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COUNTRY VIGNETTE

# LITHUANIA

## Transforming primary health care during the pandemic



## MULTI-DISCIPLINARY PRIMARY HEALTH CARE DURING THE COVID 19 PANDEMIC: IMPROVING ACCESS THROUGH REMOTE CONSULTATIONS

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## MOTIVATION

Lithuania has a strong tradition of family medicine–based primary health care services delivered through multidisciplinary teams. Primary health care is well recognized by people as the first contact with the overall health-care system and plays an essential role in coordinating care and ensuring evidence-based clinical pathways. Before the COVID-19 pandemic, 57% of all outpatient consultations were with family physicians and 98% through direct consultations. Remote consultations played a small role, although they were implemented in 2018. Since then, family physicians have provided one repeat prescription to follow up the prescription given at the direct visit.

With the COVID-19 pandemic, Lithuania, like other countries, introduced strict public health measures including lockdown physical distancing and limits to movement, making primary health care services less accessible through direct consultations. Although people and primary health care providers were not used to remote consultations, the Ministry of Health introduced measures for a quick transformation of the service delivery model from direct to remote consultations, aiming to mitigate and maintain physical distancing during the pandemic. Lithuania serves as a good example of rapid transformation, adjustment and agility, enabling primary health care to contribute to strong public health measures while also ensuring a dual-track response to the pandemic. Overall, the pandemic challenges have served as a good opportunity to scale up remote delivery of primary health care services provided by multi-profile primary health care teams, including for people with complex health needs, including COVID-19.

## TRANSFORMATIONAL INSTRUMENTS AND POLICIES

The transformation of health services required prompt and timely changes in the legal framework: involving legislation of remote consultations for primary health care team members, doctor-to-doctor consultations and payment schemes. The Ministry of Health made rapid changes to the legislative basis, aiming to shift from in-person consultations towards remote ones. These transformations were initiated by the Prime Minister's office through multilevel governance mechanisms under the leadership of the Ministry of Health and including other ministries, municipalities and other stakeholders. The main changes for primary health care were operationalized by the Family Medicine Committee under the Ministry of Health. The Family Medicine Committee included representatives from the Ministry of Health, members of the National Health Insurance Fund under the Ministry of Health and representatives of the professional primary health care organizations such as family physicians' societies and experts in family medicine. This multilevel and multistakeholder approach led to better communication and mutual agreement on decisions and ultimately contributed to wide acceptability of the legislative changes. In addition, a newly developed national connection network between the Ministry of Health and the municipalities was established. As the scope of changes during the pandemic was based on the rapidly changing epidemiological situation within municipalities, introducing these networks was a good tool for circulating information from the Ministry of Health to primary health care centre managers. The rapid changes had to be aligned with public awareness campaigns.

The biggest change was the legal framework for introducing remote consultations: for example, for remote e-prescriptions, e-referrals were performed by the orders of the Ministry of Health. However, coordination was needed with other ministries, for example, with the Ministry of Social Affairs on remote issuing of e-sick leave for patients' isolation and treatment purposes and with the Ministry of Education for extending deadlines for preventive child check-ups before school.

Implementation of remote consultations required intensive discussions with both professional and patient organizations to address strong perceptions that only direct consultations reflected good quality of care, supported by traditionally used guidelines and approaches to training. Overcoming these barriers was especially important for mental health services to increase access for people with mental health problems and for people with mental problems brought about by the pandemic.

## IMPACT OF POLICIES IN THE DAILY PRACTICE OF PRIMARY HEALTH CARE TEAMS

Remote consultations were developed in March 2020. All primary health care team members, including family physicians, nurses, social workers, physical therapists, advanced nurse practitioners and lifestyle specialists, shifted towards remote consultations. Direct consultations were possible after patients were triaged through telecommunication with primary health care providers: for example, due to exacerbation of chronic conditions and/or for laboratory and diagnostic tests.

The pandemic necessitated revising team roles and responsibilities due to massively increased workload. For example, it accelerated the expansion of the autonomy of nurses through task shifting. Nurses started to consult their patients by phone more autonomously and were directly involved in managing patients with chronic conditions and those diagnosed with COVID-19. In cooperation with family physicians, nurses were enabled to continue with e-prescription extension.

