

Radiology Support, Health Support Queensland

SUBMISSION FEEDBACK

Please provide comments on all or any of the following, particularly in relation to each Option outlined in the Consultation Regulation Impact Statement:

- The appropriateness and feasibility of the proposals.
- Whether the proposed changes will address current concerns with the regulations in the diagnostic imaging sector.
- Potential costs associated with each option.
- Potential benefits associated with each option.
- Potential workforce impacts.
- Impacts on patient access to appropriate imaging.
- Rural and remote access for patients.
- Time required to implement the potential changes.
- Impact on both smaller diagnostic imaging practices and larger practices.
- Any other comments, questions and concerns that relate to the proposed options.

In addition, you may wish to respond to questions listed against specific Options.

Submissions should include substantiating evidence, where possible.

Option 1 – No regulatory changes or deregulation (refer to page 23 of the RIS)

Features:

- The current supervision requirements remain unchanged.
- The person under the professional supervision of the radiologist would require the appropriate qualifications, credentials, or training to provide the service.
- The current substitution rules in the *Health Insurance Act 1973* remain.
- Rural and remote exemptions.

Comment

- This does not address current concerns.
- Prevents people in remote/rural areas having access to MSK ultrasound services.
- Some practices gain a competitive advantage through their interpretation of supervision requirements, which potentially lowers the quality and safety of services provided to patients.

Option 2 – Minor changes including clarification of current requirements (refer to page 24-26 of the RIS)

Features

- Amendments to the current supervision requirements to clarify the circumstances under which a radiologist and/or specialist or consultant physician must provide supervision and how the supervision must be provided.
 - Professional supervision would require: the medical practitioner be available to observe and guide the conduct and diagnostic quality and safety of the examination and if necessary in accordance with accepted medical practice, attend the patient personally, within a reasonable period of time.
- The personal attendance requirement of musculoskeletal ultrasound would be amended to align with all other ultrasound items.
- The person under the professional supervision of the radiologist would require the appropriate qualifications, credentials, or training to provide the service.
- The current substitution rules in the *Health Insurance Act 1973* remain.
- Rural and remote exemptions.
- Specified qualification requirements for ultrasound providers.
- Definition of diagnostic ultrasound.

Comment

- Appears to be the most appropriate of the three options.
- There is a need to define “within a reasonable period of time”, as it is open to interpretation.
- Opens up access to MSK ultrasound services as the presence of a radiologist is no longer required. Frees up radiologists time. Could be implemented very easily. Addresses current concerns.
- “Diagnostic ultrasound” needs to be defined for billing and for better diagnostic outcomes. A diagnostic ultrasound examination and service includes a formal report that ultimately should be linked to the Personally Controlled Electronic Health Record (PCEHR), and the images available for the patients’ ongoing medical records.
- Additionally, patients and their care-givers need to be aware of the differences between an ultrasound that is diagnostic and one that is not. A patient can be under the impression that they have had a diagnostic ultrasound, when in fact they had a fast scan or at “point of care” scan as an extension of a clinical examination, which may, or may not, have correctly identified pathology.
- Anyone providing a diagnostic ultrasound service should be suitably qualified and credentialed. Ultrasound as an imaging modality is “hands on” and directly operator-dependent. With insufficient training or expertise, pathology may be missed and false positive diagnoses are possible.
- The professional supervision clause requires clarification around rural and remote exemptions particularly in relation to CT availability and accessibility.

Musculoskeletal Ultrasound (refer to page 25-26 of the RIS)

Questions:

- Are the principles as outlined satisfactory to clarify the requirements?

- What reasons, if any, are there for the personal attendance requirements for musculoskeletal ultrasound to remain?
- Would a minimum set of guidelines for ‘accepted medical practice’ per modality be appropriate?
- What savings are anticipated to be realised from removing the personal attendance requirements for musculoskeletal ultrasound services?
- What additional costs are anticipated to be incurred by requiring a medical practitioner (e.g. radiologist) to be in close proximity to attend on a patient personally within a reasonable period of time in circumstances where this is not currently the situation?
- What other costs (if any) might be associated with the proposed changes?
- What are the potential consequences of the proposed changes?

Comment

- Principles as outlined satisfy requirements.
- There could be significant savings for practices adhering to current requirements e.g. MSK scans, the second most frequently requested ultrasound. For other practices there would be minimal or no savings.
- The requirement for the radiologist to be available (close proximity or in attendance) gives the sonographer confidence that they have backup if required.
- Brings radiologist attendance into line with other diagnostic ultrasound examinations.
- There may be a rise in the number of MSK scans performed due to increased accessibility in consequence to the radiologist direct attendance requirement being removed.
- Improves the availability of MSK scans in rural/remote locations.

