NZ TELEHEALTH
FORUM & RESOURCE CENTRE

From PASE to PACE:

responses from the sector to the PASE White Paper and recommendations for the establishment of telehealth models; an opportunity to improve access and equity of healthcare and to provide more clinician support.

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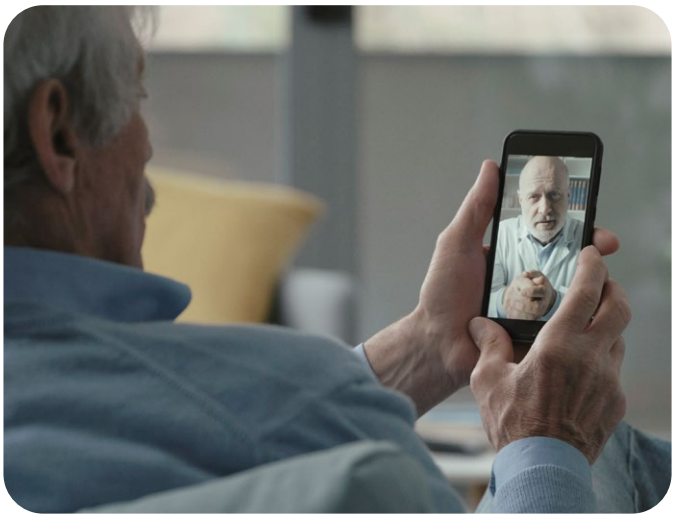
Executive Summary



The concept of Patient Anywhere, Specialist Elsewhere (PASE) was developed by the New Zealand Telehealth Forum (NZTF)[1] to describe the use of digital health pathways[2] to deliver the right healthcare at the right time by the right person. In September 2022, NZTF produced a white paper on the PASE model and sought feedback across the motu from members of the NZTF, clinical leaders and professional bodies.

The PASE paper explored the possibilities for Aotearoa New Zealand (NZ) to augment our current in-person health system with digital health technology, harnessing the power of the health system reforms and making use of over a decade of development work in the telehealth sector which has been enhanced during the pandemic. This report provides a summary of the feedback received on the PASE white paper and recommends next steps.

Feedback was received from individuals and key professional bodies in the healthcare sector. The feedback was overwhelmingly positive; however, important caveats were noted around implementation. Of note, the use of the term 'Specialist' in the acronym was generally narrowly interpreted as only specialist medical doctors. Correspondents pointed out this could be better expressed as 'Patient Anywhere, Clinician Elsewhere' (PACE) to better describe the multi-disciplinary pathways which the model enables and to be inclusive of all those who deliver healthcare.

Following the feedback on the PASE White Paper, NZTF make the following recommendations:

1. Development of a PACE model interlinked with Infrastructure projects for a national health record, national booking systems, regional commissioning, rural networks and local hubs.
2. Development of clinical efficacy and safety guidance for those practising telehealth, including telehealth-specific quality of care metrics and evaluation of outcomes.
3. Establishment of national programmes of telehealth as foundational programmes of work rather than fixed term pilots.
4. Integration of telehealth as a model of health care delivery targeted at increasing equity of access including upskilling of local workforces, both clinical and non-clinical health workforces, to support effective delivery.
5. Inclusion of digital health mode of delivery within existing clinical qualification curricula along with development of a nationally recognised micro-credential for non-clinical workers who support health care delivery in digital health literacy.
6. Establishment of a clinically led operational taskforce whose focus is the delivery of healthcare by telehealth, focusing on the areas identified in Te Pae Tata Interim Health Plan, to develop the PACE model.
7. Further work is done to consider a 'Clinician Anywhere Clinician Elsewhere' (CACE) telehealth model specifically for clinician-to-clinician support.

The Leadership Group within NZ Telehealth is made up of nearly 50 health sector experts and leaders from around Aotearoa New Zealand and is well-placed to provide the necessary support for the successful implementation of telehealth models of care.

[1] The New Zealand Telehealth is the advisory group convened in 2012 by MoH to provide clinical leadership in sustainable models of care enabled by telehealth that support equitable, patient-centred care.

