ROUNDTABLE ONLINE DISCUSSION SERIES 2022: REPORT OF MEETING 14 JULY 2022

Digital Health in Medical Education and Workforce Development – A collaboration between the Health Education England (HEE) and Australian Medical Council (AMC).

NHS
Health Education England

Australian Medical Council Limited

Contents

Acknowledgement of Country



The Australian Medical Council (AMC) acknowledges the Aboriginal and Torres Strait Islander Peoples as the original Australians, and the Māori People as the original Peoples of New Zealand.

We pay respect to these Peoples, the traditional custodians of the lands of Australian and New Zealand participants and, recognise their ongoing connection to the land, water and sky.

We recognise the Elders of all these Nations both past, and present, and emerging, and honour them as the traditional custodians of knowledge for these lands.

Background and Context

Purpose

Health Education England (HEE) and Australian Medical Council (AMC) are collaborating to explore, in an online roundtable series of sessions, issues of mutual interest in workforce development and medical education in digital health in medicine. This is the report of the discussion from meeting 3 Roundtable Session which occurred on Thursday 14 July 2022.

Roundtable Session 3: Implications of Digital Health – Improved Access and Quality Care in Community and Rural and Remote Settings

Session Description

This online HEE and AMC round table series session explored Digital Health for Better Access to Care in Community and Rural and Remote Health Settings.

Technology allows us to reimagine how care can be delivered. This can impact all aspects of care from how we monitor consumer health, and how and when we intervene and how we actually deliver care and by whom. It opens up the sites of health by bringing the health practitioners into the home setting and better integrating community and hospital healthcare delivery. Equally, this session explores digital health in rural and remote settings. Digital health is opening up new ways of access in rural health and some of the more innovative digital health practices in medicine have been implemented by rural medical health professionals. Whilst challenges of rural and remote delivery of healthcare are not homogenous there are some unique but consistent features around rurality. Challenges are predominantly due to resources tending to be concentrated within cities, the rural depopulation of younger people limiting workforce, travel and transport issues and lack of community support. To overcome these issues a redesign and development of models for predictive healthcare, leadership and ways of working are required which enable a focus on prevention and population health.

Drawing on the principles of value-based care and data driven care, this session explores how technology can be used to improve access and quality of care in community and rural and remote settings.

Background

HEE is committed to addressing health inequalities and, workforce supply and demand issues particularly in remote and rural areas through transformation and collaboration.

Areas of work that is being explored to deliver this commitment include:

- Widening Participation and health literacy.
- Promote Advanced Clinical Practice to support the medical workforce e.g.: Enhanced (Generalism).
- Innovative rural and coastal healthcare apprenticeship programmes, supporting the NHS as an ‘Anchor Institution’ within ‘places’.
- Explore Targeted Enhanced Recruitment Scheme (TERS) initiatives.
- Dental programmes.

Technology Enhanced Learning will be a ‘golden thread’ throughout each of these programmes, to drive transformation and innovation. The proposed approach will be that ownership for delivery within each locality will be a partnership approach with HEE Transformation teams locally/nationally and Integrated Care System People Boards, which will provide governance and financial oversight.

AMC Central to the Digital Health in Medicine Capability Framework has been a commitment to ensuring that this delivers improved quality and access to healthcare in community and rural and remote settings. Detailed feedback was provided by community partners and rural and remote experts in medicine which was incorporated into the framework. For details see the link to the digital

capability framework for medicine on the AMC website https://www.amc.org.au/amc-strategic-projects/

HEE Presentation

Professor Dominic Patterson, Clinical Advisor, Technology Enhanced Learning in Primary Care, gave a presentation entitled, Reimaging GP training.

Scarborough

- The presentation opened with the example of Scarborough, coastal town in decline that is struggling to attract trainees. The approach taken was to:
  - Grow the number of places
  - Run recruitment campaigns
  - Use Targeted Enhances Recruitment Scheme (TERS) a paid incentive.
- The numbers have increased dramatically.
- No evidence yet if Doctors will stay beyond their training post.

