FREQUENTLY ASKED QUESTIONS

How long is SHN@Home?

Most patients are part of the SHN@Home program for up to 16 weeks.

What happens if I need to be re-admitted to SHN?

If your medical condition changes and you need hospital care, SHN@Home will continue to support you when you return home. Your team will be kept informed and plan for your transition back home.

What happens if I need ongoing care?

AFTER 8 WEEKS

You and your team will review your progress and plan for your ongoing care.

AFTER 12 WEEKS

Your team will connect you with a Local Health Integration Network (LHIN) Care Coordinator who will conduct an assessment and plan with you for your ongoing care.

AFTER 16 WEEKS

Your team will connect you with homecare services provided by the LHIN.

For questions or concerns, please call our 24/7 line:

1-866-697-4523

BIRCHMOUNT
3030 Birchmount Road
416-495-2400

CENTENARY
2867 Ellesmere Road
416-284-8131

GENERAL
3050 Lawrence Avenue East
416-438-2911

IN PARTNERSHIP WITH

Materials shared with the expressed permission of Southlake@Home and the Southlake Regional Health Centre. Reviewed April 2020.

Supporting your transition home from the hospital

IN PARTNERSHIP WITH

SHN@Home supports you with the care you need at home.

Scarborough Health Network (SHN) is working in partnership with Bayshore HealthCare to create a care plan with you for when you are discharged from one of our hospitals.

Your SHN@Home team will consist of:

- **Care coordinators**
- **Nurses**
- **Personal support workers**
- **Occupational therapists**
- **Physiotherapists**
- **Speech-language pathologists**
- **Social workers**
- **Dietitians**

This team will work closely with you, your family and our hospital team to make sure your care plan at home meets your needs.

HOW IT WORKS

Before leaving the hospital

Your SHN@Home coordinator and team meets with you, your family and your hospital team to create your care plan. This will be shared with everyone involved in providing your home care.

Your first home visit will be scheduled before you leave the hospital and you will know the name of the person coming to your home. In some cases you will meet this person before you leave the hospital.

Arriving at home

What to expect during your first week at home after discharge:

- You will receive a phone call from a member of your SHN@Home team to make sure that you have arrived home safely.
- Someone from your team will visit you onyour first day at home. They will be checking in with you every day of this week.
- After the first week, you and your team will decide how often they need to check in with you.

Partnering together

Your team will continue to work closely with you, your family and our hospital team to ensure your goals are being met at home. They will keep your primary care provider (family doctor or nurse practitioner) up to date on your progress.

If you don't have a primary care provider, SHN@Home will work with you to find one.

Catering to your needs

Your SHN@Home team will use different ways to check in and care for you:

- Home visits
- Phone calls
- Technology (i.e. telemonitoring)
- Work with other local community resources (i.e. Meals on Wheels, transportation and caregiver support programs)

If your needs change, so will your care plan. There will be times where you may need more or less services. SHN@Home was designed with this flexibility in mind.

These supports are there so you have what you need to be at home.

For questions or concerns, contact your SHN@Home team at our 24/7 line:

1-866-697-4523