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PERSONAL VIEWPOINT

Telehealth in cancer care: during and beyond the COVID-19 pandemic

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Abstract

The COVID-19 pandemic has precipitated the rapid uptake of telehealth in cancer care and in other fields. Many of the changes made in routine clinical practice could be embedded beyond the duration of the pandemic. This is intended as a practical guide to cancer clinicians and others in establishing and improving the quality of consultations performed by telehealth.

With the need for physical distancing and reduction of foot traffic through healthcare institutions, deployment of telehealth (TH) into routine care during the COVID-19 pandemic has demonstrated benefits for patients and clinicians. We need to remain motivated to continue this modality and this document provides insights and practical considerations to support this.

A fundamental priority is maintaining high quality cancer care for all patients. Local architectural (infrastructure, resources and personnel), social and geographical constraints, creates access and quality differentials.[1–4] Particularly among those most vulnerable, such as those from regional/rural areas as well as cultural, social and linguistically diverse. Digital tools provide solution strategies to overcome logistical challenges that contribute to the disparities.

TH has enabled this during social restrictions and can be used for all mediums of care delivery, such as outpatient, pre-therapy reviews, pre-habilitation programmes, preparation for surgery, acute and late effects monitoring, chemotherapy and systemic treatment delivery ('telechemotherapy') and conduct of clinical trials ('teletrials').[5–7] The COVID-19 pandemic response has demonstrated that healthcare providers and patients are willing to embrace TH. The most important benefits are to patients and their families: reduced travel and social disruptions, financial savings, enhanced chronic care delivery and creating safe healthcare environments.

Traditional referral strategies usually adhere to the nearest available provider; however, telehealth and digital tools enable specialists at a greater distance to help provide services to regions that may not have local specialists, care models and/or specialist services. Equally, an important outcome of TH is the synchronous partnering with the local healthcare team when delivering care, enabling continuity and shared care arrangements for patients returning to their local areas after being treated at metropolitan services.

TH provides efficient and flexible service delivery, enabling clinicians to maintain involvement, independent of their physical location. The broader strategy of enabling 'synchronous' partnerships with regional or remote areas and their expert metropolitan counterparts, will provide professional opportunities for regional or

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rural specialists to help advance the science and practice of healthcare Australia wide.

There are some potential limitations with TH, compared to face-to-face (F2F) consultations.[7] Communication can be impacted if sound or vison quality is poor, due to internet connectivity or bandwidth. It can be more difficult to establish rapport during a new patient consultation or when breaking difficult news. Where physical examination is indicated, assistance at the patient's site to conduct a full physical examination, such as in partnership with a general practitioner or specialist nurse, can be required.

However, there are also many upsides. The purpose of this article is to provide insights and practical solutions, with regards to the enablers and challengers of maintaining TH as part of routine care for our patients going forward, including guidance across tumour streams, given the demonstrable patients, their families, clinicians, healthcare institutions and society.

Telehealth MBS eligibility

Rapid support from Commonwealth funding during COVID-19, including temporary new Medicare item numbers, has enabled the widespread uptake. This has exposed the opportunity and the benefits. Advocacy by expert groups and patients will need to lobby to extend funding with a more generous scope than previously.

Telehealth prerequisite and platforms

The information and communication technology should be fit for purpose. Reliable equipment that works well over the available network and bandwidth, is secure with privacy and confidentiality ensured, compatible between clinician and patient, and facilitates good communication and accurate transfer of information.

COVIU or Health Direct is set up to manage a significant increase in video calls and is favoured in the opinion of the authors over Skype, Zoom, Facetime, WhatsApp or other collaborative tools for IT, billing and security/privacy reasons. Comparisons between platforms are detailed in Table 1.

