Telehealth Programs Available to Support Heart Failure Patients

Questions	Telehome monitoring	Automated follow-up system
What is the program?	Telehome monitoring is designed for patients who require daily monitoring. This acute-intervention model provides care after discharge and/or between medical visits when patients are at risk. It uses devices with simple prompts to capture vital signs and other information which is then automatically transmitted to a central station at UOHI. The information is reviewed by an expert cardiac nurse who intervenes when required.	The automated follow-up system contacts patients one of three ways (phone, email or SMS text) to ask patients a series of questions about their health and self-management that requires a yes or no answer. Responses to the questions are triaged via an algorithm that generates alerts regarding serious health concerns for the expert cardiac nurse to contact the patient.
What service does the virtual care program provide?	The following services are available: • Fluid status monitoring: titration of diuretic according to weight, adding short course of Metolazone PRN, arranging IV diuretics PRN • Medication management: reconciliation, optimization of ACE/ARB/ARNI, BB and MRA at request of physician • Blood work F/U related to medication adjustments done by THM • Self-care & risk factor education. Note: Cardiac expert nurses have medical directives	The system is designed to meet the goals of promoting self-care education and decreasing readmission. • Assesses compliance with prescribed HF regimen such as medications, daily weight. • Educates patient on important heart failure topics such, recognizing heart failure symptoms, understanding common heart failure medications and importance of self-care such as salt and fluid restrictions • Allows patients to request addition information by mail or electronically, such as how to dine out safely or how to read a food label.
What does the patient receive?	The patient toolkit contains a tablet and associated peripheral devices –blood pressure cuff, weigh scale, pulse oximeter, and ECG cards. The patient and/or family member are scheduled an appointment to pick up the equipment and receive instruction on how to use it.	The patient receives an information pamphlet that provides instructions on the program. Patients can choose to receive their follow via automated phone message, email or SMS text.
How long is the patient enrolled in the program?	Patients are monitored anywhere from 6 weeks to 3 months depending on the service they are receiving and their condition.	Patients are contacted by the automated system every 2 weeks for a 3-month period.
What are the benefits?	Telehome monitoring and automated follow-up engages patients in self-care and results in better patient compliance with medications, diet and other daily measures. It also adds an additional layer of security by having expert cardiac nurses recognize potential health risks and intervene. This compliance is often directly correlated with avoidable emergency visits and inpatient admissions.	
What communication does the referring physician receive?	You will receive an intake letter upon the patient's enrollment, a letter upon discharge and update letters if concerns arise that require your attention	
How can I refer my patient?	The University of Ottawa Heart Institute Telehealth Office receives referrals from any physician in the community who has a Heart Failure patient who will benefit from virtual monitoring. Please click on the following link to complete the patient referral form: https://www.ottawaheart.ca/document/telehealth-referral-form	
Who do I contact if I have questions?	The Cardiac Telehealth department will be happy to answer your questions from Monday to Friday, 8 am to 4 pm, 613-696-7050.	