PATIENTS AUSTRALIA

Virtual Care Provider Standards and Accreditation

Australian Telehealth Standards Consortium

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Accreditation

Patients Australia Limited retains stewardship of any accreditation or certification framework developed in connection with the VCP Standards. We are currently engaging with stakeholders across the sector to explore the most appropriate, independent and inclusive governance model for future accreditation pathways and look forward to sharing further information as this work progresses.

Organisations interested in participating in this process are warmly invited to get in touch:
standards@patients.org.au

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Purpose

The purpose of the Virtual Care Provider Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.

This document establishes a comprehensive, sector-led framework of self-regulatory standards designed to promote high-quality, safe and ethical healthcare services delivered by Australian VCPs. The standards aim to achieve four objectives:

1. Safety: To establish minimum standards of clinical safety, quality governance and evidence-based care that protect patients and build community trust in digital healthcare delivery.

2. Accountability: To increase acceptance and confidence in telehealth services delivered by online providers by demonstrating the sector's commitment to rigorous self-regulation that complements existing regulatory frameworks.

3. Guidance: To provide VCPs with clear, actionable requirements across seven key domains - clinical governance, safe care delivery, patient partnership, practitioner accountability, ethical marketing, technology security and accreditation processes - that address the unique challenges of virtual care while aligning with national frameworks such as the National Model Clinical Governance Framework and NSQHS Standards.

4. Excellence: To establish a basis for ongoing sector collaboration, benchmarking, continuous improvement and potential future industry association, while recognising that these standards complement rather than replace existing legal, regulatory and professional obligations (including those outlined in Appendices A and B).

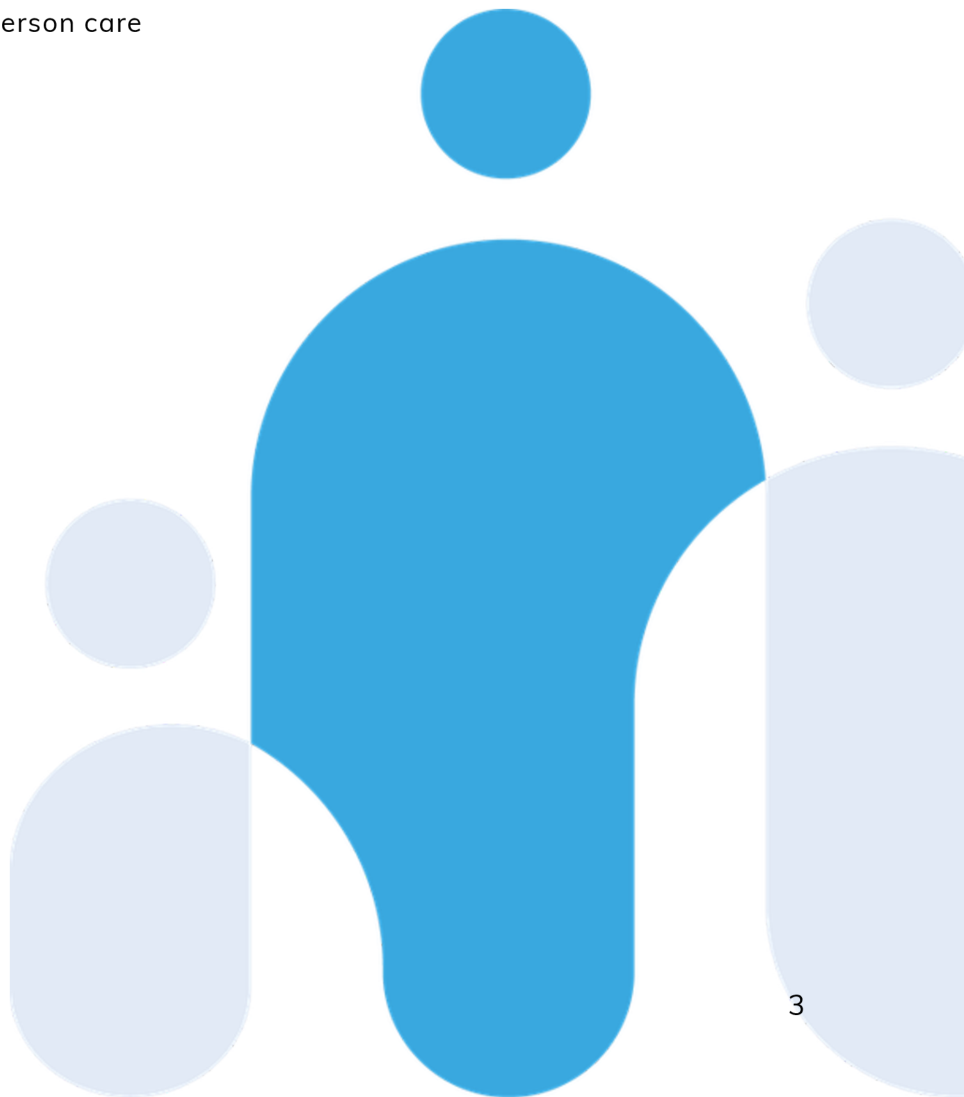
Scope

These standards apply to VCPs delivering healthcare services to Australian patients primarily through digital platforms.

They cover:

- General primary care as well as health condition-specific care including in mental health, sexual health, chronic condition management and other non-emergency health services;
- All telehealth modalities (telephone, video and asynchronous messaging), as well as in-person consultations where they complement a digital service model; and
- Episodic or ongoing care, provided within or across state and territory borders.

They do not cover hospital-based or emergency telehealth services, or traditional general practice clinics where in-person care is the primary modality.



