

Navigating Telehealth: The Patients' Perspective

Background Document

An outcome of the Health Consumers NSW
Covid-19 Consumer Leaders Taskforce project

April 2021

hcnsw.org.au

amplify.hcnsw.org.au/covid-consumer-rep-hub

ACKNOWLEDGEMENTS

Navigating Telehealth: The Patient's Perspective – Background Document

Authors:

Laila Hallam
Serena Joyner, HCNSW

The authors would like to thank all members of the *COVID-19 Consumer Leaders Taskforce NSW* for leading and sharing their expertise that led to the development of this paper.

With special thanks to:

Brad Rossiter	Lizzy Harnett
Diana Trickett	Margo Hoekstra
Helen Belcher	Anthony Brown

This background document and the associated report are available at www.hcnsw.org.au/navigating-telehealth/

Thanks to *Care Opinion* for providing public access to patients' and families' feedback on their experiences. <https://www.careopinion.org.au/>

March 2021

You may download, display, print and reproduce this material in unaltered form for your personal, non-commercial use or use within your health service, committee or community. Please acknowledge HCNSW as the source when doing so.

Consent for the personal quotes in this document have been given by health consumers to HCNSW and shared generously for the express purpose of telehealth system design and improvement. To ensure the quotes are used with this intent, written permission from HCNSW is required for the quotes to be reproduced in other materials and applications.

ISBN 978-0-9943298-4-4

Disclaimer

The views expressed in this report are those of the authors and contributors and not necessarily of organisations they may also be affiliated with. The report is intended to highlight the need to integrate the patient perspective into decision making around telehealth – and we contribute to this perspective through the results of a review of and consumer engagement process.

Health Consumers NSW
Suite 3/Level 8, 280 Pitt Street
Sydney, NSW 2000, Australia
Phone: +61 2 9986 1082
Web: <http://www.hcnsw.org.au>
Online engagement: <https://amplify.hcnsw.org.au/>
Health Consumers NSW is supported by NSW Health

INTRODUCTION

The impact of COVID-19 has been immeasurable and will likely continue to be felt for years to come. For health consumers one such area of impact has been on how they have been able to access health care through the rapid introduction of telehealth for medical consultations.

Overall, telehealth has been very well received. A welcome feature during COVID-19.

Beyond COVID-19, the rapid implementation of telehealth during 2020 has been an exercise in demonstrating what is possible. Done well, telehealth has been demonstrated to support the widespread delivery of effective health care consultations.

In 2020 telehealth use has highlighted existing issues that continue to affect health in any setting: equity of cost and access, the burden of care on patients and carers, privacy, health literacy and patient-provider communication.

While the experience and response of health consumers to telehealth has varied, it has repeatedly demonstrated that consumers want **uncompromised care that is accessible and minimises costs.**

This document is one of a set of two papers “Navigating Telehealth: The Patients’ Perspective” from the COVID-19 Consumer Leaders Taskforce. Together, they explore patient/health consumer perspectives and experiences around the changes to telehealth that occurred in response to COVID-19.

This paper is the background document.

The second paper is the summary document that brings together health consumer experience of telehealth and recommendations.

The set is intended as a resource outlining consumer experiences and feedback on telehealth to promote the voice of patients in improving the telehealth system. It is aimed at patient advocacy organisations, health system decision makers, system designers and implementers, and health consumers involved as consumer representatives.

“Navigating Telehealth: The Patients’ Perspective” is part of a series of reports developed by the COVID-19 Consumer Leaders Taskforce, facilitated by Health Consumers NSW.

The COVID-19 Consumer Leaders Taskforce comprises of leading Consumer Representatives across NSW and was formed in April 2020 to support the COVID-19 response. The activity and outputs of the Taskforce has been facilitated by Health Consumers NSW, and supported by a broader base of consumer representatives through the HCNSW Consumer Representative Hub.

TABLE OF CONTENTS

Acknowledgements	2
Introduction	3
Table of Contents	4
Context for this paper.....	5
Method	6
About telehealth.....	7
Evidence about telehealth.....	8
Telehealth in Australia.....	11
Background - telehealth before COVID-19.....	11
And then came COVID-19.....	13
According to MBS, how was telehealth used?	16
What Patients say about Telehealth – with or without COVID-19	20
What do AUSTRALIAN Consumers think of telehealth changes?	22
What we didn't find	22
What you told us	22
Improved access - when telehealth removed barriers for people accessing care	24
Improved effectiveness – when telehealth led to more effective consultations.....	25
Improved access, improved effectiveness – when everything came together	26
Reduced access – when telehealth introduced barriers for people accessing care.....	27
Reduced effectiveness – when telehealth got in the way of effective health care.....	28
Poor access and poor effectiveness.....	29
Patient Choice	30
What do consumers want to keep about telehealth?	31
What improvements consumers suggest for telehealth	32
Discussion	38
Appendix: What you told us – a virtual workshop on telehealth.....	46

CONTEXT FOR THIS PAPER

For the purposes of this review of telehealth, we have limited our focus to the most recent telehealth changes that have occurred following COVID-19; how telehealth has been used; and how it has been received.

For this paper:

Telehealth is the delivery of health care at a distance:

- whether across geographic, time, social and cultural distance - using information and communications technology.

And within its scope, the report

- limited to exploring virtual consultations, rather than the full spectrum of telehealth and telemedicine, remote care, virtual care, digital care, etc. Consultations is where the most significant changes have taken place during COVID-19;
- and virtual consultations included, involve:
 - patients, and/or families and clinicians
 - clinician to clinician /s
 - multiple clinicians (such as, local GP and virtual specialist; and/or multi-disciplinary health care teams)
 - Two or more connections and locations; and
 - Patients located either in their own personal location or in a remote clinical setting;
 - Patients in a virtual consultation with or without real time support and attendance by local clinicians.
- Within this scope, the paper also recognises that many government and non-government services have been delivering services this way over many years – including physical and mental health hotline support services.

For the purposes of this report, we have skewed towards simplicity, but with a nod to broadening our thinking beyond technology, provider groups, and typical patient groups.



METHOD

Telehealth is the second of a number of priorities identified by the COVID-19 Consumer Leaders Taskforce NSW. The resulting reports have been developed by the Taskforce with input from the Consumer Representative Hub and facilitated by Health Consumers NSW.

This work brings together personal experiences, observations, and feedback gathered since February 2020 and the onset of COVID-19; expertise of leading consumer representatives who are attuned to and experienced with system and service responses; and lessons learned by health peers both locally and internationally.

To hear from Australians who have experienced telehealth Health Consumers NSW facilitated:

- a public virtual workshop held via zoom for consumers on 28 August 2020 “Tell us about... telehealth”, and
- individual online feedback via the Health Consumers NSW platform, Amplify. (Amplify is an online engagement platform of Health Consumers NSW set up for consumers and consumers representatives to encourage people to share their experiences and give feedback.) Feedback included a quick poll, survey and story submission and attracted 132 submissions.

The group also turned to a variety of other sources including:

- Publicly available discrete disease-specific surveys
- Public and private media – listening to public discussions and comments
- Social media – listening to discussions and comments
- Care Opinion Australia
- Consumer Representatives, and
- Consumer Health Forum – national papers and discussions.

Most of the feedback has been gathered from Australian experiences, although the inclusion of feedback was not limited to Australia where the feedback reflected issues also relevant locally. Feedback from non-Australian sources are identified when used.

ABOUT TELEHEALTH

Defining telehealth

Delivery of health care at a distance¹.

Simple, clear and precise; and as suggested in the 2015 Strategic review of telehealth in NSW.

Pertinently, The International Organisation for Standardisation explicitly recognises the idea of distance as more than physical location by:

Providing health care services across geographic, time, social and cultural barriers².

And, with the World Health Organisation, explaining how telehealth:

...can contribute to achieving universal health coverage by improving access for patients to quality, cost-effective, health services wherever they may be. It is particularly valuable for those in remote areas, vulnerable groups and ageing populations.³

However, in practice, the definition is less important than the conditions and eligibilities which restrict whether and how it is applied and used. For the purposes of this paper, the discussion is being contained within health consultations between patients and/or clinicians.

Post-COVID-19, delivery of health care at a distance was universally applied in practice.

Delivery of health care at a distance... Providing health care services across geographic, time, social and cultural barriers.

¹ Strategic review of telehealth in NSW: Final report, NSW Ministry of Health, 8 April 2015, included a definition by Dr Victoria Wade (2014), <https://www.health.nsw.gov.au/telehealth/Documents/strategic-review-of-telehealth-in-NSW.PDF>

² <https://www1.health.gov.au/internet/main/publishing.nsf/Content/e-health-telehealth>

³ WHO Analysis of third global survey on eHealth based on the reported data by countries, 2016
<https://www.who.int/gho/goe/telehealth/en/>

EVIDENCE ABOUT TELEHEALTH

Prior to COVID-19

Safety and Quality - comparing telehealth with face to face consultations

NSW Agency for Clinical Innovation as part of their COVID-19 Critical Intelligence Unit conducted two telehealth reviews in May 2020. One review focused on telehealth in relation to safety and quality summarise the review as follows:

‘Before COVID-19, systematic reviews showed telehealth to be effective either in improving outcomes or providing services with no difference in outcomes, for a range of clinical conditions, such as cardiac failure, coronary artery disease, diabetes and for stroke rehabilitation.

Safety concerns pre-COVID-19 span malfunctioning equipment, potential adverse effects of delayed or missing information, misleading advice provided by apps, misunderstanding sound advice, or inaccurate findings as a result of patient or caregiver error.’⁴

A number of other additional studies also support no difference in quality or outcomes compared to usual care.⁵

The other on the effective use of telehealth for specific conditions⁶, noted the following:

- Telehealth has been shown to improve access to care, is acceptable to patients and clinicians, and available technology can provide high-quality and secure information transfer
- The application of telehealth spans from the highly technical to the person centred and from time-limited acute encounters to ongoing episodes or series of care
- Strongest evidence is available for the acute management of ischaemic stroke via telestroke and for monitoring and management of chronic conditions such as diabetes and heart failure
- Tele-ICU, tele-mental health and tele-rehabilitation have also been associated with positive outcomes, and
- Much of the available evidence is of low quality.

These findings are consistent with other studies. A 2019 Australian systematic review on the management of telehealth in non-critical emergencies in rural areas, found a reduction in unnecessary patient transfers and secondary over-triaging, while increasing the capacity of emergency department staff to diagnose and manage patients locally.⁷ Another in 2015 reviewing e-

⁴ ACI, COVID-19 Critical Intelligence Unit Evidence Check, Telehealth and COVID-19, 19 May 2020.

⁵ Rasekaba T, et al, Telemedicine Interventions for Gestational Diabetes Mellitus: A Systematic Review and Meta-analysis, Diabetes Research and Clinical Practice 110 (2015) 1-9.

⁶ ACI, COVID-19 Critical Intelligence Unit Evidence Check, Virtual Care and Telehealth for specific conditions, 28 May 2020

⁷ du Toit et al, Use of Telehealth in the Management of Non-Critical Emergencies in Rural and Remote Emergency Departments: A systematic review, Journal of Telemedicine and Telecare, 2019, Vol.25(1)3-16.

consults between providers⁸, concluded that 'e-consults provided timely access to specialty care and are well-received by primary care providers'. It found e-consults often allowed management of patients in primary care who would otherwise have been referred to specialists, with fewer inappropriate visits, fewer avoidable follow-up visits, and an increase in necessary follow-up visits. Interestingly, the narrative approach also allowed a deeper probe into the non-clinical benefits and concerns. It found primary care providers satisfaction rates were high, citing a range of reasons including: **improved convenience, educational value, rapid turnaround, improved access to speciality input, better provider to provider communication, avoidance of unnecessary patient travel**. Specialist satisfaction was less uniform, with an overlap of many of the benefits noted by primary care providers, but also with concerns about unclear clinical questions, medico-liability implications of not evaluating in person, and the need for adequate protected time and credit. Quality outcomes varied, with the study suggesting that five major directions for further investigation:

1. Implementation studies
2. Appropriate use
3. Communication
4. Effectiveness
5. Unanticipated consequences.

"I am a GP and I recently undertook a 4-week locum and... at most times the only doctor in the community, albeit supported by fantastic remote area nurses and Aboriginal health practitioners.

As a GP I am trained primarily in primary and preventative health care, however, being almost 200kms from the nearest hospital, the centre also provides emergency care to the community.

