Mind the Gap: Enhancing Continuity for Patients without a Primary Care Provider Through Digital Bridges

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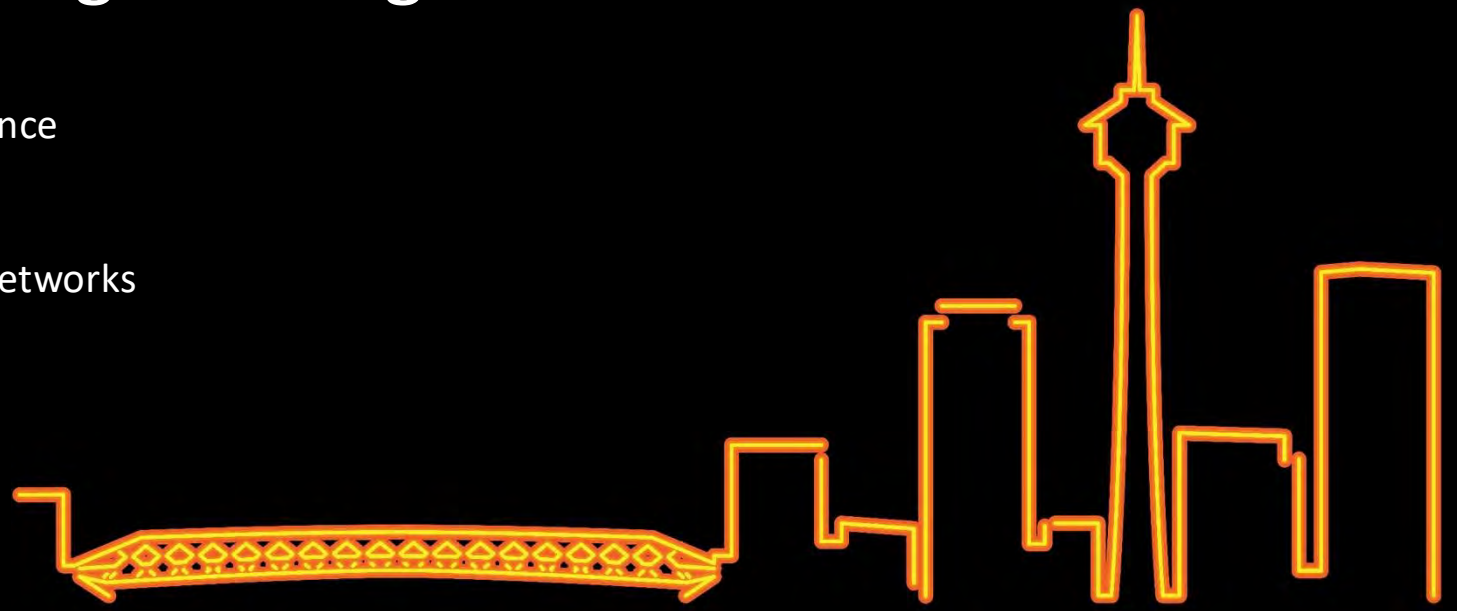


Objectives

Technology-enabled Collaboration

- Previous state: Landscape & Gaps
- Current state: Digital Solutions & Addressing Barriers
- Key Insights & Lessons Learned

Facilitating successful transitions in care

Primary Care Practices

Participate in CII/CPAR and conflict management

Educate patients with proper name, spelling and location of PCP

View CPAR admit and discharge notifications

View patients' discharge summaries

Offer and coordinate timely follow-up care

Work collaboratively to book follow up for higher risk patients before discharge

Acute Care Practices

Document PCP in Connect Care

Offer discharge readiness tools to patients during discharge planning

Incorporate Expected Discharge Date (EDD) and LACE scores in rapid rounds discussions

Share After Visit Summary with patients

Use discharge summary templates

Complete discharge documentation within 24-48hrs

Home to Hospital to Home Transitions- Alberta Health Services, 2026

Importance of Having a Primary Care Provider

"Albertans who have a continuous relationship with a family doctor and team don't just improve their health. They can also help to save costs."