Definitions

Accreditation	Formal evaluation and recognition by an independent body that a VCP meets defined standards of quality and safety in healthcare.
Asynchronous Consultation	Consultation not undertaken in real-time between a practitioner and patient, typically involving text-based or form-based communication without direct, immediate interaction. This includes live chat even if technically synchronous.
Clinical Governance	Clinical governance is the set of relationships and responsibilities established by a VCP between its Governing Body, executive, practitioners, patients and other stakeholders to ensure good clinical outcomes. It ensures that the community can be confident that systems are in place to deliver safe and high-quality health care, and continuously improve services.
Clinical Incident	Event or circumstance that resulted, or could have resulted, in unintended or unnecessary harm to a patient or a complaint.
Governing Body	Board, CEO, owner or other highest level of governance that has ultimate responsibility for strategic and operational decisions affecting safety and quality in a VCP.
High Risk Medications	All Schedule 8 (S8), Schedule 4D (S4D) medications and medications listed on State/Territory Monitored Medicines Lists.
Lead Practitioner	Person responsible for overall clinical governance: this may be a Chief Medical Officer, Medical Director, or Clinical Director role.

Patient	Person receiving medical care through a VCP's service, encompassing all individuals accessing virtual healthcare consultations and treatment.
Practitioner	Registered health professionals (including but not limited to medical practitioners, nurses and allied health professionals) who provide clinical services through the VCP's platform.
Synchronous Consultation	Real-time healthcare interaction between practitioner and patient occurring simultaneously through video, telephone or in-person modalities, enabling immediate two-way communication, clinical assessment and decision-making during the consultation.
Systems	Technology platforms, software, processes, infrastructure and digital tools used to deliver virtual care services, including electronic health records, consultation platforms, communication channels, data management and supporting administrative and clinical workflows.
Virtual Care Provider (VCP)	Multi-practitioner organisation that delivers healthcare services to Australian patients primarily through digital platforms, including telephone, video, asynchronous messaging and in-person appointments (where these form part of a digitally-enabled service model).

Clinical Governance

Principle Statement: VCPs must establish and maintain comprehensive clinical governance frameworks that ensure patient safety through evidence-based practice, systematic quality assurance, robust risk management and continuous improvement processes with clear accountability structures.

1.1 Governance Structure

1.1.1 Clinical Leadership: A clear line of clinical accountability and authority must be implemented to facilitate clinical review at all organisational levels. A Lead Practitioner with demonstrated clinical governance experience must be appointed to oversee the service's clinical governance. This individual must hold Fellowship of RACGP, FACRRM, RACMA or an equivalent specialist college qualification.

1.1.2 Committee Oversight: A Clinical Governance Committee must be established to focus on standards compliance, Clinical Incidents, Patient feedback, policy approval, risk management and quality improvement. The committee should include representation from executive leadership, senior clinicians, governance expertise, consumer representatives and administrative support. External representation should be included on the committee to provide an independent perspective. This committee must meet at least quarterly with provisions for additional meetings as required. The committee should regularly report and escalate critical incidents to the VCP's Governing Body.

1.1.3 Clinical Governance Framework: Maintain a written clinical governance framework that sets safety and quality goals, defines clinical accountabilities and responsibilities, outlines risk management processes, reporting lines, escalation procedures and relationships between committees.

1.1.4 Business and Clinical Strategy Alignment: Align business strategies to prioritise safe, high-quality care; identify and monitor a core set of clinical indicators (e.g., incident rates, prescribing safety, consultation quality) that are reviewed by the Clinical Governance Committee and escalated to the VCP's Governing Body.

1.2 Risk, Compliance & Incident Management

1.2.1 Enterprise Risk Management: Establish a live, enterprise risk register to document clinical, operational and compliance risks with stated controls, owners and review dates. Risks must be reviewed regularly through governance pathways and tied to corrective actions to safeguard regulatory adherence and consumer trust.

1.2.2 Clinical Incident Management System: Implement an organisational incident policy that establishes definitions, severity-based response times, investigation methods (e.g., root cause analysis), open-disclosure steps and external reporting triggers. Incident management systems should clearly define who is contacted at each level and who is responsible for the resolution of that incident. All incidents must be recorded in an auditable register with analysis to identify causes, missing controls, mitigations taken and future strategies. Incident trends and the effect of corrective actions must be monitored and discussed by the Clinical Governance Committee.

1.3 Clinical Protocols & Quality

1.3.1 Evidence-Based Protocols: Establish clinical protocols for practitioners delivering care that requires enhanced safety controls and risk management. These clinical protocols must be kept current, reflect the practicalities of virtual care and align to national guidance, as well as being supported by high-quality clinical studies and reflected by the majority of medical opinion in the relevant specialty. Protocols must address circumstances where virtual care is not appropriate. Governance reviews must be established to ensure protocols remain consistent with relevant guidance from medical colleges (e.g., RACGP), Australian Register of Therapeutic Goods (ARTG) requirements, TGA guidance and advice from other relevant peak bodies. Deviations from protocols by Practitioners require notification to the Clinical Governance Committee, including documentation of the clinical rationale.

1.3.2 Quality Indicators and Audit: Define consultation quality measures and conduct proactive audits (new-starter, random and targeted after Clinical Incidents and anomalies, as well as patient feedback). Findings from the audits should drive coaching and system improvements.

Safe & Effective Care

Principle Statement: VCPs must deliver care through safe and effective consultations, prudent use of AI and robust escalation protocols that detect risk early, act decisively on deterioration and integrate with emergency and public health systems.

2.1 Consultation Standards

2.1.1 Patient Identity and Fraud Controls: Ensure robust identity verification and fraud prevention measures are implemented, including the collection and review of a minimum of three patient identifiers and confirmation of at least one additional government-issued identifier (such as Medicare card numbers or Individual Health Identifier (IHI) numbers). Systems should incorporate safeguards to detect and address duplicate or suspicious accounts and establish clear escalation pathways for suspected fraud.

