VIRTUAL CARE IN SECONDARY STROKE PREVENTION
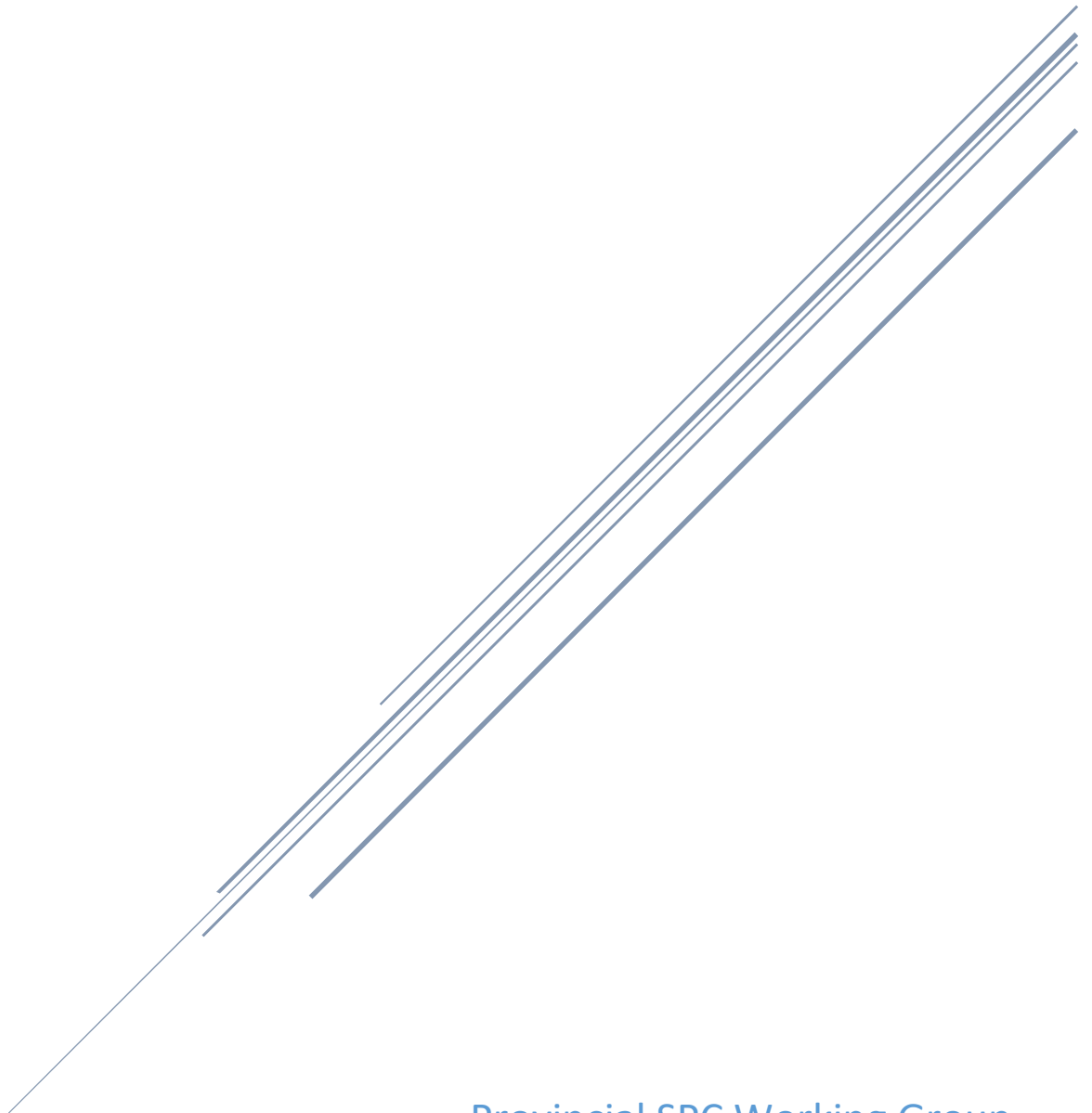
Considerations and Recommendations for Hybrid Models of Care

Provincial SPC Working Group
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Our healthcare landscape is changing due to the unprecedented impact of the COVID-19 pandemic. The ongoing fluctuations and disruptions of in-person care have led to new hybrid models of care in secondary stroke prevention clinics (SSPC). The way in which we deliver care and services may never return to our pre-pandemic state. Thus, there is an urgency to adapt to a new normal.

The hybrid model aims to determine which clinical activities are best delivered virtually while remaining in alignment with the Canadian Stroke Best Practice Recommendations for secondary stroke prevention. The rapid adoption of virtual care in Ontario's SSPC since the global COVID-19 pandemic has provided invaluable experiences and lessons learned.

Ontario's secondary stroke prevention provincial working group conducted an environmental scan to capture some of the virtual care practices in Ontario's SSPC between June and July 2021. The survey yielded an 80% response rate. Results of the survey indicate that 97% of the SSPCs have adopted virtual care within their clinic processes and practices. Virtual care is being used for both new and follow-up patients. With the various practice models and lack of SSPC-focused virtual care best practice guidelines, there is an urgent need to put forth considerations for a hybrid model of care.

