Stay@home with VON: A comprehensive Self-Management Program

Cindy Hitsman

CHNIG/CHNAC conference

May 29-31, 2008

Objectives

- **The motivation for the project**
- **The pilot project: An overview**
- **Key Indicators**
- **Key challenges and lessons learned**

VON Canada and the Erie St. Clair CCAC entered into a partnership

To pilot the VON initiative as a strategy to manage a stream of high-risk patients with diabetes in Erie St. Clair region.

Program Goals and Objectives

To create a community based Chronic Disease Management program that:

1. Improves client outcomes by highlighting the principles of evidence-based care, client self-management and system integration by
    1. Maximizing quality and efficiency of delivered services
    2. Targeting services to acute care patients at high risk for hospital re-admissions
    3. Maximizing client self-care management opportunities
    4. Facilitating active communication between all members of the inter-disciplinary team
    5. Developing effective community partnerships and leveraging strengths of each
2. Decreases health care costs by facilitating a reduction in emergency room visits, length of stay, and hospital readmission rates for persons with diabetes.
3. Maximizes health human resource utilization and management

Compared to Ontario, Erie St. Clair residents:

- Have a shorter life expectancy
- Are more obese
- Lose more potential years of life
- Have a higher use of inpatient and emergency department services
- Report higher than average rates of chronic diseases, including diabetes, heart disease and high blood pressure
- Have lower levels of stress
- Have a higher proportion of seniors

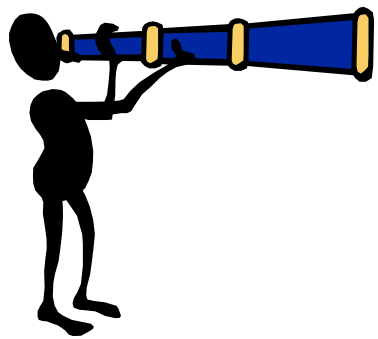
Erie St. Clair LHIN (2006). Erie St. Clair LHIN Releases First Health Care Plan. Retrieved May 15, 2007 from http://www.lhins.on.ca/english/ErieStClair/Erie%20St%20%20Clair%20IHSP%20Launch%20Media%20Release%20English-for%20Web.pdf

Erie St Clair CCAC client information

Chatham Branch	Primary diagnosis	Secondary diagnosis	Total
# clients with diabetes	40	162	202
Average # of clients with diabetes admitted each month	4	21	25
Average LOS for clients with diabetes	317	230	273.5
Average COS for clients with diabetes	$2812.06	$2796.26	$2804.16

Scope and Scale

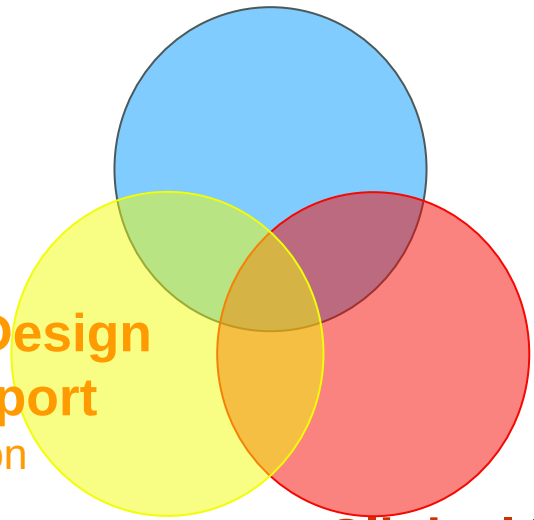
- Total of 20 - 25 clients in the program
- Monitoring and interventions taking place over one year
- Each client to be monitored for approximately 3 months
- Disease entity chosen: Diabetes