2.1.2 Clinical History & Suitability for Virtual Care: Implement systems supporting focused history-taking and patient risk assessment, including access to supplementary information, such as My Health Record, when clinically needed. VCPs should define, and ensure Practitioners follow, criteria for escalation, referral, or transition to other modalities or to in-person care.

2.1.3 Communication and Patient Information: Patient communications should be accessible, culturally appropriate and matched to patients' health literacy. VCPs should reference the Australian Charter of Healthcare Rights or equivalent framework that clearly outlines both patient rights and responsibilities within the Patient journey and on the VCP's website. VCPs must provide clear guidance on technology use, outline when in-person care may be necessary and make next steps transparent. Public information channels (e.g., website or app) should clearly state the VCP's scope, operating hours, fees, after-hours arrangements and feedback mechanisms.

2.1.4 Prescribing: Establish prescribing policies that align with evidence-based best practice (and consistently with clause 1.3.1), supported by decision-support tools to ensure safe and appropriate use. Practitioners should only recommend treatment where there is an identified therapeutic need and the treatment is a clinically recognised treatment for the patient's condition. Practitioners should review My Health Record prior to prescribing where clinically appropriate and with patient consent. VCPs should

monitor prescribing practices through audit and stewardship programs with reporting to the Clinical Governance Committee on deviations. System flags or forcing functions for anomalies in both patient activity (e.g., unusual medication requests) and Practitioner activity (e.g. frequent antibiotic prescribing) should be implemented.

2.1.5 Antimicrobial Stewardship: Standardised procedures for antibiotic prescription must be outlined, ensuring prompt and appropriate use within the scope of antimicrobial stewardship. Antibiotics should only be prescribed where clinically indicated, adhering to Therapeutic Guidelines. Broad-spectrum antibiotics for vague complaints should not be prescribed unless clearly clinically appropriate; narrower-spectrum antibiotics should be preferred. Clinicians must clearly document symptoms, duration, progression and provide a rationale for antibiotic prescription. VCPs should implement ongoing auditing and monitoring of antibiotic prescriptions.

2.1.6 High Risk Medications: VCPs must have strict protocols for the circumstances where High Risk Medications are prescribed. High Risk Medications should only be prescribed when the Practitioner is appropriately qualified and the Practitioner has followed the VCP's protocols for High Risk Medications. Protocols must include checking prescription monitoring programs, documenting clear clinical justification and escalating authorisation to a senior clinician where appropriate. All High Risk Medication prescribing must undergo clinical governance oversight through audit, justification review and Practitioner intervention when appropriate.

2.1.7 Diagnostics, Results and Public Health: Implement standardised processes for managing diagnostic results that ensure timely review, action, documentation and public health reporting. VCPs should define clear responsibilities, maintain recall and escalation systems (including after-hours) and include pathology and imaging results in the patient's clinical record. The process should include providing handover to the patient's regular GP where appropriate.

2.1.8 Medical Certificates: Implement and maintain policies for issuing medical certificates that prohibit backdating of certifications and recognise the limitations of remote assessment. Certificates should generally be time-limited, with policies encouraging conservative durations and reinforcing the role of the patient's usual treating clinician in ensuring continuity of care. Certificates must only be issued following adequate clinical assessment.

2.1.9 Asynchronous Consultations: Ensure prescribing via Asynchronous Consultation is used in

limited circumstances where an initial Synchronous Consultation has occurred within the preceding 12 months and with an established treatment history. Asynchronous Consultations must not be used for prescribing High Risk Medications except in exceptional circumstances where an existing treating relationship exists or where there is access to contemporaneous medical records. Comprehensive clinical oversight mechanisms including regular auditing and practitioner accountability must be maintained.

2.2 Artificial Intelligence in Clinical Care

2.2.1 AI Purpose and Oversight: Ensure AI tools are used to support rather than replace clinical judgment. AI tools used in clinical practice must be formally approved by the Clinical Governance Committee. Approval requires compliance with privacy and data security requirements, adherence to professional standards for clinical documentation, appropriate risk assessment, practitioner training, and ongoing monitoring to prevent unauthorised patient data exposure or compromise of clinical record integrity. VCPs should not permit use of unauthorised AI tools and software ("shadow IT") by practitioners.

2.2.2 AI-Generated Documentation Review: Require AI-generated clinical documentation to be reviewed and formally approved by a Practitioner, who retains responsibility for accuracy, clinical appropriateness and respectful language.

