Medicare Benefits Schedule Review Taskforce

Report from the Telehealth Working Group

June 2020

Important notes

1. This report does not constitute the final position on these recommendations or items, which are subject to:

- Consideration and endorsement by Taskforce;
- the Minister for Health; and
- Government.

2. This report is presently prepared for Taskforce endorsement.

3. The individual *referred recommendations* in this Report were open for consultation during the drafting process of their originating reports and were submitted to Taskforce post that consultation. Consequently, this report has been prepared by the Taskforce's Telehealth Working Group for Taskforce endorsement and has not been open for further public consultation.

Contents

Introduction

The Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) is reviewing how more than 5,700 Items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce also seeks to identify any services that may be unnecessary, outdated or potentially unsafe.

MBS Review Taskforce approach

The Taskforce is committed to providing recommendations to the Minister that will allow the MBS to deliver on each of these four key goals:

1. **Affordable and universal access**—the evidence demonstrates that the MBS supports very good access to primary care services for most Australians, particularly in urban Australia. However, despite increases in the specialist workforce over the last decade, access to many specialist services remains problematic, with some rural patients being particularly under-serviced.

2. **Best practice health services**—one of the core objectives of the Review is to modernise the MBS, ensuring that individual Items and their descriptors are consistent with contemporary best practice and the evidence base when possible. Although the Medical Services Advisory Taskforce (MSAC) plays a crucial role in thoroughly evaluating new services, the vast majority of existing MBS Items pre-date this process and have never been reviewed.

3. **Value for the individual patient—**another core objective of the Review is to have an MBS that supports the delivery of services that are appropriate to the patient's needs and preferences, provide real clinical value and do not expose the patient to unnecessary risk or expense.

4. **Value for the health system**—achieving the above elements of the vision will go a long way to achieving improved value for the health system overall. Reducing the volume of services that provide little or no clinical benefit will enable resources to be redirected to new and existing services that have proven benefit and are underused, particularly for patients who cannot readily access those services currently.

The Taskforce endorses a methodology whereby the necessary clinical review of MBS Items is undertaken by clinical committees and working groups.

Medical Services Advisory Committee (MSAC)

The Taskforce also agrees that some recommendations from the groups were better placed for submission to MSAC than for consideration through the MBS Review process, noting the Taskforce does not have the power to change professional group access to existing MBS Items.

MSAC appraises amendments and reviews of existing services funded on the MBS or other programs (for example, blood products or screening programs) on an assessment of comparative safety, clinical effectiveness, cost-effectiveness, and total cost, using the best available evidence.

The Telehealth Working Group

Over the course of the MBS Review thirteen clinical committees and working groups made twenty-one recommendations relating to MBS telehealth items.

Given the cross-cutting nature of MBS telehealth and the recommendations, the Taskforce formed a Telehealth Working Group (the Working Group) a sub-group of Taskforce members to assess telehealth on the MBS, develop Principles, apply the Principles to the referred recommendations and draft a report for Taskforce's consideration.

Working Group Membership

Prof. Steve Hambleton (Chair)
Dr Tammy Kimpton
Rebecca James (Consumer Representative)
Dr Matthew McConnell
Dr Joanna Sutherland
Prof Michael Grigg

Disclosed conflicts of interest

Prof. Steve Hambleton (Chair) also chairs the Primary Health Reform Steering Group.

Scope of the Telehealth Working Group

The scope and objectives of the working group were to:

1) Consider telehealth as a broader concept

2) Provide observations and recommendations to the Government on MBS and non-MBS telehealth models

3) Develop a set of MBS telehealth Principles (the Principles) to apply when considering the referred recommendations for endorsement by Taskforce

4) Apply the Principles to the referred recommendations and amend as needed for consideration and endorsement by the Taskforce

COVID-19 and Bushfire Items

The 2019-2020 Australian bushfires and the COVID-19 pandemic have resulted in the Australian Government's introduction of temporary MBS Telehealth items which will continue until 30 September 2020.

Given the temporary nature of these items and the Taskforce's timeframe and resources for completing their work in June 2020, these items are considered out of scope for review in this report. However, the principles set out in this report will support the Australian Government in its analysis of the operation of the time-limited items.

Key Definitions and Concepts

Defining Telehealth

This report differentiates between 'MBS Telehealth' and 'telehealth'. Where 'telehealth' is a general term that refers to all modalities, 'MBS Telehealth' refers specifically to items that have been deemed appropriate to be funded via the MBS.

The Working Group acknowledges the MBS may not be the most appropriate funding method for all models of telehealth provision.

To enable the Working Group to be consistent in assessing MBS telehealth, it considered the definition of 'telehealth' and the potential role of the MBS in subsidising these services.

Telehealth is often broadly defined. The Department of Health website references the International Organisation for Standardisation telehealth definition, the "use of telecommunication techniques for the purpose of providing telemedicine, medical education and health education over a distance"[1].

Telemedicine is defined as "the use of technology to deliver health care services at a distance"[2]. The Centre of Research Excellence in Telehealth from University of Queensland defines telehealth as "the delivery of health services in circumstances involving separation in location and/or time, using information and communication technologies"[3].

The structural requirements of MBS items necessitate a more specific definition for telehealth items. In the MBS context (MBS Telehealth), excluding bushfire relief and COVID-19 items, telehealth relates to clinical consultations via visual and audio links, with a small number of services permitted by phone, between practitioners and patients in real time who are both in eligible areas of Australia. This is the definition the Working Group has adopted for the purposes of reviewing the referred MBS telehealth items and in developing the Principles.

To respond to COVID-19 the Australian Government introduced more than 270 time limited MBS Telehealth items. This has temporarily broadened the availability of telehealth, to embrace a "telehealth first" approach to avoid face-to-face care where appropriate. This approach has also permitted more widespread use of telephone consultations, without a video element. Historically this has not been permitted as part of MBS telehealth. A list of these telehealth items is provided at www.mbsonline.gov.au.

With the emergence of blended payment models and voluntary patient enrolment (VPE), the Telehealth Working Group recognises there are opportunities for a more broadly defined telehealth concept to extend beyond the remit of the current fee-for-service MBS model.

Access

Access is understood as the availability of good, affordable and informed health services within reasonable reach of those who need them when they need them"[4].

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[1] https://www1.health.gov.au/internet/main/publishing.nsf/Content/e-health-telehealth
[2] Policy Recommendations to Guide the Use of Telemedicine in Primary Care Settings: An American College of Physicians Position Paper. https://annals.org/aim/fullarticle/2434625/policy-recommendations-guide-use-telemedicine-primary-care-settings-american-college
[3] Centre of Research Excellence in Telehealth, Final Report, The University of Queensland https://cretelehealth.centre.uq.edu.au/files/675/CentreResearchExcellenceTelehealth_FinalReport_DIGITAL.pdf
[4] World Health Organization definition of accessibility

Clinical Efficacy

Clinical efficacy refers to a consultation providing quality clinical outcomes regardless of modality, i.e. telehealth and face-to-face provide equal quality of care.

The Working Group has determined as a reference point that face-to-face consultations are the benchmark standard of healthcare service delivery, in line with MBS Review Taskforce Goal 2 *Best practice health services*.

Clinically Appropriate

Clinically appropriate is care that is (A) provided in a timely manner and meets professionally recognised standards of acceptable medical care; (B) delivered in the appropriate clinical setting; and (C) the least costly of multiple, equally effective alternative treatments or diagnostic modalities.

The World Health Organization defines appropriateness from a system's perspective as care that is effective, efficient and in line with ethical principles of fair allocation[5]

To determine if telehealth video consultations are appropriate consideration should be given to[6]:

- patient safety
- patient clinical need
- clinical effectiveness
- patient preference
- location of the practice
- availability
- training and skills of practice staff
- equipment required (hardware and software)
- appropriate auditing and compliance mechanisms
- Contemporaneous note taking

NOTE: <u>Definitions of MBS Telehealth services:</u> Additional work will need to be done to generate a definition of an MBS Telehealth "service" in terms of items and regulations and adhering to the Principles in this Report.

Convenience

The concept of convenience is underpinned by the statement that (assuming infrastructure is in place) a telehealth consultation can be just as efficacious as the same consultation delivered face-to-face, and can have fewer access limitations for a patient well known to the doctor. This is particularly true for Australians living in regional, rural and remote areas.

The Working Group accepts there are clinical scenarios where this will differ, but as a general rule, this logic defines that there are instances where telehealth services are more convenient (for either patient or practitioner, or both) than face-to-face services. This is one of the well accepted strengths of telehealth as a modality.

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[5] Anonymous Proceedings of the Appropriateness in Health Care Services . 23–25 March 2000; Koblenz, Germany. Copenhagen: World Health Organization; 2000.

[6] Adapted from https://www.racgp.org.au/running-a-practice/technology/clinical-technology/telehealth/telehealth-video-consultations-guide/introduction

For the purpose of this report the Working Group has used face-to-face care as a benchmark for the standard of healthcare. Acknowledging that in some scenarios Telehealth may improve the quality of care, as it can be

- safer i.e. wherever there is a risk of infection to either party from face to face contact
- more equitable by providing improved accessibility
- more patient centered with appropriate consents
- more efficient, convenient and timely for patient and provider

Low Value Care

Low Value Care is considered to be *'care that confers no benefit or benefit that is disproportionately low compared with its cost is of low value and potentially wastes limited resources[7]'*.

The Working Group understands that simply because a service is delivered in person does not guarantee it will be a high value service for the patient, but in line with Clinical Efficacy above, the Working Group accepts face-to-face consultations to be the benchmark standard of care.

Value

Value is understood to be health benefit for individuals and the community for the resources invested.

Value for the individual patient—supports the delivery of services that are appropriate to the patient's needs and preferences, provide real clinical benefit and do not expose the patient to unnecessary risk expense or inconvenience.

Value for the provider—achieve efficiencies and greater patient satisfaction.

Value for the health system—enables resources to be directed to services that have proven benefit.

Quadruple Aim

The Quadruple aim is a well-regarded framework for optimising health system performance. The Quadruple Aim is[8]:

1. Improving the patient experience of care (including quality and satisfaction);
2. Improving the work life of health care providers;
3. Improving the health of populations; and
4. Improving the cost-efficiency of the health system.

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[7] In search of professional consensus in defining and reducing low-value care | The Medical Journal of Australia

[8] The first three aims were popularised by the Institute for Healthcare Improvement, beginning with the work of Berwick, Nolan and Whittington (2008). Bodenheimer and Sinsky (2014) proposed the fourth aim, emphasising that the attainment of the other aims relies on positive engagement and improved experiences for service providers and clinicians.

Objective 1: Consider telehealth as a broader concept

The Working Group have consulted a range of experts and considered a diversity of research and publications relating to telehealth in Australia and internationally in considering telehealth within the Australian health system.

'A National Telehealth Strategy for Australia – For Discussion Michael Gill' states that:

> *'Telehealth as a concept is interchangeable with telemedicine in terms of utility and addresses the collection and/or exchange of information electronically between doctors, allied health and patients in both synchronous and asynchronous modes. It ranges from telephone call centres to vital sign monitoring to video imagery for the delivery of health-at-a-distance. Telehealth has particular relevance for aged care, disaster situations, individual clinician support and for team based support for complex conditions[9]'.*

With the emergence of blended payment models and voluntary enrolment, the Working Group recognises there are opportunities for the more broadly defined telehealth concept to extend beyond the remit of the current fee-for-service MBS model.

Expert consultation:

The Telehealth Working Group consulted telehealth experts from a range of professions, including dermatology, nursing, midwifery, allied health (including speech pathology and physiotherapy), psychiatry, psychology, optometry and ophthalmology, geriatric services and wound care.

<u>Dr Jim Muir (Tele-Derm National)</u>

Dr Muir has run a combined telehealth service since 2003 called Tele-Derm National. Tele-Derm uses a store-and-forward modality. This modality allows the dermatologist to provide education to the referring GP and the dermatologist is not required to be in a live virtual room and can attend cases when they need to. Tele-Derm services are freely available for members of the Australian College of Rural and Remote Medicine (ACRRM) and clinicians in sufficiently rural and remote areas. The funding is provided over 3 years by the Federal Government as a block payment to ACRRM, who then pay a salary to Dr Muir.

Additional information on Tele-Derm National is available at
http://www.ehealth.acrrm.org.au/provider/tele-derm.

<u>Prof Len Gray</u>

Prof Gray is the Director of the Centre for Health Services Research within the Faculty of Medicine at the University of Queensland and has been working in telemedicine since 2007. Prof Gray proposed a multi-modal delivery strategy. Prof Gray proposed inclusion of telephone, email and messaging as well as videoconferencing, as each modality offers something different to assist the patient, noting that telehealth modalities provide benefits outside the care given, examples given were the patient time savings from transport, monetary savings from not having to pay for parking, patients not needing to take time off work. Prof Gray identified a

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[9] A National Telehealth Strategy for Australia – For Discussion Michael Gill

limitation of current telehealth modalities is that if a practice nurse is required at the patient-end of the consult (example given if the patient is cognitively impaired) the nurse is not paid for their time.

Katherine Isbister

Ms Isbister is an employee of CRANA, who represent remote area nurses, midwives and allied health professionals. She noted in her experience telehealth services have meant people do not need to leave their family or community and this has multiple cultural safety advantages, including easier access to family and support people. Remote telehealth services can also prevent hospitalisation - which saves the system money because of the reduced need for aeromedical retrieval. Ms Isbister noted limitations of telehealth at present include lack of resourcing, lack of patient understanding and poor infrastructure and connectivity in some locations. She recommended investments in infrastructure with a focus on ease of use, and still upskilling to manage this infrastructure. She also noted store-and-forward capabilities are required. Examples given were an ECG or patient history transmitted before a telehealth consult.

