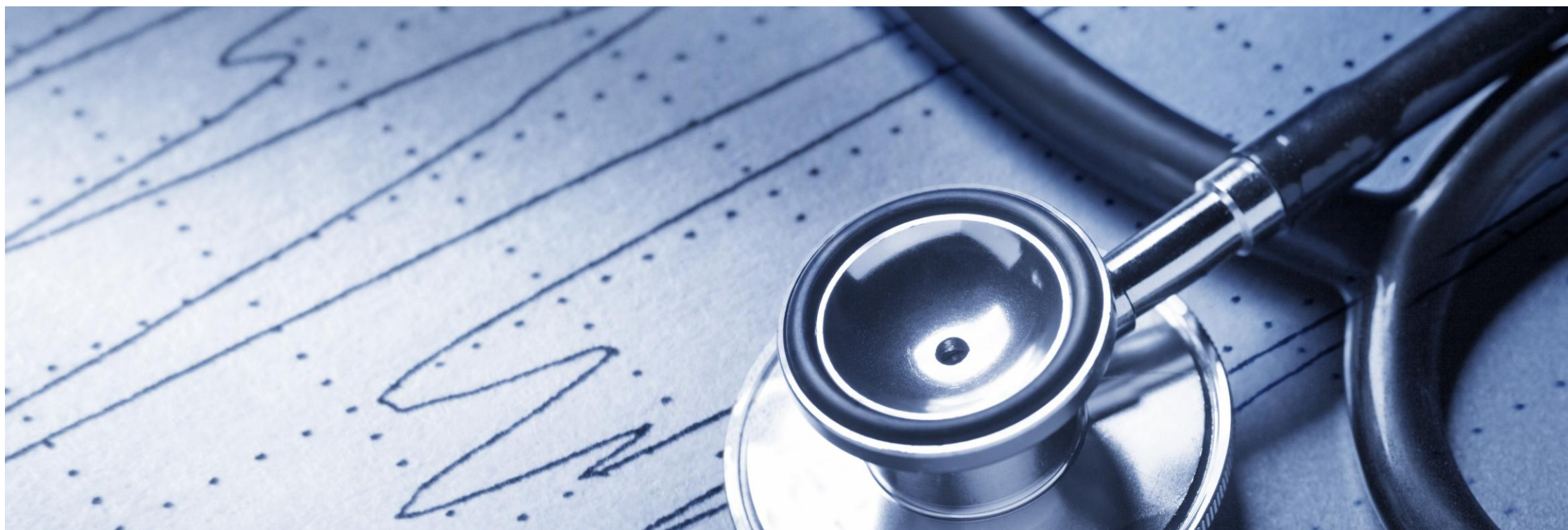
Strong HCT leadership and Nurse Practitioners  
provide continuity for the physicians coming on  
shift.



## Table Question:

How might  
your workplace  
benefit from  
implementing  
this project?