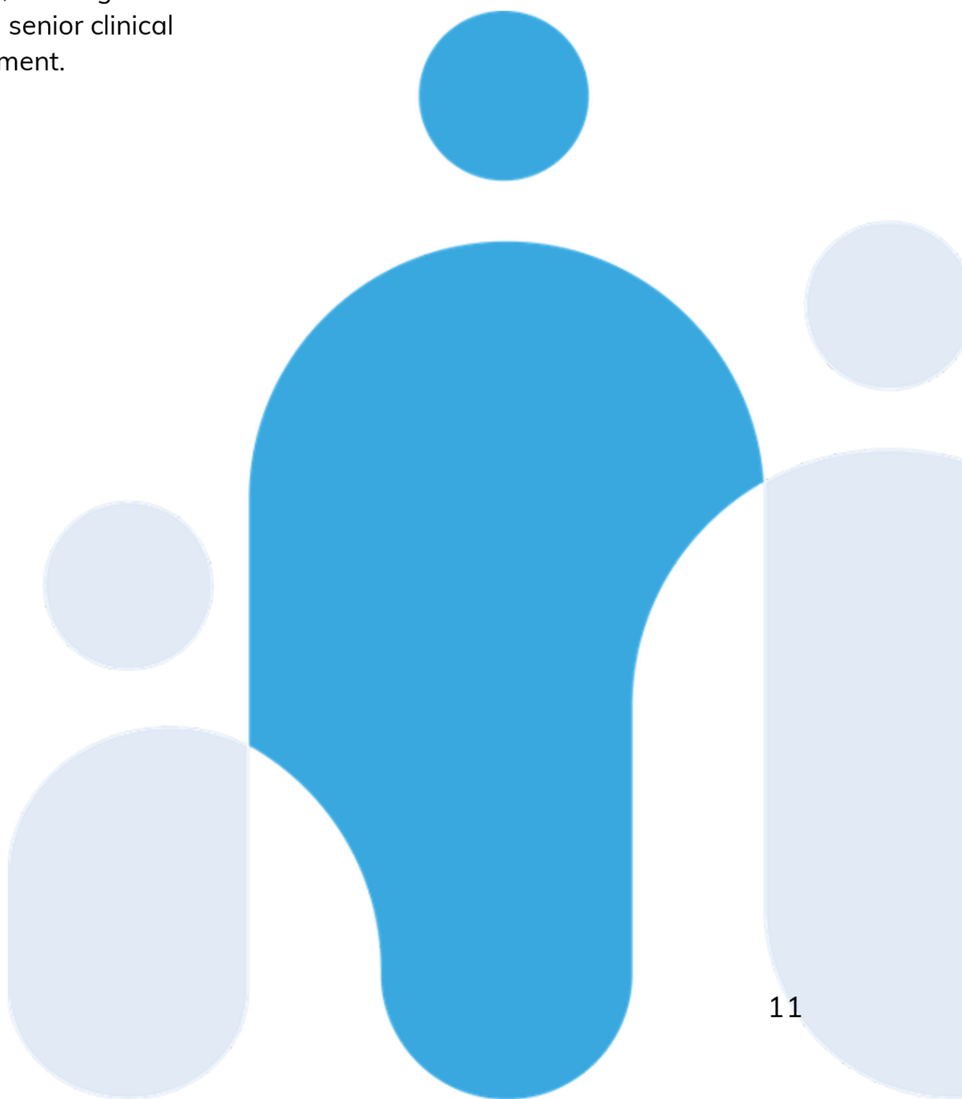
2.3 Escalation Pathways

2.3.1. External Clinical Queries: Establish and maintain accessible communication pathways that enable pharmacists, other treating healthcare practitioners, and external health services to contact prescribing Practitioners efficiently for clinical queries, prescription clarifications, medication safety concerns, or patient care coordination. VCPs should implement clearly documented contact procedures that ensure responses within clinically appropriate timeframes and designated escalation pathways when the original prescribing Practitioner is unavailable.

2.3.2 Emergency Escalation Protocols: Maintain documented protocols for recognising and responding to clinical deterioration, emergencies and medical crises. These should define risk thresholds, emergency indicators and required Practitioner actions, supported by system safeguards (e.g. forcing

functions, real-time alerts) to ensure timely escalation, documentation and accountability. Processes must include triage-based responses, effective handover, safety-netting and collection of patient location and emergency contacts to enable safe crisis management. Processes must account for geographic isolation impacting rural and remote patients who may have limited local healthcare infrastructure and extended emergency response times in rural and remote areas.

2.3.3 High-Risk Presentations and External Coordination: Maintain clear, standardised processes for managing high-risk scenarios such as self-harm, suicide risk, or prescribing High Risk Medicines. This includes comprehensive risk assessment, prioritisation, engagement of support networks and robust escalation pathways to emergency, mental health, law enforcement, or crisis support services. Workflows should ensure seamless coordination, clear contact procedures, thorough documentation, incident reporting and senior clinical review to support continuous improvement.



Partnering with Patients & Continuity of Care

Principle Statement: Care delivered by VCPs should be person-centred, inclusive and transparent which is grounded in informed consent, respect for diversity and autonomy and culturally safe communication that enables shared decision-making. VCPs must ensure continuity through time information sharing, robust results management, patient education, outcome tracking and responsive feedback systems.

3.1 Informed Consent Framework

3.1.1 Treatment Consent: Practitioners should deliver clear information on risks, benefits and alternatives of treatments being recommended with informed consent documented in the clinical record before treatment proceeds.

3.1.2 Financial Consent: Ensure patients receive clear, transparent, and accessible information about all consultation fees, prescription costs, medication delivery charges and potential downstream expenses before care commences. Present service descriptions in plain language without hidden fees or misleading pricing structures. Ensure financial consent is documented in the patient record.

3.1.3 Information Sharing Consent: Obtain informed consent prior to or during each consultation for sharing information with My Health Record and the patient's regular GP through secure messaging. Consent processes must explain what will be shared (consultations, prescriptions, results, referrals). Patients should be encouraged to consent through sharing by default. VCPs must respect patient preferences while ensuring patients understand potential risks to care coordination when withholding consent.

3.1.4 AI Consent: Ensure AI use is underpinned by informed patient consent, robust privacy protections and secure data handling. Consent must be documented. Policies must allow for the withdrawal of consent, prohibit the use of identifiable data for model training and should maintain audit trails.

3.1.5 Legal Guardian and Carer Consent: Implement processes to recognise and document the role of legal guardians, substitute decision-makers or carers and ensure their appropriate involvement in consent and communication (including the sharing of clinical information) in line with jurisdictional requirements.

3.2 Patient-Centred Care & Inclusion

3.2.1 Accessible, Respectful Communication: Practitioners should adapt communication to health literacy, language and culture, and VCPs should provide access to interpreters and accessibility features where feasible. VCPs should also provide clear pre-consultation technology guidance to support a safe and effective telehealth experience.

