

20 janvier 2021

Réponse
rapide

COVID-19 et la pratique de la
téléconsultation en médecine de
première ligne et médecine
spécialisée : principes généraux
Annexes complémentaires

Une production de l'Institut
national d'excellence en santé
et en services sociaux (INESSS)

ANNEXE A

Stratégie de repérage d'information scientifique

Tableau A-1 Bases de données bibliographiques

| PubMed (NLM) Date du repérage : octobre 2020 Limites : 2010- ; anglais, français | |
|---|--|
| #1 | Remote Consultation[majr] OR Telemedicine[majr] OR Videoconferencing[majr] |
| #2 | e-health[tiab] OR m-health[tiab] OR ehealth[tiab] OR mhealth[tiab] OR mobile health[tiab] OR remote consultati*[tiab] OR tele-care*[tiab] OR tele-consultation*[tiab] OR tele-health[tiab] OR tele-medicine[tiab] OR telecare*[tiab] OR teleconsultation*[tiab] OR telehealth[tiab] OR telemedicine[tiab] OR telephone consultation*[tiab] OR video-based[tiab] OR video conferenc*[tiab] OR video consultation*[tiab] OR videobased[tiab] OR videoconferenc*[tiab] OR virtual consultation*[tiab] OR virtual visit*[tiab] |
| #3 | e-health[ot] OR m-health[ot] OR ehealth[ot] OR mhealth[ot] OR mobile health[ot] OR remote consultati*[ot] OR tele-care*[ot] OR tele-consultation*[ot] OR tele-health[ot] OR tele-medicine[ot] OR telecare*[ot] OR teleconsultation*[ot] OR telehealth[ot] OR telemedicine[ot] OR telephone consultation*[ot] OR video-based[ot] OR video conferenc*[ot] OR video consultation*[ot] OR videobased[tiab] OR videoconferenc*[ot] OR virtual consultation*[ot] OR virtual visit*[ot] |
| #4 | #1 OR #2 OR #3 |
| #5 | Algorithms[mh] OR Clinical Conference[pt] OR Clinical Protocols[mh] OR Consensus[mh] OR Consensus Development Conference, NIH[pt] OR Consensus Development Conference[pt] OR Consensus Development Conferences, NIH as topic[mh] OR Consensus Development Conferences as Topic[mh] OR Critical Pathways[mh] OR Guideline[pt] OR Guidelines as Topic[mh:noexp] OR Health Planning Guidelines[mh] OR Practice Guideline[pt] OR Practice Guidelines as Topic[mh] |
| #6 | algorithm*[tiab] OR best evidence[tiab] OR best practice*[tiab] OR (best[ti] AND practice*[ti]) OR clinical path[tiab] OR clinical paths[tiab] OR clinical pathway*[tiab] OR clinical protocol*[tiab] OR committee opinion*[tiab] OR consensus[tiab] OR critical pathway*[tiab] OR CPG[tiab] OR CPGs[tiab] OR evidence base*[tiab] OR evidence report*[tiab] OR evidence syntheses*[tiab] OR guidance*[tiab] OR guide line*[tiab] OR gold standard*[tiab] OR guideline*[tiab] OR policy statement*[tiab] OR position statement*[tiab] OR practical guide*[tiab] OR practice based evidence[tiab] OR practice parameter*[tiab] OR practice pathway*[tiab] OR practice protocol*[tiab] OR practice standard*[tiab] OR recommendation*[tiab] OR research evidence*[tiab] OR standard*[tiab] OR standard care*[tiab] OR standard practice*[tiab] OR standard of care[tiab] OR standard of practice*[tiab] OR standards of care[tiab] |
| #7 | algorithm*[ot] OR best evidence[ot] OR best practice*[ot] OR (best[ti] AND practice*[ti]) OR clinical path[ot] OR clinical paths[ot] OR clinical pathway*[ot] OR clinical protocol*[ot] OR committee opinion*[ot] OR consensus[ot] OR critical pathway*[ot] OR CPG[ot] OR CPGs[ot] OR evidence base*[ot] OR evidence report*[ot] OR evidence syntheses*[ot] OR guidance*[ot] OR guide line*[ot] OR gold standard*[ot] OR guideline*[ot] OR policy statement*[ot] OR position statement*[ot] OR practical guide*[ot] OR practice based evidence[ot] OR practice parameter*[ot] OR practice pathway*[ot] OR practice protocol*[ot] OR practice standard*[ot] OR recommendation*[ot] OR research evidence*[ot] OR standard*[ti] OR standard care*[ot] OR standard practice*[ot] OR standard of care[ot] OR standard of practice*[ot] OR standards of care[ot] |
| #8 | Case Reports[pt] OR Comment[pt] OR Editorial[pt] OR Letter[pt] OR case report*[ti] OR comment*[ti] OR reply[ti] OR replies[ti] OR editorial*[ti] OR letter*[ti] OR case report*[ot] OR comment*[ot] OR reply[ot] OR replies[ot] OR editorial*[ot] OR letter*[ot] |
| #9 | (#5 OR #6 OR #7) NOT #8 |
| #10 | #4 AND #9 |
| #11 | Meta-Analysis[mh] OR Meta-Analysis[pt] OR Meta-Analysis as Topic[mh] OR Systematic Review[pt] OR Technology Assessment, Biomedical[mh] |
| #12 | meta-analy*[tiab] OR metaanaly*[tiab] OR met analy*[tiab] OR metanaly*[tiab] OR meta regression*[tiab] OR metaregression*[tiab] OR meta review*[tiab] OR metareview*[tiab] OR meta synthesis[tiab] OR metasynthesis[tiab] OR overview of review*[tiab] OR overviews of review*[tiab] OR (systematic*[tiab] AND (review*[tiab] OR overview*[tiab] OR search*[tiab] OR research*[tiab])) OR (review[tw] AND (medline[tiab] OR pubmed[tiab]) AND (cinahl[tiab] OR cochrane[tiab] OR embase[tiab] OR psycinfo[tiab])) OR umbrella review*[tiab] OR technology appraisal*[tiab] OR technology assessment*[tiab] OR technology overview*[tiab] OR technology reassessment*[tiab] OR HTA[tiab] OR HTAs[tiab] OR methodological overview*[tiab] OR methodologic overview*[tiab] OR methodological review*[tiab] OR methodologic review*[tiab] OR quantitative |

| | |
|-----|--|
| | review*[tiab] OR quantitative overview*[tiab] OR quantitative syntheses*[tiab] OR integrative review*[tiab] OR integrative overview*[tiab] OR integrative literature review*[tiab] |
| #13 | meta-analy*[ot] OR metaanaly*[ot] OR met analy*[ot] OR metanaly*[ot] OR meta regression*[ot] OR metaregression*[ot] OR meta review*[ot] OR metareview*[ot] OR meta synthesis[ot] OR metasynthesis[ot] OR overview of review*[ot] OR overviews of review*[ot] OR (systematic*[ot] AND (review*[ot] OR overview*[ot] OR search*[ot] OR research*[ot])) OR (review[tw] AND (medline[ot] OR pubmed[ot]) AND (cinahl[ot] OR cochrane[ot] OR embase[ot] OR psycinfo[ot])) OR umbrella review*[ot] OR technology appraisal*[ot] OR technology assessment*[ot] OR technology overview*[ot] OR technology reassessment*[ot] OR HTA[ot] OR HTAs[ot] OR methodological overview*[ot] OR methodologic overview*[ot] OR methodological review*[ot] OR methodologic review*[ot] OR quantitative review*[ot] OR quantitative overview*[ot] OR quantitative syntheses*[ot] OR integrative review*[ot] OR integrative overview*[ot] OR integrative literature review*[ot] |
| #14 | (#11 OR #12 OR #13) NOT #8 |
| #15 | #4 AND #14 |
| #16 | Narration[mh:noexp] |
| #17 | narrati*[tiab] OR metanarrative*[tiab] OR meta-narrative*[tiab] OR narrati*[ot] OR metanarrative*[ot] OR meta-narrative*[ot] |
| #18 | #16 OR #17 |
| #19 | #4 AND #18 |
| #20 | #10 OR #15 OR #19 |

| Embase (Ovid) | |
|--|---|
| Date du repérage : octobre 2020 | |
| Limites : 2010- ; anglais, français; Embase | |
| 1 | *Teleconsultation/ OR *Telemedicine/ OR *Videoconferencing/ |
| 2 | (e-health OR m-health OR ehealth OR mhealth OR mobile health OR remote consultati* OR tele-care* OR teleconsultation* OR tele-health OR tele-medicine OR telecare* OR teleconsultation* OR telehealth OR telemedicine OR telephone consultation* OR video-based OR video conferenc* OR video consultation* OR videobased OR videoconferenc* OR virtual consultation* OR virtual visit*).ti,ab,kw. |
| 3 | OR/1-2 |
| 4 | Algorithm/ OR Clinical Pathway/ OR Clinical Protocol/ OR Consensus/ OR Consensus Development/ OR Health Care Planning/ OR exp Practice Guideline/ |
| 5 | (algorithm* OR best evidence OR (best ADJ3 practice*) OR clinical path OR clinical paths OR (clinical ADJ3 pathway*) OR clinical protocol* OR committee opinion* OR CPG OR CPGs OR consensus OR (critical ADJ3 pathway*) OR gold standard* OR guidance* OR guideline* OR guide line* OR policy statement* OR position statement* OR practical guide* OR practice parameter* OR practice pathway* OR practice protocol* OR practice standard* OR recommendation* OR standard care* OR standard of care OR standards of care).ti,ab,kw. OR standard*.ti,kw. |
| 6 | Case Report/ OR Editorial/ OR Letter/ OR (case report* OR comment* OR replies OR reply OR editorial* OR letter*).ti,kw. |
| 7 | (4 OR 5) NOT 6 |
| 8 | 3 AND 7 |
| 9 | Biomedical Technology Assessment/ OR Meta Analysis/ OR "Meta Analysis (topic)"/ OR Systematic Review/ OR "Systematic Review (topic)"/ |
| 10 | (HTA OR HTAs OR evidence base* OR evidence report* OR evidence synthesis OR evidence syntheses OR meta-analy* OR metaanaly* OR met analy* OR metanaly* OR meta regression* OR metaregression* OR meta review* OR metareview* OR meta synthesis OR metasynthesis OR overview of review* OR (systematic* ADJ3 (review* OR overview* OR search* OR research*)) OR research evidence* OR technology appraisal* OR technology assessment* OR technology overview* OR technology reassessment* OR umbrella review*).ti,ab,kw. OR (review.tw,kw. AND ((medline OR pubmed) AND (cinahl OR cochrane OR embase OR psycinfo)).ti,ab,kw.) |
| 11 | (9 OR 10) NOT 6 |
| 12 | 4 AND 11 |
| 13 | Verbal Communication/ |
| 14 | (narrati* OR metanarrative* OR meta-narrative*).ti,ab,kw. |
| 15 | OR/13-14 |
| 16 | 4 AND 15 |
| 17 | 8 OR 12 OR 16 |

Tableau A-2 - Les sites internet et les pages consultés

| Agence, association, société ou organisation | Pays | URL |
|--|--------------|---|
| Collège des médecins du Québec (CMQ) | Canada (Qc) | http://www.cmq.org/ |
| Fédération des médecins omnipraticiens du Québec (FMOQ) | Canada (Qc) | https://www.fmoq.org/ |
| Fédération des médecins spécialistes du Québec (FMSQ) | Canada (Qc) | https://fmsq.org/fr |
| Réseau québécois de la télésanté | Canada (Qc) | https://telesante.quebec/index.html |
| Université de Montréal | Canada (Qc) | https://www.umontreal.ca/ |
| Université McGill | Canada (Qc) | https://www.mcgill.ca/fr |
| CHUS-Fleurimont | Canada (Qc) | https://www.santeestrie.qc.ca/ |
| Ordre professionnel de la physiothérapie du Québec (OPPQ) | Canada (Qc) | https://oppq.qc.ca/ |
| Ordre des infirmiers et infirmières du Québec (OIIQ) | Canada (Qc) | https://www.oiiq.org/ |
| Conseil interprofessionnel du Québec (CIQ) | Canada (Qc) | https://www.professions-quebec.org/fr/ |
| OTN Ontario Telehealth Network (OTN) | Canada (Ont) | https://otn.ca/ |
| Health Quality Ontario (HQO) | Canada (Ont) | https://www.hqontario.ca/What-is-Health-Quality |
| College of Physicians and Surgeons of Ontario (CPSO) | Canada (Ont) | https://www.cpso.on.ca/ |
| University of Toronto | Canada (Ont) | https://www.cpd.utoronto.ca/covid-19/virtual-care/ |
| OntarioMD | Canada (Ont) | https://ontariomd.vc/ |
| Ontario Health Insurance Plan (OHIP) | Canada (Ont) | https://www.ontario.ca/page/ohip-coverage-across-canada |
| University of Toronto | Canada (Ont) | https://www.cpd.utoronto.ca/covid-19/virtual-care/ |
| College of nurses of Ontario (CNO) | Canada (Ont) | https://www.cno.org/fr/bienvenue/ |
| Association canadienne de protection médicale (ACPM) | Canada | https://www.cmpa-acpm.ca/fr/home |
| College of Physicians and Surgeons of British Columbia (CPSBC) | Canada (BC) | https://www.cpsbc.ca/ |

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|---|---------------|---|
| Provincial Health Services Authority (PHSA) | Canada (BC) | http://www.phsa.ca/ |
| BC Mental Health (BCMH) | Canada (BC) | http://www.bcmhsus.ca/ |
| Doctors of BC | Canada (BC) | https://www.doctorsofbc.ca/ |
| BC Health | Canada (BC) | https://www2.gov.bc.ca/gov/content/health |
| BC College of Nursing Professional (BCCNP) | Canada (BC) | https://www.bccnm.ca/Pages/Default.aspx |
| University of Calgary | Canada (Alb) | https://www.ucalgary.ca/ |
| Alberta Medical Association | Canada (Alb.) | https://www.albertadoctors.org/ |
| College of Physician & Surgeon of Alberta (CPSA) | Canada (Alb.) | http://www.cpsa.ca/ |
| College and Association of Registered Nurses of Alberta (CARNA) | Canada (Alb.) | https://nurses.ab.ca/standards-and-learning/telehealth-nursing-practice |
| College of Physicians and Surgeons of Saskatchewan | Canada (Sask) | https://www.cps.sk.ca/imis |
| University of Saskatchewan | Canada (Sask) | https://www.usask.ca/ |
| Saskatchewan Registered Nurse Association (SRNA) | Canada (Sask) | https://www.srna.org/ |
| College of Registered Nurses of Manitoba (CRNM) | Canada (Man) | https://www.crnmb.ca/ |
| College of Registered Psychiatric Nurses of Manitoba (CRPNM) | Canada (Man) | https://crpnm.mb.ca/ |
| Doctors Manitoba | Canada (Man) | https://doctorsmanitoba.ca/ |
| Nurses Association of New Brunswick (NANB) | Canada (N-B) | http://www.nanb.nb.ca/ |
| Association of New Brunswick Licensed Practical Nurses (ANBLPN) | Canada (N-B) | https://www.anblpn.ca/ |
| Nova scotia health authority | Canada (N-E) | http://www.nshealth.ca/ |
| College of Physicians and Surgeons of Nova Scotia | Canada (N-E) | https://cpsns.ns.ca/ |
| Doctors Nova Scotia | Canada (N-E) | https://www.doctorsns.com/ |

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|---|--------------|---|
| Nova Scotia College of Nursing (NSCN) | Canada (N-E) | https://www.nscn.ca/ |
| Newfoundland and Labrador Medical Association | Canada (T-N) | https://www.nlmna.nl.ca/ |
| College of Registered Nurses of Newfoundland and Labrador (CRNNL) | Canada (T-N) | https://www.crnnl.ca/ |
| College of Registered Nurses of Prince Edward Island (CRNPEI) | Canada (IPE) | https://crnpei.ca/ |
| Association médicale canadienne (AMC) | Canada | https://www.cma.ca/fr |
| HSO Organisation de normes en santé (HSO) | Canada | https://healthstandards.org/fr/ |
| Collège royal des médecins et chirurgiens du Canada (CRMCC) | Canada | https://www.royalcollege.ca/rcsite/home-e |
| Agence canadienne des médicaments et technologies en santé (ACMTS) | Canada | https://www.cadth.ca/fr |
| Canada Health Infoway | Canada | https://infoway-inforoute.ca/en/solutions/digital-health-foundation/telehealth |
| Federation of Medical Regulatory Authorities of Canada (FMRAC) | Canada | https://fmrac.ca/ |
| eHealth Innovation | Canada | https://ehealthinnovation.org/ |
| Fondation des maladies du cœur et de l'AVC | Canada | https://www.pratiquesoptimalesavc.ca/recommandations/tele-avc |
| Canadian Journal of Nursing Informatics (CNJI) | Canada | https://cjni.net/journal/ |
| Mental Health Commission of Canada | Canada | https://www.mentalhealthcommission.ca/English |
| Canadian Nurse Association (CNA) | Canada | https://www.cna-aiic.ca/en |
| Society of Rural Physicians of Canada (SRPC) | Canada | https://srpc.ca/ |
| C.D. Howe Institute | Canada | https://www.cdhowe.org/about-us |
| Women's College Hospital Institute for Health Systems Solutions and Virtual Care (WIHV) | Canada | https://www.wchvihv.ca/ |
| Canadian Nurses Protective Society (CNPS) | Canada | https://cnps.ca/ |
| Dialogue Healthcare service | Canada | https://www.dialogue.co/en/ |
| Agency for Healthcare Research and Quality (AHQR) | États-Unis | https://www.ahrq.gov/ |

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|---|------------|---|
| Telehealth | États-Unis | https://telehealth.hhs.gov/ |
| American Telemedicine Association (ATA) | États-Unis | https://www.americantelemed.org/ |
| American College of Physicians (ACP) | États-Unis | https://www.acponline.org/ |
| American Medical Association (AMA) | États-Unis | https://www.ama-assn.org/ |
| American Academy of Family Physicians (AAFP) | États-Unis | https://www.aafp.org/home.html |
| Mid-Atlantic Telehealth Resource Center (MATRC) | États-Unis | https://www.matrc.org/ |
| Federation of state medical boards (FSMB) | États-Unis | https://www.fsmb.org/ |
| Caravan Health | États-Unis | https://caravanhealth.com/ |
| CMS.gov | États-Unis | https://www.cms.gov/ |
| American Nurses Association (ANA) | États-Unis | https://www.nursingworld.org/ |
| American Academy of Nursing Community (AAN) | États-Unis | https://www.aannet.org/home |
| American Association of Nurse Practitioners (AANP) | États-Unis | https://www.aanp.org/ |
| American Society of Registered Nurses (ASRN) | États-Unis | https://www.asrn.org/ |
| Center for disease control and prevention (CDC) | États-Unis | https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html |
| Telligen | États-Unis | https://telligen.com/ |
| National Consortium of Telehealth Resource Centers (TRC) | États-Unis | https://www.telehealthresourcecenter.org/ |
| Australian Department of Health (MBS Online) | Australie | http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home |
| University of Queensland | Australie | https://www.uq.edu.au/ |
| NSW Agency for Clinical Innovation (ACI) | Australie | https://aci.health.nsw.gov.au/ |
| The Royal Australian College of General Practitioners (RACGP) | Australie | https://www.racgp.org.au/ |
| Australian Telehealth society (ATHS) | Australie | http://www.aths.org.au/ |
| Australian College of Rural and Remote Medicine (ACRRM) | Australie | https://www.acrrm.org.au/ |

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|--|------------------|---|
| Haute autorité de santé (HAS) | France | https://www.has-sante.fr/ |
| Conseil national de l'Ordre des médecins (CNOM) | France | https://www.conseil-national.medecin.fr/ |
| Ministère de la santé et des solidarités de France | France | https://solidarites-sante.gouv.fr/ |
| Agence nationale d'appui à la performance (ANAP) | France | http://ressources.anap.fr/numerique/ |
| National Institute for Health and Care Excellence (NICE) | Royaume-Uni | https://www.nice.org.uk/ |
| Care Quality Commission (CQC) | Royaume-Uni | https://www.cqc.org.uk/ |
| National health service (NHS) | Royaume-Uni | https://www.england.nhs.uk/ |
| General medical council (GMC) | Royaume-Uni | https://www.gmc-uk.org/ |
| University of York | Royaume-Uni | https://www.york.ac.uk/ |
| Centre for Reviews and Dissemination (CRD) University of York | Royaume-Uni | https://www.crd.york.ac.uk/CRDWeb/ |
| British Medical Journal (BMJ) | Royaume-Uni | https://www.bmj.com/ |
| RCPCH Royal college of pediatrics and child health | Royaume-Uni | https://www.rcpch.ac.uk/ |
| University of Bristol | Royaume-Uni | https://www.bristol.ac.uk/ |
| Faculty of Sexual and Reproductive Healthcare (FSRH) | Royaume-Uni | https://www.fsrh.org/home/ |
| Mid-Wales Health Collaborative | Royaume-Uni | http://www.midwalesjointcommittee.wales.nhs.uk/home |
| Belgian health care knowledge center (KCE) | Belgique | https://kce.fgov.be/fr |
| Commission Européenne | Union Européenne | https://ec.europa.eu/ |

ANNEXE B

Membres des comités

Tableau B-1 - Listes des membres du comité consultatif

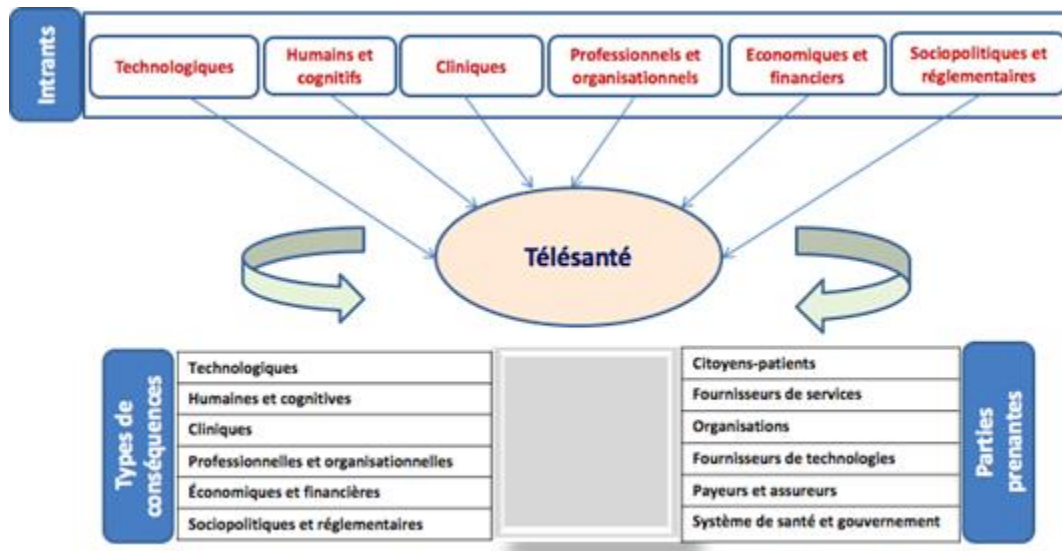
| Membres | Affiliation |
|------------------------|---|
| Mme Katy Sadpour | CUSM : Coordinatrice, centre de coordination de la télésanté du RUISSS de l'Université McGill |
| Mme Sabrina Lapointe | CIUSSSE-CHUS : Coordinatrice, centre de coordination de la télésanté du RUISSS de l'Université de Sherbrooke |
| M. Guy Paré | Professeur titulaire, Département des technologies de l'information, HEC Montréal, Titulaire de la Chaire de recherche en santé connectée (Chercheur expert en télésanté) |
| M. Sébastien Carrier | CHU : Coordinateur, Centre de coordination de la télésanté du RUISSS de l'Université Laval |
| Mme Marie-Josée Paquet | CHUM : Coordinatrice, Centre de coordination de la télésanté du RUISSS de l'Université de Montréal |
| Mme José Côté | Professeure titulaire, Faculté des sciences infirmières, Université de Montréal, Titulaire de la Chaire de recherche sur les nouvelles pratiques infirmières (cybersanté – technologies de l'information); Chercheuse au CRCHUM (Chercheuse experte en télésanté) |
| Dr Jean-Paul Fortin | Médecin expert en santé publique, Chercheur au CIUSSS de la Capitale-Nationale, à VITAM – Centre de recherche en santé durable, au CRCHUQ et au CR de l'Hôtel-Dieu de Lévis (Chercheur expert en télésanté et organisation des soins) |
| Dre Romina Pace | Médecine interne (CUSM) |
| Dre Maxine Dumas Pilon | Omnipraticienne - Montréal; Responsable projet e-Consult, Collège québécois des médecins de famille (CQMF); McGill; Médecin-conseil au MSSS |
| Dre Mélanie Garneau | Omnipraticienne – Baie-Comeau |
| Dre Maria Buithieu | Pédiatre – CHU Ste-Justine; Pilote clinique en télésanté pour le CHU |
| Dre Marie-Claude Lebel | Gynécologue-obstétricienne – Baie-Comeau |
| M. Jean Morneau | Chef des programmes de télésanté – CIUSSS Saguenay-Lac-Saint-Jean |
| Mme Stéphanie Charest | Coordinatrice des IPS - CIUSSS de l'Estrie-CHUS |
| M. Jean Légaré | Usager expert |
| Mr. Christian Chabot | Usager expert |

Tableau B-2 – Liste des collaborateurs individuels externes

| Nom du chercheur | Affiliation |
|------------------|---|
| Aude Motulsky | Professeure adjointe, École de santé publique - Département de gestion, d'évaluation et de politique de santé, Université de Montréal |
| Naeem Bhojani | Professeur agrégé, Département de chirurgie, Département de médecine sociale et préventive, Université de Montréal |
| Mylaine Breton | Professeure, Faculté de médecine et des sciences de la santé, Université de Sherbrooke |

ANNEXE C

Modèle d'utilisation de la télésanté



Modèle d'utilisation de la télésanté (adapté de Bloomrosen et al., 2011)

Le modèle identifie plusieurs dimensions de nature systémique, qui peuvent être déclinées en enjeux. Pour permettre l'analyse des données sur les meilleures pratiques, modalités et indications de la téléconsultation et le contexte d'intégration de celles-ci, une vision d'ensemble au niveau du système de santé et des services sociaux s'impose. Le modèle conceptuel adapté de Bloomrosen et al., a été pris comme assise pour structurer les différentes dimensions d'intérêt, mais il ne constitue pas une finalité en soi.

ANNEXE D

Situations cliniques, conditions cliniques et symptomatologies appropriées et inappropriées

Tableau D-1 - Liste des situations cliniques, conditions cliniques ou symptomatologies mentionnées dans la littérature grise comme inappropriées à l'utilisation de la téléconsultation

| Situations / conditions cliniques ou symptomatologies mentionnées comme INAPPROPRIÉES | Références |
|---|---|
| Toutes conditions avec besoin d'un examen physique non réalisable en téléconsultation | [AMA, 2020; AMC, 2020; Arsenault <i>et al.</i> , 2020; Car <i>et al.</i> , 2020; CDC, 2020; CMQ, 2020; Doctors Manitoba, 2020; Doctors Nova Scotia, 2020; RACGP, 2020; CMQ, 2019; RACGP, 2019; HAS, 2018; CMQ, 2015; Daniel et Sulmasy, 2015] |
| Douleur thoracique | [AMC, 2020; CMQ, 2020; NLMA, 2020] |
| Souffle court / difficulté respiratoire | [AMA, 2020; AMC, 2020; CMQ, 2020; NLMA, 2020; Daniel et Sulmasy, 2015] |
| Symptômes et insuffisance cardiaque congestive. | [AMC, 2020; NLMA, 2020] |
| Symptômes gastrointestinaux | [AMC, 2020; FMOQ, 2020; NLMA, 2020] |
| Douleur abdominale | [AMC, 2020; CMQ, 2020] |
| Vomissements | [AMA, 2020] |
| Parésie | [CMQ, 2020] |

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| Blessure ou condition musculo-squelettique | [AMC, 2020; NLMA, 2020] |
| Otalgie / Otite moyenne soupçonnée | [AMC, 2020; FMOQ, 2020; NLMA, 2020] |
| Toux | [AMC, 2020; NLMA, 2020] |
| Fièvre | [AMA, 2020] |
| Symptômes ou perte de fonction neurologique | [AMA, 2020; AMC, 2020; NLMA, 2020; HAS, 2018] |
| Agitation | [AMA, 2020] |
| Confusion / Statut mental anormal | [AMA, 2020; Bakhai <i>et al.</i> , 2020; HAS, 2018] |
| Intoxication (alcool, drogue) | [Bakhai <i>et al.</i> , 2020; HAS, 2018] |
| Besoin de soins urgent / Risque de détérioration | [AMC, 2020; Arsenault <i>et al.</i> , 2020; Bakhai <i>et al.</i> , 2020; Car <i>et al.</i> , 2020; CDC, 2020; NLMA, 2020; RACGP, 2020; RACGP, 2019; HAS, 2018] |
| Rencontre d'annonce (mauvaise nouvelle) / Sujet sensible | [Bakhai <i>et al.</i> , 2020; Car <i>et al.</i> , 2020; CDC, 2020; HAS, 2019] |
| Consultation pour des enfants avec une maladie aigue | [Bakhai <i>et al.</i> , 2020] |

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| Problème psychosocial complexe | [Bakhai <i>et al.</i> , 2020] |
| Soins esthétiques | [Bakhai <i>et al.</i> , 2020; CMQ, 2020] |

Tableau D-2 - Liste des situations cliniques, conditions cliniques ou symptomatologies mentionnées dans la littérature grise comme appropriées à l'utilisation de la téléconsultation

| Situations / conditions cliniques ou symptomatologies mentionnées comme APPROPRIÉES | Références |
|---|---|
| Problèmes de santé courants (sans besoin d'examen physique) | [AMA, 2020; Car <i>et al.</i> , 2020; CDC, 2020; CMQ, 2020; Doctors Nova Scotia, 2020; FMOQ, 2020; NLMA, 2020; RACGP, 2020; CMQ, 2019; RACGP, 2019; CMQ, 2015; Daniel et Sulmasy, 2015] |
| Maladie infectieuse de faible risque | [AMA, 2020; NLMA, 2020] |
| Infection des voies respiratoires supérieures | [NLMA, 2020] |
| Bronchite | [NLMA, 2020] |
| Sinusite | [Arsenault <i>et al.</i> , 2020; Doctors Nova Scotia, 2020; NLMA, 2020] |
| Pharyngite (avec prélèvement réalisable) | [AMC, 2020; NLMA, 2020] |
| Maux de gorge | [NLMA, 2020] |

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|---|--|
| Conjonctivite | [AMA, 2020; Doctors Manitoba, 2020; NLMA, 2020] |
| Cystites | [Arsenault <i>et al.</i> , 2020] |
| Infection urinaire simple / cystite | [AMA, 2020; AMC, 2020; Doctors Manitoba, 2020; Doctors Nova Scotia, 2020; FMOQ, 2020; NLMA, 2020] |
| Dépistage et traitement d'ITSS | [AMC, 2020; Arsenault <i>et al.</i> , 2020; Doctors Nova Scotia, 2020; FMOQ, 2020; NLMA, 2020] |
| Symptômes d'allure grippale ou de rhume | [Doctors Manitoba, 2020; NLMA, 2020] |
| Toux et rhume | [Arsenault <i>et al.</i> , 2020; FMOQ, 2020] |
| Nausée | [Doctors Manitoba, 2020] |
| Vomissement | [Doctors Manitoba, 2020; NLMA, 2020] |
| Diarrhée | [Doctors Manitoba, 2020; NLMA, 2020] |
| Infections de peau mineures | [AMC, 2020; Arsenault <i>et al.</i> , 2020; Doctors Manitoba, 2020; Doctors Nova Scotia, 2020; NLMA, 2020] |
| Cellulite | [NLMA, 2020] |

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|---|---|
| Éruption cutanée | [AMC, 2020; NLMA, 2020] |
| Eczéma | [AMA, 2020] |
| Acné | [AMA, 2020] |
| Morsures d'insectes | [AMA, 2020; NLMA, 2020] |
| Asthme | [AMA, 2020; Car <i>et al.</i> , 2020; NLMA, 2020; Taskforce on Telehealth Policy, 2020] |
| Allergies | [AMA, 2020; NLMA, 2020] |
| Suivi de la condition médicale / maladies aiguës | [AMA, 2020; Arsenault <i>et al.</i> , 2020; CDC, 2020; Doctors Manitoba, 2020; Doctors Nova Scotia, 2020; FMOQ, 2020; CMQ, 2019] |
| Suivi de maladies chroniques | [AMA, 2020; AMC, 2020; Arsenault <i>et al.</i> , 2020; Car <i>et al.</i> , 2020; CDC, 2020; CMQ, 2020; Doctors Manitoba, 2020; Doctors Nova Scotia, 2020; FMOQ, 2020; RACGP, 2020; Taskforce on Telehealth Policy, 2020; RACGP, 2019; HAS, 2018; CMQ, 2015] |
| Suivi du diabète | [ACI, 2020; AMA, 2020; AMC, 2020; Car <i>et al.</i> , 2020; CDC, 2020; FMOQ, 2020; NLMA, 2020; Taskforce on Telehealth Policy, 2020; HAS, 2018] |
| Suivi d'insuffisance cardiaque | [Taskforce on Telehealth Policy, 2020] |
| Prise en charge d'accidents vasculaires cérébraux | [Car <i>et al.</i> , 2020; HAS, 2018] |

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| Suivi de douleurs chroniques | [Car <i>et al.</i> , 2020] |
| Suivi et ajustement de la médication en ADHD | [AMA, 2020] |
| Suivi pré-admission | [ACI, 2020; AMA, 2020] |
| Suivi post-opératoire | [ACI, 2020; AMA, 2020; CDC, 2020] |
| Suivi post-hospitalisation | [CDC, 2020] |
| Douleur arthritique | [NLMA, 2020] |
| Blessures mineures | [AMA, 2020; Doctors Manitoba, 2020] |
| Blessure sportive / Entorses et foulures | [NLMA, 2020] |
| Courbatures et douleurs mineures | [Doctors Manitoba, 2020] |
| Risque de chute | [Car <i>et al.</i> , 2020; Caravan Health, 2020] |
| Suivi en santé mentale | [AMA, 2020; CMQ, 2020; Taskforce on Telehealth Policy, 2020] |