Primary health care services were even expanded during the pandemic based on doctor-to-doctor remote consultations in which family physicians had the opportunity to consult with narrow specialists on complicated cases. It was a crucial component aiming to deliver a safe decision support system for family physicians delivering a wider range of services remotely. This improved access for patients to a more comprehensive set of primary health care services without having to consult the secondary level.

Primary health care increasingly contributed to managing people with COVID-19. When the pandemic began in March 2020, the role of primary health care in COVID-19 management was limited to remote consultations for people with COVID-19 symptoms or those diagnosed with COVID-19. Patients with fever and symptoms of acute infection attended the newly established outpatient infectious ambulatory clinics, at least one per municipality, and emergency departments. These shared clinics were operated through the pooled human resources of all public and private primary health care facilities. Primary health care team members were responsible for evaluating patients' health condition, triage, treatment and consultations regarding self-isolation.

During the second pandemic wave from 7 November 2020, primary health care centres' involvement in COVID-19 management became more significant: they started to provide in-person COVID-19 diagnostic and treatment services through mobile primary health care teams or in reorganized primary health care settings.

The scope of primary health care services and level of disruption in the delivery of essential services depended on the COVID-19 epidemic situation across municipalities. The reporting system and monitoring of remote and in-person consultations proved to be necessary to track access and disruption. The special coding of remote consultations presented at the primary health care level was a good tool to identify the primary health care providers and municipalities that struggled to restart in-person consultations after the lockdown ended. Patients were afraid of acquiring COVID-19 and preferred remote consultations versus in-person consultations in health-care centres, and that mainly related to the numbers of COVID-19 cases in municipalities. Primary health care providers had to make additional efforts to actively invite patients for direct consultations.

**Box 1. The successful arrangements of the new way of working in primary health care practice and transformation in primary health care centres depended on the primary health care managerial capacity**

**Key tasks of primary health care managers included:**

- transforming and adopting the continual changes presented by the government into everyday practice, including improving the skills in the use of eHealth portals and timely information sharing and education of all primary health care team members;
- managing the increased workload: primary health care providers had to solve the questions of people with COVID-19 about isolation and their treatment and continuing to deliver essential health services, giving priority to patients with multimorbidity;
- reorganizing the delivery of primary health care services: new registration and patients' triage system (differentiating consultation type: in person versus remote) and revising task profiles for primary health care team members (such as isolation and health-care plans, close monitoring of health condition when diagnosed with COVID-19 and identifying vulnerable patients and initiating remote consultations); and
- ensuring the safety of patients' data: for instance, integrating eHealth platforms into personal computers and performing consultations using mobile phones and social portals.

## ADDITIONAL REMOTE SERVICES TO SUPPORT PRIMARY HEALTH CARE AND INFORM THE POPULATION

Making people aware of the new model of health care service delivery and getting them to accept the newly presented pathways were challenges. The dissemination of reliable information for the general public (and for the health-care providers) was presented in newly developed platforms by the Ministry of Health, such as Korona Stop (https://sam.lrv.lt/en). Two call centres were established. Call number 1808 aiming to increase access for the people with COVID-19 symptoms, minimize the workload for primary health care providers and coordinate patients' pathways. Call number 1809 is a support line for people with mental health issues. These centres, through remote consultations, were responsible for organizing COVID-19 testing, explaining isolation principles and sharing the information about isolation principles to affected foreign countries. The huge support of human resources for these call centres was provided by trained volunteers such as medical students, resident doctors, soldiers and ambulance personnel.

