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Virtual care in practice

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Introduction

Virtual care, also known as telehealth, is an integral part of a sustainable health system that delivers outcomes that matter to patients, is personalised, invests in wellness and is digitally-enabled and innovative in its practice.

Virtual care is any interaction between patients and/or members of their care team occurring remotely, using technology with the aim of facilitating or maximising the quality and effectiveness of patient care. Virtual care is simply the modality used to connect and provide care – it connects clinicians or any other person(s) responsible for providing care to patient(s) and carer(s). It can be used for the purposes of assessment, intervention, consultation, education and/or supervision.

Providing healthcare can be challenging in NSW, particularly given the large geographical distances, increasing demand and limited resources. NSW Health is committed to providing world-class care that is safe, reliable and personalised and the integration of virtual care into clinical practice will help minimise barriers to access and inequity.

The use of virtual care in NSW has evolved over many years. Advancements in technology have revolutionised the way we work and deliver services, and virtual models of care will continue to evolve with these advancements.

COVID-19 dramatically changed the landscape, demanding an immediate widescale shift in how healthcare is provided. NSW Health staff embraced this unparalleled opportunity to deliver improved outcomes and experiences for patients, carers, clinicians and the community.

For example, the use of remote monitoring to manage COVID-19 positive patients has led to greater acceptance of remote monitoring and more access to equipment. This will provide new opportunities for Hospital in the Home (HITH) and other services that benefit from enhanced patient monitoring at a distance.

Embedding sustainable virtual care services into the NSW Health system offers opportunities for patients, their family and carers, healthcare workers and the system as a whole. All services and models of care are encouraged to consider the use of virtual care as a part of normal practice. This will increase the choices available to clinicians and patients, so that there are a variety of options to provide and access care.

Every level of the NSW Health system has a responsibility to shape the future of healthcare. This includes the use of data to drive continuous improvement by systematically assessing impacts and outcomes to identify innovative practices.

From overarching strategies to the service plans at every local health district (LHD) and specialty health network (SHN), we must all continue to support the workforce to be innovative, challenge their practice, be creative, flexible and unafraid to explore the possibilities. This continued focus will ensure that the use of virtual care becomes business as usual.

Purpose

The purpose of this document is to provide information to support the uptake and ongoing use of virtual care. It aims to increase knowledge and provide guidance to healthcare providers when embedding virtual care into practice.

This guide provides the foundations to build a dynamic and adaptive workforce that can confidently integrate technology to assist all facets of service delivery.

It should be used in conjunction with national, state or locally developed clinical standards, protocols, policies and procedures for the provision of care.

Key messages

- Virtual care, also known as telehealth, safely connects patients with health professionals to deliver care when and where it is needed. Telephone, videoconferencing, email and remote monitoring are examples of the technology used to support virtual care.
- Virtual care is designed to complement existing services by connecting patients with clinical expertise.
- Healthcare professionals have been using technology to deliver care to patients for decades. Now, with advances in technology, the support for health professionals and benefits for patients are even greater.
- Virtual care enhances access to health services, particularly specialist services, and provides patients with more choice about how and where they receive that care.
- Where virtual care is clinically appropriate, healthcare professionals will explain how virtual care can be used to ensure it meets the patient's needs.
- Patient, carer and clinician experience play an important role in informing the future direction of virtual care.
- NSW Health is committed to providing world-class care that is safe, reliable and personalised. Virtual care helps us do this.

Virtual care in NSW

Virtual care is any interaction between patients and clinicians, occurring remotely with the use of technology, that aims to optimise the quality and effectiveness of patient care. Virtual care connects clinicians or any other person(s) responsible for providing care to a patient and carer(s). It can be used for the purposes of assessment, intervention, consultation, education and/or supervision.

Where clinically appropriate, virtual care is a safe, effective and valuable tool to support many models of care. Virtual care offers benefits for patients, their family and carers, healthcare workers and the health system through improved access, availability, efficiency and quality of healthcare. Patient-centred, clinician-led virtual care provides an efficient and effective model of care that complements and supplements face-to- face consultation.

The implementation of virtual care in the health sector has significant potential to address and support clinical and workforce needs.

The following virtual care modalities are addressed in this guide:

- telephone
- videoconferencing
- store and forward
- remote monitoring.

Where clinically appropriate, virtual care gives patients the option to access their healthcare from a suitable private location (home, workplace, general practitioner) or at another health facility. Rather than moving patients, health providers or educators, clinicians can use technology to support the transmission of voice, data, images and information.

Throughout NSW, virtual models of care can be initiated or implemented across many system settings (first response, emergency, admitted, non-admitted and the wider community) – with more opportunities continuing to be explored and our imagination the only limitation.

Roles and responsibilities in NSW

The NSW Ministry of Health provides overarching governance and leadership for virtual care in partnership with the pillars, LHDs and SHNs.

The Virtual Care Steering Committee has been established to provide a strategic, coordinated and consistent approach to implementing virtual care across NSW. The Steering Committee provides strategic direction and advice on NSW Health's approach to, and investments in, virtual care. It also ensures alignment with Future Health reform directions, especially as an enabler of value based healthcare. The Steering Committee is the decision making body for Virtual Care reform in NSW Health and reports to the Future Health Program Delivery Board.

The Steering Committee has direct relationships with:

- Virtual Care Strategic Working Group
- Virtual Care Monitoring and Evaluation Advisory Group
- Virtual Care Community of Practice
- Virtual Care Clinical Advisory Committee
- eHealth Executive Council (eHEC)
- Reform Area Steering Committees
- Senior Executive Forum
- Executive Directors Forum

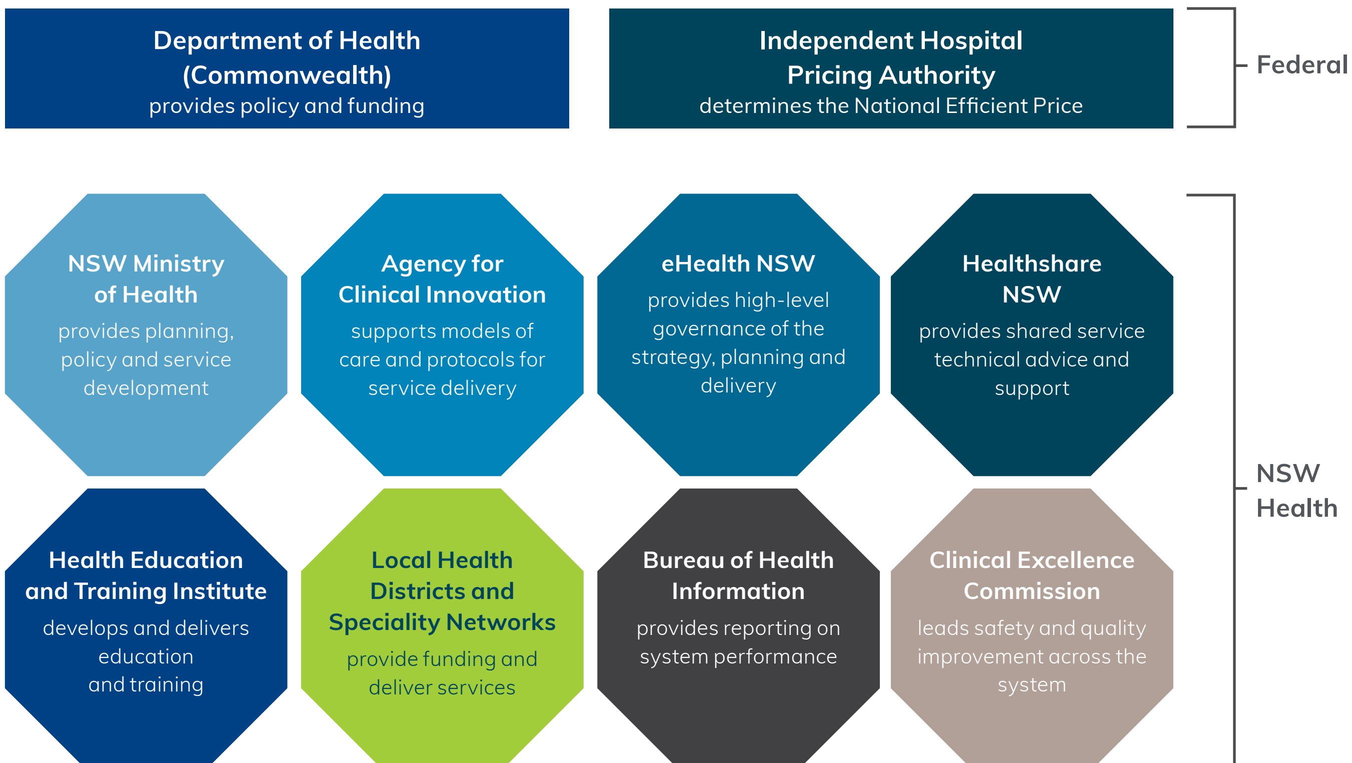
NSW Health will release a five-year Virtual Care Strategy in 2021, building on the *NSW Health Telehealth Framework and Implementation Strategy (2016–2021)* and the valuable work that has been occurring across the system for many years.

The new Virtual Care Strategy articulates a more coordinated and consistent approach to integrating virtual care into health services across NSW. It guides NSW Health to sustainably scale and embed options for virtual care that are both value-based and consumer and clinician friendly.

Rather than treat virtual care as a separate entity, this strategy demonstrates virtual care as complementary to in-person care, offering an alternative mode of delivery and providing choice and access where clinically appropriate.

Figure 1 provides an overview of the key government organisations that have a role in virtual care.

Figure 1. Roles of key government bodies in virtual care in NSW



Key roles to support the use of virtual care

Across NSW, every organisation has a duty to respond and support the delivery of care regardless of the modality. The challenge to meet the healthcare needs within allocated resources is constant. Virtual care is most effective when supported across an organisation, from the chief executive to frontline staff.

Virtual care requires a commitment to challenge current practice and to explore all delivery possibilities using available technology as the tool. Without compromising patient safety, this should be seen as a time to encourage innovation and use data to inform quality improvements, allowing virtual care to become a part of normal everyday practice. It is expected that as a system we will need to address barriers, enhance system enablers and be flexible as we adapt practice and review clinical workflows to support the adoption of virtual care as a practical and clinically appropriate modality of healthcare.

There is a growing commitment from LHDs and SHNs to have a dedicated telehealth/virtual care manager or lead to be the driving force of the local strategy.

These roles, along with other key positions, provide direct assistance in the establishment, implementation and evaluation of virtual care services. Dedicated teams to support virtual care initiatives exist within ACI and eHealth NSW and may also be a point of contact.

The Virtual Care Central SharePoint site https://nswhealth.sharepoint.com/sites/aci-VCCentral is the key reference point for NSW Health staff, providing a central hub for information and resources. It can help you to identify and connect with those that can assist and support clinical teams to integrate virtual care.

Benefits

Virtual care offers many benefits to patients, their families and carers, healthcare providers, and the broader health system.

Table 1. Reported benefits of virtual care-enabled models of care

Benefits for patients, their family and carers	Benefits for providers and local delivery systems
• Increases timely access to appropriate interventions (including faster access and access to services that may not otherwise be available) • Provides more timely access to care, securing the next available appointment • Reduces the burden of travel on health and wellbeing • Reduces the burden on carers • Reduces financial barriers and costs associated with travel • Reduces the inconvenience/impact to family and carers, work commitments and social factors • Provides access to services not otherwise available (reducing inequities in access to health services) • Provides tools to help people understand and manage their health condition • Fewer face-to-face specialist visits • Larger networks of care as more carers, family and friends can attend consultations • More patient-centred care, with increased independence and self-management.	• Extends the hours of service access and provide consistent, continuous care (greater provision of local services) • Extends the scope of practice for rural and remote clinicians through consultation and shared care with specialists • Empowers people to self-manage their health condition • Provides flexible and responsive workplaces to support workforce needs • Improves communication, networking and collaboration between healthcare professionals across the health sector • Greater support and reduced professional isolation for rural clinicians • Supports the development of flexible and sustainable service delivery models that promote integration across primary and secondary care, particularly for people with chronic conditions • Greater access to continuing education and professional development, including more experiential learning • Reduces time spent travelling, expenses related to patient transport and the burden on subsidised transport schemes.

These benefits largely relate to access to services, convenience, patient-centeredness, integration and quality of care, travel requirements, costs, support and education for healthcare workers, and a reduced burden on particular elements of the health system.

Enablers and barriers

There are several key enablers and barriers that impact the uptake of virtual care.