[2] Telehealth is health care delivered using digital technology where participants may be separated by time and/or distance, including real time video or telephone conferencing, sharing of medical images to inform clinical care, and information via email or relayed by remote monitoring.

Introduction:

The PASE white paper described telehealth as a valuable tool that can improve access and decrease inequities for New Zealanders, supporting patients and whānau closer to home. There is both national and international evidence of effective healthcare models similar to PASE based on collaborative teams involving primary care clinicians, specialist doctors, nurses, allied health service professionals, and first responders. Telehealth implemented well and embedded into the healthcare system has been shown in national and international evaluations to reduce inequity of healthcare delivery and cost[3].

Over the past two years the NZ Telehealth Forum (NZTF) has seen a rapid growth in activity across the country and has supported clinicians to provide telehealth services to their patients. We have gathered extensive telehealth activity information from two National DHB Telehealth surveys (2014, 2019)[4], the NZTF working groups and communities of practice and national experts within the various NZTF groups. This body of evidence informed the development of the PASE model presented in the first white paper (Figure 1) and revised following feedback (Figure 2).

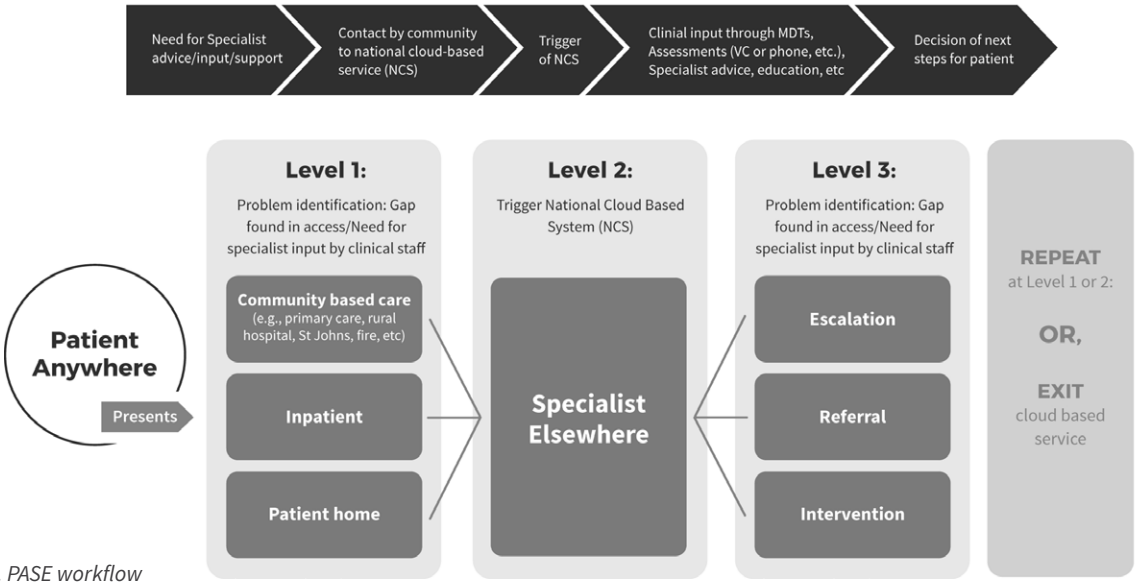


Figure 1. PASE workflow

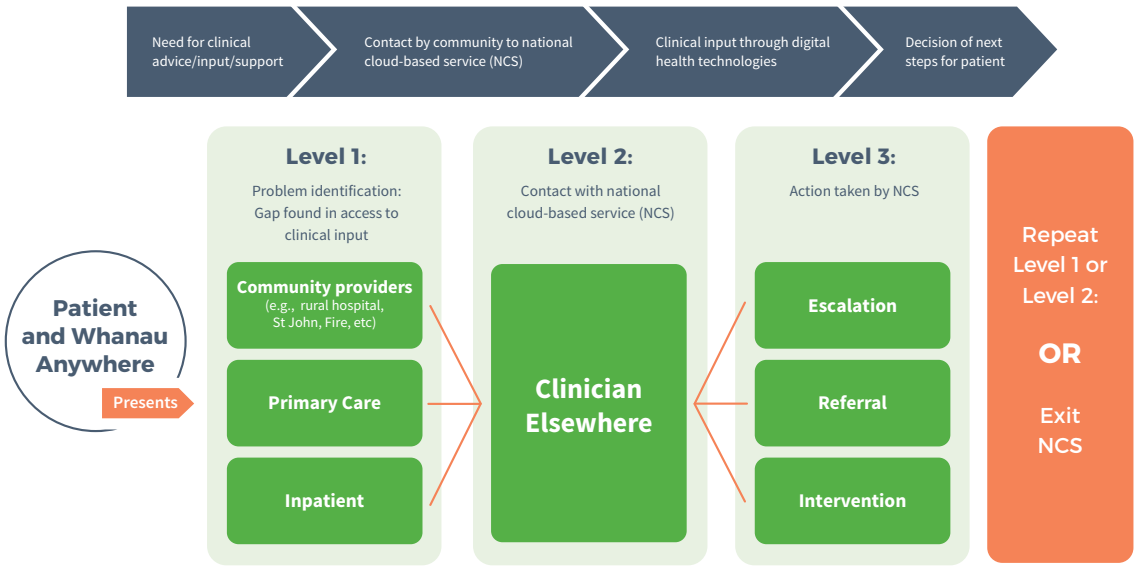


Figure 2. PACE workflow (a revision of the PASE model)

[3] Links to research and examples of projects and pilots in NZ are available on the NZTF National Telehealth Register.
[4] A 2022 survey is in process

Sector feedback on the PASE White Paper

The white paper received written feedback from 27 individuals and from the following professional bodies:

- Medical Council of NZ (MCNZ);
- the Royal Australasian College of Physicians (RACP);
- the Australasian College for Emergency Medicine (AECM);
- Association of Salaried Medical Specialists (ASMS);
- Royal New Zealand College of General Practitioners (RNZGP)
- New Zealand Nurses Organisation, and
- Allied Health Professional Leads of Te Whatu Ora Te Taki Tumai Auckland.

We also wish to acknowledge the active encouragement of our colleagues on the Board of Te Whatu Ora and Te Aka Whai ora and the inclusion of PASE in considerations by the Planned Care Workforce Taskforce in the Reset and Restore Plan.

