

Maintaining Healthcare Delivery During Shutdowns

René Amalberti

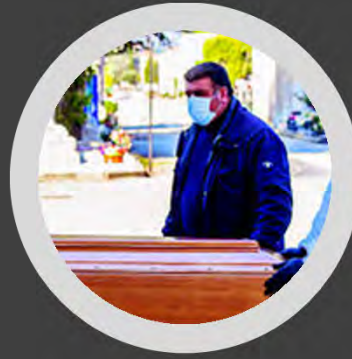
Prof, MD, PhD, director FONCSI, Senior advisor HAS

The reasons for shutdowns

- Pandemics
- Environmental disasters
- Wars

But also

- Isolated and deprived areas



Usual Negative Consequences of Shutdowns

- Interruption of routine care for chronic patients
- Major problems with emergencies
- Medical access made difficult or impossible
- Variable duration, critical point at two weeks off



The Impact of the COVID-19 Pandemic on Outpatient Visits

The number of visits to ambulatory care practices declined by nearly 60% in US and this is true worldwide

An estimate of 10% additional collateral deaths of severe chronic & cancer non-COVID patients after 3 months of shutdown

- Providers are deferring elective and preventive visits, such as annual physicals
- When possible, they are also converting in-person visits to telemedicine visits
- Patients are avoiding visits because they do not want to leave their homes and risk exposure
- Also influencing both provider and patient behaviour are the evolving local and state recommendations restricting travel and nonessential services

In French centers 100% dedicated to oncology, we note a drop of 20 to 50% in new cases, so imagine in general hospitals...

<https://www.ladepeche.fr/2020/06/03/des-milliers-de-morts-du-cancer-redoutes-level-collateral-du-coronavirus,891556z.php>

The number of visits to ambulatory practices declined nearly 60 percent by early April. Since that time a rebound has occurred, but the number of visits is still roughly one-third lower than what was seen before the pandemic.

Percent change in visits from baseline



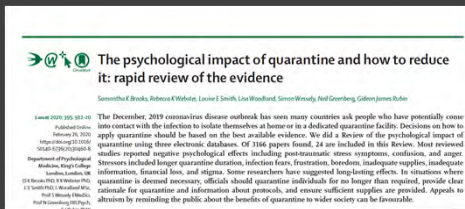
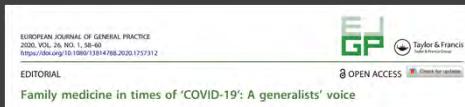
<https://www.commonwealthfund.org/publications/2020/apr/impact-covid-19-outpatient-visits>

Challenges of Medical Shutdowns

Old problems : The crisis highlights a number of inherent weaknesses in existing healthcare system

New problems

- Problems with accessing the essential resources needed to tackle this pandemic, with a lack of respirators, protective equipment and, above all, people.
- Clinical staff becoming infected resulting in periods of quarantine; some clinical staff paying the highest possible price – the loss of their life
- Growing Patients emotional problems associated with this crisis.
- New forms of stress for Doctors. Non-verbal communication, as well as physical examination, are essential tools to practice. The crisis impose to make decisions without seeing the patient and sometimes even without knowing him or her.
- Uncertainty of the situation heightened: very little knowledge about the disease caused by the virus. Unable to distinguish accurately clinically between those with a common cold or bronchitis, and those with a case of COVID-19.
- No idea how long this pandemic and the economic and social crisis accompanying it will last and it is unknown yet what toll it will take globally.



Adaptation & Coping Mechanisms

- **Demonstration of the medical profession's power to adapt, evolve and thrive, even in these times of unprecedented crisis.**
 - **Incredible solidarity and creativity. Hospitals reorganising at an impressive pace by creating new wards for infectious diseases and intensive care**
 - **Family medicine put at the centre of the health care system, even among countries with a health care system that traditionally has been hospital centred**
 - **National coordination centres being established**
- **Promoting community cohesion and building strong neighbourhoods**
- **Social media used not only to share emotions, but also to mobilise people to take action**
- **Impact and reorganisation of teamwork**
- **New guidelines developed by societies for family medicine and by professional expert groups at a speed unthinkable in normal times**



The Rise of Telehealth During the COVID-19 Crisis

Journal of the American Medical Association 2020; 323: 671-681
 doi: 10.1001/jama.2020.10007
 Advance Access Publication Date: 17 May 2020
 Perspective