Table 2. Key enablers and barriers of virtual care

Enablers	Barriers
• Increased expectations and acceptance of virtual care across the community • Culture of commitment to innovation, including willingness to share learnings across the system • Consistent, strong and clear governance at statewide and local levels • Strong local leadership, including clinical champions to assist with the change management process • Increased clinician confidence in their ability to adapt their practice to support clinically appropriate care • Dedicated positions to support the implementation and evaluation of virtual care (e.g. telehealth/virtual care manager or lead, clinical and administrative support) • Change management and redesign support to ensure models are fit for purpose • Technology that is easy to use, accessible, fit for purpose, reliable, secure and cost efficient • Investment and infrastructure development • Statewide coordination of monitoring and evaluation of virtual care.	• Patient access to appropriate and affordable devices and internet plans, and processes for patients who need additional support to use technology • There is no central repository of new initiatives and pilot projects in the system which increases the risk of duplication of effort • Long term sustainability of Medicare Benefits Scheme (MBS) telehealth item numbers • Confusion around reporting of activity, how activity-based funding (ABF) for virtual care modalities is applied, and alternative funding sources for those who are block funded • Gaps in curriculum development to support the health workforce • Need for interactive and intuitive statewide systems to effectively support clinical workflows (e.g. secure messaging, scheduling, documentation, image capture) • Need for a variety of flexible technical tools to support different service requirements (e.g. group therapy, prevention and education programs).

Table 3. Critical success factors, at the model level, for effective virtually-enabled models of care

Governance	• Virtual care is guided and supported by strong leadership. • Virtual care has clear governance arrangements that are embedded and understood.
Purpose/strategy	Virtual care is: • driven by one or more specific clinical needs and therefore has a clearly defined purpose and is clinically relevant • applied to an existing model of care where it is well defined, or to a new model of care • underpinned by a robust model of care • integrated into business as usual.
Service and value delivery	**Patient and locally focused** • Virtually-enabled models of care are patient-centred, focusing on the clinical care of patients rather than the technological aspects of the model. • Local relevance (i.e. consideration of local issues, needs and existing resources). • Virtual care is accessible to the community and patients are supported to use virtual care. **Planning** • Implementation of the model is based on robust planning, which involves key stakeholders, organisational partners and the local community from the beginning. • Medico-legal, privacy, ethical and other regulatory frameworks are assessed to determine whether they pose critical barriers to the delivery of services and relevant issues are addressed. **Monitoring** • Models are monitored and evaluated on an ongoing basis to support continuous improvement. **Funding** • A sustainable funding model underpins the service. • Funding arrangements do not act as disincentives to the use of virtual care. • There is adequate planning and upfront discussion about resourcing required at the central LHD/SHN level and the model of care level to ensure the service is sustainable (e.g. fully exploring all associated costs and how these costs will be funded). • Models are flexible to allow them to adapt to changing clinical needs. • Consideration is given to redesigning a model of care to integrate a virtual care solution. • An iterative process is used to design a model of care.
External alliances and partnerships	• There is extensive consultation and collaboration with local government and non-government agencies. • There is strong cooperation between organisations involved in the provision of healthcare.

Business processes	• Adequate clinician reimbursement is available for virtual care services. • There are resources dedicated to ensuring effective coordination. • Standard guidelines and manuals that clarify business rules and procedures are developed and implemented to ensure consistency and ongoing operation, even with changes of personnel.
Workforce	• The model is supported by a sustainable workforce. • Staff receive adequate education and training in any clinical workflow adaptions and use of technology. • There is adequate administrative support. • Ongoing technical support is readily available.
Culture	• Effective change management (including a communications plan) supports the introduction of virtual care. **Support for virtual care** • Stakeholders recognise the need for virtual care and are engaged with the model. • Staff view virtual care as improving current care arrangements.
Physical assets	• System integration supports streamlined delivery of care. • There is adequate infrastructure in place to meet minimum requirements (e.g. sufficient bandwidth). • Technology is reliable, easy to use, convenient and easily accessible. • Technology aligns with clinical service needs. • Technology is compatible across jurisdictions (including LHD/SHNs) to enable interoperability.
Organisational structure	• There is central service management and coordination.
Roles and accountabilities	• Dedicated and appropriately skilled telehealth/virtual care manager or lead and support staff are in place (typically at the LHD/SHN level), who can be called upon to provide support for individual models. • Clinical champions are located at each site.
Information management	• Coordinated and established mechanisms are in place to collect and analyse data to inform quality improvements. • Appropriate data collection mechanisms that enable measurement of costs and clinical benefits are in place. • Data is available to be transmitted and stored securely. • There is integration into the electronic medical record (eMR).

Virtual care modalities

Virtual care is an overarching term encompassing a range of modalities used to provide healthcare where technology is an enabling tool.

Clinicians need to determine the most appropriate modality to support the clinical needs of the patient.

For staff who are unfamiliar and may lack confidence with the use of technology, it is recommended to start using the technology in non-clinical situations. This may include meetings and education sessions, which will boost skills, knowledge and confidence.

Telephone

The use of the telephone to support and deliver health services is the most common virtual service contact mode reported across all LHDs and SHNs in NSW.

Telephone is often used to provide results, follow up patient progress following discharge or between consultations where real-time images are not required for consultation and where there is eMR access to the relevant results. Telephone consultation occurs between the patient and healthcare provider(s).

Videoconferencing

The use of videoconferencing to support clinical care provides a real-time audio and video link between multiple participants.

Where patients have access to a fast internet connection and suitable equipment, videoconferencing provides a more interactive and engaging experience for the clinician(s), the patient and their carer(s).

NSW Health employees have access to videoconferencing platforms backed by state infrastructure that has the ability to connect all NSW Health facilities. They also have the capability to connect with external providers outside of the NSW health network.

Store and forward

The use of email is a tool to communicate between patients, carers and healthcare providers to support patient care.

Store and forward is an electronic communication method of acquiring and storing of clinical information (including data, images, sound and video). The information is forwarded to, or retrieved by, another clinician for the purposes of clinical review for advice or management.

The advantage of this is that consultation can occur when there is available time. For example: an MRI can be taken on Monday, then consultation with the multidisciplinary team and patient can occur on Tuesday. Wound consultation with a nurse and general practitioner (GP) occurs on Tuesday with the patient. Multidisciplinary team consultation with a podiatrist and infectious disease specialist using clinical data, wound images and wound culture results occur on Friday ahead of the next GP and nurse review on the following Tuesday.

There are many digital cameras, scopes and diagnostic instruments (e.g. otoscope, digital stethoscope, blood pressure, ultrasound, ECG) that can capture both still and video images.

It is paramount to securely store and manage these images and videos, preferably in the patients, eMR.

Remote monitoring

Remote monitoring uses mobile technology to collect and send medical and healthcare data to an app, device or service outside the traditional clinical setting. This includes:

- wearable devices
- mobile equipment and devices that include peripherals
- smartphone apps that are used to collect patient measures
- online portals used to enter personal health data.

eHealth NSW have provided leadership to assess and manage a remote monitoring vendor panel. This panel provides guidance to clinical services when selecting an appropriate vendor and device. This removes the need for LHDs and SHNs to navigate the extensive market.

Dependant on the functionality of the device, the diagnostic information collected should be entered into the patient's record (automatically or manually) and provided to a healthcare professional for advice and management.

Remote monitoring can be passive (where measurements are sent from a device automatically) or active (where people collect their own clinical readings and send them to their healthcare provider). It can also involve an alert or alarm in high-risk situations, e.g. notification when a patient's monitored vitals are outside of the flags. All remote monitoring services should have clinical procedures in place that clearly identify escalation procedures that are communicated to patients.

Remote monitoring equipment or devices can be used to measure:

- blood glucose
- blood pressure
- heart rate
- heart rhythm (pacemaker)
- respiratory function
- oxygen saturation
- body temperature
- body weight
- falls.

This is not an exhaustive list. As technology continues to develop, new devices will become available to meet clinical needs.

Multipurpose devices that take different clinical readings can be useful for people with more than one chronic condition and be less overwhelming than having many devices.

Websites and applications (apps)

There are a wide range of websites and apps available to support forms of virtual care functionality, including secure messaging, phone calls, videoconferencing, remote monitoring, and educational information.

These apps and websites provide a tailored interface for both the clinical user and the consumer.

Prior to implementing an app or website, either through buying/using an existing one or developing something new, there are several key considerations, including:

- undertaking a review of the current environment to identify existing or alternate options
- data privacy and security
- clinical governance
- ethics and research
- interoperability and integration.

Online resources about apps

The following *2018 Innovation Series* online resources have basic information about health apps, and considerations required prior to development and implementation:

Workshop videos

www.youtube.com/playlist?list=PLbw1KgO1-UrGgfUP9su_VRfPAkO9SaWBT

Safety

Safety is fundamental in the provision of healthcare, regardless of the mode of delivery. All processes put in place to support safe practice also apply to virtual care. This includes undertaking risk assessments, mandatory reporting requirements and reporting of incidents into the NSW Health Incident Management System.

Where clinically appropriate, virtual care is a safe, effective and valuable modality to support patient and family-centred care. Its principles should be considered to ensure that the implementation of virtual care is clinically safe, sustainable and successful.

Core principles

Governance and leadership

- There should be strong organisational and clinical governance to help clinicians identify when virtual care is an appropriate modality for patient consultation.
- There should be established safety and quality systems in place. Clinicians should have access to the required medical and technical devices to provide high quality care.
- All NSW Health employees sign a code of conduct and must protect information from unauthorised access and misuse:
  - Consultations should always take place in a suitable and private environment. This applies at all points of connection.
  - Clinicians must ensure that clinical information is always secure and entered into the eMR at point of care. Any paper documentation should be secured in a locked bag, entered into the eMR as soon as possible and then destroyed using secured shredding bins.
  - Staff ensure that appropriate anti-viral and anti-malware software is used.

Standards and policies

- Clinical care standards, policies, guidelines and directives that apply to face-to-face consultations also apply to virtual care, regardless of the modality and location of care. These may need to be reviewed and adapted as virtual care modalities become more prevalent.
- Dedicated and appropriately skilled virtual care leads and clinical champions should be in place (typically at the LHD/SHN level) to provide support for individual models.

Skilled and confident healthcare providers

- Healthcare providers must be trained in using virtual care platforms and equipment. They require access to timely technical support.
- Providers should have access to appropriate well-informed and knowledgeable experts and clinical champions to support their knowledge of virtual care. This includes development of appropriate etiquette and support to adapt clinical practice and workflows.
- Providers should be prepared with key messages and collateral to communicate with clinicians, patients and their carers about the appropriateness and benefits of virtual care.
- Providers should be supported to become confident users of virtual care. They should be able to implement a secondary plan if technical issues arise prior to, or during, clinical consultations.

For clinicians

Clinical considerations

- The documentation requirements for virtual care are the same as in-person care.
- A patient's eMR should be updated at all points of care, including the modality used, participant details and their mode(s) of access. Where a Medicare item claim is anticipated, it is good practice to record the patient's consent.
- Clinicians must be confident to abort a consultation when they cannot continue to deliver care virtually because of assessment or patient needs, or where the technology is not fit for purpose.
- If virtual consultations take place while a clinician is in the field, patient information must be documented and transmitted using a secure platform.

Environment

- Clinicians should always select a quiet and private environment with no background noise. See Page 23 for guidance on virtual care in open plan offices.
- Clinicians should maintain a professional appearance and be aware that patterned clothing and room lighting can impact the image quality when videoconferencing.
- When using videoconferencing, the camera should be positioned to capture a clear view of all participants in the room, or have the functionality to track to the speaker in the room.
- Clinicians must ensure that no confidential patient information is visible in the background or on screen. They should also remove any distracting photographs or other items from the background of their workplace. This includes using appropriate virtual backgrounds where the platform functionality provides this feature.

Equipment

- Appropriate, reliable and convenient equipment is needed to meet clinical requirements. The three fundamental technical requirements for quality video consultations are internet connectivity, hardware and a software solution.
- Clinicians should only use videoconferencing platforms approved by NSW Health, and the approved vendor panel for remote monitoring devices and interfaces. Any remote monitoring, peripheral devices or applications required to perform clinical duties must be Therapeutic Goods Administration (TGA) approved.
- Virtual care equipment, such as phones, laptops, data storage devices and remote desktops, must be secure. Devices, firewalls and virtual private networks (VPN) must be updated with the latest security patches. A privacy and security assurance framework (PSAF) and penetration testing should be conducted to ensure security expectations are met. Check within your LHD or SHN for specific guidelines.

Patient considerations

Patient selection

- When selecting a patient for virtual care consultation, clinicians should adapt to the situation and needs of the patient by considering:
  - the level of physical assessment required
  - if their clinical needs can be fulfilled through virtual care
  - their willingness and ability to participate, including any physical, mental, cultural, social and cognitive barriers
  - availability and access to support (where required), an internet connection, devices, software and an appropriate environment.

Patient support

- The provision of virtual care should be discussed with patients to help to manage their expectations, increase awareness and provide flexibility and choice of access. They should understand that virtual care is utilised only when clinically appropriate and how it differs from in-person care.
- Patients should feel confident to ask any questions before, during and after a virtual care consultation. They should be assured that there is a process in place to facilitate this.
- When deciding on the suitability of virtual care, a clinician should consider a patient's need for privacy and confidentiality in their setting.
- Before participating in a virtual care consultation, patients should review relevant information and advice to support a successful connection. They should understand the technology required, including an appropriate device and a stable internet connection. For example, smart TVs are not often considered when discussing suitable devices.
- In specific services, a risk assessment may identify the need for a support person to be present (e.g. due to mental health reasons or to reduce the risk of falls).

