TELE-MONITORING

- a key component in caring for community clients with long term needs

Presentation by Irene Sheppard, Director, Home Health
at Canadian Home Care Association National Conference

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Objectives

- Health Authority & Initiative Context
- Describe Tele-monitoring
  - Clients – type & needs
  - Role & functions
  - Outcomes & actions
- Preliminary Findings of Tele-Monitoring clients

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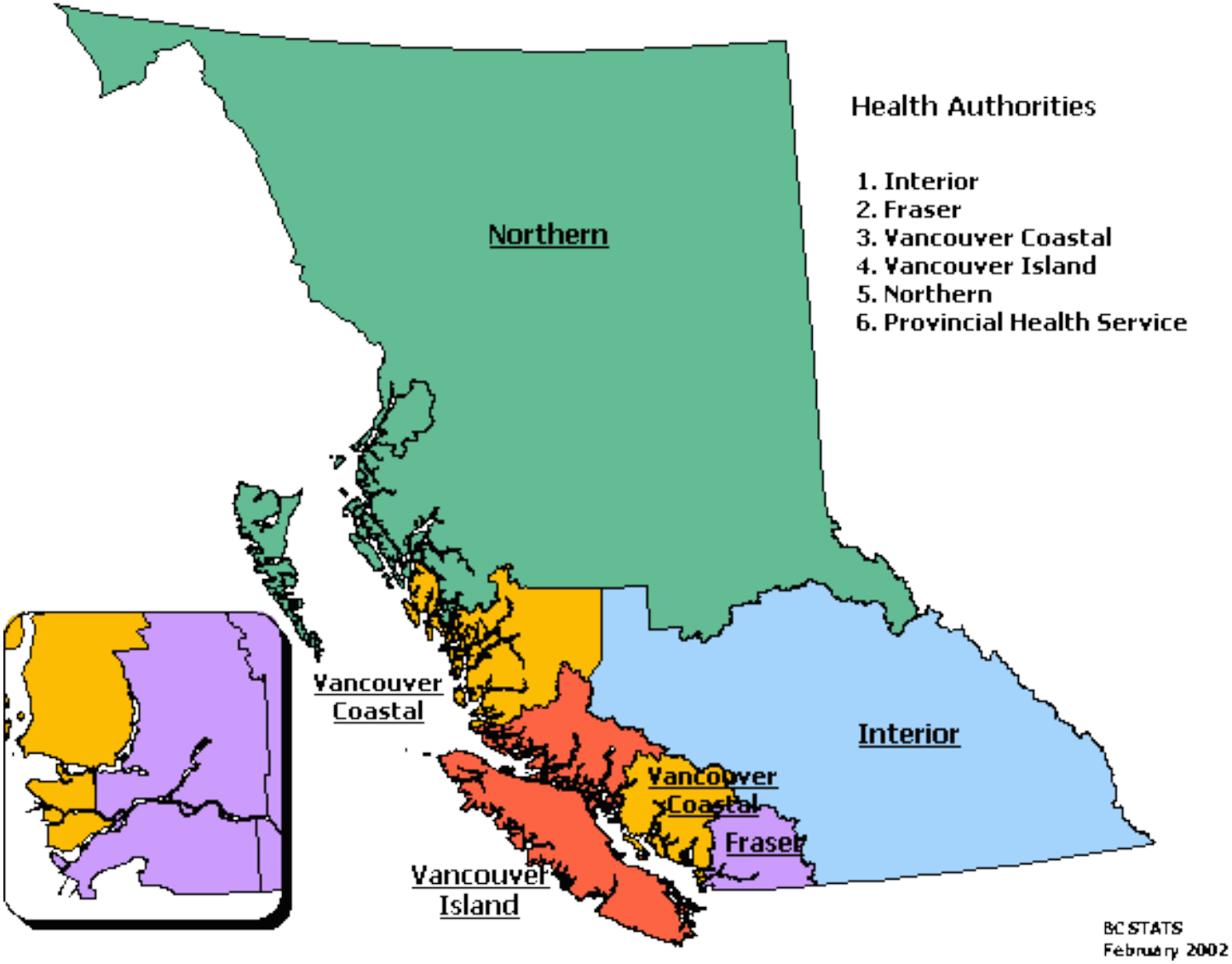
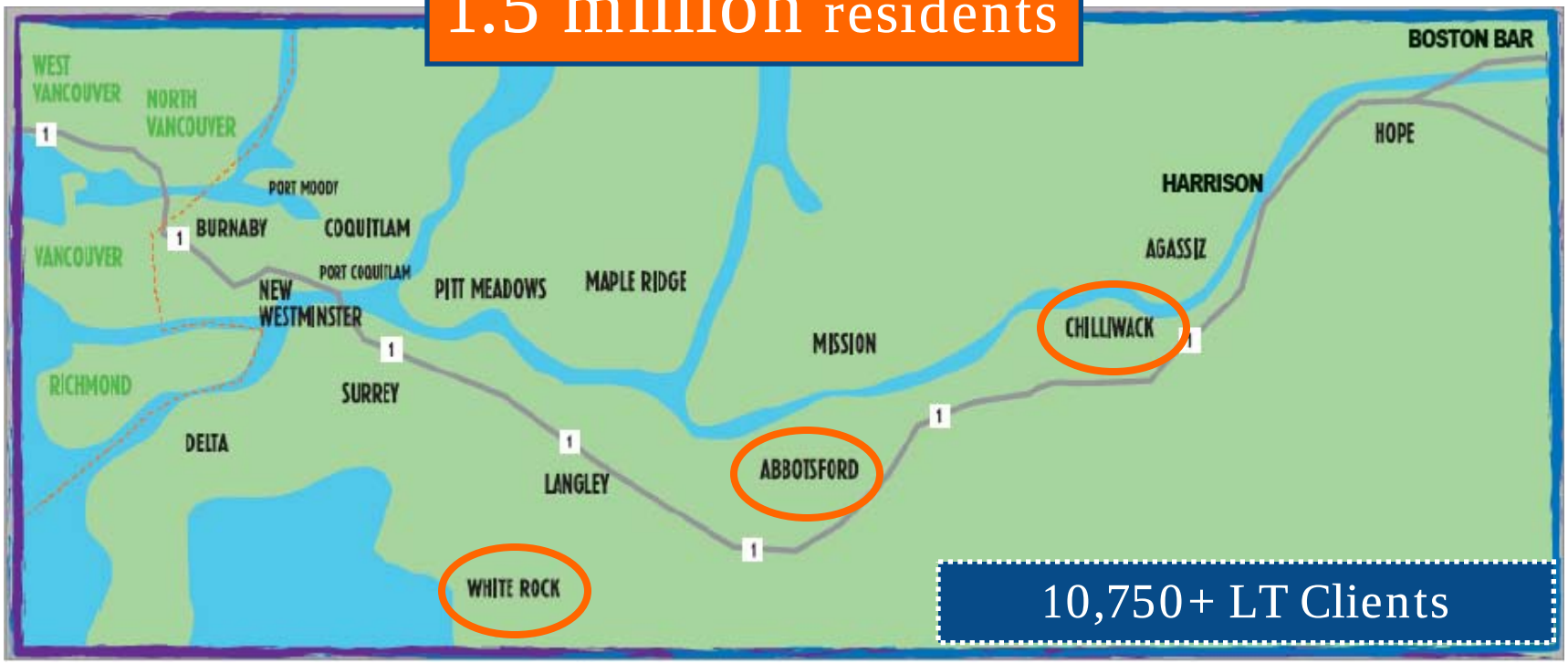
Where is Fraser Health Authority?



