People First, Technology Second

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Imagination at work

Remote Patient Monitoring

Using technology enabled solutions for patient programs that are designed to:

- Engage patients at home – collect data / change behavious
- Manage care transitions and chronic conditiions
- Reduce length of stay and readmissions
- Improve outcomes
- Increase access

Eastern Health- Remote Patient Monitoring

Program Overview

- Rural & Urban geography
- Enrollment to date: 135 patients
- COPD and Heart Failure patients
- Recruitment from acute care inpatient units, ER departments, Meditech data-mining, physician/HCP referral, pulmonary rehabilitation, heart failure clinics, etc.
- Initially, 12 month pilot with ongoing benefit analysis for this cohort of patients
- Integration & Consistency: Reports to HCP, consistency with education resources, medical director
- Funded in partnership with Canada Health Infoway and Provincial Department of Health

Program Design

- Staff – 4 FTE Registered Nurses, 1 FTE clerical support
- Staff are centrally located to promote team environment.
- Staff are dedicated to the program area and receive ongoing training in this technology-enabled method of health care delivery
- Monitoring of biometrics and symptom data with proactive education, coaching and support
- Technology – tablet & peripherals, Cellular 3G default connection, WiFi
- Device deployment, retrieval and reprocessing achieved through the use of an external company specializing in this service

Expected Outcomes

- Clinical
- Increased knowledge and self-management of condition
- Reduces exacerbations/acute episodes
- Patient Satisfaction
- Decreases travel to receive health services
- Maintain optimal wellness and improve quality of life
- Healthcare System
- Decrease use of acute care services
- Improve access to care
- Improve integration of care

Supporting Health. At Home
Remote Patient Monitoring Program

Eastern Health

Alberta Health Service - Virtual Care Management

Program Overview

- Edmonton, AB
- 125 pilot patients
- Heart Failure Patients, over 50 years living at home
- Recruitment strategy – 40 family physicians/PCN
- 2 Primary Care Networks (Urban – inner city, Suburban)
- 6 months program monitoring with 1 year follow up
- No cost to patients
- Independent research study to validate model

Program Design

- Each PCN has 1 Virtual Care Nurse and 1 Virtual Care Coordinator
- VCNs monitored centrally within one PCN and were decentralized in the other
- Clinical Nurse Specialist supported the training and orientation of VCN and VCC (Important to hire the right staff)
- Intel-GE Care Innovations Guide – in home computer tablet with linked blood pressure monitor and weigh scale
- Physician referral, intake assessment and orientation, in home installation and re--orientation

Outcomes

- 89% of participants indicating they would "probably" or "definitely" recommend the program to others, 79% of participants indicated that they were still using at least one element from the VCM program in their regular routine.
- Providers suggested that patient compliance increased as a result of the program, as patients were empowered to take responsibility for their own health.
- Health related quality of life (EQ5D) of patients increased in six months but decreased at one year after enrolment in the VCM program.
- After enrolment in the VCM program, patients used less health services resulting in reductions in health care costs.

Explore the effectiveness of virtual monitoring for CHF patients in a primary care setting.

Alberta Health Services

Questions?

Thank you!

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