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## CONFERENCE ABSTRACT

# Integrating Care from Home to Hospital to Home: Development of Provincial Transition in Care Guidelines in Alberta, Canada

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***Introduction***

Patients with complex, chronic diseases frequently have unmet care needs as they transition between hospital and home, and often return to hospital and emergency department (ED) due to post-discharge complications. Some evidence suggests readmissions and ED usage can be prevented with appropriate primary care follow-up and community supports. The objective of this initiative was to co-design transition in care guidelines, focusing on home to hospital to home transitions, in Alberta, Canada. The guidelines aim to integrate patients' transition journey and facilitate quality post-discharge follow-up in primary and community care, identified as critical for inclusion when designing solutions to optimize transitions.

***Methods***

Over a one year period, the Primary Health Care Integration Network led a collaborative process with key stakeholders to design content for transition in care guidelines. We followed an iterative mixed-method approach where stakeholder's perspectives from one phase were used to inform the next phase, leading to consensus (i.e., state of agreement). Methods described for this initiative include: i) literature review ii) learning collaborative; iii) co-design collaborative, iv) patient advisor group, v) targeted online surveys, vi) stakeholder interviews, and vii) adapted modified Delphi panel.

***Results***

A knowledge product containing best evidence was developed. The following components of a patients' transition from home to hospital to home include: Confirmation of the Primary Care Provider, Admit Notification, Discharge Planning Process, Referral and Access to Community Supports, Transition Care Plan, and Follow-up to Primary Care. The guidelines contain the activities of leading operational practice(s) including patient and family caregiver accountabilities, change management actions, potential benefits, and additional information to consider, as well as related tools and resources to support implementation.

***Discussions and Conclusions***

Key findings include a shared care model for transitions designed by and for primary care and community healthcare providers with extensive input from stakeholders including specialists, patients, families, and caregivers. This work is the result of an integrated approach for trans-disciplinary providers to collaborate and inform the design of a provincial standard for shared transition planning, and enhanced informational continuity across healthcare settings.

***Lessons learned***

Stakeholders were provided multiple opportunities to share their expertise and co-design transition in care guidelines. Providing a shared space for traditionally divergent groups such as specialists, family physicians and patients to integrate shared care models and collaboratively work towards more feasible and efficient approaches to care, was identified as a critical enabler for this work.

***Limitations***

Building consensus across a diverse group of stakeholders with varying perspectives is complex; there is no “one size fits all approach” to co-design, thus key stakeholders and contextual factors may differ across geographical settings.

***Suggestions for future research***

The development of the guidelines brought stakeholders together in a collaborative process crossing geographic, professional, and organizational boundaries. Implementation strategies for delivery of integrated care initiatives, such as the guidelines, provide additional opportunities for research. It is critically important to explore various strategies when designing local solutions for local problems, a necessary condition if the system of care is going to realize the potential articulated by this initiative.