*The Emergency Telehealth Service was of great comfort to me whilst I was working in the <rural and remote> region and I may not have accepted the role at all had I not been aware that this service was in place."*⁹

A 2017 systematic review found only two studies comparing telephone consultations with face to face in general practice, and concluded that although evidence was scant, telephone consultations 'offers an appropriate alternative option in certain settings'¹⁰.

⁸ Vimalananda et al, Electronic Consults (e-consults) to Improve Access to Specialty Care: A Systematic review and Narrative Synthesis, Journal of Telemedicine and Telecare, USA, 2015, Vol. 21(6) 323-330

⁹ Clinician feedback on Care Opinion Australia, 27 July 2020

¹⁰ Downes et al, Telephone Consultations for General Practice: a Systematic Review, 2017, BioMed Central, Australia.

Safety and Quality - comparing video with telephone consultations

However, there have been some interesting results when comparing video consultations with telephone consultations.

In 2013, a small study looked at 234 seriously ill and injured children from eight rural emergency departments reviewing medication errors found that those who received video consultations had significantly fewer physician-related errors than those by telephone consultations, or no consultations (3.4% vs 10.8% and 12.5% respectively)¹¹.

A systematic review study in 2018 also found compared to telephone, videoconferencing resulted in fewer medication errors, greater diagnostic accuracy and improved decision-making accuracy.

During COVID-19

Since the on-set of COVID-19, there has been a rush of articles, papers and opinions on Telehealth, and almost solely focused on implementation. In other words, how to support health providers to prepare and adapt to incorporate telehealth into their suite of service delivery modes so telehealth can perform optimally, and at its best.

Whilst there has been a barrage of information, there has also been considerable uniformity in the issues identified. These have included:

- Clinician and patient awareness of the technologies available
- Access to appropriate and reliable hardware – mobile devices with audio and video features
- Access to reliable internet connection – available and affordable
- How to ensure privacy – security of communication channels; as well as location of the participants, both provider and patient
- How to determine the most appropriate technology for the consultation: telephone or video
- New or refined workflow practices and management
- How to ensure the process works – on both sides – from scheduling through to follow-up;
- Approaching virtual consultations in ways which build rapport and trusting relations

One paper in particular noted uncertainty around ‘the reach of new telehealth initiatives to older people in Australia, despite the urgency around COVID-19’. Going on to explain the concern that, ‘many people disproportionately those with the greatest needs, may not have (or cannot afford) smartphone or computers... <and> depending on location, have poor (or no) connectivity. While many others may find it hard to consult over the phone and could forgo their healthcare visits until the pandemic is finished... potentially leading to other health care complications, the implications of which have not yet been fully considered.’¹²

¹¹ Dharmar et al, Telemedicine Consultations and Medication Errors in Rural Emergency Departments, Pediatrics, 2013; 132:1090-1097

¹² Fisk et al, Telehealth in the Context of COVID-19: Changing Perspectives in Australia, the United Kingdom, and the United States, Journal of Medical Internet Research, 2020 June; 22(6):e19264

TELEHEALTH IN AUSTRALIA

Background - telehealth before COVID-19

Telehealth and the Medicare Benefits Schedule (MBS)

Telehealth is not new. In Australia, Medicare introduced Telehealth rebates and financial incentives on 1 July 2011. They “were introduced to address some of the barriers to accessing medical services, particularly specialist services, for Australians in remote, regional and outer metropolitan areas”¹³. Accordingly, a suite of new item numbers was added to the Medicare Benefits Schedule (MBS) with very specific eligibility criteria.

Service provision eligibility:

1. Eligible clinical services and/or providers; **AND**
2. Every Telehealth item code was singularly identified as a ‘**video consultation**’; **AND**

Patient cohort eligibility:

3. Only available to **non-admitted patients**; **AND**
4. **Regional areas** - Eligible patients must live within **pre-defined eligible areas** as well as at a distance of **more than 15km** from their remote health provider; **AND**
5. Only to **residential aged care** patients; or **patients of Aboriginal Medical Service** or Aboriginal controlled health services.

Over subsequent years to January 2020, Telehealth item codes were incrementally added to the Medicare Benefits Schedule (MBS), to allow for:

- more eligible services
- more aged care residents or patients of Aboriginal Medical Services to access telehealth services regardless of their location:
 - From pre-defined regional areas **AND** aged care residents or patients of Aboriginal Medical Service or Aboriginal controlled health services
 - To regional eligible areas **OR** aged care residents or patients of Aboriginal Medical Service or Aboriginal controlled health services.

The only other significant change was the swift inclusion of specific MBS Telehealth item codes to accommodate people in areas affected by our 2019-2020 bushfires.

¹³ Program Guidelines: Financial Incentives for Telehealth, 2013, Australian Government, [http://www.msac.gov.au/internet/mbsonline/publishing.nsf/Content/BD043EFC05A981EFCA257CD20004A3A3/\\$File/Telehealth%20Program%20Guidelines%20effective%201%20January%202013.pdf](http://www.msac.gov.au/internet/mbsonline/publishing.nsf/Content/BD043EFC05A981EFCA257CD20004A3A3/$File/Telehealth%20Program%20Guidelines%20effective%201%20January%202013.pdf)

Even with investment support, telehealth adoption has been minimal, slow, narrow and inconsistent.

Up until COVID-19, Telehealth remained largely on the margins of service provision; rarely integrated into usual practice; and more often than not, absent altogether.

In 2019, Telehealth accounted for only 0.01% of all MBS Professional Attendances – around 255,000 out of a total of 200m in Australia

Telehealth and NSW public hospitals

A 2015 NSW strategic review concluded that the usage of telehealth ‘varies across the LHDs and SHNs, and by remoteness, types of health care facilities and individual clinicians’¹⁴. The authors also noted the ‘level of integration of telehealth services across NSW is low - The level of integration of telehealth services between LHDs, and service providers and receivers is relatively low. This is primarily due to inconsistencies in infrastructure causing a lack of interoperability’.

However, since then, and prior to COVID-19, Telehealth was prioritised in the 2019-20 NSW Health Strategic Plan, as an emerging focus. Key deliverables were spread across NSW health agencies, including eHealth and Agency of Clinical Innovation which in turn have been at the forefront of leading the charge and collaborating closely with willing Local Health District partners.

Although largely confined to health providers with a significant regional, rural and remote patient base across primary, secondary and tertiary care, some providers have expanded their scope and re-imagined care for other patient cohorts. A recent, and fortuitously timely, pilot program was the RPA Virtual Hospital which commenced at the start of February, for a handful of conditions, including patients managing cystic fibrosis, recurring leg wounds and patients and families receiving palliative care. RPA is not alone. These pockets of activities are a nod to the value of Telehealth beyond geographic distance.

¹⁴ <https://www.health.nsw.gov.au/telehealth/Documents/strategic-review-of-telehealth-in-NSW.PDF>, as accessed at September 2020

And then came COVID-19

Endeavouring to keep health care services available, while keeping both patients and providers safe from infection, COVID-19 forced telehealth to the fore.

Temporary telehealth item codes added to the Medical Benefits Schedule (MBS)

On realising the COVID-19 threat, the Commonwealth Government swiftly updated the Medical Benefits Schedule initially by adding temporary video and telephone consultation item codes, although with conditions attached.

Over the course of a few weeks of tweaking, by 30 March 2020, restrictions were removed, and telehealth was made universally available for all Australians. Provider and service restrictions were lifted, and for the first time, telehealth was opened to telephone calls, in addition to video conferencing.

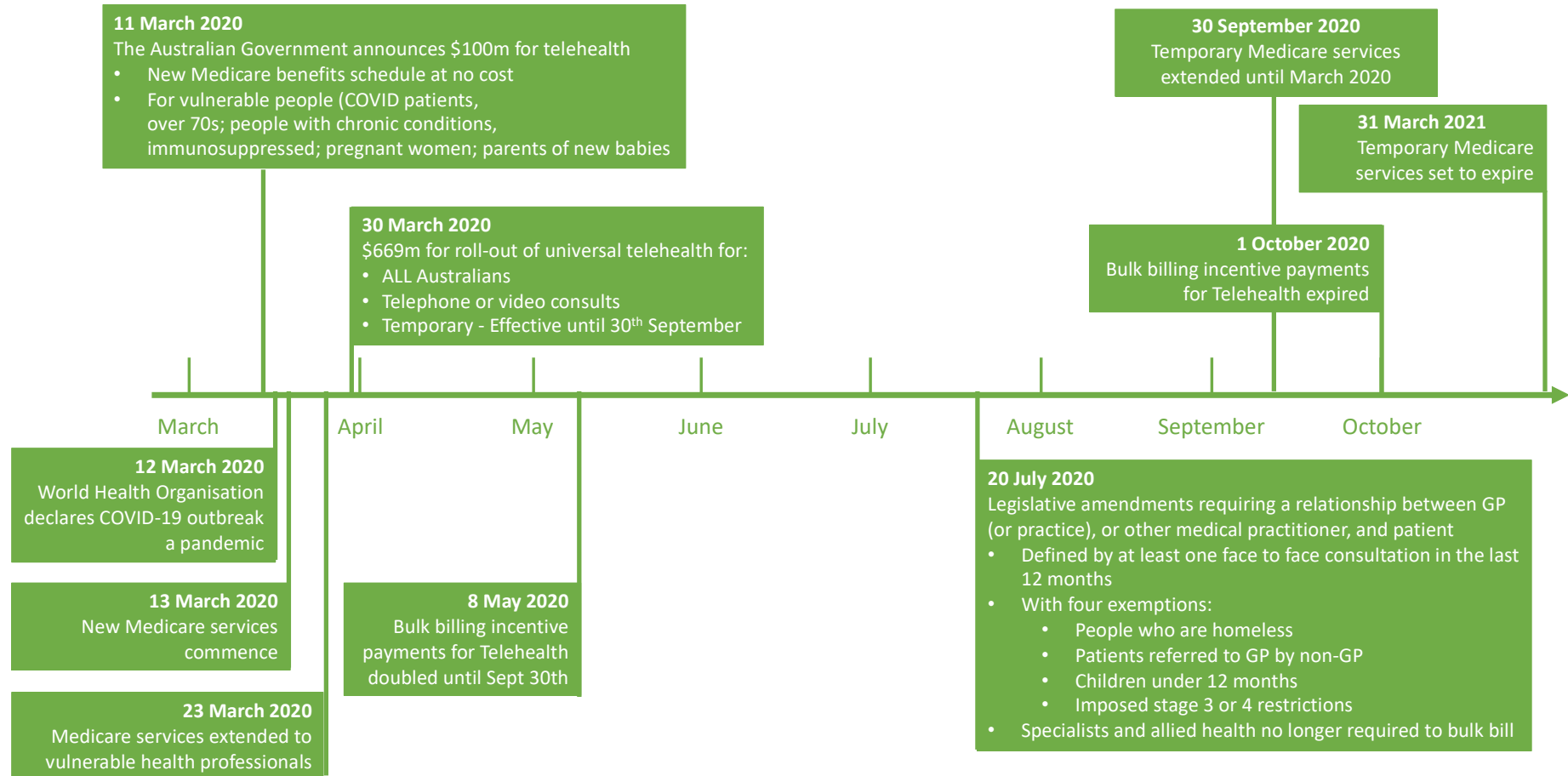
Same MBS payments – whether face to face, video or telephone consultations

The Medicare Benefits Schedule payments and bulk billing incentive payments were the same across face to face, video and telephone delivery. It did not seek to influence usage by differentiating payments. This allowed health providers to make decisions unencumbered by financial advantage (or disadvantage).

By 30 March 2020, telehealth restrictions were removed, and telehealth was made universally available for all Australians.

Coupled with bulk billing incentives, health care was available to more people than ever before.

Timeline of telehealth MBS in Australia during 2020



By 30 March 2020

Whilst there were a number of initial iterations to the eligibility, the significant amendments to telehealth over the first 3 months included:

1. Telehealth was made available for all patients, and all GPs, Specialists, and Other Medical Practitioners, regardless of location
2. In addition to video consultations, telephone consultations were allowed as an alternative option when video was not available
3. Mandatory bulk billing for GP services (face to face, video or telephone consultations) was widened to include people vulnerable to COVID-19, in addition to concession card holders and children under 16 years, while bulk billing incentives also doubled to cover these population groups^{15,16,17}
4. Interim mandatory bulk billing for specialists, later relaxed from 20 July 2020.

Vulnerable to COVID-19 was defined as a person who:

- is required to self-isolate or self-quarantine in accordance with guidance issued by the Australian Health Protection Principal Committee in relation to COVID-19; or
- is at least 70 years old; or
- if the person identifies as being of Aboriginal or Torres Strait Islander descent — is at least 50 years old; or
- is pregnant; or
- is the parent of a child aged under 12 months; or
- is being treated for a chronic health condition (a medical condition that has been present, or is likely to be present, for at least six months or is terminal); or
- is immune compromised; or
- meets the current national triage protocol criteria for suspected COVID-19 infection¹⁸.