According to the Canadian Medical Association (CMA), virtual care is defined as "any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication and information technologies, with the aim of facilitating and maximizing the quality and effectiveness of patient care."[1]

Disclaimer: While virtual care by phone is not recognized as best practice, there are examples of when it may supplement care delivery. See table 3 for examples of when it might be appropriate to use phone as a mode of care delivery.

HYBRID MODEL OF CARE

Hybrid models of care are still in the infancy stage and clinics continue to see fluctuations in care delivery models due to the ongoing pandemic. When determining the modality for delivery of stroke prevention services, the following factors should be considered: (i) the purpose of the appointment, (ii) safety and risk (can these be mitigated), (iii) patient preference and (iv) access. A combination of in-person and virtual care can be used to support ongoing clinic function while meeting patient needs.

One main consideration in the SSPC visit is the need for a physical/neurological exam which is ideally completed in-person. As per the CMA, "a physician must not compromise the standard of care. That means that if a patient whom you see virtually provides a history that

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[1] https://policybase.cma.ca/en/viewer?file=%2fdocuments%2fPolicyPDF%2fPD20-07.pdf#search=&phrase=false

requires a physical examination maneuver that cannot be executed remotely, you must redirect the patient to an in-person assessment". The CMA stipulates that "only history, gross inspection and/or data that patients can gather with cameras and common devices (e.g., glucometers, home blood pressure machines, thermometers and scales) can be delivered virtually. Additional virtual services may include

> • assess and treat mental health issues, provide travel medicine

> • assess and treat conditions monitored with home devices and/or lab tests (e.g., hypertension, lipid management, thyroid conditions and some diabetes care; in-person consultations will still be needed for some exam elements)

> • review lab, imaging and specialist reports with the patient

> • conduct any other assessments that do not require palpation or auscultation".

When resuming services, programs may initially be faced with challenging decisions regarding which patients should be prioritized to be seen in-person e.g. high-risk patient with new stroke symptom onset versus patient admitted to hospital requiring follow-up. The decision regarding which visit mode/format is most appropriate is a complex process and should be determined on a case by case basis.

Where possible, a virtual care priority decision making tool should be utilized to ensure that all patients have equitable access to best practice care. The virtual care priority tool should be utilized in conjunction with the SPC Referral Triage Algorithm to facilitate prioritization of clinical factors.

The following tables provide some key considerations when guiding decisions for the most appropriate mode of care delivery.

> **Decision regarding visit format should be individualized for each patient based on the suggested clinical requirements below. Patient preference should be taken into account if it is clinically safe to do so and there are no contraindications or risk for complications.**

TABLE 1. PRIORITIZATION LEVELS FOR IN-PERSON OR VIDEO VISIT
Determining Prioritization of Patients Who Are Appropriate for In-person Visit

PRIORITY LEVEL 1:

- New referrals where patients present with new onset high or moderate risk symptoms (MASH link)
- Referrals from any source (ED/community) and/or level A triage scale (hyperlink) still requiring further assessment or physical exam to guide diagnosis and treatment.
- New referrals where patients present with ongoing or worsening symptoms and those that have never had an in-person assessment.

PRIORITY LEVEL 2:

- New referrals with level B triage scale
- New referrals with complex risk factors that require ongoing management
- Abnormal test results that require urgent intervention
- Patients who require follow-up and there is a change in health status

PRIORITY LEVEL 3:

- New referrals from inpatient acute care with multiple co-morbidities
- Patients' preference, or patients with communication barriers (e.g. hearing/vision/cognitive impairment).
- Patients who require return to work or return to driving recommendations
- Patients who are emotionally distressed and cannot be adequately addressed via virtual care[2]

Implementation strategies

- Use a standardized triage tool (i.e. Triage algorithm) to manage incoming referrals.
- Establish a process to manage backlog referrals during fluctuations in service delivery (e.g. as a result of a pandemic) to ensure patients are seen in a timely manner.
- Consider plans to triage patients to determine need for in-person visit, video conference or phone call.
- Consider previously used triage algorithm to determine priority access and in-person care
- Regular contact for those on the third priority level to identify risk or change in priority level based on health status.

NB: Prioritization levels are based on current best practice guidelines. It is recognized that there are exceptions where video is being used in place of in-person visits due to geographical proximity and unique circumstances.

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[2] Dylan Blacquiere, Gord Gubitz, Amy YX Yu, Theodore Wein, Rebecca McGuff, Jillian Pollard, Eric E. Smith, Anita Mountain, M. Patrice Lindsay. Canadian Stroke Best Practice Recommendations, 7th Edition: *Virtual Care (Telestroke) Implementation Toolkit.* 2020; Heart and Stroke Foundation of Canada. Available at www.strokebestpractices.ca/resources

TABLE 2. DETERMINING VIRTUAL FORMAT

Determine the most appropriate virtual format for service delivery (video vs phone/or other)

A hybrid model of virtual care and in-person services should be considered as clinics continue to increase the number of in-person visits. Virtual care should be used when appropriate to support physical distancing, address potential staffing shortages, provide safer options for vulnerable populations, and support patient preference.

