Ontario Health atHome

Home First

Information for Patients & Families / Caregivers

Introduction

After hospital stays, many patients can continue their recovery safely in the comfort of their home with appropriate home care services. This approach to care is called Home First, with patient health and safety as the top priority, ensuring each person receives the right care at the right time and in the right place.

Based on your circumstances, your health care team has determined that the acute care portion of your hospital stay is complete and that you can benefit from home care services to help your safe transition from hospital.

What are the benefits of returning home rather than staying in the hospital?

- Continue with your recovery safely and in the familiar, comfortable surroundings of your own home.
- Reduces the risk of losing strength from lack of mobility while remaining in hospital.
- Services you need will come to you.
- You have the option to wait for your preferred choice of a long-term care home from your own home.
- If you and your family/caregivers are considering major decisions about future care, home is also the best place from which to do so.
- No restricted visiting hours or costs for your family/caregivers, compared to hospital visiting.

Our Services

Ontario Health atHome assesses patient care needs and delivers in-home and community-based services to support your health and well-being. We also provide access and referrals to other community services and manage Ontario's long-term care home placement process.

When your health team determines you no longer have a medical need to stay in hospital, we offer enhanced home-care services to meet your health care needs for 60 days. To be eligible, you must have:

- A doctor who is willing to manage your ongoing health needs while you are at home.
- Some caregiver support.
- A home setting to go to, which may include your own home, retirement home or your caregiver's home.

The in-home services you receive through us are at no cost to you; however, community support services, such as Meals on Wheels and others that we coordinate for you usually have some accompanying costs. Your Care Coordinator will be able to help you with this information.

00-2024 (date updated)

How will you help me transition from hospital to home?

While in hospital, one of our Hospital Care Coordinators will meet with you and your family/caregivers to assess your health care needs and establish your care plan. This plan identifies the in-home and community support services that will best meet your needs.

Each care plan is tailored to meet each patient's individual needs and **may** include:

- Visits from a **personal support worker** who can help you with personal care, such as assistance with dressing, bathing and eating and help transferring into beds or chairs or get to the bathroom.
- Visits from a **nurse** to assist with your medical needs.
- Visits from an **occupational therapist** and/or a **physiotherapist** to assist you and your caregivers to safely manage your personal care and mobility within your home.
- Visits from a **social worker**, **dietitian** or **speech language pathologist**.
- Equipment available through the medical supply catalogue, such as a walker, raised toilet seat, wheelchair, etc.
- **Respite** or short-term relief provided for family/caregivers (in-home and day program) to look after your care needs.
- Coordination with other **community support service agencies** in your area to deliver services such as Meals on Wheels, transportation and more.

After establishing your care plan, your Care Coordinator will work with you and the hospital to coordinate a discharge date that ensures your needed services will be available. We will also provide you with relevant contacts, if at any time you need urgent and non-urgent support.

After you return home

Within two weeks of your return home, one of our Community Care Coordinators will contact you to reassess your needs, review your care plan and make any needed adjustments. Over the course of the 60 days and if you are managing well, the enhanced services will be gradually reduced to regular service levels. To ensure your care needs continue to be met, your Care Coordinator will be in regular contact with you, complete ongoing reviews and reassessments and make needed adjustments to your care plan.

Long-Term Care Home Considerations

If I am waiting for a bed in a long-term care home, what happens if I receive an offer within the 60 days?

If a long-term care home bed becomes available, one of our Placement Care Coordinators will contact you with the bed offer. You will have 24 hours to consent to the admission and make needed arrangements to move in. As a long-term care home resident, all your care needs will be met by the long-term care home staff. Your Care Coordinator will arrange for the in-home services you previously received to be discontinued.

If you decide to refuse a bed offer, your name will be removed from the waiting list from all your chosen homes and your application for long-term care will be closed. You will not be able to reapply until 12 weeks after the day you were removed from the waiting list, unless there is a change in your condition or circumstances. There are limited exceptions to this rule which your Care Coordinator will discuss with you. Your

Care Coordinator will work with you to develop an ongoing care plan to meet your care needs.

What happens if I don't receive an offer for a long-term care bed within the 60 days?

Whether or not you are waiting on a long-term care bed, your Care Coordinator will work with you and your family/caregivers to determine your eligibility for services, assess your needs and develop an ongoing care plan.

If you no longer wish to go to a long-term care home at the end of the 60 days, please discuss this with your Care Coordinator. They will share your options, level of home and community care services you are eligible to continue receiving as well as optional, fee-based additional services.

What if I decide I want to remain at home and continue receiving home and community care services after 60 days?

Your Care Coordinator will work with you and your family/caregivers to determine your eligibility for services, assess your care needs and develop a new care plan of services effective at the end of 60 days.

In addition, some patients and families/caregivers chose to purchase additional services to help meet care needs. Your Care Coordinator is here to help you make informed decisions.

If you have been on a long-term care home wait list and decide to continue living at home, you may choose to keep your name on the wait list. Otherwise, you can discuss removing your name from the wait list with your Care Coordinator.

Contact Information

If you have any questions regarding this service, please contact: **310-2222** • **ontariohealthathome.ca**