Telehealth transformation: COVID-19 and the rise of virtual care

Jared Weisk,* Marat Fudin,¹ Blake Cameron,² Ziad F. Gellad,^{3,4} Ann Cho,⁵ Doran Pinsky,⁶ Simon Curtis,⁷ Matthew Roman,⁸ Eric G. Poon,^{9,10} Jeffrey Frenkel,^{11,12} Jason N. Katz,¹³ and James Tcheng¹⁴

*Division of Geriatrics, Department of Medicine, Duke University School of Medicine, Durham, North Carolina, USA; ¹Department of Neurology, Department of Medicine, Duke University School of Medicine, Durham, North Carolina, USA; ²Department of Geriatrics, Department of Medicine, Duke University School of Medicine, Durham, North Carolina, USA; ³Center for Health Services Research in Primary Care, Durham VA Medical Center, Durham, North Carolina, USA; ⁴Division of General Internal Medicine, Department of Medicine, Duke University School of Medicine, Durham, North Carolina, USA; ⁵Telehealth Services, Duke University Health System, Durham, North Carolina, USA; ⁶Thrombotic Stroke Clinic, Duke Health Access Center, Durham, North Carolina, USA; ⁷Duke Health Telemedicine Services, Durham, North Carolina, USA; ⁸Department of Psychiatry, Duke University School of Medicine, Durham, North Carolina, USA; ⁹Department of Medicine, Duke University School of Medicine, Durham, North Carolina, USA; ¹⁰Department of Psychiatry, Duke University School of Medicine, Durham, North Carolina, USA; ¹¹Department of Medicine, Duke University School of Medicine, Durham, North Carolina, USA; ¹²Department of Psychiatry, Duke University School of Medicine, Durham, North Carolina, USA; ¹³Department of Medicine, Duke University School of Medicine, Durham, North Carolina, USA; ¹⁴Department of Psychiatry, Duke University School of Medicine, Durham, North Carolina, USA

Corresponding Author: Jared Weisk, MD, Division of Geriatrics, Department of Medicine and Division of Geriatrics, Duke University School of Medicine, 2801 Erwin Road, Durham, NC, USA. jweisk@duke.edu