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| Problème d'humeur | [Doctors Manitoba, 2020] |
| Problème de sommeil | [AMA, 2020; Doctors Manitoba, 2020] |
| Conseil en matière d'ITSS | [AMC, 2020; Arsenault <i>et al.</i> , 2020; Doctors Nova Scotia, 2020; FMOQ, 2020; NLMA, 2020] |
| Conseil en matière de contraception | [AMC, 2020; Arsenault <i>et al.</i> , 2020; Doctors Manitoba, 2020; Doctors Nova Scotia, 2020; FMOQ, 2020; NLMA, 2020] |
| Visite prénatale | [AMA, 2020] |
| Suivi d'allaitement | [AMA, 2020] |
| Conseil diététique | [AMA, 2020; CDC, 2020] |
| Obésité | [ACI, 2020; Taskforce on Telehealth Policy, 2020] |
| Cessation tabagique | [ACI, 2020] |

ANNEXE E

Tableaux d'extraction des guides de pratique clinique (GPC)

GENERALITES

| #1 CMQ-2015 + Addenda COVID 2020 (Collège des médecins du Québec) Canada | #2 - AMC – 2020 + Sondage AMC (2020) (Association Médicale du Canada) Canada | #3 - RACGP – 2019 + Guide complémentaire 2020 (The Royal Australian College of General Practitioners) Australie | #4 – HAS – 2019 + Rapport d'élaboration (Haute autorité de santé) France | #5 – TTP – 2020 (Taskforce on Telehealth Policy; ATA, ACC & NCQA) États-Unis | #6 – ACI - 2020 (NSW Agency for clinical innovation) Australie | #7 – NHS – 2020 + Research findings 2019 (National health service) Royaume-Uni | #8 – ACP – 2015 (American College of Physicians) États-Unis |
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| DEFINITION | | | | | | | |
| <p>Télémédecine: « Exercice de la médecine à distance à l'aide des technologies de l'information et de la communication (TIC) ». Cette définition inclut l'utilisation de la téléphonie mobile et d'Internet, mais exclut la télécopie.</p> <p>La télémédecine comprend :</p> <ul style="list-style-type: none"> - la téléconsultation, - la téléexpertise, - la télésurveillance - la téléassistance. <p>La téléconsultation: consultation médicale qui met en relation, à distance, le patient et un ou des médecins et, le</p> | Ø | <p>Telehealth services use information and communication technologies to deliver healthcare services and transmit health information. This can include via telephone consultation, email or videoconferencing.</p> <p>Broadly, a telehealth video consultation is:</p> <ul style="list-style-type: none"> • a clinical consultation performed via a videoconferencing platform, where the patient and consulting specialist are not in the same physical location | <p>Actes médicaux réalisés à distance, au moyen d'un dispositif utilisant les technologies de l'information et de la communication. La téléconsultation et la téléexpertise sont deux des cinq actes de télémédecine définis dans le Code de la santé publique :</p> <ul style="list-style-type: none"> • la téléconsultation a pour objet de permettre à un professionnel médical de donner une consultation à distance à un patient. Un professionnel de santé peut être présent auprès du patient et, le cas échéant, assister le | <p>Telehealth as part of an integrated approach with in-person primary care and chronic disease management is different from telehealth used for urgent care or triage, which is different from telehealth used by hospitals for post-discharge follow-up.</p> | <p>Telehealth : delivery of healthcare at a distance using information communications technology (ICT). Telehealth 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.</p> <p>Telehealth: overarching term encompassing telemedicine, tele education, tele-therapy, telementoring and tele-monitoring. A range of</p> | <p>Online and video consultations enable people to make contact with their GP practice without having to wait on the phone or take time out to come into the practice.</p> <p>Patients can use online consultations to ask questions, report symptoms, submit an administrative request, discuss other information including the ability for a review of a known problem or condition and upload photos where appropriate.</p> | <p>Use of telemedicine (use of technology to deliver health care services at a distance) and telehealth services (a somewhat broader definition of telemedicine that includes not just delivery of health care services at a distance but patient and health professional education, public health, and public administration)</p> |

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| cas échéant, d'autres professionnels de la santé. | | | professionnel médical au cours de la téléconsultation; | | modalities are included: the telephone, video conferencing, store and forward, remote monitoring and the use of clinical apps. | | |
| OBJECTIF | | | | | | | |
| Poser un diagnostic, initier un traitement ou exercer la téléinterprétation ou la téléassistance. | « Faciliter le plus possible vos conversations avec votre fournisseur de soins de santé en ces temps difficiles » | The increased use of telehealth consultations is to enable general practices to better support their patients during this time of crisis. | Pallier une insuffisance de l'offre de soins locale (ex. : difficulté pour les patients d'accéder à un dermatologue) ; améliorer la prise en charge du patient (ex. : éviter des déplacements aux patients) ; rendre plus efficiente une organisation de soins, etc. | Delivering high quality, well-coordinated care to patients at home through telehealth is an important goal. | [...] given the large geographical distances and limited resources [...] ensuring people living in NSW have equal access to quality care close to home. Integrating telehealth into clinical practice will minimise barriers to access and inequity. | Ensure people can access appropriate health and care services consistently as and when they need to in a way that meets their needs. | Improve access to care, improve patient satisfaction, and reduce costs to the health care system |

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| FACTEURS CONTRAIGNANTS (BARRIERES) | | | | | | | |
| Leur utilisation augmente le risque pour le médecin d'enfreindre certains devoirs déontologiques, dont celui de préserver le secret professionnel. | Ø | Ø | Ø | <p>Prior to the pandemic, assumptions about patient safety, program integrity (fraud, waste and abuse), quality and cost were cited as reasons for these [policy] restrictions. [these] prior concerns about efficacy, appropriateness, fraud, waste and abuse and privacy that fostered previous policy restrictions still linger.</p> <p>Among the greatest barriers to broader telehealth adoption are assumptions among policymakers that allowing greater telehealth access will lead to higher utilization and costs.</p> | <p>Barriers:</p> <ul style="list-style-type: none"> • lack of consistent, strong and clear governance • new initiatives (proof of concept) and pilot projects is not centrally coordinated • level of understanding of activity-based funding (ABF) and other funding sources for those block funded • dedicated telehealth support positions where expertise in change management, clinical and ICT are connected • access to adequate and innovative technology that is interoperable within systems • lack of telehealth education and | <p>Major concerns from professionals:</p> <ul style="list-style-type: none"> • Creating more work. • Misdiagnosis/lack of observation and the potential to exclude patients who do not have access to, or ability to use the internet. • Information security and confidentiality also scored high as concerns. <p>Barriers (public findings)</p> <ul style="list-style-type: none"> • Talk to a GP/health professional face-to-face when discussing health issues (37,2 %) • Be sure that I was getting a response from my own GP – not another doctor or health professional (30,8 %) • Worry about security of information I would be asked to provide during an online consultation. (27,5 %) • Worry about the confidentiality of information I would be asked to provide during an online consultation (26,0 %) • Worry I wouldn't understand the response to an online consultation (14,4 %) • Other (10,0 %) | <p>Variations in state and federal laws, limited reimbursement, logistic issues, and concerns about the quality and security of the care provided, should not be overlooked.</p> <p>Most laws and regulations relating to reimbursement and the practice of medicine were drafted before the use of telemedicine by larger markets; state guidelines on the practice of telemedicine, prescribing, and licensing vary; Web sites that offer on demand, episodic care for minor health conditions may disrupt the continuity of care between a patient and his or her physician or medical home and undermine care coordination; and some hesitation remains among physicians and patients.</p> <p>Concerns exist about depersonalization of the</p> |

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| | | | | | training to support workforce <ul style="list-style-type: none"> • culture/attitude • need for statewide systems to effectively schedule clinical appointments that is interactive and intuitive | <ul style="list-style-type: none"> • Don't trust the internet for things like this (9,1 %) • Don't like to go online if I don't have to (5,9 %) • Not confident in using the online services (5,4 %) • None of the above (31,6 %) Barriers in details: <ul style="list-style-type: none"> • Women are more likely to distrust, dislike or have no confidence in using the internet. • Women are more concerned than men about getting an online response from 'any doctor'. • Those aged 55-74 also see the lack of face-to-face contact as a barrier. • Confidence, trust and dislike of the internet are the most significant barriers for respondents over 85. • Carers cite confidence, trust and dislike of the internet as their most significant barriers. • Respondents who consider themselves disabled are generally concerned with security and confidentiality as well as citing confidence, trust and dislike of the internet as their most significant barriers. | patient–physician relationship, particularly in the primary care setting, and the risk for harm. |

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| | | | | | | <ul style="list-style-type: none"> • Respondents with parental or guardian responsibility are most concerned with security and confidentiality as well as being concerned that they will not understand the information provided in an online consultation. <p><u>Healthwatch Newcastle</u> Barriers in details</p> <ul style="list-style-type: none"> • The majority of respondents cite the loss of face-to-face contact as a significant barrier, followed by fear of response from 'another GP' and not being able to understand the response; • Confidentiality and security are also significant concerns • Dislike, distrust and lack of confidence in using the internet are. • Men and women are equally concerned about the loss of face-to-face contact; • Men are less concerned with the issue of not getting a response from their 'own' GP but are significantly more concerned than women over issues of security and confidentiality; • People who consider themselves disabled cite | |

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| #1 CMQ-2015 + Addenda COVID 2020 <i>(Collège des médecins du Québec)</i> Canada | #2 - AMC – 2020 + Sondage AMC (2020) <i>(Association Médicale du Canada)</i> Canada | #3 - RACGP – 2019 + Guide complémentaire 2020 <i>(The Royal Australian College of General Practitioners)</i> Australie | #4 – HAS – 2019 + Rapport d'élaboration 2020 <i>(Haute autorité de santé)</i> France | #5 – TTP – 2020 <i>(Taskforce on Telehealth Policy; ATA, ACC & NCQA)</i> États-Unis | #6 – ACI - 2020 <i>(NSW Agency for clinical innovation)</i> Australie | #7 – NHS – 2020 + Research findings 2019 <i>(National health service)</i> Royaume-Uni | #8 – ACP – 2015 <i>(American College of Physicians)</i> États-Unis |
| | | | | | | confidence, dislike and dislike of the internet as their most significant barriers. | |

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| #1 CMQ-2015 + Addenda COVID 2020 <i>(Collège des médecins du Québec)</i> Canada | #2 - AMC – 2020 + Sondage AMC (2020) <i>(Association Médicale du Canada)</i> Canada | #3 - RACGP – 2019 + Guide complémentaire 2020 <i>(The Royal Australian College of General Practitioners)</i> Australie | #4 – HAS – 2019 + Rapport d'élaboration 2020 <i>(Haute autorité de santé)</i> France | #5 – TTP – 2020 <i>(Taskforce on Telehealth Policy; ATA, ACC & NCQA)</i> États-Unis | #6 – ACI - 2020 <i>(NSW Agency for clinical innovation)</i> Australie | #7 – NHS – 2020 + Research findings 2019 <i>(National health service)</i> Royaume-Uni | #8 – ACP – 2015 <i>(American College of Physicians)</i> États-Unis |
| FACTEURS FACILITANTS (AVANTAGES ANTICIPÉS) | | | | | | | |
| L'avènement des nouvelles technologies de l'information et de la communication (TIC) permettrait d'envisager de nouvelles façons d'exercer la médecine et d'offrir des services médicaux spécialisés ou ultraspécialisés dans des régions qui | De nombreux médecins trouveront qu'il est facile d'organiser leur vie professionnelle pour que certaines heures de soins aux patients se fassent de la maison. Et la plupart | Telehealth is becoming more popular as a mode of healthcare delivery due to the benefits it provides to both patients and practitioners, particularly those in rural and | En réduisant les délais et les distances, il est attendu que le déploiement de la téléconsultation et de la téléexpertise contribue à : • améliorer l'offre de soins : éviter les renoncements | "Telehealth is a proven and cost-effective way to get care out to patients, particularly during a crisis.... [...] telehealth can be an essential bridge in delivering care, | All services and models of care are encouraged to consider the use of telehealth as a part of normal practice. This will increase the choices available to clinicians and patients, so there are a variety of options to provide and access care. Benefits for patients and their carers • increase timely access to appropriate interventions | From a practice perspective, online consultations can enhance the practice's ability to effectively manage time and workload and improve staff satisfaction. Online consultations may improve access for: • a carer or those who have a carer individuals who are working, or those who have | Use of these technologies has been shown to increase patient satisfaction while delivering care that is similar in quality to, and in some cases is more efficient than, in-person care and support. Research shows that |

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|--|--|--|---|---|---|---|---|
| <p>ne pouvaient en bénéficier.</p> <p>Sans contredit, l'utilisation de ces technologies à des fins professionnelles comporte de grands avantages. Elles peuvent faciliter la communication, voire rendre accessibles des services médicaux qui autrement pourraient ne pas l'être vu l'éloignement géographique des patients, des ressources spécialisées ou en raison d'une situation d'urgence.</p> <p>Les applications de visioconférence permettent au médecin d'effectuer, à distance et en temps réel, une consultation avec son patient pendant</p> | <p>considéreront que les avantages de cette flexibilité surpassent les inconvénients de devoir installer un poste de travail à deux endroits différents.</p> | <p>remote areas. It has the potential to provide patients with more convenient and efficient access to healthcare.</p> | <p>aux soins, en particulier dans les zones où l'offre de soins ne permet pas de répondre au besoin médical de la population</p> <ul style="list-style-type: none"> • faciliter l'accès aux soins : répondre aux besoins des patients souhaitant bénéficier d'une prise en charge adaptée, au plus près de leur lieu de vie. | <p>particularly during a crisis and [...] in a post-Coronavirus world."</p> | <ul style="list-style-type: none"> • provide more accurate and timely diagnosis • reduce the burden of travel on health and wellbeing • reduce the burden on carers • reduce financial barriers and costs associated with travel • reduce inconvenience / impact to family and carers, work commitments and social factors • provide access to services not otherwise available • provide tools to help people understand and manage their health condition • less 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 <p>Benefits for providers and local delivery systems</p> <ul style="list-style-type: none"> • extend the hours of service access and provide consistent, continuous care • extend the scope of practice for rural and remote clinicians through consultation and shared care with specialists | <p>mobility issues and find getting to the surgery difficult.</p> <ul style="list-style-type: none"> • those who may find waiting in the reception area distressing or difficult. • those with information and communication needs, including those with a disability or sensory loss. • patients whose first language is not English - our case studies show they often prefer to be consulted via a text based solution. • patients that feel apprehensive about attending the surgery e.g. social anxiety, often find online consultations less stressful. • for sensitive or embarrassing problems – feedback shows patients find it easier and are more willing to disclose information online. <p>Improved access may support the continuity of care depending on how the system is implemented.</p> | <p>telemedicine can potentially reduce costs, improve health outcomes, and increase access to primary and specialty care.</p> <p>ACP supports the expanded role of telemedicine as a method of health care delivery that may enhance patient-physician collaborations, improve health outcomes, increase access to care and members of a patient's health care team, and reduce medical costs when used as a component of a patient's longitudinal care.</p> <p>Sample studies of telemedicine used in the treatment of</p> |

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| <p>laquelle sont transmis du son et une image. Cette technologie améliore grandement l'accessibilité médicale, particulièrement en région éloignée.</p> | | | | | <ul style="list-style-type: none"> • empower people to self-manage their health condition • provide flexible and responsive workplaces to support workforce needs • improve communication, networking and collaboration between healthcare professionals across the health sector • greater support and reduced professional isolation for rural clinicians • support 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 • reduced time spent travelling, and reduced expenses related to patient transport and burden on subsidized transport schemes <p>ENABLERS</p> <ul style="list-style-type: none"> • strong leadership - change management support for clinical teams dedicated positions to support the implementation and evaluation | <p>The key motivators for respondents in terms of online consultation over any other method revolve around the twin goals of response time for the patient and saving time for staff in GP practices.</p> <p>•The impact of web-savvy individuals appears relatively low, with a comparatively few (30%) stating they prefer online, because "...I do things online anyway."</p> <p><u>Healthwatch Newcastle</u></p> <p>Motivators in detail</p> <ul style="list-style-type: none"> • The majority want to save time and get a quicker response as well as not having to take time off work; • There was also significant recognition of saving time for practice staff through the use of online consultation. • Men and women were equally motivated by saving time, however, women were significantly more motivated by not having to take time off work than men; | <p>medical conditions and in various settings suggest that efficient use of telemedicine technologies can improve overall health outcomes.</p> <p>One of the broadest benefits of telemedicine is increased access to primary and specialty care for patients to physicians and subspecialists, physicians to potential patients, hospitals to patients, and physicians to other physicians.</p> |

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| | | | | | <p>of telehealth services (Telehealth Managers and clinical champions)</p> <ul style="list-style-type: none"> • effective planning and resources (human and financial) to enable telehealth models to be sufficiently supported • stable internet access • technology that is easy to use, accessible, fit for purpose, reliable, secure and cost efficient • benefit realisation for patients, carers, clinicians and the health sector • existing infrastructure • mechanism for consumers to advocate for the services they need most • statewide telehealth governance | <ul style="list-style-type: none"> • Women view the saving of practice time as more important than men; • People who consider themselves to have a disability were more motivated to use online consultation by the convenience in travel/mobility than any of the other factors. • Respondents with a child under two report they were more likely to be motivated to use online consultation because they 'do most things online' than any other factor. | |

ACCESSIBILITE DE L'INTERVENTION

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| ADMISSIBILITE | | | | | | | |
| TECHNIQUE | | | | | | | |
| Quelle que soit la technologie ou l'application utilisée, il importe, tant du côté du médecin que du côté du patient, qu'elle soit sécuritaire et qu'elle permette que la consultation se déroule dans un environnement où la confidentialité des échanges sera protégée | Ø | <p>Ensure the system you choose meets the requirements of the MBS item descriptor and applicable laws for security and privacy.</p> <p>The technical systems should support safe, secure and effective telephone and video consultations.</p> <p>To avoid near misses and mistakes in clinical care, telephone and video conferencing equipment and connectivity should be capable of delivering sound and image quality suitable for clinical purposes.</p> | <p>La téléconsultation et la téléexpertise reposant sur les technologies de l'information et la communication (échange et archivage de données de santé), une attention particulière doit être portée sur la sécurité et la protection des données personnelles de santé.</p> <p>Mettre en place les mesures de sécurité relatives à la protection des données de santé en conformité avec le règlement général sur la protection des données (RGPD) et la politique générale de sécurité des systèmes d'information de santé (PGSSI-S)20</p> | Ø | <p>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.</p> <p>The following factors should be considered: availability and access to appropriate devices including video conferencing units/systems</p> <p>When choosing telehealth hardware and software for telehealth, considering the security features of the telehealth system to ensure the technology used</p> | <p>Patients and the practice require the right equipment with the appropriate IT infrastructure</p> <p>Procure a quality assured system by using one listed on the DPS Framework (and GP IT Futures when these become available). This will provide assurance that</p> <ul style="list-style-type: none"> - automated triage, clinical decision support, third party products or any such device is CE marked as a medical device if it needs to be and complies with all relevant standards including information governance and clinical risk management - suppliers are registered with the appropriate regulatory bodies where applicable with no concerns reported <p>Verify supplier certificates and evidence prior to implementing the solution – the procurement hub can provide this support</p> | Ø |

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| | | | | | facilitates privacy and confidentiality | | |
| PROFESSIONNELS DE LA SANTE | | | | | | | |
| [...] le Collège exige du médecin qui exerce la télémedecine au bénéfice d'un patient qui se trouve sur le territoire québécois au moment de la consultation, incluant un médecin consultant en médecine de laboratoire ou d'imagerie, qu'il détienne un permis d'exercice délivré par le Collège et qu'il soit inscrit au tableau de l'ordre. | Les organismes de réglementation de la profession médicale adhèrent tous au même principe en matière de consultations virtuelles : un médecin ne doit jamais mettre en péril la diligence appropriée. Habituellement, les médecins doivent être autorisés à exercer dans la région où se trouvent les patients; sans cette autorisation, les gouvernements ne leur fournissent pas | To determine if telehealth video consultations are appropriate for your practice, consider: <ul style="list-style-type: none"> • patient safety • patient clinical need • clinical effectiveness • patient preference • location of the practice • specialist willingness and availability • staff willingness • training and skills of practice staff • equipment required (hardware and software) • Budget requirement <p>A GP's diagnostic and management capability and their prior knowledge of a patient's medical history ensures high-quality and</p> | Comme la médecine en présentiel, la téléconsultation et la téléexpertise s'exercent dans le respect : <ul style="list-style-type: none"> • des lois et règlements applicables aux conditions d'exercice notamment celles relatives : <ul style="list-style-type: none"> ○ aux diplômes et à la nationalité ; ○ à l'inscription à l'ordre professionnel ; ○ à la confidentialité des données médicales échangées au sein de l'équipe des soins¹¹ ; ○ à l'obligation d'assurance. • des règles de déontologie ; • des standards de pratique clinique (recommandations etc.) • des règles de protection et de sécurité des données personnelles. <p>Les données médicales et les informations</p> | Polymakers, in partnership with clinical subject matter experts, should identify and recommend minimum standards for assessing and ensuring patient safety via telehealth care delivery and integrate them into existing safety standards. | Regardless of the position held, the provision of healthcare is related to individuals' credentials and the clinical scope of practice, the telehealth modality does not require additional credentialing requirements. 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. Medical Board of Australia expects that medical practitioners: | Online consulting requires particular skills. The lack of sensory input and the comprehension of the patient are the most obvious differences compared to a telephone consultation, good training will provide staff with the tools and techniques to achieve safe and appropriate outcomes. Have access to the patient's NHS full primary care medical record when consulting remotely with the ability to document the content of the consultation in the patient's medical record. Keep up to date with relevant training, support and guidance for providing healthcare in a remote context. | ACP supports a streamlined process to obtaining several medical licenses that would facilitate the ability of physicians and other clinicians to provide telemedicine services across state lines while allowing states to retain individual licensing and regulatory authority. Current law requires physicians to be licensed in the jurisdiction in which a patient receives treatment, with some limited exceptions. |

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| | de numéro de facturation. | individualised patient care. | administratives nécessaires à la réalisation de l'acte doivent être accessibles au professionnel médical. | | • providing medical services to patients in Australia will be registered with the Board regardless of where the practitioner is located | | |
| PATIENTS | | | | | | | |
| En période de pandémie, le médecin doit aussi inclure dans sa réflexion le risque de contamination lors du passage du patient à la clinique ou à l'hôpital. | Le champ d'exercice virtuel se limite pour le moment aux cas dont l'évaluation peut se faire à partir des antécédents médicaux, d'une inspection visuelle sommaire ou de données que le patient est en mesure de recueillir au moyen d'une caméra ou d'un appareil à la maison (glucomètre, tensiomètre, thermomètre, pèse-personne). | Telehealth video consultations are an alternative option to access specialist medical services without personal inconvenience and cost of travel to a major center. Some patients will prefer to attend physical consultations with specialists, and this choice should be respected. Where a patient or carer expresses a preference for a video consultation, consider this preference in the context of the informed consent | La capacité du patient à bénéficier d'une téléconsultation est prise en compte : état cognitif, état psychique, état physique (vue, audition, etc.), barrières liées à la langue, barrières liées à l'utilisation des technologies. Si l'organisation le permet (ex. : patient qui consulte depuis une maison de santé ou un EHPAD), en cas de besoin et avec l'accord du patient, la présence d'un professionnel de santé accompagnant est possible. Le professionnel de santé accompagnant pourra assister le professionnel médical dans la réalisation de certains éléments de | ø | Following factors should be considered: • availability of support at the client site • availability and access to appropriate devices including video conferencing units/systems • ability of the client to participate such as physical, mental, social 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 | Research carried out by the 'Alt-con' study team, led by the University of Bristol, before introducing online consultations, you may wish to consider the following patient characteristics and challenge assumptions to ensure equity of access. • Age and social class • 'Able' patients • Patients who do not speak English as their first language • Patients' current medical / psychological wellbeing Ability to complete a questionnaire online does not provide sufficient evidence of capacity. Be vigilant when assessing free text responses from patients and consider capacity concerns. Think through any concerns flagged by their medical record, consultations | ø |

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| | | <p>process and clinical appropriateness.</p> <p>The RACGP recommends that video or telephone consultations should generally not be used, and arrangements made for an in-practice face-to-face consultation:</p> <ul style="list-style-type: none"> - where a patient's ability to communicate by telephone or video consultation is compromised and they do not have a support person to assist them during the consultation, impacting clinical quality and patient safety | <p>l'examen clinique et/ou du geste technique dans la limite de ses compétences.</p> | | <p>telehealth consultation</p> <p>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 own health, remain in good health and avoid hospitalisations.</p> | <p>or through practice knowledge and experience.</p> <p>Capacity is decision specific and can change. Where there are concerns about a potential lack of capacity, an assessment should be made in line with established good practice.</p> <p>Consider questions and exercises to help ascertain mental capacity and to identify patients who need more help.</p> | |
| RELATION PROFESSIONNEL / PATIENT | | | | | | | |
| <p>Compte tenu du risque de contamination, le Collège croit que même un patient non connu du médecin peut être</p> | <p>∅</p> | <p>The RACGP does not support the concept of on-demand telehealth consultations between unknown patients and providers.</p> | <p>La téléconsultation est d'autant plus pertinente que la relation patient-professionnel est bien établie ; néanmoins, la primo-consultation ne constitue pas un motif</p> | <p>Requiring clinicians and other providers to have a previous, in-person relationship with patients can inhibit needed access to</p> | <p>∅</p> | <p>Improved access may support the continuity of care depending on how the system is implemented. For example, whenever the patient's regular GP is at work they would have the flexibility to respond to</p> | <p>ACP believes that telemedicine can be most efficient and beneficial between a patient and physician with an established,</p> |

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| <p>vu en télémedecine, si cela est jugé approprié.</p> <p>Il n'est donc plus nécessaire, durant la pandémie de COVID-19, que la téléconsultation soit faite par le médecin traitant du patient, bien que cela soit préférable.</p> | | <p>When providing care to a patient using telephone or video consultation technologies, there should ideally be an existing relationship with the GP or general practice. To maximise quality and continuity of care, the patient should ideally have visited the practice at least once in the preceding 12 months, or have specifically indicated to the practice they wish to begin or resume seeking care from that practice</p> | <p>d'exclusion d'une téléconsultation. Il convient alors d'adapter la durée de la téléconsultation afin d'établir la relation patient-professionnel médical (interrogatoire détaillé : antécédents, traitement en cours, allergies, etc.).</p> <p>La téléconsultation et la téléexpertise s'inscrivent, en priorité, dans le parcours de santé du patient coordonné par le médecin traitant (pour les personnes ayant pu désigner un médecin traitant).</p> <p>Dans certaines circonstances, les patients pourront avoir besoin de recourir à la téléconsultation en dehors du parcours de santé coordonné par le médecin traitant, par exemple:</p> <ul style="list-style-type: none"> • patients âgés de moins de 16 ans ; • patients ne disposant pas de médecin traitant désigné ou dont le | <p>care and is not consistent with most state-level or value-based payment policies.</p> <p>Polymakers should make permanent the following telehealth policy changes enacted during COVID-19 to improve access, patient safety and outcomes:</p> <ol style="list-style-type: none"> a) Removal of strict limits on sites where telehealth visits may originate, conditions clinicians may treat and which clinicians and providers may use telehealth. b) Acknowledging that telehealth visits can establish clinician / patient relationships as | | <p>both their urgent and non-urgent queries (compared to previously where a patient with an urgent problem may need to see a different clinician because their named GP was stuck in a fully-booked clinic). Larger practices could divide their clinicians into small teams in order to achieve team-based continuity when person-based continuity was not possible.</p> | <p>ongoing relationship.</p> <p>ACP believes that a valid patient-physician relationship must be established for a professionally responsible telemedicine service to take place. A telemedicine encounter itself can establish a patient-physician relationship through real-time audiovisual technology. A physician using telemedicine who has no direct previous contact or existing relationship with a patient must do the following:</p> <ol style="list-style-type: none"> a. Take appropriate steps to establish a relationship |

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| | | | <p>médecin traitant n'est pas disponible dans le délai compatible avec leur état de santé ;</p> <ul style="list-style-type: none"> accès direct spécifique pour certaines spécialités (gynécologie, ophtalmologie, stomatologie, chirurgie orale ou en chirurgie maxillo-faciale, psychiatrie ou neuropsychiatrie et pédiatrie) ; accès direct à un spécialiste (hors gynécologie, ophtalmologie, stomatologie, chirurgie orale ou en chirurgie maxillo-faciale, psychiatrie ou neuropsychiatrie et pédiatrie) ; accès direct à une sage-femme. | <p>long as they meet appropriate standards of care or unless careful analysis demonstrates that, in specific situations, ensuring patient safety, program integrity or appropriate high-quality care requires a previous in-person relationship.</p> | | | <p>based on the standard of care required for an in person visit, or</p> <p>b. Consult with another physician who does have a relationship with the patient and oversees his or her care.</p> <p>Some courts have deemed remote technologies as adequate for establishing a patient–physician relationship even if the 2 persons never meet.</p> <p>To date, little evidence exists about the effects of telemedicine on patient–physician relationships.</p> |
| CHOIX DU TYPE DE TELECONSULTATION (TELEPHONE VS VIDEO) | | | | | | | |
| <p>Ø</p> | <p>Ø</p> | <p>Decisions about whether or not the practice will offer</p> | <p>La vidéotransmission permet aux interlocuteurs à la fois de s'identifier et de</p> | <p>Ø</p> | <p>Telephone often used to provide results, follow up</p> | <p>Offer a range of remote consulting modalities to allow for patient reference and specific needs</p> | <p>Ø</p> |

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| | | <p>telephone or video consultation services should be made by the GP and the general practice team. When making the decision to offer telephone or video consultations, careful consideration should be given to:</p> <ul style="list-style-type: none"> • deciding/agreeing on what appointments will be conducted via telephone or video consultation • clinical effectiveness / appropriateness • clinical needs of patients • patient safety, including an existing relationship between the GP or general practice and the patient • reliable and secure equipment, fit for clinical purposes • secure management of | <p>communiquer plus aisément, contrairement à un appel téléphonique.</p> | | <p>patient progress following discharge or between consultations where real time images are not required for consultation and where there is electronic medical record (eMR) access to the relevant results. Telephone consultation occurs between the patient and healthcare provider(s).</p> <p>Video conferencing Provides a real-time audio and video interactive link between multiple participants.</p> <p>As video conferencing technology has advanced and quality and access has improved, its use is more accepted. Where patients have access to good internet access and suitable equipment, video</p> | <p><u>Video consultation</u></p> <ul style="list-style-type: none"> • For most effective use, consider patient preference and what specific challenge you are trying to solve • Use alongside other approaches to augment productivity e.g. online triage and messaging to avoid consultations when self care may be sufficient • Works best when integrated with the GP clinical system <p>Pros:</p> <ul style="list-style-type: none"> • Ability to pick up on visual cues and carry out a visual examination • May offer advantages in building rapport and facilitating understanding through non-verbal communication compared to other remote consulting methods • May be used for ward rounds in a care home, housebound patients, supporting members of your MDT visiting patients. Clinicians can see and update patient records in real time <p>Cons :</p> <ul style="list-style-type: none"> • Relies on the doctor and patient being available at the same time, hence may not be exempt from long waiting times or delays • Problems with the technology can disrupt the consultation. | |

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| | | <p>patient health information</p> <ul style="list-style-type: none"> • patient experiences. <p>No need to use video if a telephone call will suffice. The decision to offer a video consultation should be part of the wider system of triage offered in your practice. It should be understood that the addition of visual images via a video link adds value to any telehealth consultation and can improve both quality and safety for more complex consultations.</p> <p>For some patients, a video consultation may be more appropriate than telephone – for example, where the patient is hard of</p> | | | <p>conferencing provides a more interactive and engaging experience for the clinician/s, the patient and their carer/s.</p> <p>First response telehealth services A number of modalities are suitable in this setting including video conferencing, store and forward and remote monitoring.</p> <p>Emergency telehealth services A number of modalities are being used in emergency situations, including telephone, video conferencing, store and forward and remote monitoring.</p> <p>Admitted (inpatient) telehealth services A number of modalities are being used in the admitted space</p> | <p>A key advantage of video over telephone is the ability to pick up on visual cues or when visual examination is important e.g. assessment of inhaler technique, people who are housebound, have a mental health problem or palliative care need or support members of your MDT visiting patients. They have the potential to reduce home visits. However people didn't see the advantage of video if they did not require the visual or even felt uncomfortable with it e.g. discussing sexual health problems</p> | |

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| | | hearing or deaf, a video consultation will provide them the opportunity to lip read. Video consultations allow GPs to view patients, which can assist in wound management and reviews and may assist in determining if they look unwell, given there is no opportunity to undertake a physical examination. | | | including telephone, video conferencing, store and forward and remote monitoring. | | |
| ÉQUITE | | | | | | | |
| Cette technologie améliore grandement l'accessibilité médicale, particulièrement en région éloignée. Elle va du système sophistiqué de visioconférence à des applications conviviales accessibles sur | Si un patient évalué virtuellement a des antécédents qui nécessitent un examen physique ne pouvant pas se faire à distance, le médecin doit rediriger ce patient vers des services en personne. | A practice with a number of patients with diabetes set up a regular telehealth video consultation clinic, where a diabetes nurse supports the patient in consultation with a distant endocrinologist. Even though the specialist | En réduisant les délais et les distances, il est attendu que le déploiement de la téléconsultation et de la téléexpertise contribue à : • améliorer l'offre de soins : éviter les renoncements aux soins, en particulier dans les zones où l'offre de soins ne permet pas de répondre au besoin médical de la population • faciliter l'accès aux soins : répondre aux besoins des patients souhaitant | Telehealth patient safety includes ensuring access for patients with technology or digital literacy gaps. Older adults and people with complex care needs want to live as independently as they can for as long as they can. Telehealth has the | Use of telehealth has long been associated with rural and regional services. Whilst the distance may not be large, it is equally important for metropolitan services to understand that telehealth provides the same benefits to their patients and workforce, alongside its significant role in supporting and | Patients should be suitably informed about health technologies, with particular focus on vulnerable groups to ensure fair access Practices and networks need to ensure that, where patients are not suitable for an online consultation, they are not excluded. Most practices offer these patients direct or fast track access to face to face or telephone appointments. | ACP believes that telemedicine is a reasonable alternative for patients who lack regular access to relevant medical expertise in their geographic area. ACP recommends that telehealth activities address the needs of all |

