ARCHES – Short-Term Transitional Care Program

Home and Community Care Support Services has partnered with community Retirement Homes to provide enhanced supports to residents in our community. Together, we are working to ensure that residents continue to receive quality care in the most appropriate setting. Through our Available Retirement Care Home Enhanced Supports (ARCHES) to Care Beds Program, we are able to help you move from the hospital to a retirement residence with enhanced supports where you can make important decisions about your future care and living arrangements. During your your time in ARCHES, we will work towards a discharge plan which may be to your own home with supports, a long-term care home, retirement home or alternate-care setting. A Care Coordinator will guide and support you in making these decisions.

What are the benefits to you?

- You can regain your strength and independence, with opportunities to participate in social activities at the retirement residence.
- Retirement residence rooms are private, furnished and meals are provided.
- The Retirement home will develop a care plan to meet your health and social needs.
- A care coordinator will assist with your long-term planning goals.
- You will receive quality, in-home health care services from retirement home staff including personal support workers, and nurses. Therapy and other supports will be added as needed, to keep you safe.

January 2024

Ontario

Packing List *Please bring the following items, as needed*

- ◯ Toothpaste, toothbrush
- ◯ Soap / body wash
- ◯ Body lotion / moisturizer
- ◯ Barrier cream (e.g., 3M Cavilon)
- ◯ Deodorant
- ◯ Shampoo
- ◯ Comb / brush
- ◯ Electric shaver
- ◯ Mouth wash / rinse
- ◯ Mouth swabs
- ◯ Denture cleanser / fixture agent
- ◯ Incontinence supplies
- ◯ Tissues
- ◯ Briefs (e.g., liners, heavy / overnight)
- ◯ Pants x7 (elastic waist recommended)
- ◯ Shirts x7
- ◯ Sweaters
- ◯ Pajamas / nightgowns (2 or 3)
- ◯ Socks / stockings
- ◯ Shoes / slippers
- ◯ Apron / clothing protector for meals
- ◯ K-basin (if required)
- ◯ Meal replacement shake (if needed)

Moving Day

- The first day can be busy and stressful, so you may wish to have a family member or friend with you to help you feel more comfortable.
- If you are able to ride in a car, a family member or friend can move you from the hospital to the retirement home. If you are unable to ride in the car, a care coordinator will assist you and your family in making arrangements for a transfer vehicle.
- A member from the Retirement home will meet you to welcome you when you arrive at the home. They will go over the Retirement Home admission package and may ask for a void cheque for pre-authorized payments that would only be used if you remained in the program past 30 days.

A care plan will be developed between you and the retirement home when you move into the home. A care coordinator will reach out to you within the first 10 days to set up a visit with you.

Contact

Home and Community Care Support Services South West

Contact a care coordinator for transition planning to long-term care and/or home.

_____, Care Coordinator

Phone: _____

Retirement Residence

Contact for information on care and services provided in the retirement residence.

Program Manager:

_____

Phone: _____

Email: _____

Office: _____

Answers to Frequently Asked Questions

How long can I stay in the program? You can participate in this program for up to 30 days. Our goal is to help you create a longer-term care plan in the community (e.g., personal home, family or loved one's home, long-term care home, retirement home). After 30 days, we will continue searching for appropriate care arrangements in the community, which may include extending your stay in the short-term transitional bed.

What is the cost of the program? The initial 30 days of the program are covered by Home and Community Care Support Services South West. Your care coordinator and Retirement Home program manager will develop a care plan to keep you safe in the community on discharge. These services are covered by OHIP and may include nursing, personal support, physical therapy and occupational therapy. Following the initial 30 days, if you have not moved on from the program and are waiting for a LTC bed you will be charged the basic accommodation rate for LTC. This fee will be collected directly by the Retirement Home. If you are unable to afford the fee based on your income, this rate may be subsidized. Your care coordinator will provide you with further information on this subsidy. The patient is responsible for incidental fees related to medications and dispensing fees not covered under Ontario drug benefits, personal grooming supplies and optional Retirement home amenities (such as cable).

Why can't I stay in the hospital? Your doctor and your care team in the hospital have determined your acute medical needs are resolved and that you are medically stable and ready for discharge from the hospital. Your care needs can be met more appropriately in the community, while we continue to support you in making decisions about your next steps.

Why should I choose more than one long-term care home option? Many homes in the South West region and across Ontario have waitlists because of the number of people who require the level of care provided in these homes. By choosing up to five long-term care homes, you are increasing the opportunity to find a long-term care home by the end of the transitional care program.

How do I confirm participation in this program? Your Care Coordinator will work with you to complete an application. You will need to sign the consent and Family Information sheet with Home and Community Care Support Services South West indicating that you will receive care in the retirement home in the community for up to 30 days at no cost.

How can I prepare to move from the hospital? You can contact the Retirement Home when you have received a bed offer from your care coordinator. The Retirement Home can tell you about services available through the retirement home (e.g. 24/7 on-site personal support worker supports and a call system). These may include free programs such as social activities, or additional services with an associated cost (e.g. cable, Internet, hairdressing).

How will I get from the hospital to the retirement home? If you are able to ride in a car, a family member or friend can move you to the retirement home. If you are unable to ride in the car, a care coordinator will assist you and your family in making arrangements for a transfer vehicle.

What happens when I arrive at the retirement home? You will continue to receive the quality care you need at the retirement home. This may include nursing, personal support worker and therapy services from Home and Community Care Support Services, depending on an assessment of your needs. You will be introduced to the retirement home, including what to expect on a daily basis (e.g. meal times, activity calendars and laundry schedules). They will go over the Retirement Home admission package and may ask for a void cheque for pre-authorized payment, that would only be used if you remained in the program past 30 days.

Are there any considerations in light of COVID-19? We are working closely with our health sector partners to ensure the continued safety and well-being of residents, families, and staff. Any specific information will be communicated directly with families.