



Contributor:

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The LeadingAge Center for Aging Services Technologies (CAST) is focused on accelerating the development, evaluation and adoption of emerging technologies that will transform the aging experience. As an international coalition of more than 400 technology companies, aging-services organizations, businesses, research universities and government representatives, CAST works under the auspices of LeadingAge, an association of 6,000 not-for-profit organizations dedicated to expanding the world of possibilities for aging.

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# PHILIPS

## Telehealth Helps Great Plains Health Patients Manage Their Conditions Confidently in the Comfort of Their Home to Improve Outcomes

### *Categories*

Increased Patient/Client Engagement and Communication around care planning and coordination; Improved Care Transitions; Improved Health Outcomes; Staff Efficiencies; Quality of Life/Satisfaction with Care; Reduced Cost of Care

### *Organization Name*

Great Plains Health

### *Organization Type*

Progressive Health System

### *Organization Description*

Great Plains Health is a progressive health system located in North Platte serving a 24-county region of Nebraska, northern Kansas and southern South Dakota. Answering the community's call for local access to advanced care that is safe, high-quality, and cost-efficient has resulted in growth to include:

- A 116-bed, not-for-profit, independent, community-owned regional medical center
- Twelve Great Plains Physician Network medical clinics in North Platte
- Fifteen outreach clinics in communities throughout Nebraska and Kansas
- Great Plains Home Medical Equipment
- Regency Retirement Community
- Great Plains Health Care Foundation

## Project Description

Julie A. Johng and her colleagues at the Great Plains Health Transitional Care Nursing Program are passionate about helping patients successfully manage chronic conditions and settle into their daily at-home routines post-discharge. The team cares for the qualifying older adult patient population who are discharged from the hospital with COPD, heart failure, acute myocardial infarction, coronary disease and/or pneumonia diagnoses and live within 50 miles from Great Plains Health.

## Telehealth and RPM System Type

Store and Forward with Patient Portal Front-end running on a tablet (called eCareCompanion) and a Care Management Back-end (called eCareCoordinator).

## Telehealth and RPM System Embodiment

Single-User/Patient Home Base Unit

## Business Model

Predominantly Medicare and Medicaid, but also some Private Pay Patients.

## Implementation Approach

The Great Plains Health team were not strangers to telehealth when they turned to Philips. Their top priorities in selecting their tailored ambulatory care partner were the ability to adapt with their needs and knowledgeable established support resources, coupled with an advanced solution that best supports their care workflows. Utilizing Philips Tailored Ambulatory Care platform and its Remote Patient Monitoring Program for Transitional Care, Great Plains Health was able to scale up their tailored ambulatory program while receiving 98% patient satisfaction scores and reducing hospital readmissions. The team also noticed significant improvements in the ability to educate patients to better take care of themselves.

The Great Plains Health team highly values the videos Philips provides on the eCareCompanion tablets. Embedding evidence-based behavior-change strategies, the videos strongly reinforce face-to-face discussions between nurses and patients when they start the program. As Julie puts it: “We can help patients finally understand the disease process from the very beginning. Once they realize how their behaviors affect weight, blood pressure, oxygen and other vital signs we measure,

they learn to hold themselves accountable, and are motivated to play their part in improving their quality of life.”

## Outcomes

### *Reinforcing Healthy Behaviors to Keep Patients out of the ER and the Hospital:*

Being able to quickly assess trends and alerts allows the Great Plains Health team to have more informed discussions with patients about how their dietary and lifestyle behaviors affect their health. Even if patients are unwilling to change their behaviors, monitoring them closely can still allow for early intervention and potentially improved outcomes.

The Great Plains Health Transitional Care team serves quite elderly, frail patients with multiple co-morbidities. Yet so far, 93% of the patients successfully completed the 30-day program, and only 6.1% of patients were readmitted to the hospital for their primary diagnosis.

Julie remembers how access to the daily vital signs measurements helped her team keep an end-stage lung, heart, and chronic kidney disease patient out of the ER even though he refused to stop smoking or adhere to food restrictions. Looking at his vital sign trends and symptoms, the care team was able to discover how much weight he could gain before he started to decompensate. Intervening early based on this information, and getting the patient treated outside of the hospital, allowed the team to prevent four likely re-admissions for this patient alone. Even after graduating from the transitional program, the patient knows to measure his weight and notify the doctor to get treatment once he surpasses the target weight, which allowed him to stay out of the hospital for three months and counting.

### *Medication Reconciliation:*

In addition to reinforcing healthy behaviors, Great Plains Health transitional care nurses help patients to reconcile their medications, and assess the home and socio-economic environment for potential improvements.

### *Security of Monitoring:*

Patients like the security of being monitored closely allowing the care team to intervene early, especially when family and friends are far away, as it's often the case.

### *Improved Care Coordination:*

The nurses create a well aligned ecosystem collaborating with physicians and specialists to coordinate care and holistically address each patient's needs. This helps patients to feel in control of their condition.

### *Excellent Patient Satisfaction:*

In patient satisfaction surveys filled out by the majority of patients, they indicate they overwhelmingly feel that the program was helpful and would recommend it to other patients, giving it a 4.9/5, or 98%, satisfaction score.

Being able to put the patient first by combining in-person visits with Philips tailored ambulatory care program to better assess trends and subtle changes allows the Great Plains Transitional Care Team to provide continuity and support as patients settle into their new routines, and learn how to best manage their new diagnosis.

### *Challenges and Pitfalls to Avoid*

Technology and data are key enablers of any telehealth program, but how they are incorporated in the clinician's workflow, and how actionable the alerts and notifications are, truly determines the impact they can have. Great Plains Health works closely with Philips to share findings and make suggestions, as well as learn about any advances in enabling technology and clinical programming they can incorporate. This allows the Great Plains Health team to provide the best possible care to transitional care patients in the North Platte area, enhancing workflows while keeping the patients' outcomes and quality of life at the core of everything they do.

### *Lessons Learned*

“Often, patients are too sick to absorb all the new information they receive before they are discharged from the hospital. We are asking people to take care of themselves with very complex health issues. They sometimes don't know what to ask, or what they still need to know, until they are home. That's where transitional care programs come in. We can educate patients, and confirm everything is in order for them to take care of themselves. We work with patients where they are, and address their situation holistically,” explained Julie.

The right technology can help providers achieve this goal and reach the population they serve with the right information at teachable moments to educate them, affect behavior, intervene and improve their outcomes.

### *Advice to Share with Others*

When deciding to embark or grow a telehealth program, it is very important to consider how remote patient monitoring fits into the clinician's workflow. The technology does not substitute, but supplement the personal touch, training, and expertise the clinicians provide. It allows them to work more efficiently and smarter by prioritizing patients, and being able to get more objective and subjective information between visits. Educating the patient to stay healthier in the long-term is key to a continuously successful program.