This broad list of COVID-specific eligibility meant that people who may have rarely had an opportunity for bulk billing in the past, were temporarily eligible, and benefiting from universal health care freely available. This was true regardless of whether the consultation was face to face, video or telephone.

¹⁵ MBS Changes Factsheet, COVID-19, Temporary MBS Telehealth Services, 20 July 2020, <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-TempBB>, as accessed on 11 Sept 2020.

¹⁶ RACGP, New Items for COVID-19 Telehealth and Phone Services, <https://www.racgp.org.au/running-a-practice/practice-resources/medicare/medicare-benefits-schedule/new-items-for-covid-19-telehealth-services>, as accessed on 11 Sep 2020

¹⁷ MBS COVID-19 Bulk Billing Incentives, Frequently Asked Questions, 8 May 2020, [https://www.ehealth.gov.au/internet/mbsonline/publishing.nsf/Content/0C514FB8C9FBBEC7CA25852E00223AFE/\\$File/FAQ%20-%20COVID-19%20Bulk%20Billing%20Incentive%20-%20080520.pdf](https://www.ehealth.gov.au/internet/mbsonline/publishing.nsf/Content/0C514FB8C9FBBEC7CA25852E00223AFE/$File/FAQ%20-%20COVID-19%20Bulk%20Billing%20Incentive%20-%20080520.pdf), as accessed on 11 Sep 2020

¹⁸ *ibid*

Specifically to telehealth, the newly introduced, but temporary, MBS items differed enormously to the original telehealth codes introduced from 2011 and up to the onset of COVID-19. COVID-19 signalled the change to the very essence of how telehealth was defined and applied in Australia.

Then, effective 20 July 2020, one further significant amendment

Following advice by the RACGP, a condition was added requiring a patient to have had at least one face to face consultation in the previous 12 months in order to qualify for a telehealth appointment. It was argued that this was to ensure an existing and continuing relationship with their GPs and Other Medical Practitioners working in general practice.

Four exemptions were allowed:

1. People who were homeless
2. Children under the age of 12 months
3. Patients referred to a GP by a non-GP specialist, and
4. People living under stage 3 restrictions.

Following advice by the RACGP, a condition was added requiring a patient to have had at least one face to face consultation in the previous 12 months in order to qualify for a telehealth appointment.

What MBS service counts, tell us about telehealth

Removing the restrictions that applied prior to COVID-19 supercharged telehealth in Australia.

Prior to COVID-19, Telehealth was negligible. It was strictly and narrowly defined and applied, and negligibly used (Figures 1 and 2);

Post COVID-19, Face to face dominated. Face to face continued to dominate with over 80% of all consultations during this period. The MBS analysis challenges the assumption that most health providers were not consulting face to face in the midst of the initial uncertainty of COVID-19 (Figures 3, 4 and 5).

Post COVID-19, Telephone ruled over video – by a long shot. This was consistent across health provider categories (GPs, specialists, and other medical practitioners) and whether Australia-wide, or NSW specifically (Figure 6).

When separating GPs and specialists, GPs were even more reluctant, with only 3% using video services. Surprisingly, specialists were more adaptive with almost 30% using video, although not as enthusiastic as self-reported in a recent survey by Royal Australasian College of Physicians suggesting more than 90% used telephone consultations, while 75% used video too¹⁹.

NSW and Australian patterns of telehealth usage were similar. Comparisons between face to face and telehealth proportions, telephone and video and general uptake were similar.

¹⁹ Results of RACP Members' Survey of new MBS Telehealth attendance items introduced for COVID-19, June 2020.

MBS performance in graphs

Figure 1:

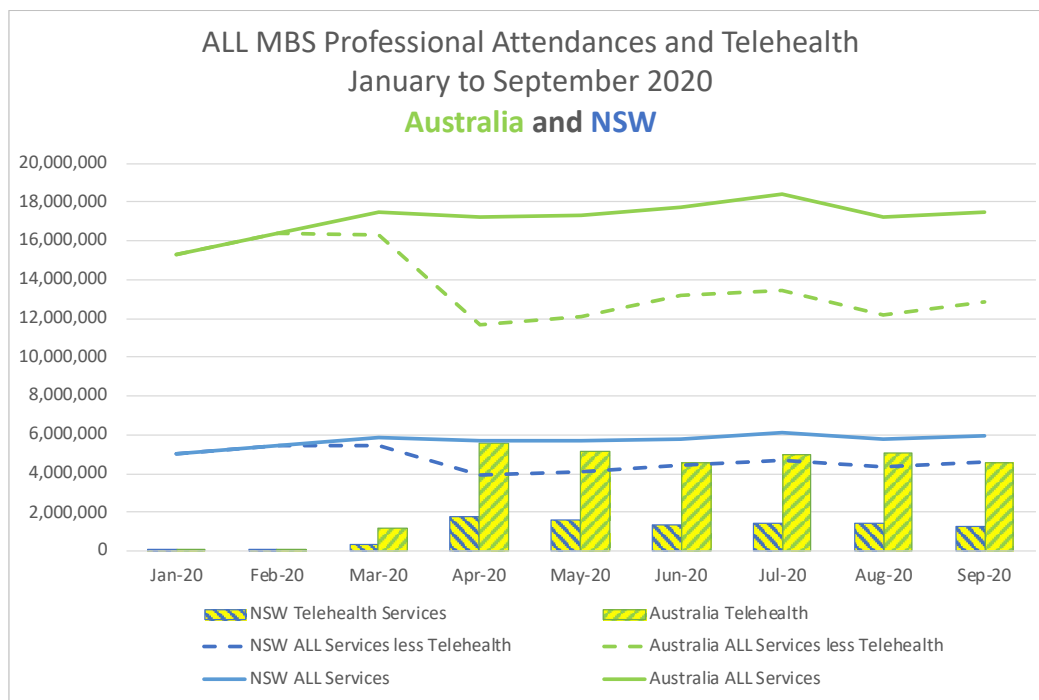


Figure 2:

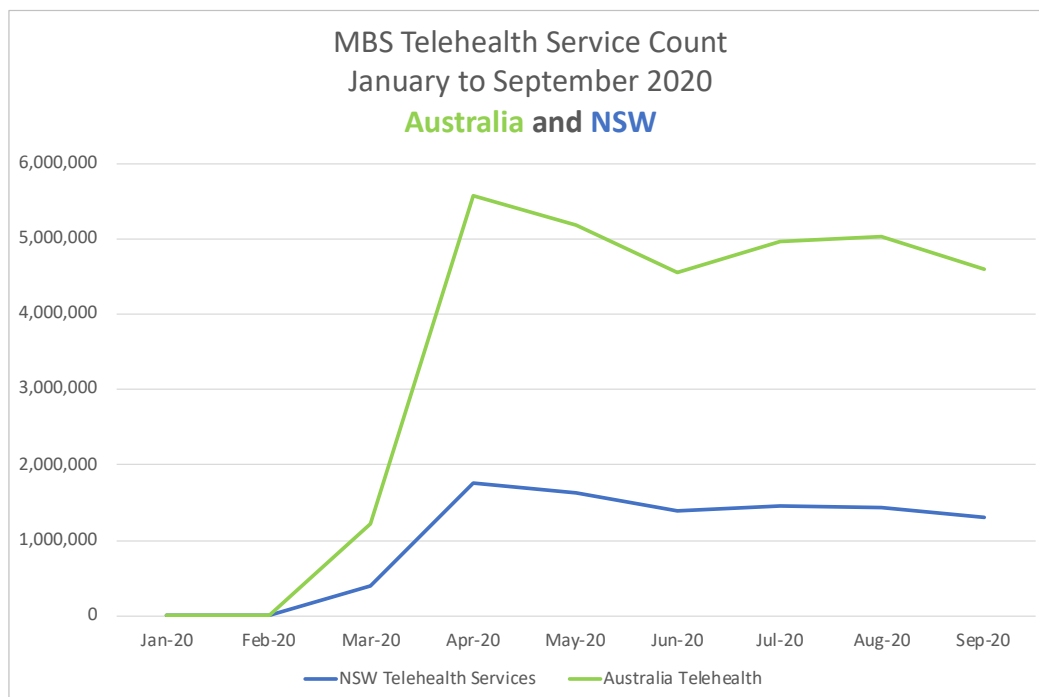


Figure 3:

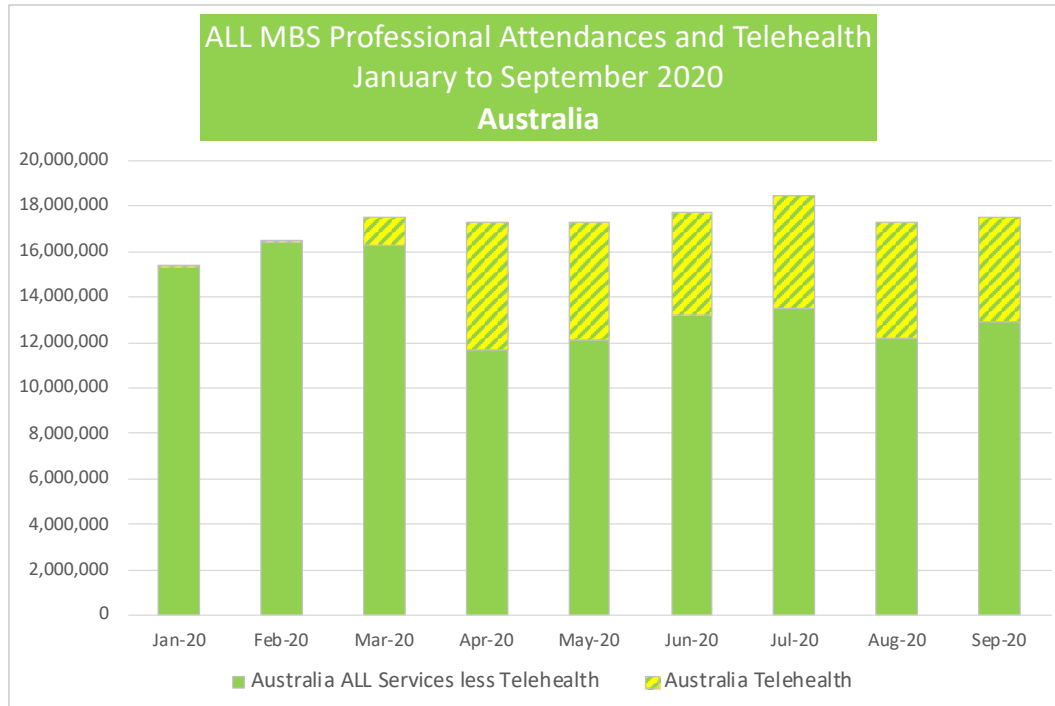


Figure 4:

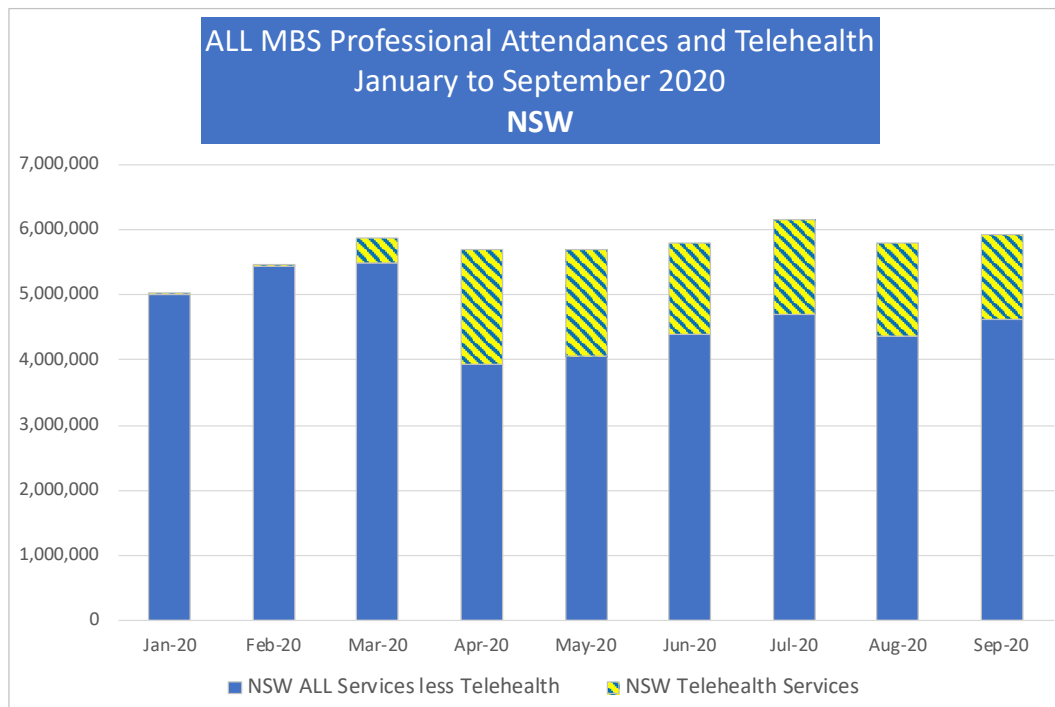


Figure 5:

