POSTER ABSTRACT

History of telemonitoring in South Western Sydney

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Introduction: According to 2014-15 National Health Survey, 1 in every 2 Australians (50%) have at least one prominent chronic condition. Telehealth is gaining recognition as key link in the delivery of health care services. Telemonitoring of patients with chronic conditions shows promise for early detection of deterioration and intervention to reduce emergency visits and hospitalisations.

Practice change: In 2015, a new model of care using telehealth developed in partnership with General Practitioners (GP) allowing regular clinical readings at home to transmit to a telehealth coordinator, has offered benefits in terms of quicker access to patient information and less time spent performing home visits, while still maintaining that crucial 'face-to-face' contact.

Aim and theory of change: This program applied the 'Benefits Realisation' approach to confirm current service gaps, identifying potential solutions and implementing the changes. This included the co design with the GP, the PHN and the consumers, reviewing the referral pathways, triage processes, geographic location of the patients, technology required and model of care.

Targeted population: The telemonitoring project was developed for a regional area community with high rates of chronic disease hospitalisations and sub-optimal access to healthcare.

Timeline: The telemonitoring initiatives commenced in 2015 and have been sustained.

Highlights: This program was implemented in stages with initial phase adopted by 7 GP practices (Total of 8 GP Practices in the region). With the roll-out to 5 more local government areas (>100 practices). This reflects the ongoing commitment, sense of clinical ownership and strong relationship between GPs, private providers and stakeholders.

Patient compliance in terms of taking required readings as predetermined in GP care plans, was very high with only 8% of missed readings, demonstrating the willingness of patients to be involved in their own care.

The results from the interview indicate the benefits from telemonitoring which are greater at an earlier stage of chronic diseases. This provides patients and carers opportunity to better understand their condition and, in turn, enables patients to better self-manage. It empowers patients to take an active part in their own health, improving self-management and reducing dependency on traditional reactive service delivery models, at a lower cost and with improved patient outcomes.

Sustainability and Transferability: Since 2015, the initiative has transitioned to become part of the Local Health District Integrated Care for People with Chronic Conditions (ICPCC) program and is now sustained within an ongoing service delivery model and has commenced roll-out to other Local Government Areas. The target patient group has also expanded to include other chronic conditions.

Conclusions: This model of telemonitoring provides a patient focused approach with the GP as key stakeholder for clinical governance and integration across different sectors of the health system, together with enhanced patient and carer experience as partners.

Discussions: The project explores innovative ways to promote greater partnerships amongst LHD, PHN, GPs, patients and private providers, linking care between hospitals (acute care), primary and community services to improve patients' self-management capability.

Lessons learned: Selecting the right patients for telemonitoring and potential for self-management.