Impacts of COVID

- Training moved from small face-to-face group to online.
- Peer support is lost in the online environment.
- Online creates more opportunities for attendance.
- A lot of GP work is now done over the phone, which GPs are not trained for.

Drivers to Think Differently

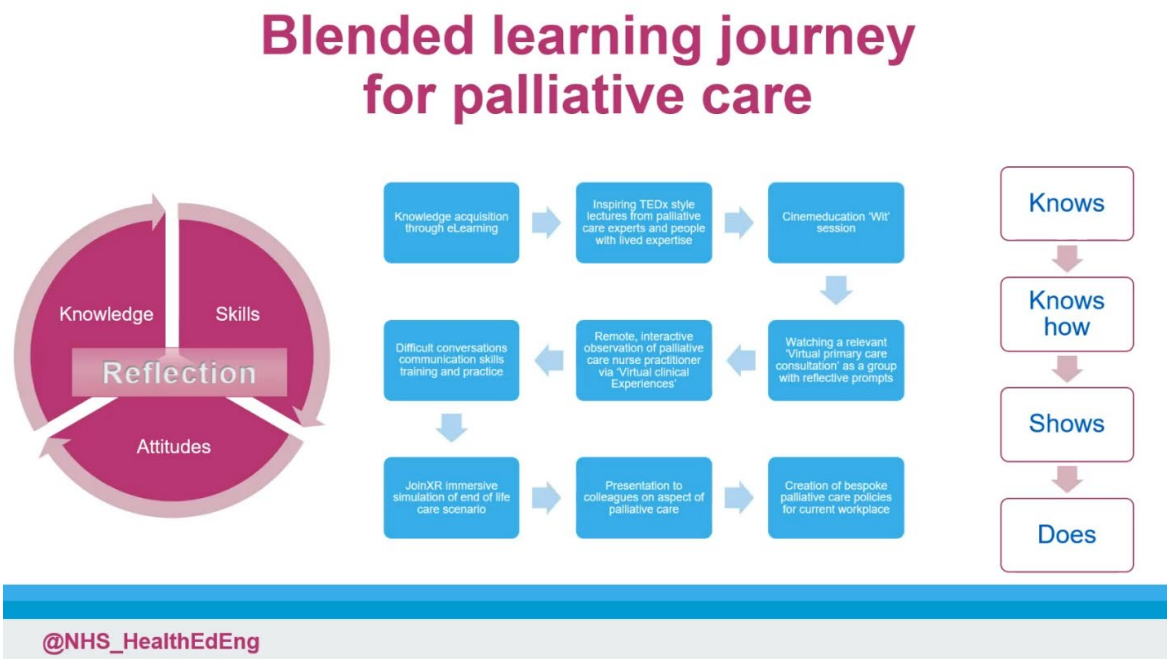
- Placement capacity and distribution.
- Remote and Rural learners struggle to access relevant high-quality placements.
- A need to develop digital skills in the primary care workforce.
- Learners want more personalised, flexible training programmes that help them achieve their learning goals.
- They want to learn on other areas that have not traditionally been a focus, including population health, health inequities and planetary health.
- Increased access to leadership development opportunities.

Blended learning may possibly be the way forward.

A blended learning placement may look like:

- A block placement for two to six months.
- Weekly supervised clinical work in a GP training practice or a remote GP services provider.
- An educational programme built on cutting edge learning science and covering areas of the curriculum that have traditionally been harder to reach.
- Core and optional models in:
  - relevant clinical areas
  - social accountability
  - extended skills
- Modules delivered to a wider audience means more consistency in training.
- Integration of immersive technology, simulation and a ‘virtual primary care’ case bank.
- Access to virtual live-streamed clinics in specialist areas.
- Peer placement enhancement throughout regional and national communities or practice.
- Leadership and education skills development.
- A placement project that contextualises learning and leadership development.
- An end of placement conference that celebrates achievements and allows sharing of projects and learning.
- Makes use of interleaved learning.