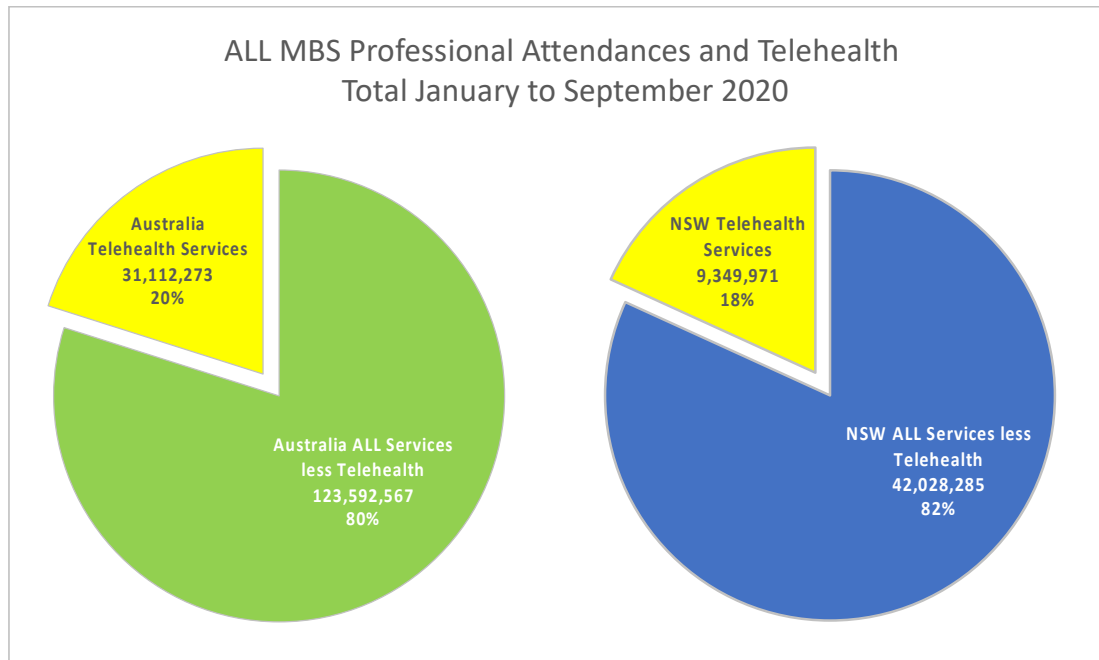
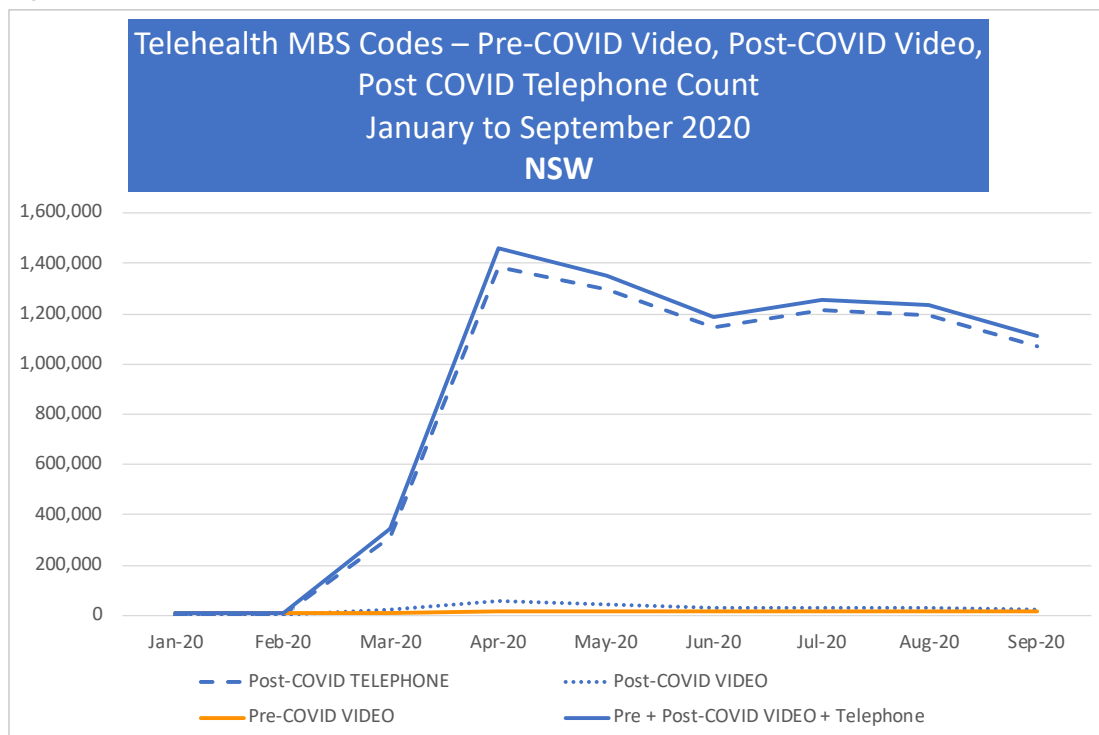


Figure 6:



Source: http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp

WHAT PATIENTS SAY ABOUT TELEHEALTH – WITH OR WITHOUT COVID-19

Healthwatch England and Patient Voices

One of the most substantial and in-depth pieces came from a UK collaborative of patient-led organisations, Healthwatch England and Patient Voices²⁰. Over a period of 10 days in June 2020, they followed 49 people using an online platform, and supplemented with an additional 20 interviews and a workshop. All had experienced telehealth consultations across primary, secondary and tertiary health settings.

This follows research in 2019 by Healthwatch from 125,000 public views and experiences collected to inform the NHS Long Term Plan. The public feedback, prior to COVID-19, 'showed:

Prior to the pandemic public feedback suggested that very few people had direct experience of a digital appointment. Yet research by Healthwatch during 2019 –which saw 125,000 people views and experiences of care gathered to shape the NHS Long Term Plan –showed:

- There was significant appetite for greater use of technology to make care easier to access
- People from rural communities (who may have long distances to travel to NHS services) and those with long term conditions particularly interested
- People felt frustrated by the limitations of existing NHS online systems e.g. not allowing them to make different types of appointments
- Clear concerns were raised about some groups of people being left behind and a need therefore to not be digital by default
- Some evidence to suggest new exclusions could also appear – e.g. young people who might be comfortable with technology but not to use it for interactions with NHS, and
- Technology is not as important to people as personalised care.

Then, in the work during COVID-19, the findings consolidated more specifically into process drivers around *seven themes*:

Boundaries - respecting peoples' time and where the appointments fit in with their lives.

Quality personal communication – no matter what!

Preparation and information – providing guidance and setting expectations.

Choice of phone, video or text/email and in-person, to meet the needs of people – what is right for the person and what is right for the situation.

Test, learn and improve – designing the virtual experience with patients and carers.

²⁰ The Doctor Will Zoom You Now, Insight report, Key findings from research June-July 2020, Healthwatch and National Voices, UK.

Being inclusive - meeting the needs of people for whom virtual is not possible or appropriate.

Opportunities - such as interaction with patient notes, recording of appointments, education and training and the use of existing patient groups to provide local support networks to increase confidence and access.'

The Kings Fund, UK

The Kings Fund also explored telehealth in a recently released report, Technology and Innovation for Long Term Health Conditions²¹. The report challenges the idea of the conservative and incremental approach to introducing technology in the UK, using four innovations that use digital technology to deliver a step change in care. The case studies include patient-led sources evaluating the models and inform the report's conclusions, which are also firmly rooted in active consumer, community and provider collaboration.

Finally, another study released by the Academy of Medical Sciences²², has also incorporated patient perspectives throughout its report capturing broad feedback using the networks of its Patient and Carer Reference Group, of whom some of the members also sit on the Expert Advisory Group from this report.

Whilst these reports are not Australian, and are not necessarily reflective of Australian conditions, their themes are familiar, and many are universal. They provide us with lessons learnt to support our movement forward.

Australian patient sources

There have also been a number of significant Australian reports, but they have been either disease-state based (Autism) or specific to a group (young adults). There may be more. Specific to these though, both very important and insightful documents, but speak generally about the impact of COVID-19 rather than to telehealth.

The most significant take-out from the review is the *absence* of published, or unpublished but available, evidence with the specific intent to collect, probe, interpret and consolidate patient perspectives that directly contributes to the 'valid' evidence base used for making systemic and local decisions.

As with published evidence prior to COVID-19, and with a few editorial exceptions, the commentary has been by academics and providers, with considerable debate on the impact of patients. This reflection highlights the missing voices and perspectives in the evidence. There is a dearth of published material sourced directly from, and interpreted by, the consumers of health services.

Capturing the value of telehealth to patients, families and communities generally – compared to

²¹ The Kings Fund, Technology and Innovation for Long Term Health Conditions, August 2020, UK.

²² The Academy of Medical Sciences, Preparing for a Challenging Winter 2020/21, 14 July 2020, UK

usual care (and in some cases, no care) – is the gap this review seeks to highlight and begin to fill.

WHAT DO AUSTRALIAN CONSUMERS THINK OF TELEHEALTH CHANGES?

What we didn't find

We could find little evidence that current telehealth programs had been co-designed with health consumers or had been informed by patients' experience of using telehealth. This was especially the case for the implementation of telehealth by GPs and specialists in response to COVID-19. We could find no statement from Commonwealth Ministers, Commonwealth Department of Health and Ageing, or MBS online committing to work with patients or health consumer groups in developing telehealth.

We are aware of some involvement by consumer representatives in NSW. We did not identify any publicly available documents or website from NSW Health that demonstrated development of telehealth and virtual health had been informed by patient experience or had involved consumer stakeholders. However, a small number of consumer representatives were engaged with different pillars and LHDs in consumer advisory groups around implementation of telehealth. In more recent months, there has been a renewed effort to incorporate patient stakeholders and patient experience feedback into refining and evaluating telehealth services in NSW.

What you told us

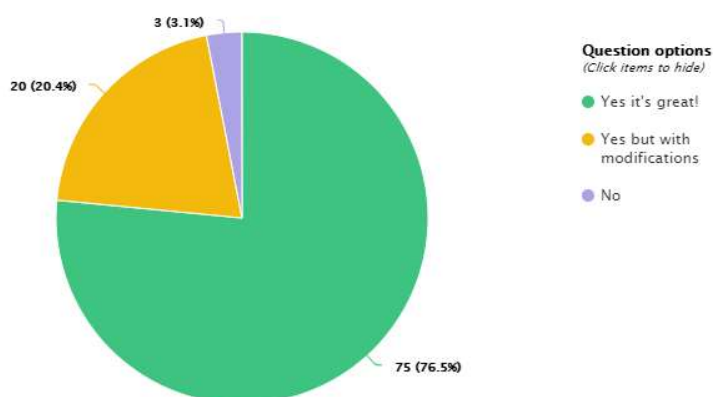
Polling

On Amplify, Health Consumers NSW posed the question:

Should the COVID-19 Temporary MBS Telehealth Services be made permanent?

- 75 (77%) Yes
- 20 (20%) Yes but with modifications
- 3 (3%) No

Figure 7: Should the COVID-19 Temporary MBS Telehealth Services be made permanent?



Whilst not asking the same question, Consumer Health Forum surveyed a variation of the question to gauge health consumers views on the quality of telehealth and found 82% considered telehealth to be excellent or good quality, and 83% indicating they would use the service again²³.

A virtual workshop on telehealth

A workshop was held with patients, carers and advocates on zoom on 28 August 2020 to find out what consumers thought about telehealth. There were breakout sessions to discuss what was working well, what could be improved and to consider when telehealth didn't work well. The outcomes have been incorporated in the findings below as well as provided in Appendix A and covers:

- What do we want to keep with regards to Telehealth?
- When is telehealth not suitable?
- How do we improve telehealth from here?
- What are the barriers?
- A final poll conducted with participants at the conclusion of the event.

