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Dear Cherie,

**RE: Framework for Action**

Thank you for the opportunity to review the Australian National Digital Health Strategy – Framework for Action.

Firstly, as President of the Australasian Telehealth Society, let me commend the Australian Digital Health Agency for the work that has been done in the development of this framework, the inclusion and recognition of telehealth as a core component of Digital Health is refreshing to the Australasian Telehealth Society.

The Australasian Telehealth Society (ATHS) have reviewed this framework and feel that we can provide feedback on three of the National Digital Health Strategic Priorities, in particular;

- Enhanced Models of Care
- Workforce and Education
- Driving Innovation

Telehealth across Australia has had varying success, in areas such as Queensland, Western Australia, South Australia and the Northern Territory where remoteness is a major issue, funding can be redirected towards a telehealth solution as it shows significant efficiencies for the state health services. However other states struggle to adopt telehealth as the cost of having access to health services accrues to the patient.

Telehealth, in its various forms, has shown improvements in the delivery of healthcare. What is interesting is that technology is becoming less and less of a barrier with the emergence of technical solutions which have addressed the technical interoperability issues. With improvements in the National Broadband Network (NBN) the reliance on technology for clinical service delivery will continue to grow.

Patients, as individuals, are also adopting social models in health. Moving away from the traditional relationship of a patient taking orders from the GP as a trusted intermediary, more people are looking to partner with clinical experts (including and beyond their own personal physicians), as well as share perspectives and support with people like themselves (as patients or caregivers). Eric Dishman of Intel pointed out that people get more engaged with their health when they see and understand their personal health data. “Remote Home Monitoring is not a surveillance model,” Dishman said; “it’s a social model.”

In the US a bill is expected to be drafted in the House Committee on Ways and Means seeking to widen telemedicine coverage under Medicare to help reduce unnecessary hospital visits by Medicare patients. The legislation would expand the coverage of telehealth services under Medicare with the goal of reducing expensive, unnecessary hospital visits.

Their approach is to make it illegal for insurance companies to deny a claim based on the service delivery mechanism being via telehealth. However, the funding provided for the consultation is as a like for like consultation, i.e. there is no additional loading provided for the consultation on the basis that it is delivered using technology.

Within Australia, there appear to be five main barriers to the adoption of telehealth into mainstream clinical practice, all related to the federal government's acknowledgment of telehealth as an effective and safe mode of delivery of clinical services. Those areas are:

1. MBS billing for Store and Forward consultations (asynchronous telehealth)
2. MBS billing for GP's for telehealth consultations, whether it is for consultations into Residential Aged Care Facilities, Urgent Care Centres or Nurse led remote health centres, or even into underserviced regional communities which cannot attract a local GP
3. Reduction/removal of the geographic restrictions for billable MBS telehealth items
4. Allow billing into Urgent Care Centres or Nurse led remote health centres.
5. Acknowledgement of remote patient monitoring

The establishment of testbeds within Australia to prove/disprove the impact on telehealth and the important financial impact on the MBS is strongly recommended. Additional examples and use cases can be found at Attachment A.

It is acknowledged that the MBS schedule does allow for some **store and forward** telehealth consultations, however, there is an opportunity for more, such as ENT, Dermatology, Geriatrics, and Orthopedics to name a few. These specialist consultations have shown to take a fraction of a consultant's time and support the provision of care by the central GP. Very much in the way that we currently consult with pathology and radiology services.

Another major missed opportunity is to leverage clinically appropriate **GP services for telehealth**, there are several opportunities to better service regional and remote, and even metropolitan patients leveraging telehealth as a service delivery mechanism. Opportunities exist for GP consultations in Residential Aged Care Facilities (RACFs). Currently, the GP has to travel to the RACF to consult with the patient, in more regional settings it is common for the GP to wait until there are a few patients to visit before making the trip to the RACF. This means that aged care patients may continue to deteriorate before adequate medical treatment can be provided. Earlier intervention could mean an improved quality of life for the patients, support for the clinical staff within the RACF and peace of mind for the patient's families.

