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NSW AND ACT PHNs
An Australian Government Initiative

Incorporating telehealth into the future of Australian Primary Healthcare

CONTINUATION OF TELEHEALTH MBS ITEMS POST COVID-19

Support and Recommendations Paper

from

NSW and ACT Primary Health Networks

May, 2020

We respect and honour Aboriginal and Torres Strait Islander Elders past, present and future. We acknowledge the stories, traditions and cultures of Aboriginal and Torres Strait Islander peoples on this land and commit to building a brighter future together.

Executive summary

TELEHEALTH – THE OPPORTUNITY

Around the world, health systems are witnessing a natural experiment with telehealth in the context of the COVID-19 pandemic. The easing of MBS item restrictions has been met with a steep rise in telehealth uptake and greater patient and provider acceptability, as well as the emergence of issues that have to be tackled in order to sustainably embed telehealth into our new normal or 'business as usual'. The continuation of telehealth MBS items and associated implementation activities recommended through this paper is a positive step in the broader reform agenda for the primary care sector.

Across NSW and ACT regions, Primary Health Networks have supported primary care through a remarkable increase in telehealth usage, and have been asked by their Clinical Councils to seek its continuation. In the Hunter New England Central Coast (HNECC) and Murrumbidgee regions in NSW, >92% of practices report using some telehealth. In HNECC, this is at least double the rate of use in the months prior to the introduction of new MBS telehealth and telephone items. Similarly, there has been a reported 300% increase in telehealth use in the Western Sydney PHN region. There is strong support from providers for maintaining telehealth, with 90-97% of providers in HNECC and Murrumbidgee supporting its continuation, citing benefits for providers and patients. However, there is still opportunity to improve uptake of videoconferencing, which is only used by ~50% of GPs and with significant variability in the platforms used, and address challenges raised by providers in relation to continuity of care, provider experience and sustainable remuneration.

Australia is not alone in witnessing this uptake, with governments across different health systems also relaxing restrictions on telehealth and being met with an uptick in demand. Providers expect to use more telehealth and patients express willingness to use it even after the pandemic resides. Most governments indicate that telehealth will be part of the future healthcare system in some form.

There is great potential in rural and remote areas for increased telehealth to support better health outcomes. These areas generally have a high proportion of vulnerable populations, lower proportion of GPs per capita and longer travel times pointing to a potential for significant impact on historically poorer health outcomes. Interestingly, anecdotal feedback and survey data have also indicated a very positive uptake of telehealth in the Aboriginal and Torres Strait Islander community and specifically Aboriginal Medical Services.

Telehealth appears to be restoring and improving confidence and access to primary healthcare. This should be sustained and further developed moving into post-COVID reality.

THE RISKS

Whilst concerns about provider and patient acceptability have been partly addressed by the ongoing experiment, the Australian government must still consider compliance challenges. Convenience of access must be balanced with the risk of misuse. Left unchecked, there is a risk that some items may drive unnecessary cost without additional benefits for patients or population health. Additionally, the fragmentation of care and negative impact on rural workforce retention must be considered in designing Australia's future telehealth system.

RECOMMENDATIONS

The NSW/ACT PHNs propose the ongoing availability of the MBS telehealth items and increase usage of telehealth for General Practice and Allied Health, under conditions that will balance patient and provider experience, population health and provider cost. This paper outlines recommendations for the next phase of telehealth in Australia, as well as activities to support effective implementation, reflecting the perspective and experience of the constituents of the NSW and ACT PHNs.

Major recommendations are:

- To continue:
  - All current MBS items relating to telehealth across all patients and geographies
  - Access to MBS items relating to telehealth by all primary care provider types.
- Remove compulsory bulk billing for telehealth
- Add:
  - A streamlined patient enrolment system for some primary care sectors with some flexibility
  - Ongoing support from government for primary care to access a standards-based video telehealth platform such as Health Direct Video Call.
- Consider:
  - The development of guidance regarding the appropriate mix of appointment types for individual patients
  - Expanded MBS items for Allied Health providers.
- Increase the role of PHNs to support the ongoing use of telehealth and further consultation be undertaken with the sector including PHN Clinical Councils.

Telehealth – the Opportunity

The escalation of the COVID-19 pandemic required the rapid scaling of telehealth services around the world due to urgent need for social distancing measures to both contain community transmission and keep healthcare workers safe. Subsequently, in Australia and globally, health systems are witnessing a natural experiment with telehealth – the benefits of which have been well described historically (see Appendix), although uptake has traditionally been limited.

There has been an immediate and overwhelming uptake of telehealth in Australia and in NSW/ACT, enabled by the step-wise loosening of restrictions from March 13, expansion of eligible service types to include almost all in-person primary care and many specialist attendances, removal of geographic constraints, and allowance of telephone only consultations.

In 2018-19, MBS subsidised telehealth items totaled ~51,000 services, or only ~0.03% of all professional attendances nationally. In March 2020 alone, the new telehealth and telephone items jumped to over ~1.2 million nationally, and surpassed 10 million in mid-May.[1] The majority of new telehealth consultations are by phone, in April representing ~30% of all claims on item numbers with a new telehealth/telephone code, compared to ~3% via telehealth with an audiovisual connection.[1]

In NSW and ACT all PHN regions have seen a dramatic increase in telehealth use. Within NSW, Hunter New England Central Coast (HNECC) Primary Health Network (which has a broad mix of practices by rurality and size) the increase in telehealth use across the region is demonstrated in the results of a *COVID-19 Impact Survey*, which received 300 responses[2], including 204 General Practices (~50% of affiliated GPs in HNECC)[3] . The Western Sydney PHN region has also reported a 300% increase in telehealth use.

The survey found that >95% of all respondents, and 100% of GP practices, are currently using some form of telehealth, and approximately half of practices reported using it for 50-100% of their scheduled appointments (See Figure 1a). This represents at least double the rate of

[1] Services Australia, MBS Item Report April 2020; AMA Statement 18 May 2020 'Patients Embrace telehealth as key part of the health system' ama.com.au/media/patients-embrace-telehealth-%E2%80%93-covid-19-reforms-must-be-made-permanent