Dr George Margelis

Dr Margelis has 15 years' experience in telehealth and provided input on telehealth access restrictions. Dr Margelis provided examples where the physical presence of the practitioner does not add value to the consult. Dr Margelis further discussed limitations of telehealth modalities and noted one of the key things from a clinician's perspective is the need for seamless integration of new telehealth modalities. Telehealth service delivery will need to be the ability to seamlessly switch between a telehealth visit vs. an in-person visit vs. a medication review.

Miranda Shaw & Dr Owen Hutchings

Ms Shaw and Dr Hutchings provided information to the Working Group about a virtual model of care being developed by NSW Health. They discussed the benefits and limitations of the new model being trialed and provided input on patient access restrictions, funding models, education and training options for clinicians and role of telehealth as part of the primary care landscape of Australian health into the future.

Dr Jenny Prentice

Dr Prentice is a clinical nurse consultant specialising in wounds, skin and ostomy care. Dr Prentice declared a conflict of interest, she is a current employee of Hall and Prior Aged Care Group and additionally currently works for an employer that provides wound management telehealth. Dr Prentice provided the Working Group information on current wound care service provided by real-time telehealth consultations via a nurse with a tablet at the patient's bedside. Dr Prentice also provided the Working Group information on synchronous and asynchronous modalities for telehealth.

A/Prof Angus Turner

A/Prof Turner is an ophthalmologist and discussed with the Working Group the role of telehealth in Optometry, which was included on the MBS Schedule in 2015. A/Prof Turner noted that an on-call service has increased Aboriginal and Torres Strait Islander community participation, and demonstrated reductions in non-attendance of consults, and surgical wait

lists. A/Prof discussed the need for mixed funding models and multi-modal telehealth delivery, including phone consultations and store-and-forward methodologies.

Phillip Hermann

Mr Hermann is a representative from Allied Health Australia and discussed the need for telehealth modalities to be flexible for different disciplines, citing the differences between speech pathology and psychology as examples. Mr Hermann discussed the need for national integration of services to allow clinicians to access services and for greater consistency in access.

Prof Mal Hopwood

Prof Hopwood is a psychiatrist and Chair of the MBS Mental Health Reference Group. Prof Hopwood discussed the role of telehealth in psychiatry services, particularly in rural and remote areas. Prof Hopwood particularly noted a lack of consistent approach in telehealth provision of services and discussed the role of private versus public funding models for psychiatry telehealth options.

General Practice and Primary Care Clinical Committee (GPPCCC):

The GPPCCC considered a range of payment options for telehealth early in stage 2 of its deliberations. Initially it considered an open fee for service model but concerns were raised about the potential risk of low value care. A number of caveats were considered to minimise this risk and they included a number of potential constraints. For example, convenience alone should not be a driver of telehealth, telehealth should initially start in rural areas, must be a regular patient of a practice, must have seen the doctor at least twice that year, must live more than 30km away from the practice and a maximum of two rebates per patient per year applies. The committee did not proceed along these lines in view of the potential red tape burden and the inability to deliver a reasonable compliance framework.

The GPPCCC ultimately considered the main strategy to minimise low value care was to link access to telehealth to voluntary patient enrolment. The committee felt a VPE gateway would maximise the benefits to the patient who would be interacting with a known provider who would be in in a position to provide an equivalent value service.

Its rationale for this included the following:

> *Evidence indicates that having a regular GP is beneficial for patient outcomes, patient experience and value for the system.*

> *Patient enrolment will encourage practices to build continuity of care into their business models, ensuring support for longitudinal care and population health as well as acute, episodic care.*

> *Enrolment will lead to stronger GP stewardship, with GPs supported to drive data-driven improvements in quality of care, and in referral and prescribing practices leading to potential downstream savings from preventable hospitalisations.*

The GPPCCC recognised that many members of the community including those living with disability and/or with transport issues, and people living in rural and remote communities, face challenges in attending general practices and believed this group would benefit from flexible access including non-face-to-face access (e.g. telephone, email, video consulting, telehealth, etc).

The committee noted that there is strong evidence that non-face-to-face care can increase access, without compromising patient outcomes.

Primary Health Networks:

PHNs are independent primary health care organisations, located throughout Australia. They are funded to undertake activities and commission services to address the health care needs of their communities and to improve efficiency, effectiveness and coordination of care.

HealthPathways

HealthPathways offers clinicians locally agreed information to make informed decisions, together with patients, at the point of care for use during a consultation. Each pathway provides clear and concise guidance for assessing and managing a patient with a particular symptom or condition. Pathways also include information about making requests to services in the local health system.

Content is developed collaboratively by general practitioners, hospital clinicians and consumers, and a wide range of other health professionals. Each pathway is evidence-informed, but also reflects local reality, and aims to preserve clinical autonomy and patient choice. HealthPathways serves to reduce unwarranted variation and accelerate evidence into practice.

Other considerations

The Working Group has also considered other pieces of work relating to telehealth, including the work of the Primary Health Care Reform Steering Committee, and papers by Len Gray and Prof. Besser

Objective 2: Observations and recommendations to Government

Observations

Bushfires 2019 and COVID-19

The 2019-2020 Australian bushfires and the COVID-19 pandemic have resulted in the Australian Government's introduction of temporary MBS Telehealth items which will continue until 30 September 2020.

Anecdotal indications are that Telehealth services have been effective in bushfire and COVID-19 response items, and the Australian community is receptive to telehealth consultations being provided more broadly.

The introduction of the temporary MBS telehealth items has altered the approach to delivering Medicare services in Australia, changing them from an almost entirely face to face service to one that has an increased level of non-face to face services delivered. This poses its own risks, such as commercialisation of telehealth service delivery by corporates with no intention to provide face to face services and ensure holistic care of patients and a reduced level of quality of health service due to increased non-face to face interaction.

It will be important for Australia, to consider the benefits and risks associated with this approach to healthcare and ensure an effective, efficient, and ethical approach to Telehealth and Telemedicine into the future.

Telehealth / Telemedicine / Virtual health

It is recognised that there are very successful international models of health care often underpinned by different funding models. Our challenge is to understand which elements can be adopted in the Australian context and the roll the MBS might play in their funding.

MBS Telehealth

Where 'telehealth' is a general term that refers to all modalities, 'MBS Telehealth' as defined in this report refers specifically to items that have been deemed appropriate to be funded via the MBS. Up until the COVID-19 pandemic response MBS Telehealth has been designed to provide rural, remote and regional communities with improved access to health care.

The MBS Review and Australia's COVID-19 pandemic response has identified there is a definite need for a National Strategy to develop a Framework and Guidelines for the use of Virtual Health / Telemedicine with a specific focus on modality of care and funding models. This will ensure consistency and flexibility in the use of advances in technology.

Alternate Funding Models – See Principle 8

Key Recommendations

Recommendation 1.

The Government develop a National Virtual Health Strategy and Framework for Australia, with National Guidelines for MBS Telehealth.

Rationale:

The Telehealth Working Group's consideration of the broader concept of Telehealth, the referred recommendations, and the expansion of telehealth, resulting from bushfire and pandemic responses, has presented a range of opportunities and risks for policy makers to consider.

This along with the emergence of blended payment models and voluntary enrolment, the Working Group agree there are opportunities for a more broadly defined Virtual Health concept in the Australian health system.

There is a need to detail the highest-value opportunities for telehealth integration into health care. Gathering national evidence, building on existing research on telehealth interventions conducted at the state and territory level and in federally funded trials will help identify a nationally consistent evidence based approach to the inclusion of the range of Virtual Health services available. However, without a strategic approach and acceptable transition there is a risk to patient outcomes and safety.

Recommendation 2.

Design MBS Telehealth policy and guidelines using the Principles in this document as a framework for providing a consistent service model for Medicare services. This design process should equally consider and address the intent from the referred recommendations including:

- Proper expansion and improved access to services for patients and health providers
- Consideration of appropriate funding models
- MBS Telehealth fee structures and service models
- Service access and flexibility

Transitional arrangements that allow application to new telehealth services and alignment over time for existing items as a means to avoid unintended consequences, sudden retreat from service provision and to allow the system time to adjust.

Rationale:

The Taskforce, through the cross-cutting nature of MBS telehealth and the Clinical Committees referred recommendations, identified a need to make recommendations for MBS Telehealth. Forming the Working Group to provide recommendations and principles to ensure consistency and to assess telehealth on the MBS and more broadly. This work has identified a need to modernise MBS Telehealth in a way that gives clear guidance and is adaptable to changes in service, health technology, patient need and clinical efficacy. This can be achieved with the development of consistent policy and guidelines.

Medical best practice and advances in health technology rapidly change. MBS Telehealth items have traditionally been designed to provide rural, remote and regional communities with access

to health care and have not always considered efficacy or patient need or patient convenience. This, along with the COVID-19 responses, expansion of telehealth and the referred recommendations point to the need for a more robust consideration of MBS Telehealth emphasising the importance of policy and guidelines to inform flexible adaptation of suitable and safe service models for the MBS.

The Working Group has endorsed the principles detailed below and applied those principles in a consistent way to the recommendations detailed below that came from a number of different working groups and recommends them to the Taskforce. In addition to the principles the working group has taken into consideration the recommendations made by the Taskforce in relation to the remained of the report of origin.

Referred Recommendations – Working Group response

- **Recommendation 1:** Improve access to allied health services via telehealth (Allied Health Reference Group Recommendation 13)
  - *Supported with qualification*
- **Recommendation 2:** - Enable GP telehealth consultations and expand GP telehealth eligibility to patients with mobility concerns who cannot easily be seen face to face. (General Practice and Primary Care Clinical Committee Recommendation 11)
  - *Supported*
- **Recommendation 3**: Increase access to telehealth services (Mental Health Reference Group Recommendation 14)
  - *Supported with qualification*
- **Recommendation 4:** Add GPs as eligible participants in Nurse Practitioners patient-side telehealth services (Nurse Practitioners Reference Group Recommendation 11)
  - *Supported*
- **Recommendation 5:** Add patients in community aged care settings to residential aged care telehealth items (Nurse Practitioners Reference Group Recommendation 12)
  - *Supported*
- **Recommendation 6:** New MBS items for direct NP-to-patient telehealth consultations (Nurse Practitioners Reference Group Recommendation 13)
  - *Not Supported with qualification*
- **Recommendation 7:** Allow telehealth consultations to take place via telephone where clinically appropriate. (Nurse Practitioners Reference Group Recommendation 14)
  - *Supported with qualification*
- **Recommendation 8:** Include GPs as eligible specialists for existing telehealth items (Participating Midwives Reference Group Recommendation 11)
  - *Supported with qualification*
- **Recommendation 9:** Facilitate telehealth consultations between women and midwives (Participating Midwives Reference Group Recommendation 12)
  - *Supported* in principle but not *through the MBS*
- **Recommendation 10:** Remove item 99's association with item 104 or 105, and instead have three item numbers that include asynchronous options) Ophthalmology Clinical Committee Recommendation 12)

- o *Not Supported with qualification*
- **Recommendation 11**: Convene a Departmental working group to explore the barriers and opportunities offered by telehealth across all areas of Health. In the case of Optometry, to develop an appropriate MBS item to meet the requirements of Optometry and Ophthalmology. Optometry Clinical Committee Recommendation 3)
  - o *Supported*
- **Recommendation 12:** Telehealth items should be available for multi-disciplinary assessment and review for pain management patients. (Pain Management Clinical Committee Recommendation 28)
  - o *Supported with qualification*
- **Recommendation 13:** Reform arrangements for item 288 - delivery telehealth consultations to regional and remote patients (Psychiatry Clinical Committee Recommendation 2)
  - o *Supported*
- **Recommendation 14:** New items to provide telehealth consultations to patients in major cities of Australia (Psychiatry Clinical Committee Recommendation 3)
  - o *Supported*
- **Recommendation 15**: Continue arrangements for Items 353-370 - consultations with psychiatrists via the phone in regional and remote areas (Psychiatry Clinical Committee Recommendation 4)
  - o *Supported with qualification*
- **Recommendation 16:** A new framework for telehealth (Specialist and Consultant Clinical Committee Recommendation 9)
  - o *Supported*
- **Recommendation 17:** Reinvest in telehealth (Specialist and Consultant Clinical Committee Recommendation 10)
  - o *Supported*
- **Recommendation 18:** Where appropriate, consideration should be given to the use of remote and non-face-to-face services (real time or asynchronous) and an appropriate funding model investigated (Wound Management Working Group Recommendation 8)
  - o *Supported*
- **Recommendation 19:** Increase access to wound care experts in RACFs, including telehealth enabled, where appropriate (Wound Management Working Group Recommendation 14)
  - o *Supported*

Referred Recommendations Already Endorsed:
- **Recommendation 20:** Eating Disorders Recommendation 1.4
  - o *Noted and with evaluation that these recommendations be aligned to the principles over time*
- **Recommendation 21:** Gynaecology Clinical Committee Recommendation 10 - Delete item 13210 (attendance on a patient by video conference)
  - o *Not Supported. Should also be aligned with the principles*

Objective 3: A set of MBS Telehealth Principles

The Working Group has developed the following principles for evaluating the Taskforce referred telehealth recommendations proposed by clinical committees and working groups.

These Principles could also be applied by policy makers when considering telehealth now and into the future.

The Principles are designed to be a suite of cohesive principles and considered together.

MBS Telehealth Principles

1. Should be patient-focused, and based on patient need, rather than geographical location.

2. Must support and facilitate services that are clinically safe and efficacious for patients.

3. Should be provided in the context of continuity of care between patient and practitioner.

4. Must not create unintended consequences or perverse incentives that undermine the role of face-to-face care.

5. Should not be specific to the technology used but video offers richer information transfer and should be favoured over phone with fewer exceptions being allowed over time.

6. Should encourage clinicians where they are required at both ends of the interaction with the patient to support optimal clinical interchange.

