group consultations

Virtual Group Consultations – Frequently asked questions from recent webinars

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JL – Jessica Lewis
GE – Garry Egger
MS – Marianne Sumego
JI – Jeannette Ickovics
JS – John Stevens
KR – Kamalini Ramdas
TT – Tracey Traveira
AM – Alison Manson
OP – Other Participants

Please note recordings of all webinars are available for download @ www.bslm.org.uk/vgc

Question		**Answer**
1.	**How long does it take to establish virtual group consultations instead of face to face?**	**FB:** With the right support you can implement overnight. **AM:** Within one week with some applying the change literally overnight. In Cleveland Virtual SMA's have risen from 1% - 33% in 2 weeks.

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		KR: You would need to experiment as you go along, making process improvements and getting feedback from patients for ideas for improvement. Dr Marianne Sumego at the Cleveland Clinic regularly collects patient feedback on VSMAs. When the Aravind Eye Hospital in Pondicherry, India, decided to trial SMAs for Glaucoma, they first did some simple pilots using counsellors rather than ophthalmologists to run the appointments, to understand how groups work. Similarly, in virtual SMAs, trial runs can be done creatively. In "peacetime" it could take a few months or more of experimentation, tailoring to your own care setting. Now, to do VSMAs, due to the urgent need to increase capacity I expect this will happen much faster.
2.	**What is the best platform for virtual group consultations?** **Is zoom compatible with NHS Systems?**	**FB:** The virtual platform is your choice and depends on the healthcare system approvals. Zoom has had security issues and seems to have addressed them. Teams and Starleaf are also an option. That choice is down to you and your organisation. As long as it supports 10-15 patients at once and is secure, it can work. **MS:** We use “American well ‘currently since as we were already using this platform for our 1:1 virtual appointments **GE-:** Zoom privacy is not such an issue with the new download which you can download for free. **OP:** We use Microsoft Teams. You need to speak to your IT support and have a play as you can have different settings according to group. Zoom also has different settings you can set up like raise your hand but not sure yet about security.

		AM: Microsoft teams seems to be preferred choice in primary care though it does have some limitations; we are currently exploring options with other telehealth companies. We will support you to set up VGC on the platform of your choice
3.	**Have you experienced any challenges with patients who struggle with using the technology?**	**MS: A**bsolutely. But I would say we are finding more often than not patients of all ages, especially the elderly, are using technology which is quite surprising. If they choose, in person SMA's it is still a great option
4.	**How do you get around the problem of patients who don't have access to technology e.g. smartphones or who are not computer literate?**	**KR:** If you have fixed base telemedicine or can access it - where by "fixed base telemedicine" I mean there is a remote telemedicine booth or centre, then patients could be asked to come there and be seen remotely in groups (provided they are no longer infectious). Some hospital systems that have fixed-base telemedicine are considering doing this. You could also try telephone conference calls for those who do not have a smartphone. **FB:** Lots of older folk use I pads or tablets and now most are skilled- self-isolation is driving tech literacy, as a way for people to reconnect and see their grandkids. **MS - T**his is definitely going to impact spread. Technology is fairly widespread, and we will have to adapt to what is available. In the future we hope the platforms are widespread enough that this limitation actual improves access to underserved areas where geography alone currently limits care
5.	**For patients from a lower socio- economic status with multi-morbidities including mental health - how do you address the fact that they do not have the finances nor the wherewithal to manage virtual technology, but are the MOST in need?**	**KR** - My colleagues and I are working with the Coper University Hospital in Camden, New Jersey. They have been using in-person SMAs for diabetes. Many of their patients only have a flip phone (not a smart phone). One possibility to consider is phone conference calls, in this situation. **OP** - Lifestyle Therapy in Australia is running an online course looking to improve immunity through lifestyle change. It is completely free to all patients/clients. www.lifestyletherapy.com/secrets