Feedback gave wide support for telehealth as a specific model of care based on both NZ and international experience and identified a vast array of opportunities, along with some challenges for implementation, outlined in the following discussion.

Key positive themes

National implementation: the vast majority of feedback supported a national approach to improve consistency of quality and timeliness of care between and within regions, to address the healthcare 'postcode lottery', to improve access to rural and remote populations and to reduce cultural social-economic barriers to access. Success of a national approach was noted to rely upon the establishment of a national employer, national booking system and a shared health record.

Co-design to improve equity: systems should be developed with full consideration to Te Tiriti obligations to improve equity for Māori and these systems must be co-designed with Māori. Co-design also for other populations who experience inequity in the healthcare system to ensure telehealth models of care support improved equity and quality of healthcare.

Leadership: there should be strong national clinical leadership in the development of the model including clinical safety and risk frameworks, and operational models should be clinically led.

Good utilisation of scarce resources: whilst all feedback acknowledged that telehealth cannot, and should not, be a panacea for specialist workforce shortages, it can enable more reach of existing specialisation and services, tele-triage and more timely access to specialists, and better access to cultural matching of the needs of the whānau.

Opportunity to improve timely access to healthcare and better outcomes: reducing barriers to diagnosis through the reduction of travel (both clinician and patient travel) for rural populations, and working with populations with late diagnosis, for example, cancer screening for Māori and Pasifika. The use of remote monitoring tools can reduce unnecessary admissions, as can timely diagnosis and support (e.g. specialist to clinician or paramedic) in health emergencies.

Clinician to Clinician support: telehealth clinics can support clinicians to continue to work where they live and to see a geographically wider group of patients. Telehealth can enable clinicians who work in isolation to work to the top of their scope with specialist support. It can also enable afterhours cover, planned and unplanned leave cover for clinicians working in isolation and prevent the burn-out resulting from working alone.