7. Should be implemented and modified through time limited transition arrangements.

8. Funding solutions will vary depending on patient need, specialty, craft group and purpose.

9. Should be guided by existing relevant guidelines and principles.

10. Requires ongoing data collection and research and evaluation into its outcomes and utility.

Principle Considerations

Application of the Principles to the referred recommendations may impact other rules within the MBS. This Working Group do not address this in their recommendations. This is considered a matter for Government in responding to the endorsed recommendations and addressed during any implementation.

The Principles created by the Working Group do not look to increase access to rapid throughput, low value telehealth under the guise of increasing convenience. As above, the Working Group acknowledges face-to-face care as the benchmark standard of healthcare. However, further research and evidence is needed for the purposes of benchmarking.

Principle 1

> *P1 – Should be patient-focused, and based on patient need, rather than geographical location.*

Up until the COVID-19 pandemic response MBS Telehealth has been designed to provide rural, remote and regional communities with improved access to health care. This Principle addresses the historic, largely geographic approach to restrictions for claiming MBS Telehealth items to one based on patient need. This is consistent with the MBS Review goal of affordable and universal access for all Australians. This principle additionally recognises that MBS Telehealth services should be patient led, not provider led where possible and support an informed consent model.

MBS Telehealth items currently universally include geography as a condition for claiming i.e. requiring that; "[the patient] must be located in a telehealth eligible area at the time of the attendance; and [the patient must be] located at least 15km by road from the specialist."

Telehealth eligible areas are currently defined as Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications, 2-5 in some instances, or Modified Monash Model (MMM) 4-7 in others. Telehealth Eligible Service Areas are defined at www.mbsonline.gov.au/ telehealth eligible areas.

The Working Group believes that MBS Telehealth should be available to patients who have a clinical need for this type of service and where face-to-face consultations are not possible. Access to MBS Telehealth by primary care and specialist providers allows:

- Patients who need care to receive it in a timely manner; and,
- Access for remote and isolated patients; and
- Access in the afterhours environment.

The Working Group recognises the important role MBS Telehealth plays in delivering services to rural, remote and regional Australians and emphasises this Principle is in no way designed to reduce these services. Access to MBS Telehealth should not be based solely on geographic location of the patient and provider, but this should not prohibit access either.

MBS Telehealth will still be geographically restricted to Australia. There is still a role for a broad geographic restriction that MBS Telehealth services should be rendered entirely within Australia, with both the patient and practitioner located in Australia.

Further Consideration

Work will need to be undertaken to define "patient need". This should not be defined by the patient or doctor alone, rather it must be a shared judgement that supports an informed consent model of agreement.

Risk: There is a risk that business that focus on high turnover and throughput may generate excessive and/or inappropriate services, rather than responding to genuine patient need for an alternative to face-to-face care. An additional risk are providers entering the market promoting MBS Telehealth services without sufficient links to established, face-to-face services. Mitigation will need to address this through preventative compliance strategies where possible.

Case Example

A patient who lives in a metropolitan area but is a two hour drive away from an appointment that can take place over the phone should be able to receive a quality clinically appropriate service.

A patient with serious mental health issues well know to a psychiatrist should be able to access psychiatric care from that psychiatrist even though both are located in the city.

Principle 2

> **P2 – Must support and facilitate services that are clinically safe and efficacious for patients.**

The premise being that the system enables clinically appropriate health care to be provided via different methods without the method compromising the quality or appropriateness of the health services.

Ongoing review of MBS Telehealth will be required to confirm that it has resulted in quality clinical outcomes and is acceptable to both patients and providers and must have provision for an appropriate compliance framework for detection of risk and abuse cases.

There could be measures of patient reported outcomes (Proms) and patient reported experience measures (Prems) incorporated into new MBS telehealth service outcomes measures to assess against Value and the Quadruple Aim.

Cognisant of the fact there are a range of methods for provision of Telehealth and Telemedicine at present, the Working Group is not specifying the technology platforms that should be used for MBS Telehealth, so long as the technology meets legislated clinical, privacy, safety, security and evidentiary standards. This should acknowledge the medico-legal implications of patient data transfer and adhere to *the MBS Privacy Checklist for Telehealth Services*[10].

All MBS Telehealth items need to include written records and communication consistent with GN.15.39 of the MBS. All practitioners who provide, or initiate, a service for which a Medicare benefit is payable, should ensure they maintain **adequate** and **contemporaneous** records.

CASE Example:

A GP provides a GP Management Plan review to a well know patient by a video consultation. The patient's blood sugar, blood pressure and weight are shared with the doctor. The GP can give appropriate clinical advice and update the practice records, provide prescriptions and updated referral when required.

The same patient three months later follows up with their regular endocrinologst as recommended in the management plan. The consultation takes place by telehealth. The consultant reviews the case provides updated advice and writes a letter back to the GP.

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[10] **PRIVACY CHECKLIST FOR TELEHEALTH SERVICES** – www.mbsonline.gov.au

Principle 3

> **P3 – Should be provided in the context of continuity of care between patient and practitioner.**

Continuity of care is a long-standing feature of healthcare, especially of general practice. It is associated with increased patient satisfaction, increased take-up of health promotion, greater adherence to medical advice and decreased use of hospital services and lower mortality.[11]MBS Telehealth should form part be part of way providers and consumers interact. It is recognised that there will be different solutions for different specialties and classes of providers.

MBS Telehealth should support integrated care and informed consent agreement with the patient.

MBS Telehealth is considered not appropriate for discrete episodes of care.

The working group recommends the availability of MBS Telehealth be accessible if:

    a. a patient meets the definition of an active patient as set out in respective guidelines i.e. the RACGP definition of an 'active patient'; or,

    b. the service is provided with the treating health provider and the referred health provider present, for handover, (recognising it is not always possible for a patient to be an active patient with a referred health provider); or,

    c. the patient is located in a rural location and enables patients to access a health professional that operates within their region i.e. not limiting to active patient definition and requirements.

Telehealth is a valuable mechanism for the delivery of services such as after hours primary care particularly from the usual doctor. Where patients are unable to access services from their regular GP after hours (either face-to-face or telehealth) there is the potential for patients to access after hours primary care through a range of face-to-face options and telehealth through Healthdirect.

There is a risk of double dipping if telehealth is used to contact a patient to request they attend a face-to-face consultation or if in order to allow a more complete physical examination the patient is required to attend face to face. Neither of these is a new episode of service, and this would only be billable under one item number. Mitigation of this will require clear descriptors, explanatory notes and compliance reviews.

Further Consideration

There are likely to be different telehealth solutions for referred specialties and non-referred services, for both telehealth and MBS Telehealth. There are examples of non-referred Telehealth outside of MBS care, for example virtual EDs.

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[11] BMJ Open 2018 Jun 28;8(6):e021161

Principle 4

> *P4 – Must not create unintended consequences or perverse incentives that undermine the role of face-to-face care.*

MBS Telehealth must reflect the need for face-to-face care and should not create unintended consequences or incentives that decrease the role of appropriate face-to-face care. MBS Telehealth is not a 'substitute for service' but is intended to be a 'complementary service' to the normal face-to-face visits where a more comprehensive physical assessments of patients can be conducted, as well as the formation and consolidation of the health professional-patient relationship.

An example of the comparison are the COVID-19 Telehealth items (which are out of scope of the Working Group but serve to demonstrate this concept). This suite of items was introduced to mirror existing MBS items, but with the provision they can be provided by telehealth. These items were released before the Telehealth Working Group's report, and therefore were not subject to the Working Group's Principles that they be complementary to face to face visits. There is evidence of high throughput "telehealth only services" providing care of questionable value emerging.

The Working Group noted the rationales provided by Clinical Committees regarding clinical efficacy. The Working Group acknowledges this evidence has been considered in developing the Principles.

The required standard of care will need to be carefully defined for each professional group offering MBS Telehealth services and an appropriate regulatory framework instituted to ensure standards are met and maintained.

Further Consideration

Work will need to be undertaken to further define "Clinical efficacy" and will require support from Professional Groups and Colleges to maximise the quality of consultations delivered via a telehealth modality.

Risk: The Working Group is cognisant that low value and high throughput models of care can be facilitated by telehealth and the need to minimise this risk.

Consent to telehealth services: After clinical appropriateness is confirmed there needs to be informed agreement by both the patient and clinician that the service will be provided via an appropriate telehealth modality.

Case Example 1

Antenatal care provided should be consistent with the Pregnancy Care Guidelines (www.health.gov.au/pregnancycareguidelines) and many of the activities that are recommended to be undertaken at antenatal appointments such as measuring blood pressure, assessing foetal growth, and testing for hyperglycaemia and anaemia would not be clinically appropriate to be provided via telehealth.

Case Example 2

A proposed model for telehealth provided by the Mental Health Reference Group notes consultations might include patients with physical disability, severe agoraphobia, and other health conditions whereby attending face-to-face consultations is not practical or for patients

who require treatment from a psychiatrist located in another city, and that report provided evidence demonstrating clinical efficaciousness for these consultations.

Principle 5

P5 - Should not be specific to the technology used but video offers richer information transfer and should be favoured over phone with fewer exceptions being allowed over time.

A) Text and email, image storing and forwarding and remote monitoring are examples of Telehealth modes of delivery that are not appropriate as MBS Telehealth subsidised models of delivery.

B) Video consultation is the preferred mode of delivery for MBS Telehealth with phone consultations being the exception.

This Principle is linked to Principle 4, any technology modality will need to be adequately secure as per that Principle.

This Principle draws another distinction between Virtual Health and MBS Telehealth. While text and emails are alternative communication tools, the Working Group does not recommend implementing a fee-for-service model such as the MBS for these episodes of service.

The Working Group also notes that video consultations offer richer information transfer and should be favoured over phone consultations with fewer exceptions being allowed over time.

Principle 6

P6 – Should encourage clinicians where they are required at both ends of the interaction with the patient to support optimal clinical interchange.

MBS payments are available to patients now for Telehealth Patient-end Support Services by Health Professionals from geographically eligible locations. A video consultation will involve a single specialist or consultant physician attending to the patient, with the participation of another general practitioner, specialist or consultant physician, at the patient end.

Input from several of the clinical committees and experts are recommending an expansion of telehealth services, where a GP would act as the consultant when allied health, nurse practitioner or eligible midwives are patient-side. The working group agrees that this would provide a clinically appropriate service and is supported.

At present no claiming is allowed unless the provider at both ends of the video conference are MBS Rebate eligible. The working group supports expansion of the eligibility so that if one of the clinicians either at the patient end or the consultant end are MBS Rebate eligible then a rebate is available. This would allow an allied health professional or aboriginal health worker or a nurse funded by different means to consult with a GP acting as a consultant. It would also allow a rebate for a GP at the patient end consulting with a specialist in a public hospital outpatient department.

This provision links in with the goal of affordable and universal access.

MBS payments are for clinically appropriate services provided directly to patients. Informal clinician communications by telephone between clinicians without the patient present are not eligible for MBS Rebates.

Further Consideration

Work will need to be undertaken to further consider if there should be a set of items for a clinician providing a patient-end service as part of MBS Telehealth or if there is a more effective funding model for these services and meeting the community need.

CASE Example:

Salaried Midwife at the patient end consulting a GP obstetrician about a medical issue with one of the midwives patients.

Principle 7

P7 - Should be implemented and modified through time limited transition arrangements.

Telehealth, especially after the effects of the COVID-19 pandemic, is a rapidly changing area of health provision. Telehealth through telephone consultation has been one of the most successful and rapid adoption of a change in clinical workflow that we have seen in this country. Despite this the working group recommends that we return to transition arrangements that are introduced over time with subsidies and changes phased in and out over time with ongoing monitoring to assess the impact of these changes.

This Principle links with Principle 10, for ongoing research into telehealth provision.

In addition, providing support for transitioning gradually to telehealth services will allow the introduction of technology in those areas who have not previously used telehealth like allied health services.

When there is funding to support implementation costs it should be gradually phased out over time to avoid locking in perverse incentives. Practices should be advised that funding for implementation is only available for a limited time so they can take action to ensure they are positioned to benefit from this funding.

In General Practice non MBS mechanisms such as the PIP may be used to support GPs to adopt products that more closely integrate into their clinical software over time.

Further, it is recommended that the phased approach to introduce new models for telehealth make use of and incorporate digital mediums including My Health Records, secure messaging and ePrescribing to improve provider workflows and therefore productivity.

CASE Example:

The recommendation to gradually reduce the loading for psychiatry telehealth as detailed in their report at recommendation 2 and at recommendation 13 of the 21 referred recommendations to this working group for consideration.

Principle 8

P8 – Funding solutions will vary depending on patient need, specialty, craft group and purpose.

Different funding models: The MBS Schedule will be appropriate for some of these models of care, block or blended payments will be appropriate for others, formal patient enrolment will be a gateway to other models of payments.

Private health insurers may embrace telehealth to support hospital in the home or other services. Patient choice to utilise private health insurance should not adversely impact access to telehealth benefits.

The working group having taken into consideration the broader views of the taskforce in relation to allied health, nurse practitioners and eligible midwives recognises that there will be varying funding models that will underpin virtual healthcare. For allied health it may be appropriate to allow some or all of their face to face item numbers to be converted to telehealth consultations. Psychologists providing services supported by PHN's may be funded by alternative means.

Teledermatology in Australia is funded via block payments and a salaried arrangement which may be appropriate for other store and forward models of care.

CASE Example:

Tele Dermatology is provided by a salaried specialist

Principle 9

P9 – Should be guided by existing relevant guidelines and principles.

There are a number of guidelines developed for telehealth by various entities that should guide delivery of Virtual Health services such as:

- The Medical Board of Australia's Good Medical Practice: a Code of Conduct for Doctors in Australia and the Guidelines for Technology-based Patient Consultations,
- The [Australian Commission on Safety and Quality in Health Care (A](#)CSQHC's digital mental health standards[12]
- The Australian Physiotherapy Association Telehealth Guidelines[13] and
- others developed by specialist nursing and allied health provider organisations.