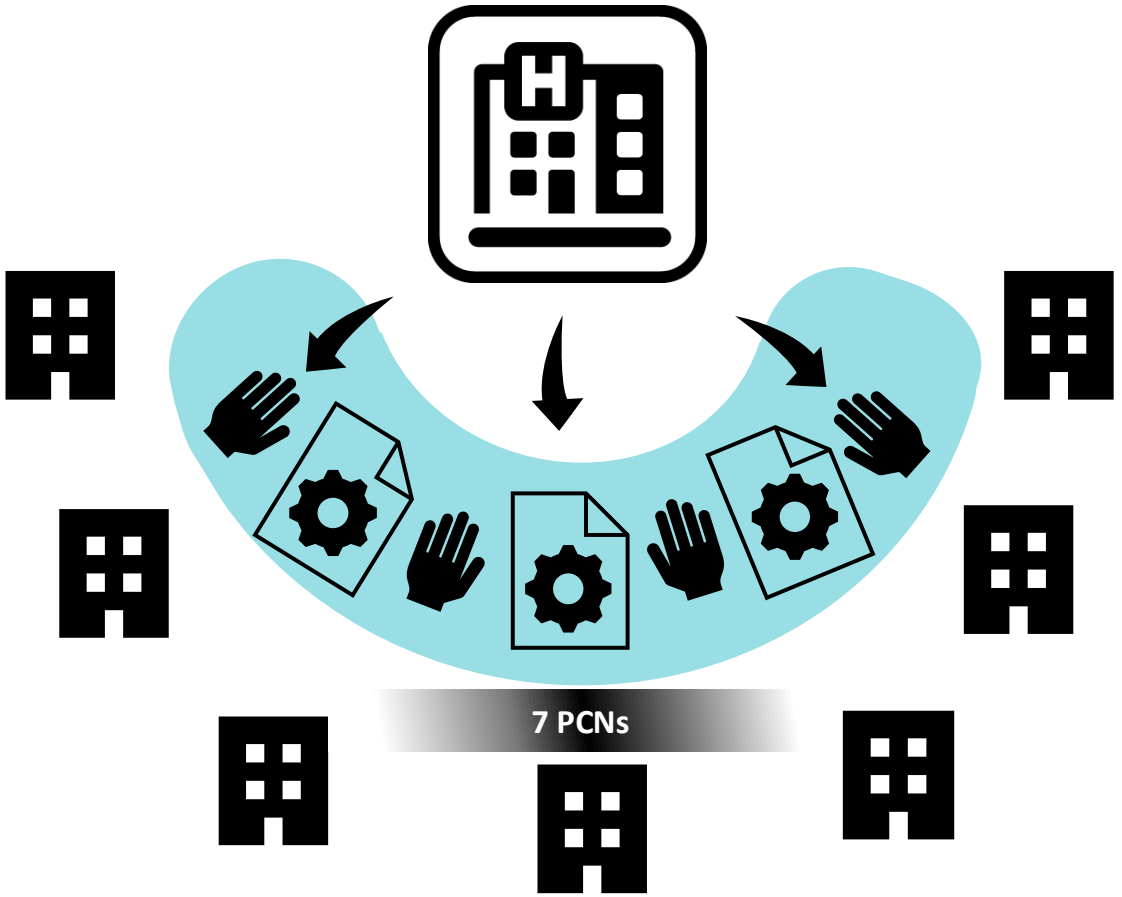
-Alberta Find a Doctor

Patients Can:

- ✓ Live longer
- ✓ Better care
- ✓ Better health
- ✓ Fewer hospital admissions, visits to emergency department
- ✓ Higher patient satisfaction

State of Health Care- Alberta Medical Association, 2025
Benefits of Having a Health Team- Alberta Find a Doctor