Underserviced regional and remote communities can also benefit from the use of clinically appropriate **GP services via telehealth**. There are a growing number of remote communities who do not have the population base to support a GP within their community. Many of these are quite remote meaning that local patients have to travel large distances to receive access to quality care, whilst not all of these consultations can be via telehealth, a large number can be. It would be recommended that these communities either nominate or be nominated by their State departments of health to be identified as a site in which these services could be delivered.

**Removal of the limitations for geographical boundaries** (not just the 15km rule which has no relevance in metro regions) also has significant opportunities within metropolitan and regional areas. For some patients who are restricted by mobility or access to adequate transportation, these urban patients may be clinically suitable and benefit from Telehealth. The equity of service should be available to metropolitan as well as rural and remote patients. This is seen as one of the major limitations to telehealth uptake for specialist service delivery. It is recommended that billing should be extended to be able to bill ANY telehealth the Base item only (no 50% loading) regardless of patient location and for all providers.

By doing this, we are:

1. Legitimising telehealth as a viable service delivery model for everyone – not just a second-best option for regional patients

2. Removing the need to screen patients for eligibility - a major administrative and clinical limitation
3. Not adding to the burden of healthcare costs as it is simply replacing current activity
4. still supporting rural or regional people by maintaining the 50% loading for RA2-5
5. Enabling all providers (including GPs) who currently bill Medicare to be able to use telehealth – again legitimising its use

**Emergency and after-hours support** models of care should be reviewed in consideration of telehealth. Currently, emergency departments struggle to evolve to be inclusive of telehealth beyond project phases due to the high volumes of patients already flowing through Emergency Departments. The addition of further video advice for unfunded consultations to regional centres is growing and clinicians are faced with dealing with those patients coming through the door or provide advice to a regional centre, understandable if the patient is not a category 1 or 2 within the region then the patient presenting face to face will take priority.

Additional support can be provided to the health service in a timelier manner by allowing GP's to consult within Urgent Care Centres or other Nurse led services through the provision of telehealth. Some respite and/or support can be provided to some regional areas who may only have one or two GP's which support their local health service through the provision of services by specialist resources the regional/larger Emergency Departments, however, funding needs to be provided to sustain this model.

Innovative models of care continue to emerge leveraging technology, most of these applications focus on patients self-monitoring their health and/or chronic conditions. However, the health app market is growing significantly, and the way in which consumers interact with providers, whether they be healthcare or commercial and consumer providers, the Australian health system needs to acknowledge this as viable service delivery mechanisms. As such the funding models which support these needs to be considered. Changes in the way chronic disease programs are funded, such as Healthcare Homes, will allow flexible funding to enable innovative service delivery models to emerge, inclusive of **remote patient monitoring programs**. The Australian Telehealth Society would encourage the federal government to continue to pursue other clinically safe programs which allow the safe use of technology to deliver healthcare outcomes.

It is clear that the ADHA have worked in consultation with peak bodies and other industry experts in the consultation process for the "Framework for Action", the ATHS would like to continue to work with the ADHA. In the past there have been various telehealth groups which have provided expertise and support to the public health sector, inclusive of the National Telehealth Working Group which reported to the National Health CIO's Forum. As these groups no longer exist, the ATHS would like to encourage ADHA to ensure that consultation with peak bodies continues.

In 2017 the Northern Territory Government were given the portfolio for the Australian Telehealth Integration Program. This program brought together some of the premier telehealth experts from across the country, this group was also guided through the established steering committee. The ATHS would recommend that the ADHA continues to leverage the expertise of this group of Subject Matter Experts in support of telehealth. It is also recommended that the ADHA considers leveraging the Victorian Telehealth Community of Practice to establish a National Telehealth Community of Practice which could be auspice by the Australasian Telehealth Society under funding from the Federal Government (refer Attachment B).

