

Self-Management - Not Just a Program

Informing Health System Design & Findings from a Telemedicine Initiative

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Priorities in NSM 2010-13

1. Improving Chronic Disease Management

- Improve access to integrated diabetes care by supporting the roll-out of the current diabetes strategy

2. Designing an Integrated Future State of the Health Care System

3. Improving Access to Appropriate Care

- Improve access to emergency department care by reducing the amount of time that patients spend in the emergency department waiting
- Improve access to hospital care by reducing the amount of time that patients spend designated alternate level of care (ALC) in a hospital bed

Enablers: eHealth and Social Marketing



Enabler – Diabetes Portal and Registry

Ontario's eHealth Strategy also identified diabetes management as a clinical priority for 2009-2012, while working towards an electronic health record for all by 2015.

“ Diabetes Management is one of our top clinical priorities since we know that more than 900,000 people in Ontario have diabetes and this number is expected to grow to 1.2 Million by next year.”

- Rob Devitt, eHealth Ontario's Interim President and CEO, Oct, 2009.

An online diabetes registry is part of the Ontario Diabetes Strategy to improve health outcomes for Ontarians living with diabetes and is in effort to reduce associated health care costs.

The registry will be an interactive, real-time system to track the care of patients with diabetes and assist both clinicians and patients in better managing their care.

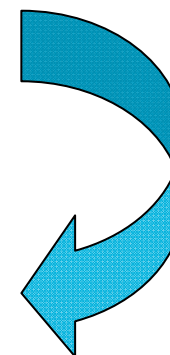
The Ontario Diabetes & eHealth Strategy ... Getting Ready

NSM – was NOT identified as an ‘early adopter’ LHIN

Development of a NSM Chronic Disease Prevention and Management Regional Action Group

- Self-Management working group
- BCI/MCI/ 3-Minute Empowerment working group

Regional Plan for Access to a Self-Management Program (Stanford) Proposed



The Scan

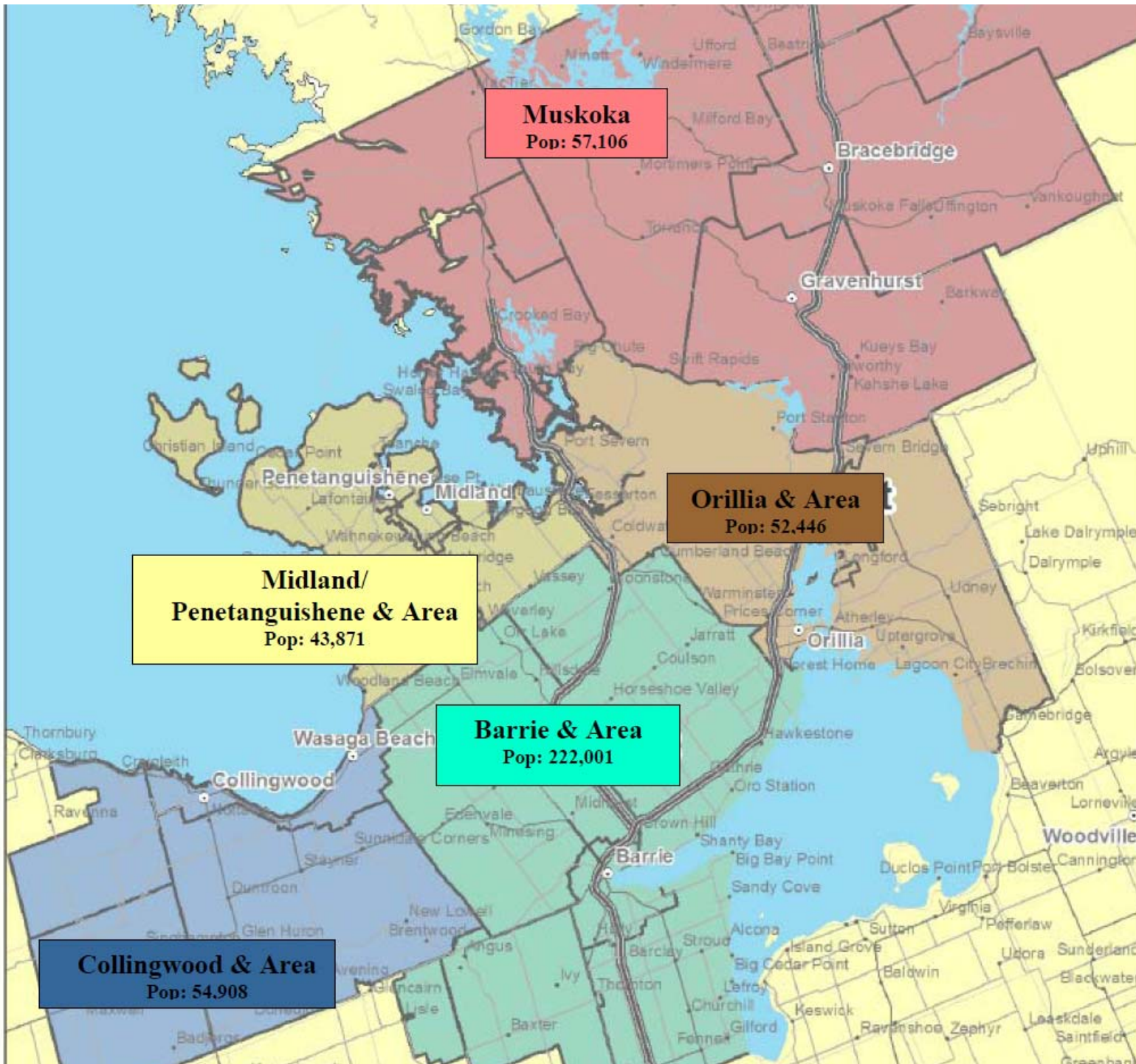
Recognition: Self-management practice and readiness will enable the successful adoption of the diabetes registry in support of the roll-out of the provincial eHealth Strategy.

