



Medicare Benefits Schedule Review Taskforce

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

August 2019



Important note

The recommendations from the General Practice and Primary Care Clinical Committee (Committee) were released for public consultation in September 2018.

The Committee considered feedback from the public consultation and made changes to a number of recommendations as is reflected in this report.

The final recommendations from the Committee and feedback from the public consultation will be provided to the Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) for consideration before the Taskforce makes its final recommendations to Government.



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1. Executive summary

The Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) is undertaking a program of work that considers how more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also seek to identify any services that may be unnecessary, outdated or potentially unsafe.

The Taskforce is committed to providing recommendations to the Minister for Health (the Minister) that will allow the MBS to deliver on each of these four key goals:

- Affordable and universal access
- Best practice health services
- Value for the individual patient
- Value for the health system.

The Taskforce has endorsed a methodology whereby the necessary clinical review of MBS items is undertaken by clinical committees and working groups.

The General Practice and Primary Care Clinical Committee (the Committee) was established in October 2016 to make recommendations to the Taskforce on the review of MBS items in its area of responsibility, based on rapid evidence review and clinical expertise.

In Phase 1, the Committee reviewed prioritised items for services rendered, referred (e.g., secondary or tertiary care services, such as Consultant Physician attendances) and requested (e.g., Diagnostic Imaging and Pathology services) by GPs; and to develop recommendations on supporting GPs as stewards of the healthcare system. The Phase 1 interim report outlined the Committee's recommendations regarding mechanisms that could support GP stewardship, MBS items covering services referred and requested by GPs, and an initial set of MBS items covering services rendered by GPs. The Committee prioritised 111 MBS items.¹

¹ Note that the number of items does not include "NK" items. See Glossary for full definition of "NK" items.



for review in this first phase of work, which in the 2014/15 financial year accounted for approximately 29 million services and \$1.6 billion in benefits.

In Phase 2, the Committee was asked by the Taskforce to review the general consultation items, chronic disease management items, health assessment items, and medication management items. The Committee prioritised 60 MBS items for review in this second phase of work. In the 2016/17 financial year, these items accounted for approximately 118 million services and \$5.1 billion in benefits.

The Committee was also asked by the Taskforce to consider the issue of consumer concerns around access to referrals and repeat scripts, raised by the Minister.

The recommendations from the clinical committees were released for stakeholder consultation in September 2018. The clinical committee considered feedback from stakeholders and has provided recommendations to the Taskforce in a Review Report. The Taskforce will consider the Review Reports from clinical committees and stakeholder feedback before making recommendations to the Minister for consideration by Government.

1.1 Key recommendations

The Committee's recommendations are intended to deliver a more person-centred model of Australian primary health care with a focus on GP stewardship. Recommendation 1 is a medium to longer-term recommendation to change the reimbursement framework in support of high-quality, person-centred primary health care with GP stewardship of the health system. Recommendations 2-10 can be implemented in the short term and seek to sustain quality care, recognising that the General Practice workforce has adapted provision of care to be viable in the current MBS framework.

Recommendation 1 reflects the Committee's vision for the future of primary health care in Australia, including: continuing care for the person rather than episodic treatment for illness; an emphasis on prevention and health promotion in addition to disease management; a focus on outcomes rather than process; provided by collaborative, multi-disciplinary teams integrated into the larger health system.

All recommendations are intended to maintain and support significant investment in general practice, noting the potential for financial and non-financial benefits downstream in the health system from investing in primary care. There is strong evidence that high quality, person-centred primary health care is key to improving effectiveness of care, preventing illness, and reducing inequities, variation and health system costs.



The recommendations are also intended to support continuing quality improvement in general practice, through processes including engagement in research and teaching, quality cycles and reflective practice. The recommendations encourage more proactive engagement in prevention, shared decision-making and patient empowerment.

The recommendations are as follows:

1. Move to a person-centred primary care model supporting general practitioner (GP) stewardship and team based care.
2. Introducing a new fee for practices to enroll a patient.
3. Introduce flexible access to primary care services for enrolled patients.
4. Implement a comprehensive package of longitudinal care for enrolled patients with chronic health conditions that promotes the effective use of primary care chronic disease management items.
 - 4.1 Combine GP Management Plans (GPMPs) and Team Care Arrangements (TCAs), and strengthen GPMPs.
 - 4.2 Link allied health chronic disease management items to the creation of a GPMP.
 - 4.3 Equalise rebates for GPMP preparation and review to encourage longitudinal patient care.
 - 4.4 Increase patient access to high quality care coordination across physical, mental and social care domains.
 - 4.5 Develop advice and support mechanisms to activate and engage patients in their own care planning, including the assessment and support of patient health literacy activities.
 - 4.6 Encourage increased patient participation and rebate attendance of non-medical health professionals at case conferences.
 - 4.7 Link Medication Management Reviews (MMR) to GPMP, and ensure the rebate accurately reflects GP activity.
 - 4.8 Increase the rebate for home visits for enrolled patients.
5. Build the evidence base for Health Assessments and ensure that the content of Health Assessments conforms to appropriate clinical practice guidelines.
6. Strengthen the quality of current Health Assessments and expand at-risk groups who are eligible for Health Assessments.
7. Undertake additional research regarding the appropriateness of the current length, content and minimum quality metrics for GP MBS consultation items (Levels A-D).
8. Introduce a new Level E consultation item for consultations of 60 minutes or more by a GP.



9. Change the schedule fee for attendances at Residential Aged Care Facilities (RACF) to reflect an initial flag fall rebate with a stable fee for each consultation completed at the RACF.
10. Modernise the terminology currently used in the MBS to describe registered and enrolled nurses and their role to reflect the important role these health professionals play as members of the practice team.
11. Enable GP telehealth consultations and expand GP telehealth eligibility to patients with mobility concerns who cannot easily be seen face-to-face.

1.2 Consumer impact

The Committee has developed recommendations consistent with the Taskforce objectives and has focused on finding ways to improve value for the patient through the delivery of appropriate primary care.

Consumers on the Committee stressed the importance of a “person-centred” approach that includes:

- Strengthening shared doctor-patient decision making about treatment options, risks, and out of pocket costs;
- Improved targeting of resources for chronic disease management;
- Support systems to enhance continuity of care;
- Timely access to the services patients need through the convenience of digitally supported consultations; and
- Streamlining payment mechanisms to reflect higher quality services at an appropriate cost.

The recommendations will benefit patients in the following ways:

(i) Access - changes to chronic disease management items will streamline the process and support patients in accessing services from GPs, nurses and allied health providers, and encourages GPs and patients to complete a full cycle of care.

(ii) Patient Experience - the recommendations support involving patients in decision-making and self-management through strengthened GPs partnership arrangements, informed consent, chronic disease management and medication management. Recommended changes recognise that the length of consultations needs to reflect the complexity of the patient’s health. The recommendations recognise the advantages of consumers being supported to navigate the system through care coordination.



(iii) High value care - recommendations relating to the structure of standard GP general attendances, including a new longer consultation item number, are based on evidence which shows improved patient outcomes are associated with longer, comprehensive consultations for patients who have complex health concerns. In addition, access to digital health will facilitate enhanced access for patients who may easily access GP services (e.g. rural and remote patients or patients with mobility challenges).

Looking ahead, the Committee supports a staged movement towards more flexibility in the funding arrangements for general practice, along with streamlined, quality and outcomes based reimbursement. An initial first step, proposed by the Committee, involves a process of a form of patient enrolment with their usual general practice. This will provide flexibility in access and service delivery, and attract resources to establish a framework (systems, data, patient engagement mechanisms) to drive improvements in quality care. Community consultation will be an important part of this process.

2. About the Medicare Benefits Schedule (MBS) Review

2.1 Medicare and the MBS

2.1.1 What is Medicare?

Medicare is Australia's universal health scheme that enables all Australian residents (and some overseas visitors) to have access to a wide range of health services and medicines at little or no cost.

Introduced in 1984, Medicare has three components:

- free public hospital services for public patients
- subsidised drugs covered by the Pharmaceutical Benefits Scheme (PBS)
- subsidised health professional services listed on the MBS.

2.2 What is the MBS?

The MBS is a listing of the health professional services subsidised by the Australian Government. There are more than 5,700 MBS items that provide benefits to patients for a comprehensive range of services, including consultations, diagnostic tests and operations.



2.3 What is the MBS Review Taskforce?

The Government established the Taskforce as an advisory body to review all of the 5,700 MBS items to ensure they are aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also modernise the MBS by identifying any services that may be unnecessary, outdated or potentially unsafe. The Review is clinician-led, and there are no targets for savings attached to the Review.

2.3.1 What are the goals of the Taskforce?

The Taskforce is committed to providing recommendations to the Minister that will allow the MBS to deliver on each of these four key goals:

- **Affordable and universal access**—the evidence demonstrates that the MBS supports very good access to primary care services for most Australians, particularly in urban Australia. However, despite increases in the specialist workforce over the last decade, access to many specialist services remains problematic, with some rural patients being particularly under-served.
- **Best practice health services**—one of the core objectives of the Review is to modernise the MBS, ensuring that individual items and their descriptors are consistent with contemporary best practice and the evidence base when possible. Although the Medical Services Advisory Committee (MSAC) plays a crucial role in thoroughly evaluating new services, the vast majority of existing MBS items pre-date this process and have never been reviewed.
- **Value for the individual patient**—another core objective of the Review is to have an MBS that supports the delivery of services that are appropriate to the patient's needs, provide real clinical value and do not expose the patient to unnecessary risk or expense.
- **Value for the health system**—achieving the above elements of the vision will go a long way to achieving improved value for the health system overall. Reducing the volume of services that provide little or no clinical benefit will enable resources to be redirected to new and existing services that have proven benefit and are underused, particularly for patients who cannot readily access those services currently.

2.4 The Taskforce's approach

The Taskforce is reviewing existing MBS items, with a primary focus on ensuring that individual items and usage meet the definition of best practice. Within the Taskforce's brief, there is considerable scope to review and provide advice on all aspects that would contribute to a modern, transparent and responsive system. This includes not only making



recommendations about adding new items or services to the MBS, but also about an MBS structure that could better accommodate changing health service models.

The Taskforce has made a conscious decision to be ambitious in its approach, and to seize this unique opportunity to recommend changes to modernise the MBS at all levels, from the clinical detail of individual items, to administrative rules and mechanisms, to structural, whole-of-MBS issues. The Taskforce will also develop a mechanism for an ongoing review of the MBS once the current review has concluded.

As the MBS Review is clinician-led, the Taskforce decided that clinical committees should conduct the detailed review of MBS items. The committees are broad-based in their membership, and members have been appointed in an individual capacity, rather than as representatives of any organisation.

The Taskforce asked the committees to review MBS items using a framework based on Professor Adam Elshaug's appropriate use criteria (1). The framework consists of seven steps:

1. Develop an initial fact base for all items under consideration, drawing on the relevant data and literature.
2. Identify items that are obsolete, are of questionable clinical value², are misused³ and/or pose a risk to patient safety. This step includes prioritising items as "priority 1", "priority 2", or "priority 3", using a prioritisation methodology (described in more detail below).
3. Identify any issues, develop hypotheses for recommendations and create a work plan (including establishing working groups, when required) to arrive at recommendations for each item.
4. Gather further data, clinical guidelines and relevant literature in order to make provisional recommendations and draft accompanying rationales, as per the work plan. This process begins with priority 1 items, continues with priority 2 items and concludes with priority 3 items. This step also involves consultation with relevant stakeholders

² The use of an intervention that evidence suggests confers no or very little benefit on patients; or where the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of the intervention do not provide proportional added benefits.

³ The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.



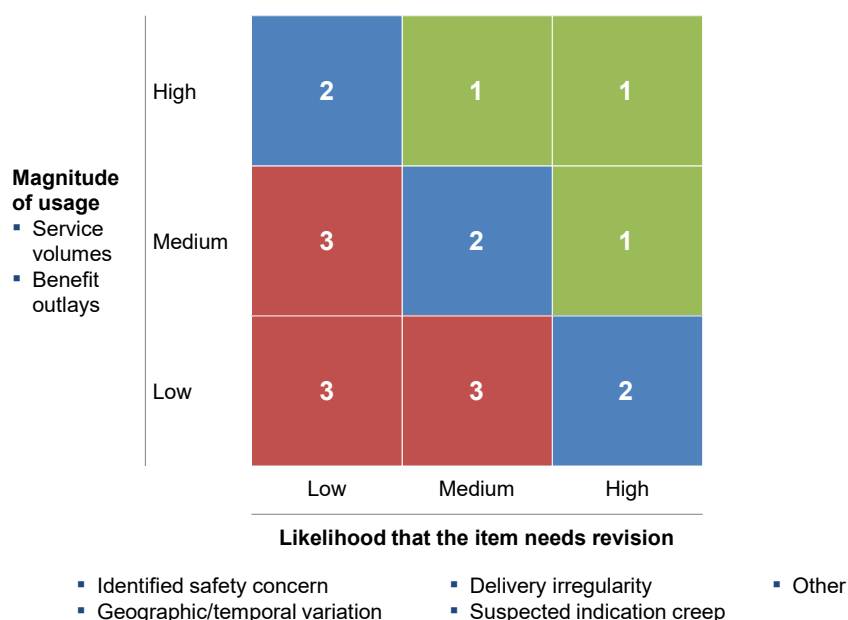
within the committee, working groups, and relevant colleagues or Colleges. For complex cases, full appropriate use criteria were developed for the item's explanatory notes.

5. Review the provisional recommendations and the accompanying rationales, and gather further evidence as required.
6. Finalise the recommendations in preparation for broader stakeholder consultation.
7. Incorporate feedback gathered during stakeholder consultation and finalise the Review Report, which provides recommendations for the Taskforce.

All MBS items will be reviewed during the course of the MBS Review. However, given the breadth of and timeframe for the Review, each clinical committee has to develop a work plan and assign priorities, keeping in mind the objectives of the Review. Committees use a robust prioritisation methodology to focus their attention and resources on the most important items requiring review. This was determined based on a combination of two standard metrics, derived from the appropriate use criteria:

- Service volume.
- The likelihood that the item needed to be revised, determined by indicators such as identified safety concerns, geographic or temporal variation, delivery irregularity, the potential misuse of indications or other concerns raised by the clinical committee (such as inappropriate co-claiming).

Figure 1: Prioritisation matrix



For each item, these two metrics were ranked high, medium or low. These rankings were then combined to generate a priority ranking ranging from one to three (where priority 1



items are the highest priority and priority 3 items are the lowest priority for review), using a prioritisation matrix (Figure 1). Clinical committees use this priority ranking to organise their review of item numbers and apportion the amount of time spent on each item.



3. About the General Practice and Primary Care Clinical Committee

The Committee is part of the third tranche of Clinical Committees of the MBS Review. It was established in October 2016 to make recommendations directly to the Taskforce, and to other Clinical Committees (from a GP provider and requester perspective), based on clinical expertise and rapid evidence review. In Phase 1, the Taskforce asked the Committee to review MBS items pertaining to services rendered, referred and requested by GPs. In Phase 2, the Taskforce asked the Committee to review general consultation items, chronic disease management items, health assessment items and medication management items, and to consider consumer concerns about access to referrals and repeat scripts.

3.1 General Practice and Primary Care Clinical Committee members

The Committee consists of 21 members whose names, positions/organisations and declared conflicts of interest are listed in Table 1.

Table 1: General Practice and Primary Care Clinical Committee members

Name	Position/organisation	Declared conflict of interest
Prof Tim Usherwood	Head of the Department of General Practice, Sydney Medical School Westmead, University of Sydney; Visiting Professorial Fellow, The George Institute for Global Health; Clinical Academic, Westmead Hospital; General practitioner, Western Sydney.	Employee of the University of Sydney; Employee at Sydney West Aboriginal Health Service (MBS bulk-billing); Health consumer entitled to MBS rebates; Board Member, Western Sydney Primary Health Network (WentWest Ltd); Chair, Diagnostics Expert Advisory Panel, NPS MedicineWise
Ms Karen Booth	Registered Nurse and Accredited Immuniser; Current President, Australian Primary Health Care Nurse Association; Primary Health Care Nurse and Nurse Manager in General Practice since 1998; Member of the National Immunisation Committee, the Advisory Committee for Safety of Vaccines, GP Round Table Member, Past Primary Health Care	Nil



Name	Position/organisation	Declared conflict of interest
	Advisory Group; Member of advisory groups for the Royal Australian College of General Practitioners (RACGP) and the Australian Commission on Safety and Quality in Health Care (ACQSHC)	
Ms Thy Cao	President of the New South Wales Branch of the Australian Physiotherapy Association; Current Chair of the University of Technology Sydney Physiotherapy Industry Advisory Board; Member, State Insurance Regulatory Authority (SIRA) Allied Health 2014-2016; Member, Allied Health Practitioner Management Framework Review Working Party	President, Australian Physiotherapy Association (knowledge of submissions made)
Eleanor Chew	GP; Member, MBS Review Taskforce; member, Professional Service Review Committee; Board member, Australian Digital Health Agency; Board member, General Practice Training Queensland; Clinical Lead, Integrated Care, Sonic Clinical Services; Provost and Board member, RACGP Queensland; Member, AMA Queensland Council of General Practice; Member, Diagnostic Imaging Advisory Committee; Member, General Practice Mental Health Standards Collaboration	GP accessing MBS items; Member, MBS Review Taskforce; member, Professional Service Review Committee; Board member, Australian Digital Health Agency; Board member, General Practice Training Queensland; Clinical Lead, Integrated Care, Sonic Clinical Services; Provost and Board member, RACGP Queensland; Member, AMA Queensland Council of General Practice; Member, Diagnostic Imaging Advisory Committee; Member, General Practice Mental Health Standards Collaboration
Dr Noel Hayman	GP and Clinic Director, Inala Indigenous Health Service; Associate Professor, University of Queensland School of Medicine	GP accessing MBS items; no work or shares in any corporate medical health settings
Prof Claire Jackson	Director, Centre for Health System Reform and Integration; Professor in Primary Care Research; Past Chair, Brisbane North Primary Health Network; Past President, RACGP	Clinical GP accessing MBS items; past Chair Brisbane North Primary Health Network; Director HCF