MBS Telehealth must be in line with the four goals of the MBS Review Taskforce, affordable and universal access, best practice health services, value for the individual patient, value for the health system.

CASE Example:

APA guidelines

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[12] https://www.safetyandquality.gov.au/standards/national-safety-and-quality-digital-mental-health-standards

[13] https://australian.physio/sites/default/files/APATelehealthGuidelinesCOVID190420FA.pdf

Principle 10

> *P10 – Requires ongoing data collection and research and evaluation into its outcomes and utility.*

As per Principle 8, the landscape of telehealth service provision is quickly changing. Research into service provision is therefore valuable to ensure best practice.

Examples of research areas include:

- Cost efficiency of MBS Telehealth services
- Quality of MBS Telehealth services
- Patient outcomes after MBS Telehealth services
- Flexibility in adapting to technologies

Objective 4: Apply the Principles to the referred recommendations

The following chapter addresses the referred recommendations from 13 Taskforce Clinical Committees and Working Groups reports:

1. Primary Care
   a) Allied Health Reference Group Recommendation 13
   b) General Practice and Primary Care Clinical Committee Recommendation 11
   c) Mental Health Reference Group Recommendation 14
   d) Nurse Practitioners Reference Group Recommendation 11, 12, 13 and 14
   e) Participating Midwives Reference Group Recommendations 11 and 12
2. Ophthalmology Clinical Committee Recommendation 12
3. Optometry Clinical Committee Recommendation 3
4. Pain Management Clinical Committee Recommendation 28
5. Psychiatry Clinical Committee Recommendation 2, 3 and 4
6. Specialists and Consultant Physician Clinical Committee Recommendation 9 and 10
7. Wound Management Clinical Committee Recommendation 8 and 14

Already endorsed by Government provided at Appendix A

8. Eating Disorders Working Group Recommendation 1.4
9. Gynaecology Clinical Committee Recommendation 10

Allied Health Reference Group

Telehealth Recommendation 1 of 21: Allied Health Reference Group Recommendation 13 - Improve access to allied health services via telehealth.

TWG recommendation: Agree to improved access via telehealth following consideration of clinical efficacy and modality of service delivery.

TWG Rationale:

The TWG supported point a), a research piece. This complements Principle 10 *Ongoing research into the efficacy and equivalent of Telehealth should accompany changes to funding structures for MBS Telehealth.*

The TWG also supported point c), the restriction to claiming of items to practitioners who can deliver comparable outcomes via teleconference as in face-to-face consultations. This links strongly with the overall theme of this report, especially Principle 4 *Must not create unintended consequences or perverse incentives that undermine the role of face-to-face care.* It should be noted that the AHRG Recommendation specifies "comparable" outcomes but the TWG Principle requires clinical efficacy. It is also notable that the restriction for point c) is specifically in relation to a new item per point b) - it is not a recommendation for all Allied Health MBS Telehealth items.

At Meeting 1, the TWG noted that the new items under point b) cannot be delivered until a) and c) are resolved. Additionally, several of the subpoints of b) are not harmonious with the Principles - for example the text references the geographic restrictions currently relevant for MBS Telehealth items and that the provider must have had at least two consultations with the patient. The telehealth working group supported modifications to align with Principle 1 *Should be patient focused, and based on patient need, rather than geographical location* and 3 *Should be provided in the context of continuity of care between patient and practitioner*, respectively.

Allied Health Reference Group Recommendations

Recommendation 13 – Improve access to allied health services via telehealth

The Reference Group recommends:
   a. undertaking a follow-on piece of work detailing the highest-value opportunities for telehealth integration into allied health care, to gather national evidence, building on existing research on telehealth interventions conducted at the state and territory level and in federally funded trials and to identify:
      (i) Telehealth interventions provided by allied health professionals with evidence for comparable or superior clinical outcomes (compared with face-to-face interventions).
      (ii) Cost savings associated with using telehealth in allied health care.
      (iii) The views of consumers and feedback on telehealth use in allied health care.
      (iv) Exploring the use of telehealth interventions to complement existing models of care, especially for rural and remote areas.

b. in the interim, creating a new MBS item for the provision of telehealth services for patients consulting with an allied health professional via teleconference, with the following restrictions:
   (i) The patient must not be an admitted patient.
   (ii) The patient must be located both within a telehealth-eligible area and at least 15 kilometres from the Allied Health Professional.
   (iii) The patient must reside in a rural or remote region (defined as Modified Monash Regions 4 to 7).
   (iv) The allied health professional must be a primary health care provider for the patient, defined as having had at least two consultations with the patient.
   and
c. that the new item should only be claimable for types of allied health professionals who can deliver comparable outcomes via teleconference as in face-to-face consultations to ensure that there is no compromise in service delivery or standard of care.

Rationale 13

This recommendation focuses on improving access to effective telehealth services. It is based on the following:

o The Reference Group acknowledged that telehealth could be used to improve delivery of allied health care for rural and remote populations. However, it also noted that the current fee-for-service system under the MBS does not always create the right incentives for telehealth.

o There are 382 allied health professionals per 100,000 people in metropolitan areas, compared to just 136 in remote/very remote areas. (46) In rural and remote areas, one in five patients report that they experience longer-than-acceptable waits to access health services (47).

o The Reference Group agreed that this recommendation has the following benefits:

o It would increase allied health service provision in remote, regional and rural areas. This would decrease the need for patients in rural and remote communities to travel (and take time off work) to receive allied health care.

o For providers already providing telehealth services, the recommendation would reduce out-of-pocket fees by allowing rebates for patients. This would relieve the financial burden on patients who already face the hardships of distance, limited service provision and inequitable access to services.

o The recommendation would increase local employment by creating opportunities for locally based allied health assistants (who may provide patient-side support).

o There is some evidence to support telehealth interventions in allied health care. A recent Australian review of allied health video consultation services found that clinical outcomes have generally been similar to outcomes for usual care, although it acknowledged large differences in the breadth and quality of evidence between different allied health professionals (48).

There is evidence that telephone counselling by a dietitian achieves dietary behaviour change and improves metabolic parameters in individuals with metabolic syndrome. Swanepoel and Hall (2010) conducted a systematic review of telehealth applications in audiology and found that outcome measures for conventional face-to-face services and remote telehealth services were similar, with no negative impact on patients who received telehealth services. Various types of audiological assessment were found to be viable, such as otoscopy, pure-tone audiometry, impedance audiometry, otoacoustic emission, and auditory brainstem response audiometry, with no clinically significant differences in results compared to face-to-face administration of these assessments (49)

General Practice and Primary Care Clinical Committee

Telehealth Working Group Consideration

<table>
<tr><td>Telehealth Recommendation 2 of 21: General Practice and Primary Care Clinical Committee Recommendation 11 - Enable GP to act as consultants when engaging patients through telehealth consultations with Nurse Practitioners, Aboriginal Health Workers and Allied Health Professionals at the patient side.</td></tr>
<tr><td>TWG Recommendation: The TWG supported this recommendation.</td></tr>
<tr><td>TWG Rationale:
All of the committees above supported this recommendation as high value care.</td></tr>
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General Practice and Primary Care Clinical Committee recommendations

Recommendation 11

> Enable GP telehealth consultations and expand GP telehealth eligibility to patients with mobility concerns who cannot easily be seen face-to-face.

- The Committee recommends that the descriptors of items 99 and 82220-82222 be expanded to make GPs eligible to provide a telehealth consultation, in addition to other specialists and consultants. Provision of these GP telehealth services should be restricted to a patient's usual provider.

- The Committee recommends that new items be created to reimburse GPs for their time for telehealth consultations (similar to items which currently exist to reimburse other specialists) to support Nurse Practitioners and Aboriginal and Torres Strait Islander Health Practitioners consulting with patients in remote and rural settings.

Rationale 11

This recommendation focuses on increasing patient access to, and usage of, telehealth services. It is based on the following observations:

- The requirement for telehealth services to take place with specialists/consultations limits patient access to telehealth items. A survey of 73 Nurse Practitioners (NPs) working in primary care and accessing MBS indicated that only 12% used telehealth items, and identified that the main reason for non-use of the telehealth items was the stipulation of having a specialist or consultant present. ([14])

- The addition of GPs as eligible telehealth providers will increase patient access to GPs, particularly in remote areas where GP access is more limited. The restriction to a patient's usual provider will ensure rural and remote practice sustainability. Rigorous consultation should be undertaken with rural and remote providers in the implementation of this recommendation.

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[14]   Currie et al., 2018

- Expanding GP telehealth eligibility criteria to include patients with mobility concerns, such as patients who are elderly and frail, will increase patient access to essential services.

The GPPCCC notes that the Nurse Practitioner Reference Group supports this recommendation.

Mental Health Reference Group

Telehealth Working Group Consideration

Telehealth Recommendation 3 of 21: Mental Health Reference Group Recommendation 14 - Increase access to telehealth services
TWG Recommendation: Supported by the TWG with qualification to align with the principles.
TWG Rationale: In the implementation consideration. All the principles need to be taken into account.

Mental Health Reference Group Recommendations

1.1   Recommendation 14 – Increase access to telehealth services

The Reference Group recommends a review of the recent announced expansion of access to mental health telehealth services in rural and remote areas in two years to:

(i)   Assess whether it has delivered the hoped-for outcomes, and

(ii) Ensure that the change is a permanent one and is not seen as a temporary emergency fix.

Rationale 14

This recommendation notes the Reference Group's agreement with a recent decision to increase availability of telehealth services. It is based on the following:

The Reference Group agreed that telehealth services were high value care for patients. However, the Reference Group agreed that there was a risk that this decision reflected a temporary change given the current state of drought, and emphasised that this decision should permanently enable all Better Access sessions to be offered via telehealth.

- The Reference Group discussed the recent announcement expanding access to telehealth services in rural and remote areas. The change, effective from 1 September 2018, allows eligible patients in rural and remote areas to access all of their Better Access sessions via videoconference (as opposed to seven out of 10 sessions) (21).

- The Reference Group supports telehealth access for people with disabilities, frail and elderly people and those residing in rural and remote areas, when accessed through their usual GP.

Nurse Practitioners Reference Group

Telehealth Working Group Consideration

Telehealth Recommendation 4 of 21: Nurse Practitioners Reference Group Recommendation 11 - Add GPs as eligible participants in Nurse Practitioners patient-side telehealth services

TWG Recommendation: The TWG supported this recommendation.

TWG Rationale:

This recommendation is in line with Guiding Principle 5 *MBS Telehealth should aim to have clinicians at both ends of the interaction with the patient to support optimal clinical interchange.*

Telehealth Recommendation 5 of 21: Nurse Practitioners Reference Group Recommendation 12 - Add patients in community aged care settings to residential aged care telehealth items

TWG Recommendation: The TWG supported this recommendation.

TWG Rationale:

This recommendation specifically mentions increasing "access to, and use of, telehealth services for patients who face difficulties accessing their primary health provider despite living in urban areas"- this complements Principle 1 *Should be patient-focused, and based on patient need, rather than geographical location.*

Any implementation of This recommendation needs to deliver consistency with Principle 2 *Must support and facilitate services that are clinically safe and efficacious for patients* and Principle 4 *Must not create unintended consequences or perverse incentives that undermine the role of face-to-face care* and

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Telehealth Recommendation 6 of 21: Nurse Practitioners Reference Group Recommendation 13 - New MBS items for direct NP-to-patient telehealth consultations

TWG Recommendation: Not Supported at this time

TWG Rationale:

The TWG agreed that based on the principle of equivalence in quality of care, the group could not support this recommendation as separate MBS item numbers at this time until training and scope of practice issues are resolved. It agree that telehealth could be an option through different funding models which might include VPE or Health Care Home blended funding.

Telehealth Recommendation 7 of 21: Nurse Practitioners Reference Group Recommendation 14 - Allow telehealth consultations to take place via telephone where clinically appropriate.

TWG Recommendation: Supported with qualification

TWG Rationale:

The TWG agreed on a preference for video consultation with telephone as the exception because of richer information transfer with video in alignment with Principle 5 *Should not be specific to the technology used but video offers richer information transfer and should be favoured over phone with fewer exceptions being allowed over time.*

Nurse Practitioners Reference Group Recommendations

1.2   Improving patient access to telehealth services

The role of telehealth

The Reference Group acknowledged that the role of non-face-to-face communications is an increasingly important one in health services and patient care. For NPs acting as a primary care giver, as well as those in more specialised roles, telehealth offers an opportunity to provide high-value care to patients who may not be able to see their health provider in person.

The Reference Group noted that the long-term solution for telehealth support, as part of a comprehensive suite of health services, may not be through a fee-for-service MBS. However, it felt it was important to include actionable, shorter-term recommendations for specific items, both existing and new, that could address the current service gap in telehealth.

The Reference Group considered various restrictions on proposed telehealth items in order to ensure that they are not abused, and that telehealth is only used when it is a mechanism for providing high-value care to a patient. These included:

- Rurality: Ensure that patients who use telehealth services are not easily able to access a relevant health provider for a face-to-face consultation.

- Usual practitioner: Ensure that patients receive telehealth support from a provider who is focused on the patient and is providing telehealth support because it is the best medium available (rather than being focused on telehealth and providing a service to a patient simply because the option is available).

- Follow-up care: Ensure that patients only receive telehealth support when the attendance is in relation to a clinical issue already discussed at a face-to-face consultation.

- Patient-side support: Ensure that, where relevant, an appropriate practitioner is physically in attendance with the patient during their telehealth consultation.

Ultimately, the Reference Group decided against identifying the specific conditions associated with these dimensions, as several exceptions could be found for each of them. Some suggestions are included with each of the recommendations below, as a starting place for implementation.

