TELEHEALTH CLINICAL GUIDELINES

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Version 9 (updated September 2014)

Introduction

1.1. Purpose

The purpose of this document is to provide generic Clinical Guidelines for the use of Telehealth in British Columbia (BC) Health Authorities (HAs). The guidelines are intended to:

- Be used in conjunction with all applicable organizational standards, protocols, and policies and procedures for care service provision.
- Are designed to guide staff, physicians, and clinical practitioners providing assessment, treatment, and consultative services via videoconferencing technologies.

The guidelines have been developed through a collaborative, consultative process amongst the BC Health Authorities. The 2003 National Initiative for Telehealth (NIFTE) Guidelines and Clinical Standards and Outcomes were used a measure for alignment.

It is recommended that organizations and individuals providing Telehealth services familiarize themselves with other NIFTE Guidelines (Human Resources, Organizational Readiness, Organizational Leadership, Technology and Equipment).

1.1. Background

The BC Ministry of Health (BC Ministry of Health, 2013) reports; Telehealth uses video conferencing and supporting technologies to put clients in touch with health professionals across distances. Telehealth is especially useful in remote areas where clients must travel long distances to meet their health care providers.

For client's telehealth:

- Reduces the travel burden
- Provides access to a wider range of specialist advice and services; and
- Can deliver faster, more efficient health care by using technology to remove the distance and time management barriers

Telehealth can also:

- Be used for general health promotion including continuing professional education that would otherwise be missed by professionals in distant locations
- Reduce CO_2 emissions by reducing physicians and clients travel requirements
- Improve staff recruitment and retention in remote locations by reducing professional isolation, improving access to continuing professional development, and providing easier access to support

- Facilitate communications between professionals and improve team-based approaches to care between different health care providers around B.C.

The BC Health Authorities have worked together using telehealth to increase not only the reach of the provincial telehealth network, but also the scope, quality, and safety of the services offered using Telehealth technologies.

These guidelines are created and maintained current recent research and knowledge

Definitions

Client: A potential or actual recipient of Telehealth services

Provider: A healthcare professional offering Telehealth services

Telehealth: The use of communications and information technology to deliver health and health care services and information over large and small distances. Telehealth uses the transmission of voice, data, images, and information rather than moving clients, health provider, or educators. 1

Client Site: Client site is also referred to as: Request Site, Remote Site, Patient Site, Distant site, Participating Site, or Referring Site. This is the site of the client or local provider(s) receiving support from consulting clinicians.

Consulting Site: The site the consulting provider broadcasts from. Consulting site may also be referred to as Host Site, Originating Site, Physician Site, Provider Site, or Referral Site.

Clinical Telehealth Support: Physical client support may be required to:

- Assistance positioning the client
- undress and re-dress wounds
- Take the client's vital signs
- Or operate a wound camera or digital stethoscope
- Assist and report physical, neurological, or haptic testing

Appropriately trained health providers such as LPN's, RN's, physiotherapists, or care aides would be used to assist clients. Adjunct telehealth equipment such as exam cameras and stethoscopes need to be available at the request site to enable enhanced remote assessment.

Remote site assistants may also be needed to conduct follow-up activities such as scheduling subsequent appointments, documenting the encounter, document management, and client education and support as required.

1 Canada Health Infoway definition (2004) derived from Picot, J. (1998). Sector Competitiveness Frameworks Series: Telehealth Industry Part 1 –Overview and Prospects. Industry Canada: Industry Sector Health Industries.

Guidelines

1.2. Telehealth and Clinical Practice

Care standards for practice, such as evidence-based best practice, should be carried through to care delivered via telehealth. Whenever possible, health professionals will use existing applicable clinical best practice guidelines (BPGs) when providing care via telehealth.

Modifications may need to accommodate for the inability to physically examine a client or the need to have physical examination performed and translated by a remote site assistant.

