



Medicare Benefits Schedule Review Taskforce

Post Consultation Report from the Nurse Practitioner Reference Group

2019



Important note

This report does not constitute the final position on these items, which is subject to:

- Consideration by the MBS Review Taskforce;

Then, if endorsed:

- Consideration by the Minister for Health; and
- Government.



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1 Executive summary

1.1 Introduction

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 The Taskforce will also seek to identify any services that may be unnecessary, outdated or potentially unsafe.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, primary care reference groups (PCRGs) and working groups.

1.2 Review of the nurse practitioner MBS items

The Nurse Practitioner Reference Group (the Reference Group) was established in 2018 to make recommendations to the Taskforce on MBS items in its area of responsibility, based on rapid evidence review and clinical expertise.

The PCRGs provide recommendations to the Taskforce in review reports. Once endorsed by the Taskforce, the review reports are released for targeted stakeholder consultation. The Taskforce then considers the revised review reports, which include stakeholder feedback, before making recommendations to the Minister for consideration by Government.

1.3 Key issues

Nurse practitioners (NPs) have been practising in Australia for 18 years and were admitted as eligible providers under the MBS nearly a decade ago. Since that time, the interaction between the MBS and the NP role has not been reviewed for functionality, relevance to consumers, or its impact on the provision of and access to high-quality health care.



Models of care provided by NPs have the primary goal of improving access to care within the MBS, particularly in priority areas including aged care, Aboriginal and/or Torres Strait Islander peoples' health, mental health, chronic condition management and primary health care. Within these models, NPs may be the primary health care provider for a consumer or may be working as part of a team.

Despite the innovation and flexibility of these models, they remain curtailed by the limited number of items for which patients may receive MBS rebates when cared for by an NP. Rebates available to patients of NPs under the MBS do not reflect contemporary NP practice in Australia. This restricted access to MBS items limits consumer choice, affects accessibility, creates fragmentation and, at times, drives unnecessary duplication and costs throughout episodes of care.

The Reference Group's recommendations are intended to address these limitations and improve patient access to high-value, best-practice primary health care. To do this, recommendations focus on ensuring that NPs are able to provide accessible and affordable services, in line with their full scope of practice.

1.4 Key recommendations

The Reference Group's recommendations are listed below, organised into four overarching themes. The Reference Group also identified four recommendations as areas of priority – Recommendations 1, 4, 8 and 9.

The Reference Group's specific recommendations are as follows.

- Support comprehensive and coordinated care for people with long-term health conditions and Aboriginal and/or Torres Strait Islander peoples.
 1. Enable patients to access MBS rebates for long-term and primary care management provided by NPs.
 2. Improve access to MBS rebates for NP services in aged care settings.
 3. Enable Domiciliary Medication Management Reviews (DMMRs) and Residential Medication Management Reviews (RMMRs) to be initiated by NPs.
- Enabling nurse practitioner care for all Australians.
 4. Significantly increase the schedule fee assigned to current MBS NP professional attendance items to more appropriately reflect the complexity of care provided.
 5. Create a new MBS item for longer NP attendances to support the delivery of complex and comprehensive care.



6. Enable patients to access MBS rebates for after-hours or emergency care provided by NPs to facilitate care provided in the most appropriate settings and in a timely manner.
7. Enable patients to access an MBS rebate for NP care received outside of a clinic setting.
- Addressing system inefficiencies caused by current MBS arrangements.
8. Remove the mandated legislative requirement for NPs to form collaborative arrangements in accordance with the National Health (Collaborative arrangements for nurse practitioners) Determination 2010.
9. Remove current restrictions on MBS-rebated diagnostic imaging investigations when requested by NPs working within their scope of practice.
10. Enable patients to access MBS rebates for procedures performed by an NP working within their scope of practice.
- Improve patient access to telehealth services by expanding the scope of providers eligible to participate in consultations, and by broadening modes of communication.
11. Add general practitioners (GPs) as eligible participants in NP patient-side telehealth services.
12. Add patients in community aged care settings to residential aged care telehealth items.
13. Create new MBS items for direct NP-to-patient telehealth consultations.
14. Allow telehealth consultations to take place via telephone where clinically appropriate.