Name	Position/organisation	Declared conflict of interest
Ms Rebecca James	Board member of the Australian Clinical Trials Alliance (ACTA) and member of the Advisory Council of the Centre for Research into Clinical Effectiveness at Bond University.	Member of Taskforce and the Colorectal and Ophthalmology Clinical Committees; Board member of the Australian Clinical Trials Alliance (ACTA); Member of the Advisory Council of the Centre for Research into Clinical Effectiveness at Bond University
Dr Walid Jammal	GP; Clinical Lecturer, Western Clinical School, Faculty of Medicine, University of Sydney; Conjoint Senior Lecturer, School of Medicine, Western Sydney University; Board Member of Western Sydney PHN; Member of GP Advisory Group, Agency for Clinical Innovation, NSW Ministry of Health; Member of Evaluation Sub-Committee, Medicare Services Advisory Committee	GP accessing the MBS; Member of Diagnostic Medicine Clinical Committee and Diagnostic Imaging Clinical Committee, MBS Review; Member of Education and Training working group, and National Clinical Champion, Health Care Homes; various review committees for Therapeutic Guidelines Ltd.
Prof Stephen Jan	Head of the Health Economics and Process Evaluation Program, the George Institute for Global Health, UNSW; Professor, Sydney Medical School; Associate, Menzies Centre for Health Policy and the Poche Centre for Indigenous Health; Chief Investigator, NHMRC Australian Partnership Prevention Centre; Board of Directors, the Sax Institute.	Advisor to NPS MedicineWise on their evaluation strategy
Dr Emma Kennedy	Senior Lecturer, General Practice, Northern Territory Medical Program, Flinders University Chair of Board Northern Territory General Practice Education Pty Ltd	General Practitioner accessing MBS items; Chair of the Northern Territory regional training program for GPs
Assoc Prof Caroline Laurence	Associate Professor and Head of the School of Public Health, University of Adelaide; Health Services Researcher	Director, Adelaide Unicare Pty Ltd
Prof Lyn Littlefield	Executive Director, Australian Psychological Society; Professor of Psychology, La Trobe University; Chair, Allied Health Professions Australia; Chair, Mental Health Professions Australia	Nil



Name	Position/organisation	Declared conflict of interest
Dr Elizabeth Marles	Director, Hornsby-Brooklyn GP Unit; Past President, RACGP; Member Pharmaceutical Benefits Advisory Committee; Director, Therapeutic Guidelines	Employee Staff Specialist GP with NSW Health, GP accessing MBS items; Director, GP Synergy, training provider for GP training
Ms Helen Maxwell-Wright	Director, Maxwell-Wright Associates Pty Ltd; President and Non Executive Director, OzChild Children Australia; Chair, State Leadership Group, JDRF; Chair, Monitoring Committee, Medicines Australia; ANZCA - SIMGS Committee and Interview Panels, - Safety & Quality Committee, - Education Executive Management Committee, - Faculty Pain Medicine, Training & Education Management Committee; AMC - Specialist Education Accreditation Committee	No direct conflicts with this Committee's role
Dr Ewen McPhee	Rural General Practitioner	Served on the Primary care advisory group
Dr Mark Morgan	Associate Professor, Bond University, Queensland; Associate GP, Eastbrooke Family Clinic, Burleigh Waters, Queensland; Member of the RACGP Expert Committee for Quality Care; Member of the MBS Review Diagnostic Medicine Clinical Committee and After Hours Working Group; Member of the Health Care Homes Implementation Advisory Committee; Member of the Digital Patient Safety Expert Advisory Group	Nil
Assoc Prof Kathryn Panaretto	Clinical Director, Gidgee Healing, Mt Isa; GP, QUT Medical Centre; Adjunct Associate Professor, School of Medicine, James Cook University; Adjunct Associate Professor, Mt Isa Centre for Rural and Remote Health; Board Member, North West Health and Hospital Service, Queensland	Nil
Mr Tim Perry	Consultant Pharmacist; Member of the Western Sydney PHN Clinical Council	Pharmacist working in General Practice and therefore have view supporting correct remuneration of both Pharmacists and GPs; working in several practices that have



Name	Position/organisation	Declared conflict of interest
		Pathology collection services but I have no relationship with, or interest in, their work; former traditional Chinese medicine practitioner, biased against MBS funding GPs doing acupuncture.
Mr Gary Smith	Practice Manager; Past National and New South Wales State President, Australian Association of Practice Management Ltd (AAPM hold Board positions with: Australian General Practice Accreditation Ltd (AGPAL) - Quality in Practice, Chair (QIP) Nepean Blue Mountains Local Health District (LHD); and General Practice Workforce Tasmania (GPW Surveyor with AGPAL and an International Surveyor with the International Society of Quality Health (ISQua)	Pathology collection centre on site at practice
Prof Simon Willcock	GP; Clinical Director of Primary Care and Wellbeing Services, Macquarie University; Chairman, Avant Mutual Group; Member, Sydney North Primary Health Network Board	I work in a practice that is part of the Macquarie University Integrate Health Sciences Centre, which incorporates the university-owned private hospital, my primary care clinic, Specialist and Allied Health clinics, Pathology services and a Diagnostic Imaging service; The General Practice component has no financial arrangement with either the Radiology or Pathology services beyond our group association as described above; Member of Health Insurer Board
Dr Steve Hambleton (ex-officio)	GP; Past President of the Australian Medical Association; Past Chair of the Primary Health Care Advisory Group; ; Co Chair Clinical Programs, Clinical Reference Group and My Health Record Expansion Program within the Australian Digital Health Agency; Member of the Atlas Advisory Group of the Australian	Nil



Name	Position/organisation	Declared conflict of interest
	Commission on Safety and Quality in Health Care	

3.2 Chronic Disease Management Working Group members

The Chronic Disease Management Working Group (the Working Group/CDMWG) is one of five clinical Working Groups that have been established to support the work of the General Practice and Primary Care Clinical Committee. It was established to review chronic disease management items, and make recommendations to the Committee based on rapid evidence review and clinical expertise.

The Chronic Disease Management Working Group consists of seven members, whose names, positions/organisations and declared conflicts of interest are listed in Table 2.

Table 2: Chronic Disease Management Working Group members

Name	Position/organisation	Declared conflict of interest
Prof Tim Usherwood (Chair)	As above	As above
Dr Eleanor Chew	As above	As above
Ms Rebecca James	As above.	As above
Dr Walid Jammal		
Prof Lyn Littlefield	As above	As above
Mr Gary Smith	As above	As above

3.3 Medication Management Working Group members

The Medication Management Working Group (the Working Group/MMWG) is one of five clinical Working Groups that have been established to support the work of the General Practice and Primary Care Clinical Committee. It was established to review medication management items, and make recommendations to the Committee based on rapid evidence review and clinical expertise.

The Medication Management Working Group consists of four members, whose names, positions/organisations and declared conflicts of interest are listed in Table 3.

**Table 3: Medication Management Working Group members**

Name	Position/organisation	Declared conflict of interest
Mr Timothy Perry (Chair)	As above	As above
Dr Emma Kennedy	As above	As above
Dr Elizabeth Marles	As above	As above
Ms Helen Maxwell-Wright	As above	As above

3.4 Health Assessment Working Group members

The Health Assessment Working Group (the Working Group/HAWG) is one of five clinical Working Groups that have been established to support the work of the General Practice and Primary Care Clinical Committee. It was established to review health assessment items, and make recommendations to the Committee based on rapid evidence review and clinical expertise.

The Health Assessment Working Group consists of six members, whose names, positions/organisations and declared conflicts of interest are listed in Table 4.

Table 4: Health Assessment Working Group members

Name	Position/organisation	Declared conflict of interest
Prof Mark Morgan (Chair)	As above	As above
A/Prof Noel Hayman	As above	As above
Prof Claire Jackson	As above	As above
Ms Rebecca James		
Prof Tim Usherwood	As above	As above
Prof Simon Willcock	As above	As above
Ms Thy Cao	As above	As above

3.5 Consultation Item Working Group members

The Consultation Item Working Group (the Working Group/CIWG) is one of five clinical Working Groups that have been established to support the work of the General Practice and



Primary Care Clinical Committee. It was established to review consultation items, and make recommendations to the Committee based on rapid evidence review and clinical expertise.

The Consultation Item Working Group consists of seven members, whose names, positions/organisations and declared conflicts of interest are listed in Table 5.

Table 5: Consultation Item Working Group members

Name	Position/organisation	Declared conflict of interest
A/Prof Kathryn Panaretto (Chair)	As above	As above
Ms Karen Booth	As above	As above
Dr Steve Hambleton	As above	As above
Ms Rebecca James	As above	As above
Prof Stephen Jan	As above	As above
Prof Caroline Laurence	As above	As above
Dr Ewen McPhee	As above	As above

3.6 Referrals and Repeat Scripts Working Group members

The Referrals and Repeat Scripts Working Group (the Working Group/RRSWG) is one of five clinical Working Groups that have been established to support the work of the General Practice and Primary Care Clinical Committee. It was established to review referrals and repeat script items, and make recommendations to the Committee based on rapid evidence review and clinical expertise.

The Referrals and Repeat Scripts Working Group consists of six members, whose names, positions/organisations and declared conflicts of interest are listed in Table 6.

Table 6: Referrals and Repeat Scripts Working Group members

Name	Position/organisation	Declared conflict of interest
Dr Emma Kennedy (Chair)	As above	As above
Ms Karen Booth	As above	As above
Helen Maxwell-Wright		
Dr Ewen McPhee	As above	As above



Mr Tim Perry	As above	As above
Prof Simon Willcock	As above	As above

3.7 Conflicts of interest

All members of the Taskforce, clinical committees and working groups are asked to declare any conflicts of interest at the start of their involvement and reminded to update their declarations periodically. A complete list of declared conflicts of interest can be viewed in Tables 1-6 above.

It is noted that the majority of the Committee members share a common conflict of interest in reviewing items that are a source of revenue for them (i.e. Committee members claim the items under review). This conflict is inherent in a clinician-led process, and having been acknowledged by the Committee and the Taskforce, it was agreed that this should not prevent a clinician from participating in the review.

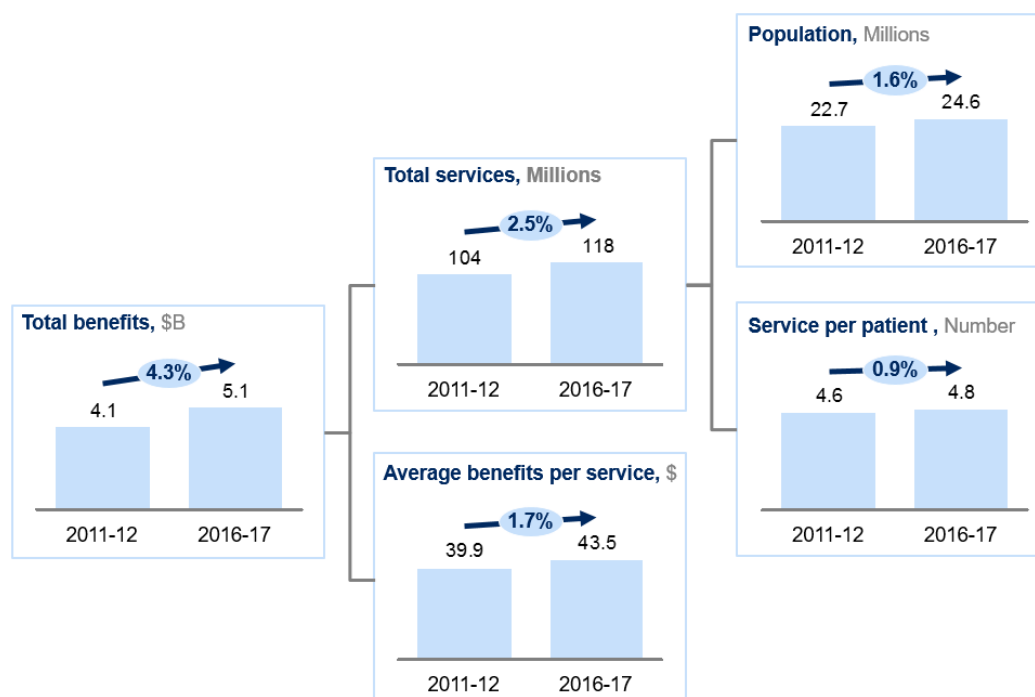
3.8 Areas of responsibility of the Committee

The Committee reviewed 60 MBS items in phase two: 48 general consultation items, 11 chronic disease management items, 5 health assessment items and 2 medication management items.

The 48 general consultation items are for consultations by GPs and other medical practitioners in consultation rooms, Residential Aged Care Facilities and other locations. In FY 2016-17, the use by GPs of these items accounted for approximately 118 million services and \$5.1 billion in benefits. Over the past five years, service volumes for these items have grown at 2.5 per cent per year, and the cost of benefits has increased by 1.7 per cent per year.

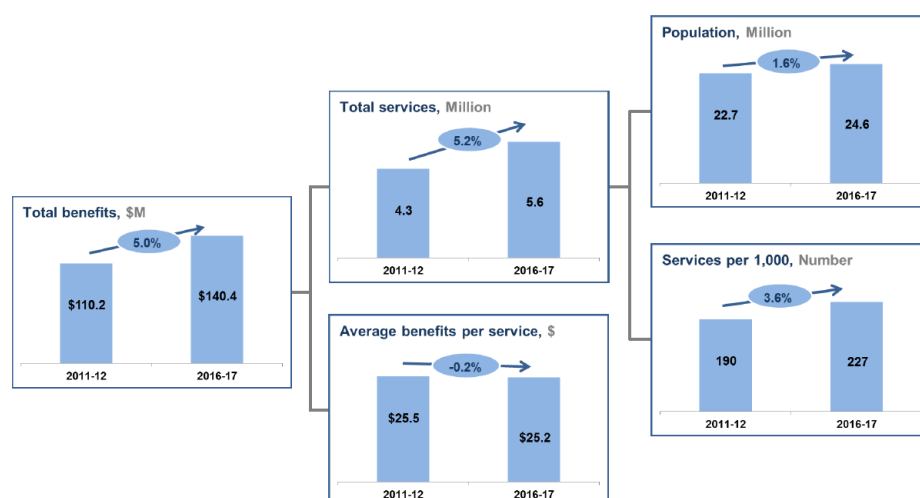


Figure 2: key statistics for A1 GP consultations, 2011-12 and 2016-17



In FY 2016-17, the use by other medical practitioners of Level A-B consultation items accounted for approximately 5.6 million services and \$140 million in benefits. Over the past five years, service volumes for these items have grown at 5.2 per cent per year, and the cost of benefits has decreased by 0.2 per cent per year.

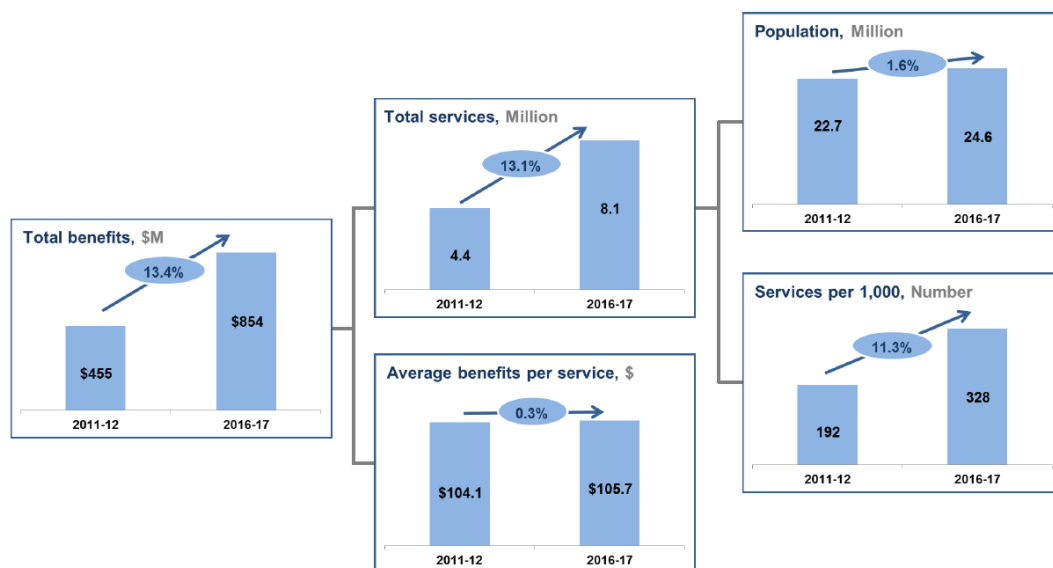
Figure 3: key statistics for A2 Other Medical Practitioner consultations, 2011-12 and 2016-17





The 11 chronic disease management items include GP Management Plans, Team Care Arrangements, and contributions to and reviews of these arrangements. In FY 2016-17, these items accounted for approximately 8.1 million services and \$854 million in benefits. Over the past five years, service volumes for these items have grown at 13.1 per cent per year, and the cost of benefits has increased by 0.3 per cent per year.

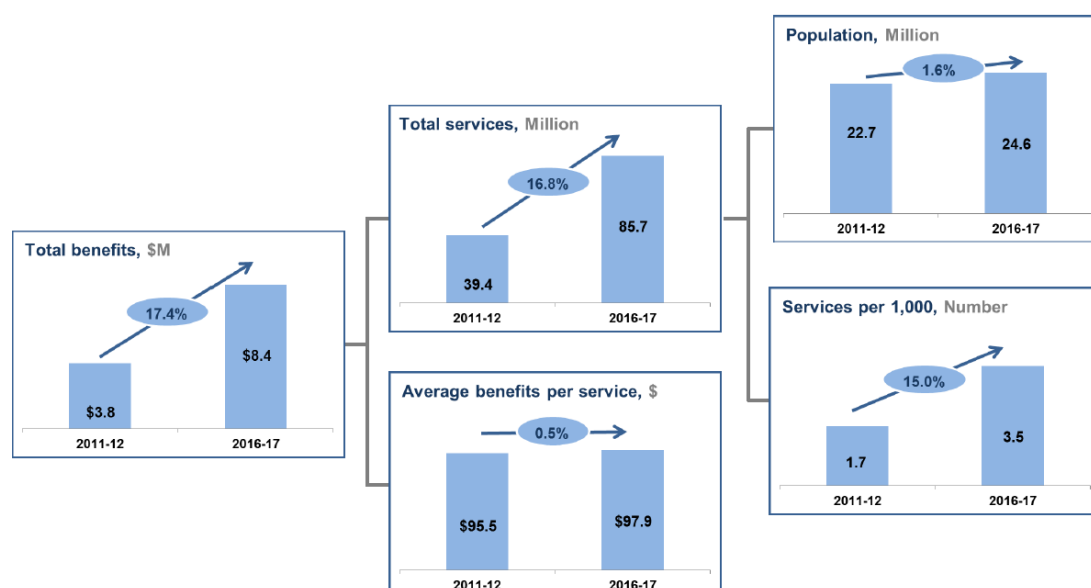
Figure 4: key statistics for Chronic Disease Management items, 2011-12 and 2016-17



The 11 chronic disease management items also include items for arranging and participating in case conferences. In FY 2016-17, these items accounted for approximately 85.7 thousand services and \$8.4 million in benefits. Over the past five years, service volumes for these items have grown at 16.8 per cent per year, and the cost of benefits has increased by 0.5 per cent per year.

