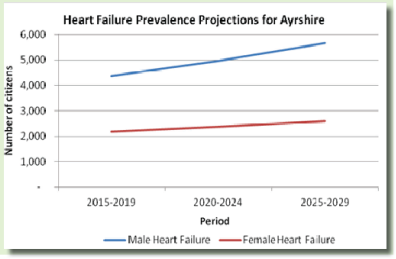
Technology Enabled Care (TEC) Home Mobile Health Monitoring (HMHM) Service in Ayrshire for Chronic Heart Failure (CHF) Patients

AIM

TEC HMHM (Telehealth) service was introduced for CHF within NHS Ayrshire & Arran due to increasing CHF 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/Integrated Resource Framework; United4Health Project (U4H); Technology Enabled Care Programme (TEC).



METHOD

Ayrshire Pilot (2011-2012): Specialist Nurse led CHF pathways developed

Criteria: CHF Diagnosis, referral to Specialist Nurse Service, 1+ hospital admission (in last year).

U4H/TEC projects (2012 – present) – Specialist Nurse led fully managed service.

Criteria: CHF Diagnosis, referral to Specialist Nurse Service, 1+ hospital admission (in last year).

Following assessment, HomePOD is installed for 6-12 months clinician led remote daily monitoring. Clinicians respond to alerts with appropriate early clinical intervention.

OUTCOMES/RESULTS

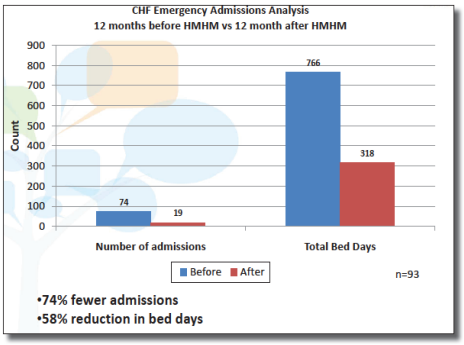
- 330+ patients since commenced Telehealth in April 2013
- All Health and Social Care Partnership practices covered by the Specialist Nurses
- Specialist Nurses refer into the South Ayrshire Health and Social Care Partnership HUB
- Positive Staff Experience
- High level of Patient Satisfaction (92%)
- Reduced travel time for patients and staff
- Improved self-management
- Reduced use of all services.

Ayrshire Pilot showed:

REDUCTIONS:

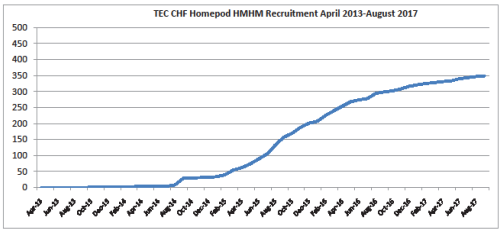
- 33% admissions
- 48% Out of Hours contacts
- Increased Specialist nursing contacts

Latest admissions analysis:



NEXT STEPS

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



Mrs Lee was diagnosed with CHF and during 2014 had to be admitted into hospital five times. Mrs Lee was referred to the CHF Specialist Nurse Service within North Ayrshire Health and Social Care Partnership at University Hospital Crosshouse. Through this service, Mrs Lee was offered telehealth to help her to monitor and manage her condition. Mrs Lee said: "I had never heard of telehealth or home health monitoring before the nurse spoke to me about it. I was a bit nervous about taking my own blood pressure but the nurse explained everything to me and reassured me that I would be able to do it. "When the technician arrived to install the equipment, he showed me how everything works, and I realised how easy it is to use. It gives me confidence seeing the results and knowing that my nurse is checking them daily. "Using the equipment every day means I can keep an eye on my weight. If my weight creeps up with no explanation, I know I have to increase my medication to bring it back down. This also helps me to manage my diabetes which is a big benefit to me." Mrs Lee has had one unavoidable admission to hospital this year but feels that this would be more if she didn't have the equipment.

Mrs Lee added: "As far as I am concerned the telehealth service and my CHF specialist nurse has made my heart failure easier to cope with."

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