**Optimising use of the new telehealth items**

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**About The Royal Australasian College of Physicians (RACP)**

The RACP trains, educates and advocates on behalf of over 18,000 physicians and 8,500 trainee physicians, across Australia and New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

Introduction

The Royal Australasian College of Physicians (RACP) regards telehealth as part of the foundation of future health reforms to improve the accessibility and quality of healthcare to Australians. From this perspective, the new MBS telehealth items which were phased in over March 2020 for a range of specialist and consultant physician and paediatrician attendances (encompassing both telephone and videoconference consultations) are to be welcomed. These items are also consistent with long stated RACP advocacy to remove the restriction on access to telehealth under the ‘standard’ telehealth items to patients who live outside a 15 km distance from a specialist service.

While these items were originally introduced to protect both patients and doctors during the first wave of the COVID-19 outbreak by minimising the need for face to face consultations, a recent survey that we undertook of our members’ use of these items strongly suggests that they should be continued beyond their term of September 30 2020 with almost 87% of respondents supporting the retention of the new telehealth items on a long term basis even after the COVID-19 outbreak is over. However, in light of recent events, it now appears that the COVID-19 pandemic is far from over and there may even be a case for retaining these new items to facilitate a more prolonged period of physical distancing beyond September 30.

Given that a significant cohort of patients treated by specialist and consultant physicians and paediatricians are those with chronic and complex care needs, the support from our members for these new items is understandable. In addition to the original reasons these items were introduced, namely to facilitate physical distancing, the benefits to this cohort of patients from the increased accessibility to specialist care and reduced failure to attend rates promoted by telehealth are potentially significant. Moreover, a significant share of the patients treated by our members may face difficulties and risks undertaking frequent face to face consultations regardless of how far away they live from the nearest specialist given their chronic and complex care needs.

At the same time, we are well aware, as are our members, that a telehealth consultation (whether it is undertaken through telephone or videoconference) cannot be a perfect substitute for every clinical attendance. For instance, responses to our survey, despite being supportive of retaining the new telehealth items, have been appropriately nuanced about the strengths and weaknesses of telehealth and recognise its numerous limitations, for instance in ensuring appropriately comprehensive clinical examinations, establishing rapport with the patient and recognising non-verbal cues which may be especially important in seeing new patients, paediatric patients and patients with cognitive impairment.

In recognition of these strengths and limitations of telehealth while ensuring that these new telehealth items can be retained as long term MBS items this paper is proposing the following set of changes to ensure optimal use of telehealth:

* Require all initial consultations with new patients under these new items to be undertaken through videoconferencing
* Introduce a differential rebate between telephone based and videoconference consultation, with a higher rebate for the latter
* Introduce a package of services to reduce the ‘digital divide’ between patients so that all patients can have access to videoconferencing for specialist consultations when required.
* Introduce new streamlined specialist telehealth items to allow for the claiming of rebates for consultations between specialists and other healthcare professionals (with or without the patient present).
* Initiate a comprehensive inquiry into the establishment of SNOMED CT as the billing system for MBS items, with broad ranging stakeholder consultation. The terms of reference for such an inquiry should also be appropriately comprehensive and cover off, among other issues:
  + The provision of subsidies and other incentives to move clinicians towards one system with appropriate provision for establishment costs as well as any ongoing administrative costs associated with such a move.
  + The provision of appropriate education, training and centralised technical support to clinical practices in moving towards such a billing system.

Require initial consultations with new patients to be through videoconferencing

Before the introduction of the new telehealth items, telehealth items for selected specialist and consultant physician attendances were already available (subject to distance/location restrictions in contrast to the new items which can be claimed by all patients) but only for videoconferencing consultations. Thus, another innovation associated with these new items has been the availability of telephone consultation for the first time.

The RACP believes that telephone-based consultations have an important place in telehealth. Moreover, based on the results of our member survey, they are also strongly preferred by particular groups of patients including the elderly (who may be less technologically literate) and those of lower socioeconomic backgrounds who may not have access to a good broadband connection or required equipment. In addition, telephone consultations are easier for clinicians to set up with their patients. Installation of appropriate software and other technology may also incur a high initial cost in terms of both time commitment and resources. Thus, it is important to preserve a place for telephone consultations in telehealth, which may be especially useful for more routine follow up consultations with and monitoring of patients with already stabilised conditions.

Nonetheless, videoconferencing has significant advantages over telephone consultation in ensuring a patient is properly diagnosed and assessed, which is particularly important in the case of new patients who are being seen for the first time. Compared to telephone-based consultation, videoconferencing facilitates at least some visual inspection including the ability to take note of non-verbal cues (which can be important, for instance, in undertaking assessment of geriatric patients), Videoconferencing is also superior in terms of establishing patient rapport and engagement (including with patients with mild hearing impairments). For new paediatric patients, videoconferencing allows the clinician to talk to the child and family at the same time.

