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Results of RACP Members' Survey of new MBS Telehealth attendance items introduced for COVID-19

June 2020

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.

Summary and recommendations

On 18 May 2020, the Royal Australasian College of Physicians (RACP) distributed a voluntary survey to all its practising Australian based members on their use of the new MBS telehealth attendance items introduced for COVID-19. Members had until close of business 25 May 2020 to complete the survey. There were 950 responses to this survey and the average completion rate was 77%.

Key findings

Some pertinent results of the survey for assessing the impacts of the new telehealth items are as follows:

- Telephone consultations are used more than videoconferencing consultations though a clear majority of respondents have used both - more than 90% of respondents had used telephone consults, almost two thirds had used videoconferencing consults.
- Telehealth now forms a significant part of our members' practice – for the largest share of respondents (27%) more than 80% of their practice now consists of these new telehealth items; for the majority (58%), more than 50% of their practice consists of these new items.
- The predominant reason that our members have used the telehealth items is because of concern about risk of exposure or vulnerability (because of age or chronic disease) to COVID 19 for patient or carer and the second most cited reason is concern about risk of exposure to COVID 19 for themselves, staff and household contacts.
- Almost half of our members can be said to strongly prefer videoconferencing to telephone attendance primarily because of its superiority in patient assessment and establishing patient rapport. By contrast less than a quarter could be characterised as lukewarmly to strongly preferring teleconferencing (primarily because of its convenience and because it is preferred by patients). In practice a larger share of members have used telephone as opposed to videoconferencing consultations; an important reason for the relatively lower take-up of the latter, based on respondents' written comments has been some patient' ' unfamiliarity and lack of comfort with using videoconferencing technology.
- A significant majority of respondents perceive that the availability of these new items have increased accessibility of healthcare to patients; - almost 75% of respondents thought that the availability of these telehealth attendance items has contributed to improved accessibility of healthcare and almost 70% stated that patients were generally more likely to keep their telehealth appointments than face to face appointments.
- The feedback that our members have received from their patients on the new items has been overwhelmingly positive – **almost 82% of respondents noted patient feedback that was 'Strongly positive for at least a majority'**.
- Our members' own view of these items has been overwhelmingly positive - when asked whether they supported retaining the new telehealth items in the MBS on an ongoing basis post COVID-19, **almost 87% of respondents supported retaining the new telehealth items**.
- 12.5%of respondents suggested some caveats, proposing some restrictions on use of these items and these typically took the form of either limiting the number of phone consultations that could be used or requiring that initial consultations cannot be undertaken through phone.
- When asked to suggest measures to improve the adoption of telehealth, the most popular responses (24%) comprised proposals to either increase ICT support for health services and clinicians including through training or the establishment of one videoconferencing platform for all health services and clinicians. The second most popular set of specific proposals was to provide ICT support for patients including education.
- Our members were also invited to suggest ideas for evaluating the clinical outcomes of use of the new telehealth items. The most popular set of proposals were to use patient satisfaction/patient surveys (28.5%) followed by measures of readmissions/Unplanned admissions/presentations (15.8%) and clinical outcome and treatment adherence measures (15%).

Recommendations

- Telehealth should be seen as part of the foundation of future health reforms to improve the accessibility and quality of healthcare to Australians.
    - In particular, given that a significant cohort of patients treated by specialist and consultant physicians are those with chronic and complex care needs, the increased accessibility to physician care and reduced failure to attend rates promoted by telehealth suggests there are long term returns from retaining the new telehealth items in terms of measures such as reducing avoidable hospital admissions and increasing treatment adherence.
- It is therefore recommended that the new telehealth items be retained beyond September 2020, at least for long enough to undertake a more considered evaluation of its impacts using the measures that have been suggested by our survey respondents, such as measures of readmissions and hospital presentations and various measures of clinical outcomes.
- We recognise as do many of our members in the survey responses that in the absence of face to face consultations, videoconferencing is a more appropriate means of assessing new patients in initial consultations than telephone consultations. However an important limiting factor in wider adoption of videoconferencing based telehealth is on the patient side as many patient cohorts including the elderly, those living in regional and remote areas and the disadvantaged lack the required familiarity with videoconferencing as well as reliable Internet connections and other technology. We therefore recommend that to ensure equitable access to telehealth the Government consider additional funding for videoconferencing technology packages for selected households. Such packages could include support for purchasing devices, initial setup and training, data packages and could be made contingent on some form of enrolment with a GP practice or to be under a treatment plan.
- It is recommended that a small working group of clinicians and consumers be established to evaluate the outcomes of extending the new telehealth items beyond September 2020 and outcomes of other measures to increase equitable access to videoconferencing-based telehealth. This group would also consider refinements to the new telehealth items to reduce inappropriate use e.g. amendments to ensure best practice assessment of patients for initial consultations through videoconferencing if possible and formulation of guidelines of when it is most appropriate to use telephone based consultations.
- The RACP welcomes further involvement and consultation on the above matters.

1 Introduction and respondent demographics

On 18 May 2020 the Royal Australasian College of Physicians (RACP) distributed a voluntary survey to all its practicing Australian based members on their use of the new MBS telehealth attendance items introduced for COVID-19. Members had until close of business 25 May 2020 to complete the survey. There were 950 responses to this survey and the completion rate was 77%.

The survey contained 41 questions[1] covering the following themes:

- Respondent demographics
- Use of the new telehealth items
- Quality and access
- Clinical outcomes
- Barriers
- After COVID-19
- Technology

This document reports on some of the results of this survey, covering some key results from each of these themes. This includes both some key quantitative results as well as results of the analysis of some written comments received.