The Australasian Telehealth Society would like to thank the Australian Digital Health Agency for the inclusion of the ATHS for the inclusion of our feedback into the national strategy. As such we look forward to further opportunities to work with ADHA on the advancement of Telehealth as part of the National Digital Health Strategy.

Sincerely,

Jackie Plunkett
President,

Australasian Telehealth Society
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# Attachment A

**AN OVERVIEW OF THE CURRENT TELEHEALTH FUNDING MODEL**

**Prepared by:**

Susan Jury and Alice King

On behalf of the Australasian Telehealth Society

**Other Medicare telehealth billing rules that negatively impact on telehealth uptake:**

1) Only a medical consultant can bill Medicare for telehealth
2) Nurse Practitioners can bill for in-person but not telehealth
3) The patient must be residing in rural/regional (RA2-5) regions
4) Patients who reside in metropolitan areas (RA1) are ineligible to received Medicare-funded telehealth
5) The patient and provider must be more than 15km apart
6) General Practitioners cannot offer Medicare-funded telehealth

| Medicare rule | Scenario | Benefits of the current funding model | Barriers and risks of the current funding model |
|---|---|---|---|
| | Regional GP refers the patient to private practice medical consultant to be seen via telehealth. | Model is designed within the private practice context to increase access to specialist services in regional areas | The model is not well suited for Medicare billable services within a hospital setting[1]. |
| Only a medical consultant can bill Medicare for telehealth | GP refers the patient to a tertiary hospital Specialist Clinic for any acute or chronic illness. Initially, the patient is seen by the Consultant who implements a plan of treatment. Patient requires ongoing review. Due to billing | **Reduces travel demands on the patient** and increases access to specialist services for those who find travel difficult.<br><br>**Suits the initial assessment and diagnosis consultation** led by a medical Consultant. | Routine review consultations, often well suited to telehealth, are often most appropriately provided by Registrars and Fellows in the tertiary hospital setting. These are not billable by telehealth. As a result, from the hospital perspective **telehealth can be** |

[1] In hospital Specialist Clinics, doctors exercise their *ROPP (Right of Private Practice)* - a widespread arrangement whereby hospitals pay doctors a salary and collect Medicare revenue on the doctors behalf

| Medicare rule | Scenario | Benefits of the current funding model | Barriers and risks of the current funding model |
|---|---|---|---|
| | restrictions, this **continued care must be done by the medical consultant**. | | **seen as a financial liability and/or an inefficient use of medical consultants** – the most expensive, least available and not always most appropriate clinician.<br><br>This i**nadvertently disadvantages others and negatively impacts waiting times**. |
| Nurse Practitioners can bill for in-person but not telehealth | **Nurse Practitioners provide a comprehensive clinical service to metropolitan patients that regional patients generally do not receive** (for example paediatric eczema, chronic renal disease, haematology, palliative care and many others). | | **Regional patients suffer gross inequity of access to Nurse Practitioner specialist care**, as unwell regional patients are even less likely to be able to travel. |
| The patient must be residing in rural/regional (RA2-5) regions | Typically, in a metropolitan tertiary hospital in Victoria providing a state-wide service, around 25 – 37% of patients are regional.<br><br>This is also an issue for major regional tertiary hospitals that are in cities classified as RA1, where a higher proportion of patients may be regional, but a significant number are still residing within the RA1 boundary. With significant growth in regional cities, it also results in some residents being | The current model is **designed to improve access to specialist services for regional people**. | Eligibility screening for Medicare billing **creates added burdens to hospital administrative systems** for identifying eligible patients, booking, scheduling, and billing and **creates a perceived and logistical barrier to uptake of telehealth**. Thus, associated **uptake is much less than the potential**. |

