Comments on the Australian Government telehealth discussion paper:

“CONNECTING HEALTH SERVICES WITH THE FUTURE: MODERNISING MEDICARE BY PROVIDING REBATES FOR ONLINE CONSULTATIONS”

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Need for telehealth
The barriers to access to medical specialist services are greater in rural and remote areas compared with outer metropolitan and hence the priority for supporting telehealth services should be for those in the rural and remote areas. Barriers are not simply distance (e.g. 1300 km from Moranbah, Qld to Brisbane) but also weather (eg flooding in Queensland currently, cyclones) and the extended time (usually requires overnight stay with implications for care of other family members).

The introduction of the federal government telehealth support should be staged, limited initially to patients at rural and remote sites. This may be justified in terms of known poorer health outcomes and less Medicare expenditure for rural and regional citizens. Once efficient services are provided at these sites consideration of extending to outer metropolitan sites may be appropriate, with demonstration both of need and cost effectiveness.

Practice Model

Having the local health care worker at other end for a specialist consultation does provide better continuity of care as well as providing professional support and development for the health care worker. For consultation from secondary to rural, having a nurse at the rural site may be the best use of limited resources especially if following up a patient; for example, a diabetic. The nurse will be able to provide physical assessment information not otherwise available to the telehealth consultant eg weight, height, BP, urinanalysis, cardiac, chest and abdominal assessment. Having the local worker also helps with operating the videoconferencing unit at the patient end (ie patients shouldn’t be left to run that). For consultations from secondary to tertiary a doctor, nurse and probably other team members, will generally be required at the secondary site.

Generally care for chronic illness is team based. Hence the provision of specialist telehealth opinion for chronic illness patients is best from the regional unit with a team providing that specialty care, e.g. paediatric diabetes, paediatric respiratory. It is best to have the telehealth facility in the specialty outpatient area at the consulting end and in the primary care site at the referring end. This ensures appropriate clinical and administrative support and facilities.

Where possible having a year programme of telehealth clinics into which patients can be booked is most efficient. For a general specialist unit such as ours we book subspecialty clinics (e.g. paediatric rheumatology) with the tertiary hospital (RCH Brisbane) and monthly general paediatric clinics are available for GPs to book.
patients into. Follow up for rural patients seen by the specialist in Mackay can be booked into the general paediatric telehealth clinic.

We have increasingly provided acute opinions via telehealth for paediatric patients in rural sites. This ensures the principle of patients having the same access to specialist opinion as if at the hospital where the specialist is based. For example, the sick child at Collinsville who if at the Mackay Base Hospital would be immediately reviewed by a paediatrician, should be similarly reviewed immediately by a Mackay paediatrician via telehealth. It also ensures support for health care professionals with challenging and stressful cases, boosting their confidence and professional experience rather than allowing increasing stress which can result in moving from that rural practice.

**After-hours specialist consultation.** I suggest establishing some pilot sites with home facility for those specialists who have a history of using videoconferencing regularly including for acute consultation to enable after hours consultation with rural sites. This would explore the potential for after hours consultation use.

Cross-catchment consultation should be avoided, unless those involved in usual referral lines approve. The current referral patterns indicate the linkages on which telehealth services should be based. In particular, metropolitan services should not provide to a rural site if there is a regional hub that is closer. If that did occur it undermines specialist role in regions/rural sites and contributes to deskilling and loss of specialist staff in the regional sites. This undermines regional provision of care. It is also bad for patients who may need acute care if they have had no involvement previously with local specialists. In particular Medicare-funded metropolitan-based entrepreneurial telehealth activity needs to be avoided.

**Specialties**

Paediatrics has been well demonstrated to be suitable for telehealth. Consultations can be for both acute and chronic conditions, so booked and emergency consultations. We have over 11 years experience of such a telehealth model with research backing, demonstrating its effectiveness. We have been able to consult in all paediatric areas from ADHD, to burns, to cardiac on-line echo studies to orthopaedic patients.

Further supporting the take-up of proven telehealth models with available technical facilities is recommended, as this will lead to greatest sustained expansion of telehealth activity. Then it is recommended to add on those where the technology is currently unavailable in the community using current models, before going to new models, eg in the home consultation, (the exceptions being for palliative care and perhaps geriatrics where models exist).