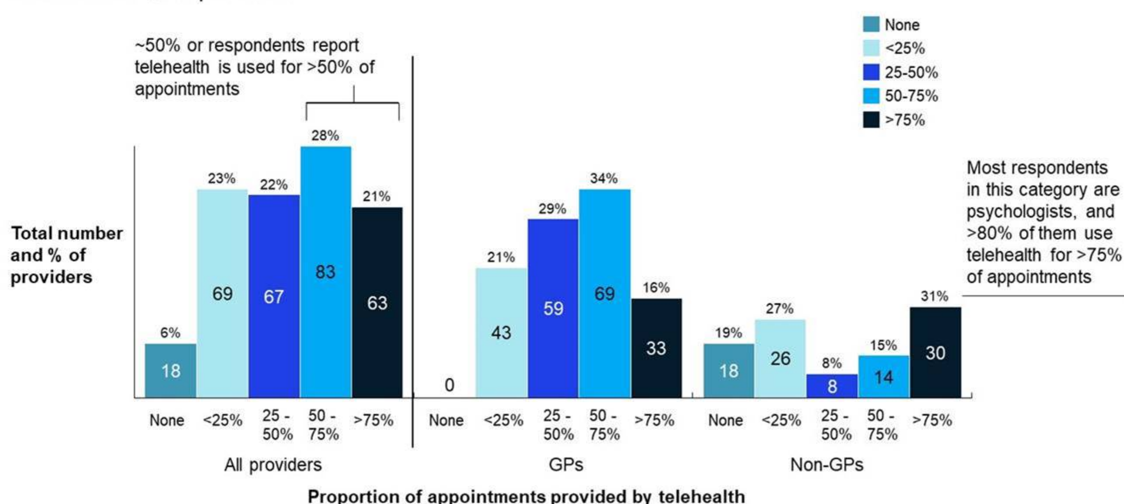
[2] We assume that each response is for an individual practice, as the survey was sent to practice managers, however the possibility of multiple responses per practice cannot be excluded.

[3] Full breakdown of practices can be found in the Appendix

telehealth use by GPs in HNECC since the introduction of the new MBS Telehealth items[4] and potentially higher due to the way the data was collected.[5]

In the Murrumbidgee Primary Healthcare Network there has also been strong uptake of telehealth within General Practice, although the intensity of use is lower than in HNECC. In the recent *COVID-19 Impact Survey* of all 86 GPs in the region, ~92% reported using some telehealth, however in comparison to HNECC, fewer report using for the majority (>50%) of their appointments (See Figure 1b)

Figure 1a, Proportion of appointments provided by telehealth in HNECC, All practices and GP versus non-GP

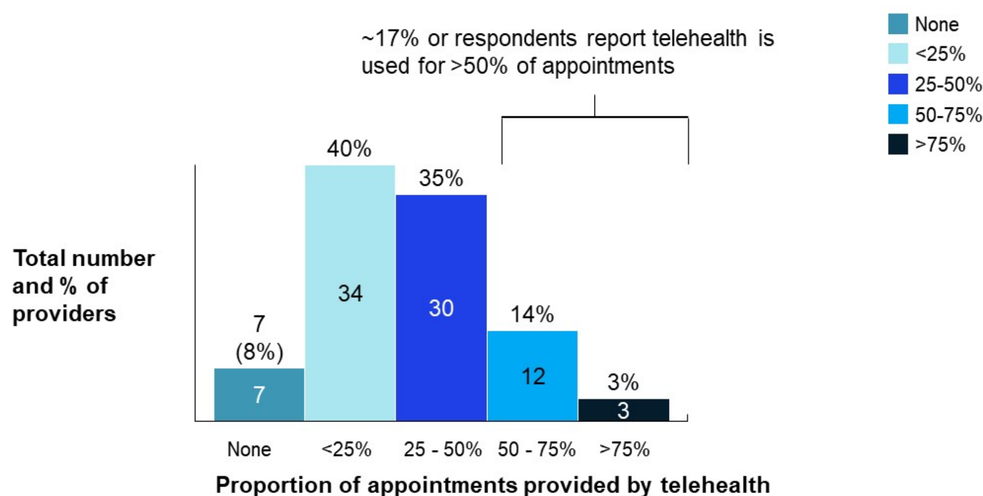


Source: Hunter New England Central Coast Primary Healthcare Network COVID-19 Impact Survey, May 2020, n=300.

[4] HNECC Telehealth Capabilities Survey (n=436, 399 GPs and 37 commission services), March - May (to minimise the chance of overlap with new telehealth item numbers and enable like-for-like comparison, this figure only incorporates responses given until 31 March for GPs.)

[5] HNECC Telehealth Capabilities surveys were collected by phone and online. Some respondents who reported using telehealth online may not have recorded whether this was only since the new items were introduced, or whether use was rebated or unpaid work.

Figure 1b, Proportion of appointments provided by telehealth by General Practices in Murrumbidgee



Source: Murrumbidgee Primary Healthcare Network COVID-19 Impact Survey, May 2020, n=86 (General Practice only, not all primary care providers).

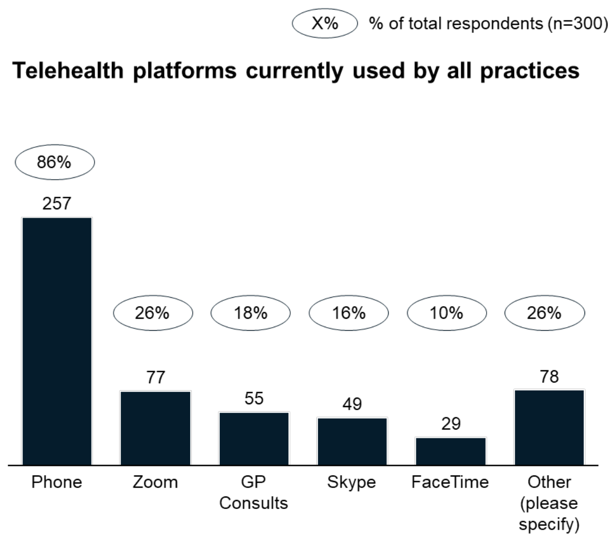
Despite good uptake, there is further room to improve, with telephone remaining more widely used than videoconferencing, and platform use remaining fragmented. This is in line with the national and state trend, despite videoconferencing being the preferred government solution.

Providers report that limited uptake of video was due to the short timeframe and absence of infrastructure for videoconferencing in the new environment (equipment or internet), as well as patient and provider preference, and patient confidence in using videoconferencing platforms. A survey collated from 5 PHNs including Central and Eastern Sydney PHN, South Western Sydney PHN and three Victorian based PHN's also found that videoconferencing represented only ~5% of all telehealth consultations in April, with similar challenges raised.[6] Limitations of access to reliable internet connections to the practice or Wi-Fi capabilities within the practice were barriers to use of video conferencing were specifically reported by some GPs in the Nepean Blue Mountains PHN region.

