

ANMF Response to the Department of Health Primary Care Reference Groups Consultation

MEDICARE BENEFITS SCHEDULE (MBS) REVIEW TASKFORCE REPORT FROM THE NURSE PRACTITIONER REFERENCE GROUP

7 JUNE 2019



Australian
Nursing &
Midwifery
Federation



Annie Butler
Federal Secretary

Lori-anne Sharp
Assistant Federal Secretary

Australian Nursing and Midwifery Federation
Level 1, 365 Queen Street, Melbourne VIC 3000

T: 03 9602 8500

F: 03 9602 8567

E: anmffederal@anmf.org.au

W: www.anmf.org.au



INTRODUCTION

Established in 1924, the Australian Nursing and Midwifery Federation (ANMF) is the largest professional and industrial organisation in Australia for nurses and midwives, with Branches in each State and Territory of Australia. The core business of the ANMF is the professional and industrial representation of our members and the professions of nursing and midwifery. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of 275,000 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions. Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

The Federation would like to commend the Nurse Practitioner Reference Group (NPRG) on their comprehensive, well-supported report. It has long been our position that nurse practitioners (NPs) have an integral role to play in primary health care delivery across Australia. We are pleased that the recommendations of the Reference Group support this model of integrated, coordinated, individualised care. The nature of the model allows care delivery that fully utilises the skills, knowledge, experience, and expertise of all members of the health care team, reducing risk while improving outcomes for individuals and for the nation as a whole.



BACKGROUND

As our health care system begins to shift from the traditional emphasis on management of emergencies and acute illnesses or acute exacerbations of illness to health prevention and management of chronic health conditions through a primary health model, the part NPs have to play in the health care team is increasingly important. NPs provide comprehensive care, not only in underserved communities (including remote areas, aged care, Aboriginal and Torres Strait Islander peoples, and homeless populations) but across metropolitan and rural areas of clinical practice. They provide safe, affordable, expert clinical care within a variety of settings.

The nature of the nursing profession means that nurses in general, and NPs in particular, are accustomed to operating as part of a holistic care team, and work well in collaboration with other health care professionals. At all levels of practice, registered nurses are adept at recognising where the knowledge, expertise and skills of our multidisciplinary colleagues are needed, then referring to and liaising with team members across the health professions.

The introduction of the NP role in Australia has improved primary health care access for marginalised, disenfranchised, and geographically isolated populations, while providing nursing expertise in such diverse areas as palliative care, cardiac health, alcohol and other drugs, and renal replacement therapy. Extending the services NPs can provide will reduce fragmentation of care by facilitating comprehensive assessment, evaluation, and treatment by NPs. It also offers increased opportunities to initiate health promotion discussions and disease prevention activities, thereby reducing the development and progress of burdensome preventable health conditions.

Dealing with one primary health provider, who in turn consults with and refers to other health care providers reduces the risk of conflicting advice or clinical decision making based on an incomplete picture, and facilitates a professional relationship between the person receiving care and the health practitioner.



RESPONSE TO THE RECOMMENDATIONS

The ANMF strongly endorses the fourteen recommendations made by the Reference Group, with comments as follows:

Recommendation 1 - Access MBS rebates for long-term and primary care management provided by NPs

Clinical case study:

B has been treated by me since 2007 for post-traumatic stress disorder resulting from exposure to family violence, sexually inappropriate material, and physical assault perpetrated by her father. She was six when I first began treating her, at which time she displayed significant anxiety, communication problems, behavioural problems and learning difficulties. She was hypersensitive to noise, smells and many social situations. She has been diagnosed by a psychologist with intellectual disability; assessed by a speech pathologist as having language and speech difficulties; and found by an audiologist and psychologist to have auditory processing problems; and in 2008 an occupational therapist diagnosed her with motor, sensory, and perceptual disorders. These, combined with a diagnosis of autism spectrum disorder, make her treatment particularly complex – NP (mental health), Vic

NPs work across diverse practice settings to provide excellent primary care, particularly for people with chronic health conditions. The above case study demonstrates that NPs provided comprehensive and coordinated care for people with complex, long term health conditions. Delivering safe, affordable, professional health management requires sufficient time to take a comprehensive history, conduct a thorough evaluation of the patient, and prepare an individualised, collaborative plan of care for and with the patient, in order to achieve best outcomes. Amending these items to include NPs offers people more choice, particularly those people living in rural and remote areas, who often have limited access to health care providers.

