# otn.telehomecare

Remote monitoring and intensive health coaching program for COPD & heart failure

Telehomecare is a six-month program that links patients with COPD or heart failure to Registered Nurses who provide remote monitoring and regular health coaching.

Patients become partners in their own care – right in their own homes.

## Telehomecare complements the care you already provide for your COPD or heart failure patients.

- Patients learn self-management skills to take control of their health
- Exacerbations are caught early
- Unnecessary trips to the hospital or ER are avoided

## Is Telehomecare right for your patient?

- Diagnosis of COPD or heart failure
- History of emergency visits and/or hospital admissions
- Capable of using simple, in-home monitoring equipment

Refer now | RxTelehomecare.ca | 1.855.991.8191

( more on back )

## OHIP Billing Codes

**K070** – Completion of referrals

**K071** – Acute home care supervision

**K072** – Chronic home care supervision

Through Telehomecare, patients gain the skills and confidence to effectively manage their condition at home. Telehomecare patients see a reduction of more than 50% in ER visits and in-patient admissions even six months after 'graduation' from the program. Supported by the Ontario Ministry of Health and Long-Term Care and Canada Health Infoway, Telehomecare has supported more than 14,000 patients since it launched in 2012.

## How Telehomecare works

### Patient enrolment

Complete and fax the referral form, available by LHIN at RxTelehomecare.ca.

Patients can also locate a program in their region and begin the enrolment process themselves at otn.ca/copd or otn.ca/heartfailure.

### Patient care delivery

Patients are provided a blood pressure cuff, pulse oximeter, weight scale, and tablet through which to send their vital signs for monitoring. They contact the patient at the first sign of an exacerbation to identify issues. Telehomecare nurses will keep you informed of your patients' progress on a schedule you prefer.

### Patient discharge

At six months, nurses complete discharge assessments and set a maintenance plan linking your patients with community resources. A final report is sent to you and your patient's circle of care.

Ontario otn.telehomecare Canada Health Infoway Inforoute Santé du Canada