

Clinic Name

ADAPT Working Group Charter



Background

Improving transitions of care is a health system priority in Alberta. Currently, many patients with complex, chronic diseases have unmet care needs and are readmitted to a hospital within 30 days of discharge due to poor care transitions. In November 2020, the provincial Home to Hospital to Home (H2H2H) Transitions Guideline was released, outlining key actions for safe and effective coordination and continuity of care as adult patients shift between hospital and their Medical Home.

A Disease-Inclusive Pathway for Transitions in Care (ADAPT) is a grant-funded implementation initiative for Alberta's H2H2H Transitions Guideline. ADAPT focuses on implementing 3 of 6 H2H2H Guideline elements: admit notification, transition planning and follow-up to primary care. The purpose of ADAPT is to support and standardize patient transitions across Alberta for high-risk patient groups with heart failure (HF), chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD), and cirrhosis. This work includes primary and acute care partners interested in improving post-discharge follow-up processes to reflect primary care needs and integrates disease-specific pathway work ongoing in Alberta.

In (Date), the (Clinic Name) joined the ADAPT study to improve transitions in care for their high-risk patients with HF, COPD, CKD and Cirrhosis. The (Clinic Name)...place details here on location, clinical services, and clinic roles.

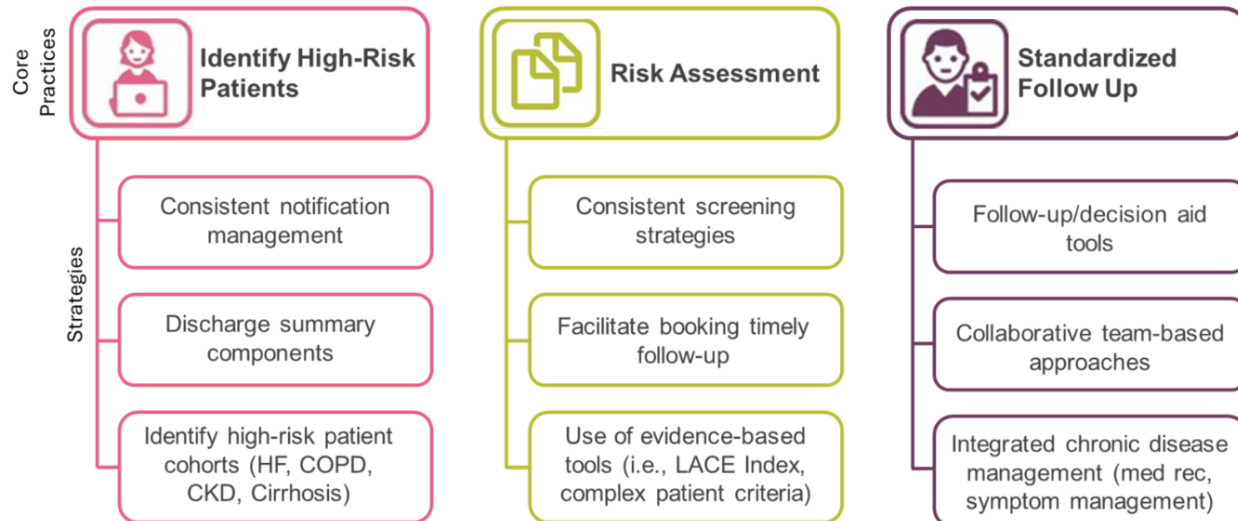
Purpose

(Clinic Name) has partnered with the ADAPT study to enhance transitional care follow-up processes in primary care, lower hospital readmission rates and improve effective and timely follow-up care with the most appropriate provider and services. The ADAPT study will provide (Clinic Name) with change management, quality improvement, and evaluation support, where needed, to design, implement, and build sustainability for effective transitions in care.

Objectives

Members from (Clinic Name) and the ADAPT study team will work collaboratively to co-create and/or optimize primary care follow-up processes consistent with ADAPT's three core practices: 1) identify high-risk patients, 2) risk assessment, and 3) standardized follow-up (shown in the following diagram). Below each core practice is a set of strategies primary care clinics can use to achieve these core practices.

