Program Goals

Support safe, timely, and successful transitions home from St. Joseph's Continuing Care Centre.

Promote recovery, independence, and confidence through individualized, goal-oriented restorative care.

Support caregivers and families through counselling, education, and connection to respite and community resources.

Reduce the risk of hospital readmissions and Emergency Department visits through coordinated, proactive support.

Coordinate follow-up care with Ontario Health atHome or community supports as needed to ensure continuity after discharge.

Your Care Team

- **Physiotherapists**
- **Occupational Therapists**
- **Nursing**
- **Personal Support Workers**
- **Social Workers**
- **Dietitians**
- **Speech Language Pathologists**

Contact Us

Questions or concerns?
There is a phone line available 24 hours a day, 7 days a week by calling:

1-866-697-4523

What if I don't have a primary care provider (family doctor or nurse practitioner)?

Your St. Joseph's Hospital to Home team will help with you to find one!

You can register with the Health Care Connect service. More information can be found online at:

https://www.ontario.ca/page/find-family-doctor-or-nurse-practitioner

Caring... beyond the moment
Au-delà des soins présents

St. Joseph's Continuing Care Centre Of Sudbury
Centre de soins continus St-Joseph de Sudbury



8-Week Transitional Optimization Stream

St. Joseph's Hospital to Home

In partnership with:

Bayshore HealthCare
Integrated Care Solutions

About Us

St. Joseph's Hospital to Home Program provides you with seamless, coordinated care when you leave our hospital, St. Joseph's Continuing Care Centre, and return home.

The 8-week Transitional Optimization stream is designed to give you a little extra help as you settle back in at home. It offers short-term, goal-focused support for patients who are ready for discharge home but would benefit from continued care and follow-up. It focuses on helping you adjust to your home environment while rebuilding strength, confidence, and independence.

The St. Joseph's team provides individualized care to help you maintain the progress made in rehabilitation. We'll work with you to create a care plan that supports your recovery, goals, and connection to community resources for lasting success.

Our goal is to ensure your transition home is safe, supported, and stress-free with compassionate care every step of the way.

FAQs

What happens before I leave the hospital?
Before you leave the hospital, your St. Joseph's Hospital to Home Program Coordinator and care team will meet with you, your family and your hospital team to create a care plan that outlines your recovery goals and support you'll receive at home.

When will my services begin?
Your first home visit will be scheduled before you leave the hospital. You will receive a short-term care plan for your first 72 hours to guide your transition, including any equipment and service coordination. Your care plan will be reviewed and updated regularly as you recover.

How long does the program last?
Your care team will help determine which stream best meets your needs:

- 16-Week Restorative Rehabilitation stream – for those requiring extended recovery and support.
- 8-Week Transitional Support stream – for those who need short-term assistance at home to recover safely.

FAQs

What happens if I need to be readmitted to Hospital?
If your medical condition changes and you require hospital care, your care team will stay in contact and help coordinate your smooth transition back home once you're ready.

What happens when I get home?
On the day you go home, you'll receive a call to make sure you arrived safely and that any equipment or supplies have been delivered.

Within 24 hours, your care team will visit you at home and check-in regularly through home visits, phone calls, or virtual appointments to monitor your recovery and update your plan as needed.

What happens if I need ongoing care?
At around 8 weeks, your care team will review your progress with you. If you still need support after 12 weeks, we'll connect you with an Ontario Health atHome Care Coordinator to assess you for ongoing home and community support services.