**New services** should demonstrate a capacity to provide sustainably prior to being supported for expansion. Such a demonstration of ongoing commitment would be a history of telehealth provision using current staff and resources. An area needing further evaluation before wider funding is the proposed GP helpline using videoconferencing, for example allocating $1-2m for trial sites over 2 years before considering spending $50 m.

There should be no large scale roll out of services in areas that have not been supported by research to be cost effective. All telehealth services should have an
auditing requirement to establish usage, cost effectiveness, patient and user satisfaction. New services /models should have a research component with the expectation of being written up and published in peer review journal.

Remuneration
Medicare item numbers would be appropriate, based around current item numbers, perhaps with add-ons, for the consulting specialist. For the referring doctor the remuneration would not be as much as if consulting but will need to be sufficient to encourage the doctor to participate in the telehealth consultation.

Financial incentives for participation. I agree there should be an attraction/incentive for taking up telehealth consultation, both for the referring as well as consulting health care professional. I don’t feel this should be an additional direct payment to the health care provider apart from the consultation fee. Rather I feel the incentive should be in form of funding for support to increase ease of use of telehealth especially administrative support to ensure all arrangements are made, telehealth connection in place, patient details etc such that there are no delays for health care professional who can just focus on the consultation. This may be best in the form of an upfront funding to establish activity and then per capita on-going funding. Health care professionals demonstrating a sustained good volume of telehealth activity (eg over 1 year) may be rewarded with the provision of a telehealth unit in their practice (see below).

Training is best on the job. Health care professionals should be expected to spend a minimum of time on training. The local telehealth coordinator should be provided with the appropriate training and on going supervision and support (usually this should be provided by telehealth, on line course and by visiting telehealth supervisor). The local telehealth coordinator can then demonstrate telehealth use and hence develop skills for health care professionals in conjunction with telehealth clinical activity. A single statewide support service (eg Qld Health Statewide Telehealth Service help desk) for technical and other support is essential, and already in place. This may require additional funding, which may be best fully funded by federal government to support all users. It should be available over an extended time period, before 8am and after 5pm on weekdays when telehealth usage is occurring and include weekends.

With telehealth consultations part of our everyday clinical activity, our trainee doctors and nurses are involved with telehealth consultation and hence learning this practice. This experience enables them to more confidently use telehealth in their future practice (for doctors either as specialists or GPs). This is an important means of growing use of telehealth amongst health care professionals. Recognition and funding for this activity would be important. For example, inclusion of telehealth consultation may be listed as a priority activity for the approval of the Federally funded Specialist Training Programme (STP), thus providing an incentive for telehealth.

Technical – compatibility with the state health statewide telehealth services is essential as most videoconferencing will be with hospitals or health department sites.

I would discourage rolling out many new units, as experience in QH is that enthusiasm wasn’t followed up with use. Providing new units would be appropriate
only in those settings where no suitable alternative unit eg Hamilton Island medical centre. Rural towns, e.g. Moranbah, have QH telehealth facilities in emergency rooms and which are close to medical centres with the doctors easily able to attend the hospital. I suggest that medical centres demonstrating a good sustained volume of activity over time, eg 1 year, may be supported with own units if they wished.

It would be appropriate for the Federal government to consider placing videoconferencing units in rural medical centres where the town’s only emergency room is sited, such as Glenden and Middlemount in the Mackay district. This would enable emergency non-trauma cases to access specialist opinion regarding management which will include the need to transfer, if so, how and when. It allows a more informed decision which may avoid emergency transfer. It will also allow other patients non-urgent patients from that town consultation in collaboration with their GP. Units should only be maintained in a centre if sufficient appropriate clinical activity is occurring.

Good telehealth services are and can be provided using current technology and facilities. It is not necessary to have the NBN to deliver much more effective telehealth. To best use the NBN capabilities however it is important that we build telehealth on current technology such that we will be in a better position to extend telehealth care further with the extended NBN capabilities.

Factors limiting telehealth uptake
The lack of remuneration for doctors especially and lack of funding for additional time for all health care professionals to take up telehealth activity has been a major impediment to telehealth clinical activity. It will be a significant stimulus to undertake telehealth consultation for both the consulting as well as the referring health care professionals to receive remuneration with Medicare rebates available.

