Telehealth in Practice

Ljubljana, Slovenia - CHF

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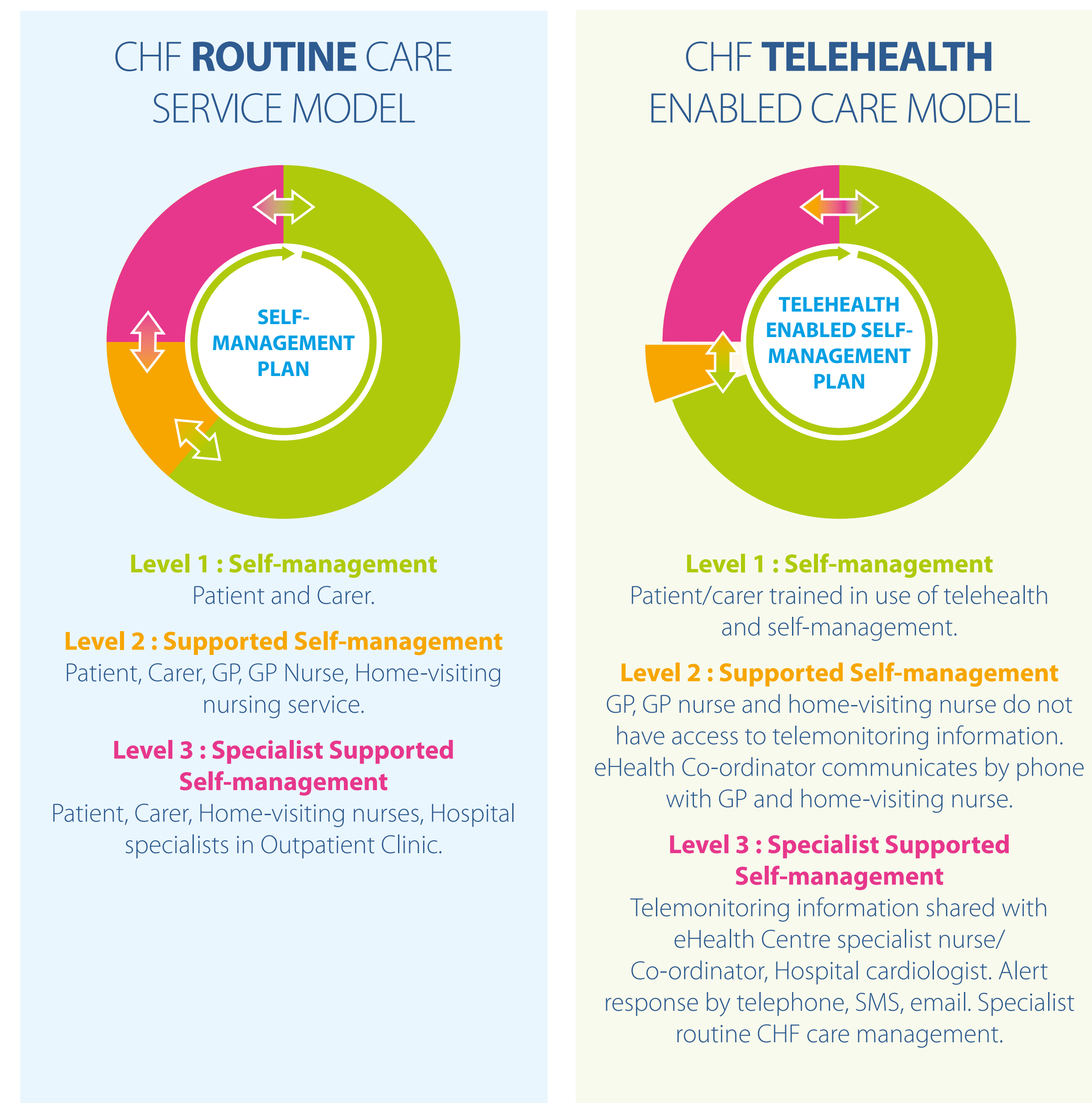
Ambition

The aim of the telehealth service for patients living with CHF is to promote self-management and enable bi-directional communication, as required, between the patient and specialist more frequently than the routine care periodic follow-up schedule. In addition, the service has been designed to enhance the level of care provided and improve clinical outcomes, quality of life and be cost effective.



CHF Care Management – routine care

Patients with CHF implement their self-management plan (Green) and have regular (6 monthly if stable) specialist consultations in hospital outpatient clinics and health centres in the Koroška region (Amber/Pink). Routine care management aims to achieve personalised goals in relation to their blood pressure, weight and blood oxygen levels. Patients enter their measurements in a booklet, the information in which is reviewed by the specialist at regular scheduled consultations. All patients are given personalised advice in relation to their diet according to their blood pressure and weight. If their physiological measurements are not well controlled (Amber/Pink) they are reviewed in the hospital outpatient clinic or regional health centre more regularly than every 6 months.

U4H Telehealth Enabled CHF Care Management

The telehealth service is provided by the Telemedicine Service Centre CEZAR from the Slovenj Gradec regional hospital. Using physiological measurement devices (blood pressure meter, pulse oximeter, weight scales), patients take their measurements daily at home. The readings are transmitted over Bluetooth to a Smartphone provided by U4H and subsequently uploaded to the CEZAR Centre at the hospital (Green). An alert is generated when, according to the clinical protocol, the telehealth system detects that one or more reading is outside the patient's set parameters. In such case, an eHealth coordinator from the CEZAR centre contacts the patient by phone to check the data upload (Pink). If the data is correct, the coordinator contacts a hospital cardiac specialist seeking advice on further action, eg change in therapy or unscheduled hospital consultation. Any changes are communicated to the patient by phone followed up by a paper report sent by postal mail. The coordinator may need to communicate with the patient's GP and/ or home-visiting nurse if there are changes, for example, to the patient's medication regime (Amber). In addition, cardiologists and specialist nurses periodically review all patients on telehealth to determine whether any changes to their care and self-management plan is required and if this is the case, a paper report is once again, sent to the patient.