Telehealth in Practice

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

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Ambition

The aim for implementing telehealth into the care management for people living with COPD is to improve health outcomes through the appropriate use of telemonitoring combined with clinical input, enabling patients to achieve more effective self-care and self-management of their own condition, leading to earlier interventions and better co-ordination of care supporting the reduction of unnecessary and inappropriate reliance on hospital services caused by exacerbations.

COPD **ROUTINE** CARE SERVICE MODEL

Level 1 : Self-management
Patient and Carer.

Level 2 : Supported Self-management
Patient, Carer, GP, GP Nurse, Home-visiting nursing service, Therapists.

Level 3 : Specialist Supported Self-management
Patient, Carer, GP, Home-visiting specialist nurses, Hospital specialists.

COPD **TELEHEALTH** ENABLED CARE MODEL

Level 1 : Self-management
Patient/carer trained in use of telehealth solution.

Level 2 : Supported Self-management
Telemonitoring information shared with GP, GP Nurse and Home-visiting nurse, Therapists. Routine GP-based disease management services (QOF).

Level 3 : Specialist Supported Self-management
Telemonitoring information shared with eHealth Centre and/or Specialist Home-visiting nurses, Therapists. Hospital-based specialist advice.

COPD Care Management – routine care
The routine care for patients with COPD living within Scotland takes place predominantly within primary care, unless there are exacerbations which require an A&E attendance and/or admission to hospital. Patients self-manage (Green) and have an annual review scheduled with a Practice Nurse within the GP practice (Amber). When a patient requires hospital admission (Pink) they may be seen by a respiratory specialist and their GP practice is sent a discharge notification which will include any changes in the patient's care plan and medication (Amber). Many patients will also be referred to a specialist respiratory nurse who works collaboratively with the patient's GP in caring and supporting the patient at home until their health status stabilises again. Treatment options and management of COPD in NHS Scotland is evidence based and places greater emphasis on reducing exacerbations, improving quality of life, early symptom management and supported self-management.

U4H Telehealth Enabled COPD Care Management
Patients were offered a telehealth service as an integrated part of their care plan either on discharge or shortly after an emergency hospital admission for a COPD exacerbation. 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 three categories of telemonitoring with the most intensive service being provided by the specialist respiratory nurses or Advanced Nurse Practitioner (ANP) for up to 10 days post-discharge (Pink). During this initial period, patients take their physiological measurements and upload the data via the telehealth device and then receive a daily teleconsultation (usually by telephone) from their specialist nurse. Clinical alerts are forwarded directly by the telehealth system to their specialised nurse (decentralised model) or for one area, managed initially by a centralised triage service which operates through a local telehealth hub. The patient transitions, when clinically safe, to a moderate level of support and self-management education from a nominated clinical team member for up to 3 months (Amber/Pink). Their care plan is updated and telehealth measurement and alert parameters adjusted as appropriate. Following this period, patients can be offered the low level service which provides regular motivational health coaching messages and support for up to 12 months (Green). The patients will still have the annual review by a Practice Nurse and involvement of the GP, emergency room or hospital admission as required (Amber/Pink).