APNA Response to:

Report from the General Practice and Primary Care Clinical Committee: Phase 2

Medicare Benefits Schedule Review

About APNA

The Australian Primary Health Care Nurses Association (APNA) is the peak professional body for nurses working in primary health care. APNA champions the role of primary health care nurses; to advance professional recognition, ensure workforce sustainability, nurture leadership in health, and optimise the role of nurses in patient-centred care.

APNA is bold, vibrant and future-focused. We reflect the views of our membership and the broader profession by bringing together nurses from across Australia to represent, advocate, promote and celebrate the achievements of nurses in primary health care.

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Our Vision

A healthy Australia through best practice primary health care nursing.

Our Mission

To improve the health of Australians, through the delivery of quality evidence-based care by a bold, vibrant and well support primary healthcare nursing workforce.

Contact us

APNA welcomes further discussion about this review and our submission. Contact::

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Introduction

The Australian Primary Health Care Nurses Association (APNA) welcomes the opportunity to contribute to the consultation regarding the Report from the General Practice and Primary Care Clinical Committee (GPPCCC): Phase 2, as part of the Medicare Benefits Schedule (MBS) Review.

We are providing this submission on behalf of our membership of Australian primary health care nurses.

Background

Primary health care nursing refers to nursing that takes place within a range of primary health care settings, these settings each sharing the characteristic that they are part of the first level of contact for individuals within the community with the health system.

Primary health care nurses are skilled, regulated and trusted health professionals who work in partnership with the multidisciplinary team and their local communities to prevent illness and promote health across the lifespan. In Australia, nurse practitioners (NP), registered nurses (RN), enrolled nurses (EN) and registered midwives (RM) practice in primary health care in a range of clinical and non-clinical roles, in urban, rural and remote settings such as:

- general practice
- community settings – including community controlled health services, correctional facilities (including juvenile and adult), refugee health, and roles within specialist service settings such as alcohol and other drugs, primary mental health and also health promotion
- aged care settings – including residential aged care
- antenatal clinics
- domiciliary settings – in the home, including residential aged care, custodial/detention settings, boarding houses and outreach to homeless people
- educational settings – including preschool, primary and secondary school, vocational and tertiary education settings
- specialist practices including skin and cosmetic clinics
- occupational settings – occupational health and safety and workplace nursing
- informal and unstructured settings – including ad hoc roles in daily life, such as sports settings and community groups.

In Australia, over 78,000 nurses work in primary health care settings, with over 13,000 based in general practices (Department of Health 2019). Recognition of the role of nurses in primary health care is increasing nationally and internationally, so that it is being seen as essential to achieving improved population health outcomes and better access to primary health care services for communities. A broader role for nurses enables health services to focus on the prevention of illness and health promotion, and offers an opportunity to improve the management of chronic disease as well as reduce demand on the acute hospital sector (ANF 2009).

APNA is contributing to this consultation because of this key role that primary health care nurses have in the delivery of care within general practice, and to bring focus to the need for the MBS Review Taskforce to consider how to fund the important high value nurse role.

About the review

APNA understands that the MBS Review Taskforce is currently seeking feedback and comments from key stakeholders in the primary care sectors on the Report from the GPPCCC, as well on those of other Primary Care Reference Groups (PCRG).

In particular we understand that the MBS Review Taskforce is seeking views on:

1. The Recommendations made in the reports – agreement/disagreement and any relevant evidence to support arguments;
2. Any aspects of primary care that have not been considered as part of the report that may be considered to require further investigation.

We are aware that this feedback will inform the final reports of the GPPCCC and the PCRGs, which will then be provided to the MBS Review Taskforce to consider and make recommendations to the Minister for Health, for consideration by Government.

Summary of APNA's position

In principle, APNA endorses the work of the GPPCCC and supports the intent of each recommendation.

However, we have the following reservations:

1. The Recommendations do not clearly enough recognise the capacity of the total health workforce. Enabling each health discipline within Australia's primary health care workforce to work to their full scope of practice, is an important principle for health care systems of the future (Leggat 2014). This is important for both improved health care access and outcomes for Australians, as well as being a component of the Quadruple Aim (Bodenheimer 2014).

