

16 February 2023

Submission in response to Draft revised guidelines: Telehealth consultations with patients

| | |
|---------------------------|---|
| Name: | Dr Paul Goodridge, Dr Mark Bloch & Dr Amandeep Hansra – on behalf of Mosh Medical and Allied Health Professionals Advisory Committee (MAHPAC) |
| Organisation Name: | Mosh Online Men's Health Clinic – Suite 2.1, 25 Cooper St, Surry Hills NSW 2010. |

Mosh thanks the Medical Board of Australia (the Board) for the invitation to provide feedback on the *Draft revised Guidelines: Telehealth consultations with patients* (the guidelines) and wish for this submission to remain in confidence and not to be published. Mosh welcomes efforts to support general practitioners and other medical professionals to deliver high quality and safe telehealth consultations to Australian patients.

1. Is the content and structure of the draft revised Guidelines: Telehealth consultations with patients helpful, clear, relevant, and workable?

The structure of the draft revised Guidelines: Telehealth consultations with patients is helpful, clear, and relevant. Please note our comments regarding content are addressed in the next two answers. Mosh also notes that the *Good medical practice: a code of conduct for doctors in Australia* (*Good medical practice*) is currently being reviewed and updated and hopes that the content and guidelines regarding telehealth consultations are aligned between these guidelines and the *Good medical practice* guidance.

2. Is there anything missing that needs to be added to the draft revised guidelines?

Background

In reference to this comment in the Background section; *The Board considers telehealth is generally most appropriate in the context of a continuing clinical relationship with a patient that also involves face-to-face consultations. A mix of face-to-face and telehealth consultations can provide good medical care.*

We agree that it is best practice for a patient to have a regular GP and ideally see that GP in person for consultations. It has become evident particularly over the last few years that there are many situations where this kind care is not practicable or accessible to some patients. There are also patient groups who do not have a regular GP or do not wish to have one, or others who wish to use alternate services for particularly sensitive conditions for example, mental health consultations, STI testing or Medical Terminations of pregnancy. Telehealth gives choice and access to care for patients that would not otherwise receive it. Good medical care consists of providing patients choice in who they see for their care needs, how they see them and when they see them. Telehealth overcomes some of the barriers to patient choice.

There are many benefits of telehealth that could be strengthened in the draft guidelines. These include the following;

- Flexible service delivery

Providing on-demand telehealth services to patients offers greater flexibility for GPs, as they can require less time and fewer resources than other types of consultations. While, in many situations, a physical consultation is more suitable, there are instances where an on-demand telehealth service would enable

convenient and accessible healthcare delivery without compromising patient safety.

- Alternative business model for practices

Many patients will be able to meet the cost of an on-demand telehealth service without the support of an MBS rebate. Practices providing on-demand telehealth services to patients can balance these with their usual face-to-face consultation services. A mixed model may enhance care delivery.

- Efficient routine care

Providing on-demand telehealth services to patients may result in less time and fewer resources spent on routine care, including fewer routine home visits for those able to use on-demand telehealth services.

- Efficient administrative services

GPs could provide administrative services (including medical certificates and repeat prescriptions) to patients using on-demand telehealth services. This could reduce appointment waiting times and resources required for face-to-face consultations that would normally be delivered in person.

- Increased access to healthcare

Patients living in rural and remote areas could access general practice care using on-demand telehealth services without having to travel long distances. This may facilitate follow up with patients in remote locations using on-demand telehealth services.

Similarly, on-demand telehealth services could improve access to care for patients with mobility issues.

- Reduced patient costs

Patients may save on the cost of transportation and avoid loss of income due to taking extended time off work to travel to appointments.

- Enhanced chronic disease management

Chronic conditions, including diabetes, hypertension, heart failure and chronic lung conditions, could be partially managed through on-demand telehealth services by GPs already known to the patient.

Definition of telehealth

We agree with the proposed definition, however, it is important to capture asynchronous consultations (e.g., via email or secure online portals) under this definition. These have been occurring between a patient's regular GP and a patient for years and are being offered in more recently developed on demand telehealth services.

A statement has been added that the Board does not support prescribing for a patient with whom a doctor has never consulted, whether face-to-face, via video or telephone, as this is not good practice.

We would like to propose that the word 'consulted' be used to include any type of consult a patient has had with a doctor including asynchronous consults which still require history taking, physical examination questions and a diagnosis and treatment plan formulation.

3. Do you have any other comments on the draft revised guidelines?

In reference to the following statement;

If you have not consulted with the patient Prescribing or providing healthcare for a patient with whom you have never consulted, whether face-to-face, via video or telephone is not good practice and is not supported by the Board. This includes requests for medication communicated by text, email or online that do not take place in real-time and are based on the patient completing a health questionnaire but where the practitioner has never spoken with the patient. Any practitioner who

prescribes for patients in these circumstances must be able to explain how the prescribing and management of the patient was appropriate and necessary in the circumstances.

