Ontario Health atHome

Home First from Hospital to Home

INFORMATION FOR CLIENTS & FAMILY/CAREGIVERS

The ‘Home First’ philosophy

After a hospital stay, many seniors can continue their recovery safely in the comfort of their home if they receive the appropriate home care services for a period of time.
Home is the best place to make major decisions about future care.

Our goal is to make sure all our clients receive care in the setting that best meets their needs—whether that is in the hospital, in their own home, in a retirement home or in another health care facility.

Based on your current health, 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 transition from hospital to home as quickly as possible. We want to do everything possible to support you and your family so you can return home while you determine your needs and plan for your future care. We feel the comfort of your own home is the best place to make this decision.

Ontario Health atHome provides coordination of the home care services needed to assist you in returning to your home, assesses your long-term care needs and helps you understand and navigate your options while you make decisions around future care plans or wait for a long-term care home bed.

What is available through Ontario Health atHome to assist me in transitioning from hospital to home?

Once it is no longer medically necessary for you to be in hospital, Ontario Health atHome can provide enhanced services to support you in meeting your health care needs in your home over the period of 60 days. To be eligible for these enhanced services, you must have a doctor who is willing to manage your ongoing health needs while you are at home and you have some care giver support and a home to go to (which could include your own home, a retirement home or your caregiver’s home).

What services will be available to me in my home?

While in hospital, a Ontario Health atHome Coordinator, a health care professional, will meet with you and your family/caregiver(s) to assess your health care needs in order to identify and set up a plan for in-home and community support services that will best meet your needs.

Once a care plan has been established, the Care Coordinator will work with you and the hospital to coordinate a discharge date and ensure that the services you need will be available upon your discharge. In addition, you will be provided with contact information should you need both urgent and non-urgent support in any way.

Within two weeks of returning to your home, you will be contacted by a Community Care Coordinator who will set up a time to meet with you to reassess your current needs and review your in-home and community support services package.

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Typically within the first few weeks of returning home, as you start to establish a routine with your care giver, your care needs will decline. The Community Care Coordinator will work with you as the hours gradually decrease in your care plan over the course of the 60 days.

A care plan is individually tailored to your needs, but **may** include:

- Visits from a **Personal Support Worker** who can help you with personal care such as assistance with dressing, bathing and eating and helping you transfer 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** as required.
- Equipment available through the medical supply catalogue needed to support you 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 Agencies** in your area to deliver services such as Meals on Wheels, transportation and more.

What is the benefit of returning home rather than staying in the hospital?

- Continue with your recovery safely and in the familiar, comfortable surroundings of your own home.
- Reduce the risk of losing strength from lack of mobility while remaining in hospital.
- Services you need to maintain your health will come to you.
- You have the option to wait for your preferred choice of a long-term care home from your home.
- Increased opportunity for time to help improve your health status during and/or prior to making a major decision about your future.
- No restricted or costly impact on your family compared to hospital visiting.

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

If you are awaiting placement in a long-term care bed and one becomes available while at home with enhanced home care services, an Ontario Health atHome Care Coordinator will contact you with an offer for a long-term care bed. You will have 24 hours to accept the offer and make arrangements to move in. In-home services will be discontinued once you move into a long-term care home.

If you decline the offer a long-term care bed, your long-term care application will close, and your name taken off the list for long-term care homes.

Re-application following the refusal of a long-term care bed takes 12 weeks. This may be sooner if there is deterioration in your medical condition or your situation.

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

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

If you determine that 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. The Care Coordinator will be happy to discuss your options and the level of home and community care services you are eligible to continue receiving at no cost to you as well as optional, fee-based additional hours.

What if I decide I would like to remain at home and continue to receive in-home and community-based services after 60 days?

Some people may decide to continue living at home and receiving care beyond 60 days.

Clients are eligible for in-home support services, based on assessed need within Ontario Health atHome guidelines. Your Care Coordinator will work with you and your family/caregiver to determine eligibility, assess your care needs and develop a new care plan of services effective at the end of 60 days.

In addition, some clients and families/caregivers chose to purchase additional services to assist with meeting care needs. Your Care Coordinator would be happy to discuss these costs so that you can make an informed decision.

If you have previously been on a long-term care home wait list and you decide to continue living at home, your name can remain on the long-term care home wait list.

If you no longer require the level of care of a long-term care home, you can discuss removing your name from the wait list with your Care Coordinator.

How much will the enhanced services through Ontario Health atHome cost me?

The in-home services you receive through Ontario Health atHome over the next 60 days are available at no cost to you.

However, services such as Meals on Wheels or others provided by Community Support Agencies that Ontario Health atHome coordinates for you, usually have some cost associated with it. Your Care Coordinator will assist you with this information.

Questions?

If you have any additional questions, please speak with your health care provider in the hospital, or contact: ____ at Ontario Health atHome, 1-800-538-0520 or at 613-745-5525, ext.__________________________ or 310-2222.

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