[6] Outcome Health (5 May 2020), 'Insights paper No. 3: COVID-19 and Australian General Practice, A preliminary analysis of changes due to telehealth use'

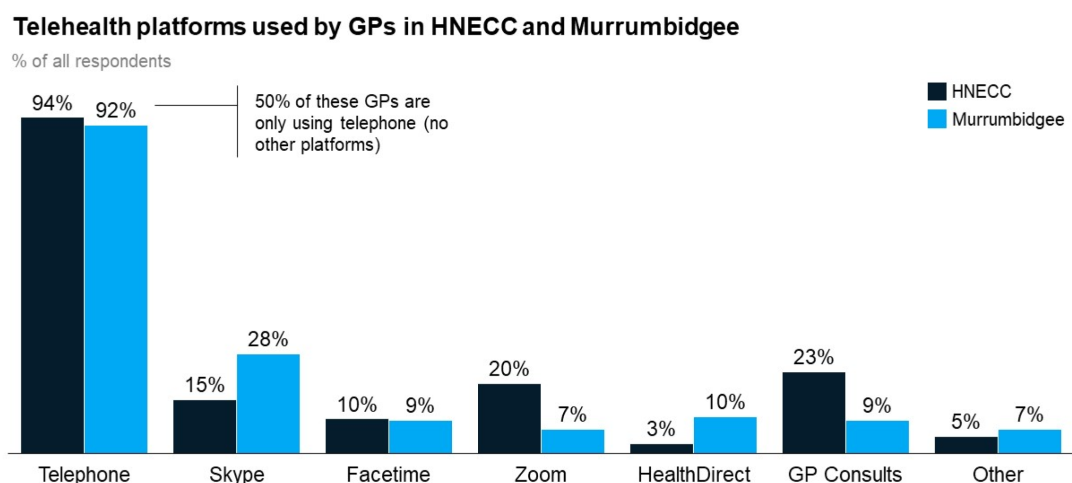
In HNECC, while 86% of primary care providers and 94% of GPs reported using telephone as one mode for telehealth consultations, the four most popular videoconference platforms were each used by only ~10-25% of practices[7] (See Figure 2a). In Murrumbidgee, 92% of GPs are using telephone, and the four most popular video platforms being used by ~7-30% of providers. In both regions, only ~50% of GPs are using a platform other than telephone, and for those using one, there is high variability in the preferred platform (See Figure 2b).

Figure 2a, Telehealth platform penetration in HNECC PHN



Source: Hunter New England Central Coast Primary Healthcare Network COVID-19 Impact Survey, May 2020, n=300.

Figure 2b, Telehealth platform penetration in General Practices in HNECC and Murrumbidgee

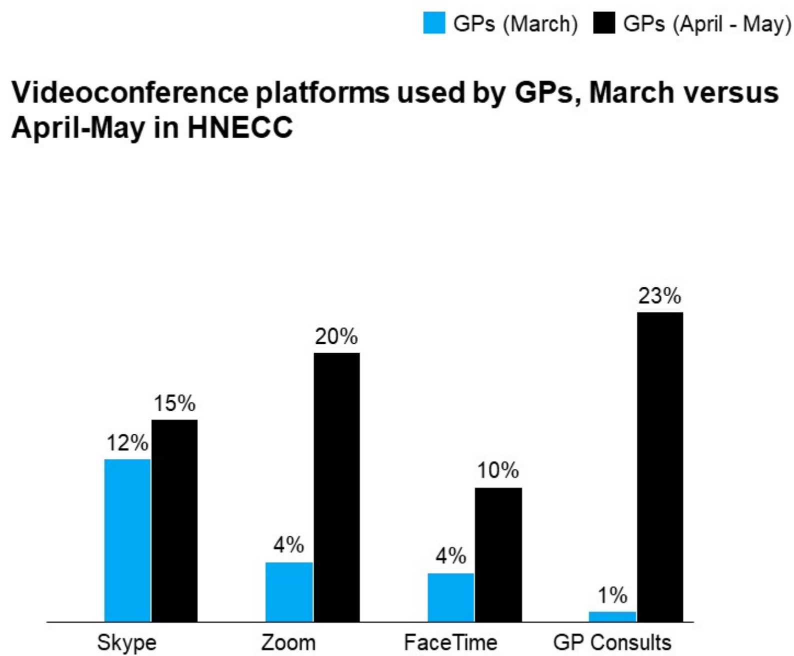


Source: Hunter New England Central Coast Primary Healthcare Network COVID-19 Impact Survey, May 2020, n=204 (GPs only); Murrumbidgee Primary Healthcare Network COVID-19 Impact Survey, May 2020, n= 86 (GPs only).

[7] The total does not equal 100%, because rrespondents could select more than one platform

While uptake remains relatively low, in the HNECC there appears to be an increase in the use of the most popular video platforms in the last month. Comparison of data collected from in March as part of the *HNECC Telehealth Capability Survey* in March 2020 showed that proportion of practices using GP consults, Zoom and FaceTime have all increased significantly.

Figure 3, Telehealth platform penetration in HNECC, March versus May



Source: HNECC Primary Healthcare Network COVID-19 Impact Survey, May 2020, n=204 (GPs only); HNECC Telehealth Grants Survey, March 2020, n=380 (GPs only).

Data from South Western Sydney PHN, Western Sydney PHN and Western NSW PHN suggests that there has been uptake of telehealth and a higher proportion of telephone use.

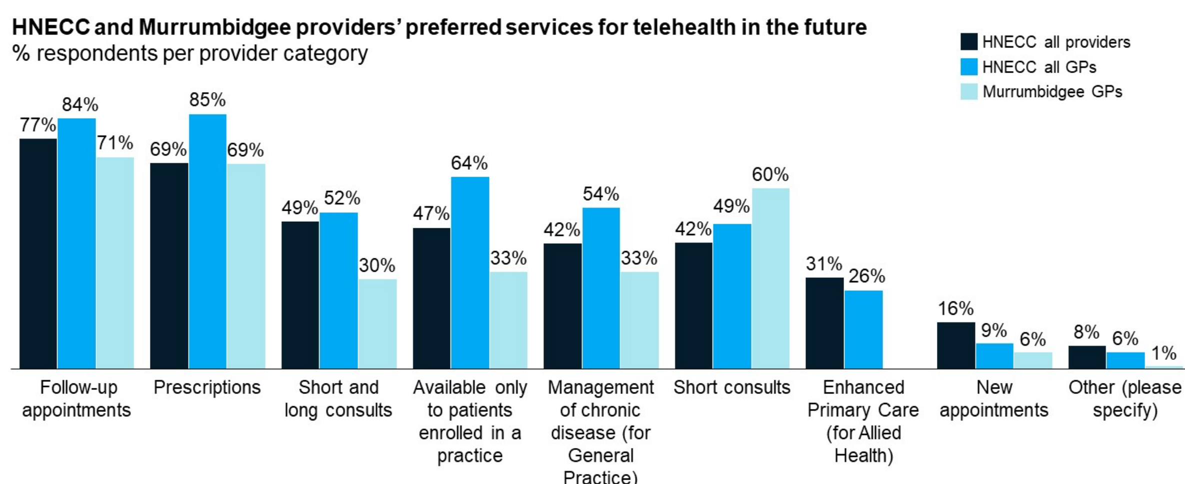
Table 1, Uptake and platform use for telehealth in SWS, WentWest and Western NSW