The participants agreed that on the whole the increase in telehealth consultations has been positive.

At the conclusion of the telehealth workshop the participants were polled. No participants voted against the continuation of telehealth, 25% voted to continue telehealth ('Yes it's great') and 75% voted to continue telehealth 'but with modifications'.

What you told us – survey and stories

Consumers had a lot to say about telehealth, and their experiences varied widely from highly positive (even life changing) to very poor and much in between. What was clear was that while telehealth has been of enormous benefit to some, it has been problematic for others and a wide range of issues and suggestions arose around how to improve telehealth for patients and providers. The stories, comments and experiences reported here have been drawn from those shared with Health Consumers NSW via the Amplify online engagement platform (survey and invitation to share stories) and also from stories shared on Care Opinion Australia (www.careopinion.org.au).

Many of the issues consumers told us about involved either better, or worse access to health care; and better or worse effectiveness of health care.

²³ Consumer Health Forum, What Australia's Health Panel said about Telehealth - March/April 2020, <https://chf.org.au/ahptelehealth>

Improved access - when telehealth removed barriers for people accessing care

Of all the comments received about telehealth, more than a third celebrated its convenience. Convenience, like access, is multi-faceted with multiple benefits flowing to patients and families. For some patients, the benefits are far greater than merely 'more convenience', with genuine health and well-being benefits arising from the avoidance of having to leave the house. Telehealth is clearly reducing barriers for many people while supporting a people to better manage chronic conditions.

Less struggle, less pain – telehealth as an aid in managing chronic conditions

Genuine relief is expressed by people for whom daily pain, fatigue, anxiety and other chronic conditions make attending in-person consultations difficult.

"Some days it's just too hard and over whelming to actually get to appointments. Telehealth has meant I could get help even if I was sitting in bed exhausted from pain."

"I am someone with chronic pain and fatigue ...and a compromised immune system. Telehealth has allowed me to access physical and mental health services without additional pain and fatigue."

I have been able to access these services without putting my health at extra risk. Sometimes I am unable to leave my house due to pain and/or fatigue. Previously I would have had to miss medical appointments, delay medical treatment or make my fatigue and/or pain worse."

"It's great. Makes it safer and easier for people who struggle with anxiety or other mental health concerns that make it hard to get out of the house."

Minimising unnecessary risk

Probably heightened by COVID-19, but not necessarily all about COVID-19, there were a range of comments about safer care as a result of virtual consultations minimising the risk of cross-infections.

"Faster, safer, and more convenient, especially for elderly people"

"Healthier as not having to wait in waiting rooms"

"Being immune suppressed it was good not to have to be in waiting rooms with heaps of people. And I could still connect with my doctor."

Minimising lost time, lost income

“Not having to wait in the surgery being able to work from home but also talk to doctor when call comes through (not losing time from work).”

Even when accessible health care is close by, a 20-minute face to face consultation can result in hours of time lost. Time is lost regularly in preparing to travel, in travel to and from, in waiting rooms, and where there are multiple appointments, the effect is also multiplied.

Time lost is further compounded if the appointment is within the patient’s paid employment working hours, where income is often lost, or workload is made up for in personal time. As well, time lost can also impact families and carers who accompany them. For people who are managing long term and or chronic conditions while also working, time lost in seeking health care has a significant impact on their work and can impact their income.

“I am a young adult working full time which often makes it challenging to find time to manage my chronic health conditions. I have had the same GP for nearly 15 years who is across all of my conditions, specialists and the nuances around my health needs, however over time, I have moved further from my GP and work nearly an hour away. The change to telehealth has made managing my health so much easier - I can now get a blood test referral over the phone, from work, in a 5-minute break, as opposed to needing to take half a day of leave to visit my doctor. Similarly, I can get the results and any necessary referrals to specialists just as easily. I feel that telehealth has reduced the impact of my health on my employment, I feel much less worried about asking for a 5-10 minute break, as opposed to requesting a half day of leave. I am also no longer using annual leave to manage my health and I am now keeping on top of my health management because I am not worried about having to take leave and the impact on my work.”

Improved effectiveness – when telehealth led to more effective consultations

As well as better access, many positive comments about telehealth point to more effective (and efficient) consultations.

Sometimes, in and out is enough

Some appointments really can be covered quickly and for these, telehealth is ideal.

“Referrals, repeat prescriptions and results of tests.”

“Can get regular scripts... a huge timesaver”

Improved access, improved effectiveness – when everything came together

In the best case scenarios telehealth as both improved access to care and also improved effectiveness.

Telehealth has cut waiting time to get an appointment and encouraged timely care-seeking

Some people found telehealth reduced time spent on waiting lists or their GP is more available than previously.

“We live remote and after being on a waitlist for a very long period, we were given the opportunity to use the Telehealth services and had an appointment within a few weeks.”

“Living remote means we often have longer wait times for essential services, but I believe Telehealth is helping bridge that gap. Thank you.”

For those who are comfortable accessing telehealth, the immediacy and ease of a phone consultation meant that some people were more likely to seek care early, rather than wait for symptoms to worsen²⁴. And coupled with improved access to consultations, quickly and early, can minimise complications and avoid unnecessary interventions.

“Ability to strategise a plan of attack and quick follow ups without going back to surgery.”

“Telehealth has meant my GP is more able to make appointments for urgent things available, if they don't require face to face consult.”

Telehealth appears to keep patient clinician discussions focused, concise

Some people felt use of time overall was better – both during appointments and in waiting time.

“Really good on the whole. Meetings are focussed. Don't waste time getting to and from appointments.”

“..waiting at home rather than in a waiting room with other sick people. Takes less time, no travel, discussion kept to the point more when on the phone.”

²⁴ Delays in cancer treatments and diagnoses would suggest this affect was not universal and we suspect it was undertaken by people managing ongoing conditions and those with an existing good relationship with care providers – see <https://www.canceraustralia.gov.au/about-us/news/first-national-evidence-reductions-cancer-medical-services-and-procedures-due-covid-19>

Reduced access – when telehealth introduced barriers for people accessing care

While telehealth removes barriers for many people, it unfortunately introduces a range of barriers for others. People told us about how they experienced new barriers to accessing care in relation to using (or not using) telehealth.

Rules limiting telehealth access to people with an existing relationship with a provider (the “12-month rule”)

In July 2020, a 12-month rule was introduced that limited telehealth to patients who had an existing relationship with a medical practice or provider (defined as at least one appointment in the previous 12 months). This rule created problems between long standing patients of GPs who were otherwise healthy and infrequent consumers of their GP’s services; healthy people who have not had the need to invest in a long standing GP relationship; people seeking one-off specialty health services, like sexual health; and other vulnerable groups who for a range of reasons do not have ongoing relationships with GPs.

“My family GP of more than 20 years this morning refused us an appt as we have not been in the last 2 years. I explained the only reason we haven't is because fortunately we are not sickly people and only need to see him today because of a weekend sporting injury (the doctor already <received> the documentation from the Hospital Emergency dept).

Apparently, it is now their new 'COVID-19' policy and told us to go elsewhere. Even a telehealth call was not an option because of the COVID-19 risk. Um, what risk if we are not in person? And still told to find someone else. I said going on that thinking every GP would refuse us on the grounds we've never been there before. He has all our history.

So, are we being punished for not being sick, not being repeat business and not draining the health system unnecessarily?

Does that mean he is no longer our GP?”

Billing and bulk billing

Reintroduction of fee for service for some telehealth consults reinstates inequitable access to health care and had led to significant confusion among consumers. We are aware the issue of bulk billing is significant, fraught and contested. At the very least information must be far clearer for patients, ideally bulk billing would continue for all telehealth.

“They should all be bulk billed, including specialists.”

“It has to be transparent what the cost of the consultation will be. I don't want to pay as high a price for a Telehealth consultation as I do for face to face.”

“More funding needs to be further considered. Should be an option for vulnerable. Rural families should have 100% access.”

Some were concerned that blanket bulk billing may mean telehealth is unsustainable for providers – highlighting the need for better remuneration.

“Bulk billing is not fair to medical practitioners - if telehealth continues it needs to be remunerated better or not bulk billed.”

Reduced effectiveness – when telehealth got in the way of effective health care

For some telehealth was accessible but not effective or problematic.

“Telehealth is a light touch consultation” - Some are restricting telehealth to short consultations

Some consumers found telehealth consultations were too short, limiting what can be addressed in the timeframe.

“My GP appointments are only available as 15 min phone consults, for which he is often late.”

“Not being able to have time to discuss issues in depth. It is a light touch consultation.”

“I also think that reasonable time should be given for the appointment... telehealth doesn't mean it will be brief.”

Privacy and private spaces

Lack of privacy was experienced by some consumers when using telehealth. This occurred for people depending on when and where they received the call from their provider, or where they live (without an available private space).

“The doctor needed to ask upfront if this was a good time. They phoned me with regards follow up to some tests. I was in a supermarket at the time.”

“I wasn't able to emotionally connect with my psychiatrist because I didn't have privacy at home.”

“I have also had times where my consults have occurred in a room with other people because I had no options for privacy. This has been uncomfortable and would rather not have been in that situation.”

While patient safety did not come up in survey data and stories provided, it was raised during the workshop – consumers identified that safety could be a serious issue for patients living in a domestic violence situation. The lack of privacy for the patient, the limits on what a provider can either glean during a telehealth consultation, or explore if they had concerns, makes telehealth

highly unsuitable for patients in these living situations.

And sometimes it's just too hard – many normal interactions aren't supported by telehealth

Many patient-provider consultations include activities that simply cannot be supported (or readily supported) by telehealth. And in some cases, the system just didn't work for people.

"Sharing documents and stuff like that is more complicated, especially with my GP since they are only using the phone."

"Physio over telehealth has been a challenge. They can't actually see the details of movements. Also trying to explain where I needed xray in my foot was really difficult. It wasn't somewhere obvious like my heel or big toe to describe."

Also the failings of technology have been a challenge, wrong room numbers for the NSW virtual rooms, internet dropping out etc."

"Only downside is that physical examination is not possible."

Poor access and poor effectiveness

For some the barriers (both in accessing telehealth and caused by telehealth) are too great.

Telehealth does not suit everyone – for some it introduces new barriers to receiving care

Some consumers have accessibility needs that are either not met at all or only very poorly met through telehealth.

"Telehealth has not had LIVE captions - the platform my GP has used has not been optimal in that sense if the patient is deaf and needs captions, THE TELEHEALTH OPTION IS USELESS and potentially very problematic with misunderstandings arising for lack of ability to understand/hear the GP. I had one telehealth appt with a specialist that was very stressful because I didn't understand anything he said, then that was it...lost my opportunity and have to wait now months to see him again in person (and hope COVID-19 won't restrict things then)."

"Some GP clinics have not accommodated to need, such as only having a male GP available (which meant I could not discuss my issues). Some reception staff have been very rude when trying to book telehealth. Sometimes GPs have been quite dismissive of severe symptoms over the phone. Some GPs also try to rush the appointment, mine gave me 5 minutes (and I am guessing billed for much longer)."

“Older relatives needing lots of help to actually access telehealth and then their privacy is compromised with needing another person to sit with them.”

“...catering to a patient’s disability... should be respected they are individuals and rights to privacy apply.”

“Everything is wrong, unless real time subtitles can be added and even then I think it's dangerous for treating mental health as they can't see body language etc”

When telehealth is not ideal for clinical and care reasons

In addition to the examples outlined above, the workshop participants also noted the following clinical and care reasons why telehealth might not be suitable:

- Some people felt that the first appointment between a patient and clinician should be in person (if safe to do so)
- When bad news needs to be shared, or major changes to treatment made, or
- When medical tests or interventions are not possible via telehealth.

Patient Choice

Telehealth does not suit everyone. Patient choice was raised by consumers as important to receiving care when needed and receiving the most effective care.

“Sometimes I think the patient knows they need to see the GP for matters Telehealth will simply not address and perhaps the patient should be able to determine this themselves because it is too costly for patients to do both Telehealth and then an appointment. It also means patients need to put aside two times for what would have been just one consult - not just the doctor that has a busy life. I think a patient should be able to say, no I need a in-clinic consult (although acknowledge the need to screen during COVID-19).

“Once it is not so critical to minimise in-person appointments it would be good to ensure that people who prefer in-person appointments can still access these.”

“In the future, whether it is a telehealth or in-person appointment, should be decided by both the provider and the consumer - we do not want telehealth visits mandatorily replace in-person appointments just because it suits the health professional or health service.”

