


BRIEF COMMUNICATION

Rapid implementation of telehealth in geriatric outpatient clinics due to COVID-19

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telehealth, older people, geriatrics, coronavirus.

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The COVID-19 pandemic has resulted in the rapid implementation of telehealth. However, little is known about its suitability for the older population. We evaluated the use of telehealth in geriatric outpatient clinics. Half of the appointments needed to be rescheduled due to language barrier, poor connection, hard of hearing and inability to perform assessments. Advantages included time efficiency and ability to visualise the home. Preference for the future was initial appointments as face–face, but reviews as either telehealth or face–face.

During the onset of coronavirus disease 2019 (COVID-19), the Australian government recommended staying home and avoiding non-essential travel. There was also a rapid and widespread implementation of telehealth for health care delivery.¹ The magnitude of the switch allowed many people to continue to receive medical treatment without exposing themselves (or health professionals) to the pathogen.

The greatest risk for illness arising from COVID-19 is among older people,² but it is older people who have many other illnesses and are also the least digitally included age group in Australia.³ It is therefore critical that vulnerable older people are not left behind, as the larger community increasingly relies upon digital health technologies during crises. Therefore, the aim of this project was to evaluate the rapid implementation of telehealth in outpatient geriatric clinics at a tertiary public hospital in Victoria, in response to COVID-19. Specifically, we aimed to determine clinician satisfaction, barriers, enablers and preferences for future use.

Participants were geriatricians who worked in the four geriatric outpatient clinics at Peninsula Health, Victoria, Australia. The four clinics were: (i) geriatric medicine (GMC), which sees patients with multi-morbidity and complex medical/psychosocial issues; (ii) cognitive

dementia and memory service (CDAMS); (iii) chronic wound (CWC); and (iv) falls. For the month of June 2020, geriatricians were asked to fill in an online survey developed in Qualtrics at the end of each clinic. The survey included the following questions: (i) number of telephone and video sessions completed, number rescheduled due to technical issues and the number requiring further face-to-face follow-up; (ii) clinician satisfaction (10-point Likert scale) with patient communication and rapport, confidentiality, quality of the picture and sound and operational aspect (including booking and help with technology); (iii) degree of agreement (10-point Likert scale) if telehealth made it difficult to assess the patient; (iv) degree of difficulty (10-point Likert) to discuss sensitive issues such as capacity, advance care directives or driving; and (v) suitability of patients for telehealth (Y/N) and reasons. In July 2020, geriatricians were asked to participate in a ~45-min semi-structured interview over zoom about their experiences with telehealth including barriers and enablers, future needs and preferences. One interviewer (MC) transcribed responses. Quantitative and qualitative data were obtained and presented from both the survey and the interview. Approval for this Quality Assurance project was obtained from the Peninsula Health research office (QA/72141/PH-2020-243 515(v1)).

A clinician or administration assistant triaged patients to telephone, video or face-to-face. The most common reason for triage to telephone over video consultation was lack of, or inability to use, technology. Reasons for

Abbreviations: CDAMS, cognitive dementia and memory service; COVID-19, coronavirus disease 2019; CWC, chronic wound clinic; GMC, geriatric medicine clinic
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triage to face-to-face included complex health problems, hearing, visual or cognitive impairment, need to visualise the patient for assessment or patient preference. There were 24 survey responses reported on 55 sessions (18 video and 37 telephone). The greatest number of sessions was in GMC (total, 35; 9 video and 26 telephone), followed by CDAMS (total, 15; 7 video and 8 telephone); Falls ($n = 2$ video) and CWC ($n = 3$ telephone). Nearly half of the appointments were re-scheduled as face-to-face. Technical difficulties necessitated

rescheduling eight appointments across clinics. Other reasons for re-scheduling included non-English speaking backgrounds, hard of hearing, inability to adequately assess (e.g. visualise a tremor, assess gait, perform a cognitive assessment) or treat (hands on wound management) the patient.