3.2.2 Medication Supply: VCPs must ensure Practitioners maintain clinical independence in prescribing decisions including where the VCPs have commercial relationships with affiliated pharmacies or medication suppliers. VCPs must implement governance mechanisms to prevent any actual or perceived conflict of interest that could influence treatment decisions or limit patient autonomy in pharmacy selection. Patients must be provided with a process to obtain a prescription that enables dispensing at an Australian pharmacy.

3.3 Continuity of Care

3.3.1 Information Sharing: VCPs must enable and encourage secure information sharing by supporting uploads to My Health Record and timely communication with a patient's usual GP through secure messaging. When patients withhold consent for this information sharing, Practitioners must consider and document concomitant clinical risks, exercise heightened prescribing caution and may decline treatment where risks outweigh benefits.

3.3.2 Patient Education: Encourage Practitioners to provide clear education and safety-net advice about treatment plans including information on medication use, side effects, lifestyle interventions and when to seek further care. Support may be delivered internally or through referral to appropriate community services (e.g., Healthdirect, pharmacies, regular GP).

3.3.3 Patient Outcomes: For both episodic and ongoing treatments, patient clinical outcomes should be measured regularly and analysed against clinical benchmarks where available. Aggregated outcomes data must be reported to the Clinical Governance Committee at defined intervals to enable quality oversight and continuous improvement.

3.3.4 Complaints and Redress: Maintain a transparent and accessible complaints process with clear responsibilities, escalation pathways and defined timeframes. Complaints should be logged, analysed

for trends and regularly reviewed by senior clinicians and escalated to the Clinical Governance Committee as appropriate, to drive system improvements.

3.3.5 Declining Treatment: If a Practitioner declines to provide treatment (e.g., due to clinical ineligibility or inappropriate telehealth modality), the patient should be supported to obtain alternative community support.

3.3.6 Clinical Handover on Cessation of Care: When a patient ceases treatment, a handover document summarising their treatment and clinical progress should be prepared upon patient request, in a form useful to a community health practitioner.

Practitioner Accountability

Principle Statement: Practitioners are rigorously credentialed, trained, supported and performance-managed to deliver safe, ethical, evidence-based virtual care within a defined scope. They are expected to maintain professional competence through ongoing education, uphold clinical autonomy and remain free from commercial coercion, while being accountable to clear professional standards.

4.1 Clinical Autonomy: Ensure all clinical decisions remain under the exclusive professional judgment of Practitioners, free from commercial, administrative, or operational pressures. Practitioners must retain the autonomy to refuse inappropriate treatments, escalate patient concerns, modify protocols based on clinical assessment, and prioritise patient safety over business objectives, in accordance with their professional obligations and AHPRA standards.

4.2 Minimum Experience: Establish minimum experience requirements for Practitioners, ensuring that medical Practitioners hold either Fellowship of RACGP, FACRRM or equivalent specialist college qualification or have completed a minimum of PGY3 (post-graduate year three), and ensuring that prescribing nurse Practitioners hold current endorsement as a nurse practitioner or a designated registered nurse prescriber. For all Practitioners, the Lead Practitioner (or their delegate) must ensure that they have demonstrated competency in their scope of autonomous practice relevant to their proposed role at the VCP. The Lead Practitioner must also be responsible for coordinating appropriate supervision for Practitioners where necessary. In exceptional circumstances where clinically justified, VCPs may engage a medical Practitioner with General Registration who does not meet the minimum experience requirements. Justification for the exception must be documented on an individual basis. In these circumstances, the Lead Practitioner is responsible for ensuring clearly defined limitations on the Practitioner's scope of practice, enhanced supervision (by a designated senior General Practitioner) and auditing of a majority of their clinical practice during a probation period and arranging regular reporting of minimum experience exceptions to the Clinical Governance Committee.

4.3 Credentialing Process: Maintain robust credentialing processes that verify registration (with AHPRA or other professional body as applicable), qualifications, scope of practice and professional indemnity insurance, address role-specific requirements (e.g. Working With Children Check), define supervision arrangements and include periodic credential checking. Regular AHPRA checks should be

established to confirm current registration, conditions, undertakings and reprimands. VCPs must conduct regular verification of Practitioner professional indemnity insurance currency and confirm that the scope of cover is adequate for the range of clinical services and consultation modalities with checks conducted at least annually. Clear protocols should be established for Practitioners based outside Australia providing care to Australian patients.

4.4 Onboarding and Supervision: Develop robust onboarding, supervision and support processes. This includes clinical participation in interviews and maintaining comprehensive Practitioner records. VCPs must ensure that Practitioners who are International Medical Graduates comply with the specific registration pathway, including any mandated supervision or practice limitations, as determined by the Medical Board of Australia and AHPRA. These Practitioners must still have completed the equivalent of PGY3 (consistent with clause 4.2).

4.5 Clinical Continuity and Safety: VCPs should encourage Practitioner use of My Health Record to inform clinical decision-making, reduce risks of adverse drug interactions, contraindications, medication misuse and duplication of therapy. When prescribing High Risk Medications, Practitioners must check relevant state and territory real-time prescription monitoring systems. VCPs must report adverse events following use of medicines to the TGA and notify positive test results for notifiable conditions to relevant state or territory health authorities in accordance with public health legislation.

4.6 Training and Education: VCPs must require role-specific training for Practitioners, refreshed periodically and evaluated for effectiveness. Training should cover compliance requirements, with completion verified before Practitioners commence on the service. Policies should be regularly updated and reinforced, including for contractors. A tiered training system linked to scope of practice, experience and competencies is encouraged.

4.7 Competency and Currency: Maintain a competency framework that links mandatory training and role-specific capabilities to clinical risk, with completion and ongoing currency monitored and reported through clinical governance.

4.8 Remuneration: VCPs must structure Practitioner remuneration to respect clinical autonomy and seek to avoid conflicts of interest, ensuring payment models do not incentivise prescribing or influence treatment decisions.

