Telehealth in Practice

Central Greece - DIABETES

info@e-trikala.gr

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 via the support of a single entry point to existing health and social services. Medical intervention and social support is combined based on the telehealth service, which becomes a catalyst to break the silos between the two different organisations (Regional Health Authorities and Municipal Social Services), aiming to provide an integrated ICT based health and care service for patients with Type 2 diabetes.

DIABETES **ROUTINE** CARE SERVICE MODEL

Level 1 : Self-management
Patient and Carer.

Level 2 : Supported Self-management
Primary care is not funded to provide diabetes care management.

Level 3 : Specialist Supported Self-management
Patient, Carer, GP, Hospital Diabetologist, Home-visiting Nurses.

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 information not accessible by GP.

Level 3 : Specialist Supported Self-management
Telemonitoring information available to Hospital Specialist, Alert response and health coaching. Data available to support hospital diabetes appointments.

Diabetes Care Management - routine care
Routine care for patients with Type 2 diabetes is undertaken by the patient themselves (Green), supported every 3 months by their diabetologist/endocrinologist at the outpatient department of the Regional University Hospital (Pink). In addition, on monthly or up to 3 months basis, their family doctor (GP) prescribe their medication and give advice when needed (Amber). Patients are invited to have, as a minimum reviews include testing their HbA1c and blood pressure every 3 months, periodic assessment of renal function and lipids, and undertaking a micro vascular/neuropathic assessment, and providing them with health and lifestyle advice as part of each consultation. In addition, patients receive a retinopathy screening appointment annually. Patients are able to be referred by their family doctor (GP) to other medical specialists in a hospital.

In case of an emergency, the patient has to refer themselves to the EMS (emergency medical services). Any patients with comorbidities, disabilities or lack of support from informal caregivers, are eligible to receive home care nursing services provided by the Municipalities.

U4H Telehealth Enabled Diabetes Care Management
In addition to routine care, individual patients were equipped with light-weight handheld physiological measurement devices as well as a suitable mobile phone to undertake regular telemonitoring as part of their self-management (Green). They received training on the telehealth equipment from the nurses within the municipal homecare service (Amber). The patients record their vital signs at home, and these were then uploaded (via the Telehealth centre) to the Regional University Hospital of Larisa (endocrinology clinics), over internet and GPRS. The diabetologist reviews the telemonitoring data and provides feedback to the patient by phone or via a request for a physical consultation in the outpatient department (Pink).

The telehealth service has been designed to help patients self manage and enhance the routine diabetes care service model delivered by health professionals working in home care settings by strengthening self-management with health coaching interventions and support. The homecare service has been expanded to include patients who have health problems, as well as those to those with social needs and disabilities. The access of the patients to their diabetologist/ endocrinologist is also more frequent than the routine care model.

In case of an emergency, the patient has to refer themselves to the EMS (emergency medical services). The telemonitoring does not provide an emergency service.