- Significant support is required.
- Virtual Primary Care (VPC) is using footage from the TV program GPs: Behind Closed Doors for training videos.
- A virtual placement app is being developed with participants and observers watching am experienced doctor wearing a video headset.
- The app also uses connected devices such as stethoscopes using sample heart rates to test learners.
- Virtual reality consultations using avatars have been developed for some cases.



- Evaluation of the blended programme is important.
- Assessment is still being looked at but will likely be blended.
- There can be challenges when the technology does not work.
- Will there be an expectation that learners provide their own devices? This can impact those without access.
- Small group support will be included so learners don't feel alone.
- The experience of different types of participants needs to be evaluated.

AMC Presentations

Professor Michael Kidd, Deputy Chief Medical Officer, Australian Government Department of Health provided perspectives on rural and community health.

- COVID has seen rapid advances in digital solutions and their rapid implementation.
  - Telehealth has rolled out across Australia with over 110 million digital consultations.
  - Electronic prescriptions have been implemented.
  - Data collection and sharing has advanced allowing a better understanding of our healthcare system, including in rural and remote areas.
  - Point of care testing has been used effectively especially in very remote communities.
  - Digital communications, such as this forum.
- Challenges for rural and remote healthcare.
  - Access to internet and bandwidth issues.
  - Delivering the technology to remote communities

- There is a new Australian Government
    - it is focused on supporting digital health innovation to improve the quality and safety of care provided to Australians wherever they are, urban or rural.
    - It has put A$220 million towards supporting general practices to deliver better digital communications with their patients, particularly to advance video consultations.
    - There is an ongoing program of practice incentives to support regular upgrading of equipment and quality initiatives supporting digital solutions.
- How to improve access for rural and remote areas.
    - It is not about technology; it is about people. The technology has to work for the people.
    - Solutions need to be designed with the consumer at the centre and be usable and accessible.
    - Looking at how digital solutions can better allow accessibility for all patients and create pathways for those living in rural and remote regions.
    - Technology can remove the barriers of distance allowing consultations without travelling large distances but can exacerbate the remoteness e.g. if follow up face-to-face is required.
    - Aim is to have digital technologies available to everyone regardless of location.
- Good examples of digital practice
    - Tele-health is a great success and was implemented very quickly
    - e-prescribing.
    - COVID vaccine rollout, with electronic find a vaccine and appointment booking.
    - Vaccine certificates immediately uploaded to your electronic health record allowing it to be shown at venues via mobile phone.
    - My Health Record, increasing in usage from 1 million people in January 2021 to 14 million in January 2022, mostly for vaccine records.
- Opportunities for collaboration.
    - Australia and the UK already collaborate well together on digital health.
    - There is a lot of sharing of experiences, successes, and failures.
    - Learning from government decisions.
- Still a lot to learn at this stage of the pandemic.
    - What did we learn?
    - What differences have been made?
    - How can we use this technology to overcome the barriers for the disadvantaged? I.e. those in rural and remote regions, Aboriginal and Torres Strait Islanders, low-income earners without access to technology, new arrivals to Australia, people for whom English is not their first language.

Dr Shaun Hosein, Medical Director Hospital in the Home, Queensland Health, spoke about virtual care.

<u>Background on Sunshine Coast Hospital and Health Service</u>

- Covers distance up to 200km and 2.5 hours to a tertiary hospital
- Has a virtual healthcare ward of 36 acute medical beds with:
    - Telehealth – including video.
    - Remote Patient Monitoring (RPM).
    - Physical and virtual visits.
    - 3 RACGP fellows, 1 FRACP ID Physician, 2 PHOs, and 1 RMO.
- Virtual COVID ward.
- Increased complexity with shared care model with specialty teams.