In addition there have been no incentives or rewards for those undertaking telehealth, despite providing substantial savings for health services and benefits for patients. Supporting a service which provides a sustained telehealth service with funding for an additional team member beyond that required for the additional clinical activity would be a substantial incentive. This would further support the development of the telehealth service. For example, the Cairns Base Hospital paediatric service needs more dietician time, and they say this is a priority ahead of a telehealth coordinator. The incentive would be to offer funding for the dietician once they had established a sustained telehealth activity with a telehealth coordinator.

A lack of administrative support, in the form of a telehealth co-ordinator, who can arrange bookings, ensure equipment is working and available, remind patient, establishes link up, is an ongoing barrier to greater telehealth consultation. Clinicians need all administrative issues addressed such that they can consult as easily as they would in a private practice consultation. Busy clinicians particularly do not want to lose time waiting for a consultation. Telehealth consultation requires additional, and different administrative arrangements including ensuring a good telehealth connection on time. Organisation needs to be more efficient than is usual for outpatient services, but this efficiency produces better productivity.
A lack of access to videoconferencing units can be a limitation to telehealth uptake. Many QH units have been placed in meeting rooms which are both remote from clinical settings, especially the outpatient department, as well as the rooms being constantly booked for meeting purposes and hence not available for clinical activity. For example, The Townsville Hospital, has a large number of units, many are fixed units in meeting rooms and hence are not available and cannot be easily be moved to a clinical setting. Videoconferencing units need to be placed in the correct settings to enable and be available for clinical use.

Although encouraging telehealth in public health care there is a lack of drivers to establish telehealth clinics and ensure patients are booked in to these clinics. These could be in the form of targets within services and for individual clinicians, and clear expectations of telehealth role at time of employment. Specialist contracts must include a clear allocation of time for telehealth consultation for rural/regional sites.

A lack of appropriate specialists both in regional and tertiary units does provide an impediment to establishing and maintaining telehealth services. For example, we have a patient workload that demands the need for doubling our paediatric orthopaedic telehealth clinics, but the lack of availability of paediatric orthopaedic specialist time is the only barrier to us providing this clinic. Hence these rural patients are not accessing medical care they should expect. The lack of specialists’ time reflects the wider issue of maldistribution of specialists not addressed by either the specialist colleges or the federal health department.

The Federally funded Medical Specialist Outreach Assistance Programme (MSOAP) funds outreach clinics. Our experience is that outreach visits are best interspersed with telehealth clinics to enable timely follow up, reduce the need for time consuming and expensive outreach trips, but maintain close contact with patients and local health care providers. It is recommended that a condition or priority for MSOAP funding be that telehealth clinics be provided between outreach visits, with a view to improving productivity, reducing need for outreach, and hence funding costs (it is noted that MSOAP funding is limited and does not cover the submissions made for assistance).

Lack of being able to undertake a physical examination is generally not a significant impediment to delivering the same assessment in a telehealth consult to that of face-to-face. Much specific physical assessment information can be made available with the help of the health care professional with the patient (see above).

Lack of infrastructure and high speed transmission capability again are not major reasons for lack of telehealth activity. In Queensland there has been widespread availability of videoconferencing units and high speed capability over many years such that the infrastructure has been in place (but perhaps in the wrong place) to do good quality telehealth consultations. Yet apart from certain services such as ours, clinical telehealth activity has been very limited.

There is not evidence that clinical standards are compromised with use of telehealth. Rather through timely availability telehealth consultation can allow early identification and management of important clinical problems. Clinicians are wary of any limitations with the consultation and provide advice in a precautionary manner
such that clinical standards are not compromised. If uncertain generally the advice is a need to review or see the patient face-to-face.

Videoconferencing at 384 kbs with current cameras now provides good quality visual imaging. Improving video quality with the NBN will not significantly alter outcomes of the telehealth consultations – they are already of a high quality.

Similarly concerns about medicolegal liability appear to be overplayed with specialists again taking a precautionary approach and having the check of the local health care professional involvement.

We have seen no resistance or dissatisfaction with telehealth consultation among our patients over the 11 years of activity. This has included feedback from formal satisfaction surveys. We have never had a complaint about our telehealth consultations. To the contrary we have had great acceptance and enthusiasm from patients about telehealth. Our patients, children, are especially keen on it.

References


- Smith A Williams M L & Justo R The multidisciplinary management of a paediatric cardiac emergency - a case report from Queensland. J Telemedicine and Telecare 2002; 8; 112-114


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