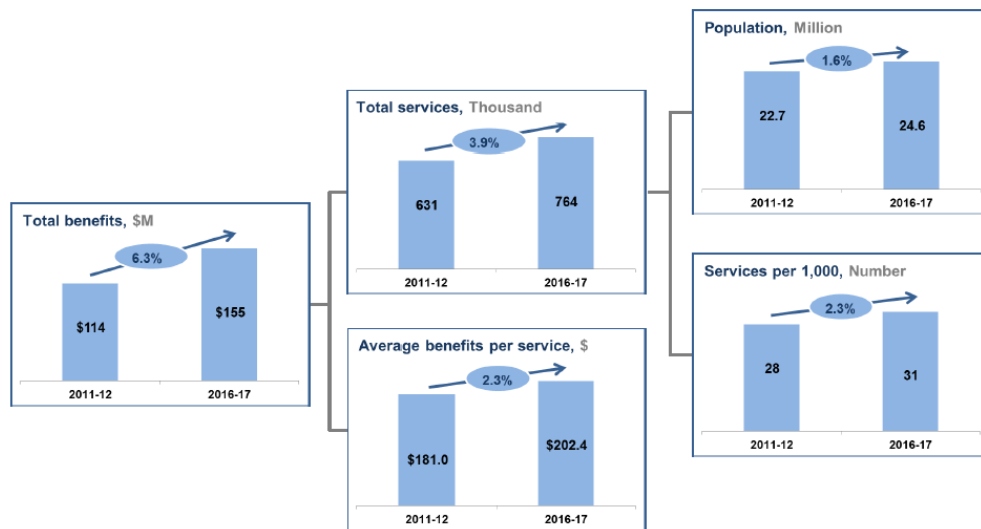


Figure 5: key statistics for case conferencing items, 2011-12 and 2016-17



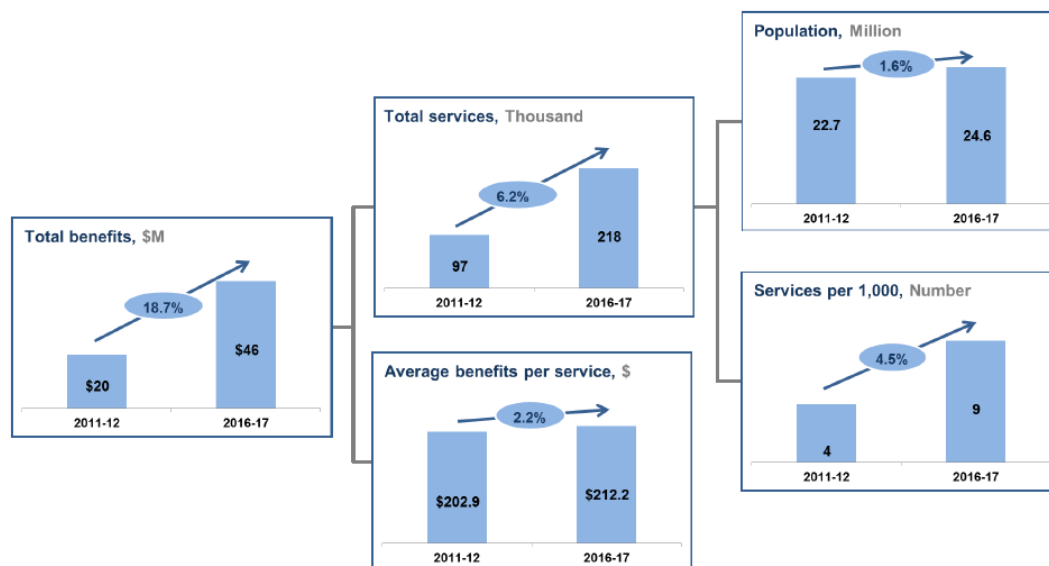
The five health assessment items include four time-tiered health assessment items. In FY 2016-17, these items accounted for approximately 764 thousand services and \$155 million in benefits. Over the past five years, service volumes for these items have grown at 3.9 per cent per year, and the cost of benefits has increased by 2.3 per cent per year.

Figure 6: key statistics for time-tiered health assessment items, 2011-12 and 2016-17



The five health assessment items also include an indigenous health assessment item. In FY 2016-17, this item accounted for approximately 218 thousand services and \$46 million in benefits. Over the past five years, service volumes for these items have grown at 6.2 per cent per year, and the cost of benefits has increased by 2.2 per cent per year.

Figure 7: key statistics for Indigenous health assessment items, 2011-12 and 2016-17

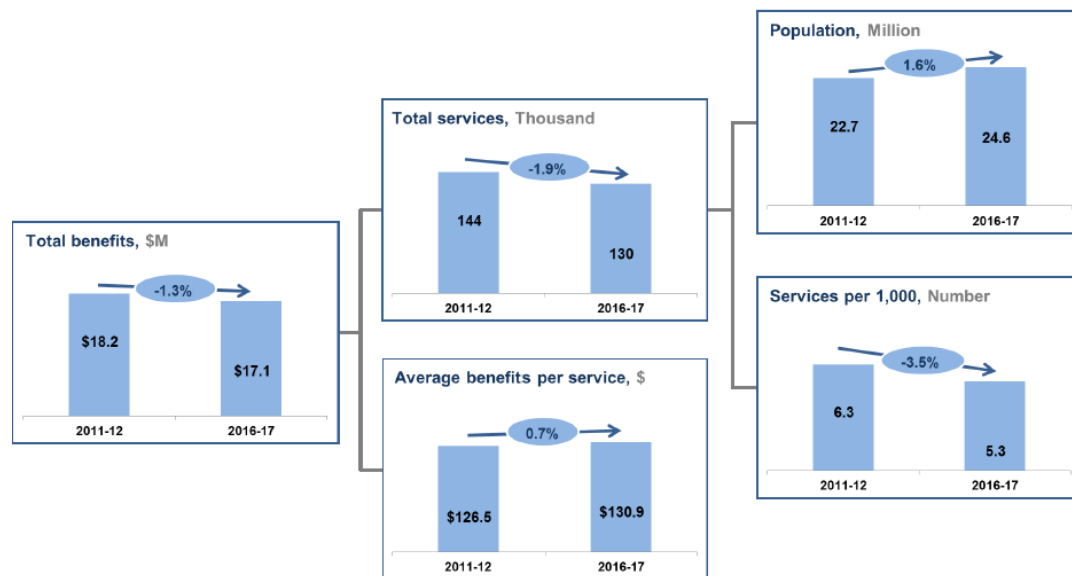


The two health assessment items are for a GP to work with a community pharmacy or accredited pharmacist to review a patient's medications and develop a medication management plan. In FY 2016-17, these items accounted for approximately 130 thousand services and \$17.1 million in benefits. Over the past five years, service volumes for these



items have decreased at 1.9 per cent per year, and the cost of benefits has increased by 0.7 per cent per year.

Figure 8: key statistics for medication management items, 2011-12 and 2016-17



3.9 Summary of the Committee's review approach

The Committee completed a review of its items across five full committee meetings, two interim full committee meetings and several additional working group meetings, during which it developed the recommendations and rationales contained in this report.

The Review drew on various types of MBS data, including data on utilisation of items (services, benefits, patients, providers and growth rates); service provision (type of provider, geography of service provision); patients (demographics and services per patient); co-claiming or episodes of services (same-day claiming and claiming with specific items over time); and additional provider and patient-level data, when required.

The Review also drew on data presented in the relevant literature and clinical guidelines, all of which are referenced in the report. Guidelines and literature were sourced from medical journals and other sources, such as professional societies. The Committee consulted with key stakeholder groups in developing recommendations and rationale.

Public consultation on draft Phase 1 and Phase 2 Committee recommendations was undertaken between September 2018 and March 2019. The Committee considered



feedback from the public consultation and made changes to a number of recommendations as is reflected in this report.

4. Recommendations

Vision for the future – GP Stewardship and team based care

Recommendation 1

Move to a person-centred primary care model supporting general practitioner (GP) stewardship and team based care.

- Challenges facing the Australian health system include an ageing population with a growing burden of chronic disease, increasing costs of interventions, unexplained variances in care delivery, inequities of access and outcome, missed opportunities for prevention, and a high proportion of avoidable hospital admissions by international standards.
- There is strong evidence that high quality, person-centred primary health care is key to improving effectiveness of care, preventing illness, and reducing inequities, variation and costs. However, there is poor fit between fee-for-service reimbursement and primary health care that provides continuing care for the person rather than episodic treatment for illness; that emphasises prevention and health promotion in addition to disease management; that focuses on outcomes rather than process; and that provides collaborative team based care integrated into the larger health system. (1)(2)
- Noting the above, the findings from the Diabetes Care Project (3), and the recommendations from the Primary Health Care Advisory Group (4), the Committee recommends that a new model for primary care funding should be developed to support high-quality, person-centred primary health care and GP stewardship of the health system that is supported by multidisciplinary team based arrangements. The Committee defines person-centred care as “a way of thinking and doing things that sees the people using health ... services as equal partners in planning, developing and monitoring care to make sure it meets their needs. This means putting people and their families at the centre of decisions and seeing them as experts, working alongside professionals to get the best outcome.” (5)



- These strategies to support person-centred care are particularly important at the interface between community, GP-care and acute hospital care.

Rationale 1

- Equitable access to high quality, person-centred health care is a fundamental human right, and an aspiration of the Australian health system.
- To achieve equitable access to high quality health care for all, our health system needs to pursue the four goals of the “quadruple aim”: (.6)(.7)
 - maximising patient outcomes
 - enhancing patient experience
 - minimizing costs
 - optimizing the experience of health providers
- The Committee has identified principles for Australian primary care, based on review of key national and international statements and reports (.8)(.9)(.10)(.11)

Figure 9: principles for primary health (.12)(.13)(.14)(.15)(.16)(.17)

The GPPCCC has identified several principles for primary health

Basic principles	1	First contact care
	2	“Gatekeeper” function providing stewardship of the health system
	3	Equitable access
	4	Care throughout the life-cycle, for persons, families & communities
	5	Evidence based care, aiming at safety & effectiveness
	6	Comprehensive – whole person, biopsychosocial approach
	7	Team-based, coordinated care
	8	Continuing care, enduring relationships
	9	Person-centred, partnering with consumers
	10	Health promoting, incorporating a preventive focus
	11	Reflective practice with continuous quality improvement
	12	Sustainable
Implications		<ul style="list-style-type: none"> ▪ Flexibility to meet the varying needs of consumers, communities and regions ▪ Access according to need ▪ Voluntary patient enrolment, supporting comprehensive, longitudinal care; linked to care planning and health assessments ▪ Person-centred care, promoting health literacy and partnering with patients ▪ Multidisciplinary team-based care, <u>recognising</u> that team members may be both internal and external to the general practice ▪ Care coordination when needed ▪ Support for health promotion and disease prevention ▪ Digital systems to optimize care across the continuum of self-, primary-, secondary- and tertiary-care (<u>MyHealthRecord</u>, care pathways, decision support, m-health, etc) and to enable reporting and feedback ▪ Support for reflective practice and continuous quality improvement, including research, innovation, teaching and learning ▪ Adequate infrastructure and funding

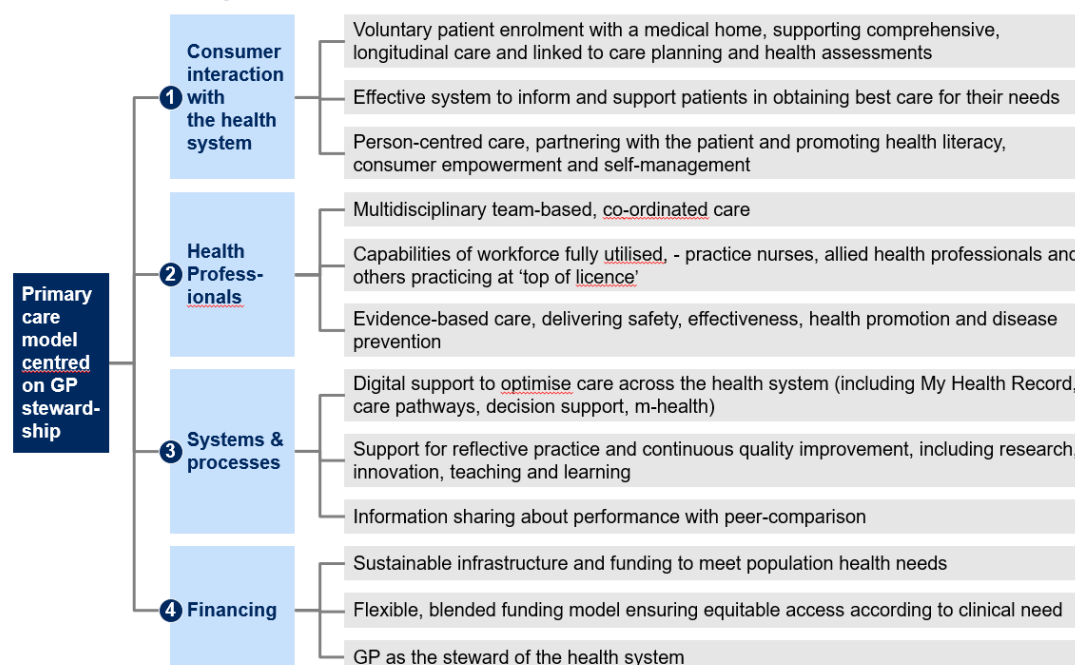


Elements of an Australian person-centred primary care model supporting GP stewardship and team based care

In Phase 1 of its work the GPPCCC identified strategies to support GP stewardship and team based care. These complement the principles and implications identified in Figure 9 above, and provide mechanisms for GP stewardship within the context of person-centred primary care.

Figure 10: elements of an Australian person-centred primary care model supporting GP stewardship and team based care

Elements of an Australian patient-centred primary care model supporting GP stewardship



Voluntary patient enrolment – enhancing patient access

The Committee supports the implementation of a voluntary patient enrolment model that encourages practices to build continuity of care into their business models, ensuring support for longitudinal care and population health, as well as acute, episodic care.

Recommendation 2

Introduce a new fee for practices to enrol a patient.



- The fee should be weighted by relevant patient characteristics, such as rurality, Indigeneity, risk, etc.
- This fee supports the holistic care that practices and GPs deliver to enrolled patients through flexible access e.g. through non-face-to-face channels, communication of results, and repeat prescriptions or referrals where clinically appropriate. The mutual obligations on the GP and the practice *for enrolled patients* should at a minimum include the following:
 - Providing *non face-to-face access* to enrolled patients
 - Providing *some after hours or emergency services* for enrolled patients
- Consumers should be able to choose whether to enrol with a practice, and nominate a GP within that practice, with flexibility so patients can see other providers within the practice. The model would also need to maintain enrolled patient access to services outside of their nominated practice, such as where patients require urgent or emergency services or may be travelling.
- The Committee recommends that the Government engage with consumers (potentially through focus groups) to develop a clear outline of the patient's role in enrolment, and to develop appropriate language around formalising the relationship between the doctor and patient, noting the importance of informed patient consent.
- This fee also supports Recommendation 1, including the need to better align the reimbursement model with the requirements of high quality, person-centred primary health care, GP stewardship of the health system, and continuous quality improvement.
- For enrolled patients, Chronic Disease Management and Health Assessment items should be restricted to those practices where a patient is enrolled. For patients who are not enrolled, these items can continue to be claimed by the patient's usual GP.
- The nominated GP should be responsible for maintaining the patient's My Health Record, where the patient has not opted-out.
- There Committee recommends that there is broad consultation with consumers and health professionals on all recommendations, noting the potentially wide-ranging impact of this specific recommendation.
- The Committee notes the unique issues with enrolment which may be faced by patients in rural and remote areas, and for mobile populations, and recommends that appropriate flexibility should be built into the model to address these challenges.



Rationale 2

- Evidence indicates that having a regular GP is beneficial for patient outcomes (.18), patient experience and value for the system (.19)(.20)(.21)(.22)(.23).
- Patient enrolment will encourage practices to build continuity of care into their business models, ensuring support for longitudinal care and population health as well as acute, episodic care.
- GPs and practices will be remunerated for consultation through multiple channels, facilitating digitally enabled care where appropriate
- Stronger connection between patient and the GP-led practice team can assist patients to navigate the health system, and can ensure more seamless communication between primary and hospital care.
- Enrolment will lead to stronger GP stewardship, with GPs supported to drive data-driven improvements in quality of care, and in referral and prescribing practices leading to potential downstream savings from preventable hospitalisations.
- Weighting of the payment is necessary because there are various factors which will change the likely cost of caring for a patient holistically over a period of time, e.g. flexible-access needs are likely to be higher for rural practices.
- This will not require a major change to existing patient behaviour. A survey in 2012 reported that 92% of Australians always attend the same practice, however many see multiple GPs within that practice (.24). A similar survey (.25), in 2013, reported over one-quarter of the sample had attended more than one practice in the previous year. Multiple practice attendance was less common with increasing age, and less likely for survey respondents from regional Australia, compared with respondents from metropolitan areas.

Recommendation 3

Introduce flexible access to primary care services for enrolled patients.

- The Committee recognises that many members of the community including those living with disability and/or with transport issues, and people living in rural and remote communities, face challenges in attending general practices. This recommendation focuses on increasing access to care.



- The mutual obligations on the GP and the practice for enrolled patients should at a minimum include the following:
 - Providing non-face-to-face access to enrolled patients
 - Providing some after hours or emergency services for enrolled patients
- If the recommendation on voluntary patient enrolment is not supported, the Committee recommends that flexible access including non-face-to-face access (e.g. telephone, email, videoconsulting, telehealth, etc) for consumers facing difficulties in accessing face-to-face consultations (e.g. remote, rural, disabled) be made available as soon as possible through other means, including new MBS items.

Rationale 3

This recommendation focuses increasing access to care. It is based on the following.