	How can virtual care be provided to the elderly, low income groups that do not have the skills or technology, (internet access) for conducting this type of care?	**AM:** One of the solutions to this (post COVID social isolation), would be to run virtual group consultations in community hubs with one computer that all participants can use to access group consultations sessions ran remotely and someone leading on technology. You also may want to think of a hybrid model where some patients attend face to face as a group with others joining in remotely to participate **FB:** We find lots of older folk are happy with I -pads and tablets- even more than smartphones. So, try it! **MS:** I find elderly often are using technology more often and for those who are not tech savvy they are more likely to use in person SMA option. **TT:** Our Tokuda et al. Int J Med Inform 2016 study and Wu et al. Plos One 2018 Study showed reduction of healthcare utilization and costs. Therefore, our health system have provided patients with cellular enabled tablets to conduct these virtual visits.
6.	**What are the conditions managed with these VSMA?**	**TT:** At the Providence VA Medical Centre, we have used vSMA to treat diabetes, hypertension, dyslipidaemia and now heart failure.
7.	**Within a particular organisation, should we ask a sample patient group if they want SMAs first? before we introduce them and ask all patients if they want to participate?**	**FB -** We recommend you try it where the need is greatest, as it really effectively deals with those bottlenecks. Problem is if you ask folk with no experience, they may not like the idea, but those same people often love it once they try it. AM – We know that once patients have experience Group Consultations over 95% of them report that they prefer these to their normal 1:1 appointment. With this is mind we need to make it easy for people to give it ago and have a simple, yet compelling recruitment message

		MS - we ask when we offer explaining the benefits and why we are suggesting the care model. We gain re-emphasize at every touch point what the visit entails. And always keep in mind their participation is voluntary but appreciated!! **RL -** Agreed. It is important to have champions in the organisations!
8.	**Are there Any resources available to take to 111 managers when discussing how virtual groups might work/benefit? I think this would really help reduce isolation and help people to realise many people are feeling the same.**	**FB:** If I was designing the system, I would encourage scheduled webinars on a topic (like 'Do I have Coronavirus?) regularly through the day +/- night, only using phone calls for rarer questions.
9.	**What is your advice on Long term conditions without clinical findings – blood results, bp etc?** **How do you conduct virtual consults without up-to-date patient data such as bloods, observations etc or are you still bringing people in to have bloods taken?**	**FB:** If possible, get the patient to use a home BP cuff, this can work really well - the biggest Group Consultation trial was in hypertension (Junling et al). Folk who need bloods still get them, but we are getting district nurse to do bloods so not bringing into hospital where COVID patients are. Then you can discuss results and motivate patients with benefits of peer support. **AM:** Virtual group consultations (VGC) provide a great opportunity for you to mobilise care and advise throughout COVID to those patients living with long term conditions who are high risk, In addition VGC can help to overcome some of the issues caused through social isolation by re - connecting people with common challenges virtually. You may need to use the most recent test results you have in absence of at home monitoring or where blood results are imperative you may be able to use community services to do at home bloods or organise for patient to attend an appointment at your practice 'cold' hub for tests/ bloods if available. Patients should also be encouraged to do home testing such as BP/o2 levels and these can be supported and taught through VGC's

10.	**Where are the references for evidence for Shared Appointments in relation to decreasing pain?**	**FB:** This is referenced in our Future Healthcare Journal article, https://www.groupconsultations.com/system-approach
11.	**Is there any experience/published data from UK/NHS or UK private practice? I would like to know more about UK experience.**	**FB -** There are two key references: one in the future healthcare journal (which cites all the data) and our 10-year experience in Rheumatology Advances in Practice. http://www.groupconsultations.com/evidence/ We are running a session on UK practice at the BLSM virtual conference too which will flag key exemplars.
12.	**Do clinicians agree to the suggestion that patients in future may be more comfortable with virtual consultations?**	**KR:** I definitely agree that from the perspective of someone who studies innovation (I'm not a clinician) that often adoption of very novel innovations is catalysed when people try something out once for themselves. **FB:** We will be asking attendees whether they will nominate patient advocates, so helpful you have raised to let them think about this. **OP:** I think it's inevitable that many "slow adopters" will reluctantly be doing things online that they would never have dreamt of. This is a great opportunity for virtual consultations to come to the fore… **OP: S**etting up a virtual one to one meeting the first time gives them confidence to join a virtual group "meeting"
13.	**Will people and systems revert back to their face to face habits and norms after**	**FB:** Only really China can answer this currently. My belief is that some things won't go back!

