Telehealth Victoria Community of Practice

Workshop 1 - March 31st 2017

PROCESSES

Susan Jury

Building telehealth into existing processes

1. An approach to capturing all the points where telehealth may interact with existing processes, etc

2. Adapting applications and software – 4 examples

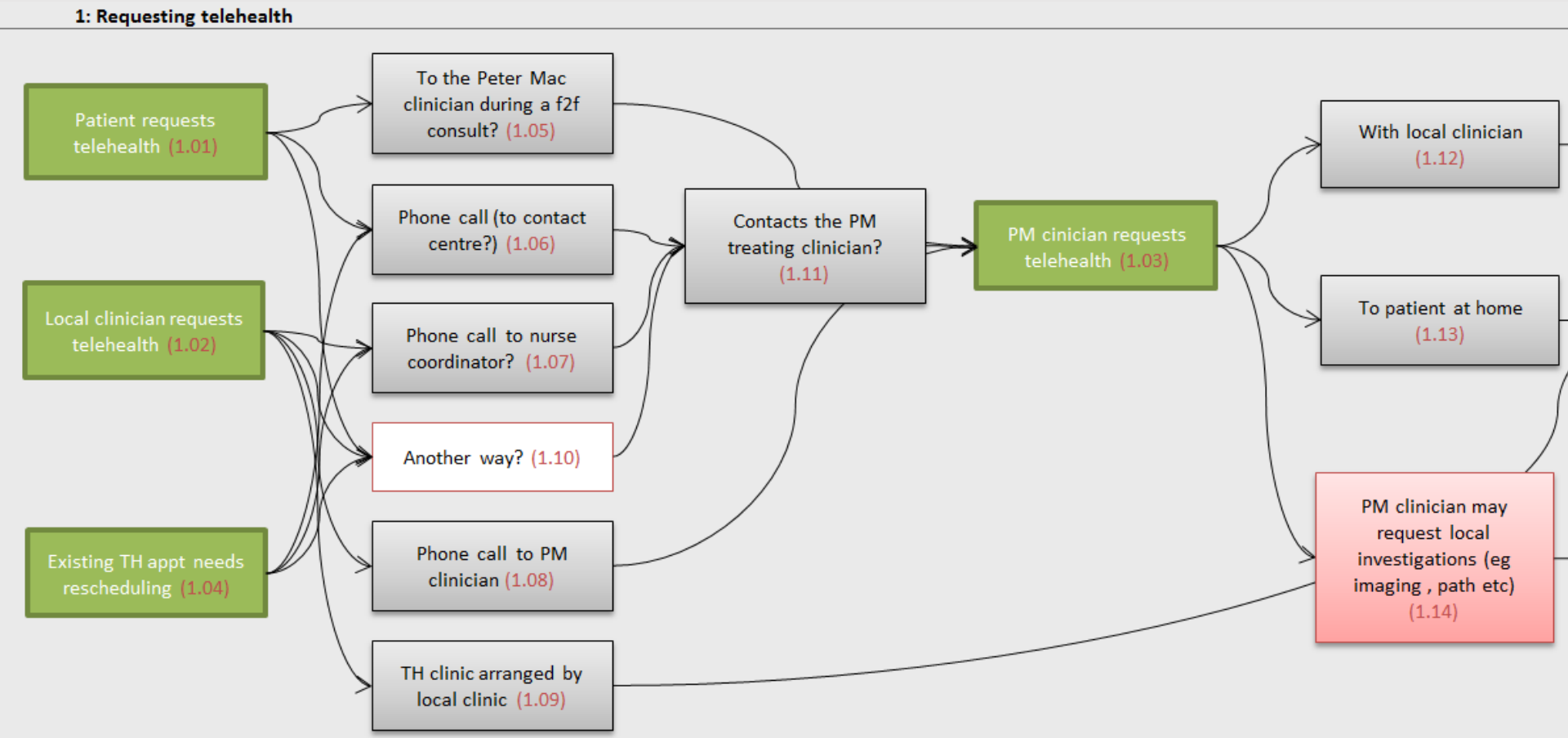
   Discussion -
   - People's approach & experiences
   - Issues
   - Solutions