Note that due to rounding, numbers may not add up to 100% for the quantitative results. Also, when reporting on the qualitative responses (i.e. written comments), percentages have been given where responses could be grouped into categories. These will also not total 100% because some statements contained several different points that were separated out.

Table 1: Location of respondents by State/Territory

State/Territory	% of respondents
NSW	34.3%
Victoria	34.7%
Queensland	14.1%
WA	5.9%
SA	7.3%
Tasmania	1.3%
ACT	2.1%
NT	0.4%

Table 2: Location of respondents' practice by remoteness

Remoteness	% of respondents
Metropolitan	80.6%
Inner regional	10.0%
Outer regional	8.6%
Remote	0.9%
Very remote	0.0%

[1] Not counting one question allowing respondents to leave their contact details if they wished.

Table 3: Qualifications of respondents

Remoteness	% of respondents
FRACP[2] (adult medicine)	70.6%
FRACP (paediatrics)	22.1%
FAChAM[3]	0.7%
FAChPM[4]	1.9%
FAChSHM[5]	1.0%
FAFPHM[6]	1.0%
FAFOEM[7]	1.7%
FAFRM[8]	2.9%
Other (please specify)	8.2%

Table 4: Repondents' work arrangements

Work arrangements	% of respondents
Full time private practice	17.3%
Full time hospital (public)	20.8%
Full time hospital (private)	0.6%
Part time private practice	46.0%
Part time hospital (public)	47.4%
Part time hospital (private)	14.2%
Other	6.8%

[2] Fellow of Royal Australasian College of Physicians
[3] Fellow of Australasian Chapter of Addiction Medicine
[4] Fellow of Australasian Chapter of Palliative Medicine
[5] Fellow of Australasian Chapter of Sexual Health Medicine
[6] Fellow of Australasian Faculty of Public Health Medicine
[7] Fellow of Australasian Faculty of Occupational and Environmental Medicine
[8] Fellow of Australasian Faculty of Rehabilitation Medicine

2 Use of the new telehealth items

More than 90% of respondents had used telephone consults, almost two thirds had used videoconferencing consults.

A significant majority (85%) of respondents had used the initial and subsequent consultant physician videoconferencing (VC) items, and more than 38% had used the VC equivalents of the complex patient management plans (see below)

Table 5: Use of new videoconference attendance items

MBS Item Numbers	% of respondents
A) 91822 and/or 91823 (specialist initial and subsequent attendances through videoconferencing)	22.9%
B) 91824 and/or 91825 (consultant physician, initial and subsequent attendances through videoconferencing)	85.4%
C) 91826 (consultant physician minor attendance through videoconferencing)	13.8%
D) 92422 and/or 92423 (consultant physician treatment and management plan, initial and review through videoconferencing)	38.7%
E) 92141 (Specialist or consultant physician early intervention services for children with autism, pervasive developmental disorder or disability through videoconferencing)	1.8%
F) 92140 (Paediatrics early intervention services for children with autism, pervasive developmental disorder or disability through videoconferencing)	4.2%
G) 92163 and/or 92173 (Paediatrician, eating disorder treatment and management plan, preparation and review through videoconferencing)	1.4%
H) 92623 and/or 92624 (Geriatric Medicine management plan, develop and review through videoconferencing)	3.4%
I) 92513, 92514, 92515, 92516 (Public health physician attendances , Level A to D through videoconferencing)	0.8%

A significant majority (87%) of respondents had used the initial and subsequent consultant physician telephone items, and more than 28% had used the telephone equivalents of the complex patient management plans (see below).

Table 6: Use of new telephone attendance items

MBS Item Numbers	% of respondents
J) 91832 and/or 91833 (specialist initial and subsequent attendances through telephone)	20.8%
K) 91834 and/or 91835 (consultant physician, initial and subsequent attendances through telephone)	86.9%
L) 91836 (consultant physician minor attendance through telephone)	18.9%

M) 92431 and/or 92432 (consultant physician treatment and management plan, initial and review through telephone)	28.4%
N) 92144 (Specialist or consultant physician early intervention services for children with autism, pervasive developmental disorder or disability through telephone)	0.4%
O) 92143 (Paediatrics early intervention services for children with autism, pervasive developmental disorder or disability through telephone)	2.2%
P) 92167 and/or 92179 (Paediatrician, eating disorder treatment and management plan, preparation and review through telephone)	0.3%
Q) 92628 and/or 92629 (Geriatric Medicine management plan, develop and review through telephone)	2.5%
R) 92521, 92522, 92523, 92524 (Public health physician attendances , Level A to D through videoconferencing)	0.6%

For the largest share of respondents (27%) more than 80% of their practice now consists of these new telehealth items. For the majority (58%), more than 50% of their practice consists of these new items. On average, 30% of the new telehealth items billed are for VC and 70% for phone attendances.[9]

For the average respondent, when delivering telehealth services, 92% of patients are at home, 3% are in aged care facilities and 5% are in other settings such as Aboriginal Medical Services, hospital and GP practices. [10]

Reasons for use of the new telehealth items were varied[11]:

- 32% used the telehealth items because of concern about risk of exposure to COVID 19 for themselves, staff and household contacts;
- 52% because of concern about risk of exposure or vulnerability (because of age or chronic disease) to COVID 19 for patient or carer;
- 2% because the patient or carer was suspected or confirmed as having COVID-19, including recent contact or possible exposure and
- 13% because of travel time and access difficulties not directly related to COVID 19.

