

## Exposure Draft of the White Paper Comment

I note the few telemedicine device trials and reference to developing ways to improve access to and utilisation rates of e-health infrastructure mentioned in the Exposure Draft of the White Paper (page 56).

One such trial that has not been mentioned is the CSIRO Telehealth Pilots Program titled “Home Monitoring of Chronic Disease for Aged Care”.

This was a national multi-centre trial across six sites, of which THO-North was one. It was testing the deployment of home telemonitoring of vital signs and symptoms for the management of chronically ill patients. The patients recruited to the trial had specific disease categories including respiratory, cardiac and/or diabetes related conditions.

At a local level 30 test patients were recruited from rural areas including Deloraine, Georgetown, Clarence Point, Weymouth, Lulworth, Scottsdale and St Helens, as well as Launceston. This trial integrated care between LGH, General Practice and Tasmanian Medicare Local.

The patients had a health monitor installed via NBN or high speed ADSL connection. It involved patients measuring a set of prescribed vital signs daily, including heart rate, temperature, blood pressure, ECG, weight, blood glucose level, lung function (spirometry) and blood oxygen saturation. There were also scheduled questionnaires patients were asked to complete, specific for their disease category. The device also had a videoconferencing function.

The patients were monitored daily by specialty nurses at LGH (respiratory and cardiac) and TML (diabetes). Deteriorations in patient conditions were detected early and interventions initiated by the monitoring nurses, thereby avoiding hospital admissions where possible.

GP's were given the option to view the patients measurement online, receive reports periodically or to not receive any information. Uptake by GP's consisted of 11 GP's requesting online access, 7 GP's requesting reports (via email or post), 4 GP's requesting to receive no information and 2 GP's not responding. Of those GP's who had online access, patients reported their GPs looking at their measurements during consultations. This gave GP's a picture of the patients health over a longer period than a short consultation during which a true picture cannot be established and the potential for “white coat syndrome” could falsely alter measurements.

Patients reported GP's making treatment alterations based on the measurements from the telemonitoring.

Patients involved in the trial became empowered through improved health literacy in relation to their conditions. Examples of this included:

- Patients with chronic heart disease noticing weight increases, indicative of fluid overload/retention and initiating changes in treatment through their GP to counteract this.
- Patients with COPD observing increased/changes in sputum production and decreases in lung function initiating changes in treatment through their GP to treat this with antibiotics/steroids.

- A patient who felt unwell, and would normally have made an appointment to see her GP assessed her measurements and decided appropriately, with input from the nurse monitoring her, that she did not require a GP visit.
- A patient who was being assessed in pre-operative assessment clinic prior to hand surgery was potentially facing postponement due to the anaesthetist requiring lung function testing to decide on whether to use a nerve block or general anaesthetic. The patient reported being on the trial, informed the anaesthetist who the monitoring nurse was and lung function measurements were obtained during the consultation, preventing unnecessary tests and postponement of the patients surgery.

The final report from the trial is due out this month (May 2015). A preliminary report was published on 30<sup>th</sup> September 2014. This report highlighted a number of positive outcomes/results, of which some were:

- 92.3% of patients (across all sites) stated the telemonitoring system was easy to use.
- Cost of telemonitoring was estimated at as little as \$3/day/patient for low care early stage chronic disease to a maximum of \$12/day/patient for patients with complex chronic disease and multiple co-morbidities.
- One full time nurse could monitor as many as 68 patients.

One LGH physician involved with patients on the trial stated that he would have confidence in this system being used not only for hospital avoidance, but also for monitoring patients who could be discharged earlier.

This trial demonstrates a number of opportunities referred to in the Exposure Draft of the White Paper:

- Primary care delivering better health outcomes for the community
- Preventative health and improving health literacy
- Strengthening primary care system linkages
- Working with partners to effect change across the system
- Reducing the need for transport and accommodation support
- Utilising technology for innovation, building capacity and improving access to services.

There is significant potential for positive patient outcomes as well as health system outcomes with the use of such telehealth technology across a range of services within the health system, and this potential should not be overlooked.

I look forward to seeing and assisting with the uptake of this opportunity.

Sincerely

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