Building Sustainable Programs: Lessons learned from the Telehomecare Program
May 29th, 2015
Objectives

- Provide an overview of the Telehomecare program
- Describe strategies to embed and sustain the program within the healthcare system
- Discuss lessons learned throughout the journey -- One year later!
Telehomecare Overview
Telehomecare Video

“The program gives me great peace of mind”
-Ulla, caregiver
Telehomecare Overview

- Supports **patients living in their own homes** through health coaching and monitoring
- Delivered by clinicians with training in **self-management support and health coaching**
- **Complements the care** provided by the primary care provider
- Time limited **secondary-prevention intervention** for patients with COPD or CHF
- Derived from **evidence based guidelines**, and approved by a provincial clinical expert committee
Telehomecare: Patient Centred Model

**Clinician Health Coaching:**
Teaching the Patient how to self-manage & meet their goals

**Efficient MRP Engagement:**
Clinician provides regular updates, consults as required

**Patient Empowerment:**
At home; Sets Personal Goals; Submits vitals/health responses

**Remote Patient Monitoring:**
Weekday feeds & Alerts

**Simple Technology in Home:**
Tablet, BP Cuff, Scale & Pulse oximeter
Telehomecare Delivery Model

Infoway & MOHLTC
- Funding
- Alignment
- Benefits evaluation

LHIN
- Sustainability
- Alignment
- Incentive

OTN
- Change Management
- Project Management
- Training
- Technology Support
- Quality Framework
- Asset Management

Host
- Coach & monitor patients
- Patient recruitment
- Clinicians, coordinator, program manager, engagement
Health System Alignment

- Patients First: Action Plan for Health Care

- Alignment with healthcare transformation initiatives including:
  - Quality Based Procedures
  - HealthLinks
  - New Integrated Care Models
Progress & Results
Telehomecare: Over 5000 Patients and Counting*...

Currently implemented in:
- Erie St. Clair
- Central West
- Toronto Central
- Central
- North Simcoe Muskoka
- North East
- North West

Planning Stage:
- South West

*as of May 1, 2015
Toronto Central - Outcomes
Acute IP & ED Activity Before, During and After Telehomecare

Patients with an ED Visit
- 61% reduction in # of patients with ED visits

Patients with a Hospital Admission
- 52% reduction in # of patients with ED visits

THC patients n = 191
Central West Outcomes
Acute IP & ED Activity Before, During and After Telehomecare

71% decrease in ER visits and a 76% decrease in inpatient admissions.

Inpatient Episodes/ED Visits

Inpatient Episodes
ED Visits

Before
During
After

0 50 100 150 200 250 300 350

#of Months
A survey of the patients who completed the program revealed the following:

- **93%** said that they understood the purpose of each medication
- **93%** said that they were able to recognize the signs and symptoms of their disease getting worse
- **80%** of patients felt that the equipment was easy to use
- **87%** of patients would definitely recommend the program to others.
Telehomecare Progam: Roadmap for Expansion

Integrated Chronic Disease Model of Care

- Chronic Kidney Disease
- Mental Health & Addictions
- End of Life
- Frail Seniors
- Diabetes
- Post Acute Care
Lessons Learned
OTN Lessons Learned

- Strong leadership
- System integration
- Alignment with current priorities
- Perpetual review of processes
- Quantitative and qualitative evaluation
Panel Discussion
Chronic Disease Patient Spectrum

**Consumer**
Healthy individuals who need occasional care for minor illnesses and prevention.

**CDM – Lite**
Individuals living with a chronic condition that can be self-managed with a little assistance.

**CDM**
Individuals living with a chronic condition that requires more active support by the health care team.

**Acute Episodic**
Individuals with significant illness requiring short-term treatment and/or diagnosis.

**Complex or Frail Elderly**
Frail elderly or individuals with multiple chronic diseases that require care from multiple services.