Connected Care Hub

Last updated: August 30, 2023

The Connected Care Hub focuses on delivering short-term transitional care, caring for patients with respiratory illnesses and recovery from other acute exacerbations or illnesses. By providing an increased intensity of care for a short duration of time, it will enable effective transition of patients into the community (or keep patients at home) and prevent unnecessary Emergency Department (ED) visits and in-patient hospital admissions.

Building from the success with virtual COVID care, the Hub aims to:

- Provide a Transitional NP:
  - for the days/weeks following hospital discharge
  - for the days/weeks following an acute episode or change in baseline
- Provide equitable and accessible care
- Better manage seasonal pressures
- Support transition to home/community

Transitional Care Model Overview

Nurse Practitioner led. Providing 1-30 days transitional care

Initial Criteria (Program-specific criteria to be added as needed)	
In Scope: • Adults (18+) • Short term need for transitional care • Discharged from hospital/ED or community-based populations including respiratory (e.g. COVID, flu, pneumonia), chronic illnesses (e.g. COPD, CHF, diabetes) and post-procedure • Specific medical populations (e.g. respiratory) • If unattached, ability to self-manage or manage with caregiver support (if so may be unattached) • Patients without OHIP-coverage	**Out of Scope:** • Pediatric (under 18) • Inpatients • If unattached and no clear hand off in community (e.g. no caregiver, no ability for self-management) • Patients in LTC/Retirement homes with clinical care • Mental health and opioid referrals

Core Components of Care Model

- Short term transition from hospital to home; and keeping people at home
  - Assessment (including screening for high risks)
  - Short term monitoring (managing risks and symptoms)
- Medication management and medication reconciliation (in the home as needed)
- Patient and caregiver education (including "red flag" indicators of worsening condition and next steps)
- Primary care provider and specialist follow-up/warm hand-off (case conferencing as needed)