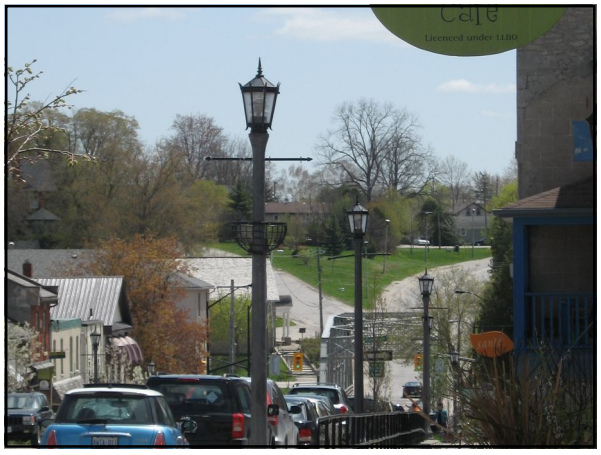
The Telehome Monitoring for Rural Seniors project

Waterloo Wellington LHIN

Lead sponsor: Wellington HealthCare Alliance
Partners: Upper Grand Family Health Team
Waterloo Wellington CCAC
Waterloo Wellington Community Futures Development Corporation

A little bit about us

- North & Centre Wellington – a mixed area of rural and small towns 1 hour west of Toronto
- 2006 Census = 6,000 senior citizens (age 65+) living in Centre Wellington and Wellington North -18% of the total population
- Wellington Health Care Alliance – a consortium of three small rural hospitals
- The Upper Grand Family Health Team and 21 physician, 22 Allied Health professional
- Waterloo Wellington CCAC
- Waterloo Wellington Community Futures Development



Partners roles

- The project will be governed and accounted for by the Telehome Monitoring for Rural Seniors Project Team Committee.
- Groves Memorial Community Hospital – IT expertise
- The Waterloo Wellington CCAC Personal Support Agency staff (PSW's) installation and training of remote monitoring equipment and as well as disease education
- Remote readings sent electronically to the UGFH Team reviewed & responded as needed by a Nurse Practitioner (NP) on a weekday basis
- Ongoing and end of project evaluation will be contracted through WWCFDC.

Care coordination and assessment

- Service will be accessed through CCAC wait list
- CCAC Case manager assesses during hospital discharge
- Based on assessment & consent client will receive stationary monitoring equipment or will receive regular visits from PSW to assist with remote monitoring of chronic condition.
- PSW will install stationary equipment and provide training and education to 50 patients
- Measurements of health status sent from remote devices to NP
- Response outside scope of NP's role will result in immediate consultation with patient's Family Physician and/or specialist consultant
- Monthly trends will be forwarded to client's physician.
- Assessment criteria will be customized for various chronic conditions

Objectives

- Reducing hospital admissions and ER visits
- Avoid LTC admits
- Improving quality of care for patients & quality of work for staff
- Improving resource management (fiscal and human)
- Increasing ability to target services to preventable "frequent flyers"
- Empowering communities to provide local quality health services to their residents
- Improving access to needed services and expert resources
- Maximizing opportunities for self-care and improved compliance to treatment plans
- Mobilizing new opportunities for patients, families, and communities to prevent illness and promoting wellness
- Encouraging new business development in the telehomecare field

Information to be collected

- Baseline data on the conditions that will be monitored through the program.
- Presence or absence of caregiver
- Suitability of residence for monitoring equipment
- Vital signs including weight, temperature, and blood pressure collected daily plus data specific to each chronic condition e.g. blood glucose if diabetic
- Client health information concerning the relevant health status indicators will be automated and electronically transmitted from the client's home to the Nurse Practitioner's monitoring station at the FHT office in Fergus

Client Benefits

- Frail elderly maintained at home through more regular monitoring of their condition;
- Improved access to health care services for rural patients with less need for travel;
- Improved patient compliance with chronic disease management (CDM) strategies;
- Increased patient self-care as part of the CDM process;
- Improved functional status and clinical outcomes for clients managing one or more chronic diseases.

System Benefits

- Reduced number of physician office visits
- Reduced utilization of hospital ED services
- Reduced number of hospital admissions and re-admissions
- Avoidance of long term care admissions
- Anticipated cost-savings (cost avoidance) based on reduced use of other more expensive components of the health care system
- Increased ability of the Ontario health care system to target services to acute care patients who are frequently readmitted to hospital

Project implementation issues

- Skilled human resource shortages
- Acceptance of and adaptation to new technology – patients and staff
- Adequate technical support and suitable technology locally
- Adequate recruitment e.g. OTN's challenges
- Client reluctance to graduate from daily monitoring – reflecting New Brunswick experience
- Sustainability in the long term unless some costs reduce although current gas prices are helping!

Questions?

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