NORTH EAST CCAC TELEHOME CARE

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KEY TELEHOMECARE DRIVERS

Chronic Disease Patient Realities

- Ontario’s aging population is growing
- Almost 80% over the age of 45 have a chronic condition
- Chronic disease can be managed if the patient is informed
- The primary (informal) caregiver is actively managing the patient's care on an ongoing basis
- Patients and caregivers are seeking information to manage their illness and lead healthier lives

Health Care System Realities

- Chronic disease is expensive to treat, it accounts for 55% of health care costs
- 1% of Ontario’s population accounts for 49% of total hospital and home care costs
- Health care executives are looking for ways to control costs and improve system efficiencies
- Increased focus on proactive primary care and preventative care models
- Technology is advancing, more readily available and increases collaboration

Evolving market dynamics support the need for an innovative model of care to support chronic disease patients.
WHO IS INVOLVED???

• Program funded by the Ministry of Health and Long term Care. The Ontario Telemedicine Network (OTN) is the sponsoring agency and Community Care Access Center (CCAC) is the host organization for the implementation of the Telehomecare Program in the North East of Ontario with LHIN continued support and partnership. Telehomecare was officially launched in the North East in July, 2012.
“The most significant part of our plan focuses on ensuring patients are receiving care in the most appropriate setting, wherever possible at home instead of in hospital or long-term care. It means structuring the system to meet the needs of today’s population, with more focus on seniors and chronic disease management.”

Recommendation 5-37 to 5-41 “Reduce mortality, hospitalizations and costs while improving patient satisfaction by connecting Ontarians who have serious chronic health problems with ongoing monitoring and support through expanded use of Telehomecare.”
BENEFITS AND EXPECTED OUTCOMES

**TELEHOMECARE IMPROVES**
- Patient self-management
- Medication compliance
- Clinical outcomes
- Patient & Provider satisfaction
- Collaborative relationships
- Best practice care for chronic disease
- Data integration

**TELEHOMECARE REDUCES**
- Emergency Room visits
- Hospital admissions
- Primary Care utilization
- Long Term Care home admissions
- Patient travel costs
- Walk-in clinic utilization
- Patient Morbidity

Based on a growing number of studies and the evaluation of the THC Pilot, we anticipate the positive outcomes listed above.
BACKGROUND

Pilot Project in 2007-2009 in 8 Family Health Teams in Ontario

• 813 enrolled patients with CHF and/or COPD
• 64–66 % decrease in hospital admissions
• 72–74% reduction in emergency dept. visits
• 16–33% decrease of primary care MD visits
• 95–97% reduction in walk-in clinic visits
• High levels of patient & provider satisfaction
PHYSICIAN ‘S PERSPECTIVE

• "From a provider perspective, Telehomecare improved my own patients' access to care, because even if they were unaware of changes in their physical conditions, a nurse was assessing them on a daily basis and could become immediately involved upon receipt of their daily vital signs. This immediate response to changes in their physical state would translate into fewer emergency room visits and/or hospitalization." – Dr. Eric Paquette
PATIENT REFERRAL

• Referrals are received from Family physicians, Nurse Practitioners, Community Health Centers, Community Care Access Center’s case managers.
• Self –referrals
• Direct referrals from Manitoulin Family Health team
• Group Health Center team managing their own patients with HF and COPD.
ELIGIBILITY CRITERIA

1. Over the age of 18
2. Established diagnosis of HF or COPD (with or without co-morbid conditions)
3. Lives in a residential setting with grounded electrical services with analog or digital phone line with or without internet connection
4. Patient or family caregiver is able to provide informed consent to participate
ELIGIBILITY CRITERIA

5. Health care provider feels the patient will benefit from Telehomecare

6. Have one or more of the following characteristics:
   - frequent hospitalizations (i.e. greater than 1 hospitalization in past year)
   - frequent ED/urgent care visits (i.e. greater than 2 encounters in past year)
   - receiving nursing services via CCAC
   - frequent primary care visits (i.e. >5 visits in past year?)
   - or Requires regular monitoring of their condition by a health practitioner
ELIGIBILITY CRITERIA

7. Is capable of learning and understanding instructions or has a care provider to assist them

8. Is willing to participate in the THC Program
• The goal is to engage and coach clients for a sufficient amount of time (~6 months), so that they are able to become more efficient and confident in managing their health.
• This program will focus on primary care integration.
• Policies and procedures are reflective of the Ministry of Health expectations and targets. Nurse /patient ratio continues to be evaluated.
STRATEGIES IN THE NORTH EAST AND LESSONS LEARNED

• Regional model

• Increase collaboration with Primary Care in the North East - Manitoulin Family Health Team, Englehart hospital and Family Health team, Group Health Center in Sault Ste Marie, Parry Sound FHT, North Bay Regional Hospital – involved with the COPD clinic initiative.

• Hire of Telehomecare Engagement Lead – December, 2013.
STATISTICS

As of March 31, 2014 – numbers of enrollments 701, now have a waiting list.
The target until December, 2014 is to enroll another 700 patients.
TELEHOMECARE OVERVIEW

Patient:
Transmits health information electronically and learns to manage their health from home.

Care Team:
Has the information and resources necessary to collaboratively deliver high-quality care.

Telehomecare Nurse:
Follows a patient’s health status and provides support through education and coaching while assisting patients to navigate the system.

Technology:
Continuous, remote monitoring allows for early intervention and reinforces behaviour change.

Implements outcomes & Reduces system costs.
Welcome to the OTN Telehomecare Centre

Together we will transform health care delivery and improve the lives of chronic disease patients.

What is Telehomecare?

Telehomecare uses technology to bring chronic disease patients the care they need – right in their home.

Telehomecare Nurses monitor each patient’s health status remotely, offering education and health coaching. The patient’s primary care provider is kept informed with ongoing updates.

Together, the goal is to inspire individuals to manage their own health at home.
BEST PRACTICE GUIDELINES- RNAO

- RNAO Best Practice Initiative North East involved in the development of the Self-Management BPG.
- OTN has been awarded the designation of Best Practice Spotlight Organization (BPSO) Candidate for the Telehomecare (THC) Expansion Program.
FUTURE PLANS

The NECCAC Telehomecare program will work closely with the THETA group who will be doing formal research for the Telehomecare program across the province.

The NECCAC will continue to work collaboratively with primary care – hospitals, Family Health Teams, Nurse Practitioners, independent practitioners, CCAC.

Continue to work closely with OTN to ensure sustainability with LHIN support.
QUESTIONS????