4.9 Safe Environments: Ensure Practitioners work in private, distraction-free environments with appropriate equipment and lighting.

4.10 Review and Coaching: Embed continuous feedback, peer review, and audits within VCPs' governance framework to support Practitioner development and performance management. Persistent non-compliance must trigger remediation or removal, while lessons from incidents, complaints and external trends should inform ongoing system improvement.

4.11 Psychosocial Risk: Implement comprehensive Practitioner wellbeing and workload management monitoring that require practitioners to declare all employment arrangements. Establish and enforce safe working hour limits that account for cumulative fatigue risk. Maintain governance mechanisms to escalate concerns and intervene when Practitioners' total workload or psychosocial risks may compromise clinical safety, professional wellbeing or quality of care.

4.12 Practice Insurance: VCPs must maintain appropriate and adequate insurance coverage for their operations, including professional indemnity insurance that covers the VCP's clinical governance responsibilities and vicarious liability for Practitioners delivering care through the service with coverage limits commensurate with the scale, scope, and risk profile of services provided. Evidence of current insurance must be documented and reviewed annually as part of governance reporting.

Advertising and Marketing Practices

Principle Statement: All advertising and marketing activities for VCPs must be ethical, responsible, transparent and fully compliant with relevant regulatory requirements and professional codes, ensuring consumers receive accurate and non-misleading information about services and treatment outcomes.

5.1 Ethical Advertising: Adopt an ethical approach to advertising with regular ethical impact assessments to identify risks of misleading marginalised and underserved patients, eroding public confidence, or compromising the therapeutic relationship.

5.2 Multi-Disciplinary Advertising Review: Implement regular formal review processes for advertising. Stakeholder involvement should include skills with clinical, legal, marketing and compliance competencies. Stakeholders should meet regularly as part of an overarching clinical governance model to assess advertising content against AHPRA guidelines, TGA requirements and internal clinical protocols.

5.3 Staff Training and Competency Management: Develop comprehensive training programs for staff involved in marketing, communications and customer-facing activities covering AHPRA advertising guidelines, TGA requirements and company-specific compliance policies. Training must be mandatory at onboarding and updated regularly (at least annually) to reflect regulatory changes.

5.4 Documentation and Evidence Management Standard: Create systems for maintaining documentation that substantiates advertising claims.

5.5 Incident Response and Corrective Action: Establish formal procedures for identifying, investigating and responding to advertising compliance issues, including complaint management processes, corrective action protocols and communication strategies for addressing regulatory concerns. This standard should include clear escalation pathways for compliance breaches, defined timelines for response and remediation, regular review of incidents to identify systemic issues and proactive communication with relevant regulatory bodies when required.

Technology, Data and Security

Principle Statement: The protection of personal health information is paramount. Robust cybersecurity measures and data protection protocols must be implemented to safeguard patient health information through industry-leading encryption, access controls and privacy compliance, while ensuring technological systems are reliable, interoperable and continuously monitored.

6.1 Digital Competency

6.1.1 Workforce Capability: All Practitioners and non-clinical staff of a VCP must maintain core digital competencies through structured training programs. Training must address platform functionality, digital communication skills, AI-assisted tools and virtual care best practices. Security and privacy training must be provided at onboarding for all new staff, refreshed regularly throughout employment and evaluated for effectiveness (e.g., through phishing simulations, competency assessments). Compliance with training requirements must be monitored and documented.

6.1.2 Clinical Communication Tools: Prohibit the use of consumer messaging apps for sharing of identifiable patient information and ensure Practitioners and staff use only approved, encrypted channels that meet privacy requirements.

6.2 Security & Privacy

6.2.1 Access Control and Monitoring: VCPs must enforce strict access controls, including unique accounts, multi-factor authentication and role-based permissions, with regular reviews to remove unnecessary access. Systems must restrict identifiable data to VCP staff members with a legitimate need, maintain detailed audit logs and generate alerts for suspicious or high-risk activity to safeguard confidentiality, integrity and availability.

6.2.2 External Assurance and Testing: VCPs must obtain independent assurance of information management and security processes for information systems developed by the VCP, which may include accreditation through recognised standards (e.g., ISO 27001, SOC 2) and regular penetration testing when appropriate, with findings incorporated into remediation plans overseen by appropriate

governance structures. For information systems not developed by the VCP (such as software-as-a-service tools), the VCP should undertake an internal security review of the system before permitting it access to its patients' personal data.

6.2.3 Data Breach Response: VCPs must maintain a documented breach response protocol that ensures timely containment, investigation, notification of regulators and patients, comprehensive audit trails and systemic remediation in line with privacy law.

6.3 Data Management & Continuity

6.3.1 Interoperability and Records: Maintain comprehensive electronic health records that capture all consultations, results, prescriptions and referrals, using standardised clinical terminologies where feasible. VCPs must uphold interoperability principles by enabling appropriate information sharing with national repositories including My Health Record.

6.3.2 Encryption, Storage and Vulnerability Management: Ensure all patient data is encrypted end-to-end, both in transit and at rest, using industry-standard protocols. Data should be stored within Australia when possible or jurisdictions compliant with Australian privacy laws. Data retention periods should be clearly defined and managed. VCPs must also operate robust vulnerability management programs to detect, patch and remediate software and database risks (including any suspected unauthorised access) in a timely manner.

6.3.3 Backup & Disaster Recovery: Maintain regular, securely accessible backups supported by comprehensive disaster recovery and business continuity plans. These must define recovery objectives, alternative communication channels and procedures to ensure patient care is maintained during outages or security incidents.

Accreditation Framework

Principle Statement: Participation in accreditation is voluntary yet fundamental to sector credibility, beginning with self-assessment and progressing to independent external evaluation by recognised agencies. Regular monitoring ensures continuous improvement and accountability to patients, regulators and the healthcare community, establishing accreditation as a mark of excellence and commitment to safe, ethical virtual healthcare delivery across Australia.

