transforming your experience

Improving patient experience through the delivery of a person-centred telehealth program in Wollondilly

Introduction

The Wollondilly Health Alliance (WHA) is a formal partnership between the South Western Sydney Local Health District, South Western Sydney Primary Health Network and Wollondilly Shire Council, which aims to proactively address local health issues and work towards creating a better services and healthier Wollondilly community.

Wollondilly LGA is a peri-urban region in Sydney with a current population of approximately 48,000. A health needs assessment by the WHA in 2014 identified Chronic Obstructive Pulmonary Disease (COPD) as the main chronic disease for frequent Emergency Department presentations and admissions.

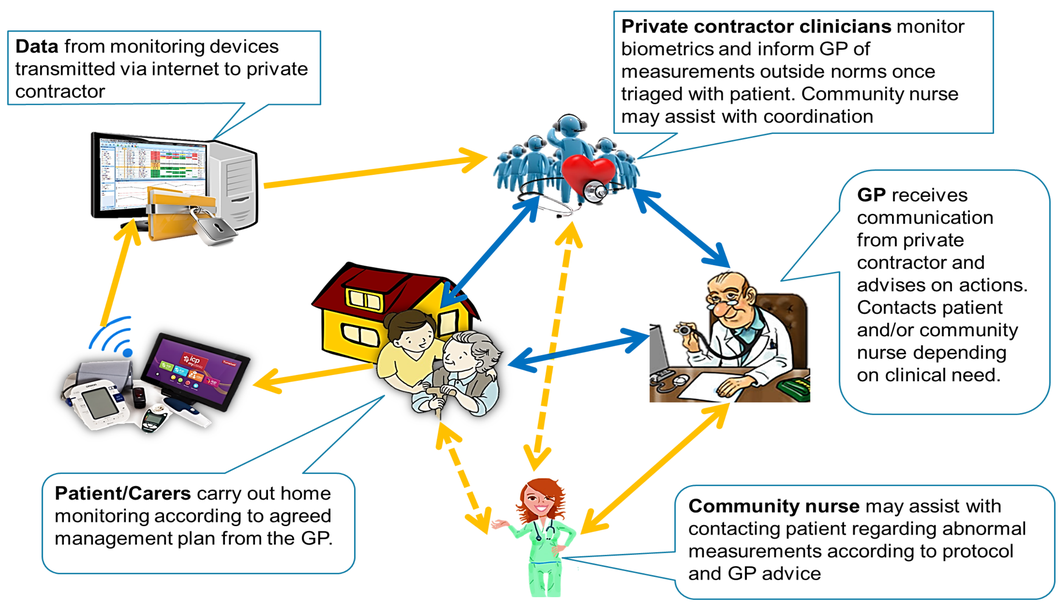
In addition, there were limited GPs, medical specialists and allied health professionals, no local hospital and no after-hours health services. Tele-health technologies, such as telemonitoring, was identified as a strategy to enable early detection of clinical deterioration, facilitate rapid intervention to avoid hospitalisation, promote multidisciplinary collaboration, and encourage patient self-management.

An individualised telemonitoring care plan is designed with the patient's GP. At home, patients/carers monitor vital signs and health conditions via peripheral devices and individualised health interviews.

These readings and responses are automatically transmitted to a third-party patient management care team for timely intervention and triaging, including referral back to patient's usual GP for further intervention or tertiary services if appropriate.

The tele-monitoring program provides self-monitoring support and care coordination to help people with chronic disease access appropriate services, manage their care needs, multi-morbidities, disease signs and symptoms and medications.

