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Telehealth: the general practice perspective

Background

Three years ago the Australian Government undertook to incentivise the adoption of telehealth videoconferencing in primary care. The incentives targeted specialist consultations with patients through their general practitioner (GP), nurse, Aboriginal health worker, and aged care facility. Rural and remote patients and their GPs have benefited from improved access to specialist care in an environment where one kangaroo through your radiator can make a compelling case for remote care delivery.

Objective

To discuss some of the practical issues, challenges and opportunities related to running a GP telehealth videoconferencing service, and describe how we deliver telehealth videoconferencing in our practice.

Discussion

The business case has taken a back seat to the intangible savings in travel costs, lost productivity, and capacity building of local health professionals. Intuitively, delivering medical care by telehealth videoconferencing should just be an extension of day-to-day clinical practice, and an enabler of local team care and attractive to rural people. However, there remains much to be done in quantifying the scope and applicability of remote care in this context, and opportunities to deliver quality care to rural and isolated people are yet to be realised fully.

Keywords

doctor–patient relations, consultation; medical informatics; telemedicine

The opportunities and challenges of rural telehealth

In 2011, initial telehealth videoconference incentives were generous and many clinicians took up the offer. Three years later, the implementation of telehealth videoconferencing has been inconsistent and patchy, yet to be normalised as part of primary care practice.¹ In part, this has been associated with restrictive item numbers, disallowing general practitioner (GP)-to-patient and associated professional access, and exclusion of metropolitan clinicians. Other aspects are a lack of clarity for clinicians in the appropriate use of telehealth, and economic and technological concerns.¹

Rural health professionals should be valued for their knowledge, skills and experience. Videoconference-based telehealth provides an opportunity for those clinicians to be the hands, eyes and ears of remote specialist clinicians. Building trust and capacity of remote clinicians can improve recruitment and retention to traditionally difficult-to-fill posts.

Appropriate clinical decisions about who to manage locally and who to transfer can only grow out of mutual understanding between health teams. Knowing the local context of care, geography and the challenges of retrieval builds local capacity and retains clinicians, as they feel more valued and supported.²

The health status of rural and remote people lags behind that of metropolitan citizens; for example, in rural and remote areas, morbidity rates for cancer are higher and outcomes for mental health poorer.³ The dislocation from family and community in order to seek care delays

recovery and has financial, social and emotional impacts that simply cannot be compensated for. Telehealth videoconferencing aids delivery of local access in a more timely manner, breaking down barriers to quality healthcare.²

Clinical champions lead innovation in models of care, defining the scope of clinical practice, safety and quality standards. Remote chemotherapy services developed by Dr Sabe Sabesan and his team have led to system-wide implementation of new models of care that value the skills of remote health workers, nurses and GPs. The consequent high levels of patient acceptance centre on partnerships between the community and their care team in a cost-effective manner.^{2,4}

Quality, safety and applicability of clinical case management via telehealth are critical issues. The principles of good clinical practice apply to telehealth as in face-to-face consultations. The added necessities of patient explanation, consent and formally setting the scene for telehealth videoconferences must be managed well. The Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) provide many resources to assist those embarking on telehealth videoconferencing.^{5–7} Many examples of online training, such as The University of New South Wales' Three steps to Telehealth (www.goodeyedee.com.au/telehealth),⁸ are available.

Telehealth and remote care delivery is much broader than just video consultations. For example, store-and-forward systems (where data are captured and stored on a device, then forwarded on to a specialist), such as ACRRM's Tele-Derm service, deliver high-quality specialist

services in an asynchronous way. However, these models, home monitoring and other systems are not currently funded.

The challenge remains that, in spite of the strong case for telehealth, we still face a lack of acceptance from clinicians. Technical barriers also exist.⁹ There is a critical need for innovation and investment in remote area broadband to support quality care for some of our most marginalised communities. The opportunities and challenges of telehealth are summarised in *Table 1*.

How we do it

The system that links my patients to their specialist is less important now than the local relationships fostered with specialist clinicians. Finding the right specialist can be difficult and the most direct avenue is to approach those people with whom you already have a relationship.

Searchable health provider directories through ACRRM and the National Health Service Directory (NHS) allow us to identify providers who can meet the needs of our patients.⁶ My practice in rural Queensland has facilitated consultations with specialists in haematology and neurology from as far afield as Victoria.

Several providers exist who offer their own specialist cohort or turnkey solutions at a price to patients and patient-end service providers. Interoperability of systems is evolving and standards-based systems that will talk to each other are by no means commonplace. The near future should see a convergence of technology standards; at present my practice has several software systems available to manage different providers. We have not invested in expensive systems.

Table 1. Opportunities and challenges of rural telehealth

- Remuneration and flexible funding
- Clarity in policy, planning and governance
- Building capacity for rural clinicians and care givers
- Retrieval medicine in context
- Improving access to care for rural communities
- Promoting quality and safety in telehealth
- Technical barriers
- Clinician acceptance

Support from practice staff is essential to ensure that videoconferencing 'works' for everyone. In our practice we have found setting aside a room that is not a regular consulting room to use for telehealth works best. This means that the room can be set up ready to go ahead of time so that when the specialist is ready the consultation can start on time.

Booking appointments for telehealth in a separate, dedicated appointment column, as well as with the doctor or nurse who is required, helps eliminate double bookings. Adequate time needs to be allocated to allow for changeover between consultations and possible shift of method if the specialists use different systems.

At the time of booking it should be checked who is calling who, and the method to be used. The patient should arrive 10–15 minutes before the scheduled time of the consultation to allow any observations to be done and to get them settled in the telehealth room. The process should be explained to the patient and a staff member should wait with them for the call to connect. At the appointment time, if the practice is to connect to the specialist, then the call should be placed or the virtual room joined and ready to begin.

In my experience, telehealth videoconferencing allows other members of the family, teachers and other providers to be present. This adds value but it is important to make sure that the specialist is aware of who is in the room, just as having observers at the provider end must be acknowledged. The potential for technology failure or recognition that desired outcomes were not achieved mandates a plan to mitigate difficulties and all members of the team need to be briefed on it.

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