# Home First

**Frequently Asked Questions**
July 2013

**What is Home First?**
The expectation is that patients who come to hospital from their home, will be discharged to home with appropriate community supports. This represents a significant shift in health provider philosophy, as hospital staff and physicians will now promote home as the **primary discharge destination**.

Working with our community partners, the patient and their family, a care plan will be developed upon admission to hospital that will support the safe discharge to home. The focus of the plan will be on what a patient and their family needs most to help them safely go home after their acute hospital stay has ended. They can recover and recuperate at home, and make any critical decisions about what is next, in a comfortable and familiar setting.

Generally, hospital patients will not be designated "ALC to Long-Term Care" until all other placement options have been exhausted and healthcare providers should avoid premature discussions with patients about specific placement upon discharge.

**Top Three Principles of Home First**

1. ***Plan for discharge home***
    - Where feasible, view everyone initially for the potential to discharge home
    - The decision about when to discharge remains the responsibility of the attending physician, in consultation with the healthcare team
    - The estimated date of discharge (EDD) must be written on the whiteboard in the patient's room within 24 hours of admission

2. ***Involve North Simcoe Muskoka Community Care Access Centre (NSM CCAC) early in destination planning***
    - The interprofessional team, which includes NSM CCAC, will determine destination upon discharge. The NSM CCAC Care Coordinator will assess for in-home services and long-term care, and develop a care plan with the hospital team
    - NSM CCAC will discuss the plan with the patient and family and explain the hours and rationale for support

3. ***Avoid premature discussion about Long-Term Care***
    - Avoid LTC discussion until the care team identifies this as the only option

**Why Home First?**
When given a choice, most seniors prefer to be at home than in a hospital. Outcomes are better when patients recuperate at home and with appropriate supports and they are not exposed to inherent risks of hospitals, including infection, pressure ulcers, risk of falls, lack of mobility and isolation.

Home First also promotes better use of healthcare resources. North Simcoe Muskoka has the worst Alternate Level of Care (ALC) situation in the province. Up to a third of our acute care beds are occupied by patients who do not need to be in hospital. If we are to be able to meet the acute care needs of our region, we must ensure patients receive the right care, in the right place at the right time. Home First must be a priority with everyone.

**Who qualifies for Home First?**
Home First is intended primarily for seniors, however the philosophy of recovering at home with community supports is being applied to all patients 18 years or older, regardless of their length of stay or condition.

**Who decides when someone is ready to go home from a hospital stay?**
The decision about whether to admit or discharge a patient remains the responsibility of the attending physician and/or nurse practitioner in consultation with the healthcare team. This team includes NSM CCAC Care Coordinators who arrange for care in the home or community.

Dedicated NSM CCAC Care Coordinators will work with hospital staff to identify high-needs patients and assess them soon after admission to hospital for discharge home, before long-term care or ALC or any other options are discussed.

Patients and their families will be partners in the process, communicated with and engaged from the very beginning.

**Will patients receive the care they need at home?**
The NSM CCAC now has more capacity to care for high-needs patients in the community, through intensive case management and enhanced service plans.

The NSM CCAC Care Coordinator will determine, in advance, what supports are required and will link the patient with community services when they are ready to go home. There are no additional care costs for many of these services and resources in the community are accessible via www.nsmhealthline.ca. Community support services, mental health and addiction services, and primary care will enable discharge to home and ensure that high needs patients are safely served in the community. Assistive living, supportive housing, adult day programs, complex continuing care and rehabilitation services are available pending eligibility by the NSM CCAC Care Coordinator.

- The NSM CCAC Care Coordinator is your primary contact for this purpose while you are in the hospital. They will determine what supports the patient will need and will make all the community connections and arrangements, so that the necessary support and services are in place as soon as the patient is ready to go home. There are no additional care costs for community services that are publicly funded. Some services such as Meals on Wheels or laundry do have a fee.

- If your healthcare team says you could benefit from rehabilitation services or that you should think about long-term arrangements, you can still go home and wait for those arrangements to be put in place.

**Will patients get the support they need at home even if they have not yet decided to move to a long-term care home?**
Yes. Patients going home from hospital need the most help during the first two months. During this time, a NSM CCAC Care Coordinator will assess and support a patient's needs and coordinate services to ensure they can recuperate comfortably in their own home. This provides a comfortable environment where a patient and their family can then make decisions about their future care.

**What additional supports will be available to patients?**
The NSM CCAC determines what resources are needed and how they will be provided on a case-by-case basis. The NSM CCAC has invested more hours and resources to support patients in their safe return to home and has an enhanced service pack and a service guarantee.

**Do patients pay fees for Home First?**
There are no additional care costs to patients to transition home if they have been identified as high needs / complex and are eligible for the Hospital to Home enhanced service package through the NSM CCAC.

**How can healthcare professionals support the Home First philosophy?**
The Home First philosophy is the responsibility of the entire healthcare team. Patients place a great deal of trust in their healthcare providers and you play an important role in the success of the Home First philosophy.

Remember: it is the NSM CCAC, in consultation with the healthcare team, who determines a patient's post-discharge destination. Hospital staff should avoid premature discussions about living arrangements after the patient leaves hospital and should avoid discussing long term care as an option. Support a patient's return to home, recognizing that community supports are available and outcomes are better when patients recuperate at home with those supports, where they aren't exposed to inherent risks of hospitals, including infection, lack of mobility and isolation. **Patients would not be discharged to home if it was not suitable to do so.**

**Key messaging for healthcare team:**

- When you are ill and injured, RVH is here for you. However, when you no longer need our specialized, acute services, your ongoing needs for care and recovery are best met at home where you are more comfortable and will recover more quickly
- From the day you arrive at RVH, your care team is planning for your safe return home. Everyone involved in your care will be asking, "What can I do to help this person get safely home?" You and your family will be part of the decision-making as we focus on providing you with the right care, in the right place at the right time
- There are enhanced homecare supports and services now available and we believe that you (patient) or your loved one (if speaking with family) would benefit from them
- Outline specific supports/services available
- Hospitals have inherent risks, such as infection, slip and falls, and pressure ulcers. You also lose mobility when you are lying in a hospital bed for a long time
- Many people find it easier making decisions about their next appropriate 'destination', while recovering in the comfort of their own home, supported by family and friends