

An Emerging Better Practice: Bundled Funding Model Supports Safe and Sustainable Transitions from Specialized Inpatient Services to Community.

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Bruyère Health, Transitional Care, Bruyère@Home Program



BACKGROUND

Overview

The increasing number of patients designated as Alternate Level of Care (ALC) were posing challenges to Bruyère's patient flow and patients planning to discharge home experienced increased gapped home care plans, greater uncertainty regarding available resources, and poor discharge experiences.

Based on documented successes of bundle funding models in acute care, the Bruyère@Home program was introduced in the specialized sub-acute inpatient setting.

Program Objectives

1. Facilitate timely, safe, and successful transitions,
2. Improve patient/caregiver experience,
3. Reduce hospital inpatient ALC days.

Program Timeline

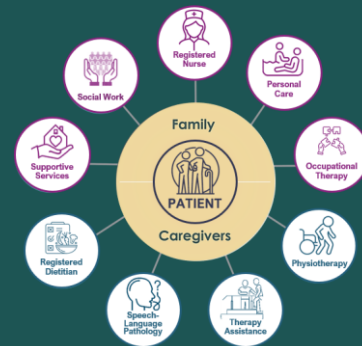


PROGRAM IMPLEMENTATION

Bundled Care Services

Bruyère@Home's program offers tailored, time-limited services bundled together based on patients' needs to support their safe transition to community.

Improving on traditional care streams, which can be fragmented and distinct in how they operate, the program brings together home care, restorative care, and community support into integrated, interdisciplinary, wraparound care.



Program Bundles

There are two types of bundle offerings*:

RESTORATIVE BUNDLE

- 8- or 16-week duration
- Rehabilitation continuity of therapeutic progress alongside nursing and supportive services
- Specific, measurable, realistic, and timely care goals

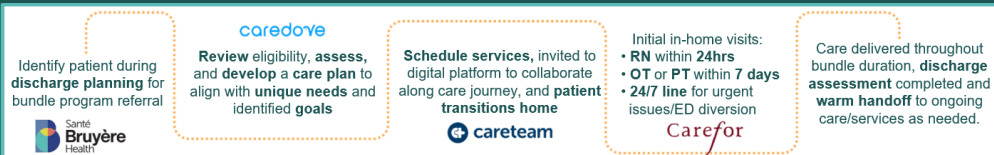
SUPPORTIVE BUNDLE

- 8-week duration
- Community services to enhance functional independence
- Navigate resources to address the broader social determinants of health

*All bundles include a 30-day assistive equipment loan at no cost.

Facilitating Discharge Planning and Improving Patient Experience

Close to 100% of patients accepted to the program are discharged within 2 days of their predicted discharge date and express an 88% overall positive experience rating.



"Without [Bruyère@Home] services, my life would be miserable. It's like gold. It's been very valuable to me." – James Brotherhood, Restorative 16-week Bundle

MEASURED OUTCOMES

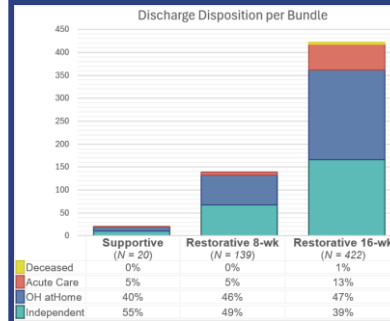
ED Visits and Hospital Readmissions

Patients enrolled in the Bruyère@Home program showed a lower 30-day presentation and readmission rate compared to Ontario Health atHome indicators^[1].



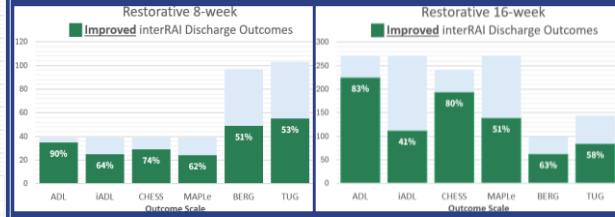
Discharge Disposition

Results based on patients discharged between January 2023 - March 2025.



Improved interRAI (CHA) Scores

Outcome scales^[2] embedded within the assessment tool used to measure patients' pre- and post-program functional status, changes in health stability/risk factors to optimize care plans and evaluate changes.



NB: The Supportive Bundle patients complete an initial screening level intake assessment and thus not included in the above outcome analysis.

DISCUSSION

Improvement Opportunities

- Increased completion rate of pre- and post-program interRAI CHA assessment,
- Employ alternative strategies to promote patient/caregiver survey completion,
- Streamline communication for seamless transitions and continuity of care goals.

Future Direction

- Broaden program upstream to vulnerable groups at risk of hospital admissions,
- Innovative digital tool for care teams to transfer knowledge and engage patients.

References:

[1] www.hqontario.ca/Home-Care-Performance ; [2] www.interrai.org/Outcome-Scales