ADAPT Core Practices and Strategies



Scope

The following activities are within scope of this project:

- Implement/optimize strategies in alignment with ADAPT's three core practices: 1) identify high risk patients, 2) risk assessment, and 3) standardized follow-up.
- Collaborate and co-create transitional care strategies to improve patient care transitions.
- Engage sponsors, partners, leadership, and frontline staff.
- Reflect and identify key team roles, responsibilities, and accountabilities in the post-discharge follow-up care process.
- Identify barriers and gaps in provision of follow-up care processes in primary care related to high-risk patient populations.
- Identify potential competing information (i.e., guidelines, protocols) in relation to disease specific pathways/resources primary care teams may need to deal with when patients present at follow-up appointments.
- Identify local solutions primary care teams have created to address barriers and gaps (these may not align with best practice, could be a workaround situation, not effective solution).
- Identify best practice in provision of follow-up appointments for high-risk patients when they are discharged from acute to (Clinic Name).
- Develop educational and training materials specific to different clinic roles (i.e., providers, nursing staff, admin staff) and identify potential champion roles to support implementation.

Assumptions & Dependencies

- The (Clinic Name) has the capacity and resources to support this work.
- Operational leads and collaborators will remain engaged and fulfill their roles.
- Primary care has knowledge and awareness of the practice changes which acute care teams may be making related to H2H2H (or broader ACBI or transition related) work.
- Acute care may be unaware of the strategies and practices primary care teams use to triage and manage high risk patient populations.
- Care transitions will remain a provincial priority, despite the current health system restructuring.

Risks

The following potential risks have been identified:

- Organizational restructuring within AHS may impact the ability of partners to resource this work.
- Changes in the structure and priorities of AHS.
- A lack of capacity within the clinic to support this work.
- Possible changes in the landscape of primary care, time, capacity, and resources (i.e. regional PCNs).
- Directives not to engage in transition in care work.

Working Group Structure

Membership, Roles & Responsibilities

Team Members	Roles & Responsibilities
Dr. (Name)	Physician at (Clinic name) and Co-Chair for the ADAPT Working Group. Responsible for co-creating and implementing ADAPT follow-up processes. Provides follow-up care to high-risk patients, post-hospital discharge.
(Name)	Nurse Practitioner at (Clinic Name). Responsible for co-creating and implementing ADAPT follow-up processes. Provides follow-up care to high-risk patients, post-hospital discharge.
(Name)	Clinic Manager at (Clinic Name). Supports systems change, quality improvements, training, and education at (Clinic Name).

(Name)	Administrative Assistant to Manager of (Clinic Name). Provides scheduling support for working group members from (Clinic Name).
ADAPT Research Team Member Name	ADAPT Operations Lead, Primary Care Alberta. Coordinates and provides oversight to the day-to-day operations of the ADAPT study. Leads and facilitate engagement with participating clinics. Supports data collection and analysis.
ADAPT Research Team Member Name	Implementation Scientist, Primary Care Alberta. Provides implementation and quality improvement support to ADAPT clinics. Identifies and helps clinics navigate enablers and barriers to ADAPT implementation.
ADAPT Research Team Member Name	ADAPT Evaluation Support, Primary Care Alberta. Supports clinics with evaluation and data collection activities. Lead for the Patient Reported Experience Measures survey.
ADAPT Research Team Member Name	ADAPT Practice Facilitator, University of Alberta. Supports clinics with ADAPT implementation, data collection, Electronic Medical Record (EMR) optimization, and other quality improvement activities.
ADAPT Research Team Member Name	ADAPT Study Coordinator, Primary Care Alberta. Supports the ADAPT study team and participating clinics/providers with scheduling, session planning, participant remuneration, and developing study materials.

Meeting Frequency

Pre-Implementation Phase: During the pre-implementation phase of the study, participating providers are expected to attend an ADAPT orientation session, complete a current-state interview, participate in a co-creation workshop, and co-create/finalize a project charter. While the timing of these meetings will vary from site to site, providers can expect to meet once every 1-2 months prior to implementation. Additional meetings between (Clinic Name) staff and the ADAPT study team can be scheduled, as needed.

Implementation Phase: During the implementation phase of the study, participants are expected to attend quarterly meetings with the ADAPT study team to discuss project progress and plans for the remaining study term. A final workshop and final interviews with participants will also occur near the study end date. Again, additional meetings can be scheduled between (Clinic Name) staff and the ADAPT study team, as needed.

Key Stakeholders & Roles

Stakeholder Group	Responsibilities	Contact
High-risk patients with HF, COPD, CKD, or Cirrhosis	Beneficiaries of the ADAPT study. Receive follow-up care post-hospital discharge at (Clinic Name).	
(Clinic Name) providers and clinic staff	Co-create and implement ADAPT intervention. Complete patient post-discharge follow-up.	(Clinic Team Names)
Primary Care - Physician Champion	Lead health care transformation and change. Engage with peers and champion for the ADAPT study.	(Clinic Team Member Name)
Acute Care – Physician Champion	Lead health care transformation and change. Engage with peers and champion for the ADAPT study.	(Acute Care Physician Name)
Home to Hospital to Home Support Implementation Network Includes ADAPT research team and Acute Care Bundles Initiative (ACBI) members	Education, Implementation, Evaluation, QI support, Change Management Support.	(Names)