1.3. Duty of Care

The duty of care for telehealth should follow the same principles as face-to-face care. For example:

- The responsible provider should give the client adequate, current, and ongoing care instructions
- If face-to-face appointments require the use of interpreters, the presence of family members or a care provider, or other aides those same supports should be arranged for telehealth appointments
- Consults to local providers: If second opinions or advice is being given by the consultant, the local clinician is ultimately responsible for the care they provide to the client
- If there is any doubt about roles and responsibilities, the consultant and local provider must reach an agreement before a telehealth consultation is provided

1.4. Program Suitability for Telehealth

The following need to be considered when undertaking a telehealth program:

- The ability to communication under a variety of conditions. If you are used to drawing pictures or rely on certain physical queues you may be limited
- Have an understanding of the scope of service being provided via Telehealth;
- Able to attend a short orientation to the technology, navigation, and telehealth environment
- Operational protocols and procedures such as scheduling, reserving rooms, timeliness
- Professional telemedicine guidelines
- The limitations of video conferencing technologies

The organization is responsible for training clinical users about the equipment and how to use it. Clinical telehealth users should endeavour to learn the basics of how to use video conferencing equipment and can seek refresher training or assistance as required [See Appendix A for BCTDC Guidelines for Point to Point Calls].

1.5. Ethics

Health care professionals involved in telehealth services need to ensure the client-provider relationship via telehealth:

- Maintains the integrity and value of the therapeutic and workplace relationships
- Upholds professional standards governing health and medical professions
- Meets the standards of quality and safety as for face-to-face services

Health care professionals must recognize when Telehealth approaches are not appropriate for the client's needs and be aware of any ethical risks to clients. Backup plans and safeguards should be developed to reduce risk. Risk reduction strategies include ensuring that clients are screened for appropriateness and duty of care is outlined in clinical workflows at the program level.

Health care professionals are required to follow the Health Authority's process and their Professional Practice Standards when addressing ethical concerns and issues that arise due to the use of Telehealth (e.g.) if the Telehealth service requires duties outside normal scope of practice.

1.6. Client Suitability Guidelines

Clinical programs should identify inclusion and exclusion criteria for perspective telehealth clients. The following list includes some factors that can influence suitability:

- Level of physical assessment required
- Availability of support at the client site
- Ability of the client to participate such as physical, mental, and cognitive barriers
- Distance between provider and client locations
- Dependency on local availability of associated imaging and lab tests
- Client desire to participate in a telehealth consultation
- Ability to schedule telehealth session within the timeframes for a service or program's standard of practice guidelines

1.7. Informed Consent

The clinical program is responsible for explaining what to expect, privacy and confidentiality measures in place, and the client's right to refuse care via telehealth. Telehealth service providers should provide materials such as telehealth posters and brochures to clients as needed.

- Clients must be informed that access to a face-to-face consultation is never denied if they opt out of or don't wish to receive care via telehealth.
- Documentation in the client record must reflect client notification and agreement to the service.

Written consent is only required by the provider site when:

- If written consent is normally required for face-to-face sessions
- Clients are asked to release requisite personal information from one organization to another
- Clients are asked to participate in research projects while in care, or
- Recording a Telehealth session is not typically performed as it may compromise the identity of a client; however, if the provider(s) involved in the videoconference have just reason for recording a clinical event, consent must be obtained.

1.8. Protecting Client Privacy and Confidentiality

Every clinical relationship is based on respect for privacy and confidentiality. Individuals accessing telehealth technology are entitled to expect their privacy to be guaranteed, including:

- Privacy of personal information
- Privacy of personal communications
- Privacy of consulting space

Clinical Telehealth service providers must be aware of and ensure compliance with relevant legislation and regulations designed to protect the confidentiality of patient-client information. Organizations and health professionals are encouraged to consult with legal counsel and relevant professional licensing/regulatory bodies when determining confidentiality policy.

For comprehensive information on protection of client privacy and confidentiality, individuals should refer to the *BC Freedom of Information and Protection of Privacy Act* and policies within their Health Authority.

Privacy Impact Assessments (PIA) and Risk Assessments are mitigating strategies recommended in the development phase of all Telehealth projects as per Health Authority standard.

Telehealth consultations take place over a confidential, technically secure connection. Data is protected and access limited to "those who need to know". This generally refers to the patient-client, provider(s), and other care providers such as family or invested local health providers. Technical support staff may be required to assist with technical difficulties. Technical support staff are employees of the Health Authority and have signed confidentiality agreements.

Backup plans such as having a phone consult, rescheduling the appointment for another time, or other alternative are important to have in place in the event a technical difficulty prevents an adequate telehealth consultation.

1.9. Client Identity

To ensure safe quality Telehealth services clients must be positively identified using best practices. Risk of misidentification and exposure to care and intervention not intended for the client is mitigated by adhering to regional standards for positive client identification prior to receiving care or intervention. Failure to correctly identify clients may result in a range of adverse events such as the client receiving information meant for a different person. Each clinical telehealth program will determine a means of identification to be used based on the type of service provided and population served. See policies within each Health Authority.