	the pandemic peaks have passed in respective areas? **How can we support it/maximise people and systems not reverting back to face to face?**	**GE:** I think they'll want to keep doing Virtual - it's so much more convenient and time effective for everyone. **AM:** By collecting and evaluating the outcomes and experiences of delivering and receiving care through virtual group consultations and making it easy for people to give it a go!
14.	**If patients really like face to face how might this translate to virtual and what challenges or blockages have you faced to date around this**	**KR:** hear from clinicians that when patients understand that face-to-face is going to take much longer, that motivates them to pick a virtual visit. I've seen the same work for patients deciding between face to face 1-1 and face to face SMAs - SMAs are typically available many weeks sooner. **MS:** We offer both virtual and in person shared appointments and let the patient select. We do encourage them to try the appointment t before deciding. Blockages are around the unfamiliarity, so we rely on the physician patient relationship for recruitment/ trust. **AM:** Over 90% of people who experience F2F Group Consultations over 1:1 appointment tell us they prefer receiving care this way, this is likely to translate into virtual group consultations for many patients particularly through COVID when VGC reconnect patients with their healthcare teams and others throughout social isolation and distancing.
15.	**Are there certain appointment types that lend themselves better to virtual shared appointments ... and are there some that don't ...? thinking along lifestyle care as there are some similarities but does one run the risk of losing some individual care focus?**	**KR:** Offering individual care in front of other patients greatly helps patients learn, when they share a common condition. Some patients are shy or forget to ask questions that are relevant to them. And sometimes what one patient is being individually told could be very relevant for another down the road - it provides a window into the possible future evolution of their own condition.

		FB: Not many things you can't do in groups, but highest value is where behavioural change needed, as this benefits most from the embedded peer support. **MS:** I think there are differences in virtual and in person. We may be capturing those folks who are not coming in person, but willing to try virtual. The interactions between the patients are not the same, but we still can build off of patient experiences. **AM:** Currently many people with chronic disease are feeling even more anxious and would benefit from connection with their healthcare teams and peers - looking at what COVID means for them and offering reassurance and support to keep well/
16.	**What is the best selling point a provider should make to a patient to get her/him to try a VSMA?**	**KR:** Right now: access to care without risking infection and learning from watching the clinician interact with other patients who share their condition. **FB:** Get them to speak to a patient who has tried it or share videos of patients sharing their experience. Even those who don't initially like the idea can really enjoy it. Compared to phone consultations – virtual group consultations are much more engaging. **MS: T**hey have flexibility in not traveling and still having care. In addition to the presence of other patients. The absence of travel time for those who are distanced is also great and honestly some of our patients are very interested in technology for care delivery. **TT:** Aside from convenience, we sell it as a "one stop shop". The patient gets the benefit of visiting with multiple provider i.e. nutritionist, pharmacist, social work or specialty care all in one setting