Stay@Home with VON
The Big Picture

Support for Self-Management

CDSMP classes, Activity, Nutrition screening, Disease Specific Education



Delivery System Design & Decision Support

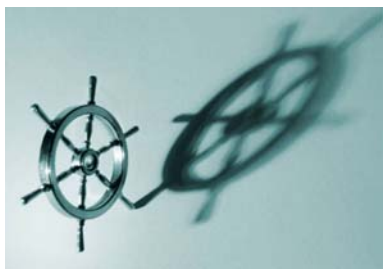
System Navigation
Advocacy
Case Management
Interdisciplinary engagement

Clinical Information Systems

Telehome Monitoring
Self-Management Portal
Electronic Record

The community based interdisciplinary team

- **Erie St Clair CCAC**
- **Chatham-Kent Health Alliance**
- **CCAC Medical Advisor**
- **VON Canada**
- **VON Corporate Centre**
- **VON Chatham-Kent Branch**



Interdisciplinary team included:

Nursing, medicine, IT, education, administration, research, and volunteers

Inclusion Criteria

- Adults over 18
- Type I or Type II diabetes
- Living in Chatham-Kent
- Referred by MD or NP
- Eligible for CCAC services
- Hx of 1 ER visit, 1 hospitalization, or 1 EMS call in past year
- Cognitive ability to undertake the program

Exclusion Criteria

- Under age 18
- Live outside geographic boundaries
- Gestational diabetes
- Dx of dementia, cognitive deficits or ABI
- Ineligibility for CCAC services
- Life expectancy of less than one year

Client Recruitment

- Multi-faceted approach
  - CCAC
  - Family Practitioners
  - Family Health teams
  - Local Hospital Emergency Room
  - Diabetes Education Unit
  - Emergency Medical Services

Each Day at an appointed time...

- **The client uses the telehome monitoring equipment to measure and record their daily blood parameters**

