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NEWS RELEASE

VON CANADA SIGNS IMPORTANT MOU WITH CCAC FOR CHRONIC DISEASE MANAGEMENT PROGRAM

FOR IMMEDIATE RELEASE

April 19, 2007 (Ottawa, ON) — An official memorandum of understanding has been signed between the Erie St. Clair CCAC and VON Canada to implement a unique chronic disease management project targeted at eligible adults living with diabetes in Chatham-Kent. The intention of the project is to improve client outcomes by targeting services to those at high risk of hospital re-admission or emergency room visits by using of innovative telehome monitoring, combined with timely interventions to deliver care to people in their homes.

"VON is pleased to be working with the Erie St. Clair CCAC on this innovative project that demonstrates leadership in health care through the introduction of technology to the home care arena," states Sue Mathews, VON Ontario East & North/National Director, Disease Management & Chief of Practice. "This partnership will provide evidence of the importance and utility of technology-enhanced care in the home resulting in improved care and cost savings to the health care system."

The project is based on the concept of client self-management and incorporates telehome monitoring, education, behavior change theory, peer support and timely interventions to prevent a health care crisis before it occurs. The focus is to provide timely recognition of changes in a client's condition and implementation of necessary interventions to prevent hospitalization or emergency room visits, thus reducing overall health care costs.

"Community Care Access Centres play a key role in Chronic Disease Management. The Erie St. Clair CCAC is happy to partner with the VON to enhance services to individuals with diabetes," states Ms. Betty Kuchta, Executive Director of the CCAC. "This project will demonstrate that access to timely information for the health care team, and the individual involved, will improve self-management of this disease. We believe the results will be exciting and will lead the way to improved care delivery models."

Project initiatives will include monitoring of daily blood results using state of the art telehome monitoring equipment. Data is transferred via a telephone line from the patient to a VON registered nurse to facilitate daily monitoring of the clients blood results, blood pressure and weight. During the first phase of the project VON expects to serve 20-25 clients with diabetes and the numbers are expected to grow after the initial year.

The VON nurse will interpret the data, noting any changes in the client's condition. Interventions (home visits, phone calls, referral to the physician) will be implemented as needed to prevent problems before they occur. Client daily results will be accessible to all members of the health care team through the use of encrypted, security enhanced technology, thus providing a venue of communication between all members of the health care team including the client, their family and caregivers.

Other project initiatives include a peer support program based on the Stanford University Chronic Disease Self-Management program. This evidence-based program provides people diagnosed with a chronic illness with information, goal setting and problem-solving skills needed to help them become informed individuals, highly involved in their own care.

The project will also provide valuable information in regard to the financial benefits of telehome monitoring to the health care system.

VON is dedicated to being a leader in the delivery of innovative comprehensive health and social services and to influencing the development of health and social policy in Canada. We are a national health organization and registered charity offering a wide range of community health care solutions that meet the needs of Canadians from coast to coast. VON is committed to continuous quality improvement and is accredited by the Canadian Council of Health Services Accreditation.

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