Received 19 April 2020; accepted 16 May 2020; published 17 May 2020

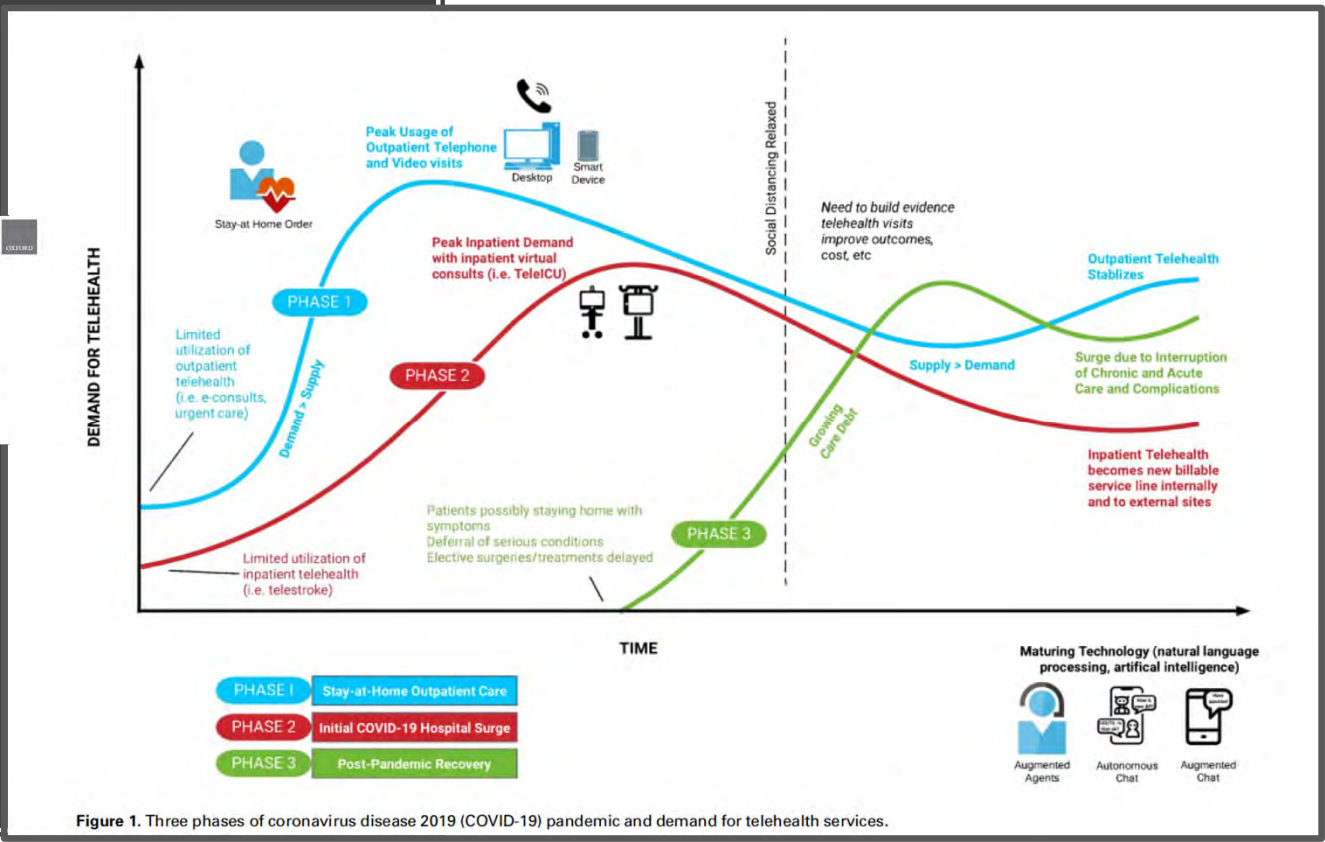


Figure 1. Three phases of coronavirus disease 2019 (COVID-19) pandemic and demand for telehealth services.

Video consultations in UK primary care in response to the COVID-19 pandemic

The COVID-19 pandemic has necessitated a rapid response from UK primary care services and has prompted practices to consider implementing alternative methods of remote consultation to minimise face-to-face visits. The recent guidance from Greenhalgh and colleagues¹ regarding the use of video consultations in primary care is therefore timely and has important practical implications.

The guidance offers a useful summary of situations in which video consultations may be appropriate for either 'COVID-related' or 'non-COVID-related' consultations and provides tips on which patients may not be suitable for video consultations. The authors also outline the steps involved in setting up a video consultation service and provide advice on how to perform an effective video consultation.



Most Utilized Areas of Telehealth in Time of Crisis

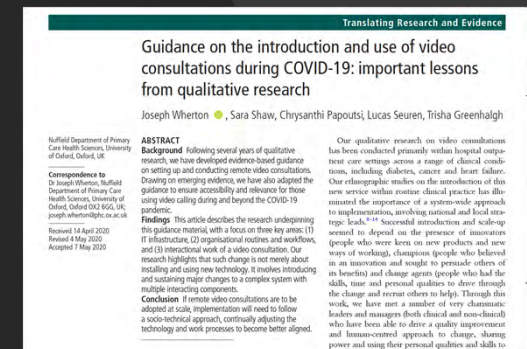
- Patient consultations, including drug delivery in sync with pharmacists
- Patient monitoring at home
- Social media and medical information sharing in time of crisis
- Medical video conferencing
 - Advent of the Tele-ICU. Small hospitals, largely unable to maintain a full retinue of intensivists, can take their ICU online to an intensivist staffed virtual ICU
- mHealth (mobile telehealth)
 - May be synchronous or asynchronous, but includes the essential video conferencing component



Telehealth: A Primer
November 2, 2018 - PSQJ1
By Dan Halpren-Ruder, MD, PhD
<https://www.psqj.com/analysis/telehealth-a-primer>

Learning to use Teleconsultation During the COVID-19 Crisis

- Three key areas
 - IT infrastructure,
 - Organizational routines and workflows
 - Interactional work of a video consultation



Telehealth as a Solution to Difficult Medical Access is not New

- Started in the 1940s
- Promoted in the 2000s by WHO and required by law in many nations as one of best solution for coping with the big changes occurring in healthcare
 - Massive aging, more patients at home
 - Critical medical demography
 - Isolated areas
- Recognized as safe and efficient enough
- But conditions for generalization not met before the COVID-19
 - Poor quality
 - Internet & digital divide
 - Payment scheme
 - Confidentiality