	UPTAKE OF TELEHEALTH	HIGHER PROPORTION OF TELEPHONE USE
South Western Sydney PHN	From late April to mid-May, 4% of all GP patients known to the practice had at least one telehealth consultation. Over 50% of 226 practices were using telehealth. 22% are using a form of video consultations	8% video vs. 92% telephone
WentWest (Western Sydney PHN)	Between March and May, there was a 300% increase in telehealth use as a proportion of total use among GPs from a starting point of 0.5%	4% video vs. 96% telephone
Western NSW PHN	In practices using HealthDirect, there were ~3000 GP, AMS and Allied Health telehealth consultations from mid-March to mid-May. Over this time the average number of consultations per day increased almost 80% (~28 to ~50)	6% video vs. 94% telephone

Source: Data from respective PHNs

Providers are supportive of the ongoing use of telehealth, considering it beneficial for their patients and practices. An overwhelming 90% of Murrumbidgee GPs and 97% of HNECC practitioners that responded to the COVID-19 Impact Survey were in favour of the continuation of the temporary MBS telehealth items. They are particularly in favour of retaining telehealth for low risk consultations (e.g. follow ups and prescriptions), as well as for the management of chronic disease. Anecdotally, this sentiment is shared across other NSW and ACT PHN regions.

Figure 6, Providers' preferred services for telehealth use in the future



Source: Hunter New England Central Coast Primary Healthcare Network COVID-19 Impact Survey, May 2020, n=300; Murrumbidgee Primary Healthcare Network COVID-19 Impact Survey, May 2020, n=86 (GPs only).

Commonly raised benefits from recent surveying included patient and staff safety, timeliness and accessibility of care – particularly for vulnerable patients, and patient convenience. Clinician feedback included the following:

> *Ongoing phone consults will benefit practices and patients, in terms of* ***time savings, reduced exposure to infection in waiting rooms****, carpark congestion and general convenience.*

> *The changes to practise for both patients and practice afforded by telehealth in logistical terms has been a really good thing to have come out of the pandemic.* ***Less time pressure****, less time spent on transit and parking hassles for patients and the ability to* ***follow up results in a timely and coordinated fashion with chronic disease plans especially****.*

> *I think telehealth for some consultations as above add a very valuable service to general practice. The* ***doctors are also re-numerated for services*** *such as repeat scripts etc… where previously they weren't. This would also assist in* ***reducing the workload on doctors*** *for face to face consults. This may help our area's severe workforce shortage.*

***Patients like telehealth** where hands on is not needed – it saves them on time, travel, sitting around waiting when surgery running behind. Of all the things to come out post COVID **we really should push to retain telehealth**.*

*10 to 20% patients don't need to see me and **they travel long distances** when it's not required.*

Providers also highlighted the benefit of being remunerated for work that is important for patient care but was previously not able to be billed. Feedback included:

*I **have always done phone consults** for patients when follow up of results is required...or for example **DV patients who are afraid of their partner finding out** they have been to a medical practice. The only difference now is that I get paid for it. I previously spent **10 hours a week of unpaid phone consults**.*

*Telehealth is essential in the COVID situation but makes a lot of sense for ongoing care. Means go can **get paid for some work previously not paid for but also really good for patients**. Works for CDM especially plan reviews.*

The Aboriginal and Torres Strait Islander community has also been a strong adopter of telehealth throughout this time. Use was particularly high amongst the Aboriginal Medical Services, showing that in all the AMSs in HNECC, 100% are using telehealth and 78% are using it for more than 50% of their consultations. Anecdotally this is supported by other PHNs. Additionally, HNECC PHN Integrated Team Care providers indicated their no-show appointment rate declined during COVID as clients were happy to undertake the appointment by telephone.

Broad based feedback from the community reported through the HNECC Aboriginal Health Access team include telehealth has meant it is:

- Easier to engage with patients
- Has enabled increased dialog with patients who have been difficult to communicate with
- Most appointments where via phone rather than video
- Community have preferred phone rather than video
- Has led to increased engagement
- One AMS has reported that their community have been reluctant to engage with tele/video consultation
- Some communities have had difficulties with accessing technology.

The COVID-19 experiment has provided an opportunity to identify and address providers' concerns in order to embed telehealth into daily practice. Common issues raised by practitioners across regions included continuity and quality of care. This is reflected in the COVID-19 Impact Survey results, which found that very few GPs (6-9%) feel comfortable using telehealth for new appointments. Additionally, 65% GPs in HNECC support the use of telehealth only for patients enrolled in the practice, although in Murrumbidgee this view is shared by only ~33% of GPs (See Figure 6). This discrepancy likely reflects the higher proportion of rural and remote (MM3+) practices in this region, who may perceive the administrative burden to outweigh the benefits of enrolment in smaller communities. Streamlining enrolment processes may help to address this.

Remuneration and financial sustainability are also top of mind. In HNECC, several providers acknowledge the additional revenue from previously unpaid telehealth work is beneficial, but this was outweighed by concerns about financial viability in the current environment, primarily due to the compulsory bulk billing requirement.

Conversely there is evidence that a small percentage of practices have shown limited capacity and malleability to adapt and therefore their viability is threatened by this disruption. For example, in SWS PHN region 3.2% (n =14) of practices have closed during the pandemic (temporary or otherwise), with most being solo GP practices and the remainder small (2-5 GPs). Another 5% (n = 22) have reduced their opening hrs. This has an immediate impact on access and continuity of care for thousands of patients. Clinician feedback included.

*It is **NOT currently financially viable u**nder existing complex model - some are compulsorily bulk billed, some private billing - this **creates confusion in terms of eligibility** for both GPs and patients (eg. parents of a child less than 1 year's old are bulk billed, but a parent of a 14month old toddler can be privately billed).*

*If telehealth must be bulk billed it is **probably not viable for quality care***

*It is essential that the gov **lifts the private billing restrictions OR increase the rebate** to a rate that allows us to provide a sustainable practice.*

Patients have also responded positively to telehealth, particularly younger generations. A recent Consumer Pulse Survey[8] of ~700 Australians indicated that the number of people using telehealth has risen from 3% to 14%, of which~60% were satisfied or very satisfied with it, and ~50% report wanting to continue using telehealth after the COVID-19 pandemic. This is relatively consistent with a recent HotDoc survey of ~350 Australians over 18, which found that ~40% of patients would like to continue using telehealth post-COVID 19, but this dropped to only 20% for patients over 60 years old. One third of respondents report concerns with telehealth, including internet issues, need for physical examination, logistics behind getting scripts to pharmacies, communication, privacy issues, and fair pricing. Whilst many of these issues can be addressed, these results suggest that it is important that Australians, particularly older generations, continue to have the option for in-person visits.