Previous State

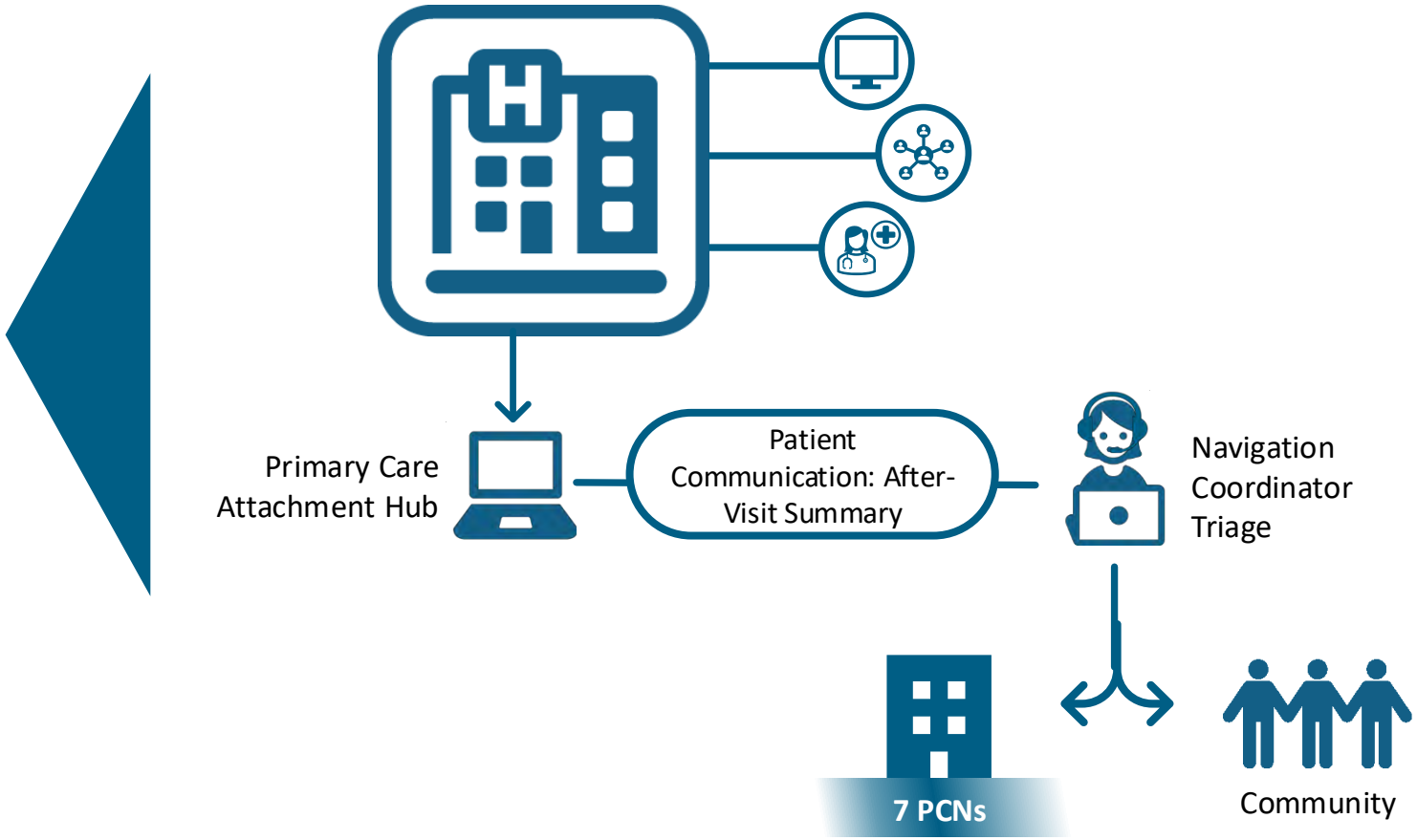


- Lack of standardization and care coordination
- Pockets of implementation in acute care
- Focus on attachment to a Primary Care Provider
- No linkages to community
- Decreased health equity and variable levels of service

Social Determinates of Health- World Health Organization, 2025

Current (Ideal) State

- Health system wide collaboration
- Improved continuity for follow-up care and attachment
- Standardized electronic process for acute care
- Community linkages and navigation supports
- Spread and scale to all four urban acute care sites

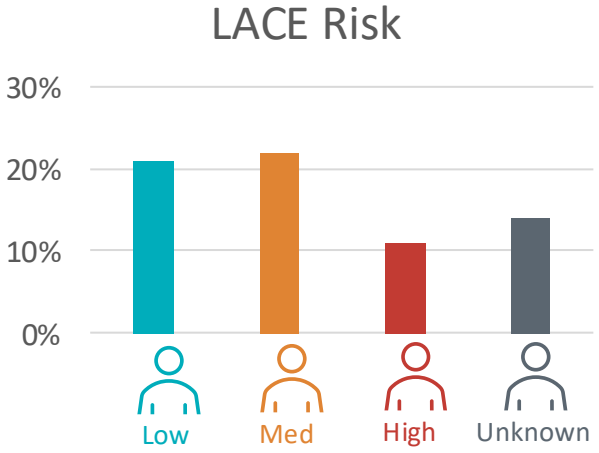


Centralized “One Way In” model for acute care to connect patients to PCN and other health and community resources