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| <p>des ordinateurs personnels, tablettes numériques et téléphones intelligents.</p> <p>Sans contredit, l'utilisation de ces technologies à des fins professionnelles comporte de grands avantages. Elles peuvent faciliter la communication, voire rendre accessibles des services médicaux qui autrement pourraient ne pas l'être vu l'éloignement géographique des patients, des ressources spécialisées ou en raison d'une situation d'urgence.</p> | | <p>is only 50 km away, the practice has found that offering video consultations has led to much better adherence to treatment among their patients, especially older patients.</p> <p>Telephone and video consultations can generally be used for:</p> <ul style="list-style-type: none"> any condition/scenario where a telephone or video consultation protects vulnerable populations, such as older patients and patients with comorbidities who are at increased risk if they do contract COVID-19 <p>For issues related to COVID-19, telephone and video consultations should be used when:</p> <ul style="list-style-type: none"> the clinician is self-isolating or is vulnerable due to | <p>bénéficier d'une prise en charge adaptée, au plus près de leur lieu de vie.</p> | <p>potential to improve access to and quality of care, while reducing strain on family caregivers</p> <p>Similarly, blanket bans on audio-only can exacerbate disparities for patients lacking video technology or broadband access. Asynchronous modalities such as RPM may also be appropriate for services that do not require real-time interaction.</p> <p>Policymakers should make permanent the following telehealth policy changes enacted during COVID-19 to improve access, patient safety and outcomes:</p> <p>a) Allowing audio-only telehealth</p> | <p>providing tertiary care to rural and regional patients.</p> <p>Telehealth can provide an equitable service delivery mechanism for people in NSW to access quality healthcare. This includes but is not limited to Aboriginal populations, people from culturally and linguistically diverse (CALD) backgrounds and people with disadvantage or disability.</p> <p>In regards to telehealth modalities, it is important to have an awareness that not all capabilities of the technology will be culturally appropriate and may be individualised to the patient. When considering if a telehealth modality is</p> | <p>If a patient lacks capacity to make a decision consider whether a remote consultation is appropriate, including whether you can meet the requirements of mental capacity law.</p> <p>In circumstances where patients may not have regular access to the internet or computer technology, or, may not be IT literate, steps should be taken to provide alternate routes for consultation. This is also applicable where a patient has information or communication needs that cannot be met through an online consultation.</p> <p>If using a remote consultation consider which modality would be most appropriate e.g. online messaging, video, telephone. If there are any concerns about certain patients using a remote service, have a process to flag these patients and arrange for them to be seen face to face. Patients should be informed of this decision.</p> | <p>patients without disenfranchising financially disadvantaged populations or those with low literacy or low technologic literacy. In particular, telehealth activities need to consider the following:</p> <ol style="list-style-type: none"> The literacy level of all materials (including written, printed, and spoken words) provided to patients or families. Affordability and availability of hardware and Internet access. Ease of use, which includes accessible interface design and language. <p>ACP supports lifting geographic site restrictions that limit reimbursement of</p> |

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| | | <p>their age or medical conditions</p> <ul style="list-style-type: none"> the patient is self-isolating or is vulnerable due to their age or medical conditions <p>Just as in a face-to-face consultation in the practice, GPs will need to use strategies to reduce the risk of missing or omitting important information, including:</p> <ul style="list-style-type: none"> finding solutions to communication, language or cultural barriers avoiding medical or technical jargon assisting the patient to use any home monitoring devices they may have, such as blood pressure monitors. | | <p>where evidence demonstrates it to be effective, safe and appropriate, or where it is likely to be so and offers access to care that would otherwise be unavailable to a patient.</p> <p>b) Allowing asynchronous telehealth (e.g., remote patient monitoring) when it is the preference or need of the patient on a limited basis as more clinical evidence is generated on best practices for ensuring quality, safety and program integrity.</p> <p>c) Allowing insurers to provide telehealth technology, such as smartphones</p> | <p>culturally appropriate you may speak with cultural advisers or a liaison officer to better understand if any specific adjustments are required. Always discuss the features of the technology with the patient and ask them if they would like to receive their care in this way. The patient may identify modifications required to make it culturally appropriate (e.g. may not want their face photographed).</p> <p>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</p> | | <p>telemedicine and telehealth services by Medicare to those that originate outside of metropolitan statistical areas or for patients who live in or receive service in health professional shortage areas.</p> <p>With research showing that expansion of telemedicine can benefit many patient groups, including underserved populations, those who use telemedicine or create and distribute information on telehealth services should be cognizant of the factors that may hamper patients'</p> |

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| | | | | <p>and tablets, as supplemental benefits</p> <p>Broadband and technology greatly facilitate telehealth and contribute to telehealth's patient safety benefits, but they are not available to or affordable for all patients, particularly rural and underserved populations. Policymakers must promptly expand efforts to ensure universal access to broadband and other needed telehealth technology to bridge these gaps and avoid exacerbating disparities as health care moves into the digital age</p> | <p>of health, wellbeing, disease and illness</p> | | <p>understanding or use of telemedicine and how it applies to their individual needs.</p> |

PERTINENCE DE L'INTERVENTION

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| QUALITE DE L'INTERVENTION | | | | | | | |
| <p>Le Collège rappelle que les mêmes normes déontologiques s'imposent aux médecins qui exercent par télémedecine, notamment en matière de qualité de la relation professionnelle, de secret professionnel, de consentement, d'obligation de suivi ou de tenue de dossiers dans la conduite d'une téléconsultation que lors d'une consultation en personne</p> <p>Dans tous les cas, il est important de se rappeler que le médecin engage pleinement sa responsabilité et qu'il doit établir son diagnostic avec la plus grande attention, en utilisant les méthodes scientifiques appropriées.</p> <p>En télémedecine, tout comme dans la pratique quotidienne en clinique, le médecin doit collaborer avec les autres professionnels de la santé dans le but d'optimiser les soins donnés aux patients.</p> | <p>Les organismes de réglementation de la profession médicale adhèrent tous au même principe en matière de consultations virtuelles : un médecin ne doit jamais mettre en péril la diligence appropriée.</p> | <p>General practice consultations should continue to be delivered under a high-quality general practice framework, as defined in The Royal Australian College of General Practitioners' (RACGP's)</p> <p>Just as in a face-to-face consultation in the practice, GPs will need to use strategies to reduce the risk of missing or omitting important information,</p> <p>Despite the different method of delivery, the principles and procedures for conducting a telephone or video consultation are generally the same as for an in-practice face-to-face consultation.</p> | <p>La téléconsultation et la téléexpertise répondent aux mêmes exigences que l'exercice médical en présentiel.</p> | <p>Quality: Telehealth is essentially a setting or modality of care, rather than a type of care. This means that it should be held to the same standards and quality measures as in-person care where possible and appropriate.</p> <p>Integrated patient safety standards should align with quality standards across health care policies, given the close relationship between safety and quality.</p> | <p>Clinicians have a duty of care to their patients regardless of whether they review in person or via a telehealth modality.</p> <p>Patient-centred, clinician-led telehealth provides an efficient and effective model of care that complements and supplements face-to-face consultation.</p> <p>It is expected that the choice of modality and the technology identified to support the service should</p> | <p>Online consultations do not replace the ability to access a face-to-face appointment but can help prioritize use based on need.</p> | <p>Physicians should not compromise their ethical obligation to deliver clinically appropriate care for the sake of new technology adoption.</p> <p>ACP believes that episodic, direct-to-patient telemedicine services should be used only as an intermittent alternative to a patient's primary care physician when necessary to meet the patient's immediate acute care needs.</p> <p>ACP recommends that telemedicine be held to the same standards of</p> |

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| <p>En fonction de son jugement clinique, le médecin pourra demander des examens complémentaires, dont il aura la responsabilité d'assurer le suivi.</p> | | | | | <p>be fit for purpose and provide the clinician with the same capabilities as a face-to-face service.</p> | | <p>practice as if the physician were seeing the patient in person.</p> <p>Care delivered via telemedicine should provide information equal to an in-person examination, conform to the standard of care expected of in-person care, and incorporate diagnostic tests sufficient to provide an accurate diagnosis.</p> |
| IMPLICATION DU JUGEMENT DU PROFESSIONNEL AVANT ET PENDANT L'INTERVENTION | | | | | | | |
| <p>Le médecin qui veut utiliser ces technologies doit selon nous les connaître, en peser les avantages et les risques et viser le meilleur équilibre selon les circonstances.</p> <p>Le médecin est en mesure de sélectionner les patients</p> | <p>ø</p> | <p>The RACGP acknowledges that while video or telephone consultations are generally not ideal for the following circumstances, the GP may need to exercise a judgement as to the</p> | <p>Le professionnel médical qui va réaliser la téléconsultation doit juger de la pertinence d'une téléconsultation</p> <p>Le professionnel médical peut estimer que la téléconsultation</p> | <p>ø</p> | <p>For clinical services, the clinician should determine the appropriateness of the service in line with the clinical standards.</p> | <p>Practices should take the necessary steps to check the appropriateness of the service for the patient and implement a system for flagging and managing urgent or non suitable queries safely. It is good practice to</p> | <p>ACP believes that physicians should use their professional judgment about whether the use of telemedicine is appropriate for a patient.</p> |

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| <p>auxquels il peut donner des soins en télémedecine. L'évaluation risque-bénéfice des soins à donner en téléconsultation par rapport à des soins dispensés en personne est à soupeser.</p> <p>Il appartient au médecin de déterminer si l'état de santé du patient nécessite un examen physique, ce qui signifie dans la grande majorité des cas qu'une évaluation en personne sera requise.</p> | | <p>balance of risks of a physical examination.</p> | <p>n'est pas adaptée à la situation clinique du patient...</p> <p>Il n'est pas toujours possible d'identifier, a priori, les situations exigeant un examen physique direct ; elles peuvent se révéler au cours de la téléconsultation et nécessitent alors la mise en place d'une organisation adaptée.</p> <p>À tout moment, si le professionnel médical juge que la téléconsultation n'est pas ou n'est plus adaptée à la situation du patient, il trace la décision médicale de ne pas réaliser ou de mettre fin à la téléconsultation dans le dossier du patient (et dans le dossier médical partagé, si le patient en possède un), il propose au patient une prise en</p> | | <p>The Medical Board of Australia expects that medical practitioners: consider the appropriateness of a technology-based consultation for each patient's circumstances</p> <p>Generally, a practitioner should be satisfied that an examination or observation using a method such as a telehealth video conference can be carried out with sufficient skill and care so as to form a clinical opinion.</p> | <p>document the rationale for the decision.</p> <p>A patient may start a consultation online but processes should allow the practice or patient to switch to a face-to-face review seamlessly at any point.</p> <p>Consider whether the modality may impair the ability to make an effective assessment.</p> | |

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| | | | charge adaptée et informe le médecin traitant, le cas échéant. | | | | |
| TRIAGE (CONSIDERATION, CRITERES, PROCESSUS...) | | | | | | | |
| <p>La consultation peut avoir pour but de poser un diagnostic, d'initier un traitement ou d'exercer la téléinterprétation ou la téléassistance.</p> <p>La téléconsultation ne peut remplacer le questionnaire et l'examen physique du patient, même lorsque la consultation est demandée par un collègue médecin.</p> <p>Il se pourrait, par exemple, que l'urgence d'une situation justifie de prendre certains risques sur le plan de la confidentialité. Il reste que le médecin doit toujours s'assurer que la technologie utilisée est adaptée au caractère plus ou moins sensible des informations échangées.</p> <p>Le médecin doit s'assurer d'obtenir toutes les informations nécessaires (histoire de la</p> | <p>Si un patient évalué virtuellement a des antécédents qui nécessitent un examen physique ne pouvant pas se faire à distance, le médecin doit rediriger ce patient vers des services en personne.</p> <p>Autrement dit, le champ d'exercice virtuel se limite pour le moment aux cas dont l'évaluation peut se faire à partir des antécédents médicaux, d'une inspection visuelle sommaire ou de données que le patient est en mesure de recueillir au moyen d'une caméra ou d'un appareil à la maison (glucomètre,</p> | <p>To determine the clinical appropriateness of a telehealth video consultation, consider:</p> <ul style="list-style-type: none"> the clinical imperatives, including contraindications and patient preference where a clinician other than the GP is required to support the patient, and whether the clinician has the requisite knowledge, skills and experience to act on the GP's behalf whether a physical examination by a distant specialist is critical for diagnosis or treatment (if so, a physical consultation would generally be required). <p>Nevertheless, some patients will prefer to attend physical</p> | <p>Le professionnel médical qui va réaliser la téléconsultation doit juger de la pertinence d'une téléconsultation au regard :</p> <ul style="list-style-type: none"> de la situation clinique du patient, de la disponibilité des données du patient de la capacité du patient à communiquer à distance et à utiliser les outils informatiques <p>Le professionnel médical peut estimer que la téléconsultation n'est pas adaptée à la situation clinique du patient, par exemple si cette dernière exige un examen physique direct (sauf si un professionnel de santé présent a les</p> | <p>Should not hold telehealth to higher standards than other care sites, and we should trust clinicians providing telehealth services to triage patients needing a higher level of care or in-patient care, as we do in other care settings.</p> <p>As is done in other care settings, patients' preference for obtaining care in-person vs. telehealth should be respected</p> <p>Strict limits on providing telehealth across state lines that were waived</p> | <p>Throughout NSW, telehealth models of care can be initiated or implemented across any system settings (first response, emergency, admitted, non-admitted and the wider community).</p> <p>Telehealth can be used to support clinical services, indirect services and non-clinical services</p> <p>Determination of whether a telehealth model of care is entirely substituted for</p> | <p>In some practices a dedicated team manages the online consultations and allocates them to the most appropriate person (within the scope of their practice)</p> <ul style="list-style-type: none"> pharmacy requests go to the prescribing pharmacist asthma/COPD/diabetes related requests can be dealt with by the specialist nurse admin issues go to administrative staff only requests which require the expertise of a doctor are sent to the GP a 'continuity cohort' is identified and directed to the right place / person to meet their needs <p>Practices should take the necessary steps to check the appropriateness of</p> | <p>Circumstances under which a patient may seek on-demand telemedicine should be made on a case-by-case basis according to the patient's medical needs.</p> <p>If an in-person physical examination or other direct face-to-face encounter is essential to privacy or maintaining the continuity of care between the patient's physician or medical home, telemedicine may not be appropriate.</p> |

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| <p>maladie actuelle, antécédents pertinents, allergies, liste de médicaments, habitudes de vie) afin d'élaborer, puis de préciser son diagnostic différentiel.</p> | <p>tensiomètre, thermomètre, pèse-personne).</p> | <p>consultations with specialists, and this choice should be respected. Where a patient or carer expresses a preference for a video consultation, consider this preference in the context of the informed consent process and clinical appropriateness.</p> <p>If any doubt about the clinical appropriateness of a video consultation, a physical consultation is likely preferable.</p> <p><u>There is no need to use video if a telephone call will suffice. The decision to offer a video consultation should be part of the wider system of triage offered in your practice.</u></p> <p><u>COVID-19</u> For issues related to COVID-19, telephone</p> | <p>compétences nécessaires pour réaliser certains gestes à la place du professionnel téléconsultant).</p> <p>Une consultation d'annonce devrait idéalement être réalisée en présentiel. En cas d'impossibilité, une organisation adaptée doit être mise en place autour du patient (relais par le médecin traitant et les autres professionnels prenant en charge le patient).</p> | <p>during the pandemic also do not appear warranted. Waiver of these restrictions, allowed for additional surge capacity, dramatically lessened wait times for telehealth visits and helped triage many conditions that might otherwise have resulted in unnecessary in-person care that put patients at risk.</p> | <p>face-to-face services or complimentary to face to face services should be case by case determined by the clinician and acceptable by the patient.</p> <p>Decision to determine if an appointment is suitable for telehealth is determined by the clinical provider and will take into account clinical and patient related factors.</p> <p>Models of care using telehealth may require consideration of inclusion and exclusion criteria, but each clinical business function</p> | <p>the service for the patient and implement a system for flagging and managing urgent or non-suitable queries safely. It is good practice to document the rationale for the decision.</p> <p>Considerations may include:</p> <ul style="list-style-type: none"> • whether the issue is acute or a follow up • the patient is well known to the practice • there is sufficient and reliable information for safe and effective decision making (or if a carer or member of the MDT can help) e.g. trained care • home staff may assess and convey vital signs reliably <p>GMC has produced a remote consultations flowchart that may help you decide if a remote consultation is appropriate. (https://www.gmc-</p> | |

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| | | <p>and video consultations should be used when:</p> <ul style="list-style-type: none"> the clinician is self-isolating or is vulnerable due to their age or medical conditions the patient is self-isolating or is vulnerable due to their age or medical conditions the patient or clinician is a confirmed COVID-19 case or is self-isolating under the Communicable Diseases Network Australia national guidelines for public health units the patient or clinician has symptoms that could be due to COVID-19 and the use of telephone or video consultation protects the community more broadly the patient is well but anxious and requires additional reassurance from their usual GP or general practice the patient is in a residential aged care | | | <p>will be an individual assessment and will vary from patient to patient.</p> <p>Following factors should be considered:</p> <ul style="list-style-type: none"> level of physical assessment required client desire to participate in a telehealth consultation <p>Patients should be assessed on a case-by-case basis and based on their functional capacity, rather than on their condition or diagnosis.</p> <p>Where a patient is assessed as not having capacity it may</p> | <p>uk.org/ethical-guidance/learning-materials/remote-consultations-flowchart</p> <p>Some practices have decided in which circumstances admin staff should directly schedule an appointment without the need for triage by a clinician, although it may still be useful to triage the urgency. Examples of scenarios that practices have incorporated in their protocols include:</p> <ul style="list-style-type: none"> Need for a clinical examination, investigation or collection of certain physiological data to provide safe care Concerns about valid consent, capacity or safeguarding A high risk of deterioration A need to break bad news or where there are complex ethical issues | |

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| | | facility with staff on hand (as required) to support a telephone or video consultation • there is a need for remote support to meet increased demand in a particular locality (eg during a local outbreak when staff are unwell). | | | still be possible for them to participate in a telehealth consultation with their parent / guardian / person responsible. | • Frequent consultations online for the same problem • Vulnerable adults, children in need or patients on the child protection register • Significant cognitive impairment, severe learning disabilities and/or significant physical disabilities | |
| CONDITIONS CLINIQUES ADEQUATES POUR L'INTERVENTION | | | | | | | |
| Certaines situations cliniques ou raisons de consultation se prêtent davantage à la téléconsultation (ex. : suivi de maladies chroniques, problèmes psychologiques d'intensité légère). | Possible d'évaluer et de traiter sans danger les cas suivants par voie virtuelle : • Problèmes de peau divers (les photos envoyées à l'avance offrent une résolution bien supérieure à ce que les meilleures webcams permettent) • Infections urinaires, infections des sinus, infections mineures de la peau (et pharyngites, si vous arrivez à obtenir une culture de gorge) | Telephone and video consultations can generally be used for: • any condition/scenario where a telephone or video consultation protects vulnerable populations, such as older patients and patients with comorbidities who are at increased risk if they do contract COVID-19 • medical certificates or issuing repeat prescriptions for medicines • mental health consultations, counselling and similar services | ∅ | Agency for Healthcare Research and Quality (AHRQ) recently released an issue brief that cited studies on telehealth and patient safety. ⁷ Among the findings were: • The evidence-base for telehealth is strong, especially for the remote management of chronic health conditions. ⁸ | Examples include: cardiology, paediatrics, geriatrician, genetics, endocrinology, psychiatry, dietetics, physiotherapy, speech therapy, preadmission clinics, post operative clinics, sexual health clinics, mental health review, wound reviews, smoking | ∅ | Although episodic telemedicine provides on-demand, convenient care, this does not necessarily equate to long-term, high-value care. This type of telemedicine may be suitable for part of overall care, not independent care or as a long-term replacement for a primary care physician. |

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| | <ul style="list-style-type: none"> • Santé sexuelle, dépistage et traitement des infections transmises sexuellement (ITS), contraception hormonale • Médecine des voyages • Problèmes chroniques surveillés à l'aide d'un appareil à la maison ou de tests en laboratoire (hypertension, gestion des lipides, affections de la thyroïde, certaines formes de diabète; certains éléments d'examen nécessiteront quand même une consultation en personne) • Analyse de rapports de laboratoire, d'imagerie ou de spécialistes • Toute autre évaluation qui ne requiert aucune | <ul style="list-style-type: none"> • routine chronic disease check-ups, especially if the patient is stable and has monitoring devices (if required) at home • any consultation where the trade-off between attending in person and staying at home favours the latter • COVID-19 related conditions – refer below to 'Telephone and video consultations related to COVID-19'. | | <ul style="list-style-type: none"> • Systematic reviews confirm that telehealth improves health outcomes, utilization and cost of care for a host of chronic diseases, including heart failure, diabetes, depression, obesity, asthma and mental health conditions. | <p>cessation, weight management, diabetes clinics, breast screening, chest clinic – tuberculous medication supervision, high risk foot clinics and tele-dentistry.</p> <p>Telehealth may be used as a hospital avoidance strategy to monitor the patient in their own environment.</p> | | <p>There are many examples of the usefulness of telemedicine and telehealth in individual specialties, such as dermatology, radiology, stroke, mental health, and cardiology;</p> |

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| | palpation ou auscultation | | | | | | |
| CONDITIONS CLINIQUES INADEQUATES POUR L'INTERVENTION | | | | | | | |
| <p>Le médecin doit éviter de poser un diagnostic si les conditions pour le faire ne sont pas présentes; il doit alors diriger le patient vers des ressources appropriées, par exemple pour avoir un examen physique ou un test diagnostique. Idéalement, des corridors de service devraient être préalablement établis.</p> <p>D'autres symptomatologies ne doivent pas être traitées en télémedecine (ex. : douleur thoracique, parésie, difficulté respiratoire, douleur abdominale). Le jugement du clinicien est de mise.</p> <p>La télémedecine n'est pas une plateforme de travail adéquate pour exercer la médecine esthétique.</p> | <p>Des problèmes ne sont pas encore traitables par voie virtuelle : nouveaux symptômes urgents et importants (douleurs thoraciques, essoufflement ou perte des fonctions neurologiques), otalgie, toux, symptômes abdominaux ou gastro-intestinaux, maladies et blessures musculosquelettiques ainsi que la plupart des symptômes neurologiques et d'insuffisance cardiaque congestive.</p> <p>Si un patient évalué virtuellement a des antécédents qui nécessitent un examen physique ne</p> | <p>RACGP acknowledges that while video or telephone consultations are generally not ideal for the following circumstances, the GP may need to exercise a judgement as to the balance of risks of a physical examination.</p> <p>The RACGP recommends that video or telephone consultations should generally not be used, and arrangements made for an in-practice face-to-face consultation:</p> <ul style="list-style-type: none"> for assessing patients with potentially serious, high-risk conditions requiring a physical examination, particularly for patients with chronic disease who are unable to self-monitor appropriately | <p>Une consultation d'annonce idéalement en présentiel. En cas d'impossibilité, une organisation adaptée doit être mise en place autour du patient (relais par le médecin traitant et les autres professionnels prenant en charge le patient).</p> <p>Position du groupe de travail La consultation d'annonce ou l'annonce de mauvais résultats d'examen ne doivent pas être réalisés en télémedecine. Toute organisation réalisant de la télémedecine doit prévoir cette situation en amont dans ses procédures et mettre en place les actions nécessaires pour que le patient soit reçu par un</p> | <p>TTP did not achieve full consensus on all recommendations. For example, we found strong, but not unanimous, support for permanently lifting all controlled substance prescribing restrictions in telehealth.</p> | <p>Ø</p> | <p>Examples of scenarios that practices have incorporated in their protocols include:</p> <ul style="list-style-type: none"> A high risk of deterioration Assessment of young children with an acute illness Complex psychosocial issues Substance misuse Requests for controlled or high-risk drugs (especially where there are concerns about misuse or addiction) Severe mental health problems Frequent consultations online for the same problem Complex medical problems or polypharmacy | <p>Telemedicine: Limitations to care delivery and may not be appropriate for all patients or conditions. The lack of physical interaction can affect the type of care a patient may receive and the degree to which a physician can examine the patient. For example, it may not be appropriate for a man aged 57 years with a history of cardiovascular disease reporting upper respiratory distress to seek care through an ondemand telemedicine service.</p> |

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| | pouvant pas se faire à distance, le médecin doit rediriger ce patient vers des services en personne. | and patient groups deemed high risk for poor outcomes from COVID-19 • when a physical/internal examination is required / cannot be deferred to support clinical decision making • in situations where there is any doubt about the clinical appropriateness of a telephone or video consultation (in these instances, attending the practice in person for a face-to- face consultation is preferable). | médecin en présentiel en cas de consultation d'annonce ou de diagnostic péjoratif. Le compte-rendu ne pourra être accessible au patient qu'après l'accord du médecin qui lui aura annoncé le diagnostic. | | | | |
| CONSIDERATIONS PARTICULIERES CONCERNANT LA PRESCRIPTION LORS D'UNE TELECONSULTATION | | | | | | | |
| Le médecin ne doit pas faire de prescription initiale (nouvelle ordonnance) de narcotiques en téléconsultation. Une évaluation médicale en personne est requise. Lors de la prescription de médicaments ou dans le cas d'une ordonnance non pharmacologique, le médecin | ∅ | ∅ | ∅ | Public comments received, in particular, provided anecdotal feedback suggesting that telehealth improved access, uptake and, potentially, outcomes for behavioral health for which controlled | ∅ | Before prescribing for a patient via telephone, video-link or online, must satisfy yourself that you can make an adequate assessment, establish a dialogue and obtain the patient's consent. May prescribe only when you have adequate | Writing prescriptions "based only on an online questionnaire or phone-based consultation does not constitute an acceptable standard of care". |

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| <p>doit s'assurer que le patient a bien compris les consignes.</p> <p>Le médecin doit être prudent lorsqu'il procède au renouvellement d'ordonnances, particulièrement pour un patient qu'il ne connaît pas. Avant de rédiger une telle ordonnance, le médecin doit s'assurer que la médication est toujours requise, qu'elle est bien tolérée et que sa posologie et son dosage sont adéquats pour l'état du patient. Un questionnaire pertinent est de rigueur et un examen physique peut être requis.</p> <p><u>COVID-19</u> En période de pandémie uniquement, le Collège assouplit les règles en ce qui concerne les prescriptions suivantes :</p> <ul style="list-style-type: none"> • Benzodiazépines et psychostimulants Un médecin traitant pourra effectuer une prescription de benzodiazépine/ psychostimulant pour un patient qu'il connaît déjà, s'il s'assure d'effectuer un suivi adéquat en | | | | <p>substances are often prescribed, such as medication assisted therapy for substance use disorder.</p> <p>Policymakers should carefully evaluate the experience of allowing prescription of controlled substances via telehealth during the pandemic, particularly for medication-assisted treatment of substance abuse disorders, and how continuing this policy can be done in a manner that protects patient safety and prevents overprescribing or abuse.</p> <p>Should include consideration of:</p> | | <p>knowledge of the patient's health, and are satisfied that the medicines serve the patient's needs. You must consider:</p> <ul style="list-style-type: none"> • the limitations of the medium through which you are communicating with the patient. • the need for physical examination or other assessments. • whether you have access to the patient's medical records. <p>GPhC have introduced further safeguards for the public using online pharmacy services. One of these areas includes pharmacy owners ensuring the following categories of medicines are clinically appropriate before supplying them with:</p> <ul style="list-style-type: none"> • antimicrobials (antibiotics) • medicines liable to abuse, overuse or misuse, or where there is a risk of addiction | |

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| <p>temps opportun, que cela soit par une visite en personne ou par une téléconsultation (ex. : suivi du poids et de la tension artérielle dans le cas d'un psychostimulant).</p> <p>Une prescription de benzodiazépine/psychostimulant est permise dans le cas d'un nouveau patient chez qui il est jugé et documenté au dossier qu'un délai de prise en charge pourrait entraîner un préjudice. Un suivi approprié en temps opportun doit être effectué, soit par une rencontre en personne, soit en téléconsultation.</p> <p>• Opioides Le renouvellement d'une ordonnance d'opioïdes pourra être réalisé à la suite d'une téléconsultation, selon le jugement professionnel du médecin, si le médecin prescripteur :</p> <ul style="list-style-type: none"> - est le médecin traitant habituel du patient; - n'est pas le médecin traitant, mais a accès au dossier médical du patient tenu par son médecin traitant; | | | | <p>a. How prescribing controlled substances in a telehealth encounter can comply with regulations and enforcement currently applied to in-person prescribing.</p> <p>b. The burden for compliance should be no greater than compliance with the same rules for in-person care.</p> <p>c. How policies should align with SUPPORT for Patients and Communities Act requirements for Medicare Advantage plans to use e-prescribing for controlled substances starting in January 2021.</p> <p>d. How existing and emerging technologies, such as artificial</p> | | <p>and ongoing monitoring is important</p> <ul style="list-style-type: none"> • medicines that require ongoing monitoring or management • non-surgical cosmetic medicinal products | |

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| <p>- n'est pas le médecin traitant, mais a accès au DSQ pour retracer les ordonnances antérieures du patient.</p> | | | | <p>intelligence and machine learning, may have potential to help detect and mitigate fraud and abuse.</p> <p>Policymakers should look closely at the effect of expanding prescribing authority to telehealth, as authorized by the public health emergency. They should evaluate what policies and guidelines could be applied, to virtual prescribing to ensure patient safety and avoid adverse outcomes.</p> | | | |

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| SECURITE | | | | | | | |
| Ø | Ø | <p>General practices offering telephone and video consultation services need to be mindful of the unique risks involved in consultations where the GP and the patient are at different locations. It is important for general practices to identify these risks and determine how they should be managed.</p> | <p>À tout moment, si le professionnel médical juge que la téléconsultation n'est pas ou n'est plus adaptée à la situation du patient, il trace la décision médicale de ne pas réaliser ou de mettre fin à la téléconsultation dans le dossier du patient (et dans le dossier médical partagé, si le patient en possède un), il propose au patient une prise en charge adaptée et informe le médecin traitant, le cas échéant.</p> <ul style="list-style-type: none"> • Suivre et analyser les événements indésirables (problèmes techniques, problèmes d'organisation, problèmes de communication avec le patient) | <p>Goal for patient safety in a telehealth or in-person care encounter is the same.</p> <p>Care provided must not result in preventable patient harm or mortality. Telehealth patient safety includes ensuring access for patients with technology or digital literacy gaps.</p> <p>Patient Safety: Telehealth can enhance patient safety by preventing care delays, reducing exposure to pathogens and minimizing travel needed for in-person care. Policymakers should fund research on telehealth best practices for patient safety and update existing patient safety event reporting</p> | Ø | <p>No evidence of harm from the use of online consultations within NHS Primary Care. However, this is not the same as evidence of no harm. We need to continue to monitor the safety of systems to understand their impact.</p> <p>Flag any urgent requests – if they need a response urgently, reception staff should ensure that it is seen by a clinician promptly</p> <p>Consider safety as a feature of system processes as a whole (not just the technology) – how will serious concerns be picked up and managed? e.g. clinical triage carried out by a qualified person, flagging systems to prioritise urgent clinical queries, accurate and timely signposting, rapid response times, underpinned by a strict governance structure.</p> <p>Majority of online consultation tools warn</p> | <p>ACP recommends that physicians ensure that their use of telemedicine is secure and compliant with federal and state security and privacy regulations.</p> <p>When these types of sporadic telemedicine visits occur, the continuity of a patient's care may be disrupted and result in larger issues later on if the information from the visit is not appropriately communicated to the patient's physician or medical home and may undermine the establishment or maintenance of a patient–physician relationship.</p> |

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| | | | | <p>structures to incorporate telehealth.</p> <p>Policymakers should update existing policy for in-person-care-related adverse patient safety events to incorporate telehealth, including collecting necessary information and data, as well as leveraging existing patient safety event reporting structures and the work of Patient Safety Organizations (PSO).</p> <p>a. Integration of PSO patient safety event reporting could ensure the collection of standardized data on patient safety events in a telehealth encounter that result in serious injury or death.</p> <p>For nonurgent complaints in primary care settings, diagnostic accuracy and the likelihood of diagnostic</p> | | <p>patients that they should not be used in emergencies. Risk may be reduced further by either:</p> <ul style="list-style-type: none"> • The tool taking an automated history that picks up red flags such as chest pain, and instructing the patient to call 111/999; or • Practices operating on the basis that online consultation requests are triaged promptly (during core hours) to identify and action urgent queries so symptoms don't go ignored for long periods. <p>A patient may start a consultation online but processes should allow the practice or patient to switch to a face-to-face review seamlessly at any point.</p> | |

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| | | | | error appear to be roughly comparable in tele-diagnosis vs. face-to-face encounters. | | | |
| PLAN D'URGENCE TECHNIQUE | | | | | | | |
| Ø | Ø | <p>To avoid lengthy disruptions to telehealth video consultations, should:</p> <ul style="list-style-type: none"> • have ready access to technical support for videoconferencing equipment and connectivity • develop and maintain documented contingency plans for managing technical problems • during a video consultation (eg completing interrupted consultations by telephone) • ensure all participants are aware of the contingency plan (eg who will call whom) • keep troubleshooting guides with the teleconferencing equipment for common technical problems • have a dedicated person in the practice who can | <p>Prévoir les modalités de travail en mode dégradé (ex. : dysfonctionnement du matériel, rupture de la connexion internet, nécessité de prise en charge du patient en urgence, etc.)</p> <p>Le professionnel médical doit connaître la localisation exacte du patient au moment de l'acte et son téléphone (en cas de nécessité d'organiser une prise en charge en urgence ou de recontacter le patient si la téléconsultation est interrompue).</p> | Must be contingencies in place to address technology failures. | Having familiarity of systems will provide a high level of confidence that will support the clinician to be solution focused and to be able to calmly put in place a backup plan such as having a phone consult, rescheduling the appointment, or having other alternatives in place in the event of a technical difficulty that | Have a contingency plan in case of staff absence, holidays, technical failure, usability/access issues to ensure submissions are responded to in a timely manner | Ø |

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| | | provide technical support on the spot. Practices are also advised to have a documented plan for managing technical difficulties during a telephone or video consultation, as these can potentially compromise the effectiveness of the consultation or the patient's safety. | | | prevents an adequate telehealth consultation. | | |
| PLAN D'URGENCE CLINIQUE | | | | | | | |
| Ø | Ø | It is recommended that practices have a documented contingency plan for managing patients who become distressed during a telephone call or video consultation. This is particularly important if the telephone call or video consultation session is being conducted at a location where the practice's usual systems and resources for handling contingencies and medical emergencies are not available. | Prévoir les modalités de travail en mode dégradé (ex. : dysfonctionnement du matériel, rupture de la connexion internet, nécessité de prise en charge du patient en urgence, etc.) Le professionnel médical doit connaître la localisation exacte du patient au moment de l'acte et son téléphone (en cas de nécessité d'organiser une prise en charge en urgence) | Ø | Ø | Good communication is key, checking your understanding matches the patient's and safety netting with specific instructions the patient can refer back to. Monitor the validity of any assumptions and the effectiveness of risk control measures to ensure the perceived level of clinical risk remains representative and acceptable. Have a system in place to identify potentially "at risk" persons e.g. flagging frequent requests for controlled drugs, | Ø |