Blood Pressure

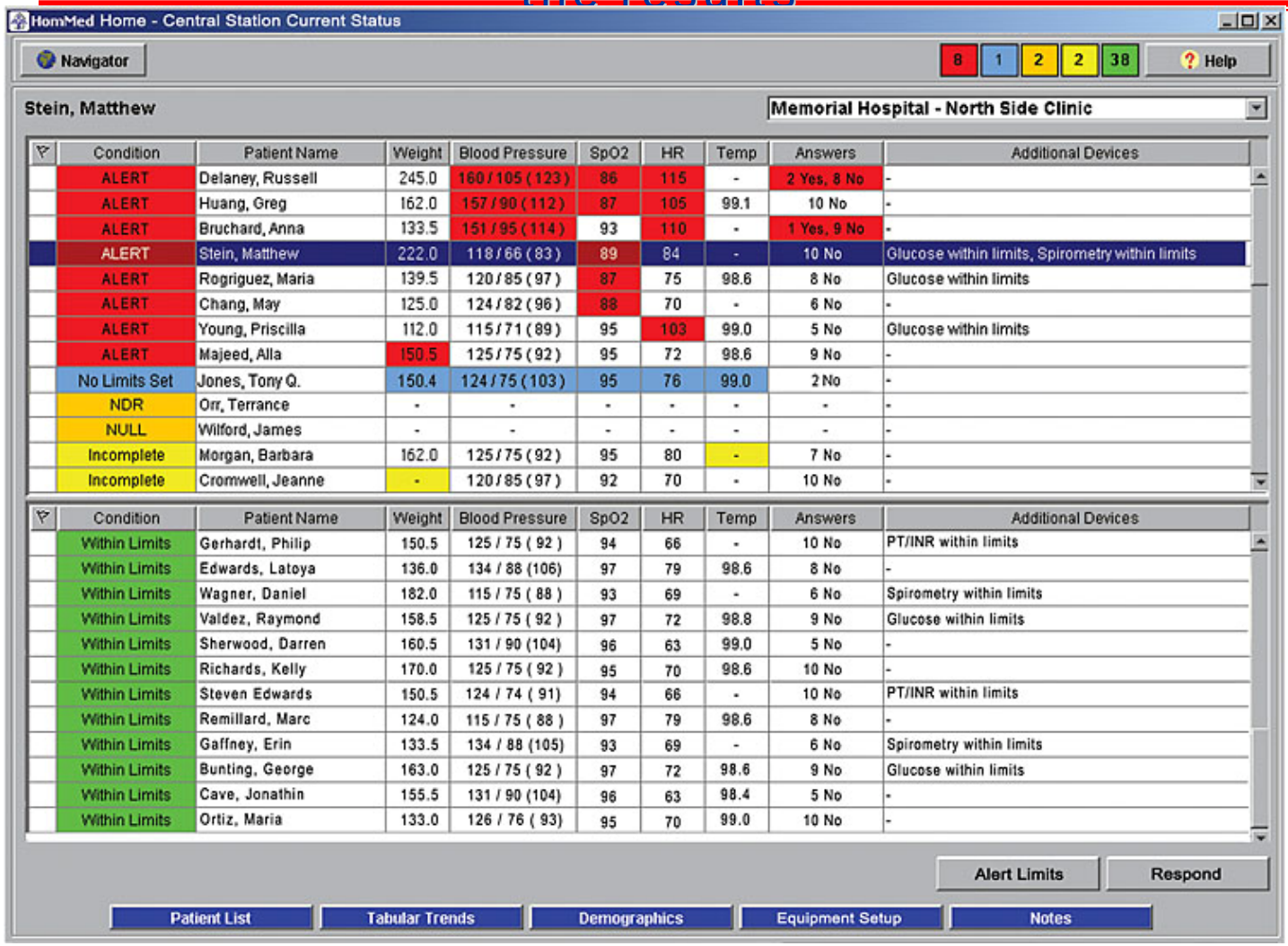
Glucose

Weight

This information is transmitted via a telephone line to a central monitoring station..

Graphics obtained from www.hommed.com

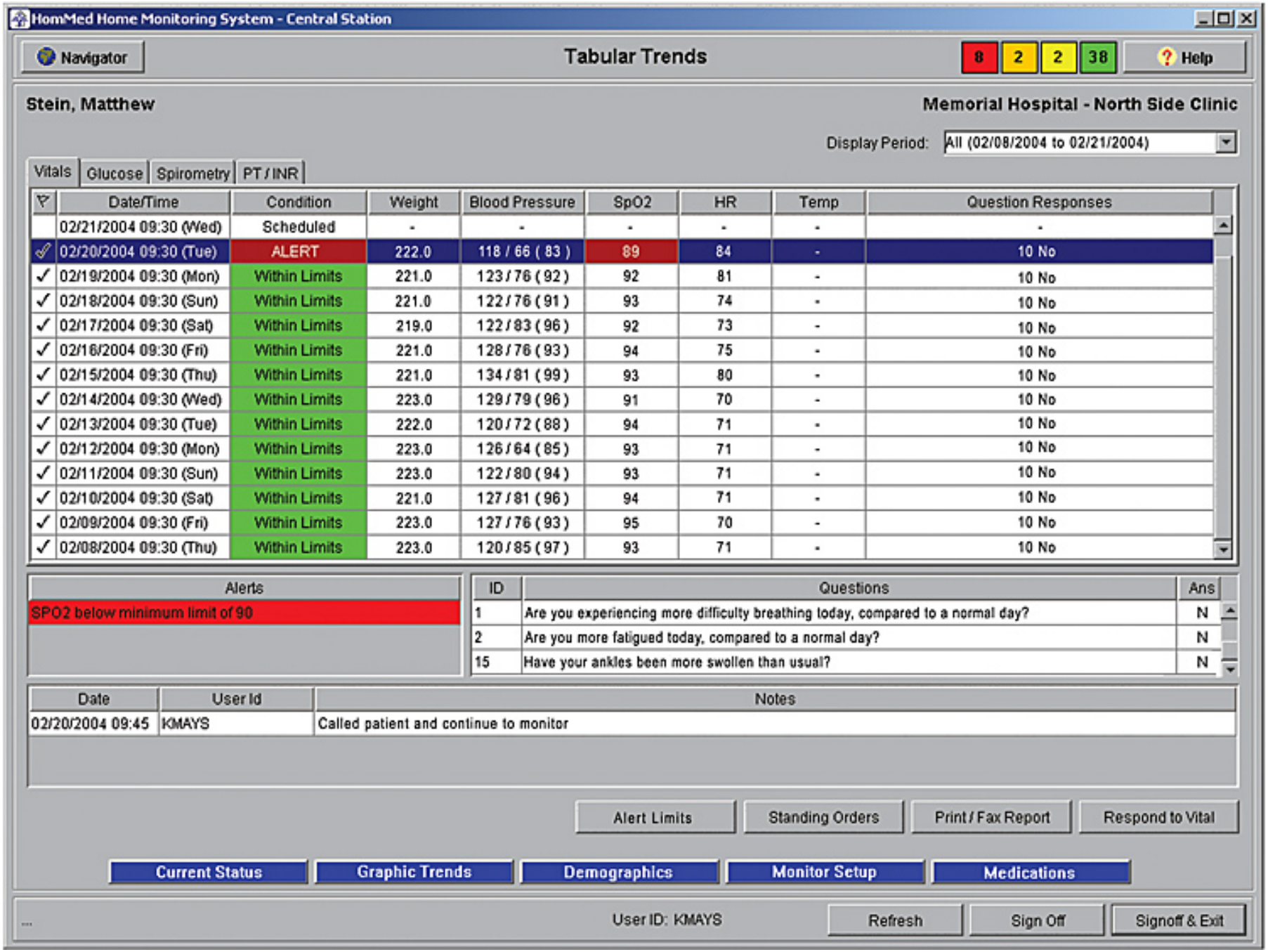
Where a nurse at a central station monitors the results