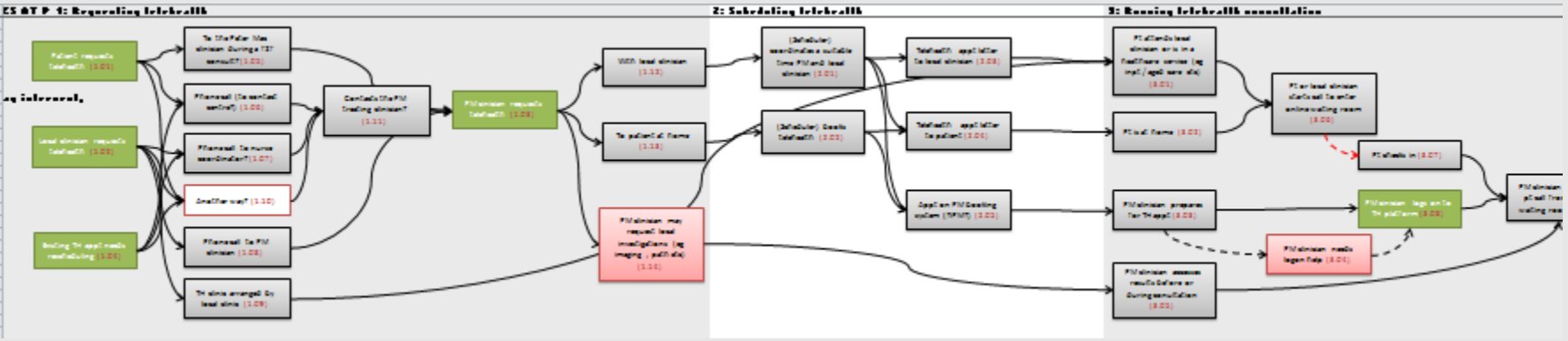
Building telehealth into existing processes

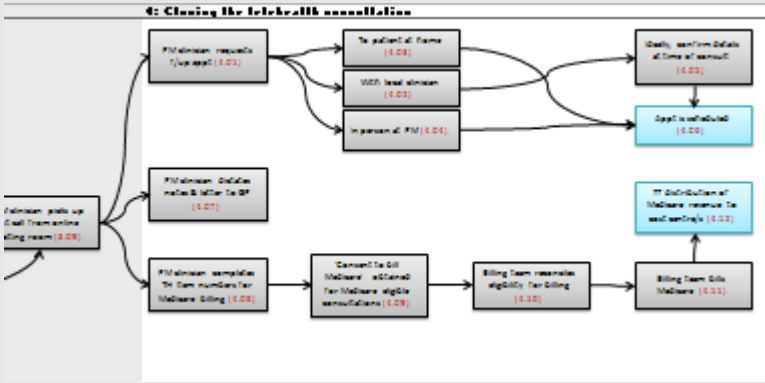
1: Requesting telehealth
2: Scheduling telehealth
3: Running the consultation
4: Closing the consultation

Process mapping

Requesting telehealth




2: Scheduling telehealth
3: Running telehealth consultation


4: Closing the telehealth consultation

Some key Applications changes required

1. **Telehealth appointment types**
   - Scheduling systems
   - Request forms (electronic or paper)
   - Viewers – for clinicians, patients, admin

2. Ability to book a telehealth apt at any time (eg outside of usual scheduled clinics)

3. **Telehealth letters** (x 3)

4. **Checking in telehealth patients**

5. Medicare Items in post consult forms (paper or electronic)

6. Obtaining **consent to bill Medicare**

7. Future planning for telehealth – eg ward discharge planning, etc

8. **Other?**

1: Telehealth appointment types

1. Telehealth – patient only
2. Telehealth – with clinician

   (affects pathways for scheduling, rescheduling, cancelling, running etc)

Requirements:

- For requesting – clinician
- For scheduling – administrators
- Clearly and readily identifiable clinicians and admin
- Countable and reportable
- Easy to use
- Minimise cost of change
- Minimise impact on existing reporting etc

1: Telehealth appointment types

- What issues have you encountered?
- What tweaks have you made?
- What solutions have you come up with?

Eg:

- Qflow
- iPM
- IBA
- EMR
- Verdi
- Others?

2: Telehealth letters

1. For patient: *Telehealth – patient only*
   - Instructions for joining call, test call etc

2. For patient: *Telehealth – with clinician*
   - Instructions to go to local clinician
   - Address for local clinician, etc

3. For local clinician: *Telehealth – with clinician*
   - Instructions for joining call, test call etc

2: Telehealth letters

- Issues?
- Tweaks?
- Solutions?

Eg:

- Editability / individualise
- Need for 2 letters when local clinician
- Address to send to?
- Integrating –
- Up-to-date GP details?
- Which Dr?

3: Checking-in / visibility of telehealth appointments in clinic list

- Telehealth patients can not ‘check in’ (eg at kiosks or at front desk)
- May look to the doctor that the patient did not show up – results in a ‘DNA’
- And/or – Dr doesn’t know when patient is actually online and ready to go
- Need to see if patient only, or with local clinician (timing)

3: Checking-in / visibility of telehealth appointments in clinic list

- Issues?
- Tweaks?
- Solutions?

Eg:

- Reception or desk monitors online ‘Waiting Area’?
- Online check in?
- Check in widget etc? (eg Qflow)
- Qflow / Clinic list shows telehealth appt type?

