

Discussion outputs from DIGITAL HEALTH LEADERSHIP SUMMIT, March 2021

Topic 10: Moving healthcare closer to home: What is working, what can we do differently, and does tech make access to home-based care better or worse for some?

This topic was discussed by groups in Auckland, Wellington and Christchurch.

Auckland delegates' responses

Barriers/challenges	<ul style="list-style-type: none">• People don't know what's available and what is working• Some people have resources and literacy to digitally enable people to live at home but not nationally available, so creates equity issues• How do you assess benefits gained home monitoring with respect to working our return on investment and application under a public funding model?• Can it be personalised enough to give people respect and dignity to live at home• Some concerns raised that there is no clinical trials/evidence of the benefits of tech-enabled home within the NZ market• Equity concern raised that not all consumers have Internet access and therefore the impact of digital literacy• Clinicians not all digitally literate• People can't get to hospital - distance, time, cost of taking time off• Health system designed to deliver people to health <u>not</u> health to people, supporting this is the workload factor that means clinician's time is stretched, and most efficient way is to bring people to them• People can't use devices/data to use telehealth or get remote care• Groups of people don't access health services until acute, then go to ED• Health professionals can't see patient notes/make notes in community = more wasted time and loss of confidence• Workforce not being well-utilised = clinicians too busy → HCAs could do more• Funding a big inhibitor; incentivises people to be seen 'in-person' at GP practise (potentially) than under a remote arrangement• Digital prescriptions have proven things can change relatively quickly if the need is there and has proven successful, in the most part• Consent and control of data – this is largely an unknown or unstructured area currently so can lead to reluctance to participate• Cost of tech → equity
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	<ul style="list-style-type: none"> • Health literacy or risk of over-reliance on tech leads to trust concerns by clinicians that consumers may opt to Dr Google without foundation of clinical opinion
Solutions/ideas	<ul style="list-style-type: none"> • It would be great to have a register giving some views on what is in general use in the market, ideally if this was centrally managed and maybe certified to remove concern over applicability and suitability • Free up capacity in system to send people into community/homes. Suggested option to look at models where GP extenders (Physician Associate) are used at to complete triage and complete remote consults • Recruit more health professionals to meet demand • Outreach clinic at schools/marae – but would require Co-design of services to ensure meets social / cultural aspects as well as medical • Portable patient records so people can view and enter patient data in community and suitable devices and connection • ‘Continuum of enablement’ → delivery of digital health services, depending on person’s digital literacy • Data/information flow is critical • Versatile with workforce • Use wearables to monitor in community • Better sharing of ideas nationally • Standardisation of what needs to be done to discharge home and keep people safe at home – potential to include tech as part of discharge process to enable extension of monitoring services into the home • Focus on outcomes not outputs! • Relationship building/time to support communities of care/share ideas, e.g., telehealth co-ordinators working together so don’t reinvent the wheel! • Health navigators to help work out holistically what people need for wellbeing • Open notes at GP clinic and make them meaningful and useful – it was discussed that a lot of practises do not enable the consumer access of visibility to their own records, some because of technology restrictions, some because they feel/fear risk of having to be transparent with notes, see spelling mistakes etc. • Continue to deliver ‘in-person’ interactions even when healthy in the home • Long-term conditions monitoring • Age appropriate or cohort communication to be relevant to get message across or benefit • Funding based on direct contacts → need to revise how can be done • MoH to fund a single system or state lead the requirement for standards or system/platform