The advantages of telehealth

For patients, the main benefit of using telehealth services is increased access to health care, with non-inferior outcomes, where clinically appropriate. Evidence for this includes the following:

- Surveys have consistently found high patient satisfaction with telehealth consultations (34) (35) (36).

- Compared to usual care, a range of telehealth interventions have been found to produce at least equivalent outcomes in the management of asthma (37) (38), blood pressure (39) and depression, and in overall quality of life (40).

A systematic literature review of telehealth services in rural and remote Australia reviewed models of care and factors influencing success and sustainability. Funding for general medical and other practitioners for the provision of telehealth services is limited or non-existent (41).

In a study in the United States, the transaction costs of in-clinic consultations and telehealth presentations were compared for chronic pain management provided by community-based providers including NPs, primary care physicians and physician assistants. Although similar in terms of cost, telehealth consultations demonstrated preliminary evidence for improved patient satisfaction with treatment, improved provider satisfaction with the consultation process, reduced wait times and reduced health care utilisation (42).

Recommendation 11 - Add GPs as eligible participants in NP patient-side telehealth services

The Reference Group recommends:

a. adding GPs as eligible participants in NP patient-side telehealth services (items 82220, 82221 and 82222)

b. including all Aboriginal and/or Torres Strait Islander peoples, not only patients of Aboriginal Medical Services or Aboriginal Community Controlled Health Services with a 19(2) exemption, and

c. amending the item descriptors along the lines of the following example:

Item 82220 – example text

A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating NP that requires the provision of clinical support to a patient who:

Note: The Reference Group recognises that this item would require GPs to have access to reimbursement for telehealth service provision, whether through an MBS item number or a different funding model.

Rationale 11

This recommendation focuses on increasing patient access to, and use of, telehealth services. It is based on the following:

● Telehealth services provide high-quality care options for Australians.

● GP-to-patient telehealth items with an NP on the patient side would help to fill current access gaps and allow for the provision of clinically effective, high-value services to patients, including:

  o GPs as eligible telehealth providers will increase patient access to primary care, particularly in remote areas where such access is more limited. NPs are well placed to support these telehealth services due to their relatively higher presence in remote areas (compared to GPs).

  o GPs would also decrease wait times to see the GP (by enabling consultation at the time of need), minimise cost for the patient (by mitigating the need to travel to the GP) and enhance buy-in from remote sites (43).

  o Limiting the video telehealth attendance to clinical support with a specialist or consultant physician restricts patient access to health care providers when an NP is seeking consultation with a patient and a GP. Often it is more appropriate, cost-effective and efficient to consult with a collaborating GP, rather than a specialist or consultant physician, especially for people who are geographically marginalised (living in Modified Monash Model areas 4 to 7), people in aged care and people in palliative care who are being managed at home.

● The current structure of telehealth items limits NP uptake. A survey of 73 NPs who work in primary care and access the MBS indicated that only 12 per cent had ever used telehealth items. It identified the requirement to have a specialist or consultant present as the main reason for non-use of telehealth items (44). MBS data showed that there were only 1,033 telehealth rebate claims in 2016/17 (less than 0.3 per cent of NP services for the year).

- GP telehealth items enable collaborative relationships between NPs and GPs, as NPs support from the patient side to facilitate care.

- The Royal Australian College of General Practitioners has developed clinical guidelines to enable the implementation of video consultations in general practice. These guidelines provide valuable insight and strategies to mitigate risk (45).

- Access to telehealth items for Aboriginal and/or Torres Strait Islander peoples in all regions, from urban to remote, may help to improve uptake of services where low cultural safety limits their ability to access services.

Recommendation 12 - Add patients in community aged care settings to residential aged care telehealth items

The Reference Group recommends adding patients in community aged care settings to residential aged care telehealth items (82223, 82224 and 82225) with the proposed descriptors as follows:

"… patients in receipt of, or assessed as eligible for, Government-funded Home Care Packages."

Rationale 12

This recommendation focuses on increasing access to, and use of, telehealth services for patients who face difficulties accessing their primary health provider despite living in urban areas. It is based on the following:

- NPs often provide services to older people living in RACFs and those who are still living at home but in receipt of (or assessed as eligible for) Government-funded HCP.

- Patients receiving funding through the HCP program have similar levels of frailty and dependence to those living in residential aged care. Despite living in urban areas, they often have mobility and illness limitations, which impede their ability to access medical and nurse practitioner services.

Recommendation 13 – Create new MBS items for direct NP-to-patient telehealth consultations

The Reference Group recommends:

a. creating new MBS items for direct NP-to-patient telehealth consultations (items 8222A, 8222B and 8222C) with the proposed descriptors (using item 8222A as an example):

New Item 8222A – example text
A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating NP practising in MMM 2-7 that requires the provision of clinical support to a patient who:
       a) is participating in a video consultation with the NP; and
       b) is not an admitted patient; and
       c) is located:
              (i) both:
                    (A) within an MMM 2-7 area; and
                    (B) at the time of the attendance - at least 35 kilometres from
           the NP's location (a); or
              (ii) in Australia if the patient is of Aboriginal or Torres Strait Islander
         descent.

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b. these items should parallel the time-tiers of existing patient-side items (i.e. less than 20 minutes, at least 20 minutes and at least 40 minutes), and

c. there should be no requirement for any particular health service professional to be patient-side.

Rationale 13

This recommendation focuses on increasing patient access to, and use of, telehealth services. It is based on the following:

- Telehealth services are high-quality care options for Australians.

- Telehealth sessions between an NP and a patient will improve access to timely care, reduce fragmentation, reduce or avoid the need for patients to be transferred to access required care, and allow for clinically effective, high-value services for patients. For example:

  o Telehealth services could be used for managing a patient who may already have medications/dressing available, to triage for the need for a physical consult, and/or to follow up on a face-to-face consult.

  o Telehealth services can increase access for patients in isolated areas. For example, a patient based at a cattle station will require access to care for an initial contact, for urgent or emergent care, or for follow-up care. If provided face to face, patients would face barriers including cost, travel and time away from community.

  o Telehealth consultations can help improve access for patients with physical disabilities (who may find it difficult to get to an NP's office) and for patients with intellectual disabilities (who may not respond well to unfamiliar surroundings).

  o Telehealth consultations can support NPs in providing primary care across the aged care sector. Enabling aged care nurses to access the support of NPs, particularly after hours, would further enhance NPs' contribution to improving health outcomes and avoid deterioration in health status for older people.

- The Reference Group acknowledges that there could be benefit in a patient-side attendance by an RN, an Aboriginal and Torres Strait Islander health worker or health practitioner, an allied health professional, an enrolled nurse, or other health care providers.

Recommendation 14 - Allow telehealth consultations to take place via telephone where clinically appropriate

The Reference Group recommends allowing telehealth consultations to take place via telephone where clinically appropriate (i.e. without requiring a video connection) (items 82220, 82221, 82222, 82223, 82224, 82225, 8222A, 8222B and 8222C).

Rationale 14

This recommendation focuses on increasing patient access to, and use of, telehealth services. It is based on the following:

- Requiring video connections between patient and practitioner has been shown to limit patient access to telehealth services (46) (47).

- Patients may be unable to undertake video communication due to:

  o Poor internet connections, often due to remoteness.

  o Lack of access to necessary technology.

  o Lack of understanding of or comfort with technology.

- Telephone communication for telehealth services offers non-inferior outcomes, where clinically appropriate (47) (48).

Participating Midwives Reference Group

Telehealth Working Group Consideration

Telehealth Recommendation 8 of 21: Participating Midwives Reference Group Recommendation 11 - Include GPs as eligible specialists for existing telehealth items
TWG Recommendation: The TWG supports this recommendation assuming an alternative funding model.
TWG Rationale: The TWG agreed that any outputs from this group should reflect what the Taskforce has said and that an MBS funded model of independent midwifery care is unlikely to lead to a successful business model and other funding models would be more suitable. That said the TWG supports this recommendation assuming an alternative funding model. This recommendation is similar to a recommendation made by the NPRG and GPPCCC.

Telehealth Recommendation 9 of 21: Participating Midwives Reference Group Recommendation 12 - Facilitate telehealth consultations between women and midwives
TWG Recommendation: Supported in principle but not through the MBS
TWG Rationale: The TWG supported this recommendation subject to all the other principles but did not support this recommendation through the MBS as the model of care requested in this report could not be supported by the MBS.

Participating Midwives Reference Group Recommendations

Table 1: Items 82150–82152

Item	Descriptor	Schedule fee (AUD)	Services FY2016/17	Benefits FY2016/17 (AUD)	Services 5-year annual avg. growth
82150	A professional attendance lasting less than 20 minutes (whether or not continuous) to a patient who is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	28.30	1	24	-24.2%
82151	A professional attendance lasting at least 20 minutes (whether or not continuous) to a patient who is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	53.70	2	91	-16.7%

82152	A professional attendance lasting at least 40 minutes (whether or not continuous) to a patient is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	78.95	15	1,007	NA

Note: There were no claims for item 82152 in 2011/12 to calculate a growth rate

Recommendation 11 – Include GPs as eligible specialists for existing telehealth items

The Reference Group recommends amending the item descriptors (items 82151 and 82152) to include GPs in the list of doctors who can participate in the video consultation, as follows (changes in bold):

> **Item 82151**
>
> A professional attendance lasting less than 20 minutes (whether or not continuous) to a patient who is participating in a video consultation with a specialist / consultant in paediatrics, obstetrics **or general practice**.

and

> **Item 82152**
>
> A professional attendance lasting at least 40 minutes (whether or not continuous) to a patient participating in a video consultation with a specialist / consultant in paediatrics or obstetrics **or general practice**.

Rationale 11

This recommendation focuses on ensuring that the MBS provides adequate access to high-quality clinical services for women. It is based on the following:

- The Reference Group agreed that there is a need to expand midwifery services to rural and remote populations. There is a clear relationship between distance to maternity services and poorer clinical and psychosocial outcomes (31; 32). Key Australian maternity documents cite rural and remote maternal location as a barrier to quality maternity care (16; 33). The Australian Rural Birth Index project found that maternity services in Australia do not match population need (34).

- The Reference Group agreed that telehealth items are one way to drive increased access to midwifery services for rural and remote populations.

- Current midwifery telehealth items are underutilised. MBS data shows that items 82150–82152 were claimed a total of 18 times in 2016/17. The Reference Group proposed two reasons for this low service volume:

  - Telehealth attendances must include a specialist obstetrician or paediatrician, who often does not have the time to undertake telehealth consultations on an ad-hoc basis.

  - Claims for items 82150–82152 require the participating paediatrician or obstetrician to have submitted an MBS claim for their participation in the teleconference. Reference Group members with experience using these items highlighted that specialist practitioners do not always bill for these attendances as they are a small part of their scope of practice. As such, MBS service volumes may be artificially low.

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- The Reference Group agreed that including GPs in the descriptors for current telehealth items would be beneficial to women accessing midwifery care. GPs (especially those with a sub-specialisation in obstetrics) are well placed to deliver medical advice to women and their caring midwives during pregnancy. The Reference Group identified two potential use cases for this:

  - Women who live in rural or remote regions may have their early antenatal care primarily with their GP and may plan to birth in the city with midwifery continuity of care. There may be occasions when a telehealth consult will occur between the woman, the GP who is providing her antenatal care and the intended midwife for intrapartum and birth care.

  - There may be occasions when the women and her primary midwife will benefit from access to their regular GP for a team discussion. This discussion may include the results and implications of recent tests or detail on the ongoing management of chronic conditions. Ensuring key clinicians such as the woman's GP are actively involved in her pregnancy will optimise outcomes.

- GPs are better dispersed across Australian rural and remote areas than obstetricians and paediatricians. As such, women and their midwives may be able to undertake telehealth consultations with GPs more proximal to women's homes. The Reference Group agreed that this may drive more local continuity of care for women and these practitioners. The number of practitioners eligible to deliver these services will increase, driving increased access and overcoming the time constraints of specialists.

- The Reference Group agreed that use of this item should be reviewed in 12 to 24 months.

Recommendation 12 – Facilitate telehealth consultations between women and midwives in the antenatal and postnatal period

The Reference Group recommends:

a. creating three new telehealth items (821FF, 821GG and 821HH) for women consulting with a midwife via teleconference, with a nurse, Aboriginal and Torres Strait Islander health worker or professional, or another midwife on the patient side

b. creating time tiers for these new items in line with items 82150–82152, and

c. that proposed new item descriptors be as follows:

New Item 821FF – example text

A professional attendance lasting less than 20 minutes (whether or not continuous) to a patient, supported by a nurse, Aboriginal Health Worker/Professional or midwife, who is participating in a video consultation with a participating midwife.

New Item 821GG

A professional attendance lasting at least 20 minutes (whether or not continuous) to a patient, supported by a nurse, Aboriginal Health Worker/Professional or midwife, who is participating in a video consultation with a participating midwife.

> **New Item 821HH**
>
> A professional attendance lasting at least 40 minutes (whether or not continuous) to a patient, supported by a nurse, Aboriginal Health Worker/Professional or midwife, who is participating in a video consultation with a participating midwife.

and

d. adding the following restrictions, in line with items 82150–82152:

(i) The woman must not be an admitted patient.

(ii) The woman must be located both within a telehealth-eligible area, and at least 35 kilometres by road from the participating midwife mentioned in the above descriptors.

(iii) The woman must reside in a rural or remote region (defined as Modified Monash Model areas 4–7).

(iv) The midwife must be intending to undertake the woman's birth, or in the case of postnatal care, be the primary provider of postnatal care or breastfeeding support for the woman.

Rationale 12

This recommendation focuses on ensuring that consumers in remote and rural areas can access high-quality, cost-effective maternity care. It is based on the following.

- As noted in Recommendation 9, the Reference Group agreed that there is a need to expand midwifery services to rural and remote populations.

