Ontario Health atHome

London Health Sciences Centre

Connecting Care to Home

Patient Information Sheet

Connecting Care to Home (CC2H) is a two-to-six-week program that supports a safe transition from hospital to home, for those with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and/or Congestive Heart Failure (CHF).

The program is designed to help you achieve the best possible quality of life and includes:

- Ongoing in-person and virtual monitoring and support;
- Education;
- Communication with your most responsible provider (MRP) on progress, concerns; and assistance with guidance on treatment plan;
- Regular check-ins; and
- Equipment which may include blood pressure cuff, oximeter and/or weight scale.

How does the program work?

A COPD/CHF Hospital Navigator will speak with you about the program, answer your questions and get your consent to begin the referral process.

A care coordinator from Ontario Health atHome will assess home care support such as occupational therapy, physiotherapy, nutritional services, personal support worker, and respiratory therapy.

Once you are at home, a registered nurse specializing in chronic disease management will visit you within 72 hours of your discharge from hospital.

You will be given medical equipment for daily monitoring of your weight, blood pressure and oxygen levels daily.

The nurse will provide information on ways to manage your symptoms.

After the first visit, your appointments with the nurse may be in-person or over the phone.

What if I don't feel well or my condition worsens?

Once registered for CC2H, you will have access to a remote registered nurse by phone at **1-844-866-2248**, 24 hours a day, seven days a week.

The nurse has your healthcare file and will understand your care needs.

Depending on the severity of your symptoms you may be asked to follow up with your primary care provider (e.g., doctor) or go to the nearest emergency department.

CC2H is not an emergency response program. For medical emergencies, always call 911.

Your privacy

Your privacy is important to us. We follow the Personal Health Information Protection Act.

08-2026

The CC2H team

Your care team may include the following team members.

Heart Failure/COPD Navigator: a registered health-care professional that visit, assesses and provides education during your stay in hospital. The Navigator works with your Clinical Care Coordinator to ensure a smooth and safe discharge home. Once you are home, the Navigator provides continued support with your health care team.

Clinical Care Coordinator: a registered nurse that will visit you within 72 hours of being home to provide assessments, education about your condition(s), review your medications, share information about what to expect from your care team, and answer your questions.

Care Coordinator: regulated health care professional who plans and organizes your care, making sure you receive the right services and support at home and in the community. They work with you, your family and your health care providers to help you reach your health goals safely and smoothly.

E-Clinic: this is a team of skilled staff working with a remote nurse. The registered nurse will direct the care and service provided to you by the individual in your home. Visits may take place daily for the first two weeks you are at home either face-to-face or over the phone and then decrease over time.

Personal Support Worker: helps with personal care, such as bathing, dressing, grooming, and toileting. They can assist with activities of daily living such as heating up a meal and/or medication reminders. They can also check your equipment to ensure it is being used correctly.

Occupational Therapist: may visit to assess your safety at home and to help with equipment required to keep you safe, such as grab bars or bathing aids. The occupational therapist will also teach you how to conserve your energy.

Physiotherapist: may visit to assess your mobility and provide you with a home exercise program to help manage your symptoms.

Registered Dietitian: may provide nutritional information, basic tips on how to manage salt intake and manage fluid restriction. Dietitians may also help with reading food labels.

Respiratory Therapist: may visit to assess your respiratory status and support your COPD-specific education needs.

Contact Information

If you have any questions regarding this service, please contact:
1-833-515-1234 • **ontariohealthathome.ca**