Practice changes and attitudes toward remote care following COVID-19 restrictions

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Introduction

- UK lockdown guidance in response to COVID-19 stated *'However, all are called to stop routine face to face services. It should be noted that where services can be adapted and delivered remotely, this should be the preferred choice'* [1]
- Rapid changes in clinical practice were thus required. Face-to-face care was almost entirely brought to a halt. Remote care became a necessity.
- To identify barriers and facilitators of remote care in audiology we conducted a survey of audiologists practicing in the UK during spring 2020

Methods

Survey

Closed-set (answered on a 5-point Likert scale) and open-ended questions that addressed:

- Practice patterns prior to COVID-19 restrictions
- Service provision during COVID-19 restrictions
- Experience with remote care
- Opinions about remote care for patients and service provision

Procedure

Data collection: 29th May to 15th June 2020

A link to the survey was emailed to audiology networks and professional contacts, and was posted on social media sites.

Participants

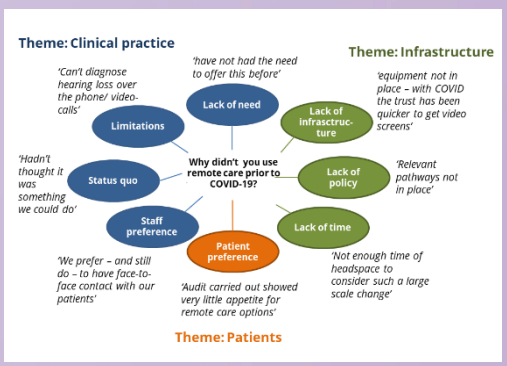
- 120 audiologists practicing in the UK.
- They provided paediatric care (75%), adult initial evaluations (57%), adult hearing aid fittings (58%), tinnitus care (53%(0 and vestibular care (38%).

Results

Respondents' use of remote care

- Prior to COVID-19: 32%
- At time of survey completion: 98%
- Intent to continue using: 89%

When asked why they had not previously used remote care, content analysis of open-ended responses uncovered three themes (Figure 1). Example quotes are provided.



Practice patterns during COVID-19 restrictions

Table 1 shows practice patterns for different patient populations/appointment types during COVID-19 restrictions. It illustrates that:

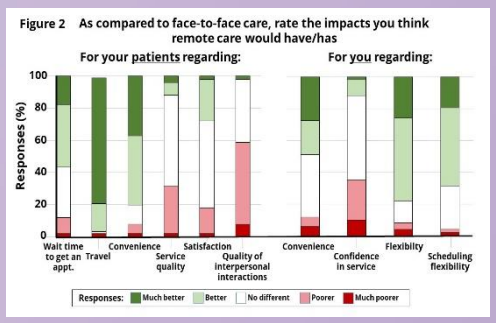
- Care as usual was rarely provided
- The majority of appointments were put on a waiting list but this varied by type of service
- Use of remote care different across population/service type with almost twice the proportion of audiologists offering it for tinnitus care as for all other types of care
- 'Other' care approaches offered included working with teachers of the deaf, 'doorstep' hearing aid drops, hybrid appointments (e.g. remote history combined with in-person evaluation.

Table 1. Management approaches taken during COVID-19 restrictions. Percentage of audiologists who managed more than 25% of their patients using each approach. Number of respondents in parentheses.

	Management approach used					
Patient population/ appt. type	Saw patient as usual	Rescheduled appt.	Put on a waiting list	Offered a remote care appt.	No alternative arrangement	Other
Paediatric	0% (46)	26.8% (41)	75.6% (45)	39.1% (46)	6.1% (33)	22.2% (18)
Adult initial evaluations	2.3% (43)	2.6% (38)	90.2% (41)	39.0% (41)	12.5% (32)	27.3% (11)
HA fittings & f/u (adult)	0% (40)	21.6% (37)	85.4% (41)	34.9% (43)	12.5% (32)	7.7% (13)
Tinnitus care	2.8% (36)	25.8% (31)	62.8% (35)	65.7% (35)	11.1% (27)3	0.0% (10)
Vestibular care	4.2% (24)	18.2% (22)	88.0% (25)	29.1% (24)	0% (16)	0% (7)

Opinions about remote care

Opinions about the impacts of remote care for patients and audiologists were mostly positive (Figure 2).



Respondents who thought remote care would have detrimental impacts were asked to explain why.

Content analysis of these open-ended responses revealed that impacts on quality of personal interactions, and the quality and confidence in services , would be poorer/much poorer due to: *(quotes in italics)*

- **Lack of non-verbal cues and hearing loss will impact communication**. *'It's harder for both the pt. and the clinician to read each other.' 'Harder to communicate with the hard of hearing remotely.'*
- **Limitations and fear of technology**. *'A feeling of not being able to show some complex things very well to patients.' 'Many patients and staff are scared of technology or don't have access to it.' 'Technology break down issues primarily.'*
- **In-person care 'being better' or preferred.** *'I like the personal interaction I have with my pts and the counselling opportunity.' 'Always better to converse face to face.'*
- **Clinical limitations.** *'Not able to offer testing, adjustments of hearing aids, etc.' 'Lack of verification options.'*
- **Patient preference.** *'Many of our patients have not wanted to try video and would rather wait an unknown length of time'*
- **Lack of experience.** *'It all feels a bit like a game at present; like we're just tinkering with our job.' 'Hopefully the confidence will increase as time goes on and we all get used to providing services this way.'*

Many respondents reported having had good experiences with remote care and plan to continue using it in the future. *'It has been very positive and I feel we require to keep aspects of this going forward.' 'Overall it has been refreshing to know we can still help pts when we are miles away.' 'This is an opportunity to develop our role to best serve our patients.'*

Discussion

Practice patterns changed dramatically following lockdown. Provision of remote care increased, while face-to-face care became almost non-existent. Similar occurred in other medical fields[2,3].

Management of the situation differed by patient population. Choices made likely reflect real and perceived limitations of remote care combined with knowledge about the urgency of interventions and impacts of delayed treatment.

Two major barriers to use of remote care are (i) Inability to compete number of clinical procedures, and (ii) a lack of infrastructure. Until technological innovations overcome the former and policy changes overcome the latter, these barriers will remain.

Nonetheless, many respondents reported positive experiences with remote care - some of which have been noted elsewhere[4].

In sum, audiologists have generally positive opinions about remote care, but improvements to infrastructure are necessary. Further, for the foreseeable future, the inability to complete some clinical procedures remotely necessitates access to hybrid-care pathways.

For more details see: Saunders & Roughley. Int J Audiol. 2020 Sep 10:1-8. doi: 10.1080/14992027.2020.1814432

References

[1] Joint Guidance from the UK's professional Bodies. 2020. http://www.thebsa.org.uk/wp-content/uploads/2020/04/COVID-19-joint-guidance-8-4-20.pdf
[2] Madden et al. Am J Perinatol. 2020;37(10):1005-1014
[3] Yellowees et al. Psychiatr Serv. 2020;71(7):749-752
[4] Singh et al. Int J Audiol. 2014;53(12):850-860.

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