- The evidence demonstrates high patient satisfaction and consumer support for non-face-to-face care (.26)
- There is strong evidence that non-face-to-face care can increase access, without compromising patient outcomes (.27)(.28)
- There is strong stakeholder support for flexible access, including non-face-to-face access (see submissions from stakeholders to the Committee)

Chronic disease management – supporting coordinated, comprehensive and continuing care

Recommendation 4

Implement a comprehensive package of longitudinal care for enrolled patients with chronic health conditions that promotes the effective use of primary care chronic disease management items.

The Committee recommends that a range of enhancements to MBS supported chronic disease management items to increase high value primary care, enhance multidisciplinary care planning and coordination activities, and support increased patient activation.

These enhancements represent an analogous package of care for patients with chronic health conditions, and are not intended to be considered in isolation.

See Appendix A.1. for a full list of Chronic Disease Management Items and usage.

**Recommendation 4.1**

Combine GP Management Plans (GPMPs) and Team Care Arrangements (TCAs), and strengthen GPMPs.

- Item 723
 - Delete item
- Item 729
 - Delete item
- Item 731
 - No change to item
- Item 721
 - Change item descriptor, schedule fee and explanatory note
 - The descriptor should:
 - State that this item is available at the enrolled practice, for patients who are enrolled, or to be performed by the usual GP for patients who are not enrolled.
 - Include the coordination of the development of team care arrangements where required.
 - The explanatory note should:
 - Note that a GPMP should include an assessment of physical, psychological and social function, and should encompass a comprehensive preventive health plan (beyond the scope of existing chronic diseases),
 - Note that the GPMP must address all the patient's known health care needs, health problems and other relevant conditions
 - Include the requirement to review the patient's health record to ensure currency and accuracy
 - Require the GPMP to be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable
 - Include a strengthened definition of chronic condition, being a condition that "requires a structured and holistic approach", with detailed guidance added to the explanatory note on what does and does not constitute a chronic condition.



- The proposed new descriptor for item 721 is as follows:

Attendance by a patient's usual general practitioner and other health professionals in the practice where the patient is enrolled (or the usual practice for patients who are not enrolled), for preparation of a GP management plan and to coordinate any necessary team care arrangements for a patient (other than a service associated with a service to which any of items 735 to 758 apply).

- The proposed new explanatory note for item 721 is as follows:

This CDM service is for a patient who has at least one medical condition that:

(a) has been (or is likely to be) present for at least six months and requires a structured, ongoing and holistic approach; or

(b) is terminal.

A rebate will not be paid within twelve months of a previous claim for item 721, or within three months of a claim for item 732, except where there are exceptional circumstances that require the preparation of a new GPMP.

A comprehensive written plan covering management of the patient's chronic disease(s) and comprehensive preventive health plan must be prepared describing:

- *All the patient's known health care needs, health problems and other relevant conditions, including an assessment of physical, psychological and social function, and reviewing the patient's health summary to ensure currency and accuracy;*
- *A comprehensive health promotion and disease prevention plan, agreed with the patient;*
- *management goals with which the patient agrees;*
- *actions to be taken by the patient;*
- *treatment and services the patient is likely to need;*
- *arrangements for providing this treatment and these services;*
- *arrangements to review the plan by a date specified in the plan;*
- *if required, arrangements for multidisciplinary care of the patient, including treatment and service goals, treatment by other providers, and patient actions*



In preparing the plan, the provider must:

- *explain to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in preparing the plan; and*
- *record the plan; and*
- *record the patient's agreement to the preparation of the plan; and*
- *offer a copy of the plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);*
- *add a copy of the plan to the patient's medical records, and upload a copy of the plan to My Health Record, unless patient consent is withdrawn, and where reasonably achievable;*
- *provide an appropriate written referral to collaborating providers with copies of relevant parts of the document attached, and advise that the document has been uploaded to My Health Record where appropriate*

Rationale 4.1

- This recommendation focuses on reducing administrative burden and low value care, and increasing patient activation in their own care planning.
- The Committee agreed that planned proactive health care is critical to patient outcomes
 - Approximately 50% Australians have at least one prominent chronic health condition (i.e. arthritis, asthma, back pain, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes or mental ill-health). Nearly a quarter of all Australians (23%) have two or more chronic conditions. Chronic conditions are responsible for around three-quarters of the total non-fatal burden of disease in Australia. (.29)
 - Aboriginal and Torres Strait Islander people experience poorer health than other Australians, with a burden of disease 2-3 times greater than the general Australian population. Much of the difference is due to chronic conditions (.30). Chronic disease is also a major cause of higher morbidity and mortality in remote and rural areas, and in economically disadvantaged communities.
 - The World Health Organization argues that in order to respond to the emerging epidemic of chronic, non-communicable disease and the growing costs of referred care, health services need to develop as integrated, person-centred health



systems, founded on strong, coordinated and well-resourced primary health care.
(.31)(.32)

- Essential elements of integrated care of patients living with chronic disease include: (.33)(.34)(.35)(.36)
 - Person-centredness, including personal goal setting, empowerment, activation and education
 - Evidence-based treatment that is safe and effective
 - Proactive care with a focus on prevention (primary, secondary, tertiary)
 - Continuity of care with availability of health information as & when required
 - Individualized care planning and regular reviews
 - Flexible, multi-disciplinary team-based care
 - Care facilitation for those who require it
 - Equitable and timely access to care
 - Continuous quality improvement
- Person-centredness is the clinical method used by the GP to effectively incorporate patient experience and expectations into the clinical care. (.37)(.38) This approach incorporates and facilitates empowerment goal setting and engagement by the patient in their health concern. The method used as a standard approach in all consultations leads to a more collaborative approach to patient concerns and health care.
- An evidence review by McKinsey reported significant reductions in hospitalization rates from patient empowerment and education, multidisciplinary team care, care coordination, and individualized care plans. (.39)
- The Australian Diabetes Care Project found statistically significant improvement in HbA1c, blood pressure and other key clinical variables, and reduced hospital costs, from an intervention comprising an integrated information platform, data-driven CQI, funding based on risk stratification, QI support payments and dedicated Care Facilitators. (.40)
- The Committee agreed that GPMPs and TCAs should be combined into one item to reduce administrative burden and reduce duplication.
 - There is strong support from AMA and other stakeholders to reduce administrative burden and red tape for chronic disease management items



- The majority of GPMPs and TCAs are currently claimed together(41):
 - 77% of GPMPs are co-claimed with TCAs in the same appointment, an increase from 37% in 2005-06
 - 62% of GPMP and TCA reviews are co-claimed
- Some TCAs are claimed for patients who do not use the associated allied health services: 30% of patients who claimed a TCA did not use any allied health services that calendar year(42)
- The Committee agreed that item 729 should be abolished as its usefulness is limited
 - Item 729 was only used 2574 times in 2016-17(43)
- The Committee agreed that there should be no change to item 731 as in the context of Residential Aged Care Facilities, an item for contributing to a care plan is more appropriate
 - Item 731 was used 131,935 times in 2016-17(44)
- The Committee agreed that a copy of the GPMP is to be uploaded to the My Health Record (unless patient consent is withdrawn, and where reasonably achievable) to assist in information sharing between the patient and their care team
 - There should be exemptions for patients who have opted-out of My Health Record and for GPs and practices where it is not reasonably achievable e.g. with insufficient access to high-speed internet

Recommendation 4.2

Link allied health chronic disease management items to the creation of a GPMP.

- Items 10950-10970 and 81100-81125
 - Change the descriptors to remove references to Team Care Arrangements and make clear that allied health services will be linked to the creation of a GPMP.

Rationale 4.2

This recommendation focuses on simplifying Chronic Disease Management items. It is based on the following.

- The Committee agreed that allied health items should be directly linked to the creation of a GP Management Plan, and the item for Team Care Arrangements should be deleted
 - 77% of GPMPs are co-claimed with TCAs in the same appointment, an increase from 37% in 2005-06(41)



- 30% of patients who claimed a TCA did not use any allied health services that calendar year (42)

Recommendation 4.3

Equalise rebates for GPMP preparation and review to encourage longitudinal patient care.

- Item 732
 - Change the descriptor, explanatory note and schedule fee
 - The schedule fee for items 732 and 721 should be of equal value, noting that the recommendations support an increase to funding for general practice, including chronic disease management.
 - The descriptor should:
 - State that this item is available at the enrolled practice, for patients who are enrolled, or to be performed by the usual GP for patients who are not enrolled.
 - Specify that a 732 is only available 3 months after the creation of a 721, then every 3 months, with a maximum of three claims for item 732 in the first year and four claims in subsequent years. Note that an alternative is that after the creation of a 721, up to four 732s are performed a year without the need for further 721s. The Committee supports either option, noting that this is primarily an administrative issue.
 - The explanatory note should specify that any changes in the Care Plan triggered by the review should be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.
- The proposed new descriptor is as follows:

Attendance by a patient's usual general practitioner at the practice where the patient is enrolled (or the usual practice for patients who are not enrolled) to undertake a comprehensive review of a GP management plan prepared by a general practitioner to which item 721 applies, and to coordinate any necessary team care arrangements.

Each service to which item 732 applies may only be claimed after three months has passed from the creation of the GP management plan (item 721), and then every three months up to a maximum of three claims in the first year and four claims in subsequent years, except where there are exceptional circumstances that necessitate earlier performance of the service to the patient.



- The proposed new explanatory note is as follows:

When reviewing a GP Management Plan, the medical practitioner must:

- *explain to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in the review;*
- *record the patient's agreement to the review of the plan;*
- *review all the matters set out in the relevant plan;*
- *make any required amendments to the patient's plan and add any new clinically relevant conditions as needed;*
- *offer a copy of the amended document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);*
- *provide for further review of the amended plan by a date specified in the plan;*
- *add a copy of the plan to the patient's medical records, and if the plan is amended upload a copy of the amended plan to My Health Record, unless patient consent is withdrawn and where reasonably achievable;*
- *provide copies of relevant parts of the document or advise that the document has been uploaded to My Health Record in referrals to collaborating providers.*

- Item 721

- The schedule fee for items 721 and 732 should be of equal value, noting that the recommendations support an increase to funding for general practice, including chronic disease management.

Rationale 4.3

This recommendation focuses on improving access to longitudinal care for patients with chronic disease and ensuring proper use of chronic disease management items. It is based on the following.

- The Committee agreed that increased use of item 732 would deliver increased longitudinal care for patients with chronic disease
 - Longitudinal care and reviewing and updating the plan by the patient's usual GP is important in optimising patient outcomes from CDM planning (45)
 - 55% of patients with GPMPs did not receive a review within a year in 2016/17 (46)



- Reviews are currently reimbursed at around half the schedule fee of the creation of a GPMP
- The Committee agreed that the quality of item 732 would be strengthened by ensuring that it is conducted by a GP at the practice where the patient is enrolled and requiring the updated plan to be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.
- Requiring the review to be conducted by a GP at the practice where the patient is enrolled will ensure that the review is facilitating longitudinal care
- Requiring the updated plan to be uploaded to My Health Record will enable patient and the patient's other health care providers to access the current plan.

Recommendation 4.4

Increase patient access to high quality care coordination across physical, mental and social care domains.

Rationale 4.4

This recommendation focuses on increasing access to care coordination services that encompass bio-psycho-social models of care and supports active patient involvement in their own care planning. It is based on the following:

- Consumers report difficulty with care navigation, including limited information and choice for patients about cost, quality and availability
- Consumers with complex health care needs would benefit from greater assistance with care coordination and navigation from a registered nurse, enrolled nurse or Aboriginal health practitioner or Aboriginal health worker.

**Recommendation 4.5**

Develop advice and support mechanisms to activate and engage patients in their own care planning, including the assessment and support of patient health literacy activities.

Rationale 4.5

This recommendation focuses on improving patient experience and increasing patient activation in care planning.

The Committee agreed that patients need to be more involved in their own care planning, including

- effective care coordination means actively involving the patient in goal setting and decision-making, and providing self-management support(47); and
- clinical experience suggests that patients may not be sufficiently supported or engaged in their own care planning

Recommendation 4.6

Encourage increased patient participation and rebate attendance of non-medical health professionals at case conferences.

- Items 735, 739, 743, 747, 750
 - Change the explanatory note to:
 - Specify that the patient or their nominated representative should usually be invited to attend the case conference, subject to patient agreement;
 - Require the GP to provide a summary of the conference to the participants and to upload the updated care plan if changed by the case conference to My Health Record, unless patient consent is withdrawn, and where reasonably achievable;
 - Note that case conferences can take place via telephone.
 - State that these items are available at the enrolled practice, for patients who are enrolled, or to be performed by the usual GP for patients who are not enrolled.
 - The proposed new explanatory note is as follows:



Items 735 to 758 provide rebates for general practitioners to organise and coordinate, or participate in, multidisciplinary case conferences for patients in the community or patients being discharged into the community from hospital or people living in residential aged care facilities.

To organise and coordinate case conference items 735, 739 and 743, the provider must:

(a) explain to the patient the nature of a multidisciplinary case conference, ask the patient for their agreement to the conference taking place, and ask the patient if they would like to attend the case conference (unless there is a valid clinical reason why the patient should not attend, which must be documented); and

(b) record the patient's agreement to the conference; and

(c) record the day on which the conference was held, and the times at which the conference started and ended; and

(d) record the names of the participants; and

(e) offer the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a summary of the conference and provide this summary to other team members; and

(f) discuss the outcomes of the conference with the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and

(g) record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records, and upload to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.

To participate in multidisciplinary case conference items 747, 750 and 758, the provider must:

(a) explain to the patient the nature of a multidisciplinary case conference, ask the patient for their agreement to the conference taking place, and ask the patient if they would like to attend the case conference; and

(b) record the patient's agreement to the general practitioner's participation; and

(c) record the day on which the conference was held, and the times at which the conference started and ended; and

(d) record the names of the participants; and



(e) record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records, and upload to My Health Record any consequential changes to the Care Plan, unless patient consent is withdrawn and where reasonably achievable.

Usual general practitioner

- *Items 735-758 should generally be undertaken by the patient's usual general practitioner. This is the patient's nominated general practitioner, or a general practitioner working in the medical practice where the patient is enrolled. For patients who are not enrolled, the usual general practitioner is the GP, or a GP working in the medical practice, who has provided the majority of care to the patient over the previous twelve months and/or will be providing the majority of GP services to the patient over the next twelve months.*

Multidisciplinary case conference team members

- *Examples of persons who, for the purposes of care planning and case conferencing may be included in a multidisciplinary care team are Nurse Practitioners and allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dietitians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.*
- *A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers.*
- *The patient's informal or family carer may be included as a member of the team in addition to the minimum of three health or care providers. The patient and the informal or family carer do not count towards the minimum of three.*

Discharge case conference

- *Organisation and coordination of a multidisciplinary discharge case conference (items 735, 739 and 743) may be provided for private in-patients being discharged into the community from hospital.*
- Create three new items to rebate attendance at a case conference by non-medical health practitioners, one for 15-20 minutes to align with item 747, and one for 20-40 minutes to align with item 750, and one for >40 minutes to align with item 758.



- The first proposed new descriptor is as follows:

Attendance by a health practitioner (including allied health professionals, registered nurses and nurse practitioners, but not including a general practitioner, specialist or consultant physician), as a member of a multidisciplinary case conference team, to participate in:

(a) a community case conference; or

(b) a multidisciplinary case conference in a residential aged care facility; or

(c) a multidisciplinary discharge case conference;

if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which items 721 to 732 apply)

- The second proposed new descriptor is as follows:

Attendance by a health practitioner (including allied health professionals, registered nurses and nurse practitioners, but not including a general practitioner, specialist or consultant physician), as a member of a multidisciplinary case conference team, to participate in:

(a) a community case conference; or

(b) a multidisciplinary case conference in a residential aged care facility; or

(c) a multidisciplinary discharge case conference;

if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which items 721 to 732 apply)

- The third proposed new descriptor is as follows:

Attendance by a health practitioner (including allied health professionals, registered nurses and nurse practitioners, but not including a general practitioner, specialist or consultant physician), as a member of a multidisciplinary case conference team, to participate in:

(a) a community case conference; or

(b) a multidisciplinary case conference in a residential aged care facility; or

(c) a multidisciplinary discharge case conference;

if the conference lasts for at least 40 minutes (other than a service associated with a service to which items 721 to 732 apply)



Rationale 4.6

This recommendation focuses on improving access to case conferencing as part of effective chronic disease management, and ensuring that the patient is engaged in their own care planning. It is based on the following.

- The Committee agreed that use of case conferencing was important:
 - Approximately 50% Australians have at least one prominent chronic condition (i.e. arthritis, asthma, back pain, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes or mental ill-health) (.48)
 - Multi-disciplinary team based care, with efficient and accurate communication between providers, is essential for the safe and effective care of patients living with chronic disease. (.49)(.50)(.51) This was one of the elements identified by McKinsey in an evidence review as providing significant reductions in hospitalization rates. (.52)
 - While much communication between providers is appropriately written, verbal communication can complement this and is widely seen as essential for safety and quality in chronic disease management. (.53)(.54)(.55)
- The Committee agreed that uptake of case conferencing items is variable
 - The number of GP case conferencing items per 1000 population varies widely across States and Territories (highest in NT, lowest in SA, a 4.4-fold difference). Rates are also significantly higher in remote and rural communities. Rates are highest in patients aged 70 years and older. (.56)
 - GPs report that it is logistically difficult to arrange a face to face or teleconference meeting with at least two other providers, and that the requirement for contemporaneity makes inclusion of additional members even more challenging.
- The Committee agreed that patients should be given the opportunity to participate in case conferences
 - Consumers report limited awareness of these items' availability.
 - Effective care coordination means actively involving the patient in goal setting and decision-making, and providing self-management support
- The Committee agreed that enabling non-doctor health practitioners to claim an MBS item for participation in a case conference may increase uptake of case conferences
 - Multi-disciplinary team based care, with efficient and accurate communication between providers, is essential for the safe and effective care of patients living with chronic disease.



- While much communication between providers is appropriately written, verbal communication can complement this and is widely seen as essential for safety and quality in chronic disease management.
- Case conferencing items are not highly utilised, with 3.5 services per 1000 patients, but their use is growing (15% CAGR) (.57)

Recommendation 4.7

Link Medication Management Reviews (MMR) to GPMP and ensure the rebate accurately reflects GP activity.

