Talking telehealth beyond Covid-19

The Covid-19 pandemic has meant a rapid increase in the use of IT to support distance consultation through telehealth. ASMS National Executive member and Auckland paediatrician ***Dr Julian Vyas*** *has been thinking about the implications for members.*

The restrictions necessary for interpersonal distancing during the Covid-19 pandemic have significantly impacted custom and practise around clinician contact for health care. DHBs have had to balance the need for sustained patient access to health care, with national lockdown and travel restrictions, as well as a duty of care to employees (especially those considered to have increased vulnerability to coronavirus). As a result, there has been rapid increase in use of IT to support distance consultation via telehealth.

There can be little doubt that in the right context there is much that can be achieved using IT to improve patient and carer access to high quality health information and clinical care. As such, telehealth in its broadest form is key to improving health literacy, enabling prompt clinical contact, and affording patients ready access their health records - an area in which hospital services are lagging. Much has been written about the use of telehealth: its functionality as well as medico-legal and best practise requirements. Despite the seeming intuitiveness of telehealth, we counsel caution from members against "getting the app and having a go." Members who are contemplating initiating or increasing the use of telehealth in their clinical work are advised to acquaint themselves with the recently updated MCNZ statement, as well as their respective College guidance on the issue and their DHB's policy guidelines on telehealth. In addition, The NZ Telehealth Project website (www.telehealth.org.nz) links to many relevant documents and guidelines for clinical practise as well as technical requirements. We also suggest reviewing other peer-reviewed literature on telehealth related to their specific area of practise. There are several platforms (via downloadable Apps and online) that can host video or audio meetings. At present Zoom seems to be the platform of choice in NZ and globally. Members who wish to use other platforms (e.g. doxy.me) are advised to clarify if their DHB will support the use of alternative video conferencing platforms rather than just using them. In general, before providing clinical care via telehealth it is important that various aspects of its immediate and long-term use are duly considered.

The Patient

Telehealth allows patients with restricted ability to attend hospital appointments to be able to have clinical contact with a relevant clinician. This is perhaps most advantageous for those who live remotely, for whom travel is onerous. Reducing the time cost to patients is of intrinsic benefit, but also means patients/ carers can avoid losing pay for taking time off work. Remote contact will also reduce travel costs, time spent looking for car park space or in a waiting room, and (if appropriate) allows a wider group of whanau/family support to be "present" and hear the same information. If mutually agreed, a Zoom meeting can be saved by the patient, and viewed later, as an aide memoire. Although Covid-19 may have given temporary respite from the climate crisis, telehealth can clearly help reduce the travel-related carbon footprint for health care.

However, there are several issues that members need to consider regarding their patients, prior to initiating virtual clinics. Patients suffering from material hardship may not have the necessary IT equipment and/or internet accessibility to support virtual video consults. Similarly, network reliability and bandwidth availability in remote areas may not be sufficient for a video review. Estimates for amount of data needed for a 30-minute Zoom meeting vary (depending on several factors, including quality of imaging used) but are of the order of 30-100MB. Patients need to have access to a place to conduct the consult, that provides the desired degree of confidentiality. Patients who are less confident with use of IT may also be reluctant to use this.

In a recent audit done by Waitemata DHB, two-thirds of patients who had virtual clinic review reported there was less good rapport achieved with the clinician and that they felt unsupported after conclusion of the consult. Telehealth is not a panacea for problems of ensuring patient contact with clinical services. Ultimately, use of telehealth must be the patient or carers choice, and not be insisted upon by the clinician, or DHB.

The Clinician

Virtual clinical contact can allow contact with patients usually seen in a visiting clinic, away from the members base location. Again, reductions in travel time, travel costs and carbon footprint are all clear benefits from this model of care.