Other advantages of Health Direct include:

1 Maintaining the professional working environment between clinicians and patients
2 Allowing third parties, such as, interpreters, other clinicians and 'remote' family members to join the consultation
3 Providing additional tools such as screen sharing, chat and whiteboard capabilities to enhance communication and interactions

Other options, if required

1 Microsoft teams: a secure platform but does not have the additional tools
2 PEXIP: can be integrated within secure host IT systems but performance can be problematic with poor Internet connections and does not have additional tools

Basic principles of delivering care via telehealth

Some underlying principles of TH include:

- TH is no different from any medical consultation and should be conducted exactly as you would F2F with engagement of the patient, thorough assessment and review, further recommendations for assessment, clarification of diagnosis and recommendations for treatment.
- TH does not need to be used exclusively, but rather as an adjunct to maintain continuity of care (e.g. alternate visits F2F and TH).
- TH consultations should maintain the patient's privacy and confidentiality at all times, with processes in place to facilitate this as per standard F2F consultations.

Selecting patient suitability for telehealth

Not all consultations may be suitable for TH. Key principles to be considered include:

1 It is fundamental that the patient/carer or family member are able and willing to participate

Allowing the patient to be in their 'own' preferred environment, rather than the formal clinic, can provide a greater degree of comfort in the conversation and more likely to divulge the required information to assess needs. This can be particularly relevant for psychosocial needs, culturally and linguistically diverse communities

2 Clinical factors:

Consideration of scheduled investigations on the same day of review, need for comprehensive clinical examination (see below), using TH to provide an opportunity for enhanced continuity and shared care with local providers

3 Practical factors:

Availability of appropriate technology, quality of connectivity and patient-end support; ability of the patient

Table 1 Comparison of technology platforms used in telehealth consultations

Software	Health Direct, COVIU	Microsoft Teams	Zoom	Skype – Office
License				
Cost to provider	Free for approved organisations Fee plans available (/user/ month)	Free Part of Microsoft Office	Recommend paid version as free version limited to 40-min sessions	Free Part of Microsoft Office
Cost to patient	Nil	Requires Microsoft 365 access Free version available for those without a paid Office 365 subscription	Nil	Nil Need to download application onto computer or smartphone and register for an account
Purchase agreement	Business case application for health department approval of Enterprise implementation COVIU has plans suitable for GP, specialist and Allied Health practices	Online sign-up	Online sign-up	Online sign-up
Technology requirement				
Network compatibility	All can function on NBN, ADSL, cable, optical fibre, 3G, 4G, 5G			
Bandwidth (min per 2 end-point call)	350 Kbps (+350 Kbps for each extra party)	Unknown	2.0 Mbps up and down for single screen 2.0 Mbps up 4.0 Mbps down for dual screen 2.0 Mbps up 6.0 Mbps down for triple screen For screen sharing only: 150 –300 Kbps For audio VoIP: 60–80 Kbps	Unknown
Data usage (min) Assume 30 min call	30 (min) x 60 (s) x 350 Kbps x 2 (users) / 8 (bytes) = 158 MB	Unknown	Unknown	Unknown
Browser–based, no downloads required	Yes	Yes	Yes	No
Software requirement And Device capability	Windows, Android, MacOS Windows, Android MacOS, iOS MacOS, Windows Android	Google Chrome - Version 72 or later Firefox - Version 68 or later Apple Safari - Version 12.0 or later Microsoft Edge - Version 79 or later Microsoft Edge - Version 44 or later	Mac OS X with Mac OS 10.10 and higher Windows 7 and higher	Skype on Mac requires Mac OS X 10.10 or higher and the latest version of QuickTime Windows 10 (version 1809) or higher
Guidance and support				
Scalability	Designed to scale using stateless microservices architecture (i.e. multiple consultations can be carried out with the one implementation)	Only one videoconference can be initiated per Team account	Only one videoconference can be initiated per Zoom account	Can have multiple outgoing videocalls on one Skype account