1.5 Consumer impact

The Reference Group has developed recommendations that are consistent with the Taskforce's objectives, with a primary focus on improving patient access to affordable, high-value and best-practice primary health care provided by NPs, in line with their scope of practice.

Consumer representatives on the Reference Group stressed the importance of patient choice in accessing primary care that is timely, uncomplicated, culturally safe and affordable. This is central to many of the Reference Group's recommendations.

Patients will benefit from the Reference Group's recommendations through improved access to continuity of primary care models and higher quality clinical services, particularly in aged care, chronic disease management, and rural and remote areas. This includes:



- **Improved access to primary care by an NP:** The Reference Group has recommended a series of schedule fee changes throughout the report, which will facilitate access to NP care. Enabling patients to access an MBS rebate for NP care in after-hours and out-of-clinic settings will improve access, especially where other medical practitioners may not be available (including in palliative and aged care settings).
- **Removing inefficiencies and barriers to care:** Patients cared for by NPs are limited in the MBS items they can access under current MBS arrangements. The Reference Group has made several recommendations to enable patients to access MBS rebates for more complete episodes of care provided by NPs to reduce fragmentation and ensure high-value care and continuity of care across the health system.
- The Reference Group's recommendation to remove collaborative arrangements focuses on improving access to affordable, universal and high-value care for patients by removing the mandated need for NPs to form collaborative arrangements in accordance with legislation. The existing legislative requirements impose an unnecessary additional impediment to NPs functioning as a flexible workforce initiative, which was the original intent of implementing the role almost 20 years ago.
- The recommendations to enable access to MBS rebates for NP-performed procedures and NP-requested diagnostic imaging will reduce duplication, delays and inefficiencies when a patient is referred to a medical practitioner for a procedure in order to access the MBS rebate to which they are entitled.
- **Improved patient access to telehealth services:** The Reference Group has recommended a series of changes to telehealth services to improve access for patients:
 - Including GPs as eligible participants in NP patient-side telehealth services will support continuity of care through decreased wait times, particularly in remote areas where GP access is more limited.
 - Including patients in community aged care settings in residential aged care telehealth items will benefit patients in community aged care to receive care in a timelier manner.
- Patients who are unable to undertake video communication due to poor understanding of the necessary technology or infrastructure, particularly in remote areas, will benefit from the recommendation that allows telehealth consultations to take place via telephone where clinically appropriate.

Consumers, NPs and the Australian health care system will benefit from overall increased investment in NP continuity of primary care, as recommended in this report. These benefits will accrue from high-quality, cost-effective health outcomes that benefit families and the community.



The Reference Group was provided the following three consumer centred case studies to highlight the diverse and essential services provided by Nurse Practitioners.

Case Study – In-home services for sexual and reproductive health

Crystal hasn't lived with her family for a long time, she's a 'foster kid' or as the lady from the welfare calls it 'Out of Home Care'. Crystal has lived in a lot of different houses and been to a few schools. She's missed out on some immunisations and hasn't had a Pap test even though she's been having sex since she was eleven. She doesn't like going to community health centres or doctor's surgeries where she has to fill out the forms and say she's a foster kid, so she puts up with it when she feels sick and doesn't tell anyone. Yesterday her foster mum, Deb, called her into the kitchen for a hot chocolate and to meet this lady (Karen) who was visiting. While she drank her hot chocolate, Deb and Karen talked about the local area and how it used to be an 'Olympic Village' and was now all public housing. Deb asked Karen about her job and Karen said she was an outreach nurse practitioner from the community health centre. She said a lot of young women in the area didn't want to be seen by nosy neighbours going into the Sexual and Reproductive Health Clinic, so they'd decided to offer their services in people's homes. Deb asked Crystal what she thought. Crystal shrugged but thought to herself 'that'd be ok'.