GP Inclusive - Implementation Model of Care



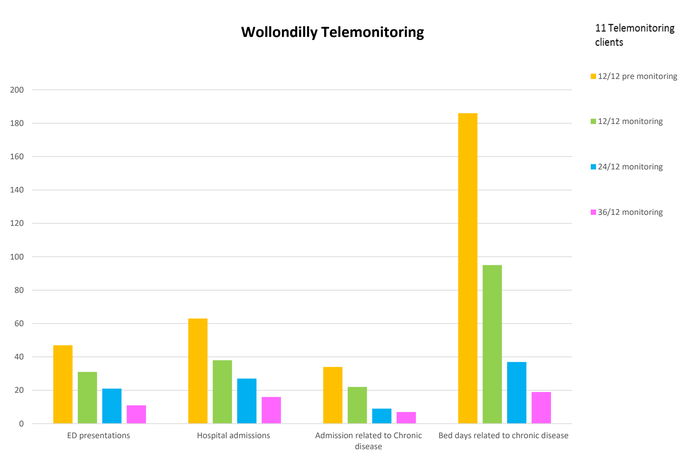
Patients' Feedback

The telemonitoring program achieves the NSW Integrating Care Quadruple aim of (i) improved experiences for individuals, families and carers; (ii) improved experiences for service providers and clinicians; (iii) improved health outcomes for the population; and (iv) improved cost efficiency of the health system.

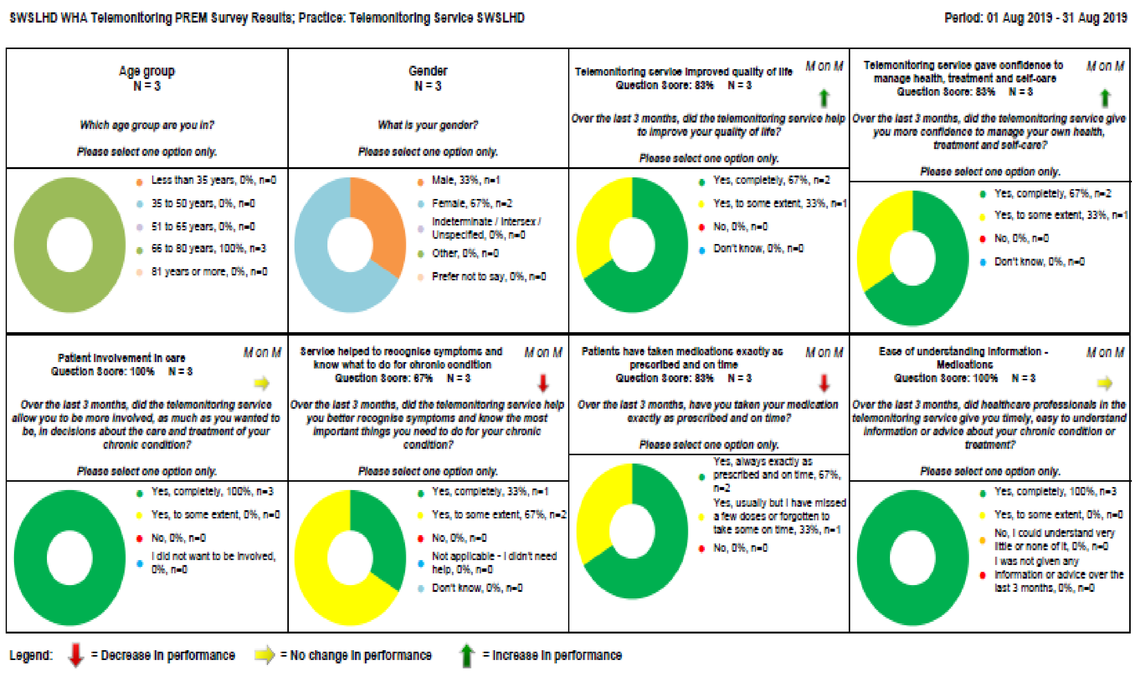
Evaluation

Hospital admissions data

35%	Decrease in chronic disease-related hospital admissions YTD
34%	Decrease in bed days for chronic disease have decreased YTD
9%	Decrease in chronic disease related admissions vs escalations to GP compared to escalations YTD



Patient reported experience measures (PREMs)



Conclusion

- The program demonstrates a significant reduction in hospital admissions and bed days.
- Patient reported experience measures demonstrate that the program improves quality of life, increases confidence to self-manage and self-care, and reduces reliance on hospital services. There are future opportunities for scaling of the program across the District.

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