Ideally three identifiers should be used (when available) prior to the provision of any service or procedure. Examples include:

- Unique identifiers such as Personal Health Number (PHN)
- The client's legal name
- Date of Birth
- Client barcodes
- Double witnessing or a client wristband
- A client's room number is not to be used as an identifier.

1.10.   Documentation and Client Records

1.10.1 Client Information required by Clinical Telehealth Program at provider site

The information required is determined by the individual Clinical Telehealth Program. This is generally the same as what's required for a face-to-face appointment and provided in advance of the Telehealth appointment or session.

1.10.2 Consultation Report

A report from the telehealth provider is documented and incorporated into the client record. Documentation timelines for telehealth consults are consistent with existing clinical processes for face-to-face consultations.

1.10.3 Client Information required by healthcare providers at client site

Information required by the client site is coordinated through the provider site and may consist of electronic and paper charts, diagnostic images and lab reports.

1.10.4 Clinical Telehealth Support Notes

Clinical documentation by clinical support staff who attend the client should be completed as determined during program development and recorded in the same timely manner face-to-face events are documented.

1.10.5 Responsibility for Records

The original client record is held with the Provider. Copies of the Telehealth consult report or note are shared with the referring physician or clinician as they would be for face-to-face consultations.

1.11.   Quality Measurement

Telehealth encourages clinical telehealth programs to establish evaluation methods for their telehealth appointments. Appropriate categories for evaluation may include:

- **Access:** e.g.: number of client seen, number of clients who may not have previously had access to care
- **Quality** : Outcomes, client and provider satisfaction,
- **Productivity**: Improved productivity amongst clinical staff, multidisciplinary team meetings

Outcome indicators would be determined within the clinical telehealth program. The indicators will be used to identify successes and opportunities for improvement. Results will be shared with relevant stakeholders.

Standardized Telehealth Provider and Client satisfaction surveys have been created by the BC Telehealth Development Committee for general use across the province. Telehealth programs are welcome to implement a more specific survey at their discretion.

Sources Used

This document has been created, reviewed and amended by various groups and individuals as noted in the document control table in Section 6.0. The document authors would like to acknowledge that have considered and included information and/or passages from the following documents.

- Accreditation Canada, 2010. Telehealth Services Standards
- BC TeleThoracic Project Team, 2009. TH-5 Standard of Care Protocol
- BCCA Telehealth Committee, 2009. Telehealth Terminology
- Capital Health, Alberta, 2006. Telehealth Consent Policy
- College of Registered Nurses of BC, 2005. Telehealth Practice Standard
- Government of Western Australia, Telehealth Development Unit, 2003.Telehealth Policy and Guidelines for the Delivery of Clinical and Other Services
- National Initiative for Telehealth (NIFTE), 2003. National Initiative for Telehealth Framework of Guidelines.
  https://dspace.ucalgary.ca/bitstream/1880/42967/3/NIFTEguidelines2003eng.pdf

1.12. Additional Resources

The reviewers and authors of this document have conducted numerous literature reviews to inform this document. During the course of this research they have identified (below) resources that may be useful to organizations and/or individuals offering Telehealth services.

- Accreditation Canada, 2013. Telehealth Services Standard.
- RACGP, 2012. Implementation guidelines for video consultations in general practice (3rd Edition) http://www.racgp.org.au/your-practice/e-health/telehealth/gettingstarted/guidelines
- European Code of Practice for Telehealth Services 2014
- http://www.telehealthcode.eu/images/stories/telehea/pdf/TELESCOPE_2014_CODE_FINAL_PDF_-_RELEASE_29_OCT_2013.pdf
- American Telemedicine Association. ATA Standards & Guidelines (multiple domains). http://www.americantelemed.org/practice/standards/ata-standards-guidelines

Reviews and Document Control

This document has been [o rwill be] sent to the following listed below for their review and comment, and part of their role is to obtain feedback from key stakeholders in their organization.

