The Royal Australian College of General Practitioners

Submission to Department of Health and Ageing

Discussion Paper

Connecting Health Services with the Future: modernising Medicare by providing rebates for online consultations

27 January 2011
1. Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the Department of Health and Ageing (DoHA) for the opportunity to contribute to discussions regarding the provision of Medicare rebates for on-line consultations.

The RACGP is the specialty medical college for general practice in Australia, responsible for defining the nature of the discipline, setting the curriculum for education and training, setting and maintaining the standards for quality clinical practice, and supporting general practitioners in their pursuit of excellence in patient care and community service.

This submission has been made in response to the discussion paper titled Connecting Health services with the Future: modernising Medicare by providing rebates for on-line consultations, issued by the Australian Government on 30 November 2010, which can be viewed at: http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/News-20101130-Telehealth_Discussion_Paper

2. Overview and response to discussion paper

In this submission, the RACGP is responding to the Australian Government’s request for views on:
- optimal service models
- optimal remuneration models
- the need for additional financial incentives to encourage initial uptake and ongoing participation
- training and support requirements
- advice on the likely technical issues and other limiting factors.

The RACGP believes that there is no single ‘optimal telehealth consultation model’ for the delivery of medical specialist services to general practice patients in rural and remote parts of Australia.

Despite some medical specialties (particularly psychiatry, dermatology, radiology and paediatrics) developing their own telehealth consultation models in recent years, the RACGP believes that only a flexible and adaptable service model, that can be applied to all medical specialties, would be practical and realistic. One way of achieving this would be through the combined use of synchronous and asynchronous telehealth consultation methodologies flexibly in accordance with individual patient’s needs.

General Practitioners could be remunerated for the provision of synchronous and asynchronous telehealth consultations through the MBS by broadening the definition of ‘professional attendance’ to include specific forms of synchronous and asynchronous telehealth consultation. This would allow a patient’s regular general practitioner to use existing MBS Items for level A – D consultations and, those in Groups A11, A15, M2, M12, as they are currently used for face-to-face consultations.

In addition to receiving remuneration for episodic care, the patients regular general practitioner should be compensated for the cost of setting up the necessary technological infrastructure in each general practice (which is where RACGP believes it should be) and for the time and effort involved in establishing and maintaining the business systems and processes needed to participate in telehealth consultations.

Underpinning this, there will need to be an appropriate set of clinical and technological standards that define at least the minimum requirements for establishment and operation of telehealth facilities.
Further, to facilitate uptake, general practitioners and their practice staff will need to learn how to set up, operate, and maintain the telehealth technologies, and learn how to use the various methods of synchronous and asynchronous consultation to efficiently and effectively achieve the best patient outcomes. The RACGP is well placed to provide the necessary training through its on-line GP-Learning modules.

3. **RACGP response to consultation paper**

### 3.1 Improving access to medical specialists through on-line consultations

The RACGP has long advocated for health service improvements in outer-metro, rural, and remote areas through the use of e-mail, telephone, and point-to-point video-conferencing.

Rural and remote communities generally have a relatively low ratio of consulting medical specialists proportional to their population. National figures for secondary and tertiary medical specialists (FTE) per 100,000 population, across different geographic areas, are as follows:

- Major cities 122.0 specialists per 100,000 population
- Inner regional 56 specialists per 100,000 population
- Outer regional 38 specialists per 100,000 population
- Remote/very remote 16 specialists per 100,000 population.

The ability to see the patient's condition live (via a video session) and receive digital information regarding a patient's vital signs, clinical test results, and diagnostic imaging, may allow for earlier and improved access to specialist opinion and advice, reducing the time for investigation, diagnosis and treatment.

The use of telehealth consultations may also reduce the duplication of diagnostic tests, and the need to transfer patients to distant health services for further investigation of treatment, thus reducing the burdensome travel time and associated costs for patients, their families and health service providers.