Query: Where and how to individuals, who do not access self-management programs, get ready to be active self-managers?

Resulting Objective: Conduct a local scan to identify the current state of the local diabetes context to inform planning in support to the roll-out of the provincial diabetes and eHealth strategies.

Focus: Diabetes services with a lens on self-management practices and programs across the 5 geographic areas of the LHIN.





Findings Informing Direction

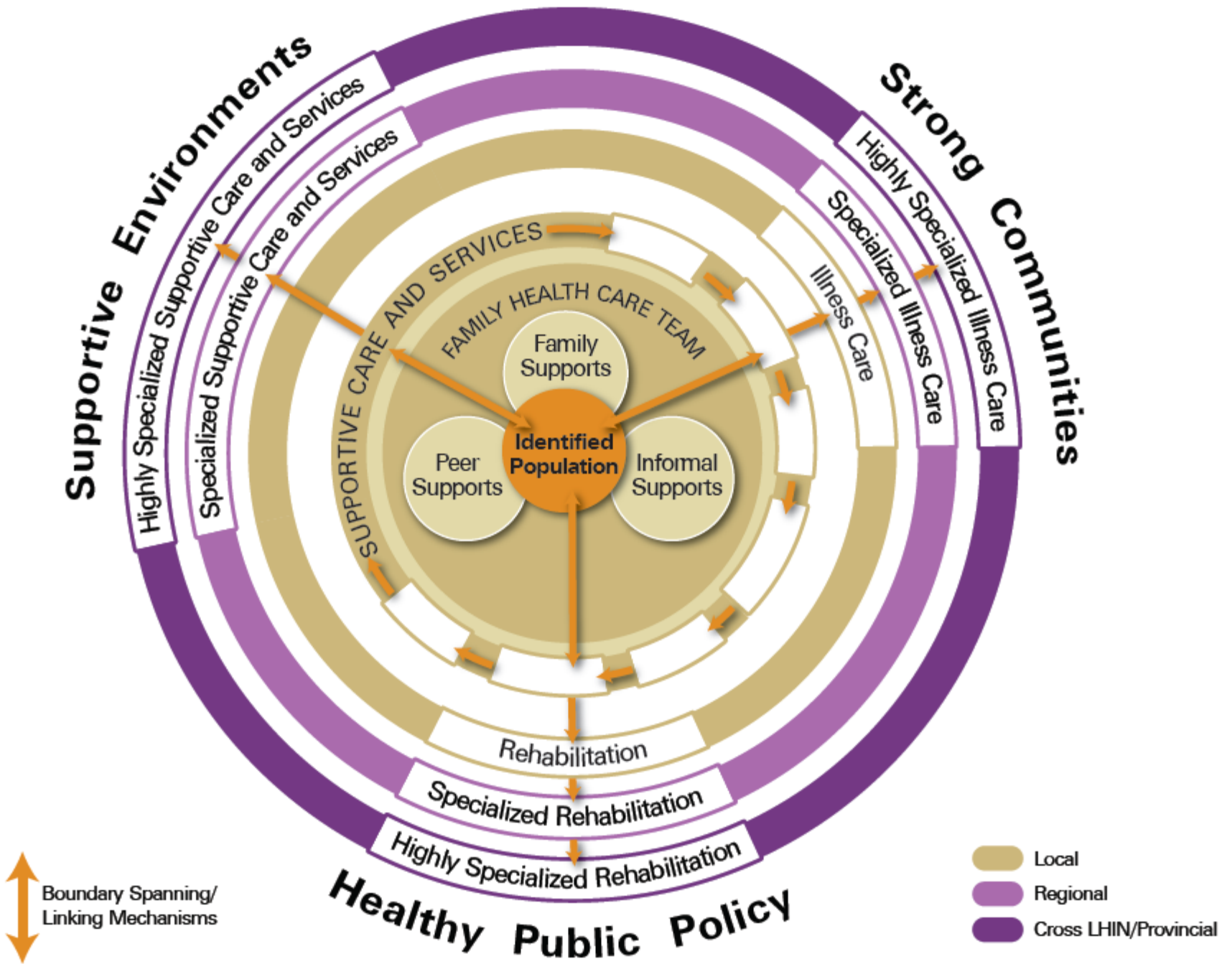
Self-Management is **MORE** than a Program