| Medicare rule | Scenario | Benefits of the current funding model | Barriers and risks of the current funding model |
|---|---|---|---|
| | within the RA1, while their neighbours are outside the RA1 in growth suburbs.<br><br>Currently, most clinical and PAS systems do not highlight that a patient is regional at the time of requesting the follow-up appointment and there is **no easy way for clinicians or administrative staff to identify eligible regional patients**.<br><br>Additionally, with a clinic of for example 15 patients, this is ~4-6 patients per clinic. Even if 10% were suitable for telehealth, this translates to the infrequent use of telehealth by individual clinicians, meaning it is **still perceived as an 'add-on'**. | | |
| Patients who reside in metropolitan areas (RA1) are ineligible to receive Medicare-funded telehealth | **A great many urban patients may be clinically suitable and benefit from telehealth**.<br><br>A few examples:<br>• The elderly who require a carer to take them to appointments<br>• Parents with children and childcare commitments<br>• People with work commitments<br>• Socially or financially vulnerable or compromised<br>• Patients on chemotherapy who are immunocompromised and should avoid travel | There **may be a perception of increased cost to the health budget** and overuse of services if they are too easily accessible. | Rules and **exclusion criteria do not promote a perception of 'business as usual'**. Telehealth remains 'an add-on' and as a result, **metropolitan AND regional patients are still not benefited**.<br><br>If telehealth is considered an appropriate model for regional (RA2-5) patients, it should be so for urban patients also. |

| Medicare rule | Scenario | Benefits of the current funding model | Barriers and risks of the current funding model |
|---|---|---|---|
| The patient and provider must be more than 15km apart | **Many people, with chronic illness, in particular, find travel difficult even over short distances because of their medical condition** (e.g. breathlessness and/or the use of oxygen; mobility) and **may be clinically suitable for and benefit from telehealth**.<br><br>The examples above for the RA1 restrictions are also relevant for the 15km rule, in metropolitan, regional and rural settings. | There **may be a perception of increased cost to the health budget** and overuse of services if they are too easily accessible. | Rules and **exclusion criteria do not promote a perception of 'business as usual'**. Telehealth remains 'an add-on' and as a result, **both metropolitan AND regional patients have still not benefited**.<br><br>Patients who have difficulty accessing health care due to their health status, socioeconomic status, caring requirements and work commitments are at risk of **not attending required and appropriate health care** and may deteriorate so that **future health care requirements are greater**.<br><br>If telehealth is considered an appropriate access option for a patient then their distance from a provider should not be a determining factor. |
| General Practitioners cannot offer Medicare-funded telehealth | Many people have difficulty attending their GP, for example, because they are elderly with transport or mobility issues, have family or work commitments, or travel frequently etc.<br><br>This is particularly risky for those with chronic illness who require regular contact with a consistent GP. | The perceived benefits may be that a patient *must* see their GP in person. | This **may result in poor or inconsistently managed care** as people either do not see a GP or do not maintain a regular GP.<br><br>**People in aged care facilities have great difficulties accessing GP services** due to the logistics and costs of patient travel and difficulty in securing GPs to undertake home visits. |

**AN OVERVIEW OF A PROPOSED TELEHEALTH FUNDING MODEL**

1) All providers who can bill Medicare to provide an in-person clinical service can bill to provide the same service via video if clinically appropriate.
2) Any person can be seen by telehealth if clinically appropriate.
   - Where the patient is rural/regional (RA2-5), a 50% telehealth loading is added
   - Where the patient is metropolitan (RA1), there is no loading
   - There is no 15km distance limitation between clinician and patient

| Medicare rule | Scenario | Benefits of the proposed funding model | Barriers and risks of the proposed funding model |
|---|---|---|---|
| | Regional GP refers the patient to private practice medical consultant to be seen via telehealth. | **Unchanged, as above** | |
| Match provider rules for telehealth to in-person consultations | GP refers the patient to a tertiary hospital Specialist Clinic for any acute or chronic illness. Initially, the patient is seen by the Consultant who implements a plan of treatment. Patient requires ongoing review.<br><br>**Ongoing reviews can be provided by the most appropriate clinician, as would be done in person.** | Reduces travel demands on the patient and increases access to specialist services for those who find travel difficult.<br><br>Is suited to the initial assessment and diagnosis consultation led by a medical Consultant and **supports equity of access to multi-disciplinary and team-based care** as is provided to metropolitan counterparts.<br><br>**Enables the growth of the use of telehealth without financial liability** to the tertiary health service. | There **may be a perception that if patients do not need to see a consultant they should be seen by their GP** and this model might encourage 'retention' of patients by the tertiary service. In reality, **telehealth *enhances* team-based care by enabling inclusion of the GP.** |