In the Nepean Blue Mountains PHN region the Community Advisory Committee identified particular patient groups who would benefit greatly from the continuation of telehealth in general. These included those who have difficulty accessing healthcare services due to transport, mobility, and childcare. In the Nepean Blue Mountains PHN region these groups make up over 7% of the population.

[8] McKinsey & Company COVID-19 Australia Consumer Pulse Survey 5/8-5/11/2020, n = 704;

The global experience

Australia is not alone in seeing a rise in the uptake of telehealth. Around the world, governments have encouraged the use of telehealth to support social distancing regulations, by loosening restrictions and encouraging investment, and have seen significant increase in use. On average, in major health systems it has been estimated that the use of virtual care in all settings increased by 10-15x in the early stages of the pandemic response.

In the UK, remote primary care consultations by telephone doubled between February and April, from 14% to 28%. Video calls have also increased, supported by an NHS initiative to fast track the procurement of digital tools for primary care. Over 90% of primary care clinics in England are using AccuRx's video function, and other telehealth platform providers are reporting a 70-100% increase in the use of their services. Governments across Canada, Japan, Germany, Singapore and the Nordics have also made substantial investments in telehealth, and platform providers are all reporting large increases in use, ranging from 30% to over 300%. Federally, the US has introduced >130 waivers to Medicare and Medicaid telehealth restrictions for seniors and low-income earners, and introduced legislation allowing all healthcare providers to use informal videoconferencing platforms on their own devices.

Providers expect to use more telehealth in the future. Across five European countries, physicians surveyed expect remote consultation to stabilise post-crisis to 15-35% of total consultations, representing 1.5-2x more than the survey suggested from the before-crisis state[9]. In the US, practitioners expect to use telemedicine for ~20% of their patient consultations after the pandemic, compared to 7% beforehand.[10] In Japan, where telehealth has previously been restricted to follow up appointments for those with chronic disease, 70-80% Japanese healthcare providers expect to use more telehealth to consult on physical and mental health conditions post-COVID[11].

Patients have responded positively to the telehealth experience. A recent US Consumer Survey (May 2020) reported that ~75% of respondents consider it likely or very likely that they will use telemedicine in the future, compared with only 11% actual use in 2019. Of those that had received healthcare from their primary healthcare provider since March 1, ~40% was delivered by telemedicine, and ~75% were very satisfied with the experience. Doctors

[9] SermoCOVID-19 HCP survey, April 2020 (n=943)

[10] SermoCOVID-19 U.S. Healthcare Practitioner Survey, May 2020 (n= 382)

[11] Sermo COVID-19 Healthcare Practitioner Survey, April 2020, (n=110)

appear to have a key role to play in advocacy, with ~50% patients reported being motivated to do a telehealth consult because it was recommended by their primary care provider.

It is likely that eased telehealth restrictions will continue post-COVID in most countries, although the early response is mixed. Many countries are still in a more acute phase of the pandemic than Australia and have not yet announced definitive policy choices about telehealth post-COVID. However, experts from the UK, US, Canada and the Nordics have said that reversing the changes will erode benefits to patients, providers and the system. In one of the strongest statements, Canadian Medical Association Virtual Care Task Force report that telemedicine will remain a hallmark of Canada's healthcare system long after the pandemic dies down. Japan has taken a much stricter approach, with the government explicitly stating that rules allowing telehealth for new appointments are only a temporary measure. In Germany, which has traditionally been slow to adopt digital healthcare innovations, changes to the cap on telehealth visits (to 20% per quarter) per patient are currently only in place for Q2.

Managing the risks of telehealth

Historically, telehealth has been a minor component of primary health care delivery, both in Australia and around the world. This is due to an assumption of limited interest on the part of providers and patients, the funding available, as well as concerns regarding potential misuse.

The COVID-19 telehealth experiment addresses the first assumption, with evidence from Australia and around the globe proving that clinicians and patients are not only willing to engage in telehealth, but that in many cases they prefer it to in-person appointments.

In order to sustainably embed telehealth as 'business as usual' in Australia, some challenges must be addressed at the system level.

Convenience of access must be balanced with the risk of misuse. While there is no concrete evidence that telehealth item numbers are being misused, there is a potential risk for this to occur, and in a manner that disrupts continuity of patient care. It is anticipated however that the vast majority of healthcare professionals will abide by the standards as set by their regulating bodies in the provision of patient care, and the risk can further be mitigated by implementing measures such as a streamlined patient enrolment with a GP practice and a requirement for at least one face to face visit prior to utilising telehealth item numbers.

The NSW/ACT PHNs propose that the most important aspect to manage in this respect are clinician-initiated pathology calls (for normal results) or after-hours appointments.

The relatively broad bulk-billing requirements currently in place (only for GPs, and not for allied health or specialists) to disincentivise misuse are unlikely to be a sustainable control for the ~80% of Australian GPs that do not routinely bulk bill.[12] Remuneration has typically been a key driver of telehealth uptake, with ~50% of GPs who were not already using it in 2018 suggesting that this would change their practice[13]. Insufficient remuneration, and particularly compulsory bulk billing, was raised as a barrier to providing sustainable quality care in commentary from the COVID-19 Impact Survey, reflecting feedback we are hearing from our PHN constituents. In this paper's recommendations, we consider other options to balance this risk.

In order to balance the potential economic impact to the government and the development of an unsustainable system due to broadening of the use of telehealth MBS items, we

[12] RACGP Health of the Nation Report 2019

[13] RACGP Views and attitudes towards technological innovation in general practice: Survey report 2018

recommend consideration of the following aspects which are further explored in the recommendations section of this document:

- A streamlined patient enrolment model
- Restrictions around after-hours usage
- Compliance be monitored in accordance with the existing regulations.

The fragmentation of care and negative impact on rural workforce retention are other potential unintended consequences of unrestricted telehealth which must be addressed. Of the 300 primary care practices surveyed in HNECC PHN, ~50% would prefer that telehealth only be provided to patients enrolled at the practice. This reflects the commonly held concern that openly available telehealth may erode the doctor-patient relationship, as well as make it challenging for GPs to make new diagnoses where physical examination is required. Another concern is that the ability to complete all primary care virtually may reduce the incentive (and need) for doctors to remain in rural areas long term for primary care.