Explore health system design in the context of Diabetes Management with Two Populations of Focus

1. Person living with the chronic disease
2. Professionals working with people living with chronic conditions

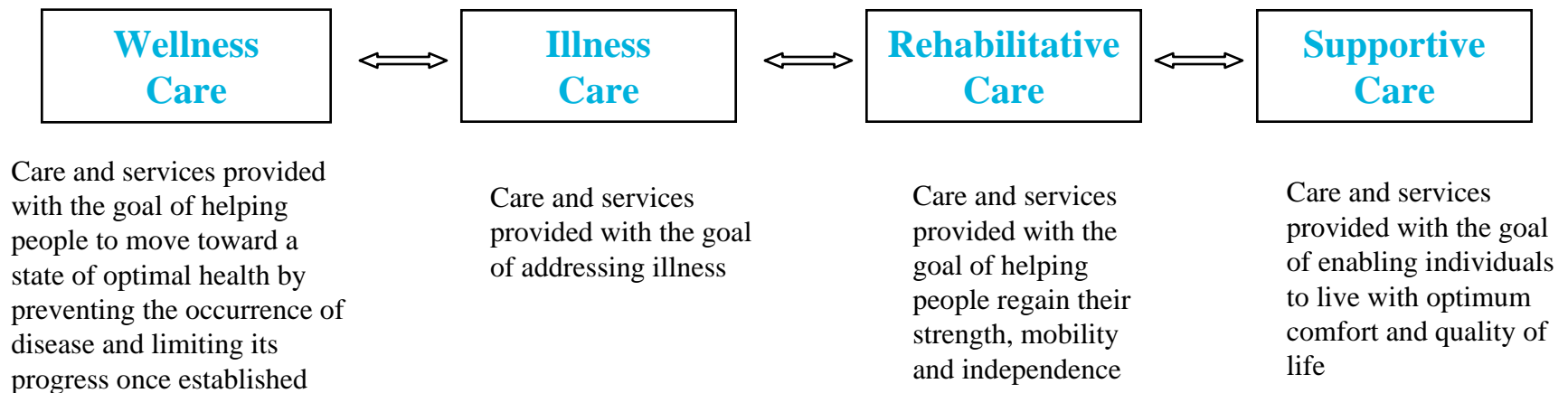


Conceptual Model of an Integrated Health System



The Continuum of Care

**Integrated Health Systems must support
the delivery of care and services across the full continuum**



Adapted from “The Family Physician’s Role in a Continuum of Care Framework for Newfoundland and Labrador. A Framework for Primary Care Renewal.” Available from <http://www.gov.nl.ca/publicat/pcac/pcac.PDF>.

Early Findings The ReACT Initiative



Re-ACT[©] 'Remote Access to Care Technology'

- Clinical wireless e-health service funded by Aging at Home to address Ministry priorities:
 - Emergency Department Diversion
 - Reduction in Hospitalizations
 - Reduction in Length of Stay for Alternative Level of Care (ALC) Days
- 97 active clients; 1 RN to ~100 Clients
- Partners are: We Care Home Health (providing the nursing monitoring, Healthanywhere (e health and technical backup), NSM CCAC (support agency) and Bell (connectivity)


ReACT Initiative

Focus Population: Residents in NSM trying to live independently in the community with a chronic health problem.

