HOW TO USE TELEHEALTH AND ADVANCED ILLNESS MANAGEMENT

VISITING NURSES ASSOCIATION OF THE ROCKFORD AREA

Deb Rolf, Director Home Health
David Taylor, RN Telehealth Supervisor

OBJECTIVES

• To understand successful implementation of a telehealth program.
• To understand telehealth’s role in reducing hospitalizations.
• To understand how telehealth integrates with advanced illness management.
• To understand advanced illness management principles and role in reducing hospitalizations.
Telehealth’s Role

- Reduces re-hospitalization due to early identification and intervention for disease exacerbations
- Evidence based Practice Guidelines
- Increases patient encounters with health care providers
- Routine reporting and feedback
- Reinforces self monitoring behaviors and improves disease self-management

Traditional Home Monitoring Equipment
## Tablet Monitors

- Handheld touch screen tablet
- Integration with telehealth transmission software
- Supports mobile networks and WI-FI
- Spoken vitals and questions
- Live video conferencing

## Problem Statement

Hospital readmission for homecare patients due to HF exacerbation continued to be high, and not all patients with a diagnosis of heart failure were placed on a Telehealth Monitor.
VNA Quality Data

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<th>Indicator</th>
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<td>71.6%</td>
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Plan of Action--2012

- Implement “Telehealth Nurse” position.
- Promote Use of Telehealth monitors for primary and secondary diagnosis of Heart Failure.
- Phone contact for patients who cannot utilize Telehealth monitor.
- Continue Utilization of Best Practice Heart Failure Standardized Guidelines.
Plan of Action continued

- Weekly update to physicians regarding patients’ symptoms.

- Implementation Fluid Management Guidelines and Diuretic protocol.

- Expand Telehealth services to all RHS Heart Failure patients who do not qualify for home health care.

- Expand Telehealth technology to support all Chronic Disease Management Programs developed through RHS.

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VNA Heart Failure Readmission Rates:

- 2009 - 29.2%
- 2010 - 28.4%
- 2011 - 27.0%
- 2012 - 24.7%
- 2013 - 19%
- 2014 - 11%

Heart and Vascular Program

- Collaborated with RHS Heart and Vascular physician and nurse practitioner group.
- Identified patients who were not eligible for VNA home health services but had a discharge diagnosis of HF.
- Installed telehealth equipment to provide early recognition and early intervention to reduce hospitalizations.
- Program started in November 2012.
Heart and Vascular Program Success

• 197 Patients entered into the program since its beginning.

• Telehealth nurse monitors transmissions and contacts patients for early symptom recognition and intervention.

• Telehealth nurse communicates findings to Heart and Vascular staff for follow up.

Heart and Vascular Program Success

• Heart and Vascular staff communicate with patients for early intervention.

• Early intervention includes scheduling same day appointment for patients or moving their appointment forward to avoid hospitalization.

• To date, readmissions all cause 10% CHF related 4%
How could we use telehealth to make a difference with patients other than heart failure patients?

- We decided to implement an Advanced Illness Management program.
- We had three Integrated Care Management Specialist Trainers.
- We trained all home health staff in the principles, but selected a couple on each team to focus on the implementation and offered them more support and time for visits in the field in the beginning.
Purpose of AIM Team

- To Identify High Risk patients=those patients at risk for hospitalization.

- To front load visits including two consecutive visits and three visits the first week of care.

- To assess each individual patient situation and plan their care based on their goals.

Purpose of AIM Team

- To engage patients and caregivers in the disease management process.

- To provide supportive interventions including telehealth and palliative care.
So, why Advanced Illness Management?

- Rarely one diagnosis per patient.
- Poor care transitions.
- Poor care coordination.

What does this care model look like?