Patient communication

- Patients need to be assured that any communication via virtual care takes place through secure channels.
- Patients should be informed that they can change their mind at any time about how they access care, providing the mode they choose is appropriate.
- Clinicians must be considerate of the comfort level of patients and their carers. These should be openly addressed to determine any issues and resolutions.
- Patients are always offered the resources designed to support them including:
  - how virtual care will support the provision of care
  - how to connect to the care team
  - who to contact if they have an issue.

Where to start

Your first point of contact should be your organisation's telehealth/virtual care manager or lead. This person will be able to:

- provide knowledge and advice about local governance and available technologies supported by your organisation that are most likely to meet your needs and requirements
- provide guidance and support around the clinical change management processes of ICT implementation
- provide practical advice and information on procurement, such as what to request and support to develop a business case.

Other contacts within the organisation may include:

- clinical leaders
- clinical redesign manager
- innovation manager
- colleagues within your professional network that have used virtual care as a part of their practice
- chief information officer
- ICT manager or ICT support officers
- project management officer or planning manager
- finance/performance team members
- ACI clinical network managers
- ACI manager of virtual care
- eHealth Conferencing Services team.

Please refer to **Virtual Care Central SharePoint** for your organisation's first point of contact.

Clinical function

The clinical function is the type of clinical interaction or activity that is required to address the patient's need.

Virtual care can be used to support clinical services, indirect services and non-clinical services. The patient journey may require one, two or several episodes of care, which can be provided by a range of face-to-face and virtual care modalities depending on the clinical need. This is commonly referred to as a blended mode of access.

For clinical services, the clinician should determine the appropriateness of the service in line with the clinical standards. It is expected that the choice of modality and the technology identified to support the service should be fit for purpose and provide the clinician with the same capabilities as a face-to-face service. Depending on the clinical function, it may be necessary to adjust the model of care to ensure that the normal activity can be achieved. This may include other health providers (where physical examinations are required), or a change in administrative processes to arrange access to patient information, such as diagnostic results, images and referrals. In most instances these are only minor adjustments.

All NSW Health entities are engaged and committed to providing appropriate use of technology to support clinical, indirect and non-clinical uses for the benefit of patients, their carers and the NSW Health workforce. It is important to become familiar and confident in the use of the hardware and systems to be used and receive training and troubleshooting techniques prior to the commencement of patient services.

To provide a successful virtual care service the following elements must be considered:

1. The **clinical function** of the session
2. The **workflow** that supports that business function
3. The **participants** in the session and their role
4. The **features/capabilities** of the systems that support the activity
5. The **spaces** where the participants will be providing or accessing healthcare
6. The **communications infrastructure** that connects the spaces
7. The **hardware** that is required to support the activity of the participants in those spaces.

This leads on to the design, implementation and the operational processes to support the delivery of the clinical service.

First response services

The use of technology in first response settings supports time critical access to specialists to support emergency care.

Several modalities are suitable in this setting, including videoconferencing, store and forward and remote monitoring. Examples of models include:

- Care/advice accessed between the ambulance and the receiving ED for consultation liaison
- Care/advice accessed between an ED and a speciality retrieval service for consultation liaison (e.g. rural/regional hospital to the Neonatal and Paediatric Emergency Transport Service (NETS))
- Care/advice accessed from a non-medical site using mobile equipment to connect to a speciality service for consultation liaison.

Examples: 000 call centre/control centre, emergency command centre, early access to mental health assessment, disaster management and accident site management. Retrieval vehicles may include road vehicles, helicopter or fixed wing aircraft.

Emergency services

The use of technology in emergency departments is time-critical, as it provides direct access to specialists.

A number of modalities are being used in emergency situations, including telephone, videoconferencing, store and forward and remote monitoring.

Virtual care is being used to access specialists who are rostered on-call or support statewide services. The technology advancements provide remote access to over-bed cameras, other mobile devices and the eMR system.

Virtual care may be used as a hospital avoidance strategy to monitor the patient in their own environment.

Examples of the models include:

- Care/advice accessed between an ED and another ED for consultation liaison (e.g. rural to regional hospital or to a metro based hospital)
- Care/advice accessed between an ED and centralised Patient Flow Unit
- Consultation liaison provided to a patient in an external health facility but the patient is not transported to ED (e.g. residential aged care facilities to EDs).

Examples: stroke, cardiology, trauma, burns, maternity, toxicology, forensic assessment, resuscitation, mental health assessments, RACF, paediatric assessments.

Admitted (inpatient) services

The use of technology for patients in hospital can support their management, reduce length of stay (LOS) and provide opportunities to integrate care with a range of providers to assist with the patient's ongoing care post discharge. Access to the technology can be made available from the patient's bedside or any other space across the hospital including clinic rooms, imaging units, allied health therapy rooms.

Modalities being used in the admitted space include telephone, videoconferencing, store and forward and remote monitoring.

Examples include:

- Consultation liaison to an admitted patient
- Handover prior to transfer from one health facility to another health facility or external health provider (patient's GP)
- Hospital in the Home (HITH)
- A multidisciplinary clinical review/case conference with clinician(s) with or without the patient from the health facility and with carer(s), other health or social care providers.

Additional examples: daily ward rounds, pre-discharge reviews, surgery, patient deterioration, end of life planning, mental health, stroke rehabilitation, trauma care, allied health rehabilitation and therapy sessions such as speech, occupational health and physiotherapy.

Non-admitted (outpatient or community) services

A large range of specialities use technology to enhance healthcare for non-admitted patients. Typically, these services are provided from outpatient clinics or community health settings and may include a variety of modalities that are appropriate for the clinical need.

These can be one-to-one or involve a group of patients.

Clinicians should determine whether a model of virtual care is to be entirely substituted for, or complementary to face-to-face services, on a case-by-case basis, as acceptable to the patient.

Several non-admitted models are possible from outpatient and community health facilities, such as:

- A healthcare provider is located at a health facility. The patient attends their appointment using their own resources from a private location, e.g. home, work or mobile location
- A healthcare provider is located at a health facility. The patient accesses their appointment from their home with another healthcare provider
- A healthcare provider is located at a health facility. The patient accesses their appointment from their home, workplace or other suitable location. No provider is present at the patient end
- A healthcare provider is located at a health facility and the patient and other providers are located at another location (private or other NSW Health facility).
- a multidisciplinary clinical review/case conference with several providers from health facility/es. The patient is at home, at a health facility, or with another health or social care provider
- case conferencing and care planning with no patient present. Health providers are located across one or more facilities. These may or may not include other health or social care providers
- remote monitoring where a patient is provided with a device to monitor and report relevant patient metrics. The management of the patient data is closely monitored and regulated by local clinical guidelines and procedures
- remote monitoring where a patient's personal device is used to monitor and report relevant clinical diagnostics. The management of the patient data is closely monitored and regulated by local clinical guidelines and procedures.

Specific examples: cardiology, paediatrics, geriatrician, genetics, endocrinology, psychiatry, dietetics, physiotherapy, speech therapy, pre-admission clinics, post-operative clinics, sexual health clinics, mental health review, wound reviews, smoking cessation, weight management, diabetes clinics, breast screening, chest clinic – tuberculous medication supervision, high risk foot clinics and teledentistry.

Indirect services

Technology can support person-to-person interaction that supports the provision of healthcare. This may include:

- use of a healthcare interpreter
- inclusion of a patient's family, carer, social or educational provider.
- carer to clinician or healthcare provider.

Non-clinical use of technology

The same technology that is used for clinical care also supports corporate requirements. This can include day to day management of clinical services, project management, education, training and supervision. These sessions can be one-on-one between clinicians, small groups or larger groups to suit the purpose.

Videoconferencing can help our workforce and partners to increase their knowledge, skills and networks without leaving their community. This is beneficial from a capacity building and financial perspective (travel, accommodation, shift coverage) and can determine whether or not clinicians can access professional information and are well connected to their colleagues.

Organisers are encouraged to provide videoconferencing and live streaming of events. Even workshops can be successfully delivered virtually and, with some creative thinking, give participants a great experience.

The eHealth NSW Conferencing Services team can assist with videoconferencing and live streaming logistics. Organisers should contact the team in the initial planning stage, so they can assist and support with venue requirements. Where possible, NSW Health events should utilise the many facilities across the state that are connected to the NSW Health network.

The team can be contacted via email: **EHNSW-VideoConf@health.nsw.gov.au** or phone on 1300 679 727.

External providers and support services

External providers can be included to enhance the patient's holistic outcomes. They can be across health, social or educational sectors, including:

- affiliated health services
- cross-border health services
- residential aged care facilities
- general practice
- Aboriginal medical services/Aboriginal controlled health organisations
- non-government providers
- private providers
- educational providers
- other government organisations.

Workflow

The delivery of care virtually is an extension of existing face-to-face services. Changes to existing clinical workflow should consider the following steps:

1. Determine the clinical appropriateness of the provision of virtual care. The clinician has undertaken appropriate training and development to effectively engage and provide care using technology.
2. Develop patient information guides/resources.
3. Discuss with the patient the different modes of delivery relevant to their needs. A wide range of patient suitability considerations should be reviewed and monitored as their healthcare needs change. This may also include appropriate support at the patient end during physical assessments or when there are safety concerns for the patient, e.g. a risk of falls and mental health concerns.
4. Determine the location of all participants and the requirements of each location (see Spaces).
5. Determine the required hardware and software (see Communication Infrastructure and Hardware).
6. Schedule an appointment, book any required resources (human and physical) and arrange imaging or pathology (where required).
7. Conduct the appointment, including:
    - Arrive early to test or to arrange administrative or technical support to assist
    - Introduce all participants
    - For videocalls ensure all participants are captured in the video frame or ensure device can reposition to capture the participant speaking
    - Establish communication etiquette
    - Consider the use of signage (dependent on the location) to advise of the appointment to minimise distractions and to maintain patient's privacy.
8. Document in the patient record and complete activity reporting as per local requirements.
9. Complete other usual processes, such as scheduling the next appointment, referrals, patient correspondence and payment (where required).

Participants

Clinical and patient needs will determine the number of participants. The use of technology supports the integration of care and the holistic management of a patient's needs from multiple locations.

Patient suitability

The clinician will determine if virtual care is suitable, taking into account clinical and patient related factors. Virtually enabled models of care may require consideration of inclusion and exclusion criteria, but each clinical function will be an individual assessment and will vary from patient to patient.

The following factors should be considered:

- If a physical assessment is required
- Availability of support at the patient's location
- Availability and access to a suitable device e.g. videoconferencing units/systems or a personal device capable of videoconferencing
- Ability of the patient to participate such as physical, mental, social and cognitive barriers
- Local availability of required imaging and lab tests
- Patient desire to participate in a virtual care consultation
- Ability to schedule virtual care session within the timeframes for a service or program's standard of practice guidelines.
- If joining from home, the patient's access to fast internet connection
- Internet or mobile data quota/allowance
- Patient capability/capacity to access care this way.

If a patient is unable to access virtual care independently due to any of the above reasons, consider the following options:

- Can the patient attend their GP clinic or Aboriginal Medical Service for support?
- Can the patient attend a local hospital or community health centre?
- Can a family member or friend support the patient to connect to their appointment?

Equity of access

NSW Health aims to provide services that are non-discriminatory and equitable, providing patients with respect, understanding and compassion. Every patient is an individual and, regardless of the mode of delivery, healthcare providers should discuss the patient's needs with them and avoid making assumptions.

Adjustments may need to be made to the way virtual care is delivered. For example, adjustments may include support for patients with cultural differences, Culturally and Linguistically Diverse (CALD) backgrounds or living with a disability, complex health needs or challenging behaviours.

Where it is not possible to make adjustments and the quality of care is impacted, a patient should receive in-person care.

CALD Assist

Healthcare interpreters can join a consultation via video or telephone to assist with the delivery of care. This should be scheduled using the existing booking processes.

When accessing a video interpreter, it is expected that interpreters connect to existing clinical rooms. The clinician should take the time to brief the interpreter prior to connecting the patient. Where the clinical service does not have an established virtual service, the virtual interpreter room can be used.

CALD Assist is an example of an app that provides timely and effective basic care interactions when an interpreter is not available. CALD Assist was designed in collaboration with clinicians, specifically for use by nurses, dietitians, occupational therapists, physiotherapists, podiatrists and speech pathologists.

Deaf and hard of hearing

For patients who are deaf and hard of hearing, there are a number of options available which can support the delivery of care including:

- AUSLAN interpreters
- voice to text apps
- sound amplifying apps
- transparent face masks
- written notes.

Applications are available on open sources such as the App Store (Apple) or Play Store (Android). Up-to-date information on the best applications to use can be found on The Deaf Society website (**deafsociety.org.au**).