17.	**Has anyone tried virtual group consultations for COVID-19 patient follow-up?**	**FB:** I guess China will have the best data. In general, folk affected are infectious for longer than routinely understood, so virtual approach may be safest option. **MS:** At this point no, we are in the midst of expanding and our initial response to COVID was to understand the needs, we may be able to use for following up of patients being managed at home
18.	**I can see the benefits for educational purpose but how do you adjust medication for say inflammatory arthritis in a group? Is there a CQC endorsement in UK?**	**FB -** As you would usually. Send a prescription for local or hospital pharmacy, if a new drug. Or just advise dose changes.
19.	**We as UK GP's are now tasked with follow-up of patients who have been triaged by the COVID assessment service. VSMA seems tailor made for this - potentially at PCN level.**	**FB:** Agreed, and having tried it once, a whole cohort will be ready to use it for other problems.
20.	**How do you mitigate issues arising from Data Protection laws + patient confidentiality in a virtual group consultation setting?**	**FB:** Patients sign a waiver covering both. Same systems used for data protection as other communications. **AM: Y**ou would get them to electronically sign a confidentiality form - templates are available via the Group Consultations APP - www.groupconsultations.com/app. You should also get these signed by family members /carers who are present at the session. Also get verbal acknowledgement of confidentiality at check in at each session.

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21.	**How do you manage the issue of privacy, where persons are uncomfortable sharing their health issues?** **How do you show patients results when consulting virtually and how do you address confidentiality issues?**	**KR:** Some clinicians I have spoken with say virtual one-on-one consults can be very empowering for patients because the patient may be able to see the same information (e.g., a scan) that the clinician is looking at. In VSMAs it could be possible, depending on the platform, to share results through a private chat, for example. **AM:** You can get patients to electronically sign confidentiality forms templates are available via the Group Consultations APP - www.groupconsultations.com/app.
22.	**How do you manage the issues of consent, confidentiality and clinical record keeping in a shared medical appointment?**	**FB** - Consent & confidentiality with a standard waiver (available via the Group Consultations app). You keep records the way you usually would. **AM -** using best practice templates which include confidentiality forms available via app. **JI** - Sharing information is always voluntary -- that is, patients share only what they want. We set up group norms/guidelines in advance regarding confidentiality. Moreover, one of the best aspects of group care is the fact that some are willing to articulate questions (or answers) when others are too shy or embarrassed or feeling vulnerable. I share this as someone who has been involved in group prenatal care for more than a decade - and with thousands of patients.
23.	**Are there any "model" forms of what the confidentiality form might look like. I know this might be institution and country/locale dependent, but for those that haven't held a group session before, it might be helpful to know where to start?**	**AM:** Yes, these are available via the Group Consultations APP - www.groupconsultations.com/app.
24.	**Do you send out guidance notes to patients before they join session virtually**	**FB:** They need to know what they are coming for, but best to offer opt out as a default.

		AM: An information sheet and confidentiality form can be sent electronically or via telephone - templates are available via the Group Consultations APP - www.groupconsultations.com/app.
25.	**What if patients join the session and they are others in the room with them (could be children, friends or family) how would you address this, and this could also be an issue with confidentiality**	**KR:** It is also useful to ask patients to mute themselves so as to avoid background noise disturbance. **TT:** We actually encourage care givers or members of social support to participate in the sessions. However, we review privacy rules with all participants at the beginning of each session. **AM:** They must all however adhere to confidentiality guidance and principles.
26.	**How long does the virtual session last and what are the optimum number of patients for each session**	**KR:** 1 hour to 1.5 hours would work. Number of patients would depend on the condition. I've seen 5 to 10 in in-person SMAs (sometimes even more), for virtual, it would be similar within specialty. **MS: W**e still do 90 minutes; the number can be up to 15 but I feel more than that starts to detract from the individual sharing and planning and results in a more didactic session. **TT:** Our visits run 90-120 minutes that are held weekly for 4 weeks followed by bi-monthly booster sessions
27.	**What are the min and max numbers for virtual groups?** **Do you mute everyone & have them raise their hand or type questions to speak up? Based on other zoom meetings I attend,**	**KR:** When I teach classes (I am a B-School professor, not a clinician) I request students to mute and on some platforms the host can mute everyone. Hand raise icon works very well. You can also do votes on some platforms in classroom teaching and show how many answered yes or no to a question. To deliver medical care, platform choice will need to depend on security, confidentiality, etc. How many should depend on the purpose. One specialist mentioned to me she would have liked