Option 3 – Practice based approach (refer to page 27-34 of the RIS)

Features

- Amendments to the current supervision requirements to clarify the circumstances under which a radiologist and/or specialist or consultant physician must provide supervision and how the supervision must be provided.
 - Professional supervision would require: the medical practitioner be available to observe and guide the conduct and diagnostic quality and safety of the examination and if necessary in accordance with accepted medical practice, attend the patient personally, within a reasonable period of time.
- The personal attendance requirement of musculoskeletal ultrasound would be amended to align with all other ultrasound items.
- The person under the professional supervision of the radiologist would require the appropriate qualifications, credentials, or training to provide the service.
- Computed Tomography services would only be able to be provided in a comprehensive practice, with the exception of CT of the coronary arteries (items 57360 and 57361).
- Supervision would be tailored to the type of diagnostic imaging practice.
- A comprehensive practice would require a radiologist to be available during agreed operating hours.

- Where a radiologist is on site during ordinary operating hours, the radiologist would be allowed to determine the supervision requirements for the practice and have the flexibility to implement and supervise efficient and effective processes.
- Where a radiologist is on site during ordinary operating hours, the radiologist would be allowed to substitute a requested service for a more appropriate service, without the need for consultation with the requester, if the substituted service has a lower MBS fee than the requested service.
- The current substitution rules in the *Health Insurance Act 1973* remain.
- Where a radiologist is NOT on site during ordinary operating hours, a radiologist must be on site for the performance of the following services:
 - Mammography;
 - The administration of contrast; and
 - Image guided intervention procedures/surgical interventions.
- The reporting and supervising radiologist would not have to be the same person, but practices would be required to maintain records which indicate the name of all the radiologists involved in the service.
- Rural and remote exemptions.
- Specified qualification requirements for ultrasound providers.
- Definition of diagnostic ultrasound.

Comment

- Option 3 allows a radiologist to substitute a service for one that has lower MBS fees than the requested service. The substitution should be driven by:
 - the responsibility to keep the patient dose as low as reasonably achievable
 - superior diagnostic yields
- Cost is another factor. Missing pathology may be more expensive in the long term than outlaying a larger cost initially for an investigation that has superior or equivalent diagnostic yields with a reduced exposure to ionising radiation.

A Comprehensive practice (refer to page 28-29 of the RIS)

Questions:

- Are there any other types of practices which have not been identified?
- Are there comprehensive practices that do not currently have a radiologist onsite?
- What are the costs of employing a radiologist onsite during ordinary operating hours?
- What are the costs of non-comprehensive practices expanding to become comprehensive practices?
- Are there enough radiologists for this to occur? What are the barriers?
- Is there any role for standalone CT and, if so, how would current safety and quality concerns be addressed? What will be the impact of this change on providers and patients?
- What other costs (if any) might be associated with the proposed changes?
- What are the potential consequences of the proposed changes?

Comment

- The disadvantage of the stand-alone CT practice is that the potential for substitution

of services within the practice is removed.

- Where ultrasound could answer the same clinical question and be more appropriate, e.g.: a child or pregnant woman – this could not be offered at a stand-alone CT practice
- Rural practices may be disadvantaged if such requirements are introduced without defined and effective rural and remote exemptions in place.

Non-radiologist specialist practice (refer to page 30-31 of the RIS)

Question

- Are there any other services currently performed by non-radiology specialists?

Comment

- In some centres modified swallow (barium) examinations are performed by speech pathologists with radiographers, supervised by radiologists within the practice/department. This may be a future consideration.

ADDITIONAL ISSUES FOR CONSULTATION

1. Rural and remote exemptions (refer to page 31-32 of the RIS)

The intention of having rural exemptions is to ensure patients have access to services without compromising on quality. However, current arrangements for rural exemptions vary for each of the modalities, creating confusion due to an inconsistent approach. The current approach is also difficult to administer.

Questions

- Does the current rule meet its goal of increasing access for patients without comprising on quality?
- Should exemptions be geographically/distance based rather than looking at population base and local availability of specialist services?
- Are there any other mechanisms that provide incentives for local services provision in rural Australia?
- What is the role of tele-radiology? Should it be the only service, or an adjunct the local service provision?
- Should the exemption not be available for certain types of services?

Comment

- Within Queensland Health, the level of medical imaging services provided is guided by the Clinical Services Capability Framework. There are similar arrangements throughout Australia.
- Maintaining quality of services may be addressed through professional networks; e.g. medical radiation practitioners can ensure quality and safety standards in consultation

with radiologists.