Etiquette

Patient etiquette

When offering virtual care, it is important to discuss and provide information to the patient that addresses expected etiquette. Patient etiquette information is available at **https://aci.health.nsw.gov.au/make-it-happen/telehealth/telehealth-for-patients,-carers-and-other-providers**

At the beginning of a consultation, clinicians should always introduce themselves and disclose if anyone else is present at the consultation. They should request that patients do the same.

Care between NSW Health facilities

Where there are two NSW Health facilities involved in a virtual appointment, the consulting end determines the choice of videoconferencing platform.

For example, if a patient is admitted to a rehabilitation ward and will attend a virtual follow up appointment at an outpatient clinic, it is up to the outpatient clinic to advise on the platform to be used.

In exceptional circumstances, the platform at the patient end may be used in order to meet the clinical need. All platforms must be endorsed for use within NSW Health.

Functionality

The technical solution used needs to be determined by the clinical requirements. These are often known as the functionality of the system. The following is a list of common functions available, these change with technology advancements and system upgrades:

- Audio/voice instant messaging
- Screen sharing
- Document sharing
- Sharing of session
- Waiting room
- Recording – in some clinical circumstances e.g. group work sessions
- Interactive features
- Connect to peripheral devices, e.g. digital stethoscope, probes and scopes.

As innovative models of care are developed, new requirements are realised. It is beneficial to liaise with your virtual care contact to ensure that new capabilities can be communicated and sourced through the appropriate channels.

Spaces

Across health facilities there are many spaces that are used to provide clinical services. In many cases there is already technology available (fixed or mobile), or the capacity to enhance existing equipment. Where there is limited technology available, the identification of new equipment to support the clinical need should ensure that it is fit for purpose.

All NSW Health facilities are enablers of virtual care. A reciprocal agreement exists between LHDs and SHNs to assist patients and their carers to utilise appropriate equipment to support successful virtual care consults.

Table 4. Suitable environments

Clinical	Non-clinical
First response • Call centre/control centre • Ambulance • Retrieval vehicles (helicopters/fixed wing aircrafts) **Hospital setting** • Resuscitation bay • Mental health safe assessment room • Adult and neonatal intensive care unit • Inpatient wards/bedrooms • Operating theatres • Outpatient clinics • Imaging (x-ray, ultrasound) • Physiotherapy group room/gym • Monitoring stations • Nurses station **Community settings** • Local community health facility • Patient's residence/workplace • Residential aged care facility • Courtroom • Aboriginal medical service • Affiliated health service • Correctional facility • Private provider • GP clinic • Gym	• Private residence • Workplace • Community identified space (library, etc.) • Accident site • Office space • Meeting rooms/boardroom • Simulation lab • Tutorial room • Huddle room • Auditorium • Lecture theatre

Spatial attributes

It is beneficial to engage with your local telehealth/virtual care manager or lead to support the identification of suitable spaces to conduct virtual care.

Consider the following attributes of the physical space that can affect the outcome of the clinical session:

- Facility (hospital, community, patient's home, private rooms, mobile)
- Size
- Environment (location of air conditioning vents/microphones/speakers)
- Wall and floor colours and finishes
- Lighting and window treatment
- Accessibility (wheelchair access, etc.)
- Furniture
- Room layout/orientation
- Installed technology
- Privacy (e.g. glass walls)
- Acoustics (including hearing induction loops)
- Dedicated or shared (whether the space is dedicated for clinical/corporate use).

When taking part in virtual care consultations, it is important to make sure the rooms that all participants use are private with no audible external noise or disturbances which might interrupt the consultation.

Open plan spaces

Before delivering clinical care in an open plan space, ensure that it is clinically appropriate for the type of consultation.

When providing care in an open plan space review the following suggestions:

- Always wear a headset (consider a high-quality headset to minimise background noise)
- If practical, consider using a divider or banner to block out the background (this should be wide enough to cover the camera angle and have minimal imagery so as to not cause distractions, e.g. only a simple logo). Do not use a banner if there is a risk it will be a trip hazard
- Consider the use of acoustic partitions or roof mounted partitions
- Set up a dedicated area in a quieter and less trafficked area of the office
- If available, consider using a smaller shared office for appointments.

Communications infrastructure

The technology and infrastructure within NSW Health facilities is supported by eHealth NSW and locally by your ICT team.

The NSW Ministry of Health, the pillar agencies and the LHDs and SHNs are all part of the Health Network and have direct access to internally networked unified communication infrastructure, this includes videoconferencing facilities.

There are three fundamental requirements to enable quality video consultations to take place:

1. Internet connectivity
2. Hardware
3. Software solution

ACI and eHealth NSW are constantly reviewing new technology and performing horizon scanning for the latest technology and pricing across multiple suppliers to ensure that the hardware meets the needs of the clinical workforce.

Internet connectivity

A quality internet connection with sufficient bandwidth is required at both ends of the consultation or this may cause a low quality consultation. A poor connection can result in audio problems, freeze frames, lip sync problems and pixellation.

The audio-visual quality of a video conference is directly related to the speed at which the data is transmitted along the internet connection. This is relevant when connecting to patients in a private location. For clinical video consultations, the recommended upload speed for the internet connection is 512kps.

Testing the speed of an internet connection can be easily undertaken by visiting **http://speedtest.net**. If the upload speed of the internet connect is too slow (i.e. less than 512kps), contact your internet service provider to discuss options for improving your current connection. NBN and 4G/5G wireless connections are the most desirable options. Satellite connections do not generally meet the minimum data transfer requirements.

If the internet connection cannot be improved, videoconferencing may not be possible. Participants may be able to test an alternative location or attend their local NSW Health facility where a quality connection can be assured.

If the current upload speed is adequate, it is also important to discuss the cost for the holder of the plan (whilst minimal) and whether the network can cope with the extra data transfer for video consultations. The extra network activity may have an impact, e.g. upload and download speeds slow dramatically on some network connections when extra data usage occurs).

Hardware

A variety of hardware (i.e. devices) is available for use by NSW Health employees to support clinical and corporate services. With technology advances and mobile equipment, the tools to implement care are now more accessible and efficient.

It is recommended that you engage with your telehealth/virtual care manager or lead who can help to identify existing devices, assist with the modification of existing devices (e.g. clinical carts, workstation on wheels), or purchase new equipment to support the clinical requirements.

The purchasing of hardware is regulated to ensure that it is interoperable with the existing local and state infrastructure and meets clinical standards. Your telehealth/virtual care manager or lead will work with clinical teams to ensure that the right equipment for the clinical need is:

- selected (fit for purpose)
- supported
- the latest model
- purchased at a competitive price.

telehealth/virtual care managers or leads and ICT department managers are encouraged to contact the eHealth NSW Conferencing Services team to assist with the identification of hardware, quoting and installation of all videoconferencing equipment.

The following hardware is commonly located in NSW Health facilities and mobile workspaces that support the implementation of virtual care services:

- Cameras (webcam, wall mounted, ceiling mounted)
- Microphones
- Speakers
- LCD screens (including dual monitor arrangements)
- Desktop computer/tablet/iPad/laptop
- Portable wireless trolley
- Workstation on wheels (WoW)
- VC trolley/cart
- Mobile phones
- Hearing induction coils
- Headsets
- Specialist mobile devices and a range of clinical peripherals are available. These include, but are not limited to: endoscopes, ultrasounds, intra-oral cameras, exam glasses, probes, blood pressure monitors, pulse/oximeters and digital stethoscopes.

Video conference equipment overview

The equipment identified in Table 5 may vary across organisations and from site to site.

Table 5. videoconferencing equipment overview

Equipment type	Description
Standard mobile trolley	Mobile videoconferencing system with high quality camera and features such as zooming in/out, voice tracking, etc. Small footprint trolley with the option of either a 32 or 43-inch TV.
Clinical mobile trolley	This may be an enhanced way of working to include videoconferencing software, high quality camera and features such as zooming in/out, voice tracking, etc. It is a small footprint battery powered trolley with screen.
Desktop video conference	All-in-one videoconferencing unit with life-size video on a 23-inch touch screen. A second monitor can be attached to enable access to health information systems (e.g. eMR) whilst a video conference is in progress.
Personal computer	Laptops provide mobility with a built-in webcam, remote access to health systems and videoconferencing capability.
iPad/Tablet	Tablets provide mobility with remote access to health systems and videoconferencing capability. Users can use both the forward and rear facing camera. The mobility allows for use within and outside of health facilities, providing greater accessibility and support to our patients wherever they may be.
Mobile phones	Mobile smart phones are widely accessible by clinicians, patient, carers and other providers. These devices (either Android or Apple iOS) can support web-based applications, including videoconferencing, as well as image capture, videos or clinical information transfer via clinical apps.

Equipment type	Description
Ceiling mounted cameras supporting video capability	Specialised install with clinical and technical features, including zoom, pan, tilt cameras to provide the best angles and vision of the patient during an emergency. These have the ability to connect additional medical devices for live vision. These are installed solutions in emergency (resus and paediatric Beds), ICU and neonatal units. Similar devices can also be installed in ambulances and retrieval vehicles.
Room based videoconferencing – wall mounted	A videoconferencing system is installed on the NSW Health Network. Often these rooms are shared spaces and can be used for patient/family consultations. They are suitable for a medium to large number of participants (based on the room size at each location). The room based systems are interoperable with NSW endorsed platforms. Option of single or dual TV setup with size options from 32–70 inches. These systems vary across the health system.

Platforms and software

eHealth NSW is responsible for providing ICT solutions across the public health system to enable excellent patient care. These solutions need to be clinically fit for purpose as determined by clinicians. eHealth NSW aims to ensure that technology is interoperable within the NSW Health infrastructure, user friendly, robust, private, secure and reliable.

eHealth has developed the **NSW Health Video Conferencing ICT Platforms Guideline** (available on NSW Health network) which outlines the platforms supported and endorsed for the delivery of clinical care. These platforms include:

- myVirtualCare
- Pexip
- Skype for Business

NSW Health organisations have access to a variety of unified communication systems that support virtual care. Our needs have changed, with an increasing need for staff and patients to be able to connect across the state and across jurisdictional borders to support patient care. This has led the NSW Health system to realise the benefits of statewide standardisation, and the impact that consistency has not only for our workforce, but for patients' ease of access.

It is important that NSW Health employees understand that accepting non-endorsed platforms, software and hardware may compromise the system and the organisation, placing themselves and their patients at risk. This practice is not supported in NSW Health and telehealth/virtual care managers or leads will assist to ensure that care can be provided using safe and effective tools.

When determining the platform and software to support a clinical service, the clinical requirements should be identified and matched to the functions or the capabilities of the platform(s) available.

Telehealth/virtual care managers or leads work closely with the ACI and eHealth NSW and can provide advice where new capabilities are identified by clinical teams.

It is recommended that clinicians have a high level of confidence before using videoconferencing platforms and remote monitoring interfaces for clinical use. This may be enhanced if clinicians are using the technology for administrative and educational purposes in partnership with their local support.

Being familiar with the systems used will help clinicians to be confident users and to be solution focused. In the event of a technical difficulty that prevents a quality consultation from taking place, clinicians should be able to calmly implement a backup plan, such as having a phone consult, rescheduling the appointment, or having other alternatives in place.

Service considerations

Carer engagement

The use of technology in healthcare enables the inclusion of carers in a patient's care, regardless of their geographical location.

Technology allows carers to be engaged at any point of the patient's healthcare journey (emergency, admitted and non-admitted) and also supports both the carer and the patient to be in different locations (e.g. the patient is physically with their clinician while the carer is at his/her workplace, or the patient and carer both virtually attend an appointment from two separate locations).

This provides carers with greater flexibility to manage competing demands alongside the multiple other responsibilities that they may be juggling. This saves them time, money and stress.

It is important to implement local strategies to promote the inclusion of carers at the point of care with clinical teams, patients and carers.

This may be as simple as amending existing patient and carer resources, introducing a process to identify and invite carers, or working with a communications team to showcase a carer story where virtual care has supported the healthcare journey.

As a NSW Health priority, every LHD and SHN has a NSW Health Support Program and a Family Carer Mental Health Program to support increased engagement and recognition of carers. See the **NSW Health website** for information.

Clinical documentation

It is a requirement that all clinical activity is documented in the patient's medical record, regardless of the modality of care. This should also include details of all participants providing advice or participating in the consultation.

For virtual care services, it is essential that medical record documentation is completed by clinicians at both ends of the consultation (if there are NSW Health clinicians at both ends) in accordance with medico-legal requirements.

Where the clinical service is provided by another LHD or SHN, it is expected that the patient is registered, and a patient record is established. This is particularly important to ensure the activity is recorded at both sites and can be counted and costed accordingly. If the patient is not registered in the external organisation, the treating clinician should provide timely clinical notes to be uploaded in the patient's record. eHealth NSW is in the beginning stages of supporting a single digital patient record for NSW. When this is implemented, the second registration process will not be required, as the patient's record will be accessible across all LHDs and SHNs in NSW.

Where there is only a treating clinician and no one is with the patient at the time of consultation, it is the responsibility of that clinician to enter the notes into the patient's medical record and to notify other relevant providers of the outcome of the consult.