When asked to provide written comments on the relative differences between the videoconferencing and telephone attendance items, the largest share of comments (49.2%) expressed a preference for videoconferencing (with or without reasons and sometimes subject to caveats). By contrast the percentage of respondents who could be said to lukewarmly to strongly prefer TC was 23.5%.

The most popular specific responses could be grouped into the following categories

- Videoconference (VC) better for patient assessment (19.3%)
- VC preferred for new patients/paediatric patients/subject to caveats/no reasons given (15%)
- Teleconference (TC) more convenient/preferred by patients (14.7%)
- VC better for establishing rapport (13.7%)
- VC subject to more technical problems (6.2%)

Other responses were both have their problems, both have their roles, VC better for sharing documents, TC is adequate, TC less valued by patients and VC is marginally better but may not be worth the trouble.

[9] This figure was calculated using the raw data from the survey – and all responses that did not add up to 100% had to be omitted to obtain a meaningful breakdown.
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Some direct quotes from our members are presented below.

Videoconference (VC) better for patient assessment
Video if the patient can manage is preferable allowing better communication and some examination

telephone removes all physical examination (including general inspection), facial cues possible with VC but not telephone when trying to gauge understanding/acceptance of treatment plan etc.

Video facilitates at least some physical examination and potentially enables additional non-verbal cues to be detected, but is often limited by latency in the audiovisual stream and/or technical issues

Video is preferred in order to do cognitive and physical examinations in geriatric practice. Telephone is not quite as valuable but can be used for other assessments.

Video-Conferencing allows me to visualise the patient hence in some scenarios, may aid better physician judgement of patient's condition. And patient management. Particularly useful in NESB patients Doctor may notice physical changes or symptoms that patient may have not mentioned

Video allows you to visualise the patient which is needed in geriatric medicine

VC preferred for new patients/paediatric patients/subject to caveats/no reasons given
Video conference is undoubtably better, particularly for new patients or patients who are not stable. Phone attendances are adequate for stable patients or for patients who have a few queries in between their longer appointments (the 91836 has been an excellent addition for these types of appointments). The phone item number has been essential for patients that do not have access to video on their phone/computer or who do not know how to operate their video.

Paediatric patients - telehealth I can visually see the patient whereas telephone appointments I often have no interaction with the child (patient) at all

increased communication with telehealth especially with new patients, more patient engagement on telehealth

Video essential for new patients. Video better -- for seeing facial expressions/ body language, and inspection of limbs/ROM. Telephone more convenient for long term well known patients, with relatively simple problems.

Videoconference can talk to child and family at same time .. Can see symptoms if applicable

Video best for new or unfamiliar patients, good to get a view of patient. Better for building rapport. I think had to see anew patient just by telephone. Video not really necessary for old patients you know well, telephone works fine. Actually able to schedule review and be reimbursed for telephone consultations.

Teleconference (TC) more convenient/preferred by patients
Patients prefer telephone. Video is limited by patient IT knowledge

My patients are often blind deaf and cognitively impaired. Video conferencing is a very challenging task to do Many elderly patients found it difficult to use videoconferencing. There was a lot of confusion about what platforms were secure. Many patients preferred phone consults

Phone is easier to set up and for patients to manage

Most of my patients are happiest with telephone reviews, and many lack access to the technology to facilitate video-conferencing. I have not found the addition of video particularly helpful in my consultations.

Prefer video but many patients do not have access or are poorly IT literate. I found this surprising but the elderly find the technology difficult

VC better for establishing rapport
I find video-conferences much more useful to establish a better rapport, during history taking and answering questions. Essential for the initial consultation

Video gives a better experience both in establishing rapport and in being able to pick up non verbal cues do a superficial examination but many patients find the technology daunting.

I think video is the better option - allowing me to see the patient both for clinical assessment and to facilitate communication

Video conferencing is vastly superior- for the body language content for both physician and patient and their relatives, for the screen share capabilities enabling a usual consultative experience (I can show the patient and their family their previous results in my practice software on my screen with screen sharing). Those with mild-moderate hearing impairment are helped by the ability to concentrate on the screen and earphones.

Telephone attendance is a poor relative here for me as e.g. I can't see the patient and therefore when our type out my patient instruction the patient cannot see them instantly. I only use the telephone when there are technical difficulties at the patient end.

Telephone much harder to build rapport, unable to even obtain general observation about appearance etc which is important in geriatrics. Telephone frequently not answered despite multiple attempts at ringing, better attendance rate with videoconferencing as patients often have assistance from family. Unable to do comprehensive cognitive assessment or give definitive dementia diagnosis over the phone as only able to complete limited assessment, can do a proper MOCA via videoconference. Only able to do a screening call for cognition via phone and then still need to see patient face to face to do further assessments and make a diagnosis

3 Quality and access

Almost 75% of respondents thought that the availability of these telehealth attendance items has contributed to improved accessibility of healthcare and almost 70% thought that patients were generally more likely to keep their telehealth appointments than face to face appointments.

When asked to provide written comments on the advantages and disadvantages of the new telehealth items, almost half (47%) saw both advantages and disadvantages in having telehealth available. A further 30% saw advantages while 16% nominated primarily disadvantages.

