A Mixed Methods Evaluation of the Community Remote Care Management Program: An Integrated and Person-Centred Hybrid Model of Chronic Disease Management

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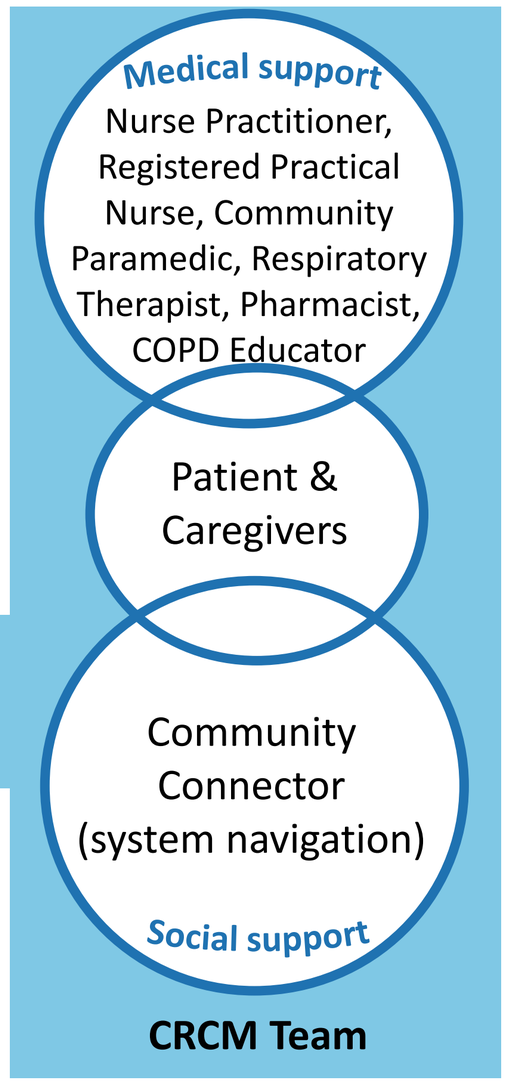
CONTEXT

The **Burlington Ontario Health Team** is a collaboration of health and social service providers who plan and work together, as one coordinated team, to provide integrated services and supports to meet the health needs of Burlington and surrounding communities (Ontario, Canada).

At maturity, the Burlington Ontario Health Team will be accountable for delivering care to its attributed population. The attribution methodology is not based on geography, but rather where and how patients access care. In 2019/2020, there were approximately 230,000 individuals attributed to the Burlington Ontario Health Team: 18.9% were over 65 years and 18.0% of individuals were living with a major or moderate chronic condition. While the vast majority had a primary care provider, only 16.0% were enrolled in an interdisciplinary team-based primary care model.

The vision of the **Community Remote Care Management (CRCM) Program** is to increase access to an **interdisciplinary team-based primary care model**, initially focusing on patients with Chronic Obstructive Pulmonary Disorder (COPD) or Congestive Heart Failure (CHF).



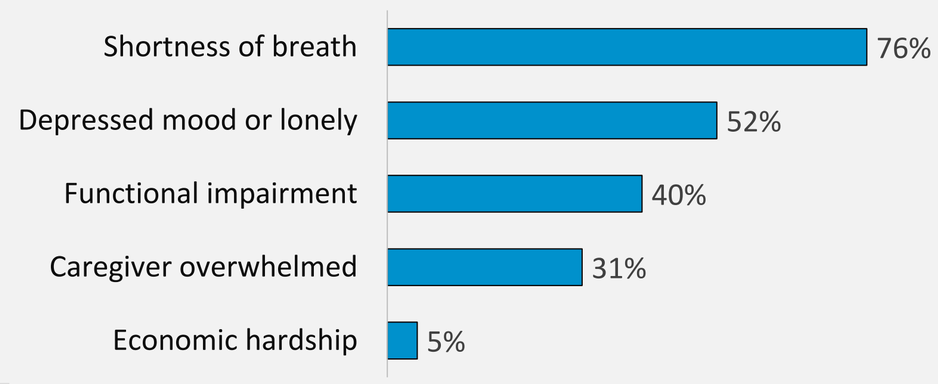
PROGRAM OVERVIEW

Central intake for referrals

- **50** referrals to date, **42%** from primary care providers

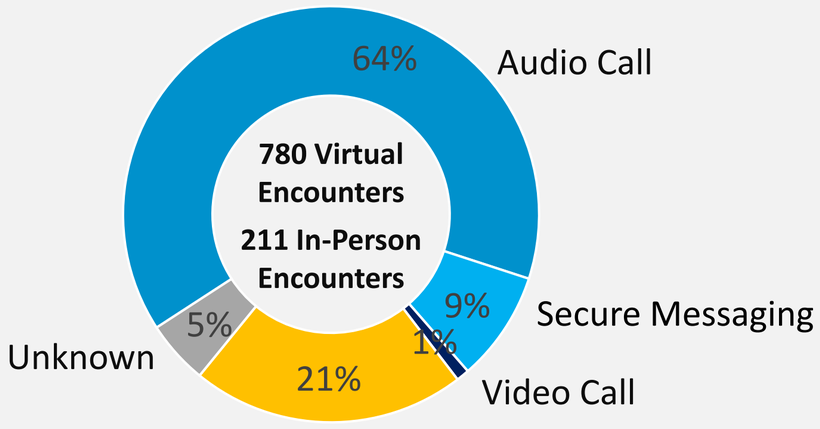
Comprehensive assessment and team identification

- **100%** of assessments identified a health or social need other than the presence of COPD/CHF



Patients receive a tablet and biometric devices to record vital signs and symptoms

IT-enabled monitoring and communication among patient, caregivers, and CRCM team



IT-enabled provider-to-provider communication

Patient-Reported Experience and Outcome Measures collected every three months

METHODS & RESULTS

We employed a mixed methods approach to evaluate the CRCM program grounded in the Quadruple Aim Framework.

VALUE

CRCM program helped to **avoid 244 ED visits** as rated by providers

- 17% of virtual encounters (132/780)
- 53% of in-person encounters (122/211)

Check-ins, providing education, and connecting with home care were the most common interventions

HEALTH OUTCOMES

CRCM program improved patients' ability to manage their COPD/CHF

- **83% (19)** said they were better able to manage their COPD/CHF as a result of the CRCM Program
- **48% (11)** rated themselves higher in "knowing when my signs and symptoms are normal, or when they are getting worse" compared to their first survey

N=23 patients who were on the program for ≥3 months and completed ≥2 surveys

PATIENT EXPERIENCE

"I had nobody to tell me how to manage my condition, and nobody to call when things started slowly getting worse. This program has given me contact with professionals who have taught me so much about the progression and management of my COPD."

"To know that I can call, even when it's not an emergency, just to ask a question, brings me so much comfort."

PROVIDER EXPERIENCE

"The Remote Care Management Program has been just the program that Assisted Living has needed for many years. Clients have become increasingly complex with their health care needs and are aging in place more and more. Without the RCM program, the Personal Support Workers would have no choice but to send a client to hospital for further assessment when in doubt. Having a Paramedic to communicate with, and make recommendations makes all the difference in keeping clients stable and out of hospital. We would love to see this program expand one day to include complex patients who have diagnoses other than CHF/COPD".

Acknowledgments

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