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POSTER ABSTRACT

The Centralized Community Health Professions Team (CCHPT): Strengthening Transitions from Hospital to Community through an Integrated Health Professions Model

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Older adults who no longer need hospital care but are not yet ready to return home often stay in the hospital while waiting for community supports. These patients are referred to as “Alternate Level of Care” (ALC) patients. At Sunnybrook Health Sciences Centre, ALC patients account for about 12.5% of hospital beds, which contributes to emergency department crowding and delays for incoming patients. Hospitals are not well suited to meet the personal and rehabilitation needs of ALC patients, who would be better supported in the community. In 2025, Sunnybrook Health Sciences Centre, in partnership with LOFT Community Services and five Community Reintegration Care Units (RCUs)—Bellwoods Centres, LOFT White Squirrel Way, Reconnect,

The Neighbourhood Group, and Les Centres d’Accueil Héritage—launched the Centralized Community Health Professions Team (CCHPT). Supported by Ontario Health provincial funding, the initiative aims to strengthen discharge pathways and support safe, person-centered recovery for clients who require short-term transitional care before returning home.

Approach: To effectively meet those patients’ needs, Sunnybrook created the Centralized Community Health Professions Team (CCHPT). The CCHPT brings together occupational therapists, a physiotherapist, therapy assistants, and a psychogeriatric case manager to deliver consistent services across all RCUs. The model advances core pillars of integrated care, including people-centered care, coordinated and seamless transitions, workforce capability, and resilient partnerships.

A single interdisciplinary team ensures equitable access to rehabilitation and psychosocial services, while shared referral, assessment, and documentation processes support continuity and reduce duplication. By mentoring front-line RCU staff and working alongside RCU teams, the CCHPT builds local capacity to support clients with complex physical, cognitive, and psychosocial needs, reinforcing collaborative care across sectors.

Results: Since April 2025, the CCHPT has completed 1,285 visits, including 1,179 direct therapy sessions, supporting 39 clients with an average of eight visits each. Services have included ADL retraining, mobility and transfer training, equipment provision, pain management strategies, psychosocial support, and home safety planning. Early feedback from partners and staff points to smoother transitions, clearer communication, and greater confidence supporting clients with complex needs. I would insert a quote here – we have a few.

Implications: The CCHPT demonstrates how shared health professional resources can reduce variation, improve equity, and enhance recovery for clients transitioning from hospital to community settings. The model operationalizes key ICIC pillars in practice by aligning goals across partners (coordinated care), grounding therapy plans in individual goals (person-centered care), building confidence and consistency across care teams (workforce capability), and strengthening cross-sector relationships that support stable community transitions (resilient communities and alliances).

An implementation evaluation, led by the The Sunnybrook Research Institute , is underway to examine delivery, experience, and sustainability using an implementation science approach. Early indications suggest the CCHPT is bridging gaps between sectors and offers a scalable, collaborative approach to more connected, responsive, and sustainable transitional care in Ontario.