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CONNECTED CARE

Remote Monitoring

Of High Risk Patients to support Winter Pressures

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The Challenge

Call to Action

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Situation

Our primary care workforce is under immense pressure. Complex and frail patients have the highest risk of experiencing unexpected illness and deterioration over winter. Residents need more.

Ambition

To move from a reactive to a more proactive and holistic model of care using data, technology and our workforce differently.

Seek health equity and accelerate the optimisation of our patients.

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Reactive to Proactive

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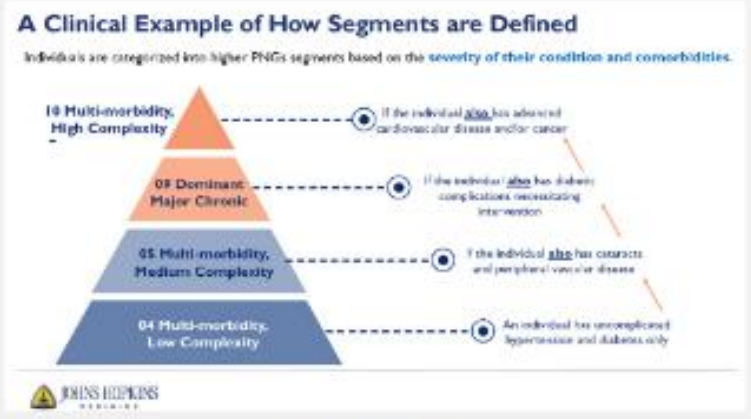
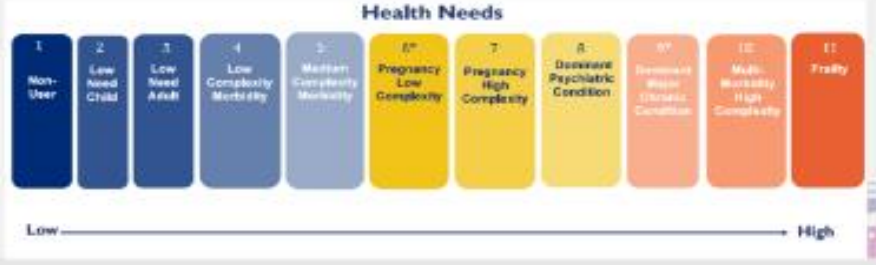
Advanced Population Health tools allow us to identify and target our most complex and frail patients.
Using patient profiling based on Johns Hopkins ACG System - ACG Patient Need Group segmentation which looks at diagnoses and the needs of a patient. We targeted High Risk Patients in groups 10 and 11.





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Implementation

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- ✓ CLINICAL PATHWAYS
- ✓ STANDARD OPERATING PROCEDURE
- ✓ GOVERNANCE
- ✓ ENGAGEMENT MATERIALS
- ✓ DIGITAL HEALTH TEAM READY

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Clinical Model

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1

The monitoring consists of a weekly question set and a monthly question set for patients who are stable, plus an “unwell & deteriorating” question set for the patient to use if they feel unwell. The questions cover clinical, mental health, social wellbeing and health promotion domains

2

The questions will trigger RAG-rated responses which in the main can be dealt with by the digital health team , a nurse led clincial team.

3

Where required they may escalate to an appropriate service such as Duty Doctor, UCR, 999 etc.

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Impact

Patients have offered thanks for their ongoing care / advice and checking on their welfare.
Simple advice on closing your mouth when taking your temp, warming hands before SPO2 etc have changed the data that alerted into normal parameters.

Increasing fluid intake during day or reducing salt/cholesterol high foods, the patients are gaining more knowledge on their health.

A patient was put on daily monitoring by the Nurses on the remote monitoring team, it was then escalated and the patient received a diagnosis which could have been life threatening if not treated.

Since mid December 2022.....

24 Practices are now part of the service and growing
Over 4500 patients have been identified as suitable to be part of the initiative

1700 High Risk patients are now being supported by Remote Monitoring with the digital health team dealing with 98% of alerts.

"A gentleman, who, to begin with was not very keen on being part of the remote monitoring service, however as the weeks are passing, the patient is now very glad to be part of the service, he has more insight into his health and becoming more aware of his ongoing conditions."

'As duty GP, we received a call from the monitoring team which allowed us to get the right support to the patient before they went into crisis and keep the patient at home'

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Preliminary evaluation of 545 patients against a control group of High Risk patients not enrolled in Remote Monitoring.