	allowing everyone to be unmuted could get distracting and disorganized.	to do a group visit to tell patients she needed to cancel regular appointments. That could be a large number of patients together. If doing diagnosis and prescription then depending on specialty regular SMAs do 5 - 10, sometimes even more patients. Virtual SMAs might parallel that. **FB:** Min is up to you - small ones can be quick. Our mean size is 23 face-to-face and higher scaling possible online. Bigger can be better as not limited by room size and more questions and answers from 12-15 rather than 6-8. **MS: E**xactly, the platform will dictate the number with zoom having more capacity. can be from 6 to 15, need to balance the number of patients with the quality of the appt similar to in person. We start by setting the expectation that we will save questions; however, patients do occasionally unmute and then we address or reset expectation. **AM:** Resources on setting up and managing virtual group consultations dynamics are available via the Group Consultations APP - www.groupconsultations.com/app.
28.	**Consultations are complex what do we do when patients wander into areas they did not plan to. How do you select appropriate patients? How do we handle difficult patients in a group setting?**	**MS –** We followed best practice guidelines initially set out by Dr Nofffsinger There is a waiver signed at every visit with acknowledgement to the group of privacy expectations. We do keep the form for reference. **AM –** To ensure success follow the tried and tested process mapped out in our process flow, apply critical success factors, including having clear roles and responsibilities and use the templates to keep the group on track and focus. All of these are available on the app www.groupconsultations.com/app
29.	**How do you deal with Cultural competency issues in shared medical consultation?**	**MS -** the group will have a cultural character and we chose providers familiar with the setting as in our Spanish speaking SMA. Embedded current care can be used to optimize the experience for the patients in addition to building off the care they currently are comfortable with, including family based etc.

30.	**Has anyone had any negative experiences of pooling patients according to language (using an interpreter) where the patients share a language but not a culture?**	**AM-** Many practices have done this and have either used a member of the practice team who can speak in this language to facilitate – this has worked really well. Alternatively using an interpreter for the group is a really efficient use of this service as the interpreter can work with whole group as opposed to just one patient
31.	**Can we make a diagnosis during virtual consultations and if we can't what is the decision for this situation and next follow-ups?**	**KR -** Certain conditions can be diagnosed while others would need in person exam or further testing. The Aravind Eye Hospital is able to identify Cataract virtually but not Glaucoma, for example. In-hospital testing is needed for Glaucoma.
32.	**What areas were covered in each of the diabetic VSMA sessions?**	**TT -** We covered healthy eating, physical activity, coping with diabetes, sick day management, monitoring, and medications. Each session focused on 1 or 2 self-management behaviours only. **AM:** This would be dependent on several factors, for example most patients now will want to know how COVID will affect the management of their diabetes. As with face to face group consultations it is important to strike a balance between education – what matters to people in the group – what you need to measure /monitor to keep people well. There is more information on how to do this from both a planning and in-session perspective via the Group Consultations APP - www.groupconsultations.com/app
33.	**We are trying to develop a PSMA for weight loss in patients with non-alcoholic fatty liver disease which is probably very similar to diabetes and obesity - does anyone have any resources or similar programmes we could use to help us to develop this?**	We have a 'programmed SMA' from weight control which has been tested. (Egger et al., Aust J Gen Prac. 2019. Programmed shared medical appointments for weight management in primary care: An exploratory study in translational research. *Aust J Gen Prac* Oct 2019; 48(1): 681-8.) We do not have permission though from the funding body to release this yet but if you would like to contact John Stevens direct (john.stevens@scu.edu.au) this might be possible.

