

# **Using Technology to Improve Quality of Care**

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# Health Rural Services Administration

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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

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## 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

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- 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

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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

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## 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

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## 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

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- *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

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

# Outcome Results for 2009-2011

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- 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

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- 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

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- “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

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Thank you.  
Questions or Comments?