A Soft Landing: The Patient Journey from Hospital to Community Care

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Background

Seniors admitted to the hospital having completed their acute treatment, may have deconditioned functionally and cognitively. If they do not meet rehab criteria to assist them in returning to their previous functional level, they may be at risk for not being able to return home.

Objectives

The collaboration between the acute care sector (Scarborough Health Network) and community care sector (Carefirst Seniors and Community Services Association Transitional Care Centre, TCC) aims to provide patients and caregivers seamless transitions across the health care continuum that begins in the hospital, continues into the community with their transition to TCC and is maintained once participants have returned home. The goals of the program extend beyond strengthening and returning to previous functional levels to providing participants and caregivers access to services that will improve or maintain their ability that could enable to continue to live in the community independently.

Description

The partnership between Carefirst’s Transitional Care Centre (TCC) and Scarborough Health Network (SHN) allows seniors who require reconditioning after their acute medical illness access to physiotherapy, nursing, personal support, and community support services.

Through ongoing collaboration between the participants, SHN, Carefirst, and the Central East LHIN individuals are supported in a timely, coordinated and seamless manner as they move from SHN to TCC and then back into the community with the required supports in place that would enable to them to continue to live in their homes for as long as possible.

Aim

Transitional Care helps provide supportive inpatient care post hospitalization, so that seniors are able to return home.

Actions Taken

This collaborative program was developed to ensure that seniors, who are at high risk for not being able to return home, receive the reconditioning to enable them to continue to live in the community independently. This restorative program is an innovative model that provides wrap around care that continues once the participant has been discharged home from TCC. The care team then leverages all available resources in order to assist participants in achieving them and reintegrating them back into the community.

Interventions and Programs Based on Participant/Caregiver Goals and Needs

Impact and Results

TCC and SHN Partnership Overview 2017/2018

Program Statistics

Quantitative and qualitative data was collected to demonstrate the effectiveness of the collaboration between SHN and Carefirst.

Quality of Care

87% felt that quality of care received was very good or excellent

Coordination of Care

84% of participants felt that staff were able to answer their questions and coordinate their services outside of TCC

Patient/Caregiver Overall Experience

87% their overall experience as very good or excellent

Readmissions

TCC 10.3%  Medicine is 10.4%

Participants are at higher risk for readmission, but have readmission rates similar to SHN readmissions

Wrap Around Care

100 % of participants continue with some services post discharge from the program

Services

Virtual Ward, GAIN (Day Programs), Activation/Enhanced, Recovery, Geriatrician, Falls, Transportation

Conclusions and Spread

The collaboration and integration of acute care and community care is essential in ensuring that patients are discharged from hospitals in a safe, effective manner that optimizes their well-being, reduces caregiver burden, reduces length of stay and prevents readmissions. This program ensures that patients receive the reconditioning they require to increase their strength and mobility and the community resources needed to enable them to continue to live in the community independently. This restorative program is an innovative model that demonstrates how to move care out of the hospital and closer to home whilst ensuring participants receive quality care.

Next steps:

Increase opportunities to include participants directly from the Emergency Department avoiding unnecessary hospital admissions

Further expand the program to the include participants from the Centenary Site

About Carefirst

Carefirst Seniors & Community Services Association is a non-profit charitable community services agency established since 1976, together with Carefirst Family Health Team (since 2007) and Carefirst Foundation (since 2008). We are committed to serve the community with our belief that “Care” for our client’s needs has always been our “First” and primary level of concern and focus.

Our mission is to ensure the seniors and those in need of our services enjoy independent, enriched and quality living in the community through our social, health care and supportive services, and is recognized as a centre of excellence in orthopaedic surgery, cancer care, and mental health.

About Scarborough Health Network

At Scarborough Health Network (SHN), a quality patient experience comes first. Affiliated with the University of Toronto, SHN consists of three hospital sites (Birchmount, General, and Centenary) and five satellite sites in Scarborough. SHN delivers a broad spectrum of health services to one of the most diverse communities in Canada, including a full-service Emergency Department at each site, advanced maternal and neonatal care in state-of-the-art birthing centres, and specialized paediatric services. SHN is home to a number of regional programs serving the central east Greater Toronto Area (GTA) and beyond, including nephrology, cardiac care, vascular surgery, and vision care, and is recognized as a centre of excellence in orthopaedic surgery, cancer care, and mental health.