Bakuska R et al, 2026, Southlake@home + ACE: Hospital Care Doesn't Stop at Discharge: +ACE at Home Shows How. International Journal of Integrated Care 26(S2):525 DOI: doi.org/10.5334/ijic.ICIC26525

POSTER ABSTRACT

Southlake@home + ACE: Hospital Care Doesn't Stop at Discharge: +ACE at Home Shows How

International Conference on Integrated Care (ICIC26), Birmingham, 13-15 April 2026

Renee Bakuska[1], Kathleen McQueen[2], Jennie Popplow[1]

1: Southlake Health, Canada
2: CBI Home Health, Canada

Background: Hospitalization often accelerates frailty, functional decline, and loss of independence among older adults. Evidence-based Acute Care for the Elderly (ACE) models mitigate these risks through interdisciplinary, person-centered care. Building on Southlake@home and the hospital's ACE Unit, Southlake@home +ACE extends best-practice geriatric care beyond hospital walls into a coordinated hospital-to-home pathway—in partnership with CBI Home Health—delivering early rehabilitation, functional assessments, and restorative interventions to optimize recovery and support aging in place.

Approach: Southlake@home +ACE integrates hospital, home, and community care for older adults with complex medical and functional needs. The model builds on Southlake Hospital's ACE Unit, providing targeted interventions within a senior-friendly environment led by geriatric-trained staff.
An embedded coordinator participates in daily ACE Unit rounds to identify eligible patients and initiate transition planning. Interventions are guided by a holistic assessment, functional independence index, and key geriatric assessment domains, emphasizing early mobilization, therapy engagement, proactive delirium and fall prevention, and co-designed care planning with patients, families, and caregivers.

Post-transition, patients receive a home visit within 24 hours for comprehensive geriatric assessment, medication reconciliation, and individualized restorative care planning. Coordinated nursing, therapy, behavioral, and social care interventions, augmented by remote patient monitoring (RPM) and real-time communication across the interdisciplinary team, ensure safety, continuity, and timely response to emerging needs. Ongoing assessment, digital monitoring, social prescribing, enhanced caregiver supports, and 24/7 clinical support further optimize recovery. Program evaluation uses a Quintuple Aim balanced scorecard with continuous feedback driving improvement.

Results: Within 16 weeks, 93% of patients met personalized goals, with functional improvements including 63% in balance and mobility, 63% reduction in frailty, and a 2.6-point average increase on the Modified Barthel Index. Reliance on acute care decreased: ED visits fell 64%, seven-day readmissions were 0%, 30-day readmissions 0.7%, and 75% avoided institutionalization.
Care metrics were strong: 100% received first home visits within 24 hours, 92% had medication reconciliation within 48 hours, and 77% had facilitated PCP visits within seven days. DIVERT scores improved (−55% risk of ED/hospital) and CHESS scores showed 94% improvement in frailty/instability. Falls risk decreased in 75% of patients, 100% were screened for social determinants, and 71% of caregivers reported reduced distress. System-level benefits included a 3.7-day reduction in hospital length of stay and an average 8.4 ALC days saved per patient. Provider experience remained high, with 96% reporting weekly “Joy in Work” and a 100% Net Promoter Score.

Implications: Southlake@home +ACE demonstrates that ACE principles applied across a hospital-to-home pathway improve outcomes while easing system pressures. Early supported discharge, integrated medical, rehabilitation, behavioral, and social supports, and person-centered care enhance transitions. RPM and real-time team communication strengthen responsiveness and continuity across settings. Ongoing engagement with patients, families, and caregivers reduces readmissions and ED use.

For international audiences, this model illustrates how aligning hospital, home, and community services under the Quintuple Aim can advance safety, independence, equity, and system sustainability. It offers a scalable, transferable framework for sustainable, outcome-driven, patient-centered care for older adults worldwide.