Goal: to promote self-management of their chronic disease, thus learning to self-identify when there are exhibiting signs or symptoms indicative of a health problem which should need medical attention – in a timely manner. As a result:

- decreasing the incidence of complications which usually results in avoidable urgent visits to the Emergency Department
- unnecessary hospitalizations and
- increased ALC length of stay/ bed utilization.

Benefits to the Client

- Promotes client knowledge & confidence in disease management; Empowers client to manage their own health
 - Identifies health problems earlier, allowing timely interventions & prevention of complications
 - Enhances quality of life & longevity
 - Equitable healthcare in rural areas
- 
- A decorative graphic at the bottom of the slide consisting of a thick, light blue wavy line that spans the width of the page. Below this line is a solid grey area that also spans the width, creating a layered, wave-like effect.

Admission Requirements

- Comprehensive Nursing Assessment
- Environmental Assessment
- Falls Risk Assessment
- Completion of the Personal Health Profile
- Identification of Level of CDM (A,B,C,D)
- Identification of Clinical Frailty Level (1-7)
- Goal Setting and Discharge Planning
- Contact with Doctor to provide parameters for vital signs
- Ordering of equipment
- Second visit to install equipment and teach client / family

Bluetooth Medical Peripherals



Blood Pressure Cuff:

Model: UA-767 Plus BT
Manufacturer: A&D Company Ltd.



Weight Scale:

Model: UC-321PBT
Manufacturer: A&D Company Ltd.



Oximeter:

Model: OxyPro
Manufacturer: CARD GUARD



PMP⁴ Spiro Pro

Spirometer:

Model: Spiro Pro
Manufacturer: CARD GUARD



Glucometer:

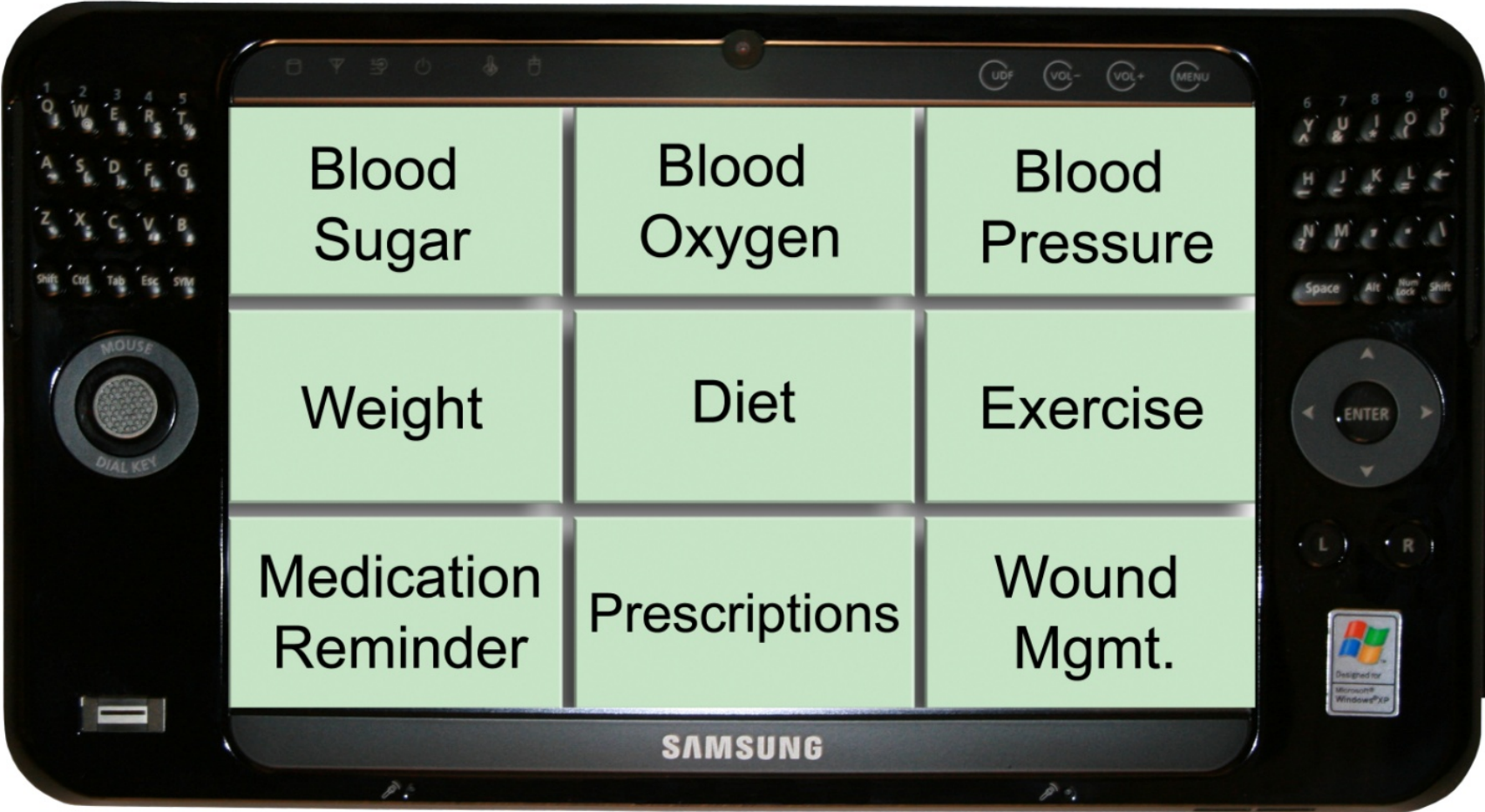
Model: OneTouchUltra2
Manufacturer: LifeScan Inc.