Patient preference is an important consideration in providing care. Patients are now more comfortable than they have ever been with accessing care through technology. This includes accessing care asynchronously.

Asynchronous is a commonly used form of telehealth that decouples the patient doctor interaction, which allows the interaction to occur at a time that is convenient for both parties. This has been shown to have efficiency gains and allows in many cases for more thorough history taking as the patient has multiple opportunities to recollect history they wish to share with the GP.

The Centre for Connected Health Policy (CCHP) has documented many benefits to asynchronous telemedicine including the below:

- "Primary care providers can review patients cases regardless of their respective locations"
- "Patients can get timely specialty care without needing to travel beyond the location of their primary care providers."
- "Wait times for specialty care are lessened, especially in areas with shortages of medical specialists."
- "The store-and-forward process can overcome language and cultural barriers."

Asynchronous telehealth has been safely and commonly used in radiology, pathology, dermatology, and ophthalmology for many years and has reduced the barrier to access to specialist review and expertise. A paper published in the *Journal of General Internal Medicine* evaluating the efficacy and benefits of asynchronous telemedicine found that there is consistent evidence suggesting that asynchronous telehealth could lead to shorter wait times, fewer unnecessary referrals, high levels of patient and provider satisfaction, and equivalent (or better) diagnostic accuracy when compared with face-to-face consultations¹.

An article published in the *Primary Care: Clinics in Offices Practice* also comments on the benefits of asynchronous telehealth and suggests that many of the risks can be mitigated through measures such as;

“Development of a Standard Guideline document outlining explicit management principles can mitigate the inherent risk created from an asynchronous model (secondary to the lack of real-time dialogue allowing clarification of clinical history content)².”

Furthermore, a recent literature review by Fuster-Casanova *et al* (2022) concluded that asynchronous telehealth consultations led to a decrease in face-to-face visits and waiting times and could be used strategically to improve the effectiveness of consultations and access to care. It was also highlighted that appropriate training of both professionals and patients is essential to ensure safe implementation of this form of consultation³.

Mosh is a telehealth company focused on providing men with access to health care services in a convenient and efficient way, with an objective of maintaining a high standard of care and patient safety. Mosh exists as a men’s online health platform and was born out of necessity. Men are less likely to reach out to receive healthcare. In 2018–19, Australia’s males claimed more than 178 million services through Medicare and received an average of 14 Medicare services per person in that year. By comparison, females claimed 19.5 Medicare services per person⁴. The average number of services claimed by males varies by age group. In 2018–19, those aged under 45 claimed fewer than 8 services per person on average and those 75 and over claimed 48 services per person on average⁴.

Mosh clinicians focus on stigmatised conditions that men traditionally find embarrassing. This model of care allows patients to safely and comfortably access

healthcare that they would not otherwise be receiving. Changing these guidelines to not support asynchronous telehealth, will restrict access to health care for patients across Australia particularly those more vulnerable, less likely to access care or who have stigmatised conditions.

Mosh provides patients access to consultations either asynchronously through chat technology or synchronously through video or telephone. Thorough and in-depth medical questionnaires are completed by the patient at their own pace, which includes accurate descriptions of the history of presenting complaints, current and past medical history, medications, social history and inclusion of patient concerns or specific questions. Whilst these questionnaires are regularly reviewed and updated by senior doctors and specialists, they are not the only relied upon source of information for assessments by medical practitioners, as further information can be clarified or requested via secure messaging or telephone or video consultations. Consultations involving messaging occur asynchronously are not limited to patient questionnaires or conducted as a one-way communication channel requesting a prescription but rather, as a usual consultation would occur in person, where history is collected from a patient, questions asked relating to physical examinations (and in many cases photos or videos asked for) and then a diagnosis is made. It is important to note that a consultation is still done in these settings; patients have the ability to communicate two ways with the doctors as history is collected, a diagnosis made, and a treatment plan formulated.

The asynchronous communication model used by Mosh involves two-way communication between a patient and a GP and at any opportunity the GP or patient is able to turn the chat consultation into a synchronous consultation through phone or video reached with a treatment plan. Consultation notes are thoroughly documented on clinical practice software (MediRecords) and any communication with the patient retained in their clinical notes. These communications are reviewed by each consulting doctor and provide potentially more detailed documentation

than many face-to-face consultations, with questions and answers directly recorded rather than relying on recollection of the doctor about what was said in a consult. Correspondence is always offered to patients back to a regular GP with the patients' consent to ensure continuity of care. Therefore, good patient care is preserved during asynchronous consultations without an initial synchronous consult, if certain criteria are met including patient access to ongoing support and ability to provide a synchronous consult if required, regular follow up consultations and ensuring appropriate training of healthcare providers. The fact that consultations occur asynchronously and over a period of time does not mean it cannot be conducted safely.

