**Team Care Planning Roles and Responsibilities** Home to Hospital to Home Transitions

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| *H2H2H Team Tasks* | *Who?* |
| **Could do it****(in scope)** | **Has interest/ experience/ availability** | **RESPONSIBLE** | **CROSS TRAIN** |
|  | ***Examples of QI and clinical tasks:*** |  |  |  |  |
| *Regularly schedule QI team meetings* |  |  |  |  |
| *Identify patients admitted to the hospital (Note: CII/CPAR does this)* |  |  |  |  |
| *Identify patients discharged from the hospital (Note CII/CPAR and e-delivery do this)* |  |  |  |  |
| *Identify Admit/Discharge notifications received for patients* ***NOT*** *on the panel* |  |  |  |  |
| *When notified, review the patient discharge summary and/or Netcare* |  |  |  |  |
| *Check the risk of readmission score is documented in the community EMR* |  |  |  |  |
| *If no score, develop a process to determine and document the risk of readmission score* |  |  |  |  |
| *Determine if a post-discharge appointment is needed* |  |  |  |  |
| *If the patient does not require a follow-up appointment, phone to check in to promote relational continuity* |  |  |  |  |
| *Review the discharge summary to prepare for a follow-up visit* |  |  |  |  |
| *Identify outstanding requisitions and tests*  |  |  |  |  |
| *Identify team members the patient needs to see* |  |  |  |  |
| *Review existing test results* |  |  |  |  |
| *Schedule follow-up appointment post-discharge, as necessary (determine if follow-up is in-person or virtual)* |  |  |  |  |
| *Assess the need for a family member at the follow-up visit*  |  |  |  |  |
| *Contacting specialist advice programs, homecare, and other* |  |  |  |  |
| *Review and update the care plan with the patient* |  |  |  |  |