Further, by allowing patients to stay in their own communities, caregivers and other health care professionals (who might not be free to travel) can participate in patient consultations thus facilitating a team approach and improving continuity of care.

The use of telehealth consultations also encourages metropolitan hospitals to show clinical leadership and support for their regional colleagues by 'virtually' working beside them, offering specialist advice and assistance with identification of the best treatment options for their patients. Such interaction creates opportunities for ongoing medical education and training, supervision, collegiate networking, and peer support.

Collectively such benefits improve the prospects of medical and allied health workforce recruitment and retention and thus the viability of rural and regional health services.

### 3.2 Benefits for specific patient groups

Ideally the system adopted should be flexible enough to use for all patient groups that require medical specialist attention.

For example, given Australia's ageing population there is an urgent need for disease prevention or early intervention. To this end, tele-health technologies can be used to monitor wellbeing indicators (such as blood pressure and glucose levels) and obtain other health-related information which general practitioners, working collaboratively with community nurses, can use to monitor ongoing trends, prioritise patient care, and detect patients who would benefit from early intervention. To support such valuable clinical activities, Government should consider extending use of MBS items for telehealth consultations to general practitioners consulting nurses in community and residential aged care settings.
Additionally, patients with disabilities, who have difficulty with mobility and transportation, are another group that have been found to benefit from the use of telehealth consultations.

Depending on the level of technological investment intended by Government, telehealth systems can be used for chronic disease management given the capacity to screen patients for diabetes, eye disease, kidney problems, nerve damage, and vascular disease among other things. As such rural and regional patients with chronic and complex diseases could benefit considerably from the introduction of multi-modal telehealth consultations.

It is also worth noting that the introduction of telehealth conferencing will be particularly beneficial for patients who have sustained physical or psychological trauma and require urgent and/or critical medical specialist care. The Victorian Loddon Mallee Region Virtual Trauma and Critical Care Unit Project has revealed some important insights into how such patient groups can best be served by the use of such technology.3

Mental health services have also proven to be particularly well suited to telehealth consultation for the treatment of mild to moderate symptoms of affective disorders through:

- direct patient consultation
- case conferencing with the patient
- case conferencing without the patient
- web enabled self-care.

However, according to the Royal Australian and New Zealand College of Psychiatrists, telepsychiatry is not usually advisable in cases of severe mental illness. Thus, in such cases it is not recommended for use without a health professional (e.g. mental health nurse, general practitioner) physically present with the patient.4

Exploring models of telemedicine for Indigenous Australian is also critically important given their significant disparities in the health status, morbidity and mortality rates when compared with non-indigenous Australians.

### 3.3 Specialties that are hardest to access

As previously noted, all medical specialties that currently attract MBS rebates should be accessible through a nation wide telehealth scheme.

However, whilst not ideal, if a staged roll-out is intended for video-linkage due to resource or other constraints, then it is worth noting that the following medical specialties have been identified as being particularly difficult to access in rural and remote areas:

- psychiatry
- dermatology
- radiology
- neurology
- geriatrics
- ophthalmology
- physicians
- cardiology
- pain management
- gastroenterology
- surgery
- rehabilitation

Also as mentioned in section 3.2 RACGP sees a particular need to facilitate telehealth consultations between general practitioners and nurses in community and residential aged care facilities.

### 3.4 Optimal service models

#### 3.4.1 Flexibility and adaptation

RACGP is of the view that it would be impractical and unrealistic to try and impose a single ‘optimal’ telehealth consultation model on general practitioners and medical specialists because:
1. The type of clinical situations that would benefit from the use of telehealth technologies are many and varied
2. General practitioners’ and medical specialists’ availability and resource constraints vary
3. Different medical specialties (particularly psychiatry, dermatology, radiology and paediatrics) have developed different telehealth consultation models for use, in accordance with their unique clinical requirements.

Therefore RACGP would argue that Government should support development and implementation of a flexible and adaptable consultation model which involves the combined use of both synchronous and asynchronous telehealth consultation methodologies, in conjunction with face-to-face consultations, as required.