Shared care models: increased opportunities for multidisciplinary care planning and care delivery beyond the physical team in any one setting. Supporting discharge planning between secondary and primary healthcare providers and involving remote members of the care team and whānau.

Improving rural care: providing referral to specialists/clinicians not available in region. Removing the 'round-trip' travel for a 15-minute follow up with their specialist, particularly for the patient and whanau where there are large distances, low mobility, limited access to transport, unaffordability of petrol and parking costs, alienation from the hospital environment.

Improving chronic care: reducing barriers to planned and unplanned engagement for chronic conditions requiring ongoing support e.g. taking a multidisciplinary approach, remote monitoring, health and mental health support through web-based applications.

Key themes of concern

The feedback received also noted a number or areas where telehealth could be a less effective and less available model than in-person care and noted a number of operational issues that need to be well managed. The themes of concern along with suggested mitigations are tabled below.

Theme	Concern	Mitigations
Limited scope of telehealth	Narrow interpretation of the model as 'access to a specialist' given that telehealth has a broader application.	Re-focusing from PASE to PACE to be inclusive of pathways across the healthcare workforce. Develop care pathways that incorporate telehealth engagement, electronic exchange of diagnostics, remote monitoring and improved care planning between health professionals involved in the patient's care.
Limited specialist resource	Transfer of specialist resource in short supply to a national resource; disruption to current pathways.	Smarter use of the available specialist resource in current location through remote consultations and better distribution of specialist resource via referral to a national cloud-based service (NCS). Improve equity of timely access to specialists through NCS referrals.
Emergency assessment includes physical exam and bedside tests	Telehealth cannot be equivalent or enhancement of current services in Emergency Department (ED).	Telehealth is not a replacement for ED but provides timeliness of assessment in situations where there is no ED / no available clinician on site.
Limitations of delivery of telehealth	Telephone interventions may miss important indicators essential to assessment and be an inferior experience of the clinician-patient relationship.	Telehealth clinical pathways identify suitability and management of clinical safety. Consider video rather than telephone to enhance engagement.
Limited access to telehealth	People without access to digital technologies and communities with poor infrastructure disadvantaged by lack of devices, data, broadband and familiarity.	Digital literacy training for support workers including cultural-specific and disability workforces. Devices and data (e·g· access to zero-rated data) provided to enable digital healthcare. Rural and remote hubs networked to larger health centres. Targeted approaches to specific populations e·g· digitally enabling marae and cultural-specific engagement practices.[5]
Telehealth scheduling constraints	Perception that administrators would be further burdened.	National booking system with a standard video conferencing system. 'Bundle' telehealth clinics in the weekly/monthly workflow.
IT infrastructure constraints	Poor access to technology for clinicians including system firewalls and poor IT department engagement.	Access to telehealth appropriate devices. Dedicated telehealth support available.
Patient hesitation	Patients may not want to engage this way.	Telehealth is an option for care and not a requirement of care. Patient hesitation may be experienced initially though a well-supported telehealth experience is known to build trust, confidence and improved access for the patient.
Clinician hesitation	A spectrum of views will exist within the clinical workforce with uptake dependent on the willing.	Only establish telehealth care pathways where equivalent value can be established. Establish telehealth skills as one tool in the mode of delivery toolkit. Build telehealth engagement training into the clinician's training as a national training module and ensure readily accessible telehealth CPD programmes. Clinician hesitation may be overcome by clinical pathway development and a well-supported telehealth experience.

[5] Telehealth as a tool for equity: pros, cons and recommendations, NZMJ 19 February 2021, Vol 134 No 1530

Concerns were also expressed about the potential for redistribution of workload for already pressured health care workers and note was made that services should be designed to augment and not replace in-person services. It was noted, however, that telehealth delivery by existing workforces is a more resource effective mode of health delivery. This is especially true for rural populations where clinicians and patients travel for follow-up consultations or for routine monitoring.

Conclusions on taking the PACE model forward

If we can establish well-embedded models for telehealth, then it is the view of NZTF that we will significantly improve equity of access to health resources and we will reap the most benefit from our health system for our communities.

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