Telehealth in Practice
ASP Cosenza, Italy - DIABETES

aspcosenza.contact@gmail.com

Ambition
The overall aim for implementing telehealth into the care management programme for patients living with Type 2 diabetes 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 developing diabetes-related complications.

DIABETES **ROUTINE** CARE SERVICE MODEL

Level 1 : Self-management
Patient and Carer.

Level 2 : Supported Self-management
Patient, Carer, Diabetologists and Specialist nurses in the Community-based diabetic centre. GP's are not involved in Diabetes care management.

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
Telemonitoring data available in eHealth portal/PHR accessed by eHealth centre nurses, GP and local diabetes clinic specialists. Secure messaging and telephone between patient and eHealth centre nurses, GP, local diabetes clinic.

Level 3 : Specialist Supported Self-management
Home-visiting Nurses, GP, Specialist Services, Hospital-based Teams have access to shared telehealth monitoring information. Alert response, text messaging health coaching provided.

Diabetes Care Management - routine care
On a daily basis, patients with Type 2 and Type 1 diabetes monitor their blood glucose levels (Green) with any routine care predominantly undertaken in the Community Based Diabetes Centres by diabetologists and diabetes specialist nurses (Amber/Pink). Patients have follow-up appointments according to their individual care plan and as a minimum are offered an annual review which includes testing their HbA1c, renal function, lipids; measuring their blood pressure, and follow-up/secondary prevention of complications with specialist consultation (cardiology, neurology, nephrology, oculist). Patients are able to be referred to medical specialists in the hospital if required.

U4H Telehealth Enabled Diabetes Care Management
The telehealth service has been designed to enhance the routine diabetes care service model for patients living with Type 1 and Type 2 diabetes, by strengthening interventions and support to help patients self-manage (Green).

Patients send their blood glucose readings using the glucometer and the Eurotouch Home® PHR according to the regime agreed between the patient and the diabetologists (Amber/Pink).

Biweekly, diabetologists review the patient data uploads received and contact the patients if data is missing or readings are outside the parameters set for the patient.

Patients can be offered:
- additional telehealth training and support if required;
- 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 email, SMS 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.

Diabetes telehealth configuration & key interactions: ASP Cosenza, Calabria, Italy