# Supporting Self-Management and Reducing Hospital Admissions for Patients with Chronic Obstructive Pulmonary Disease and Chronic Heart Failure

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# Background



Technologies such as Telehealth have the potential to transform the way people engage in and control their own healthcare, empowering them to manage it in a way that is right for them.

Telehealth helps to reduce non-elective/unplanned hospital admissions for patients, offer care closer to home and assist with directing clinical resources where they are most beneficial/required.



# Benefits of self management

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Empowered patients

Reassured carers

Informed clinicians

Improved health literacy

Patient centred care

Cost effective service

# Current Position in Dorset

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600+ Telehealth users to date

250+ Telehealth Users at Present

50% of Telehealth Users have Chronic Obstructive Pulmonary Disease

34% of Telehealth Users have Chronic Heart Failure

70% of Telehealth Users are referred by and supported by Community Matrons and Community Heart Failure Specialist Nurses

50% of Telehealth Users state their prime reason for using Telehealth is for self-management

15% of Telehealth Users state their prime reason for using Telehealth is for prevention of deterioration/hospital admission

7% of Telehealth Users state their prime reason for using Telehealth is for reassurance



# Outcomes of 2 year pilot



£700 per patient

231 patients with COPD and/or CHF were studied over a period of 12 months prior to Telehealth and 12 months post installation;

80% of patients have reduced or had no change in the cost of hospital admissions; of these 43% demonstrated a reduction in cost

81% of patients have reduced or had no change in length of stay; of these 41% demonstrated a reduction in length of stay

Average saving of £1300 per patient



# Outcomes of 2 year pilot



53 patients have been on Telehealth for 18 months +
(9% of total users and 23% of 231 cohort)

77% of these patients demonstrated a reduction or no change in length of stay after 12 months on Telehealth; of these 23% of patients demonstrated a reduction in length of stay after 12 months on Telehealth

**However, the pod costs are such that Telehealth does not represent a good financial return if people remain on it indefinitely with senior nurse support. There is a balance between creating a dependency and using Telehealth as part of a nurse specialist toolkit and a proactive route to self-management**



# Outcomes of 2 year pilot



**Heart Failure Specialist Nurse**

‘Telehealth has freed up time for me to see new referrals quicker both at home and in the clinic setting, thus potentially improving patient care and reducing unnecessary admission to hospital.’

**Practice Nurse**

**‘**Telehealth equipment can have real benefits to patients and the health community as analysis of patients’ use of the health system before and after the installation of Telehealth shows a significant reduction in the number of admissions and visits/calls from GPs and nurses.’



# Outcomes of 2 year pilot



**Patient A**

'I was diagnosed in 2001 with COPD, and was admitted to hospital quite often. Since having telehealth this is the first year I haven't needed any admissions. I believe I am now meeting my goal, which was to gain a better understanding of my health and reduce admissions. I can control my health now and have clearly seen benefits and would certainly recommend it to others.'



## Patient B

‘I have Chronic Heart Failure (CHF), and I have a triple heart bypass in 2000. I have been using telehealth for a couple of months after my Community Matron recommended it to me. I take my tests and send them to my Community Matron, and if she is ever concerned about the results she will call me, come visit me at home if needs be. If I am feeling unwell, I sometimes take extra tests for my peace of mind, as I do not have to send the results to my Matron. I would recommend it to others as it doesn’t just benefit me, it also benefits the Matrons to enable them to look after more patients.’



# Next steps



Embed the service within community services

Increase referrals from Primary Care to reflect top % of current QOF registers;

4.3% of COPD patients

8.8% of CHF patients

Study the outcomes of Oncology and Mental Health pilots



https://www.youtube.com/watch?v=qtFjqcejB7M



# Thank you

Dorset Clinical Commissioning Group

For further information

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