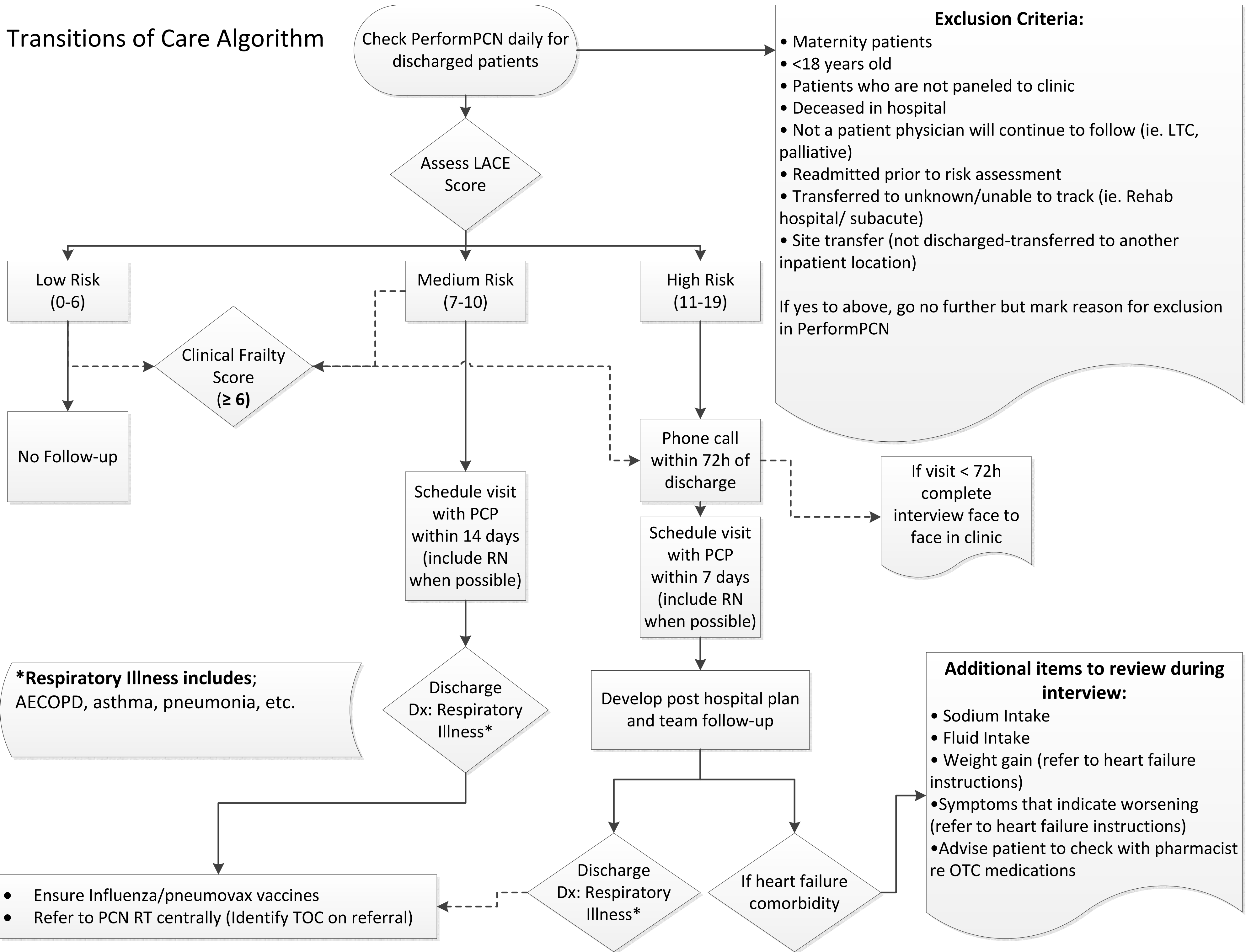

Transitions of Care Algorithm
Check PerformPCN daily for discharged patients
Exclusion Criteria:
• Maternity patients
• <18 years old
• Patients who are not paneled to clinic
• Deceased in hospital
• Not a patient physician will continue to follow (ie. LTC, palliative)
• Readmitted prior to risk assessment
• Transferred to unknown/unable to track (ie. Rehab hospital/ subacute)
• Site transfer (not discharged-transferred to another inpatient location)
If yes to above, go no further but mark reason for exclusion in PerformPCN
Assess LACE Score
Low Risk (0-6)
Medium Risk (7-10)
High Risk (11-19)
Clinical Frailty Score (≥ 6)
No Follow-up
Phone call within 72h of discharge
If visit < 72h complete interview face to face in clinic
Schedule visit with PCP within 14 days (include RN when possible)
Schedule visit with PCP within 7 days (include RN when possible)
*Respiratory Illness includes; AECOPD, asthma, pneumonia, etc.
Discharge Dx: Respiratory Illness*
Develop post hospital plan and team follow-up
Additional items to review during interview:
• Sodium Intake
• Fluid Intake
• Weight gain (refer to heart failure instructions)
•Symptoms that indicate worsening (refer to heart failure instructions)
•Advise patient to check with pharmacist re OTC medications
Discharge Dx: Respiratory Illness*
If heart failure comorbidity
• Ensure Influenza/pneumovax vaccines
• Refer to PCN RT centrally (Identify TOC on referral)