LHINfo MINUTE | HEALTH CARE UPDATE

North West LHIN

Telehomecare: Managing a Chronic Disease without Trips to Clinics or Hospital

April 27, 2012 – The burden of chronic diseases such as Congestive Heart Failure (CHF) or Chronic Obstructive Pulmonary Disease (COPD) can be a heavy one, both on patients and on the health care system. An innovative Telehomecare program launched this past fall by the North West LHIN seeks to reduce that burden. The program is designed to help people with these diseases better manage their conditions, in their homes, with the help and support of a nurse practitioner, pharmacist, and in the case of COPD sufferers, a respiratory therapist.

The program is run through Thunder Bay Regional Health Sciences Centre, with equipment provided by the Ontario Telemedicine Network (OTN). This equipment allows selected people with CHF and COPD to regularly send vital signs such as pulse rate, temperature, respiration rate, and blood pressure to their support team over the phone line. The information is assessed and patients are telephoned, as appropriate, to discuss management of their conditions. A nurse practitioner might want to talk about diet, exercise or medication adherence, while a pharmacist would provide advanced medication advice.

The aim of the program is to improve the care that patients with chronic conditions are receiving, in part by teaching them how to help themselves. Health literacy rates in the North West LHIN, which measure the extent to which people understand how to take better care of themselves, are among the lowest in Canada. The isolation of many people and communities has a great deal to do with that. Telehomecare reduces the effects of that isolation by enabling health care consultations that would otherwise have been difficult, if not impossible. As patients become more knowledgeable and comfortable managing their conditions, their health is expected to improve, and fewer visits to the hospital will be required.

The program is in its very early stages. CHF consultations began a few months ago, and the COPD initiative is only just starting. The goal for the program is 150 CHF patients and 150 COPD patients per year, and it is expected those numbers will be reached in the first full year of service delivery. Ideally, patients would stay on the program for approximately four months, after which time they would have the knowledge, tools and confidence they need to manage their conditions on their own with the help of their regular family doctors.

While it is still too soon to evaluate the Telehomecare program's success, patients are reported to be enthusiastic, and appear to benefiting as well. Early results seem to indicate a positive trend, with patients participating in the program making fewer hospital visits. It is anticipated that when the program is fully up and running, it will bring about a 20 percent reduction in emergency department visits and hospital admissions for patients with CHF and COPD in Northwestern Ontario.