Northumberland
Family Health Team

HOME BASED TRANSITION CARE TEAM

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Information for Health Care Providers

Who is this program for?

Patients with CHF and COPD and associated conditions e.g. acute kidney injury caused by chronic disease

- Being discharged from hospital
- At risk for hospitalization
- Unstable symptoms or unable to self-manage
- Newly diagnosed with these conditions

What do we do?

We provide support including:

- Assessment/monitoring
- Adjustments to care plan to encourage disease stability
- Education to patient/caregivers about their disease and how to self-manage
- Development of action plans

Program is delivered through home visits, telephone calls and other virtual care based on patient needs. Patients are given a phone number which they can call during business hours if they need non-urgent assistance or advice.

We work with primary and interprofessional healthcare providers, community partners and patients/caregivers to strive for disease stability, decrease hospital visits and support optimal quality of life.

How long do patients stay in the program?

Services are generally provided until symptoms stabilize and the patient/caregiver is comfortable with management. This can typically be accomplished within 4-6 weeks following a patient discharge or from first visit. Some patients benefit from a single visit from our team.

Communication with Healthcare Providers:

- EMR messaging is preferred but for urgent concerns, we will contact you by phone.
- To keep up to date with HBTCT patient visits, please refer to our notes in the EMR.
- If you would like to discuss the plan of care, feel free to reach out to us via phone or email (see contact info).

How to Refer to HBTCT

Using the NFHT general referral form, indicate HBTCT, specific condition and if there is a focus of care which you would like us to target and fax form to: 289-252-2243.

CONTACT INFO:

MONDAY – FRIDAY 8 AM - 4PM

CELL: 289-691-2139

EMAIL: ATOLONEN@NFHT.CA
CLEWIS@NFHT.CA