Home Health Monitoring
Call for General Practitioner Participation

Home Health Monitoring (HHM) is evolving and we'd like you to be part of the innovation!

The HHM Project Team is looking to involve GPs in the development of new HHM Protocols:

- HHM Multi-morbidity Protocol, or
- Palliative Virtual Care

As well as participating in protocol development, we are looking for your input on how the HHM Service can align with and support you in delivering chronic disease management.

Participants only need to be interested in one of the protocols. Involvement will include virtual meetings to discuss protocol development on a bi-weekly basis. Meetings will run for 1-1.5 hours between the hours of 800-1700. We ask that interested GPs be willing to participate for a minimum of 2 months (4 meetings) but we are happy to have you remain part of our team for the duration of the project (April 2018).

The Future of HHM:

Multimorbidity Monitoring: the next stage of HHM is to incorporate new chronic conditions into a client-centric monitoring protocol. Through the development of a HHM multi-morbidity protocol, HHM clients living with multiple chronic conditions and their families will experience:

- Increased access to care,
- Enhanced understanding and self-management support of their chronic conditions,
- Reduced need for acute care utilization

Primary care providers, specialists, and other care providers will benefit with enhanced availability of services for their patients with multiple chronic conditions, and efficient communication and care coordination with the HHM clinical team.

Palliative Virtual Care will focus on a simple monitoring plan based on the Edmonton Symptom Assessment Score with customized education plans and videoconferencing. Anticipated benefits of the program include:

- Palliative care clients, families, and care provider teams will benefit from enhanced palliative care service through monitoring, enhanced virtual care, and optimization of home visits.
- Palliative care protocol will support clients and their informal care team in optimizing quality of life and managing symptoms at home.

HHM Today:

Over the past 5 years, HHM has been available across Island Health to clients with heart failure and COPD. Key evaluation findings include:

- Heart failure self-management improved following HHM participation (20% of patients scored at a high level of self-care on enrolment vs 60% at discharge; using the Self Care of Heart Failure Index tool).
- 98% of patients reported a high level of overall satisfaction with the HHM service (average age 78 years).
- Pre/post evaluation demonstrated an average of 67% reduction in hospital admissions, 59% reduction in length of stay, and 53% reduction in Emergency Department visits.

If you know any GPs that are interested in participating in the HHM Innovation Project, we strongly suggest contacting Lisa Saffarek. Thank you for your time,

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