4: Consent to bill Medicare

- Medicare rules for obtaining consent
- Requires email or fax
- Each health service also has their own rules or processes (for non telehealth)
- Potential to result in non-billing

4: Consent to bill Medicare

- Issues?
- Tweaks?
- Solutions?

Eg:

- Existing health service rules
- Email is fine?
- SMS consent

A shared / State-wide approach?

- Qflow?
- IBA?
- iPM?
- Epic (EMR)
- Verdi?

- Integration with Video Call?

- Other priorities?

FUNDING & COUNTING

Penelope Watson

Funding & Counting

VINAH & counting telehealth consultations

Should telehealth activity for MBS clinics be reported via VINAH?

YES

Should a telehealth consultation be counted by both sides of the consultation?

YES

…..Where a patient is in the physical presence of a health care provider(s) at one health service and care delivery involves the participation of a health care provider from another health service via telehealth, the contact should be reported by both health services using a contact delivery mode of (3) Telehealth.

(Section 3 – Data Elements, VINAH manual, 12 Edition, July 2016 – Contact Delivery Mode p 29 -30)

Another useful reference with examples

Tier 2 Non-Admitted Services Compendium 2016-17, Independent Hospital Pricing Authority, pages 12 &13

Funding & Counting

VINAH Business data elements for telehealth consults

Provider end

- **Contact Client Present Status**
  Code 13 - via telehealth if Contact Delivery Mode = telehealth & patient is **NOT** physically present
- **Contact Delivery Mode**
  Code 3 - telehealth

Patient end

- **Contact Client Present Status**
  Code 10 - patient/client **present with or without carer(s)/relatives** if Contact delivery mode = telehealth & patient **IS** physically present at health service (use Codes 11 & 12 for palliative care patients/clients only)
- **Contact Delivery Mode**
  Code 3 - telehealth

Funding & Counting -
Telehealth MBS Item numbers 101

What do I need to know when setting up a MBS clinic?

- *Specialist clinics in Victorian public Hospitals – A resource kit for MBS-billed services February 2011*
  https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/specialist-clinics/specialist-clinics-program/specialist-clinics-resources
- The majority of specialist clinic activity is funded through VACS however MBS clinics may also be established.
- Not required to physically separate the location of VACS funded and MBS specialist clinics
- Still count all activity regardless of whether or not the clinic is VACs funded or MBS funded
- Signage should indicate that clinic is public, private or mixed and that patients have the choice to treated as a public or private (MBS-billed) patient.
- Sustainability of MBS clinic: anyone have a modelling spreadsheet for item number projections?

Another useful resource

Non-Admitted (Acute) Frequently Asked Questions:
Explains non-admitted Activity Based Funding, although Victoria does not yet use activity based funding for non-admitted, activity needs to be counted in order for the Commonwealth to acquit its funding obligations. This data is extracted from VINAH!

https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/activity-based-funding/abf-services-streams/non-admitted-care

Funding & Counting -
Telehealth MBS Item numbers 101

To be eligible the patient must be:

- Located in a telehealth eligible area (RA 2 – 5) at the time of the attendance (go to doctor connect to check); AND
- located at least 15km by road from the specialist;
  or
- a care recipient of a residential aged care facility (located anywhere in Australia);
  or
- a patient of an eligible Aboriginal Medical Service (located anywhere in Australia).

MBS Online Telehealth

- http://www.mbsonline.gov.au/telehealth
- Telehealth Criteria
- Telehealth Item numbers
- Telehealth Eligible Areas
- Telehealth Program Overview etc.

Funding & Counting -
Telehealth MBS Item numbers 101

Telehealth MBS rebates available for

- The specialist completing the teleconsultation using specific telehealth MBS item numbers with associated item numbers.
- Nurse practitioners, midwives, GPs or practice nurses and aboriginal health workers providing services on behalf of the GP. They must be physically present at the telehealth consultation.

- http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/connectinghealthservices-itemlist

Things to watch out for:

- Assigning of benefits/bulk billing: how do you get permission from the patient and how do you keep a record of it?
- Referrals – a valid referral must be received to enable a medical practitioner to bill specialist clinic services against the MBS.