Figure 1 shows the responses for satisfaction. Overall satisfaction with clinics rated a mean of 5.9 (standard deviation (SD) 2.3). Mean (SD) satisfaction for communication and rapport was 5.5 (2.5); quality of the picture

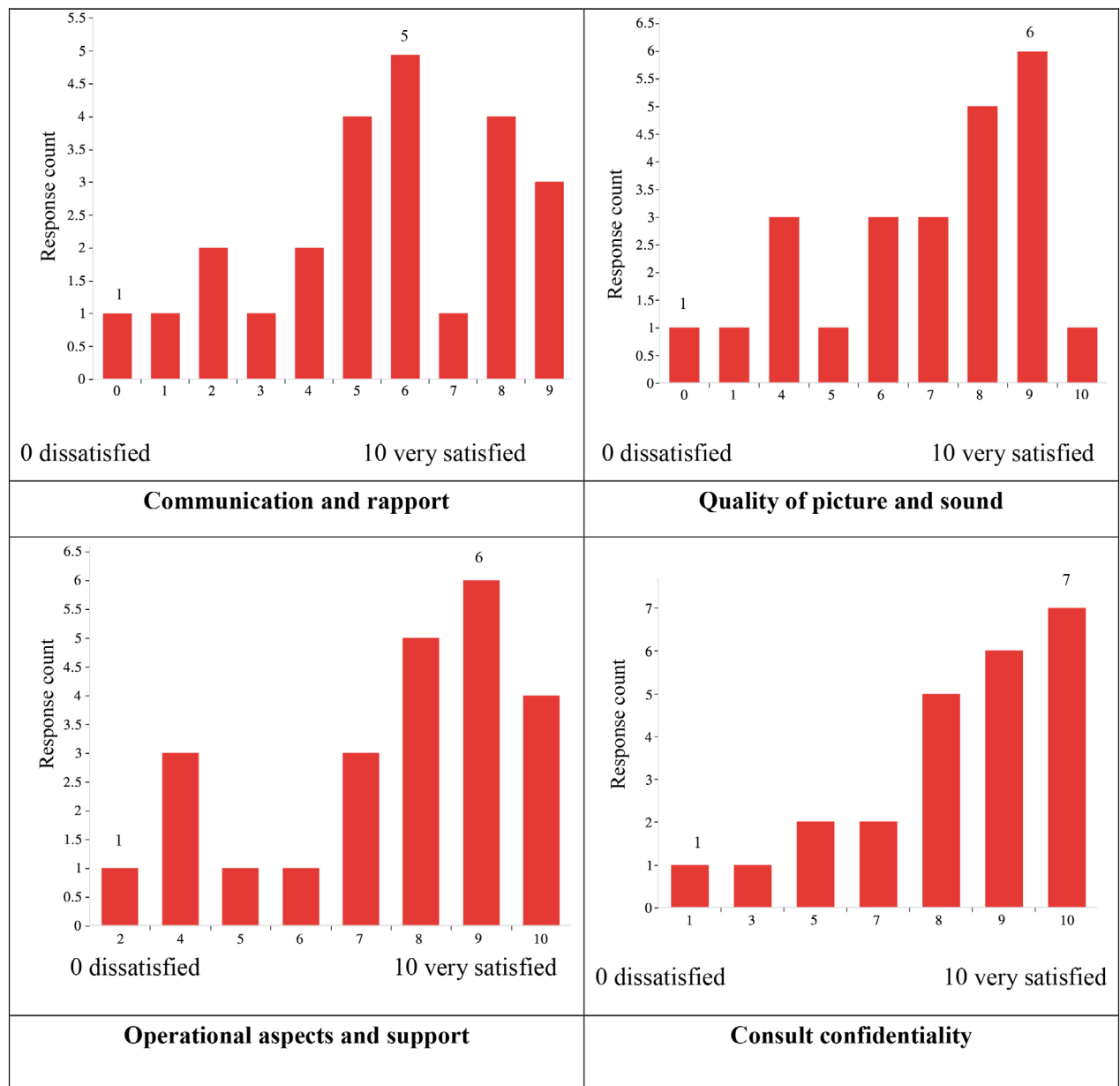


Figure 1 Count of responses to survey questions on satisfaction with telehealth.