“It should ... be recognised that rural people don’t always have terrific reception and so telehealth is sometimes just not going to work. Not everyone is computer

literate either, so Telehealth for elderly family members has required tech support from the family. I think they have felt stressed by this at times."

"having the option of face to face, telephone or video conference."

"Telehealth should also never be offered if it cannot cater to a patients' disability. They should be respected they are individuals and rights to privacy apply."

What do consumers want to keep about telehealth?

It was overwhelming clear that for the cohort for whom telehealth has worked well, consumers wish to keep the option for suitable consultations.

Access to health through telehealth consultations has significantly improved or increased for some due to:

- Patients living remotely or a long distance from providers
- The COVID-19 vulnerability of the patient and or carer
- Other health and disability-related access issues (e.g. managing chronic pain, managing anxiety)
- Where carers (eg parents) are not co-located and included in telehealth consultations,
- Convenience – for those whom access wasn't a significant issue before telehealth consultations, the benefits are best described as convenience. Being able to attend a consultation from home, work, without needing to find child care etc.
- Cost – travel savings (as well as the associated time and income savings) and where bulk billing is (or was previously) supported
- Where there is already a good patient-provider relationship
- Where there are skills, experience and existing technology
- Some regions had enabling technology and systems in place and have been able to rapidly scale up to meet the new demand, and
- When it is used to support good health care integration e.g. for multidisciplinary team consults.

Finding the ideal mix – telehealth as a tool within the face to face setting

Some consumers cited examples of when telehealth was used to very good effect within a mix of in-person consultations. Very high levels of satisfaction were reported by consumers with the convenience and effectiveness of these approaches.

"Getting simple things like referrals and scripts without having to go physically to the doctor's surgery. For consultations that have to be in person, having a telehealth visit first really streamlines the actual physical appointment."

“General quick follow-ups which don’t require any hands-on such as injections, physical assessments and wound dressings. Good for quick discussions on following up on results that require some form of verbal discussion but nothing too serious.”

“Using a mix of in-person and telehealth visits has been ideal. Prescription renewals, follow ups, medical certificates, health guidance all have been efficient and safe via telehealth services. Assessment and provision of referral by email was the best possible option - not having to take a sick person, especially a child, out of their bed and in the car to wait to see a doctor in person should definitely be an option for many situations.”

“The consultations were follow-ups of prior face to face consultations, which included physical examinations.”

Bring people together – regardless of their location, and with minimal lost time. Telehealth can be a tool to encourage and support multiple health professionals coming together with their patient and family at the same time to better co-ordinate care within and across specialties; and as people move into different health environments.

“My very elderly parent, ...was admitted very ill during the night recently. When I saw my parent in the morning so very ill, I can honestly say that at that point in time I thought we were very close to losing them. Well, with the amazing care of the nursing manager, the nursing staff and the tele-link medical consultants, over the following week I am overjoyed to say that my parent is now fully recovered and in very good health. I would like to take this opportunity to thank each & every one of the staff for the absolute outstanding care & love that you gave to my parent. You really are all such beautiful, kind, supportive and caring people. Thank you. ♥”

Suggested improvements for telehealth

Consumers highlighted a range of problems and suggestions for making telehealth more efficient and effective for all.

Telehealth needs certainty

If health providers and health receivers are to commit to and invest in the effort required to make telehealth work effectively, require certainty. Ideally this would mean making telehealth permanent. Consumers are asking that this happens.

“Lack of certainty about whether / how long <telehealth> will continue to be available.”

“Not happy that now services are disappearing.”

“More funding needs to be further considered. Should be an option for vulnerable. Rural families should have 100% access.”

“Make it available for all people”

Improve the range of telehealth and in-person options available to all, including with accessibility options.

Consumers report dissatisfaction with limited choices, for example when only telephone consults were available, or when telehealth was the only option and in-person was unavailable. Those who were able to access a mix of in-person and telehealth were very satisfied. People clearly want a range of options available for different situations.

“More video consults”

“My GP only does telephone telehealth. This makes the communication poorer, especially if you've never met in person.”

“Perhaps make it the exception rather than the only option. Need to apply to use it and for specific reasons. Face to face is safer.”

“Follow up physical should be part of it if needed.”

“Some guidance on identifying where face to face is required including periodic face to face checks in relation to ongoing condition treatment and monitoring.”

Significant barriers to using telehealth have been faced by people with accessibility needs and while not all of these can be addressed some can be solved through better technology choices.

“Make it available for all people”

While limited range of available telehealth options was of concern, so was the variety of platforms that providers were using – a natural outcome of the need to rapidly adopt telehealth in areas that were not ready to.

Expand the opportunity for multidisciplinary team consults and look for innovative opportunities

Given the ability of telehealth to bring multiple parties together easily, there is a growing opportunity to replicate the positive aspects of a face to face multidisciplinary clinic visit via TH. The opportunity to include carers and family members more easily should also be explored.

Mixing the best of both worlds: In order to bring the benefits of access to vulnerable patients

there was discussion about having health centres where consumers could get the support they needed to have a telehealth appointment with a provider they might otherwise not easily see. When COVID-19 is not a risk, bringing for example elderly patients together in a regional community clinic supported by nursing staff would involve valuable social interaction, yet also support telehealth consults with specialists who are not physically present.

Improve connectivity and technology

Ironically, the people who need reliable and affordable access to the internet most – people located in rural and remote area; those financially disadvantaged; low socio-economically with lower digital literacy; etc – are those who are less likely to have it. This obviously impacts on their ability to access telehealth.

“Problems with connectivity.”

“Telehealth has required a good internet connection and has sometimes dropped out which has wasted valuable time. More time has been spent troubleshooting on internet and connection issues, than the consult itself.”

“Video telehealth using a system designed for health care (e.g. CoviU <https://www.coviu.com/>) should be mandated unless there is some significant reason that this isn't possible.”

“It should ... be recognised that rural people don't always have terrific reception.”

“Telehealth providers having better systems/internet set up so once a few people are on the system doesn't lag.”

Streamline appointment management

Participants suggested that more needs to be done to prepare both patients and health providers for telehealth appointments. Health consumers felt more effective consultations would result from patients being aware beforehand of:

- how the telehealth appointment would proceed
- costs, if any, and how they were to be paid
- any expectations on them, and
- how to receive a record of the appointment afterward

Both sides of the telehealth appointment need to be clear about the ‘rules of engagement’. Some suggested formal protocols or processes would support this.

Communication also includes clear messaging around making appointments and how to join them. Some participants reported having to wait hours for a telehealth appointment and increasing anxiety levels as to if they had done something wrong and/or missed the appointment or health professional had changed appointment and it not going ahead. Being in a physical

waiting room is very different to waiting at home for a phone call or a Skype/Zoom connection. Issues being reported related to both making appointments and then attending them (waiting). Sitting around waiting is not acceptable to patients. Waiting on the phone or on the video call is not the same as waiting in the waiting room. Expectations are being reset.

“GP rang me unannounced. It wasn't a scheduled appointment and I wasn't ready with any questions.”

“Time keeping issues. For my first GP appointment my GP called 10 minutes early, and for my second she was 15 minutes late. Being able to see when the appointment is likely to happen would be very helpful.”

“Some doctors have been running late, my mum had 1 doctor ring over an hour after appointment time & didn't let her know he was running late.”

“We live on a farm. My husband had a 10am appointment. He waited with the phone for a call that didn't come. We called, only to be told the appointment was for 2pm. We were not notified. Again, he came back in and waited with the phone. 30 mins later, the call did not come. He went back out. The call finally came at 2:45pm. He missed it. Try again.”

“It is definitely better when there is a fairly reliable time of appointment. This has not been very reliable with my GP. I hope in time they might be better this. Having said that they have been very good when I needed to pass on information to my GP but was unsure if I needed an appointment for my concern.”

Improve preparation, communication and co-ordination

The importance of quality communication between patient and provider was identified as critical for good health outcomes and it influenced many aspects of telehealth. Many providers need training/skills development in how to communicate better when using telehealth to build a richer consultation.

“It's harder to pick up subtle cues from my Dr with whom I have a great rapport.”

“Not a great relationship builder - my mother-in-law, while she loved the convenience of the consultation, after two consultations, she still doesn't know who the doctor is she has been talking to. I wonder what would happen if she had to call them for any reason, rather as it works now for her - a scheduled call organised by the health service.”

“I think a patient's records need to be looked at before the referral so the practitioner can be aware of medication issues and allergies.”

“Improve MyHealthRecord - none of my recent hospital admission (public hospital) details are available on MyHealthRecord which has created some challenges. I would have previously taken a discharge record to the appointment as a default for face to face appointments.”

“Some kind of email receipt confirming what scripts go to what pharmacy etc”

“At times (particularly earlier on) poor communication about who was going to contact who and how exactly the consultation would take place.”

“A little bit more structure, confirmation of attendance (billing confirmation - ensure that the right items are being billed)...”

Design smooth transition contingencies into the process - when the consultation needs to shift from telehealth to face to face

Some telehealth consultations need to shift to in-person follow up. This needs to be designed into the process and supported with appropriate MBS billing items.

“Follow up physical should be part of it if needed.”

“Some patients use attending physical appointments to also see allied health, nursing and other team members or just pick up supplies, so physical appointments still need to be available.”

Design for clinical appropriateness

The workshop participants emphasised that the use of telehealth should be based on clinical appropriateness (taking patient preference and need into account). A mix of face to face and telehealth was seen as ideal for most people as there are a number of preventative interventions that happen at GP visits in particular: like a blood pressure check, medication reconciliation, etc. Consumers must be part of developing these guidelines. These views were reflected in the data around comments on guidelines and processes.

“There needs to be more guidelines for what Constitutes a situation which makes Telehealth appropriate. There needs to be a better baseline.”

“Some guidance on identifying where face to face is required including periodic face to face checks in relation to ongoing condition treatment and monitoring.”

Better processes and supports - get it right so telehealth delivery can perform at its best

Many of the problems consumers have cited relate to the systems around telehealth. Appointment management, setting expectations, clear processes and guidelines and follow up processes - all offer big opportunities for improvement.

Consumers are asking for guidelines and factsheets – all useful artefacts of a well designed systems supporting all stakeholders.

“There needs to be some really easy factsheets/resources on how to participate in a telehealth appointment.”

“Better team/clinic telehealth appointments so that the teamwork aspect of these kinds of visits is not lost.”

Build skills - telehealth requires confidence, skill and practice

Care providers were asked to rapidly implement telehealth in areas that were not prepared and this was undertaken to a very impressive degree. This rapid uptake left some providers doing things they had little or no preparation for. Skills development and support for providers in delivering telehealth will be of considerable benefit to both patients, providers and overall health outcomes.

“In the first telehealth appointment with my GP, my GP seemed quite uncomfortable, even though we were only doing administrative stuff (repeat prescriptions, referrals and blood tests). She seemed more comfortable the second time around, even though this was discussing a test result, which would seem more complicated.”

“It's strange having your consult over the phone and takes a while to get used to doing it this way.”

Address privacy

Addressing privacy for consumers using telehealth could be part of a factsheet and make up part of the checklist for when in-person consultations may be better for particular consumers or in particular situations.

At a system level, digital privacy will need to be addressed, particularly if telehealth consults are to be recorded (many participants would like a copy of the recording as a valuable record).

DISCUSSION

“Why did this not happen sooner?”

“How do I feel? ... Elated”

“Living remote means we often have longer wait times for essential services, but Telehealth is helping bridge that gap”

Overall, telehealth has been very well received. A welcome feature during COVID-19.

Beyond COVID-19, the rapid implementation of telehealth during 2020 has been an exercise in demonstrating what is possible. Done well, telehealth has been demonstrated to support the widespread delivery of effective health care consultations.

Telehealth use this year has also highlighted existing issues that continue to affect health in any setting: equity of cost and access, the burden of care on patients and carers, privacy, health literacy and patient-provider communication.

*While the experience and response of health consumers to telehealth has varied, it has repeatedly demonstrated that consumers want **uncompromised care that is accessible and minimises costs.***

Patients are not willing to trade-off access to care for effective care, and whilst far from perfect, telehealth has demonstrated enormous value with significant opportunity for further enhancements.

For regional, rural and remote communities, telehealth is a game changer. It has shown that when clinically appropriate and where patients are open to it, telehealth can yield significant benefits for patients and families associated with minimising unnecessary travel.

For some who were previously unfamiliar and unconvinced, if the consultation was done well, they were more likely to be converted and willing to use telehealth again in the future in the right circumstances.

