St.Thomas Elgin General Hospital

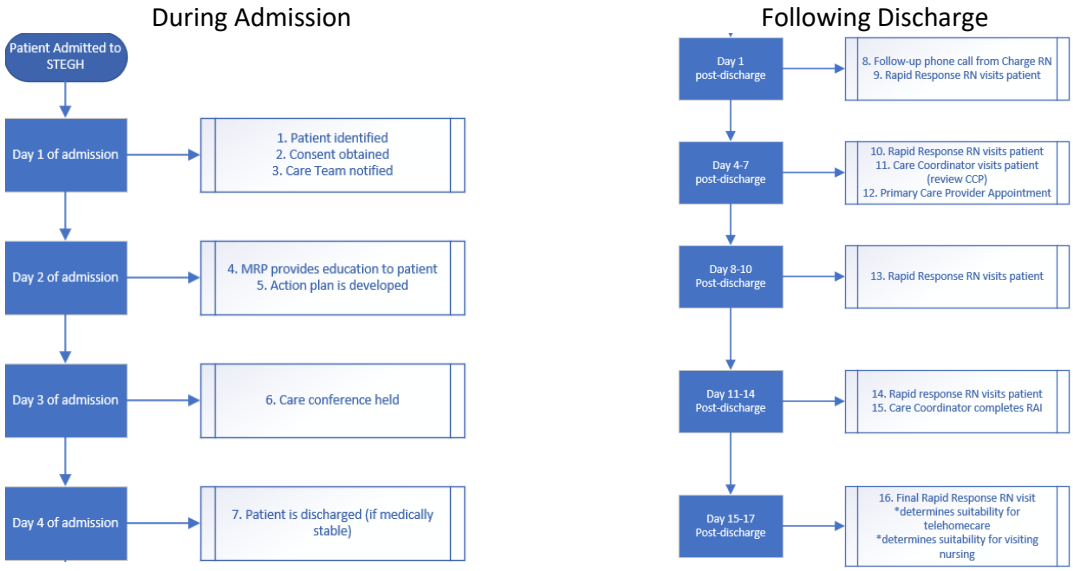
Introducing the PREVENT Program: Preventing Readmissions and Emergency room Visits in Elgin through Novel Transitions

Rationale

The transition from hospital back to community can be challenging for both patients and providers to navigate. Patients with CHF and/or COPD on AMU and in the ICU are often complex and at high risk of readmission following hospital discharge. The PREVENT program utilizes Health Links coordinated care planning to facilitate communication among hospital, home care and primary care providers in order to smooth the transition process and improve patient outcomes.

The PREVENT Process

PREVENT involves changes to both inpatient management and outpatient follow up. Patients identify care goals and receive self-management education while admitted. An action plan is created which is shared with primary care and home care during a 15-minute handover conference prior to discharge. Following discharge, patients are supported by rapid response nursing, their home care coordinator, and primary care provider. They also have access to ongoing specialist care and additional nursing support as required.



We'd like to hear from you! If you have questions or feedback please don't hesitate to contact us.