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| | | Just as in a face-to-face consultation in the practice, GPs will need to use strategies to reduce the risk of missing or omitting important information, including: creating an action plan if the patient's symptoms worsen. | ou de recontacter le patient si la téléconsultation est interrompue). | | | assessing concerns regarding capacity, warnings in their medical record, assessing risk of child sexual exploitation in sexually active young people. This includes an alert to flag any safeguarding concerns and escalate them to the appropriate individual for further assessment. | |

EFFICACITE

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| ÉVALUATION DE LA TELECONSULTATION | | | | | | | |
| Ø | Ø | Track your experiences with video consultations by collecting and analyzing practice data about the implementation process and outcomes. | Évaluation de la satisfaction et de l'expérience des patients : • Des questionnaires de satisfaction, ou un entretien avec le patient selon la méthode du patient- | Telehealth is well suited to improving the measurement of patients' experience of care. Policymakers should leverage telehealth's uniquely digital aspects to | New evidence around the use of telehealth is always emerging. It is good practice when engaging in clinical redesign to implement a telehealth model of care or when | When starting a new way of working, it may be worth carrying out a simple evaluation so you can capture your achievements and any challenges and make improvements. | Ø |

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| | | | <p>traceur peuvent être réalisés.</p> <p>Évaluation de la satisfaction et de l'expérience des professionnels :</p> <ul style="list-style-type: none"> La prise en compte de la satisfaction et de l'expérience des professionnels permet, notamment, d'évaluer les besoins en termes de formation et d'apporter des améliorations dans l'organisation... <p>Évaluation de l'activité :</p> <ul style="list-style-type: none"> La réalisation d'un bilan d'activité et le suivi d'indicateurs d'activité (ex nombre de téléconsultations pourcentage de temps en téléconsultation par rapport aux consultations en présentiel, durée d'une téléconsultation) permettent d'évaluer l'usage de la télé médecine | <p>improve timeliness, targeting and engagement in assessing patient experience, which is an essential aspect of quality.</p> <p>Measurement should focus on whether a telehealth encounter delivers what the patient needs, improves health outcomes, provides an experience the patient can interact with appropriately and integrates with the patients' overall health care.</p> <p>Any standards and measures related to RPM should be designed to capture the tangible impact of this modality's effectiveness, efficiency and closer monitoring of chronic conditions that can prompt earlier interventions to reduce costly exacerbations, improve outcomes and patient and family caregiver experience and ensure data flow in a</p> | <p>implementing new technology to include evaluation strategies.</p> <p>It is expected that evaluation of clinical care should be evaluated in the same way regardless of the modality of care. In some instances, you may need to add in questions to capture modalities offered or to capture a mix of modalities provided to support the patient's journey. This will also support to identify if the use of telehealth modalities has impacted on the service access or care in comparison to face-to-face services.</p> | <p>Consider the following three areas:</p> <ul style="list-style-type: none"> Service monitoring: the routine functioning of online and video consultations. Are they doing what you wanted them to do? Process evaluation: the way in which online and video consultations are implemented and run. What can you learn from the process? Impact evaluation: whether or not online and video consultations are delivering the objectives set. Are you getting the outcomes you anticipated? <p>Question about 'does it save time' is very important and it is essential to monitor. Negative or unexpected adverse outcomes should trigger investigation to inform further improvement. It is important to use both qualitative and</p> | |

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| | | | <p>Évaluation des pratiques professionnelles et gestion des risques :</p> <ul style="list-style-type: none"> • Les pratiques professionnelles sont évaluées avec l'ensemble des professionnels impliqués dans les actes de télémédecine. • Les incidents et événements indésirables doivent être analysés périodiquement pour mettre en oeuvre les actions correctrices. • Tracer les cas où la téléconsultation ou la téléexpertise n'ont pas été adaptées, afin d'apporter les améliorations nécessaires ; <p>Plusieurs méthodes peuvent être utilisées pour évaluer les pratiques professionnelles, par exemple :</p> | <p>way that maximizes its impact.</p> <p>Telehealth also offers a "leap forward" opportunity for patient experience measurement. Because the initiation, completion and follow-up for a telehealth visit often occur digitally, there exists the possibility of assessing patient experience in a more real-time, clinician and other provider specific fashion that improves response rates and provides faster, more meaningful feedback than current mailed paper surveys.</p> | | <p>quantitative measures to understand the effects.</p> <p>Patient Perspective Practice perspective Staff perspective</p> <p>Monitor for any unintended adverse consequences. Employ an inclusive approach to ensure that by spending more time consulting online, you don't have less time for patients with complex health needs that need to be seen face to face.</p> | |

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| | | | <ul style="list-style-type: none"> Audit clinique, patient-traceur, revue de pertinence des soins Revue de morbi-mortalité (RMM), Comité de retour d'expérience (CREX), <p>Parmi les méthodes d'évaluation des pratiques: méthode du patient-traceur</p> | | | | |
| RESULTATS D'INTERETS (OUTCOMES) | | | | | | | |
| SATISFACTION DES PATIENTS ENVERS L'INTERVENTION | | | | | | | |
| Ø | Nombre grandissant d'études indiquent qu'en matière de consultations virtuelles, la satisfaction du patient et les résultats sont équivalents à ce que l'on obtient par des consultations en personne. | Ø | Ø | May have a positive impact in supporting family caregivers, as they often play a critical role in patients' health and well-being. Measure stewards. | Ø | What improvements have practices seen? Patient experience <ul style="list-style-type: none"> High levels of satisfaction Feel more at ease Continuity of care Avoid the waiting room Save time/cost in travelling Alt-Con Study indicated that although some aspects of the consultation can be lost, | VHA's Care Coordination/Home Telehealth program, with the purpose of coordinating care of veteran patients with chronic conditions, grew 1500% over 4 years and saw ... a patient mean satisfaction score of 86%. Analysis of patient satisfaction with physicians during telemedicine |

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| | <p>Bien que la majorité des gens recourent toujours aux consultations en personne pour obtenir les conseils d'un médecin, près de la moitié d'entre eux ont déjà consulté par téléphone, courriel, vidéoconférence ou message texte. Les niveaux de satisfaction – élevés – ne sont que légèrement inférieurs à ceux pour les consultations en personne.</p> <p>Depuis le début de la pandémie, le recours aux options virtuelles est en hausse. Les niveaux de satisfaction sont bons, et toutes les</p> | | | | | <p>such as non-verbal cues, it was still possible to maintain a relationship. Some patients reported feeling that with their GP communicating via an alternative to a face-to-face consultation they were demonstrating a greater level of care. Atherton et al. (2018)</p> <p>Many practices have found that it has improved their control over their day to day workload enabling more effective use of working time, and improved staff satisfaction.</p> <p>Video consultations were popular with those that used them. Patients value its convenience.</p> | <p>encounters found little difference between encounters in the in-person or virtual setting.</p> |

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| | options virtuelles obtiennent des résultats supérieurs à ceux pour une visite à l'urgence. <u>Téléphone</u> - 29 % Entièrement satisfait - 62 % Satisfait - 9 % Insatisfait En contexte COVID-19 - 91 % Satisfait <u>Vidéoconférence</u> - 20 % Entièrement satisfait - 61 % Satisfait - 18 % Insatisfait En contexte COVID-19 - 90 % Satisfait | | | | | | |
| SATISFACTION DES PROFESSIONNELS ENVERS L'INTERVENTION | | | | | | | |
| Ø | Ø | Ø | Ø | Ø | Ø | What improvements have practices seen? Supporting staff • Staff satisfaction | Ø |

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| ACCESSIBILITE | | | | | | | |
| Ø | <u>Téléphone</u> En contexte COVID-19, obtention des conseils dans un délai raisonnable - 90 % oui <u>Vidéoconférence</u> En contexte COVID-19, obtention des conseils dans un délai raisonnable - 82 % oui | Ø | Ø | Early data suggest telehealth also increased access to behavioral care | Ø | What improvements have practices seen? Access <ul style="list-style-type: none"> • Timely advice, information and services • Reduced waiting times • Convenience • Support people who prefer to access care remotely Following the implementation of online consultations at Witley and Milford Surgeries, when patients requested a specific staff member this was accommodated 90% of the time on average each week. Witley and Milford data (24 March–13 May 2019) | A comparison study of patients waiting for an evaluation by an ear, nose, and throat subspecialist before and after the introduction of telemedicine in an Alaskan community saw significant decreases in the number of new patients waiting 5 months or longer for a consultation (47% before vs. 8% after) and the average wait time for an appointment (4.2 vs. 2.9 months). Two thirds of the patients who participated in the Extension for Community Healthcare Outcomes program were part of minority groups, suggesting that telemedicine could be beneficial in helping underserved patients connect with sub- |

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| | | | | | | | specialists they would not have had access to before, either through direct connections or training for primary care physicians in their communities, regardless of geographic location. |
| ADHERENCE AU RENDEZ-VOUS | | | | | | | |
| Ø | Ø | Ø | Ø | Early evidence also suggests that the expansion of telehealth has helped drive a reduction in the rates at which patients missed appointments (no shows), which has been demonstrated to increase care plan adherence, improve chronic disease management and yield downstream cost savings. Early findings from COVID-era experience suggest that telehealth may reduce missed appointment (no-show) rates in comparison with in-person visits. | Ø | Ø | Ø |

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| | | | | <p>Health systems and clinician practices consistently report lower no-show rates with telehealth, especially in behavioral care, where telehealth removes the stigma of visiting a behavioral clinic.</p> <p>Baseline no-show rate for psychiatry services is between 19% and 22% of appointments — while MDLive reports no-show rates of only 4.4% – 7.26% for its behavioral health telehealth visits.</p> | | | |
| REDUCTION DES DEPLACEMENTS | | | | | | | |
| Ø | Ø | Ø | Ø | Early data suggest telehealth also relieved travel burdens | Ø | <p>What improvements have practices seen?</p> <p>Supporting staff</p> <ul style="list-style-type: none"> • Save time in travelling | An analysis of cost savings during a telehealth project at the University of Arkansas for Medical Sciences between 1998 and 2002 suggested that 94% of participants would have to travel more than 70 miles for medical care. |
| AUGMENTATION DU NOMBRE DE RENDEZ-VOUS OU DE PRESENTATION A L'URGENCE | | | | | | | |

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| Ø | Ø | Ø | Ø | <p>Data collected to date indicate that the virtually unfettered availability of telehealth has not resulted in excess cost or utilization increases, even as supply and demand for in-person care has rebounded.</p> <p>Data gathered by the TTP: telehealth largely substituted for in-person care and did not increase the total number of visits</p> <p>TTP: telehealth can help reduce more costly urgent and ED care, as well as use of costly and often overused services such as imaging.</p> <ul style="list-style-type: none"> Ascension Health found that, from March to May of this year, nearly 70% of patients would have gone to either urgent care or the ED had they not had access to virtual care. These patients would have used more costly options without access to telehealth. | Ø | <p>ViCo study found the duration, content and impact on re-consultation rates were similar to telephone for follow up consultations in primary care.</p> | <p>VHA's Care Coordination/Home Telehealth program, with the purpose of coordinating care of veteran patients with chronic conditions, grew 1500% over 4 years and saw a 25% reduction in the number of bed days, a 19% reduction in numbers of hospital readmissions, and a patient mean satisfaction score of 86%.</p> |

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| | | | | <ul style="list-style-type: none"> Nemours found that 67% of parents who used its 24/7 on-demand virtual care service before COVID-19 reported they otherwise would have visited an ED, urgent-care center or retail health clinic had telehealth not been available. A pre-COVID-19 Anthem study of Medicare Advantage claims data for acute and non-urgent care utilization found savings of 6%, or \$242 per episode of care costs, by diverting members to telehealth visits who would have otherwise gone to an ED. The study also found less use of imaging, lab tests and antibiotics. In a pre-COVID-19 study of 40,000 Cigna beneficiaries, the 20,000 beneficiaries who used the MDLive telehealth platform had 17% lower costs when compared with non-virtual care. Virtual care users also experienced a 36% net reduction in ED use per | | | |

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| | | | | 1,000 people compared to non-virtual care users. | | | |
| QUALITE DES SOINS | | | | | | | |
| Ø | <u>Téléphone</u> En contexte COVID-19, résolution du trouble médical - 85 % oui <u>Vidéoconférence</u> En contexte COVID-19, résolution du trouble médical - 86 % oui Bien des gens considèrent qu'un recours accru aux soins virtuels présenterait des avantages pour les patients (commodité, promptitude de l'accès aux conseils médicaux, aux tests et aux spécialistes), améliorerait la | Ø | Ø | Early evidence suggests that the expansion of telehealth has helped drive a reduction in the rates at which patients missed appointments (no shows), which has been demonstrated to increase care plan adherence, improve chronic disease management and yield downstream cost savings. | Ø | What improvements have practices seen? Quality of care <ul style="list-style-type: none"> • Pick up red flags early using triage • Comprehensive symptom enquiry • Empower self-care • Prioritize care based on needs | Telemedicine as a case-management tool has been shown to improve outcomes in older patients with diabetes with limited access to care and in patients with other chronic conditions |

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| | santé générale de la population canadienne et réduirait les coûts des soins de santé au Canada. Très peu de gens voient des désavantages à ce que cette option soit plus souvent offerte. | | | | | | |
| PREFERENCES DES PATIENTS | | | | | | | |
| Ø | À l'avenir, 38 % des répondants (40 % au Québec) souhaiteraient que le premier contact se fasse par téléphone, vidéo-conférence, courriel ou message texte plutôt qu'en personne lorsqu'ils ont besoin de consulter un médecin. | Ø | Ø | Early data suggest telehealth also increased enabled patients to choose virtual visits across a much broader range of services | Ø | Although video consultations are well received, generic uptake is usually low. Patient contact preference data from a sample of 21 practices revealed a much higher preference for secure messaging, telephone or face to face consultations compared to video (askmyGP data first quarter 2019). A preference for telephone is also reflected in the recent evaluation of | Ø |

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| | <p>Pour chacune des options, la majorité des gens voudraient avoir le choix entre une consultation virtuelle ou en personne.</p> | | | | | <p>Babylon's GP at Hand Service.</p> <p>When asked "Would you be interested in having an online consultation with a GP/other health professional in the future?"</p> <ul style="list-style-type: none"> • Most respondents (67%) said they would. • A further 69 respondents (2.3%) said their practice already provides this. • A minority of 566 respondents (19%) said they would not be interested, 365 (12%) respondents were unsure. • Seventeen (0.6%) said they already use a paid for private provider. <p>Preferred method of access</p> <ul style="list-style-type: none"> • The most popular choice for future access to online services is through typed messages (43%) • Followed by video chat (36%). | |

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| | | | | | | <p>Preferred device</p> <ul style="list-style-type: none"> • smartphone at 52%. • Closely followed by PC or laptop at 51%. • Around one third of respondents (34%) would like to use their tablet. • There is also a potential growth in access through gaming systems at 0.5%. <p><u>Healthwatch Newcastle</u> Future use of online consultations In response to the question "Would you be interested in having an online consultation with a GP/other health professional in the future?" the respondent sample indicated:</p> <ul style="list-style-type: none"> • 50% are interested in engaging with their practice online in the future; • 35% are not; • 12% are currently uncertain. <p><u>Healthwatch Newcastle</u></p> | |

| #1 CMQ-2015 + Addenda COVID 2020 (Collège des médecins du Québec) Canada | #2 - AMC – 2020 + Sondage AMC (2020) (Association Médicale du Canada) Canada | #3 - RACGP – 2019 + Guide complémentaire 2020 (The Royal Australian College of General Practitioners) Australie | #4 – HAS – 2019 + Rapport d'élaboration (Haute autorité de santé) France | #5 – TTP – 2020 (Taskforce on Telehealth Policy; ATA, ACC & NCQA) États-Unis | #6 – ACI - 2020 (NSW Agency for clinical innovation) Australie | #7 – NHS – 2020 + Research findings 2019 (National health service) Royaume-Uni | #8 – ACP – 2015 (American College of Physicians) États-Unis |
|---|---|--|---|---|--|--|---|
| | | | | | | Preferred method <ul style="list-style-type: none"> Similar to the general public feedback, the favorite method is by online chat (46%) very closely followed by video chat | |
| EFFICIENCE | | | | | | | |
| Ø | Ø | Ø | Ø | <p>One study estimates that virtual care could substitute for up to \$250 billion of current U.S. health care spending, and the emerging data from the pandemic shows this could be correct. It is still too soon for large-scale, academically rigorous analysis of what is happening that properly discount pandemic effects, but the evidence from March to July is promising for telehealth.</p> <p>Behavioral health has been an exception. The TTP found anecdotal and data-driven evidence of significant increases in uptake of tele-behavioral health under the public</p> | Admitted (inpatient) telehealth services Telehealth in the admitted space can support the management of patients, reduce a patient's length of stay (LOS) with Hospital in the Home (HiTH) initiatives and provide opportunities to integrate care with a range of providers to assist with the patient's ongoing care post discharge. | What improvements have practices seen? Efficiency <ul style="list-style-type: none"> Signpost patients to the right place or professional Optimise appropriate use of skill-mix Clinician has access to the history before the consultation Less time spent documenting and better data capture | <p>VHA's Care Coordination/Home Telehealth program, with the purpose of coordinating care of veteran patients with chronic conditions, grew 1500% over 4 years and saw a 25% reduction in the number of bed days, a 19% reduction in numbers of hospital readmissions, and a patient mean satisfaction score of 86%.</p> <p>A study on this program found that a patient treated in a telestroke network, consisting of 1 hub hospital and 7 spoke hospitals, reduced costs by \$1436</p> |

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|---|---|--|---|---|---|---|---|
| | | | | <p>health emergency. In part, the increase in demand may be related to the stresses and dislocation brought on by the pandemic, the lessening of social stigma some may attach to visiting in-person sites for this type of care or the reduction in regulatory barriers. Increased utilization of behavioral health services has the potential to decrease net costs and improve outcomes, as untreated behavioral conditions can contribute to greater physical health needs and overall spending.</p> <p>Data, while collected at a time of immense change and uncertainty, have not shown the large increases in net costs that some predicted broader access to telehealth services would bring.</p> <p>Data generated from provider organizations and</p> | | | <p>and gained 0.02 years of quality-adjusted life-years over a lifetime compared with a patient receiving care at a rural community hospital.</p> <p>Program in New Mexico that used telemedicine to provide hospital-level care in a patient's home found savings of 19% over similar patients who were treated in the hospital setting, mostly derived from shorter length of stay in the hospital and fewer diagnostic and laboratory tests.</p> <p>Research suggests that the most cost-effective uses of telemedicine are in radiology, home health care, psychiatry, and prisoner health care but less so in other applications due to lack</p> |

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|---|---|--|---|---|--|---|---|
| | | | | the federal government to date show that total health care utilization remained steady during telehealth's expansion and did not substantiate concerns about supply-induced demand. | | | of reimbursement by payers. |
| AUTRES OUTCOMES (SOINS DE TRANSITION, STAFF, SECURITE) | | | | | | | |
| Ø | Ø | Ø | Ø | <p>Early data suggest telehealth also increased reduced skilled nursing facilities transfers to hospitals, boosted transitional care management</p> <p>Increased the use of transitional care management services that improve outcomes and reduce readmissions, mortality rates and costs.</p> <p>Transitional Care Management (TCM): While the TTP did not have time to collect enough data to fully analyze TCM, we received anecdotal evidence that TCM code</p> | Ø | <p>What improvements have practices seen?</p> <p>Supporting staff</p> <ul style="list-style-type: none"> • Greater control over workload • Opportunities for flexible and remote ways of working increasing staff retention and practice capacity • Give people the time they need <p>No evidence of harm from the use of online consultations within NHS Primary Care. However, this is not the same as evidence of no harm. We need to continue to</p> | Ø |

| #1 CMQ-2015 + Addenda COVID 2020 <i>(Collège des médecins du Québec)</i> Canada | #2 - AMC – 2020 + Sondage AMC (2020) <i>(Association Médicale du Canada)</i> Canada | #3 - RACGP – 2019 + Guide complémentaire 2020 <i>(The Royal Australian College of General Practitioners)</i> Australie | #4 – HAS – 2019 + Rapport d'élaboration <i>(Haute autorité de santé)</i> France | #5 – TTP – 2020 <i>(Taskforce on Telehealth Policy; ATA, ACC & NCQA)</i> États-Unis | #6 – ACI - 2020 <i>(NSW Agency for clinical innovation)</i> Australie | #7 – NHS – 2020 + Research findings 2019 <i>(National health service)</i> Royaume-Uni | #8 – ACP – 2015 <i>(American College of Physicians)</i> États-Unis |
|---|---|--|---|---|---|---|---|
| | | | | billing increased during COVID-19. This suggests that clinicians, other providers and patients are more robustly utilizing TCM services. Previous analysis has suggested that increased TCM usage can lower readmissions, thereby reducing health care costs. | | monitor the safety of systems to understand their impact. We want to learn from every event and make continuous improvements. | |
| CONTINUITE DES SOINS | | | | | | | |
| Ø | Ø | Ø | Ø | Ø | Ø | Ø | Little research has been done on how remote consultation Web sites or applications may affect the continuity of a patient's care, and anecdotal evidence suggests that antibiotics may be overprescribed in this setting. |

ANNEXE F

Tableaux d'extraction des revues systématiques (RS)