Recommendation 2 - Improve access to MBS-subsidised NP services in aged care settings

As submissions and statements to the Aged Care Royal Commission have clearly demonstrated, this is an under-served population with increasingly complex medico-pharmacological needs. Yet the AMA's 2017 Aged Care Survey Report¹ demonstrates that, despite rising demand in both number of residents and need for health practitioner attendance, fewer GPs are prepared to service this sector. In contrast, NPs are both willing and able to provide safe, efficient, quality primary care to the ageing community.

1. Australian Medical Association Survey Report (2017) <https://ama.com.au/system/tdf/documents/2017%20AMA%20Aged%20Care%20Survey%20Report.pdf?file=1&type=node&id=48948>



Recommendation 3 - Enable DMMRs and RMMRs to be initiated by NPs

We agree with the recommendation which, if implemented, will improve consistency of care where a NP is the primary health care provider, reducing polypharmacy (and thus reducing morbidity and mortality) in older people. Amending these items to include NPs will be particularly beneficial for the aged members of rural and remote communities, whose reduced access to health care practitioners mean less opportunity and capacity for review of medications. This will also assist with comprehensive medicines review for older persons in residential aged care, where in the absence of GPs, NPs can refer residents to an accredited pharmacist for a RMMR and implement the recommendations of the pharmacist's report.

Recommendation 4 - Increase the schedule fee assigned to current MBS NP professional attendance items

Clinical case study:

The restrictions of MBS impact on me financially: I have not been able to pay myself since opening my practice 9 months ago. I am currently being supported by the farm. However, I continue to do this work because I am passionate that this is a model of health care that can work and can meet the needs of the community. – NP (primary health), SA

The ANMF echoes the statements made in the *MBS Review Taskforce Report from the Nurse Practitioner Reference Group* in support of this recommendation, which note that NP sustainability is only workable when NP-led care is a financially viable option; NPs receive the lowest rebate for services of all advanced practitioners.² With the present scheduled fees, NPs must choose between taking the time needed to comprehensively address their patients' presenting issue, restricting the remuneration they attract, or delivering abbreviated care and generating income to cover their employment.

2. Middleton S, Gardner A, Della P, Lam L, Allnutt N, and Gardner G (2016) How has the profile of Australian nurse practitioners changed over time? *Collegian* 23(1):69–77 doi: 10.1016/j.colegn.2014.10.004



Recommendation 5 - Longer NP attendances to support the delivery of complex and comprehensive care

Clinical case study:

One of the procedures I undertake is intrauterine device insertion, as a contraceptive and to help manage painful or heavy menstruation. There's a substantial amount of pre- and post-insertion counselling and education involved, in addition to the insertion itself, plus paperwork, but I can't access MBS rebates when the session goes past 40 minutes. – NP (*women's health*), NSW

We recognise the need for sufficient time to fully assess need and deliver care interventions for all patients. Whether related to the patient themselves, or the condition being treated, complex cases necessitate a longer time period for this to be performed safely and competently. Adding an MBS item that reflects this requirement will allow NPs to provide these patients with the comprehensive, individualised care their situation demands.

Recommendation 6 - Access MBS rebates for after-hours or emergency care provided by NPs

Clinical case study:

It is difficult for NPs to work to their full scope as we are unable to bill for treatment or procedures. For example if a patient presents with a deep laceration or complex wound that requires local anaesthetic, regional nerve block, exploration, removal of foreign body, washout and closure, the NP can only bill for time under code 82205/82210 or 82215. This means if an NP sees this patient, these procedures and treatments are not billed. This means that in some cases these patients are not seen by the NP but are seen by the ED general practitioner, as they are able to bill for all of the procedures/treatment. This increases ED waiting times, leading to access block and patient dissatisfaction. There are many other examples from ED including: management of bleeding in early pregnancy, bedside ultrasounds, DVT management, vaccination administration, eye examination and FB removal, skin infections, cellulitis, sprains and strains, joint dislocations, fracture management, closed reductions, and casting. Limiting our billing affects our capacity to work to our full scope and potential. – NP (*emergency*), SA



Health accidents, emergencies, and condition deterioration occur regardless of time or day, so that even when in-hours access to health practitioners is unrestricted, out-of-hours health care is confined to accident and emergency departments, locum home visits, and where available, twenty-four hour clinics. This means not only fragmented care, but utilisation of scarce high-level resources when less cost-intensive options could be considered. This is particularly the case for residents in aged care, who too often face transfer and distressing and lengthy delays in an unfamiliar environment, which contributes to confusion and disorientation. Amending these items to incorporate NPs will reduce overall cost to the health care system, relieve pressure on accident and emergency departments, and facilitate integrated care with minimal disruption to residents and other patients, without requiring additional changes.

