

28 August 2020

The Hon Greg Hunt MP
Minister for Health

By email to: Minister.Hunt@health.gov.au

Dear Minister

Re: Telehealth proposal for psychiatry private hospital inpatients during COVID-19

Thank you for your letter dated 14 August 2020 in regard to the implementation of MBS item numbers for the delivery of psychiatry services to private hospital inpatients via telehealth during the COVID-19 pandemic. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has developed the enclosed proposal to provide further advice on how telehealth could be implemented as an option for inpatients in private psychiatric hospitals. This proposal has been developed with the input of members of our Section of Private Practice Psychiatry and also our Telehealth Advocacy Steering Group, including a number of psychiatrists who have expertise and experience of working in private psychiatry hospitals.

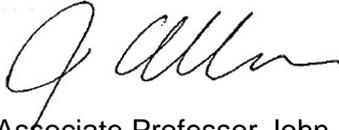
The RANZCP strongly supports that telehealth for inpatients should only be used under specific circumstances during the COVID-19 pandemic as a way of ensuring that quality care can continue to be provided in a way that minimises risks of interrupted care to patients and prevents the spread of infection. Within the proposal, the RANZCP suggests guidelines to ensure that the psychiatrist continues to be involved in the ongoing multidisciplinary care provided in-hospital, and that telehealth is used only in circumstances where it is clinically and practically appropriate rather than as a replacement for face-to-face care.

We recommend that private facilities develop their own policies and procedures to support the implementation of the proposal, but that they not be obligated to use telehealth if it does not suit their particular setting. It is also noted that the implementation of this proposal would not lead to increased costs for either Medicare or private health insurers as telehealth consultations would only replace those that would have alternatively and routinely been billed for face-to-face consultations.

We would be pleased to discuss this proposal further with your Department as well as private health insurers and private hospital service providers.

For any queries on the points raised, please contact Rosie Forster, Executive Manager, Practice, Policy and Partnerships Department via rosie.forster@ranzcp.org or by phone on (03) 9601 4943.

Yours sincerely



Associate Professor John Allan
President

Ref: 1894

CC: Ms Mary Warner, Director, MBS Specialist Services Section (mary.warner@health.gov.au)
Mr Andrew C. Peters, CEO, RANZCP

RANZCP Proposal for telehealth inpatient care in psychiatry

Purpose

This proposal provides advice on the implementation of telehealth as an option for inpatients in private psychiatric hospitals under specific circumstances during the COVID-19 pandemic. This will allow psychiatrists to provide quality care under the circumstances of a pandemic where maximum flexibility is required to minimise risks of interrupted care and prevent spread of infection.

Background

The RANZCP President, Associate Professor John Allan, wrote to the Minister for Health, Greg Hunt, on 17 July 2020 requesting that further urgent consideration be given to implementation of telehealth item numbers for the delivery of psychiatry inpatient services in private hospitals. Minister Hunt responded on 14 August 2020, requesting further evidence on situations that would be appropriate for telehealth. This proposal addresses the questions raised by the Minister.

There are a number of scenarios in which patient care could be enhanced during the pandemic if certain services to inpatients could be delivered via telehealth. The primary benefit would be to allow a patient to continue to see their psychiatrist with whom they have an established relationship (for example in a situation where either the psychiatrist or patient is in isolation awaiting a COVID-19 test or is COVID-19 vulnerable). This is important as the risk of spread of infection may be greater for psychiatry given many psychiatrists attend multiple public and private hospitals, as well as residential aged care facilities, many of which are subject to current COVID-19 infections. Minimising the use for PPE (which can make psychiatrist–patient communication difficult) is also beneficial. Information previously submitted to the Department of Health providing rationale for this service includes:

- Feedback Template: Phase 5 – Feedback on MBS specialist services for possible expansion to phone and/or telehealth, 7 April 2020
- Response to Department of Health questions in regard to introduction of Medicare telehealth items for inpatients in psychiatry, 24 July 2020.