- The provision of a safe accessible x-ray service to the sparsely populated rural and remote areas of Queensland requires a different approach to that in regional or metropolitan centres that are staffed by radiographers. There are 338 licensed x-ray operators working within QH providing general x-ray services (being supervised by a radiographic advisory service and/or supported by a sole radiographer) at 93 rural and remote facilities (QH Radiology Services Profile 2013-2014). X-ray operators are persons who are permitted to use plain film diagnostic x-ray equipment to perform a limited range of plain film diagnostic radiography involving the irradiation of a person, but who do not have formal qualifications in diagnostic radiography. .
- The current Australian Standard Geographic Classification (ASGC) exemption rule has ensured access in rural/remote communities. A number of Queensland Hospital and Health Services have outsourced radiology and/or medical imaging services. These radiology practices may provide services across outer regional, remote and very remote areas (Remoteness Areas RA3, RA4 and RA5).
- Comprehensive practice with remote supervision is necessary to increase accessibility and equity for rural and regional areas where it may be difficult to recruit and retain radiologists. In the hospital environment ACHS and NSQHS standards and protocols apply to ensure quality and safety for patients.
- Currently there are a number of regional hospitals throughout Queensland that are installing CT scanners into their departments along with an already existing ultrasound and plain x-ray service. These local services are critical as they offer a key diagnostic tool to clinicians including the determination of whether to transport the patient to a tertiary centre, which may mean expensive air travel or a lengthy road trip.
- Rural hospitals are hubs for the whole community and therefore access to expanded services at the facility assists the broad community and primary care providers. Treating patients in their local community is much more cost effective across the board.
- Plans are underway in a number of centres to establish rural stroke units with the Queensland Ambulance Service presently undertaking training to provide first line thrombolysis treatment (involving quality CT services). Patient outcomes are expected to improve dramatically as earlier intervention and local rehabilitation within the resident community will become possible.
- Patient access to quality rural and remote radiology/medical imaging services including CT and ultrasound is underpinned by quality PACS services. This is achieved utilising Real Time Remote Supervision (RTRS). The radiologist is able to review imaging in real-time and communicates with the radiographer and other health professionals in the provision of a timely, safe and effective service for patients and referrers. During the use of IV contrast for CT, a medical officer would be present and functioning emergency equipment at hand in case of severe reaction to medication. RTRS radiology services may be supplemented by regular outreach services where interventional radiology services, local training around the clarification of requesting

criteria and clinical pathways, and personal liaison with local clinicians as may be required.

- Increased use of telehealth can improve access. The issue of CT radiation dose may be dealt with by the use of modern diagnostic equipment and training. The use of state-of-the-art ultrasound machines by highly trained and qualified professionals will ensure high quality imaging.
- Rural and remote exemption rules are effective in achieving the goals of accessibility and quality. Improved governance and audit procedures may be advantageous in assuring quality care and systems.
- Departments and practices operating in rural and remote areas have made significant commitments to ensure the delivery of a safe, effective and timely service.
- The increasing use of RTRS along with improving modern communication technologies enables the role of tele-radiology to be expanded, without forgoing quality, safety, timeliness or effectiveness. Distance need not be a factor between communicating parties in regards to the issue of supervision and patient care, provided that appropriate robust procedures, training and infrastructure are in place.
- Removing current exemptions for certain types of services may render operations unviable across the whole imaging facility, therefore removing access to diagnostic imaging altogether from some rural and remote communities and their surrounding catchments. Most, if not all facilities in more remote areas are low volume in comparison to large metropolitan sites. The current complex rural and remote exemptions require modification e.g. the wording of the 30K rule needs to be simplified.

2. Implementing any changes and the relative role of regulation and the Diagnostic Imaging Accreditation Scheme (DIAS) (refer to page 33-34 of the RIS)

The relative role of regulation and accreditation in enhancing the quality framework for MBS funded diagnostic imaging services will be determined following feedback received from stakeholders under this consultation process.

Questions

- Would changes to supervision be better placed in the DIAS or remain in the regulations?
- How would a practice based supervision approach be incorporated into regulation?
- Is it necessary to have a modality based approach in the regulations (as a minimum) and a practice based approach in accreditation?

Comment

- Changes to supervision would be better placed in the regulations. These can then be used to implement changes in the DIAS.
- Accreditation already goes down two paths, being simultaneously practice based and modality based. This appears to work.

3. Any additional proposals, suggestions or comments?

Comment

- Diagnostic imaging that uses ionising radiation always presents potential for harm. In 2013-14 there were 2.7 million CT scans performed and only 0.8 million MRI scans. Consideration needs to be given to reducing radiation doses by substituting MRI for CT scans. In rural and remote areas, CT will be performed for complex MSK questions in the absence of MRI. CT scanning for young active people needs to be questioned, particularly for adolescents who more susceptible to the effects of ionising radiation.
- Consideration needs to be given to increasing the availability and subsequent access to MBS funded MRI services including improving the availability of such services to rural and regional centres.