7.1 Evaluation and Monitoring: VCPs adopting these guidelines must undertake a transparent monitoring and evaluation processes based on a phased approach:

- Phase 0: Establish a framework for measurable and auditable criteria within each domain.
- Phase 1 (0-12 months): Self-accreditation, using a tiered accreditation template with review levels of Foundational, Advanced, and Exemplary.
- Phase 2 (12–24 months): Transition to external and independent accreditation with either an independent body or a recognised agency.
  - Potential agencies include Australian General Practice Accreditation Limited, the Australian Council on Healthcare Standards or Quality Innovation Performance.
  - Further definition of the accreditation framework will need to include:
    - Assessment methodology
    - Frequency of review
    - Public reporting
    - Complaints and appeals processes

7.2 Reporting and Transparency: VCPs should commit to appropriate transparency including:

- Reporting of quality indicators and outcomes
- Continuous improvement planning and implementation
- Participation in industry benchmarking activities
- Contribution to sector-wide quality improvement initiatives
- Engagement with regulatory bodies and professional organisations

7.3 Enforcement and Industry Leadership: VCPs must seek to establish mechanisms for:

- Voluntary adoption and implementation of these guidelines
- Accountability processes
- Recognition of compliant services and excellence in practice
- Collaborative improvement and standard development
- Professional development and capacity building support

Appendix A: Relevant Laws & Regulations

This appendix lists the key legal and regulatory frameworks applicable to VCPs.

A.1 Commonwealth (Federal) Legislation

A.1.1 Privacy and Data Protection

Privacy Act 1988 (Cth)

- **Purpose:** Governs the collection, use, disclosure and storage of personal information
- **Key Requirements:** Compliance with Australian Privacy Principles (APPs), privacy policies, data breach notification
- **Application:** Patient health information handling, consent mechanisms, data storage and transmission

A.1.2 Health Practitioner Regulation

Health Practitioner Regulation National Law Act 2009

- **Purpose:** National framework for health practitioner registration and regulation
- **Key Requirements:** Practitioner registration, professional standards, complaints handling
- **Application:** All Practitioners must be registered with AHPRA

State-Based Health Practitioner Regulation National Law Acts:

- **ACT:** Health Practitioner Regulation National Law (ACT) Act 2010
- **NSW:** Health Practitioner Regulation National Law (NSW) No 86a
- **NT:** Health Practitioner Regulation (National Uniform Legislation) Act 2010
- **QLD:** Health Practitioner Regulation National Law (Queensland)
- **SA:** Health Practitioner Regulation National Law (South Australia) Act 2010
- **TAS:** Health Practitioner Regulation National Law (Tasmania) Act 2010
- **VIC:** Health Practitioner Regulation National Law (Victoria) Act 2009
- **WA:** Health Practitioner Regulation National Law (WA) Act 2010

Health Insurance Act 1973

- **Purpose:** Ensure access to affordable, equitable health coverage
- **Key Requirements:** Defines eligibility, benefits and insurer obligations
- **Application:** Regulates Medicare and private health insurance systems

A.1.3 Therapeutic Goods and Medicines Regulation

Therapeutic Goods Act 1989

- **Purpose:** Regulation of therapeutic goods including medicines and medical devices
- **Key Requirements:** Medicine registration, advertising restrictions, quality standards
- **Application:** Prescribing restrictions, medicine advertising compliance

Therapeutic Goods Regulations 1990

- **Purpose:** Detailed regulations supporting the Therapeutic Goods Act
- **Key Requirements:** Specific technical and administrative requirements
- **Application:** Compliance with medicine supply and advertising regulations

Poisons Standard (National)

- Purpose: National classification system for medicines and poisons
- Key Requirements: Scheduling of medicines (S2, S3, S4, S8), access restrictions
- Application: Compliance with scheduling restrictions for prescribing and supply

A.1.4 Competition and Consumer Law

Competition and Consumer Act 2010 (Cth)

- Purpose: Promotes competition and fair trading, protects consumers
- Key Requirements: Prohibition of anti-competitive conduct, consumer protection provisions
- Application: Industry collaboration compliance, advertising standards, consumer rights

A.2 State and Territory Legislation

A.2.1 Medicines and Poisons (including Delivery) Legislation by Jurisdiction

- **NSW:** Poisons and Therapeutic Goods Regulation 2008
- **VIC:** Drugs, Poisons and Controlled Substances Regulations 2017
- **QLD:** Medicines and Poisons (Medicines) Regulation 2021
- **WA:** Medicines and Poisons Regulations 2016
- **SA:** Controlled Substances (Poisons) Regulations 2011
- **TAS:** Poisons Regulations 2018
- **ACT:** Medicines, Poisons and Therapeutic Goods Regulation 2008
- **NT:** Therapeutic Goods Regulations 2014

A.2.2 State-Based Health Legislation

Each state and territory maintains additional health legislation covering:

- Health service delivery standards
- Public health requirements
- Mental health provisions
- Mandatory reporting obligations
- Professional conduct standards
- Health records and information privacy
- Pharmacy ownership

A.3 Employment and Workplace Safety Legislation

A.3.1 Workplace Health and Safety

Work Health and Safety Act 2011

- **Purpose:** Workplace health and safety obligations
- **Key Requirements:** Duty of care to workers, risk management, incident reporting

- **Application:** Practitioner fatigue management, safe working conditions

Fair Work Act 2009

- **Purpose:** Employment rights and obligations
- **Key Requirements:** Working hours, conditions, unfair dismissal protections
- **Application:** Practitioner employment conditions, roster management