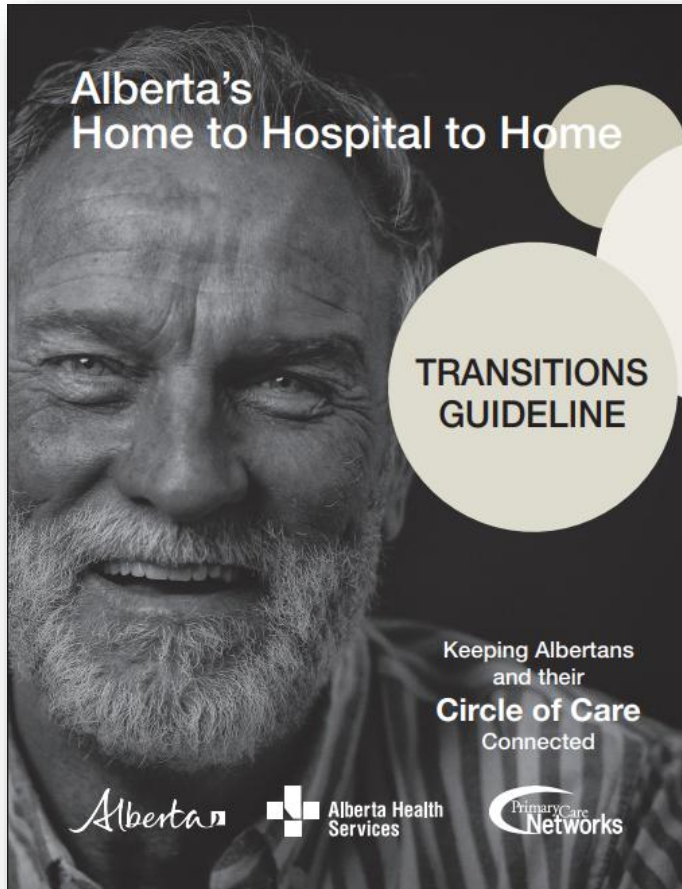




# Project Overview

# Home to Hospital to Home

## Transition Guide



# First Step

Current State Mapping:

How Patient Follow-Up Occurs Post-Discharge



Patients, families, primary care providers and reception at PCP offices were all unsure of when and how follow-up was arranged.



Tool if used  
lowers hospital  
readmission  
rates and  
improves  
effective and  
timely follow-up  
care with  
primary care  
providers.



# What is the LACE Index used for?

LACE Score	Risk of Readmission	Recommended PCP Follow up Time
0-6	Low	Within 30 days
7-13	Medium	Within 21 days
14-19	High	Within 14 days

# How is the LACE Score Calculated?

**L** = length of stay

**A** = acuity of admission

**C** = comorbidities

**E** = Emergency department visits (in the past 6 months)

***Connect Care calculates this!  
LACE scores can be part of the discharge  
summary template.***

# Follow-up to Primary Care

## Provincial H2H2H Dashboard

Patients who had a timely follow up in Primary Care had significantly reduced rates for 30-Day unplanned readmission to hospital.

- High Risk: **22%** **14% lower** compared to 36%
- Moderate Risk: **10%** **10% lower** compared to 20%

Source: Alberta Health Services (2025)

Another  
reason follow  
up with  
primary care  
is important

## Patients need their prescriptions



# New H2H2H Process

Calculate  
LACE score

**Connect  
Care**

Patient has an  
appointment  
booked with  
their PCP  
prior to  
discharge

**Unit Clerk calls  
the office of the  
PCP**

Patient  
provided After  
Visit  
Summary  
including  
booked  
appointment

**Unit Clerk**

# Process Map



# Westview Health Centre Rapid Round Optimization

High and Medium Risk patients identified

Daily ADOD (anticipated date of discharge)

- Review & confirm daily w/ team
- Update in real time during RR (EDTC)
- Update patient & family (& bedside whiteboard)

Daily discharge readiness

- Multi-D discharge/transfer readiness tab updated daily prior to RR or in real time
- Discipline barriers discussed in RR as needed

# Westview Family Medicine Unit



High/Medium risk patients identified during Transition Planning



Care Team determines PCP f/u based on the LACE score and clinical Judgement



3 days before Discharge, Unit Clerk contacts PCP to schedule f/u (Virtual Care Clinic for Unattached Patient)



Appointment is documented in CC and Auto-Populated to After Visit Summary and Discharge Summary

# Primary Care Providers



MOA receives call from Hospital Unit Clerk



MOA schedules Follow-up Appt with PCP (provides Date and Time to Unit Clerk)



Primary Care Provider receives Discharge Summary with Follow-up Appt Information



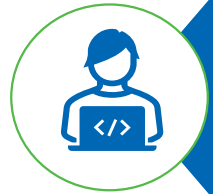
Primary Care Provider sees patient in clinic

**Same process for non-WestView PCN physicians**

# Virtual Clinic Unattached Patient



Hospital Unit Clerk calls PCN



PCN staff schedules Follow-up Appt with Virtual  
Clinic NP within Recommended Timeline  
(provides Date and Time to Unit Clerk)

