



AACP

AUSTRALIAN ASSOCIATION
OF CONSULTANT PHYSICIANS

SUBMISSION

from the

**AUSTRALIAN ASSOCIATION
OF CONSULTANT PHYSICIANS**

on

Government's e-health / e-consultation initiatives

February 2011

Introduction

The AACP has been pleased to be involved in discussions through the Technical Advisory Group (TAG) that has provided a range of viewpoints for consideration. The release of the Government's Discussion Paper (*Connection health services with the future: modernising Medicare by providing rebates for online consultations*) has also provided a guide to the issues on which the Government is seeking input in implementing online consultations. The AACP has used the discussion paper as a framework for our recommendations, as set out below.

Online / e-consultations

As discussed at the first meeting of the TAG, this initiative should not be restricted to online or video consultation since this will significantly restrict the potential coverage of this e-health initiative. You indicated at the meeting that the DoHA did not wish to rule out the possibility of phone consultations and that you would be happy to discuss an extension of the initiative to phone consultations, but that this would not occur for the 1 July 2011 implementation date.

From the consultant physician/paediatrician (CPP) point of view, phone consultations where the patient and referring doctor are present in the referring doctor's rooms and speaking direct with a CPP who has access to relevant patient records provide a valuable opportunity to expand access to CPP consultation and advice, particularly for those patients located in rural and remote areas where there is not ready access to a CPP. It should be noted that the referring doctor may be a general practitioner, a specialist, or a CPP.

Denying a rebate for such phone consultations will significantly restrict the application of this initiative, particularly for consultation with CPPs who may not have ready access to videoconferencing facilities. Further, there are many situations where phone consultation may be both adequate and appropriate and provide access to consultant advice that may otherwise be difficult to access.

An example the AACP has already brought to the attention of the Department of Health and Ageing (DoHA), in the context of the need for a Medicare item for CPPs where an extended consultation is required, is that of rural CPPs who have patients with multiple and complex conditions that require a level of diagnosis and treatment that exceeds that envisaged for items 132/133. While not necessarily a common situation, the lack of an extended attendance item significantly disadvantages patients in these circumstances.

The example given was of a consultant paediatrician in a rural location who has patients with significant and multiple morbidities that require diagnosis and treatment of such complexity that the current 132/133 arrangement is inadequate. For this consultant paediatrician and the patients, there are two options: the paediatrician provides extended consultations to work through all the clinical issues (that involve a range of different conditions), order and review test results and develop and monitor treatment and ongoing management. However, under the current Medicare itemisation the patient rebates are inadequate to support the level of care provided in these cases. The second option is that the patient is referred to a series of sub-specialists in a metropolitan area for each of the particular problems that need to be addressed. This involves the family travelling and staying with

the patient in the city and the coordination and cost (both to the family and to Medicare) of a series of sub-specialty consultations.

The AACP will continue to seek an appropriate attendance item for such situations, but at the same time recognises that the use of targeted e-consultations, by telephone, between the initiating CPP and sub-specialists located in the city, can supplement the medical care options in these situations.

The other matter to be considered in relation to access to Medicare rebates for telephone consultations, as outlined above, is that while there have been significant resources made available to general practitioners in recent years to install and upgrade communications facilities, CPPs and specialists have been excluded from accessing such resources.

All the current documentation and discussion on the matter of e-consultations/e-health has focussed on general practice and the resources available to general practitioners. There needs to be clear recognition that this initiative applies to all medical practitioners, and that resources are needed across the sector to support the initiative.

Recommendations:

That access to appropriate Medicare rebates for phone consultations as part of the e-consultation initiative be implemented as a priority.

That access to resources to support wider implementation of e-health and e-consultations be expanded to CPPs and specialists.

Asynchronous e-consultations

As also discussed at the first meeting of the TAG, this initiative should not be restricted to synchronous consultation; again, this would significantly restrict the use of e-consultations, particularly where they involve a GP, patient and specialist, the latter located remotely. The DoHA has stated that implementation of the e-consultation initiative should not proceed at the expense of existing arrangements. It is unrealistic to expect that CPPs in particular can reorganise appointment schedules to undertake e-consultations in all cases, and it is expected there also will be situations where asynchronous arrangements will be equally appropriate for the consideration of particular patients' cases. The AACP strongly supports the view that e-consultations should be a supplement to existing quality patient care systems.

As indicated, in areas such as cancer case conferencing, there are already examples of consultation where the patient may not be physically present at the time of the conference. The AACP notes that such consultations are subject to referral and will be subject to demonstration that an appropriate level of service was provided to the patient. This is discussed later under *Remuneration Models*.

Again, restriction of this initiative to synchronous e-consultations only will restrict access to e-consultations, particularly for specialists and CPPs whose appointment schedules are determined weeks, and frequently months, in advance. Accordingly, patients would have limited access to CPPs under an e-consultation arrangement that required both clinicians to be available at the same time and in all circumstances.

Recommendation:

That access to Medicare rebates for asynchronous consultations as part of the e-consultation initiative be implemented as a priority.