Recommendation 7 - Access MBS rebates for NP care received outside of a clinic setting

Clinical case study:

I own and manage a practice in country SA. I purchased a building and started my current practice in October 2018. I practice here three days per week and work at two other country sites, one day each per week. I employ a GP one day per week. As well as having some of his own patients the GP signs off all the MBS documents that I need.

We have a great collaborative relationship as he really believes in and supports the NP model of care; if he was unsupportive, I would be unable to meet the needs of the community. If I do get access to more MBS items, I would continue to employ him as our relationship is mutually beneficial. He does a lot of the pregnancy care, so women do not need to go to a larger town for appointments. He has many years' experience and this is beneficial for me and our patients.

I am unable to sign off mental health care plans, enhanced primary care plans, or GP management plans. I am unable to order mammograms, renal ultrasounds, spinal x-rays, head x-rays or any CT scans.– NP (primary health), SA

As discussed above, the predominantly acute care-focused nature of the Australian system has resulted in few options for health care access out of hours and outside clinical settings. This issue is exacerbated in, but not confined to, rural and remote areas with few health practitioners. Adding items that allow NPs to contribute to meet this need will again improve access to care, reduce overall cost to the health care system, relieve pressure on accident and emergency departments, facilitate integrated care, and allow preventative health initiatives like NP-led occupational and preventative health programs in workplaces.



Recommendation 8 – Requirement for NPs to form collaborative arrangements

Clinical case study:

J came to see me with change in her breast; her GP is male, and she didn't want to see him for women's health issues. I completed the work up with a history and clinical breast exam and, in accordance with national guidelines, needed to refer J for a diagnostic mammogram and ultrasound. As I can't order these myself, I gave her the choice of being referred to my collaborating GP, or to her own GP, for these tests – for which she had to pay another consultation fee.

The ultrasound detected a mass, with a fine needle biopsy recommended. Again, I needed to either get my collaborating GP to request the test, or refer the woman back to her GP and hope the GP will do the follow up. Either way means delay, additional anxiety, and fragmented care for J. – NP (women's health), NSW

The requirement for collaboration, as defined in the *National Health (Collaborative arrangements for nurse practitioners) Determination 2010*³, with a medical practitioner is the result of doctor's concerns expressed a decade ago about fragmentation of care based on a limited understanding of NP education, experience and scope of practice. NPs are qualified health practitioners, subject to regulation, and legally accountable for practicing within their scope of practice, which is determined by their education, experience, practice setting, and role. While the underlying premise of mandating this arrangement was to reduce fragmentation of care, safeguard patients, and facilitate collegial professional communication between NPs and their medical colleagues, this has not been the result in practice.

A predicted logistical drawback is that locating available, accessible medical practitioners with whom NPs can create a collaborative arrangement has proven difficult in areas where access to health care practitioners is already reduced, particularly remote and very remote regions. Additionally, as NPs are reliant on the good will of the collaborating medical practitioner, the nature of the relationship places the NP in a dependent position, rather than on an equal professional footing.

3. Australian Government - National Health (Collaborative arrangements for nurse practitioners) Determination 2010.



An unintended consequence of this requirement has been that the resulting arrangements are in fact anti-collaborative and have not promoted safe practice, genuine collaboration, or appropriate mentorship. This appears to have occurred because the named collaborating medical practitioner has in many cases viewed the arrangement as a formality which, once acknowledged on paper, did not progress to case discussion or mentoring. In other cases the collaborating medical practitioner has interpreted the position as one of supervision, regarding the NP as a subordinate rather than an autonomous health practitioner in their own right, thus reducing their capacity to wholly inhabit the role. This misunderstanding of the intent of a formalised collaboration has had a negative impact on employment arrangements, as some medical practitioners have misconstrued their obligation and determined that they have neither time nor resources to oversee a practitioner from another discipline. The result is that, rather than leading to a mechanism which supports effective liaison between NPs and medical practitioners, the stipulation of mandatory collaboration has led to delays in treatment for patients, reduced utilisation of NPs, and poorer access to care.

Nurses want genuine collaboration, while also working autonomously within a team environment. They recognise that real, meaningful collaboration contributes to better health outcomes for those for whom they provide care. Removing the legislated requirement for a collaborative arrangement will not reduce NPs' willingness to confer with their cross-disciplinary colleagues. Eliminating this provision will, however, contribute to a health care system that is able to capitalise on the full potential of NPs, while also creating an environment that facilitates mutually beneficial, genuine cross-disciplinary consultation, collaboration, and where appropriate, mentorship. Making that change will result in better, more integrated, safer patient care.

