



## Better Health. At Home.

### A new way to care for your COPD and Heart Failure patients.

Telehomecare links patients with chronic conditions to Registered Nurses who provide remote monitoring and regular health coaching sessions. Patients become partners in their own care - right in their own home.

#### Is Telehomecare right for your patient?

- An established diagnosis of Heart Failure or COPD
- History of emergency visits and/or hospital admissions
- Capable of using simple in-home monitoring equipment

## Refer now.

Simply fax the  
completed referral to:

**f. 416.217.1439**

**[Referral Form](#)**

To learn more contact  
Toronto Central CCAC:  
t. 416.217.3841  
telehomecare@  
torontocentral.ccac-ont.ca

# 3 Great Reasons to Enrol Patients

Patients will:

- ✓ Feel better
- ✓ Gain confidence
- ✓ Take control of their own health

- 65% in hospital admissions
- 73% in ER visits
- 16-33% in primary care visits
- 96% in walk-in clinic visits

Based on results of  
Telehomecare Pilot Program, 2007

*"We have all kinds of stories of appreciative patients whose isolation and despair were lifted by this program. Very few services in health care are so personable and caring."*

Dr. Eric Paquette, Site Lead Physician, Timmins Family Health Team

## CCAC OHIP Billing Codes

- K070** Completion of CCAC Referrals
- K072** Chronic home care supervision

## How Telehomecare Works



### Patient Enrolment

Complete and fax the referral form to the Toronto Central CCAC.



### Patient Care Delivery

CCAC Telehomecare Nurses will call you to approve the initial care plan. You will be kept informed of your patient's progress through the six month program. Telehomecare does not replace existing care services.



### Patient Discharge

Nurses complete a discharge assessment and set a maintenance plan linking your patient with community resources. A final report is sent to you and your patient's circle of care.

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toronto.ccac-ont.ca or telehomecare.otn.ca