Optimal Practice Models

From the perspective of CPPs, the likely arrangement for an e-consultation would be either a synchronous consultation with the patient and the referring doctor physically located in the same situation, and therefore with the patient having appropriate clinical support, or an asynchronous consultation. In the latter case, how such a consultation is managed would be very dependent on the individual circumstances and whether the CPP is consulting with the patient (in the absence of the referring doctor) or reviewing information provided by the referring clinician to provide a diagnosis, an opinion or a treatment recommendation to the referring clinician at a later stage. The AACP agrees with the importance of the patient having a suitable clinical support person. Further, there may be a requirement for the provision of a prescription or test referral as a result of the involvement of the CPP.

As noted, access to videoconferencing facilities is dependent on access to resources and, for non-hospital based CPPs, the majority are unlikely to have suitable facilities available at this time. In part this reflects the lack of resources made available to support online or videoconferencing activities at practice level and there is a need for access to resources to be expanded to include CPPs in order to maximise the potential of the e-consultation initiative in the longer term.

Optimal Specialties

The majority of attendance-based specialties are suitable for e-consultations, but the extent to which this applies will be dependent on whether physical examination undertaken by the CPP is required at the time.

The Discussion Paper notes that e-consultation may be especially beneficial where the patient, because of age, mobility or independence, is not able to readily attend to see a CPP. The AACP supports this view and notes again the example provided of the rural paediatrician's patients. However equally, where patients have limited ability and thus difficulty in presenting physically to different practice locations, it is reasonable to assume that an e-consultation arrangement will support improved quality of care by enabling an e-consultation to take place between patients and CPPs or specialists (whether located locally or at a distance) and thus minimising the requirement for such patients to travel. As also noted, such attendances do not always require the face to face element envisaged by video or on-line consultation; often telephone consultation is appropriate and satisfactory.

Remuneration Models

One of the concerns in implementing an e-consultation initiative is ensuring that the service for which a Medicare rebate is provided, is delivered. The AACP notes that e-consultations will be subject to a referral arrangement, and the production of an accepted "discharge summary" by the CPP or a similar document or note suitable for the medical record that can be provided to the referring doctor confirms that the required service is provided. Such document would be subject to Medicare audit in the same way as any similar document or record.

One issue that has not been explored in depth is that of obtaining informed financial consent and the billing of a patient by a "remotely located" CPP or specialist. The AACP believes this may present some difficulties, and is likely to require a higher level of interaction between the referring doctor and the CPP / specialist than may normally occur. This would ensure that the patient is aware of the likely charge and/or whether the CPP/specialist intended to bulk bill the patient. These are matters for the patient and the patient's medical practitioners to determine, however they need to be duly acknowledge in any arrangements.

Existing Medicare fee relativities should be retained in relation to any new Medicare items, and there needs to be close consideration of the level of Medicare fee applicable to the services provided by the "remotely located" CPP or specialist. Notwithstanding that they may not provide all elements of a "normal face to face" consultation, there is both the need to review all documentation in advance as well as an additional level of complexity associated with providing such a consultation via the e-consultation. Both forms of consultation have complexities that need to be considered.

As noted under the "Limitations" section following, successful implementation of both case conferencing, and initiatives such as e-consultation, require significant organisation within the practice if they are to be efficient and provide a sufficient degree of predictability to all involved. Case conferencing, involving as it does a number of clinicians and/or health professionals, is at one end of the spectrum. At the other end of the spectrum is the daily example of the referring doctor, or other medical practitioner, who calls the CPP seeking advice on a particular case. In both examples there should be an appropriate Medicare benefit available, given there are responsibilities and indemnity issues associated with both examples. Participation in video, on-line or e-consultations sits within this spectrum of consultation, but equally has associated responsibilities and indemnity issues that are quantifiable.

In order to ensure there is both proper input to the patient's care, and a "paper trail", there needs to be documentation that identifies how the transaction has contributed to the patient's care. In the case of the phone call from the medical practitioner, the AACP regards such documentation as being analogous to the provision of a discharge summary in a hospital setting. In the case of the e-consultation, there is an appropriate note generated for the patient's medical record as well as directions for tests or other medical services, as appropriate. These processes can be codified to ensure all parties receive the necessary documentation and in each case the documentation provides the necessary confirmation that the required service has been delivered, even if the patient has not been physically present with the CPP/specialist.

Recommendation:

- (i) That existing Medicare fee relativities between CPP, specialist and GP items be maintained in relation to e-consultation; and**
- (ii) That appropriate documentation, along the lines of a "discharge summary" generated in relation to an e-consultation, case conference or telephone enquiry be considered adequate for the purposes of eligibility for Medicare rebates under the e-consultation initiative.**

That Medicare fees for e-consultation reflect the clinical requirements of the service provided and acknowledge the complexities associated with undertaking a consultation when the patient is not physically present.

Financial Incentives

As indicated, there is a need for broader access to resources and incentives to support installation and maintenance of suitable facilities for e-consultations.

Limitations to uptake not related to technological or financial issues

A significant hurdle to uptake of e-consultation (whether by video or telephone conference, or on-line) by CPPs will reflect the capacity of the practice to organise daily appointments to accommodate this additional arrangement and the capacity of the practice to provide the services efficiently and effectively. In both cases this reflects the need for specific administrative arrangements to be implemented, and for adequate training and resources to be available to support the initiative. Again, existing programs to support general practice need to be expanded to support implementation by CPPs and specialists.