Telehealth in Practice

South Karelia, Finland - DIABETES

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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 to help patients self manage and to reduce their risk of developing diabetes-related complications. South Karelia is also assessing whether patients who effectively self-manage using the telemonitoring service require the same routine diabetes clinic follow-up twice yearly regime as patients who do not telemonitor.

DIABETES **ROUTINE** CARE SERVICE MODEL

Level 1 : Self-management
Patient and Carer.

Level 2 : Supported Self-management
Patient, Carer, GP, GP Nurse, local diabetes clinics.

Level 3 : Specialist Supported Self-management
Patient, Carer, Hospital Specialists.

DIABETES **TELEHEALTH** ENABLED CARE MODEL

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

Level 2 : Supported Self-management
Telemonitoring data available in eHealth portal/ PHR accessed by eHealth centre nurses, GP and local diabetes clinic specialists. Secure messaging and telephone between patient and eHealth centre nurses, GP, local diabetes clinic.

Level 3 : Specialist Supported Self-management
Hospital attendance/admission specialists have access to eHealth portal/PHR/secure messages.

Diabetes Care Management - routine care
When patients are first diagnosed with diabetes their GP and GP nurse provide their care management and education about diabetes in order for the patient to be able to carry out effective self-management (Green) and update their Diabetes Record book regularly. Patients have two follow-up face-to-face appointments with GP nurse or diabetes specialist nurse, each year to review their diabetes care and adjust their treatment if necessary (Amber). Patients whose diabetes is not well controlled are also able to be reviewed by their GP at these clinic appointments. Hospital specialists are not involved in the management of patients with Type 2 diabetes unless they have a hospital admission (Pink). There is a shared electronic health record (EHR) which contains all the healthcare information for an individual patient irrespective of whether the care takes place in a hospital or GP practice.

U4H Telehealth Enabled Diabetes Care Management
The telehealth service has been designed to help patients self manage (Green) and enable them to seek remote advice from their diabetes care team (Amber).

Patients take and enter their blood glucose levels in accordance with their self-management plan into their Personal Health Record (PHR) which is part of the eHealth portal (www.hyvis.fi). If their readings are outside the agreed parameters or they are experiencing a worsening in their symptoms, patients can message their diabetes care team through the secure messaging function within the eHealth portal. The GP Nurse or diabetes specialist nurse is able to respond to the patient's message through the eHealth portal and provide them with any necessary health coaching information. The diabetes specialist nurse is also able to seek advice from a GP through the secure messaging function if required. Clinicians gain access to the eHealth portal through the use of their smart card and patients use their bank authentication device and logon details.

When a patient attends the diabetes clinic twice a year, their telemonitoring information and any secure messages are available to enhance the information exchange during the review consultation.

If a patient attends the emergency room or has a hospital admission, the telemonitoring information is available to the hospital specialists through the eHealth portal (Pink).