Case Study – Rural and remote access

The farm is 95 km out of Hay in NSW. Bill has been working this farm since he was knee high to a grasshopper, with his dad Fred. When Fred got too old Bill took over, planting sorghum, making hay, some cash crops. Now Bill is too old, well not really, but when the cancer was diagnosed, he lost a few years in a day. These days he's in the double bed alone, Jean's moved into the spare room 'so he be more comfortable'. It also gives her a space to rage and cry. Bill's days are getting fuzzy now. Jean is so grateful for the visiting Palliative Care Nurse Practitioner who visits every day, listens to Jean's worries while quietly organising Bill's syringe driver, checking him over and reassuring the old man she won't let him die in pain. The NP works closely with Bill's GP and the oncologist at the Base Hospital. 'She doesn't miss a trick, that nurse', Jean says.

Case Study – Aboriginal and Torres Strait Islander health

Mary is a proud Yorta Yorta woman, who lives in insecure housing on the outskirts of Echuca, Victoria. As an elder, she is central to her community's wellbeing. She suffers chronic, complex diseases that require regular management. She does not feel culturally safe attending the small local hospital or either of the two Primary Care clinics in town. Her granddaughter takes her to see the Nurse Practitioner who runs a Chronic Disease Clinic at the Aboriginal Health Centre in another town. It's a bit of a drive but she's still on-country, feels safe and the NP spends time getting to know her. She goes every month for six months and is feeling pretty good. Then her granddaughter gives her bad news. The health service had to let the NP go because they weren't getting the rebates from Medicare that they would if they had a doctor. Mary hears that the new doctor is a nice young woman who used to work in a Hospital in Malaysia, and she can get people on those 'Closing the Gap' prescriptions and get tests done without you having to go somewhere else too, but Mary doesn't return.



1.6 Next Steps

The Taskforce will consider the Post Consultation Report and any stakeholder feedback before making recommendations, if required, to the Minister for consideration by Government.



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 Liberal National 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 MBS 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 too many specialist services remains problematic, with some rural patients being particularly under-served.

- **Best practice health services**—one of the core objectives of the MBS 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 Taskforce also established PCRGs to review MBS items largely provided by non-doctor health professionals. The committees and PCRGs are broad-based in their membership, and members have been appointed in an individual capacity, rather than as representatives of any organisation



2.4.1 What is a primary care reference group?

The Taskforce established the PCRGs to focus on items that are primarily or exclusively provided by non-doctor health professionals, and which have a close relationship to primary care. The MBS Review Taskforce established five PCRGs:

- Aboriginal and Torres Strait Islander Health Reference Group
- Allied Health Reference Group
- Mental Health Reference Group
- Nurse Practitioner Reference Group, and
- Participating Midwives Reference Group.

The PCRGs are similar to the clinical committees established under the MBS Review. Each PCRG reviewed in-scope items, with a focus on ensuring that individual items and usage meet the four goals of the Taskforce: affordable and universal access, best-practice health services, value for the patient and value for the health system. They also considered longer-term recommendations related to broader issues (not necessarily within the current scope of the MBS) and provided input to clinical committees, including the General Practice and Primary Care Clinical Committee (GPPCCC). Each PCRG has made recommendations directly to the Taskforce, as well as to other committees, based on clinical expertise, data, and evidence collected by members of each PCRG.

The PCRGs are unique within the MBS Review for several reasons:

- **Membership:** Similar to clinical committees, the PCRGs include a diverse set of stakeholders, as well as an ex-officio member from the MBS Review Taskforce. As the PCRGs focus on items that are primarily or exclusively provided by non-doctor health professionals, and which have a close relationship to primary care, membership includes many non-doctor health professionals, as well as an ex-officio member from the GPPCCC. Each PCRG also includes a GP, a nurse, and two consumers.
- **Connection to the GPPCCC:** As part of their mandate from the Taskforce, the PCRGs were tasked with responding to issues referred by the GPPCCC. The GPPCCC ex-officio member on each PCRG helped to strengthen the connection between the two bodies and supported communication of the PCRGs' responses back to the GPPCCC.
- **Newer items:** The items reviewed by the PCRGs have a shorter history than other items within the MBS; many were introduced only in the last decade. While this means that there is less historical data for PCRG members to draw on, it also means that there are fewer items under consideration that are no longer relevant, or that no longer promote best-practice interventions, compared to other committees.



