Telehealth in Practice

The Basque Country, Spain - CHF

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Ambition

The aim of the telehealth service for patients living with CHF is to support and improve levels of self-management and achieve equally good clinical outcomes as routine care, particularly in relation to body weight, blood pressure and cholesterol, quality of life and cost-effectiveness.

CHF **ROUTINE** CARE SERVICE MODEL

Level 1 : Self-management
Patient and Carer.

Level 2 : Supported Self-management
Patient, Carer, GP, GP Practice Nurse (home visits if necessary).

Level 3 : Specialist Supported Self-management
Patient, Carer, GP,GP practice nurse (home visits if necessary), hospital cardiologist, hospital nurse.

CHF **TELEHEALTH** ENABLED CARE MODEL

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

Level 2 : Supported Self-management
GP, GP practice nurse (home visits if necessary), eHealth centre, Telecare centre. All healthcare professionals access telehealth monitoring information. Alarm management, health coaching provided.

Level 3 : Specialist Supported Self-management
GP, GP practice nurse (home visits if necessary), cardiologists, hospital nurse, eHealth centre, Telecare centre. All healthcare professional access telehealth monitoring information. Alarm management, health coaching provided.

CHF Care Management – routine care
Patients with CHF in The Basque Country have their CHF care management regularly reviewed and are supported to self-manage by the primary care nurses (Green and Amber). Between 48-72 hours after discharge following a hospital admission, a patient is contacted by telephone by a nurse from the eHealth centre. The nurse will ask structured, validated questions to elicit up-to-date information on the patient's health status and how they are coping. The nurse will decide on the appropriate next steps in line with answers given by the patient. These options for further care, support, and/or treatment include the patient being seen by the GP or GP nurse in the health centre within 24-48 hours, 48-72 hours or a week later depending on the severity of the patient's health status. During the consultation the GP and/or the GP nurse will assess the patient and determine whether any further tests and investigations are required as well as agree appropriate self-management and patient empowerment support. One month after hospital discharge, the patient will be offered an outpatient consultation with the Cardiologist in the health centre (Pink). A medication review will be undertaken, together with any additional laboratory tests and ECG. Once the patient's condition has stabilised again, they will be reviwed by the GP and GP nurse on a six-monthly and three-monthly basis respectively (Amber).

U4H Telehealth Enabled CHF Care Management
A patient will follow the routine care model until their telehealth solution has been installed and training given by the Telecare Centre. This period usually covers 5-10 days post discharge. Once a patient has commenced transmitting their physiological measurements, a Cardiologist reviews the data uploaded and adjusts their care plan and medication regime as necessary. During ongoing telemonitoring (Green), an operator from the Telecare Centre monitors the data uploads and if any alerts are generated as a result of readings being outside the patient's parameters, the patient is contacted to verify the uploaded data. If the alerts are corroborated and the patient's health status has worsened, the call is transferred to a nurse at the eHealth Centre (Amber). Depending on the severity of the situation, the nurse will follow the clinical protocol and take the necessary action which could involve scheduling an appointment with the patient's GP (face-to-face or phone consultation), referral for a specialist appointment (face-to-face or phone consultation), or activate an ambulance for transfer to the emergency room. The Cardiologist will also continue to regularly review the telemonitoring data until the patient (Pink) is considered stable and then responsibility for ongoing CHF care management and proactive follow-up is transferred to the GP and GP nurse. If the GP or GP nurse has any cause for concern in relation to the patient's CHF health and wellbeing, they will contact the patient, re-assess the care and self-management plan and revise as necessary.