Technology Enabled Care (TEC) Home Mobile Health Monitoring (HMHM) Service in South Ayrshire for COPD Patients

NHS Ayrshire & Arran

TEC Technology Enabled Care

AIM

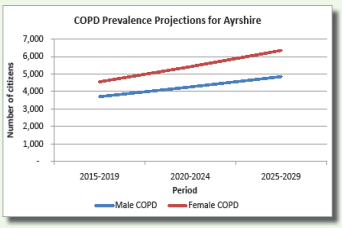
TEC HMHM (Telehealth) service was introduced for COPD in South Ayrshire due to increasing COPD prevalence, hospital admissions, multi-morbidity and ageing population. Technology allows remote monitoring of patients and enables supported self-management with independent living, also contributes to improved patient outcomes and reducing demand on primary/acute services.

Funding: Change Fund/IRF; United4Health Project (U4H); Technology Enabled Care Programme (TEC).

METHOD

Ayrshire Pilot (2011-2012): District Nurse led COPD pathways developed, Patients offered self-management training and rescue medication.

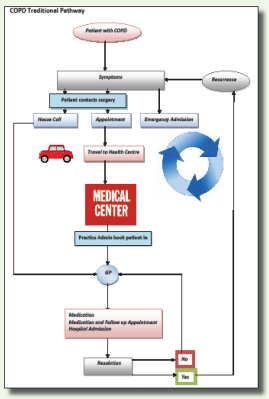
Criteria: COPD Diagnosis, 2+ exacerbations, 2+GP consultations, 1+ hospital admission (in last year).

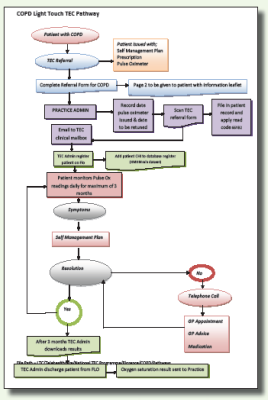


U4H/TEC projects (2012 – present) – Advanced Nurse Practitioner led fully managed service, evolved from Community Ward led service for United4Health with MDT working/ACP/self-management care plans.

Criteria: COPD Diagnosis, initially U4H to identify patients after COPD admission, commencing monitoring within 7 days of discharge. TEC: 1+ exacerbation of COPD in last year whether led to emergency admission or managed in the community.

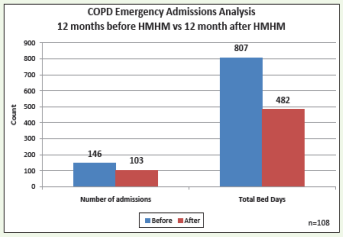
Following assessment, HomePOD is installed for 12 weeks clinician led remote daily monitoring. Clinicians respond to alerts with appropriate early clinical intervention. Thereafter patients 'step down' onto Florence COPD light touch, a patient led self management approach.





OUTCOMES/RESULTS:

- 450+ patients since commenced Telehealth in April 2013
- All South HSCP practices referring to TEC HMHM hub
- Additional 3 East and 4 North practices have referred
- Positive Staff Experience
- High level of Patient Satisfaction (92%)
- Increased use of rescue medications
- Reduced travel time for patients and staff
- Improved self-management
- Reduced use of all services.



Ayrshire Pilot showed:

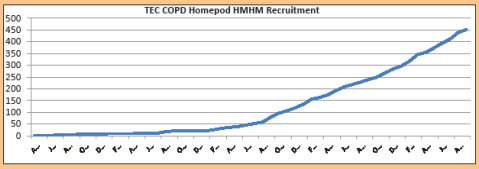
REDUCTIONS:

- 80% admissions
- 27% GP appointments
- 90% District Nurse home visits
- 40% Out of Hours contacts
- Increased district nursing contacts

Latest admissions analysis:

NEXT STEPS

- deployment at scale
- further evidence/analysis
- sustainability and spread



Dr William Park, Station Road Medical Practice, Prestwick

"We have recently noticed a significant drop in the number of house calls and are fairly convinced that people self managing their COPD with the help of TEC has been a factor in this. Patients with COPD seem more confident about when and why to start their rescue medication."

Mr Hunter was diagnosed with COPD and before using Telehealth, he had to go to hospital two to three times a month due to his condition. Mr Hunter was referred for the Telehealth service within South Ayrshire Health and Social Care Partnership at Girvan Community Hospital to help him to monitor and manage his condition. Mr Hunter said: "The home pod has been absolutely brilliant. There is a feel good factor with it - when I can see that my blood pressure is good every day that makes me feel better. "If I am feeling bad or the questions on the pod are not correct I know that I will get a phone call which cuts down on visits to the hospital. I only go into hospital now for my yearly check up. "I would recommend this to anybody. It is so easy to use and it gives you piece of knowing the nurses are only ever a phone call away."

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