Condition	Patient Name	Weight	Blood Pressure	SpO2	HR	Temp	Answers	Additional Devices
ALERT	Delaney, Russell	245.0	160 / 105 (123)	86	115	-	2 Yes, 8 No	-
ALERT	Huang, Greg	162.0	157 / 90 (112)	87	105	99.1	10 No	-
ALERT	Bruchard, Anna	133.5	151 / 95 (114)	93	110	-	1 Yes, 9 No	-
ALERT	Stein, Matthew	222.0	118 / 66 (83)	89	84	-	10 No	Glucose within limits, Spirometry within limits
ALERT	Rogriguez, Maria	139.5	120 / 85 (97)	87	75	98.6	8 No	Glucose within limits
ALERT	Chang, May	125.0	124 / 82 (96)	88	70	-	6 No	-
ALERT	Young, Priscilla	112.0	115 / 71 (89)	95	103	99.0	5 No	Glucose within limits
ALERT	Majeed, Alla	150.5	125 / 75 (92)	95	72	98.6	9 No	-
No Limits Set	Jones, Tony Q.	150.4	124 / 75 (103)	95	76	99.0	2 No	-
NDR	Orr, Terrance	-	-	-	-	-	-	-
NULL	Wilford, James	-	-	-	-	-	-	-
Incomplete	Morgan, Barbara	162.0	125 / 75 (92)	95	80	-	7 No	-
Incomplete	Cromwell, Jeanne	-	120 / 85 (97)	92	70	-	10 No	-

