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

Case Review

Meet Patient and/or Family/Caregiver

Pre-Discharge Home Visit

Review Assessment /Recommendations

Post-Discharge Home Visit(s)

Observe Therapy Session (if needed)
Transition Home - Data to Date

- 71 Transition Home patients to date

- Positive Subjective Feedback/Responses
  - Referring inpatient teams
  - Patients
  - Family members and/or caregivers
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 pre-discharge visits provide timely identification of potential discharge issues and help guide my final treatment and discharge recommendations.

-Inpatient Physiotherapist
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
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
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

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Thank You