If your needs change, so will your care plan. There are times you may need more services and other times you may need less. HEART@home was designed with this flexibility in mind.

HEART@home offer these supports so you have what you need to be at home.

If you have any questions or concerns when you are home, call the HEART@home team (24/7) at:

1-855-619-5019

Plan to visit your Primary Care Provider...

Visit your primary care provider **within the first 7 days following discharge** to:

- Discuss your discharge instructions and test results
- Review your medicine for any changes since your hospital stay
- Coordinate referrals or follow-ups to specialists, blood work, or other tests or procedures
- Look at what brought you to Humber River Health and help keep you healthy and out of the hospital
- Have a chance to ask questions.

HEART@home is an integrated program by the North Western Toronto Ontario Health Team (OHT).

Humber River Health

In partnership with:

Health · LUMA CARE · Circle of Care Sinai Health · LOFT COMMUNITY SERVICES · reconnect community health services

This brochure has been adapted from Southlake@home's materials.

HUMBER RIVER HEALTH
1235 Wilson Ave., Toronto, Ont., M3M 0B2

Form # 005261

Humber River Health

HEART@home

(Humber's Elderly Assess and Restore Team @ home)

Information for Patients and Families

English
This information is important! If you have trouble reading this, ask someone to help you.

Italian
Queste informazoni sono importanti! Se ha difficoltà a leggere questo, chieda aiuto a qualcuno.

Spanish
¡Esta información es importante! Si tiene dificultad en leer esto, pida que alguien le ayude.

www.hrh.ca

What is HEART@home?

HEART@home is a new program that provides you with the care you need at home after you are discharged from Humber River Health. The program was created by the North Western Toronto Ontario Health Team and other community partners - Humber River Health, Lumacare, SE Health, LOFT, Circle of Care, and Reconnect. The goal of the program is to make your first weeks at home as easy for you as possible.

The HEART@home team consists of your HEART@home care coordinator, nurses, personal support workers, occupational therapists, physiotherapists, speech therapists, social workers, and dietitians. They will work closely with you and your hospital team to make sure your care plan at home meets your needs.

How does HEART@home work?

What happens before I leave the hospital?

Before you leave the hospital:

- You and your family will meet with your hospital team and the HEART@home team. Led by the care coordinator, you will create your care plan.
- Your care plan will be shared with everyone involved in providing your homecare.
- You will have your first home visit scheduled and know the name of the person going to your home. In some cases, you will meet this person before you leave the hospital.

What happens when I get home?

On the day you are discharged, a member of your HEART@home team will call you to make sure that you have arrived home safely.

Your HEART@home team will:

- Visit you in person or over the phone within 24 hours of your return home.
- Check in with you every day for the first week. Then, after the first week, you and your team will decide how often they need to check in with you.
- Work closely with the hospital to ensure your goals are being met after you get home.
- Keep your primary care provider (such as a family doctor or nurse practitioner) up to date on your progress. If you do not have a primary care provider, HEART@home will work with you to find one.
- Use different ways to check in and care for you, such as home visits, phone calls, technology like telemonitoring.
- Work with other local community resources including Meals on Wheels, transportation, and caregiver support programs.

What happens if I need to be readmitted to Humber River Health?

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

How long does HEART@home last?

Most patients are part of HEART@home for up to 16 weeks.

What happens if I need ongoing care?

At about 8 weeks, you and your team will review your progress and adjust your care plan, if needed. Around 12 weeks, if your progress shows you will still need ongoing care beyond the 16 weeks, your HEART@ home team will help you start planning for this care. They will connect you with a care coordinator from the Home and Community Care Support Services, who will conduct an assessment, plan with you, and connect you with homecare services that you can receive after the 16 weeks.