2. There must be a stronger emphasis on team-based, patient-centred care being funded through more flexible funding models, as per Recommendation 1. Nurses in particular play a key role for patients (e.g. patient carer, organiser, quality controller, educator and problem solver) within collaborative, team-based care (e.g. agent of connectivity) (Phillips et al 2009), and any funding model must recognise and enable nurses to undertake these valuable functions.

3. Consideration needs to be given to the measurement of nurse activity and contributions to patient care (and that of other health professional activity), so that ultimately data analysis can occur to link service provision to outcomes, that will assist to inform efficient and effective models of health care. This is particularly the case under more flexible funding models, such as the Health Care Homes program, to track inputs into a patient's care.

APNA Submission

Overarching view

- The MBS Review is an important opportunity to **contemporise and forward focus Australia's universal health care system** to meet the health needs of the population and for financial sustainability, where chronic disease management is a high need.

- Further, the MBS Review is a key opportunity to examine how to develop the MBS funding model to better **capitalise on the capacity of the total health workforce, including the nurse workforce** who are the largest and most geographically spread health workforce in Australia. It is unarguable that in the face of likely health workforce shortages, and changing health care challenges, the health workforce must realign itself to deliver the skilled and evidence based chronic disease management now required by the population (Leggat 2014).

- This includes looking at **how the capacity of each discipline is enabled to work to their full scope of practice by the MBS funding model.** Where this cannot be supported by the MBS funding model, **other models such as block funding must be considered to support more efficient, effective patient care.** This is because the way healthcare is funded influences the structure and viability of models of care and the roles and tasks of the health workforce that works within this (including primary health care nurses). The complexities of the current financing structure in general practice constrains nursing practice, including the ability to initiate and lead care that would usually fall within their scope of practice. There is a need for more flexible funding models to ensure primary health care nurses are fully utilised, particularly in general practice settings, as part of the team-based, patient-centred approach to care.

- It is indisputable that team-based, patient-centered care is required to address the **complexities of chronic disease management,** which is multifaceted in its causes and progression. Medico centric funding models pose a challenge to contemporising the health care system (Willis 2006; Cashin 2015) where **multidisciplinary team-based care is required for optimal management** (Freund 2015). The importance of improved team care should not be undersold, as less reliance on GP fee-for-service visits at the centre of the general practice funding model will result in improved access, better value care for all Australians. **Funding models for primary health care must reflect this.**

- APNA endorses the work of the GPPCCC and supports the intent of each Recommendation and the direction that these are moving the health care system toward as the central recommendation of the GPPCCC report – i.e. patient-centred care. However **we would like to see a greater emphasis placed on how the MBS funding model enables the input and viability of team care and the multidisciplinary workforce, especially the nurse role.**

The vital role of nurses in the health system of the future

- There is evidence to indicate that primary health care nurses working to the breadth of their scope of practice facilitates better outcomes for patients as well as increased patient satisfaction, enhanced productivity and value for money for health services (Keleher et al 2009; Helms et al 2015; Bradbury et al 2017).

- Primary health care nurses also play an important role in sharing the workload in general practice. They can enable the general practice team to expand the type of services they are able to offer their patients. Nurse practitioners can add additional or complementary services.

- With respect to patient-centred chronic disease management, we emphasise the important nurse specific roles of patient carer, organiser, quality controller, problem solver, educator and agent of connectivity (Phillips et al 2009). These roles are vital, particularly for patients with complex chronic conditions, to help them optimally manage their health and improve their health outcomes (Parkinson & Parker 2013), however they are not typically funded through the MBS. These roles could be optimised under a more flexible funding model.

- The MBS Review Taskforce should also closely consider the care nurses can deliver to populations of high needs if appropriate funding mechanisms are put in place. This would include home visits to older people, telehealth services to people in rural and remote areas of Australia, nurse prescribing and chronic disease management. This would be with the aim of improving access to and improving the value of health care, for such population groups.

- APNA welcomes Recommendation 17 to change language across the MBS to better reflect the professional role of nurses in primary health care. APNA agrees that the MBS language is outdated and does not reflect the role that nurses play in modern primary health care, or provide any distinction between nursing registration classifications. The supervision of nurses by doctors is not a legislative requirement (NMBA 2016a and 2016b). We highlight that this is not about substituting nurses for doctors. It is about all health professionals working to their full scope of practice, in collaborative, team-based approach to care, with the patient, with the shared goal of delivering high quality health care to improve the quality of life for patients, and their families and carers.

