Headwaters launches program delivered to seniors in their homes

Written By **Paula Brown**

Headwaters Health Care Centre (HHCC) is extending patient health care beyond the hospital walls with the start of a new program partnership.

The local hospital announced in a July 3 press release that they have partnered with Bayshore Health Care Integrated Solution to enable patient recovery at home through the Headwaters2Home program.

The Headwaters2Home program is designed to assist older adults in transitioning safely back home after staying in the hospital. The program offers up to 16 weeks of comprehensive care delivered directly to patient's homes by the Bayshore team, with support from a Headwaters program coordinator.

?We believe that Headwaters2Home will help in maintaining flow throughout the hospital, ensuring all patients have suitable access to care and beds,? said Danielle Holler, regional director for Home Care, Integrated Care Solutions. ?We are fortunate to have a fantastic collaborative community and hospital team that works together daily to secure safe and timely transitions for patients returning home after a hospital stay.?

According to Headwaters, the program has served over 50 patients since its launch in December 2023.

Tom Porter, a former patient at Headwaters Hospital and Headwaters2Home client, described being in the program as ?a godsend and a blessing?.

Porter was enrolled in the program following a fall at home due to complications from arthritis, a herniated disc, and urological issues. After a brief hospital stay, he received nursing care, laboratory services, and physiotherapy at home from Bayshore staff as part of the Headwaters2Home program.

?The service, the people, and the health care workers ? nurses, doctors ? form an amazing team. I can only pray and thank them for everything they have done for us personally and what they endure daily,? said Porter.

Eligible patients and their families engage with Headwaters staff to explore enrolling in the program, discuss expectations, and collaborate on developing personalized care plans in consultation with Bayshore professionals.

Headwaters said the approach ensures a smooth transition from hospital to home for the patient and optimizes their patient care experience.

?This new program aligns with our strategic direction to connect through partnerships to support seamless, equitable and timely access to care,? said Annette Jones, vice president of patient experience at Headwaters.

While Headwaters2Home benefits patients and their families by enabling recovery at home, another outcome of the program is its help in managing patient capacity and flow at the hospital.

The hospital said the program addresses capacity issues by allowing patients, particularly seniors transitioning to alternate levels of care (ALC), to receive necessary care at home post-discharge.

Headwaters noted that if patients need care beyond the 16-week period, additional assessments can determine their eligibility for continued support.