

# Telehealth in Practice

## Ayrshire & Arran, Lanarkshire, and Greater Glasgow & Clyde Scottish local partnership areas - CHF

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### Ambition

The aim of the telehealth service for people living with CHF in Scotland is to support the treatment and management of CHF by enabling earlier detection of deterioration allowing timely intervention, better care co-ordination, fostering increased patient self-management and preventing unplanned crisis episodes requiring hospital admission or readmission.



### CHF Care Management – routine care

The routine care for patients living with CHF is provided by specialist nurses working as a key intermediary between patients and other healthcare practitioners including cardiologists in secondary care and staff in GP practices. Patients are reviewed and assessed by specialist Heart Failure (HF) nurses in a variety of settings: outpatient clinics, community clinics, and in their homes to detect early clinical deterioration or offer additional support post hospital discharge. (Amber). Patients undertake daily weight monitoring and report any increase (Green) to their main healthcare practitioner. If a patient requires hospitalisation, they will be referred to a home-visiting HF nurse who will visit the patient at home within a week of being discharged. One month after discharge patients are offered an outpatient consultation with the hospital cardiac team. Patients and families are encouraged to make contact in the event of problems or changes in their condition by telephone, eg to specialist HF nurse. Subsequent visits and contacts are determined by individual patient needs. The specialist nurses implement agreed care plan protocols, including any prescription changes, in liaison with the Cardiologist and information is sent directly to the GP (Amber/Pink). Most specialist HF nurses also offer facilitation of self-management to practice nurses and GPs.

### U4H Telehealth Enabled CHF Care Management

Patients are offered a telehealth service as an integrated part of their care plan either on discharge or shortly after an emergency hospital admission for a crisis episode. Care pathways have been developed in each of the

deployment sites - NHS Ayrshire and Arran, NHS Greater Glasgow & Clyde and NHS Lanarkshire. The telehealth care pathways provide telemonitoring which is co-ordinated by the specialist CHF nursing teams based within the community services or on an outreach basis from hospital cardiology departments. For one site, installation and referral co-ordination is supported by a Telehealth Hub (contact centre).

Patients are provided with a monitoring device and peripherals (weighing scales, blood pressure cuff) within 24 hours of discharge. The device is installed and training provided by the nursing or Telehealth Team alongside education in self-management principles. The physiological measurements taken by the patient (Green) are uploaded via the telehealth device and made available to the CHF nursing team who review the measurements against set individual clinical parameters and make any necessary changes to the patient's medication or care plan. Depending on the status of the readings, the patient can receive a teleconsultation (usually by telephone) from their specialist nurse who, if required, will arrange an urgent outpatient appointment or home visit. Throughout the monitoring period, patients using SMS devices will receive motivational health and wellbeing coaching messages from the HF team. (Green). Across all sites, patients continue to provide data uploads for initially up to 6 months or until their CHF is stable after which care management is co-ordinated by the GP practice or practice nurses. Patients continue to have outpatient appointments as required with their Cardiologist or GP, A/E or hospital admission as required. (Amber/Pink).