Synchronous consultations methods involve all the participants interacting at the same time, as in the case of live point-to-point video-link, whereas asynchronous consultation methodologies involve the delayed exchange of clinical information and images, that have been collected and stored in the telecommunication equipment for use by collaborating health professionals when it is possible for them to view, analyse and respond to things.

Adopting specialty specific or an inflexible telehealth consultation model would hamper development of a universal operating system, clinical standards and guidelines, that could be applied to all medical specialties as required.

### 3.4.2 General practitioner attendance

Rural general practitioners in particular carry the weight of responsibility for the ongoing assessment and treatment of their patients, even after a medical specialist has been engaged in the process.

Therefore it will be important for a general practitioner, or their delegate, to be present at synchronised consultations during the initial stages of their patient’s assessment, which might be followed by a string of both asynchronous and synchronous exchanges of information between the general practitioner and medical specialist.

Where the general practitioner is virtually present at a synchronous consultation they may be required to:

- demonstrate physical symptoms (such as making the patient wince as a general practitioner pushes on their inflamed appendix or diverticulitis, or using equipment such as auroscopes or ophthalmoscopes or proctoscopes or vaginal speculae) to show the specialist the problem for which they are seeking their advice
- conduct any further clinical tests for an on behalf of the medical specialist if more biometric information is required to make an accurate diagnosis
- receive direct advice on the most appropriate treatment strategy – which is likely to be delivered by the general practitioner and other health professionals acting under the delegated authority and supervision of the treating general practitioner
- write and sign-off on investigations and prescriptions requested by the consulted medical specialist(s). Such requests should not be relayed to general practitioners by intermediaries nor should such activities be recoded by Medicare as diagnostic tests and prescriptions generated by general practitioners.
- determine whether the patient can be treated in their local community or require (in some cases urgent) transportation to another location.

Throughout this process, regardless of whether the general practitioner is, or is not, present at each and every patient consultation, the general practitioner must be kept informed of all patient interactions and outcomes to ensure that they can properly contribute to the treatment process and effectively manage their patients’ care.
Another important reason for general practitioners, or their delegates, to participate in all synchronous or asynchronous telehealth consultations is that it can significantly increase the recruitment and retention of general practitioners and other health professionals in rural and regional Australia by:

- increasing learning opportunities while ‘virtually’ working along-side their metropolitan colleagues
- providing stored clinical material that can be used for training purposes in rural and regional settings
- providing opportunities for collegiate networking and peer support.

### 3.4.3 Role of allied health professionals

Rural and Remote general practitioners should be the primary point of contact for medical specialists involved in the assessment or treatment of their patients.

Their possession of the most advanced clinical knowledge and skills among the allied health professions enables them to make the most effective decisions about how best to allocate scarce resources to achieve the best possible patient outcomes. This includes making decisions about how best to coordinate the services of allied health professionals contributing to a patient’s care.

Allied health professionals should assume roles and responsibilities that are commensurate with their education, training, clinical scope of practice, and experience. Allied health professionals should not be deployed as a first point of contact and left to make treatment decisions without consulting a patient’s usual general practitioner.

They should only attend telehealth consultations in place of a patient’s usual general practitioner if this has been requested or agreed to by the treating general practitioner.

This would promote development of more cohesive multidisciplinary team based approach to patient care and help establish the much needed critical mass of health workforce expertise required to attract and retain other health care professionals to rural and remote areas thus improving the viability of local health services.

### 3.5 Remuneration for consultations

If the definition of ‘professional attendance’ can be broadened to include specific forms of synchronous and asynchronous telehealth consultations, then existing MBS Items for general practitioner attendances (Level A – D) and, those in Groups A11, A15, M2, M12, could be used for telehealth consultations as they are currently used for face-to-face consultations.