- Item 900
 - Change the descriptor, explanatory note and schedule fee.
 - The descriptor should:
 - Specify that the item must be claimed at the same time or within 12 months of a GPMP (item 721), for a patient at risk of medication misadventure due to unstable health status, use of high risk medicines, not meeting therapeutic goals, or issues surrounding adherence.
 - State that this item is available at the enrolled practice, for patients who are enrolled, or to be performed by the usual GP for patients who are not enrolled.
 - Require a copy of the MMR to be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.
 - The explanatory note should:
 - Allow appropriately trained allied health professionals to assist with information gathering that would allow an accredited pharmacist to complete the MMR without being physically present, for use in very remote communities where timely access to an accredited pharmacist is not feasible.
 - The schedule fee should be substantially reduced, and any savings should be re-invested into other initiatives to support general practice such as voluntary patient enrolment.
- Item 903
 - Change the descriptor and schedule fee.



- The descriptor should:
 - State that this item is available at the enrolled practice, for patients who are enrolled, or to be performed by the usual GP for patients who are not enrolled.
 - Require a copy of the MMR to be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.
 - Allow a proxy to request a medication review where they have sought consent from the patient's usual general practitioner, and where the patient is either being discharged or lives in MMM 5, 6, or 7.
- The schedule fee should be substantially reduced to make it equal to item 900, noting that any savings should be re-invested into other initiatives to support general practice such as voluntary patient enrolment.
- The proposed new descriptor for item 900 is as follows:

Participation by a patient's usual general practitioner at the practice where the patient is enrolled (or the usual practice where a patient is not enrolled) in a Domiciliary Medication Management Review (DMMR) for a patient living in a community setting, in which the general practitioner, or their proxy, with the patient's consent:

 - (a) assesses the patient as:*
 - (i) having a GP Management Plan or review which was created in the last 12 months; and*
 - (ii) being at risk of medication misadventure due to unstable health status, use of high risk medicines, or issues surrounding adherence; and*
 - (iii) not having their therapeutic goals met; and*
 - (b) following that assessment:*
 - (i) refers the patient to a community pharmacy or an accredited pharmacist for the DMMR; and*
 - (ii) provides relevant clinical information required for the DMMR; and*
 - (c) reviews the pharmacist's report from the DMMR including suggested medication management strategies; and*
 - (d) updates the medication management section of the GPMP following discussion with the patient; and*



(e) uploads the current medication management plan to My Health Record, unless patient consent is withdrawn and where reasonably achievable.

For any particular patient—applicable not more than once in each 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR.

A proxy can request a medication review only if they:

- 1) Seek and receive consent from the patient's usual general practitioner who will complete the MMR; and*
- 2) are a hospital doctor or senior hospital staff member caring for patient being discharged, or are a remote area nurse or aboriginal health practitioner where the patient is located in MMM5, 6 or 7.*

- The proposed new explanatory note for item 900 is as follows:

A Domiciliary Medication Management Review (DMMR) (Item 900), also known as Home Medicines Review, is intended to maximise an individual patient's benefit from their medication regimen, and prevent medication-related problems through a team approach, involving the patient's GP and preferred community pharmacy or accredited pharmacist.

Patient eligibility

The item is available to people living in the community who meet the criteria for a DMMR.

The item is not available for in-patients of a hospital, or care recipients in residential aged care facilities.

DMMRs are targeted at patients who are likely to benefit from such a review: patients for whom quality use of medicines may be an issue or; patients who are at risk of medication misadventure because of factors such as their co-morbidities, age or social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimen, or a lack of knowledge and skills to use medicines to their best effect.

DMMR's are targeted at patients who are:

- currently taking five or more regular medications or taking more than 12 doses of medication per day; and*
- have had significant changes made to medication treatment regimen in the last three months; or*



- *taking medication with a narrow therapeutic index or medications requiring therapeutic monitoring; or*
- *experiencing symptoms suggestive of an adverse drug reaction; or*
- *displaying sub-optimal response to treatment with medicines; or*
- *suspected of non-compliance or inability to manage medication related therapeutic devices; or*
- *having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties; or*
- *attending a number of different doctors, both general practitioners and specialists; or*
- *recently discharged from a facility / hospital (in the last four weeks).*

In referring a patient for a DMMR, general practitioners should note that only patients meeting the following criteria will have the pharmacist portion funded through a Community Pharmacy Agreement program:

- *Is a Medicare and/or Department of Veterans' Affairs (DVA) cardholder or a person who is eligible for a Medicare card;*
- *Is subject to a chronic condition and/or complex medication regimen; and*
- *Is failing to respond to treatment in the expected manner.*

If the patient does not meet these criteria, the general practitioner can still issue a referral under this item. However, the remainder of the service will be on a "user pays" basis as determined by the accredited pharmacist.

REGULATORY REQUIREMENTS

In conducting a DMMR, a general practitioner must, with the patient's consent:

- (a) assess a patient is subject to a chronic medical condition and/or complex medication regimen but their therapeutic goals are not being met; and*
- (b) following that assessment, refer the patient to a community pharmacy or an accredited pharmacist for a DMMR and provide the relevant clinical information required for the review; and*
- (c) discuss with the reviewing pharmacist the result of that review including suggested medication management strategies; and*
- (d) develop a written medication management plan following discussion with the patient; and*



(e) provide the written medication management plan to a community pharmacy chosen by the patient.

For any particular patient - applicable not more than once in each 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR.

In the case of very remote communities where a visit from an accredited pharmacist is unlikely, the home visit may be conducted by a suitably trained remote area nurse or aboriginal health practitioner who will act on behalf of the centrally located accredited pharmacist completing the MMR.

Claiming

A DMMR includes all DMMR-related services provided by the general practitioner from the time the patient is identified as potentially needing a medication management review to the preparation of a draft medication management plan, and discussion and agreement with the patient.

The benefit is not claimable until all the components of the item have been rendered.

Benefits for a DMMR service under item 900 are payable only once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (e.g. diagnosis of a new condition or recent discharge from hospital involving significant changes in medication). In such cases the patient's invoice or Medicare voucher should be annotated to indicate that the DMMR service was required to be provided within 12 months of another DMMR service.

Provision of a subsequent DMMR must not be made solely by reaching an anniversary date, and the service is not intended to be undertaken on an ongoing review cycle.

If the DMMR is initiated during the course of a consultation undertaken for another purpose, this consultation may also be claimed separately.

If the consultation at which the medication management review is initiated is only for the purposes of initiating the review, only item 900 may be claimed.

If the general practitioner determines that a DMMR is not necessary, item 900 does not apply. In this case, normal consultation items should be used.

Where a DMMR cannot be completed due to circumstances beyond the control of the general practitioner (e.g. because the patient decides to not proceed further with the DMMR, or because of a change in the circumstances of the patient), the relevant MBS attendance items should be used.



FURTHER GUIDANCE

A DMMR should generally be undertaken by the patient's usual general practitioner. For a patient who is enrolled, this is a general practitioner in the practice where a patient is enrolled. For a patient who is not enrolled, this is the general practitioner, or a general practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

The potential need for a DMMR may be identified either by the general practitioner in the process of a consultation or by receipt of advice from the patient, a carer or another health professional including a pharmacist.

The process of referral to a community pharmacy or an accredited pharmacist includes:

- Obtaining consent from the patient, consistent with normal clinical practice, for a pharmacist to undertake the medication management review and for a charge to be incurred for the service for which a Medicare rebate is payable. The patient must be clearly informed of the purpose and possible outcomes of the DMMR, the process involved (including that the pharmacist will visit the patient at home, unless exceptional circumstances apply or they are an Aboriginal or Torres Strait Islander patient), what information will be provided to the pharmacist as part of the DMMR, and any additional costs that may be incurred; and*
- Provision to the patient's preferred community pharmacy or accredited pharmacist, of relevant clinical information, by the general practitioner for each individual patient, covering the patient's diagnosis, relevant test results and medication history, and current prescribed medications.*
- A DMMR referral form is available for this purpose. If this form is not used, the general practitioner must provide patient details and relevant clinical information to the patient's preferred community pharmacy or accredited pharmacist.*

The discussion of the review findings and report including suggested medication management strategies with the reviewing pharmacist includes:

- Receiving a written report from the reviewing pharmacist; and*
- Discussing the relevant findings and suggested management strategies with the pharmacist (either by phone or face to face); and*
- Developing a summary of the relevant review findings as part of the draft medication management plan.*
- Development of a written medication management plan following discussion with the patient includes:*



- *Developing a draft medication management plan to be incorporated into patient's GPMP and discussing this with the patient; and*
- *Once agreed, offering a copy of the written medication management plan to the patient and providing a copy to the community pharmacy or accredited pharmacist and uploaded to My Health Record*

The agreed plan should identify the medication management goals and the proposed medication regimen for the patient.

- The proposed new descriptor for item 903 is as follows:

Participation by a patient's usual general practitioner in the practice where a patient is enrolled (or the usual practice for a patient who is not enrolled) in a residential medication management review (RMMR) for a patient who is a permanent resident of a residential aged care facility-other than an RMMR for a resident in relation to whom, in the preceding 12 months, this item has applied, unless there has been a significant change in the resident's medical condition or medication management plan requiring a new RMMR

The RMMR should result in an update to the resident's medication management plan and the current medication management plan should be uploaded to My Health Record, unless patient consent is withdrawn and where reasonably achievable.

Rationale 4.7

This recommendation focuses on better targeted MMRs and ensuring that the rebate accurately reflects the practitioner's effort.

- The Committee agreed that item 900 should be limited to those patients who have had a GP Management Plan or review performed in the last 12 months.
 - MMRs have the greatest benefit for patients with chronic diseases or on complex medication regimes(58)(59).
 - 72% of patients with a DMMR have a GPMP initiated within a year of their medication review.
 - The item descriptor for item 900 includes significant overlap with GPMPs.
- The Committee agreed that the schedule fee for items 900 and 903 should be substantially reduced.
 - The current rebate for item 900 is \$154.60 and for item 903 is \$106.00 compared with \$144.25 for item 721.



- Item 900 will likely be performed in conjunction with a GPMP or a review of a GPMP.
- The Committee agreed that the descriptor should reflect risk of medication misadventure
 - The descriptor previously required the patient to have a chronic medical condition or a complex medication regimen
 - Linking item 900 to GPMPs will mean that most patients have a chronic medical condition
 - There are some patients with a complex medication regimen who may not be at risk of medication misadventure
- The Committee agreed that the MMR should trigger the upload of a current medication management plan to My Health Record, unless patient consent is withdrawn and where reasonably achievable, to facilitate increased patient awareness and data sharing between health practitioners
- The Committee agreed that access to MMRs should be improved for patients in rural and remote areas, and for patients who are being discharged from hospital
 - There is significant geographical variation in MMR claiming patterns, with overall claims 3.4 times higher in NSW compared with NT.

Recommendation 4.8

Increase the scheduled fee for home visits for enrolled patients.

- Items 24 37 and 47
 - Increase the schedule fee for a home visit for patient when attended by a GP from the practice where the patient is enrolled.

Rationale 4.8

This recommendation focuses on increasing support for home visits for patients who are enrolled within a practice. It is based on the following:

- With an ageing population, it is important to facilitate people who want to stay in their homes.
- Extension of higher rebates to all patients could have unintended consequences similar to those experienced in urgent after-hours care(60).



Health Assessment Items - better alignment with need and evidence

Recommendation 5

Build the evidence base for Health Assessments and ensure that the content of Health Assessments conforms to appropriate clinical practice guidelines.

- The Committee recommends that a process be established to gather evidence on the effectiveness and frequency of Health Assessments with a focus on at-risk populations, including using data at a Primary Health Network (PHN) level based on existing groups eligible for Health Assessments, and commissioning studies on the evidence for Health Assessments for new at-risk groups.

Note: See Appendix A.2. for a full list of Health Assessment items and usage.

Rationale 5

This recommendation focuses on increasing the evidence base for Health Assessments to ensure that preventative care is delivered in the most effective way. It is based on the following:

- The Committee agreed that there is limited evidence around Health Assessments
 - The Hereco literature review commissioned by the Committee found evidence for Health Assessments in certain populations:
 - Persons with intellectual disability: There is substantial evidence to suggest that health assessments lead to detection of unmet needs, which leads to increases in activities conducive to better health outcomes, can prevent disease in people with intellectual disability, and can reduce preventable emergency admission(61)(62)(63).
 - There is evidence that annual health checking is justifiable, with a similar number of new health problems found at the repeat check compared to the initial check(64).
 - Persons over the age of 75: A systematic review found that the majority of "more methodologically sound studies" were found to report improvements in health but the review found no evidence that targeting of the frail elderly enhanced outcomes (65).
 - Persons over the age of 65: One RCT focused on people 65+ found a mean decline in health status was 2% lower in intervention group than control group, and death rate was significantly lower in intervention than control



(8.3% vs 11.1%). No differences were observed in changes in health behaviours (.66).

- However there was limited evidence found for Health Assessments in the general population or other populations:
 - Health checks led to an overall increase in the number of new diagnoses and more treatment(.67), and lessened patient worry(.68), but did not improve morbidity or mortality, leading most studies to conclude that health checks on the general population are not warranted(.67)(.69)
 - There is some evidence that CVD systematic risk assessment may have favourable effects on CVD risk factors, but not enough to justify introduction of general screening(.70)(.71)

Recommendation 6

Strengthen the quality of current Health Assessments and expand at-risk groups who are eligible for Health Assessments.

- Items 701, 703, 705 and 707
 - Change the descriptors and explanatory notes
 - The descriptors should:
 - State that this item is available at the enrolled practice, for patients who are enrolled, or to be performed by the usual GP for patients who are not enrolled.
 - Include the requirement that the GP must personally explain the findings and implications of the Health Assessment to the patient, and agree with the patient a plan for health promotion and disease prevention based on these findings.
 - Include the requirement that the Health Assessment be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.
 - The explanatory notes should:
 - Expand eligibility of Health Assessments to new at-risk populations and modify existing populations to better align with clinical and service needs.
 - Ensure that the content of Health Assessments should conform to guidelines generally acceptable to the wider body of the profession such as



the Guidelines for preventive activities in general practice 9th edition (Red Book) or future editions where appropriate.

- Item 715
 - Change the descriptor and explanatory note
 - The descriptor should:
 - State that this item is available at the enrolled practice, for patients who are enrolled, or to be performed by the usual GP for patients who are not enrolled.
 - Include the requirement that the GP must spend a reasonable time reviewing the Health Assessment with the patient.
 - Include the requirement that the Health Assessment be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.
 - The explanatory note should
 - Include the requirement that the Health Assessment be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.
 - The explanatory note should refer to guidelines generally acceptable to the wider body of the profession such as the Guidelines for preventive activities in general practice 9th edition (Red Book) and the National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people, or future editions where appropriate
 - The proposed new descriptor for item 703 is as follows:

Professional attendance by a patient's usual general practitioner at the practice where the patient is enrolled (or the usual practice, where the patient is not enrolled) to perform a standard health assessment, lasting more than 30 minutes but less than 45 minutes, including:

(a) detailed information collection, including taking a patient history; and

(b) an extensive physical examination; and

(c) initiating interventions and referrals as indicated; and

(d) providing a preventive health care strategy for the patient



The GP must personally explain the findings and implications of the Health Assessment to the patient, and agree with the patient a plan for health promotion and disease prevention based on these findings.

The health care strategy must be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.

- The proposed new descriptor for item 705 is as follows:

Professional attendance by a patient's usual general practitioner at the practice where the patient is enrolled (or the usual practice, where the patient is not enrolled) to perform a long health assessment, lasting at least 45 minutes but less than 60 minutes, including:

- (a) comprehensive information collection, including taking a patient history; and*
- (b) an extensive examination of the patient's medical condition and physical function; and*
- (c) initiating interventions and referrals as indicated; and*
- (d) providing a basic preventive health care management plan for the patient*

The GP must personally explain the findings and implications of the Health Assessment to the patient, and agree with the patient a plan for health promotion and disease prevention based on these findings.

The health care management plan must be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.

- The proposed new descriptor for item 707 is as follows:

Professional attendance by a patient's usual general practitioner at the practice where the patient is enrolled (or the usual practice, where the patient is not enrolled) to perform a prolonged health assessment (lasting at least 60 minutes) including:

- (a) comprehensive information collection, including taking a patient history; and*
- (b) an extensive examination of the patient's medical condition, and physical, psychological and social function; and*
- (c) initiating interventions or referrals as indicated; and*
- (d) providing a comprehensive preventive health care management plan for the patient*



The GP must personally explain the findings and implications of the Health Assessment to the patient, and agree with the patient a plan for health promotion and disease prevention based on these findings.

The comprehensive health care management plan must be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.

- The proposed new descriptor for item 715 is as follows:

Professional attendance by a patient's usual general practitioner at the practice where the patient is enrolled (or the usual practice, where the patient is not enrolled) at consulting rooms or in another place other than a hospital or residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent-not more than once in a 9 month period.

The GP must personally explain the findings and implications of the Health Assessment to the patient, and agree with the patient a plan for health promotion and disease prevention based on these findings.

The health assessment must be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.

- The proposed new explanatory note for items 703, 705 and 707 is as follows:

There are three time-based health assessment items, consisting of standard, long and prolonged consultations.

Standard Health Assessment (MBS Item 703)

A standard health assessment is used for straightforward assessments lasting 30-45 minutes.

Long Health Assessment (MBS Item 705)

A long health assessment is used for an extensive assessment, where the patient has a range of health issues that require more in-depth consideration, and longer-term strategies for managing the patient's health may be necessary. The assessment lasts at least 45 minutes but less than 60 minutes.

Prolonged Health Assessment (MBS Item 707)

A prolonged health assessment is used for a complex assessment of a patient with significant, long-term health needs that need to be managed through a comprehensive preventive health care plan. The assessment takes 60 minutes or more to complete.



General practitioners may select one of the MBS health assessment items to provide a health assessment service to a member of any of the target groups listed in the table below. The health assessment item that is selected will depend on the time taken to complete the health assessment service. This is determined by the complexity of the patient's presentation and the specific requirements that have been established for each target group eligible for health assessments.

MBS Items 703, 705 and 707 may be used to undertake a health assessment for the following target groups:

Target Group	Frequency of Service
A health assessment for people aged 40-49 years (inclusive) who are at risk of developing chronic disease including type 2 diabetes	Once only to an eligible patient
A health assessment for people aged 75 years and older	Provided annually to an eligible patient
A health assessment for people aged 75 years and older where the medical practitioner judges there is a safety risk in the home	Provided annually to eligible patients in the home, including an additional loading
A comprehensive medical assessment for permanent residents of residential aged care facilities	Provided on admission and annually to an eligible patient
A health assessment for people with a severe intellectual disability	Provided annually to an eligible patient
A health assessment for refugees and other humanitarian entrants	Once only to an eligible patient
A health assessment for former serving members of the Australian Defence Force	Once only to an eligible patient
A health assessment for children in out-of-home care	Provided annually to an eligible patient



<i>A health assessment for prisoners within three months of discharge from prison following a sentence of at least six months.</i>	<i>Once only following each period of imprisonment</i>
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A health assessment means the assessment of a patient's health and physical, psychological and social function and consideration of whether preventive health care and education should be offered to the patient, to improve that patient's health and physical, psychological and social function.