Group	Member
BC TDC	Fraser Health Authority
	Interior Health Authority
	Northern Health Authority
	Provincial Health Authority Services
	Vancouver Coastal Health
	Vancouver Island Health Authority (Island Health)
	University of BC MedIT

1.13.   Document Control

Date	Author	Version	Change Reference
Oct. 18, 2010	S. Wyatt	1.0	Outline & contents, including input from some IHA clinicians
Nov. 10, 2010	S. Wyatt	2.0	Update to outline & contents incorporating input from Oct. 21st BC TDC meeting & Nov. 4th working group meeting
Nov. 17, 2010	S. Wyatt	3.0	Update/revision of contents incorporating input from Nov 16th working group meeting
Nov. 26, 2010	S. Wyatt	3.1	Incorporated feedback from VIHA
Dec 2, 2010	S. Wyatt	3.2	Update/revision of partial contents incorporating input from Nov 29th working group meeting
Dec 14, 2010	S. Wyatt	4.0	Update/revision of contents incorporating input from Dec 9th working group meeting
Dec. 15, 2010	S. Wyatt	5.0	Revision of contents incorporating input from Dec 15th working group meeting
April 18, 2011	J. Henderson	6.0	Revision of contents incorporating input from BCTDC meeting
July 30, 2012	J. Henderson	7.0	Added BCTDC approved Telehealth definition
Oct. 23, 2012	J. Henderson	7.1	Added Appendix "BCTDC Guidelines for Point to Point Calls" Removed Ethics and Privacy/Confidentiality Health Authority Appendix placeholders
May 8, 2013	N. Gabor / J. Henderson	7.2a	Update/revision of partial contents incorporating input from Provincial Ethics committee members
October 21, 2013	J. Henderson	7.2b	Removed Appendix D – Provider Survey and associated references within the document
November 26, 2013	L. Caron	7.2c	Updated contents to disclose the origin of document contents and alignment with NIFTE Guidelines. Addition of Additional Resources Section.

Date	Author	Version	Change Reference
January 14, 2014	L.Caron	8.0	Reviewed with BCTDC Clinical Guidelines WG. Modified, accepted changes per Nov. 2013
September 2014	Mdeachma	9.0	Pagination, formatting, headers, footers, and appendices numbering updated

Appendix A.   BCTDC Guidelines for Point to Point Calls

BCTDC Guidelines for Point to Point Calls

Telehealth - Enabling access and removing barriers to quality care

Recent changes to the Health Authority (HA) network infrastructure in British Columbia (BC) have altered the way in which video conferencing endpoints may connect with one another. These guidelines are intended to support HA Telehealth programs and ensure that point to point calls between the regions and other authorized organizations follow agreed upon principles to assure quality, safety and the protection of privacy for all participants.

These guidelines, created and adopted by the BC Telehealth Development Committee (BCTDC) address point to point calls involving video conference participants using a video conferencing endpoint which has been approved through the appropriate HA processes and which has a network address associated with the secure HA networks and the eHealth Network Gateway (eNG) used to securely link all six regional HAs. Calls connected through a bridge or facilitated through video conferencing system management software are not addressed within this document, nor are calls involving participants outside of the eNG / HA network.

SECTION 1 – Terminology and Definitions

Call Types

Point to Point (Direct) - One video conference endpoint calls another directly (in scope of these guidelines). Also, where video conferencing system management software – ex. Tandberg Management Suite (TMS) or Converged Management Application (CMA) - is used to schedule the direct connection of two endpoints, but without including any bridge (multipoint control unit or MCU) infrastructure (out of scope)

Point to Point (Bridged) - Two endpoints are connected through a bridge (a technology hardware component used to connect multiple video conference endpoints together in one conference) (out of scope)

Multi-point (Direct) - Multiple endpoints are called directly by one host endpoint using multi-point software on that device (out of scope)

Multi-point (Bridged) - Multiple endpoints are connected via a bridge (out of scope)

End Point Types

Current (HA approved, established and recognized (commissioned) facility-based video conferencing devices and enterprise-based video conferencing applications currently in use). The vast majority of video conferencing end point devices, applications and infrastructure in use within the HAs are manufactured by either Polycom or Cisco (Tandberg). A small number of Sony, Picture Tel and LifeSize units also exist which may be connected to the network.   Current types include:
- Standards based, fixed room-based video conferencing unit
- Standards based mobile video conferencing unit (a clinical cart)
- Standards based desktop video conferencing units (ex. Cisco EX90, Polycom HDX 4000)
- Desktop computer (or laptop) software based video conferencing standard application (ex. Cisco MOVI)

Future (Exploratory applications which may currently be approved for test or pilot studies, or which may be considered for use at a later time). Future types may include:
- Computer (PC or laptop) based video enabled applications – MS Communicator; Lync

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- Vidyo, cloud computing applications like Blue Jeans network, etc.
- Tablets, iPads, mobile phone applications, etc.

