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Author/s:

Tambakis, G;Lee, T;Shah, R;Wright, E;Connell, W;Miller, A;Demediuk, B;Ryan, M;Howell, J;Tsoi, E;Lust, M;Basnayake, C;Ding, N;Croagh, C;Hong, T;Kamm, M;Farrell, A;Papaluca, T;MacIsaac, M;Iser, D;Mahady, S;Holt, B;Thompson, A;Holmes, J

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Low failure to attend rates and increased clinic capacity with Telehealth: A highly effective outpatient model that should continue beyond the COVID-19 pandemic

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Tambakis George (Orcid ID: 0000-0001-8785-7661)
Wright Emily (Orcid ID: 0000-0003-3896-7826)
Tsoi Edward (Orcid ID: 0000-0002-9083-4185)
Basnayake Chamara (Orcid ID: 0000-0001-6103-769X)
Hong Thai (Orcid ID: 0000-0002-7399-4531)
Kamm Michael (Orcid ID: 0000-0003-3319-7199)

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Low FTA rates and increased clinic capacity with Telehealth: a highly effective outpatient model that should continue beyond the COVID-19 pandemic

Short running title:

Telehealth is highly effective and should be continued beyond the COVID-19 pandemic

Authors & Affiliations:

Tambakis GA^{1*}, Lee T¹, Shah R¹, Wright E¹, Connell W¹, Miller A¹, Demediuk B¹, Ryan M¹, Howell J¹, Tsoi E¹, Lust M¹, Basnayake C¹, Ding N¹, Croagh C¹, Hong T¹, Kamm MA¹, Farrell A¹, Papaluca T¹, MacIsaac M¹, Iser D¹, Mahady M¹, Holt B¹, Thompson AJ¹, Holmes JA^{1*}

¹Department of Gastroenterology, St. Vincent's Hospital, Melbourne, Victoria, Australia

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Corresponding authors:

George Tambakis
Department of Gastroenterology
Level 4 Daly Wing
35 Victoria Parade
Fitzroy, VIC, 3065
Email: george.tambakis@svha.org.au
Contact Number: +61 3 9231 2211

Jacinta Holmes
Department of Gastroenterology

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Level 4 Daly Wing
35 Victoria Parade
Fitzroy, VIC, 3065
Email: jacinta.holmes@svha.org.au
Contact Number: +61 3 9231 2211

Low FTA rates and increased clinic capacity with Telehealth: a highly effective outpatient model that should continue beyond the COVID-19 pandemic

To the editor,

We read with interest the article from Zorron Cheng Tao Pu and colleagues on the benefits of phone consultation for two hospital-based endoscopy clinics during the COVID-19 pandemic¹. The authors demonstrated reduced overall failure to attend rates (6.4% vs 12.6%, $p < 0.01$) during the COVID-19 outbreak with telephone consultations compared to face-to-face consultations in the pre-COVID era.

Failure to attend is expensive and resource demanding, with reported failure to attend rates (FTAs) up to 30% in some centres^{2,3}. In Western Australia, 160,000 outpatient appointments were FTAs at public hospital clinics over 12 months, resulting in \$26 million in lost productivity⁴. Non-attendance is influenced by many factors, including logistics surrounding attendance, work commitments, financial hardship, transportation access, competing health interests, change in clinical need for review and forgetfulness^{5,6}. Telehealth can be conducted via videoconferencing or telephone, and represents an attractive model to reduce FTAs and increase outpatient clinic throughput, which is important given the long waiting times for many clinics, and the financial ramifications of missed appointments. However, telehealth may not be appropriate or feasible for all patients, including persons who are elderly, culturally and linguistically diverse, itinerant or

homeless, from low socioeconomic backgrounds, have poor health literacy, who may not have ready access to or be able to navigate telehealth. It also may not be suitable for certain hospital outpatient disciplines. Therefore, we aimed to build on the work of Zorron Cheng Tao Pu and colleagues by evaluating FTAs across a wider range of gastroenterology clinics including a broader patient demographic, larger cohort, and encompassing all major gastrointestinal outpatient services. Furthermore, we compared FTAs between the different telehealth modalities (videoconferencing versus telephone consultations) during the COVID-19 period, in addition to comparing telehealth with face-to-face consultations over the past 5 years.

At our institution, the COVID-19 pandemic triggered the immediate and almost universal implementation of the telehealth model of care for outpatient appointments. We evaluated the efficiency of telehealth at a single tertiary hospital in Melbourne, Australia, over a nine-week period during the first COVID-19 lockdown, focusing on the impact of telehealth on the number of scheduled appointments and clinic FTAs across all 13 gastroenterology outpatient clinics encompassing inflammatory bowel disease, hepatology, hepatoma, general gastroenterology, endoscopy and functional gut disorders. Over the nine-week period, the total number of scheduled outpatient appointments and FTAs were compared to the average numbers over the same time period during the preceding five years. Data collected included total number of appointments scheduled, FTAs and appointment type (videoconferencing, telephone or face-to-face).

A total of 2,626 outpatient clinic appointments were scheduled during the 9-week study period, with 2,237 (85.2%) appointments attended and 389 (14.8%) FTAs, representing a 2.2% improvement in attendance rate compared to the average attendance rate during the same 9-week time period in the preceding 5 years ($p=0.035$). Of the 2,626 appointments in the COVID-19 era, 1,319 (50.2%) were videoconferencing consultations and 1,307 (49.8%) were telephone consultations. When evaluating the appointment type, we found that consultations carried out by telephone resulted in significantly lower FTAs compared to videoconferencing consultations (9.0% vs 20.6%; $p<0.001$). In the preceding five years,

an average of 2,304 outpatient clinic appointments (395 fewer appointments) were scheduled during the same 9-week period, with 1,912 (83.0%) appointments attended and 392 (17.0%) FTAs. Of the 2,304 appointments, only 33 (1.4%) were videoconferencing consultations, despite the availability of videoconferencing appointments

In keeping with the findings of Zorron Cheng Tao Pu and colleagues¹, we found that rapid and almost universal implementation of the telehealth model resulted in a dramatic and significant overall reduction in FTAs over a very short period of time across all 13 gastroenterology outpatient clinics, primarily driven by reduced FTAs with telephone consultations. Furthermore, an additional 395 clinic appointments occurred during the evaluated 9-week period compared to previous 5 years, demonstrating increased appointment capacity with the telehealth model. Our data demonstrates the telehealth model is highly efficient, and provides a strong case for ongoing state and federal government support beyond the COVID-19 pandemic, importantly including both videoconferencing and telephone consultation, as well as expansion beyond current patient eligibility criteria to allow all patients to access telehealth where appropriate. This will improve efficiency and reduce the financial burden associated with missed outpatient appointments.

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