Ontario Health atHome

Telehomecare

Remote monitoring and intensive health coaching program for COPD & heart failure

What is Telehomecare?

Telehomecare is a six-month program that links patients with COPD or heart failure to Registered Nurses who provide remote monitoring and regular health coaching. Patients become partners in their own care – right in their own homes. Telehomecare complements the care you already provide for your COPD or heart failure patients

- Patients learn self-management skills to take control of their health
- Exacerbations are caught early
- Unnecessary trips to the hospital or ER are avoided

Is Telehomecare right for your patient?

- Diagnosis of COPD or heart failure
- History of emergency visits and/or hospital admissions
- Capable of using simple, in-home monitoring equipment

OHIP Billing Codes

- **K070** – Completion of referrals
- **K071** – Acute home care supervision
- **K072** – Chronic home care supervision

How Telehomecare works

Through Telehomecare, patients gain the skills and confidence to effectively manage their condition at home.

Patient enrolment

Complete and fax the referral form, available at ontariohealthathome.ca Patients can also locate a program in their region and begin the enrolment process themselves at otn.ca/patients

Patient care delivery

Patients are provided a blood pressure cuff, pulse oximeter, weight scale and tablet through which to send their vital signs for monitoring. Telehomecare nurses contact the patient at the first sign of an exacerbation to identify issues and will keep you informed of your patients' progress on a schedule you prefer.

Patient discharge

At six months, nurses complete discharge assessments and set a maintenance plan linking your patients with community resources. A final report is sent to you and your patient's circle of care.

Contact Information

If you have any questions regarding this service, please contact: **310-2222** • **ontariohealthathome.ca**

06-2024