Patient safety is at the forefront of the Mosh business model, with equivalent standards of clinical care and thoughtful evaluation compared to those in face-to-face consultations. The model of care has been developed in consultation with clinicians to ensure that patients are consulted with highly trained practitioners in clinical areas managed at Mosh. Additionally, a robust clinical governance system has been implemented that strives to uphold the 7 pillars of clinical governance - education and training, clinical audit, clinical effectiveness, staff management, patient and public involvement, risk management and information management. This system that upholds these values and strives for continued improvement is supported and reviewed by a high-level data security and cloud-based clinical practice software for integrated documentation and medication prescribing. Good governance at Mosh ensures the 3 components of risk management - risk to patients, risk to practitioners and risk to organisations is mitigated and managed proactively.

The doctors working on the service, many who are fellows of the RACGP, utilise clinical guidelines that have been developed by Australian specialists and represent best practice and evidence-based care. Mosh also has a robust clinical incident process and is pleased to say has reported very few adverse events

related to the services provided. Mosh doctors are provided thorough clinical training as part of onboarding and are regularly monitored and audited to ensure clinically safe practice. The company also has oversight and governance through a Medical and Allied Health Professionals Advisory Committee. Over 50,000 men have used the services provided by Mosh Health and many of these would not have seen a face-to-face GP had they not had access to online services.

Removing this form of telehealth would be denying our patients choice and accessibility and we would not be addressing the needs of vulnerable patients/populations. In the case of Mosh, men are less likely to reach out to receive healthcare as discussed above, and the areas Mosh focuses on target stigmatised conditions that men traditionally find embarrassing. Mosh's model of care allows patients to safely and comfortably access healthcare that they would not otherwise be receiving and aims to continue limiting clinical scope to those conditions that are only appropriately managed via telehealth consultations. Changing these guidelines will restrict access to health care for patients across Australia.

Finally, a German study evaluating the lessons learned from synchronous and asynchronous telemedicine applications in primary care in rural regions of northern Germany showed that "Overall satisfaction with the TAs (telemedical applications) was generally high. GPs as well as specialists were especially satisfied with asynchronous TAs"⁵. Many clinicians in Australia have a preference for delivering healthcare via telehealth consultations, with a record number of health care practitioners now delivering telehealth to patients. A significant number of these doctors work for services that offer asynchronous telehealth, with many of these practitioners having membership to colleges including the RACGP. Furthermore, the COVID-19 pandemic has highlighted that telehealth is a safe, viable, effective way to deliver healthcare to patients across our disperse nation, regardless of location and physical accessibility. Practitioners are returning to the workforce, who

may not have been able to previously, because they can now deliver telehealth consultations from home. In an environment where we are facing a workforce shortage in healthcare, offering providers a choice in the type of work they engage in, is crucial to ensure we continue to utilise our full workforce.

We would encourage that the Board's revised guidelines recognise that asynchronous telehealth can be conducted in a safe and effective way for a range of clinical conditions, as long as the components of a good clinical consultation continue to occur including history taking, physical examination (that which is possible over telehealth), diagnosis and formulation of treatment plan that is completely understood by the patient. This can be achieved within a robust clinical governance framework that prioritises patient safety and minimises risks and potential harm.

Recommendations could also be advocated that services using asynchronous models must apply clinical guidelines or meet minimum standards both in the conduct of the consultation and also in the technology platform used to ensure privacy and security. Medical colleges such as the RACGP could be involved in the development of these minimum standards. There is also an opportunity for telehealth providers to be accredited the same way physical practices undergo accreditation through organisations like AGPAL, ACHS, QPA etc. A further consideration would be to implement a register of practitioners undertaking asynchronous teleconsultations with AHPRA, thereby providing further clarity of the extent of use of this form of consultation within the community. Mosh is more than willing and able to contribute to any formulation of guidelines, standards or accreditation process for telemedicine providers if required.

References

1. Deshpande A, Khoja S, Lorca J, McKibbin A, Rizo C, Husereau D, Jadad AR. Asynchronous telehealth: a scoping review of analytic studies. *Open Med.* 2009 Jun 2;3(2):e69-91. PMID: 19946396; PMCID: PMC2765770.
2. Stephens J., Greenberg G.M. Asynchronous Telehealth. *Prim. Care Clin. Off. Pract.* 2022;49(4):531-541. DOI: 10.1016/j.pop.2022.05.004
3. Fuster-Casanovas, A., & Vidal-Alaball, J. (2022). Asynchronous Remote Communication as a Tool for Care Management in Primary Care: A Rapid Review of the Literature. *International Journal of Integrated Care*, 22(3), 7. DOI: <http://doi.org/10.5334/ijic.6489>
4. *The health of Australia's males, primary health care*. Australian Institute of Health and Welfare. (n.d.). Retrieved February 1, 2023, from <https://www.aihw.gov.au/reports/men-women/male-health/contents/access-health-care/primary-health-care>
5. Waschkau, A., Traulsen, P., & Steinhäuser, J. (2022). Evaluation of Synchronous and Asynchronous Telemedical Applications in Primary Care in Rural Regions of Northern Germany-Results and Lessons Learned from a Pilot Study. *International journal of environmental research and public health*, 19(22), 14860.