Liability risks - In the current COVID environment, the benefits of telehealth far outweigh the risks. However, in post-COVID times, the greatest risk for telehealth providers and host providers is misdiagnosis, which can then incur liability and reputational risk. The risks of misdiagnosis, for example, are likely to be heightened in the context of providing a health service via telehealth because of the inherent limits of the clinical assessment. Additional risks particular to telehealth are also potential liabilities arising from inferior equipment and technology and the storage/ transmission of digital images.

Recommendations

The COVID-19 global pandemic has been a transformative experience requiring many aspects of our society to shift and change at unprecedented pace. As we sit in this pivotal point in time, there is the opportunity to embed the once in a generational shift in the mode of delivery of primary health care that has embraced both audio and video telehealth. Data from PHN constituents indicate there has never been a more opportune time to drive telehealth into business as usual for primary health care.

The NSW/ACT PHN's acknowledge and welcomes the government's signaling of support for the ongoing continuation of the expanded MBS Telehealth items and provides this paper for consideration and to further strengthen the advocacy landscape. This paper outlines some practical considerations and approaches for the primary care sector.

The NSW/ACT PHNs as a collective support the continued availability of the MBS Telehealth items to leverage the wholesale uptake of telehealth as a result of the COVID-19 pandemic, with some restrictions that aim to balance patient and provider experience, population health and sustainable cost.

The continuation of the MBS Telehealth items should be supported by a comprehensive education program for both health practitioners and the general community and other implementation measures that will maximise the chance of effective uptake

The position proposed in this paper is aligned to the following principles:

1. Telehealth should not replace face-to-face encounters but be a complementary option where it suits patients and clinicians
2. Telehealth methods of care (e.g., audio or video) need to be clinically appropriate for the patient and appropriate consent protocols are embedded in the services
3. Telehealth should add value to patient and clinician experience
4. Telehealth should be both cost effective and efficient for both the primary care sector, patients and government
5. Telehealth use should be designed to increase access to care particularly for vulnerable groups
6. Telehealth should be used to promote uptake of general digital health tools including self-help, my health record, and evolving platforms such as e-prescribing and e-referrals.

System-wide recommendations on how telehealth should be made available

WHAT SHOULD BE CONTINUED

RECOMMENDATION	RATIONALE
Continue all primary care MBS items currently offered for both audio and video telehealth. (i.e. no restrictions on service types)	As a result of the COVID experience there has been a significant uptake but its acceptance and utility is still evolving and a continuation would allow its use to mature. To support this evolution, usage guidelines should be developed.
Continue access to MBS items for all patients, including all geographical regions .	Allows for improved access for those in urban and metro areas for those who might be part of vulnerable and hard to reach groups. There is a case for urban use as much as there is for rural.
Continue access to MBS items by all primary care providers, including Allied Health, Practice Nurses, Nurse Practitioners and multi-disciplinary case conferencing.	To ensure that team care arrangements are supported by telehealth and that all professional groups operate on a level playing field.

WHAT SHOULD BE REMOVED

RECOMMENDATION	RATIONALE
Remove compulsory bulk billing for all groups.	To ensure sustainability for the primary care sector.

RECOMMENDATION FOR EXPLORATION/CONSIDERATION	RATIONALE
Telehealth should not be used as a method of care for existing patients with new conditions.	To safeguard patient care and provide appropriate clinical care.

WHAT SHOULD BE ADDED

RECOMMENDATION	RATIONALE
For General Practice, Aboriginal Medical Services (AMS), Residential Aged Care Facilities (RACF) a streamlined patient enrolment process should be introduced.	To encourage patients to have a regular general practice and care team, to assist with continuity of care and familiarity with the patient's condition. *note the recommendation is with the practice not the practitioner to accommodate circumstances where care is provided by a locum and registrar. The final methodology to be worked through and confirmed with peak bodies.
Some flexibility regarding being an enrolled patient should be provided for residents of RACF and new patients to a geographical locality or an area of market failure.	Not to disadvantage people who may move geographical locations or into RACF or in instances where GP services are no longer available in a locality due to market failure (e.g., remote townships).
For afterhours, the practice should have formal arrangements in place with a nominated after-hours service provider.	To ensure there is an effective relationship between the daytime general practice and after-hours provider, ensuring continuity and clinical handover.
Primary care should be incentivised and/or supported to access a standards-based video telehealth platform such as Health Direct Video Call.	The adoption of a single platform universally across the primary health sector will provide many benefits for clinicians and patients such as consistency of user experience for both clinicians and patients, quality and security. An easy to use platform that is well supported and benefit ongoing usage. Incentive methods could be included in the current Digital Health PIP, or a cost neutral option to be considered is a small technology levy be included into the MBS telehealth item rebates to offset the cost of the application.

RECOMMENDATION FOR EXPLORATION/CONSIDERATION	RATIONALE
Consideration should be given to determining an appropriate mix of appointment types for individual patients. The proportion of telehealth appointments to in person appointments will need to be carefully examined and implemented.	To ensure consistent care and support clinician – patient relationship. *this should be applied flexibly according to the care profession (e.g., Allied Health may operate with higher degree of telehealth appointments or multiple telehealth appointments may be suitable for a patient recently discharged from hospital who is unable to drive).
Options should be explored for allied health providers for additional MBS item expansion in a pre and post-operative context. For example, hip and knee osteoarthritis and total joint replacement.	There is such a wide variety of post-operative clinical contexts that would require consultation with relevant peak bodies.

Implementation recommendations

The continued provision of telehealth as a viable option for care within the primary care sector must be supported by focused sector wide implementation activities and education.

Despite the recent trend towards greater uptake and acceptance, telehealth requires clinicians to learn new workflows, and new ways of interacting with their patients.

For this reason, improving telehealth knowledge through education and training at both the undergraduate and post-graduate level is needed to facilitate wider utilisation.

Below are aspects of implementation that should be considered in tandem with the continuation of the MBS Telehealth items.

Training and Education support:

- Consider a comprehensive education program for current primary care practitioners to maximise uptake by the sector and ensure quality of care for patients. This could include best practice examples of telehealth models of care and business sustainability.
- Telehealth education should be immediately included in medical and nursing schools curriculum, RACGP post graduate studies, and allied health curriculum
- Build upon work resources and work within the telehealth hub resource centre which has been developed and released by the Digital Health Cooperative Research Centre (DHCRC).
- PHNs in collaboration with the relevant peak bodies should provide ongoing support and training for the implementation of telehealth as a business as usual activity in primary care. PHNs have demonstrated a capacity and capability to respond at a regional level to support and implement initiatives such as embedding telehealth into practice and are ideally placed to ensure that training and education is supported with local scenarios. For example, HNEC PHN ran a series of COVID-19 related livestream events with over 9,000 individual participants across a significant footprint including international participants. The telehealth livestreams attracted over 230 viewers with over 310 subsequent YouTube views.
- Consider a comprehensive public health campaign promoting the benefits and availability of telehealth to the community. Patient expectations around choice and convenience are likely to help drive the uptake of telehealth, however improved consumer awareness of the value, convenience, and safety of telehealth is essential before this can happen. This campaign would be particularly important for older Australian's who may need support embracing technology.