Principles for how telehealth for inpatients could work in operation

Telehealth should be available as an essential option for psychiatrists to enhance inpatient care as part of multidisciplinary team, rather than to replace face-to-face services. The RANZCP proposes that there should be MBS telehealth items for provision of psychiatry inpatient care as follows:

- COVID-19 telehealth item numbers for in-hospital psychiatric services introduced to mirror item numbers 297, 320, 322, 324, 326 and 328.
- Existing COVID-19 telehealth item number for consultations with non-patients to be eligible to use for hospital inpatients (92458, 92459, 92460, 92498, 92499, 92500).

The RANZCP suggests including the following guidelines to ensure that the psychiatrist continues to be involved in the ongoing multidisciplinary care provided in-hospital. Person-centred care and assessment of the clinical and practical circumstances, and patient needs, can determine whether telehealth is appropriate and the degree it is used for any given patient episode of care. If a psychiatrist providing care is COVID-19 vulnerable, then not all of the following guidelines will be applicable, especially in relation to face-to-face consultation.

- Comprehensive assessment process for the admission consultation should be face-to-face where possible. If there is an existing relationship, an admission assessment may occur via telehealth if appropriate.
- Psychiatrist to provide face-to-face consultations if/as required in addition to telehealth where possible.
- Psychiatrist to discuss patient care with staff involved in their care by phone or video after each telehealth consultation if deemed clinically necessary.
- Psychiatrist to be involved in discharge planning (using the existing case conference items 861, 864, 866), which can be by face-to-face or video or teleconference.
- Psychiatrist to contact the family or relevant others for consultation as per the policy of the hospital. This could be face-to-face, telephone or video. Consent of the patient and family would need to be taken into account.
- Videoconferencing preferred and recommended option of telehealth consultations that involve inpatients.
- Telehealth only provided by a psychiatrist who is already accredited to provide services at that hospital and therefore works with the multidisciplinary team and policies and procedures within the hospital.
- MBS inpatient telehealth item numbers only to be used to replace those that would have alternatively and routinely been billed for face-to-face consultations, rather than additional consultations.

Further information and background that supports the proposal, and addresses the questions raised by the Department of Health, are outlined in the section below. This proposal has been developed by the RANZCP Telehealth Advocacy Steering Group that includes representation from the community.

Further information and background to support the proposal for telehealth inpatient care

Rationale overview: inpatient psychiatry would benefit patients

For private psychiatric patients requiring inpatient care, there are no MBS telehealth items for psychiatric consultation. While this might seem intuitive, i.e. that patients requiring inpatient care have more severe illness requiring in-person care and consultation, there remains the possibility that, as a scarce specialist resource, psychiatrists may either not be available (depending on the infection status of the COVID-19 pandemic) or individual psychiatrists might be vulnerable to COVID-19 (age, comorbid illness, etc.). On this basis, consideration should be given to specific conditional options for telehealth for psychiatric inpatients to ensure continued access to psychiatrists during COVID-19. [1]

The RANZCP agrees that most people requiring inpatient care would be very unwell and need team-based care. The proposal is to use telehealth as an essential option for service delivery, especially if the psychiatrist is COVID-19 vulnerable, quarantined or travel-restricted, rather than to entirely replace face-to-face services. It is an individualised decision as to whether telehealth is appropriate for a patient. In-person psychiatric consultation will still be the preferred mode of practice for many patients and psychiatrists, [2] as is the case for outpatient consultations. The RANZCP is supportive of the need to ensure that appropriate/consistent care is maintained and the psychiatrist is available and accessible to nursing staff and other team members.

The use of telehealth psychiatry inpatient care is already established, and has benefited those within the public health system, both admitted inpatients or patients in short term residential units. Many public rural and remote inpatient services were provided this way prior to COVID-19. A recent study (pre-COVID-19) of telehealth for psychiatry inpatients in rural areas with schizophrenia, bipolar disorder, or depressive disorders noted that patients expressed positive experience with telehealth and no preference for in-person care; all patients seen by telehealth preferred this continuity and telehealth was viewed as versatile, effective, and enabled continuity of care [3]. In respect to COVID-19 specifically, the feedback so far has largely been positive around engagement (ability for the patient to see and hear the psychiatrist unobscured by PPE), minimisation of exposure/ transmission risks during transport for carers and clinicians and allaying anxieties of clinicians involved in multidisciplinary care.