Health assessments are not available to people who are in-patients of a hospital or care recipients in a residential aged care facility (with the exception of a comprehensive medical assessment provided to a permanent resident of a residential aged care facility).

Before a health assessment is commenced, the patient (and/or his or her parent(s), carer or representative, as appropriate) must be given an explanation of the health assessment process and its likely benefits. The patient must be asked whether he or she consents to the health assessment being performed. In cases where the patient is not capable of giving consent, consent must be given by his or her parent(s), carer or representative. Consent to the health assessment must be noted in the patient's records.

A health assessment must include the following elements:

- information collection, including taking a patient history and undertaking or arranging examinations and investigations as required;*
- making an overall assessment of the patient;*
- recommending appropriate interventions;*
- providing advice and information to the patient;*
- keeping a record of the health assessment, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment; and*
- offering the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.*

A health assessment may only be claimed for services provided by a medical practitioner (including a general practitioner but not including a specialist or consultant physician).

A health assessment should generally be undertaken by the patient's 'usual doctor'. For the purpose of the health assessment items, 'usual doctor' means the patient's



nominated medical practitioner, or a medical practitioner working in the practice where the patient is enrolled. Where a patient is not enrolled, 'usual doctor' means the GP, or a GP working in the medical practice, who has provided the majority of care to the patient over the previous twelve months and/or will be providing the majority of GP services to the patient over the next twelve months.

MBS health assessment items, 703, 705, 707 must be provided by a medical practitioner personally attending upon a patient. Suitably qualified health professionals, such as registered or enrolled nurses or Aboriginal and Torres Strait Islander health practitioners, employed and/or otherwise engaged by a general practice or health service, may assist medical practitioners in performing health assessments. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the medical practitioner. This may include activities associated with:

- information collection; and*
- providing patients with information about recommended interventions at the direction of the medical practitioner.*

The medical practitioner should be satisfied that the assisting health professional has the necessary skills, expertise and training to collect the information required for the health assessment.

Medical practitioners should not conduct a separate consultation for another health-related issue in conjunction with a health assessment unless it is clinically necessary (i.e. the patient has an acute problem that needs to be managed separately from the assessment). The only exception is the comprehensive medical assessment, where, if this health assessment is undertaken during the course of a consultation for another purpose, the health assessment item and the relevant item for the other consultation may both be claimed.

Items, 703, 705 and 707 do not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, items 703, 705 and 707 can be claimed for services provided by medical practitioners salaried by or contracted to, the Service or health clinic. All other requirements of the items must be met.

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with any health assessment, provided the conditions of item 10990 and 10991 are satisfied.



Rationale 6

This recommendation focuses on improving the quality of Health Assessments and expanding eligibility to at-risk populations. It is based on the following.

- The Committee agreed that Health Assessment requirement should reflect Guidelines for preventive activities in general practice 9th edition (Red Book) and the National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people.
 - The Guidelines for preventive activities in general practice 9th edition (Red Book) and the National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people provide the most up to date summation of evidence for preventative activities at each stage of a person's life.
- The Committee agreed that health assessment eligibility should be expanded to certain at-risk populations:
 - Children in out-of-home care (annually):
 - A Health Assessment for children in out-of-home-care is in line with a number of strategies in place to improve the quality of care provided for children and young people in out-of-home care. As part of the National Framework for Protecting Australia's Children 2009-2020, the National Standards for Out-of-Home Care⁴ (2011) were developed and endorsed by all States and Territories. These standards aim to drive greater consistency and improve the quality of care provided to children and young people. Standard five requires that children and young people have their physical, developmental, psychosocial and mental health needs assessed and attended in a timely way.
 - To support achievement of standard five and to streamline services available, the National Clinical Assessment Framework - Children and Young People in Out-of-Home Care⁵ was established by the Commonwealth Department of Health in 2011. The Framework outlines a best practice

⁴ <https://www.dss.gov.au/our-responsibilities/families-and-children/publications-articles/an-outline-of-national-standards-for-out-of-home-care-2011>

⁵ <http://health.gov.au/internet/publications/publishing.nsf/Content/ncaf-cyp-oohc-toc>



approach, highlighting general practitioner participation as primary to establishing continuity of care for children and young people in out-of-home care. It has been endorsed by the Commonwealth; however, it has not yet been fully adopted in any of the States or Territories. The introduction of a dedicated MBS item would directly support clinical assessments of children and young people in out-of-home care and is in line with the Framework. This includes supporting Child Protection agencies and other stakeholders to have a common framework to contribute to the assessment.

- The 2013 ACIL Allen Consulting report, Health Assessments and Interventions for Children and Young people in the Child Protection System, shows that this group also have poorer historical engagement with the health system and poorer health records.⁶
- Prisoners on discharge from prison (once following each episode of imprisonment for six or more months)
 - Availability of a structured, funded health assessment item would support former prisoners' access to primary care, and the assessment and management of their healthcare needs, with likely benefits for their own health, for population health (through the detection and management of infectious diseases), and possibly reducing re-offending.
 - 1) Many people in prison and youth detention suffer poor health, often with their needs incompletely met. Mental disorders and infectious diseases are more common in prisoners than in the general population. High rates of suicide within prison and increased mortality from all causes on release have been documented in many countries. (.72) Amongst women released from prison in NSW, 49% were on psychotropic medication and most required ongoing management for: mental health (71%), substance misuse (65%) and physical health (61%) problems. (.73)
 - 2) Former prisoners are at high risk of preventable morbidity and mortality following discharge. In a NSW study, in the first 12 months following

⁶ https://www.dss.gov.au/sites/default/files/documents/10_2014/health_assessments.pdf



discharge, all-cause SMR was 3.7 in men and 7.8 in women. The excess mortality was due to all major causes, and was even higher in Aboriginal men and women.(.74) A Queensland data-linkage study concluded that “Young people are at markedly increased risk of death after release from prison and the majority of deaths are preventable”.(.75)

- 3) However, there is poor transfer of care from prison to community.(.76)
- 4) Barriers include both structural problems, and former prisoners’ perception of GPs’ unwillingness to care for prisoners. Consequently, former prisoners may not seek care, or their needs may not be fully assessed and met.(.77)(.78)(.79)
- 5) Engagement with general practice after release increases health service utilization, enabling health promotion and disease management, and may reduce recidivism. An observational study in Queensland showed that early primary care physician contact was positively associated with mental health, alcohol and other drug treatment, and with subsequent primary care physician service utilisation over 6 months of follow-up.(.80) Another study showed that re-offending was reduced in former prisoners who had a family doctor, had good general health, were not depressed, had good nutritional health, and were not using cannabis or cocaine.(.81)
- The Committee agreed that health assessment eligibility should be modified to better align with clinical and service needs
 - Home visits for over 75 with a safety risk (annually)
 - 40-49 at risk of chronic disease (once)
 - RACF on admission and annually

Consultation Items - aligning consultation items with contemporary healthcare

Recommendation 7

Undertake additional research regarding the appropriateness of the current length, content and minimum quality metrics for GP MBS consultation items (Levels A-D).

Rationale 7

This recommendation focuses on increasing high value care. It is based on the following.



- The system should create incentives for GPs to provide higher value care and the development of a sophisticated set of metrics could be used to gauge the quality of consultation.
- Short consultations may not always constitute high value care but may be sufficient for issues including repeat scripts and referrals, vaccinations, etc (especially within the context of an ongoing relationship between the GP and patient). Additional research, including the time intersect between consultation items can be used to guide appropriate changes to the Level A-D consultation rebate or in voluntary patient enrolment.

Note: See Appendix A.3. for a full list of Consultation items and usage.

Recommendation 8

Introduce a new Level E consultation item for consultations of 60 minutes or more by a GP.

- The new descriptor should be as follows:

Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 60 minutes and including any of the following that are clinically relevant:

- (a) taking an extensive patient history;*
- (b) performing a clinical examination;*
- (c) arranging any necessary investigation;*
- (d) implementing a management plan;*
- (e) providing appropriate preventive health care;*

for one or more health-related issues, with appropriate documentation-each attendance.

- The new schedule fee should have the same per-minute rate as a Level D consultation

Rationale 8

This recommendation focuses on increasing support for long consultation where they are required. It is based on the following:

- There are some limited circumstances where a consultation of 60 minutes or more may be appropriate.
- GPs should be appropriately compensated for the time spent with patients.

**Recommendation 9**

Change the schedule fee for attendances at Residential Aged Care Facilities (RACF) to reflect an initial flag fall rebate with a stable fee for each consultation completed at the RACF.

- Items 20, 35, 43, 51, 92, 93, 95 and 96
 - Change the schedule fee to reflect an initial flag fall rebate for attendance at a RACF, with a stable fee for each consultation completed at the RACF (irrespective of the number of consultations).

Rationale 9

This recommendation focuses on increasing access to RACFs and addressing stakeholder concerns. It is based on the following.

- There does not appear to be an access issue for patients in RACFs
 - All consultations (including after hours) in RACFs increased from 15 per resident in 2009/10 to 23 per resident in 2016/17(.82)
 - 2008 and 2012 AMA surveys suggest an average time of around 16 minutes per patient (.83)
 - There is a very strong correlation between the population in regional and remote areas and the percentage of total RACF services in 2016-17
- The number of GPs visiting RACFs has increased over the last 10 years
 - 37% of GPs visited RACFs in 2016/17 – 13,379 out of a total 35,9421. The number of providers performing level B consults in RACFs increased annually by 1.2% between 2006-07 and 2016-17(.84)
- However, stakeholders expressed concern at the current structure of fees, noting the unpredictability and the difficulties with privately billing patients where appropriate (see stakeholder submissions to Committee).
 - On this basis the Committee agreed that the fee calculations should be restructured, without a significant change in the overall rebates.

Other recommendations**Recommendation 10**

Modernise the terminology currently used in the MBS to describe registered and enrolled nurses and their role to reflect the important role these health professionals play as members of the practice team.



Rationale 10

- The term 'practice nurse' conflates the distinct groups of registered nurses and enrolled nurses.
- The language of 'for and on behalf of' does not appropriately reflect the role played by registered and enrolled nurses.

Recommendation 11

Enable GP telehealth consultations and expand GP telehealth eligibility to patients with mobility concerns who cannot easily be seen face-to-face.

- The Committee recommends that the descriptors of items 99 and 82220-82222 be expanded to make GPs eligible to provide a telehealth consultation, in addition to other specialists and consultants. Provision of these GP telehealth services should be restricted to a patient's usual provider.
- The Committee recommends that new items be created to reimburse GPs for their time for telehealth consultations (similar to items which currently exist to reimburse other specialists) to support Nurse Practitioners and Aboriginal and Torres Strait Islander Health Practitioners consulting with patients in remote and rural settings.

Rationale 11

This recommendation focuses on increasing patient access to, and usage of, telehealth services. It is based on the following observations:

- The requirement for telehealth services to take place with specialists/consultations limits patient access to telehealth items. A survey of 73 Nurse Practitioners (NPs) working in primary care and accessing MBS indicated that only 12% used telehealth items, and identified that the main reason for non-use of the telehealth items was the stipulation of having a specialist or consultant present. (85)
- The addition of GPs as eligible telehealth providers will increase patient access to GPs, particularly in remote areas where GP access is more limited. The restriction to a patient's usual provider will ensure rural and remote practice sustainability. Rigorous consultation should be undertaken with rural and remote providers in the implementation of this recommendation.
- Expanding GP telehealth eligibility criteria to include patients with mobility concerns, such as patients who are elderly and frail, will increase patient access to essential services.



- The GPPCCC notes that the Nurse Practitioner Reference Group supports this recommendation.

5. Stakeholder Impact statement

The Committee expects that both patients and providers will benefit from these recommendations, as they address concerns regarding quality of care and take steps to simplify the MBS, making it easier to use and understand. Patient access to services was considered for each recommendation. Some recommendations were intended to reduce inappropriate access without significantly affecting appropriate access.

When considering various recommendations, the Committee considered what impacts they may have on several specific groups, for example health assessments for patients with chronic disease/s.

Where items have been recommended for deletion, alternative items have been proposed or created when necessary. Items that are obsolete have been recommended for deletion without replacement with the intent that any associated funding will be reinvested into primary care GP services.

The Committee also considered each recommendation's impact on provider groups to ensure that the changes are reasonable and unbiased. Where the Committee identified evidence of potential item misuse or safety concerns, recommendations were made to encourage best practice, in line with the overarching purpose of the MBS Review.

Reductions in inappropriate use and low-value care are expected to deliver savings for the health system; with the expectation that reinvestment would occur along with a number of cost-neutral changes. The Committee considered potential implications for provider groups and took steps to ensure that recommendations are as fair and reasonable as possible. Some business models may need to change or adapt to the proposed changes moving forward.



6. Glossary

Term	Description
CAGR	Compound annual growth rate or the average annual growth rate over a specified time period.
Change	When referring to an item, 'change' describes when the item and/or its services will be affected by the recommendations. This could result from a range of recommendations, such as: (i) specific recommendations that affect the services provided by changing item descriptors or explanatory notes; (ii) the consolidation of item numbers; and (iii) splitting item numbers (for example, splitting the current services provided across two or more items).
Delete	Describes when an item is recommended for removal from the MBS and its services will no longer be provided under the MBS.
Department, The	Australian Government Department of Health
DHS	Australian Government Department of Human Services
FY	Financial year
High-value care	Services of proven efficacy reflecting current best medical practice, or for which the potential benefit to consumers exceeds the risk and costs.
Inappropriate use / misuse	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
Low-value care	Services that evidence suggests confer no or very little benefit to consumers; or for which the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of services do not provide proportional added benefits.
MBS	Medicare Benefits Schedule
MBS item	An administrative object listed in the MBS and used for the purposes of claiming and paying Medicare benefits, consisting of an item number, service descriptor and supporting information, schedule fee and Medicare benefits.
MBS service	The actual medical consultation, procedure or test to which the relevant MBS item refers.



Misuse (of MBS item)	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
MSAC	Medical Services Advisory Committee
New service	Describes when a new service has been recommended, with a new item number. In most circumstances, new services will need to go through the MSAC. It is worth noting that implementation of the recommendation may result in more or fewer item numbers than specifically stated.
No change or leave unchanged	Describes when the services provided under these items will not be changed or affected by the recommendations. This does not rule out small changes in item descriptors (for example, references to other items, which may have changed as a result of the MBS Review or prior reviews).
Obsolete services / items	Services that should no longer be performed as they do not represent current clinical best practice and have been superseded by superior tests or procedures.
PBS	Pharmaceutical Benefits Scheme
Services average annual growth	The average growth per year, over five years to 2014/15, in utilisation of services. Also known as the compound annual growth rate (CAGR).
SSU	Short Stay Unit
The Committee	The General Practice and Primary Care Clinical Committee of the MBS Review
The Taskforce	The MBS Review Taskforce
Total benefits	Total benefits paid in 2014/15 unless otherwise specified.



Appendix A Chronic Disease Management Items

Table 7: Item introduction table for items 721, 723, 729, 731, 732, 735, 739, 743, 747, 750, 758

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
721	Attendance by a general practitioner for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 735 to 758 apply)	\$144.25	2,525,291	\$364,277,509	11%
723	Attendance by a general practitioner to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 735 to 758 apply)	\$114.30	2,123,085	\$242,668,167	11.2%
729	Contribution by a general practitioner to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 735 to 758 apply)	\$70.40	2,574	\$181,241	3.3%
731	Contribution by a general practitioner to: (a) a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or (b) a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider	\$70.40	131,935	\$9,288,299	13.4%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	(other than a service associated with a service to which items 735 to 758 apply)				
732	Attendance by a general practitioner to review or coordinate a review of: (a) a GP management plan prepared by a general practitioner (or an associated general practitioner) to which item 721 applies; or (b) team care arrangements which have been coordinated by the general practitioner (or an associated general practitioner) to which item 723 applies	\$72.05	3,290,643	\$237,100,794	16.2%
735	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which items 721 to 732 apply)	\$70.65	29,866	\$2,097,235	19.7%
739	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or	\$120.95	18,382	\$2,219,344	13.8%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	(c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which items 721 to 732 apply)				
743	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 40 minutes (other than a service associated with a service to which items 721 to 732 apply)	\$201.65	11,051	\$2,225,937	18.8%
747	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which items 721 to 732 apply)	\$51.90	18,008	\$914,563	19.1%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
750	<p>Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in:</p> <p>(a) a community case conference; or</p> <p>(b) a multidisciplinary case conference in a residential aged care facility; or</p> <p>(c) a multidisciplinary discharge case conference;</p> <p>if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which items 721 to 732 apply)</p>	\$89.00	5,166	\$457,393	9.1%
758	<p>Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in:</p> <p>(a) a community case conference; or</p> <p>(b) a multidisciplinary case conference in a residential aged care facility; or</p> <p>(c) a multidisciplinary discharge case conference;</p> <p>if the conference lasts for at least 40 minutes (other than a service associated with a service to which items 721 to 732 apply)</p>	\$148.20	3,184	\$471,218	9.1%



Appendix B Medication Management Items

Table 9: Item introduction table for items 900, 903

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
900	<p>Participation by a general practitioner in a Domiciliary Medication Management Review (DMMR) for a patient living in a community setting, in which the general practitioner, with the patient's consent:</p> <p>(a) assesses the patient as:</p> <p>(i) having a chronic medical condition or a complex medication regimen; and</p> <p>(ii) not having their therapeutic goals met; and</p> <p>(b) following that assessment:</p> <p>(i) refers the patient to a community pharmacy or an accredited pharmacist for the DMMR; and</p> <p>(ii) provides relevant clinical information required for the DMMR; and</p> <p>(c) discusses with the reviewing pharmacist the results of the DMMR including suggested medication management strategies; and</p> <p>(d) develops a written medication management plan following discussion with the patient; and</p> <p>(e) provides the written medication management plan to a community pharmacy chosen by the patient</p>	\$154.80	66,748	\$10,332,345	-3.1%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	For any particular patient—applicable not more than once in each 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR				
903	Participation by a general practitioner in a residential medication management review (RMMR) for a patient who is a permanent resident of a residential aged care facility-other than an RMMR for a resident in relation to whom, in the preceding 12 months, this item has applied, unless there has been a significant change in the resident's medical condition or medication management plan requiring a new RMMR	\$106.00	63,973	\$6,780,681	-0.7%



