HEART FAILURE/COPD REMOTE PATIENT MONITORING

Health PEI
One Island Health System

FREQUENTLY ASKED QUESTIONS:

Is Remote Patient Monitoring (RPM) a proven way to care for patients with heart failure and/or COPD?

Yes. Canada Health Infoway (federal funder of RPM), commissioned a review of RPM before supporting pan-Canadian implementation. The review of evidence showed benefits including less Emergency Department visits and hospitalizations; improved patient satisfaction/quality of life; improved compliance; decreased caregiver burden; and decreased per client health cost.

Health PEI established a home monitoring program available at no cost to Islanders living with heart failure and/or COPD. Weekdays, a trained nurse(s) monitors vitals; provides education; self-management support; and, can instruct patients regarding changes to medications as directed by physicians/NPs' pre-determined targets.

What are the benefits to my patient for participating in the RPM Program?

Monitored vitals and individualized self-management support gives patients a better understanding of their health and the consequences of their actions and behaviours (diet, activity, etc.) on their heart failure/COPD.

What is monitored?

For up to 3 months, vitals are transmitted to the RPM nurse in the mornings by 3G/4G network or by analog phone technology. Home monitoring kits include: tablet, weigh scale, BP cuff & pulse oximeter as well as questions to monitor daily symptoms.

How often will I hear from the RPM Nurse?

The RPM nurse will contact you when your patient is enrolled to determine target ranges for vitals. Patients submit data early mornings; data is uploaded and sent to the RPM RN daily Monday to Friday. If vitals are abnormal, they are double-checked. You will get a report every 3 weeks unless follow-up action is required. In the event of an emergency, patients are instructed to call 911 or go to an Emergency Department.

"This program helped to encourage my patient to become more proactive in her own health care. With the support of the program, she became more educated on heart failure, and felt more in control of her illness. It also was very helpful for me to have regular updates from the program, so that I could stay involved in her management."

Dr. Shannon Curtis
Family Physician

Who is Eligible for RPM?

See *Eligibility* and *Referral Form* for details.

What do I need to do to enroll or refer my patients?

This program is available to all heart failure/COPD patients. Sign the referral form and provide the target range for your patient's vitals. Fax the referral to the RPM program at **902-620-3267**.

Heart Failure and COPD Action Plans have been developed & can be used to guide patients' awareness of their signs and symptoms of heart failure/COPD and what to do when their vitals/status change.

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