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|---|---|
| 1) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| Barriers and Facilitators That Influence Telemedicine-Based, Real-Time, Online Consultation at Patients' Homes: Systematic Literature Review | Systematic review of the literature | <ul style="list-style-type: none"> Nombre d'études incluses : 45 articles in the final review Articles published from 2008 to 2018 Included studies : United States (n=23), Australia (n=5), Canada (n=4), Italy (n=4), United Kingdom (n=2), China (n=1), Spain (n=1), Korea (n=1), Norway (n=1), Denmark (n=1), and Iran (n=1). |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitants) Facteurs facilitants et barrières à la consultation en ligne à domicile External factors <ul style="list-style-type: none"> High Internet speed affects the quality of the consultation and can positively influence patients acceptance of and satisfaction with HOHC. In fact, the results indicate that patients and clinical staff showed higher satisfaction and acceptance of online consultations when the Internet speed was high. However, low Internet speed can negatively influence patients' acceptance of and satisfaction with HOHC. with, satisfaction with, and acceptance of HOHC, which might be one of the reasons that some patients preferred in-person consultations rather than HOHC when the Internet speed was low. Saving costs on health care services for both health care providers and patients is a key driver for adopting HOHC. It is evident that online consultations reduce service costs as well as eliminate travel costs and wait times for health care providers and patients, indicating a correlation between saving costs for patients and convenience. Patients' and clinicians' training is considered a facilitator by both patients and clinicians, which enables them to use the HOHC system easily. Conversely, lack of training poses a challenge to the use of online systems and might influence users' adoption and increase their resistance to them. The ease of use of the online consultation system can positively influence patients' acceptance of and satisfaction with HOHC. However, some patients with complex health conditions require complex HOHC systems, which include vital signs monitoring sensors linked to the health care provider's data center for real-time monitoring or requiring patients to regularly report data to the health care provider. The correlation between management and providing support to patients can be supported by the flexibility offered by online consultation in the terms of choosing a suitable time for the online treatment, documenting and tracking patients' treatment progress in real time, as well as giving feedback to patients in a timely manner. Also, the flexibility and scheduling capabilities of online consultation systems promote convenience and compliance with treatment. Compliance with treatment over HOHC can be more effective than in-person treatment, as it is enforced by the HOHC approach and the system as a whole. This is because patients are held accountable and are encouraged by their family members to follow the online treatment procedures. Also, compliance is |
| | Thérapie comportementale Blessures par brûlures Cancer Maladies cardiovasculaires Maladie pulmonaire obstructive chronique Thérapie cognitive Diabète Dystrophie musculaire facioscapulohumérale Réhabilitation gériatrique VIH Maladie d'Huntington Scléroses multiples Maladie de Parkinson Dialyse péritonéale Activité physique Chirurgie plastique Syndrome de Prader-Willi Psychothérapie Service de réhabilitation pour les personnes âgées Schizophrénie | |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|--|---|
| | Maladies graves Thérapie du langage Soins de plaie | <p>aided by the convenience of the online consultation, as patients follow the treatment from the comfort of their homes at a convenient time that suits them. This indicates that compliance with treatment has a correlation with convenience and family involvement.</p> <ul style="list-style-type: none"> • The lack of organizational support regarding the law, policy, and reimbursement are some of the most argued barriers to online consultation because health insurance companies do not fully support this type of consultation. In addition, lacking support from hospitals to integrate HOHC with patients' health records, for full record documentation, and for cross-synchronization with other system platforms is limiting the adoption of HOHC. • Accessibility to specialist care is one of the drivers that promote the use of HOHC, since it improves patients' access to health care specialists, despite patients' remote locations and lack of experts in their area. • Home obstructions are a barrier to online consultation. Patients are distracted by other things happening at home and the family members around them, which affects their privacy concerns. <p>Internal factors</p> <ul style="list-style-type: none"> • Saving time for both health care provider staff and patients is one of the most appreciated facilitators of HOHC. Eliminating travel time is important, especially for patients in underserved areas or for nurses who perform in-person home visits. Online consultation also promotes convenience by eliminating patients' waiting times at hospitals, outpatient units, and specialist offices. • Online consultation resistance often comes from patients' lack of knowledge, unfamiliarity with technology, and resistance to change to new approaches. In this context, it should be noted that patients' familiarity with the system is important in reducing their resistance. Based on the reviewed papers, users who were familiar with similar and mainstream video conferencing systems did not show resistance to online consultations. • Patients' past treatment experiences and familiarity with clinicians can assist in reducing technology resistance. Patients who previously had treatment for a specific health condition or patients who were familiar with the clinician who provided care for them during face-to-face consultation were more open to use HOHC systems and were encouraged to use them. • HOHC systems enable engagement and motivation between therapists and participants. Video conferencing can enable excellent body language and communication between patients and therapists, thus supporting patients' confidence. However, lack of eye contact as well as physical and social contact (ie, poor body language and communication) during online consultation can be a barrier as well. In this context, emotional support is provided in real-time feedback, which encourages patients to commit to the treatment program. • Patients' positive perceptions of the system's privacy and security—the sense of privacy while conducting the online consultation at home—can encourage the use of HOHC. However, despite the technical effort to ensure patients' data security and privacy, some patients show concern regarding the security of the system and their personal privacy. Patients' perceptions of HOHC privacy and security are subjective; thus, it can be considered as both a facilitator and a barrier, positively or negatively influencing the view and understanding of the HOHC system. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|----------|--|
| | | <ul style="list-style-type: none"> Several studies indicated that law and policy prevented the uptake of online consultation. Most of the laws and policies were related to legal issues and reimbursement that the health organization did not support <p>Effectiveness of Home Online Health Consultation and Patients' Satisfaction</p> <ul style="list-style-type: none"> Most patients gain a high level of convenience when HOHC systems are easy to use and reduce travel time and costs, which is reflected in their satisfaction with online consultation. Also, patients are satisfied with HOHC because it is effective and convenient and provides a similar experience to face-to-face (ie, in-person) consultation. However, a small number of patients preferred face-to-face consultation for their own reasons, such as their belief that the physical presence of a health care professional would enable superior interpretation of body language and emotional expression or simply because it was their personal preference. HOHC systems are effective in delivering health care services, as indicated in 44 out of 45 (98%) of the included studies. However, the use of HOHC systems with young and old patients might be difficult because young children might not engage in the online treatment (n=1) and patients older than 80 years might find it challenging to use them. Since these results were reported only in 2 studies, and other studies with younger and older patients have been successful without reporting additional difficulties, we, therefore, do not consider age to have a significant influence on the use of HOHC. Patients' different health conditions, especially ones that require physical examinations, might be perceived as less accessible to clinicians by patients. Patients who underwent plastic surgery perceived that HOHC resulted in lower access to clinicians, who are to examine their surgical scars; however, the findings of that study were not significant (n=1). In contrast, using HOHC with patients with burn injuries, which require a physical examination, has been successful (n=1). Therefore, we can argue that the varying health conditions of patients have no significant influence on the use of HOHC. <p>Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen)</p> <ul style="list-style-type: none"> Technologiques <p>Security et confidentiality :</p> <ul style="list-style-type: none"> Very important requirements because the communication supported by HOHC is personal and confidential. The security and privacy of the HOHC can be considered from the aspect of its compliance with the HIPAA. This act sets the standard for security and privacy for patients' sensitive health information and records that are held or transferred in electronic form between health care providers and patients. Another requirement is the Internet service availability for this type of consultation, without which patients cannot access online consultation. The availability of a device is a requirement and it can be either a personal device (eg, mobile phone, tablet, or PC) or a telemedicine device provided by the health care provider to patients. These |
| Auteurs/Pays | | |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|--|---|
| | | requirements are essential for delivering any HOHC, and online consultation cannot be performed without them. |
| Almathami et al. | Spécialité | <ul style="list-style-type: none"> Humains et cognitifs |
| Australia | N/A | ∅ |
| | Types de professionnels | <ul style="list-style-type: none"> Cliniques |
| | Fournisseur de soins – habituellement un médecin | ∅ |
| | Types de patients/clients | |
| | Patients à leur domicile | <ul style="list-style-type: none"> Professionnels et organisationnels |
| Année de la revue | Interventions | ∅ |
| | Télémédecine (n'importe quel type de consultation médicale en ligne entre un patient et un professionnel de la santé, par n'importe quel fournisseur de soins; consultations réalisées à distance au domicile du patient (i.e. e-consultation); systèmes de consultations qui fournit des consultations synchrones par vidéoconférences. | |
| 2020 | Comparaison (le cas échéant) | |
| Objectifs de la revue | N/A | <ul style="list-style-type: none"> Économiques et financiers |
| The aim of this study is to provide an answer to our main question: (1) What are the facilitators and barriers to HOHC systems that influence their uptake? We also aim to | | ∅ |
| | Limites/Biais | <ul style="list-style-type: none"> Sociopolitiques et réglementaires |
| | | ∅ |
| | | Conclusions des auteurs et recommandations générales |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|---|---|
| <p>provide answers to our subquestions: (2) Are HOHC systems effective? and (3) Are users satisfied with HOHC systems?</p> | <ul style="list-style-type: none"> • Qualitative content analysis method to discover themes of facilitators and barriers to HOHC systems. • Method is subject to our subjective interpretation of the findings, which may have introduced bias into the study. • Focused on a specific type of online health consultation system: a real-time HOHC system. • The results may not be generalizable to all online health consultation systems, such as store-and-forward online health consultation. • Despite these limitations, most of the included articles elicited similar requirements, facilitators, and barriers to HOHC, which propose a strong framework of facilitators and barriers for HOHC systems. | <p>HOHC systems can be of great benefit to patients in terms of convenience, reliability, health care availability, and cost savings. HOHC systems are tailored to meet patients' needs, as well as to ensure effectiveness in improving patients' well-being and satisfaction with the health care provided. Patients' acceptance of HOHC is enforced by the facilitators, which promote effective and convenient remote treatment. However, some patients influenced by the identified barriers preferred face-to-face consultation and showed resistance to the HOHC.</p> |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|---|---|
| 2) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| Satisfaction with the use of telehealth during COVID-19: An integrative review | Integrative review | <ul style="list-style-type: none"> Nombre d'études : 18 articles fit the inclusion and exclusion criteria set Période : Articles included in the review were those published from January 1, 2020 to July 11, 2020, Ten of the articles (56%) were studies conducted in the US, two were from the United Kingdom, and one study each from Italy, France, Slovenia, Hong Kong, China, and India. |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitateurs) |
| | Allergy and immunology, pediatricians, head, eyes, ears, nose and throat (HEENT), oncologist, otolaryngologist, gastroenterologist, vascular surgeons, rheumatology, musculoskeletal and sport medicine, and orthopedics. | <ul style="list-style-type: none"> Services offered by the healthcare system or providers varied by study, but the majority of services offered were in sub-specialty areas, such as allergy and immunology, pediatricians, head, eyes, ears, nose and throat (HEENT), oncologist, otolaryngologist, gastroenterologist, vascular surgeons, rheumatology, musculoskeletal and sport medicine, and orthopedics. Sixteen out of 18 studies evaluated patient satisfaction and five studies examined healthcare providers' satisfaction with the use of telehealth. The majority (14/16) of the studies showed high level of patient satisfaction with the use of telehealth during the COVID-19 pandemic. The study by Itamura et al. (2020) reported that patients were more satisfied with inpatient (93%) rather than virtual consultation (93% vs. 74%, respectively). One study did not report any score on patient satisfaction but reported high level based on caregiver's positive comments with use of telehealth Of the five studies that evaluated clinician satisfaction with the use of telehealth, four studies reported high level of satisfaction based on scores of 80% and above, whereas one study reported healthcare provider's satisfaction score of 78 out of 100. Several studies noted that patients and healthcare providers were willing to continue to use telehealth as part of their follow-up visits even after the COVID-19 pandemic |
| Auteurs/Pays | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) |
| Andrews et al. | Spécialité | <ul style="list-style-type: none"> Technologiques |
| United States | N/A | ∅ |
| | Types de professionnels | <ul style="list-style-type: none"> Humains et cognitifs |
| | Nurses | ∅ |
| | Types de patients/clients | <ul style="list-style-type: none"> Cliniques |
| | Any | ∅ |
| Année de la revue | Interventions | <ul style="list-style-type: none"> Professionnels et organisationnels |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|---|--|
| | Different telehealth platforms (Phone calls, Zoom video, SARA platform, Attend Anywhere platform, audio calls, audio-video, video using WeChat, WhatsApp, oxy.me, Zoom, Google Hangouts, Apple Facetime, Skype, Upfox, VSee, InTouch) | <ul style="list-style-type: none"> From an educational perspective, current nurses may need to be trained or re-trained to the various telehealth platforms. They should be open and willing to adjust their own practice based on the ever-changing technology and patient need. Nurse should also participate in developing guidelines for best practice in telehealth nursing. |
| 2020 | Comparaison (le cas échéant) | |
| Objectifs de la revue | N/A | |
| To examine current evidence on patient and provider satisfaction regarding the use of telehealth during the COVID-19 pandemic. | | <ul style="list-style-type: none"> Économiques et financiers |
| | | ∅ |
| | | <ul style="list-style-type: none"> Sociopolitiques et réglementaires |
| | | ∅ |
| | Limites/Biais | Conclusions des auteurs et recommandations générales |
| | <ul style="list-style-type: none"> All the studies have level of evidence VI. Several of the articles were published pre-proof by the journals. The duration of each study was very short. Surveys used to measure satisfaction were mostly researcher developed. The validity and reliability of instruments were not addressed. Potential for election bias is high since most of the participants who were surveyed had no choice but to choose telehealth because of the pandemic. | <ul style="list-style-type: none"> Findings from this integrative review showed high level of satisfaction with the use of telehealth by patients and healthcare providers during the COVID-19 pandemic. The finding of high patient satisfaction with use of telehealth was supported by several studies prior to the pandemic (n=3). This result may not be too surprising, as one of the main reasons for increased use of telehealth services is driven by necessity. Telehealth presented an avenue for the patients to have continuity of care during this unprecedented time. This integrative review presented additional support on satisfaction with the use of telehealth. The findings in this review may not be surprising as individuals, healthcare providers, and health systems had to transform their way receiving and delivering health care out of necessity. It showed the adaptability of healthcare systems and providers in developing an alternative way of delivering care to patients during a crisis as well as resilience of individuals in quickly adapting to the new system. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|--|--|
| 3) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|-------------------------|---|
| The clinical use of Skype—For which patients, with which problems and in which settings? A snapshot review of the literature | Systematic review | <ul style="list-style-type: none"> Nombre d'études : 27 studies; twelve (44%) of the included studies as "feasibility studies"; nine (33%) as "clinical studies"; and six articles (22%) as "clinical education" studies Twenty five (93%) of the articles described single country studies. The remaining two (7%) articles described international studies between Canada and Botswana, and between Australia and the United States Période : 2006 - 2014 |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitateurs) |
| | Any | <ul style="list-style-type: none"> Clinical application area : Chronic disease, Clinical education, Speech and language pathology, Critical illness, Mental health, Pathology, Urology, Orthopaedics Twenty-six (96%) of the twenty-seven studies reported results that were supportive of the use of Skype. A single study, of home-based polysomnography which included the use of Skype to communicate with the patient, suffered technical problems. While the study was positive about the use of telemedicine in home-based sleep studies, the authors concluded that Skype was perhaps not the best interface for communication and that mobile telephone could be an effective alternative. Eight clinical application areas were represented in the review, with chronic disease management being the most common. All but one study was supportive of the use of the clinical use of Skype which may suggest publication bias Communication, both verbal and non-verbal, was discussed in five studies. All reported that Skype allowed good communication between individuals and health professionals. Three studies measured communication through surveys with participants while one used a speech reading test. While not all studies considered the economic effects associated with using Skype, those that did agreed that Skype was more economical than face-to-face appointments with savings accruing from avoided travel. Skype is being used for patients across the age spectrum, though more often for adult rather than for paediatric applications. Skype is being used primarily for chronic disease management. While free/inexpensive approaches to telemedicine may be of most benefit to developing countries, most reports to-date have been of work conducted in developed countries. Applications to the home are not yet prevalent. The evidence base remains scant, however formal studies of Skype are increasing and this will eventually lead to a clearer understanding of its effectiveness in clinical care. |
| | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) |
| | | <ul style="list-style-type: none"> Technologiques |
| | | Ø |
| Auteurs/Pays | Spécialité | |
| Armfield et al. | N/A | <ul style="list-style-type: none"> Humains et cognitifs |
| Australia | | <ul style="list-style-type: none"> Skype is being used for patients across the age spectrum, though more often for adult rather than for paediatric applications. While free/inexpensive approaches to telemedicine may be of most benefit to developing countries, most reports to-date have been of work conducted in developed countries. |
| | Types de professionnels | <ul style="list-style-type: none"> Cliniques |
| | | <ul style="list-style-type: none"> Skype is being used primarily for chronic disease management. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|---|--|
| | Nursing and allied health disciplines. | <ul style="list-style-type: none"> Professionnels et organisationnels |
| | Types de patients/clients | |
| | Patients across the age spectrum, but with an emphasis on adults | |
| Année de la revue | Interventions | <ul style="list-style-type: none"> Économiques et financiers |
| | Skype video consultation | |
| 2015 | Comparaison (le cas échéant) | |
| Objectifs de la revue | Usual care or none | |
| The aim of this study was to review the peer-reviewed literature and explore for which patients, which clinical application areas and in which countries Skype is being used to provide healthcare. | Limites/Biais | <ul style="list-style-type: none"> Sociopolitiques et réglementaires |
| | <ul style="list-style-type: none"> Only included studies in the English language, which may have excluded some reports, particularly in developing countries where English may not be spoken or may not be the first language. Yet, these may be the very countries to benefit the most from low-cost telemedicine. Only on the peer-reviewed literature yet we understand anecdotally that many Skype-based services are operating but are not formally studied or reported. Thus, the view they have provided of the clinical use of Skype may not be truly representative of its use in routine practice as a whole. | <ul style="list-style-type: none"> Économiques et financiers |
| | | <ul style="list-style-type: none"> Sociopolitiques et réglementaires |
| | | Conclusions des auteurs et recommandations générales |
| | | Since Skype is free, easy to use and may be installed on a range of devices, its clinical use may grow. It may be that the use coalesces around a small number of clinical application areas or settings, or that Skype is found to be more generally useful and acceptable to clinicians and patients. Alternatively, it may be also be found to be inadequate for some clinical work. At the moment, the picture is still unclear. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|---|--|
| 4) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| Exploring the role of nurses in after-hours telephone services in regional areas; A scoping review | Scoping review | <ul style="list-style-type: none"> Nombre d'études : 42 included studies Période : Studies from 2000 to 2018 |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitants) |
| | Chronic diseases | <ul style="list-style-type: none"> Theme 1 –Nurse-led decision making. Two of the key factors integral to the success of nurse-led telephone services are apparent in the reviewed literature and are key elements of the theme of decision making. Firstly, registered nurses need to be experienced, and secondly there is a consensus that they need tailored training in providing advice. Theme 2: Consumer profile. Demographic and geographic profile of consumers. The provision of telephone-based support is discussed throughout the literature in the context of people who have limited access to quality healthcare for social, financial, cultural or geographical reasons. Rurality and distance to major centres influences how the service is utilized by the target population. What models of care are used to provide after-hours services to chronic and complex patients? <ul style="list-style-type: none"> There is no 'one-size-fits-all' answer. The approach to providing after-hours care is dependent on the location, the population and the service availability. The success of managing follow-up care for patients in remote areas is variable, dependent on the patient's knowledge of modern communication technology and remoteness. Protocols for nurse delivered care have been developed to support a process of care, however evidence supporting chronic and complex conditions is not conclusive. Findings suggest that experienced and/or trained nurses are essential, because of the dislocation of service, i.e. many of the after-hours services are conducted over the telephone, so that it is necessary for nurses to understand what they are hearing and what questions to answer in the case of a change in condition. There are varying models put forward in the literature, none focusing on a disparate group of patients involving complex issues. Findings suggest that models of care need to be developed according to the location and population group it serves. |
| | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) |
| | | <ul style="list-style-type: none"> Technologiques |
| Auteurs/Pays | | Ø |
| Baldwin et al. | Spécialité | <ul style="list-style-type: none"> Humains et cognitifs |
| Australia | N/A | <ul style="list-style-type: none"> Rural and remote areas would be best served by utilizing a call service within existing health service structures, given the fact that community members prefer calling their own health service providers. Issues related to the health and digital literacy of the user are also highlighted in the existing literature. The literature reports that digital technology is useful for the younger generation but not necessarily for the older populations whose frame of reference is still focused on physically seeing a doctor in the hospital or on medical premises |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|--|--|
| | | <ul style="list-style-type: none"> Cliniques |
| | Types de professionnels | <ul style="list-style-type: none"> It is clear also, that for those patients with chronic and complex conditions, follow up from such calls is important and this could be undertaken within a healthcare team or referral process that allows for on-the-ground follow up, particularly for those people living far from a health service, or those unable to attend a clinic. However, if a call line were to be implemented across a number of services, access to health records or an escalation of service plan, may support better use of clinical expertise. Issues related to this approach would be privacy and access to patient health records, and this would have to be factored into planning. |
| | Nurses | |
| | Types de patients/clients | |
| | Patients with chronic diseases | <ul style="list-style-type: none"> Professionnels et organisationnels |
| Année de la revue | Interventions | <ul style="list-style-type: none"> Given that there are great differences in distances and level of services available in regions, the phone-based services need to be adapted across multiple interfaces, and in many cases the type of service provided is poorly understood by the consumers, their community and the health professionals who live and work in the area. |
| | After-hours telephone services | |
| 2020 | Comparaison (le cas échéant) | |
| Objectifs de la revue | N/A | |
| <p>This scoping review aimed to better understand existing models and current evidence of after-hours telephone services. This scoping review addressed the following questions:</p> <ul style="list-style-type: none"> What models of care are used to provide after-hours services to patients with chronic and complex conditions? Are there models of nurse-led after-hours care and are they effective? Are there any models or systems of after-hours care for patients with chronic and complex conditions that | | <ul style="list-style-type: none"> Économiques et financiers |
| | | Ø |
| | | <ul style="list-style-type: none"> Sociopolitiques et réglementaires |
| | | Ø |
| | Limites/Biais | Conclusions des auteurs et recommandations générales |
| | <ul style="list-style-type: none"> No paper discussed the problem of access to digital or telephone technology; the assumption given is that this is not a problem. | <p>This search sought answers to managing chronic and complex conditions across a diverse population group and geographical locations using nurse-led mobile telephone services. Whilst the search itself was rigorous, no definitive answer to the questions were found, except to suggest that models of care for after-hours telephone services needs to be uniquely developed for the population group it serves, inclusive of the geography of the region within which it is located, and the level of media/telecommunication available and understood. However, it is apparent that the provision of an after-hours telephone service, whatever model is used, should be considered within a framework of an evidence-based Chronic Care Model, with elements of each component well suited to the approach. In this way, after-hours telephone services provided by experienced nurses, supported by ongoing professional development and relevant protocols, form part of the ongoing improvement for chronic care management as a health priority.</p> |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|----------|--------------------------|
| address geographical isolation and are they effective? | | |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|---|---|
| 5) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| The Empirical Foundations of Telemedicine Interventions in Primary Care | Systematic review | <ul style="list-style-type: none"> 86 studies/publications included From 2005 to 2015 inclusive |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitateurs) |
| | Any | <ul style="list-style-type: none"> Patients were in favor of having access to their PCP over the Internet or telephone during off-hours, as well as when seeking advice on health problems, prescription renewals, and making appointments. Patients tended to adhere to health advice and coaching provided by nurses over the telephone as a substitute for in-person visits. Patients were satisfied with the convenience of e-visits and e-prescribing, and they equated e-consulting with in-person except for conditions that require physical examination, where they preferred in-person visits. Nurse-led telephone triage improved prompt follow-up for patients with appendicitis; also, nurse guidance over the telephone improved appropriate use of antibiotics for URIs. |
| | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) |
| Auteurs/Pays | | <ul style="list-style-type: none"> Technologiques |
| Bashshur et al. United States | Spécialité | <ul style="list-style-type: none"> Humains et cognitifs |
| | Primary care | <ul style="list-style-type: none"> Cliniques |
| | Types de professionnels | <ul style="list-style-type: none"> Professionnels et organisationnels |
| | Primary care physicians | |
| | Types de patients/clients | |
| | Primary care patients | |
| Année de la revue | Interventions | |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|--|--|
| | Telemedicine intervention | |
| 2016 | Comparaison (le cas échéant) | |
| Objectifs de la revue | N/A | |
| The main objective of this article, like the others, is to ascertain the evidence regarding the feasibility, acceptance, and effects of telemedicine interventions—in this case primary care. | Limites/Biais The majority of the articles were based on research done in the United States, but substantial numbers were based on research done in other countries. | <ul style="list-style-type: none"> Économiques et financiers |
| | | ∅ |
| | | <ul style="list-style-type: none"> Sociopolitiques et réglementaires |
| | | ∅ |
| | | Conclusions des auteurs et recommandations générales All things considered, there is ample evidence from rigorous scientific research that low-cost telemedicine interventions in primary care are feasible and acceptable to both patients and physicians, typically resulting in improved quality and cost savings. Future developments pointing to improved technological capabilities, more ubiquitous distribution, and declining price would ultimately lead to the inevitability of incorporating this modality of care in mainstream healthcare. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|--|--|
| 6) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| The Impact of COVID-19 on Telemedicine Utilization Across Multiple Service Lines in the United States | Systematic review | <ul style="list-style-type: none"> Nombre d'études : 44 studies included Période : Articles included were published between 2016 and 2020. |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitateurs) <ul style="list-style-type: none"> Telemedicine has been effective through risk mitigation, improved access, convenience, lower cost, and patient satisfaction, of which improved access and risk mitigation were the leading themes. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|--|--|
| | Dermatology, oncology, obstetrics/gynecology, and mental health. | <ul style="list-style-type: none"> A relaxation of licensure requirements, thereby allowing providers to practice across state lines, as well as with HIPAA regulations so devices including smartphones and tablets can be utilized for video conferencing within applications such as Zoom, FaceTime, and Google Hangouts Meet The leading indicators for telemedicine utilization expansion were efforts to increase access to patients, deploy social distancing measures, and attempt to mitigate the risks of exposure to other patients. By virtue of the telemedicine platform, patients were less encumbered by geographic distance, particularly those residing in rural areas, as well as physical limitations, and transportation concerns, thereby allowing them to engage their providers outside of the clinical space. In effect, this increased access enabled a dual track of social distancing allowance and risk mitigation that precluded concerns of having to avoid contact with other patrons in lobbies, hallways, exam rooms, restrooms, etc., where an exchange of microbes is commonplace. Telemedicine provides a more convenient method of care provision as patients can obtain services within the confines of their preferred location whether its their home, oce, car, etc. This reduces the burdens of travel time, missed work and/or school, and opportunity and monetary costs. Two of the more notable barriers to wide spread telemedicine adoption prior to COVID-19 dispersion were issues related to HIPAA compliance in the context of privacy concerns with secure communication lines and data sharing, burdensome regulations, interstate licensure requirements, and reimbursement disparities amongs tU.S. insurers who rendered payouts not on-parwith in-person visits. These obstacles were relaxed by CMS, DHHS, and public and commercial payers to accommodate a new care provision reality. Even though telemedicine was marginally utilized prior to the spread of COVID-19, additional training and education for patients and providers are necessary to adapt to changing protocols, assessment criteria, and basic understanding of telemedicine functionality. Healthcare providers realized the need to still provide critical services to their patient populations and understood telemedicine platforms were the perfect vehicles to rise to the occasion. A direct result of this expansion was the need to fully educate providers, clinical/administrative support staff, and patients in how to effectively utilize this new model of care provision. This included webinars and online tutorials, quick reference guides, phone consultations, and do-it-yourself learning. Patient satisfaction levels were not widely discussed in the literature, but there were indications they were generally satisfied with their telemedicine experience, provided they could connect with their providers in the virtual domain and achieve desirable outcomes from the encounters (n=4). While many patients prefer to be with their providers in-person for face-to-face encounters, and likewise from the provider perspective, telemedicine was viewed as a suitable replacement considering the present COVID-19 environment. |
| | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) |
| | | <ul style="list-style-type: none"> Technologiques |
| | | ∅ |
| Auteurs/Pays | | |
| Betancourt et al. | Spécialité | <ul style="list-style-type: none"> Humains et cognitifs |
| United States | Dermatology, oncology, obstetrics/gynecology, and mental health. | ∅ |
| | | <ul style="list-style-type: none"> Cliniques |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|--|---|
| | Types de professionnels | <ul style="list-style-type: none">From the four selected service lines of dermatology, mental health, OB/GYN (obstetrics and gynecology), and oncology, mental health has had the most documented outcomes with the use of telemedicine. This is due in large part because mental health is conversational in nature and the provision of care does not hinge upon in-person interactions. Each service line has found effective uses of telemedicine during the COVID-19 pandemic and, although there are still areas that will require in-person visits for testing, ultrasounds, physical exams, etc., telemedicine is demonstrating that many visits do not require physical attendance and has significantly reduced the total number of patients being seen at a healthcare facility. |
| | Healthcare providers | |
| | Types de patients/clients | <ul style="list-style-type: none">Professionnels et organisationnels |
| | Patients receiving care in dermatology, oncology, obstetrics/gynecology, and mental health. | |
| Année de la revue | Interventions | Ø |
| | Telehealth and telemedicine | |
| 2020 | Comparaison (le cas échéant) | |
| Objectifs de la revue | N/A | |
| This review strived to answer this specific question: "What impact has the current COVID-19 pandemic had on the provision of care through telemedicine across unique health service lines that include dermatology, oncology, obstetrics/gynecology, and mental health?" | <div>Limites/Biais</div> <ul style="list-style-type: none">Recent phenomenon of COVID-19 dramatically restricts research timeline and availability of pertinent articles due to novel, mercurial circumstances.With protective measures ebbing and flowing in real time in response to the changing tides of COVID-19s effects, healthcare services may reinstitute in-person services (i.e., elective surgeries, minor procedures, physical exams, etc.) or scale them back as conditions on the ground dictate in any given locality; these fluctuations, in turn, will | <ul style="list-style-type: none">Économiques et financiers |
| | | Ø |
| | | <ul style="list-style-type: none">Sociopolitiques et réglementaires |
| | | Ø |
| | | <div>Conclusions des auteurs et recommandations générales</div> <p>Telemedicine has had a transformative impact on the provision of care in the era of COVID-19. It is evident from the presented research that the service lines covered are demonstrating nimble and effective responses to the COVID-19 outbreak through workflow adaptations via telemedicine within their respective care provisions. While general obstacles were encountered, which encompassed a lack of reimbursement parity, telemedicine infrastructure capabilities, regulatory and HIPAA compliance guidelines, lack of internet connectivity, and patient/provider discomfort with technology, each developed the capacity to accelerate telemedicine adoption to adjust to the needs of their patient populations by marshaling resources, expertise, and access. It behooves legislative and industry leaders to re-examine the benefits of telemedicine to remove barriers to its application not just in times of public health crises, but also for normal and customary clinical practice.</p> |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|--|--------------------------|
| | <p>cause a see-saw effect of telemedicine utilization.</p> <ul style="list-style-type: none"> • Selection bias • Publication bias—our searches were narrowly conducted across only two databases and did not include any forms of grey Healthcare 2020, 19 of 21 literature • Due to the novel presentation of SARS-CoV-2, source material was generally in short supply as there was a dearth of peer-reviewed studies to inform our search results. | |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|---|--|
| 7) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| A systematic review of health service interventions to reduce use of unplanned health care in rural areas | Systematic review | <ul style="list-style-type: none"> • Nombre d'articles : 33 articles were included • Période : From 1984 to April 2014 |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitateurs) |
| | Minor injuries, Trauma, Post-hospitalization Care, Asthma | <p>Effectiveness of telehealth</p> <p>Outcomes from included studies</p> <ul style="list-style-type: none"> • On study on cancer <ul style="list-style-type: none"> ◦ Intervention : Telemedicine model for cancer care (teleoncology) in northern Queensland, Australia, compared with the usual model of care from the perspective of the Townsville and other participating hospital and health services <p>Outcomes :</p> <ul style="list-style-type: none"> ◦ No reduction or mixed changes in use of urgent care, no testing for statistical significance (10 patients were seen urgently and received urgent chemotherapy, thus avoiding transfer to regional centre) • One study on mental illness (any) <ul style="list-style-type: none"> ◦ Intervention : Video assessments of mental health conditions |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|-------------------------------------|--|
| | | <p>Outcomes :</p> <ul style="list-style-type: none"> No reduction or mixed changes in use of urgent care, no testing for statistical significance (The proportion of patients admitted to a hospital after emergency mental health assessment increased from 35% to 43% between 2008 and 2009 (χ^2 2df = 27.4, $P < .000$). Over the same time period 50 fewer patients were admitted to an MHIPU—a decline in the MHIPU referral rate from 73% and 52% of all admissions in 2008 and 2009, respectively (χ^2 2df = 72.8, $P < .000$)) One study on heart failure <ul style="list-style-type: none"> Intervention : Telehealth technologies and a heart failure nursing outreach programme. Phone calls and daily symptoms monitored by Cardiocom telescale for 90 days. <p>Outcomes :</p> <ul style="list-style-type: none"> Reported reductions in use of unplanned care but no test of statistical significance (Compared to U.S. 30-day readmission rate of 24.8% and study tertiary hospital rate of 21.2%, study subjects readmitted 51 (14.8%) for all-cause, 15 (4%) for unscheduled HF, and 2 (0.5%) deaths) |
| | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) |
| Auteurs/Pays | | <ul style="list-style-type: none"> Technologiques |
| Brainard et al. | Spécialité | <ul style="list-style-type: none"> Humains et cognitifs |
| United Kingdom | N/A | ∅ |
| | Types de professionnels | <ul style="list-style-type: none"> Cliniques |
| | Any | <ul style="list-style-type: none"> Targeting chronic illnesses management, telemedicine and community health clinics, may be effective at reducing emergency presentations. |
| | Types de patients/clients | |
| | Patients from rural communities | <ul style="list-style-type: none"> Professionnels et organisationnels |
| Année de la revue | Interventions | ∅ |
| | Telehealth | |
| 2015 | Comparaison (le cas échéant) | |
| Objectifs de la revue | Usual care | |
| | | <ul style="list-style-type: none"> Économiques et financiers |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|--|--|
| This review aimed to determine which, if any, health service interventions reduce use of unplanned health care by rural populations. | | <ul style="list-style-type: none"> Because of higher travel costs and travel distances to health care facilities, it seems likely that telemedicine will continue to be especially cost-effective in rural areas. |
| | | <ul style="list-style-type: none"> Sociopolitiques et réglementaires |
| | Limites/Biais | ∅ |
| | <ul style="list-style-type: none"> Some implemented interventions may never have been considered for publication Searched for under-evaluated and under-reported interventions in grey literature but found relatively few items. More studies should be rigorously reported and evaluated. Publication bias may also have impacted findings. | Conclusions des auteurs et recommandations générales <p>Our review on rural residents broadly concurs with other reviews on combined urban–rural populations that, targeting chronic illnesses management, telemedicine and community health clinics, may be effective at reducing emergency presentations. It is useful to establish that interventions that work well in combined urban– rural populations seem to also be effective in the rural subgroup alone. Telemedicine was most consistently reported as effective at reducing unplanned care use or expensive emergency transport, particularly when it brought specialist skills to remote locations. Because of higher travel costs and travel distances to health care facilities, it seems likely that telemedicine will continue to be especially cost-effective in rural areas.</p> |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|---|---|
| 8) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| Telephone consultations for general practice: a systematic review | Systematic review | <ul style="list-style-type: none"> Nombre d'études : 3 articles inclus Période : From inception to 2015 |
| | | Résultats (Outcomes incluant les barrières et facilitants) |
| | Contexte clinique | Consultation length |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|--------------------------------|--|
