ATLANTIC LEARNING EXCHANGE

HEALTH QUALITY & PATIENT SAFETY

Supporting Health. At Home

Remote Patient Monitoring Program

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Rationale for the project

- Aging population
- Rural geography - rural access to health services
- Continued rise in chronic disease conditions-RPM Program aligns with objectives of Eastern Health's Regional Chronic Disease Strategy
- Need for an increased focus on proactive primary care and preventative care models
- Require cost-effective innovations to deliver quality health services

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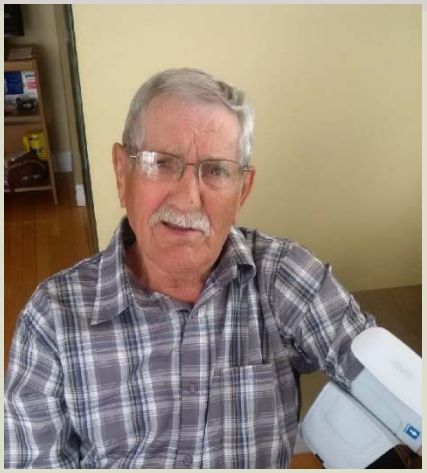
The Goal of the Project or Strategy

For the Patient:

- Increases knowledge of their disease condition
- Improves ability to manage disease symptoms
- Reduces number of exacerbations and acute episodes
- Decreases travel to receive healthcare services
- Maintains optimal wellness at home
- Increases quality of life



For the Organization:

- Decreases use of acute care services (ER visits, admissions, LOS)
- Improves access to care
- Supports patients to stay at home in their communities
- Improves integration of care

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Intervention - Monitoring

- Eligible patients are enrolled for a 4 month monitoring period and are supplied with an iPad, BP cuff, pulse oximeter and weigh scale
- Patients report their biometric and symptom data daily through an enabling technology which is monitored by a Registered Nurse
- Alerts are triggered when data falls outside of range for a particular patient
- A combination of remote monitoring and proactive coaching is the model which produces the best outcomes
- Medication reconciliation and coaching regarding medication compliance is a key factor in positive outcomes
- Primary Care Providers have access to patient trending data and receive regular reports

Experienced team with backgrounds in Critical Care and Emergency Nursing

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Intervention - Coaching

- The primary RPM program objective is to improve patients' chronic disease management knowledge – with a goal of self-management
- Therefore, the project design includes implementation of proactive health coaching provided by the RPM nurses.
- Enrolled patients will receive a minimum of two health coaching sessions via telephone with their assigned nurse.
- Reinforces the health information that is provided by the patient's care providers.
- Educates on nutrition, medications, exercise, anxiety reduction, smoking cessation, etc.
- Include family and caregivers.

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Measures

Patient's Self Efficacy for Managing Chronic Disease

- Pre-program, after 4 months monitoring duration, 6-months post-program

ED visits, hospital admissions, and duration of hospital stays (LOS)

- 12 months prior to the program, after 4 months monitoring duration, and12 months following program completion.

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Key Insights and Lessons Learned

- Important to collaborate with existing programs and stakeholders in program development
- Key success factor is the right person in the role; and the right patients enrolled
- Ensure clinical content, policies and procedures vetted through appropriate parties
- Initially focused enrollment on acute inpatient admissions but learned higher uptake through ED and direct referral
- Open communication between program and vendor is crucial
- Clinical algorithms are important but nursing expertise and judgment is as well.
- High incidence of undiagnosed patients using health care resources
- Exclusion of some of our higher users of acute care and emergency departments due to LTC

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Tips & Tools for Others

- Include patients from the planning phase
- Include stakeholders in the process
- Keep messaging simple and consistent
- Open and ongoing communication is key!!
- Get input from the experts!
- Incorporate feedback into the program
- Important to build efficiencies into the clinical model
- Explore every opportunity to promote program awareness and engage clinicians and patients
- Be open to change - continuous evaluation.

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