

Transitioning Home: From Inpatient Rehabilitation to Community Living

**Rapid Podium Presentation
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TRANSITION HOME

An innovative, specialized partnership
between a community outreach team and inpatient rehabilitation units
to assist the transition of medically complex, frail, geriatric patients from

Inpatient Rehabilitation Units → Community Living

- Time-limited intervention
- Dedicated care provider (OT or OT/PT), backed up by an inter-professional team
- Pre-discharge home visit and/or Post-discharge home visits

“Right care at the right time and in the right place” (MOHLTC, 2012)

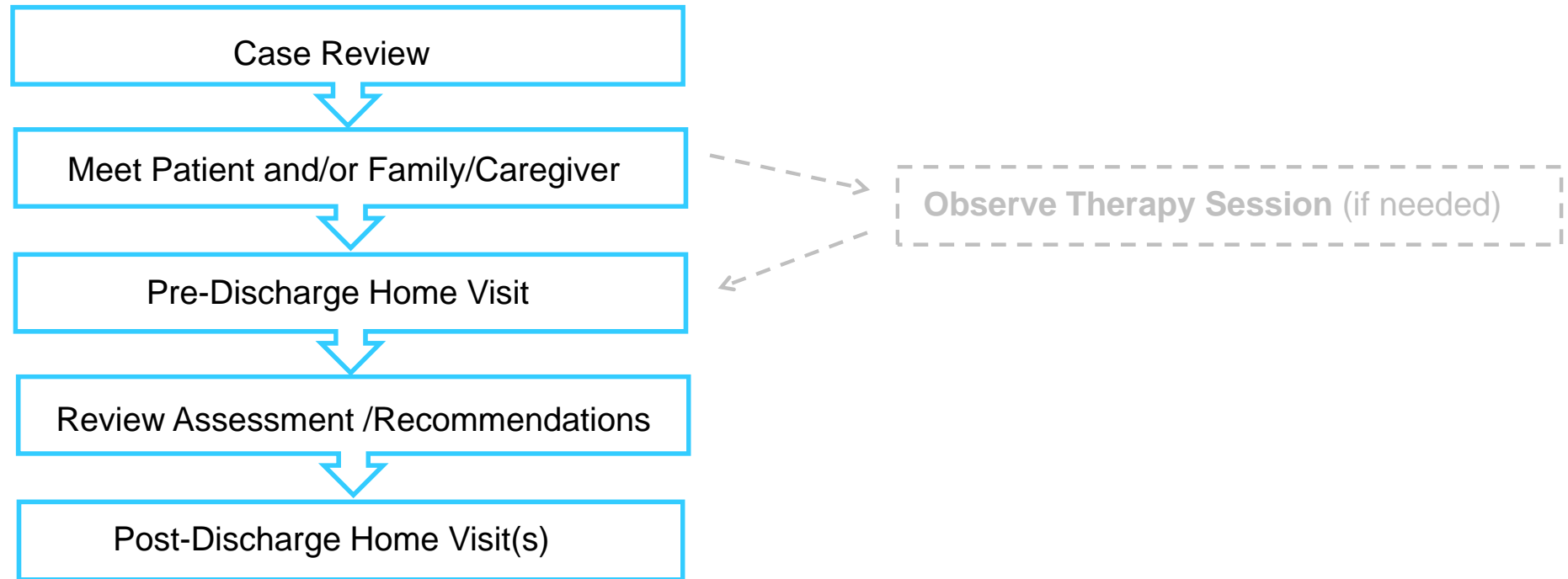
Transition Home- Goals

- Adhere to inpatient rehabilitation units' length of stay targets
- Optimize discharge home for patient
- Optimize discharge home for patient's family /caregiver
- Provide immediate continuity of care
- Reduce frequency of emergency department visits and acute care readmissions
- Reduce number of Alternate Level of Care hospital beds
- Delay or even avoid admission into LTC facilities

