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The Impact of Home Telehealth on Veterans with Chronic Heart Failure at the Atlanta

Veteran Affairs Medical Center

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## Abstract

Home telehealth is a cost efficient and suitable method to provide health-care treatment to homebound patients via applying health informatics and various disease management technologies. Home telehealth is also known as a VA service. This is because this kind of healthcare service plays a supporting role in the provision of healthcare service to those of the CHF veterans who are mostly homebound. VistA medical information and CPRS (Computerized patient record system) are HIT infrastructures. Home telehealth program comprises a table-top monitor which is interconnected to the Internet router or landline phone. Based on home telehealth, these health care services are usually meant to prevent hospitalization or admission of CHF veterans in conventional healthcare facilities. This kind of service enables veteran patients to participate equally in managing CHF by using telemedicine tools.

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Numerous prompts accordingly instruct CHF patients sent from the interconnected wireless device. This process helps take readings of pulse oximeter, blood glucose, BP, and weight scales. A careful selection of required parameters is discretely tailor-made along the lines of clinical presentation and comorbidities of a veteran. These computerized devices have a built-in capability to collect information about the patient's physical health conditions, psychological status and any behavioral changes occurred during the care provision simply by asking multiple health questions. The collected information is accordingly transferred to a physician for due examination and interventions if required.

The VistA and CPRS play a leading role in supporting the transition of healthcare provision between hospitalizations to the rest of the outpatient settings. (Balinsky W, Muennig, 2003) This technique is mainly used to support communication with patients simply by using medical peripherals and interactive video & audio capabilities, as well as a range of wireless devices, which systematically gathers physiologic data and information. (Choi J, Park JW, Chung JH, Min BG., 2005)

Home telehealth is an effective way to manage CHF in the homecare settings. CHF (congestive heart failure) is amongst the topmost DRGs (diagnostic-related groups). Within existing multi-hospital system, CHF is also supposed to be a top revenue loser. Kobb R, Maudlin J, and Keene J. (2006) conducted a 2-year study on CHF veterans who were suffering from a life-limiting illness.

In their research, the researchers determined the effectiveness of a home telehealth-based care method. The study was meant to manage the emotional, functional, physical, and spiritual requirements and needs of the research participants by bridging the CHF patients into hospice by educating them about palliative care.

AIPC (Advance Illness/Palliative Care) conducted a pilot study making an innovation evidence, which was revealed partly via anecdotal, qualitative, and quantitative indication. In the study, the 100 veterans with CHF were selected who had a limited life expectancy not more than 2 to 3 years. Later on, the researchers screened these homebound study participants before deploying telehealth equipment in their homes. Physical parameters and measures of vital signs were carefully assessed and transmitted by using videophone/texting equipment. (Shaughnessy PW, Crisler KS, Schlenker RE, Arnold AG, Kramer AM, Powell MC, Hittle DF. 1994)

Researchers with evidence-based VA clinical practice guidelines compared the quantitative information. Post-implementation and pre-implementation researchers examined hospitalization ratio and emergency hospital visits to that of total care costs. (Shaughnessy PW, Crisler KS, Schlenker RE, Arnold AG, Kramer AM, Powell MC, Hittle DF. 1994) After a thorough analysis, the collected data revealed a phenomenal drop in hospitalizations and reduced emergency visits, as well as declined costs per CHF patient in comparison with national average spending per patient.

Designed by the AIPC, a post-implementation survey provided another supporting evidence about the effectiveness of the telehealth program simply by knowing the patients' feelings, experience, and perspectives, in general.

Significant results were unfailingly constructive across numerous measures of patient satisfaction. (Shaughnessy PW, Crisler KS, Schlenker RE, Arnold AG, Kramer AM, Powell MC, Hittle DF. 1994) Anecdotal evidence of patients' satisfaction enhanced security sense, and connectedness was felt from the patients' reluctance to hand over their telehealth equipment even when caregivers were available to care for the CHF patient.

Veterans with CHF need advanced methods of care transition and management, and this can be achieved through incorporation, better infrastructure, and co-operative dealings and relationships. An inventive model brings operative healthcare to veterans and patients, particularly to the people with lasting illness. (Shaughnessy PW, Crisler KS, Schlenker RE, Arnold AG, Kramer AM, Powell MC, Hittle DF. 1994)

As revealed by the AHRQIE (Agency for Healthcare Research and Quality Innovations Exchange) in 2013, the evidence rating of this program was adequate. The evidence rating, in fact, tends to be an appraisal of the strength, effectiveness and quality of the study to support that the described results are attributable to the innovation mainly.