34.	**How do you deal with Cultural competency issues in shared medical consultation?**	**MS -** the group will have a cultural character and we chose providers familiar with the setting as in our Spanish speaking SMA. Embedded current care can be used to optimize the experience for the patients in addition to building off the care they currently are comfortable with, including family based etc.
35.	**Has anyone used Virtual SMA's involving dietitian input and are patients happy with this set up?**	**TT:** Yes, we conducted VSMA out of Providence, RI to patients living in American Samoa that included a dietician from Honolulu who was familiar with the Samoan diet. We also routinely use a dietician in our non-virtual SMA because patients often have the most questions regarding diet **OP:** We are currently running a dietitian-led virtual group lifestyle and wellbeing programme, we´ve seen an increase in interest and sign-ups since CoVid-19.
36.	**Any tips for the facilitator? Zoom meetings can be quite difficult to chair with people talking over each other** **I have used Micro teams- only thing I did not like was you can't send a message to one person in the group- the message is visible to all, and you can't raise your hand as in zoom, the screen on zoom looks less cluttered.**	**KR:** You can ask audience to mute or in some platforms you may be able to mute the audience as the meeting host. I am a B-School professor and have taught classes of 30-40 on Zoom recently at a day's notice. It's good to set some rules at the start, requesting people to raise hands to speak, for example. **AM:** Both the facilitator and clinician need to be familiar with the platform they are delivering VGC from and should do a mock-up run through before their first session. We are currently developing several resources to support facilitators and clinicians available via the Group Consultations APP - www.groupconsultations.com/app
37.	**How is the clinician 1:1 clinical part conducted in the group setting (ex: reviewing current status, labs, and developing the plan, etc.)? Does the whole**	**KR: Yes, the whole team would hear. There are some in-person (non virtual) groups in which patients are seen in private for a minute or two (e.g., in Physicals SMAs.)**

	team "hear" the clinical discussion about/with that patient?	**FB: Your choice. vSMA- everyone hears everything. You can use private chat rooms on some platforms or direct to phone 1:1 follow-up if necessary. Usually won't be!**
38..	**What EMR or record keeping, appointment setting, and billing systems are needed to support these visits?**	**KR:** I have seen in-person SMAs where the clinic note was taken during the SMA by a staff person, checked by the physician and printed and shared with each patient at the end of the SMA. **FB:** Just adapt your usual systems. Some use recorders to type as Kamalini describes, but most just insert into several records during or after or dictate for transcription like a normal clinic. **AM:** Make use of templates on your current systems such as EMIS /Systm One. This prevents the need for repetition of key information allowing you to enter specific information relating to individual patients too
39.	**At Cleveland clinic VSMA what age group are your patients who have taken this on?**	**MS:** Our shared appts are all ages, the virtual has focused on older, chronic disease
40.	**I am wondering how to charge in group consultation. How much do patients have to pay? Can you please speak to how you bill for these?** **In the US, what are the billing codes that can be utilized for SMA's?** **What about 99411, 99412?**	**KR:** If one-on-one care is provided in a shared setting then the appointment can be billed the same as a one-on-one is, by at least some US insurers. https://qioprogram.org/sites/default/files/editors/141/B2_SMAs_20160602_FNL2_E4review.pdf - This article has useful information. In the US, patients seen in in-person SMAs can be billed at same rate as in one-on-one care if one-on-one care is provided. In virtual SMAs, a higher rate applies to video consults than to telephone consults. **FB:** They usually pay the same- good value for better care.

	I was advised that 99213-5 do not fit and would cause a potential legal liability by over coding, since these are individual imbursement levels.	**MS:** we use the same codes but work within a framework that does not still universally cover, there are patient costs proportional. **TT:** A new patient usually bills at 99244 or 99245 and follow-up usually bills at 99213 99214 or 99215 depending on the complexity and depth of medical decision making
41.	**How do patients afford the copays associated with this idea? I'm in a specialty, so some of my patients have up to $50/visit copay. A "series" of SMAs sounds financially impossible for them.**	**MS:** The concerns of copays does need considered. Many of our SMAs are not series so we can increase the affordability for patients. In general, we try to balance cost and benefit.
42.	**What is content of the huddle at Cleveland clinic?**	**MS:** At a high level it addresses the organizational approach and changes, at a local level the direct process and changes in screening, amount of PPE, and care
43.	**In Cleveland, do your patients need to reside in the State where the provider is licensed?**	**MS: Y**es, we do care for patients who fall under our licensure
44.	**Is this control group (Tokuda et al. VSMA in Hawaii) also in a SMA just not virtual or 1-on-1 traditional care?**	**TT:** The control group was traditional one to one care.