| | Any | <ul style="list-style-type: none"> One study found that there was a reduction in the time spent on consultation in the telephone group of 1.5 min (0.6 to 2.4). <p>Frequency of consultations</p> <ul style="list-style-type: none"> Secondary outcomes found that patients in the telephone consult group had 0.2 (0 to 0.3) more follow-up consultations than in the face-to-face group and were less likely to have blood pressure measured. Although telephone consultations led to an increase in the number of repeated visits, there was still a reduction in time spent with patients overall. One observational study estimated a 39% reduction in the number of patients requiring face-to-face consultation, this was based on the number of patients that received a face-to-face consultation after the telephone consultation and was not based on comparative estimates. <p>Appropriateness of the consultations</p> <ul style="list-style-type: none"> One study concluded that both patients and health care providers considered the telephone as an appropriate means of communication and an appropriate alternative to a face-to-face appointment or home visits. This study also suggested that telephone consultations may lead to a decrease in demand for face-to-face consultations. Overall the included studies demonstrated that telephone consultations provide an appropriate alternative to face-to-face consultations. One study indicated that these situations could encompass a broad spectrum of problems and listed, management of urinary tract infections in women, monitoring for depression; management of diabetes, counselling for smoking cessation, among others as having good evidence. The triage system may provide a further benefit in reducing work load in a general practice setting, as it will streamline the process and reduce the number of patients receiving a telephone consultation where a face-to-face consultation would have been more appropriate. However, this may not be the case when GPs conduct the triage as Campbell et al. concluded that the number of GP contacts per person is increased when GP triage was compared to usual care. <p>Satisfaction</p> <ul style="list-style-type: none"> Patient satisfaction with telephone consultations is dependent on ease of access to the GP and hence the patient-to-telephone line ratio of the practice is important. In general the included observational studies tended to agree with the higher level evidence showing a similar degree of patient satisfaction with GP telephone consults and strengthening the argument that the telephone consult was appropriate in certain situations. <p>Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen)</p> <ul style="list-style-type: none"> Technologiques <p>∅</p> |
| Auteurs/Pays | | |
| Downes et al. | Spécialité | <ul style="list-style-type: none"> Humains et cognitifs |
| Australia | Primary care | ∅ |
| | Types de professionnels | <ul style="list-style-type: none"> Cliniques |
| | General practitioners/GP | |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|--|--|
| | Types de patients/clients | <ul style="list-style-type: none"> The triage system may provide a further benefit in reducing work load in a general practice setting, as it will streamline the process and reduce the number of patients receiving a telephone consultation where a face-to-face consultation would have been more appropriate. Car and Sheikh indicate that these situations could encompass a broad spectrum of problems and listed, management of urinary tract infections in women, monitoring for depression; management of diabetes, counselling for smoking cessation, among others as having good evidence. |
| | Patients | <ul style="list-style-type: none"> Professionnels et organisationnels |
| Année de la revue | Interventions | Ø |
| | Telemedicine (Telephone) | |
| 2017 | Comparaison (le cas échéant) | |
| Objectifs de la revue | Normal care (face-to-face consultation) | <ul style="list-style-type: none"> Économiques et financiers |
| The aim of this study was to undertake a systematic review of the evidence on the use of telephone consultation as an alternative to general practice visits. | | Ø |
| | | <ul style="list-style-type: none"> Sociopolitiques et réglementaires |
| | Limites/Biais | Ø |
| | <ul style="list-style-type: none"> The searches only identified one randomized control trial that addressed the question and as such a meta-analysis of numerous studies was not possible, which may have added some weight to the results of the review. There were some lower level evidence studies that were identified that were in agreement with the identified randomized control trial. | Conclusions des auteurs et recommandations générales <p>Given the minimal research in telephone GP consultations as an alternative for face-to-face GP consultations, it is difficult to make conclusions on the effectiveness of such programmes, especially in a new setting like Australia. From this current evidence, it is likely that GP telephone consults offers an appropriate alternative in some settings. It is important that future research explores the potential for telephone consultations, incorporated with a triage model and the impact this has on service utilization and health outcomes.</p> |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|--|--|
| 9) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| Telemedicine in the OECD: An umbrella review of clinical and cost-effectiveness, patient experience and implementation | Systematic review | <ul style="list-style-type: none"> • Nombre d'études : 98 reviews were included in this umbrella review • Période : Between January 2014 and February 2019. |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitateurs) |
| | Any | <p>Effectiveness</p> <p>Cardiovascular disease</p> <ul style="list-style-type: none"> • Two reviews found that remote monitoring, and structured telephone support was superior to usual care in reducing the odds of mortality and hospitalization related to heart failure, improve survival rates and reduce cardiovascular disease risk factors such as weight, BMI and blood pressure. • Four reviews, including two high-quality reviews found no difference between remote monitoring with telephone support and face-to-face care to reduce planned hospital visits and to improve modifiable cardiovascular risk factors through cardiac rehabilitation. • One review produced mixed results and found that telemedicine delivered through structured telephone support reduced heart failure specific readmissions but not all cause mortality readmissions. Of the remaining two reviews, one concluded that telephone or remote monitoring interventions compared to nurse home visits had no significant improvement on readmission or mortality in heart failure patients, while the other found insufficient evidence that remote monitoring and counselling reduced overall cardiovascular disease risk • The remaining two reviews assessed the effectiveness of telemedicine in stroke management. • The first review investigated the safety and efficacy of treatment delivered through telestroke networks (real-time telemedicine) for patients with acute ischemic stroke compared to face-to-face care and concluded that telemedicine was safe and effective with no difference in mortality or functional independence between intervention and comparison groups. The second review concluded that telephone consultations used in the management of oral anticoagulation may lower the risk of major thromboembolic events, but not other clinically relevant outcomes. <p>Rehabilitation</p> <ul style="list-style-type: none"> • For musculoskeletal conditions, video and telephone consultations were effective in the improvement of physical function compared to conventional care. • In surgical populations, wireless monitored exercise, web-based support and telephone consultations were at least as clinically effective as face-to-face care, with greater improvements in quality of life compared to face-to-face care • For pain and disability, exercise monitoring, web-based programs and telephone consultations had no significant effect compared with usual care, but interventions that combined usual care and telemedicine were more effective than usual care alone. <p>Mental health</p> |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|----------|--|
| | | <ul style="list-style-type: none"> Ten reviews assessed the effectiveness of telemedicine interventions in mental health and behavioral conditions compared to usual care or no intervention. Nine studies concluded that telemedicine was at least as effective as face-to-face interventions, while one study was inconclusive. For maternal depression, remote monitoring, and telephone consultations were effective in improving maternal depression symptoms. <p>Physical activity and diet</p> <ul style="list-style-type: none"> Remote monitoring, video and telephone consultations could improve diet quality, as well as fruit, vegetable, and dietary sodium intake for people with chronic conditions and malnourished community dwelling older adults. <p>Respiratory disease</p> <ul style="list-style-type: none"> The first review concluded that mobile app-based remote monitoring interventions which facilitated professional support improved asthma control and exacerbation rates. The second review found no difference in asthma symptom scores between the intervention groups, (remote monitoring and telephone consults) and face-to-face care groups. <p>Other specialties</p> <ul style="list-style-type: none"> Remote monitoring, video and telephone consultations delivered by allied health professionals to patients in rural areas were at least as effective as face-to-face interventions. For glaucoma, tele-glaucoma via video consultations was more effective than face-to-face examinations in detecting glaucoma besides reducing waiting times, offering services to rural areas, and reducing travel. <p>Patient experience</p> <p>Acceptability</p> <ul style="list-style-type: none"> Six reviews addressed patient acceptability of telemedicine. All reviews found that telemedicine interventions were acceptable to patients. In primary care settings, remote monitoring and real-time telemedicine interventions are generally acceptable, however the level of acceptability varied by population demographics such as gender, age and socio-economic status. Furthermore, these interventions were more acceptable to patients than to health care providers. <p>Satisfaction</p> <ul style="list-style-type: none"> Cancer patients and survivors had a positive experience with remote monitoring and telephone consultations. They reported that interventions were convenient, acceptable, fostered independence and remote reassurance, reduced burden and provided the safety net of a professional health care connection. Telemedicine interventions including remote monitoring and real-time telemedicine improved social and emotional wellbeing of indigenous people receiving care in the community, improved patient outcomes and access to specialist services, and resulted in greater patient empowerment due to improved health literacy. <p>Feasibility</p> <ul style="list-style-type: none"> Feasibility includes clinical, organizational or technical factors determining the practicality of implementing telemedicine services. Remote monitoring and real time telemedicine was feasible in patients with neurological diseases, in primary care settings. Real-time and store-and-forward intervenitons were feasible in dentistry. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|---|---|
| | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) |
| | | <ul style="list-style-type: none"> Technologiques |
| Auteurs/Pays | | ∅ |
| Ezel et al. | Spécialité | <ul style="list-style-type: none"> Humains et cognitifs |
| United Kingdom | Any | <ul style="list-style-type: none"> Patients find interventions acceptable and report high satisfaction levels, although barriers to uptake and use, such as lack of training and usability problems remain. |
| | Types de professionnels | <ul style="list-style-type: none"> Cliniques |
| | Healthcare providers (physicians, nurses and others) | <ul style="list-style-type: none"> The provision of health care for sicker patients and those who live in rural areas is also relevant in the context of telemedicine. There is often a trade-off between efficiency and equity when delivering care to remote populations |
| | Types de patients/clients | |
| | Patients with diverse conditions | <ul style="list-style-type: none"> Professionnels et organisationnels |
| Année de la revue | Interventions | ∅ |
| | <ul style="list-style-type: none"> Télémédecine Real-time interventions use synchronous communication methods e.g. video and telephone consultations. | |
| 2020 | Comparaison (le cas échéant) | |
| Objectifs de la revue | Usual care | <ul style="list-style-type: none"> Économiques et financiers |
| | | ∅ |
| | | <ul style="list-style-type: none"> Sociopolitiques et réglementaires |
| | Limites/Biais | ∅ |
| | <ul style="list-style-type: none"> Synthesizing evidence from reviews, and relying on review author interpretations, some important details | Conclusions des auteurs et recommandations générales |
| | | <ul style="list-style-type: none"> That patients demonstrate high acceptability and satisfaction with telemedicine. Telemedicine affords patients convenience, and independence to manage their conditions at home or within their communities. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|---|---|
| | <p>that may have been included in primary studies was lost.</p> <ul style="list-style-type: none"> A small number of primary studies (5%) from non-OECD countries were included in reviews. The overall methodological quality of the included reviews was low. Publication bias was noted in some reviews, meaning that positive results on the effect of telemedicine were more likely to be published. Language bias may have been introduced by the exclusion of non-English language studies. Telemedicine is a rapidly evolving field, and although we attempted to include the most current review level evidence, many systematic reviews included much older primary studies. The inclusion of evidence from older primary studies may lead to conclusions regarding clinical and cost-effectiveness that are no longer timely. | <ul style="list-style-type: none"> The cost of devices and technological illiteracy may present a barrier to patient uptake of telemedicine especially in low-income populations and low resource settings. Other identified patient barriers to the wider use of telemedicine associated with high dropout rates and attrition are modifiable from the implementers perspective and include technical and usability challenges. This umbrella review also finds that telemedicine is feasible and identifies several factors that may affect its sustainability. Diverse and growing body of literature on telemedicine and provides a broad summary of the use of telemedicine within the OECD. Eighty-three percent (44/53) of effectiveness reviews found that telemedicine interventions were at least as effective as face-to-face care. In disease areas such as diabetes management, all included reviews found that telemedicine interventions were effective. Two (4%) of reviews found that telemedicine was ineffective compared to face-to-face care, and seven (13%) reviews were uncertain about the effect of telemedicine. Although most reviews found positive effects for the use of telemedicine, these findings should be interpreted cautiously, given heterogeneity across populations, interventions, settings and the overall low quality of included reviews. Telemedicine is comparable to face-to-face care across several disease and specialty areas. Patients find interventions acceptable and report high satisfaction levels, although barriers to uptake and use, such as lack of training and usability problems remain. The provision of health care for sicker patients and those who live in rural areas is also relevant in the context of telemedicine. There is often a trade-off between efficiency and equity when delivering care to remote populations. An unintended consequence of telemedicine is that it is likely to reach relatively healthier and tech savvy patients in urban areas, rather than sicker digitally excluded patients in rural areas. Again, policy oversight may be required to improve access to health care, and to ensure that telemedicine is inclusive in reaching those patients who already experience limitations in accessing conventional models of care. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
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| 10) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| | | <ul style="list-style-type: none"> Nombre d'études : 93 trials included |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|--------------------------|--|
| Interactive telemedicine: effects on professional practice and health care outcomes (Review) | Systematic review | <ul style="list-style-type: none"> Période : From inception to june 2013 |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitants) |
| | Any | <p><u>Effectiveness</u></p> <ul style="list-style-type: none"> The included studies recruited patients with the following clinical conditions: cardiovascular disease (36), diabetes (21), respiratory conditions (9), mental health or substance abuse conditions (7), conditions requiring a specialist consultation (6), co morbidities (3), urogenital conditions (3), neurological injuries and conditions (2), gastrointestinal conditions (2), neonatal conditions requiring specialist care (2), solid organ transplantation (1), and cancer (1). <p><u>Video-conferencing</u></p> <ul style="list-style-type: none"> Real-time videoconferencing was used in total in 36 of the included studies. Five studies recruited participants with heart failure, five studies participants with diabetes, seven studies participants requiring mental health services, two studies participants recovering from a stroke, of which one, was delivered with a combined virtual-reality rehabilitation application, two studies recruited participants with co-morbidities receiving home health care, six studies used TM to deliver a specialist consultation, two studies recruited participants after minor urological surgical procedure, and one, recruited participants with urinary incontinence, two studies recruited participants with non-acute neurological injuries and conditions, two studies recruited parents of neonates requiring specialist care, one study recruited participants recovering after solid organ transplantation. One study, which recruited participants with home parenteral nutrition, used videophones to deliver the intervention. <p><u>Effects of telemedicine (TM) targeting patients with mental disorders or substance abuse</u></p> <p><u>Effects of real-time videoconferencing versus usual care</u></p> <p><u>Clinical outcomes</u></p> <ul style="list-style-type: none"> No difference in the response to therapy delivered over videoconferencing as compared to face-to-face delivery (patients with mental disorders or substance abuse) (7 studies). <p><u>Effects of telemedicine interventions targeting patients with conditions requiring a specialist consultation</u></p> <p><u>i) Dermatological conditions</u></p> <ul style="list-style-type: none"> No difference in the duration of the initial appointment between video-consultation and face-to-face consultations, and a similar proportion of follow-up appointments after the index consultation in both groups (2 studies) Higher net societal costs for initial TM consultation than for face-to-face consultations (1 study) <p><u>ii) Acute injuries and conditions (patients visiting the ED)</u></p> <p><u>Mortality, morbidity and healthcare resource use</u></p> <ul style="list-style-type: none"> No difference between groups in mortality for patients with emergency neurosurgical conditions receiving video-consultation and those receiving telephone consultation at six months follow-up. The same study reported high failure rate for video-consultations (1 study) No difference between groups in mortality and functional outcomes at 90 days follow-up (patients with stroke). There was no difference in the use of intravenous thrombolysis (TM: 31/111 (28%); usual care: 25/111 (23%), OR 1.3, 95% CI 0.7 to 2.5, P = 0.43). There was more missing data in the usual care telephone group than in the TM group (12 % versus 3 %) (1 study) <p><u>iii) Non-acute conditions (outpatients visiting the GP)</u></p> |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|----------|--|
| | | <p>Quality of life, healthcare resource use and costs</p> <ul style="list-style-type: none"> No difference between joint tele-consultations and face-to-face consultations on QoL (2 studies) No differences in patient satisfaction or independence between groups at six months. (1 study) Greater proportion of intervention patients were offered a follow-up outpatient appointment (results from Loane 2000 with longer follow-up), and a greater number of tests and investigations were ordered for intervention patients as compared with control, while resource use in terms of additional in-and outpatients visits (contacts with GP, ED visits, number of inpatient stays, and number of day surgery and inpatient procedures) were similar. In addition, one study reported higher overall NHS costs at six months for the joint teleconsultations than for face-to-face outpatients consultations (the index consultation accounted for this excess), while the cost savings of patients were greater in the joint tele-consultation group (1 study) <p><u>Effects of telemedicine (TM) interventions targeting patients with gastrointestinal conditions</u></p> <ul style="list-style-type: none"> No difference in QoL or hospital anxiety and depression scores at six months when nurse video-phone consultations were used to provide care and support to patients with home parenteral nutrition, as compared to telephone support only (1 study). Disease activity, quality of life, and medication adherence did not differ between participants with ulcerative colitis receiving home tele management including monitoring and control group participants receiving 'best available care' at 12 months follow-up (1 study). <p><u>Effects of telemedicine interventions targeting patients with urological conditions</u></p> <ul style="list-style-type: none"> No difference in the effects of real-time videoconferencing as compared to face-to-face consultation on patient satisfaction, post-operative complication rates or in the length of hospital stay after minor urologic procedure (2 studies). No difference between rehabilitation delivered over videoconferencing and face-to-face in reducing the number of incontinence episodes for participants with urinary incontinence (1 study). <p><u>Effects of telemedicine (TM) interventions targeting patients with non-acute neurological injuries and conditions</u></p> <ul style="list-style-type: none"> Two studies reported on the effectiveness of real-time TM (videoconferencing, Home- Care Activity Desk) as compared to face-to-face rehabilitation training of participants with spinal cord injury; and participants with stroke, traumatic brain injury and Multiple Sclerosis. Improved arm/hand function in the Bologna part of the study, but no effects in the other two sites, and no effect on the ability of patients to perform daily tasks. No differences were reported for clinical complications or healthcare resource use (1 study). No differences in arm-hand function between groups (1 study). <p><i>Solid organ transplant recipients discharged from hospital</i></p> <ul style="list-style-type: none"> No difference between using videoconferencing to provide follow-up care and depression screening, as compared to care provided to face-to-face to participants discharged from hospital after solid organ |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
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| | | <p>transplantation, on infections, rejections and hospital admissions (6 month follow-up only), or on depression scores and hospital visits (1 study).</p> <p>Quality of life and patient satisfaction</p> <ul style="list-style-type: none"> No difference in general health status between TM and usual care (2 studies). No differences in patient satisfaction scores between groups, while one study reported increased satisfaction with TM care, compared with control (2 studies). Greater improvement in general mental health scores (assessed with SF-36) at six months ($P = 0.04$) in the TM group as compared with control, but no difference in the physical component scores or level of satisfaction in patients at high risk of hospital admission (1 study). No difference in general QoL, and increased satisfaction in the TM group at three and six months follow-up (participants with heart failure, chronic lung disease and diabetes) (1 study). <p>Healthcare resource use and costs</p> <ul style="list-style-type: none"> No difference in healthcare resource utilization between groups (2 studies). More patients receiving usual care being transferred to a higher level of care at six months as compared with TM group patients. This study also reported lower cost per visit in the video- and monitoring group (1 study). Greater decrease in the average healthcare costs per participant in the TM group (costs six months before the intervention compared to costs during the six-month intervention) (1 study). Lower total costs per abstinent participant for TM as compared with usual care, with the difference mostly pertaining to the travel costs of the therapist (1 study); Higher costs for TM, but no differences between groups when the therapists' travel costs had been accounted for (1 study). <p>Security</p> <p>Effects of telemedicine (TM) interventions targeting patients with co-morbidities receiving home care</p> <p>Effects of TM (all types) versus usual care</p> <p>Mortality</p> <ul style="list-style-type: none"> No difference in mortality between TM patients (patients with heart failure and COPD; videoconferencing and monitoring) and usual care, as compared to patients who received usual care only (1 study). <p>Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen)</p> <ul style="list-style-type: none"> Technologiques <p>Ø</p> |
| Auteurs/Pays | | |
| Flodgren et al. | Spécialité | <ul style="list-style-type: none"> Humains et cognitifs |
| United Kingdom | Any | <ul style="list-style-type: none"> Prior to establishing a TM service, an assessment of barriers may facilitate successful implementation. Providing training to both providers and patients in how to manage the equipment, and the development of user-friendly TM systems, may also improve implementation. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
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| | | |
| | | <ul style="list-style-type: none"> Cliniques |
| | Types de professionnels | <ul style="list-style-type: none"> The included studies recruited patients with the following clinical conditions: cardiovascular disease (36), diabetes (21), respiratory conditions (9), mental health or substance abuse conditions (7), conditions requiring a specialist consultation (6), co morbidities (3), urogenital conditions (3), neurological injuries and conditions (2), gastrointestinal conditions (2), neonatal conditions requiring specialist care (2), solid organ transplantation (1), and cancer (1). |
| | Any | |
| | Types de patients/clients | |
| | Any | |
| | | <ul style="list-style-type: none"> Professionnels et organisationnels |
| Année de la revue | Interventions | Ø |
| | Interactive telemedicine (telephone only interventions excluded) | |
| 2015 | Comparaison (le cas échéant) | |
| Objectifs de la revue | Usual care | |
| To assess the effectiveness, acceptability and costs of interactive TM as an alternative to, or in addition to, usual care (i.e. face-to-face care, or telephone consultation). | | <ul style="list-style-type: none"> Économiques et financiers |
| | | Ø |
| | | <ul style="list-style-type: none"> Sociopolitiques et réglementaires |
| | Limites/Biais | Ø |
| | Limited number of publications for each of the different conditions assessed. | Conclusions des auteurs et recommandations générales Implications for practice <ul style="list-style-type: none"> Telemedicine (TM) has the potential to be an effective tool for delivering more frequent and timely health care to people with chronic conditions at a distance, and for improving access to health care. While one aspect of successful implementation is the acceptability of TM by patients and practitioners, few studies included in the review directly assessed this. In addition, since only 10 of the included studies evaluated the effect of TM on practice related outcomes, it is not possible to draw any conclusions about how the use of TM may affect professional practice. A high refusal and drop-out rate in the TM group in three of the studies suggest that in some circumstances TM was not acceptable. Fourteen studies recruiting participants with heart failure reported no increase in hospital admissions associated with using TM as an alternative to usual care. However, few of the studies included in this review reported data on unintended consequences and further evidence is required from implementation studies. Prior to establishing a TM service, an assessment of barriers may facilitate successful implementation. Providing training to both providers and patients in how to manage the equipment, and the development of user-friendly TM systems, may also improve implementation. With the increasing ownership and use of |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
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| | | mobile technologies, such as mobile phones, Smartphones and ultraportable computers, these issues may become less important. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
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| 11) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| Use of telehealth for health care of Indigenous peoples with chronic conditions: a systematic review | Systematic review | <ul style="list-style-type: none"> Études incluses : 32 studies met the inclusion criteria Période : 2007 à 2017 |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitants) |
| | Chronic diseases Chronic conditions described in the included studies were: cancer; congestive heart failure; chronic obstructive pulmonary disease; type II diabetes; mental health conditions; otitis media; heart failure; diabetic retinopathy and injury. | <p>Effectiveness</p> <ul style="list-style-type: none"> The studies also suggested telehealth can be at least as good as face-to-face clinical care assessment, and may improve access to care. Unfortunately, as there were no comparative published studies on health outcomes it is difficult to prove equality or superiority. <p>Satisfaction</p> <ul style="list-style-type: none"> The studies reported Indigenous peoples tend to be satisfied with the use of telehealth particularly as it can address the barriers associated with living remotely and away from specialized care. However some studies reported Indigenous people having reservations about the information and communication technologies including concerns about privacy and confidentiality³⁰ and feeling generally uncomfortable. <p>Feasibility</p> <ul style="list-style-type: none"> For the studies reported by health services, telehealth was feasible in terms of health care and service delivery, and healthcare professionals were somewhat satisfied with using telehealth; however, they found difficulties with information and communication technologies a consistent barrier. Telehealth appears to be feasible for health services in terms of healthcare delivery, and healthcare professionals have mostly positive views of using telehealth. Results indicated improvements in client involvement with health services. Comparative and interventional studies to assess clinical service feasibility of telehealth showed that, for diagnosis reliability, face-to-face compared with real-time videoconferencing for mental health diagnosis <p>Security</p> <ul style="list-style-type: none"> The results indicated that telehealth may improve morbidity and QOL and reduce mortality <p>Acceptability of telehealth by Indigenous peoples</p> <ul style="list-style-type: none"> In particular, Indigenous peoples liked reduced travel costs. Facilitators to acceptance of telehealth revolved mostly around healthcare professional cultural competence and information and communication technologies capability. Indigenous clients described preferring face-to-face contact because of loss of connection and relationship with the healthcare |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|----------------------------------|--|
| | | <p>professional. An initial face-to-face meeting was thought to facilitate acceptance of telehealth, especially for mental health assessments.</p> <ul style="list-style-type: none"> Client–healthcare professional relationships, linked strongly to trust and rapport, were a recurring theme across these studies. In one study examining the use of real-time videoconferencing for management of type two diabetes mellitus, a downfall of telehealth was described by its inability to enable good relationships. A study that explored acceptability of telehealth for mental health management using real-time videoconferencing highlighted a lack of culturally competent healthcare professionals and systems as key deterrents to the use of telehealth. Conversely, some participants reported greater continuity and access to mental health services, reduced travel time, and increased comfort in disclosure through telehealth. <p>Acceptability of telehealth by healthcare Professionals</p> <ul style="list-style-type: none"> All studies reported mostly positive views of telehealth (videoconferencing) as a modality for the delivery of chronic condition management. Acceptance of telehealth appeared to be facilitated by two main themes: knowledge of and access to reliable information and communication technologies, and specific cultural factors including. Indigenous healthcare professionals and using traditional practices. Reported acceptance was based upon different aspects of care provision, for example good quality care, time-saving and enhanced collaborative care. Culturally competent healthcare professionals and health service delivery may facilitate culturally acceptable telehealth. Although reporting overall positive satisfaction, a small study based in Canada that surveyed healthcare professionals and interviewed five found that real-time videoconferencing was not appropriate for specific mental health conditions and limited the ability of healthcare professionals to intervene. When language barriers, inability to form trusting relationships, cultural factors and discomfort with information and communication technologies are barriers to delivery and receiving effective health care, other modalities must be implemented. Two studies focused on different aspects and perspectives of telehealth suggested that initial consults must be face-to-face in order for relationship development. <p>Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen)</p> <ul style="list-style-type: none"> Technologiques <p>∅</p> |
| Auteurs/Pays | | |
| Fraser et al. | Spécialité | <ul style="list-style-type: none"> Humains et cognitifs |
| Australia | N/A | ∅ |
| | Types de professionnels | <ul style="list-style-type: none"> Cliniques |
| | Any healthcare professionals | <ul style="list-style-type: none"> The results indicated that telehealth may improve morbidity and QOL and reduce mortality. Two studies focused on different aspects and perspectives of telehealth suggested that initial consults must be face-to-face in order for relationship development. |
| | Types de patients/clients | |
| | Indigenous people | <ul style="list-style-type: none"> Professionnels et organisationnels |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|---|---|
| | For the included studies, the Indigenous peoples of the countries Australia, North America, New Zealand and the Pacific Islands are referred to as Aboriginal and Torres Strait Islanders; First Nations, American Indian, Alaska Native and Hawaiian; Maori; and Islanders, respectively. | |
| Année de la revue | Interventions | Ø |
| | Real-time video-conferencing | |
| 2017 | Comparaison (le cas échéant) | |
| Objectifs de la revue | N/A | <ul style="list-style-type: none"> Économiques et financiers |
| This review is a systematic meta-synthesis to describe the effectiveness of telehealth for the care of Indigenous peoples with chronic conditions. | | Ø |
| | Limites/Biais | <ul style="list-style-type: none"> Sociopolitiques et réglementaires |
| | <ul style="list-style-type: none"> Ambiguity exists regarding a precise definition of both culturally competent care and the holistic management of chronic conditions. Although every effort was made through our comprehensive systematic search approach to identify all relevant research available, some studies may not have been identified. | Conclusions des auteurs et recommandations générales <ul style="list-style-type: none"> Telehealth is a multifaceted concept involving all aspects of the health system. Its implementation and use as a modality to health care is complex and it is experienced differently on all accounts by services, healthcare professionals and end users. In addition, the use of telehealth with Indigenous peoples raises important consideration of cultural appropriateness and acceptability. This review highlights that telehealth is being used across the world to manage a wide variety of chronic conditions experienced disproportionately by Indigenous peoples, but lacks conclusive evidence as to its overall effectiveness, acceptability and feasibility. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
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| 12) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| Effectiveness of interventions utilising telephone follow up in reducing hospital readmission within 30 days for individuals with chronic disease: a systematic review | Systematic review | <ul style="list-style-type: none"> Nombre d'études: 10 articles included Période: From database inception to 19th May 2015. |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitateurs) |
| | Cardiovascular disease, chronic respiratory disease and diabetes. post-discharge | Effectiveness <ul style="list-style-type: none"> Effectiveness of a heart failure TFU case management intervention delivered by nurses combined with the provision of post-discharge printed education pamphlets and consultation with physicians in community hospitals on the US Mexico border (1 study). Nurses used a decision support software program when telephoning intervention patients and conducted a mean of 10.5 calls per patient starting 5 days post-discharge. The program provided guidance to the nurse about decisions related to patient medication adherence, diet, signs and symptoms of worsening illness, and determined the frequency of calls. There was no effect of the intervention on all-cause (8.7 % vs 13.8 %; P = 0.42) and heart failure readmissions at one month post-discharge (15.9 % vs 20.0 %; P = 0.65). Effectiveness of a daily teleconsultation by video with a nurse for five to nine days after discharge amongst COPD patients compared to patients receiving usual care (2 studies). Nurses made clinical observations, measured oxygen saturation levels and lung function, and informed patients how to prevent exacerbations and how to use their medication. The nurses made one TFU call one week after the teleconsultations however no call detail was reported. Neither study reported a significant difference in mean total readmissions or COPD readmissions between intervention and control groups. |
| | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) |
| | | <ul style="list-style-type: none"> Technologiques |
| Auteurs/Pays | | ∅ |
| Jayakody et al. | Spécialité | <ul style="list-style-type: none"> Humains et cognitifs |
| Australia | Any | ∅ |
| | Types de professionnels | <ul style="list-style-type: none"> Cliniques |
| | Health providers Resident doctors, nurses, trained volunteers who were university students pursuing a premedical track | <ul style="list-style-type: none"> Of the ten intervention studies which met the EPOC research design criteria, five were effective in reducing readmissions within 30 days (patients with cardiovascular disease, chronic respiratory disease and diabetes). |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|--------------------------------|---|
| | Types de patients/clients | |
| | Patients with chronic diseases | <ul style="list-style-type: none">• Professionnels et organisationnels |
| Année de la revue | Interventions | Ø |
| | Telephone follow up | |
| 2016 | Comparaison (le cas échéant) | |
| Objectifs de la revue | Standard care | |
| The aim of this review is to assess the methodological quality and effectiveness of interventions using TFU in reducing readmission within 30 days amongst patients with cardiovascular disease, chronic respiratory disease and diabetes. | | <ul style="list-style-type: none">• Économiques et financiers |
| | | Ø |
| | | <ul style="list-style-type: none">• Sociopolitiques et réglementaires |
| | Limites/Biais | Ø |
| | | <ul style="list-style-type: none">• The methodological quality of studies was poor.• Most had similar limitations, which weakens the overall strength of evidence.• Lack of uniformity in how readmission was measured which highlights the need for consistency and precision in the measurements used in studies aiming to reduce readmission.• Most studies were single site interventions and thus findings may have limited generalisability.• Wide variation in standard care provided to control groups.• Some studies included very little information on what constituted standard care. This made it difficult to interpret study results in relation to the circumstances under which the |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|--|--------------------------|
| | <p>interventions were likely to be effective or ineffective.</p> <ul style="list-style-type: none"> All identified studies combined TFU with other intervention components. The outcomes of TFU may be masked by many factors such as individual professional and patient actions and behaviour, social interactions and environmental settings. | |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|--|---|
| 13) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| Effect of Telehealth Interventions on Hospitalization Indicators: A Systematic Review | Systematic review | <ul style="list-style-type: none"> Études incluses : 22 existing studies Période : From January 2005 to November 2013. |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitateurs) |
| | Any | <p>Outcomes presented for each study :</p> <p>1) Wakefield et al.</p> <p>Intervention :</p> <ol style="list-style-type: none"> Telephone (R) Patient station consisting of television monitor and video camera kit with a microphone (R) Combined tools (R) <ul style="list-style-type: none"> Follow-up in Months 12 <p>Statistically Significant Outcomes</p> <p>Hospitalization</p> <ul style="list-style-type: none"> Intervention 3 : Combined tools: all-cause of hospitalization significantly decreased <p>Length of Stay</p> |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|----------|---|
| | | <ul style="list-style-type: none"> • None <p>2) <u>Morguet et al.</u> Intervention :</p> <ul style="list-style-type: none"> • Telephone and the telemonitoring equipment (R) • Follow-up in Months 11 <p><i>Statistically Significant Outcomes</i> Hospitalization</p> <ul style="list-style-type: none"> • All-cause of hospitalization significantly decreased • Other : Hospitalization for noncardiac reasons significantly decreased <p>Length of Stay</p> <ul style="list-style-type: none"> • Length of stay for all-cause significantly decreased • Other : Length of stay for cardiac reasons significantly decreased <p>3) <u>Bowles et al.</u> Intervention :</p> <ol style="list-style-type: none"> 1. Telephone (R) 2. Physiological monitor equipped with a blood pressure cuff, body weight scale, glucometer, pulse oximeter, digital stethoscope, and videoconferencing devices (R) <ul style="list-style-type: none"> • Follow-up in Months 2 <p><i>Statistically Significant Outcomes</i> Hospitalization</p> <ul style="list-style-type: none"> • None <p>Length of Stay</p> <ul style="list-style-type: none"> • None <p>4) <u>Steventon et al.</u> Intervention :</p> <ul style="list-style-type: none"> • Telephone (R) • Follow-up in Months 12 <p><i>Statistically Significant Outcomes</i> Hospitalization</p> <ul style="list-style-type: none"> • None <p>Length of Stay</p> <ul style="list-style-type: none"> • None <p>5) <u>Ferrante et al.</u></p> |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|----------|---|
| | | <p>Intervention :</p> <ul style="list-style-type: none"> • Telephone (R) • Follow-up in Months 12-48 <p>Statistically Significant Outcomes</p> <p>Hospitalization</p> <ul style="list-style-type: none"> • Hospitalization for heart failure significantly decreased <p>Length of Stay</p> <ul style="list-style-type: none"> • None <p>6) <u>Jia et al.</u></p> <p>Intervention :</p> <ul style="list-style-type: none"> • Home telehealth device (messaging device) and telephone • Follow-up in Months 48 <p>Statistically Significant Outcomes</p> <p>Hospitalization</p> <ul style="list-style-type: none"> • None <p>Length of Stay</p> <ul style="list-style-type: none"> • None <p>7) <u>Chen et al.</u></p> <p>Intervention :</p> <ul style="list-style-type: none"> • Telephone (R) • Follow-up in Months 6 <p>Statistically Significant Outcomes</p> <p>Hospitalization</p> <ul style="list-style-type: none"> • All-cause hospitalization significant decreased. • Hospitalization for Heart failure, significant decreased. <p>Length of Stay</p> <ul style="list-style-type: none"> • All-cause length of stay significantly decreased • Length of stay for heart failure significantly decrease. <p>8) <u>Weintraub et al.</u></p> <p>Intervention :</p> <ul style="list-style-type: none"> • Telemeasurement devices and an interactive communication device (A) • Follow-up in Months 3 <p>Statistically Significant Outcomes</p> <p>Hospitalization</p> |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|----------|---|
| | | <ul style="list-style-type: none"> • None <p>Length of Stay</p> <ul style="list-style-type: none"> • None <p>9) Schofield et al.</p> <p>Intervention :</p> <ul style="list-style-type: none"> • In-home messaging device, a secure Internet site, and telephone (R) • Follow-up in Months 6 <p>Statistically Significant Outcomes</p> <p>Hospitalization</p> <ul style="list-style-type: none"> • All-cause hospitalization significantly decreased <p>Length of Stay</p> <ul style="list-style-type: none"> • All-cause length of stay significantly decreased <p>10) Cleland et al.</p> <p>Intervention :</p> <ol style="list-style-type: none"> 1. Telephone (A, R) 2. An electronic weighing scale, an automated sphygmomanometer, single-lead electrocardiogram using wristband electrodes, all communicated to a hub connected to patient's phone line and central web server and then workstations via secure Internet connection (A, R) <ul style="list-style-type: none"> • Follow-up in Months 8 <p>Statistically Significant Outcomes</p> <p>Hospitalization</p> <ul style="list-style-type: none"> • None <p>Length of Stay</p> <ul style="list-style-type: none"> • None <p>11) Dansky et al.</p> <p>Intervention :</p> <ul style="list-style-type: none"> • Tele-home-care system: telephone-based communication system with medical peripherals (A, R) • Follow-up in Months 2, 4 <p>Statistically Significant Outcomes</p> <p>Hospitalization</p> <ul style="list-style-type: none"> • At 2 months: hospitalization significantly decreased. (not significant at 4 months) <p>Length of Stay</p> <ul style="list-style-type: none"> • None |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|--------------------------------------|--|
| | | <p>Synthesis:</p> <ul style="list-style-type: none"> About 60 percent of the interventions reported no significant effect on the hospitalization rate, and a significant decrease was observed in only 40 percent of the interventions. Length of stay, no significant effect was reported in 64 percent of the studies, and a significant decrease was observed in 36 percent of the studies. |
| | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) |
| | | <ul style="list-style-type: none"> Technologiques |
| | | Ø |
| Auteurs/Pays | | |
| Kalankesh et al. | Spécialité | <ul style="list-style-type: none"> Humains et cognitifs |
| Iran | Any | Ø |
| | Types de professionnels | <ul style="list-style-type: none"> Cliniques |
| | Any | Ø |
| | Types de patients/clients | |
| | Any | <ul style="list-style-type: none"> Professionnels et organisationnels |
| Année de la revue | Interventions | Ø |
| | Any type of telehealth interventions | |
| 2016 | Comparaison (le cas échéant) | |
| Objectifs de la revue | Usual face-to-face care | |
| | | <ul style="list-style-type: none"> Économiques et financiers |
| | | Ø |
| | | <ul style="list-style-type: none"> Sociopolitiques et réglementaires |
| | Limites/Biais | Ø |
