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Telehealth, Digital Access, Innovative Remote Strategy Solutions and Service Development

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Synapse
Global Medical Administration

Medicare Benefits Schedule telehealth changes have reduced access to health services for Rural, Regional and Remote people.

Medicare Benefits Schedule (MBS) changes came into effect on 1st July, 2022 with further changes already legislated but not implemented (someone just needs to press the "go button!"). The new Medicare items essentially are discriminatory against some cohorts of health care consumers and clinicians in the sense they are excluding these people from doing telehealth. Rural, regional, remote (RRR), digitally excluded health care consumers and those health care consumers who prefer to access services via phone will no longer be able to access many health services via telehealth. For some health care consumers, it reduces their choice of service - essentially forcing them to use videoconferencing against their will.

Dr Margaret Faux, CEO, Synapse Medical has completed her PhD on the MBS. She believes these changes have a negative impact on RRR Australians as well as other health care consumers. The majority of the telephone Medicare rebate-able services have been removed. A few remain, but are either for very short consultations, or are underfunded for longer consultations. There is only one GP telephone service remaining for people living in Modified Monash Model classifications 6-7 (remote and very remote locations), which must be 20 minutes or longer. This means a 6 minute phone consult for a script will not be Medicare billable.

Margaret Faux is concerned these changes are not based on clear evidence: "They say the changes are evidence based, but I have yet to see the evidence. Because from what I know, the evidence was that everybody wanted telephone services. That was the evidence and yet we seem to be doing the opposite of what the evidence says. And forcing consumers and doctors both to do the opposite of what they want." (Margaret Faux).

Changes to Medicare Telehealth Item numbers will exclude many RRR people.
Doctors will have to use videoconferencing instead of telephone for most consultations. Whilst that sounds straightforward and simple in theory, there are reasons which will make it unworkable:

1. Many RRR people (clinicians and health care consumers) have unreliable internet (St Clair and Murtagh, 2019). Our current CRCNA research project (Developing a simple, robust telehealth system for remote communities) has confirmed access to affordable, reliable and adequate internet for videoconferencing is still a major barrier to Telehealth in 2022. The legal specifications for the telehealth videoconferencing Medicare items ***require the clinician to maintain audio and visual connection with the health care consumer for the entire consult.*** This will mean, if the clinician or health care consumer drop out for even a few seconds, the doctor may be in breach of Medicare requirements and therefore be unable to claim that consultation on Medicare. This will increase out-of-pocket costs for health care consumers.

2. Some health care consumers do not want to use videoconferencing. Aboriginal people or people with mental health or other sensitive issues often do not feel comfortable with videoconferencing.

3. Many people are digitally excluded due to a lack of digital skills or access to the necessary digital tools (smart devices and internet). Many Aboriginal and elderly people fall into this category.

4. Many people are isolated, not necessarily by geography. They may have health or other logistical issues that render them isolated. These people may not have the ability or desire to do telehealth via videoconference.

Further to dot point 1: The legal requirements clearly state the clinician has to maintain continuous audio and visual contact throughout the consultation. It is likely the Professional Services Review (PSR) Agency (the Medicare watchdog) would check on connectivity outages if doing an audit.

Feedback from the Telehealth for the Bush (TH4B) Trial and findings from CRCNA funded project "Development of a simple, robust telehealth system for remote communities" has clearly indicated health care providers had issues with connectivity when consulting health care consumers.

Another consequence of these changes is that specialists or GPs may opt not to bill to Medicare for consultations and charge the health care consumer for the full cost of the consultation. The Royal Australian College of General Practitioners is currently encouraging its members to increase their charges to health care consumers. This will mean the loss of valuable public health data as the Medicare rebates are not being claimed, therefore, resulting in a loss of a primary source of data. This may have a long-term negative affect on the health system. Some clinics have already stopped bulk billing health care consumers (see NT Newspaper Article: https://www.ntnews.com.au/news/northern-territory/top-end-medical-centre-to-no-longer-bulk-bill/news-story/a0e5329b1bc823627dfa42d09e442641). Many Darwin GP practices are now charging a gap fee of approximately $40 - $60. This will result in more health care consumers presenting to emergency departments.

