

Using Technology to Improve Quality of Care

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Health Rural Services Administration

Project 1: Rural Health Care Services Outreach Grant Program

Project 2: Telehealth Network Grant Program

Focus Area

CHF and COPD patients discharged from hospital as home health care patient.

CHF and COPD patients discharged from hospital with health coach providing 90 days of motivational interviewing.

Asante Health System - Service Network

Home Care Agencies

- Three Rivers and Riverside Home Health Care, Josephine County
- Coastal Home Health Care, Curry County
- Sky Lakes Home Health Care, Klamath County
- Mercy Medical Home Health Care, Douglas County
- Siskiyou Home Health Care, Yreka, CA

Hospitals

- Three Rivers Community Hospital
- Rogue Valley Medical Center

Patient Demographics

- Age group – 71-90 years old
 - 21% of general population in Southern Oregon is comprised of persons aged 65 and older. 90% of Americans over the age of 65 have one or more chronic diseases
- Payment Source – Medicare
 - Majority consumers within the healthcare delivery system. This represents 50% of hospital care, 80% of home care services, and 90% of nursing home beds. Utilization is 3-4 times more frequently than those under age 65.
- Living Status – Alone or with caregiver
- Chronic disease management
 - Focus target: elderly population for improved chronic disease management services, and reduced costs of care.

Project Goals

Goal I – Improve medication management

Goal II – Improve quality of care using
Telehealth technology

Goal III – Increase efficiencies and reduced
costs of care using Telehealth technology

Project Objectives

Objectives

- Improve by 25% the patient/provider satisfaction
- Improve by 25% communication among providers across points of care including hospital, physicians, and homecare
- Reduce total number of hospital readmissions and emergent care visits by 50%
- Improve medication compliance and reduce medication related hospital readmissions and emergent care visits by 50%.
- Reduce by 25% the number of visits per homecare episode as a result of using Telehealth technology.
- Reduce overall cost of healthcare by reducing hospital readmissions and emergent care visits by 50%

Motivational Interviewing

Methodology

- Telehomemonitoring employed directly after hospital discharge
- Hospital-based home health coaching
- Shared patient constituency
- Health management intervention

Evidence-based outcomes

- Provider interaction will influence the likelihood of treatment adherence and lifestyle change
- “Change talk,” evoked by the provider from the patient predicts greater commitment strength to the treatment plan or behavior change by the patient.
- Correlation – positive clinical outcome.

Strategic Objectives

- *Clarifying and focusing on our long-term impact – creating a shared vision*
- *Understanding our program's place in the community – identifying the system*
- *Aligning our daily activities with the system and impact in the future – taking action*
- *Collecting data that will show the outcomes of our actions – evaluating progress*

Challenges

- Patient and Family Support
- Connectivity Issues
- Staff, patient, and physician training

Outcome Results for 2009-2011

- Through this telehealth technology patient vitals signs and physiological metric data are transmitted on the telehealth monitor and review by clinical staff.
- Since 2009, the program has served over 450 patients in four counties.
- Since 2010, study enrollment is at 250 patients; goal is to enroll 500 patients to the study.
- Overall results: Early identification of heightened health risk status, timeliness of medical response, improved communication among and between the health care team, and improved stakeholder satisfaction of care.

Data Review

- Improve patient/provider satisfaction by 32%
- Improve communication among providers across points of care including hospital, physicians, and homecare by 28%
- Reduce total number of hospital readmissions and emergent care visits by 56%
- Improve medication compliance and reduce medication related hospital readmissions and emergent care visits by 48%
- Reduce the number of visits per homecare episode as a result of using telehealth technology by 16%
- Reduce overall cost of healthcare by reducing hospital readmissions and emergent care visits by 23%

Patient Story

- “Before I became a patient, if I forgot to check my vital signs in the morning, my disease could sneak up quickly and cause me to go into heart failure which would result in a serious hospital visit.”
- Feedback from staff, “Patients like it because it makes them feel very secure in their homes.”

Wrap Up

Thank you.
Questions or Comments?