The following service outcomes have been seen in our enrolled patients:

- **A net decrease of 33% in monthly admissions**
- **A net decrease of 55% in monthly GP F2F consultations**
- **A net decrease of 32% in monthly A&E activity**

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Service Outcomes (651 patients)

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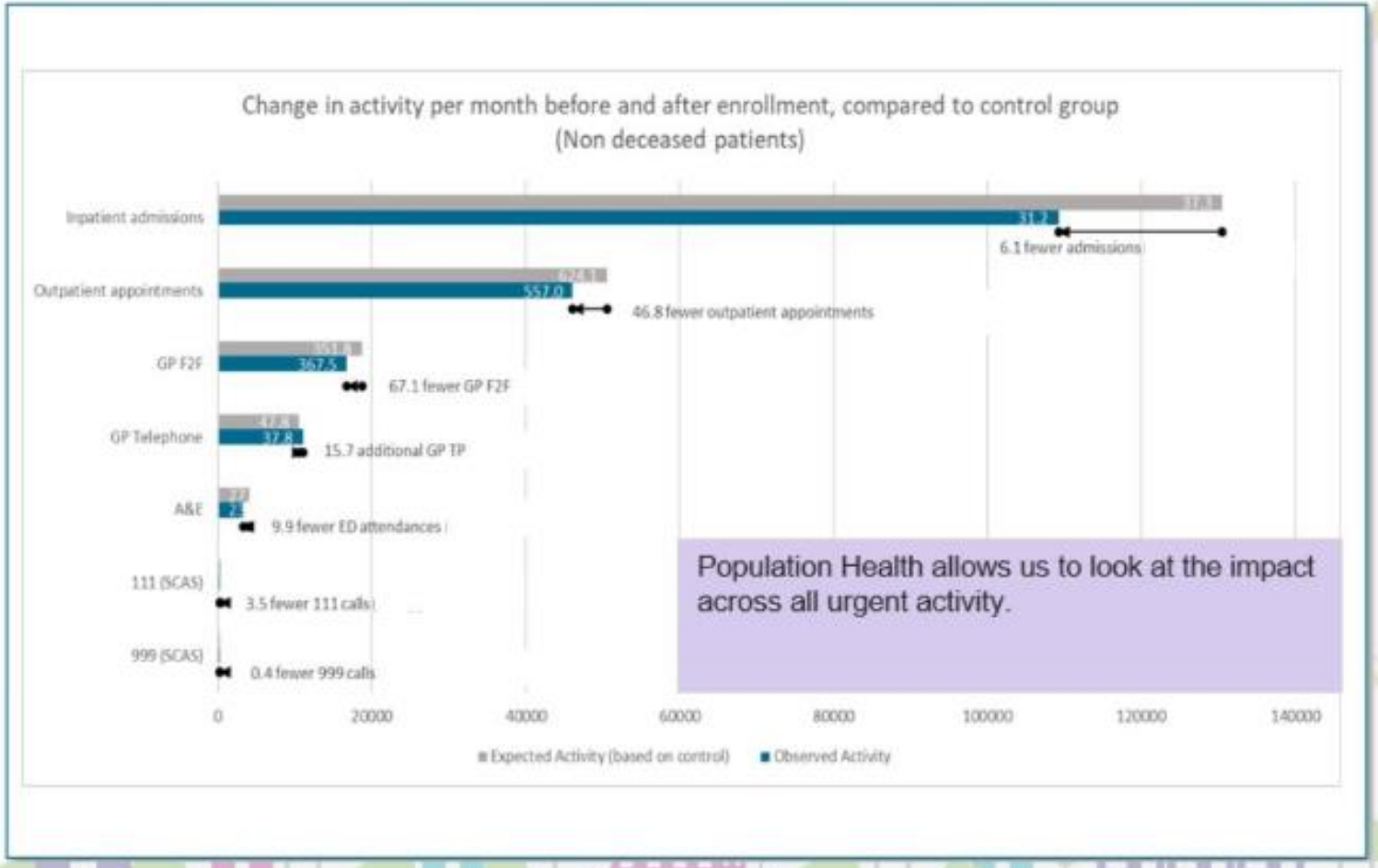


