LEGHO Demonstration Project

Improving Capacity, Access and Flow: Ensuring a Seamless Transition from Hospital to Home

Overview

A collaborative partnership between ONE CARE Home and Community Support Services and Stratford General Hospital (HPHA) and engaging Home and Community Care Support Services began in April 2024.

Goal: Streamline system coordinated access to community support services (CSS) and improve transitions from hospital to home by addressing improvements across the Quintuple Aim.

Intervention: Embedding a *Let's Go Home (LEGHO)* Care Planner (CP) into daily interdisciplinary hospital discharge planning meetings on E1-500 at Stratford General Hospital. This early supported discharge model features:

- Care planning initiated by a community nurse prior to discharge, with follow-through in community
- Access to bundled CSS at no charge to the clients
- Caregiver support enhancements (resources, guidance, preparation)

Outcomes of Interest:
- Reduce Alternate Level of Care (ALC) length of stay
- Reduce 30-day hospital readmissions
- Reduce avoidable ED visits post discharge
- Improve timely and equitable access to community-based services and support for clients and caregivers

Status Update

Moving from Pilot Project to Demonstration Project

During the first nine months of the LEGHO pilot project, 88 patients were supported by the ONE CARE LEGHO CP in advance of hospital discharge, typically visiting the patient in the hospital on the same day as discussed in discharge planning rounds. In February 2025, the LEGHO CP will expand service to E3-500 at Stratford General Hospital. This expansion, from pilot project to demonstration project, is supported by a range of positive outcomes and impacts, a few of which are listed below.

Improvements in Capacity, Access and Flow leading to system savings

Early indicators point in a positive direction. For instance, a decrease in the number of ALC patients on the intervention unit when compared to previous year and 708 fewer ALC days compared to the same period; an 18% reduction. These modest improvements in Capacity, Access and Flow are leading to system savings and easing pressures on acute care, especially as it relates to reducing social barriers to discharge.

Client experiences:

- Continuity of care provider is viewed as a key feature of this pilot project
- Meeting with the CP in the hospital prior to discharge is resulting in lower levels of client worry and anxiety about going home, with 100% of clients agreeing that would recommend this program to others
- Number of days between referral to first interaction with CP is 0 in the pilot, compared to 2.3 outside of the LEGHO pilot
- LEGHO pilot clients receive more services across the board compared to those not attached to the pilot project, perhaps because the CP develops a deeper understanding of needs through regular rounds

Perspectives of the discharge planning team partners

Discharge planning team partners strongly value this new model:

- Helps to streamline referrals to community support services
- Gets clients the right supports they need well after hospital discharge
- Partnering with ONE CARE in this new way is improving capacity to better support patient/client flow
- Continuity of care provider is viewed as a key feature of this pilot
- helps to build a better understanding about the breadth and depth of community support services, in general, and more awareness of the benefits the LEGHO service bundle specifically