- We refer to work occurring by the Australian Institute of Health and Welfare (AIHW) on the Primary Health Care Data Asset. Their current document *National Primary Health Care Data Asset: Data Development Plan* (2019) indicates that recording data about provider type/role should be considered, to help evaluate multidisciplinary care. We believe this is an important point, so that ultimately, work can occur to link service provision to outcomes, to best inform how to deliver efficient and effective health care. How this measurement could best occur is subject to debate and needs further examination e.g. nurse provider number, nurse activity codes. However, we strongly suggest that the measurement of nurse activity (and that of other health professionals) needs to be further considered.

- We also refer to the Practice Nurse Incentive Payment (PNIP), being renamed as the Workforce Incentive Payment (WIP) from 1 July 2019. Under the Commonwealth Department of Health PNIP Guidelines (DHS 2017), the PNIP pays for clinician time based solely on hours worked, without any

restriction on the kind of activity undertaken by the clinician (usually a nurse). We strongly suggest that this incentive could be much better utilised to capitalise on the skills of the nurse. In 2018, APNA commissioned a financial viability study of its project work in building the capacity of primary health care nurses. This work highlighted that there is an opportunity cost in the use of these Government funds, because general practices can have a tendency to use these funds to remunerate nurses to perform administrative tasks that could more efficiently be undertaken by less qualified administrative staff, allowing nurse capability for clinical work can be capitalised on. The study made a number of recommendations including:

- That the Australian Government review the PNIP Guidelines with a view to tying the funding to nursing *clinical* activities"; and
- That the Australian Government increase or redirect block funding through the PNIP to support nursing clinical activities.

An enhanced PNIP (soon to become the WIP) would be part of the funding solution for enhanced nurse activity within a team-based, patient-centred model of care (along with other funding methods such as block funding or a bundled payment approach such as is being trialled under the Health Care Homes program). This would provide a greater incentive to general practices to enable nurses to work to work to their full scope of practice.

Response to specific GPPCCC Recommendations

We now provide APNA's feedback on specific criteria as contained within the *Review of the RNAS: Consultation paper 3* document:

Recommendation 1 – move to a patient centered primary care model supporting GP stewardship

APNA acknowledges that in most cases, it is the medical practitioner who is ultimately responsible under the MBS funding model in guarding against low value care. For most people, GPs are the lead clinician, however we highlight that for some patients NPs are the lead clinician.

APNA asks that the GPPCCC Report provides some clarity regarding the term "GP stewardship". That is, does "GP" stand for general practitioner or general practice? These terms should not be used interchangeably as often occurs. This would provide clarification regarding whether the term GP stewardship applies to individual GPs assuming this responsibility, as it currently appears.

Nonetheless, we strongly agree with the GPPCCC Report comments that it is a patient-centred care primary care model that is essential for the health needs of Australians now and into the future, and that the Quadruple Aim (Bodenheimer 2014) is a strong model on which to approach primary health care models.

We emphasise that multidisciplinary team-based care is an important component of a patient-centred primary care model. As we have stated in our "overarching view" above, it is indisputable that *team-based*, patient-centered care is required to address the complexities of chronic disease management, which is multifaceted in its causes and progression, and the funding model for primary health care must reflect this.

Recommendation 2: Introduce a new voluntary patient enrolment fee

We agree with this Recommendation, however community consultation will be very important with respect to patient enrolment. We agree that there are clearly benefits to patient enrolment, however a move in this direction needs to take account of how this impacts on different cohorts of the community, to ensure the system remains fit for all.

Recommendation 3: Introduce flexible access linked to voluntary patient enrolment

We agree with this Recommendation.

Recommendation 4 – combine GPMPs and TCAs and strengthen GPMPs
AND
Recommendation 6 – equalise the rebate for GPMPs and GPMP reviews

APNA agrees with combining the GPMP and TCA items, and equalizing the rebate for GPMPs and GPMP reviews, to ensure funding for complex care is spread over the year and facilitates comprehensive follow-up of those with complex health issues, rather than front-loaded care plan

items that may be not followed up. According to AIHW, only 27% of patients receiving a GPMP and TCA receive follow-up complex care management.

We also agree that there needs to be a guideline regarding time to be spent on developing a GPMP. Forty minutes would appear to be an appropriate time frame in order to address the elements in the proposed "explanatory note" in full (as listed on page 36 and 37 of the GPPCCC Report). The concept of a minimum time will help general practices and health professionals better understand the necessity of setting aside adequate time to address complex care needs, including providing required education to patients who may have low health literacy levels.