Funding & Counting -
Telehealth MBS Item numbers 101

Telehealth MBS Item	MBS Group	Associated Items
99	GROUP A3 – SPECIALIST ATTENDANCES	104, 105
112	GROUP A4 – CONSULTANT PHYSICIAN	110, 116, 119, 132, 133
149	GROUP A28 – GERIATRIC MEDICINE – CONSULTANT PHYSICIAN OR SPECIALIST	141, 143
389	GROUP A12 – CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES	385, 386
2820	GROUP A24, SUBGROUP 1 – PAIN MEDICINE ATTENDANCES	2801, 2806, 2814
3015	GROUP A24, SUBGROUP 3 – PALLIATIVE MEDICINE ATTENDANCES	3005, 3010, 3014
113	GROUP A3 – SPECIALIST ATTENDANCES	Stand alone item
114	GROUP A4 – CONSULTANT PHYSICIAN	Stand alone item
384	GROUP A12 – CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES	Stand alone item
2799	GROUP A24, SUBGROUP 1 – PAIN MEDICINE ATTENDANCES	Stand alone item
3003	GROUP A24, SUBGROUP 3 – PALLIATIVE MEDICINE ATTENDANCES	Stand alone item

EVALUATION

Jane Kealey

An introduction to evaluation

- MAST – Model for Assessment of Telemedicine applications (INTL. J. OF TECHNOLOGY ASSESSMENT IN HEALTH CARE 28:1, 2012)
- 2009 – framework to assess application of telemedicine
- More detail workshop 2
- Now, Elements of MAST…

Preceding consideration

- Purpose of the telemedicine application?
- Relevant alternatives?
- International, national, regional or local level of assessment?
- Maturity of the application?

Multidisciplinary assessment

1. Health problem and characteristics of the application
2. Safety
3. Clinical effectiveness
4. Patient perspectives
5. Economic aspects
6. Organisational aspects
7. Socio-cultural, ethical and legal aspects

Transferability assessment

- Cross-border
- Scalability
- Generalizability

Evaluation – considerations

- Begin planning at very start of project
- Engage experts (university)
- Consistency with current evaluation
- Ethics submission
- Know your audiences
- Be prepared to modify approached and methods if responses low
- EB important future funding – embedding, expanding existing services & new services

An introduction to evaluation

Regional Emergency Department Telehealth support to Urgent Care Centres after hours in Northeast Victoria, Australia: A study of the technological, human and system factors for success

Northeast Health Wangaratta; Department of Rural Health, University of Melbourne; Health and Biomedical Informatics Centre , University of Melbourne

Longitudinal, mixed methods study. Data analysis - based on the Australian Institute of Health and Welfare (AIHW), **National Health Performance Framework**.

Participants in the evaluation included **patients, nurses, ED junior and senior doctors, GPs, clerical staff and Chief Executive Officers (CEOs) or Directors of Clinical Services/Nursing**.

Evaluation – questions & findings

- **Accessibility** – improvement acknowledged by all participants, reduction in car and ambulance transfer perceived as important
- **Continuity of Care** – supported by telehealth, technology sound, document exchange timely, variable levels of awareness and perception of benefits in GP cohort (proportional to maturity of service)
- **Responsiveness** – indicated by patients & clinicians, to be no different to face-to-face consultations (dignity and respect of patients and staff maintained).
- **Is telehealth effective?** Clinicians were confident that telehealth was able to provide care that achieved the desired outcome, did not add to work place stress, but sometimes had low level clinical confidence (Jnr Dr) – trust between clinicians important
- **Is telehealth safe?** NHW ED telehealth database audited by snr ED physician and found quality of referrals and management of patients within telehealth guidelines, and clinically appropriate; Victorian Emergency Minimum Dataset has no provision for identifying telehealth consultations currently, which has implications for safety and accuracy of resource intensive, 'manual' entry database
- **Is telehealth sustainable?** Yes. Potential of telehealth understood by higher management, through expansion and maturity of services. Time is required for clinicians to adapt to utilisation of technology in delivery of after hours care, however more established sites report improvement in GP lifestyle and retention.

Evaluation – recommendations

1. **Increase awareness of after hours telehealth** > GPs and the community – find balance of timely access to urgent care without creation of defacto after hours GP service; encourage utilisation of service to prevent GP burnout
2. **Guideline around GP letters** to improve communication and improve continuity of care following ED telehealth consultation
3. **Include telehealth in VEMD** to make direct quality and safety comparisons with standard care
4. **Embed ED telehealth education and training** through integration into local and regional programs and electronic learning platforms – include resources developed (videos, learning packages, handbooks)
5. **Include telehealth in broader rural health curriculum** – inclusion in undergraduate curriculum to ‘normalise’ telehealth
6. **Ongoing regional leadership and governance of telehealth** to fully embed after hours telehealth and grow uptake in the region

Evaluation – lessons learned

- Begin planning at very start of project
- Engage experts (university) - valid
- Consistency with current evaluation in telehealth
- Know your audiences
- Ethics submission
- Be prepared to modify approaches and methods if responses low
- EB important future funding – embedding, expanding existing services & new services

FUTURE COP ACTIVITIES

Future COP activities

- Website
- SIG
- Online discussions
- Other

- Future workshops – Save the date!
  - Friday 12/5/17
  - Monday 19/6/17
  - Thursday 31/8/17

Contact us

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