The benefits of Videoconferencing for telehealth over audio only.

Many clinicians (GPs in particular) were not offering health care consumers the option of telehealth consultation via videoconference and, in some cases, refused to provide a video consultation when asked to do so by the health care consumer (Digital Health for the Bush 2021 Forum). It is clear there are significant benefits doing a telehealth consultation via videoconference as it improves the two-way communication between the health care consumer and the clinician as well as providing the clinician with useful information. It allows the clinician to visually assess the health care consumer and do a number of diagnostic processes. It also improves health care consumer safety and protects the clinician by ensuring the health care consumer is correctly identified (sometimes an issue in Aboriginal communities).

It is believed the changes to the Telehealth Medicare items were intended to encourage clinicians to use videoconferencing rather than just audio. However, these changes effectively discriminate against RRR health care consumers and clinicians. Many RRR people rely on accessing a large proportion of their health services via telehealth, particularly in an emergency – it may be many hours travel to a major health centre. Ideally, videoconferencing should be one of the main tools a clinician has to meet the needs of their health care consumers, but these changes to Medicare effectively have reduced access to health services for the people most in need!

Discrimination against some cohorts of health care consumers and clinicians.
Many health care consumers and some clinicians in RRR areas may have inadequate internet to ensure fully continuous videoconferences. People living in the northern parts of Australia are frequently subject to severe storms and cyclones. These weather events render the satellite internet and many other telecommunications services inoperable until the storm passes (St Clair & Murtagh, 2020). With storm events, there are frequent incidences of damage to hardware which results in the telecommunications service being unusable until it is fixed (this may take many weeks or months to rectify and repair the service).

The changes to the Medicare Item numbers requiring continuity of video and audio streaming throughout the consultation discriminates against health care consumers and clinicians who do not have adequate internet (i.e. capacity and stability). There are also many health care consumers (eg Indigenous and elderly) who may not have the digital knowledge, smart phones or internet connectivity to use videoconferencing. There are times when health care consumers may prefer to have a phone call for accessing mental health or other culturally sensitive services and may feel more comfortable accessing services via audio or message chat service.

Minimising transmission of COVID-19.
With the increase in COVID-19 cases and the stress on the health system, increasing efficiency by using telehealth is essential. In the current pandemic, clinicians and health care consumers can reduce the risk of being contaminated with the virus by doing telehealth (when appropriate) instead of in-person consultations. This will reduce the number of health care consumers in waiting rooms and the risk of transmission from health care consumer to health care consumer, and clinic staff to/from health care consumers. In the current exponential growth of COVID-19 cases, any reduction in transmission of the virus will assist the health care system to cope with this health system crisis.

Professional Services Review (PSR).
Clinicians must meet all the requirements of the Medicare item number before they can claim payment. The policing infrastructure of Medicare, the PSR, is so punitive and brutal clinicians are fearful of being subjected to PSR processes. (There is near 100% conviction rate.) Medicare is clawing back so much money via the PSR that doctors are very fearful of being reviewed by the PSR. Doctors can be required to pay back very large sums of money from previous years (Faux, 2021). If the doctors are not confident of meeting all the requirements of the Medicare item, they will stop providing those services as it represents too much risk to them. This may result in clinicians charging the health care consumer and not bulk billing items – increasing costs to health care consumers (many who cannot afford the additional costs and therefore may not access services they need).