Quality framework, safeguards and evaluation frameworks:

- Develop policy and quality frameworks and guidelines to support telehealth as an integral element of primary care provision including clinical context and patient safeguards
- Support for primary care to build telehealth into clinical governance should be considered
- Consider the inclusion of telehealth practices in accreditation standards.
- Consider the development of comprehensive evaluation frameworks to measure the effectiveness and long-term outcomes of telehealth.

Financial support:

- Consider further government support for primary care providers by way of additional telehealth grants to support either telehealth capability or expansion of telehealth services within a practice, service, or business.
- Consider increasing PHN funding to scale telehealth support and provide intensive focus on training for the implementation of telehealth with a quality care focus.

Technical Provisions:

The Commonwealth should establish minimum requirements and preferred platforms to conform with privacy and clinical requirements. See appendix for initial recommendations regarding appropriate platforms and minimum required hardware.

Appendix

POTENTIAL MODELS OF CARE

Allied Health Professionals – Potential models of care for delivery of telehealth

- First visit is usually face-to-face to familiarise the patient with the professional and the key activities or pieces of equipment which are required. This is not always the case though.
- Delivery is usually weekly or in line with recommended best practice protocols.
- Bringing patients into practices has been done but most intervention have lasted approx. 12 weeks and were delivered primarily remotely. There is no evidence base that suggests entirely remote programs are ineffective. i.e. They are at least as effective as face to face interventions
- For exercise-based treatment and rehabilitation post injury, there is evidence that telehealth-based programs can result in greater adherence to treatment programs.
- Patient acceptance is quite high, particularly where technology is simple, equipment is available and video conferencing is the prime modality.

This approach is most suitable for exercise, nutrition or psychology-based services and some optometry and auditory services if they have correct equipment. For example, physiotherapist delivering exercise therapy or rehabilitation versus podiatrists delivering debridement services, impossible to delivery by telehealth.

Nurse Practitioners – Potential models of care for delivery of telehealth

- For Nurse Practitioners, continuation of the access to MBS telehealth items and continuation of ability to use these numbers under a mixed billing model
- Access for MBS Telehealth item numbers for specialist Nurse Practitioners providing services into RACF, in collaboration with the resident's GP

Mental Health Nurses and other Registered Nurses working outside the NSW Health system - Potential models of care for delivery of telehealth

- Provide qualified, experienced, and credentialed mental health nurses with MBS item numbers for the provision of mental health services directly related to COVID-19, Via telehealth with appropriate conditions in place.

It should be acknowledged that telehealth may not be suitable for some services or patients altogether (e.g. psychological / behavioral assessment of children who need to be observed) and guidelines must be developed to support clinicians to make this assessment.

THE BENEFITS OF THE INCREASED USAGE OF TELEHEALTH IN PRIMARY CARE

Telehealth increasingly offers new and emerging value propositions when compared to traditional healthcare service modalities. New and emerging telehealth modalities can now deliver quality, effective care at lower costs than their traditional counterparts. In fact, telehealth is adding value to healthcare, both in its role as an adjunct treatment modality and now in relation to treatment modalities delivered remotely in their own right.

Other key value propositions of telehealth include:

1. **Increasing access to care for vulnerable and/or harder to reach consumers** – virtual consultations create a means of enabling healthcare consultations and interactions to occur in places of comfort which are easy to access and overcome traditional geographical barriers to care. This allows greater access to care for those in geographically rural or remote places, for vulnerable consumers who would otherwise find it difficult to access healthcare in their community and for our elderly where relocating from place/facility to other places or facilities is traditionally more difficult and arguably more dangerous for these consumers. Telehealth offers an effective, valuable option for care provision.

2. **Avoiding preventable hospitalisations** – Telehealth may be able to help reduce possible preventable hospitalisations and more effectively redirect care. Through remote monitoring between clinician and consumer, disease states can be better managed in real time situations and changes in disease management treatment initiated early and effectively where required. This can reduce the risk of preventable hospitalisations that would otherwise have resulted from unchecked escalating disease progression or mismanagement. In addition, telehealth can assist with clinician to clinician management of consumer conditions. Peer to peer advice or Specialist to GP consultation can help better manage health conditions and situations, redirecting care to the most appropriate setting prior to referral to hospital. This approach may negate the need for patients to attend an emergency department in both the short and long term.

3. **Effectively optimising limited resources** – Telehealth allows for multiples clinicians to collaborate about a patient, without requiring them all to necessarily be where the patient is located. Tests can be shared in real time for clinicians or stored and forwarded later, minimising use of diagnostic resources. Multiple consults can be held with patients in different locations, reducing cost of travel for both consumers AND clinicians, whilst utilising limited physician resources in more time efficient ways. Finally in locations with very limited or no Specialist services, available services (or visiting services) could

be more efficiently utilised through a mix of telehealth and face-to-face consultation and this may provide a means of delivering services in areas that are typically hard to reach.

4. **Potential benefits for retention of rural and remote GP workforce** – the increased usage of telehealth throughout our rural and remote regions may provide greater support for overworked GP's and enable them to be renumerated for services that are often provided without compensation. This could support a vulnerable workforce and lead to increased retention and stability of primary care throughout rural and remote networks.

5. **Increased broader health sector integration** - Continued and increased use of telehealth can also provide opportunities to better partner with LHDs e.g. by combining telehealth outpatient department appointments for patients that include the GP. This could be supported with provision of MBS item numbers for this use. There is also the opportunity for improved access to specialists for GPs – telehealth item number for GP and specialist consultation to minimise need for patients to be referred to OPD i.e. may be able to be circumvented with advice provided by specialist. Provision of item numbers for this service may further encourage use of such a service by GPs.

IMPACT OF COMMON TELEHEALTH APPROACHES

In making decisions around funding telehealth approaches it is helpful to understand the research around strength of evidence and weighted benefit for clinical focus areas and telehealth function categories. Where Strength of Evidence (SoE) is high, this means it has been well studied and the evidence is strong for this intervention type. Where SoE is low, this means there is less evidence. Weighted benefit on the other hand estimates the benefit of the intervention based on outcomes reported by the available study types.