and sound 6.7 (2.5); consult confidentiality 8.0 (2.3); operational aspects and support 7.5 (2.2). The average score for agreement (0 disagree and 10 strongly disagree) on difficulty in carrying out an assessment or management was 6.4 (2.9). Fifty-two percent responded yes to difficulty discussing sensitive issues using telehealth and rated this as difficult (mean 7.2, SD 1.4).

Interviews were completed with six geriatricians. Advantages to telehealth included time efficiency and flexibility, as they did not have to travel. Video had advantages over telephone in that they could 'see' into the home. For example, 'I could see the bathroom where they do the wound dressing', 'where they slept in a recliner chair' or 'the general cleanliness of the home'. Video had other advantages, such as 'better rapport and eye contact' as well as 'the ability to pick up on non-verbal communication', 'lip read if hard of hearing' or 'use demonstration if there was a language barrier'. Although many telehealth appointments were re-scheduled to face-to-face, some staff reported they were still useful to triage patients, provide advice on medications, educate patients about COVID-19, refer them for scans and get a family history. Clinicians also mentioned they believed telehealth advantageous for patients and family, as they could connect from home, work, inter-state or in one case even in hospital. Other believed benefits included '...comfort of own home, so they may do better', 'moving patients with dementia out of residential care can be disruptive – so visual and care staff's presence make telehealth a good option'.

Barriers to telehealth included poor triage of referrals leading to time inefficiencies, with one geriatrician reporting 'cost is expensive in consultant time if not suitable – and many weren't suitable'. Some clinicians reported patients or carers not prioritising phone calls perhaps not realising it was for more than just a quick check-in. Some did not answer or took them when they were out – 'one lady was in the car wash'. Rapport was sometimes an issue where 'they were annoyed with suggestions to reduce falls risk – I feel I could have calmed them if face-to-face', 'one hung up on me'. Other barriers included patient lack of technology, data, insufficient bandwidth, needing assistance with set-up or sensory impairments. Clinicians reported, 'Finding it really challenging to conduct cognitive assessments via videoconference, as often patients have hearing impairment and if their speakers or internet connection isn't good it's really difficult' or 'Harder for them to lip read as microphone covers my mouth'. Although having family could be helpful, one clinician reported 'It was easier for patients to cheat – my patient today was looking at a clock while drawing one, but I couldn't see what he was looking at, fortunately his daughter was cluey and informed me he was copying a clock he could see'. Job satisfaction and

telehealth fatigue were also mentioned, with one clinician reporting 'assessments were not as holistic' and 'job satisfaction not as good – miss face-face and can't do job quite as well'. The difficulty of training registrars was raised, with concern regarding the quality of training with a loss of face-to-face and having to be in a separate room to join the call due to social distancing requirements.

When asked about preferences post COVID-19 the majority of clinicians preferred a mixed model, with face-to-face for initial assessments and a choice of telehealth or face-to-face for reviews. However, sensitive or complex reviews may still need to be face-to-face. Several tips for using telehealth were suggested and these are summarised in Table 1.