Recommendation 9 - Remove current restrictions on diagnostic imaging investigations

Clinical case study:

One of the treatment options for heavy menstrual bleeding under the national guidelines is a Mirena IUD. I need to work the woman up before recommending this course of treatment, including checking for a cause for the heavy bleeding. The clinical pathway requires a pelvic ultrasound as part of this process, but I can't order one, either then or to check the IUD position if there are any problems following insertion (i.e. to check position or to manage complications such as expulsion, perforation, low lying IUD), and have to refer my patient to a GP at least once. – NP (women's health), NSW



The ANMF unreservedly agrees with the Reference Group that expanding the MBS-rebatable diagnostic imaging items recommended will result in more streamlined care that is more efficient, less onerous for patients, and less costly for the government. There is consistent research demonstrating no significant increase in utilisation of these investigations when indicated by NPs compared with medical practitioners.⁴

... our case study found that existing restrictions on NP access to MBS items for allied health referrals and diagnostic imaging were responsible for duplication of care, interrupted workflows and practice inefficiencies. These issues potentially translate into increasing costs for healthcare provision and would benefit from further review by the Australian Government.⁵

Recommendation 10 - Access MBS rebates for procedures performed by an NP

Clinical case study:

Patients have presented to the [after hours] clinic with lacerations; as an NP I can perform suturing but not claim it from Medicare; I have to tell them they can pay the out of pocket expense, or go to the Emergency Department. – NP, NSW

Clinical case study:

The MBS was so restrictive for my NP role that I couldn't function to capacity. I couldn't claim for urinary catheter insertion, pessary insertion, pelvic floor assessment, ultrasound, and I was unable to order a broader range of investigations for my clients. My only item numbers were for length of consult with women paying a gap. – NP (women's continence service), SA

Granting NPs access to the recommended MBS items does not extend their scope, but will allow patients to avoid out of pocket expenses associated with these procedures. Cohorting these procedures within NP practice reduces cross-service provision; for example, a NP creating an asthma management and prevention plan is currently hampered by either needing to refer the patient to a medical practitioner, requiring the patient to pay privately for the procedure of spirometry, or performing spirometry without cost.

4. e.g. Brown MA and Grimes DE (1995) A meta-analysis of nurse practitioners and nurse midwives in primary care *Nursing Research* 44(6): 332-9; Kapu AN, Kleinpell R, and Pilon B (2014) Quality and Financial Impact of Adding Nurse Practitioners to Inpatient Care Teams *The Journal of Nursing Administration* 44(2): 87-96 doi: 10.1097/NNA.000000000000031; DesRoches CM, Gaudet J, Perloff J, Donelan K, Iezzoni LI, and Buerhaus P (2013) Using Medicare data to assess nurse practitioner-provided care *Nursing Outlook* 61(6): 400-7 <https://doi.org/10.1016/j.outlook.2013.05.005>; Hughes DR, Jiang M, and Duszak Jr R (2015) A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits *JAMA Internal Medicine*. 2015;175(1):101-107. doi:10.1001/jamainternmed.2014.6349; Katz M (2015) Editor's Note: The Right Care by the Right Clinician *JAMA Internal Medicine* 175(1):108. doi:10.1001/jamainternmed.2014.6441
5. Helms C, Crookes, C, and Bailey D (2013) Financial viability, benefits and challenges of employing a nurse practitioner in general practice *Australian Health Review* 39(2) 205-10 <https://doi.org/10.1071/AH13231>



Referral to a medical practitioner means two charges, two attendances (unless a GP is available within a short time span), two assessments, and two sets of documentation; the subsequent out-of-pocket costs will result in some patients not having the necessary test conducted in a reasonable timeframe, if at all; and NPs implementing (without MBS reimbursement) procedures that they are competent to perform results in data gaps, affecting health statistics that contribute to disease management planning, potentially providing a distorted picture of disease incidence and management across the country.

Recommendation 11 - Add GPs as eligible participants in NP patient-side telehealth services

The primary care model promotes a coordinated team approach to health care delivery, of which NPs are one component. While specialists form a necessary component, GPs are an integral part of this multidisciplinary approach and, alongside NPs, are patients' first point of contact for chronic conditions and mental health planning, and most health care encounters. It therefore makes sense to include GPs in NP-led telehealth interactions.

Increasing the eligibility of Aboriginal and Torres Strait Islander peoples to access telehealth regardless of their affiliation with Aboriginal Medical Services or Aboriginal Community Controlled Health Services with a 19(2) exemption will contribute to closing the health outcomes gap between Indigenous and non-Indigenous Australians by making it easier for these individuals to access safe, quality health care regardless of their geographical location or their choice of health service facility.