Stakeholder Engagement Strategies

Stakeholder engagement in this work is informed by the following principles and strategies:

- Embrace co-creation principles; or in other terms, actively involve all stakeholders in the process as much as possible: Primary Care Network, Alberta Health Services, Primary Care Alberta, operations partners, end users, developers, consultants, decision makers, patients and caregivers and so on.
- Co-creation with acute care, primary care, and community stakeholders will be used, where possible.
 - Co-creation refers to an approach to creating solutions, in which partner members are treated as equal collaborators in the co-creation process.
- Learn from promising practices, where appropriate, and support scale and spread.
- Leading Operational Practices (LOPs) developed will consider and accommodate local adaptations (all LOP principles), while striving to find local solutions for consistent patient experience (flexible standardization).

- Active listening, respectful dialogue, and acknowledging power differences between partners (if they exist).

Project Plan

Objective: Identify High-Risk Patients. Complete a Risk Assessment Using Evidence-Based Screening Tools.

Timelines	Deliverables	Measurements	Stakeholders
	Establish a risk stratification process using the LACE Index as the agreed upon tool for flagging patients as high risk of readmission.		(Clinic Name): Risk-stratify patients using LACE Index
	ADAPT study team to provide LACE Index education, training and resources		ADAPT team: Send LACE resources to (Clinic Name) staff

Objective: Standardized/Timely Follow-Up (within 7, 14, 21 or 30 days)

Timelines	Deliverables	Measurements	Stakeholders
	Develop a process for booking patients for follow-up post-discharge utilizing LACE scores to determine recommended timing for follow-up.		(Clinic Name): - Establish a booking process using LACE - Book follow-up

Objective: Standardized follow-up visit

Timelines	Deliverables	Measurements	Stakeholders
	- Identify the roles and responsibilities of chronic disease management (CDM) nurses at (Clinic Name). Identify where these providers might be able to support patient follow-up post-discharge. - Explore whether the CDM nurse could take on medication reconciliation prior to patients following up with their Primary Care Provider (PCP). - Determine whether the CDM nursing group could play a role in providing disease-specific patient education. If so, develop a process for this. - Establish and agree to a set of standardized items PCPs cover with patients during the follow-up appointment.		(Clinic Name): - Establish a booking process using LACE - Book follow-up appointments - Clarify roles and responsibilities of clinic team members - Provide standardized follow-up

Evaluation Plan

Metric	Description	Data source(s)	Indicator of success
30-day readmission rates	The percentage of ADAPT patients readmitted to a hospital within 30-days of being discharged from hospital	Clinic EMR data Physician claims Connect Care DAD NACRS	There is a reduction in 30-day readmissions in the ADAPT patient population
Emergency department visit rates	The percentage of ADAPT patients who have an unplanned visit to an emergency department within 7 and 30 days of discharge from the hospital	Clinic EMR data Physician claims Connect Care DAD NACRS	There is a reduction in the unplanned ED visits (7- and 30-day) among ADAPT patients
Patient follow-ups with primary care within the recommended timeframe (7, 21, 30 days)	The percentage of patients that follow-up with primary care post-discharge from hospital within the recommended timeframe, depending on their risk of readmission	Clinic EMR data Physician claims Connect Care DAD NACRS	Increases in the number of high-risk and medium-risk patients who follow-up with primary care within 7 and 21 days of discharge from hospital, respectively.
LACE score included within discharge summary.	The percentage of ADAPT patients that had a LACE risk score included within their discharge summary	Clinic EMR data Connect Care DAD NACRS	Increases in the percentage of patients with a LACE risk score included within their discharge summary
Confirmation of the Primary Care Provider	The percentage of patients that report having a primary care provider during their hospital stay	CPAR data	Increases in the percentage of patients that report having a primary care provider during their hospital stay
Patient reported experience	Patients' views of their experience receiving care	PREMs survey	Patients report positive care transition experiences
Provider experience	Provider experience of co-creation and implementation	Team Experience Survey (Adapted from the Normalization Measures Development (NoMAD) survey) Semi-structured interviews	Survey: Positive assessment of implementation progress and changes in perception over time. Interviews: Positive experiences co-creating and implementing ADAPT core practices and

			working with the ADAPT research team
Implementation fidelity	The extent to which clinic teams implement and deliver their ADAPT interventions as intended	Provider self-reports and observational measures	Clinics demonstrate high fidelity and adherence to their implementation plans
Health system costs		EQ5D Survey	There is a reduction in health system costs

ADAPT Process Map