Among the advantages perceived:

- 51.5% respondents cited convenience (e.g. cost, parking, reduced childcare etc)
- 10.2 % cited ease of access, improves timeliness
- 8.6% cited safety

Among the disadvantages perceived:

- 8% cited concern about ability to interact, especially regarding children or do cognitive assessments
- 35.2% cited inability to do physical/clinical assessments
- 7.6% cited poor patient technology skills or connection issues
- 7.8% cited time required to prepare for appointments and handle lab requests, prescriptions and correspondence afterwards.
- 10% explicitly said reduced quality of care or risk
- 1.8% commented on reduced income

Our members were asked to relay any feedback they had received from their members about telehealth items. Responses received[12] could be divided into three broad categories.

- 81.6% of respondents noted feedback that was 'Strongly positive for at least a majority'
- 14.3% noted feedback that was mixed/ambiguous
- 4.1% noted feedback that was mostly negative

Some direct quotes from our members are presented below.

Strongly positive for at least a majority of patients
Patients have been very grateful for the service. They have been understanding of technological glitches. They are overjoyed with how convenient it is.

Very grateful for not having to come to rooms for simple things (the elderly but also those who work full time and those with children), more rapid feedback of results

Extremely positive and want to continue long term

Patients are requesting whether it can be continued as many parents are extremely busy and attending clinic requires more time out of work.

Loved the opportunity to teleconference and wish it was a permanent arrangement

very positive, mostly related to ease of use and able to have their follow-up and not leaving their house

Mixed/ambiguous
Delighted with the convenience and the avoidance of risk. Not very pleasant for those with hearing impairment. Significant difficulty in dealing with the (quite straightforward) technology.

Elderly people felt safer, but would not want to only have a Telehealth option.

[12] After excluding comments that did not directly respond to the question or were blank or marked as N/A.

Quality can be a bit variable depending on internet connection at patients' end. Most patients grateful to have the option during this high-risk period given my practice is in malignant Haematology and most patients have some degree of immunocompromise; but also express that they prefer face-to-face if feasible.

Most patients prefer alternating between T/H and face to face consults

They like the convenience of telehealth. Some issues they prefer to attend in person.

Mostly negative
Problems with negotiating technology, lack of equipment or knowledge, inefficiencies of Telehealth platforms, security concerns, visual/hearing difficulties, NESB and problems with interpreter access/comprehension, dementia

Older patients more anxious initially whilst learning to use Telehealth

Several patients have noted that they have felt more isolated and overwhelmed and have missed the non-verbal communication and sense of care they get when they are in the presence of a physician. The human caring interaction.

When asked to provide written comments about limitations of telehealth:

- 7% of respondents said there were no limitations
- 93% said there are **limitations, such as:**
    - 58% Not able to do clinical, physical examinations, certain tests, weighing, BP (unreliable home equipment)
    - 12.5% Hard to assess state of well-being, those unwell or risk missing subtleties, non-verbal communications, or cognitive assessments, including establishing a patient rapport (or children). Medication changes
    - 9.2% Cannot use telehealth for new patients
    - Not effective for hearing impaired, language issues, where there are connectivity problems or lack of IT proficiency, assessing children, changing medications or where there are new symptoms.
    - Some sensitive discussions need to be done face to face.

Findings on vulnerable groups (disadvantaged backgrounds, Indigenous people and patients with chronic complex conditions)

We looked specifically at physician experience of telehealth and people with

1) Disadvantaged backgrounds
2) Indigenous people
3) Patients with chronic complex conditions

When asked if they thought the introduction of the new telehealth attendance items enabled greater access to specialist care by people from disadvantaged backgrounds

- 23.5% of physician respondents thought telehealth offered no greater access
- 39.2% did not know
- 36.7% thought telehealth enabled great access to specialist care

Direct quotes from our members on this question supportive of the proposition that telehealth has increased access:
I have had almost 100% attendance in my complex care clinic (hospital avoidance) = all low socioeconomic and poor health literacy patients

Gives patients in ICUs without intensivists present access to intensivist assistance for those not in the metro area, we can now access them at their location. Previously required long commutes re-imbursed to the patients via PATS. But those who are very disadvantaged and have no computer- the telephone is a poor alternative.

I have one patient who had not attended for several appointments pre-COVID because she didn't have access to transport on my clinic day. I have seen her 3 times since starting telehealth. Many similar stories around transport, costs of coming to clinic.

It allows for more frequent and shorter consults, which has allowed reduced fees for consults. It has reduced the associated cost of travel, parking, and time off work. It also allows access to appointment slots in the middle of the day, or before school pickup, which otherwise would be impracticable due to travel time.

The intellectually disabled who need careers to bring them along, who may live at distance etc are more easily seen, those with physical disability find it far easier too be seen in their own homes via video.

Easier, more convenient for patients with disabilities and I bulk bill all HCC holders.

Elderly love it as they don't have to leave their house

It means my country patients, and immune-suppressed patients, have bene able to continue access to expert health care despite isolation requirements due to the pandemic. Also have some country patients with complex disease who I see regularly via telehealth who would otherwise just not get care as they cannot afford a trip to Sydney all the time.

I'm seeing a lot of people who were on public waitlists as they couldn't afford private fees before

Many first peoples not happy for telehealth or phone calls

I have a number of disadvantaged families whom I have been able to keep in contact with, due to telehealth, which has meant they did not need to visit my rooms physically but I could still provide care. This was the group where I usually have the majority of my failure to attends, yet I have not had a single failed appointment with Telehealth.

Absolutely. Single parents who have casual employment can have consults on meal breaks and not lose precious income. Elderly, housebound patients can get regular appointments without the cost & hassle of arranging transport. Rural patients can get the same care as their city counterparts - it's been a big deal to find it easier for them to see other specialists quickly via telehealth rather than waiting 6 months to be seen face to face near their homes.