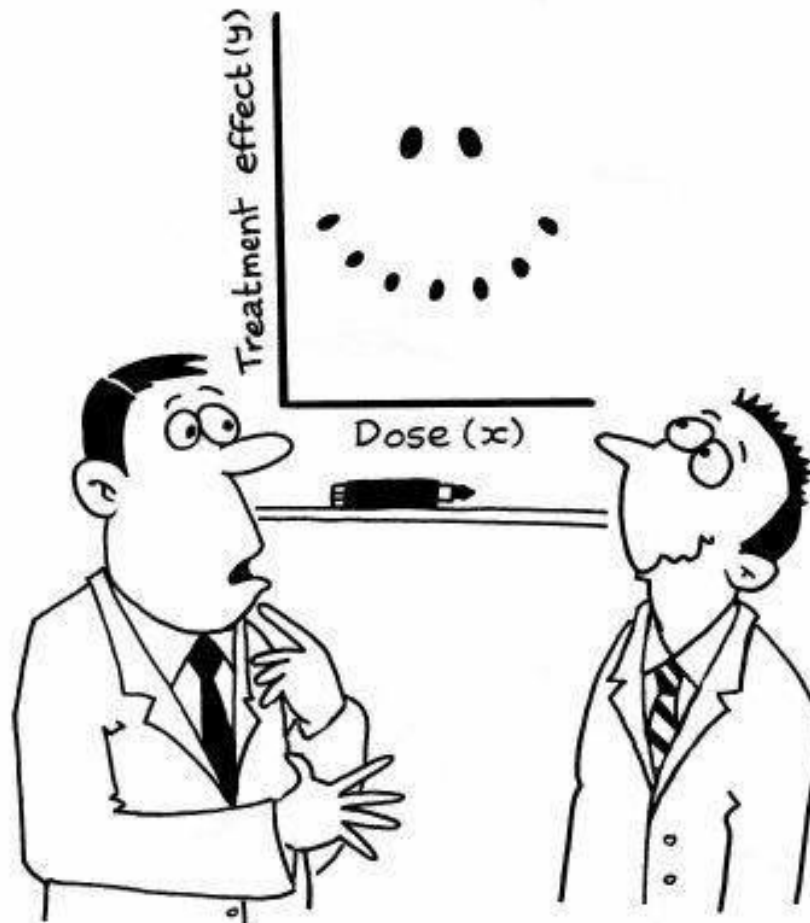


NP receives Discharge Summary with Follow-up  
Appt Information



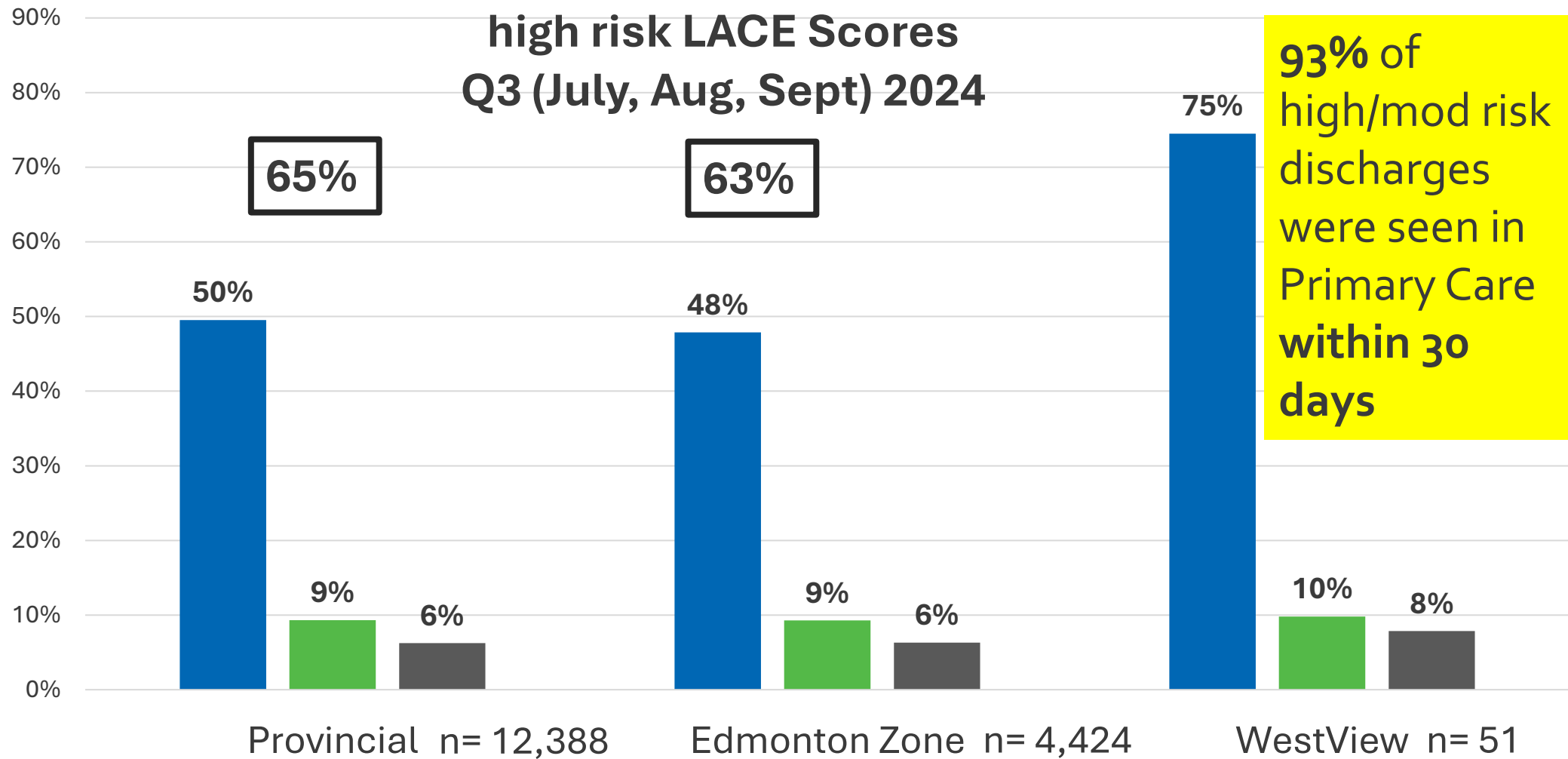
NP meets with Patients via Zoom or Telephone

# DATA!



"It's a non-linear pattern with outliers.....but for some reason I'm very happy with the data."

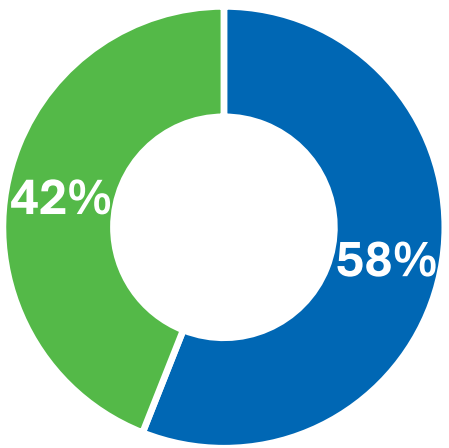
# PCP follow-up after hospital discharge for moderate and high risk LACE Scores Q3 (July, Aug, Sept) 2024



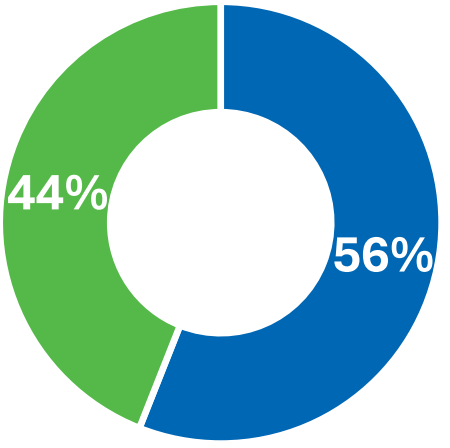
**93%** of high/mod risk discharges were seen in Primary Care within 30 days

■ Within 14 Days (<=14) ■ Within 14-21 Days (>14 and <=21) ■ Within 21-30 Days (>21 and <=30)