Psychiatry admissions during COVID-19 cannot be deferred, as would be the case for some other medical specialties and can be conducted remotely. Furthermore, psychiatry consultations can be particularly long and thus the shared risk of COVID-19 transmission between patients and psychiatrists is considerably higher. Introducing telehealth for private inpatients will allow for patients, family members, psychiatrists and other hospital staff to feel secure knowing they can reduce face-to-face contact when necessary, consistent with social distancing restrictions. Telehealth care for inpatients is particularly relevant given the Stage 4 restrictions for Victoria and uncertainty of any future COVID-19 waves.

Why and how telehealth for inpatients could work in operation

1. Inpatient telehealth services would not devalue the concept of hospital admission if treatment was provided via telehealth

- Psychiatrists would need to assess each individual's suitability to be treated via telehealth, including their capacity to access technology, severity of symptoms, presence of psychosis or risks of harm. [4,5]. The introduction of COVID-19 telehealth items for outpatients has demonstrated that many people, even those with complex disorders, can be well managed this way. It is suggested that hospital practices may find it easier to manage those patients because there is an onsite team present to assist/facilitate/compensate for the psychiatrist being offsite.

- Private practice psychiatrists are not always on-site, as some will attend as needed to visit their inpatients. Therefore, there is an existing healthcare culture of psychiatrists managing aspects of patient care remotely using the telephone and sometimes videoconferencing, delivered as part of the routine ongoing clinical care that visiting psychiatrists are expected to provide to inpatients. It is intended that these MBS telehealth inpatient item numbers would be used only to replace some of the face-to-face ward rounds (e.g. when the Visiting Medical Officer (VMO) psychiatrist regularly and routinely reviews their inpatients), where this is deemed clinically appropriate. MBS inpatient telehealth item numbers would only be used to replace those that would have alternatively been billed for face-to-face consultations. This would be cost-neutral to Medicare and private health insurers as psychiatrists would only be expected to bill for the standard number of consultations they would routinely provide in a week, in line with hospital and health insurance policies and clinical need.
- When it is judged clinically appropriate to do so, it may be appropriate to combine with face-to-face care for individual patients. Telehealth reduces face-to-face contact and the degree to which it would be used would be dependent on the assessment of the psychiatrist and the clinical team. Factors to be considered relate to the patients being cared for (their characteristics and needs etc.) and the context of what other resources are available, including the rostered on-call psychiatrist (e.g. is there an alternative VMO psychiatrist to cover if a psychiatrist has to self-isolate).
- Psychiatrists would be expected to continue to be available face-to-face where needed. In a situation in which the patient is very unwell, and if the treating psychiatrist has to self-isolate and there are no alternative face-to-face options for consultation with a psychiatrist, then onsite team members (nurses and other consistent members of staff) could be present when the patient conducts the telehealth consultation with the off-site psychiatrist.
- It is crucially important to have organised leadership, clear communication, and involvement of all disciplines in decision making [6]. The key role of the psychiatrist as the leader of the treating team and main contributor to the treatment plan is essential. Psychiatrists must coordinate with nursing and allied care staff, who are with the patient most of the time, while ensuring that the telehealth service does not impact on their patient care responsibilities, e.g. through additional work in coordinating the use of the telehealth system, or management of behavioural emergencies in the absence of the psychiatrist [7]. It is recognised that the patient will be receiving multidisciplinary care from a team of clinicians including not only one or more psychiatrists but also mental health nurses, registered and other types of nurses, psychologists, social workers, occupational therapists, physiotherapists, exercise physiologists, dieticians; the patient will therefore not be clinically isolated during a telehealth consultation. They would further continue to be supported by other hospital administrative staff and peer supports.