| This article presents the reported evidence on the effect of telehealth and the characteristics of those reports. The intention of this article is not to assess or pass | | Conclusions des auteurs et recommandations générales |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--------------------------------------|---|---|
| judgment on the value of telehealth. | The conflicting effects observed in telehealth studies could arise from factors other than the intervention itself. | This systematic review reveals conflicting effects of the telehealth interventions on hospitalization rates in different studies. About 60 percent of the interventions reported no significant effect on the hospitalization rate, and a significant decrease was observed in only 40 percent of the interventions. Although these findings are consistent with the findings of different reviews reporting the weak effect of telehealth on some aspects of healthcare and healthcare delivery, they are contrary to other evidence reporting the positive effect of telehealth in different domains of healthcare. In terms of the effect of telehealth on length of stay , no significant effect was reported in 64 percent of the studies, and a significant decrease was observed in 36 percent of the studies. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|--|---|
| 14) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| Telehealth and patient satisfaction: a systematic review and narrative analysis | Systematic review | <ul style="list-style-type: none"> Études incluses : 44 studies included Période : From 2010-2017 |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitants) |
| | Any | Impact on outcomes : Improved outcomes 24/44 studies Preferred modality 12/44 studies Ease of use 11/44 studies Low cost or cost savings 9/44 studies Improved communication 9/44 studies Travel time 8/44 studies Improved self-management 7/44 studies Quality 5/44 studies Increased access 4/44 studies Increased self-awareness 4/44 studies Decreased wait times 4/44 studies Fewer miles driven 4/44 studies Decreased in-person visits 3/44 studies Improved self-efficacy 3/44 studies Good modality for education 3/44 studies Low time to manage 3/44 studies |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|----------------------------------|--|
| | | <p>Improved medication adherence 3/44 studies Decreased readmissions 2/44 studies Fewer missed appointments 1/44 studies</p> <p>Effectiveness</p> <ul style="list-style-type: none"> Providers and patients should embrace telehealth modalities because of : <ul style="list-style-type: none"> Ease of use (10 studies) Tendency to improve outcomes (24 studies) and communication (9 studies) Low cost.(9 studies) Decrease travel time (8 studies) and increase communication with providers. Provide a high-quality service, increase access to care,(4 studies) Increase self-awareness (4 studies) Item powers patients to manage their chronic conditions (7 studies) Healthcare organisations should embrace telehealth because it: <ul style="list-style-type: none"> Decreases missed appointments (1 study) Is a good modality for education (3 study) Decreases wait times (4 studies) Decreases readmissions (2 studies) Improves medication adherence (3 studies) Policymakers need to help legislation catch up with the technology by enabling additional means of reimbursement for telehealth because the modality improves outcomes (24 studies) which improves public health. <p>Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen)</p> <ul style="list-style-type: none"> Technologiques |
| Auteurs/Pays | | Ø |
| Scott Kruse et al. | Spécialité | <ul style="list-style-type: none"> Humains et cognitifs |
| United States | Any | <ul style="list-style-type: none"> As telehealth continues to be developed, special care should be given to incorporate features that enable acceptance and reimbursement of this modality. |
| | Types de professionnels | Ø |
| | Any | |
| | Types de patients/clients | |
| | Any | <ul style="list-style-type: none"> Professionnels et organisationnels |
| Année de la revue | Interventions | Ø |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|---|---|
| | Telehealth | |
| 2017 | Comparaison (le cas échéant) | |
| Objectifs de la revue | N/A | |
| This review had multiple research questions. R1: Is there an association of telehealth with patient satisfaction? R2: Are there common facilitators of either efficiency or effectiveness mentioned in the literature that would provide a positive or negative association between telehealth and patient satisfaction? | Limites/Biais <ul style="list-style-type: none"> This study included both asynchronous and synchronous interventions with all ages. Selection bias is possible within this study; however, the group consensus methods will have mitigated against this risk. Publication bias is another risk, particularly as they did not extend their search to the grey literature. Limiting the search to only two databases could easily have omitted valid articles for our review. The final limitation identified was the young age of the telehealth modality of care. | <ul style="list-style-type: none"> Économiques et financiers |
| | | ∅ |
| | | <ul style="list-style-type: none"> Sociopolitiques et réglementaires |
| | | ∅ |
| | | Conclusions des auteurs et recommandations générales <p>Overall, it was found that patient satisfaction can be associated with the modality of telehealth, but factors of effectiveness and efficiency are mixed. We found that patients' expectations were met when providers delivered healthcare via videoconference or any other telehealth method. Telehealth is a feasible option for providers who want to expand their practices to remote areas without having to relocate or expand their footprint of their practice. As telehealth continues to be developed, special care should be given to incorporate features that enable acceptance and reimbursement of this modality.</p> |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|--|--|
| 15) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| Application of Ethics for Providing Telemedicine Services and Information Technology | Review | <ul style="list-style-type: none"> • Nombre d'études : 36 included studies • Période : 2012 to 2017 |
| | Contexte clinique | <p>Résultats (Outcomes incluant les barrières et facilitateurs)</p> <p>Security</p> <ul style="list-style-type: none"> • Some other ethical problem has to do with the security of medical devices, formerly controlled by the "National Health Services" (NHS) and now under the supervision of the "European Union Directives" (n=1). Tele-consultation is a main ethical challenge in telemedicine. <p>That is due to the fact that:</p> <ul style="list-style-type: none"> • Doctors are required to be highly competent in service provision. • Doctors are supposed to recognize the value of virtual communications. • Computer systems are yet unsafe even if they are supposedly privileged with high security. • Tele-consultation provides a full access for all to new information and skills. • Telemedicine is growing rapidly with new relevant standards (n=1). <p>ETHICS AND DOCTOR-PATIENT RELATIONSHIP (the main ethical issue)</p> <p>The ethical rule set by the ethicist Edmund Pellegrino attributes three components to doctor-patient relationship (n=1):</p> <ul style="list-style-type: none"> • A patient who is sick and needs help. • A doctor who feels responsible for helping the patient. • Medical action/application of medical science. <p>Here, the patient is supposed to voluntarily refer to a doctor whom s/he trusts. Processing the decision making is supposed to be a mutual act which requires both doctor's and patient's decision. On the other hand, the doctor is expected to respect the patient's decisions and independence. As a consequence, both the doctor and patient are mutually communicating to think of the right therapy (n=1). Edmund Pellegrino's ethical rule narrows down the doctor-patient relationship (n=1):</p> <ul style="list-style-type: none"> • Patient's respect for doctor's comments. • Doctor's respect for patient's choice of therapy. • Use of telemedicine device cuts down on this relationship. besides, to abide by ethical rules, the doctor is expected to obtain patient's informed consent. <p>ETHICS AND SECURITY AND CONFIDENTIALITY</p> <p>Using telemedicine services threatens patient's information security and confidentiality. According to the General Medical Council (GMC), clinical specialists need to make sure of the confidentiality of patient's electronic data while receiving, storing and transferring the data. They should feel responsible for the security and confidentiality of electronic data. Newton et al. observed that the foremost concern patients have about receiving telemedicine</p> |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|--|---|
| | | <p>services is with the confidentiality of the information they provide. To remove the concern just mentioned, NHS has published a guideline for the Trust Committee so as to meet legal and ethical expectations (n=1).</p> <p><u>ETHICS, TELEMEDICINE AND JUSTICE</u></p> <p>Some other ethical issue arises when:</p> <ul style="list-style-type: none"> • Several families are deprived of telemedicine services due to lacking knowledge or the required technology (the net) which has to do with the justice and equality aspect (n=1). <p>There are several countries with very limited internet band width to use the net (n=1).</p> <p>Several other countries cannot afford to buy telemedicine equipment due to its high cost or they may lack the required number of specialists in this domain (n=1).</p> <p><u>ETHICS AND PATIENT'S INFORMED CONSENT</u></p> <p>One solution to prevent ethical problems is to obtain patient's informed consent in advance to any medical step to be taken. The basic components of this informed consent are (n=1):</p> <ul style="list-style-type: none"> • a full description of the therapy procedures, • a full description of the probable problems after the therapy and the probable risks, • a full description of the positive issues expected, • clarification of alternative processes that can be applied for that certain patient, • a demand that can be responsive to the emergence of any problem, • a procedure that can be canceled by the patient upon choice. |
| Auteurs/Pays Langarizadeh et al. Iran | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) |
| | | <ul style="list-style-type: none"> • Technologiques |
| | Spécialité | <ul style="list-style-type: none"> • Humains et cognitifs |
| | Any | |
| | Types de professionnels | <ul style="list-style-type: none"> • Cliniques |
| | Any | |
| | Types de patients/clients | |
| | Any | <ul style="list-style-type: none"> • Professionnels et organisationnels |
| Année de la revue | Interventions | |
| | Telemedicine Services and Information Technology | |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|---|---|
| 2017 | Comparaison (le cas échéant) | <ul style="list-style-type: none"> Économiques et financiers Sociopolitiques et réglementaires There is a need for setting certain guidelines and standards which make the therapist responsible for what s/he does |
| Objectifs de la revue | N/A | |
| The goal of this review is gathering all articles that are published through 5 years until now (2012-2017) for detecting ethical issues for providing telemedicine services and Information technology. | Limites/Biais | |
| | The End of this study is to gather all articles that are published through 5 years until now (2012-2017) for searching ethical issues for providing telemedicine services and Information Technology. This time was chosen for telemedicine and technology improvement through these years. | |
| | | Conclusions des auteurs et recommandations générales Basically, in many countries the quality of telemedicine services is of a great significance. Therefore, in order to raise the quality of these services by therapists and specialists, there is a need for setting certain guidelines and standards which make the therapist responsible for what s/he does. These all help patients to get ensured of the quality of telemedicine services |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|--|--|
| 16) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| The Use of Video Conferencing for Persons with Chronic Conditions: A Systematic Review | Systematic review | <ul style="list-style-type: none"> Études incluses : A total of 27 articles were included in this review Période : The literature search began on 5/1/2015 and concluded on 7/16/2015. |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitateurs) <u>Effectiveness</u> |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|--------------------|--|
| | Chronic conditions | <ul style="list-style-type: none"> • Videoconferencing has been used in many different areas of healthcare and has been generally successful in improving patient outcomes. The types of chronic illness that researchers evaluated using VC included: <ul style="list-style-type: none"> ○ mental health issues (n = 11) ○ neurological (n = 6) ○ long term care patients (n = 2) ○ oncology (n = 2) ○ rehabilitation (n = 2) ○ obesity (n = 1) ○ angina/heart failure (n = 1) ○ diabetes (n = 1) ○ Human Immunodeficiency Virus (n = 1). • Video Conferencing was shown to be feasible, result in positive patient experiences, improve outcomes, decrease hospital days, be similar to in-person care, decrease cost, and improve caregiver quality of life(n=25). Two studies found VC to be less efficient or potentially not feasible in certain populations (n = 2). • The studies that found VC to be ineffective attributed the lack of efficacy to the age of the participants, technical difficulty, or a desire to have in-person sessions. A study of real-time web-based monitoring on two patients recovering from strokes was done to help improve their walking ability. One individual strongly favored the technology and the other strongly opposed it due to wanting the primary therapist in person at all times. A study on in-home video conferencing for geriatric rehabilitation was not successful for a variety of reasons including vision and hearing impairment, client anxiety and stress, dementia, cluttered home environment and in-home assistance being needed to operate the equipment and the need to remain with the patient due to high risk for falls. The authors of this study recommended use of video conferencing in a geriatric population that is higher functioning with fewer co-morbidities. <p>Mental Health</p> <ul style="list-style-type: none"> • Most of the literature on use of VC is related to mental health and neurological disorders. Ten different studies report the use of VC in the care of patients and families with dementia, neurodegenerative disorders, and mental health issues. Most of these studies had positive results, including being more cost effective and time efficient for both the healthcare provider and patient. However, one study had mixed results. <p>Lifestyle Modification</p> <ul style="list-style-type: none"> • Some success has been reported with VC for group and lifestyle intervention programs aimed at preventing diabetes (n=1), improving obesity (n=1), and healthy relationship habits (n=1). <p>Oncology</p> <ul style="list-style-type: none"> • Oncology patients have also experienced benefits with use of VC. <p>Follow-Up Care</p> <p>Video conferencing has also been used in older populations for follow-up care for common chronic conditions and acute exacerbations of chronic conditions. Video conferencing was also an effective model of care for residents of long-term care facilities to enhance medical decision making for unscheduled conferencing with on call-physicians (n=1) and to facilitate consultation with specialty care (n=1).</p> |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|-------------------------------------|---|
| | | Feasibility Mental Health Diagnosis & Assessment <ul style="list-style-type: none"> • Diagnosis and assessment related to mental health and neurological disorders is possible using VC. While the in-person administered training showed better improvements in self-efficacy and in problem-solving, the diagnosis of dementia using VC was feasible, effective and there were no differences in other measures. Thus, a combination of in-person and VC training for patients with ABI may be beneficial. Mental Health Treatment <ul style="list-style-type: none"> • Treatment of mental health and neurological disorders for both patients and caregivers can be delivered through or assisted by VC. |
| Auteurs/Pays | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) <ul style="list-style-type: none"> • Technologiques |
| Mallow et al. | Spécialité | <ul style="list-style-type: none"> • Humains et cognitifs |
| United States | N/A | <ul style="list-style-type: none"> • The studies that found VC to be ineffective attributed the lack of efficacy to the age of the participants, technical difficulty, or a desire to have in-person sessions. |
| | Types de professionnels | <ul style="list-style-type: none"> • Cliniques |
| | Any | <ul style="list-style-type: none"> • Diagnosis and assessment related to mental health and neurological disorders is possible using VC. Treatment of mental health and neurological disorders for both patients and caregivers can be delivered through or assisted by VC |
| | Types de patients/clients | <ul style="list-style-type: none"> • Video conferencing has also been used in older populations for follow-up care for common chronic conditions and acute exacerbations of chronic conditions. Video conferencing was also an effective model of care for residents of long-term care facilities to enhance medical decision making for unscheduled conferencing with on call-physicians (n=1) and to facilitate consultation with specialty care |
| | Patients with chronic conditions | <ul style="list-style-type: none"> • A combination of in-person and VC training for patients with ABI may be beneficial. |
| Année de la revue | Interventions | <ul style="list-style-type: none"> • Professionnels et organisationnels |
| | Video conferencing | |
| 2016 | Comparaison (le cas échéant) | |
| Objectifs de la revue | None | |
| | | <ul style="list-style-type: none"> • Économiques et financiers |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|---|--|
| The purpose of this paper is to present a systematic review of studies that used Video Conferencing intervention for common chronic conditions. | | ∅ |
| | | <ul style="list-style-type: none"> Sociopolitiques et réglementaires |
| | Limites/Biais | ∅ |
| | <ul style="list-style-type: none"> Publication bias is a potential issue with this review. This systematic review also contains clinical and methodological heterogeneity across studies. The types of participants, intervention and outcomes differ in each study and variability in study design occurs across studies. Statistical heterogeneity cannot be assessed in this article because a meta-analysis was not completed. | Conclusions des auteurs et recommandations générales Although VC has been studied for the past 15 years, evidence of effectiveness is limited by a low number of RCTs with large numbers of participants. Small samples and methodological weaknesses of the studies are major limiters to generalizability of the findings. However, studies of VC have shown feasibility, acceptability, efficacy, and cost effectiveness. In addition, initial assessment of movement and mental health disorders using VC may be different from in person care. However, diagnosis and treatment ability have been found to be the same as in-person care. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|---|---|
| 17) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| Internet videoconferencing for patient–clinician consultations in long-term conditions: A review of reviews and applications in line with | Review of reviews | <ul style="list-style-type: none"> Études incluses : 35 review articles were included in the review Période : 2009 - 2017 |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitateurs) |
| | | Effectiveness |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|----------------------|--|
| guidelines and recommendations | Long-term conditions | <ul style="list-style-type: none"> There was insufficient evidence regarding its effectiveness in the routine management of mental health patients. (n=1) Furthermore, a review of videoconsulting for depression found it to be as beneficial as in-person care. (n=1) Two reviews indicated that a good therapeutic alliance between clinician and patient is possible via video, (n=2) but no improvement in health outcome was found in one of these reviews. (n=1) There were two reviews that indicated that this modality may be better than inperson care for some conditions, such as autism (n=1) and anxiety-related disorders.(n=1) In the review of the use of telemedicine in diabetes, 23 of the 27 randomised controlled trials reported improved metabolic outcomes. Another review of 19 studies using videoconferencing in oncology found no conclusive evidence of a difference between video consultation and face-to-face consultation. (n=1) A review of telemedicine for asthma concluded that there was a reduction in hospital admissions. (n=1) A review of telemedicine for heart failure concluded that videophone did not improve outcomes but structured telephone follow up and telemonitoring did, including all-cause mortality. (n=1) In the review on the use of telemental health, Hilty et al. reported reduced length of hospitalisation and better medication adherence. Although the sub-analysis of a larger systematic review (n=1) and meta-analysis into heart disease (n=2) found that structured telephone follow up and telemonitoring reduced heart failure-related hospitalisation admittances, the authors found no conclusive evidence that this occurred with videoconferencing. <p><u>Satisfaction</u></p> <ul style="list-style-type: none"> A review of telecounselling for depression pooled results from 498 adults of African-American, Spanish, and Asian origin and found some evidence of increased satisfaction among individuals from ethnic minority communities. Limited data also pointed towards longer-term health benefits for these patients. (n=1) <p><u>Safety</u></p> <ul style="list-style-type: none"> The review of telepsychiatry analysed results from a total of 1054 patients from psychiatric services and concluded that telepsychiatry is safe to use. <p><u>Feasibility and acceptability</u></p> <ul style="list-style-type: none"> The feasibility, acceptability, and sustainability of telemental health for children and adolescents have also been reported. Overall, two reviews found that telemental health assessment with this group of patients was, in general, reliable and feasible. (n=2) Arnfield and colleagues summarised evidence from the 27 published studies and concluded that 26 of the 27 articles presented results that were supportive of Skype. In particular, Skype was adequate for patients across the age spectrum, although the majority of studies described applications involving adult patients. Overall, five studies concluded that Skype offered good communication between patients viewed as beneficial to therapy because written communication allowed clinicians to recount the young person's personal and health experiences. <p><u>Cost and resources</u></p> |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|------------------------------------|---|
| | | <ul style="list-style-type: none"> Schlegi and colleagues found that videoconferencing provides little benefit for clinical staff in terms of cost or time savings, but may assist patients who live in remote places to access specialist psychological service. In another review on the use of telemedicine for older patients, 36 of the 50 studies (that included a medical endpoint) comprised various health service outcomes (i.e. cost, hospitalisation, healthcare utilisation). (n=1) The conclusion of the review was that video consultation may be an effective method for decreasing healthcare expenditure. A review focused on telepsychiatry reported that there were limited data in support of the cost-effectiveness of video technologies. (n=1) Another review of internet videoconferencing for long-term conditions reported similar findings about the evidence for cost-effectiveness. (n=1) Armfield and colleagues reported that Skype was more economical than face-to-face appointments with savings accruing from avoided travel, (n=1) while the review of Peeter et al. of the financial benefits of videoconferencing in comparison with usual care at home reported no advantages compared with usual care. (n=1) |
| | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) |
| | | <ul style="list-style-type: none"> Technologiques |
| Auteurs/Pays | | ∅ |
| Ignatowicz et al. | Spécialité | <ul style="list-style-type: none"> Humains et cognitifs |
| United Kingdom | N/A | <ul style="list-style-type: none"> Choosing to utilize internet videoconferencing may be influenced by patients' preference, their digital resources and skills, clinician's motivation to use it, the organizational and resource considerations, the healthcare setting and the actual long-term condition. |
| | Types de professionnels | <ul style="list-style-type: none"> Cliniques |
| | Healthcare professionals | <ul style="list-style-type: none"> In line with the current evidence and guidelines, internet videoconferencing could be implemented to help clinicians support patients through: <ol style="list-style-type: none"> Advice and education: supporting patients in developing strategies to promote and maintain independence and self-efficacy. Information: signposting and providing patients with information about their condition. Relationships: enabling and helping to maintain better communication, and supporting patient and their family's psychological and social needs. There is a range of clinical, supportive, educational and administrative functions for which internet videoconferencing may be useful, from supporting care planning and monitoring, organising follow-up consultations, reviewing or adjusting medication to providing group or individual educational programmes for patients with diabetes. Videoconferencing could be implemented to meet patient need and preference at the appropriate time and for specific reasons. Patient education, either group or individual, could be undertaken using internet videoconferencing. Care planning, reviews and monitoring, especially for those patients that have considerable distances to travel for their appointments or are not well enough, could be assisted using videoconferencing. |
| | Types de patients/clients | |
| | Patients with long term conditions | <ul style="list-style-type: none"> Professionnels et organisationnels |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|---|--|
| Année de la revue | Interventions | Ø |
| | Internet videoconferencing | |
| 2019 | Comparaison (le cas échéant) | |
| Objectifs de la revue | Usual care or face-to-face consultation or none | |
| <p>The aims of this paper are:</p> <ol style="list-style-type: none"> 1. To summarise the existing reviews of literature relating to the use of internet videoconferencing between patients with long-term conditions and their treating clinicians from the patient's own home (or mobile device). 2. To review the NICE guidelines for long-term conditions (LYNC study conditions: psychosis and schizophrenia, HIV, diabetes, liver fibrosis, eczema, psoriasis, cancer, asthma, cystic fibrosis, arthritis, kidney and sickle cell disease). 3. To identify where, in the patient pathway, the use of videoconferencing might be possible and of advantage to the patient, their clinician and/or the healthcare system. | | <ul style="list-style-type: none"> • Économiques et financiers |
| | | Ø |
| | | <ul style="list-style-type: none"> • Sociopolitiques et réglementaires |
| | Limites/Biais | Ø |
| | Overall, the methodological quality of included reviews was poor. The most common methodological weaknesses were limited details of the included study characteristics, such as clinical outcomes, participants' demographics and potential biases in the selection of articles. Within the included reviews, low and variable uptake and the cost of establishing videoconferencing services across primary studies were often identified as a limitation. | Conclusions des auteurs et recommandations générales <ul style="list-style-type: none"> • In the home setting, for patients with long-term conditions, the review of reviews indicates that there is no formal evidence in favour of or against the use of internet videoconferencing. Evidence for its impact on health outcomes suggests it mostly has equivalence with face-to-face communication. The evidence for equivalence seems to be the strongest in mental health conditions. Furthermore, internet videoconferencing seems to be an acceptable mode of care delivery for patients with long-term conditions. • Research indicates that patients who have experienced videoconferencing with clinicians, like it. However, there is limited evidence about healthcare professionals' satisfaction with this mode of communication. Little is also known about the impact of videoconferencing on health service costs. The discussion sections of most reviews often suggest that further research is needed around cost, ethics and safety, and the practical challenges when implementing internet videoconferencing. • Finally, this review of reviews identified only one review of the clinical use of Skype. Many of the reviews identified included internet videoconferencing as one of a number of communication channels with the patient, making it difficult to disentangle the actual impact of videoconferencing. • With a growing number of opportunities for adoption and expansion of videoconferencing, further research exploring the actual implementation challenges to inform and support the development of services is also needed. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|---|--|
| 18) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| The role of telehealth during COVID-19 outbreak: a systematic review based on current evidence | Systematic review | <ul style="list-style-type: none"> Études incluses : 8 études (3 études de cas, 5 études cross-sectionnelles) Période : 31 décembre 2019 au 3 avril 2020 |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitateurs) |
| | Role of telehealth services in COVID-19 <ul style="list-style-type: none"> Telehealth in all aspects of health care (primary, secondary or tertiary level health care) to provide clinical services, diagnosis, assessment of symptoms, triage of patients, consultation services, and training or supervision of clinicians | <ul style="list-style-type: none"> By using virtual care for very regular, essential medical care, and deferring elective procedures or yearly checkups, we can free up medical staff and equipment required for those who become seriously ill from COVID-19. Additionally, by not congregating in small spaces like waiting rooms, the ability of the coronavirus to transmission from one person to another were thwart. Telehealth can mobilize all aspects of healthcare potentials to decrease transmission of disease, conduct people to the right level of health care, ensure safety for provide health services online, protect patients, clinicians, and the community from exposure to infection, and finally diminish the burden on the healthcare providers and health system. Some of the telehealth usage cases for patients were control and triage during the outbreak of COVID-19 pandemic, self and distance monitoring, treatment, patients after discharge in health centers (follow-ups) and implementation of online health services. These methods have the potential to reduce morbidity and mortality during pandemic. For all healthcare workers and clinicians with mild symptoms can still work remotely with patients, facilitate quick access to medical decision making, seek second opinion for severe cases of patients, exchange cross-border experiences, and offer teleradiology and online trainings for health workers. To provide continued access to necessary health services, telehealth should be a key weapon in the fight against the COVID- 19 outbreak. |
| | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) |
| | | <ul style="list-style-type: none"> Technologiques |
| Auteurs/Pays | | ∅ |
| Monaghesh et al. | Spécialité | <ul style="list-style-type: none"> Humains et cognitifs |
| Iran | N/A | ∅ |
| | Types de professionnels | <ul style="list-style-type: none"> Cliniques |
| | All aspects of health care (primary, secondary or tertiary level health care) | <ul style="list-style-type: none"> Telehealth with use of live video conferencing or a simple mobile call allow health care professionals to ask special questions and collect required information, triage of patient and supply consultation, or if a person can continue to self-monitor symptoms at home while recovering. It can also be applied for regular check-ins such as respiratory, blood pressure and oxygen level rate needed in home Live video could be very useful for patients seeking consultation on covid-19, for people with heightened anxiety and instead of in-person visits in cases of chronic disease reviews (such as diabetes and cancer), some medication checks, and triage when telephone is insufficient |
| | Types de patients/clients | |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|---|---|
| | Population générale | <ul style="list-style-type: none"> Professionnels et organisationnels |
| Année de la revue | Interventions | <ul style="list-style-type: none"> To reduce the number of those who receive face-to-face services of health care, healthcare workers can contact with patients through telecommunication tools for triaging, assessing and caring for all patients Results demonstrate that to manage COVID-19, there are many easy-to- set-up potentials in live video consulting. Live video conferencing can lead to the avoiding of direct physical contact, thereby diminishing the risk of exposure to respiratory secretions and preventing the potential transmission of infection to physicians and other healthcare providers |
| | Function type of telehealth in prevention, diagnosis, management and treatment of COVID-19 | |
| | In the included studies, most of telehealth and social media channels were applied during COVID-19 pandemic such as telephone, live video conferencing, and e-mail. | |
| 2020 | Comparaison (le cas échéant) | |
| Objectifs de la revue | None | <ul style="list-style-type: none"> Économiques et financiers |
| The aim of this systematic review was to identify the role of telehealth services in preventing, diagnosing, treating, and controlling diseases during COVID-19 outbreak. | | ∅ |
| | | <ul style="list-style-type: none"> Sociopolitiques et réglementaires |
| | | ∅ |
| | Limites/Biais | Conclusions des auteurs et recommandations générales |
| | <ul style="list-style-type: none"> Possible that some relevant studies were not taken into account because they have been published in languages other than English (e.g. Chinese). Did not have access to some other databases such as CINAHL and PsycINFO. There could be some other studies on this theme in the literature that skipped their attention and analyses though we did our best to adopt a comprehensive search strategy and cover a broad range of evidence across the world. | <p>Telehealth has the potential to address many of the key challenges in providing health services during the outbreak of COVID-19. Also, telehealth can help us avoid direct physical contact and minimize the risk of COVID transmission and finally provide continuous care to the community.</p> <p>Based on the findings of this review study, clinicians and patients are strongly recommended to apply telehealth tools as an appropriate option to prevent and contain COVID-19 infection.</p> |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|---|---|
| 19) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| The Use of Patient-Facing Teleconsultations in the National Health Service: Scoping Review | Systematic scoping review | <ul style="list-style-type: none"> • Nombre de participants : non-disponible • Nombre d'études incluses : 101 études (There was a large variation in study type : Pilots, audits, service reports, and case series/reports represented more than half of the articles included for review, whereas there were 13 RCTs.) • Période : Tout jusqu'au 31 décembre 2018 |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitants) |
| | Tous | <p>Satisfaction and user experience with teleconsultations was reported in 43 articles.</p> <ul style="list-style-type: none"> ○ Satisfaction was assessed using feedback questionnaires in 23 articles, including 3 RCTs. <ul style="list-style-type: none"> ▪ Of these, 19 reported high levels of satisfaction with the medium. In 2 RCTs, satisfaction in the teleconsultation arm was actually greater than the face-to-face group (n=2), whereas another found no difference (n=1). ▪ By contrast, only 1 small RCT found that patients were less satisfied with teleconsultations due to poor image and audio quality (n=1). ▪ One pilot found that, while patients were satisfied, health care staff were uncomfortable with it ○ Several studies found that patients were satisfied with teleconsultations but also that they would still want the option to attend in person as they believe it to be the gold standard (n=3). ○ Qualitative studies exploring users' experiences of teleconsultations find that the main benefits commonly reported by patients are <u>convenience</u>, <u>reduced travel</u>, and <u>greater accessibility to specialist care</u> and <u>improved flexibility</u> of appointments, allowing minimal disruption to daily life (n=2). ○ Several studies found that the medium allowed patients to <u>open up more</u> than face-to-face consultations and that they felt empowered to ask more questions (n=2). ○ Among staff, a greater sense of job satisfaction and a reduced burden of travel have been reported (n=1). ○ Among a teenaged population being treated for chronic fatigue, participants raised <u>concerns about privacy</u>, fearing that they might be overheard by family. Their parents worried that the connection might not be secure enough to ensure privacy, while some health professionals thought it was an invasion of patients' personal space ○ There was the awareness that teleconsultations had <u>certain physical limitations</u>. ○ Qualitative analysis from the large RCT by Wallace et al (n=1) found, either due to patient expectation or physician need, that <u>the inability to perform physical examinations limited its usefulness</u> (n=1). ○ Morris et al reported that patients and staff could find the medium awkward and uncomfortable when there was no previous relationship built up (n=1). <p>Clinical Effectiveness : There were 48 articles</p> <ul style="list-style-type: none"> ○ Psychiatry : <ul style="list-style-type: none"> ▪ a single-cluster balanced crossover, blind study (where each patient had both a face-to-face and teleconsultation with a different researcher and each researcher was blind to the psychiatric assessment |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|----------|---|
| | | <p>of the other) concluded that there was significant <u>inter method concordance</u>, confirming its accuracy in psychiatric assessment (n=1).</p> <ul style="list-style-type: none"> ○ Acute stroke : <ul style="list-style-type: none"> ▪ In total, 3 retrospective studies of a combined 287 patients conducted in the United Kingdom confirm that its <u>implementation has been safe</u>; ▪ door-to-needle time, morbidity, mortality, and discharge rates were <u>comparable to national standards</u> for acute stroke management ○ Neurology: <ul style="list-style-type: none"> ▪ 2 case-control studies in neurology assessed the concordance of diagnosis in both an inpatient and outpatient setting and found 96%-100% of cases were accurately diagnosed and managed via teleconsultation ▪ An RCT in a neurology outpatient setting compared face-to-face consultations with teleconsultations and found that the teleconsultation arm generated more investigations despite no difference in the diagnostic category of the cases seen. ▪ A cohort study of 111 inpatients assessed by video link found no difference in 3-month mortality compared with all other hospital admissions during that time. ▪ On follow-up, no patient had their diagnosis or management changed when seen face-to-face, and no difference was seen in the use of hospital services in the following 3 months after discharge (n=1). ○ Rheumatology: <ul style="list-style-type: none"> ▪ Graham et al found rheumatologists—using a junior doctor as a proxy—were only <u>40% accurate</u> in assessments via teleconsultation with physicians missing subtle but clinically important signs of inflammation. ▪ Leggett et al concluded that teleconsultations—using a 3-way consultation between the patient, GP, and specialist—were <u>97% accurate in diagnosing</u> fibromyalgia, degenerative arthritis, rheumatoid arthritis, and soft tissue disease. ○ Ophthalmology: <ul style="list-style-type: none"> ▪ Some eye conditions such as simple ptosis and strabismus could be accurately assessed in up to 97% of cases. ▪ However, more complex eye conditions such as socket problems in patients who had a previous enucleation or those with nonspecific ocular pain were better assessed in a face-to-face consultation (n=2). ○ Diabetes : <ul style="list-style-type: none"> ▪ In a hospital diabetic clinic setting, over 4 years, appointment did not attend (DNA) rates were lower (13% vs 28%) in patients choosing to attend by teleconsultation with improved hemoglobin A1c control (n=1). ○ Multispecialty: <ul style="list-style-type: none"> ▪ A large multispecialty RCT, by Wallace et al, enrolled over 2000 patients. They measured the number of investigations per patient and follow-up rates and, in contrast to the previously mentioned RCT, found that teleconsultations actually resulted in fewer investigations, at a rate of 0.79 per patient. ▪ However, this figure is offset by a higher rate of subsequent follow up seen in this group. <p><u>Logistical and Operational Considerations</u> : There were 16 studies</p> <ul style="list-style-type: none"> ○ Consultation length: |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|--|---|
| | | <ul style="list-style-type: none"> Several studies make reference to consultation length, in which teleconsultations are as much as 4 times as long as their face-to-face equivalent (n=3). However, several others found them to be shorter in length (n=3). Williams et al found no difference in consultation length but reports that by avoiding travel to peripheral clinics, clinicians were able to provide more emergency care with the time saved, thus maximizing their clinical efficiency. |
| | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) |
| | | <ul style="list-style-type: none"> Technologiques |
| Auteurs/Pays | | <ul style="list-style-type: none"> The technology employed in these studies has now been superseded by Web-based platforms. Using these modern solutions does not prevent technical issues, and contingency plans need to be considered to overcome common problems, such as poor internet speed and lack of an audiovisual stream with Web-based solutions |
| O'Cathail et al. | Spécialité | <ul style="list-style-type: none"> Humains et cognitifs |
| Royaume-Uni | N/A | <ul style="list-style-type: none"> In total, 9% of the population (disproportionately older people) have never used the internet (n=1). This, among other reasons outlined below, makes teleconsultation services unlikely to be accepted as a replacement to traditional care models and more likely that it should be offered as a choice. |
| | Types de professionnels | <ul style="list-style-type: none"> Cliniques |
| | Any | <ul style="list-style-type: none"> The most enduring success of patient-facing teleconsultations in the United Kingdom is its use in acute stroke management, an intervention which was first reported in 2012 Teleconsultations appear to be a safe and effective way to assess and manage a variety of clinical situations. Clinical consensus, even within specialties, is not universal, however, and the types of consultations that are suitable are dependent on their complexity and physician comfort with the medium. Neurological conditions and simple ophthalmological presentations such as strabismus could be safely diagnosed and managed. Although physical examination is limited in teleconsultations, there are many examples in both inpatient and outpatient settings that demonstrate its utility. |
| | Types de patients/clients | |
| | Population générale | <ul style="list-style-type: none"> Professionnels et organisationnels |
| Année de la revue | Interventions | <ul style="list-style-type: none"> Altering the way patients are seen can lead to improved operational efficiencies. By selectively choosing patient populations with high DNA (did not attend) rates, it is possible to achieve more operational efficiency. The use of proxy examiners is unlikely to be viable; therefore, the outcomes reported in such studies may not be replicable in today's health service. The successful adoption of technology may be predicated on demonstrating safety and acceptability, but it will only survive in the real world if it can be integrated into existing health care pathways. |
| | Teleconsultations involving real-time video link with patients | |
| 2020 | Comparaison (le cas échéant) | |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|---|--|
| Objectifs de la revue | N/A | <ul style="list-style-type: none"> Teleconsultations may not be suitable for every population. Therefore, teleconsultation services should be introduced gradually in a way that allows proper evaluation, with staff and patient feedback being used to fine-tune the pathway to suit local service needs and expectations. |
| This review aimed to examine the extent and nature of the use of patient-facing teleconsultations within a health care setting in the United Kingdom and what outcome measures have been assessed. | Limites/Biais | <ul style="list-style-type: none"> Économiques et financiers |
| | | ∅ |
| | | <ul style="list-style-type: none"> Sociopolitiques et réglementaires |
| | | ∅ |
| | Scoping reviews are not intended to assess the quality of the literature included; therefore, the conclusions of this review are based on the existence of published research rather than the quality of it. Many old publications. | Conclusions des auteurs et recommandations générales Teleconsultations appear to be safe and effective in the right clinical situations. Where offered, it is likely that patients will be supportive of such measures, although they should only be offered as an option to support traditional care models rather than replace them outright. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|---|---|
| 20) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| Systematic review of patient and caregivers' satisfaction with telehealth videoconferencing as a mode of service delivery in managing patients' health | Systematic review | <ul style="list-style-type: none"> Nombre de participants : 3607 Études incluses : 36 (5 clinical trials, 26 observational (cohort) studies and five qualitative studies) Période : Janvier 2003 à décembre 2017 |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitateurs) |
| | Any | <ul style="list-style-type: none"> Satisfaction <ul style="list-style-type: none"> System experience (<i>accessibility, time and cost savings, comfort, technical support and operations, and usability</i>) – (29 studies) <ul style="list-style-type: none"> There were <u>high levels of satisfaction</u> across all these domains, especially with regards to service accessibility. This was linked to <u>convenience</u> of attending an appointment in one's local community, saving travel time and costs. There were minor accounts of discomfort with <u>screen formatting and using equipment</u> (n=3) Reduced <u>audio-visual quality</u> also affected satisfaction and patient and caregivers' ability to participate in the appointment (n=1). Information sharing (<i>communication quality, confidentiality, thoroughness of clinical assessment, information completeness and usefulness, and patient comprehension</i>) (21 studies) <ul style="list-style-type: none"> There were <u>high levels of satisfaction</u> across all these domains. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|--------------------------------|--|