| Medicare rule | Scenario | Benefits of the proposed funding model | Barriers and risks of the proposed funding model |
|---|---|---|---|
| | | Ensures the Consultant medical workforce is used appropriately, **without impacting wait lists.**<br><br>Without the need for eligibility screening, requesting scheduling, booking and billing telehealth is the same as in-person and **administrative barriers are greatly reduced.** | |
| | Nurse Practitioners (NP's) provide a comprehensive clinical service to **any patients, in the most appropriate way, which may include in person or by telehealth**. | **Any patients who have difficulty with travel, experience greatly enhanced equity of access** to Nurse Practitioner specialist care, which is particularly relevant to the typical **chronic illness cohort** of many Nurse Practitioners. | There **may be a perception of increased cost to the health budget by increasing access to Nurse Practitioners**, however, NP's typically play a key preventative role in chronic illness with **well documented long-term cost benefits to the overall health budget**. |
| Any person can be seen by telehealth if clinically appropriate | ***Anyone* can benefit from the use of telehealth** regardless of their geographical location. | An added **focus will remain on regional populations by maintaining the 50% telehealth loading**.<br><br>The replacement of existing activity with telehealth for some urban patients without increased loading will **increase uptake, thus also benefiting regional patients**. | There **may be a perception of increased cost to the health budget** and overuse of services if they are too easily accessible. It has been thus proposed that there is **no added 50% loading for urban patients** – telehealth is **simply replacing travel**. |
| GP's can bill to consult via video if | ***Any* person who has difficulty attending their GP is able to have follow up** | **Increased access to primary health care** in particular for vulnerable groups and | There **may be a perception the GPs must always see patients in person.** However, as with all clinical |

| Medicare rule | Scenario | Benefits of the proposed funding model | Barriers and risks of the proposed funding model |
|---|---|---|---|
| clinically appropriate | **consultations by video** when clinically appropriate. | others with transport, travel or mobility issues<br><br>**Supports improved chronic disease management** through better GP access<br><br>**Supports ongoing care by the GP** (who in the current model cannot consult using telehealth) **instead of referring to tertiary services** (who in the current model *can*) – for example in aged care and chronic illness.<br><br>**Greatly improves access to routine GP care in aged care** as patient travel logistics and costs are removed. **Greatly reduces the cost of GP home visits to Aged Care Facilities**.<br><br>The **cost benefits of keeping care in the community and in primary care** are well known and documented. | consultations, telehealth is at times equally or more clinically appropriate and GP's should have that decision-making authority. |

## A national Telehealth Community of Practice: Position paper to the ADHA

Submission made by the Australasian Telehealth Society (ATHS) and the Telehealth Victoria Community of Practice

July 2018

This paper recommends the expansion of the existing Victorian Telehealth Community of Practice as a National Telehealth Community of Practice auspiced by the ATHS.

It is well recognised that embedding telehealth in to routine service delivery is complex and takes long-term financial and organisational commitment; and that there are considerable challenges to adoption, scaling and sustainability of telehealth access to services[2].

As part of the Department of Health and Human Services (DHHS) Victoria commitment to supporting 16 major telehealth initiatives funded in Victoria in 2017, it also funded the establishment of the Telehealth Victoria Community of Practice (TVCOP; https://telehealthvictoria.org.au/) to enable these initiatives to connect, collaborate, and share knowledge and resources.