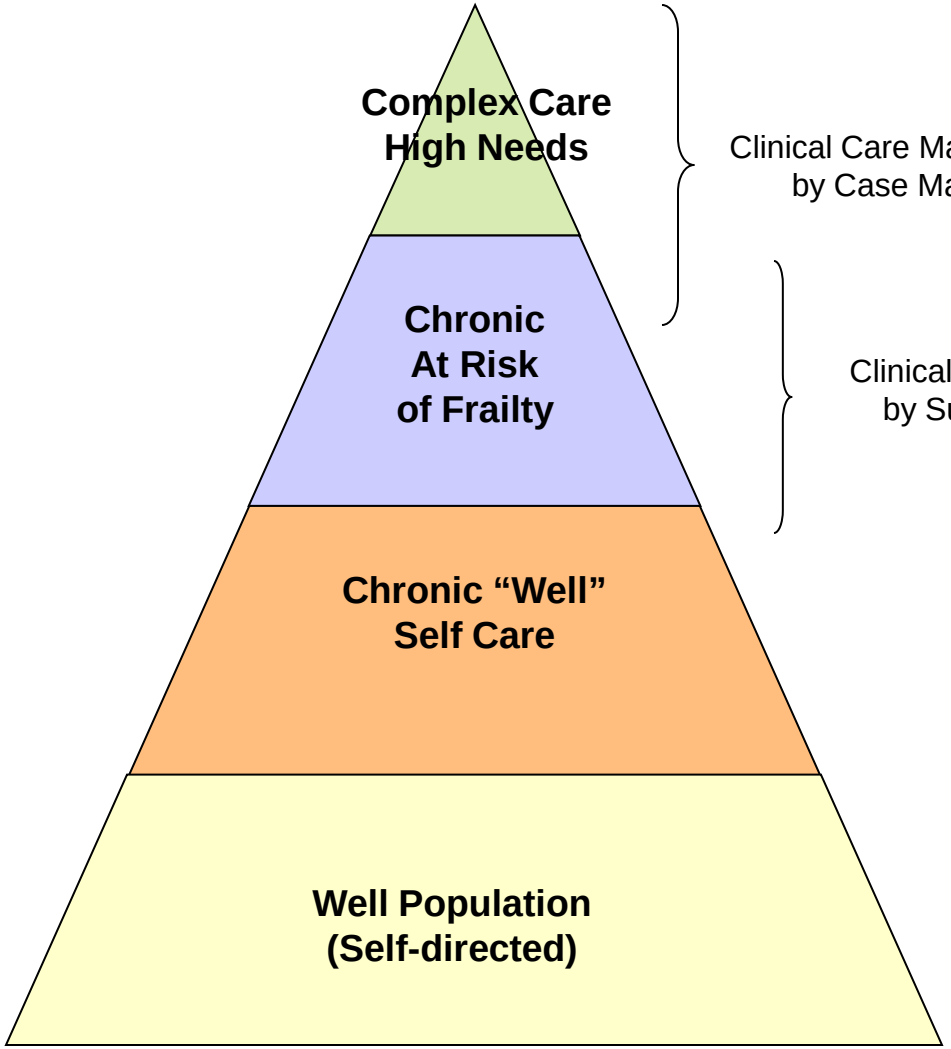
Primary Health Care

Where 80% of health care happens



~2,900 clients (27%)

Complexity Triangle to Understand Home Health Target Population



Clinical Care Management
by Case Manager

Clinical Care Management
by Surveillance Nurse

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Transforming LT Program in Community

Prototype – now in 3rd Community

1. Clinical Care Management
2. Care Managers Partnered with GPs
3. Care *Team* – including Tele-Monitoring by Surveillance Nurse

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Surveillance RN monitors & supports stable clients by phone

- proactive monitoring
- build on care plans*
- Coaching for self-management**
- manage care at transitions
- return to Case Manager for more intensive support

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Key Phrases for Monitoring Call

