Best Practice

Distant care and efficient planning

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NOG NEDERLANDS OOGHEELKUNDIG GEZELSCHAP

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1. Summary

This Best Practice document is meant to help telemedicine, distant care. In the Netherlands 7% of CO_2 emissions are attributed to healthcare, 22% of which to transport of patients and care workers. 38% is caused by estate related energy use, 3% by paper, and 22% by water, internal transport in hospitals and catering. Distant care and efficient planning can reduce this carbon footprint.

Telemedicine has more advantages though. It increases access to care, and it is a cost effective alternative to patient transport. It also reduces time and cost drag on society. Finally, telemedicine is part of the drive towards appropriate care.

The appropriate care movement looks critically at how care can be delivered differently, and challenge the status quo. This Best Practice will be helping to look into new models of care and hand examples.

2. Advice on distant care and efficient planning

Here we will give practical examples, and try to inspire new thinking in how care can be provided. Clinics and patient populations may be different so the same advice may not be applicable to each department, but similar principles can be applied throughout. Some examples are obvious, and some show that there are different ways of achieving the same outcome.

- Is physical presence of patients required at each consultation?
- Try and introduce as many 'one stop visits', where many appointments on different days can be done in one day
- Make sure the patient understands the meaning of physical consults and distant consults, and what they are meant to achieve [1].
- Discuss dilation requirement for next visits. If not, this saves on travel movements of accompanying persons/drivers.
- Organise care as close to patient's residence as possible: refer back to local care points: GP, opticians.
- Reduce travel of care workers and admin personnel: is home working possible? This may require planning of the type of work that can be done remotely on one day: tele-consults, admin, e-consults.

Care around cataract surgery

- Pre op one stop visits: consult, biometry, and planning next steps.
- Planning the post op check on the day of the second eye surgery
- Immediately Sequential Bilateral Cataract Surgery saves on 2 physical visits: one for operation and one for checkup
- See also 'distant care for cataract' by the Federatie Medische Specialisten [2], where it has been advised:
  - Diagnosis of cataract is not possible at a distance
  - Discuss with the patient if distant care can be used for discussions or giving results
  - Decide with patient if distant postoperative care is possible: checkup and complaints
  - 4 week checkup is not possible post-operatively

Care around intravitreal injections

- Try and plan such that diagnosis and actual intravitreal treatment can be done on the same day, saving an extra visit.
- Choose treat and extend and lengthen the interval of visits, and plan monitoring visits with treatment on the same day. This may save 1 or 2 visits per patient: see guideline nLMD 'behandelstrategie anti-VEGF medicatie' [3].

Care around chronic conditions

- Diabetic patients that have a medical consult: consider fundus photos at that visit, with optometrist or PA supervision. Patients under the care of the GP for diabetes, who do not have retinopathy yet, arrange screening with fundus photography [4].

Digital consultation

In this remit, more is possible between patient and doctor or between doctors, with or without the patient's presence. A phone consult can potentially replace initial visit as well as a follow up visit. Some conditions need to be met for such e-care contact, which are described on page 130 in the chapter 'eHealth' in the FMS registratiewijzer [5]. Outside the registratiewijzer, there are other options:

- In second opinions with digital images, initial consults can be done via video
- Results of tests should be discussed where possible on the follow up visit day or later via phone consult

Example from the UMC Utrecht
Teletriage team: optometry students with supervision. They assesed if patients follow up visits are required based on guidelines, and complaints. Some of the patients can be dealt with via phone (4%), or a colleague closer by their residence (13%), or not at all (6%) [25].

Financial implications.

- The first consult does not always need to be a physical consult (article 23 and 24 regeling medisch specialistische zorg [6]. This consult can be, according to the Nederlandse Zorgautoriteit be replaced with
  - A telephone consult
  - A video consult
  - A consult in writing (email, chat)

  Content wise and time wise the consult has to fulfil the same conditions as the normal physical consult, with documentation in the patient's file.
- Telephone follow up consultations can be registered as 'follow up consult', if the consult has been complete (history, conclusion, change in treatment).
- See also https://www.oogheelkunde.org/nieuwsberichten/regels-over-registratie-van-een-consult-op-afstand
- Instead of referring a patient to an academic/tertiary care provider, there is a billable possibility for a conference call with a recognised expert centre [7]. There are 2 care activity codes available (190174, 190175) for secondary care providers who consult with a VWS recognised expert centre in 'rare diseases' on diagnosis/ treatment. These activities can be added on by secondary care providers who subsequently arrange visits at the expert centre. These care consults can only be registered and billed for once in the care pathway. Expert centres can be found on a list, see [8].

3. Why distant care?

The Netherlands wants to be climate neutral by 2050 [9]. Reduction in carbon emissions will need to be 49% by 2030. This has been agreed in the Green deal sustainable care. The health council recently advised that sustainability has to be part of good healthcare [11]. To get to the required target, this means reduction in emissions of 6-8% annually. NOG has committed to this target. NOG members therefore all have to work towards this. Gupta consultancy has reported on healthcare impacts and how to change to achieve these targets [12].