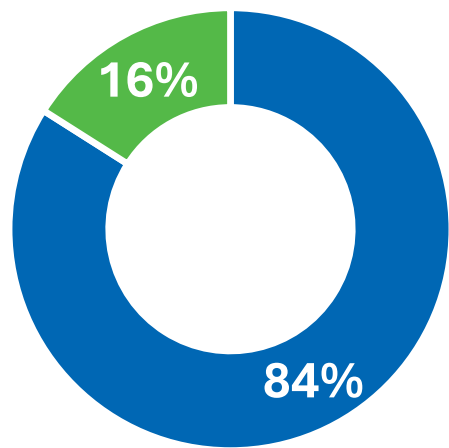
# PCP follow-up after hospital discharge within LACE recommended timeframe for moderate and high-risk LACE Scores Q3 (July, Aug, Sept) 2024



**Provincial**  
(n=12,388)



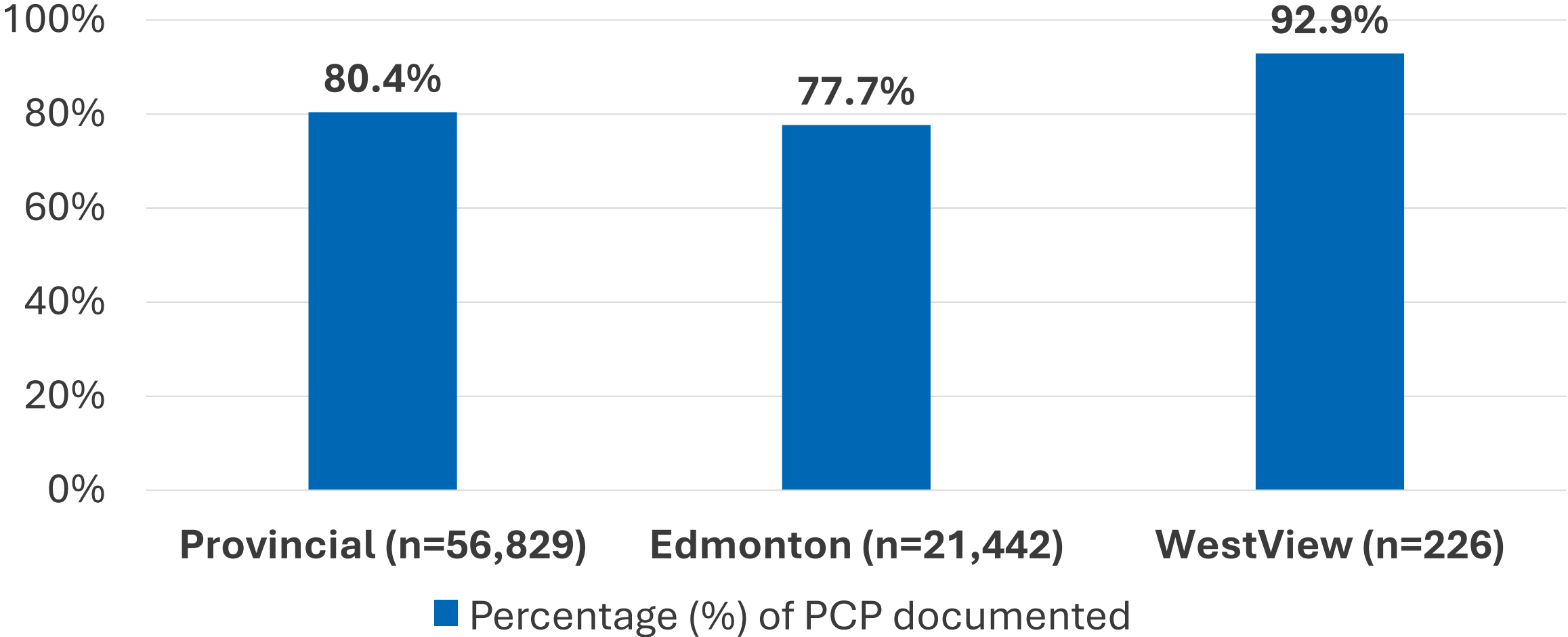
**Edmonton Zone**  
(n=4,424)



