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perspectives brief

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title **Providing telehealth in general practice during COVID-19 and beyond**

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Introduction

In Australia, virtual healthcare has traditionally been viewed as a way of enhancing access to care for people living in rural and remote communities. However, at a time when the COVID-19 pandemic has severely restricted patients' ability to see their GPs, virtual healthcare is now helping to expand access to care to our more vulnerable Australians.

In March 2020, new temporary MBS telehealth items were made available which allow GPs to conduct telehealth GP management plans and team care arrangements for the purpose of chronic disease management.

While the Government has indicated support for this rebate to continue in the long term, it will be important to anticipate the opportunities that virtual healthcare can provide to the healthcare sector in order to ensure its long-term future.

This will require understanding how telehealth service provision can deliver high quality, safe, patient-centred care; and how funding arrangements are able to adapt to the implementation of new technologies.

COVID-19 has seen a big change in the experience of receiving and providing healthcare for patients and GPs. Sharing stories of change, and how change has led to better patient outcomes is important.

A GP's experience of virtual health care

"With the introduction of the new, temporary MBS items for telehealth my daily workflow as a GP has changed for the better. My overall stress levels have dropped and I am not feeling the usual 'waiting room pressure' when running behind.

I can spend time with the complex longer-term patients and use the phone and video for other patients interspersed with face-to-face consults or booked as a block at either end of the day. This has been assisted by my practice nurses who are able to be used more effectively to reach out to patients with chronic conditions with care plans to check on their self-care and their concerns.

It has also been interesting to reflect that my billing practices are now more mixed, with personal MBS billing for the same period increased, despite a drop in private billing.

I believe that virtual health care should not be seen as a simple substitute for a face-to-face consultation, but rather an extension of an existing relationship between a GP and patient that should be continued into the future."

Patient centred care

Patient centred care involves seeking out, and understanding what is important to the patient. It has the capacity to improve the value of care being delivered to patients by achieving better outcomes at lower overall cost to the health system and the community.

Patient centred care delivered through virtual means, can support patients to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and health care (Case study 1).

While not all health care can be managed virtually, redesigning services to incorporate virtual health care will be increasingly necessary for care delivery that is responsive to the needs of patients, while improving clinical effectiveness and increasing service efficiency.

Systems for measuring patient reported measures should be used to drive reforms that involve patient centred virtual health care.

Case study 1

Case study 1 describes a 66-year-old male with Type 2 Diabetes who was travelling around Australia with his partner. He has been known to his GP for a long time.

COVID-19 had found the man in rural Australia with health issues relating to his diabetes. The man made contact with his GP via SMS to check if it was possible for him to get any assistance and to avoid overloading the local rural general practice with a new patient. A videoconsult was set up to discuss the management of his diabetes and a weekly videoconsult check-in with his city GP acting as coach was arranged for the remainder of his travels.

Equity

Complex clinical situations are made even more complicated by the fact that patients do not always have the ability to visit General Practice for themselves, particularly for the regular follow-ups that are often required for some people to maintain good health. This situation is made even more difficult for the patient by the fact that it is not always feasible for the GP to commit to regular home visits.

Virtual health care has demonstrated capacity to offer more equitable access to care, including for those people with mental illness. However, barriers to accessing virtual health care are increased for vulnerable populations. This includes limited access to technology, poor digital literacy, unreliable internet coverage and affordability of virtual health care (Case Study 2).

Proactive planning and the development of strategies that mitigate the impact of health inequities, particularly for vulnerable populations, are needed and should be backed up by concrete actions to improve the health of all Australians through virtual health care.

Case study 2

Case study 2 describes a female aged 64 with schizoaffective disorder who lives alone. She does not own a computer or smart phone and relies on friends and relatives for transport.