For those, where the experiences were exceptional, telehealth demonstrated that it could be an integral part of health communication between providers and consumers.

Further, telehealth has re-set expectations around things most patients have come to accept. Some consumers were thrilled to be able to avoid a waiting room, either as a carer of sick child or adult, or to better manage their own conditions from home. Also, the waiting time reported to get an appointment seems to be significantly shorter for a telehealth appointment than for physical appointments, which can take weeks to months.

However, for some the virtual waiting room created a different expectation, with no visual and

audio cues, and diminished the tolerance of many patients to just sit and wait for their appointment as time passes. This contrasts to patients who can wait for significant time in physical waiting rooms. Consulting from home or work therefore means people are less likely to be willing to just sit and wait, and a likely expectation that service interactions will be held to the appointment times set. Transferring the old system to a telephone or video call, which was understandable during a rapid implementation, is an approach to telehealth that people are now less likely to accept. Rather than rely on an old process, the telehealth system needs to be redesigned – with consumers – from start to finish.

For a short time, many more consultations were being bulk billed, giving people access to specialists that they may not have otherwise been able to afford. Unfortunately, this universal access to bulk billing has been progressively wound back. Care though must be taken now to ensure patients are aware, upfront, of any costs they will incur following their telehealth appointment.

Telehealth has allowed people to join a consultation from their familiar environment. This has been reported by many to be less exhausting, daunting, and more relaxed. It is important to recognise that for some this change resulted in significant and much appreciated convenience. At the other of the spectrum the advantage has been far more significant with less pain, anxiety and exhaustion from attending in person, less impact to their work or income, and a propensity to access care they may not otherwise have accessed.

Together, some of these subtle changes may help create more balanced relationships between patients and clinicians, particularly in relation to the cost and opportunity cost of accessing health care.

A number of consumers have outlined poor or mixed experiences with telehealth. While some of the issues identified are specific to telehealth, such as hardware technology, internet connection, and the skill and confidence of the participants to manage the interaction – many of the other issues were familiar to provider-patient interactions generally. People have mentioned concerns with communication, information sharing, co-ordination of care, timely care, respecting patient preferences, and waiting times.

In part some of the poor experience reported come down to inconsistency with some providers doing it really well – e.g. being well prepared, being respectful of patients' time, understanding how to get the most out of a telehealth appointment. Others are taking old bad habits and simply transferring them to a new mode of delivery.

However, it is also clear that for some consumers telehealth has introduced new barriers to receiving care. These barriers range from inappropriate inaccessible technology, difficulty communicating over telehealth, internet access, privacy and others. While better telehealth technology and practices will address some of these issues, some will be insurmountable. Consumers emphasised how important patient choice was in the type of telehealth options available as well as whether telehealth was to be used at all in some cases.

What does Telehealth address?

"A great idea, as someone with massive health issues on disability pension, I often don't go unless I'm half dead - the 2 to 3 days exhaustion, recovering from leaving the house, plus the risk of catching something waiting for 40 min in a waiting room has to be worth the risk. Due to expense, I often don't go unless it's bulk billed"

"Some days it's just too hard /over whelming to actually get to appointments. Telehealth has meant I could get help even if I was sitting in bed exhausted from pain.

Telehealth has meant my GP is more able to make appointments for urgent things available, if they don't require face to face consult.

It also meant that in the peak of my husband's mental health crisis he was able to access help without it impacting on his job, this was CRITICAL in keeping him well as mental health care and construction don't mix."

Telehealth removes barriers to access health care

At its best, telehealth removes barriers for people accessing health care. Telehealth addresses the distance between the person seeking health care services and the availability of the optimal service required.

Prior to COVID-19, in Australia, 'distance' had been specifically restricted to spatial distance – ie, a vast physical distance between the need and the service - rural need and metro service.

"Telehealth is now a brilliant Service available at my local Hospital... This avoids previous Patient Assisted Travel Scheme (PATS) transfers and flying with an escort, just for a 10-minute consult with a <city> Surgeon or Specialist. Now avoids the PATS costs, usually a 14-16 hour day, and often very painful experiences - sitting in a transit wheelchair for this time - plus, often a long wait in clinic waiting rooms &/or transport back to airport terminals."

However, 'distance' can be measured in other less obvious ways – all of which of barriers to accessing appropriate care:

- The physical and emotional obstacles that can block the path of the two who are otherwise nearby – the person seeking care who cannot climb the stairs in order to reach the service provider; or the person requiring care but not yet prepared to reveal themselves to their care provider; or even the person who minimises their need to avoid a consultation altogether because they do not share a language both can understand;
- The length of time between *when* the care is needed, and when the expertise is available – whether the waiting is reliant on the fly-in service provider; or the logistics required to align travel with a city appointment;

- The cost burden that can either limit the interaction between the two below optimal care levels, or worse still prevent the two coming together at all;
- The inflated time burden of preparing, travelling (even short distances) and waiting for a brief physical consultation – can lead to hours of time required, often for a 20-minute consultation;
- The real or perceived burden (of their time, costs, income lost and/or emotional toll) on family members the person depends on in order to reach their appointment.

"I'm disabled, I usually find the travelling exhausting and a major barrier to accessing even basic healthcare with my GP. <Telehealth> has been a godsend."

"Not having to travel 40 minutes to see my GP - very hard to do when chronically ill so made appointments much easier."

"Prompt renewal of prescriptions and faxing to Chemist. Time management...no need to book a wheelchair taxi and get in and out and wait in the surgery ...quicker consultations and mostly very close to scheduled timeslot."

Access to optimal and timely care is a fundamental tenet of quality care

Telehealth significantly improves patients' ability to access care. Telehealth brings together health expertise that may not have been previously available to patients. If an individual cannot access the care when they need it - the skill of the clinicians and calibre of its facilities is no longer relevant.

Usual care for some can mean *minimal*, or no care

Most the of the comparison of telehealth is reviewed against *usual care*. *Usual care* is the term used for the status quo, sometimes assumed to refer to *physical care*. For some though, particularly in rural and remote areas, usual care may be *minimal* or *no care*.

"I am homebound due to my disabilities. I rarely see a GP, even when sick. Having access to telehealth meant I could speak to a GP for medication renewal and about health issues I was having. It also meant I could get a COVID test as it required a GP referral. Without telehealth I could not have been tested for COVID and could not get my medication."

"I had an accident in January. Was non weight bearing for over 8 weeks. Have been unable to access the surgery since then due to my slow recovery. It has been a great asset."

"..in the peak of my husband's mental health crisis he was able to access help without it impacting on his job, this was CRITICAL in keeping him well as mental health care and construction don't mix."

Minimising unnecessary travel and relishing the associated benefits

There was significant feedback reflecting the direct and indirect benefits gained from minimising travel. Unsurprisingly, those patients who must travel for their health care needs, consistently referenced a range of benefits associated with telehealth including:

- money saved from the cost of travel;
- significantly minimising time, and sometimes income, lost from work or family responsibilities – often measured in days rather than hours;
- the physical discomfort sometimes associated with the travel itself and the waiting around;
- for many, reduced times in waiting rooms on the day of their appointment; and
- for some, reduced the waiting time to get an appointment.

These costs are predominantly borne by the patients and their families and tend to be invisible costs of receiving health care.

Telehealth – making it easy for people to seek care

Of all the comments received about telehealth, more than a third celebrated its convenience. Convenience, like access, is multi-faceted with multiple benefits flowing to patients and families.

This is pertinent in safety and quality where ‘efficiency’ is recognised as an important pillar to evaluating a health system’s overall quality. The difference is that efficiency is usually measured from the perspective of the system and service providers. It does not incorporate the burden that is transferred to health service consumers in order for the system to appear efficient.

Efficiency can be measured in costs incurred, income lost, as well as the additional costs incurred by either, or both, the system, and the consumer, when it could have been avoided if care was sought and received optimally. The costs incurred by consumers receiving the service are unmeasured, unreported, and on the whole invisible to health care system discussions.

As a result, health system oversight regularly discounts, and sometimes dismisses, consumer convenience as a relatively unimportant priority. However, it can be argued that when **inconvenience culminates in a person delaying or avoiding seeking care when they should, it becomes a barrier to care and inaccessible care.**

“I have been able to keep in contact with my doctor through some difficult weeks combining lockdown and mental health issues.”

“It has been a wonderful thing to have functioning for my rural living situation (live 5hrs away from my doctors) where I have been able to avoid some unnecessary trips for consults in clinics. I have regular doctors and in this instance it works well because they know me so well.”

“Has allowed people to fit their medical appointments around work and other commitments, especially ... to commute a significant distance. Has also allowed

for more regular appointments that would previously have been manageable and therefore better partnerships between practitioners and patients.”

What telehealth does NOT address?

Telehealth is not a replacement for physical care. It is another tool in the medical bag of service delivery.

- Telehealth cannot perform a physical examination – even with technology improving the range of digital monitoring tools.
- Telehealth cannot support deep person to person connections, that build trusting and confident relationships that are needed to sustain interactions and treatment adherence through difficult times. To choose to touch, to sit quietly alongside another person, to simply be there, are human touches that sustain people at their most anxious, distressed, or even joyful.
- Telehealth can increase the disconnection that comes when people are isolated and are not engaging with others. For some, and as difficult as it might be, physically meeting with their health care provider is good for their emotional health.
- On its own, it will not make better or worse the known issues that can currently plague our face to face consultations. Around 20% of our survey respondents indicated poor communication with telehealth. The problem of poor communication has plagued our health system for decades. Therefore, it is a misinterpretation of the result to attribute poor communication as exclusive to telehealth. It is a skill gap, rather than a technology gap. We must address the skill rather than misalign it specifically to telehealth:
 - Alone, it will not improve communication. It will not improve co-ordination of care. It will not make care safer or more effective
 - It is a tool. An enabler to build from. A platform to commence from
- It is not a new model of care. It does not re-create optimal care. Service provision begins with evidence-based optimal care. Service delivery options must align with optimal care, which telehealth should not compromise.
- It is also situation dependent. There will be times when telehealth cannot replace a face to face consultation; these situations can be true for clinical appropriateness; as well as for patients who may need the reassurance that comes with the physical presence of their clinician or when the technology does not meet their accessibility needs.
- It will not work for any one person every time. Nor will it work for every person. Accessibility will always remain a critical aspect of telehealth for many people – where that can be resolved for individuals they may find it works well for them, however where

telehealth cannot bridge that gap it will be inappropriate.

- And its effectiveness, like face to face consultations is dependent on the:
 - appropriateness of the equipment, process and contingencies when needed (e.g. smooth processes when transition to in-person care is required)
 - clinical skill, ability to adapt to different ways of receiving information, and
 - extra effort and willingness to focus on communicating and sharing information, as well as attentiveness to non-verbal cues of all involved in the interaction - to build enough rapport to feel comfortable and confident to confide willingly and freely. Particularly given the lack of physical presence will tend towards the less personal.

Barriers

The feedback from consumers also identified a number of barriers to the efficient rollout of a well co-designed telehealth system. Some of those highlighted include:

- Reluctance by some providers to use telehealth: Understandably providers will have a wide range of reasons for this reluctance and we will leave their exploration to the organisations that ably represent them. Stakeholder engagement and investment in skills and co-designed protocols would assist with this issue.
- Provider remuneration: Reintroduction of fee for service for most telehealth consults reinstates inequitable access to health care and had led to significant confusion among consumers.
- We are aware the issue of bulk billing is significant, fraught and contested. At the very least information must be far clearer for patients, ideally bulk billing would continue for all telehealth. Bulk billing is also more likely in urban environments because of competition among providers.
- Digital literacy needs to become part of the wider health literacy work. Simple factsheets, checklists and protocols need to be developed to assist both clinicians and consumers to use the technology. There also needs to be checklists or decision tools for determining when telehealth is a good option and when it might not be the best choice and in-person consult/intervention is required. Consumers must be part of developing these tools and resources.
- Carer burden: Whilst it can be easier for carers to attend telehealth appointments with the person they are caring for, it can also mean a much bigger burden on them in terms of having to provide much of the intervention that would take place at a in-person visit themselves, which can further increase their caring load. This needs to be taken into consideration with increased supports for carers taking on these tasks.

The 12 month rule

One barrier that is a special case is 12-month rule introduced in July 2020. This rule has raised significant access issues for a very wide range of health service consumers, outlined succinctly in an editorial article in MJA's Insight²⁵, and supported by 69% in the survey following the article; and the substantial commentary responding to it.

