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POSTER ABSTRACT

Sunnybrook-to-Home: An Integrated Transitional Care Model Improving Patient Flow, Timely Home Care, and Community Supports for Older Adults in Toronto

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Older adults living with frailty often experience fragmented transitions from hospital to home, contributing to prolonged Alternate Level of Care (ALC) stays, delayed access to services, and preventable emergency department (ED) revisits.

To address these challenges, Sunnybrook Health Sciences Centre , SPRINT Senior Care, SE Health, and VHA Home Healthcare partnered to launch the Sunnybrook-to-Home (SB2H) program in June 2024. The model was designed to deliver coordinated, people-centred, and timely transitional care.
SB2H aims to improve patient flow, reduce ALC pressures, and deliver wraparound community-based supports that respond to the needs and goals of older adults. SB2H reflects core ICIC pillars through:
- Coordinated and Integrated Care: unifying hospital teams, home care providers, and community support service organizations through a shared transitional pathway;
- People-Centered Care: tailoring goals and supports to what matters most for each patient and caregiver;

Improved Transitions and System Performance: reducing delays, facilitating earlier discharge, and preventing readmissions and ED visits.

SB2H is delivered through a standardized transitional care pathway. A unique feature of the model is the embedded use of community-based SPRINT Senior Care Transitional Care Leads (TCLs) who act as navigators between hospital and community services. The TCLs screen and enroll eligible patients, coordinate discharge planning, ensure service set up through home our care providers and proactively address social determinants of health by linking patients to resources such as Meals on Wheels, transportation, housing supports, and food security programs. Their community expertise enables early identification of social barriers that may jeopardize recovery, ensuring each transition plan is practical, equitable, and sustainable. The

TCLs collaborate closely with hospital clinicians and home care providers to maintain continuity and create seamless transitions home.

Since its inception, SB2H has enrolled over 500 patients, with more than 30% referred directly from the ED, helping to avoid unnecessary admissions. SB2H patients receive their first home care visit within 1 day, compared to approximately 10 days for provincially-funded home care services, supporting early stabilization at home. The average ALC length of stay is 3.7 days for SB2H patients, compared to 7.5 days for similar patients discharged home with traditional services. Nearly 20% of participants required navigation support, directly addressing social and practical needs that influence recovery. Qualitative interviews showed improved confidence, with one participant sharing: “I felt more secure going home knowing someone would follow up with me.”

By combining expert navigation of community support service leaders, rapid home care access, and cross-sector collaboration, SB2H has accelerated safe discharge, diverted hospital admissions, reduced ALC days, and improved patient and caregiver experience. Embedding community service navigators with deep local knowledge has been essential to achieving meaningful, people-centered outcomes and advancing health equity for vulnerable seniors in North Toronto.

SB2H offers a scalable pathway for jurisdictions seeking to improve patient flow and support aging in place. Its innovative integration of SPRINT Senior Care TCLs demonstrates how addressing social determinants of health can enhance both clinical and system outcomes, while strengthening community-based health and social care, recovery and system capacity.