

Piloting an innovative solution to delivering CHD services using telehealth and telemedicine (The lessons learned so far)

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Tele?

- Telehealth is remote monitoring of patients with a long term condition.
- Telecare is commonly known as a pendant alarm system used by vulnerable adults in their own home – but it is so much more!
- Telemedicine is the use of video conference to provide consultations from a local hospital to a centre of specialism anywhere in the country.

What is telehealth?

- It is the ability to remotely monitor patients with a long term condition e.g. COPD, diabetes, heart failure, depression. It can also be used as a health promotion tool
- It uses technology to engage the patient in their own condition management.
- It is well suited for use in rural areas where transport is scarce and access to specialists is often at a distance.

What does it look like!



Remote monitor

- Monitor based in the patients own home that have a variety of 'plug in' peripherals to individualise the monitoring that takes place.
- The clinician sets acceptable parameters for the readings e.g. blood sugar levels and once these are violated an alert is generated to the clinician.
- The patient is taught how to perform the tasks asked on the monitor screen as well as answer a few quality of life questions set by the clinician.

Telehealth promotes self management

- Engages patients and their carers in the monitoring of their condition.
- Raises awareness of symptoms and possible deterioration before it reaches a critical point.
- Professionals can monitor a patient over time to see trends in their condition and offer appropriate care at the right time.
- Results from monitoring can be viewed remotely so consultants can view a patients condition progress which is better than a one off consultation.
- Monitoring is designed to prevent crisis admission to hospital and possible onward transmission to out of the area sites.
- Empowers patients to be part of the disease management process and become 'experts' in their own condition.

Heart Failure Pilot

- Partnership with GG&C, West Dumbarton CHP & Argyll & Bute CHP
- Linked to GG&C heart failure nurse service in VOL
- Proposed 2 year pilot
- Support and monitor on discharge
- Community nurse involvement
- Prevent readmission
- Send alerts if changes outwith agreed set parameters
- Potential link to OOHs in future
- Weaned off approach!

Issues

- Lack of guidance on key issues
- Procurement, who to contact for advice!
- Finding reputable companies
- IT issues, (minefield)
- Lack of e health resources
- Patient information security issues, data transfer
- Cross health board working
- Finance
- Engagement





“I don’t want to talk to a doctor. I want my symptoms to go straight through to your computer.”

Telecardiology pilot

- Develop a cardiology OP clinic from a community hospital linked to Glasgow Royal Infirmary via videoconferencing

- Pilot
- Will be evaluated
- OP clinic appointment at Mid Argyll hospital
- Echo, ECG, ETT, carried out locally, real time initially until staff trained
- Nurse/cardiac physiologist led
- Protocol driven
- Clear referral criteria agreed locally and by Cardiologist
- Linked to cardiologist and cardiology services in Glasgow Royal Infirmary



WHY?

- Improves the patients journey
- Reduces the need for lengthy travel
- Will only travel to Glasgow if Intervention required
- More appropriate referral to Glasgow
- Offers potential for roll out to other hospitals and diseases
- Improved access to specialist care from a rural area

Role development

- Cardiovascular nurse will support the clinic, and work with cardiac physiologist to carry out ETTs and echoes, role will also be coordinating the local cardiac rehab follow up and class.
- Cardiac Physiologist will deliver as an extension to an existing echo outreach service

Planning

- Small working group initially
- Steering group
- Proposal submitted to CHP for approval, Dec/Jan
- SCT advice and support
- Test, 1st, March 08
- Recruitment
- Purchasing
- Pilot clinic Summer 2008
- Evaluate



Challenges

- Different model
- Clarifying Pathway
- Engagement
- E health support
- Data transfer (ETT & Echo)
- Competencies of staff involved
- Recruitment
- Cross health boards
- Getting the right advice and guidance
- Project management



What could help future projects?

- National Toolkit
- Increased E health resources to support these projects
- Funding and how to access it
- National network linking project leads to enable shared learning (virtual network)
- E record

Whats next!

- 2 other pilots in development
 - COPD
 - Sheltered housing/care home complex
- Patient education via VC

Lots of potential and lots of ideas for future development!

Thank you