### 3.6 Other financial incentives

#### 3.6.1 Initial capital costs

As telehealth consultations should be provided to patients through their local general practice as part of a well integrated continuum of care, additional funding will be required to assist general practices purchase related computer hardware and software.

Initial capital costs could be covered through allocation of a one-off incentive payment made to practices facilitating telehealth consultations.

#### 3.6.2 Ongoing costs

It is expected that there would be on-going costs associated with internet use, download, data storage and retrieval, security inscription, technical support, and other related activities.
Therefore general practices hosting telehealth consultations should be assisted financially, via a Practice Incentive Payment, to make service provision a viable option.

### 3.7 General practitioner training and support

#### 3.7.1 Specific areas where technical training is required

There will undoubtedly be a need for both general practitioners and their practice staff to learn how to set up, use, and maintain telehealth technologies. They will also need to learn how to use the various synchronous and asynchronous consultation methods to improve patient services possibly through clinical education modules and guidelines aimed at improving patient care through use of telehealth consultations.

#### 3.7.2 Role of the RACGP

Given the RACGP’s experience in the development and delivery of education and training to general practitioners and their practice staff through internet based platforms, College is well placed to work with the relevant stakeholders to develop and deliver the required training for general practitioners and their practice staff.

### 3.8 Tele-health consultation standards

The RACGP is widely recognised as the legitimate, authoritative body which defines the nature of general practice; sets and maintains the standards for high quality Australian general practice; leads the education, training and assessment processes; advocates on behalf of the discipline; and supports this country’s general practitioners in meeting the primary medical care needs of the Australian public. Responsibility to patients and to public interest is paramount for the College.

In July 2011, the Government will be implementing several telehealth initiatives, including:
- Medicare rebates for GPs, and other medical specialists, to participate in online consultations
- Expansion of healthdirect Australia, to include a GP after hours helpline, and online triage and basic medical advice via videoconferencing
- Training and supervision for health professionals using online technologies

Given these initiatives, there is an urgent need for the establishment and implementation of telehealth standards.

Although timelines are extremely tight, the RACGP is in an ideal position to efficiently develop quality standard for general practice telehealth. The College can deliver high quality standards for general practice telehealth, which protect patient safety and the community, and are acceptable to the profession.

### 3.9 Technical issues

#### 3.9.1 Technical Procurement Framework

In addition to the telehealth consultation standards described above, the Government needs to consider establishing a procurement model, or framework agreement, for the purchase of telehealth technologies to protect general practitioners from exploitation by information technology vendors and suppliers. Such a framework would mandate minimum service, interoperability, and technical standards. It is crucial that a procurement model is used to drive standards, otherwise there will be a continued stand-off with suppliers and opportunity for market leaders to exploit a proprietary trap, which adds to the costs and prevents new innovations from entering the market.
3.9.2 Interoperability Framework

Due to the risk of either computer hardware or software incompatibility between IT systems used by general practitioners and the medical specialists (who will be located either in their own consulting rooms or a public or private hospitals) the Government should also consider developing and enforcing a national interoperability framework and standards.6

3.9.3 Equipment and capabilities

Approximately 96 percent of general practitioners use computers to support their daily clinical activities.7 However, it is unknown how many general practitioners have the appropriate hardware and software needed to support both synchronous and asynchronous forms of telehealth consultation with medical specialists in metropolitan or regional centres. Government could assist the RACGP conduct an audit to determine this.

Ideally general practices should have:
- a prompt internet connection without technical interference
- a high rate of data transmission
- a high level of video resolution
- facilities for multi-party interactions, for example care team planning sessions, multidisciplinary team diagnosis, across multi-sites
- facilities for augmented interactions, for example portable medical device inputs, haptic/tactile sensations
- telepresence/realism enhancements for critical care situations
- facilities for multi-party interactions, for example portable medical device inputs, haptic/tactile sensations
- automated or virtual interactions, for example logging of patient data by ambulatory monitoring, smart environment devices, home telehealth stations, and patient surveillance.8

It might also be beneficial for the systems in place to allow for the patient record to be viewed while using teleconference facilities.

