Quinte@Home

By Quinte Health



Over the past several years, **Quinte@Home** has demonstrated the value of local health and social care partners working together to help patients safely recover at home with the supports they need. Since 2023, the 16-week program has supported more than 800 patients with complex needs, ranging from infections and fractures to bowel obstructions requiring colostomies, respiratory failure and tracheostomies. In collaboration with SE Health, Quinte@Home coordinates care with Community Care for Seniors (CCS), Community Paramedics, GOTCARE and Ontario Health atHome.

Strong partner relationships and regular communication are central to the program's success. Daily team touchpoints, biweekly leadership meetings with SE Health, and weekly meetings with Ontario Health atHome help partners address patient needs, resolve barriers and improve transitions between services. Recent discussions with CCS leaders have also helped identify opportunities to strengthen collaboration. Together, these connections support a more coordinated approach to care, with partners working together rather than independently.

Since 2023, Quinte@Home has supported more than 800 patients, strengthening connections between hospital, home care, and community services across Hastings and Prince Edward. During 2025–2026, the program recorded:

286 admissions,
285 discharges, and
345 unique patients served.

57% **of patients** accessed Community Care for Seniors (CCS) support during their enrollment.

96 **patients (34%)** were discharged to self-care, independence, or following completion of their service plan.

55 **patients (19%)** transitioned to Ontario Health atHome for continued services.

57 **patients (20%)** transitioned to other community services, including assisted living and community support services.

39 **patients (14%)** experienced hospital readmission within the 16-week program timeframe.

68 **patients** responded to the eight-week satisfaction survey, with **62% reporting being "Satisfied" or "Extremely Satisfied."**

These results highlight Quinte@Home's role in supporting patients at home and strengthening connections with community partners. With 57% accessing CCS support and 39% transitioning to Ontario Health atHome or other community services, the program demonstrates the value of coordinated care and strong partnerships in building a more connected healthcare system.

- Large geographical area of Hastings and Prince Edward counties
- The rural region presents challenges to provide consistent access to services across all communities.
- OHT partners may not be able to provide the level or type of service required at a particular time.

These geographic and service-capacity challenges reinforce the importance of strong communication between partners. By maintaining open communication and working together to identify alternatives, the Quinte@Home team and its partners can explore solutions that best meet the needs of individual patients.

- Explore flexible care pathways within Quinte@Home to better meet individual patient needs, including potential 8-week, 2-week or dedicated respiratory pathways.
- Match support to patient needs by adjusting the intensity and duration of care while maintaining safe transitions home and appropriate community-based support.
- Strengthen partner collaboration across hospital, home care, community, paramedicine and social care services.
- Use ongoing learning from patient experiences and partner feedback to adapt the model to emerging needs across Hastings and Prince Edward.

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Hastings Prince Edward
Ontario Health Team

Quinte@Home has reinforced that strong relationships and consistent communication are essential to building a more connected health and social care system. Regular communication between partners helps identify barriers early, coordinate transitions, and develop solutions together.

We have also learned the importance of flexibility, as each patient's needs and circumstances are different. Working collaboratively across organizations allows us to adapt supports, learn from patient experiences, and continuously improve the pathway.

Most importantly, no single organization can meet every patient's needs.

By working together, sharing knowledge, and maintaining open communication, we can provide more coordinated and seamless care for patients and families.