Telehealth in Practice

Galicia, Spain - COPD

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Ambition

The aim of the telehealth service for patients living with COPD is to provide an alternative way support self-management through the provison of an appropriate level of telemonitoring that is flexible and can respond with fluctuations in their health status and thus avoid future emergency hospital admissions due to a COPD exacerbation.

COPD **ROUTINE** CARE SERVICE MODEL

Level 1 : Self-management
Patient and Carer.

Level 2 : Supported Self-management
Patient, Carer, GP, GP Nurse – including home-visiting if required. All have access to shared EHR .

Level 3 : Specialist Supported Self-management
Patient, Carer, Hospital specialists, Specialist Nurses. All have access to shared EHR.

COPD **TELEHEALTH** ENABLED CARE MODEL

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

Level 2 : Supported Self-management
Shared telehealth monitoring information available to GP and GP Nurse through EHR and they provide alert response, telephone, health coaching provided.

Level 3 : Specialist Supported Self-management
Shared telehealth monitoring information available to Hospital Specialists and Specialist Nurses through EHR and they enrol patients onto telehealth and provide advice as necessary to GP and GP Nurse.

COPD Care Management – routine care
Routine care for patients with COPD is undertaken by the patient themselves (Green) supported predominantly by their GP and GP nurse who also undertakes home visits in accordance with the patient's health status (Amber). Clinical information is recorded in the shared EHR. Following the GesEPOC guidelines published in 2013, patients are invited to have scheduled appointments to review their treatment and self-management plan. Patients are able to be referred to medical and nursing COPD specialists in the hospital if required (Pink).

U4H Telehealth Enabled COPD Care Management
The telehealth service has been designed to help patients self manage (Green) and enhance the routine COPD care service model delivered by professionals working in primary care settings (Amber) by strengthening self-management with health coaching interventions and support.

Patients are enrolled into the telehealth service upon discharge from a hospitalisation following an exacerbation of their COPD and information is entered into the patient's EHR (Pink). The GP Nurse receives an appointment (day and time) notification through the EHR indicating that the patient is being discharged from hospital and requires the telehealth service. The Nurse emails a request to the telehealth provider (Enterprise) detailing the date and time of installation, patient details including physiological measurement parameters set by the hospital specialists. The patient receives the telehealth equipment and receives training from the Enterprise staff member.

The patient's telemonitoring information is received by the GP Nurse who makes the daily video call to the patient (HLTM) for up to 30 days dependent on the individual patient's health status. The GP Nurse also enters the telemonitoring information into the patient's shared EHR (Amber). The GP Nurse continues to receive the telemonitoring information on a daily basis (MLTM) and responds to any alerts and seeks advice from the GP and hospital specialists as required. Health coaching is provided via a video call for patients receiving the HLTM and MLTM service. The GP nurse reviews the patient's health status regularly and decides when the telemonitoring equipment can be removed from the patient's home for the patient to continue to self-manage, contacting the GP nurse by telephone if required. During any telephone consultation, the patient will be guided through the symptom management questionnaires (LLTM) for up to 12 months.

Any worsening systems will be treated according to local standard protocols, eg GP consultation or the patient can attend the emergency room following which they may be admitted. The GP can also refer the patient for a outpatient appointment with the hospital specialist. (Pink).

During the final phase of U4H, Galicia integrated the telemonitoring information automatically into the EHR which means telemonitoring is now one of the "prescriptions" available upon discharge.