Documentation timelines and follow up for virtual care consults are consistent with existing clinical processes for face-to-face consultations. It is important to ensure that there is clear communication for the responsibility of the referral process post consult, including communicating the responsibility of actions to provide the care plan.

Patient information

The information required is determined by the clinician(s) and is reflective of clinical standards, local guidelines and policies. This rarely varies from what would be required for a face-to-face appointment. The information may include the patient referral, test results, diagnostic images, lab reports, discharge summary and the care plan.

Where documentation is not kept within the patient's eMR, the patient may need to provide this in advance of the virtual care session. NSW Health staff may need to assist the patient to ensure that the patient information is transferred securely (e.g. transferred through a secure messaging service such as Argus, internal email to internal email, or scanned and uploaded into the patient's record by a NSW Health employee with appropriate access to patient records).

If using a videoconferencing platform, you will have the functionality to share your screen, which will enable you to share the patient's medical record and other files stored on the network or device being used. This may include previous episodes of care, electronic and paper charts, diagnostic images and lab reports. Where another clinician external to the patient is reviewing the patient's record via videoconferencing, the clinician sharing the medical record should document who they are sharing the medical record with and for what purpose.

Consent

In line with expectations for in-person services, the healthcare provider is responsible for explaining to patients which options and modalities are available to support their care requirements. The patient retains the right to identify the best option for them at the time and to vary this throughout the patient journey as their needs change. Regardless of the modality of care chosen, patients must be informed that their access to the service will not be affected if they change their mind on the modality of care.

Written consent is only required if consent is normally required for face-to-face sessions or for research. In this instance an ethics application will determine and provide approved documentation.

If the need to use virtual care arises in a situation where the patient is incapacitated, the patient and their carer should be advised of how virtual care supported their care and who was involved in the consultation.

Consumer enablement is the extent to which people understand their health conditions and have the confidence, skills, knowledge and ability to manage their health and wellbeing. Increasing consumer enablement can help people actively manage their health, remain in good health and avoid hospitalisations.

A guide to consumer enablement has been developed by the ACI to help clinical services to be more conscious of consumer needs, and how clinical services can adapt to provide consumer enablement as a part of the delivery of patient-centred care. The guide can be accessed at **https://aci.health.nsw.gov.au/networks/primary-care/consumer-enablement/consumer-enablement/guide**

Complaints

As per normal service delivery, patients accessing virtual care services should be advised on the process to make a complaint if they are not happy with their care. This is in line with the LHD or SHN and should be reported into the NSW Incident Management System (ims+).

Cross-boundary services

In supporting patient needs and clinical pathways, NSW Health organisations and services can occur across NSW Health facilities and state jurisdictions. Regardless of the modality to support the service delivery, medical providers must be credentialled in the LHD and SHN. It is also expected that a Service Level Agreement (SLA) or a Memorandum of Understanding (MOU) is in place that outlines the details of the service requirements.

Considerations for the model of care in regard to technical interoperability, especially for across state jurisdictions, should be included, as well as escalation pathways to assist if issues present. For more details on your local agreements contact your telehealth/virtual care manager or lead or other relevant contact (general manager) in your LHD/SHN.

The eHealth NSW Conferencing Services team has strong relationships with other state ICT teams and will assist to ensure a quality connection. They should be consulted prior to the clinical consult and can be contacted on 1300 679 727 or email:

ehnsw-videoconf@health.nsw.gov.au

Culturally responsive practice

Regardless of the modality of service delivery, patients whose health professionals are culturally responsive are more confident and motivated to access the health services they need. LHDs and SHNs will have a local policy and strategy to support culturally responsive practice and this should be included in the clinical redesign of technology enabled models of care

People's cultural background can affect the way they communicate, make decisions and manage their health. As a health professional, you need to understand how culture impacts people's understanding of health, wellbeing, disease and illness.

Cultural responsiveness is important for all priority populations and social and cultural groups, including:

- Aboriginal and Torres Strait Islander peoples
- People from CALD backgrounds
- refugees or displaced migrants
- people at all life stages, including end of life
- people with different abilities, including intellectual and cognitive disabilities
- lesbian, gay, bisexual, transgender, intersex and queer/questioning (LGBTIQ+) people.

NSW Health staff should review new digital technologies and be aware that not all functionalities will be culturally appropriate. These may also be individualised to the patient. Cultural advisers or a liaison officer should be engaged to better understand if any specific adjustments are required.

For more information on culturally responsive practice see the **Consumer Enablement Guide**.

Credentialing

Regardless of the position held, the provision of healthcare is related to individuals' credentials and the clinical scope of practice. Using a virtual modality does not require additional credentialing requirements.

It is expected that all NSW Health employees maintain clinical registration as a condition of their employment.

LHDs and SHNs have a responsibility to ensure all appointed clinicians provide services within the scope of their education, training and skills, and within the specific health facility's service delivery capacity.

The **Credentialing and delineating clinical privileges for senior medical practitioners and senior dentists policy directive PD 2019 _011** outlines the process to the skills of a senior medical practitioner or senior dentist with the needs of a healthcare facility. This ensures that the appropriate senior clinicians are providing appropriate services in the appropriate facilities.

This policy directive applies to visiting practitioners, staff specialists, clinical academics and senior dentists. It provides clarity about credentialing requirements when providing clinical advice and clinical management to patients across LHD and SHN boundaries.

Generally, cross-boundary pathways exist. With NSW Health credentialing processes being standardised, credentialing documentation can be shared and accepted across LHDs and SHNs. The local director of medical services or the medical administration team will be able to provide advice in regard to the local adoption of this process.

The Australian Health Practitioner Regulation Agency (AHPRA) is the organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia. AHPRA registration can be confirmed quickly on the website at **https://www.ahpra.gov.au**

When establishing services with organisations outside of NSW Health, including with private providers, the registration status of all clinicians involved should be provided to the organisation commissioning the service. This requirement should also be included in formal service documents such as an SLA or an MOU.

Education and training

Education and training for all staff to use the technology with confidence will further support the increased implementation and uptake of virtual care.

Locally and statewide developed resources and training modules are available and continue to be developed to reflect clinical service and patient requirements. NSW Health Staff should check training opportunities on My Health Learning.

It is recommended that you contact your local telehealth/virtual care manager or lead to find out more information.

Integrated care

Integrated care is a way of working that enables care to be provided in a way that reflects the whole of a person's health needs:

- from prevention through to end of life
- across both physical, psychosocial and mental health
- in partnership with the individual, their carers and family.

The use of technology in healthcare provides a seamless way to coordinate better communication and connectivity between healthcare providers in primary care, community, and hospital settings. It also provides better access to community-based services closer to home.

At the point of care, the use of telephone and videoconferencing technology can support multiple participants to be in the one consultation, bringing the physical and virtual participants together.

Legal considerations

Many clinicians raise concerns regarding legal issues when implementing virtual care. Generally, these concerns are easily resolved and in most circumstances are not handled differently to face-to-face services.

See the list of frequently asked questions in the resource section of this document. You can also discuss your concerns with your telehealth/virtual care manager or lead who can escalate your question to the Ministry of Health, Legal Branch.

Patient resources

Existing patient resources should be updated to include the alternative modalities that are available.

Additional resources to outline the alternative service modalities and how to access these should be developed for patients. These may include:

- what is virtual care?
- how will virtual care benefit my healthcare needs?

User guides for specific platforms, clinical interfaces, remote monitoring and clinical apps. Statewide resources are available via the **Virtual Care Central SharePoint site** and the ACI Website.

All patients will have a different network of support and varying degrees of familiarity and confidence with technology. It is good practice to help a patient to test the technology prior to their appointment, especially if they are going to be using their own device in a private location such as their home or workplace. This could occur at a face-to-face appointment or at a prearranged time, ensuring that the patient has access to the device that will be used and identified support people (if required).

There are multiple people that can assist to provide this level of patient support, including Aboriginal Health Practitioners, Clinical Support Officers, Project Support Officers and administrative staff. It is important to engage the complete team when integrating technology as a part of the model of care. This will build capability across the team and develop a sustainable workflow.

It is always good to promote service delivery in any patient newsletters, via social media and on local health websites. Your local telehealth/virtual care manager or lead or other key positions including the Communications team may provide you with support to develop patient resources and to promote the service.

Privacy, confidentiality and security

Every clinical relationship is based on respect for privacy and confidentiality. Individuals accessing health services via information and communication technologies are entitled to expect their privacy will be guaranteed to the same standard as face-to-face consultations.

The use and disclosure of personal health information by NSW Health agencies must comply with the requirements of the *Health Records and Information Privacy Act 2002 (NSW)*. These requirements apply regardless of whether services are provided by a virtual care modality or face-to-face consultation. The Act requires health services to comply with 15 Health Privacy Principles, including principles relating to the collection, use and disclosure of health information, and the transfer of health information outside of NSW. Particular care should be taken to ensure that the provision of services to patients outside of NSW complies with relevant privacy requirements.

The introduction of new solutions and technology (such as remote monitoring solutions, clinical interfaces and apps) require a comprehensive privacy and security assessment. The Privacy and Security Assurance Framework (PSAF) can be commenced through discussions with your telehealth/virtual care manager or lead, chief information officer and the eHealth Customer Account Manager (CAM). Further information is available on the **SARA portal**.

Some procedures clinicians should use to manage risks to privacy and confidentiality are outlined below:

- Inform the patient at the commencement of the consultation that their confidentiality will be respected, that all communications are secure and that the session will not be recorded. Explain to the patient that although the virtual care session will not be recorded it will still be documented through taking clinical notes, which will be entered into the patient's medical record (as happens in face-to-face consultations).
- Particularly in the case of new patients, ensure patients have received a copy of the **NSW Health Privacy Leaflet for Patients**. This can be emailed or posted to patients. It includes information about how health information may be used and disclosed by NSW Health and how to make a privacy complaint.
- If there is a valid reason for recording a consultation, the provider must receive the written consent of the patient or the patient's authorised representative prior to the consultation. Ensure that the consent and the recording are stored securely.
- Ensure procedures are in place to document all people who have access to confidential data. Ensure confidentiality agreements are signed by all people who have access to confidential information, including employees, contractors or consultants. For examples of confidentiality agreements, see the **NSW Health Privacy Manual for Health Information**.
- Ensure that there are no interruptions at either the clinician or patient end of the consultation. This includes using signage to alert other staff that a virtual care consultation is in progress.
- Ensure that when providing care, healthcare providers are in a private and sound-proof environment. Educate patients participating in the virtual care consultation to join from a suitable environment where they will not be disturbed.
- When choosing hardware and software for virtual care, considering the security features of the system to ensure the technology used facilitates privacy and confidentiality.
  - It is important to only use videoconferencing platforms that are supported by eHealth and your organisation. Using approved platforms ensures that you are providing a secure and private environment where a patient's privacy can be assured. Unsecure platforms that are discouraged for clinical and corporate uses include, but are not limited to, personal Skype, FaceTime, Zoom, WhatsApp, Snapchat, Facebook Messenger, etc.
  - When store and forward is used, consideration must be given to the methods of transmission and storage of images to maintain privacy, security and confidentiality (see Transfer of clinical information).
- Maintain appropriate secure storage of all reports provided for, or generated from, the consultation and ensuring compliance with NSW Government *General Retention and Disposal Authority policy (GDA17; 2011)*.

Please consult with your telehealth/virtual care manager or lead or chief information officer on the most suitable technology and software to ensure your consultations meet relevant privacy and data security requirements including the *NSW Health Electronic Information Security Policy (PD2013_33)*, *Photo and Video Imaging in Cases of Suspected Child Sexual Abuse, Physical Abuse and Neglect (PD2015_047)* and the NSW Health Privacy Manual for Health Information.

If you have questions regarding the application of the manual, please contact the Privacy Contact Officer in your health service.

Recording

With technological advancements, healthcare providers, patients and other participants may have devices that have the functionality to record consultations, e.g. most mobile phones have this feature. However, recording virtual care sessions is not standard practice.

The primary purpose of a virtual care service is the provision of patient care. However, in exceptional cases, there may be a justification for the provider to record a virtual care session for use for a secondary purpose. Secondary purposes that may be justified include educational and training purposes, research purposes or as a part of an evaluation of the service.

In the event of a recording, the patient should be consulted prior to the recording and advised on how this material will be recorded, used and stored. Consent should be formalised as per the local organisational protocols. The patient's authorised representative is usually either the patient's spouse, parent, carer, a legal guardian or an enduring guardian appointed by the patient. An explanation of the legal meaning of the term 'authorised representative' is provided in the NSW Health Privacy Manual for Health Information. If you have a question regarding who is the 'authorised representative' of a patient please contact the Privacy Contact Officer in your health service.

The consent should be documented in the patient's medical record and, where required, written consent received should be stored appropriately, uploaded into the patient's record or kept electronically with the recording. It is good practice to invite the patient to view the content of a recorded session prior to using the recording for the secondary purpose. Patients have the right to decline or withdraw their consent at any time. Where feasible, identifying information should be removed as part of the editing process, e.g. ensure the patient's name is not visible on tags, screens or documents appearing in the recording, and that personal information such as date of birth, address and marital status are not disclosed.