- Members of the Reference Group who work primarily with Indigenous women or remote/rural services report that most of these women have access to a health worker such as a nurse. The identified telehealth need is for that worker and the women to be able to consult with a midwife.

- The Reference Group agreed that there are multiple instances where a participating midwife could provide high-value care to a woman via telehealth without the participation of a medical professional. For example:

  o Women who live or work in rural or remote areas (for example, Anangu Pitjantjatjara Yankunytjatjara [APY] lands) but are planning to come to the city to birth can access midwife care regularly throughout their pregnancy and build rapport with their midwife before seeing them face to face. This provides opportunities for explanation and education.

  o A woman residing in a remote area might attend a number of antenatal consultations via telehealth with a participating midwife who is her intended midwife for labour and birth. Due to the remote location, all antenatal consults cannot be attended face to face.

  o Women returning to remote areas after birth can consult via telehealth with the known birthing midwife, providing continuity of care.

  o Women who live several hours away from their midwife can check in for antenatal discussion and education. A local health worker can perform a basic clinical examination.

- The Reference Group agreed that having practitioners on the patient side during these consultations is important to enable appropriate observations and basic examinations during the attendance.

- The Reference Group agreed to include midwives in the list of eligible practitioners on the patient side under this item. The Reference Group agreed that a participating midwife consulting with

another midwife via teleconference would be particularly useful when women are planning on moving to a metropolitan area to give birth. For example:

- o Women may move from a rural/remote area to the city for birth. Telehealth offers the opportunity for midwives to introduce rural and remote women to the participating midwife who will be undertaking their birth in a metropolitan region. This allows familiarity for those who are unable to meet their participating midwife face to face.

- o Women who live in rural or remote regions may be experiencing breastfeeding challenges. The remote area midwife may not have any additional training in this area and may request help from a specialised midwife in the city. Together with the woman, they may be able to provide an assessment of attachment, remedial assistance and support to enable ongoing breastfeeding.

- The Reference Group noted the importance of continuity of care in ensuring high-value use of telehealth items in a fee-for-service system and has targeted its recommendations to promote this.

Ophthalmology Clinical Committee

Telehealth Working Group Consideration

Telehealth Recommendation 10 of 21: Ophthalmology Clinical Committee Recommendation 12 - Remove item 99's association with item 104 or 105, and instead have three item numbers that include asynchronous options
TWG Recommendation: The TWG agreed that more work needs to be done to meet the needs of patients and this recommendation should be put forward as a research piece, and that asynchronous care may not work on the MBS.
TWG Rationale: The TWG expressed concern about the suitability of telehealth for MBS payments for asynchronous services needs further research and alternative funding models may be more appropriate. See Teledern. The TWG further considered asynchronous care from the input of the experts during TWG Meeting 2. There are provisions for this in Principle 3 *MBS Telehealth should support different solutions for different specialties where required and may require a variety of funding models.*

Ophthalmology Clinical Committee

The Committee acknowledges that telemedicine items are not within its area of responsibility, and that the Optometry Clinical Committee will determine the final recommendations. However, the Committee has suggested an approach to restructuring MBS telemedicine items for the consideration of the Optometry Clinical Committee. It noted that telemedicine has a crucial role to play in improving rural and remote eye health, given the maldistribution of the ophthalmology workforce and limited uptake in the current system.

Recommendation 12

- Remove item 99's association with item 104 or 105, and instead have three item numbers that include asynchronous options:

  o Item A: Videoconference with patient and referrer present, independently claimed, for bulk billing only.

  o Item B: Virtual "home visit" via telephone or video with only patient present, for optometry referrals only.

  o Item C: Asynchronous management advice via report to optometrist and patient, for optometry referrals only, with a requirement to send a formal report to the optometrist and patient.

Rationale for Recommendation 12

This recommendation aims to increase the uptake of telehealth services and promote a coordinated and asynchronous approach to eye health care. It is based on the following.

- The current system presents difficulties in coordination, requiring three people to be present at once. This means that if someone is running late, it affects everyone. Asynchronous health care is important and has been proven internationally to be effective in the coordination of telehealth.

- There is significant maldistribution in the ophthalmology workforce across Australia, with 84 per cent of ophthalmologists working in metropolitan areas.[22]

- Ophthalmology telehealth services have a single referral group: optometrists. This is an unusual primary care source with advanced equipment. Ophthalmologists often receive multiple scans, images or field tests in a patient referral, which require asynchronous interpretation of results.

Optometry Clinical Committee

Telehealth Working Group Consideration

Telehealth Recommendation 11 of 21: Optometry Clinical Committee Recommendation 3 - Convene a Departmental working group to explore the barriers and opportunities offered by telehealth across all areas of Health. In the case of Optometry, to develop an appropriate MBS item to meet the requirements of Optometry and Ophthalmology.
TWG Recommendation: The TWG supported a working group/research piece.
TWG Rationale: The first part of this recommendation is harmonious with Principle 10 *Ongoing research and evaluation into the efficacy and equivalence of Telehealth should accompany changes to funding structures for MBS Telehealth.*

The recommendation also involves development of appropriate MBS items to meet the requirements of Optometry and Ophthalmology which is supported in principle but an MBS item number may only be part of the solution.

Optometry Clinical Committee

Recommendation 3

- Convene a Departmental working group to explore the barriers and opportunities offered by telehealth across all areas of Health. In the case of Optometry, to develop an appropriate MBS item to meet the requirements of Optometry and Ophthalmology.

Rationale for Recommendation 3

- This recommendation focusses on the Committee discussion that acknowledged the value and importance of telehealth in providing access to patients across Australia.

- The Committee acknowledged the potential for telehealth to be applied in consultations, improving patient access and offering potential asynchronous consultations between patient, referrer and practitioner.

- The Committee noted the broad application and potential of telehealth across all of the providers operating within the MBS as its benefits are not just limited to optometry. To ensure consistency and avoid duplication of effort and to invest sufficient time and effort to develop a comprehensive understanding of the rapidly changing technology, it was suggested that a cross discipline working group be established.

Pain Management Clinical Committee

Telehealth Working Group Consideration

Telehealth Recommendation 12 of 21: Pain Management Clinical Committee Recommendation 28- Telehealth items should be available for multi-disciplinary assessment and review for pain management patients.

TWG Recommendation: Supported with qualification

TWG Rationale:

It was agreed to request more information from the clinical committee and consider how to adapt case conferences to solve this issue.

Pain Management Clinical Committee Recommendations

Recommendation 28 - Telehealth

The Committee recommends that telehealth items should be available for multidisciplinary (medical, nursing and/or allied health professionals) assessment and review for pain management patients. This could be achieved via generic telehealth or pain specific item numbers.

Rationale 28

This recommendation focuses on ensuring continuing effective access to rural and remote patients. It is based on the following assessment (McGeary, McGeary, & Gatchel, 2012) (Pronovost, Peng, & Ker, 2009) (Eccleston, et al., 2014):

- Under the current MBS arrangements telehealth provides a means of accessing specialist services when consumers are located in rural and remote areas with no local service.

- Telehealth funding could better support access to complete pain services in regional areas including education for consumers and health practitioners.

- The inability to access effective multidisciplinary pain management, especially in rural and remote areas, costs the health system more in the long term and carries a substantial economic burden through lost productivity and increase health care utilisation (Keogh, Rosser, & Eccleston, 2010).

- People who live in urban areas and have severely limited mobility, due to pain or other reasons, may also benefit from telehealth consultations. Telehealth has the potential to address one of the key factors that currently inhibit patient access to tertiary pain management services.

- The advantages of telehealth are that it enables provision of a service with a high level of specialist expertise, but in a mode that is highly accessible without the costs and challenges involved in transport and accommodation (Keogh, Rosser, & Eccleston, 2010).

- The creation of telehealth items for the assessment and review of pain management treatment plans would:

  - Aid in the triage process and guide planning

  - Engage consumers and local primary care services

  - Support local staff in modifying a pain management plan

  - Be potentially used for the purpose of MDT Review (NSW Agency for Clinical Innovation, n.d.), and

- The Committee notes this is a whole-of-MBS issue, which the Committee hopes will be considered as applicable to the practice of pain medicine.

Psychiatry Clinical Committee

Telehealth Working Group Consideration

Telehealth Recommendation 13 of 21: Psychiatry Clinical Committee Recommendation 2 - Reform arrangements for item 288 - delivery telehealth consultations to regional and remote patients.
TWG Recommendation: Supported
TWG Rationale: The TWG supported this recommendation.

Telehealth Recommendation 14 of 21: Psychiatry Clinical Committee Recommendation 3 - New items to provide telehealth consultations to patients in major cities of Australia.
TWG Recommendation: Supported

TWG Rationale:

The TWG supported this recommendation with caution to ensure that services are not lost in rural and remote areas. This is consistent with Principle 1 *Should be patient-focused, and based on patient need, rather than geographical location* and should take that and the other principles into consideration.

Telehealth Recommendation 15 of 21: Psychiatry Clinical Committee Recommendation 4 - Continue arrangements for Items 353-370 - consultations with psychiatrists via the phone in regional and remote areas

TWG Recommendation: Supported with qualification

TWG Rationale:

1. The TWG supported this recommendation with caution in relation to removal of the loading to ensure that services are not lost in rural and remote areas. Any change should be consistent with all the principles but in particular Principle 7 *Should be implemented and modified through time limited transition arrangements.*

Psychiatry Clinical Committee

Telehealth

Table 2: Item 288

Item	Short item descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
288	Telehealth add on for psychiatrist	Derived fee	37,626	$10,759,694	62.2%

Recommendation 2 - Reform arrangements for item 288 - delivering telehealth consultations to regional and remote patients

The Committee recommends:

a. removing item 288 from the MBS.

b. a new suite of time-tiered items be introduced to provide for telehealth consultations to regional and remote areas (RA2–5), with:

- remuneration at the same rate as standard consultation items (300–308 (2)), with the exception of the initial consultation, which should provide additional remuneration to reflect the increased time and complexity associated with this service, and

- the initial consultation item split into two time tiers mirroring the standard initial consultations items 296 and 297 (2).

c. that the Taskforce should consider recommending an incentive payment, or another similar funding mechanism be instituted, to continue to stimulate services in regional and remote areas.

Rationale 2

Item 288 provides for a 50% loading for all consultations delivered via video conference to telehealth eligible areas in Australia (RA2–5).

This recommendation focuses on ensuring that the MBS is used as intended while ensuring that patient outcomes are not compromised. It is based on the following assessment:

● The Committee noted that the original intent of this loading was to accelerate the adoption of telehealth by all specialists and consultant physicians, including psychiatrists. The Committee acknowledged the loading was introduced as a time-limited incentive.

● The Committee noted that while psychiatrists had been the most successful in terms of adoption, the uptake of new providers had slowed from an initial growth of 256% in the first year to just 8% between the 2015/16 and 2016/17 financial years. The Committee noted this could indicate the loading was no longer stimulating the uptake of telehealth by new providers.

● The Committee noted advice from the Taskforce and its Principles and Rules Committee that MBS items should recognise only the time and complexity associated with delivering that service, and that additional loadings to incentivise service delivery to regional and remote areas should be provided outside the MBS.

● The Committee agreed that there were additional complexities associated with delivering a telehealth consultation to a new patient and that extra remuneration should be available to ensure providers can effectively deliver this service. These additional complexities include:

  - Increased time spent building relationships with regional and remote referrers.

  - Increased time spent orienting patients on the use of technology and troubleshooting connection and audio-visual issues.

  - Greater difficulty in conducting a physical examination of the patient.

  - More onerous reporting and prescribing requirements following the initial consultation.

● The Committee noted concerns that these changes could lead to a decrease in telehealth services or significantly alter service delivery, such as for the production of management plans for regional and remote GPs to implement. Therefore, the Committee agreed the Taskforce should consider recommending an incentive payment or another similar funding mechanism be instituted to continue to stimulate services in regional and remote areas.

● If opting not to introduce an incentive payment or similar, item 288 should be gradually withdrawn rather than removed, as a means to avoid any sudden retreat from its use and to allow the system time to readjust.

Recommendation 3 - New items to provide telehealth consultations to patients in major cities of Australia

The Committee recommends:

  a. introducing a new suite of items to provide for time-tiered telehealth consultations (via videoconference) to patients in major cities (RA1), to be remunerated at the same rate as consultation items 300–308 (2).

  b. access to these items should be triggered by an initial assessment by a psychiatrist via videoconference, on referral from a GP or nurse practitioner, where an assessment of the patient is conducted and it is concluded the patient would benefit from telehealth for reasons of either severe physical disability, a mental health disorder that prevents them from attending a

face-to-face consultation, or psychosocial stress (for instance if a patient cannot take time off from work).

c. telehealth services in major cities be restricted to 12 services per calendar year per patient, including the initial assessment and that these 12 consultations contribute to a patient's annual service cap (50 sessions or 160 for complex patients).

Rationale 3

This recommendation focuses on providing access to alternative delivery mechanisms to meet the needs of patients with appropriate needs. It is based on the following assessment:

- The Committee agreed that face-to-face consultations represent a higher value service in psychiatry, in terms of being able to provide more comprehensive physical assessments of patients, as well as in the formation of the psychiatrist-patient relationship.

- However, the Committee agreed that it is challenging for some patients in major cities to access a psychiatrist and for those patients consultations via videoconference are preferential to ensure they are receiving adequate care. This includes, for example, patients with severe agoraphobia and physical disabilities, such as quadriplegia, that would impact their ability to access transport.

- All members of the Committee have experience with patients being unable to attend an appointment for physical health, social or psychiatric reasons.

- While there hasn't been a study and therefore no resulting evidence that people with physical disability have difficultly accessing psychiatry services, there is good evidence that physical disability is a risk factor for mental illness, which in turn creates demand for psychiatry services. Holmes et al. [3] found that persistent disability is a risk factor for late-onset mental disorder after serious injury. Other evidence shows that people living with physical disabilities are at least three times more likely to experience depression compared to the general population [4].