APNA also supports the explanatory note and/or item descriptor as a means by which to help strengthen the GPMP process as the Recommendation states. Having a more detailed *process* by which to develop a quality GPMP makes it more likely that there will be consistency GPMP development across general practices. This process must further stress that a GPMP needs to be meaningful and understandable to the patient themselves, that it must be comprehensive and holistic, and involve multidisciplinary input where appropriate.

This more defined process may assist in addressing issues which APNA's membership has reported as common concerns about the GPMP and TCA process as it currently stands:

- Patients often do not know about their GPMP
- The information GPMPs contain is often "dropped in" from "autofill items" and includes medical terminology that is meaningless to some patients
- Most health professionals do not assess health literacy skills to be able to determine if the GPMP is meaningful and understandable to the patient
- It is often questionable if there is informed patient consent for the development of a GPMP on their behalf, and whether the goals are in fact really "agreed goals"

The Report does not clearly recognise the role of nurses in the development of GPMP and that this is an ongoing issue in general practice. We are aware of the reasons for this including: the GPMP item number is a GP item number; and some general practices do not employ nurses. However nurses are key to the development of a *patient-centred* GPMP. This is particularly due to their care facilitation/coordination skills including liaison between the patient and the multidisciplinary team, follow up to ensure GPMP implementation, and coordinating the review process. These processes of a GPMP are vital, particularly for patients with complex chronic conditions, to help them optimally manage their health and improve their health outcomes.

Therefore, we request the MBS Review Taskforce considers alternative funding mechanisms (such as described earlier) for nurses to be involved in the development of GPMPs, as part of a team-based, patient-centred approach to care.

Further, in order to reflect a team-based patient-centred approach to care, the GPMP should instead be renamed to something more closely related to its aim e.g. Patient Care Plan or Patient Self-Management Plan.

Recommendation 5 – link allied health items to GPMPs

We agree with this Recommendation.

Recommendation 7 – increase access to care facilitation for patients

APNA agrees that patients with complex health care needs would benefit from greater assistance with care coordination and facilitation from an RN or EN, or from an Aboriginal health practitioner or health worker for those who identify as an Aboriginal and Torres Strait Islander. This is currently a gap in general practice funding. We again refer to the work of Phillips et al (2009) which highlights that care facilitation is a strength of the nursing role. APNA recommends that a funding method that will enable nurses to be able to provide this complex care service is explored.

One of the funding options the report puts forward under this Recommendation is "new fee-for-service funding for care facilitation under the current set of items available for allied health appointments, for patients with a GPMP" (page 43). APNA has concerns that grouping care facilitation items with allied health service items, may detract from patient access to much needed to allied health professional services and cause some inter-professional discord. APNA suggests that care facilitation items be a standalone group set of items that are able to be charged by nurses. Alternatively, funding could be loaded into nurse incentive payments to general practices, with evidence that the care facilitation work is attached to each patient where this has been provided. Block funding for care facilitation outside of the MBS but delivered from within the general practice where possible would be preferred (such as occurs through the Department of Veterans Affairs Coordinated Veterans' Care Program (Commonwealth of Australia 2011). There needs to be consistency of health professionals involved in providing this support for patients ideally through the minimum number of services providers as possible, so allocation of funds to PHNs for this service could conflict with this, and additionally funding for services through PHNs can be less reliable in the longer term.

Care facilitation, versus other similar terms such as care navigation and care coordination would need to be well defined as part of implementation of such funding.

Recommendation 8 – activate and engage patients in their own care planning

APNA strongly agrees with this Recommendation. Activating and engaging patients in their own care planning should be initiated at the initial development of the GPMP and we highlight that this work fits well with the skill set of nurses as patient carer, organiser, quality controller, problem solver, educator and agent of connectivity (Phillips et al 2009). APNA members often talk of the limitations on their role in being able to adequately educate a patient to the degree that they engage in their own care planning (or alternatively so that they make an informed choice not to do so), which relates back to the current limitations of the MBS funding model.

Recommendation 9 - rebate participation in case conferencing for non-GP health professionals

APNA agrees with this Recommendation in principle, but emphasise that nurses in general practice and like clinics, often play a key role in the organisation and coordination of case conferences when they occur. The proposed three new item numbers for "nurses and other health professionals" should reflect this, and not simply rebate attendance.