Condition	Patient Name	Weight	Blood Pressure	SpO2	HR	Temp	Answers	Additional Devices
Within Limits	Gerhardt, Philip	150.5	125 / 75 (92)	94	66	-	10 No	PT/INR within limits
Within Limits	Edwards, Latoya	136.0	134 / 88 (106)	97	79	98.6	8 No	-
Within Limits	Wagner, Daniel	182.0	115 / 75 (88)	93	69	-	6 No	Spirometry within limits
Within Limits	Valdez, Raymond	158.5	125 / 75 (92)	97	72	98.8	9 No	Glucose within limits
Within Limits	Sherwood, Darren	160.5	131 / 90 (104)	96	63	99.0	5 No	-
Within Limits	Richards, Kelly	170.0	125 / 75 (92)	95	70	98.6	10 No	-
Within Limits	Steven Edwards	150.5	124 / 74 (91)	94	66	-	10 No	PT/INR within limits
Within Limits	Remillard, Marc	124.0	115 / 75 (88)	97	79	98.6	8 No	-
Within Limits	Gaffney, Erin	133.5	134 / 88 (105)	93	69	-	6 No	Spirometry within limits
Within Limits	Bunting, George	163.0	125 / 75 (92)	97	72	98.6	9 No	Glucose within limits
Within Limits	Cave, Jonathin	155.5	131 / 90 (104)	96	63	98.4	5 No	-
Within Limits	Ortiz, Maria	133.0	126 / 76 (93)	95	70	99.0	10 No	-

Graphics: www.hommed.com



Graphics: www.hommed.com

Chronic Disease Self-Management Classes

First class January–February 2008 with 15 participants

- "…the first week, I met someone and that's what made me go back. She had the same diagnosis as me and felt on one was paying attention to her either. It's so good to find someone from my planet because sometimes you feel like a total idiot complaining about pain that can't seem to be fixed."
- "Things changed in little bits and pieces during the program. I listened to the voice in me that I hadn't been paying attention to by listening to others in the room. I realized I had to stop thinking about how I got here and start thinking about how I get out. I needed to take back the control I had given away to everyone else."
- "It's like being active again."

Anticipated Measurables from *Stay@Home with VON*

- 10% reduction in Emergency Room visits by people with diabetes that previously visited the ER 2 or more times in previous year
- 10% reduction in hospital readmissions by people with diabetes that previously were admitted 1 or more times in previous year
- Patients/caregivers will report an increased ability to manage their own care and treatment plan
- Professional home health care providers will report an improved ability to triage their caseload
- CCAC will report improved utilization of specialized services and more focused care
- Hospital wait list will be contained or reduced

Client Behaviour Change Indicators (Based on the 7 Chronic Disease Self-Mgmt Behaviours)

- **Minimum of 1 chronic disease behaviour goal and action plan**
- **Minimum of 1 improvement in healthy eating**
- **Minimum of 1 improvement in ‘being active’**
- **Minimum of 1 improvement in ‘taking meds’**

Other indicators

- **Clinical Outcomes**
  - **A1c levels, ↓ BP and/or ↓ weight if target set on admission**
- **Health Services Utilization**
  - **# ED visits/hospitalizations over year**
  - **# ambulance calls over year when transport is refused**
- **Nursing Skills and Knowledge**
  - **Increase in knowledge re self-mgmt support**
  - **# times Knowledge Education" is listed as an intervention vs. # of other interventions used**

Challenges and Key Learnings

You learn something new every day…..

Use Multiple Marketing Strategies... Both internally and externally

- **Initially, interest is keen, however follow through is not guaranteed**

- **Designation of a dedicated resource in the community for access by referral sources**
- **Added benefit of building community partnerships and strengthening existing relationships**
- **Ask for input from staff re CQI opportunities – *be sure to implement staff input!!!***

Lesson #1: *Never underestimate the need for communication!!!*

Expect resistance and plan for it

- **Technology can be uncomfortable and frightening to those unfamiliar with it**

- **Plan education, training, and mentoring**
- **A visible, hands-on champion is appreciated by staff**
- **Make friends with the IT team…you're going to need them!**

Lesson #2:

Never underestimate the need for contingency planning!!!

Remember the little train that could……

- **I think I can…I think I can…I *know* I can…**
- **Time spent in planning will save you time in the future**

Lesson #3:

Never underestimate the need for perseverance!!!

Lesson #4:

Never underestimate the power of team work!

Thank you!!