It also highlighted that '...This decision will hinder sexual and reproductive healthcare access in Australia because some patients' own GPs:

- Work in clinics that do not always offer specialist sexual and reproductive health services
- Have not completed the additional training required to provide specific sexual and reproductive health services
- Conscientiously object to providing sexual and reproductive health services
- Experience a range of challenges in providing accessible services due to a range of access, equity and agency issues.'

Issues surrounding the rule was also raised in an open letter sent to Hon Greg Hunt on 14 July 2020, and signed by 10 pages of leading individuals and organisations in sexual health, families and welfare, and requesting the rule be wound back, and that changes be made in consultation with community.²⁶

The premise of the rule to maintain connections between patients and providers is supported. However, it is a blunt instrument to force a relationship that must be built on trust between patient and clinician. It must be re-imagined and renegotiated by administrators, consumers, communities and providers (and the industry associations that represent them) to find better ways.

Work with the Commonwealth Government to raise the issues that the current 12-month rule is creating for health consumers and communities.

²⁵ BAIRD A, Telehealth: latest changes may exclude some patients in need, 20 July 2020, MJA Insight <https://insightplus.mja.com.au/2020/28/telehealth-latest-changes-may-exclude-some-patients-in-need/> as accessed on Sept 2020

²⁶ <https://resources.maristopos.org.au/OpenLetter.pdf>

APPENDIX

What you told us – a virtual workshop on telehealth

The virtual event held 28 August 2020 included a brief presentation on the context of the telehealth discussion and summary of what consumers had told us prior to the event. There were breakout sessions to discuss what was working well, what could be improved and consider when telehealth didn't work well. The following has been outlined below:

- What do we want to keep with regards to Telehealth?
- When is telehealth not suitable?
- How do we improve telehealth from here?
- What are the barriers?
- A final poll conducted with participants at the conclusion of the event.

What do we want to keep with regards to Telehealth?

The participants agreed that on the whole the increase in telehealth consultations has been positive.

Getting scripts, referrals and general check-up and updates with doctor that you already have a trusting relationship with has been particularly useful. This is a huge improvement on having to attend GP or specialist for these interventions.

With regards to mental health and chronic illness and pain, some consumers have found telehealth excellent – better access, no travel, reduction in pain, and can reduce anxiety of face to face visits for some people. Having an established trusting relationship with health professional first was considered essential, and then subsequent visits/interventions via telehealth worked well.

On the other hand, some consumers had a different experience and accessing health care via telehealth can increase anxiety and generally make interventions less effective than face to face. The importance of the choice for consumers moving forward is critical – telehealth must be person centred.

For appointments regarding children, having parents/carers from different locations Zoom/Skype etc.. into the appointment has been very positive, as has not having to bring multiple children to a face to face visit (again this has not been everyone's experience).

Of course, telehealth has already been operating well in a number of areas, for example Hunter New England Local Health District (HNELHD). HNELHD has had it in place for a long time; particularly for remote users, and it has had great feedback. Primary care practitioners in the region adopted telehealth very quickly (patientinfo.org.au) (www.hnehealth.nsw.gov.au/telehealth/Pages/Telehealth%20Home.aspx). HNELHD simply scaled up existing technology and already had the enabling systems in place for this to happen quite

seamlessly.

Phone help lines have existed long before COVID-19 and often involve long complex health interactions. The experiences of these providers could be tapped into to better support emerging telehealth practice.

A multidisciplinary clinic visit via telehealth was a very positive example of using telehealth for better health care integration and access, however this experience hasn't been widely reported.

Summary: What is working well about telehealth?
- Access to health through telehealth consultations has significantly improved or increased for some due to: - Patients living remotely or a long distance from providers - The COVID-19 vulnerability of the patient and or carer - Other health and disability-related access issues (e.g. managing chronic pain, managing anxiety), - Where carers (eg parents) are not co-located and included in TELEHEALTH CONSULTATIONS, - Convenience – for those whom access wasn't a significant issue before TELEHEALTH CONSULTATIONS, the benefits are best described as convenience. Being able to attend a consultation from home, work, without needing to find child care etc. - Cost – travel savings (as well as the associated time and income savings) and where bulk billing is (or was previously) supported - Where there is already a good patient-provider relationship - Where there are skills, experience and existing technology - Some regions had enabling technology and systems in place and have been able to rapidly scale up to meet the new demand. - Phone help lines have existed long before COVID-19 and often involve long complex health interactions - When it is used to support good health care integration e.g. for multidisciplinary team consults.

When is telehealth not suitable?

Patient choice was highlighted as important. Sometimes telehealth is difficult for those who are a lot older, for those with poor digital literacy or access to technology and those consumers who find communicating via phone or video challenging (for a variety of reasons). This needs to be decided with the consumer (and possibly with their carer) - it is inappropriate to make generalisations as an older person may have great access to and use of technology and a young

person may not.

Patient safety and privacy were identified, particularly in situations where there is family violence. Privacy is an issue for patients where they are not able to conduct their telehealth consultation in a private space.

Participants acknowledged that telehealth worked well in a mix with face to face consultations. There was a view that as the first appointment between patients and providers is considered important in developing a good relationship that ideally face to face was preferred where possible.

For clinical and care reasons F2f consultations are superior when bad news needs to be shared or major changes to treatment made. Clearly a physical visit is required due to the medical test or intervention not being possible via telehealth. Baby health checks were given as an example of telehealth appointments that were being conducted too quickly leaving new mothers feeling insecure.

Summary: When is telehealth not suitable?

- If the patient does not wish to use telehealth
- Patient related - where communication via phone or video is not ideal or possible (age, disability, language or other)
- Where the safety of the patient can't be assured (in situations of family violence)
- Where the privacy of the patient can't be assured (living situation means privacy during consult isn't possible)
- Where there are clinical and care reasons that telehealth is not adequate:
 - The first appointment between a patient and clinician
 - When bad news needs to be shared, or major changes to treatment made
 - When medical tests or interventions are not possible via telehealth.

How do we improve telehealth from here?

Patient choice

The importance of the choice for consumers moving forward is critical – telehealth must be person centred! (see When is telehealth not suitable)

Clinical appropriateness

Participants emphasised that the use of telehealth should be based on clinical appropriateness (taking patient preference and need into account). A mix of face to face and telehealth was seen as ideal for most people as there are a number of preventative interventions that happen at GP

visits in particular: like BP check, medication reconciliation, etc. Consumers must be part of developing these guidelines.

Access

Some patients have found that they have been excluded from receiving health care due to the new rules around telehealth only being available with a GP with whom they have a 12 month relationship with. This will block primary health care access to people who are already vulnerable. It is recommended that this is revisited with consideration given to how patients without long standing relationships with a local GP can access a GP and can access telehealth if appropriate.

For others, because the type of telehealth consultation that was offered was not accessible to them personally (due to disability, language or technology access) they were no able to access health care. Alternative, accessible methods of telehealth need to be available to all.

Reintroduction of fee for service for some telehealth consults reinstates inequitable access to health care and had led to significant confusion among consumers. We are aware the issue of bulk billing is significant, fraught and contested. At the very least information must be far clearer for patients, ideally bulk billing would continue for all telehealth.

Quality communication

The importance of quality communication between patient and provider was identified as critical for good health outcomes and it influenced many aspects of telehealth. Many providers need training/skills development in how to communicate better when using telehealth to building a richer consultation.

Participants suggested that understanding how the telehealth appointment would proceed beforehand, costs if any, understanding the expectations on them and receiving a record of the appointment would be useful afterward, but would also make for a more effective consultation. Both sides of the telehealth appointment need to be clear about the 'rules of engagement'. Some suggested formal protocols or processes would support this.

Communication also includes clear messaging around making appointments and how to join them. Some participants reported having to wait hours for a telehealth appointment and increasing anxiety levels as to if they had done something wrong and/or missed the appointment or health professional had changed appointment and it not going ahead. Being in a physical waiting room is very different to waiting at home for phone or Skype/Zoom etc..

Digital literacy

Digital literacy needs to become part of the wider health literacy work. Simple factsheets, checklists and protocols need to be developed to assist both clinicians and consumers to use the technology. There also needs to be checklists or decision tools for determining when telehealth is a good option and when it might not be the best choice and face to face consult/intervention is required. Consumers must be part of developing these tools and resources.

Technology

Many providers need training and skills development to support their use of technology.

Currently some providers had only made telehealth available by phone and some felt that the technology used (eg phone or video) should be based on patient preference and clinical need (and video was considered preferable for quality communication). It was also suggested that technology standards should be established to better support patients and providers.

Every provider using a different system is challenging particularly for those whose digital literacy is low. It would be good to have a universal, secure, supported telehealth platform for health, which lets you know what time the appointment is happening, it could also include other things like the cost of TH appointment, reminders, if running late etc.

Privacy

Privacy is a big issue for consumers who need family/carer to access the technology for TH. In face to face appointments carer can just step out of the room when consumer needs to discuss confidential information. Consumers who live at home with parents or in share households can often not get the privacy they need for telehealth appointment – examples were given of people doing appointments in their car or outdoors in a park etc... to get some privacy. How to handle this situation could be part of a factsheet and make up part of the checklist for when face to face may be better than telehealth for particular consumers or in particular situations.

At a system level, digital privacy will need to be addressed, particularly if telehealth consults are to be recorded (many participants would like a copy of the recording as a valuable record).

Carer burden

Whilst it can be easier for carers to attend telehealth appointments with the person they are caring for, it can also mean a much bigger burden on them in terms of having to provide much of the intervention that would take place at a face to face visit themselves, which can further increase their caring load. This needs to be taken into consideration with increased supports for carers taking on these tasks.

Expanding the opportunity for multidisciplinary team consults

Given the ability of telehealth to bring multiple parties together easily, there is a growing opportunity to replicate the positive aspects of a face to face multidisciplinary clinic visit via TH. The opportunity to more easily include carers and family members should also be explored.

Mixing the best of both worlds

In order to bring the benefits of access to vulnerable patients there was discussion about having health centres where consumers could get the support they needed to have a telehealth appointment with a provider they might otherwise not easily see. When COVID-19 is not a risk, bringing for example elderly patients together in a regional community clinic supported by nursing staff would involve valuable social interaction, yet also support telehealth consults with specialists who are not physically present.

Summary: How do we improve telehealth from here?

- Patient choice
- Clinical appropriateness – mix of F2f and telehealth preferred, involve consumers in developing guidelines
- Access
 - Revisit how patients without long standing relationships with a local GP (frequently vulnerable groups) can access a GP and can access telehealth if appropriate.
 - Make alternative, accessible methods of telehealth available to all.
 - Bulking billing - at the very least information must be far clearer for patients, ideally bulk billing would continue for all telehealth.
- Quality communication is central
 - Provider training to support richer consultation using telehealth
 - Clear communications beforehand on how the telehealth appointment would proceed
 - Clear messaging around making appointments
- Digital literacy for providers and patients
 - Factsheets, checklists
- Technology
- Training and skills for providers
 - Technology standards (eg video always except when patient prefers phone)
 - Standard technology – a universal, secure, supported telehealth platform
- Privacy
 - Guidelines on either how to improve privacy or when to use F2f instead of telehealth
 - Privacy issues around recording consultations must be addressed, some consumers want recordings.
- Carer burden if taking on interventions due to telehealth
 - Increased supports for carers taking on these tasks
- Expanding the opportunity for multidisciplinary team consults
- Mixing the best of face to face community resources with telehealth to support vulnerable groups to access scarce or virtual health care/specialists.

Barriers

Some of barriers to moving forward with telehealth improvements were identified by participants are outlined below.

Reluctance by providers to use telehealth

Understandably providers will have a wide range of reasons for reluctance and we will leave their exploration to the organisations that ably represent them.

Provider remuneration

Reintroduction of fee for service for some telehealth consults reinstates inequitable access to health care and had led to significant confusion among consumers. We are aware the issue of bulk billing is significant, fraught and contested. At the very least information must be far clearer for patients, ideally bulk billing would continue for all telehealth. Bulk billing is also more likely in urban environments because of competition among providers.

- Cohort who need it most are most likely to miss out telehealth I general or bulk billing
- Universal access

Enablers that may remain barriers until they can receive the funding and time required to address them:

- Provider upskilling and accreditation
- Addressing privacy and security of telehealth channels
- Consistency of technology platform

Poll

At the conclusion of the Telehealth event the participants voted in the quick poll resulting in the following result. Note that the support for 'Yes but with modifications is highest with $\frac{3}{4}$ of participants choosing that option.



COVID-19 Consumer Leaders Taskforce

amplify.hcnsw.org.au/covid-consumer-rep-hub

Health Consumers NSW

T 02 9986 1082 | E info@hcnsw.org.au | @HCNSW

www.hcnsw.org.au