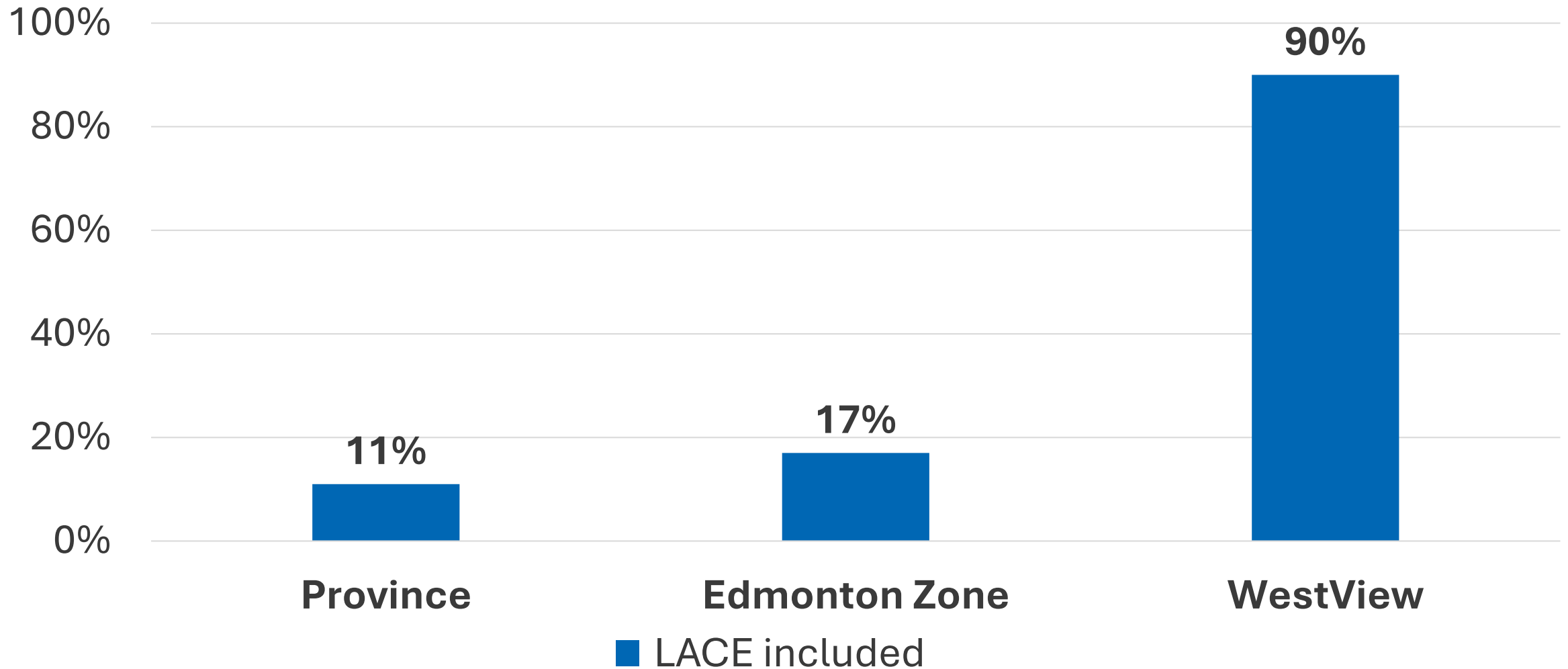
**WestView**  
(n=51)

- Followed-up within LACE recommended timeframe
- Did not follow-up within LACE recommended timeframe