CO_2 emissions in healthcare

Healthcare is responsible for 4-10% of carbon emissions [13-17]. In the Netherlands this is about 7% of national emissions [18,19], 22% of which by transport of patients are care workers. 38% is caused by estate related energy use, 3% by paper, and 22% by water, internal transport in hospitals and catering. Distant care and efficient planning can reduce this carbon footprint. Travel is mostly by car, and public transport could be used instead, achieving emission savings.

Appropriate care and reduction of carbon footprint

To reduce carbon emissions, 'appropriate care' is being focussed on. In short: right care at the right place. The Integraal Zorgaccoord (Integrated care deal) has stipulated that care should be digital, if possible, but physical if really required. This means preventing non value adding care, the right care in the right place, and more digital care. Telemedicine/ distant care saves travel. With the Carbon Calculator for remote care one can establish how much CO_2 emissions are prevented, through less travel.

Quick wins are possible

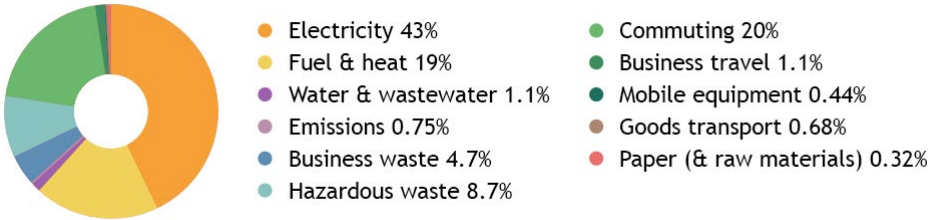
System changes are complex and slow, but what the covid pandemic showed us that quick changes are possible: needs, must [2,24]. A recent paper describes how the 'tele-triage-team' was developed: optometry students at UMC hospital Utrecht triaged patients on a waiting list under specialist supervision. Turns out that out of half the cases a non-physical alternative to physically attending for a consult.

Telemedicine makes an impact

Distant care increases access to care and offers society a more time and cost effective alternative to physical transport of patients [26,27]. Think also of the accompanying person's time, parking, days taken off work, and time spent [28,29]. In other words: telemedicine can make an impact. There are however also barriers to home health measurements. The guideline "Zorg op afstand" (see also acceptability, feasibility. And implementation) advises to think also about digital ability, and availability such as presence of IT modalitities to patients: PC, phone, webcam [2]. Therefore, some patients will not be able to do home measurements alone, though possibly they will with help of persons nearby. It is therefore incumbent on the care provider to think about this as well.

What does the patient think?

The patient federation in the Netherlands has reported on generic suggestions about telemedicine. See chapters 4 to 7 for conditions that need to be met for effective and deliverable telemedicine. 23,515 patients answered surveys from 2020 to 2022 about their experiences with telemedicine. It is rated as 7 out of 8: the experience is as good as the care where they are physically present. Flexibility and time efficiency is rated highly. Negatives are described as it being less personable and less fluent in communication.



4. Points of discussion, questions, ideas

To reduce our CO_2 emissions we need to be critical of the status quo, and change: look at new ideas, and new ways of working. This Best Practice gives us a push in to new ways of working, and hopefully inspiration. New knowledge and technology will open more new ways of working, and new processes unknown to us now. We would like to start discussion on new ways of working by offering generic suggestions to our carbon footprint problem, listed below. Please get in touch with us with more: duurzameoogheelkunde@gmail.com

- How to reduce patient travel?
- How to reduce careworker travel?
- How can we make digital contact smoother between patient and caregiver-suggestions are welcome
- How is digital care being stunted, by current regulation and guidelines or lack of infrastructure. And is there scope to remove these barriers?
- Can patients be diagnosed without examination? For example: herpes virus patients with or without complaints?
- Can IVI be done at GP practices?
- Online post op cataract check, with online eye test? [30]
- Stable glaucoma or at risk patients to be seen by the optometrist in the community? Because optoms cannot prescribe, this needs to be thought through, and planned well.

5. What is the status of Best Practice documents?

It is important to state that this Best Practice is advisory, and not mandated: it is not a guideline. A guideline is more or less binding, though one can diverge based on sound reasons. Best Practices are built on the foundation of guidelines, evidence based, and approved by the NOG.

Thus: one can diverge from Best Practice guidelines, though it is encouraged to implement these in your practice.

All guidelines will be incorporating, in the future, sustainability, and in so doing, converge with sustainable practice guidelines

This Best Practice is written for eye specialists and theatre assistants.

Best Practices contain many examples that can easily be implemented in current practice, without much ado. The documents are living documents, and so will change with new evidence surfacing.

Disclaimer:

- *None of the authors have declared conflicts of interest*
- *This advice has been collated based on evidence available at the time of writing*
- *This Best Practice is meant to support current processes, but is not a guideline*
- *Even though care has been taken to put this document together, the NOG cannot be held liable for it's contents.*

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