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**CONFERENCE ABSTRACT**

# Empowering Patients as Partners to Develop Person-Centric Tools for Post Hospital Discharge: The Patients Transitions Resources Team

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## *Introduction*

Many patients experience fundamental breakdowns in the healthcare system as they transition between hospital and home and do not get follow-up care they need. These patients lack confidence in the delivery of healthcare and feel completely alone with little support after discharge. This issue has been amplified with the arrival of COVID-19. To improve health system integration and health outcomes, empowering patients to identify their own care needs and preferences is critical. In Alberta, Canada, a patient led group called the Patient Transitions Resources Team (PTR) has been collaborating with healthcare teams to develop person-centric resources for patients and families.

## *Aims Objectives Theory or Methods*

As part of the COVID-19 response, Alberta Health Services (health services delivery arm; AHS) called upon the PTR team to develop a person-centric discharge planning tool for hospitalized COVID-19 patients to reference as they transition back to their communities. Over an 8-week period, the team created the prototype, reviewed related literature, drew upon their own lived experiences, and conducted intensive interviews with patients and families. Patients and PTR team members engaged in a true partnership, building a foundation of trust, shared accountability, respect, and collaborative purpose, resulting in a united team with common vision and passion for the work.

## *Highlights or Results or Key Findings*

The discharge planning tool, My Next Steps, has been distributed to all acute care hospitals in Alberta and is available on a provincial patient portal called MyHEALTH Alberta. The checklist was designed by patients for patients, written in plain and readily understandable language. It serves as a guide to empower patients to clearly understand what they can do and expect during their transition (e.g., points for conversations with your doctor/health team). Empathy for patients during transitions is key; while providing guidance to empower them to be fully involved in their return to health. The checklist content is acknowledged by AHS as vital to safer transitions from hospital. Key success factors of this work included AHS team members engaging with patients in a true

partnership to empower patient leads as equal decision-makers to develop resources and tools which fit their needs and better support patients and families on their healthcare journey.

### *Conclusions*

This patient-led collaborative work provided valuable lessons about co-design processes that can be shared with other teams looking to empower patients and families in their own care, and integrate the patient voice to advance person and family-centered care to support high quality transitions.

### *Implications for applicability/transferability sustainability and limitations*

My Next Steps is now being used by the PTR team to create a generic discharge tool (i.e., not COVID specific) for patients and families transitioning from hospital to home. This new version will be adopted across all Alberta's acute care hospitals, embedded within a new provincial electronic health system.