

Ensuring a Smooth Transition Hospital to Home

Toronto Rehab Institute

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GOAL

- To work together to identify the model which best ensures that all clients:
 - have a smooth transition hospital to home
 - have access to a qualified community team
 - enjoy timely funding approval for services

- To clarify roles and responsibilities

- To improve efficiencies and reduce stress on clients/families/professionals

WHAT IS GOING WELL AT TRI CMS PERSPECTIVE

- Most clients have a CM
- CM feel part of the team, attend all meetings etc.
- TRI is one of the best at giving early notice of dc date- e.g. 3-4 weeks if 6-8 week stay
- Hospital team working to make early recommendations for community programming
- Hospital team preparing TX Plan OCF-18
 - and provide to CM to add provider and costs
- Hospital team gate-keeper
 - try to check if CM and providers are qualified

3

CHALLENGES

- Many CMs are assigned by the insurer and do not have experience working with individuals with brain injury
- Hospitals often carry the burden of discharge planning, without input regarding how the client functions in the community

4

CHALLENGES cont'd

- CMs and families may need help to identify qualified service providers (i.e. providers with brain injury experience who provide multi-disciplinary services) – logistics?
- There are new challenges with Bill 198 – e.g. OCF 22, more comprehensive OCF 18
- There is a need to develop innovative models for transition in challenging cases

5

TRANSITION MODELS USED

- Letter to insurer / GP outlining needs (no CM)
- CM involved in final DC planning meeting
- CM involved in early DC meetings
- Community OT does early home / attendant care assessment
- Community OT does early home / attendant care assessment and works with team in transition planning

6

TRANSITION MODELS USED cont'd

- Community OT and possibly other therapists are actively involved in the home before DC (Gradual Discharge)
- Community rehab coach involved before DC (under the supervision of the hospital team) and then assists in the transition home (working under the supervision of the community team)

7

PROPOSED MODEL TO PILOT WITH NRS

- Early referral for OT when client begins weekends home or at least two months before discharge
- The OT is not only to assess the client in the home / community, but to work with the team to develop a transition plan

8

BENEFITS

- Rehab hospitals and CMs do not need to fill out forms – provider can do so
- Ensures early identification of functional needs of client at discharge
- OT can help in development of a transition plan tailored to the clients needs

9

THANK-YOU

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10