Recording sessions for research purposes should be included in the research project's ethics approval application. Formal documentation is required for research projects. The patient should be provided with information about the research project, including the purpose of recording the session, how it will be recorded and how it will be stored and managed. The patient should also be provided with a consent form to sign.

Patients should be advised that they should not attempt to record their consultation without permission. In some circumstances, a patient may request that she or he be permitted to record a session or request that the provider make a record of a session available to the patient or a family member. Such requests should be assessed according to the patient's circumstances and purpose of the recording. It is a breach of privacy if a patient records the consultation without consent and patients can be fined.

Transfer of clinical information

To maintain patient privacy and protect confidential information, it is important that the transfer of clinical information is secure.

When virtual services are being provided it is important that the clinician has all the patient information required. Please contact your LHD/SHN privacy contact officer or a local health information manager for advice and direction about local policies and protocols regarding the transfer of clinical information.

For clinicians external to the LHD or SHN, this information will need to be sent via a secure messenger or file transfer service. **Accellion Secure File Transfer** provides a means for staff to send and receive documents and files over the internet or network in a secure manner.

For further information, please contact the privacy contact officer in your health service.

Monitoring and evaluation of virtual care

Monitoring and evaluating clinical care has long been informing quality improvement and supporting innovation in healthcare at the local level.

The ACI is leading the implementation of the statewide Patient Reported Measures (PRMs) program. The program aims to enable patients to provide direct, timely feedback about their health related outcomes and experiences to drive improvement and integration of healthcare across NSW.

The PRMs program endeavours to support patients and clinicians and add value to their interactions. The program is divided into two sections:

- Patient Reported Outcome Measures (PROMs) are used to help assess and follow up a patient's clinical progress
- Patient Reported Experience Measures (PREMs) help to assess the patient's experience of the care received.

The development and implementation of the PRMs Program was identified as a key enabler in the NSW Health Integrated Care Strategy and Leading Better Value Care to support consumers, clinicians, LHDs, SHNs, PHNs and primary healthcare.

For more information on the PRMs program, see **aci.health.nsw.gov.au/make-it-happen/prms**

With the rapid uptake of virtual care and in alignment with the development of the NSW Health Virtual Care Strategy (2021- 2026), a Virtual Care Monitoring and Evaluation Plan has been developed. This will establish a framework to assess virtual care, provide information on the impact of investment and determine future opportunities to scale, spread and sustain appropriate virtual care models.

The monitoring and evaluation plan adopts a value based healthcare approach centred on the:

- outcomes that matter to patients
- patient, family and carer experiences of virtual care
- the clinician experience of delivering virtual care
- the efficiency and sustainability of virtual care.

This value-based healthcare approach to monitoring and evaluation will incorporate a common set of measures to assess the impact and outcomes of virtual care from a system perspective, and enable comparisons across cohorts, modalities and care settings. Districts will have the flexibility to tailor their monitoring and evaluation activities beyond the core set of measures to suit local needs.

In partnership with the NSW Ministry of Health, the Bureau of Health Information (BHI) has developed a retrospective virtual care patient experience survey and a virtual care clinician experience survey.

The NSW Health videoconferencing portal myVirtualCare (myVC) has the functionality for point of care patient experience feedback. All LHDs and SHNs using myVC use the same data set.

A number of services have implemented PRMs or patient satisfaction surveys. If you would like to implement a patient survey raise this with your local telehealth/virtual care manager or lead to understand the current state and to access existing surveys.

Services are encouraged to discuss monitoring and evaluation needs with your patient reported measures lead and telehealth/virtual care manager or lead to ensure that your survey is consistent.

Financial considerations

Activity reporting: Counting and costing virtual care services

There is not a widespread understanding of the importance of counting and costing virtual care activity, and there continues to be confusion regarding the funding of virtual care services. It is essential to understand the relationship between the classifying, counting, costing and pricing of services.

It is important to note that regardless of the modality, all care delivered in NSW Health facilities is funded, and there are multiple funding sources that support this activity.

To better support the understanding and increased reporting of virtual care activity, specific resources have been developed in consultation with LHDs and SHNs. These resources provide overarching recommendations, guidance and direct advice to ensure that virtual care activity is reflective of current virtual care service models and responsive to future innovative care.

The following comprehensive reports assist clinicians, service managers, telehealth/virtual care managers or leads, and employees working in performance and finance roles. These reports aim to enhance understanding and accurate activity reporting to increase the uptake of virtual care across NSW Health services (reports available on NSW Health network):

- Telehealth Master Guide 2019/20
- Telehealth End User Guide 2019/20
- NSW Activity Based Management and Activity Based Funding Compendium
- Non-Admitted Patiend Data Collection: Reporting requirements for services provided from 1 July 2019

It is important to engage with your local telehealth/virtual care manager or lead or performance management/finance team to identify the funding model and current Activity Based Funding (ABF) incentives that will apply to your model of care. They will ensure that you are reporting your activity correctly and accessing the appropriate funding model for your service (e.g. NWAU or Medicare Benefits Schedule). They will also support the set-up of processes to support applicable billing where services are revenue based.

For further Activity Based Management information, email ActivityBasedManagement@health.nsw.gov.au

For collecting and reporting information, contact MOH-DataGovernance@health.nsw.gov.au

Medicare funding

For services that would typically bill Medicare for a face-to-face consultation, it may be appropriate to bill for a virtual care consultation.

Medicare Benefits Schedule - Note AN.0.68 outlines the billing requirements for all video consultations provided by specialists, consultant physicians and psychiatrists, regardless of whether there is support at the patient end.

General requirements for these specialist services include:

- The patient can't be admitted (includes HITH)

  AND
- the patient can't be an emergency dept patient

  AND
- the patient must be located in a virtual care eligible area at time of attendance

  AND
- the patient must be located at least 15kms by road from specialist or consultant physician

  AND
- the item can only be claimed if the item requirements of the face-to-face service are met

  OR
- be a care recipient of a RACF with an s19(2) exemption (located anywhere in Australia) -15km rule doesn't apply

  OR
- be a patient of an eligible AMS ORACCHS with s19(2) exemption (located anywhere in Australia) -15km rule doesn't apply.

The consultant must be located in Australia, they can be located anywhere in Australia, but the patient must be in a virtual care eligible area at the time of the consultation. The patient, specialist or consultant physician must not travel to a place to meet this requirement.

Under *section 20A of the Health Insurance Act 1973* the patient's signature is still required on the assignment of benefit form (DB4).

COVID-19 Medicare funding

Due to the COVID-19 pandemic, Medicare has temporarily funded the delivery of virtual care for all. As of this guide's publication, these numbers may be billed by clinicians until 31 March 2021.

Efficiencies

Whilst not the driver for virtual care, in some circumstances there are system efficiencies that may result in cost savings.

As the use of virtual care increases, more opportunities for cost savings have been highlighted through service redesign and local quality improvement processes. The following list is not exhaustive. You are encouraged to speak with your direct manager and virtual care contact to explore innovative ideas to support clinical workflow and patient experiences and outcomes.

The following examples are relevant in the hospital setting and have significant impact on patient experiences and outcomes. Where clinically appropriate, consider the use of virtual care in these settings.

Reduced length of stay

Admitted patients may access HITH services if they can be safely and effectively managed at home. A statewide investment in remote monitoring equipment provides opportunities to safely discharge patients and continue to monitor their recovery at home. These devices may also have an impact as part of an early intervention strategy that reduces the number of admissions over time for chronic and complex patients.

Consultation liaison

Patients may receive access to specialist consults from their bedside rather than waiting for a bed in another hospital, waiting for the specialist to return to the hospital or transferring a patient to another facility. It is preferable to use videoconferencing to support this initiative so the specialist can speak with the patient. This may remove the need for patient transport, which includes a driver, vehicle and a nurse to accompany the patient.

Additional participants, such as a carer or the patient's GP, can be easily included in these consultations, supporting continuity and transition of care.

Time efficiency

Across all organisations there is both the opportunity and the requirement to participate in training, education, mentoring, clinical supervision and organisational meetings. With some additional planning and training, these can be completed virtually with ease, resulting in greater efficiency and significant cost savings. It is preferable to use videoconferencing over telephone to promote participant engagement and connectedness. It is important for the whole system to lead by example. When not offered you should enquire about the possibility of these virtual activities, as this can often start the conversation.

More common in metropolitan organisations, staff can frequently move between facilities for clinical needs. With the use of technology this can be alleviated, thus impacting on rosters and unproductive use of resources, especially clinical time.

Virtual care can also support specialists who are 'on call' to provide clinical assessment and consultation from their home before determining next steps.

Service availability

Having a virtual workforce provides opportunities to maintain the continuity of services. This can provide cost savings, as employees may be remotely located reducing the need to enter into expensive private contracts. This can also be used as a strategy to support service continuity whilst vacancies are being recruited. You may engage with other LHDs or SHNs to provide a virtual workforce or temporarily employ a virtual provider to maintain the service.

Workforce

The integration of virtual care offers many opportunities to provide and enhance service delivery. This in turn provides greater choice, opportunity, diversity and flexibility that can be very attractive to prospective employees and enhance retention of the existing workforce.

As the integration of virtual care becomes normal business, the technology will continue to evolve and there inevitably will be much greater need for a virtualised workforce. With a virtual workforce, acceptance of non-traditional working environments will be required.

There are already many innovative models of care in place that inadvertently provide effective workforce strategies. We encourage clinicians to continue to redesign models of care and to be innovative in thinking about how a virtualised workforce may assist to keep a skilled, happy workforce that meets the clinical service needs of your organisation.

Resources

Key documents

Strategic Review of Telehealth in NSW: Final Report 2015 Nous Group

https://www.health.nsw.gov.au/telehealth/Documents/strategic-review-of-telehealth-in-nsw.pdf

NSW Telehealth Framework and Implementation Strategy 2016-2021

https://www.health.nsw.gov.au/virtualcare/Publications/nsw-telehealth-framework.pdf

NSW Health Virtual Care Strategy (2021 – 2026) Under development.

https://www.health.nsw.gov.au/virtualcare/Pages/default.aspx

NSW Health Video Conferencing ICT Platforms

http://hseh.intranet.health.nsw.gov.au/__data/assets/pdf_file/0009/1237698/HS20-4287-Video-Conferencing-Platforms-Guideline.pdf

Virtual care Community of Practice

https://nswhealth.sharepoint.com/sites/VirtualCareCoP-ACI

Telehealth Capability Interest Group

https://aci.health.nsw.gov.au/make-it-happen/telehealth/telehealth-capability-interest-group

Consumer Enablement Guide

https://aci.health.nsw.gov.au/networks/primary-care/consumer-enablement/consumer-enablement/guide

Centre for Healthcare Redesign

https://aci.health.nsw.gov.au/make-it-happen/centre-for-healthcare-redesign

Privacy Manual for Health Information

https://www.health.nsw.gov.au/policies/manuals/Pages/privacy-manual-for-health-information.aspx

NSW Health Privacy Contact Officers

https://www.health.nsw.gov.au/policies/manuals/Pages/privacy-manual-for-health-information.aspx

Privacy Assurance Framework.

https://sara.health.nsw.gov.au/customerportal?id=sc_cat_item&sys_id=b5a0fbd0db550810b9d0cef40596199f

Virtual Care Central SharePoint

https://nswhealth.sharepoint.com/sites/aci-VCCentral

Contact ACI-VirtualCare@health.nsw.gov.au to become a member.

Virtual Care Exchange

https://nswhealth.sharepoint.com/sites/ACI-VCCENTRAL/SitePages/Innovation-Exchange.aspx

ACI Innovation Exchange

https://aci.health.nsw.gov.au/ie/projects/police-ambulance-early-access-to-mental-health

https://aci.health.nsw.gov.au/innovation-exchange/projects/v-dots

https://aci.health.nsw.gov.au/innovation-exchange/projects/unlocking-care

https://aci.health.nsw.gov.au/innovation-exchange/projects/improving-the-critical-care-advisory-service

https://aci.health.nsw.gov.au/innovation-exchange/projects/collaborative-care-outreach

https://aci.health.nsw.gov.au/innovation-exchange/projects/confident-and-connected-at-home-on-haemodialysis

https://aci.health.nsw.gov.au/innovation-exchange/projects/enhancing-remote-physiotherapy-services

https://aci.health.nsw.gov.au/innovation-exchange/projects/transforming-acute-stroke-care

Virtual care videos

Pain management

https://vimeo.com/249756219

Genetics

https://www.genetics.edu.au/health-professionals/online-learning/tele-health/index.php

NETS Ambulance

https://vimeo.com/275759689

Patient flow and critical care advisory service

https://www.youtube.com/watch?v=pK5I44s66YM

Hunter New England LHD Patient story

https://www.youtube.com/watch?v=yfFPHLIinHM

St Vincent's Hospital Network

https://www.youtube.com/watch?v=7O8yXgrx93g

Virtual reality in the paediatric environment

https://www.youtube.com/watch?v=3Kg7-Ww77qc

Virtual care: Fiona and Killian's story

https://vimeo.com/516010766

The benefits of virtual care

https://vimeo.com/515997565

About virtual care (animation)

https://vimeo.com/516012935

Patient resources

Agency for Clinical Innovation: Attending your appointment using telehealth

https://aci.health.nsw.gov.au/__data/assets/pdf_file/0004/573268/ACI-Telehealth-Generic-Appointment-patient-fact-sheet.pdf

Agency for Clinical Innovation: Attending your appointment using telehealth

https://aci.health.nsw.gov.au/__data/assets/pdf_file/0003/573267/ACI-Telehealth-Attending-an-appointment-using-telehealth-patients.pdf

Western NSW LHD: Preparing for a telehealth appointment

https://wnswlhd.health.nsw.gov.au/our-services/telehealth/telehealth-for-patients#preparing-for-your-appointment

Western NSW LHD: What is telehealth?

https://youtu.be/Edq8MH0e5Q4

Hunter New England LHD

https://www.youtube.com/watch?v=Zf-773FWzvw

Frequently asked questions

When can virtual care be used?