Transition Home - Referral Criteria

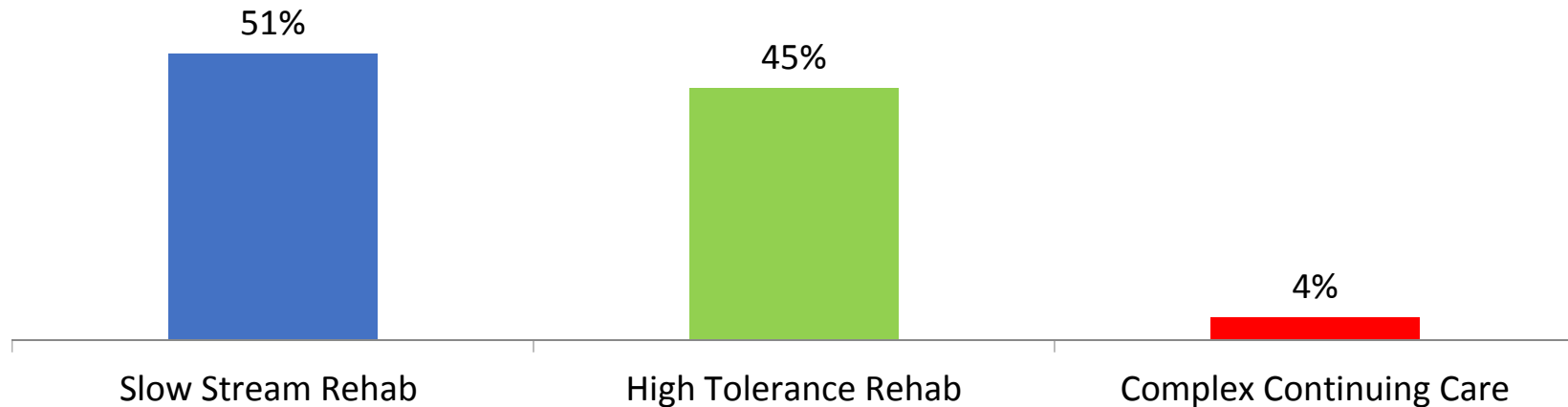
- ✓ Inpatient rehabilitation or Complex Continuing Care unit patient; 65 Years old+
- ✓ Live in specific catchment area (NB: exceptions made on basis of continuity of care)
- ✓ Significant change from baseline level of function
- ✓ Concerns identified by inpatient team regarding safe return home and/or management of care needs post-discharge
- ✓ Immediate services post-discharge required to ensure safety

Transition Home-Process



Transition Home- Data to Date

- **71 Transition Home patients to date**



- **Positive Subjective Feedback/Responses**

- Referring inpatient teams
- Patients
- Family members and/or caregivers

Transition Home- Feedback

*Pre-discharge home visit pictures, videos and reports act **as our eyes and ears into the patient's home** . Home visits provide the best, most accurate description of the patient's **functional abilities** and **whether their home environment is safe**.*

-Inpatient Occupational Therapist



Transition Home- Feedback

*Transition Home pre-discharge visits provide **timely identification of potential discharge issues** and **help guide my final treatment and discharge recommendations.***

-Inpatient Physiotherapist



Transition Home- Feedback

*Transition Home recommendations were not only practical and helpful, but really **helped to relieve my patient's and their family's anxiety** and stress about returning home.*

-Inpatient Social Worker



Transition Home- Feedback

Recommendations for my safe discharge home weren't just provided, but were actually implemented before I got home and that made all the difference.

-Inpatient Rehabilitation Patient



Transition Home- Feedback

*I was much **less anxious** about my mother returning home as practical **solutions and strategies**, as well as a **support system** had been put in place.*

-Inpatient Rehabilitation Family Member



Transition Home – Future Steps

- Further **objective evaluation**
 - ED visits
 - Acute care admissions
 - Inpatient rehabilitation unit readmissions
 - Time spent post-discharge living in community prior to LTC admission



- **Incorporate technology:** Virtual home assessments through Ontario Telemedicine Network (OTN)
- Increase **post-discharge phase length and involvement** to optimize outcomes (Werner et al., 2019)
- **Create and/or enhance existing partnerships** to improve the integration, coordination and distribution of senior's healthcare services in Ontario

Werner, N. E., Tong, T., Borkenhagen, A., & Holden R. J. (2019) Performance-Shaping Factors Affecting Older Adults' Hospital-to-Home Transition Success: A Systems Approach. *The Gerontologist*, 59(2), 303–314.

The Baycrest logo consists of the word "Baycrest" in a white, sans-serif font, centered within a light blue rounded rectangular background.

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Thank You