



Health



## Media Release

February 3, 2026  
For Immediate Release

### WRH 'HOSPITAL TO HOME' PROGRAM LAUNCHES WITH GREAT EARLY SUCCESS

**WINDSOR, ON** \_ Windsor Regional Hospital, in partnership with SE Health, has launched Hospital to Home (H2H) – an innovative approach to help patients transition safely from a hospital stay back into their homes.

Funding for this new program, which provides wrap-around services for up to 16 weeks of care following discharge from WRH, comes from a provincewide \$1.1-billion home care investment by the province (<https://news.ontario.ca/en/release/1006653/ontario-investing-11-billion-to-protect-and-expand-home-care#quickfacts>), which was announced in advance of the government's Fall Economic Statement.

The goal of the program, launching at hospitals around Ontario, is to expand access to care at home for patients who no longer require acute care in a hospital setting, while also reducing avoidable return visits to the Emergency Department and hospital readmissions.

“We are very excited to be able to offer this new program for our patients, which improves patient outcomes and independence at home,” said WRH President and CEO Karen Riddell. “Our aging population requires unique and improved approaches to ensuring patients have the supports they need when leaving our facilities. This program provides excellent patient-centered support while at the same time reducing hospital pressures and ensuring beds are available for acute care needs.”

WRH is proud to partner with SE Health (<https://sehc.com/>), a national, not-for-profit social enterprise and a catalyst for H2H Programs, to help connect patients with community-based services in the home and social support services, providing holistic care from nurses, PSWs, physiotherapists, occupational therapists, speech language pathologists, social workers and dietitians.

“We are thrilled to collaborate with Windsor Regional Hospital on this innovative and integrated model that is redefining how we deliver authentic, people-centered care,” said John Yip, SE Health President and CEO. “At SE Health, we know home care is a proven catalyst for system efficiency. By expanding services and strengthening programs like Hospital to Home, we reduce

---

hospital pressures, shorten lengths of stay, and improve patient flow. Every dollar invested in home care multiplies its impact – delivering high-quality care where people want it most, while optimizing resources across the health system.”

“This nearly \$2-million investment ensures patients can receive high-quality care in the comfort of their own homes,” said Andrew Dowie, MPP for Windsor–Tecumseh. “The Hospital to Home program strengthens recovery support, improves outcomes, and reflects our government’s commitment to expanding home and community care across Ontario.”

“The Ontario government continues to make important investments to provide Ontarians with care where and when the need it,” said Anthony Leardi, MPP for the riding of Essex.

The H2H program is specifically designed to assist:

- Patients at risk of becoming or already designated as Alternate Level of Care (ALC), which means they have completed their acute care stay in hospital and are ready for discharge with appropriate supports.
- Patients with frequent Emergency Department visits or complex discharges.
- Patients who can benefit from restorative, rehabilitative or reactivation support.

Eligible patients must live at a Windsor or Essex County address and require at least two identified services at home.

Patients are referred by their in-patient unit or from the Emergency Department to WRH’s H2H team, which assesses and then develops a transitional care plan with the patient, their family and providers. WRH team members will check in with the patients over the course of their interdisciplinary care at home; after the completion of their care plan they will transition to community supports provided by Ontario Health at Home should they require ongoing home care.

The H2H team works closely with primary providers and ensures follow up appointments are secured to foster the continuum of care within two weeks of discharge. For individuals without a primary care physician, a WRH physician follows them in the community until they are attached to a primary care provider, and a follow-up appointment within the two-week timeframe is confirmed. Continued collaboration between community physicians and the H2H program supports coordinated care, reduces emergency department use, and helps people remain safe at home longer.

The first patient for this startup program was onboarded on October 30, 2025. Since that time, 115 patients have been registered in the program and we expect to onboard more than 230 patients by March 31, 2026.

-30-

**For media inquiries contact:**

Steve Erwin, Director, Public Affairs & Communications  
519-564-4902 (cell) / [steve.erwin@wrh.on.ca](mailto:steve.erwin@wrh.on.ca)