A.4 Mandatory Reporting Requirements

A.4.1 Child Safety and Protection

Children and Young Persons (Care and Protection) Act 1998 (NSW)

- **Purpose:** Child protection and safety
- **Key Requirements:** Mandatory reporting of suspected child abuse
- **Application:** Recognition and reporting of child safety concerns

Similar legislation in all jurisdictions

- **Purpose:** Child protection across all states and territories
- **Key Requirements:** Healthcare provider mandatory reporting obligations
- **Application:** Virtual consultation child safety protocols

A.4.2 Public Health Reporting

Public Health Act 2010 (NSW) and equivalent legislation

- **Purpose:** Public health protection and disease surveillance
- **Key Requirements:** Notifiable disease reporting, public health measures
- **Application:** Disease notification procedures, public health compliance

A.5 Technology and Digital Health Legislation

A.5.1 Digital Health Records

My Health Records Act 2012

- **Purpose:** National digital health record system
- **Key Requirements:** Patient consent, information sharing, privacy protection
- **Application:** Integration with national health records, interoperability

Health Identifier Act 2010

- **Purpose**: Unique identification of healthcare providers and patients
- **Key Requirements**: Secure, accurate and consistent identifier management
- **Application**: Supports electronic health records and data exchange

A.5.2 Artificial Intelligence and Digital Tools

Privacy Act 1988 considerations for AI

- **Purpose:** AI and automated decision-making privacy implications
- **Key Requirements:** Transparency, accountability, human oversight
- **Application:** AI-assisted diagnosis, transcription tools, decision support

Note: VCPs should obtain specific legal advice to ensure full compliance with all applicable laws and regulations in their operating jurisdictions. Legislative requirements may change and this document should be regularly reviewed and updated.

Appendix B: Relevant Standards and Regulations

B.1 Professional Standards and Guidelines

B.1.1 AHPRA Professional Standards

National Board Codes of Conduct

- **Medical Board of Australia:** Good Medical Practice guidelines
- **Nursing and Midwifery Board:** Professional conduct standards

AHPRA Guidelines Specific to Telehealth

- Good medical practice: A code of conduct for doctors in Australia
- Information for practitioners who provide virtual care
- Guidelines for telehealth consultations
- Technology in health practices guidelines
- Patient safety and quality of care standards

B.1.2 College Guidelines

Royal Australian College of General Practitioners (RACGP)

- Standards for general practices (5th edition)
- Telehealth guidelines and practical tips
- Good practice standards: Criterion 2.2 – Follow-up system
- RACGP position on the use of telehealth in general practice
- Privacy and managing health information guidelines

Royal Australasian College of Physicians (RACP)

- Telehealth guidelines and practical tips
- Professional conduct standards

B.1.3 Federal, State and Professional Body Standards

Department of Health and Aged Care

- Better Access Telehealth – FAQs

State Health Departments

- NSW Health - Virtual care in practice guide
- Safer Care Victoria's Incident Severity Rating (ISR)

Australian Commission on Safety and Quality in Health Care

- National Safety and Quality Health Service Standards
- National Safety and Quality Digital Mental Health Standards
- National Safety and Quality Primary and Community Healthcare Standards
- Australian Charter of Healthcare Rights (second edition)
- Patient-centred Care
- Antimicrobial stewardship clinical care standard
- The Australian Open Disclosure Framework
- Position statement on paediatric prescribing

Australian Digital Health Agency

- Clinical Governance Framework for Digital Health
- National Digital Health Strategy
- Interoperability standards

B.2 Industry-Specific Standards and Accreditation

B.2.1 Healthcare Accreditation Standards

Australian Council on Healthcare Standards (ACHS)

- EQuIP6 standards
- Clinical governance requirements
- Quality improvement frameworks

Quality Innovation Performance (QIP)

- QIC Health and Community Services Standards
- Performance measurement frameworks

National Safety and Quality Primary and Community Care Standards

- Australian Commission on Safety and Quality in Health Care standards
- Community healthcare delivery requirements

B.2.2 Health Informatics Standards

ISO 13131:2021 - Quality Criteria for Telehealth Services

- **Purpose:** International standard defining quality and safety criteria for telehealth
- **Key Requirements:** Service quality frameworks, clinical governance & patient safety
- **Application:** Virtual care quality assurance and clinical governance frameworks

B.2.3 Information Security Standards

ISO 27001 - Information Security Management

- **Purpose:** International standard for information security management systems
- **Key Requirements:** Risk assessment, security controls, continuous improvement
- **Application:** Protection of patient health information, system security

AICPA SOC 2 (Service Organization Control 2)

- Purpose: Security, availability, processing integrity, confidentiality & privacy controls
- Key Requirements: Independent audits of service organization controls
- Application: Third-party service provider compliance

PCI DSS (Payment Card Industry Data Security Standard)

- Purpose: Security standards for organizations handling credit card information
- Key Requirements: Secure payment processing, data protection
- Application: Patient payment processing security

B.3 Consumer Protection and Rights Legislation

B.3.1 Healthcare Consumer Rights

Australian Charter of Healthcare Rights (second edition)

- **Access**: Right to healthcare services
- **Safety**: Right to safe and high-quality care
- **Respect**: Right to respectful treatment
- **Partnership**: Right to be included in decisions
- **Information**: Right to information about treatment
- **Privacy**: Right to privacy and confidentiality
- **Comment**: Right to comment and complain

Health Ombudsman Act 2013 (Qld)

- Purpose: Independent investigation of health service complaints
- Key Requirements: Complaint handling procedures, investigation powers
- Application: Patient complaint resolution mechanisms

State-Based Health Complaints Commissioners

- **Purpose:** Handle health service complaints in each jurisdiction
- **Key Requirements:** Accessible complaint processes, investigation procedures
- **Application:** Patient redress mechanisms for virtual care

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AUSTRALIA