Appendix C Health Assessment Items

Table 8: Item introduction table for items 701, 703, 705, 707, 715

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
701	Professional attendance by a general practitioner to perform a brief health assessment, lasting not more than 30 minutes and including: (a) collection of relevant information, including taking a patient history; and (b) a basic physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing the patient with preventive health care advice and information	\$59.35	47,026	\$2,791,142	-4.8%
703	Professional attendance by a general practitioner to perform a standard health assessment, lasting more than 30 minutes but less than 45 minutes, including: (a) detailed information collection, including taking a patient history; and (b) an extensive physical examination; and (c) initiating interventions and referrals as indicated; and	\$137.90	185,481	\$25,578,394	0.1%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	(d) providing a preventive health care strategy for the patient				
705	<p>Professional attendance by a general practitioner to perform a long health assessment, lasting at least 45 minutes but less than 60 minutes, including:</p> <p>(a) comprehensive information collection, including taking a patient history; and</p> <p>(b) an extensive examination of the patient's medical condition and physical function; and</p> <p>(c) initiating interventions and referrals as indicated; and</p> <p>(d) providing a basic preventive health care management plan for the patient</p>	\$190.30	211,834	\$40,312,239	8.3%
707	<p>Professional attendance by a general practitioner to perform a prolonged health assessment (lasting at least 60 minutes) including:</p> <p>(a) comprehensive information collection, including taking a patient history; and</p> <p>(b) an extensive examination of the patient's medical condition, and physical, psychological and social function; and</p> <p>(c) initiating interventions or referrals as indicated; and</p> <p>(d) providing a comprehensive preventive health care management plan for the patient</p>	\$268.80	319,899	\$85,992,949	8.2%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
715	Professional attendance by a general practitioner at consulting rooms or in another place other than a hospital or residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent-not more than once in a 9 month period	\$215.25 \$	217,678	\$46,202,133	17.6%



Appendix D Consultation Items

Table 10: Item introduction table for items 3, 4, 20, 23, 24, 35, 36,37, 43, 44, 47, 51, 52, 53, 54, 57, 58, 59, 60, 65, 92, 93, 95, 96, 5000, 5003, 5010, 5020, 5023, 5028, 5040, 5043, 5049, 5060, 5063, 5067, 5200, 5203, 5207, 5208, 5220, 5223, 5227, 5228, 5260, 5263, 5265, 5267

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
3	Professional attendance at consulting rooms (other than a service to which another item applies) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management-each attendance	\$16.95	3,094,749	\$52,643,193	2.6%
4	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies) that requires a short patient history and, if necessary, limited examination and management-an attendance on one or more patients at one place on one occasion-each patient	The fee for item 3, plus \$25.95 divided by the number of patients seen, up to a maximum of six patients. For	28,718	\$708,027	3.8%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
		seven or more patients - the fee for item 3 plus \$2.00 per patient.			
20	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in a residential aged care facility (other than accommodation in a self-contained unit) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management-an attendance on one or more patients at one residential aged care facility on one occasion-each patient	The fee for item 3, plus \$46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus \$3.30 per patient.	256,294	\$6,712,174	8.4%
23	Professional attendance by a general practitioner at consulting rooms (other than a service to which another	\$37.05	91,108,178	\$3,397,988,754	1.3%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	<p>item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant:</p> <p>(a) taking a patient history;</p> <p>(b) performing a clinical examination;</p> <p>(c) arranging any necessary investigation;</p> <p>(d) implementing a management plan;</p> <p>(e) providing appropriate preventive health care;</p> <p>for one or more health-related issues, with appropriate documentation-each attendance</p>				
24	<p>Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant:</p> <p>(a) taking a patient history;</p>	<p>The fee for item 23, plus \$25.95 divided by the number of patients seen, up to a maximum of six patients. For</p>	722,724	\$34,475,772	-4.0%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	(b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one place on one occasion-each patient	seven or more patients - the fee for item 23 plus \$2.00 per patient.			
35	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan;	The fee for item 23, plus \$46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23	2,700,650	\$130,077,367	5.2%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	(e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one residential aged care facility on one occasion-each patient	plus \$3.30 per patient.			
36	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance	\$71.70	17,352,777	\$1,250,389,193	9.3%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
37	<p>Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant:</p> <p>(a) taking a detailed patient history;</p> <p>(b) performing a clinical examination;</p> <p>(c) arranging any necessary investigation;</p> <p>(d) implementing a management plan;</p> <p>(e) providing appropriate preventive health care;</p> <p>for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one place on one occasion-each patient</p>	The fee for item 36, plus \$25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus \$2.00 per patient.	226,132	\$19,128,295	3.2%
43	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table	The fee for item 36, plus \$46.70 divided by the number of	365,265	\$33,004,027	13.2%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	<p>applies), lasting at least 20 minutes and including any of the following that are clinically relevant:</p> <p>(a) taking a detailed patient history;</p> <p>(b) performing a clinical examination;</p> <p>(c) arranging any necessary investigation;</p> <p>(d) implementing a management plan;</p> <p>(e) providing appropriate preventive health care;</p> <p>for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one residential aged care facility on one occasion-each patient</p>	<p>patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus \$3.30 per patient</p>			
44	<p>Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant:</p> <p>(a) taking an extensive patient history;</p>	\$105.55	1,577,381	\$169,266,460	11.5%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	(b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance				
47	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan;	The fee for item 44, plus \$25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus \$2.00 per patient.	74,336	\$8,508,528	8.3%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	(e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one place on one occasion-each patient				
51	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients	The fee for item 44, plus \$46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus \$3.30 per patient.	61,661	\$7,920,914	18.5%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	at one residential aged care facility on one occasion- each patient				
52	Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which any other item applies)-each attendance, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies	\$11.00	62,606	\$693,813	2.8%
53	Professional attendance at consulting rooms of more than 5 minutes in duration but not more than 25 minutes (other than a service to which any other item applies)-each attendance, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies	\$21.00	4,350,283	91,903,805	4.8%
54	Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45	\$38.00	860,329	\$33,269,495	9.1%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	<p>minutes (other than a service to which any other item applies)-each attendance, by:</p> <p>(a) a medical practitioner (who is not a general practitioner); or</p> <p>(b) a general practitioner to whom clause 2.3.1 applies</p>				
57	<p>Professional attendance at consulting rooms of more than 45 minutes in duration (other than a service to which any other item applies)-each attendance, by:</p> <p>(a) a medical practitioner (who is not a general practitioner); or</p> <p>(b) a general practitioner to whom clause 2.3.1 applies</p>	\$61.00	148,762	\$10,243,165	3.0%
58	<p>Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies), not more than 5 minutes in duration-an attendance on one or more patients at one place on one occasion-each patient, by:</p>	<p>An amount equal to \$8.50, plus \$15.50 divided by the number of patients seen, up to a</p>	4,192	\$46,770	16.3%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	<p>(a) a medical practitioner (who is not a general practitioner); or</p> <p>(b) a general practitioner to whom clause 2.3.1 applies</p>	<p>maximum of six patients. For seven or more patients - an amount equal to \$8.50 plus \$.70 per patient</p>			
59	<p>Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 5 minutes in duration but not more than 25 minutes-an attendance on one or more patients at one place on one occasion-each patient, by:</p> <p>(a) a medical practitioner (who is not a general practitioner); or</p> <p>(b) a general practitioner to whom clause 2.3.1 applies</p>	<p>An amount equal to \$16.00, plus \$17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$16.00 plus \$.70 per patient</p>	50,050	\$945,795	1.6%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
60	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 25 minutes in duration but not more than 45 minutes-an attendance on one or more patients at one place on one occasion-each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies	An amount equal to \$35.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$35.50 plus \$.70 per patient	22,458	\$815,988	2.2%
65	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 45 minutes in duration-an attendance on one or more patients at one place on one occasion-each patient, by:	An amount equal to \$57.50, plus \$15.50 divided by the number of patients seen, up to a	14,871	\$795,210	-0.5%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	<p>(a) a medical practitioner (who is not a general practitioner); or</p> <p>(b) a general practitioner to whom clause 2.3.1 applies</p>	<p>maximum of six patients. For seven or more patients - an amount equal to \$57.50 plus \$.70 per patient</p>			
92	<p>Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self-contained unit) of not more than 5 minutes in duration-an attendance on one or more patients at one residential aged care facility on one occasion-each patient, by:</p> <p>(a) a medical practitioner (who is not a general practitioner); or</p> <p>(b) a general practitioner to whom clause 2.3.1 applies</p>	<p>An amount equal to \$8.50, plus \$27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$8.50 plus</p>	3,319	\$61,877	-10.9%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
		\$1.25 per patient			
93	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self-contained unit) of more than 5 minutes in duration but not more than 25 minutes-an attendance on one or more patients at one residential aged care facility on one occasion-each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies	An amount equal to \$16.00, plus \$31.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$16.00 plus \$1.25 per patient. Derived fee	43,974	\$1,001,216	3.6%
95	Professional attendance (other than a service to which any other item applies) at a residential aged care facility	An amount equal to \$35.50,	10,359	\$470,776	-1.1%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	<p>(other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self-contained unit) of more than 25 minutes in duration but not more than 45 minutes-an attendance on one or more patients at one residential aged care facility on one occasion-each patient, by:</p> <p>(a) a medical practitioner (who is not a general practitioner); or</p> <p>(b) a general practitioner to whom clause 2.3.1 applies</p>	<p>plus \$27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$35.50 plus \$1.25 per patient</p>			
96	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self-contained	An amount equal to \$57.50, plus \$27.95 divided by the number of patients seen, up to a	2,602	\$179,740	7.4%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	unit) of more than 45 minutes in duration-an attendance on one or more patients at one residential aged care facility on one occasion-each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies	maximum of six patients. For seven or more patients - an amount equal to \$57.50 plus \$1.25 per patient			
5000	Professional attendance at consulting rooms (other than a service to which another item applies) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management-each attendance	\$29.00	85,776	\$2,490,232	14.6%
5003	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies) that requires a short patient history and, if necessary, limited examination	The fee for item 5000, plus \$25.95 divided by the number of patients seen, up to a	4,705	\$213,977	21.0%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	and management-an attendance on one or more patients on one occasion-each patient	maximum of six patients. For seven or more patients - the fee for item 5000 plus \$2.00 per patient.			
5010	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is accommodated in a residential aged care facility (other than accommodation in a self-contained unit) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management-an attendance on one or more patients at one residential aged care facility on one occasion-each patient	The fee for item 5000, plus \$46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5000 plus \$3.30 per patient.	37,746	\$1,586,936	18.0%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
5020	<p>Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant:</p> <p>(a) taking a patient history;</p> <p>(b) performing a clinical examination;</p> <p>(c) arranging any necessary investigation;</p> <p>(d) implementing a management plan;</p> <p>(e) providing appropriate preventive health care;</p> <p>for one or more health-related issues, with appropriate documentation-each attendance</p>	\$49.00	7,560,845	\$371,243,123	7.1%
5023	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting less than 20	The fee for item 5020, plus \$25.95 divided by the number of patients seen, up to a	457,087	\$32,431,215	24.3%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	<p>minutes and including any of the following that are clinically relevant:</p> <p>(a) taking a patient history;</p> <p>(b) performing a clinical examination;</p> <p>(c) arranging any necessary investigation;</p> <p>(d) implementing a management plan;</p> <p>(e) providing appropriate preventive health care;</p> <p>for one or more health-related issues, with appropriate documentation-an attendance on one or more patients on one occasion-each patient</p>	<p>maximum of six patients. For seven or more patients - the fee for item 5020 plus \$2.00 per patient.</p>			
5028	<p>Professional attendance by a general practitioner (other than a service to which another item in the table applies), at a residential aged care facility to residents of the facility, lasting less than 20 minutes and including any of the following that are clinically relevant:</p> <p>(a) taking a patient history;</p> <p>(b) performing a clinical examination;</p>	<p>The fee for item 5020, plus \$46.70 divided by the number of patients seen, up to a maximum of six patients. For</p>	528,637	\$35,029,300	15.8%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	(c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one residential aged care facility on one occasion- each patient	seven or more patients - the fee for item 5020 plus \$3.30 per patient.			
5040	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care;	\$83.95	972,587	\$81,818,808	18.2%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	for one or more health-related issues, with appropriate documentation-each attendance				
5043	<p>Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant:</p> <p>(a) taking a detailed patient history;</p> <p>(b) performing a clinical examination;</p> <p>(c) arranging any necessary investigation;</p> <p>(d) implementing a management plan;</p> <p>(e) providing appropriate preventive health care;</p> <p>for one or more health-related issues, with appropriate documentation-an attendance on one or more patients on one occasion-each patient</p>	<p>The fee for item 5040, plus \$25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5040 plus \$2.00 per patient.</p>	48,266	\$5,151,327	14.4%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
5049	<p>Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant:</p> <p>(a) taking a detailed patient history;</p> <p>(b) performing a clinical examination;</p> <p>(c) arranging any necessary investigation;</p> <p>(d) implementing a management plan;</p> <p>(e) providing appropriate preventive health care;</p> <p>for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one residential aged care facility on one occasion-each patient</p>	<p>The fee for item 5040, plus \$46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5040 plus \$3.30 per patient.</p>	72,665	\$7,950,769	19.4%
5060	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 40 minutes	\$117.75	74,693	\$8,968,199	17.4%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	<p>and including any of the following that are clinically relevant:</p> <p>(a) taking an extensive patient history;</p> <p>(b) performing a clinical examination;</p> <p>(c) arranging any necessary investigation;</p> <p>(d) implementing a management plan;</p> <p>(e) providing appropriate preventive health care;</p> <p>for one or more health-related issues, with appropriate documentation-each attendance</p>				
5063	<p>Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant:</p> <p>(a) taking an extensive patient history;</p> <p>(b) performing a clinical examination;</p>	<p>The fee for item 5060, plus \$25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more</p>	9,169	\$1,300,323	17.0%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	(c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients on one occasion-each patient	patients - the fee for item 5060 plus \$2.00 per patient.			
5067	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care;	The fee for item 5060, plus \$46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5060 plus \$3.30 per patient.	13,551	\$2,020,350	19.4%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one residential aged care facility on one occasion-each patient				
5200	Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)-each attendance	\$21.00	1,586	\$33,432	-9.8%
5203	Professional attendance at consulting rooms of more than 5 minutes in duration but not more than 25 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)-each attendance	\$31.00	184,515	\$5,753,088	-1.4%
5207	Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)-each attendance	\$48.00	33,072	\$1,705,654	-0.6%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
5208	Professional attendance at consulting rooms of more than 45 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)-each attendance	\$71.00	24,510	\$2,039,172	6.0%
5220	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting not more than 5 minutes-an attendance on one or more patients on one occasion-each patient	An amount equal to \$18.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$18.50 plus \$.70 per patient	71	\$2,210	15.9%
5223	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at	An amount equal to \$26.00,	15,526	\$631,672	26.5%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 5 minutes, but not more than 25 minutes-an attendance on one or more patients on one occasion-each patient	plus \$17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$26.00 plus \$.70 per patient			
5227	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 25 minutes, but not more than 45 minutes-an attendance on one or more patients on one occasion-each patient	An amount equal to \$45.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For	1,492	\$84,816	30.5%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
		seven or more patients - an amount equal to \$45.50 plus \$.70 per patient			
5228	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 45 minutes-an attendance on one or more patients on one occasion-each patient	An amount equal to \$67.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$67.50 plus \$.70 per patient	319	\$25,226	25.6%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
5260	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of not more than 5 minutes in duration by a medical practitioner (other than a general practitioner)-an attendance on one or more patients at one residential aged care facility on one occasion-each patient	An amount equal to \$18.50, plus \$27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$18.50 plus \$1.25 per patient	151	\$5,197	25.8%
5263	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility	An amount equal to \$26.00, plus \$31.55 divided by the number of patients seen,	11,565	\$496,443	11.3%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	(other than accommodation in a self-contained unit) of more than 5 minutes in duration but not more than 25 minutes in duration by a medical practitioner (other than a general practitioner)-an attendance on one or more patients at one residential aged care facility on one occasion-each patient	up to a maximum of six patients. For seven or more patients - an amount equal to \$26.00 plus \$1.25 per patient			
5265	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of more than 25 minutes in duration but not more than 45 minutes by a medical practitioner (other than a general practitioner)-an attendance on one or more patients at one residential aged care facility on one occasion-each patient	An amount equal to \$45.50, plus \$27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal	1,408	\$90,544	-3.1%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
		to \$45.50 plus \$1.25 per patient			
5267	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of more than 45 minutes in duration by a medical practitioner (other than a general practitioner)-an attendance on one or more patients at one residential aged care facility on one occasion-each patient	An amount equal to \$67.50, plus \$27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$67.50 plus \$1.25 per patient	582	\$49,645	35.6%



Appendix E Summary for consumers

This table describes the medical service, the recommendation(s) of the clinical experts and why the recommendation(s) has been made.

GENERAL PRACTITIONER STEWARDSHIP AND TEAM BASED CARE

Item	What the item does	Committee recommendation	What would be different	Why
Recommendation 1				
Move to a person-centred primary care model supporting general practitioner (GP) stewardship and team based care				
-	Puts people and their families at the centre of decisions, working with health professionals to get the best outcomes.	New model of primary care funding to support high-quality, person-centred care that is organised around the patient's general practitioner as the steward of care, supported by multidisciplinary team based arrangements.	A stronger focus on effective, consumer focused interaction with the health system. This would strengthen consumer decision making, empowerment and self-management, provide better access to multidisciplinary team-based care, systems and processes to support continuous quality improvement, and new funding avenues through flexible, blended payments.	This system aims to introduce greater flexibility to enable GPs to organise care that reflects patients' needs, values and preferences.