Table 1 *Continued*

Software	Health Direct, COVIU	Microsoft Teams	Zoom	Skype — Office
Security and privacy				
Encryption	Full end-to-end encryption Including share docs and apps	Full end-to-end encryption Including share docs and apps	GCM AES 256-bit encryption from version 5.0 onwards. No end-to-end encryption as yet and no plans for this to be introduced to free version	Skype to skype messages are encrypted
Australian privacy policies	Adheres privacy policies	Adheres privacy policies	Adheres privacy policies	Adheres privacy policies
Data sovereignty	Data stored and confined to Australian legal jurisdiction	Data stored and confined to Australian legal jurisdiction	Data centre regions have to be manually set to Australia and other regions deselected in Advanced settings in paid version	Data stored and confined to Australian legal jurisdiction
Clinical experience				
Patient access	Does not require your patients to sign up, they enter the virtual waiting area and consultation by providing their first and last name and phone number for identification confirmation			
Waiting areas	Capability to triage, admin support			
Multiple participants	Yes	Yes: up to 250	Yes: up to 100	Yes: up to 50
Additional functionality				
Share applications	Yes: medical, training, health device	Can share screens	Can share screens	
Share documents	Yes: documents, images, photos			
Share whiteboard	For pictorial discussion, which can be saved and printed at every end-point			

ADSL, asymmetric digital subscriber line; GP, general practitioner; NBN, National Broadband Network.

to travel, including family, work, SES, cultural situation; patient capacity, vision and hearing impairments require consideration.

If patients are undergoing more intensive or new therapies, with the possibility of emergent side-effects or toxicity, TH allows more frequent reviews mitigating extra travel and commitment to attend in person. This holds true for any clinical situation requiring frequent reviews. Specific consideration for tumour subgroups is outlined in Table 2.

Clinical examination component of telehealth

A common concern regarding TH is the need for clinical examination; these strategies can enhance the process:

1 Include local healthcare providers who can assist with the clinical examination and provide the environment for care continuity
2 **Without** the local healthcare provider (i.e. patient only)

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a Preparation: Prior knowledge of patient's history and examination, access to medical records
b Adequate lighting, free from background noise and disturbances to enhance the virtual assessment
c Additional questions to draw out physical changes that may not be apparent (compared with F2F)
d Remote monitoring tools can be used to supplement this
e Where an examination is required during the consultation, the patient can attend local healthcare provider for further assessment or to attend clinic in person

Practical tips for the clinician during the consultation

1. An appropriate device: smartphone or tablet; Home computer or laptop with a webcam/microphone/speaker (with Chrome installed).
2. Access to TH software platform, with secure log-in.
3. Resources to enable clinician and patient:

a. Instructions to the patient, outlining their upcoming appointment
b. E-forms for requesting investigations
4. Patient flow mapping

As with all in-person appointments, patient flow through the consultation needs to be mapped and enabled:

a Instructions to patients when booking appointments, capture of key patient information including clinical and supportive care requirements
b Patient check-in – to alert the clinician they are in the virtual waiting room
c Post clinic activity capture - including billing items and next follow-up appointments pre-next review
  i Pathology: scan and email or post to patient
  ii Radiology: scan and email or post to patient or radiology provider
  iii Referrals to other specialists or providers
  iv Prescriptions
  v Documentation of the review in the medical record and correspondence to appropriate healthcare providers

5 Prescription
  a COVID 19 emergency provisions have allowed e-prescriptions, original being retained for 2 years
  b Most pharmacies will honour a scan or photo prescription, but require the original
  c Specifically, schedule 4 or 8 medicines require verbal confirmation with the pharmacy

Teletrials

Finally, an important outcome will be the delivery of clinical trials via the Tele-Trial Model.[8-10] Cancer Council Victoria data has shown that <5% of patients from regional/rural Victoria participate in trials due to the same logistic challenges (Underhill, pers. comm.). The VCCC teletrials programme has facilitated the conduct of three trials across seven sites in metropolitan and regional Victoria. In addition, a phase 1 study is being conducted by TH between a Victorian and an interstate site. A fourth study has opened, and several others are in start-up. More than 80 patients from regional Victoria have been recruited to the three clinical trials. In 2017, only 81 cancer patients in regional Victoria were recruited to studies, so this represents a considerable improvement in recruitment and access to trials for regional patients.