- In 2017, the Australian Institute of Health and Welfare reported that nearly 2 in 5 (38%) people with a disability (aged 5-64 years) had difficultly accessing buildings or facilities in the last 12 months [5]. This report does not specifically refer to access to psychiatry, only medical specialists.

- There is evidence that telehealth consultations can be effective in treating these populations [6]. Significant improvements in coping skills and strategies, community integration, and depression were observed immediately after tele-health consultations, with modest improvements in quality of life maintained at 12 months post-intervention.

- In relation to people with agoraphobia, Rees and Mclaine [7] conclude that videoconference-delivered therapy for anxiety disorders is supported by evidence of effectiveness, and results that are comparable with in-person provision of treatment. The authors note that '*given that anxiety disorders tend to be characterised by avoidance and low help-seeking behaviour, it is critical that continued efforts to improve access to efficacious psychological treatments are pursued'.* Lindner et al. [8] demonstrated evidence for videoconferencing as an effective tool in treatment delivery for panic disorder with agoraphobia.

- The Committee agreed that patients should have an appropriate balance of face-to-face and telehealth consultations. The Committee noted that for the patient populations in question, it would be counter-productive to mandate for the first consultation to be face-to-face. The Committee also agreed that it would be difficult to set milestones whereby patients would be required to have a face-to-face consultation (e.g. every fourth consultation).

- The Committee affirmed that the new items should not be used for convenience and that eligible patients should have a genuine unmet need that can be addressed via video conference consultations.

- The Committee has specified that these attendances should not replace face to face consultations, but should supplement them in particular circumstances and that there should be no loading on telehealth item numbers for urban consultations.
- The Committee anticipates that telehealth consultations for urban-based patients would have a relatively low uptake.
- A model for telehealth consultations might include limiting eligibility for a referral to specific patients (including patients with physical disability, severe agoraphobia, and other health conditions whereby attending face-to-face consultations is not practical or efficient), or for patients who require treatment from a psychiatrist located in another city (for example, patients who are temporarily located interstate).
- These criteria should be included in the explanatory notes for the item with the number of sessions to be capped at 5 in a 12-month period.

Telepsychiatry

Table 3: Items 353–370

Item	Short item descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
353	Telepsychiatry consultation < 15 mins	$57.20	342	$17,415	7.6%
355	Telepsychiatry consultation > 15 mins < 30 mins	$114.45	887	$91,513	0.7%
356	Telepsychiatry consultation > 30 mins < 45 mins	$167.80	944	$141,379	14.0%
357	Telepsychiatry consultation > 45 mins < 75 mins	$231.45	621	$133,427	4.0%
358	Telepsychiatry consultation > 75 mins	$282.00	47	$12,696	13.5%
359	Telepsychiatry review of referred patient assessment and management	$325.35	10	$2,809	-41.3%
361	Telepsychiatry initial consultation with new patient > 45 mins	$299.30	75	$19,337	31.6%
364	Attendance by psychiatrist after telepsychiatry consultation < 15 mins	$43.35	4	$195	N/A
366	Attendance by psychiatrist after telepsychiatry consultation > 15 mins < 30 mins	$86.45	11	$809	29.7%
367	Attendance by psychiatrist after telepsychiatry consultation > 30 mins < 45mins	$133.10	25	$3,044	90.4%
369	Attendance by psychiatrist after telepsychiatry consultation > 45 mins < 75 mins	$183.80	141	$25,794	52.7%

370	Attendance by psychiatrist after telepsychiatry consultation > 75 mins	$213.15	2	$665	N/A

Recommendation 4 - Continue arrangements for items 353 to 370 - consultations with psychiatrists via the phone in regional and remote areas

The Committee recommends:

a.   retaining the telepsychiatry items on the MBS, as they are still providing a high value service to patients who currently access these services,

b.   aligning the schedule fees for these items with the consultation items 300–308, and items 296 and 297 for the initial consultation item via telepsychiatry, and

c.   re-evaluating the need for these services in the next review of psychiatry items.

Rationale 4

The telepsychiatry items provide for consultations with psychiatrists over the phone in regional and remote areas (RA3-5).

This recommendation focuses on ensuring continued access to services relevant to patient need. It is based on the following assessment:

●   The Committee noted low service volumes for these items, but additionally noted the number of services had not decreased between 2011/12 and 2016/17.

●   The Committee agreed these services were still providing high value care to patients who could not otherwise access consultations face-to-face or over videoconference.

●   Moffatt and Eley [9] reported on the benefits of telehealth for rural Australians, finding that patients in rural and remote locations in Australia are reported to benefit from telehealth by increased access to health services and up-skilled health professionals. Their review findings suggest that the increased use of telehealth has the potential to reduce the inequitable access to health services and the poorer health status that many rural Australians experience.

●   Hareriimana, Forchuk & O'Regan [10] reported on the beneficial impacts on health outcomes for telehealth involving older adults with depression, finding that telehealth for mental health care among older adults demonstrates a significant impact on health outcomes, including reduced emergency visits, hospital admissions, and depressive symptoms, as well as improved cognitive functioning.

●   The Committee found it is necessary to retain these items as many patients will have access to a telephone, including a mobile phone, but may not be able to reliably access video consultations in regional and remote areas. The Committee agreed removing these items from the MBS could have unexpected consequences that would be detrimental to patients currently receiving these services.

●   The Committee agreed, in line with other recommendations, that a face-to-face consultation is a higher value service and there should not be a financial incentive to conduct consultations via the phone, particularly when video conferencing can be used.

Specialist and Consultant Physician Clinical

Committee

Telehealth Recommendation 16 of 21: Specialist and Consultant Clinical Committee Recommendation 9 - A new framework for telehealth
TWG Recommendation: Supported
TWG Rationale: In accordance with all the principles but in particular: Principle 1 *Should be patient-focused, and based on patient need, rather than geographical location* Principle 2 *Must support and facilitate services that are clinically safe and efficacious for patients.* Principle 3 *Should be provided in the context of continuity of care between patient and practitioner.* Principle 4 *Must not create unintended consequences or perverse incentives that undermine the role of face-to-face care.* The TWG agreed that any restructuring should be in line with SCPCC item number restructuring.

Telehealth Recommendation 17 of 21: Specialist and Consultant Clinical Committee Recommendation 10 - Reinvest in telehealth
TWG Recommendation: Supported
TWG Rationale: The TWG agrees that access to Telehealth should be expanded.

Specialist and Consultant Physician Clinical Committee

Current telehealth framework

The MBS has 17 telehealth attendance items with 67,000 services provided in conjunction with an existing consultation item in FY2016/17.[15] These items include:

- Nine telehealth loading items valued at 50 per cent of the schedule fee for the attendance item with which they are co-claimed, accounting for more than 98 per cent of telehealth service volume and spend.

- Eight items for telehealth attendances under 10 minutes,[16] accounting for just 159 services in 2016/17.

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[15] See item-level data for all telehealth attendances in Appendix - A.3.

[16] One item each for specialists, consultant physicians, occupational medicine, pain medicine, palliative care, neurosurgery, addiction medicine and sexual health medicine.

The Committee noted that the 2011 telehealth incentive scheme and loading items have been successful in capturing early adopters, with almost 2,000 providers using these items in 2016/17. However, the Committee recognises that barriers to uptake persist, as evidenced by the significant slowing of growth in services (from 167 per cent growth in the first year of implementation down to 8 per cent growth last year).

There are currently two applications of telehealth in Australia:

- Patient supported by a health professional: A health professional (for example, a GP, nurse practitioner or physiotherapist) is with the patient for the telehealth attendance. This creates a communication bridge between consumers, primary care and consultant specialists, minimises the number of times a patient has to "tell their story", and allows for a more complex examination than can be undertaken if the patient is alone.

- Directly with the patient: This item is better suited to providing ongoing or follow-up care, is more cost-effective, and increases access by patients to consultant specialist services.

Benefits of telehealth

The Committee recognises that there are huge benefits to be gained from the uptake and appropriate use of telehealth, including:

- Increased access for patients in rural and remote areas, and for those who may find it difficult to attend consulting rooms or a hospital (for example, consumers with significant mobility challenges, or parents who have a child with a disability).

- Reduced travel time and costs for patients, resulting in patient savings, fewer travel grants and less time off work.

- Reduced travel time and costs for clinicians, resulting in saved clinician days.

Barriers to telehealth growth

Recognising the significant slow-down in growth of services, the Committee has noted significant barriers to the increased adoption of telehealth, particularly patient and primary care awareness and consultant specialists' perception of telehealth.

- Patients may not have access to information about when to request telehealth, how to access it, and a clear understanding of its benefits.

- GPs may not be aware of the patient population groups that would benefit most from telehealth, when to recommend it to these patients, and how to integrate it into their practice. Likewise, consumers may be unaware this service option is available.

- Primary care workers may not be aware of existing MBS items for providing clinical support to a patient who is participating in a telehealth attendance.

- Clinicians may be unwilling to change their clinical practice to adopt telehealth and may not be convinced of its effectiveness (4). There may be a lack of understanding of the functionality and security of telehealth.

Telehealth also requires additional technology and administrative support to enable efficient delivery, such as telehealth equipment, scheduling software, and mechanisms to collate and email patient records and investigation results. These technical issues may be regarded as significant barriers to access to potential provider users.

Recommendation 9 – A new framework for telehealth

The Committee recommends:

a. Removing the eight specialty-specific telehealth attendance items (items 113, 114, 384, 2799, 3003, 6004, 6025, and 6059) from the MBS;

b. incrementally reducing derived fee for the nine telehealth loading items loading items (items 99, 112, 149, 389, 2820, 3015, 6016, 6026, and 6060) to zero;

c. undertaking annual analysis of the phase out so to identify potential unintended consequences; and

d. introducing new telehealth-specific attendance items (after the nine loading items have been removed) that mirror the standard time-tiered attendance items, with the same fees, and with item descriptors that describe recommended activities to be performed in each tier.

Table 6: Telehealth attendance item descriptors

Level (item) [17]	Duration	Item descriptor

Level B (THB)	6-20 minutes	Professional attendance of **more than 5 minutes but not more than 20 minutes** by a consultant specialist in the practice of his or her speciality if:
		a) the attendance is by video conference; and
		b) the patient is not an admitted patient; and
		c) the patient:
		  i. is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from the consultant specialist; or
		  ii. is a care recipient in a residential care service; or
		  iii. is a patient of: (a) an Aboriginal Medical Service; or (b) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the act applies.
		
		An attendance including any of the following that are clinically relevant:
		a) a focused patient history
		b) implementing a management plan
		c) outcomes documented and communicated in writing to the referring practitioner

Level C (THC)	21-40 minutes	Professional attendance of **more than 20 minutes but not more than 40 minutes** by a consultant specialist in the practice of his or her speciality if: d) the attendance is by video conference; and e) the patient is not an admitted patient; and f) the patient: iv. is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from the consultant specialist; or

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[17] Item numbers listed here indicate a structure for the DHS to follow when assigning item numbers.

		v. is a care recipient in a residential care service; or
		vi. is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies.
		
		An attendance including any of the following that are clinically relevant:
		  a) detailed patient history of a major single or multiple minor conditions
		  b) single or multiple minor diagnostic problems considered
		  c) a non-complex management plan and, if required;
		  d) discussion of multiple treatment options available, including;
		    i. Discussion of treatment options to assess pros and cons of each option given patient characteristics and medical history
		    ii. Consideration and discussion of necessary referrals to other health professionals
		    iii. Written documentation made available for the patient and/or carer that facilitates informed consent, such as treatment options, costs, and information on associated risks and benefits
		  e) outcomes documented and communicated in writing to the referring practitioner

Level D (THC)	41-60 minutes	Professional attendance of **more than 40 minutes but not more than 60 minutes** by a consultant specialist in the practice of his or her speciality if:
		g) the attendance is by video conference; and
		h) the patient is not an admitted patient; and
		i) the patient:
		  vii. is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from the consultant specialist; or
		  viii. is a care recipient in a residential care service; or
		  ix. is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies.
		
		An attendance including any of the following that are clinically relevant:
		  a) comprehensive patient history of multiple conditions or a complex single condition
		  b) multiple diagnostic problems considered
		  c) a comprehensive management plan and, if required;
		  d) discussion of multiple treatment options available, including;
		    i. Discussion of treatment options to assess pros and cons of each option given patient characteristics and medical history
		    ii. Consideration and discussion of necessary referrals to other health professionals

		iii. Written documentation made available for the patient and/or carer that outlines treatment options and information on associated risks and benefits e) Outcomes documented and communicated in writing to the referring practitioner

Level E
(THE)
	More than 60 minutes	Professional attendance of **more than 60 minutes** by a consultant specialist in the practice of his or her speciality if:
		j) the attendance is by video conference; and
		k) the patient is not an admitted patient; and
		l) the patient:
		   x. is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from consultant specialist; or
		   xi. is a care recipient in a residential care service; or
		   xii. is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies.
		