First level	Second level
Common Questions: designed to elicit a general response to help determine stability	Specific Questions designed to elicit information about the clients care plan and progress
1. I am calling to check in to see how you are doing, as we have not called you for _____ (months, years, weeks). 2. I am following up with this phone call to see how you are progressing? 3. I am wondering how you are doing? 4. Have you noticed any difference?	1. Dr _____ recommended _____ have you started/tried _____? 2. Have you tried any of the ideas we/you discussed with your doctor/myself/case manager? 3. If you have not tried anything we discussed why not? 4. Have you tried anything else? 5. Are you willing to give some thing new a good try? (2 weeks)

Health Improvement Plan

Topic	My steps	Surveillance Nurse Tasks	Review Date
Pain Activity	Take Tylenol arthritis 650 mg 3 times per day, breakfast, afternoon and bedtime everyday for 2 weeks. Taking Tylenol regularly helps control pain better then taking when the pain gets bad Walk everyday – start with 5 mins a day for 1 week 10 mins a day for 1 week 15 mins a day for 1 week With the goal to walk 20 mins a day, the 20 mins can broken in to 5 mins walks with the goal to walk the full 20 mins all at once eventually. Movement helps the pain in joints by increasing blood flow and oxygenation to the joints and some people find their pain decreases with a mild activity such as walking daily	Send pain booklet for you to read as discussed Will follow up in a month to see how you are doing with the plan we decided on together today	Lori will call you the week of Oct 24, 2011

Transfer to primary Care Manager

Return client to primary Care Manager if:

- surface multiple issues (eg. 3 - 4 phone calls in one week & client still requires intervention)
- major client event
- need for a different level of care
- assessment in person is required
- Routine RAI-HC reassessment (q 2 years)

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Operational Parameters

- 250-275 clients per 1 FTE RN
- 1% to 4% of clients per month transferred back to CM
- Initial & follow-up calls take 20-60 mins (most 20-40 mins)
- Scheduled call-backs – 1 to 6 months

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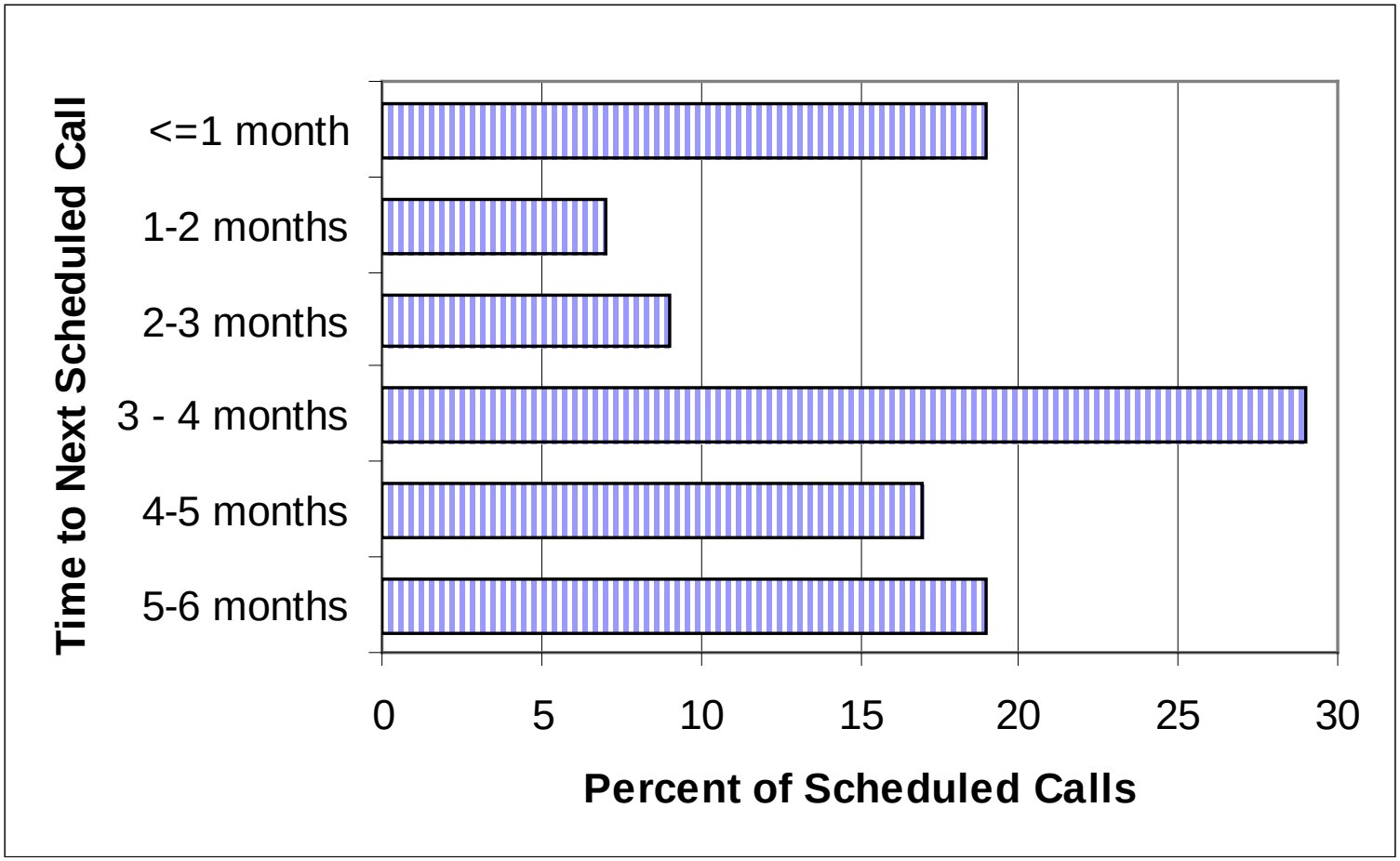
SN Scheduled Call-back Frequency (at 4 months from Initiation)