# Primary Care Physician (PCP) general field within Connect Care Q3 (July, Aug, Sept) 2024



## LACE included in discharge summary Q3 (July, Aug, Sept) 2024

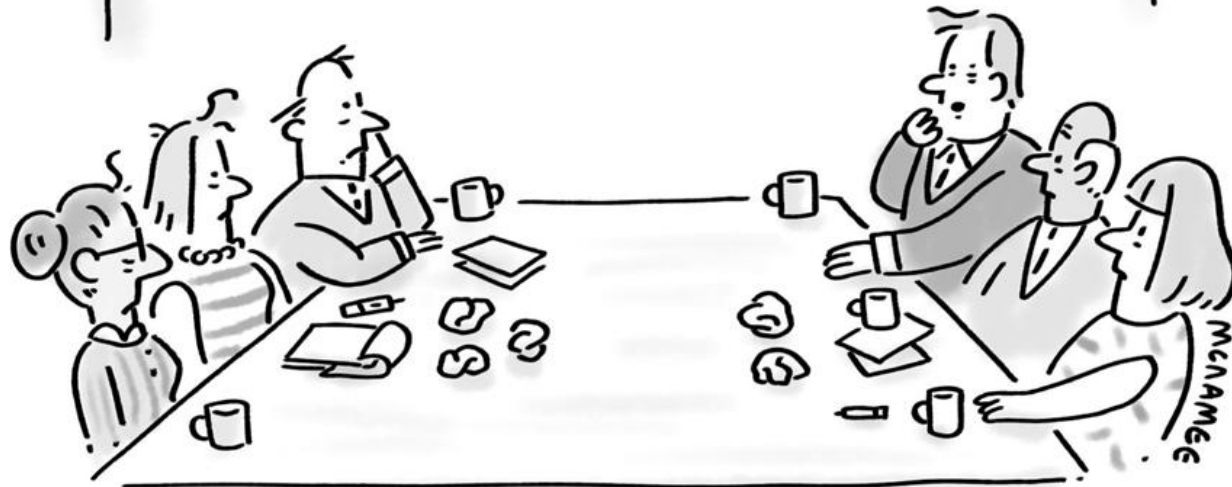
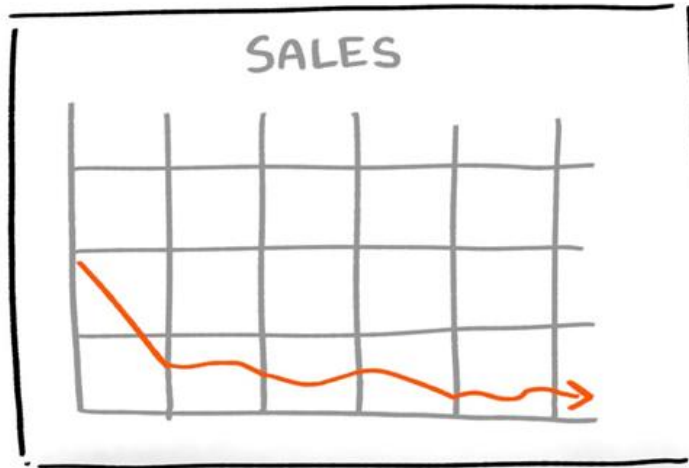


# April 2025 Status

- Unit Clerk books appointment with PCP/Virtual Clinic. Physician's happy that hospital is doing this.
- Patient's happy to leave hospital with a follow up appointment booked.
- Process developed for cancelling PCP appointment of readmitted patients.
- High LACE score needs additional discharge supports.
- Evaluation interviews underway, outcomes measurement TBD.



SALTY M&M'S and DEBRIS, Inc.



*“What if we changed the name to TrailMix.”*

# Primary Care Feedback



Efficient follow-up,  
appointment scheduling  
and visit process



Reduced  
administrative burden

# Patient Feedback

Patients appreciate having appointment booked prior to leaving hospital



*“Thanks to the member of the team who arranged the follow up appointment with our family doctor and the lab, contacted our pharmacy, and prepared a folder with the discharge information, including the Goals of Care to be placed on our fridge in case of future emergencies”.*

# Hospital Team Feedback

Unit Clerks recognize this is important work to improve the patient experience and feel they can easily complete it within their day.

Hospital Care Team Physicians and staff have integrated LACE score discussion into discharge planning process.

Unit Clerk getting less phone calls after discharge about follow up

**Patients like it**

**Doctors like it**

**Support Staff  
like it**

**WIN!**

**WIN!**



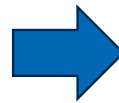
**WIN!**

# Next Steps

The ADAPT research team is completing an evaluation of this project.

Other Edmonton Zone Suburban sites going live May 2025





## Table Question:

What barriers would you need to overcome to implement this project? How would you overcome them?



# Transitions in Care

This project is a collaboration between



Want to move forward with this project in your Region?

Email:

**Attention: H2H2H Implementation Query**

[PCA@primarycarealberta.ca](mailto:PCA@primarycarealberta.ca)

Thank you  
very much  
for attending!



# References

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