Title. Adapting hospital-to-home transitional care interventions to the Ontario rural healthcare context

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Lay abstract.

When hospital discharges are poorly planned, patients may not know how to manage their post-discharge care. They may need to visit the emergency room or be readmitted to the hospital. Hospital-to-home Transitional Care (TC) is provided by Ontario nurses to help patients and their families manage care after a hospital stay, but patients in rural areas have more emergency room visits and hospital readmissions than patients in urban areas. These trends indicate problems in TC in rural areas. Because TC was designed and evaluated with patients in urban areas, it may not meet the needs of rural patients or their families.

The overall goal of this study is to improve TC in rural areas in Ontario.

This goal will be achieved by inviting patients from rural areas, their families, and nurses who provide TC to them, to tell us how to revise TC to better meet their post-discharge care management needs. This will result in more relevant and feasible TC for people living in rural areas. The expected impacts are better prepared patients and families for managing care after hospital discharge, fewer emergency room visits and hospital readmissions, and cost savings to Ontario's healthcare system.