Successful clinical trial conduct, which facilitates advancement in science and healthcare delivery, has geographical constraints; challenges around variable regulatory arrangements across jurisdictions; slow patient recruitment processes and timelines, which are cost prohibitive, lead to trial closure, and reduce potential access to trial programs. The ability to participate in trials closer to home will reduce burden and costs and enhance patient recruitment and retention. The tele-trial model will overcome major barriers to trial conduct; provide equity of access to patients; invest personnel, infrastructure and resources in regional/rural centres; and help advance the science and practice of cancer care Australia-wide.

Going forward: sustained and scaled implementation of digital health

The rapid adoption of TH across all cancer services within Victoria during COVID-19 pandemic surfaced significant barriers to implementation of telehealth via video consultation. The top major barriers through a survey were infrastructure, IT and organisation support as well as patient literacy.[11] However, the COVID-19 pandemic response has demonstrated that healthcare providers and patients are willing to embrace digital tools to maintain and continue high quality care delivery.

Areas that require ongoing effort are enabling different health systems to freely and safely share data, allowing patients to receive care at any time and place. Government investment and support of infrastructure and resources to support deployment of digital health will be required, including connectivity and access for remote areas, elderly and vulnerable patients. In addition, harmonisation of government policy and the regulatory environment for widespread adoption of systematic and best clinical care models and the teletrial model for trial access is needed. Embedding telehealth into cancer care is likely to result in improved outcomes, especially for regional and other disadvantaged populations.

Table 2 Specific considerations for telehealth (TH) consultations by tumour

Therapy	
For all anticancer therapy	• If therapy-related toxicity occurs, TH can actually facilitate unplanned reviews during the treatment cycle, via nurse-led clinic, with registrar or consultant back-up as needed • If patient is coming to the centre for treatment may be preferable to do standard in-person review • Pre-treatment visit checks can be done via TH the day prior to save unnecessary trips to treatment centre, or to determine treatment modifications in advance • Depending on the circumstances of the individual case, some reviews may not be suitable for TH due to the need to examine the patient to determine effectiveness of treatment
For clinical trials	• Consider use of TH during setup/study feasibility: what components of care could be performed by TH? • Consider preforming screening visits where examination not required via telehealth • Consider preforming mid-cycle visits (if examination not required) via telehealth • Screen/manage mid-cycle toxicity via telehealth if possible
Post therapy longer term follow up and surveillance	• For all TH: patient distance from centre, patient suitability, capability and acceptability needs to be determined • Converting follow-up visits from in person to telehealth consultation may be suitable for some visits, especially if done with GP who can support patient and perform physical examination, which also enables shared care • Use Nurse Practitioner/supportive care staff led follow-up clinics for supportive care issues, which can also be converted to TH • If follow-up radiological examinations or other procedures scheduled same day, then face to face may still be preferred
In addition: specific areas to consider	
Early breast cancer	
Neoadjuvant therapy	• Depending on the circumstances of the individual case, some reviews may not be suitable for TH due to the need to examine the patient to determine effectiveness of treatment
Her2 positive (HER2+)	• TH can be utilised for pretreatment checks prior to single or dual agent Her-2 therapy in the adjuvant or metastatic settings
Advanced disease	• If on oral therapy, consider alternative visits, via TH, with GP present for support/recording examination and to enable shared care model
Colorectal cancer	
Neoadjuvant disease	• If patient is attending centre for radiotherapy and/or chemotherapy, visits should be face-to-face unless scheduling is an issue, where TH can be utilised as an adjunct
Adjuvant therapy	• If patient is coming to centre for treatment may prefer to continue with in-person review
Advanced disease	• If on oral therapy, consider alternative visits with GP for support/ examination and promoting shared care for longer term continuity
Gastro-oesophageal cancer	
Neoadjuvant Therapy	• If patient coming to centre for treatment may prefer to continue with in-person review
Adjuvant Therapy	• If the patient is coming to centre for treatment may prefer to continue with in-person review