Case Study #1 – Mrs W.

During an initial call the SN surfaced the client was constipated and had been using enemas to relieve her constipation

Action:

- bowel basics – fibre, fluid and activity
- Mailed info re managing chronic constipation -- the Bristol stool chart, list of foods and fibre content, and the fruit laxative recipe.
- Generated HIP
- Coached to see GP prn and take the above to the appointment

Result:

- One month later --having regular bowel movements for the 1st time in life
- The GP saw the information and HIP at a regular appointment; he was impressed and validated the actions for the client, encouraging her to continue doing what she was doing

Case Study #2 – Mr. R

Initial call surfaced client may be depressed and not motivated. Used PHQ9 and had conversation with client and daughter.

Action:

- Coached for visit to GP and action. Information given to daughter

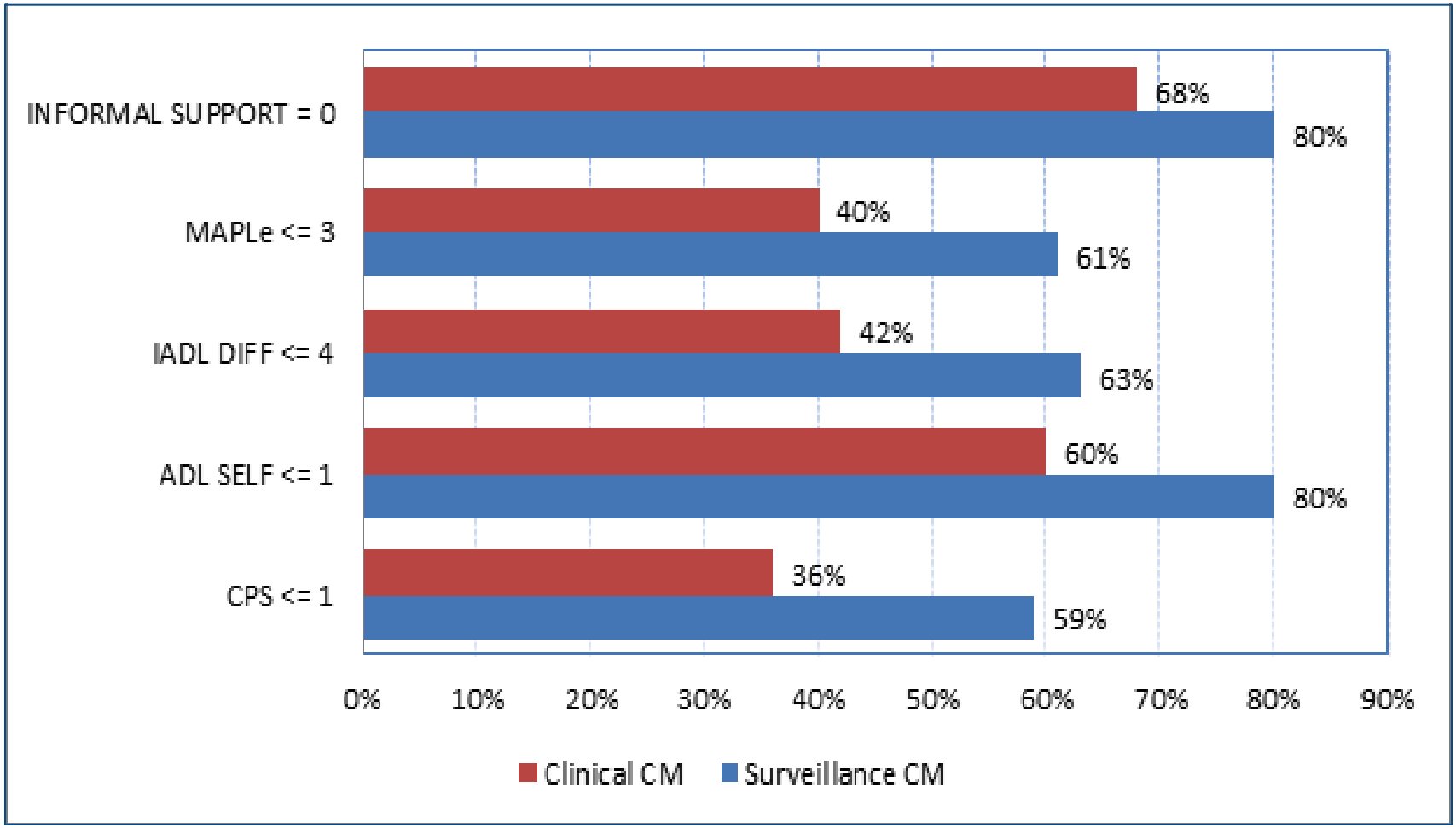
Result:

- Meds adjusted by GP. Client going for walks, to bible study and daughter is less stressed.

Profile of Clients Monitored by Telephone

- Registered in LT program
- Self – rated health is fair +
- Can self-manage (with service/supports)
- Significantly lower ….
  - less use of ER, acute, HS
  - Lower scores for ADL self-performance, IADL difficulty, Maple, CPS

Chilliwack – Active LT Clients



Preliminary Findings – Self Report

- Phone survey comparing 253 SN and 69 CM clients:
  - 66% of SN clients had not been to ER in last 6 months vs 33% of CM clients
  - 82% of SN clients had not been admitted to hosp. in last 6 months vs 59% of CM clients
  - 32% of SN clients and 4% of CM clients rate that they/caregiver are VERY CONFIDENT they can manage their own care

Provider Experience – what the nurses say about the job

- *"I wasn't sure I could do this by phone, but I can connect with people and make a clinical difference"*

- *"I am surprised at how open clients are with receiving information and advice with someone to answer their questions*"

Implementation Learnings

- Slow process to initiate
- Many clients had not been contacted in months
- Clients very appreciative
- Little reticence to talk on phone
- Takes 6-8 months to reach 250
- SN schedules calls more frequently in beginning but then lengthens time

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Next Steps

- Continue to develop the full model of team based clinical care management, including SN
- Continue to use PDSA approach
- Evaluate impact of full model on client outcomes incld. health care utilization at 1 & 2 year post full implementation of CCM – compare between communities, over time, and overall

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