- Agreed service delivery model based on clinic structure and operations.

- Consider clinical appropriateness based on initial clinical presentation and risk.

- Consider patient safety - do the potential benefits of a virtual care visit outweigh the risks?

- Establish the purpose of consultation, needs and goals of the visit – e.g., initial assessment, diagnosis and management, follow-up, or ongoing monitoring.

- Consider the patient's ability to participate in a virtual visit (such as cognitive impairments, physical deficits, functional abilities, sensory or perceptual deficits, vision/hearing, communication/language, safety, and available assistance from family and caregivers).

- Consider patient factors such as demographic vulnerability (age, ethnic minority, distance, socio-economic status), physical and/or cognitive impairment, caregiver support, availability and comfort level with the use of technology.

NB: Consider patient preference only if safe to do so - but need to determine clinical appropriateness first!

Implementation Strategies

- Communication between team members to ensure collaborative decision-making for identifying patients who are appropriate for in-person, video or phone visits.

- Initial tests should be completed prior to a patient's virtual appointment.

- The following are factors to consider when preparing for a virtual visit and may require administrative support:

  o **Patients:** ensure patients are aware of the importance of attending the visit even if it is in a virtual format; they should be aware of the need to maintain privacy, safety and confidentiality; patients should be prepared for the visit by having their blood pressure measurement and medication list ready for review if possible.
  o **Technology:** assess availability and experiences with technology, set up, trial run to test speaker and camera.
  o **Environmental:** ensure proper camera location, sufficient lighting, safety, and privacy.
  o **Clinical:** medication reconciliation, medical history, relevant diagnostic imaging results and clinical notes. etc.), and inclusion of caregiver/family during visit (e.g. the patient

has the technology and if they need to be set up, will support the planning process for the patient/family, etc.)

- Consider goals of the visit and appropriateness of mode of visit.

- Consider patients' and caregivers' preferences and assess their comfort level with technology.

- Consider providers' preferences and identify the virtual care competency and training required.

- Regularly update clinical lists, including algorithms to determine which individuals can be seen virtually (by video) versus those that must be seen in-person.

Additional Considerations

- Data Collection: consider tracking mode of visit (specify video versus phone) for future planning and evaluation purposes- attendance, adverse events, etc.

VIRTUAL CARE VISIT MODE DECISION TOOL

Table 3: CLINICAL CONSIDERATIONS TO DETERMINE VIRTUAL MODE OF VISIT*			
A <u>VIDEO</u> VISIT MAY BE MOST APPROPRIATE FOR:		A <u>PHONE</u> VISIT MAY BE MOST APPROPRIATE FOR:	
Stroke patient with a recent discharge from acute care		Follow-up from an in-person SSPC visit requiring minimal assessment (at 3 and 6 month check-ins)	
Symptoms resolved (triage level B, or C or D or E) but require intake history and remote assessment to decide on medical work-up and management		Symptoms resolved (triage level B, or C or D and E) intake history with no virtual access	
A stable, routine assessment including administering outcome measures/ assessment/screening tools that may be appropriate to administer remotely		Follow-up of those with no reported changes to their medical or cognitive status since previous in-person visit	
Sharing of test results that require medication management		Sharing of test results (unless there are complex issues and further interventions are required immediately)	
Intake/history assessment for patients with symptoms less likely to be TIA		Linking and referring to other services	
New concerns identified by a primary care practitioner and/or patient/ caregiver		High functioning patients who are able to self-manage	
Pre-driving assessments (perceptual, visual, sensory and physical skills)		Medication reconciliation and refills	
Educational virtual group sessions			
*when in doubt, an in-person visit should be considered			

Patient Access & Preferences	YES	NO
Does the patient/caregiver have access to the required technology? - Phone; or - Device offering video (webcam/microphone/speakers) and stable internet		
Does the patient/caregiver have the cognitive capability to participate in a virtual visit?		
Does the patient/caregiver have the digital literacy/comfort to participate in a virtual visit?		
If "no" to any of the above questions, an in-person appointment should be considered.		
Does the patient/caregiver have a preference for virtual visits due to in-person appointment challenges (e.g. transportation, mobility, accessibility of caregiver or translator, etc.)?		
Does the patient/caregiver have a preference to virtual visit due to being immunocompromised		
If "yes" to the above question, a virtual visit should be considered wherever possible.		

References and Guidance Documents

https://policybase.cma.ca/en/viewer?file=%2fdocuments%2fPolicyPDF%2fPD20-07.pdf#search=&phrase=false

Dylan Blacquiere, Gord Gubitz, Amy YX Yu, Theodore Wein, Rebecca McGuff, Jillian Pollard, Eric E. Smith, Anita Mountain, M. Patrice Lindsay. Canadian Stroke Best Practice Recommendations, 7th Edition: *Virtual Care (Telestroke) Implementation Toolkit.* 2020; Heart and Stroke Foundation of Canada. Available at www.strokebestpractices.ca/resources

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