Requirement for GPs to see the health care consumer in person prior to being able to claim Medicare Telehealth items.
Currently, the health care consumer needs to have seen the GP or another GP from the same practice within the previous 12 months before any GP from that practice can claim Medicare Telehealth Items. Under the new legislation, when implemented, ***health care consumers will have to see the same practitioner in person three times before they can access telehealth from that practitioner!*** Essentially limiting the health care consumer's ability to access services from another provider and locking them into only being able to access services from the one GP! We recommend this requirement be immediately lifted for RRR populations,

many of whom have limited or no access to a GP. This rule, known as the '12 month rule' has been one of the greatest barriers for GPs to provide services for RRR people through telehealth. If a person cannot travel to access a GP, they are effectively excluded from accessing services through telehealth.

Voluntary Patient Registration

The recently announced *Primary Health Care 10 Year Plan* includes 'voluntary patient registration' (VPR). The practical effect of VPR for RRR people is GPs will retain their constitutional right to charge whatever fees they choose, while consumers will lose their reciprocal right to choose their GPs if they want to access telehealth.

There is nothing voluntary about being forced into having a potentially expensive telehealth consultation with your 'usual GP' for a short consultation (e.g. for a repeat prescription). The health care consumer will not be permitted to call another clinic which may do bulk billing for such services). There is no control over the fees the GP can charge and the option to change to another provider is removed.

It is recognised GPs are underfunded for the services they provide and assistance for them to remain viable in the current system is required. However, increasing consumer out-of-pocket expenses is not a sustainable solution. Many health care consumers will attend the nearest public hospital emergency departments instead of using a GP service. This movement away from GPs will further exacerbate GPs' financial situation. Additionally, many hospitals are under great pressure due to the pandemic, so this situation would place further pressure on a system that is already struggling to cope with current workloads.

The introduction of VPR may result in increased medical expenses for health care consumers and is already legislated – someone just needs to push that 'Go Button!'

Videoconferencing can improve the telehealth experience from both the health care consumer and clinician perspective: It is important that clinicians and health care consumers maximise the effectiveness and efficiency of health services provided by telehealth. Clearly videoconferencing provides an improved quality of service due to improved communication between the clinician and the health care consumer. However, the implementation of the new Medicare Telehealth Items will result in:

- Reduced access to health services for RRR health care consumers, Aboriginal people, the elderly, isolated people, the digitally excluded and people living in areas subject to severe weather events.
- Increased transmission of COVID-19 and other transmittable diseases.
- Increase costs to health care consumers for services.
- Reduce health data collection for policy and decision makers.
- Further increase mental pressure and stress on clinicians.

Can Nurse Practitioners reduce the gap in services to RRR people?

Only 500,000 people live in Australia's most remote locations, but, they have disproportionate access to health services and consequently, poorer health outcomes (National Rural Health Alliance, 2016)

There are often long waits to access services, and in many instances, people are unable to access the services they need in a timely manner. Our research also demonstrated Telehealth

can be part of the solution to this long-term problem and supplement the services currently not available in RRR areas e.g. (St Clair & Murtagh, 2021).

Through the Telehealth for the Bush (TH4B) Trial, Project Partners, Simbani Research and Synapse Medical have developed a pathway that connects doctors, specialists and nurse practitioners to health care consumers in the same way ride sharing companies connect drivers. Nurse Practitioners (NPs) are highly qualified Registered Nurses with extensive experience before doing a masters level degree. They are taught pathophysiology and how to diagnose. They also specialise in areas such as: Emergency, Aged Care, Medical, Surgical, Rural and Remote, Community, Drug and Alcohol, Women's Health, Mental Health, Paediatrics, Chronic and Complex Care, Private Practice - they are highly skilled professionals. NPs are educated and authorised to work independently, diagnosing, and treating health care consumers in collaboration with medical practitioners. NPs can provide in person (face-to-face) and telehealth consultations without a previous in person consultation through Medicare rebates, provide prescriptions and access to PBS medicines, order diagnostic tests and refer health care consumers to specialists. National standards ensure NPs provide high quality, consumer-centred health care working in similar roles as GPs.