The clinician needs consider their own clinical liability, when assessing a patient without the benefit of it being in person, and without clinical examination. MCNZ and MPS both state that the clinician is charged with ensuring that there is no compromise to the standards of patient care if using telehealth. This includes confirmation the person present in the video conference is the patient, consent from the patient to conduct the consult in this manner (including an explanation of your employers data security measures), and an obligation that where the outcome of the consultation has been hindered by an inability to examine a patient, a solution is forthcoming.

Best practise for use of telehealth includes adequate clinician training for use of telehealth. The huge variety of clinical work that members do means that consideration needs to be given to which groups, or subgroups, of patients may be suitable for telehealth contact. Services should develop their own agreed guidelines for which patients can or cannot be reviewed in this way. Specific aspects may include limiting virtual review to patients:

- already seen in person
- when the clinical question prompting referral might be adequately answered remotely
- where the referring medic has indicated they do not need clinical examination
- where there seems little likelihood for added testing in clinic (echo, radiology etc),
- where there is little likelihood of needing discussion of an emotionally sensitive nature is unlikely.
- where hearing or visual impairment will not compromise the pastoral or clinical quality of the review.

When deciding which patients to see via virtual clinics, a clinician or service must consider if to do so will in anyway significantly risk harm to the patient, from not having examined them in person. For patient referrals to hospital services (secondary or regional/ national) it may be helpful for the referrer to advise on the suitability or otherwise of the patient being seen in a virtual clinic.

When conducting the consultation, it is important to establish who else is in the room with the patient/ carer. And whether they consider the environment they are in allows for a private conversation.

Similarly, if the patient is to be reviewed virtually by a trainee due consideration should also be given about adequate supervision by the consultant. It appears that neither the RACS, nor the RACP have published documentation on supervision of trainees when they are doing telehealth clinics.

For members conducting clinics away from the workplace, thought should be given to protecting the confidentiality of patient related clinical information; including temporary storage or destruction of any clinical notes taken, prescription pads etc. Again, DHBs should have guidance for best practise in these circumstances e.g. the security of the WiFi access that is used; or ensuring confidentiality if others can overhear the consultation.

The District Health Board

The biggest advantage to DHB's for increased use of virtual clinics is likely to be a net savings on expenditure. Money needed for travel costs for clinical staff or patients, loss of revenue for DNA's due to difficulty for the patient to attend, meeting unmet need in remote parts of more rural DHB catchment areas etc. Given the prior DHB's budget overspend throughout New Zealand, and the (as yet) unknown costs to the health service from of Covid-19, it is unclear if any savings accrued from increased virtual clinical activity will need to be used to pay off budget deficits, or might be reinvested back into the clinical services that have made these savings. In addition, any net reduction in demand for in person attendance at clinics may lessen the environmental pressure and costs on DHBs for adequate parking space, waiting areas as well as clinic rooms.

DHBs should support the safe, and functional use of telehealth by employees (medical and non-medical). This is best achieved by national agreed standards of practise by DHBs for provision of health care via telemedicine. Such standards should ensure that equipment to be used is of the necessary standard (both for video quality, and data security) as defined by Telehealth NZ. Anecdotally, many members have started undertaking virtual clinics using their mobile devices, due to a lack of adequate camera/audio equipment in clinic rooms or offices. Telehealth NZ best practise states that in order to ensure optimal data security and image quality, a desk top computer with 2 screens (so patient records can be viewed simultaneously) is the necessary standard and use of a mobile device should be a last resort. Therefore, DHBs must provide ready access to the preferred quality of device. Likewise, rooms where virtual consults occur should afford privacy for reasons of patient confidentiality. This is perhaps at odds with the recent trend for DHBs to accommodate more and more senior dental and medical staff in shared, open plan offices.

DHBs need to produce comprehensive guidance for clinical teams that will be increasing their use of telehealth. In addition, guidance for patients should also be produced that enables the patient to make an informed choice about choosing between a virtual consultation or one in person.