We also note that the proposed descriptor for these new item numbers (top of page 47), refers to "health practitioner" and then describes these in brackets as "allied health professionals and nurse practitioners" with no reference to a RNs and ENs. This should state "nurse roles and allied health professionals", especially since it will often be the RN or EN in general practice or like clinic who would be the allocated patient care facilitator.

Recommendation 10 - build the evidence base for Health Assessments and ensure that the content of Health Assessments conforms to appropriate clinical practice guidelines

APNA strongly agrees with taking an evidence-based approach to the need for certain item numbers, to support value and outcomes based health care.

Recommendation 11 - delete Health Assessments less than 30 minutes and expand the at-risk groups who are eligible for Health Assessments

APNA agrees with this Recommendation.

Recommendation 12 – link Medication Management Reviews (MMRs) to GPMPs and reduce the schedule fee

APNA agrees with the principle of linking MMRs to GPMPs.

Recommendation 13 – increase the rebate for home visits for patients with a GPMP

APNA supports the recognition of higher intensity care needs of complex patients with a GPMP, and the higher rebate to support the provision of this care in home.

Recommendation 14 – introduce a 6 minute minimum time for a Level B consultation item

APNA agrees with this Recommendation.

Recommendation 15 – introduce a new Level E consultation item at 60 minutes or more

APNA supports this Recommendation, however we suggest limiting the availability of this item to a small number of visits per patient annually, where case conferencing does not fit the attendance item.

Recommendation 16 – increase access to primary health care in Residential Aged Care Facilities (RACF)

APNA strongly agrees with this Recommendation and commends the GPPCCC for addressing this issue for older Australians.

RACFs can be a very stressful environment for patients and carers. Nurses are often managing close to sub-acute level of care needs of older people in this setting, which is also often affected by staff shortages and lack of access to appropriately skilled staff. It is particularly difficult for nurses to facilitate adequate access to medical care when the number of GPs providing RACF visits is dropping,

this being largely due to their true visit costs not being adequately recovered under the current MBS scheme. It is anticipated that this Recommendation will encourage and better support medical care in RACFs.

APNA suggests that NPs in RACFs may also compliment GP activities and importantly support patient access to care, as well as help to address the issue of GP workloads especially in areas of medical workforce shortages.

Recommendation 17 – update language across the MBS to better reflect the role of registered and enrolled nurses

APNA welcomes this Recommendation to change in language across the MBS to better reflect the professional role of nurses in primary health care. We agree that the term “practice nurse” conflates the distinct groups of RNs and ENs, who in fact have different training, a different scope of practice and different degrees of responsibility in their work roles. Further to this, NPs have a different scope of practice again. The MBS must be updated to reflect the important distinctions between these roles.

APNA also emphasises that the language “for and on behalf” does not appropriately reflect the capacity of nurses in general practice. Whilst APNA agrees that the medical practitioner is central to general practice as the most highly trained health professional, NPs and RNs are able to practice autonomously of a medical practitioner within their scope of practice (NMBA 2016b), and ENs work under the supervision/delegation of a RN (NMBA 2016a).

We suggest however that this Recommendation needs to be worded as “update language across the MBS to better reflect the role of nurses” so as to incorporate NPs as well as RNs and ENs.

Recommendation 18 – amend the specialist consultation telehealth items to make clear that GPs are able to claim the items

APNA agrees with this Recommendation.

Concluding comments

APNA endorses the work of the GPPCCC and supports the intent of each Recommendation. However we ask the MBS Review Taskforce to further consider:

- How to improve primary care funding models so they recognise the capacity of the total health workforce and place a strong emphasis on team-based, patient-centred care, including through incentives such as the soon to be implemented WIP;

- The vital role that nurses in play particularly for patients with complex chronic disease (e.g. patient carer, organiser, quality controller, educator and problem solver) within collaborative, team-based care (e.g. agent of connectivity) (Phillips et al 2009). Any funding model must recognise and enable nurses to undertake these valuable functions.

- The measurement of nurse activity (and other health professional activity) so that ultimately work can occur to link service provision to outcomes, to assist in informing efficient and effective models of health care.

The Australian College of Nurse Practitioners (ACNP) has been consulted by APNA in the forming of this submission and is in agreement with the APNA position.

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