For Hospital 2 Home questions or referrals contact:
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Hosptial2Home.Org

WHAT IS HOSPITAL 2 HOME?

Hospital 2 Home (**H2H**) Care Transitions are designed to aid and support adults with memory loss or those dealing with the effects of COVID-19 and their caregivers during the transition from hospital to home. This transitional care program is delivered by licensed social workers who provide care coordination by in-person, virtual and telephone support. H2H offers immediate response, crisis intervention and Respite Coaching services to each individual family. We are a dedicated team that works directly with all professional, community and caregivers support resources.

ROLE OF AN H2H CARE TRANSITION SPECIALIST

1. Connect to programs and services in the community by providing info, referrals and support
2. Help find solutions to issues that could lead to hospital readmissions
3. Inform and educate about care options and develop care plan based on individual needs.
4. Advocate on behalf of patient and caregiver
5. Support patient and caregiver in navigating care plans and complex discharge plans.
6. Find solutions to medication management issues
7. Support connection with primary care physician
8. Help access support programs such as SNAP, ADSD waivers, respite programs, home health agencies, home modifications and more.

BENEFITS OF HOSPITAL 2 HOME:

- IMPROVED medication management
- MEDICAL stability—short and mid-term
- REDUCED caregiver burden
- ACCESS to long term care resources
- INCREASED patient engagement
- IMPROVED health outcomes

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