3.9.4 Privacy and security

Use of portable devices and new technologies poses a new set of security issues. RACGP Computer security guidelines (3rd edition) recommends that portable devices must have appropriate encryption set up to ensure patient and provider confidentiality. The RACGP Computer security guidelines (3rd edition) also recommend9:
- limiting power of the routers’ radio (Wi-Fi) signal so that it does not extend past the walls of the practice
- disabling network broadcasting to reduce the risk of devices on the network announcing themselves to other devices on the network
- enabling MAC (media access control) address filtering to restrict unauthorised devices connecting to your wireless network
- change the SSID (service set identifier) or the public name of the wireless network to something unique that does not identify the brand of device/s used or the business name.

Due to the degree of separation between the healthcare provider and patient with telehealth consultations, the security environment can be extremely complex and vulnerable to interruption. The main challenge is configuring the infrastructure in such a way to enable a wide range of security protocols to be implemented.10

Further, security is only as good as the people practicing it.11 Sufficient audit tracking processes need to be established to monitor who is using tele-health facilities and when.

Telehealth consults carried out in many community pharmacies or other non-clinical multi-purpose settings could also pose a threat to privacy security.. Therefore, it is advisable that telehealth facilities only be installed and operated from within treating general practitioners’ consulting rooms as part of a properly integrated continuum of care well away from the ears and eyes of others. Sufficient sound proofing would also need to be considered.
3.9.5 Medical identity theft

While there is limited information available specifically for the health care industry, identity theft in general was estimated to have cost the Australian Government in excess of $4 billion in 2001. Therefore, Government needs to be aware of risks associated with the use of telehealth technologies, and implement the appropriate security measures to prevent medical identity theft from occurring. Potential security measures might include:
- assignment and use of unique patient, health practitioner, and health service authentication numbers
- use of a single web portal to access telehealth services, from multiple locations, with patient, health practitioner, and health service, authentication occurring through use of user log-in and passwords.

Where this poses problems with broadband connectivity (particularly if logging in from a patient’s home), it could be overcome by ensuring that the supporting technology has capacity for high quality resolution and security encryption.

3.10 Other limiting factors likely to affect uptake

Because of their geographic isolation, as well as the poorer health of their population, rural and remote areas stand to benefit most from telehealth consultations yet they are likely to have the poorest infrastructure, resources, and capacity for successful adoption of this service option.

In addition initial uptake and ongoing participation may be affected by issues arising from:
- absence of the appropriate legal framework
- privacy and patient confidentiality concerns
- risks to the security of medical information
- medical indemnity concerns
- quality of images, sound, and other signals
- speed of transmitted information
- health professionals knowledge, and expertise with use of the equipment,
- adequacy of financial rewards
- scalability of the technology
- interoperability with other health services
- integration with facilitators core clinical IT systems
- over specialised models of care
- broadband capabilities

4. Concluding comments

Overall, the RACGP welcomes the Australian Government’s proposed review of the MBS through the use of telehealth consultation methods, with the aim of improving rural general practitioners and their patients’ access to medical specialists in metropolitan and regional centres.

Telehealth consultation models are a vital service option that will significantly enhance the quality and effectiveness of patient care, while at the same time addressing a range of barriers that have prevented the medical profession from effectively providing its services in rural and remote parts of Australia in the past.

The RACGP hopes that the comments contained in this submission help the Australian Government in its deliberations, and would welcome further opportunities to engage in discussion about the matter.
References


3 The Victorian Loddon Mallee Region Virtual Trauma and Critical Care Unit Project http://vitccu.lmha.com.au/app_cmslib/media/lib/0808/m4372_v1_vitccu%20project%20brief%20v1.1.pdf

4 The Royal Australian and New Zealand College of Psychiatrists, Rural Station: the education resources for rural psychiatry http://rural.ranzcp.org/content/view/19/40/


6 Ibid


11 Ibid