Healthanywhere
A Division of IgeaCare Systems Inc.



IgeaCare
Systems Inc.

Client Tablet in the Home



Patient Chart

IgeaCare Inc. - Health@nywhere Nursing Interface - Mozilla Firefox

File Edit View History Bookmarks Tools Help

http://demo.healthanywhere.com/jsp/vital_reading.jsp

Getting Started Latest Headlines

Healthanywhere
A Company of IgeaCare Systems Inc.

Jun 4, 2008 10:12:41 AM [Contact Us](#)
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[Summary](#) [Patient List](#) [Care Plan Manager](#) [Video Visit Manager](#) [Wound Manager](#) [Visiting Nurse Manager](#) [Reports](#)

Jost, Sara Age: 29 (F)

[Patient Personal Information](#) [Device Configuration](#) [Rx Chart](#) [Vital Signs](#) [Video Visit](#) [Wound](#) [Diet](#) [Exercise](#) [Schedule](#) [Questionnaire](#) [Clinical Notes](#) [Reports](#)

Filter Past 30 Days

Blood Pressure

Date	Systolic (mmHg)	Diastolic (mmHg)	Pulse (BPM)
6/3/08 12:29 PM	126.0	88.0	73.0
6/3/08 10:43 AM	91.0	66.0	71.0
6/3/08 10:42 AM	120.0	80.0	66.0
6/2/08 10:38 AM	136.0	96.0	82.0
6/2/08 9:14 AM	138.0	90.0	70.0
6/2/08 8:21 AM	134.0	95.0	70.0
5/29/08 6:52 PM	132.0	96.0	68.0
5/29/08 6:50 PM	121.0	86.0	86.0
5/29/08 6:49 PM	142.0	91.0	80.0
5/29/08 6:47 PM	122.0	84.0	74.0
5/27/08 2:38 PM	97.0	67.0	67.0
5/27/08 12:59 PM	129.0	94.0	83.0
5/21/08 7:19 AM	114.0	80.0	82.0
5/20/08 4:45 PM	106.0	70.0	65.0