Following a lengthy hospitalisation in a public hospital psychogeriatric unit for treatment, the woman was discharged home. Her son took time off work and brought her to the practice post-discharge for an initial face-to-face discussion about medications and other issues of concern. She had fallen while in hospital prior to discharge and had not been fully assessed. She was examined by her GP, sent for x-rays and found to have 3 broken ribs.

A weekly telephone call was arranged to discuss the x-ray results, manage her pain and medication, monitor her mental health and to discuss the other services involved in supporting her at home during the initial weeks following her hospital stay. Medication changes, blood tests and mental health support were all possible using telehealth. Video consults were subsequently arranged to enable the all-important eye contact with her care coordinators.

This complex situation was handled smoothly and effectively using telehealth which would not have been achieved otherwise. Without this high level of primary care support, the person's outcome may have been a further presentation at a hospital Emergency Department.

Team-based health care

Shifting the focus of care from a single disease, to one that acknowledges multimorbidity and an aging population will be an important strategy for addressing many of the challenges the Australian health system currently faces.

Team-based care is the provision of health services to individual patients and their families by at least two health service providers working in collaboration. It allows care providers with shared goals, both within and across settings, to achieve coordinated, high quality, patient centred care, particularly for the elderly and those with complex and chronic conditions (Case study 3).

Given that virtual health care is primarily about enhancing team-based care, collaboration and patient access, ensuring that collective goals and priorities among virtual care teams are prioritised and underpinned by effective clinical governance will be necessary to implementing high value, sustainable, team-based virtual health care models for the future.

Case study 3

Case study 3 describes a male aged 64 with existing heart disease, diabetes, and obesity, presenting with anxiety and depression. He has been known to his GP for 10 years.

Vulnerable to COVID-19, the male multi-morbid patient presented to the practice showing mild psychological distress and anxiety. He was becoming increasingly concerned that he was going to catch COVID-19 and die. He was prescribed a program of exercise, mindfulness and short-term anti-anxiety medication.

2 weeks later the man's partner contacted the practice, informing the GP that the patient was still struggling with poor sleep, overwhelming anxiety and now mild depression. A mental health assessment was performed over the phone and further medication was prescribed to manage his symptoms. Separately, the GP was able to call and email the pharmacy to order the medication and the script was dispensed.

Following-up, the male patient, still fearful of leaving his home due to the worry of becoming infected with COVID-19, consented to a videoconsult to review the effects of the medication, manage his symptoms and to provide counselling to the patient and his partner. This occurred twice in the first week and, as symptoms settled, became a weekly videocall for 4 weeks, and then fortnightly as he improved.

Interoperability

Providing access to the right information at the right time is critical to addressing and treating the needs of each patient (Case Study 4). Within general practice, interoperability, or the ability of systems to exchange and make use of information, is necessary for standardising care across a patient's care journey, regardless of the patient's care setting within the wider health care delivery network.

As virtual health care delivery is integrated more directly into models of health care, it will be necessary to reflect on any downstream events that can impact on operational and clinical workflows and impede the exchange of data across health care delivery points.

With this in mind, the development and implementation of nationally consistent clinical terminology for data entry, software interoperability standards for data exchange and sharing, and support for organisational adoption of new digital health technologies will be required to promote easy access to health information for both patients and GPs.

Case study 4

Case study 4 describes an 80-year-old woman with dementia and her partner, an 81-year-old man presenting with carers stress and swollen legs; and who often experienced difficulties obtaining a minder for her when attending solo appointments outside of the house. Both have been known to their GP for 30 years.

An 80-year-old woman living with dementia had become increasingly anxious and agitated over a 2-week period, and began describing her husband as "a strange man in the house". While not happy about travelling to the practice for a face to face consultation, she was able to attend an initial assessment to check for infection, constipation, and other causes of behaviour change associated with dementia.

Review of her medication and symptom management were carried out via telehealth, with both by phone and video consults. Care management occurred over a 4-week period via weekly telehealth consultations. This also provided an opportunity to deliver counselling to the 81-year-old man, while issues with his legs and repeat prescriptions were able to be managed via videoconsult.