Videoconferencing has its own limitations relative to face to face consultations where a more comprehensive physical examination is required (for instance for musculoskeletal conditions) so ideally the patient-clinician relationship should not be conducted exclusively through telehealth where confirmation of diagnosis requiring more comprehensive examination is required (though this could be through another trusted healthcare service provider).

However, in order to ensure that use of the new telehealth items is optimised and clinically appropriate at least for initial consultations, we recommend that the new items be amended to require that the first consultation with a new patient using these items must be through videoconferencing. We recognise, however, that not all patients and clinical practices are properly set up for videoconferencing which is why we propose some additional recommendations (discussed below) to increase the take-up of videoconferencing on both the clinician and the patient ends.

Differential rebates for videoconferencing versus telephone consultations

As discussed previously, videoconferencing has numerous clinical benefits over telephone based consultations as a form of telemedicine. These benefits (patient rapport, reading non-verbal cues, enhanced communication, etc) extend beyond the initial consultation. Videoconferencing also allows the clinician to share screens with the patients to display and discuss test results (e.g. X-rays) and other crucial information and documentation with their patients. These benefits suggest that ideally all clinical practices which want to provide telemedicine should be set up to provide some videoconferencing consultations. At the same time, videoconferencing requires additional time and resources for practices to set up, particularly given the need to provide a secure and reliable videoconferencing platform which safeguards patient privacy. In recognition of these additional benefits for patient care and the additional costs to clinicians of establishing a secure and reliable videoconferencing platform, we recommend that there should be a differential rebate between videoconferencing and telephone based consultation with a correspondingly higher rebate for videoconferencing. These differential rebates should be achieved by increasing the rebate for videoconferencing given that the current rebate is equal to the one for face to face consultations, rather than by reducing the rebate for telephone consultations.

Reduce the digital divide between patients

While incentivising the use of videoconferencing over telephone based consultation through higher MBS rebates for the former can induce more clinicians to adopt videoconferencing in catering to their patients, there are limits to this approach if the digital divide between patients is not also directly addressed. The digital divide refers not just to the fact that some patients have access to better broadband speeds and mobile devices facilitating reliable videoconferencing than others but also to some patients having higher levels of general digital and technological literacy than others. This divide is referred to in many of the written comments that respondents to our member survey have provided. For instance, some of these written responses have noted that elderly patients and patients with cognitive and other impairments may have difficulties using videoconferencing while other responses note that some patients simply do not have access to the required technology whether this be computers, mobile devices or a reliable broadband connection.

To address this digital divide and therefore ensure that patients are also well equipped to take advantage of videoconferencing consultations we recommend that the Commonwealth and States should jointly fund a package of service offerings. As a start, the two levels of government should

* jointly contribute to the funding of an ‘army’ of telehealth coordinators who would then be equipped to target different kinds of support to patents with differing levels of need. While some of these telehealth coordinators would be practice nurses who are additionally trained to provide such services, this army could also be recruited and skilled up from the general community. The role of these coordinators could vary depending on patient needs. For instance, some would staff videoconferencing ‘portals’ set up at strategic locations accessible to patients (see below), others might be available to assist patients with phone enquiries on how to set up videoconferencing platforms in their own homes while others might undertake home visits if more direct assistance is needed for patients to set up their videoconferencing arrangements.
* fund the establishment of free videoconferencing ‘portals’ in community health centres, Aboriginal Medical Services, aged care facilities and other strategic locations (e.g. libraries and retirement villages) which are likely to be accessible to patients, As discussed previously, these portals would be staffed by telehealth coordinators who would be able to assist patients with setting up videoconferencing sessions with their doctors. This funding would be particularly well targeted at patients who have some ability to travel but lack facility with technology.
* fund a subsidy for and access to expedited installation of broadband connections and/or laptop computers for patients who need them. This funding would be especially well targeted at patients who are technologically literate but who currently lack adequate facilities for videoconferencing. Telehealth coordinators could be available for patients who access this option but would still like guidance and other information on available service packages. These coordinators could also arrange to have the equipment delivered to patients’ homes and installed if required.

The services proposed above are meant to be complementary – as described, they target patients with varying needs in terms of mobility, knowledge and financial resources. Central to all these proposed services is the funding provided to telehealth coordinators who should be able to customise the right level of support at patients depending on their circumstances.

Introduce new streamlined specialist telehealth items for consultations between specialists and other healthcare professionals

While existing case conferencing items in the MBS already allow clinicians to undertake case conferencing using telephone or videoconferencing[[1]](#footnote-1) , these items require the participation of a minimum of three health or community care providers (one of whom must be a general practitioner). However there are a range of other secondary consultations which clinicians routinely undertake with each other which are not recognised under these multidisciplinary case conference items – these include one on one consultations between one type of specialist and another (e.g. a cardiologist and an endocrinologist), between a specialist and a general practitioner and between a specialist and an allied health professional (e.g. a paediatrician and a speech therapist). We recommend that an MBS item which is more streamlined than current case conference items facilitating these secondary consultations between specialists and other healthcare professionals (with or without the patient present) should be introduced.