I am seeing more rural and remote patients under usual telehealth codes due to increased familiarity with telehealth practice.

some indigenous patients are better supported by attendance of carers

Direct quotes from our members on reasons why telehealth may not have enabled increased access to care for some people:
People from disadvantaged backgrounds are the ones who would benefit more from face-to-face because they are not usually health literate and technically savvy. Difficult to manage over the phone and prone to medication errors due to lack of understanding of their health issues.

Maybe for other disciplines outside palliative care. The only staff in palliative care who have been able to do telehealth to increased advantage in visits would be our Counsellors.

When asked if they thought the introduction of the new telehealth attendance items enabled greater access to specialist care by people with chronic and complex diseases:

- 21.7% of respondents did not think telehealth offered increased access for these patients
- 30.6% did not know
- 47.5% thought it increased access

Direct quotes from our members on this question supportive of the proposition that telehealth has increased access:
100% attendance rate compared to 60% attendance when only face to face

elderly with multiple medical problems, poor mobility and institutionalised patients

It makes it a lot easier for chronic and complex patients to attend multiple appointments.

There is an ability for patients who are well known to clinicians to have intermittent face to face and telehealth consultations depending on the current issue and clinical need. This substantially reduces the time and cost of appointments for patients and carers when provided via telehealth, with the option to attend at any time if a clinical examination is required.

increase their compliance with treatment

Parents who have multiple children, multiple children with developmental/behavioural concerns, or children with particularly challenging behavioural issues. Parents who don't have their own transport, or who have their own health concerns.

Patients with chronic and complex conditions are often frustrated by the number of clinics they attend and are grateful much can be achieved with telephone support

More regular appointments are required to optimise management of chronic and complex conditions. Patients with these conditions often have trouble with organising themselves to attend face to face appointments and often miss appointments.

I am better able to monitor my patients regularly due to the new item numbers. I would often space out appointments with some patients, being conscious of the cost to them of attending. Now, I see/speak to them as often as they need my advice. Our rheumatology patients call a lot to ask for advice and I was often spending a few hours a day returning phone calls and giving advice, with no Medicare reimbursement. The 91836 item number has been excellent for this now.

Enabled quicker follow-up of new problems in well known long-term patients.

It has forced us as a profession and a system to consider these methodologies as viable options (though there is room for improvement in how care is delivered)

Patients from rural/remote locations able to access high quality specialised care without travel.
children with disabilities have greater difficulties travelling to the hospital. Treatment in their own home is far kinder to them and their families. It reduces transit times and increases times for other cares.

When asked if they thought the introduction of the new telehealth attendance items enabled greater access to specialist care by Indigenous people

- 16.8% of respondents did not consider telehealth offered greater access for Indigenous patients
- 72.1% did not know
- 10.8% thought it increased access

4 Clinical outcomes

Our members were asked to provide suggestions on how to evaluate health outcomes from the use of the new telehealth items. The most popular responses fell into the following categories

- Patient satisfaction/patient surveys (28.5%)
- Readmissions/Unplanned admissions/presentations (15.8%)
- Clinical outcome and treatment adherence measures (15%)
- Provider satisfaction surveys (9.6%)
- Cost savings, health economic analyses (6.6%)

Other proposals include Randomised Controlled Trials and controlled studies (which overlap with some of the above but only differ with respect to specificity of methodology), measuring access indicators, failure to attend rates and patterns of early diagnosis and surveillance testing.

Some direct quotes from our members are presented below.

Patient satisfaction/patient surveys
Direct feedback from patients.

Patient satisfaction scores, likelihood of admission to hospital compared to comparable cohort from a year earlier.

Assess well being of patients every 3 months

Patient experience questionnaires

Assess patient satisfaction. For diabetic patients, test their self care ability

Readmissions/Unplanned admissions/presentations
increased emergency presentations/admissions

Deemed to be successful if decreasing the number and regularity of hospital admissions that otherwise occurred in the past. Look at patient and family satisfaction.

For geriatric medicine monitor presentations that could have been avoided through better CGA in person e.g. falls, fractures, emergent need for nursing home placement from hospital

Medicare health utilisation, emergency department attendances and hospital admission data should provide insight. A comparison of 12months pre-COVID data and a 12-month period after COVID restrictions are lifted may prove valuable.

Clinical outcome and treatment adherence measures

Clinical outcome and treatment adherence measures
For diabetes - HbA1c, hospital admissions, hypoglycaemia, Young T1DM - hospital presentations, DKA

Reduced hospital admissions, patient satisfaction, patient attendance rates. Hba1C for diabetic patients, Reduction in hospital admissions, compliance with medications

Look at objective health indications e.g. Hba1c, unplanned admissions, time from referral to diagnosis for cancer etc.

Provider satisfaction surveys
Make post conference call survey from various practices. Involve some of the at risk doctors or nurses to do the questions

By a repeat survey of Drs opinions as to what is being used and is useful and what is not

You are free to survey my patients and the GPs who referred to me . I am trying to set up in electronic health record system that simultaneously collects registry data so we can systematically measure outcomes in

relation to different diagnoses. If this was in place it would be easy to measure the impact of usual care, with or without the Covid 19 influence. If you can help please let me know.