Based on the patients reported progress, care was managed better at home, with greater individual carer support being achieved than would have occurred if both patients had to attend the practice for every appointment.

Funding

There is significant opportunity to support models of virtual health care that better address the health care needs of Australians, and in particular, disadvantaged groups.

The temporary MBS items for telehealth, introduced to protect both patients and service providers against the impact of COVID-19, allows patients to access essential health services in their home or workplace, easing the economic and medical strain of chronic illness and isolation (Case study 5). This is particularly important for the more vulnerable within our population who struggle with the impact of regular care appointments.

As we move forward, telehealth rebates should continue post the planned September 2020 cut-off. However, the restrictions placed on telehealth arrangements that only allow access to rebates for those providers who "have an existing and continuous relationship with a patient" may be a challenge for rural and some regional communities, for those who infrequently see a GP, or who want to change practice or where access to a regular GP is more of a problem.

Data capture mechanisms, including identifiers for telehealth-enabled occasions of service, will be critical for service planning and continuous improvement, and should include information on what people want and view as providing value.

The continuation of telehealth MBS items across the virtual health care team will also need to reflect the cost of providing the service, enable and incentivise team-based care and represent value for money for patients and government.

For virtual health care to be introduced at scale to meet health system goals, patient and performance measures should be aligned and coordinated with other sectors.

Case study 5

Case study 5 describes a 54-year-old male with long standing bipolar disorder, who missed a face-to-face appointment with his GP for follow up of a medication change the previous month. He is casually employed.

After missing his appointment, the GP enquired after the man by phone, who then consented to a teleconsult, during which his symptoms were reviewed.

This initial teleconsult was followed with a weekly phone call to review his medication. The man was very appreciative of his GP calling when in his previous experience the GP themselves would not make usually contact if an appointment was missed. He has agreed to accept weekly telehealth to support his mental health improvement. This has also reduced his need to take time off work to attend the practice. His employer, aware of his bipolar disorder, is supportive of him accessing the GP using telehealth while at work.

Cross sector leadership and governance

Virtual health care is broader than just consultations by telephone or video conferencing. To be effectively embedded in the long term, virtual health care must be underpinned by decision making that is transparent, ensures community trust, and fosters collaborative relationships between clinicians and other health stakeholders (Case study 6).

This will require national governance that allows GPs to rethink the way cross-organisational services and joint actions are coordinated and regulated; and how outcomes are assessed for the patient, care teams and the system.

Mechanisms to harmonise regional and national governance responses must be entrenched and actively coordinated, including planning and monitoring. This will require joint planning and funding at a local level to drive the integration of virtual health care into care models and pathways.

Case study 6

Case study 6 describes a male aged 76 living with dementia for the past 12 months. He lives with his carer, a female aged 74. Both have been known to their GP for 30 years.

A male with dementia was initially brought to the practice for medication review, symptom review, symptom assessment and management. As the patient would get agitated both with travel to the practice and spending time in the practice waiting room, a videoconsult was arranged for 48 hours later to discuss the test results and review his behaviour.

During the videoconsult the man remained calm, which in turn visibly reduced his carer's stress levels. Over the following 2 weeks, a weekly videoconsult occurred to review symptoms and to provide support to the carer. Secure electronic messaging of these updates was sent to the geriatrician by the GP, which in turn triggered a phone review of the patient and clinical support for the GP. Medication changes occurred and a referral was arranged by the GP for the carer to receive counselling through Dementia Australia Carer Counsellor Support Service.

Conclusion

COVID-19 has created opportunities to change the Australian health care system for the better. For example, new MBS rebates for virtual health care. However, in order for changes to be of any real value to patients, service providers and the system, they will need to be embedded for the long term; and low value activities, which we have stopped, will need to be identified and not resumed.

Understanding what matters to people, and how the Australian health care system can respond through virtual health care is a good place to start.

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