Virtual care can be used whenever it is clinically appropriate and as long as the patient meets suitability criteria. For example: the patient is accepting of receiving their care virtually, doesn't require support and has a suitable device.

Even when the patient is attending in person, the use of technology can support carers or other social or health providers to connect to and be involved in the consultation.

Consent

Do you need to gain/keep formal consent from a patient when offering or providing virtual care?

Patient consent to medical treatment can be in writing, given verbally, or implied by the patient's participation or acquiescence to treatment (for example, holding out their arm to receive a needle).

You should be able to infer a patient's consent to a consultation based on their participation in the consultation. No special consent is required to offer or provide virtual services

However, patients should be offered the option of a either a face-to-face or virtual care consult and should be informed of any limitations for either approach.

For research purposes, ethics applications will require approval of participation and may also include the recording of clinical sessions. This documentation will need to be kept and the process requirements will be included as a part of the ethics approval process.

Recording

What permissions are required to record a virtual appointment?

Neither patients nor staff can be recorded without their knowledge and consent.

If you are seeking permission, a discussion should occur with the patient prior to the appointment to ensure that the patient has been provided enough time to ask questions and consider the reasons for recording the session and any benefits of recording. Information will need to be provided to the patient about the use, storage and management of the recording. This needs to be in line with existing NSW Health policies. The recording can be provided to the patient.

If a consultation is being recorded, the consent should be documented in the patient's medical record. Where required, written consent received should be stored appropriately, uploaded into the patient's record or kept electronically with the recording. Patients should be aware that if they do not consent to a consult being recorded, that does not mean that no record will be kept. The health professional is still be obliged to keep a written record of the consultation in the health record.

When is it appropriate to record a session?

Recording the audio and visual of a clinical appointment is rare. Cases where recording could be appropriate include for further clinical review by another healthcare provider, to document progress of the treatment plan, to demonstrate or model therapy, to manage risk, or for education and training.

If a session is being recorded and the recording will be used for purposes not related to the care and treatment of the individual patient (i.e. for research or training), then written consent of the patient should be obtained for that use.

How do I get a session recorded?

This depends on the platform that you are using. You should discuss your needs with your service manager and local telehealth/virtual care manager or lead who will provide information based on the platform requirements. It is recommended that this is formalised as privacy legislation requires the recording to be securely managed.

Credentialing

What are the key things that should be included in an MOU/SLA between districts for virtual care?

Generally, care pathways are already in place. Depending on the service arrangement, the operational model may be face-to-face, blended or entirely delivered remotely. These arrangements will vary depending on the clinical service.

Credentialing of service providers will occur as part of the normal processes. This ensures that providers are credentialed to provide the service within their scope of practice. The mode of delivery (face-to-face or via virtual care) does not require specific credentialing.

Some additional requirements should include technology implications and escalation processes if connection issues are experienced, and inclusions to support a quality user experience at both the clinician and patient end. The local telehealth/virtual care manager or lead will be able to provide advice on adjustments to support service implementation.

What credentialing, if any is needed for a clinician to provide virtual care?

No separate credentialing requirements are required to provide virtual clinical services.

What is classified as advice as opposed to providing clinical services across boundaries?

Providing advice is considered a normal expectation under the employment of NSW Health. This is discussed in detail in the **NSW Health Policy: Credentialing & Delineating Clinical Privileges for Senior Medical Practitioners & Senior Dentists PD: 2019_011**. This is not considered clinical management of a patient, and the primary provider maintains responsible for the patient's care plan. Credentialing is not required for the provision of advice.

Providing advice to and from jurisdictions other than NSW

How does differing state laws and LHD policy impact virtual consultations if the clinician is conducting the consult while physically located in another jurisdiction?

Registration

The National Law for the registration of medical practitioners means that registered practitioners can now legally practice in all jurisdictions in Australia.

See **https://www.medicalboard.gov.au/codes-guidelines-policies/faq/information-interjurisdictional-technology-consultations.aspx**

The Medical Board of Australia expects that medical practitioners:

- providing medical services to patients in Australia will be registered with the Board regardless of where the practitioner is located
- consider the appropriateness of a technology-based consultation for each patient's circumstances
- comply with the requirements of the Health Practitioner Regulation National Law as in force in each state and territory (the National Law) and the Board's registration standards, codes and guidelines including the Professional Indemnity Insurance Registration Standard, which requires that a medical practitioner is covered for all aspects of their medical practice
- who conduct technology based consultations with a patient who is outside Australia establish whether they are required to be registered by the medical regulator in that jurisdiction (for example, the General Medical Council for a patient in the United Kingdom)
- ensure that their patients are informed in relation to billing arrangements for consultations and whether the patient will be able to access Medicare or private health insurance rebates.

Conduct (misconduct)

Conduct complaints and investigations are managed in the jurisdiction in which the conduct in question occurred. Therefore, a practitioner whose principal place of practice is in NSW who misconducts themselves when providing advice to a patient whilst at a conference in Melbourne would have that matter dealt with in Victoria. Medical Defence Organisations may have views as to whether they would assist a practitioner respond to a conduct issue in another jurisdiction.

Performance (impairment)

If a health practitioner has an incident being dealt with as a performance issue or a health issue, it would be managed in the jurisdiction of their principal place of practice.

Negligence claims

Patients can commence claims in the jurisdiction where the incident occurred or where they reside. There needs to be a connection between the claim and where it is filed. This means that if advice is provided outside NSW, patients may be able to choose which jurisdiction to bring their claim. Some jurisdictions can award higher amounts of compensation than others and this would be a consideration. Generally, any claims against NSW Health professionals should be filed in NSW courts. This is so they can be managed by local lawyers according to NSW laws, thereby saving costs. The insurance cover would for claims in other jurisdictions would need to be investigated/considered.

Insurance

The existing insurance arrangements for NSW Health staff are as follows:

- All employee doctors, including Level 1 Staff Specialists (including when treating private patients), and Level 2–5 Staff Specialists are covered by the legal liability section of the Treasury Managed Fund Statement of Cover (version 4.1.1) (TMF) when treating public patients.
- Relevantly, sub-clause 4.1(a) of the TMF provides that the TMF covers all sums which the TMF Agency becomes legally liable to pay by way of compensation and damages in respect of claims, caused by an occurrence, in connection with the activities of that agency worldwide and happening during the period of cover. Sub-clause 4.1(c) extends this cover to an employee of a TMF Agency, subject to the exclusions in clause 4.3.
- Where such an employee is delivering services within the scope of their employment, acts reasonably in the circumstances and makes full and frank disclosure of all relevant circumstances, they will likely be covered by the liability section of the TMF, subject to the exclusions in clause 4.3.
- For Level 2–5 Staff Specialists exercising rights of private practice and who have entered into a contract of liability coverage for indemnity under the TMF, there is indemnity in respect of services provided to private rural and/or paediatric patients in or at public hospitals or as part of other services provided by the Public Health Organisation.
- For Visiting Medical Officers (VMOs), indemnity for particular services will depend on their specific contract of liability coverage. Note that the TMF will not cover any claim that does not fall within the terms of coverage set out in the contract of liability coverage between the LHD and the VMO.

Outside Australia

Technology is now more mobile than ever before and patients are increasingly accessing services on their personal devices, meaning their location may not be known before they connect.

In general, there appears to be an unquantifiable legal risk in that a practitioner needs to ensure that providing services to a patient located in another country does not breach any legal requirements of that country, though the legislation varies globally. For example, a practitioner may need to comply with the registration requirements of the medical regulator of the jurisdiction in which the patient is located before delivering medical services to the patient. Issues of liability and choice of law/jurisdiction may also arise.

The legal risks with providing services overseas are impossible to quantify and so this is not recommended without a thorough review of such services and the incorporation of explicit advice about this in policy. This may include considering whether the virtual care is clinically necessary or whether there are alternative options, such as rescheduling the appointment or advising the patient to seek the advice of a local practitioner at their overseas location. It would also be advisable to develop a protocol where a preamble is used when a patient signs into a service. This should state that the advice is provided to the patient on the understanding that they are in Australia and the patient must let the practitioner know if this is not the case.

Service provision and access

Can you refuse to provide a service if you don't think it is clinically appropriate to deliver virtually?

Yes. This will need to be explained to the patient, carer(s) and other provider(s) (if required). Generally, a practitioner should be satisfied that an examination or observation using a method such as videoconferencing can be carried out with sufficient skill and care so as to form a clinical opinion. The practitioner should be competent at communicating over the relevant medium (in this case, videoconferencing) and using any remotely controlled devices involved, as well as understand the possible limitations of the process. Such limitations could include an inability to do a hands-on assessment where required, lack of appropriate technology or potential issues with the quality of images or audio and video links.

There may be alternatives to who can provide support at the patient end to assist in ensuring that it is clinically appropriate.

Can a clinician identify participants not suitable for virtual care (e.g. dementia, disability)?

Patients should be assessed on a case-by-case basis and based on their functional capacity, rather than on their condition or diagnosis.

Where a patient is assessed as not having capacity, it may still be possible for them to participate in a virtual care consultation with their parent/guardian/person responsible present

Can you provide virtual care appointments to people on holidays in Australia or abroad?

Technically, it is possible to provide service in this case, but the situation should determine the provision of service. Generally providing consultations under these circumstances is not recommended. A clinical decision is required to determine the need to continue the service, which will consider the service required and time away from home or possibility to transfer care to a local provider whilst away.

Providing advice in the event of an emergency or supporting continuity of care of a patient receiving treatment overseas would be considered appropriate and a part of normal expectations.

Can a clinical Medical Officer (MO) refuse to provide support services via video if the LHD has developed an appropriate model of care to use when there is no MO onsite?

This is an employment/code of conduct issue for the LHD to manage with staff.

Are there any special legal considerations regarding the use of virtual care following patient trauma (for instance, sexual assault)?

In these circumstances particular attention needs to be focused on ensuring appropriate consent is obtained. Ask your local team about legal requirements

The patient's needs must be prioritised and this matter should be treated with greatest sensitivity. The patient may not wish to be transported to another facility to have an assessment, so virtual care may support them toaccess this service close to home under the guidance of an experienced clinician.

Access to appropriate trained and qualified senior doctors to provide a specialised assessment is paramount. Generally, it is recommended to access a suitably qualified senior doctor (for instance, someone skilled to collect samples/evidence within the time required).

Is a misdiagnosis via virtual care any different to a misdiagnosis following a face-to-face appointment?

No. Clinicians have a duty of care to their patients regardless of whether they review in person or via a virtual care modality.

However, the precise nature of the duty owed to the patient might vary depending on the circumstances and whether advice is provided by video. Clinicians must ensure that they ask the right questions and give the right, or at least reasonable answers, and are mindful of any impact the technology is having on their ability to do this.

There might be some increased risks, some decreased risks, and some new risks, as with any new service method.

Patient information

Do our NSW Health patient brochures need to be amended to include virtual care, or are they suitable regardless of modality?

Patient brochures have applicability regardless of the modality. There are no special requirements for services delivered by virtual care. Clinicians may need to consider how they provide these to the patient if their service does not include an initial face-to-face service. This may require emailing or sending by post to the patient or to the secondary service provider to provide at the time of service.

Clinical documentation

Who needs to document a virtual consultation?

All providers should document in the patient record. Where there are multiple providers in one LHD, it is reasonable to review and note that you have reviewed the entry and add any further detail (as required).

It is expected that clinicians across LHD boundaries should register the patient and document in the patient record. Alternatively, patient documentation can be provided by another LHD and uploaded into the local file to support a clinical note.

This requirement will be removed when a single digital patient record is available across NSW Health, however that is not expected to be available for a few years.

What are the implications of providing a virtual consult and accessing images that are not stored (but are used to inform the diagnosis)?

This is a risk for the facility and health professionals.

It would be difficult to later prove that the diagnosis or treatment was reasonable if it was based on an image or other record that was not kept.

Technology devices

What equipment does the patient need?