Survey specialists to see if they will continue offering telehealth without incentives (technical issues can make telehealth more burdensome for the clinician)

Cost savings, health economic analyses
health economics evaluation considering family costs, patient satisfaction data, impact on hospital admissions, monitoring adherence to screening protocols, attendance for chronic disease surveillance
difficult to measure except re effect on other health cost, readmission rate and ED presentations

Compare to reduction in other item numbers, compare total costs/savings

It would be good to evaluate the overall cost of care - because some patients initially evaluated by telehealth will go on to need an in-clinic assessment anyway.

When asked if the introduction of the new telehealth attendance items led to better outcomes for patients:

- 18.3% said no
- 40.1% did not know
- 40.8% said yes.

The main reason provided in written comments for why they led to better outcomes is that they increased the attendance of patients who otherwise would have cancelled on or missed their appointments.

When asked if the introduction of the new telehealth attendance items led to **worse** outcomes for patients:

- 43.8% said no
- 42.8% did not know
- 12.7% said yes.

5 Barriers

When asked about challenges associated with implementing telehealth

- 11.9% said there were none or minimal challenges
- 46.2% nominated administration (such as significantly more phone calls, postage, pathology, scripts, informed consent, getting payment and billing processes. *This may mean the doctor doing administration*
- 19.5% nominated IT, software, hardware (having to purchase, wait for to arrive, have issues with)
- 17.65% said that patients have difficulty with equipment/ method or prove unreliable keeping appointments, not picking up calls, limited patient understanding of telehealth or patients cannot email information in
- 10.7% nominated Internet connectivity

53% thought that additional costs have been incurred by their clinical practice since they started using these new attendance items. Two thirds of respondents who provide written comments elaborating on this again cited the costs (including time) associated with increased administration as the source of additional costs.

More than 50% did not think there were any additional savings whether in terms of time or resources because of the use of these new attendance items, though more than 30% did. The most popular reason cited for savings among those respondents who also provided a written response was savings in time, due to reductions in travel time and being able to work from home.

6 After COVID-19

When asked whether they supported **retaining** the new telehealth items in the MBS on an ongoing basis post COVID-19, almost 87% of respondents supported retaining the new telehealth items. Among those who provided additional written comments explaining their answer, almost 50% cited general benefits to all patients (in terms of increased convenience and accessibility to services) and did not propose any additional restrictions on use of these items even if COVID-19 were eradicated and 21% highlighted benefits for particular patient groups or in particular circumstances though without proposing additional restrictions on use of these items post COVID-19. Of the written comments, 12.5% saw the need for some restrictions. Some typical restrictions proposed were to either limit the number of phone consultations that could be used or require that initial consultations cannot be undertaken through phone.

Some direct quotes from our members are presented below.

Cited the benefits of these items and expressed general support without proposing additional restrictions

These item numbers are so much more convenient for patients. I would suggest that many reviews can be done via telehealth. Allows easier access to both parents

I have long wanted to be able to do some of my consultations by TeleHealth. May reduce need to be in multiple locations/overheads. Potential great saving of time/money for patients. carers and caring relatives with regards to time off work, travel costs/time, parking. Should reduce spread of other viral illnesses/coughs/colds etc

Would seem such a retrograde step to move away from telehealth. Forcing people to need to attend in person, in Sydney with transport issues & job security issues seems pointless. Telehealth should be used in combination with face-to-face in clinic consultation

I am city based, I do clinics in a regional centre 2x/monthly, and patients have been travelling long distances to see me. Telehealth is to everyone's advantage

Most of my reviews depend on history over physical examination. Telehealth review is often adequate and more efficient. COVID-19 might never quite end and is likely to be a threat for a while at least for my population of vulnerable patients. Many patients would prefer not to need to come in all of the time. It would allow for some patients to have a series of more frequent reviews for the short term easily.

Very much so. Hospital parking costs are extremely high and public transport access limited in some areas.

the 15km cut-off is madness

I strongly support retaining the codes as Endocrinology/Diabetes lends itself well to Telehealth. The patients like it as it is convenient and saves travel time. The specialists like it as it offers flexibility that the traditional sessional model face to face consultations do not"

Australia has a unique opportunity to make this a standard way of conducting clinics
Telehealth is absolutely appropriate for some patients. As long as there is a rapid mechanism for face to face review if clinically warranted the items should be retained.

Highlighted benefits for particular patient groups or in particular circumstances though without proposing additional restrictions

To allow those patients who really struggle to get to the rooms / clinics due to advanced age / physical disability / need for carer accompanied travel to still have a consultation with some medicare support rather than paying the whole consultation cost.

My patients have chronic heart failure and multi-system dysfunction, have mobility issues as they are elderly and some of them live in remote areas making it at times hard to arrange for transportation to visit health facilities.

The benefit to a select group of patients - older, mobility restricted, distance to travel seems clear - especially in the follow up/chronic condition situation

They would be very useful in certain circumstances eg vulnerable patients, those with mobility or behavioural issues, those from regional/remote areas

Proposed some restrictions post COVID-19
But item numbers need to be reviewed. Ideally initial consultation should be face to face and telehealth can be on follow up if safe and applicable

Yes these items should remain available although the emphasis should be on telehealth rather than phone consultations

These item numbers could be retained as a less desirable alternative to traditional item numbers but only as a last resort when the benefit to the patient clearly outweighs the downside.

Nothing can substitute for a face to face interaction, particularly when physical examination forms a critical part of patient assessment. However, Telehealth certainly has a role in the management of rural and remote patients, patients with reduced mobility, and patients in supported care environments. While these calls should not completely replace physical review, they are able to supplement face to face interactions, and can be used to triage the need for early review.