Table 2 *Continued*

Therapy	
Advanced disease	• If on oral therapy, consider alternative visits with GP for support/examination and promoting shared care for longer term continuity
Pancreatic and biliary cancer	
Neoadjuvant therapy	• If patient coming to centre for treatment may prefer to continue with in-person review
Adjuvant therapy	• If the patient is coming to centre for treatment may prefer to continue with in-person review
Advanced disease	• If on oral therapy, consider alternative visits with GP for support/ examination and promoting shared care for longer term continuity
Epithelial ovarian, fallopian tube and Primary peritoneal cancer	
First line therapy for advanced disease: Stage 3/4	• May not be suitable for telehealth, if there is a need to examine patient to determine effectiveness of treatment • If on oral therapy, consider alternative visits with GP for support/examination and promoting shared care for longer term continuity
Endometrial cancer	
Metastatic therapy	• If chemotherapy used, may not be suitable for telehealth, if there is a need to examine patient to determine effectiveness of treatment • If on oral therapy, consider alternative visits with GP for support/examination and promoting shared care for longer term continuity
Small-cell lung cancer	
Limited stage	• May not be suitable for telehealth, if there is a need to examine patient to determine effectiveness of treatment
Extensive stage	• May not be suitable for telehealth, if there is a need to examine patient to determine effectiveness of treatment
Non-small-cell lung cancer	
Adjuvant therapy	• If patient coming to centre for treatment may prefer to continue with in-person review
Chemoradiation	• If patient attending centre for radiotherapy, chemotherapy visits should be face-to-face unless scheduling is an issue
Advanced disease	• If chemotherapy used, may not be suitable for telehealth, if there is a need to examine patient to determine effectiveness of treatment • If on oral therapy, consider alternative visits with GP for support/examination and promoting shared care for longer term continuity
Other thoracic cancers	
Mesothelioma	• Toxicity could be addressed during cycle via telehealth consultation to Nurse-led clinic (SURC clinic or other) with registrar or consultant back-up as needed
Thymoma/thymic carcinoma	• If infusional therapy used, may not be suitable for telehealth, if there is a need to examine patient to determine effectiveness of treatment • If on oral therapy, consider alternative visits with GP for support/examination and promoting shared care for longer term continuity
Genitourinary cancer	
Hormone-sensitive metastatic prostate cancer	• If infusional therapy used, may not be suitable for telehealth, if there is a need to examine patient to determine effectiveness of treatment • If on oral therapy, consider alternative visits with GP for support/examination and promoting shared care for longer term continuity