Christchurch delegates' responses

<p>Barriers/challenges</p>	<ul style="list-style-type: none"> • Data/information flow is critical • A lot of practises do not enable the consumer access of visibility to their own records, some because of technology restrictions, some because they feel/fear risk of having to be transparent with notes, see spelling mistakes etc. • Thinking about moving healthcare closer to the home, how many of the group regularly use or don't use wearable devices and what is the underlying reason: <ul style="list-style-type: none"> ○ Wear: <ul style="list-style-type: none"> ▪ Goals, competition, motivation ▪ Like data, so wear ▪ Track health-fitness age ○ Don't wear: <ul style="list-style-type: none"> ▪ Want to be more present ▪ Don't want to be always booked into tech and digital devices ▪ Cost of them ▪ Don't like wearing watches etc. ▪ Rural/remove areas: Connectivity, equity issues ▪ Don't want to as worried about data privacy • Data: <ul style="list-style-type: none"> ○ Do we place value on this data (as a system)? ○ Is there trust around the use of this data, i.e., insurance company? ○ Are we collecting this data in the hope that it's going to be useful soon? ○ If we are going to use this data for things, is there consent and trust? • Inequity – people most in need of tech probably can't access it or use it. This is not insurmountable, just a challenge to solve • Emerging providers/vendors/suppliers have a larger focus on consumer experience over technical capability and can be limited to single use rather than cross functional at this point • Digital literacy vs. health literacy – both need to be lifted in order to move home are closer to the home as go hand in hand • Accessibility to data and what's useful for me – this can vary greatly based on age demographic as well
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- The workforces play a key role in educating the population – how confident are we that our health professional can use the emerging tech and or can support its implementation by giving confidence and trust to a patient/consumer?
- Funding between primary and secondary – need to figure out how to change as current is not sustainable to allow innovation into the system
- How to we educate the current and next generation of clinicians so they can trust tech to be a part of the treatment toolset?
- A conversational thread around the general topic of technology: How can we provide a consistent an accessible repository to list and track the tech trends, what is available and when
- How do we encourage preventative healthcare?
 - The tools that can be utilised cost \$\$ - who foots the bill, private vs. public - can they do anything because it is not going to be equitable?
 - How do we (as HCPs) engage with the patient and understand what their goals are
- IT system cannot initiate this change or lead the design as this as is a “Model of Care” change and needs to come from within the clinical communities
- What technology and services are more mobile now?
- How do we only take people to a hospital when it’s absolutely necessary?
- No structure in place to administer at scale
- Funding challenges continues to be a large obstacle in move care closer to the home:
 - Annual budgets do not allow for investment that will need to span multiple years
 - Love it or lose it structure of budget does not support innovation
 - Measured on output, not outcomes to again, inhibiting innovation
- Virtual consults – F2F:
 - Need balance
 - Issues with what tools were “allowed” to be used
- Lots of possibilities and opportunities but need to find and close with big challenge or requirement - how do we deploy them?
- Prevention health in the population is not limited to just the medical world or issues. They are just one part and need support across a whole range of social determinants
- There is still a part of the community, both consumer and clinical, that remains and/or requires that people come together. Bottom line, not everything can be virtual or remote - “Can’t beat being together”

	<ul style="list-style-type: none"> • Other terms/locations are clinician centric • What services are we sharing in the hospital that we could do in the home? <ul style="list-style-type: none"> ○ Different requirements based on conditions so may be challenging to enable fully for all people at home ○ Pakeha elder person often alone, so equity around digital literacy (as well as health) could be issue ○ Near home vs. in the home. Maybe there is a step in the middle to move to hub, such as marae, where access could be enabled. However, this could inhibit use as well if privacy becomes a concern – do I want my community knowing I am going to a GP? ○ People typically don't want HCPs in their home, prefer community somewhere ○ Don't want family knowing etc.
Solutions/ideas	<ul style="list-style-type: none"> • Free up capacity in system to send people into community/homes. Suggested option to look at models where GP extenders (Physician Associate) are used at to complete triage and complete remote consults • Recruit more health professionals to meet demand • Outreach clinic at schools/marae – but would require Co-design of services to ensure meets social / cultural aspects as well as medical • Portable patient records so people can view and enter patient data in community and suitable devices and connection • 'Continuum of enablement' → delivery of digital health services, depending on person's digital literacy • Versatile with workforce • Use wearables to monitor in community • Better sharing of ideas nationally • Standardisation of what needs to be done to discharge home and keep people safe at home – potential to include tech as part of discharge process to enable extension of monitoring services into the home • Focus on outcomes not outputs! • Relationship building/time to support communities of care/share ideas, e.g., telehealth co-ordinators working together so don't reinvent the wheel! • Health navigators to help work out holistically what people need for wellbeing • Open notes at GP clinic and make them meaningful and useful • Continue to deliver 'in-person' interactions even when healthy in the home • Long-term conditions monitoring • Age appropriate or cohort communication to be relevant to get message across or benefit • Funding based on direct contacts → need to revise how can be done

	<ul style="list-style-type: none"> • MoH to fund a single system or state lead the requirement for standards or system/platform • There is a need to understand and define what the data is and what it is going to be used for – is it non-clinical in nature and so may not always be available, leads to questions around storage and persistence • Could GPs or clinical teams prescribe tech as part of the process to keep or move patients home sooner? • About individual/consumer, rather than it being a clinical or tech conversation • Re-design of how consumer wants to interact will be required, for example, looking at current patient portals like MyIndici & ManageMyHealth, both are very limited in UX design and interaction and not designed from a consumer perspective • What data is valuable to go onto the record? • Will the specific/tailored platforms/apps make different contributions • What is working well at present: <ul style="list-style-type: none"> ○ Video consults for rehabilitation, lessening the need to travel to follow-up appointment unless required by treatment or physical need ○ Flexibility to providers allowing different approaches and potentially increasing efficiency but does require a change in management overhead to organise and ensure scheduling flexibility • Triaging and screening can be a strong use case for moving tech closer to edge, benefit both patient and provider, retention in the community and not into facilities • Working well? <ul style="list-style-type: none"> ○ Individual consults - wounds, for example ○ Community clinics ○ Nurse Maude or other in-home care services that extend beyond primary health ○ Some models for funding monitoring • Do we ask the patient, “What works for you?” • Virtual/phone calls helped. Broke the ice before F2F and gave patients less anxiety
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Wellington delegates’ responses

