

Name of Document: **Home at Last**

Date: ?

Agency: Partnership between Halton CCAC, community support service agencies, and hospitals in Etobicoke and Peel. Project funding provided by MOHLTC.

Initiative: Purpose of the project was to:

- Minimize delays in hospital discharges
- Minimize preventable readmissions
- Facilitate smooth transitions from hospital to home
- Ensure needed community supports are in place
- Reduce inappropriate ALC

CCAC Care Coordinator works with patient and family to establish a pre-determined discharge time. CCAC Care Coordinator arranges transportation home. PSW accompanies patient home, assists to pick up prescription and necessary groceries, and stays with patient until family arrives or 9:00 p.m. The Care Coordinator follows up the next day to see how patient is doing and what other community supports are necessary. (Refers to “wrap-around care”.) Patients must be able to direct their own care, be cognitively capable, be mobile with minimal assistance, be medically stable, and be over 65. Project was based on “Balance of Care” model from the UK.

Results: Evaluation under development.