However, NPs are not encouraged or supported to "close the divide between urban and RRR health service delivery". MBS funds are limited for NPs. GPs and Medical Colleges need to recognise the value of NPs. A GP can claim $39.75 for a 6 minute consultation (MBS Item 23). A NP will typically spend an hour with a new health care consumer. For a consultation with a GP of more than 40 minutes, the GP will receive $141.15, but a NP will only receive $52.70. Again, the MBS system needs extensive changes. "We don't need to increase funding to Medicare, we just need to be more efficient and effective in the way we spend Medicare funds! The system is broken, but it can be fixed if a new, more innovative approach was taken" Dr Margaret Faux.

Telehealth for the Bush Trial update.

The TH4B Trial (the technology combined with the NP pathway developed as part of the current CRCNA Telehealth project) has evolved to provide access to a wide range of health services to forty-two health care consumers over the last 18 months. They have had appointments through the TH4B Trial and accessed Telehealth-based healthcare which supplemented available services or provided services that were not available. Some of these health care consumers have had more than one subsequent appointment with a specialist, others have had pathology and diagnostic imaging services provided and two have required surgery. One health care consumer was linked into the public wait-list and had their surgery within a few weeks in the public health system. For some, TH4B replaced services where there was no continuity of care or provided access to services that were unavailable to the health care consumer.

In response to feedback from our networks, a number of child-orientated specialists, including allied health professionals, have been made available for the TH4B trial. In particular, participants in the case study research and the Digital Health for the Bush Forum have specifically identified long wait periods (in some cases years) to have children assessed for developmental issues. This lack of access or delayed access can result in children not receiving treatment early and therefore reducing development potential (Digital Health for the Bush 2020, Digital Health for the Bush 2021).

Through our research we have already identified these issues:

- Health professionals do not always share diagnostic results or communicate well to maximise their effectiveness in treating health care consumers.
- Referring specialists are not necessarily providing discharge/consultation summaries to the health care consumer's referring practitioner.
- Some health professionals are refusing to upload health care consumer's health data to My Health Record when the health care consumer requests this action.
- Some health professionals are refusing to provide the health care consumer with their health data when the health care consumer requests those diagnostic results. (This poses the question: Who owns the data? Medicare, who paid for the diagnostic test? The provider who provided the test? The referring clinician? Or should the health care consumer own their own health data?)
- Many RRR people are not getting the care they need in a timely manner and are often experiencing lengthy delays for diagnosis and treatment resulting in much poorer health outcomes
- There is a lack of access to a range of services in RRR areas possibly due to a lack of available professionals.

The MBS changes pose a serious threat to the continuation of the TH4B Trial with a number of specialists already withdrawing from the program including Oncologists and Psychiatrists.

Broadband for the Bush is seeking to have these MBS changes reversed at least for RRR health care consumers and clinicians. We are organising a delegation to Canberra in October/November and will be advocating for:

1. Regional and remote clinicians and health care consumers be immediately exempted by the requirement to have continuous video and audio contact throughout the consultation.
2. The Medicare changes be urgently reviewed by a panel that includes:
    - RRR health care consumers and clinicians (including Nurse Practitioners and Aboriginal Health Professionals).
    - Aboriginal people.
    - Aboriginal Medical Services.
    - Geographically isolated and other isolated people (and/or their representatives).
    - Aged people and their representative groups.
    - Digitally excluded people.
    - Technical experts such as Satellite technologists, e.g. NBN Co.
    - Dr Margaret Faux – Australia's expert on Medicare Billing.
3. A round table discussion with key stakeholders be held to investigate how MBS funds could be used more effectively and efficiently, increase access to a wider range of health services for all health care consumers including RRR people and investigate how NPs can ease the deficit of GP availability.

For information about total number of MBS consultations report in Quarter 1 2022 please see:
https://coh.centre.uq.edu.au/telehealth-and-coronavirus-medicare-benefits-schedule-mbs-activity-australia

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