The tables below provide this information and a means of making more informed decisions around intervention type functions and clinical focus areas.

CLINICAL FOCUS AREA	STRENGTH OF EVIDENCE	WEIGHTED BENEFIT
Mixed studies	High	High
Mixed chronic condition	High	High
Diabetes	High	Moderate
Cardiovascular disease	High	Moderate
Physical rehabilitation	Moderate	Moderate
Behavioural health	Low	Moderate
Dermatological	Low	Low – Moderate
Respiratory disease	Moderate	Low – Moderate
Burn Care	Low	Low
Surgery support / post sx support	High	Low

3. Modified from: Totten, Womack, Eden et al.,(2016). Telehealth: Mapping the evidence for patient outcomes from systematic reviews. Technical brief 26, *AHRQ*

TECHNICAL RECOMMENDATIONS

APPLICATION
Health Direct Video Call
GP Consults
COViU
Attend Anywhere
Skype for Business
Scopia
Pexip

The above list is by no means a complete list rather it is a list of platforms that are commonly used by primary care that provide a level of security that is satisfactory.

Key hardware components for Telehealth to occur:

- Telephone
- Computer or Laptop
- Camera or Webcam
- Headset.

Other hardware components could be:

- Tablets
- Smart Phones (including apps that assist with measuring the health of a patient)
- Remote monitoring devices.

SCOPE OF RECOMMENDATIONS

The scope of the PHN recommendation is limited to the primary care sector and covers the following:

- General Practice
- General Practice service into Residential Aged Care Facilities
- Aboriginal Medical Services
- Allied Health Professions.

The recommendations do not cover Pharmacy, Hospital, Specialists, Commissioned Services of PHNs.

ACKNOWLEDGEMENT

To facilitate the development of this recommendation paper a number of key stakeholders were engaged to provide data, research sources and importantly localized information. The collective group of NSW and ACT PHNs have reviewed and endorsed in principle the information and recommendations contained within this document. There is acknowledgement that these are broad brush recommendations and, in many cases, the granular details around eligibility, implementation and more detailed policy will need to be consider moving forward.

Other stakeholders who have provided input, expertise and recommendations include:

- HNECC PHN Clinical Council Chairs
- McKinsey and Company Consultants.

There were a variety of research and data sources utilised to build the evidence base to support the continuation of the telehealth MBS items and these included:

- HNECC PHN COVID-19 Impact survey
- HNECC PHN Telehealth Capabilities Survey
- Polar report
- HotDocs survey
- Review of the global literature on uptake and provider and patient preferences.

This paper was developed to capture current circumstances, future opportunities and potential implementation details of telehealth across NSW and the ACT post COVID. Whilst every attempt has been made to accommodate all view points and information it should be acknowledged that there may be differing views or interpretations across the PHN network and broader Primary Care sector. Further consultation across a broad range of stakeholders within the primary care sector is encouraged to support the incorporation of telehealth moving forward.

HNECC PHN (as the author) would gratefully acknowledge the resources, expertise and insights provided by all stakeholders to ensure the validity and integrity of this paper, and particularly acknowledges the assistance from McKinsey & Company in preparing the paper.

SURVEY METHODOLOGY

HNECC PHN has conducted two separate surveys of primary health care providers in the HNECC region since the introduction of the new temporary telehealth MBS item numbers.

HNECC PHN COVID-19 Impact Survey

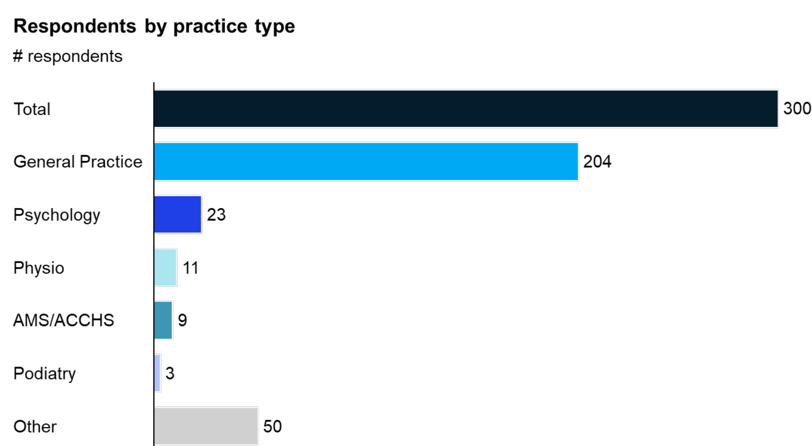
The COVID-19 Impact Survey was conducted to provide HNECC PHN with a region-wide snapshot of the health of primary care during the pandemic. The purpose of the survey was to:

1. Understand the impact of COVID-19 restrictions on activity levels in practices, including staffing levels
2. Inform the direction of continued support from the PHN on telehealth implementation, including training, advocacy, etc
3. Receive feedback on the current support delivered by the Primary Health Network, and to identify key areas of future support required moving into the recovery phase.

The survey was promoted through the PHN digital contact channels, where users clicked on a link which took them to the survey form. The survey was designed to be completed in a few minutes and was completely anonymous. The survey was designed such that anyone could respond, with individual clinicians encouraged to participate, thus not necessarily confining practices to a single response. Further, participants were encouraged to distribute the survey link among their own professional networks.

The survey began on 11 May 2020 and submissions closed on 19 May 2020. All responses were included in any analysis included in this paper. The breakdown of respondents is described below:

Respondents to the HNECC PHN COVID-19 Impact Survey, by Practice type



Source: Hunter New England Central Coast Primary Healthcare Network COVID-19 Impact Survey, May 2020, n=300.

HNECC PHN Telehealth Capability Assessment Survey

Shortly after the introduction of the new telehealth MBS items, HNECC PHN sought to gauge the capability of General Practices and the PHN's commissioned service providers in the HNECC region in providing telehealth consultations to patients and clients. The survey included a range of questions on practices' current capacity to provide telehealth, whether they had been engaging clients through telehealth consultations and the means by which they currently provide telehealth.

The survey was conducted by HNECC staff completing a telephone interview with practice staff, or alternatively, by practice staff completing an online survey form. Surveys were completed on a practice basis, but if practices had multiple locations, each location was surveyed.

Most surveys were completed during the last two weeks of March 2020. The results of this survey were used in this paper to provide a baseline of telehealth capability in March, and as such, surveys completed after this were excluded from the analysis in the paper.

AUTHORSHIP AND CONTACT

Authorship
Hunter New England and Central Coast Primary Health Network

Contacts
Richard Nankervis (CEO)
RNankervis@hneccphn.com.au

Melissa Collins
MCollins@hneccphn.com.au

phn
NSW AND ACT PHNs

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