45.	**Can I apply virtual visit for chronic disease care for clients out of the country?**	**MS: V**irtual visits would be treated as in person care and the limitations of your licensure. Our appts are within our state license.
46.	**Do any of you use EPIC mychart video visit platform to do these group visits?**	**MS: W**e are on epic and i chart in epic while accessing the platform for virtual. the integration into epic is not seamless and complete, so does present some workflow challenges. We are on epic, but our platform does not directly communicate with epic. We chart simultaneously
47.	**Does a group consultation set up for chronic mechanical low back pain patients look similar to other set ups for other chronic health conditions?**	**MS: I** would think low back pain is a great idea, especially given the focus on nonpharmacologic interventions!!! **TT:** I would agree with Dr Sumego. Fantastic idea.
48.	**Is there a cost for the resources of groupconsultations.com?**	**AM: N**o, all resources for virtual group consultations via our app and website are free. More intensive training packages are chargeable for our blended learning programmes currently available for face to face group consultations in partnership with Practice Unbound.
49.	**is there a booking system patients can use to sign up?**	**FB:** You would use your usual booking system and usually offer as a default.
50.	**Is anyone using a platform to coach patients "automatically"?** e.g. After the group consultation, and actions/lifestyle modifications have been agreed, the app would then coach the patient via their smartphone, with feedback via a dashboard to the clinician, like a patient-centred application i.e. when	**OP** - Lifestyle Therapy in Australia has a functioning, tested course called Whole Way ready for use by those keen to offer a structured virtual SMA program. You can get information about this course from: jon@lifestyletherapy.com Lifestyle Therapy in Australia is running an online course looking to improve immunity through lifestyle change. It is completely free to all patients/clients. www.lifestyletherapy.com/secrets

	individuals' actions are agreed in a group consultation (take meds, reduce carbs, do 10,000 steps etc.) the app would then coach the person automatically to do that, the data then collated and reported on.	**AM:** We are currently exploring this and hope to produce a list of virtual resources that can be used in this way
51.	**We have access to NHS Near Me for virtual 1:1... but I'm unclear of the permissions in place in NHS Scotland for Group Consultations app**	**AM:** NHS near me provides virtual one to one consultation via telephone or video. Currently we are unsure if this facility can be used to deliver virtual group clinics and will contact them to find out if and how this might work. T The Group Consultations APP is not intended as a resource for patients it is a hub where information and resources for healthcare providers can be accessed www.groupconsultations.com/app.
52.	**Hoping someone on the webinar can give some guidance RE allowances for billing for group telehealth consultations under the Australian MBS.** **How do we bill virtual SMAs in Australia?**	**GE:** We assume this will be the same as for face-to-face using item numbers (23, 10991 and 10997) but nobody is doing this yet. We are still working on research grant to prove the value of the process, so payments come from the grants.
53.	**Another issue is the medical indemnity coverage for telehealth since some companies in Hong Kong do not indemnify doctors on any virtual consultations**	**MS -** We also have been influenced by available coverage. we have been conducting VSMA with the idea that as the coverage expands, we will have data and evidence of the quality. I do feel we are in a new era and will see this change driving our ability to adopt!!!
54.	**Will the recording of this webinar be available to share w/colleagues who were not able to participate?**	**AM: Y**es, via BSLM website: https://bslm.org.uk/vgc/