Barriers/challenges	<ul style="list-style-type: none"> • Manage My Health working for some, limited in use but offered some transparency to patient’s data • Telehealth working – major progress in this as result of COVID-19, however, general concern this would revert to pre-COVID limited use
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	<ul style="list-style-type: none"> • Health literacy key but also requires digital literacy to support a move towards the home • Technology only an enabler for systems change • Tidal wave of technology • Digital inequity/access and literacy • Availability vs. accessibility • What vs. “so what” • Proof of concept: <ul style="list-style-type: none"> ○ Non-regulated workforce employed across the primary health space and will need to resolve how to incorporate them into model of care so can support the growth in requirements on health system from aging population ○ ROI – years out ○ Siloed systems → move towards single point of truth ○ Access, consistency, and resources to support ○ Loneliness → changing conversation from “carers” to “community” → carer burnout ○ Strategic alignment and vision ○ Co-design and choice empowerment & whānau-centred care ○ Data self-ownership – understanding of what, how and why data sharing can occur • Initiative funding helpful (MoH) – needs central funding so innovation can occur in a market that is single funding cycle driven • Siloed systems → move towards single point of truth • Access, consistency, and resources to support • Loneliness → changing conversation from “carers” to “community” → carer burnout • Strategic alignment and vision • Co-design and choice empowerment & whānau-centred care • Data self-ownership – understanding of what, how and why data sharing can occur • Social governance • Embedding change – regression to the norm. Accessibility? • You don’t know what you don’t know – where do we go to find out what is available and how it is being used in a very fragmented and siloed system - even within a single entity and across the DHB boundaries • Less likely for clinicians to believe “non-tested” technology (but may rely often on subjective in other areas so how to break down these barriers to entry)
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	<ul style="list-style-type: none"> • Interoperability – across departments and DHB areas • ROI - \$ and funding cycles mean multi-year investment programs very difficult to commit to and achieve funding • Not consumer led • Digital literacy • Patient portal → patient owned data is working but limited and not consumer centric in design at this stage, a lot more could be done though current capability is limited in understanding across user population • Informed consent: <ul style="list-style-type: none"> ○ Safeguarding ○ Disabler, not consistent ○ Single point of consent
Solutions/ideas	<ul style="list-style-type: none"> • Health One identified as something that is working well with respect to an over-arching layer that has enabled data to be shared across primary and secondary health providers in South Island • eReferrals/diagnostics/e-prescribing • Keep it simple/co-design/care identity • Data portability/interoperability • Trust is key/whānau centred • Equity: <ul style="list-style-type: none"> ○ access: language, pockets, or technology, capturing the patient journey ○ ROI – often years out, does fit with current funding models ○ Trust ○ proof of concept across clinical areas could lead to wider adoption given no single or one-size fits all • Proof of concept: <ul style="list-style-type: none"> ○ Digital prescriptions ○ Funding must follow ○ Outcomes vs. outputs – whole of system ○ Health literacy and consumer empowerment ○ Co-design across groups to gain acceptance and uptake ○ Workforce and workforce development – communities? ○ Allied Health – focus more on prevention/wellness so fits in with remote patient ○ Monitoring and could be a lead area to prove models

	<ul style="list-style-type: none"> ○ Visibility and timeliness and access ● What's working? The following points/areas were provided as solid outcomes that have seen change over last 1-2 years. <ul style="list-style-type: none"> ○ E-prescriptions ○ Emailing/portal/Telehealth ○ Simple / consistent solutions leading to engagement of users – control/power/enablement ○ Digital leadership – banner removal, united voice/support ○ Using as an enabler ○ ROI – focus on prevention rather than reactive delivery of services ● Self-inputting data for monitoring ● Zoom pharmacy ● I-Moko ● Good digital change leadership ● Technology enabling the management of long-term/chronic health conditions – could be low hanging fruit to prove out models of care to move closer to home. Examples around diabetes and heart conditions that have shown how tech can support consumers remain healthy through remote monitoring and interventions in the home ● International models of best practice (Estonia) have shown how single systems can be implemented to enable patient data to become accessible across entire legacy health ICT systems ● Agile methodology – products over projects approach needed to make any progress, big bang approach will fail ● Strong standards needed to ensure privacy, consent and ownership are managed
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