Key insights

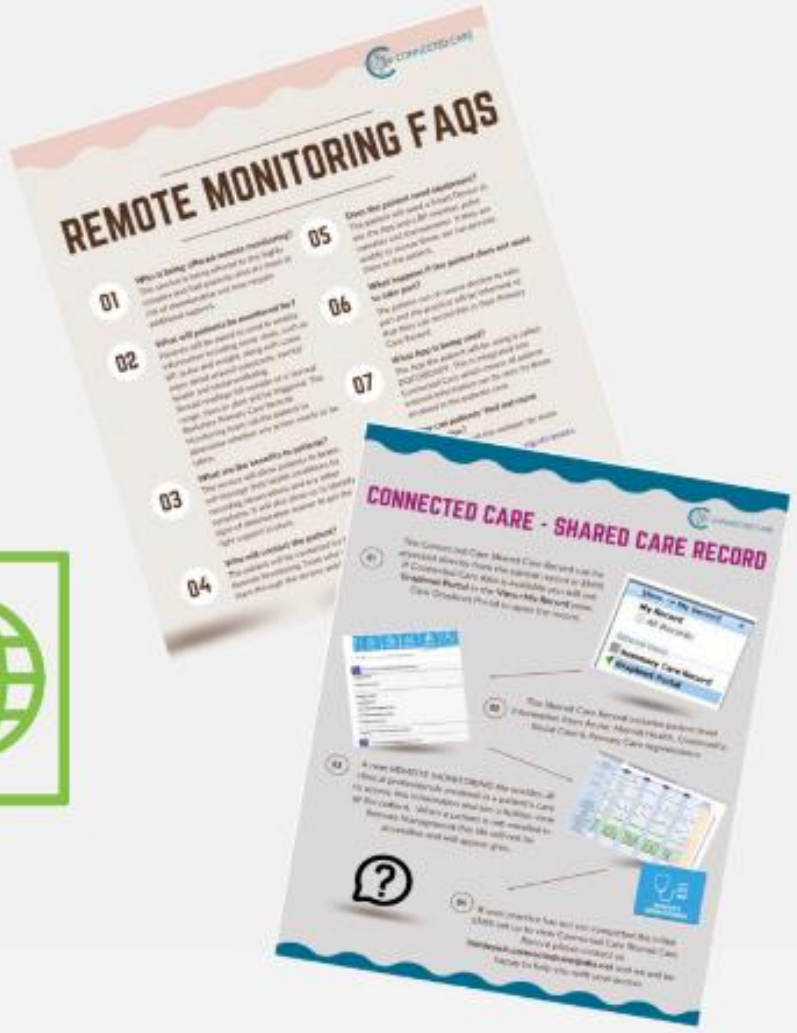
- We plot the change in admissions before and after intervention, this is compared to their expected admissions if they exhibited the same trend as the control group.
  - *Our control group was set as any patient currently in the John Hopkins' Frailty and Patient Need Groups not enrolled in the programme*
  - *For enrolees we compare 12 months of activity pre enrolment to activity post enrolment (average follow period of 2.6 months)*
  - *For controls we compare monthly activity 12 months before the programme started (Dec21 – Nov22) to the 3 months since the programmes have started (Dec22-Feb23)*

We observed the following service outcomes in our enrolled patients:

- 6 fewer admissions per month
- 47 fewer outpatient appointments per month
- 67 fewer GP F2F consultations per month
- 16 additional GP TP consultations per month
- 10 fewer ED attendances per month
- 54 fewer monthly 111 calls per month
- 0.4 fewer 999 calls per month

No statistical modelling has been completed to control for small sample sizes

Iterate



We continue to adapt and iterate as we learn.

Initial reservations from patients on the legitimacy of the service no longer present as we refined our introductory text to come from a named GP and introduced a website.

Patients felt all staff at the practice did not understand the offer - we created further engagement materials aimed at primary care.

The digital team found that early evening calls got a good response for onboarding, so adapted their shift patterns.

Learnings

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Learnings

- ✓ DON'T WAIT FOR PERFECT
- ✓ TAKE A RISK
- ✓ START WITH INNOVATORS
- ✓ KEEP AN OPEN MIND- EXPLORE NEW IDEAS AND ITERATE

What Next

- Onboard more practices/patients
- Seasonal model to de-escalate
- Prescribe Remote Monitoring in the community / at discharge
- Further evaulation and applied learnings

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Thank You

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