Virtual care definition

- There is no universal definition of virtual care.
- Broadly, virtual care
    - Has a remote aspect, the patient is located elsewhere.
    - Engages people via different mechanisms such as phone or video.
    - Uses integration of digital tools such as digital records, virtual visits, and RPM.

Virtual Health Risk Assessment

- Ultra-low, the patient is able to self-care.
- Low, GP planned care.
- Medium low, Virtual specialist. Stable complex co-morbidities.
- Medium, Virtual specialist. Complex co-morbidities.
- High, patient requires hospital care.

Virtual Health Variables

- Medical
- Patient, need to consent, may have anxiety about virtual care.
- Cultural, different backgrounds create different outlooks on virtual care
- Social, is the home environment suitable for the patient.
- Environmental, floods for example may impact the use of virtual care.

Lessons Learnt in Virtual Health

- Critical thinking and appraisal.
    - Using the Virtual health variables to identify risk and mitigate
        - Chronic pain management
    - Limitations of virtual – balance
        - Physical examination
- Communication and setting expectations
- Ethical and legal issues
    - Sensitive site infections – Chaperones
    - Digital tool – Virtual health practice
- Ongoing engagement and change
    - Span the spectrum of medical education to complete the circle
- Virtual / Digital Health Experience & Practice

Future Directions

- Further developing service with shared care.
- Recruiting training doctors
    - GP training
    - Opportunity for UK doctors
- Digital – Virtual health education series
- Virtual health Community of practice
- Research

Breakout Discussions

Participants focused on one of four key questions related to the roundtable session topic.

Key Breakout Discussion Points

Question 1: How are digital technologies allowing us to reimagine community health delivery?

Facilitator: Dr Amandeep Hansra

- Digital transforms the rural and community because technology dissolves the differences between rural and metro.
- There is though the question and problem of digital connection – there is marked differences between rural and metro digital infrastructure and how this impact on care. Inequality is always going to be there if accessibility is not there. This is starker in Australia than in the UK. Trying to deliver a medical course in Australia we were definitely limited by what we could and could not do. With the potential of this getting worse rather than better.
- We are moving towards a digital first point of care in the UK, but the infrastructure will make this problematic if they don't have connectivity.
- Digital care is a great improvement but what needs to happen is more integrated cross disciplinary care. How does technology support the interdisciplinary teams – it is very hard to provide this care because the teamwork mentality is not developed enough, and it is a particular challenge in rural areas.
- The role of the patient support groups to overcome isolation through digital health is particularly valuable for rare complaints.
- Digital support for the solo GP is very important so that it is less daunting to provide care for all. This points to the need to use technology systems to provide education and peer support.
- The rules around placements for trainees can be quite restrictive and this really impacts the ability of trainees to learn in rural settings. There could be opportunities for intern training to expand settings safely with access to technologies.
- The RACP has a project funded by the Commonwealth Government focused on expanded training settings in rural areas.
- A further RACP initiative is the ROC – RACP Online Community https://www.racp.edu.au/about/membership/the-roc where members can debate, ask questions and discuss. There is an online mentoring function whereby members can find a mentor to support their learning.
- The framework we developed at the AMC supports the development of some basic skills in telehealth and electronic records as well as ePrescribing. Also, in the framework we highlight some personalised technologies (wearables, and focus on data transformation of care and prevention) and how this can support healthcare delivery in the homes. At the higher end is the critical appraisal of emerging technologies, value-based care and data analytics.

Question 2: How can we improve access and quality health provision in rural and remote settings?

Facilitator: Henrietta Mbeah-Bankas

- Many rural hospitals now have access to digital radiology to enable better diagnoses and support with retrieval and treatment. Having the support from more senior and experienced colleagues, even in a virtual world, can provide support and give confidence to staff on the ground in more remote locations.
- Within Australia there is an issue with inter-operability particularly between states and territories. There is a lack of communication and agreement between different care providers and given the remoteness of many rural communities across the country, more joined up healthcare would provide a better experience for all patients, across all communities no matter how remote. Is there a possibility for collaboration between the UK and Australia? Australia

has a Collaborative Research Centre (CRC), which would link well with colleagues in the UK, particularly in Health Education England (HEE) to share learning and practice developments. Mutual learning is key to progressing the digital agenda.

