Home to Hospital to Home Transitions Guideline: Snapshot

Note: the guideline activities summarized below may shift as leading operational practices evolve

Guideline elements

Patient admitted

Confirmation of the primary care provider (PCP)

Primary Care Provider/Team (PCP)

- Consider participating in CII/CPAR
- Confirm patient attachment
- Agree to care for unattached patient when applicable

Collaboration Zone

- Connect patient to PCP if unattached & patient expresses need

Hospital Team

- Ask patient/ family for PCP name or clinic name
- Confirm patient's PCP in Netcare (functionality coming soon)
- Contact PCP to confirm attachment

Admit notification

Primary Care Provider/Team (PCP)

- Open and read admit notifications
- Send relevant patient information to hospital team

Collaboration Zone

Hospital Team

- Send admit notification to identified circle of care, including PCP
- Request and receive relevant patient information from PCP

Transition planning

Primary Care Provider/Team (PCP)

- Provide patient information to hospital team

Collaboration Zone

- Arrange follow-up with PCP/specialist

Hospital Team

- Develop transition care plan with patient & family
- View information from PCP EMR in Netcare
- Use discharge safety checklist & complete med reconciliation
- Identify high-risk patients & arrange tests, referrals

Referral & access to community supports

Primary Care Provider/Team (PCP)

- Build plan to work with hospital team to ensure non-clinical supports like transportation, food services, etc., and to ensure clinical supports like home care, medications, equipment, etc.

Collaboration Zone

Hospital Team

- Work with supportive care teams & PCP to coordinate functional assessments for development of transition care plan
- Work with patient/family to arrange and document support/ assessment arrangements in transition care plan

Transition care plan

Primary Care Provider/Team (PCP)

- Confirm receipt of transition care plan
- Book tests and procedures to be done post-discharge
- Contact patient if follow-up appointment not scheduled

Collaboration Zone

- Send discharge notificaiton to PCP

Hospital Team

- Send transition care plan to PCP via eNotification (on discharge day)
- Provide patient-oriented plan (My Next Steps), after-visit summary and pharmacist report to patient
- Evaluate & provide support for patients to access meds till PCP follow-up visit

Follow-up to primary care

Primary Care Provider/Team (PCP)

- Perform medication reconciliaion, discuss patient goals, order tests
- Clarify questions re: transition care plan with hospital team
- Work with hospital team to provide timely follow-up

Collaboration Zone

Hospital Team

- Work with PCP team to book follow-up appointments
- Determine whether follow-up with PCP is needed

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