I would prefer the video-conferencing to be maintained, not sure about telephone. The video is easier than patients think it is

Limited to 2/ year or 1 x mandated face to face per year

But in specific circumstances and I believe that they should be bulk-billed only. Great system for providing results to patients, screen-sharing and ability to have private consultations with parents without their children being present (and potentially upset by hearing their parents talk about them in a negative manner). Also makes economic sense if parents can simply take 30 mins off work rather than claiming a whole day of carer's leave.

Need some criteria e.g. ADHD patients could be seen annually face to face with a Telehealth review at the 6 month mark.

only for short consultations after initial visit in suitable patients

Video should be at least 50% more $ amount that telephone (ie. like the rural telehealth item number 112) as video is far superior.

When asked whether they supported **removing any of** the new telehealth items in the MBS post COVID-19, more than 52% did not think any of the new items should be removed, and less than 8% did. Interestingly, among those who responded to the question of whether some items should be removed with additional written comments, the largest share of these written comments (37.5%) also proposed the removal of initial consultation items, 132/133 equivalents and/or phone consultations.

Some direct quotes from our members are presented below.

Removal of initial consultation items, 132/133 equivalents and/or phone consultations
Initial consultation items, as impossible to evaluate new musculoskeltal patients without examining them.

I think a first appointment should be face-to-face. Subsequents can be TH. Perhaps this can still be an option, but I think the remuneration needs to reflect the absence of an adequate physical examination in an initial assessment and be rebated less than the 132/110 equivalent

Personally I don't think a 132 equivalent is realistic via telehealth

I doubt the appropriate use of Item 135 by Telehealth... I do a formal autism assessment when diagnosing ASD, needs to be F2F. Other clinicians perhaps rely on reports from others, but would still need to observe the child in their rooms before being comfortable to diagnose ASD.

Remove all new patient phone attendance. I would be happy retaining short follow up phone and follow up non complex phone e.g. 116 133 should really be video as too much missed communication both directions by phone

I have concern around telephone items for complex consultations

I'm not sure that phone calls really count as a full assessment

Abolish all the new telehealth items
I believe a consultant physician cannot evaluate a patient without seeing them face to face. The clinical examination is important as there are often unexpected findings in areas unrelated to the original referral.
If after COVID, these telehealth items remain, I would very much fear the eruption of "convenience" medicine vs comprehensive assessment.

My outrage on these telehealth provision came exactly from this concern. It may be all good now to play the "good cop" by providing such services using "COVID19" as the reason. But when the crisis is over, I doubt the authority will remove this - it has political advantage at the expense of clinicians' income!

Survey respondents were also invited to nominate other MBS items that should be allocated telehealth attendance numbers. The two most popular responses fell into the following categories:

- Case conferencing/Multidisciplinary team (MDT) meetings (37%)
- Review of tests and results/short consults (16.8%)

In addition to these broad categories, specific item numbers mentioned as meriting telehealth equivalents were

- The ones for family therapy (170, 171, 172)
- Additional geriatric medicine items (145, 147)
- Occupational and Environmental Medicine specific items (385, 386).

Other responses included compensation for time spent on patient emails and other paperwork, higher remuneration for the new items.

Some direct quotes from our members are presented below.

Case conferencing/Multidisciplinary team meetings
liaison with allied health or education in regard to a patient being seen would be extremely valuable.

case conference between paed and Psychologist or paed / teachers i.e. remove the requirement for min 3 people. I spend HOURs talking to Psychologists and teachers .

I strongly advocate for new MBS items for multidisciplinary meeting with or without child/family. e.g. video conference with child's allied team members, school/educators, other sub-specialists.

Phone consults with ward nurses. Speaking with ward patients via phone Speaking with families via phone - often takes up considerable time and almost creates a second patient to manage.

Review of tests and results/short consults
Review of ECG monitoring,

glucose monitoring results and insulin pump downloads

Pacemaker remote items should be reviewed if remote check done in conjunction with consult.

Titration of blood sugars - during pregnancy, when new therapy commenced

Proposals for more flexible use of MDT meetings and case conferencing through telehealth again also dominated when members were asked to raise other issues not already covered in the questions so far. 46.3% of respondents raised proposals that revolved around this theme.

Some direct quotes from our members are presented below.
A zoom meeting between a number of specialists or a single specialist to discuss a complex patient could be funded by Medicare. May avoid multiple attendances to different specialists by the patient.

Could be useful for patients who are requiring a second opinion for very complex issues. Also could be used like a multidisciplinary conference between specialists when more than one specialist is required to instigate treatment. E.g. medical oncologist, radiation onc and surgeon all giving an opinion on the patient at the same time.

Everyone being informed concurrently. Less confusing for patient and much less running around when patient is probably exhausted emotionally and physically.

Telehealth multidisciplinary item numbers to support multi discipline allied health synchronous consultations. It is not patient centred care for allied health referrals to require a GP referral for reimbursement

I'd love an item number for a video call between myself, a diabetes educator & a patient. This is a common scenario that would really be helpful.

Interstate consultations with specialists not available in your own state. Use for conferences etc.

TH to support specialists to provide secondary consults eg paediatricians to GPs, psychiatrists to pediatricians and GPs etc

7 Technological issues

Zoom (40%), Skype (35%) and Healthdirect (26%) were the most popular videoconferencing platforms used by respondents **(some have more than one).**

Table 7: Use of videoconferencing platforms

Platform	% of respondents
Facetime	22.9%
Skype	34.6%
Zoom	40.1%
Healthdirect	26.1%
Other (please specify)	46.6%

Other platforms mentioned in written comments included Doxy, Pexip and COVIU.