Virtual clinics need adequate clerical staff support to establish if a patient the clinician has identified as suitable for a virtual review wishes to be reviewed in this manner. Clerical staff need to be trained to schedule the Zoom meeting according to best security practise for Zoom meetings, as listed by Telehealth NZ (e.g. having a "waiting room," locking meetings once all invitees are present, hosting them from a desktop rather than a mobile device et. There should also be a means of notifying the patient without disclosing the clinician's contact details.

DHBs need clarify if they agree to virtual clinics being done from home. If so, the minimum standard for equipment and data security needs be defined.

If images are captured during the consultation, they need to be able to be incorporated into the patient's clinical record.

If it is recognised during the virtual consultation, that a patient needs to be reviewed in person, there must be adequate outpatient capacity to offer these patients an in-person clinic consultation without undue delay.

The Association of Salaried Medical Specialists

ASMS is reviewing the industrial aspects of telehealth. These have not yet had much consideration from health unions, either within New Zealand, or internationally. The ASMS MECA has no specific reference to telehealth, although many of the clauses relating to workplace equipment provision will encompass it. Whether there is a need for a specific clause will be discussed by ASMS' leadership in the future.

Nonetheless, aspects of care provision and ultimate consequences of virtual clinics may need to be agreed upon by services and their DHB, before embarking on a long-term change in service provision. The MECA is very clear that DHBs cannot introduce or increase service delivery via telehealth without adequate pre hoc consultation and engagement, and ultimately agreement, with clinical staff.

- Working from home: Costs for doing this may need to be agreed between the DHB and employee prior to starting virtual clinics. e.g. if upgraded amount of broadband data, or other IT infrastructure improvements are needed. Such costs are at the DHB's discretion, and so prior discussion is important to avoid members being left to foot any bill incurred solely because of the added clinical work.
- Change to current duties and job planning practise: the MECA is clear that this cannot happen without agreement between the DHB, and individual clinicians. The DHB cannot require anyone working under the terms of the MECA to commence virtual clinics without the employee's agreement.
- Change to service revenue: In instances where services receive some of their funding from inter-district flow, or other tertiary/ quaternary funding arrangements, it is important to ascertain what, if anything, will happen to the current service budget levels. For some FSAs, revenue for a distant consult is less than that of an in-person attendance by the patient. If revenue will fall, does the DHB intend to reduce service FTE (medical, nursing or both)? Or will the DHB maintain revenue by increasing clinical throughput – essentially increasing the clinical demand on the service. Given that many members currently use their non-clinical time to keep up with clinical demands on their time, will added clinical work further erode non-clinical time, even though it is a contractual right under the MECA.
- Technology: as stated above, the DHB should provide appropriate IT equipment, accommodation and policy guidance to support telehealth contact with patients. Laptops purchased from CME budgets may be suitable for telehealth. Each DHB should clarify whether it will accept a service responsibility for a laptop a member has bought with their CME allowance, particularly if the device does not run Windows. Similarly, DHBs should clarify whether they will support purchase of peripheral items (internet camera, headphones or speaker devices) for use

with the DHB's own desktop computers or expect that these will also be purchased using CME monies.

The current coronavirus pandemic has highlighted that ongoing distant contact with patients is inevitable and can generally be thought of as a desirable adjunct to health care services. Where geographical or financial constraints disadvantage some patients, telehealth can help address areas of inequity of patient access. However, the disparate nature of clinical work and patient complexity means that each service must assess how telehealth might be implemented for patient groups within in its case mix. We would encourage members who are considering expanding their clinical support for patients through telehealth to take a circumspect approach to the numerous implications and ramifications for their usual practise before committing to this. Where necessary, clarification from the employing DHB should be obtained pre hoc, on issues such as liability, equipment purchase and maintenance, and funding and workforce consequences of telehealth contact.

Look out for further ASMS research and advice on the issue and if have any concerns around telehealth get in touch with your ASMS industrial officer.