Telehealth in Practice

Ljubljana, Slovenia - DIABETES

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Ambition

The aim of the telehealth service for patients living with diabetes is to support and improve levels of self-management and achieve equally good clinical outcomes as routine care, particularly in relation to glycated haemaglobin HbA1c, body weight, blood pressure and cholesterol.

DIABETES **ROUTINE** CARE SERVICE MODEL

Level 1 : Self-management
Patient and Carer.

Level 2 : Supported Self-management
Patient, Carer, GP, GP Nurse, Home-visiting nursing service.

Level 3 : Specialist Supported Self-management
Patient, Carer, Home-visiting nurses, Outpatient And/or Primary Health Care Centre.

DIABETES **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 nurse and home-visiting nurse do not have access to telemonitoring information. eHealth Co-ordinator communicates by phone with GP and home-visiting nurse.

Level 3 : Specialist Supported Self-management
Telemonitoring information shared with eHealth Centre specialist nurse/Co-ordinator, Hospital diabetologist, Primary Health Care diabetic centre. Alert response by telephone, SMS, email. Specialist routine diabetes care management.

Diabetes Care Management – routine care
Patients with diabetes 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 glycated haemoglobin HbA1c. Patient self-management plans vary according to their disease level with the frequency of blood glucose monitoring varying for those on insulin, oral medication or diet only. Patients enter their blood glucose measurements in a dedicated diabetes booklet, the information in which is reviewed by the diabetologist at regular scheduled consultations. All patients are given personalised advice in relation to their diet and activity according to the blood glucose levels. If their blood glucose levels 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 Diabetes Care Management
The telehealth service is provided by the Telemedicine Service Centre CEZAR from the Slovenj Gradec regional hospital. Using physiological measurement devices (glucometers), patients take at home their blood glucose measurements once a week 3-6 times during that day (whole daily profile). 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 the service system detects that the blood glucose readings are outside the patient's set parameters. In such cases, 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 diabetes 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, diabetologists 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.