The RACP has long argued for the recognition of these direct health professional communications[[2]](#footnote-2) either through the creation of a new MBS item or through provision of other government financial incentives. Given the significant progress that the government has already made in introducing these new telehealth items, the addition of these proposed new streamlined items would be of significant benefit to the quality of care provided to patients, particularly those with chronic complex conditions which require management and coordination by multiple specialists.

Investigate the establishment of SNOMED CT as a billing system for MBS telehealth items

As has been pointed out by some medical billing experts, the complexity of the MBS system contributes to the level of inappropriate or non-compliant MBS claims[[3]](#footnote-3) which is estimated to be at least $1 billion annually.[[4]](#footnote-4) Unintentional mistakes caused by its complexity are arguably more important than intentional fraud or ‘gaming’. At the same time it is imperative that governments require accountability in the claiming of MBS rebates and ‘value for money’ and the collection of transparent and easily analysed data on MBS claims can facilitate this. These considerations may be heightened for government policymakers if these new MBS telehealth items (plus the additional ones for secondary consultation that we have proposed) are to be retained in the MBS permanently.

In order to facilitate a greater degree of transparency in analysing MBS data while simplifying coding and classification and making it easier for clinicians to bill (and thus reducing the volume of inappropriate billing) the Commonwealth government should investigate the options for moving to a better optimised billing system that can be readily installed into clinician software and easily used. One candidate which has recently been proposed by some medical billing experts is SNOMED CT. [[5]](#footnote-5) Among its advantages:

* Australia is already an inaugural member of the organisation which owns and manages SNOMED CT.
* It is designed for clinical use directly for patient care and there are millions of SNOMED CT codes, which provides for a greater level of specificity and detail than other clinical codes. Note that obviously use of SNOMED CT does not require clinicians to be directly conversant with all these codes as they can be integrated into clinical software systems so that these systems will automate the finding of the closest code to the description entered by the clinician. This brings us to the next point below.
* SNOMED CT does not require human coders, which allows for easier implementation and administration as long as clinicians have compliant clinical software systems. Many Australian software vendors have already integrated SNOMED CT into their clinical systems.

Notwithstanding these advantages, there are some potential stumbling blocks to broader use of SNOMED CT for MBS telehealth items (and potentially to encompass all MBS items in the longer term):

* Not all specialist clinical practices have installed clinical software, much less software is that compliant with SNOMED CT
* Among those clinicians with knowledge of SNOMED CT there are remaining concerns regarding patient privacy
* SNOMED CT codes would need to be integrated into all software systems used by Australian healthcare professionals.

While none of these concerns are insurmountable, they do suggest that a broader inquiry and consultation with all healthcare service providers is needed before a move to a uniform system for billing MBS telehealth and potentially all other MBS items can be implemented. We recommend that such a comprehensive inquiry into the establishment of SNOMED CT as the billing system for MBS items be initiated, with broad ranging stakeholder consultation, The terms of reference for such an inquiry should also be appropriately comprehensive and cover off, among other issues:

* The provision of subsidies and other incentives to move clinicians towards one system with appropriate provision for establishment costs as well as any ongoing administrative costs associated with such a move.
* The provision of appropriate education, training and centralised technical support to clinical practices in moving towards such a billing system.

1. <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-caseconf-factsheet.htm> [↑](#footnote-ref-1)
2. Most recently in its 2020-21 Pre-budget submission <https://www.racp.edu.au/docs/default-source/advocacy-library/b-2020-21-pre-budget-submission-dec-2019_slg-app.pdf?sfvrsn=a735e51a_6> [↑](#footnote-ref-2)
3. Faux MA, Wardle JL, Adams J. No payments, copayments and faux payments: are medical practitioners adequately equipped to manage Medicare claiming and compliance?. *Intern Med J*. 2015;45(2):221-227. doi:10.1111/imj.12665 [↑](#footnote-ref-3)
4. Faux M and H Grain, Opinion: telehealth is not quite the colt from old Regret but it sure as hell has got away, Pulse IT, 18 May 2020, <https://www.pulseitmagazine.com.au/news/australian-ehealth/5509-opinion-telehealth-is-not-quite-the-colt-from-old-regret-but-it-sure-as-hell-has-got-away> [↑](#footnote-ref-4)
5. Faux M and H Grain, Opinion: telehealth is not quite the colt from old Regret but it sure as hell has got away, Pulse IT, 18 May 2020, <https://www.pulseitmagazine.com.au/news/australian-ehealth/5509-opinion-telehealth-is-not-quite-the-colt-from-old-regret-but-it-sure-as-hell-has-got-away> [↑](#footnote-ref-5)