Integrated Care for Heart Failure

Through our innovative model of care delivery **one Medly Nurse** is able to provide comprehensive care for up to **300 complex chronic patients**.

A single point of contact for patients:

The coordinator is able to build trust with patients & caregivers, understand the patients' comprehensive needs & medical history, and support patients with care navigation.

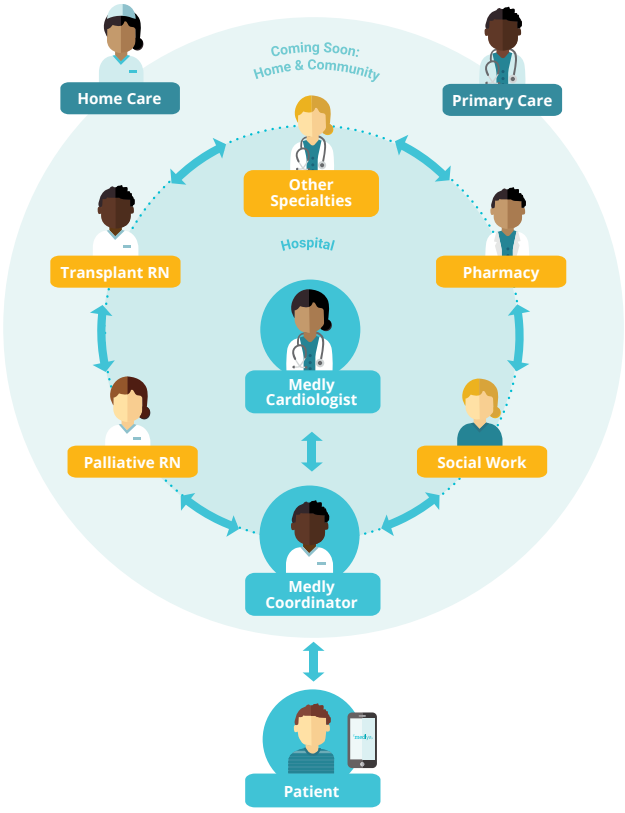
Tight network of healthcare providers located in the hospital:

The coordinator is able to interact with all of the providers within the patients' circle of care through a shared digital record and secure email. This allows for more cohesive care management, and smoother transitions between clinical services.

Coming soon: Integration with Home & Community Care, and Primary Care.

Leverage straightforward technology to improve the delivery of care:

The Medly application and clinician dashboard helps foster care coordination, communication between patients and providers, and create efficiencies.



OUR IMPACT:

Clinical Outcomes

- Significant improvement in heart failure-related quality of life at six months (MLHFQ) [1,2]
- Clinically significant improvement in BNP at six months [1,2]

Patient Engagement

- The 12-month average adherence is 74%, due, in part to ease of use of technology & improved relationship with care team [3]
- Significant improvement in self-care & maintenance at six months (SCHFI) [1, 2]

Resource Efficiency

- 28% reduction in number of hospitalizations [2]
- 25% reduction in length of stay [2]

1. Seto, Emily, et al. "Mobile phone-based telemonitoring for heart failure management: a randomized controlled trial." Journal of medical Internet research 14.1 (2012): e31.
2. Preliminary Results from Medly Program Evaluation (2018-2019).
3. Ware, Patrick, et al. "Patient Adherence to a Mobile Phone–Based Heart Failure Telemonitoring Program: A Longitudinal Mixed-Methods Study." JMIR mHealth and uHealth 7.2 (2019): e13259.

Visit www.medly.ca for more information.