VOLUNTARY PATIENT ENROLMENT - ENHANCING PATIENT ACCESS

Item	What the item does	Committee recommendation	What would be different	Why
Recommendation 2				
Introduce a new fee for practices to enrol a patient.				
-	Enables enrolment of a patient with a practice and nomination of a particular GP within that practice.	Introduce a new reimbursement fee for practices and GPs to enrol a patient. This fee would be weighted according to characteristics such as rurality, and indigeneity. It would enable access to additional services available through a “usual GP” to support continuity over a cycle of care.	<p>Patients would gain access to flexible communications channels, including test results, repeat prescriptions or referrals. This would particularly benefit rural and other communities where face-to-face access is difficult.</p> <p>GPs and practices would have access to resources to improve care i.e. to aid doctor-patient communications, undertake local needs assessments, and the design and delivery of services to fit the patient profile of the practice.</p> <p>Informed patient consent would be included in the enrolment process.</p>	<p>Primary care services evolving due to changes in the community’s health profiles, access to information, innovation, and community expectations. This requires primary care to adapt to deliver appropriate levels of care, and in particular to address growing chronic disease.</p> <p>There is strong community support for flexible, non-face-to-face communications with their GP for things like repeat prescriptions.</p> <p>Person-centred care requires the targeting of care to fit patient needs, preferences and values.</p> <p>Voluntary Patient Enrolment provides a means of attracting additional resources to build the systems that will be required to ensure the delivery of high quality care in the future.</p>



Item	What the item does	Committee recommendation	What would be different	Why
				<p>Having a usual GP is beneficial for ongoing patient outcomes, patient experience and supports value for the system by reducing costs associated with fragmented care, and uncompleted and unreviewed team care arrangements.</p> <p>Practices would be supported to develop services to address prevalent local health issues, and to offer more personalised assistance to patients with chronic conditions.</p>



Item	What the items does	Committee recommendation	What would be different	Why
Recommendation 3				
Introduce flexible access to primary care services for enrolled patients				
-	Provides access to GPs for patients who are unable or not required to attend a doctor's surgery.	Flexible communications i.e. telephone, email, video-consulting, telehealth etc be supported through voluntary patient enrolment.	<p>Voluntary Patient Enrolment will modernise the delivery of primary health care through introducing flexible communication and care models.</p> <p>It would mean people living in rural and regional areas could avoid the costs and inconvenience associated with travelling long distances to see a GP.</p> <p>Patients living with disabilities or in aged care facilities would have easier access to some GP services that do not require face-to-face consultations.</p>	This measure will improve patient experience, and free up doctor time when the consultation is for something that is straightforward and does not require a face-to-face investigation. It will support rural and remote communities and those with mobility issues, consistent with the principle of equitable access.



CHRONIC DISEASE MANAGEMENT - SUPPORTING COORDINATED, COMPREHENSIVE AND CONTINUING CARE

Item	What the items does	Committee recommendation	What would be different	Why
Recommendation 4				
Implement a comprehensive package of longitudinal care for enrolled patients with chronic health conditions that promotes the effective use of primary care chronic disease management (CDM) items.				
This recommendation incorporates a number of changes to the MBS as outlined below. It is expected that patients will benefit from this package of recommendations as they increase high value primary care, enhance multidisciplinary care planning and coordination activities, and support increased patient involvement in chronic disease management.				
Recommendation 4.1				
Combine GP Management Plans (GPMPs) and Team Care Arrangements (TCAs), and strengthen GPMPs.				
Item 721	<p>The preparation of a GP management plan (GPMP) for a patient by an individual medical practitioner.</p> <p>GP management plans aim to develop a targeted plan to manage a patient's ongoing or chronic condition. The plan can incorporate referrals to allied health services such as physiotherapy and podiatry, and the package can be reviewed to identify progress.</p>	<p>Combine GPMPs and team care arrangements (TCAs) into one item.</p> <p>Strengthen the descriptor of item 721 to enhance quality, including making this item available at a patient's enrolled practice, for patients who are enrolled, or through the usual GP for patients who are not enrolled.</p>	<p>One item would be available for a GP to develop a patient's chronic disease management plan, including all required allied health arrangements.</p> <p>This service would be available at the enrolled practice, for patients who are enrolled, or by the usual GP for patients who are not enrolled.</p>	<p>Combining these items will simplify the MBS and enhance quality of services received by patients by:</p> <ul style="list-style-type: none"> • reducing administrative burden; • enhancing care planning and regular care for patients with chronic diseases; • simplify CDM items by linking allied health services directly to a GPMP; • removing unnecessary co-claiming of team care arrangements with GPMPs.



Item	What the items does	Committee recommendation	What would be different	Why
723	Coordinate the development of team care arrangements (TCAs) for a patient by an individual medical practitioner.	Delete item	This item would be deleted	Deletion of this item will reduce administrative burden for practitioners and streamline chronic disease management services for patients. Multidisciplinary team care remains available through item 721.
729	Contribution by an individual medical practitioner to either a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider.	Delete item	The item would be deleted	Deletion of this item will simplify the MBS and remove an obsolete item. Deletion of this item is not expected to affect patient access to essential services.



Item	What the items does	Committee recommendation	What would be different	Why
731	Contribution by an individual medical practitioner to a multidisciplinary care plan prepared by either: a) a residential aged care facility (RACF) for one of their patients, or to a review of an RACF's plan; or b) another provider for a resident to be discharged from a hospital or an approved day-hospital facility, or to a review of another provider's plan.	No change		The Committee identified the importance of older patients accessing the services they need. The Committee agreed that in the context of Residential Aged Care Facilities, an item for GPs to contribute to or review the care plan for patients of Residential Aged Care Facilities is appropriate. Similar provisions are recommended to guide patient transition from hospital to home and community care.



Item	What the items does	Committee recommendation	What would be different	Why
Recommendation 4.2				
Link allied health chronic disease management items to the creation of a GPMP.				
10950-10970 81100-81125	Provision of allied health services for patients with complex healthcare needs.	Link allied health items to the creation of a GPMP, removing reference to a TCA.	Patients' access to allied health care coordinated through a single plan (GPMP).	This change simplifies Chronic Disease Management items, while enabling care plans to include services provided by allied health professionals.
Recommendation 4.3				
Equalise rebates for GPMP preparation and review to encourage longitudinal patient care.				
732	The review or coordination of a review of a GPMP or TCA.	Equalise the schedule fee for creating (item 721) and subsequently reviewing a GPMP and strengthen the descriptor to enhance quality. Reviews would be available to enrolled patients or those with a usual GP.	The schedule fee for GPMP preparation and review would be the same, rather than a lower fee for review.	Consumers would receive reviews of their GPMP more frequently and these would be of a higher quality as patients would be more involved in the planning and review of their care. Currently, 55% of patients with a GPMP never receive a review. Longitudinal care, over a cycle of care, is important for effective management of chronic disease and this change would support this care.



Item	What the items does	Committee recommendation	What would be different	Why
Recommendation 4.4				
Increase patient access to high quality care coordination across physical, mental and social care domains.				
-	-	Increase access to care coordination services that encompass bio-psycho-social models of care.	Consumers would experience increased support to access care and be more actively involved in their own care planning.	<p>This recommendation will support consumers accessing care, including informed choice regarding cost, quality and availability of services.</p> <p>Consumers with complex health care needs would benefit from greater assistance with care coordination and facilitation from a registered nurse, enrolled nurse or Aboriginal health practitioner or Aboriginal health worker.</p>



Item	What the items does	Committee recommendation	What would be different	Why
Recommendation 4.5				
Develop advice and support mechanisms to activate and engage patients in their own care planning, including the assessment and support of patient health literacy activities.				
-	-	Develop advice and support mechanisms to activate and engage patients in their own care planning.	<p>Patient engagement and information would be available to support joint decision making.</p> <p>Improved care co-ordination can help patients manage their conditions.</p>	<p>Evidence demonstrates a link between outcomes and patient satisfaction when patients are actively involved in making decisions about their health care. Improved health literacy can be strengthened through better doctor-patient communication and through a commitment to informed patient consent.</p> <p>Developing advice and support mechanisms will assist consumers engaging in their own care planning and improve health outcomes for consumers.</p>



Item	What the items does	Committee recommendation	What would be different	Why
Recommendation 4.6				
Encourage increased patient participation and rebate attendance of non-medical health professionals at case conferences.				
735, 739, 743, 747, 750, 758	Organisation, coordination and attendance by a medical practitioner, of a multidisciplinary case conference in the community or after a patient is discharged from hospital	<p>Patients to be invited to attend the case conference.</p> <p>Non-medical health practitioners should receive rebates for attendance at case conferences.</p> <p>Outcomes of the case conference to be uploaded to the patient's My Health Record, with the patient's consent.</p>	<p>Patients would be encouraged to be actively involved in goal setting and decision-making through a person-centred approach. Informed patient consent included in the development of the plan.</p> <p>Non-medical health practitioners would receive funding to attend case-conferences. Case conferencing would be more widely accessed.</p>	<p>This will improve access to case conferencing as part of effective chronic disease management, and will support doctor-patient communication and patient self-management of their health.</p> <p>It will allow the GP and relevant service providers to consider and coordinate an individual patient's circumstances (including needs, preferences and values), in the development of an appropriate plan to co-ordinate and manage their care.</p> <p>Case conferencing by phone or video supports patient convenience and access.</p>



Item	What the items does	Committee recommendation	What would be different	Why
<p>Three new items for case conferences lasting:</p> <ul style="list-style-type: none"> • from 15-20 mins. • from 20-40 mins. • at least 40 mins. 	Attendance by a non-medical health practitioner at a case conference.	Create new items to provide a rebate for non-medical health practitioners to attend a case conference organised and coordinated by a medical practitioner.	Non-medical health practitioners would receive funding to attend case-conferences in addition to medical practitioners.	<p>Enabling non-medical health practitioners to participate in a case conference may increase uptake of case conferences and improve coordination and management of patient's care.</p> <p>This recommendation will support the ongoing management of the patient's health, supporting increased participation of relevant health practitioners involved in the patient's care.</p>



Item	What it does	Committee recommendation	What would be different	Why
Recommendation 4.7				
Link Medication Management Reviews (MMR) to GPMP and ensure the rebate accurately reflects GP activity.				
900, 903	<p>Participation by a medical practitioner in a medication review for patients who will benefit from a review, including patients on multiple medications, those who have complex medical conditions, have recently been discharged from hospital or require assistance in managing their medications effectively.</p> <p>Certain patients are able to have the pharmacist portion funded through a Community Pharmacy Agreement program, i.e. Department of Veterans' Affairs card holders.</p>	<p>The MMR would be conducted for a patient at risk of medication misadventure in conjunction with a GPMP or review of a GPMP.</p> <p>Upload the MMR to My Health Record.</p> <p>Reduce the schedule fee and reinvest in GP chronic disease management services.</p>	<p>MMRs would have a reduced schedule fee and be linked to GPMPs.</p> <p>MMRs would be uploaded to My Health Record with a patient's consent.</p>	<p>MMRs have the greatest benefit for patients with chronic diseases or on complex medication. Linking MMRs to GPMPs will maximise patients' benefit from their medication regimen, and prevent medication-related problems through a team approach involving patients' GP and pharmacist.</p> <p>The reduced fee reflects the streamlining of the item by linking medication reviews to management plans for patients with chronic medical conditions or a complex medication regimen.</p> <p>Including a current medication management plan on My Health Record will facilitate increased patient awareness and data sharing between health practitioners.</p>



Item	What it does	Committee recommendation	What would be different	Why
Recommendation 4.8				
Increase the scheduled fee for home visits for enrolled patients.				
4, 24, 37, 47	These items are for a GP consultations somewhere other than consulting rooms or a residential aged care facility.	Increase the schedule fee for a home visit for patient when attended by a GP from the practice where the patient is enrolled.	Patients enrolled with a practice will receive more support in their homes;	With an ageing population, it is important to help older people stay at home; ensuring high value care and consistency across items



Item	What it does	Committee recommendation	What would be different	Why
Recommendation 5				
Build the evidence base for Health Assessments and ensure that the content of Health Assessments conforms to appropriate clinical practice guidelines.				
701, 703, 705, 707, 715	<p>These items are for a medical practitioner to perform a Health Assessment for certain patient groups</p> <p>A Health Assessment means the assessment of a patient's health and physical, psychological and social function and consideration of whether preventive health care and education should be offered to the patient, to improve that patient's health and physical, psychological and social function.</p>	<p>Set up processes to gather evidence on the effectiveness of Health Assessments with a focus on at-risk populations, including using data at a PHN level based on existing groups eligible for Health Assessments, and commissioning studies on the evidence for Health Assessments for new at-risk groups.</p>	<p>Evidence would be available to guide prevention and early intervention and promote quality health outcomes for high risk patients.</p> <p>This would enable consideration of expanding entitlement to Health Assessments based on evidence of their effectiveness and benefit to patients.</p>	<p>This recommendation will generate better health outcomes through evidence-based prevention, assessment and self-management strategies.</p>



Item	What the items does	Committee recommendation	What would be different	Why
Recommendation 6				
Strengthen the quality of current Health Assessments and expand at-risk groups who are eligible for Health Assessments.				
701, 703, 705, 707	These items are for a medical practitioner to perform a Health Assessment for certain patient groups.	<p>Expand eligibility to new at-risk populations and modify existing populations to better align with clinical and service needs.</p> <p>The content of Health Assessments should conform to professional guidelines.</p> <p>Upload the management plan Health Assessment to My Health Record; GP to spend a reasonable time reviewing the Health Assessment with the patient.</p> <p>These items would be available to enrolled patients or from the usual GP, and include interventions and referrals, and a preventive health management plan as agreed by the patient.</p>	<p>Health Assessments would now be available to new at-risk populations, enrolled patients or from the usual GP, and include interventions and referrals, and a preventive health management plan as agreed by the patient.</p> <p>Health Assessment items are targeted to specific at-risk groups including people aged 40-49 who are at risk of developing Type 2 diabetes, people aged 75 years or over, residents of aged care facilities, people with severe intellectual disabilities, refugees, former serving members of the Australian Defence Force, children in out-of-home care, and prisoners on discharge.</p>	<p>These changes improve the quality of Health Assessments and provide better health support to at-risk populations.</p> <p>Planning and uploading onto My Health Record will support coordination and continuity of care, and improved patient health literacy.</p>



Item	What the items does	Committee recommendation	What would be different	Why
715	Attendance by a medical practitioner to perform a Health Assessment for a patient who is of Aboriginal or Torres Strait Islander descent at consulting rooms or a place other than a hospital or residential aged care facility. This can only be performed once every 9 months.	The content of Health Assessments should conform to professional guidelines; upload the Health Assessment to My Health Record; GP to spend a reasonable time reviewing the Health Assessment with the patient.	Health Assessments available to Aboriginal and Torres Strait Islanders updated to reflect Guidelines for preventive activities in general practice 9th edition (Red Book) and the National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people, or future editions where appropriate	These changes improve the quality of Health Assessments and provide better health support for Aboriginal and Torres Strait Islander populations. Planning and uploading onto My Health Record will support coordination and continuity of care, and improved patient health literacy.



Consultation items (recommendations 7-9)

Item	What it does	Committee recommendation	What would be different	Why
Recommendation 7				
Undertake additional research regarding the appropriateness of the current length, content and minimum quality metrics for GP MBS consultation items (Levels A-D).				
All GP consultation items	These items are consultation by a GP in various settings.	Set up processes to gather evidence on the appropriate length, content and minimum quality metrics for GP consultation items (Levels A-D).	Evidence would be available to guide duration and minimum requirements for face-to-face encounters with a patient.	Ensuring the appropriateness of the duration and minimum requirements for the face-to-face encounters with a patient that are indicative of the total amount of work and promote a more appropriate balance of procedural and consultative work.



Item	What the items does	Committee recommendation	What would be different	Why
Recommendation 8				
Introduce a new Level E consultation item for consultations of 60 minutes or more by a GP.				
New item (for each setting - RACF, consulting rooms and other).	Level E - Consultation by a general practitioner lasting at least 60 minutes. The rebate would have the same per-minute rate as a level D consultation.	Create a new item for consultation of 60 minutes or more by a GP requiring: an extended patient history, clinical examination, arranging an investigation, implementing a management plan or providing preventive health care.	GPs would be compensated appropriately for longer consultations, where they are required.	Provides increased support for long consultations where they are required, and appropriate compensation to GPs for time spent with patients.



Item	What the items does	Committee recommendation	What would be different	Why
Recommendation 9				
Change the schedule fee for attendances at Residential Aged Care Facilities (RACF) to reflect an initial flag fall rebate with a stable fee for each consultation completed at the RACF.				
20, 35, 47, 51, 92, 93, 95, 96	These items are for a medical practitioner attendance at a residential aged care facility.	Change the schedule fee to reflect an initial flag fall rebate for attendance at a RACF, with a stable fee for each consultation	GPs who attend RACFs will be paid an initial flag fall plus a stable fee for each consultation, irrespective of the number of consultations	This will increase access to RACFs and address stakeholder concerns about the level of GP remuneration, and concerns about GP visits to aged care facilities. Note that all consultations (including after hours) in RACFs increased from 15 per resident in 2009/10 to 23 per resident in 2016/17 with an average time of approx. 16 minutes.



Other Recommendations

Item	What the items does	Committee recommendation	What would be different	Why
Recommendation 10				
Modernise the terminology currently used in the MBS to describe registered and enrolled nurses and their role to reflect the important role these health professionals play as members of the practice team.				
-	-	The Committee recommends that the terminology currently used in the MBS to describe registered and enrolled nurses and their role be modernised to reflect the important role these members play as a member of the practice.	Language across the MBS would more appropriately reflect the role played by registered and enrolled nurses.	<p>The term 'practice nurse' conflates the distinct groups of registered nurses and enrolled nurses.</p> <p>The language of 'for and on behalf of' does not appropriately reflect the role played by registered and enrolled nurses.</p>



Item	What the items does	Committee recommendation	What would be different	Why
Recommendation 11				
Enable GP telehealth consultations and expand GP telehealth eligibility to patients with mobility concerns who cannot easily be seen face-to-face.				
99, 82220-82222	-	<p>The Committee recommends that the descriptors of items 99 and 82220-82222 be expanded to make GPs eligible to provide a telehealth consultation, in addition to specialists and consultants.</p> <p>The Committee recommends that new items be created to reimburse GPs for their time for telehealth consultations (similar to items which currently exist to reimburse other specialists) to support Nurse Practitioners and Aboriginal and Torres Strait Islander Health Practitioners consulting with patients in remote and rural settings.</p>	GPs would be able to provide telehealth consultations in rural and regional areas, and patients with mobility concerns.	<p>The requirement for telehealth services to take place with specialists/consultations limits patient access to telehealth items.</p> <p>The addition of GPs as eligible telehealth providers will increase patient access to GPs, particularly in remote areas where GP access is more limited.</p>



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