# Waypoint At Home Program

The Waypoint At Home Program provides 8 to 16 weeks of transitional service to patients who are safe to return to a community setting with supports from an interprofessional team. The Waypoint At Home Program will support stabilization after hospitalization and optimize recovery while being connected to other community supports.

At present, the program will provide service to patients who reside in Midland, Penetanguishene, Tiny or Tay. As the program develops, there may be the opportunity to broaden the reach to other areas of the region on a case-by-case basis. The criteria for the program is listed below. The Waypoint At Home Program will provide services based on patient need and may include care coordination, professional or personal support services, and homemaking or community support services in alignment with Home and Community Care regulations.

Waypoint At Home will provide care coordination and oversight to those receiving service from the program and Bayshore Integrated Care Solutions will be the organization that delivers the care. The services required will be individualized and co-designed with the patient, family and the care team.

**Key Program Components:**

- Care conferences, as necessary, for transition planning with clinical teams, Waypoint At Home Care Coordinator and Bayshore Integrated Care Solutions.
- Collaborative care plan development to support patients/caregivers with transition from hospital to home.
- Coordination of care and services by Waypoint At Home Care Coordinator, in collaboration with Bayshore Integrated Care Solutions.
- Care and service adjustments to meet the patient needs.
- Routine huddles/care rounds between the Waypoint At Home Care Coordinator and Bayshore Integrated Care Solutions.
- Care conferences, as necessary, for end of service planning with Waypoint At Home Care Coordinator, Bayshore Integrated Care Solutions and Home and Community Care Support Services (if applicable).

| Bayshore’s Bundle of Care - Duration: 8 or 16 Weeks of Service |
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| • In person nursing assessment for comprehensive care planning<br>• Social Worker to connect patients to community support services<br>• Support with activities of daily living and instrumental activities of daily living as needed<br>• Specialized services based on assessment of patient need:<br>o Mental health support services may include psychotherapy, mental health counselling, psychiatry<br>o Addiction support services may include addiction counselling, consultation with addiction physician<br>o Behavioural support services may include behavioural therapist, behavioural support worker, behavioural care planning and implementation<br>• Access to art & music therapy programs<br>• OT consultation for equipment as required<br>• Necessary equipment rental or medical supplies arranged for 30 days<br>• Care plan visits are front-end loaded at the beginning of service and titrated down throughout the duration of the remaining weeks<br>• Ongoing care management and transitional care planning off the service |

| Waypoint At Home Program – Inclusion & Exclusion Criteria |
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| **Inclusion** |
| • Patient consents to program<br>• Has a valid Ontario Health Card<br>• Primary Care Provider (PCP) such as General Physician or Nurse Practitioner preferred, or in the process of initiating connection with a PCP or alternative clinic<br>• Resides within Midland, Penetanguishene, Tiny, or Tay<br>• At risk of becoming designated ALC, requiring readmission, making future ED visits<br>• Has optimization, restorative, reactivation or rehabilitation care needs<br>• Requires assistance with, or skill development with activities of daily living (e.g., bathing, toileting, meals) or instrumental activities of daily living (e.g. light housekeeping, shopping, meal prep)<br>• May require social and community support services to remain independent in community (e.g., access to housing, financial resources)<br>• May require medical management (e.g., obtaining medications, physician follow-up, chronic disease management)<br>• May require follow-up mental health/addiction support<br>• Mild to moderate cognitive impairment<br>• Equipment provision for the first 30 days |
| **Exclusion** |
| • No stable residence (e.g., no physical address) - shelters will be considered on a case-by-case basis<br>• Patients outside of Midland, Penetanguishene, Tiny or Tay<br>• Patients unsafe to be supported in the community<br>• Patients requiring 24/7 care with no informal caregivers<br>• Patient requiring continuous nursing monitoring and/or palliative care<br>• On demand 1-2 person assist (typically one health care provider and family)<br>• Patient awaiting crisis placement |