

Remote shared care delivery: a virtual response to COVID-19

Care providers are adopting virtual consultations to mitigate the risks associated with coronavirus disease 2019 (COVID-19). Remote shared care delivery is one such model, which enables multiple patients to be seen at once, via virtual platforms. Outside of clinical medicine, use of remote shared service delivery has rapidly increased—eg, in education, where instructors with no prior online teaching experience have been quick to transition.

Clinicians can follow suit. In the USA, the Cleveland Clinic has offered in-person shared medical appointments (SMAs) since 1999, in which patients with similar conditions meet with a clinician simultaneously and each receives one-on-one attention. The SMA format allows patients to learn about their disease from both the clinician and peers. In India, Aravind Eye Hospital has successfully trialled SMAs for patients with glaucoma.¹

People who provide SMAs often report improved outcomes and productivity gains through eliminating repetition of common advice;² however, acceptance of SMAs has been limited by inertia among patients and

clinicians.³ In the current COVID-19 pandemic, embracing virtual SMAs has potential to enhance provider capacity while mitigating transmission risks and enabling privacy: identity can be withheld, voices disguised, and patient video made visible only to the clinician.

Providers experienced in both SMAs and telehealth can lead the way. The Cleveland Clinic offers virtual SMAs and is rapidly expanding their use.⁴ In India, Aravind Eye Hospital has provided telemedical appointments since 2004,⁵ group counselling since 1980, and is now considering opportunities to combine these models.

Through remote shared care delivery, specialists can efficiently advise many people facing cancellation of essential scheduled services. Clinicians can virtually monitor patients in many rooms (eg, in hospitals or in hotels converted into temporary field hospitals), remotely counsel infection-free patients on COVID-19 implications for specific chronic diseases (eg, in apartment building lobbies), or counsel people in their homes through loudspeaker-equipped vehicles (eg, in densely populated areas).

Remote shared care can help address the backlog of consultations building up because of cancellation of non-urgent services. Routine care of people with physical or mental

chronic diseases, and of pregnant women, which is more readily feasible through virtual SMAs, will help prevent future clinical events that require hospitalisation (figure). The shared care format enables patients to spend more time with their clinician and also to interact with one another, both of which can be calming in the current context of social isolation.

Unavailability of high-quality electronic medical records and remote monitoring equipment prevent certain types of virtual interactions—eg, diagnosing need for surgery. Universal barriers to providing virtual care include clinician acceptance (affected by a reduced ability to examine and test patients), patient acceptance, and insurance coverage. However, clinician training is being developed by National Health Service (NHS) England, NHS Improvement, and by the British Society of Lifestyle Medicine.

Technology firms can facilitate adoption of virtual SMAs by enhancing features around privacy and monitoring. The success of telehealth is already apparent in the COVID-19 pandemic. Looking ahead, both providers and patients must adjust their expectations and embrace remote shared care.

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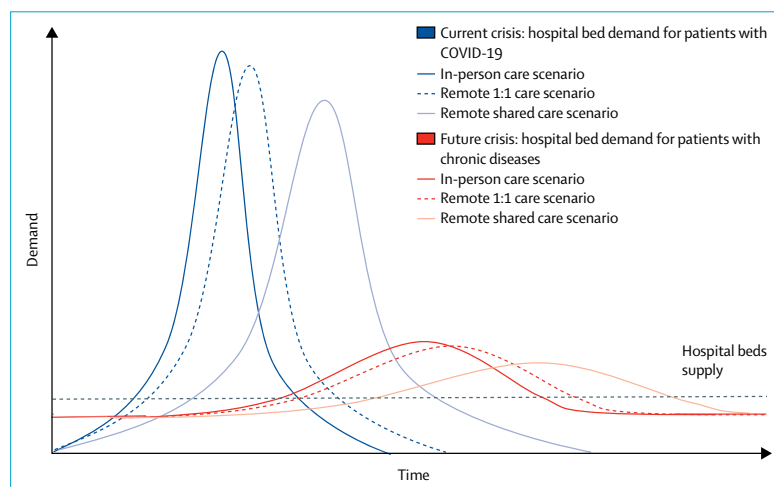


Figure: Hospital bed demand and supply for patients with COVID-19 and chronic diseases under in-person care, remote 1:1 consultations, and remote shared care delivery scenarios

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