Tillsonburg Transition Care Team

Brief description of the project:
The Transition Care Team consists of key stakeholders from **Tillsonburg District Memorial Hospital (TDMH)**, **Multi Service Centre, Maple Manor Nursing Home**, **SW CCAC and SW LHIN.** This team assists seniors to remain in their own homes, decrease bed pressures ER/Inpatient and reduction in Complex Continuing Care beds.

Target Population: Seniors who reside in the TDMH Catchment

Quick Stats:
- There has been movement within the Assisted Living Community (ALCOM)/Supportive Housing program allowing for a reduction in waitlisted clients.
- Expansion of Transition Team with new partner members
- Interim Long-Term Care Home (LTC) beds used 14 times 2011/2012 fiscal year
- 12 patients received Social Work in 2011/2012 fiscal year
- Occupancy rates are below 100% over recent weeks for Acute Care and Complex Continuing Care.

Goals & Objectives of the Project:
Build a collaborative team of key stakeholders to facilitate a smooth transition for clients from hospital to home ensuring safe transitions of care by the right provider at the right time in the right place.

Milestones:
- Development of the Oxford Falls Prevention Collaborative in a cooperative venture with Public Health
- The Antibiotic Resistant Organisms (ARO) flow chart accepted by Public Health and being utilized.
- Engaged new community partners as part of the transition team

Lessons Learned and Actions:
- Adapted to the demands for services
- Education to young elderly promoting healthy lifestyle and valuing their contributions to society by highlighting ways to showcase our community as an age friendly community

How eHealth enables/impacts the Project:
- Health Partner Gateway (HPG) provides a gateway to send electronic referrals
- Integrated Assessment Repository (IAR) allows assessments to be uploaded for viewing so the client only has to tell their story once

Challenges:
- Increase demands for service
- Increase demand for LTC services
- Increase in waitlisted clients for service
- Occupancy rates while improving still remain a challenge

Success Story
A 75 year old medically fragile gentleman, who also is primary caregiver for his spouse who suffers from Alzheimer 's disease, was seen at TDMH more than 10 times in a 1 year period. During these frequent hospital visits, crisis arrangements were made to care for the client's spouse. Transition Case Manager assessed and discussed the needs of the client and family determining that the ALCOM program would be suitable. ALCOM was initiated in August 2010. The Client continues to live at home and care for his spouse with the supports of the ALCOM program and has not returned to hospital in over 1 year.

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Next Steps: .
- Engaging community partnerships to strategize for future needs.
- The initiation of the Home First philosophy.
- Expanding the transition team to include other community partners. Alexandra Hospital now a team member and are casting the net to incorporate other community partners.