- Patients that are engaged, motivated, and possess the skills and information to manage their disease.
- Patient centered care.
- A provider team that is engaged and prepared to coordinate care.
Key Components of Advanced Illness Management

- Patient activated learning
- Assessing health literacy needs
- Engaging the patient
- Introducing self management support
- Transitioning care across the continuum
- Using telehealth to empower patients

Patient Activated Learning

- Assess what the patient wants to address first.
- Provide them with a choice of topics.
- Assess what they already know about the topic.
- Ask permission to share information.
Patient Activated Learning

• Assist patient to solve problems.

• Provide information in small chunks.

• Utilize Teach Back method.

Health Literacy Defined

Defined by the Institute of Medicine, “is the ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions and follow instructions for treatment.”
Assessing Health Literacy

Health literacy also includes:
- Prose literacy (reading)
- Document literacy (navigating health instructions)
- Quantitative literacy (adding, subtracting, etc)

AMA Foundation’s “Health Literacy and Patient Safety: help patients understand”—6 Steps
- Slow down.
- Use plain, non-medical language.
- Show or draw pictures.
- Limit the amount of information provided and repeat it.
- Use the “teach-back” technique.
- Create a shame-free environment: encourage questions.
Engaging the Patient

- Patient engagement is defined as “Actions individuals must take to obtain the greatest benefit from the health care services available to them.” Center for Advancing Health

- We are changing our role from Directors to Guides.

- We are putting the patient and their caregivers in the driver’s seat for patient centered care.

Introducing Self Management Support

“Self-management support is the assistance caregivers give to patients with chronic disease in order to encourage daily decisions that improve health-related behaviors and clinical outcomes.”

-Institute for Healthcare Improvement
Resources


- Home Health Quality Improvement Initiatives, Best Practice Interventions Package, “Patient Self-Management”.

- Sutter Care at Home, Integrated Chronic Care Management.

How do we elicit behavior change?

- Implement motivational interviewing techniques.

- Listen for change talk.

- Provide support to sustain the behavior change.
Motivational Interviewing
Four Guiding Principles-R U L E

- RESIST the righting reflex.
- UNDERSTAND the patient’s motivations.
- LISTEN to the patient.
- EMPOWER the patient.

Listen for Change Talk
- DESIRE=tells you something the patient wants.
- ABILITY=tells you what the patient believes or perceives is within his or her ability.
- REASONS=tells you reasons for a particular change.
- NEED=need or necessity to change.
Introducing Self Management Support

- Building self confidence through mastery of goals.
- Collaborative goal setting.
- SMART goals—Specific, Measurable, Attainable, Relevant, Time-based.

Transitions of Care

Advanced Illness Management’s primary focus is chronic illness management including primarily Heart Failure, COPD, Diabetes, and Depression.

We hope to assist the patient and caregivers to navigate the care continuum from home to physician offices, to SNF, to Rehab and to acute care hospitalization.

Our goal is to have patient centered care with patients and their caregivers taking the lead and utilizing us and our expertise to empower and engage them to manage their illness.
Transitions of Care

Palliative Care specializes in the relief of pain, symptoms and stress of serious illness. The goal is to offer patients and families the best possible quality of life.

Palliative Care can be provided at any stage of serious illness, from the time of diagnosis through advanced stages in conjunction with curative treatment and at end of life care.

What is Palliative Care?

- Palliative care goes hand in hand with Advanced Illness management. Both care models meet the patient “where they are”.
- Palliative care provides more support for the patient and family regarding symptom management.
- Palliative care addresses the physical, psychological, social and spiritual symptoms and concerns which impact a patient’s quality of life.
What is Palliative Care?

- Palliative care can be provided for short term symptom relief for an acute illness or long term symptom relief for terminal illness.

- Palliative care can be provided with Hospice care or instead of Hospice care if a patient is not accepting Hospice care.

Goals of Palliative Care

- Ensure that patients with chronic or advanced illnesses get optimal symptom management and support regarding care issues and options.

- Improve outcomes with regard to pain measures, hospitalization rates.

- Increase timely referrals to Hospice.
Palliative to Hospice

- Advanced Illness Management including Palliative Care can transition to Hospice if the patient and family are willing to embrace end of life care.

- Palliative care continues throughout the Hospice care provision.