Evaluation of the TVCOP showed significant benefits. Members identified that it enabled them to share knowledge, resources, collaborate and problem-solve issues. This consequently assisted telehealth practitioners to connect with the right people when organising specialist care for rural and regional patients, assisted regional and rural practitioners to link up more readily and contributed to members feeling less professionally isolated. Meeting each other at workshops, finding contacts via the members' database, posting questions on the online discussion forum, were all avenues that enabled relationship building and collaboration. Members who connected at workshops also organised subsequent meetings and site visits to further discuss specific issues or explore standardised approaches; for example, in data collection, reporting and mapping, use of interpreters and to address issues with common clinical software programs used.

The following quotes from members reinforce the valuable role the COP played in enabling telehealth service delivery in Victoria…

> *'The ability for new and experienced telehealth practitioners to meet, share and collaborate improves the quality of telehealth services in Victoria and reduces the implementation time and burden for new services. The collaboration also allows us to problem-solve for the benefit of all, and to provide collective input into regional, state and national initiatives.'*
>
> *'The Community of Practice is inclusive and provides a communication channel for rural and regional health services, which often have no choice but to work in relative isolation.'*
>
> *'…enabling knowledge and ideas to be shared without time wasted on duplication of effort.'*

In a field such as telehealth – with the speed at which technology is developing – and in healthcare – where resources and funding are often limited – this kind of collaboration is a significant benefit to the health system as a whole: reducing the change burden and implementation timeframes for the introduction of innovative and effective models of care supported by new technology.

While Victoria has implemented the TVCOP, there are national and other state organisations that also bring together telehealth practitioners, such as

- Australasian Telehealth Society (ATHS)

[2] Greenhalgh, T. et al. (2017) Beyond Adoption: A New Framework for Theorizing and Evaluating Nonadoption, Abandonment, and Challenges to the Scale-Up, Spread, and Sustainability of Health and Care Technologies. *J Med Internet Res* 19(11):e367 doi:10.2196/jmir.8775

- Health Informatics Society of Australia (HISA)
- Centre of Research Excellence in Telehealth (CRE), at the University of Queensland
- Australian College of Rural and Remote Medicine (ACCRM)

These organisations also facilitate at least some, if not many, of the same activities at the TVCOP – resource sharing, webinars, workshops and conferences, within their own jurisdictions / member base.

In addition, events such as Telehealth Awareness Week in Western Australia facilitates activities that both bring together practitioners and raise the profile of telehealth access across the State.

While jurisdictional variation in health service strategy and delivery, technology availability and infrastructure means that there will always be variation to deliver fit-for-purpose telehealth access to health services, there is still a lot that can be shared and learned across boundaries. Doing this nationally supports the broad agenda to provide a consistent digital access to health care across Australia.

The value of a COP to support new initiatives and reduce their learning curve is significant. While the potential benefits to future projects are hard to measure, they are associated with reduced risks of duplication, greater consistency in practice, and decreased time to implement new projects and services.

Sustainability of a COP requires ongoing coordination and leadership. At this stage no single body has ongoing resources to support a telehealth community of practice. A collaborative approach between existing organisations would be beneficial, with some resourced coordination and support.

Coordination of a community of practice can support activities such as:

1. Website, online discussion forum, member database, resource/knowledge base, health service directory, regular newsletter, which provide a platform for:
    - members to find & connect with others
    - asking questions and collaborating on solutions
    - promotion of new evidence, best practice, latest news and upcoming events
    - sharing resources and knowledge

2. Workshops, which provide an opportunity for members to:
    - connect with one another
    - share knowledge & resources
    - problem solve
    - identify solutions to common challenges
    - seek advice from the experiences of more established telehealth programs.

3. Webinars and web meetings, which provide
    - a platform to explore a specific topic with emphasis on active participation
    - the basis for SIGs and driving activity to collaborate on solutions
    - increased diversity of engagement (regional and external parties)

4. COP member engagement and growth, development of partnerships, which
    - Reduces isolation of often regional and rural telehealth practitioners
    - Enables common issues to be addressed, and solving of problems across a broad base of organisations (e.g. addressing future workforce skills by inclusion of telehealth in curricula)

5. Resource management, which includes
    - Resources & templates can be developed and shared in a structured way on website
    - Knowledge sharing to reduce learning curve