Video conferencing Application Types
- Clinical (patient to clinician; clinician to clinician(s))
- Educational (clinician to clinician; educator to staff; etc.)
- Administrative (general; finance; HR; interviews; performance reviews; etc.)

SECTION 2 – Basic Principles

The majority of direct point to point calls are for clinical sessions. There may be exceptions for some educational or administrative meetings. The following points outline common understanding and guidelines for point to point calls in a clinical setting where both end points are accessed within the eNG.

- It is recommended that prior to establishing a point to point call or series of calls, that both locations are apprised of the plan, how it is different from bridged calling, and then asked to confirm their approval
- Point to point calls involving a HA location must still be scheduled, so as to avoid any conflict with other use of the room or equipment. This also enables technical support staff to be aware of the call taking place and provides them with the information necessary for troubleshooting. NOTE – the exception to this would be any urgent or emergent established service, such as Telestroke.
- Where one of the locations is not physically within a Health Authority facility, the end point unit or application must be provided or approved by the Health Authority to meet the standards for security, privacy and quality. (Refer to BCTDC Provincial Telehealth Guidelines documents for more information)
- Where one of the locations is not physically within a HA facility, participants must make every effort to adhere to the Health Authority standards for maintaining the security and privacy of the session. For example, joining the call from a private room where no one who is not part of the session can see or hear any part of the conference. (Refer to BCTDC Provincial Telehealth Guidelines documents for more information)
- The providing site (where the clinician is) will initiate and disconnect the call, unless different arrangements are made prior to the appointment. Every effort must be made to ensure that the caller has the correct "dialling" information for the patient location.
    - Recommendation – dialling information is provided directly to the clinician each time via a confirmation form, which also provides information on how to access technical support
    - Recommendation – endpoint directories are maintained with information that is current and which clearly identifies each location
- There are two time zones in BC. Respecting these is critical.
    - Recommendation – a list of communities on Mountain Time is created and shared as a tool for education or for posting in clinical rooms.
    - Recommendation – endpoint directory is amended for communities on Mountain Time to identify these for the caller.
- All callers must adhere to scheduled start and end times for appointments (NO early calling or extended appointments). Failure to observe this may negatively impact other scheduled consultations, resulting in unnecessary calls for support, and may also result in a breach of privacy, should another meeting or consultation be in progress at that time.
- Endpoint units with multipoint software should not be used for clinical consultations or for meetings or conferences where confidential patient information is discussed, as other callers may inadvertently call in.
    - Recommendation – endpoints with multipoint software should be identified across the regions so that they can be easily identified and avoided for use in clinical situations.
- Performing pre-test of endpoints prior to session to ensure no connectivity issues are present

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Appendix B.   College of Physicians and Surgeons of BC Professional Standards and Guidelines - Telemedicine

College of Physicians and Surgeons of British Columbia

Professional Standards and Guidelines

Telemedicine

Preamble

This document is a standard of the Board of the College of Physicians and Surgeons of British Columbia.

According to the Federation of Medical Regulatory Authorities of Canada:

"Telemedicine is the provision of medical expertise for the purpose of diagnosis and patient care by means of telecommunications and information technology where the patient and the provider are separated by distance. Telemedicine may include, but is not limited to, the provision of pathology, medical imaging and patient consultative services."

College's Position

The role of the College is to regulate physicians, not technology, and to remind physicians that the use of technology does not alter the ethical, professional and legal requirements around the provision of appropriate medical care.

Physicians who are physically located in British Columbia must ensure that they are registered with this College, and should be aware that this College may address complaints relating to the provision of medical care in other jurisdictions.

Physicians in British Columbia should advise patients that accessing medical care from a physician who is not located/registered in this province may pose risks related to lack of appropriate medical licensure or training and that this College may not be able to assist them with complaints relating to inappropriate medical care.

Physicians should also be aware that practising medicine using only electronic communication or across different jurisdictions may affect their liability insurance and they should disclose such information to their liability insurer.

In providing medical care using telecommunications technologies, physicians are advised that they are responsible to:

- ensure that both the physician-site and the patient-site are using appropriate technology that complies with legal requirements regarding privacy and security and accreditation standards where required

- ensure that the physician's identity is known to the patient and the identity of the patient is confirmed at each consultation

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