Recommendation 12 - Add patients in community aged care settings to residential aged care telehealth items

As is evident through testimony and submissions to the Royal Commission, initiatives and support to help older, frail people stay in their homes are an integral part of effective, individualised, safe aged care. Affording this population the opportunity to receive high quality, consistent health care by utilising telehealth mechanisms to accommodate mobility and transport concerns means they not only have equity of access, but are more likely to seek health care review in the earlier stages of emerging or deteriorating conditions. This corresponds with less extensive, expensive, and onerous interventions, including hospitalisation and potential reclassification of care needs.



Recommendation 13 - New MBS items for direct NP-to-patient telehealth consultations

Clinical case study:

I cover a large area of rural NSW, and my patients are often frail, so face-to-face consultations aren't always ideal, or even possible. One of my patients, who I'll call Bob, lives in an aged care community setting. He has metastatic prostate cancer, and managing his symptoms has been tricky. It would be unduly onerous on Bob (and his daughter, who drives him in to town for appointments) to require him to come to me, and it has been more cost-effective for me to waive any reimbursement and review the effectiveness of his interventions though telehealth than to drive two hours each way for a brief consultation. – NP (*palliative care*), NSW

As clearly illustrated in this case study, adding MBS items that allow NPs to consult with patients via videoconferencing will contribute to better health care outcomes, particularly for patients who are geographically isolated or physically incapacitated and would therefore have difficulty attending a face-to-face appointment.

Recommendation 14 - Allow telehealth consultations to take place via telephone where clinically appropriate

The advent of telehealth has substantially improved the capacity for Australia's health care practitioners to deliver safe, cost-effective, timely care to populations who previously had difficulty seeing a clinician, and therefore often delayed seeking help until their conditions had significantly worsened. It is unfortunately the case that for many of these people, the same geographic or financial isolation that contributes to poorer health access and poorer outcomes also manifests as reduced technological access, related to cost, internet reliability, access to the required infrastructure, and/or proficiency in using the equipment and programs required.

As the report notes, there are other instances where the capacity for NPs to use audio-only communication will facilitate integrated care, including patient reporting on the effectiveness of an intervention, direction or clarification, and triage.



Additional comments

NB: the greater than/less than signs in the consultation time graph on p. 38 of the report are reversed.

In addition to the commentary provided above, the ANMF has taken note of the following feedback from our members:

Clinical observation:

The inability to refer to allied health practitioners outside of the health department without getting a GP referral is really frustrating for those needing to see a psychologist for counselling at a rate my clients can afford. – NP (mental health), NSW

This, in conjunction with the observation by Helms et al. cited in our support of recommendation 9, is the basis for recommendation of an additional change to the MBS: that allied health practitioners be able to claim for review of and interventions for patients referred by NPs. While this is not an aspect of the MBS that affects NPs financially, it directly affects their patients access to health care, and is therefore within the purview of the Reference Group.

Making this change will reduce the current issues resulting from NPs needing to send patients to GPs for allied health referrals, which include duplication of assessment, health practitioner workload, unnecessary cost in both time and money to the patient and the health care system, and delay in accessing appropriate treatment.



CONCLUSION

The NPRG review of nurse practitioner access to MBS items has determined that changes to the Schedule (including additional items) will streamline the safe, timely provision of quality health care to Australians, reduce costs, duplication of work and documentation, and improve equity of access to those who face disadvantage. The present restrictions on some of these items increases inequity in already disadvantaged populations (particularly older Australians and those living in rural and remote areas), and impair the viability of successful NP practices, both independent and within health care clinics. In many cases, these restrictions on access to MBS items mean that GPs need to review and assess patients who have already been evaluated by NPs, not because of their clinical condition or complexity, and not because of concern on the part of the NP, but to facilitate appropriate testing and further management.

The ANMF strongly supports the recommendations made in the *MBS Review Taskforce Report from the Nurse Practitioner Reference Group*. The potential benefits to consumers, NPs and the health and aged care systems are thoroughly detailed in the report. These recommendations, supported by strong, relevant evidence, present a compelling case for changes to the MBS that are long overdue. If implemented, these recommended changes will improve access to safe, quality health care, enable people to access rebates for a wider range of services, provide more timely delivery of healthcare, reduce fragmentation of care, and support NPs to work to their full scope of practice, increasing their contribution to integrated, efficient healthcare for the Australian community.

We thank the taskforce for the opportunity to offer feedback to the Reference Group, and look forward to assisting with communicating the outcomes of this important work to our members following completion of the next phase of this project.