2. Phases of care including admission, discharge, and ongoing multidisciplinary team care could be provided appropriately via telehealth, particularly where there is an established relationship

- Requirements for clinical assessment, including of risk, and suitability for discharge require particular consideration. In such cases the involved psychiatrist should be able to facilitate the best outcome, which should include the onsite attendance as clinically indicated and if practicable.
- Face-to-face admission remains best practice. This is likely to be needed in most circumstances to coordinate the admission and develop the management plan. It may in some circumstances be possible to conduct an admission consultation via telehealth, particularly if there is an established relationship between the psychiatrist and the patient (for example if the admitting psychiatrist is the same as the patient's outpatient psychiatrist, or if the patient has previously been admitted by the admitting psychiatrist).

The psychiatrist should liaise with the hospital staff to discuss the needs of the patient and the safety issues in the context of the proposed admission, including whether telehealth is appropriate.

- Preserving the ability for a patient to see their regular psychiatrist is a key tenet of this proposal. It is acknowledged that patients who have an existing relationship with a psychiatrist will generally be better suited for ongoing psychiatry appointments via telehealth too. Allowing for inpatient care via telehealth will allow this vital relationship to continue in a situation of COVID-19 vulnerability.
- It is recognised that there may be circumstances in which it is not possible for a psychiatrist to perform an admission assessment or ongoing care face-to-face owing to non-availability of psychiatrists. In these circumstances, consultations should be provided under the principles as previously outlined (i.e. judged as appropriate based on clinical need, and only where there is no face-to-face availability).
- The psychiatrist should discuss patient care with staff involved in their care by phone or video after each telehealth consultation if deemed clinically necessary.
- The psychiatrist could meet for discharge planning case conferences (using existing MBS item numbers 861-866 that are available for telehealth) at whatever frequency is appropriate for the patient, the nature of those mental health services, and the team. This could be face-to-face or by videoconference. Team meetings with staff can also be arranged using videoconferencing software.

3. Team care planning and engagement with families/carers would still be provided

- Engagement with families and carers, dependent on consent and risk issues, can take place via telehealth including the patient and any other team members. In Victoria, during Stage 4 restrictions, telehealth is necessary to engage with family and other clinicians, owing to severe restrictions on visitors to private hospitals. Currently these consultations can take place face-to-face using MBS item numbers 348–352 in hospitals. The RANZCP therefore recommends that, to facilitate best practice that engages family members, the existing COVID-19 telehealth item number for consultations with non-patients to be eligible to use for hospital inpatients (92458, 92459, 92460, 92498, 92499, 92500).

4. Telehealth is practical in private inpatient facilities

- Telehealth is practicable in hospitals where there are adequate protocols and resources for patients and the facility to access the technology required. It should be permitted for patients to use their own equipment, where it is their preference.
- Telehealth is already being utilised in private inpatient hospitals. Many allied health consultations (both individual and group) are already being conducted via telehealth, in line with hospital policies to reduce risk of transmission from patient to staff and also staff to patient. Therefore, to allow psychiatrists to provide telehealth consultations where appropriate would be in line with established COVID-19 hospital practices to minimise spread of infection.
- It is acknowledged that systems would need to be determined by hospitals to ensure documentation of telehealth consultation details in the patient's medical record. It is noted that many hospitals would have capacity within their systems to record that a consultation had taken place via telehealth, but recording of this would need to be implemented in line with health record management policies and health insurance requirements.
- It is recommended that the telehealth inpatient consultation items should apply in circumstances where the psychiatrist is offsite for the telehealth consultation (e.g. psychiatrist who is in their consultation room) and where the psychiatrist is in another

room within the hospital and uses telehealth. The latter situation would be particularly useful in circumstances of high risk of COVID-19 in an individual patient.

5. Group therapy in private hospitals by telehealth

- The RANZCP acknowledges that group therapy is an important part of patient care and supports its ongoing use during COVID-19. Day patients attending day programs for group therapy in private hospitals is particularly important, as attendance may help reduce admission as an inpatient. The RANZCP supports that this therapy is best delivered face-to-face, although there may be benefit in delivery of some of these services via telehealth if face-to-face is unavailable. In private hospitals it is acknowledged that health insurance funds contribute funding for the delivery of these services, and the RANZCP would be willing to discuss this further with relevant parties to support the transition to telehealth services where feasible.

References

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