Telehealth in Practice

ARSAN, Campania, Italy - DIABETES

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Ambition

The overall aim for implementing telehealth into the care management programme for patients living with Type 2 diabetes with complications who monitor their blood glucose levels, is to support and improve the individual patient's endeavours to self-manage and lead a lifestyle to reduce their risk of exacerbation and of developing further diabetes-related complications.

DIABETES **ROUTINE** CARE SERVICE MODEL

Level 1 : Self-management
Patient and Carer.

Level 2 : Supported Self-management
Patient, Carer, GP, Diabetologists and Specialist nurses in the Community-based diabetic centre.

Level 3 : Specialist Supported Self-management
Patient, Carer, Diabetes specialist nurses in the Community-based diabetic centre, Hospital-based specialists only involved if patient attends emergency/admitted.

DIABETES **TELEHEALTH** ENABLED CARE MODEL

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

Level 2 : Supported Self-management
Diabetologist in Community-based diabetes centre receives telemonitoring information, responds to alerts by telephone, SMS and/or email. Routine diabetes care management consultations. GP informed of patient on telemonitoring but has no access to web portal.

Level 3 : Specialist Supported Self-management
Diabetologist in Community-based diabetes centre as Level 2. Hospital-based teams do not have access to telemonitoring information.

Diabetes Care Management - routine care
Routine care for patient with Type 2 diabetes varies according to the severity of their disease and the level of patient self-management (Green) and is part of an integrated care model as follows:

- Patients with no complications are managed by GPs, who receive the patient's individual care plan from the diabetologist which includes their blood glucose levels and monitoring regime. The patient's GP is contracted to monitor their anthropometric indices (height, weight, waist circumference), provides educational reinforcements at least every 3 months, and HbA1c values at least every 6 months. In addition, the GP ensures the patient is referred for relevant specialist assessments including the screening for any complications annually (Amber).
- Patients living with unstable diabetes and related complications are managed by the diabetologists in the community based Diabetes Centres. Their follow up (including the assessment and screening for complications) is in accordance with their individual care plan and review (Pink).

Patients are able to be referred to medical specialists in the hospital and/or community services if required.

U4H Telehealth Enabled Diabetes Care Management
The telehealth service is only offered to patients living with unstable diabetes and related complications and has been designed to improve the routine care service model delivered by specialists working in the community-based Diabetes Centre by strengthening interventions and support to help patients self-manage (Green/Amber).

Patients take and upload their blood glucose readings using the glucometer and telehealth device gateway provided by the Diabetes Centres according to the regime agreed between the patient and the diabetologists (Pink).

On a weekly basis, a member of the patient's care team reviews the patient data uploads received and contacts the patient by phone, SMS or email if data is missing and they will offer the patient additional telehealth training and support if considered necessary. If the data upload review shows that a patient's blood glucose readings are outside their agreed parameters, the care team member will seek advice from the diabetologist on how to proceed. The diabetologist would contact the patient to elicit additional information to assess the severity of the situation and take one or more of the following actions:

- health coaching to reinforce their diabetes self-management education, psychosocial support and/or motivational guidance, in order to improve their adherence to their self-management plan and to facilitate lifestyle changes;
- self-management plan changes, eg diet or activity level
- an unscheduled outpatient consultation for further investigations or if a change in their blood glucose monitoring regime is required.

Remote contacts with the patients are by e-mail, text or telephone according to the preferences, capabilities, and individual needs of the patient.

GPs and home nurses, if relevant, are notified when a patient has the telehealth service added to their care plan.