Primary Care Follow-Up: By the Numbers*

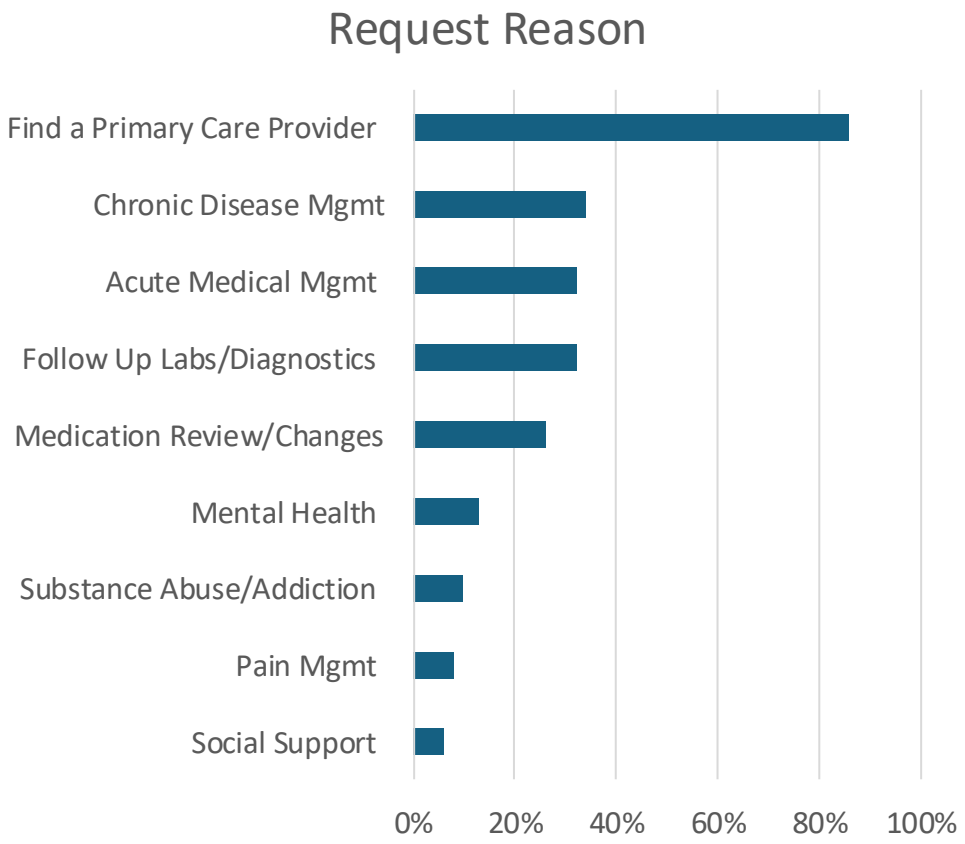
Number of Requests **913**

90% of patients are contacted within seven days of discharge



What staff are saying:

- …more efficient, reduces duplication
- …supports safer transitions of care
- …enhances coordination between acute care and community services



Primary Care Follow-Up Patient Experience Feedback

Satisfaction with the navigation coordinator's ability to listen and understand your concerns:

100% of the time

Degree that you feel the navigation coordinator recommended the most appropriate resources to you:

91% extremely large and large degree

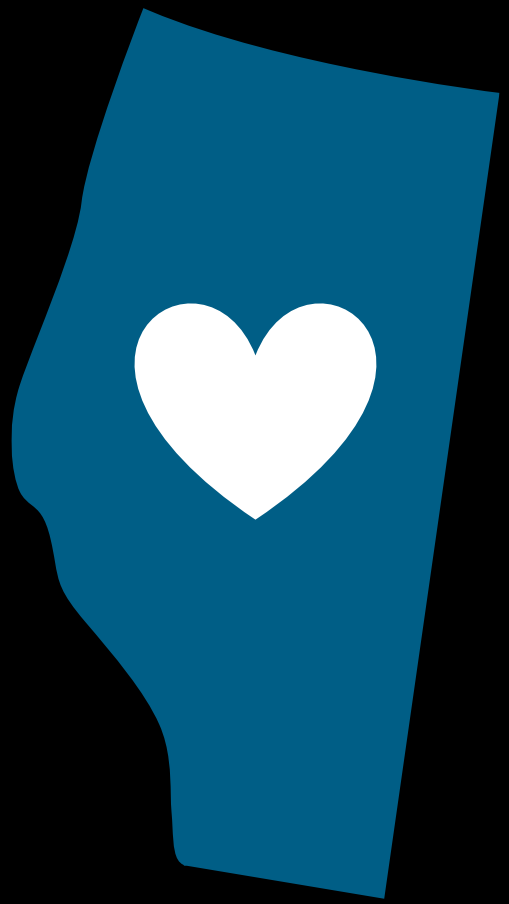
"[The navigation coordinator] provided everything I needed, and if I still need more support or help, she mentioned to call her back and will look at things further if need be."

*Data - July 2024 to December 2025

Key Learnings & Next Steps

- Digital Standardization
- Collaborative Design
- Patient-Centered, Equitable Care
- Change Management
- Grassroots Engagement
- Scalable Model
- System-Level Impact

Thank you.



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