Communiqué to Hospital Chiefs of Staff in the North East LHIN *April 2015*

Telehomecare **is aligned with many initiatives including quality based procedures, Health Links and new integrated care models. There are opportunities to formalize automatic referrals on clinical order sets, particularly for EDs, as well as transition to home clinics/programs.**

Telehomecare is a coaching intervention for patients with significant chronic illness based on evidence-based guidelines approved by an expert committee including the RNAO. It's a time-limited intervention lasting six months, geared towards teaching the patient self-management skills. Patients learn through a combination of using remote monitoring technology on a daily basis and working with nurses who have specialized in health coaching training. In turn, the nurses work closely with the patient's primary care provider and/or specialist, to support all decision making.

Referrals in the North East LHIN

More than 1,400 patients have been enrolled in the program since it began, with 368 currently participating. Referrals come from many sources including: hospital, CCAC and primary care.

Why use Telehomecare?

There are consistent results across the nine LHINs using the program:

- **48-56% reduction in ED visits**
- **44-57% reduction in hospital admissions**
- **Sustained reduction in ED visits and hospital admissions for patients six months post program**.
- Patients are reporting **positive experiences**: with 87% saying they would recommend to others.

Consider: This program improves a patient's quality of life as they learn to better self-manage with support, education and coaching over distance. **For clinical details on the program contact: Melanie Tulini, Telehomecare Engagement: 705-522-3560 or 1-800-461-2919 X 4585.**

What You Should Know About Telehomecare in the NE LHIN

- Initially piloted at a Timmins Family Health Team in 2006, the project showed: a 62-64% decrease in hospital admissions; 72-74% decrease in visits to the ED.
- In 2012, the North East LHIN was selected as one of three early adopter LHINs.
- The NE CCAC delivers the program through its five FTE RNs and RPNs, coordinating with OTN nurses, the Group Health Centre, and Family Health Teams
- Initially for patients with **COPD** and **Heart Failure**, it is expanding this fiscal to include **diabetes as a co-morbidity** as well as exploring **Palliative Care, Mental Health and Prevention/Maintenance.**

North East Telehomecare Physician Champion

"There is a growing and complex body of evidence that attests to the potential of Telemedicine for addressing the problems of access to care, quality of care, and health care costs in the management of heart failure. The amount of evidence points to significant trends in reducing hospitalizations and emergency department visits, preventing or limiting illness severity and episodes resulting in improved outcomes."

-- Dr. Atilio Costa-Vitali, Cardiac Pacing and Electrophysiology Specialist, Medical Director of Heart Failure Disease Management Program at Health Sciences North, and Assistant Professor of Medicine at the Northern Ontario School of Medicine

For more information about how the NE LHIN is supporting Telehomecare, and other telemedicine initiatives, contact Tamara Shewciw our Chief Information Officer and eHealth Lead at (705) 256-1366 or tamara.shewciw@lhins.on.ca.