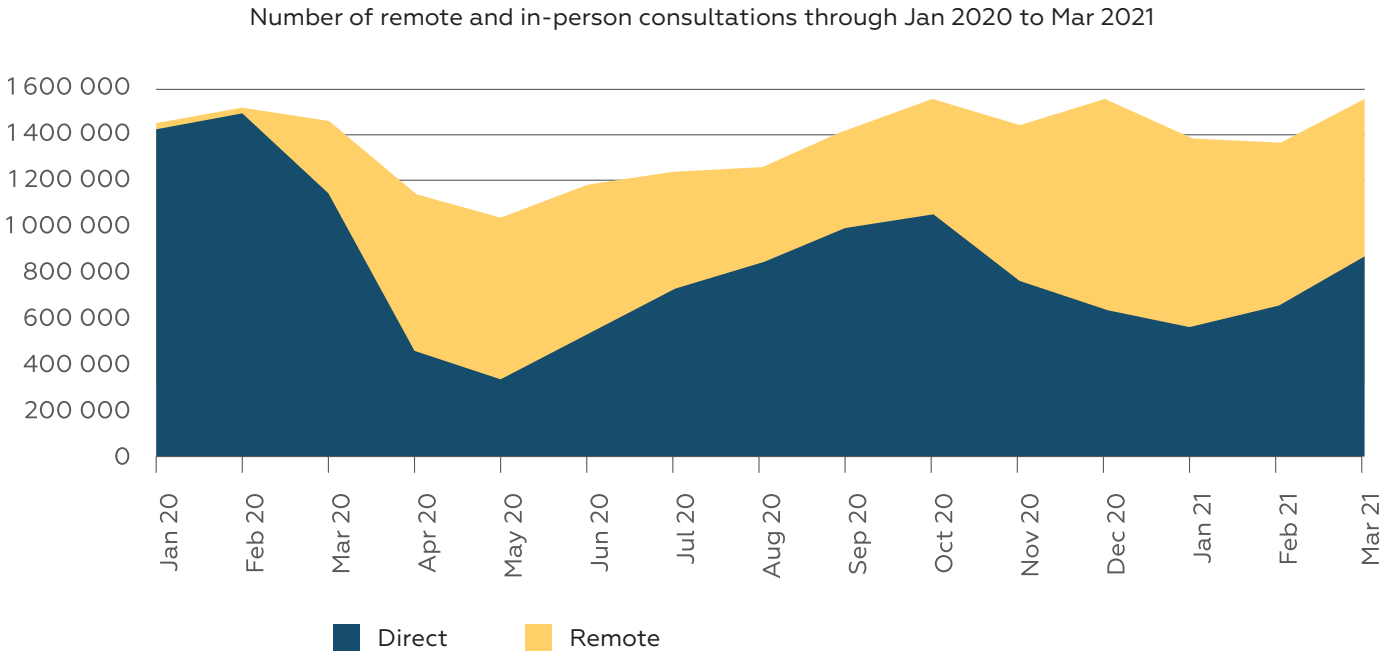
**"THE PANDEMIC NECESSITATED REVISING TEAM ROLES AND RESPONSIBILITIES DUE TO MASSIVELY INCREASED WORKLOAD. FOR EXAMPLE, IT ACCELERATED THE EXPANSION OF THE AUTONOMY OF NURSES THROUGH TASK SHIFTING."**

## EARLY ACHIEVEMENTS

The number of remote consultations increased as the number of COVID-19 cases increased (Fig. 1).

The number of remote consultations led by nurses increased, and the number of consultations performed by family physicians declined. The total number of consultations performed by family physicians decreased by 5% — from 1.13 million in January 2020 to 1.073 million in January 2021. During the same period, the number of consultations performed by nurses and community nurses increased by 400%, from 17 000 in January 2020 to 83 100 in January 2021. Other primary health care team members demonstrated their ability to carry out consultations independently during the transformation.

**Fig. 1. Consultation types in primary health care from January 2020 to March 2021**




Source: Compulsory Health Insurance Information System

The transformation presented new achievements for a sustainable, contemporary and more advanced primary health care model. Primary health care team members were acknowledged with the new roles, especially nurses and social workers, who were recognized as more autonomous consultants. The remote consultations between family physicians and narrow specialists increased the interdisciplinary cooperation and made the first steps towards telemedicine.

Primary health care demonstrated its importance in meeting societal health needs more than ever. Primary health care not only contributed strongly to the public health measures but also ensured the functioning of essential health services through a dual-track response. Accessibility was retained through rapid introduction of remote consultations. By actively identifying vulnerable patients, primary health care team members responded to their needs and managed chronic conditions, aiming to leave no one behind. At the same time, primary health care teams were directly involved in COVID-19 diagnosis, treatment and isolation. The primary health care system demonstrated the possibility of accepting transformations rapidly and successfully. All primary health care centres were involved in the remote consultations, whereas before the pandemic the involvement was extremely low.

The following measures reduced paperwork and the administrative burden: more intensive use of eHealth services (description of health status, referrals for consultation, referrals for tests, electronic prescriptions for medicines etc.), legalized possibility to register with a primary health care institution and choose the family doctor remotely, an approved procedure for issuing certificates of incapacity for work and sickness during the state of emergency and quarantine remotely, automatic transmission of information about COVID-19 disease after entering the diagnosis into eHealth to the National Public Health Centre under the Ministry of Health.