Warning Thresholds

Systolic Diastolic Pulse

Min

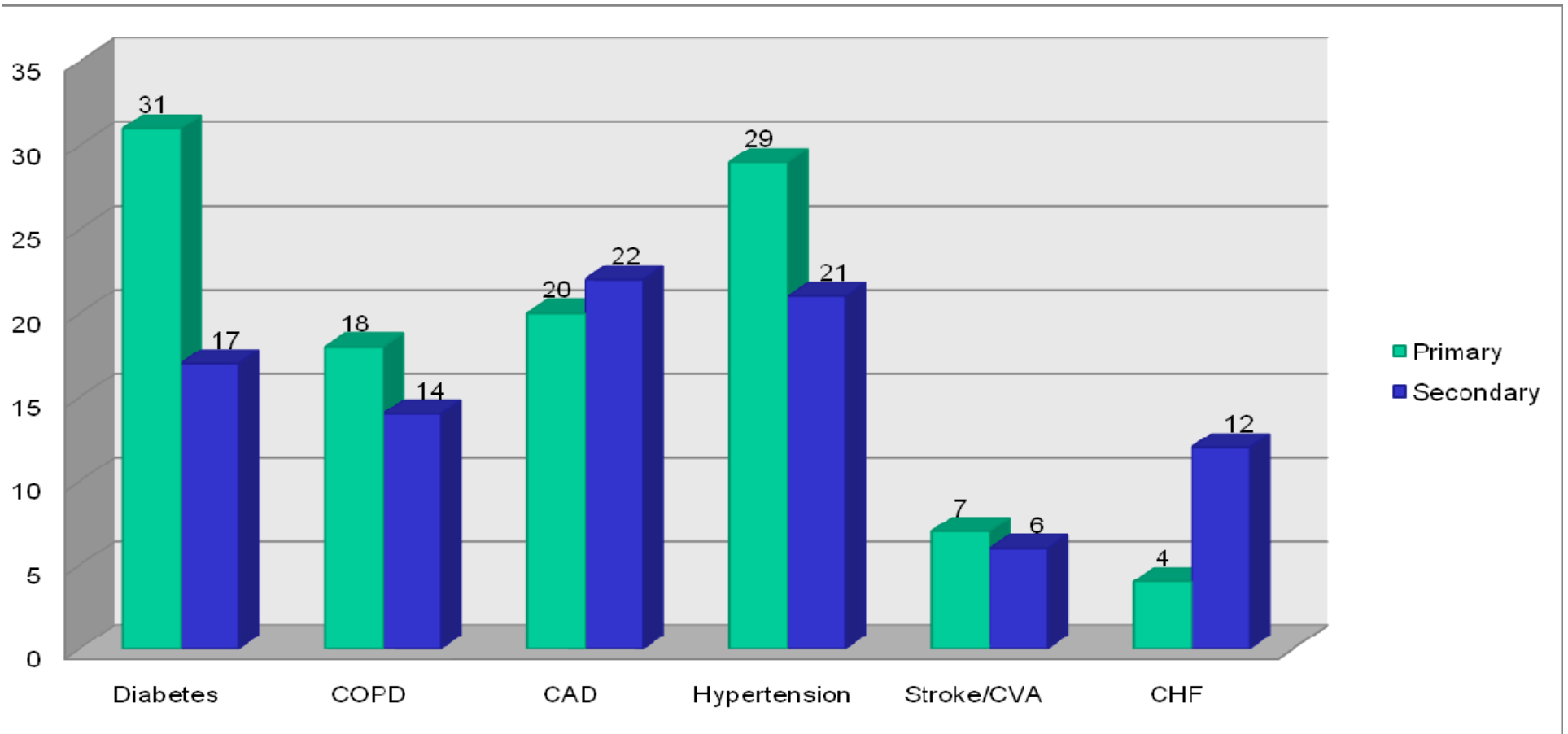
Max

Blood Pressure

Done

Windows taskbar: Bell Mobile Connect, Creative - Microsoft..., PowerPoint - Messa..., 3 Microsoft Office..., IgeaCare Inc. - Healt...

Re-ACT Diagnoses:



Performance Indicators and Outcomes

Performance Indicator	Indicator Type	Performance Target
% reduction in events / incidences resulting in Emergency Room visits	ED	30%
% of clients placed in LTC from program	LTC WT	10%
% of clients requiring crisis placement	LTC WT	5%
% of clients that are able to be maintained in the community	ALC	80%

Benefits to the Health Care System

- Cost containment
- 1/3 cost of a home visit
- Reduces ER visits & hospitalizations
- Addresses HHR issues
- 1 RN monitors 100 clients
- Reduces burden to Physicians & FHTs
- Additional clinical support & education
- Fewer on-demand visits
- Decreases wait lists for CCAC
- allowing intake of additional clients
- Real-time sharing of client data
- electronic data is captured, stored and shared

Future Directions

A focus on self-management and self-management supports will enable behaviour change, consistency in the development of care plans and facilitate the adoption of the eHealth Strategy's diabetes portal for providers and patients.

Next Steps are focused on the development of a self-management task group with a role in the identification of strategic directions towards the implementation of a comprehensive, integrated health system embedded with self-management supports.

Residents will experience self-management supports across the continuum of care.



Questions?