- There is a need to engage with remote and rural locations whilst also keeping in mind the level of disruption to lifestyles and cultural beliefs related to healthcare and preventative medicine. Providing high levels of healthcare digitally or remotely through technology may not be welcomed into this cultural space, and there needs to be clear understanding of how best to provide healthcare and how best to engage local populations.
- Post-pandemic, there is an established ethos and philosophy of practice that we can maintain, having managed our lives remotely. The need to keep the population engaged with managing things in a virtual environment is essential. Technology must be kept as simple as possible for the end user, so it does not appear to be exclusive or difficult to manage. Thinking along the lines of how easily people engage with online shopping, keeping healthcare virtual systems user friendly is essential to help users engage.
- Data sharing agreements need to be kept in place to ensure safety of patient information and patient confidence in digital system development. This is not just a political issue, as news headlines about loss of data by public organisations can cause the public to be uneasy with technology being used, particularly in relation to their most personal information such as medical records.
- Having a single health platform to bring together patient records into a single place is in train in Australia.
- There is a need to provide space and time for clinicians to train in the use of digital platforms to ensure the systems are understood and used to their best once in place. Universities need to be providing trainee clinical staff with digital competency, so the newly qualified workforce are fully conversant with technological advances when graduating into the workforce.

Question 3: What are some good practice examples of digital health in community and rural settings?

Facilitator: Associate Professor Michael Franco

- Service user driven requirements are missing from current developments. Working with paediatrics and child health groups and families within these groups it has become evident that patients and their families need telehealth and digital capability as during the pandemic.
- Postgraduate work to provide a continuum of work within groups who wish to attain higher level qualifications is also needed.
- Younger colleagues have grown up with technology as part of their lives, and it may be a better viewpoint to address colleagues who did not have this background and looking at these colleagues to bring them up to speed with digitalisation would be a better approach to enhance healthcare safety across the board. It is not about being better at using technology, it is about finding those colleagues who do not have ability and making them better.
- There is a disconnect between communicating what is meaningful from a clinical perspective versus what is useful in a technological space. Simply providing a system where clicking a mouse prescribes the same process or treatment as a physical consultation does not enhance healthcare, the advancement of digitalisation needs to also be meaningful and bring change and improvement. If something takes time, as long as the end result is good quality, safe healthcare provision, then it is worthwhile.
- There needs to be more conversation about how frameworks are implemented and used rather than simply discussing what we have and how good it could be. Implementation is key.
- Education programmes are set in routine and the past, what has worked well does not get changed. There is a need to make changes using digital technology. This is not recreating the wheel; this is using the wheel in a different way. The conversation needs to take place within communities that hold the ability to teach the “how”.

- Reform of teaching methods must not always be top down. If the value of what is being implemented is clear, it is far easier to engage all colleagues with change and drive it forward. Those who initially resist change should not be pushed into accepting it, as the usual pattern is that they will eventually see the benefit of the change and will engage.

Question 4: How could our countries collaborate to improve healthcare delivery in community and rural and remote settings through leveraging digital technologies?

Facilitator: Patrick Mitchell

- Sharing collected data and evaluations
- How do you use technology to aid regions that have limited access/training to tech?
- Continue to build on health literacy incorporating digital.
- Mutual agreements to adopt and adapt the tools and resources we have.
    - EG. UK easy read resources for different cultures and literacy levels could help.
- Training requires ongoing support
- Evaluation needs to be in-depth, share how we evaluate.
- How can systems replace the need for learning?
- We can share evaluations that are working.
- Share assets, not just the final research report
- Share assessment changes due to COVID and evaluations of what worked.
- Sharing on how we help those without increasing the digital divide.

If you have any follow up questions regarding the event, please email:

digitalmedicine@amc.org.au