## SUSTAINABILITY PROSPECTS AND THE NEXT STEPS

The implementation of remote consultations requires careful planning and defining its limitations. Country experiences showed that the population tends to choose to return to in-person consultations in preference to remote ones. During the lockdown, remote consultations became more acceptable for a specific group of the population, especially the younger generation, who prefer to solve their health problems remotely. Older people feared possibly acquiring COVID-19 by visiting primary health care centres. Primary health care staff had to encourage patients to attend in-person consultations. For example, people were encouraged to again use preventive services through direct visits, aiming to avoid delay of cancer diagnoses and/or deterioration of chronic and mental health conditions.

However, one year after the pandemic started, remote consultations in Lithuania have become sustainable and a routine practice in primary health care.

## LESSONS LEARNED FOR OTHER COUNTRIES

**1. Transformation from face-to-face to remote consultations requires a prompt and timely change of a legal framework.** The decisions introduced by the government, the leadership of the Ministry of Health and its cooperation with other ministries, communication with municipalities and experts in family medicine are the key priorities.

**2. The successful transformation in primary health care centres depends on the primary health care managerial capacity.** The rapid reorganization of the service delivery, transformation and adoption of continual changes presented by the government into everyday practice require organizational skills, goodwill and capacity of managers in change management.

**3. When introducing transformation, primary health care demonstrated its advantage during the pandemic.** Primary health care was able to respond to the lockdown initiated by government rapidly and being one of the keystones for health care and social systems to better meet patients' needs. Primary health care providers, which have the best network and trust within the community, play an essential role in controlling infection and maintaining essential services for patients with noncommunicable diseases during the pandemic.

**4. The rapid transformation acknowledges the new role of primary health care team members.** The introduction of remote consultation for nurses was a good opportunity to accelerate task shifting to nurses and gain their recognition by patients. Nurses represented themselves as independent consultants regarding the immunization, continuous e-prescribing and health status assessment.

**5. Threats to patients' safety and quality of care through remote consultations should be assessed. It would be useful to clarify when remote consultations are inappropriate, such as for pregnancy, newborn and maternal care.** In addition, the sustainability of remote consultations should be reconsidered for vulnerable patients (older people, patients with mental health problems and patients with special needs and social problems). Vulnerable patients may have difficulty in accessing primary health care providers due to lower eHealth literacy when using portals. Primary health care should identify vulnerable patients, aiming to reduce social inequalities and launch the delivery of essential health and social services.

**6. Education on and investment in eHealth use are necessary. Extremely important is sufficient government investment in digital technologies and integrating e-networks between the mental health and social sectors.** Involving health-care personnel in developing eHealth platforms is crucial, since they are direct eHealth users. The continual support for eHealth users (health-care providers and society) must be facilitated through education and providing instructions on using eHealth portals.

**7. The sustainability of remote consultations should be a priority for future primary health care.** Transformation requires continual solutions, aiming to increase the quality of the current remote consultation system and services. National guidelines on delivering remote consultations and stratification of remote consultation procedures are recommended, since they will facilitate the tasks for local primary health care managers. The education of eHealth users (health-care providers and patients) as well as the wider scope and safety of the remote services are crucial. Developing telemedicine services will expand remote consultations between primary health care and narrow specialists and increase the accessibility for specialized care for patients.

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## ACKNOWLEDGMENTS

The authors thank the following people for sharing their insights and resources for drafting the report, and for reviewing the document:

**Odeta Vitkuniene**, Director, Personal Health Department, Ministry of Health, Lithuania

**Jurate Sabaliene**, Head, Division of Data and Analysis, Information Technologies Department, the National Health Insurance Fund under the Ministry of Health, Lithuania

**Radvile Jakaitiene**, Adviser, Strategic Planning and Management Division, Ministry of Health, Lithuania

**Rasa Bieksiene**, Head, Primary Health Care and Nursing Division, Personal Health Department, Ministry of Health, Lithuania

**Artur Kozlov**, Chief Specialist, Division of Data and Analysis, Information Technologies Department, the National Health Insurance Fund under the Ministry of Health, Lithuania

**Melitta Jakab**, Head, WHO European Centre for Primary Health Care

**Toni Dedeu**, Senior Consultant, WHO European Centre for Primary Health Care

**Zulfiya Pirova**, Technical Officer, WHO European Centre for Primary Health Care

**Ingrida Zurlyte**, Head of WHO Country Office in Lithuania