| | | <ul style="list-style-type: none"> Communication between the patient and health care provider <u>positively influenced satisfaction</u> with telehealth by enabling patients to feel listened to, have their concerns addressed, have time to ask questions and participate in the information sharing and decision making. Patients were <u>mostly satisfied</u> that information was safely shared and remained confidential, though there were minor reports that videoconferencing might increase the risk of breach of confidentiality of patients' health information (n=1). Two studies reported that the anonymity of telehealth was helpful in discussing personal information that were perceived to be more difficult to discuss face-to-face (n=2). In absence of physical examination, some patients remained neutral or less satisfied with telehealth reporting 33–75% dissatisfaction (n=3). Consumer focus (<i>adherence to patient-centred care, health care provider empathy and rapport with the patient, quality of care, local health care provider support, emotional support, professionalism and health care provider cultural competence</i>) – (17 studies) <ul style="list-style-type: none"> Patients and caregivers <u>were satisfied</u> across all these domains of consumer focus with telehealth. While face-to-face appointments were preferred, <u>telehealth remained a satisfactory option</u> through avoided travel and costs from attending an appointment in an urban centre. The studies were unclear why face-to-face appointments were preferred in these settings but hypothesised an <u>older demographic</u> (n=1), the perceived <u>need to develop rapport</u> with the health care provider (n=1) and <u>unfamiliarity</u> with telehealth (n=1) as factors potentially influencing patient choices. There were accounts of <u>improved self-efficacy</u> in managing one's condition via telehealth (n=3), <u>enjoyment</u> of the telehealth experience (n=2), <u>positive attitudes</u> of receiving health care via telehealth (n=1) and <u>agreement</u> that patient treatment needs were being met (n=3). There were only minor reports of telehealth <u>being less personal</u> (n=1) and <u>unable to provide psychosocial support</u> (n=1). Overall satisfaction – (24 studies) <ul style="list-style-type: none"> Numeric rating scale was used by three studies (n=3) ranging from 4.45 to 4.7 out of 5. Respondents of questionnaires scored greater than <u>80% agreement in overall satisfaction</u>. In the semi-structured interviews, <u>81% of participants reported being satisfied</u> with the telehealth experience (n=1). |
| Auteurs/Pays | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) <ul style="list-style-type: none"> Technologiques <p>Advances in technology and improved consumer internet connectivity and computer literacy may empower people in rural and remote areas to manage their health conditions by better connecting to health care services (n=2).</p> |
| Orlando et al., Australia | Spécialité | <ul style="list-style-type: none"> Humains et cognitifs <p>Telehealth can still remain a personal experience through elements of the communication skills that include listening to patients, providing adequate time for patient questioning, investing time in building patient rapport, involving caregivers in the appointment and emphasising patient choice.</p> |
| | N/A | |
| | Types de professionnels | <ul style="list-style-type: none"> Cliniques |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|--|---|
| | Any | <p>Specifically, attending an appointment in one's local community via telehealth outweighed the inconvenience of travelling long distances to an urban centre for the same appointment. This was especially highlighted for people with <u>chronic conditions</u> (n=4), <u>parents with young children</u> (n=3) and <u>caregivers of elderly patients</u> (n=1)</p> <ul style="list-style-type: none"> Professionnels et organisationnels |
| | Types de patients/clients | |
| | General population | |
| | Rural and remote areas | |
| Année de la revue | Interventions | <ul style="list-style-type: none"> Telehealth can play an important role for supporting rural and remote patients where clinically appropriate and hence avoid the inconvenience of travel to an urban centre for a face-to-face appointment. While health care providers should not underestimate patients' ability to engage with technology, this could be complemented with functional aspects of care, as they would in a face-to-face appointment. Given patient and caregivers' satisfaction with telehealth, health services could feel confident that this form of service delivery enables health care for patients in rural and remote areas and is not a barrier from the patient and/or caregivers' perspective. While telehealth does not replace face-to-face appointments, it does offer an alternative mode of service delivery that when integrated into an established service could form part of patient choice when clinically safe and appropriate. |
| | <ul style="list-style-type: none"> Outpatient appointment delivered remotely via telehealth videoconferencing between the patient in their home or local health care centre and the health care provider in another location | |
| 2019 | Comparaison (le cas échéant) | |
| Objectifs de la revue | N/A | |
| The aim of this systematic review was to examine whether patients and their caregivers living in rural and remote areas are satisfied with telehealth videoconferencing as a mode of service delivery in managing their health. | | <ul style="list-style-type: none"> Économiques et financiers |
| | | Ø |
| | | <ul style="list-style-type: none"> Sociopolitiques et réglementaires |
| | | Ø |
| | Limites/Biais | Conclusions des auteurs et recommandations générales |
| | <ul style="list-style-type: none"> Ne considère pas les consultations téléphoniques Manque d'uniformité dans les mesures des résultats d'intérêts Regroupement de paramètres à valider | <p>Summarising the findings from quantitative and qualitative research, there is consistent evidence that telehealth has an overall positive impact on patient and caregivers' satisfaction. System experience seems to enhance better access to health care for patients and their caregivers living in rural and remote areas highlighting that distance may no longer be a barrier. Telehealth also appears to enhance communication and engagement between health care providers and patients and their caregivers, especially through real-time videoconferencing.</p> |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|--|---|
| 21) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| Registered nurse and midwife experiences of using videoconferencing in practice: A systematic review of qualitative studies | Systematic review | <ul style="list-style-type: none"> Études incluses : 9 (2 reported ethnographic methods and 7 the use of a "qualitative" method or approach) Période : 1993 à avril 2017 |
| | Contexte clinique | <p>Résultats (Outcomes incluant les barrières et facilitateurs)</p> <ul style="list-style-type: none"> Useful on a continuum <ul style="list-style-type: none"> Nurses and midwives saw VC as useful along a continuum from direct, face-to-face, contact with patients to a telephone consultation. Where direct contact was not possible and consultations needed to be conducted at a distance, VC was preferred over telephone contact because it brought a richer and deeper dimension to consultations Where VC allowed families to be present during in-home consultations, this rendered situations more "real" or "personal" to clinicians and helped to sustain a focus on the needs of the patient This facilitated a better rapport with patients and provided opportunities to assess the physical and mental condition of caregivers, in a way not possible via telephone VC was not always perceived as necessary because some assessments could just as easily be made over the telephone. It was thus perceived as a complement to, but not a necessary constituent of, standard care models. Where VC reduced the need for travel, kept people in their own communities and allowed the support of family and local doctors, it was particularly valued. This conferred a benefit to the healthcare system because it could reduce hospital overcrowding and clinic wait times. An added benefit was that continuity could be maintained because patients could see the same oncologist from the tertiary centre and the same local nurse and doctor at their home hospital, at each consultation. Nurses and midwives reflected that parents could gain a sense of safety and self-confidence with the parental role, knowing they could have video contact with the hospital at all hours. This was especially so for parents living in rural areas or where home visits were not possible. Synthesis : <ul style="list-style-type: none"> VC makes consultations more real VC does not replace human contact VC reduces the need for travel and keeps people in their communities Broader range of information (VC allows a broader range of information to be gathered that facilitates safer and more inclusive care) <ul style="list-style-type: none"> VC allowed nurses and midwives : <ul style="list-style-type: none"> to observe family members together, including parent/infant interactions, and assess body language; to observe breastfeeding and to observe the physical condition of patients. Seeing patients made it easier to confirm whether instructions and information were understood Synthesis : |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|-------------------|---|
| | | <ul style="list-style-type: none"> VC allows nurse/midwife to see and hear the patient which improves assessment Including the family in VCs facilitates collaborative care and communication VC facilitates collegial support, reduces professional isolation and improves decision-making <ul style="list-style-type: none"> • Implications for professional practice <ul style="list-style-type: none"> ○ The presence of patients and caregivers together with the healthcare team during VC made it difficult to communicate about sensitive topics, or deal with unexpected disclosures made by patients and caregivers ○ Furthermore, nurses worked hard to allay fears of children around <u>privacy</u> and who would be viewing examinations of a sensitive nature during VC ○ A lack of standardised practice relating to VC raised professional concerns for and placed additional demands upon nurses, particularly where it was not clear who was responsible to ensure consultations ran smoothly. ○ There were also concerns that patient deterioration would not be detected as readily via VC compared to home visits, and that this could put a nurse's registration at risk. Nurses perceived that their credibility in the eyes of the patient could also be affected if VC was substituted for home visits ○ Synthesis: <ul style="list-style-type: none"> VC can undermine professional credibility, security and the professional role Nurses/midwives have concerns for safety and privacy • Barriers influence use of VC (<i>barriers reported by nurses and midwives significantly influenced the feasibility of VC</i>) <ul style="list-style-type: none"> ○ A perception of greater time and resources required for VC, difficulties in scheduling consultations and gaining access to equipment, as well as difficulties with video and sound quality were considered significant barriers to use of the technology. ○ Preconceived beliefs about the appropriateness of the technology in clinical situations were also barriers ○ Orientating patients to the equipment and establishing a trusting nurse–patient relationship, particularly with young children, also required more time. Similarly, having family join in VC extended the discussion time in team meetings ○ Nurses and midwives drew attention to the need for good video and sound quality for assessments ○ Some paediatric nurses reported feelings of being observed by parents and some, but not all, felt that being visible in a picture affected their manner, including the ability to be natural during VC consultations ○ Synthesis : <ul style="list-style-type: none"> VC requires more time There are practical barriers to negotiate Video and sound quality are necessary |
| | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) <ul style="list-style-type: none"> • Technologiques |
| Auteurs/Pays | | |
| Penny et al., | Spécialité | <ul style="list-style-type: none"> • Humains et cognitifs |
| Australie | N/A | <ul style="list-style-type: none"> • Training must include not only orientation to the equipment but also to develop skills in assessment, communication and relational practice that characterise the virtual context. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|--|---|
| | | |
| | | <ul style="list-style-type: none"> Cliniques |
| | Types de professionnels | <ul style="list-style-type: none"> Findings of this meta-synthesis concur with other studies that suggest electronic communication with patients does not fit with all aspects of clinical care. For example, new introductions to patients, patient counselling, assessment of devices and technical aids and discussion of sensitive topics or to convey "bad news" are examples of situations where face-to-face interactions would be more appropriate |
| | Registered nurse and midwife | |
| | Types de patients/clients | |
| | Population générale | <ul style="list-style-type: none"> Professionnels et organisationnels |
| Année de la revue | Interventions | <ul style="list-style-type: none"> The findings of the meta-synthesis highlight the lack of training that existed to address the full range of issues related to VC use. To become a legitimate part of healthcare service delivery, VC must be seen as part of a repertoire of interactions to be applied in specific contexts where this adds value to patient care and professional practice. Ongoing work is required to define more clearly boundaries between clinical, professional and technological expertise required for technologies like VC. For VC to be seen as a normal, and not novel, part of service delivery, it must be assessed in the light of the findings of this meta-synthesis. Strategies to overcome the experience of service separation and develop presence in VC must be considered if nurses and midwives are to adopt the technology in routine practice. If nurses and midwives are to take a lead in adopting VC in practice, they must gain experience in the use of the technology and build knowledge through evaluation and research. |
| | Videoconferencing | |
| 2018 | Comparaison (le cas échéant) | |
| Objectifs de la revue | N/A | |
| | | |
| The aim of this review was to synthesise the evidence of registered nurses' (RNs) and midwives' experiences of videoconferencing (VC) with the objective of identifying perceptions of appropriateness, meaningfulness and feasibility of this technology in professional and clinical practice. | | <ul style="list-style-type: none"> Économiques et financiers |
| | | Ø |
| | | <ul style="list-style-type: none"> Sociopolitiques et réglementaires |
| | | Ø |
| | Limites/Biais | Conclusions des auteurs et recommandations générales |
| | <ul style="list-style-type: none"> Ne considère pas les consultations téléphoniques Uniquement des études qualitatives Qualité des études incluses variable | While videoconferencing offers benefits, it comes with personal, organizational and professional consequences for nurses and midwives. Understanding potential benefits and limitations, training and support required and addressing potential professional implications all influence adoption and ongoing use of videoconferencing. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|--|---|
| 22) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| Telephone communication between practice nurses and older patients with long term conditions – a systematic review | Systematic review | <ul style="list-style-type: none"> • Nombre d'études incluses : 5 (3 used quantitative methodologies, 1 used qualitative and 1 used a mixed methods) • Période : Tout jusqu'à Août 2015 |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitants) |
| | Long term conditions | <ul style="list-style-type: none"> • Health indicators <ul style="list-style-type: none"> ○ Diabetes <ul style="list-style-type: none"> ▪ Telephone interventions showed improvement in blood pressure and health-related quality of life (HRQoL), and reduction in depressive symptoms for diabetes patients. ▪ Another study showed glycaemic control was better in intervention patients but there was no significant difference in HRQoL or diabetes-related symptoms. ▪ Another intervention with diabetes patients showed significant differences in HRQoL and transiently for blood pressure and depression. ○ COPD <ul style="list-style-type: none"> ▪ One study that aimed to improve health behaviours in COPD patients found the intervention provided a positive change in physical activity and smoking cessation. ▪ Telephone health mentoring helped form a partnership between the participant and the mentor, leading to the participant's starting or increasing positive health behaviours. ▪ Furthermore, some participants felt a responsibility to their health mentor to accomplish some of the predetermined goals • Satisfaction <ul style="list-style-type: none"> ○ Walters interviewed patients about using telephone delivery of the health mentoring telephone programme and found telephone delivery was highly acceptable and enabled good rapport. Most participants found telephone health mentoring valuable. They believed that the mentors assisted in identifying goals, activities and strategies that helped COPD self-management and their general wellbeing. ○ In comparing communication profiles between telephone and videophone, there were no significant differences in patient satisfaction or significant difference in communication profiles over time. • Barriers <ul style="list-style-type: none"> ○ Level of engagement and commitment was seen as important for both the nurses and the patients. ○ In the Weinberger study age and associated level of illness was considered a factor in the intervention's being less effective. ○ In the Mons study they determined that an intervention specifically tailored to each individual's needs might have been more effective. |
| | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) |
| | | <ul style="list-style-type: none"> • Technologiques |
| Auteurs/Pays | | ∅ |
| Raphael et al., | Spécialité | <ul style="list-style-type: none"> • Humains et cognitifs |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|---|--|
| Nouvelle-Zélande | N/A | <div>Ø</div> <div>• Cliniques</div> |
| | Types de professionnels | <div>Ø</div> |
| | Practice nurses | |
| | Types de patients/clients | <div>• Professionnels et organisationnels</div> |
| | Older adults (defined as over 65 years of age) | |
| Année de la revue | Interventions | <div>• Whilst all the studies had older people as participants, the interventions were not targeted specifically at older people and their individual needs. This is an important finding as older people have a higher risk of multimorbidity and targeting specific LTCs is inappropriate.</div> |
| | Telephone communication in primary care settings. | |
| 2016 | Comparaison (le cas échéant) | |
| Objectifs de la revue | N/A | <div>• Économiques et financiers</div> <div>Ø</div> <div>• Sociopolitiques et réglementaires</div> <div>Ø</div> <div>Conclusions des auteurs et recommandations générales</div> <div>All telephone communication interventions in this review focused on a specific long-term condition, which they aimed to help patients self-manage. While all studies' samples included older patients, they did not consider them separately in relation to the effectiveness of the intervention.</div> |
| <p>1. To examine the extent to which practice nurse–patient telephone communication has been used previously with older people.</p> <p>2. To explore which aspects of telephone communication have been successful with older people.</p> <p>3. To determine whether older people see the telephone communication method as useful in meeting their needs.</p> | | |
| | Limites/Biais | |
| | Despite a systematic search strategy, it is possible that some studies may not have been identified. It was not possible due to the differences in study design to conduct any statistical analysis. Also, although the eligible studies contained older people, they were not solely focused on older people and did not break down the results by age groups. | |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|--|--|
| 23) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| Videoconference compared to telephone in healthcare delivery: A systematic review | Systematic review | <ul style="list-style-type: none"> • Nombre de participants : 2058 • Études incluses: 8 (4 randomized controlled trials, 2 randomized trials with no control group, 1 retrospective chart review and 1 quantitative repeated measures trial. • Période : Tout jusqu'au 25 avril 2018 |
| | Contexte clinique | <p>Résultats (Outcomes incluant les barrières et facilitants)</p> <ul style="list-style-type: none"> • Healthcare resource utilization <ul style="list-style-type: none"> ○ Healthcare visit rates and readmission <ul style="list-style-type: none"> ▪ Jerant et al. found significant differences in healthcare utilization between telephone, telecare (VC) and usual care groups. Six months' postdischarge, there were fewer HF-related ED visits ($p=0.0342$) with follow up care using VC or telephone compared to usual care. ▪ Jerant et al. found that the mean non-HF-related ED visits, all-cause ED visits, HF-related hospital readmissions, non-HF-related hospital readmissions, or all-cause hospital readmissions <u>did not differ between the three groups</u>. ▪ Parents who received follow up care by VC (for their child with CHD) were <u>less likely to seek medical attention</u> for their child, to have fewer health service episodes per week ($p < 0.001$), and their children <u>were less likely to be readmitted</u> to the hospital during a 10-week period ($p=0.004$) than those families receiving follow up care by telephone or the control group ($n=1$). ▪ Ninety-six percent of patients who had a telephone consultation <u>were recommended to obtain further healthcare</u> attention compared to 40% of those receiving a VC consultation ($p < 0.01$). ○ Length of intervention <ul style="list-style-type: none"> ▪ Regardless of the definitions used, with one exception, across studies <u>consultation times were significantly longer</u> with VC than with telephone. ▪ Kobak et al. found <u>no difference in the length of interviews</u> when using the MADRS depression rating tool during VC or telephone interviews. • Clinical Effectiveness <ul style="list-style-type: none"> ○ Diagnostic and decision-making <ul style="list-style-type: none"> ▪ Evidence supported <u>fewer errors and greater diagnostic</u> and decision-making accuracy with use of VC. ▪ When assessing follow-up consultations with parents of children with CHD, McCrossan et al. found that clinicians believed that they could <u>better address parents' concerns when using VC</u> compared to telephone ($p=0.01$). ○ Smoking cessation <ul style="list-style-type: none"> ▪ For a smoking cessation intervention, the only significant difference was <u>the greater use of smoking cessation medications in the VC arm</u> ($p=0.03$) ($n=1$) • Satisfaction <ul style="list-style-type: none"> ○ Although they reported overall high satisfaction in both intervention arms, <u>more participants in the VC arm</u> had already recommended, or would recommend the program to a friend ($p=0.0075$). [20] |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|--|---|
| | | <ul style="list-style-type: none"> ○ In their administration of the MADRS depression rating tool, Kobak et al. conducted interviews by telephone, videoconference, and FTF in a counterbalanced order. Patients responses of "liked a little" or "liked a lot" was <u>significantly greater for telephone (and FTF) than for VC</u> (p=0.007). Significantly more patients reported healthcare providers' ability to accurately evaluate their symptoms and feelings "well" or "very well" using telephone (and FTF) than VC. (p=0.009). ○ McCrossan et al. assessed follow-up consultations between physicians and parents of children with CHD. Parents found that <u>VC consultations better facilitated communication</u> and provided greater overall benefit when compared to telephone (p=0.001). Parents in the VC group gave significantly higher scores than the telephone group when asked whether the doctor was able to understand their concerns (p=0.001), if their issues and questions <u>were satisfactorily resolved</u> (p=0.001), and if the <u>consultation was beneficial</u> (p=0.001). |
| | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) |
| | | <ul style="list-style-type: none"> • Technologiques |
| | | ∅ |
| | | <ul style="list-style-type: none"> • Humains et cognitifs |
| | | ∅ |
| | | <ul style="list-style-type: none"> • Cliniques |
| | | ∅ |
| | | <ul style="list-style-type: none"> • Professionnels et organisationnels |
| | | <ul style="list-style-type: none"> • According to existing evidence, overall, VC was equally (n=3) or more (n=1) effective than telephone in reducing healthcare utilization for acute stroke consultations and at-home patient follow-ups (n=1). • Further, the strategic use of VC for situations that require visual assessment, may be more effective in reducing healthcare utilization and associated costs (n=1). • Findings revealed that consultations using VC typically took longer than by telephone. The visual assessment possible with VC, but not telephone, could explain both the extended VC consultation time and the increased referrals and earlier call termination seen with telephone (n=1). • The limited evidence suggested that VC may have advantages over telephone on provider-related outcomes. |
| | | <ul style="list-style-type: none"> • Économiques et financiers |
| Auteurs/Pays | | |
| Rush et al., | Spécialité | |
| Canada | N/A | |
| | Types de professionnels | |
| | Any | |
| | Types de patients/clients | |
| | Adults and children | |
| Année de la revue | Interventions | |
| | Videoconference (VC) | |
| | <ul style="list-style-type: none"> • Four of these studies involved provider-to-provider consultations • Four studies involved direct <u>patient-to-provider</u> communication | |
| 2018 | Comparaison (le cas échéant) | |
| Objectifs de la revue | Telephone | |
| | | |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|---|---|
| To conduct a review comparing the effectiveness of videoconference versus telephone in the delivery of healthcare. | | Ø |
| | | • Sociopolitiques et réglementaires |
| | Limites/Biais | Ø |
| | <p>The heterogeneous sample of eight studies, half with small sample sizes, coupled with variable patient populations, telehealth interventions, and locations limits the generalizability of the findings.</p> <p>Study designs that lacked randomization or control groups reduced internal validity with the possibility of competing explanations to explain findings.</p> <p>Lack of blinding of modality</p> <p>As telehealth trials have evolved to include complex interventions, such as use of sensor monitors, web portals for information exchange, SMS (n=1), this review may appear to offer a limited view in its examination of only two specific modalities/services for providing care.</p> <p>Poorly described "telephone" interventions, making it difficult to judge their quality, with low quality potentially impacting acceptability and usability (n=1).</p> <p>It is possible relevant papers not providing a direct comparison of VC and telephone interventions were excluded.</p> <p>Included teleexpertise</p> | Conclusions des auteurs et recommandations générales |
| | | The limited evidence to date suggests that VC is comparable, and in some cases superior to telephone. Home follow up care by VC was found to reduce healthcare utilization, particularly for the condition being treated. VC appears to be comparable to telephone in terms of patient outcomes. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|--|---|
| 24) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| Evaluating barriers to adopting telemedicine worldwide: A systematic review | Systematic review | <ul style="list-style-type: none"> • Nombre de participants : 2058 • Études incluses: 30 • Période : 2011 à 2016 (juin) |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitateurs) |
| | Any | <ul style="list-style-type: none"> • Barrier <ul style="list-style-type: none"> ○ Organizational <ul style="list-style-type: none"> ▪ Cost ▪ Reimbursement ▪ Legal liability ▪ Privacy and confidentiality concerns ▪ Security of data ▪ Efficiency ▪ Workflow. ▪ Effectiveness ▪ Outdated equipment ▪ Rural setting ▪ Profit status ▪ Organization size ▪ Teaching status ▪ Lack of implementation models. ○ Patient <ul style="list-style-type: none"> ▪ Age ▪ Level of education ▪ Limit of eHealth or computer literacy ▪ Bandwidth of dwelling ▪ State of unawareness of the existence of several telemedicine products and services ▪ High expectation of users ▪ Apathy ▪ No phone ▪ Socioeconomic status ▪ Gender ▪ preference ○ Staff <ul style="list-style-type: none"> ▪ Limitations of a technically challenged staff ▪ Resistance to change ▪ Licensing issues ▪ Perception of impersonal care |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|--|---|
| | | <ul style="list-style-type: none"> ▪ information overload ○ Programmers <ul style="list-style-type: none"> ▪ Issues of interoperability ▪ Poor application design ▪ Language barriers |
| | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) |
| Auteurs/Pays | | <ul style="list-style-type: none"> • Technologiques • The ubiquitous presence of high-speed bandwidth would help bridge a geographical gap of medical access in rural settings. • If competitive markets have failed to bring this bandwidth and equipment to these communities, then the respective governments should consider implementing policy to cover the gap. |
| Kruse et al., United States | Spécialité N/A | <ul style="list-style-type: none"> • Humains et cognitifs |
| | Types de professionnels Any | ∅ |
| | Types de patients/clients General population | ∅ |
| Année de la revue | Interventions Telemedicine | <ul style="list-style-type: none"> • We recommend that the policymaking bodies of each country should consider the use of telemedicine to bridge gaps of coverage in all geographical areas, but particularly those in rural settings. • Incentives should be considered to encourage participation in telemedicine modalities of care. Incentives can take the form of monetary rewards, such as the US with its 'Meaningful Use' criteria, or disincentives such as fines or less-than-full reimbursement for care. |
| 2018 | Comparaison (le cas échéant) | |
| Objectifs de la revue | N/A | |
| The objective of this study is to examine the various | | <ul style="list-style-type: none"> • Économiques et financiers |
| | | ∅ |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|--|---|
| challenges faced in implementing telemedicine among several different countries to identify any new trends compared with similar studies from several years past. | Limites/Biais <ul style="list-style-type: none"> Only five years were examined. An objective assessment of study bias was conducted in this review, but when articles/studies are screened for selection criteria, human judgment can sway the results. | <ul style="list-style-type: none"> Sociopolitiques et réglementaires <p>Ø</p> <p>Conclusions des auteurs et recommandations générales</p> <p>Telemedicine is widely used in a majority of the countries discussed as a tool to increase the access to healthcare through the elimination of proximity from the equation of care. However, technology barriers and lack of computer literacy prevailed as a major issue in successfully implementing telemedicine.</p> |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|---|---|
| 25) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| The Current State of Telehealth Evidence: A Rapid Review | Rapid review of systematic review and meta-analyses | <ul style="list-style-type: none"> Nombre d'études incluses: 20 (RS) Période : Janvier 2004 à mai 2018 |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitateurs) |
| | Any disease or condition | <ul style="list-style-type: none"> Telemental health (8 RS) <ul style="list-style-type: none"> Assessment (2 RS) <ul style="list-style-type: none"> The findings related to assessment indicate some support for the <u>equivalence</u> of remote assessment via telehealth compared to in-person assessment for psychiatric conditions Treatment (7 RS) <ul style="list-style-type: none"> Systematic reviews of mental health treatment via telehealth tended to report that telehealth treatment outcomes for psychiatric conditions <u>were similar to in-person</u> treatment outcomes. Janine Olthuis and coauthors reported differences by condition and by point in time of outcome measurement (for example, immediately after treatment versus follow-up at three to six months). Conclusion <ul style="list-style-type: none"> Studies examining telemental health services generally found that outcomes of telehealth interventions <u>did not differ significantly from in-person</u> interventions. Telerehabilitation (5 RS) <ul style="list-style-type: none"> Two studies reported <u>significant improvement in physical</u> functioning for telerehabilitation compared to usual care, one reported <u>significant improvements</u> in pain for telerehabilitation, and two <u>showed no significant differences</u> between telerehabilitation and control groups. Telerehabilitation tended to require <u>more provider time</u> for consultations Tele dermatology (2 RS) <ul style="list-style-type: none"> Warshaw and coauthors reported that, overall, diagnostic accuracy <u>of in-person clinic dermatology is better</u> than tele dermatology (when comparing both to a gold). |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|-------------------------------------|--|---|
| | | <ul style="list-style-type: none"> For management accuracy, overall <u>accuracy was equivalent</u> between teledermatology and clinic dermatology, but teledermatology was inferior for malignant lesions. Bashshur and coauthors found that evidence consistently <u>supported teledermatology's effectiveness</u> in diagnostic and treatment concordance with in-person dermatology. • Teleconsultation (2 RS) <ul style="list-style-type: none"> They found that telephone consultation <u>reduced immediate visits</u> to general practitioners, but it is unclear whether some visits were simply delayed. The authors <u>did not report an increase in adverse events or emergency</u> visits associated with telephone consultation. Martin Downes and coauthors concluded that such consultations <u>can be an appropriate alternative</u> to in-person consultations. Regarding utilization, the authors reported that teleconsultations resulted <u>in more repeated visits but required providers to spend less total time</u> with patients. • Other (3 RS) <ul style="list-style-type: none"> Oral anticoagulation management <ul style="list-style-type: none"> They found that most reported outcomes (bleeding events, hospitalizations, and mortality) were <u>similar across telehealth and usual care</u>. Malnutrition-related interventions <ul style="list-style-type: none"> The authors concluded that telehealth interventions <u>are as likely as usual care</u> to result in clinical improvement, but they also noted low to very low confidence in the reported effect sizes. Diabetic foot ulcer treatment <ul style="list-style-type: none"> The authors found that telehealth for diabetic foot ulcers <u>showed high diagnostic accuracy and agreement</u> with assessments performed in person. However, it was unclear whether telehealth treatment of diabetic foot ulcers had favorable clinical outcomes. |
| Auteurs/Pays | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) |
| | | • Technologiques |
| | | ∅ |
| | | • Humains et cognitifs |
| | | ∅ |
| | | • Cliniques |
| | | • Telemental health findings indicated that for assessment and treatment for a variety of mental health conditions, outcomes of telemental health were not significantly different from those of in-person care. |
| | | • Telerehabilitation findings indicated that care delivered via telerehabilitation was generally either equivalent to or yielded better outcomes than in-person care. |
| | | • Teleconsultation findings indicate that teleconsultation may be an appropriate alternative for in-person consultation. |
| | | • Teledermatology findings vary. |
| | | • Professionnels et organisationnels |
| Shigekawa et al., États-Unis | Spécialité N/A Types de professionnels Any Types de patients/clients Adults and children | |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|---|---|
| Année de la revue | Interventions | <ul style="list-style-type: none"> We therefore observe that it is unclear whether the use of telehealth services reduces the use of other services, duplicates services, or improves access to beneficial services. Some research indicates that telehealth use may not change the volume of in-person office visits. Increased access leading to increased use of needed services that patients would not otherwise receive is desirable. However, it is difficult to differentiate between needed and duplicative services. Another implication of our findings is that telehealth has the potential to improve access to care for specific patient populations of particular concern, including people living in rural areas, those with transportation barriers, and those facing provider shortages |
| | Any diagnosis or treatment intervention delivered via live videoconferencing; asynchronous store and forward of data; or telephone (excluding telephonic disease management delivered by nurses), email, text, or chat messaging directly with a health care provider. | |
| 2018 | Comparaison (le cas échéant) | |
| Objectifs de la revue | Usual care or in-person treatment | |
| This rapid review examines recent evidence both about telehealth's efficacy by clinical area and about telehealth's impact on utilization. | | <ul style="list-style-type: none"> Économiques et financiers |
| | | ∅ |
| | | <ul style="list-style-type: none"> Sociopolitiques et réglementaires |
| | | ∅ |
| | Limites/Biais | Conclusions des auteurs et recommandations générales |
| | Because of the wide variety of conditions with which patients can present, it was difficult to measure diagnostic agreement between teleconsultation and in-person consultation. Some noteworthy findings from individual studies not included in this systematic review merit attention. | This rapid review suggests that current evidence supports the effectiveness of telehealth interventions for certain conditions, but there is insufficient evidence about the impact of telehealth on utilization. Despite this lack of evidence, some research suggests that telehealth interventions that could substitute for office visits are instead likely to increase the use of services more broadly (both in-person and telehealth services). |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|---|---|
| 26) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| Effects of Telehealth By Allied Health Professionals And Nurses In Rural And Remote | Systematic review | <ul style="list-style-type: none"> Nombre d'études incluses: 43 (14 case-series and 29 used a design where 2 or more groups were compared) Période : Tous jusqu'au 31 juillet 2016 |
| | | Résultats (Outcomes incluant les barrières et facilitateurs) |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|--|--|
| Areas: A Systematic Review And Meta-Analysis | Contexte clinique | <ul style="list-style-type: none"> • Effects of interventions <ul style="list-style-type: none"> ◦ Meta-analysis <ul style="list-style-type: none"> ▪ There were no significant differences for interventions using a <u>cognitive approach</u> between telehealth and standard treatment, with effects slightly favouring standard treatment ($p = 0.665$) ▪ There were no significant differences for interventions adopting a <u>physical approach</u> between telehealth and standard treatment ($p = 0.737$) ▪ Conversely, there were significant differences for interventions using a combination of cognitive and physical approaches between telehealth and standard treatment, with a moderate effect <u>favouring telehealth-delivered</u> interventions ($p = 0.031$) |
| | Any Information on therapeutic interventions was categorized in physical, cognitive and/or social emotional approach. | |
| Auteurs/Pays | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) |
| Speyer et al. Australie | Spécialité | <ul style="list-style-type: none"> • Technologiques |
| | N/A | ∅ |
| | Types de professionnels | <ul style="list-style-type: none"> • Humains et cognitifs |
| | Allied health professionals: Physiotherapists, occupational therapists, speech pathologists, psychologists, social workers, dieticians, nurses. | ∅ |
| | Types de patients/clients | <ul style="list-style-type: none"> • Cliniques |
| Année de la revue | Interventions | <ul style="list-style-type: none"> • The results of meta-analysis indicate that telehealth is not less effective compared with face-to-face interventions, which is a finding consistent with previous studies ($n=2$) • It is possible that intervention effectiveness may depend on a range of factors, such as severity of health conditions, type of interventions provided, and factors associated with the healthcare provider |
| | Telehealth intervention, not by phone and only synchronous | |
| 2018 | Comparaison (le cas échéant) | <ul style="list-style-type: none"> • Professionnels et organisationnels |
| | | <ul style="list-style-type: none"> • These results support telehealth as an important alternative treatment modality for allied health and nursing services in rural and remote areas. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|---|--|
| Objectifs de la revue | Face-to-face interventions OR usual care OR No intervention OR Phone | |
| To describe telehealth interventions delivered by allied health professionals and nurses in rural and remote areas, and to compare the effects of telehealth interventions with standard face-to-face interventions. | | <ul style="list-style-type: none"> Économiques et financiers |
| | | Ø |
| | | <ul style="list-style-type: none"> Sociopolitiques et réglementaires |
| | | Ø |
| | Limites/Biais | |
| | Given the study heterogeneity in outcomes between interventions, the results of this meta-analysis should be interpreted with caution | Conclusions des auteurs et recommandations générales Overall, studies in this review were of strong methodological quality, and indicated that telehealth interventions may be as effective as face-to-face interventions, with a small, but not statistically significant, advantage for telehealth-delivered interventions compared with standard face-to-face-delivered treatments. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|---|--|---|
| 27) Titre de la revue ou de l'article | Type de publication (Revue narrative, revue systématique, étude primaire, autre) | Nombre de participants (Études incluses, professionnels et patients)/Période couverte par la revue (Études incluses) |
| Exploring patients' and clinicians' experiences of video consultations in primary care: a systematic scoping review | Systematic scoping review | <ul style="list-style-type: none"> Nombre d'études incluses: 7 (1 RCT, 4 cross-sectional study, 1 qualitative interviews, 1 case study) Période : 1^{er} janvier 2010 au 11 octobre 2018 |
| | Contexte clinique | Résultats (Outcomes incluant les barrières et facilitateurs) |
| | Primary care | <ul style="list-style-type: none"> Convenience and access <ul style="list-style-type: none"> Patient <ul style="list-style-type: none"> Convenience and improved access were identified as patient perceived benefits of VCs Three studies, all set in the US, showed that patients had chosen VCs in certain circumstances; that is, to reduce travel costs or to minimise time waiting for an appointment or for certain types of condition Satisfaction <ul style="list-style-type: none"> Patient <ul style="list-style-type: none"> In a cross-sectional survey, approximately 94–99% of patients were reported to be 'very satisfied' after a VC, with 95% (521/551) of patients stating that they would definitely personally use VCs again.³⁸ A randomised control trial comparing video with routine visits reported that patients were more satisfied overall with face-to-face consultations Patients with chronic conditions were more likely to prefer a face-to-face consultation Patients reported difficulties in finding private places to conduct a VC, and this potentially affected the ability to share sensitive information.³⁹ Technological issues, such as time lag in images and audio, connections and password logins, hindered fluidity in consultation for some patients. |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|--|---|---|
| | | <ul style="list-style-type: none"> ○ Clinicians <ul style="list-style-type: none"> ▪ Glaser et al³⁶ found that 88.2% (650/737) of participating clinicians felt that a VC visit had improved the patients prognosis, and that 89.4% of clinicians (652/729) agreed clinical decision making was successfully accomplished using VC. ▪ In the RCT by Stahl and Dixon clinicians felt that their ability to take a history was not impaired.⁴⁰ However, the same study found that clinician satisfaction with VC was reduced when new treatments were initiated, clinicians felt less satisfied with their ability to order appropriate laboratory tests when consulting via VCs.⁴⁰ ▪ In two studies, one RCT⁴⁰ and an interview study,²⁰ clinicians reported a preference for face-to-face consultations ▪ Reasons given for this included poor physical exam capabilities, reduced ability to choose correct investigations, and challenges using this medium for assessing mental health patients |
| Auteurs/Pays | | Meilleures pratiques/recommandations pour la téléconsultation selon les thèmes (Bloomrosen) |
| Thiyagarajan et al., | Spécialité | • Technologiques |
| Royaume-Uni | N/A | Ø |
| | Types de professionnels | • Humains et cognitifs |
| | Any | Ø |
| | Types de patients/clients | • Cliniques |
| | Any | • The findings of this scoping review show that primary care patients and clinicians report both positive and negative experiences when using VCs and these experiences are to a certain extent, context dependent. |
| Année de la revue | Interventions | • Professionnels et organisationnels |
| | Use of synchronous video consultation (VC) for a two-way communication | • The review suggests VC has a role for certain types of consultation and can in some cases be more convenient for patients. Acknowledging this variation is key when planning a VC service. |
| 2020 | Comparaison (le cas échéant) | • VC is potentially more convenient for patients, but is not considered superior to a face-to-face consultation. |
| Objectifs de la revue | Usual method of consultation (face-to-face, telephone, email, any other two-way mode of consultation) or no comparator. | |
| The study aimed to explore both patients' and clinicians' experiences of VCs in primary care | | • Économiques et financiers |
| | | Ø |
| | | • Sociopolitiques et réglementaires |
| | Limites/Biais | Ø |

| Description de l'étude ou du guide | Méthodes | Résultats et conclusions |
|------------------------------------|--------------------------|---|
| | Small number of studies. | <p data-bbox="970 311 1619 342">Conclusions des auteurs et recommandations générales</p> <p data-bbox="970 349 2074 487">The available evidence demonstrates that patients and clinicians are largely satisfied with VC, although this is dependent on the nature and circumstance of the consultation. Patients felt that VCs are patient-centred and that it is possible to build rapport; however, for both patients and clinicians, the face-to-face consultation is still preferred. Convenience and access are the key benefits for patients, but not all types of patients are engaging in VC and these benefits may not be afforded to all patients.</p> |

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