International Journal of Integrated Care

Bakuska R et al, 2026, Southlake@home PLUS - "From Hospital to Home — Care That Understands". International Journal of Integrated Care 26(S2):526
DOI: doi.org/10.5334/ijic.ICIC26526

POSTER ABSTRACT

Southlake@home PLUS - "From Hospital to Home — Care That Understands"

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

Renee Bakuska[1], Kathleen McQueen[2]

1: Southlake Health, Canada
2: CBR HEALTH, Canada

Background: Caring for older adults with responsive behaviours is a persistent challenge across health systems. These behaviours frequently delay or prevent long-term care (LTC) admission, contribute to Alternate Level of Care (ALC) designations, and extend hospital stays. Families, often under-supported, experience high stress that can lead to crisis admissions when care at home is no longer manageable.

To address these gaps, Southlake@home Plus was developed. Building on the ORIGINAL Southlake@home model, the program targets seniors with complex needs through intensive in-home supports and structured caregiver respite. By engaging the full circle of care—including families—before discharge, the program has enabled smoother transitions, reduced caregiver anxiety, and delivered sustainable community supports. Service providers and community agencies collaborate under a single integrated model with shared care planning, minimizing duplication and ensuring continuity.

Approach: The model was co-designed with patients, families, and providers, ensuring lived experience shaped priorities. Families were not only consulted but also co-led committees and shared decisions on resource allocation, embedding their voice in program design.
Stakeholders consistently prioritized caregiver support, early involvement in discharge planning, and behavioural management in the home.
The model is structured around four pillars:

Client engagement: Patients and families are active partners in planning, feedback, and decision-making.
Integrated care: Hospital, primary care, and community providers function as one coordinated team with shared care plans.
Insights driven: Evidence-based practices emphasize outcomes, efficiency, and continuous improvement.
Proactive wellness: Evidence-informed strategies reduce behaviours, strengthen independence, and protect caregiver resilience.

Joint care planning meetings and in-home visits ensure caregivers feel confident managing complex behaviours, while integrated service delivery eliminates duplication and builds seamless, person-centred care.

Results: The program has demonstrated measurable impact:
86% of patients with responsive behaviours successfully transitioned to LTC, compared to <40% previously.
30% reduction in hospital ALC length of stay, (averaging 12 fewer days per patient).
25% reduction in emergency department visits among participants.
95% of families reported increased confidence and feeling better supported in managing care at home.
Zero duplication of services through coordinated, shared planning across providers.
Qualitative feedback highlighted smoother transitions, reduced caregiver stress, and stronger collaboration across sectors, with fewer readmissions and more efficient resource use.

Implications: Southlake@home Plus shows that seniors with complex, behaviour-related challenges can be safely and effectively supported in the community when care is co-designed and integrated.
Key transferable lessons include:
Co-design with families creates practical, sustainable services.
Integrated care with shared planning reduces duplication and improves system flow.
Proactive behavioural supports reduce hospital pressures and enhance LTC placement success across diverse contexts.
This work aligns with the conference theme of Improved Outcomes through Community-Based Care and the principle of People as Partners in Health and Care. By placing families and patients at the centre, Southlake@home Plus improves outcomes, strengthens collaboration, and restores dignity and independence for older adults.