Table 2 *Continued*

Therapy	
Castration-resistant prostate cancer	• If infusional therapy used, may not be suitable for telehealth, if there is a need to examine patient to determine effectiveness of treatment • If on oral therapy, consider alternative visits with GP for support/examination and promoting shared care for longer term continuity
Metastatic renal cell carcinoma	• If infusional therapy used, may not be suitable for telehealth, if there is a need to examine patient to determine effectiveness of treatment • If on oral therapy, consider alternative visits with GP for support/examination and promoting shared care for longer term continuity
Urothelial carcinoma	• For neoadjuvant or adjuvant chemotherapy: May not be suitable for telehealth, if patient coming to centre for treatment • For chemoradiation: May not be suitable for telehealth, if patient coming to centre for treatment • For metastatic disease ○ If infusional therapy used, may not be suitable for telehealth, if there is a need to examine patient to determine effectiveness of treatment. ○ If on oral therapy, consider alternative visits with GP for support/ examination and promoting shared care for longer term continuity
Testicular and germ cell tumours	• For adjuvant chemotherapy: • May not be suitable for telehealth, if patient coming to centre for treatment • For metastatic disease ○ If infusional therapy used, may not be suitable for telehealth, if there is a need to examine patient to determine effectiveness of treatment ○ If on oral therapy, consider alternative visits with GP for support/ examination and promoting shared care for longer term continuity • Follow-up protocols require physical examinations. Visits requiring restaging scans can be tomes with face-to- face visits, visits not requiring scans, could in some instances be done in collaboration with GP for support and the physical examination component if acceptable to GP and patient
Melanoma	
Adjuvant therapy	• If infusional therapy used, may not be suitable for telehealth, if there is a need to examine patient to determine effectiveness of treatment • If on oral therapy, consider alternative visits with GP for support/examination and promoting shared care for longer term continuity
Metastatic therapy	• If infusional therapy used, may not be suitable for telehealth, if there is a need to examine patient to determine effectiveness of treatment • If on oral therapy, consider alternative visits with GP for support/examination and promoting shared care for longer term continuity
Cancers of the head and neck	
Locally advanced disease	• For neoadjuvant/adjuvant chemotherapy: may not be suitable for telehealth, if patient coming to centre for treatment for chemoradiation: may not be suitable for telehealth, if patient coming to centre for treatment
Advanced disease	• If infusional therapy used, may not be suitable for telehealth, if there is a need to examine patient to determine effectiveness of treatment • If on oral therapy, consider alternative visits with GP for support/examination and promoting shared care for longer term continuity
Brain cancer	
Newly diagnosed GBM (Grade 4)	• If infusional therapy used, may not be suitable for telehealth, if there is a need to examine patient to determine effectiveness of treatment • If on oral therapy, consider alternative visits with GP for support/examination and promoting shared care for longer term continuity
GBM recurrent disease	• If infusional therapy used, may not be suitable for telehealth, if there is a need to examine patient to determine effectiveness of treatment • If on oral therapy, consider alternative visits with GP for support/examination and promoting shared care for longer term continuity

Telehealth: refers to video-conferencing strategies for delivering healthcare.

Additional useful resources

Resource title	URL
Pre-COVID19 TH eligibility (which continues) can be ascertained by using the Locator tool	https://www.health.gov.au/resources/apps-and-tools/health-workforce-locator/health-workforce-locator
Introduction and instructions for telehealth: for patients	Supporting Information Appendix S1
Introduction and instructions for telehealth: for clinicians	Supporting Information Appendix S2
E-forms	https://connect.petermac.org.au/document/ecg-echo-cpx-and-rft-request https://connect.petermac.org.au/document/petct-request-form https://connect.petermac.org.au/document/diagnostic-imaging-request-form https://connect.petermac.org.au/document/mri-request-form
COVID-19 Temporary MBS Telehealth Services	http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-TempBB
Cam Scanner	https://www.camscanner.com/
Doctor and Patient Communication during telehealth	https://insightplus.mja.com.au/2020/18/doctor-patient-communication-and-relationship-in-telehealth/
Teletrials	
Teletrial model implementation toolkit	https://www.viccompcancerctr.org/what-we-do/clinical-trials-expansion/teletrials/resources/
Australasian Tele-trial Model	https://www.cosa.org.au/media/332325/cosa-teletrial-model-final-19sep16.pdf
Pharmacy	
Fact Sheet. National Health Plan. A Guide for Pharmacists.	https://www.health.gov.au/sites/default/files/documents/2020/04/covid-19-national-health-plan-prescriptions-via-telehealth-a-guide-for-pharmacists.pdf
COVID-19 National Health Plan – prescriptions via telehealth – a guide for prescribers	https://www.health.gov.au/resources/publications/covid-19-national-health-plan-prescriptions-via-telehealth-a-guide-for-prescribers
Electronic prescribing	https://www.health.gov.au/initiatives-and-programs/electronic-prescribing

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Supporting Information

Additional supporting information may be found in the online version of this article at the publisher's web-site:

Appendix S1. Introduction and instructions for telehealth: for patients.
Appendix S2. Introduction and instructions for telehealth: for clinicians.