More than 57% of respondents said they experienced initial technical difficulties in using telehealth.

Genie was the most popular practice management software used by respondents (26%) though 26% had none (see below)

Table 8: Use of practice management software

Platform	% of respondents
Genie	25.9%
Best Practice	4.2%
Medical Director	9.7%
None	25.7%
Other (please specify)	34.50%

Other software mentioned included Audit 4, ZedMed and Clinic2Cloud.

Our members were invited in the survey to submit written comments on proposals which might increase the rate of telehealth adoption. After omitting answers that did not directly respond to the question or were blank or marked as N/A, the most popular responses fell into the following categories

- ICT support including training (15.1%)
- ICT support for patients including education (8.9%)
- One platform for all health services (8.9%)
- Guidelines (7.6%)
- Adequate remuneration/incentives (7.6%)

Other proposals included addressing privacy and security concerns, better electronic prescribing/ordering, better comm infrastructure in general including improving the NBN, continuing item numbers and less bureaucracy.

Some direct quotes from our members are presented below.

ICT support including training

Technically trained staffs to help patient and clinics

ICT support for patients including education

The problem is in the patients' side. I don't know what you can do to help them to do videoconferencing.

Central support Service which provided IT assistance for patients in setting video conferencing.

Mainly from the patient's perspective. A significant proportion of my elderly patients don't have access to computers / internet data (many unable to do VC on phone as they only have phone plan with limited data)

Easier platform/setup for patient home use.

I have everything I need. Patients sometimes don't have suitable hardware or broadband for video.

One platform for all health services
centralised video consult portal through Medicare.

If there was a dedicated, recommended videoconference platform we could use.
Government approved video call services for provision of these items will reduce the risk of litigation and privacy complaints in future.

Telehealth platform linked to medical record and billing software

A platform that is made available to doctors/health workers that is reliable and secure, instead of relying on platforms such as Facetime or Skype

Guidelines
Clear regulations about the use. Protection of privacy. Including protection of the practitioner from recording of interactions etc. And that there must be physical assessment at some point. It cannot be entirely online, unless there is a GP or other person that can perform the necessary physical examination or assessment. resources to guide which software platforms to use, consent forms for patients, etc

Recommendations about software security with respect to the various platforms. Availability of "non-attendance" Medicare items.

RACP quick reference guide with screenshots on how to use these platforms to make calls, schedule appointments, etc.

clear guidelines around when these should be used in preference to face to face when the later is an option

Adequate remuneration/incentives
There needs to be compensation for the extra administrative time that it takes to establish.

Practice nurse incentive payments, electronic PIPs like GPS receive. Payment for accessing, utilising and interacting with patients' MyHRs.

Higher rebate for Video-conference. There is little incentive to use the extra time & complexity over telephone.

MBS item number for phone consults. We do umpteen phone consults on diabetic management to adjust insulin doses. All for free. The new time based fee structure will not presently take these consults into account

Appropriate funding that means you get no less $$ than for an equivalent face to face consultation

When asked whether they faced or still faced initial technological difficulties in using telehealth, the most popular categories that the written comments provided fell into were as follows:

- general problems with speed, quality or reliability of Internet connection (18.3%)
- patients find it difficult to use or don't have right equipment (17.5%)
- health services and private practices not having the right equipment/not compatible or problems with videoconferencing platform (10.9%)

Other categorizable responses were need for interpreters and administrative support, billing related issues, no or only minor teething problems and privacy related issues.

It is worth noting that the written responses to this question identified patient related difficulties with videoconferencing as a significant factor of difficulty in using telehealth. This aligns with the findings from the

previously reported question on how to increase uptake of telehealth which also identified measures to increase accessibility on the patient side.

Some direct quotes from our members are presented below.

general problems with speed, quality or reliability of Internet connection
internet dropping out, video freezing, time delay between patient speaking and hearing their response, so we both interrupt each other.

poor NBN, congestion is worse now also. I am 1 km from the node so my internet cannot be improved from what it is now.

Internet connection quality is an ongoing issue

occasional freezing- v dependent on bandwidth at patient's home. Have had to abandon ship at times and ring

Poor internet performance. Drop outs. Getting patients connected esp. NESL/ESL patients

Poor connection for nursing home patient

patients find it difficult to use or don't have right equipment
Some patients not tech savvy and need support to guide them through it.

Many patients don't have access to FaceTime - which is the quickest option. For all others they have to have downloaded an app to access and older, less tech-savvy patients cant do this - so Phone is better option

a number of my patients could not manage it so I have elected at this time to use telephone only. Also less time-consuming to get started and patients expressed marked preference for telephone over trying telehealth.

Sometimes patients have not been able to follow instructions to connect

Low tech knowledge in patients is a real block - as simple as not knowing which link to click on at times.

Mainly related to patients' internet connections, which can be variable. Did have to complete a couple of Telehealth consults by phone because of poor connection.

Older patients don't have mobile phones/computers. Can't work tech

health services and private practices not having the right equipment/not compatible or problems with videoconferencing platform

Microsoft teams does not work with some email servers e.g. University of Sydney email addresses.

Health direct is clunky. It would have been very very useful for RACP to have provided more support on the platform used as then issues could be sorted quickly. FaceTime works best when patients have iPhone

Difficulty with Skype found phone consults just as easy and less distracting

The Amazon Chime platform via Genie has had some connection problems

Still waiting for webcams at one workplace