This will depend on the service, clinical need and the modality chosen to suit their needs. Most patients have access to a phone, however not all will have an appropriate device (smartphone, tablet) with a data plan that allows them to participate in video calls.

This also applies to personal devices, peripherals or other remote monitoring devices that may be used to support clinical care. Clinicians should not assume that patients have access to the required technology and should discuss this with each patient. This may include a discussion about their personal devices or those that they can access through a carer, workplace or from another health facility or social care provider.

What equipment does the clinician need?

This will be determined by the clinical requirement and the virtual modality deemed suitable. NSW Health employees should use equipment that is fit for purpose to ensure that the clinical information can be provided completely and that all participants have a quality experience. There is a vast range of technology available to support clinical needs. Appropriate equipment should be identified by a clinician, detailing their current clinical workflow that reflects best practice standards. The technology should be matched to support the clinical workflow, rather than changing the clinical workflow to fit the technology. Your local telehealth/virtual care manager or lead can assist to identify appropriate technology and should be a first point of contact to discuss your clinical needs.

Can I use earbuds in lieu of a headset?

The quality of earbuds vary. Some provide high quality sound and reduce or cancel out background noise, whereas other do not. The device chosen should provide clear audio and, if it does not, alternative options should be implemented. This may include postponing the consultation or transferring the care face-to-face.

Funding of clinical services

How does funding work for virtual care?

This is dependent on the service and is relevant to how service manager, telehealth/virtual care manager or lead and finance team to determine if your service is block funded, will report ABF or will claim Medicare. This will ensure that you set up your clinic correctly.

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Glossary

Term	Definition
ABF	Activity based funding
ACI	Agency for Clinical Innovation
Affiliated health organisations	Not-for-profit religious, charitable or other non-government organisations that provide health services and are recognised as part of the public health system under the Health Services Act 1997.
Bandwidth	A measure of the capacity of an electronic transmission medium (ie a communications channel) to transmit data per unit of time – the higher the bandwidth, the more data/ information can be transmitted.
Broadband	Telecommunication that provides multiple channels of data over a single communications medium using frequency multiplexing- the term can refer more generically to a higher bandwidth that will support real-time, full motion audio and videoconferencing.
CALD	Culturally and linguistically diverse
Carer	Carers are individuals who provide unpaid, informal care and support to a family member or friend who has a disability, mental illness, drug or alcohol dependency, chronic condition, terminal illness or who is frail.
CIO	Clinical Information Officer
CXIO	Chief Clinical Information Officer
Connectivity	The ability of systems to interact, among the various operating systems on local, regional, national, and ultimately, international scales.
Desktop video conference	The ability to engage in a videoconference, using high definition face-to-face communications from a personal workstation.
Direct clinical care	Care that is provided between provider/s and the patient and carer/s.
Electronic Health Record (eHR)	A longitudinal collection of personal health information concerning a single individual, entered or accepted by healthcare providers, and stored electronically. The information is organised primarily to support continuing, efficient and quality health care and is stored and transmitted securely. The EHR contains information which is a) retrospective: an historical view of health status and interventions; b) concurrent: a now view of health status and active interventions; and c) prospective: a future view of planned health activities and interventions.
Electronic Medical Record (eMR)	The eMR is a single database where patient details are entered once and then become accessible to all treating clinicians, with authorised access, anywhere in the hospital. Information gathered about the patient from many hospital service departments can guide clinical decisions through rules and alerts brought to the attention of clinicians.
Encryption	Asecurity feature that ensures that only the parties who are supposed to be participating in a video conference or data transfer are able to do so.
Firewall	A hardware or software based system that filters network traffic based on a set of rules. Simple firewalls normally block access to specific ports.

Sources: Blignault, I and Crane, M. Australian Telehealth Glossary of Terms. University of Queensland, Queensland Health; 1999.

Health Support Services NSW Health. What is the eMR? [Internet]. 2014 (cited 2014 Sept 4). Available from: http://nswhealth.moodle.com.au/DOH_HSS/eMR/wbt/index.php/home

Term	Definition
GP	General practitioner
ICT	Information communication technology
Indirect clinical care	Clinical discussions between providers/carers where the patient is not present.
Internet Protocol (IP)	The basic language when referring to connection of technical systems (i.e. videoconferencing units) using the internet.
Latency	The delay between the length of time it takes a packet to move from source to destination.
LHD	Local health district
Local site	In the context of telecommunication, the site that is geographically connected to the remote site.
Local Area Network (LAN)	A computer network linking computers, printers, servers and other equipment within an enterprise, which can also support audio, video and data exchange.
Modality	The service contact mode.
NGO	A non-profit organisation or provider that operates independently of any government.
Packet	A unit of data made into a single package that travels along a given network path. Data packets are used in IP transmissions for data that navigates the web and other networks.
Packet loss	When one or more packets of data travelling across a computer network fail to reach their destination. Packet loss is either caused by errors in data transmission, typically across wireless networks, or network congestion.
Peripheral devices	Attachments to a virtual care system to augment communications and/or medical capability by capturing images, anatomic sounds or other physiological parameters, including items such as electronic stethoscopes, ophthalmoscopes, video cameras and scanners.
Picture archival and communications system (PACS)	Also known as digital image management systems and digital image networks. These systems, although generic in concept, apply to many medical and non-medical applications, are generally associated with the digitalisation of radiology departments. PACS consist of various modules integrated to form a coherent system: • image acquisition • digital networks • image archives; and • image display workshops.
Pillar	A distinct organisation within NSW Health that provides expertise and support for the public health system. Pillars of NSW are: the Agency for Clinical Innovation, Bureau of Health Information, Cancer Institute NSW, Clinical Excellence Commission and Health Education and Training Institute.
Point-to-point videoconferencing	Direct communication between two systems via a communications link.
Provider end (hub site/ clinical end)	The clinician whose expertise is requested via a physical referral or telemedicine referral.
Receiver end (spoke site/patient end)	The site at which the primary assessment, examination or activity is conducted and from which a referral is made to another practitioner.
Referring practitioner	The healthcare provider who initiates a referral following a primary examination.

5 Wade, V. (2014). How to make telehealth work: Defining Telehealth Processes and Procedures. 2nd ed. Adelaide: e-unicare, pp.1-43. Available from: www.e-unicare.com.au/wp-content/uploads/2014/10/unicare_ebook_edition_2.pdf

Term	Definition
Remote patient monitoring	The monitoring of patients outside of conventional clinical settings (e.g. in the home) which may increase access to care for patients and decrease healthcare delivery costs.
Remote monitoring	Using technology to collect and send medical and healthcare data to an app, device or service outside the traditional clinical setting.
Remote site	In the context of telecommunications, any site that is geographically separated from the local site.
Resolution	Number of pixels per unit of area. The more pixels the higher the resolution and detail of an image. There are two components: • contrast resolution measures the ability of distinguishing two objects of different composition • spatial resolution is related to the sharpness of an image, measuring the ability to separate two closely placed objects.
SARA	Search and Request Anything
Service contact mode	The mode of service delivery (in person or using a suitable virtual modality).
SHN	Speciality health network
Store and forward	A mode of transmission involving data that have been acquired and saved in format, e.g. a digital camera is used to take images of a patient's skin condition, which are electronically saved to a computer hard drive and subsequently transmitted.
Teleconferencing	Interactive electronic communication between two or more people at two or more sites, using voice transmission systems.
Virtual care	Also known as telehealth, virtual care is any interaction between patients and/or members of their care team occurring remotely, using any forms of communication or information technologies with the aim of facilitating or maximising the quality and effectiveness of patient care.
Virtual care activity	Any health-related activity that is conducted at a distance between two or more locations using technology-assisted communications. Virtual care activities can be classified, but not limited by, the following: • patient care services, e.g. consulting or diagnostics see also virtual care services • education and training, e.g. mentoring, continuing medical education, distance learning • management and administration • research and evaluation • consumer and community use • health promotion; and • public health.
Videoconferencing	Connection of two or more people or locations via video camera and monitors, allowing all parties to speak to each other, see each other and in some cases exchange data simultaneously.

Appendix: Virtual care implementation checklist

This implementation checklist is designed to help guide your approach to offering virtual care services and enable their successful implementation.

This tool can be completed at any stage of virtual care implementation, both during initial set-up to identify key areas for inclusion in your service, and to identify areas for improvement once services are already offering virtual care.

Your service may not yet meet each of these requirements, but this shouldn't be a deterrent for using virtual care.

Consideration	Yes	No	Comments
Getting started			
Identify opportunities and a need for virtual care to enhance service provision.			
Engage as early as possible with the telehealth/virtual care manager or lead regarding virtual care implementation, including: • understanding the current model of care and adaptions needed to support an effective virtual care workflow • broader considerations when implementing virtual care • identifying appropriate modalities (telephone, videoconference, remote patient monitoring, store and forward) • identifying the most appropriate videoconferencing platform in line with the services nere and equipment requirements, • quotes and demonstration of suitable solutions.			
Identify a project lead for implementing virtual care.			
Establish executive support for virtual care. This may be from a head of department, service manager or clinical director.			
Ensure there is a mechanism for the project lead to discuss and escalate with the executive member.			
Engage with key individuals affected by the addition of virtual care, this may include: • clinicians • administration staff • service managers • consumers and their families/carers.			
Ensure there is a timeline of key tasks and milestones to embed virtual care in the service.			

Consideration	Yes	No	Comments
Understanding the need for virtual care			
Consider if virtual care will be delivered in a standalone session or integrated into existing clinic sessions.			
Collect appropriate data to support the case for enabling virtual care.			
Identify which patients are in and out of scope for virtual care.			
Review existing administration processes for scheduling and communicating appointments to patients and how they will need to be adapted for virtual care.			
Planning the change			
Ensure there is an appropriate physical space to deliver virtual care.			
Identify an administration process to schedule patients for virtual care, including: • how patients will be provided information before and after the appointment • scheduling of follow up appointments (face to face or virtual).			
Identify how and when virtual services will be promoted to consumers and other clinicians (e.g. verbal, posters, letters to GPs, referral triage forms, booking follow up appointments).			
Consider the safety and clinical governance implications of delivering care virtually, including: • escalation process in the event of deterioration • governance and leadership • local policies and guidelines • clinician confidence and skill • statewide virtual care policies and guidelines.			
Establish a standard and consistent method for: • recording consultation notes in a patient's medical record (if between NSW Health sites this needs to occur at both ends) • reporting occasions of service/activity (if between NSW Health sites this needs to occur at both ends).			
If the service intends to bill Medicare, consult with a revenue manager or business manager to ensure processes are compliant with Medicare rules. Consider: • the process to obtain a billing consent • the process to obtain an up to date referral.			
Consider how clinicians will access investigations (e.g. imaging, pathology) conducted at non-NSW Health facilities and how to process referrals, scripts and patient information following a consultation.			

Consideration	Yes	No	Comments
Planning the change (continued)			
Undertake a discussion with team members and other clinicians who will be engaging in consultations/case conferencing via virtual care. This may include: • changes in roles and responsibilities • training on how to use the platform • etiquette on delivering care virtually • how to access technical support (e.g. local desktop support and eHealth Conferencing support).			
Conduct a virtual care pilot with select patient groups to test the proposed approach prior to wider implementation.			
Consider opportunities for patients to ask questions before, during and after their virtual appointment.			
Ensure patients have a device suitable for accessing virtual care.			
Ensure patients have adequate data quota and internet bandwidth to access virtual care.			
Ensure patients receive all relevant clinical and service information and advice for participating in a virtual appointment. This may include: • service information e.g. operating hours, complaints process etc. • how to join the appointment • how to include carers, family and other health and social care providers in the virtual appointment • general patient information about virtual care.			
Establish a process to explain to patients that virtual care is only used when clinically appropriate. Ensure they have the opportunity to refuse a virtual consultation for any reason.			
Making and sustaining the change			
Establish a process for monitoring outcomes, including: • occasions of service/activity • PREMs and PROMs • capturing patient stories • staff experience surveys.			
Consider opportunities to use monitoring data to undertake continuous quality improvement.			
Establish a process to evaluate the outcomes of the virtual service.			
Establish a way to communicate outcomes with the executive sponsor.			
Identify opportunities to share service outcomes and innovations that have been realised with the addition of virtual care e.g. presentations, conferences, local awards.			

The Agency for Clinical Innovation (ACI) is the lead agency for innovation in clinical care.

We bring consumers, clinicians and healthcare managers together to support the design, assessment and implementation of clinical innovations across the NSW public health system to change the way that care is delivered.

The ACI's clinical networks, institutes and taskforces are chaired by senior clinicians and consumers who have a keen interest and track record in innovative clinical care.

We also work closely with the Ministry of Health and the four other pillars of NSW Health to pilot, scale and spread solutions to healthcare system-wide challenges. We seek to improve the care and outcomes for patients by re-designing and transforming the NSW public health system.

Our innovations are:

- person-centred
- clinically-led
- evidence-based
- value-driven.

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Our vision is to create the future of healthcare, and healthier futures for the people of NSW.