Managing LTC Using Telehealth (UK)

SIFT 22-25 October 2018
The problem

Approximately 15 million people in the UK have a long term condition and their management is one of the greatest challenges facing the National Health Service (NHS) today.
Taking on the challenge

A pilot

• NHS Halton & St Helens Primary Care Trust in Widnes conducted a 12-month pilot to evaluate the benefits of embedding telehealth within its care pathways for people with long term conditions (LTCs)
Pilot commissioning

• 60 telehealth packages were commissioned from Tunstall Healthcare and offered to patients from three chronic disease areas:
  • Heart failure
  • COPD (chronic obstructive pulmonary disease)
  • Stroke
Pilot aims

- Integrate social welfare and health care
- Proactive healthcare management
- Tailored to the individual
- Hospital avoidance
- Condition improvement or stabilisation
- Program compliance
- Medication compliance/titration
- Patient education
- Co-morbidities support
- Resource maximisation
- Support informed clinical decision making
How Tunstall’s Connected Health System Works

Clinician alerted

myCare patient

Monitoring

myClinic vital signs

Clinical triage and video conferencing with ICP

Secure data
Example Health Interview Questions

- Is your breathing worse today than it usually is?
- Do you have a cough?
- Have you tried using your reliever?
- Do you have any other symptoms related to your cough?
- Are you coughing up sputum?
- Has the amount of sputum increased?
- Are you following your diet?
Early Intervention

- Easy to view data allowing for clinical staff to review trends
- Out of range readings alert to Careline staff
- St Helen’s Clinicans review and provide clinical triage
Joe’s story

- Joes profile:
  - 59 years old
  - Managed by the Community Stroke Service for over two years.
  - Comorbidities- Hypertension, Type 2 diabetes, morbid obesity and shortness of breath.
  - ADL Low and QoL Low

- On the program he
  - Measured his BP, SPO2, pulse, temp, and BGL at least daily.

- As a result he:
  - Gained understanding of his condition
  - Stopped smoking
  - Increased physical activity
  - Lost 3 Stone in weight
  - Reduced his BP, BGL, Insulin dosage
  - Improved breathing

“I generally felt much better for having been on the program”
Outcomes

- £48,494 savings over 12-month period.
- 85% of patients improved their understanding of their condition.
  - reduction in anxiety,
  - better medication compliance,
  - increased knowledge and self – management.
- Reduced community nursing home visits
- Integrated working between health and social care was greatly improved.

Saved £ 808 pp/pa
What happened next

• Their plan was to continue and
• Expand the program into transition care and residential aged care
• Increase engagement with hospitals and GPs
• Check out our Poster to see what happened next with their re-ablement service
• Restructure dissolved the program
Acknowledgements

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Halton and St Helens
Community Health Services