Table 1 Tips and strategies for telehealth

Be prepared	<ul style="list-style-type: none"> • Patients/family need to be prepared to explain the format and reason for appointment • Patient might need to practise with administration before the appointment • Administration should remind patient and family of how and when you will call • Patients should be informed of any limitations or that they may need face-to-face afterwards to complete a consult • Information such as photos of wounds can be obtained before the consultation • Encourage family involvement if appropriate • Better referrals or information to triage to telehealth or face-to-face based on: <ul style="list-style-type: none"> ◦ Need for an interpreter ◦ Cognitive function ◦ Hearing ◦ Vision ◦ Need of physical assessment ◦ A carer or health service support ◦ Right technology and bandwidth ◦ Need to discuss sensitive issues
Communication	<ul style="list-style-type: none"> • Get patient to repeat information back and re-check at the end of appointment or ask them to write it down • Give opportunity to ask questions throughout • Look at camera and be more expressive to get the message across including careful placement of microphone to avoid blocking your mouth • If multiple people: practise bringing them in and decide who leads the conversation
Technology and data	<ul style="list-style-type: none"> • Use a lower bandwidth if platform allows • Quality headsets/microphones that do not cover mouth • A lending service for tablets and data • Education and training for staff by clinicians experienced in using telehealth and updates on new digital assessment tools

For further tips see IMJ telehealth series – for example References 4,5.

Discussion

This project evaluated geriatricians' experiences of using telehealth in outpatient clinics after its rapid implementation due to COVID-19. Approximately, half of appointments were rescheduled due to technical difficulties, patient-related factors or inadequacy for assessment. Satisfaction was average to good, with advantages including time efficiency and ability to see the home environment. Barriers were similar to reasons for rescheduling, but also included difficulty discussing sensitive issues, training registrars and job satisfaction. Tips and future preferences for telehealth were presented.

Telehealth provides a solution for delivering healthcare during COVID-19, as well as addressing barriers for patients such as long travel times or poor mobility.⁶ Patients and carers may also feel more comfortable in their own home with less disruption of routines.⁷ In this evaluation, time efficiency and location flexibility were reported as an advantage for staff. Although fewer video calls were utilised, clinicians reported a preference for this mode over telephone to facilitate assessment, rapport and communication. Others have also reported benefits of using video visits to check on safety at home including the ability to navigating obstacles, see how medications were stored and to assess the home environment.⁸

Satisfaction with telehealth was good overall, but slightly less than a recent review that found high patient and physician satisfaction for virtual geriatric clinics.⁹ This may have been due to the rapid implementation of telehealth. We identified several barriers to telehealth including reduced ability to carry out assessments, discuss sensitive issues, developing rapport and staff training. Perceived patient barriers included lack of suitable technology, insufficient data, or cognitive and sensory impairments. A study of older people (mean age, 79.6 SD) in the United States, estimated that 38% of older people were not ready for video visits due to inexperience with technology, and also not ready for telephone visits due to difficulty hearing, communicating or due to dementia.¹⁰ Taken together, our

findings, and those of others, suggest more support and equipment are required for older people.^{6,7}

Older people attending public hospital geriatric clinics often have multiple health conditions, are frailer than the general population, or may have low health literacy. Clinicians should expect they may require additional assistance with telehealth.¹⁰ Strategies identified to improve the use of telehealth included knowing who is suitable and for what aspects of care (e.g. history taking, rationalising medications, providing education), being prepared, greater training for both patients and staff, and using additional communication strategies. Greater training for staff is likely to improve confidence,¹¹ and in turn be important for uptake and acceptance of the wide range of emerging new digital platforms and assessment tools.¹² Strategies to improve patient uptake may require tailoring to the individual based on their interest and capability.⁶ Additional calls to provide training, having a back-up plan, borrowing devices from family,⁶ starting with telephone to facilitate confidence and rapport, or using familiar communication platforms and applications such as Whatsapp⁸ have been previously recommended.

Limitations of this project were its short duration, limited sample size and evaluation of a single health service. Strengths include review of telehealth in a real-world setting after rapid implementation. The focus on geriatric clinics, rather than a specific disease, meant that our evaluation may be more generalisable to older people with complex health problems who are also more likely to have difficulty with telehealth. Finally, this work could be strengthened by also evaluating the service from the patient perspective.

In conclusion, our findings identified benefits and aspects for future use of telehealth in outpatient geriatric clinics. However, policy-makers and clinicians need to acknowledge the difficulty that some older people will have with telehealth. Greater support or alternatives will avoid an inequitable health system.

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