		An attendance including any of the following that are clinically relevant:
		a) extensive history of multiple complex conditions
		b) multiple complex diagnoses considered
		c) a comprehensive management plan and, if required;
		d) discussion of multiple treatment options available, including;
		   i. Discussion of treatment options to assess pros and cons of each option given patient characteristics and medical history
		   ii. Consideration and discussion of necessary referrals to other health professionals
		   iii. Written documentation made available for the patient and/or carer that outlines treatment options and information on associated risks and benefits
		e) Outcomes documented and communicated in writing to the referring practitioner

Recommendation 10 – Reinvest in telehealth

The Committee recommends reinvesting all savings from removing the telehealth loading towards mechanisms designed to increase uptake of telehealth services in Australia. Both MBS and non-MBS mechanisms should be considered, and options could include the following:

    a. increase utilisation of telehealth services among consumers, GPs and PHNs, by:

        i. developing and sharing the value proposition of telehealth with consumers, including the potential savings in time, travel and other costs;

        ii. funding PHNs and consumer representatives (community champions) to carry out telehealth education and awareness building in targeted communities (for example, where GPs already provide telehealth);

iii. educating GPs and PHNs to identify and promote telehealth withpatient population groups that would most benefit from telehealth attendances—both those held directly with the consultant specialist (for example, follow-up care) and those supported by a health professional (for example, more complex cases or where further support with health literacy is needed);

iv. investing in education and training of primary care workers, including telehealth training days and the development of training material (for example, online modules); and

v. promoting the use of MBS items that already exist for primary care workers to provide clinical support to patients participating in consultant specialist telehealth attendances (Category 8 of the MBS, Groups M12, M13, and M14).

b. increasing the supply of telehealth services offered by consultant specialists, by:

i. developing the value proposition of telehealth for providers and sharing this with provider population groups that are most likely to offer telehealth services;

ii. educating consultant specialists to identify and promote telehealth with patient population groups that would most benefit from telehealth attendances;

iii. developing materials on how to set up and run telehealth services;

iv. coordinating with Colleges to promote telehealth education and training, including awarding CPD points for telehealth training;

v. encouraging Colleges to educate consultant specialists on the benefits of telehealth, how to set it up, and when it should be used; and

vi. developing guidelines and tools to determine and resolve any clinical governance issues and concerns.

Rationale 9 & 10

This recommendation focuses on removing an MBS telehealth loading that is no longer effective and reinvesting this saving to increase uptake of, and targeted access to, telehealth services. It is based on the following reasons:

- Telehealth is already a cost-effective way of delivering care. A number of systematic reviews have found that telehealth is a cost-effective way of delivering care, and follow-up via telehealth has been shown to have lower associated costs than in-person clinic assessment (4) (5). A study by Marsh et al (6). in 2014 showed that patients followed up after hip surgery via telehealth travelled less (28km versus 104km) and had lower associated costs ($10 versus $21), and that attendances took less total time to complete (122 minutes versus 229 minutes).

- The Committee also noted that many countries and health services, including Finland (7), British Colombia and the UK (8), have built successful telehealth services without providing any financial incentive to physicians (Figure 5).

- **Figure 5: How are telehealth attendances reimbursed in other geographies?**

Location	Payment mechanism	Tariff	Requirements/ Restrictions
Germany	Item on reimbursement catalogue since April 17	Additional technology subsidy of 4.21 EUR for every hour of video consultation provided up to 800 EUR annually on top of the reimbursement for a standard in person attendance	▪ Can only be used by certain doctor groups (GPs, ophthalmologists) ▪ Only for certain suitable indications (e.g. Visual postoperative follow-up of an operation wound)
Finland	KELA (Finnish Social Insurance Institution) started reimbursement for digital appointments in 2016	Cost of tele-consultations varies from EUR10.5 per 10 min up to EUR27 for 60 min, same as for face-to-face visits	▪ No restrictions stated
British Columbia (Canada)	The medical service commission payment schedule includes telehealth consultation items (in specialty chapters)	Varies by specialty but is the same as the standard consultation item for that specialty	▪ "Telehealth Service" is defined as a medical practitioner delivered health service provided to a patient
United Kingdom	Teleconsultations (video or phone) for outpatient specialist care have been available since 2008-09, and are funded with the same DRG code as face-to-face appointment	Diagnoses-related group payment that differs by specialty, and by single vs multiple professional and first vs follow up appointment. No telehealth uplift.	▪ No restrictions stated ▪ Currently, 2-3% of outpatient consultation are coded as teleconsultations (2% for 1st attendance, 3% for follow-up) ▪ The majority are telephone consultations

- Telehealth loading is not the optimal mechanism to incentivise physician uptake. In Australia, growth in utilisation of telehealth for consultations has slowed significantly since the introduction of the loading items in 2011[18], indicating that they are not incentivising appropriate provider uptake of telehealth. Physicians cite a lack of acceptance of telehealth as the main barrier to uptake.[19]

- Consumers lack awareness of telehealth services. Bradford et al. (9) conducted a study in rural Queensland in 2015 which showed that 60 per cent of participants were aware of telehealth, but only 13 per cent had used telehealth services. The authors observed that trust is required for telehealth to be an acceptable application for patients, and concluded that greater public awareness and understanding of the potential benefits of telehealth was needed.

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[18] MBS data 2011/12 to 2016/17

[19] Wade et al. (2014) conducted a qualitative study of 36 Australian telehealth services and concluded that physician acceptance of telehealth was the main driver of low uptake.

Wound Management Working Group

Telehealth Working Group Consideration

Telehealth Recommendation 18 of 21: Wound Management Working Group Recommendation 8 - Where appropriate, consideration should be given to the use of remote and non-face-to-face services (real time or asynchronous) and an appropriate funding model investigated.
TWG Recommendation: Supported
TWG Rationale: The group agreed that further work was required - that this may fit into a VPE model or case conferencing or specialist consultation items that currently exist.

Telehealth Recommendation 19 of 21: Wound Management Working Group Recommendation 14 - Increase access to wound care experts in RACFs, including telehealth enabled, where appropriate.
TWG Recommendation: Supported
TWG Rationale: This recommendation was supported by the TWG but agreed that further work was required - that this may fit into a VPE model or case conferencing or specialist telehealth consultation items.

Wound Management Working Group

Recommendation 8: Remote and non-face-to-face services (real time or asynchronous)

The Working Group recommends that where appropriate, consideration should be given to the use of remote and non-face-to-face services (real time or asynchronous) and an appropriate funding model investigated.

Ideally a healthcare provider would attend a patient face-to-face, however, the Working Group agrees that telehealth is an appropriate alternative in many situations, particularly to assist referral to a wound care specialist.

The situation of obtaining an expert/specialist opinion is one that in the opinion of the Working Group is well suited to asynchronous telehealth, which would increase potential access to specialist services and also in many cases be more convenient for the patient, without any reduction in clinical value.

This treatment modality may be appropriate in a number of situations, including rural and remote settings and RACFs, as well as to assist established teams working within different location.

Rationale for Recommendation 8

This recommendation focuses on increasing access to best practice wound management services, including value for the patient and the health system.

It is based on the following:

- Telehealth should not be a substitute for face-to-face care, however can play an important role in the management of chronic wounds.

- Utilisation of remote and non-face-to-face services has been proven beneficial in a number of clinical situations, including in the provision of remote specialist wound consultations (46) (55) (48) (57) (58). These services have been used for a number of years in remote areas in Australia, addressing many of the key challenges to providing health care in Australia.

- Telehealth is a recognised modality of providing equitable access to wound care expertise. Use of telehealth has been observed to reduce hospitalisations, improve wound healing, reduce cost of care and assist with facilitating inter-professional practice between GPs, allied health, specialists and the acute sector (60) (61) (62) (63) (55) (65), and should be considered in a number of situations, including RACFs.

- This recommendation is in line with the General Practice and Primary Care Clinical Committee (GPPCCC) draft recommendation supporting flexible access to services, including utilisation of asynchronous and non-face-to-face technologies.

Recommendation 14: Access to wound care experts in RACF

The Working Group recommends improved access to wound experts, including service teams (on-site or telehealth-enabled, where appropriate), to assist RACF staff to provide evidence-based wound management of chronic wounds for residents. This should take into account existing services (variable across States and locations) that currently support RACF staff through provision of expert wound care services.

The model for such a service may parallel the Government's existing Dementia Management and Advisory Services (DBMAS) program, which provides assessment, clinical support, short term case management and mentoring/clinical supervision of care providers within RACF.

Rationale for Recommendation 14

This recommendation focuses on providing universal access to best practice wound management services.

It is based on the following:

- As the Working Group has recommended (see Rec 7), improvement in a wound must be observed or referral to an appropriate specialist wound care practitioner mandated. A wound may be classified as non-healing after appropriate assessment (59), as is often the case with malignant wounds or wounds that arise during end stages of life. For instance, malignant wounds (fungating or ulcerating) seldom heal yet require specific treatment to ameliorate symptoms such as pain, bleeding, exudate and malodour. These wounds are often challenging to manage due to their location, frequency of dressing changes and amount of dressing products used at any one time to manage the wound (43) (45). As such, ensuring access to wound experts when appropriate is an essential element in any setting in which a wound is being managed. This is particularly the case in RACFs where RACF staff have various levels of skills and experience in wound management (40).

- Telehealth is a recognised modality of providing equitable access to wound care expertise (see Rec 8) (60) (61) (62) (63) (55) (65).

- This recommendation should be read in line with Recommendation 22, defining credentialing requirements of specialists in wound management.

Appendix A: Recommendations already endorsed

The working group notes that the following items have already been endorsed by government. The working groups suggestion is that evaluation of the outcomes of these items should proceed and considers that where based on their evaluation and variance from these principles, if changes are needed, there should be a uniform approach over time to bring them into line with other telehealth items.

Eating Disorders

Telehealth Working Group Consideration

Telehealth Recommendation 20 of 21: Eating Disorders Recommendation 1.4
Recommendation: *Noted and with evaluation that these recommendations be aligned to the principles over time*
TWG Rationale: The TWG noted that this Recommendation has been implemented, and as above, suggested that in response to evaluation future changes are guided by these principles.

Eating Disorders Working Group Recommendations

Recommendation 1.4

The Working Group recommends the services referred to in recommendation 1.2 be allowed to be provided via telehealth (under the same eligibility requirements that exist for other MBS services) in order to increase access to services for patients in rural and remote areas.

Recommendation 1.2:   The Working Group recommends the introduction of a new suite of items to provide a comprehensive stepped model of care for:

o   all patients with anorexia nervosa; and

o   patients with bulimia nervosa, binge-eating disorder and other specified feeding or eating disorders who have complex needs, have not responded to treatment at a lower level of intensity and are assessed as 'high-risk' of serious medical and psychological complications.

The new items would provide for:

o   the development and review of a treatment and management plan by a medical practitioner (such as a GP).

o   This item would trigger eligibility for a comprehensive model of care, consisting of an initial and more intensive course of psychological and dietetic treatment depending of the patient's needs.

Initial course of treatment

o   Triggered by the development of a treatment and management plan by a medical practitioner (GP):

•   an initial course of up to 20 psychological sessions; and

- • an initial course of up to 10 dietetic sessions.

o The GP will assess the patient throughout the treatment process, but should assess whether the patient should progress beyond 10 psychological sessions and 5 dietetic sessions by conducting a review consultation (with a New Item Number) before or around 9 or 10 sessions completion mark, to approve and trigger another course of 10 psychological sessions and 5 dietetic services (up to 20 psychological sessions and up to 10 dietetic sessions). This review item will involve a full medical and psychological history, a full physical examination and ordering and reviewing relevant investigations.

o The mental health professional involved in the patients treatment will be required to formally report back to the practitioner before or around the 9 to 10 services completion mark to certify the patient's diagnosis and confirm that the patient requires a further course (an additional 10 psychological sessions) of treatment.

More intensive treatment

If the patient has not responded to treatment at a lower intensity, upon formal review and assessment of the patient by a psychiatrist or paediatrician, the patient would be eligible for:

o an additional course of up to 20 psychological sessions (40 sessions in total per year) ; and

o an additional course of up to 10 dietetic sessions (20 sessions in total per year).

GP reviews

It is expected that as the central care provider, the GP will review the patient throughout the treatment process, performing the necessary medical assessments, including ordering and reviewing the required tests, and assessing the patient's response to treatment.

Reports back to the GP from the mental health professional and dietitian

It will be a requirement that the mental health professional and dietitian delivering care to the patient provide written reports back to the managing GP after each set of services (that is, after each set of 10 psychological services and 5 dietetic services).

Gynaecology

Telehealth Working Group Consideration

Telehealth Recommendation 21 of 21: Gynaecology Clinical Committee Recommendation 10 - Delete item 13210 (attendance on a patient by video conference)
TWG Recommendation: Not Supported. Should also be aligned with the principles.
This recommendation has already been submitted to Government and this item has not been claimed in 5 years but given the recent exposure of this craft group to telehealth the TWG recommends that telehealth rebates be available in accordance with all of the principles but in particular principles 1, 2 , 3, 4.   Principle 1 *Should be patient-focused, and based on patient need, rather than geographical location*   Principle 2 *Must support and facilitate services that are clinically safe and efficacious for patients.*   Principle 3 *Should be provided in the context of continuity of care between patient and practitioner.*   Principle 4 *Must not create unintended consequences or perverse incentives that undermine the role of face-to-face care.*

1.3   Professional attendance (items 13209 and 13210)

Table 9: Item introduction table for items 13209 and 13210

Item	Descriptor	Schedule fee	Volume of services FY2015/16	Services 5-year-average annual growth	Total benefits FY2015/16
13209	Planning and management of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies or for artificial insemination payable once only during 1 treatment cycle	$84.70	78,387	3.7%	$6,154,271
13210	Professional attendance on a patient by a specialist practising in his or her specialty if: (a) the attendance is by video conference; and (b) item 13209 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an Aboriginal Medical Service; (b) or an Aboriginal Community Controlled Health service for which a direction made under subsection 19 (2) of the act applies	$42.35	-	0.0%	$-

Recommendation 10

Δ   Item 13209: No change.

Δ   Item 13210: Delete item.

Rationale

This recommendation focuses on modernising the MBS. It is based on the following.

Δ   Item 13209:

– This item remains appropriate for contemporary care.

Δ   Item 13210:

– MBS data shows that item 13210 was not claimed at all in FY2015–16 or within the past five years. The Committee appreciates the intention to extend access to the patients detailed in the descriptor, but it notes that this has not yet resulted in any use of the item.