- **Growth recommendations:** Several of the PCRGs' in-scope items have seen significant growth since their introduction, often with the potential to alleviate cost pressures on other areas of the MBS or the health system, or to increase access in low-access areas. As a result, many recommendations focus on adjusting items that are already working well, or expanding recently introduced items through increased access or expanded scope.

2.4.2 The scope of the primary care reference groups

All MBS items will be reviewed during the course of the MBS Review. Given the breadth of the review, and its timeframe, each clinical committee and PCRG developed a work plan and assigned priorities, keeping in mind the objectives of the review.

The PCRG review model approved by the Taskforce required the PCRGs to undertake three areas of work, prioritised into two groups.

- Priority 1 - Review referred key questions on draft recommendations from the GPPCCC and develop recommendations on referred in-scope MBS items.

As part of this work, the PCRGs also reviewed and developed recommendations on referred issues from other committees or stakeholders where relevant.

- Priority 2 - Explore long-term recommendations.

These included recommendations related to other MBS items beyond the PCRGs' areas of responsibility, recommendations outside the scope of existing MBS items, and recommendations outside the scope of the MBS, including recommendations related to non-fee-for-service approaches to health care.



3 About the Nurse Practitioner Reference Group

The Nurse Practitioner Reference Group (the Reference Group) was established in 2018 to make recommendations to the Taskforce on MBS items within its area of responsibility, based on rapid evidence review and clinical expertise.

3.1 Nurse Practitioner Reference Group members

The Reference Group consists of 13 members, whose names, positions/organisations and declared conflicts of interest are listed in Table 1.

Table 1: Nurse Practitioner Reference Group members

Name	Position/organisation	Declared conflict of interest
Assoc. Professor. Tom Buckley (Chair)	Academic Lead, Research Education, Susan Wakil School of Nursing and Midwifery, Faculty of Medicine and Health, University of Sydney; Chair of the Australian Nursing and Midwifery Accreditation Council NP Accreditation Committee	Nil
Ms Julianne Bryce	Registered Nurse; Senior Federal Professional Officer of the Australian Nursing and Midwifery Federation	Nil
Professor. Andrew Cashin	Mental Health NP; Professor of Nursing, Southern Cross University	Nil
Ms Julie Davey (Consumer representative)	Member, Stroke Foundation Consumer Council; Associate Fellow, Australasian College of Health Service Managers	Nil
Dr Christopher Helms	Primary Healthcare NP, Bridging Healthcare	Member of the Healthcare Homes Implementation Advisory Group; Member of the NP Advisory Committee for the MBS Review Taskforce; Provider of MBS-rebated in-scope services; Practitioner member of the Nursing and Midwifery Board of Australia
Mr Peter Jenkin	Palliative Care NP	Provider of MBS-rebated in-scope services



Name	Position/organisation	Declared conflict of interest
Ms Penelope Lello (Consumer representative)	Director, Deepening Change; Co-Chair and Committee roles held Australian Medical Council; South Australian Health and Medical Research Institute; and the Department of Health and Wellbeing SA Allied Health Clinical Governance Committee, and Women's and Children's Hospital Network	Nil
Ms Lesley Salem	NP, Primary Health, Indigenous Health	Nil
Dr Jane Truscott	NP; Senior Lecturer at the School of Nursing, Midwifery and Social Sciences, CQ University; Chairperson of the Rural Locum Assistance Program (LAP) Board	Employed at Aspen Medical (intermittently) Chair of Rural LAP
Ms Karen Booth (GPPCCC ex-officio member)	Registered Nurse and General Practice Manager; President, Australian Primary Health Care Nurse Association	Nil
Adj. Professor. Steve Hambleton (Taskforce ex-officio member)	Former Federal President of the Australian Medical Association; Chair of the Primary Health Care Advisory Group	Nil
Ms Liza Edwards (Department Advisor)	Principal Nurse Advisor, Department of Health	Nil

3.2 Conflicts of interest

All members of the Taskforce, clinical committees and PCRGs 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 Table 1.

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

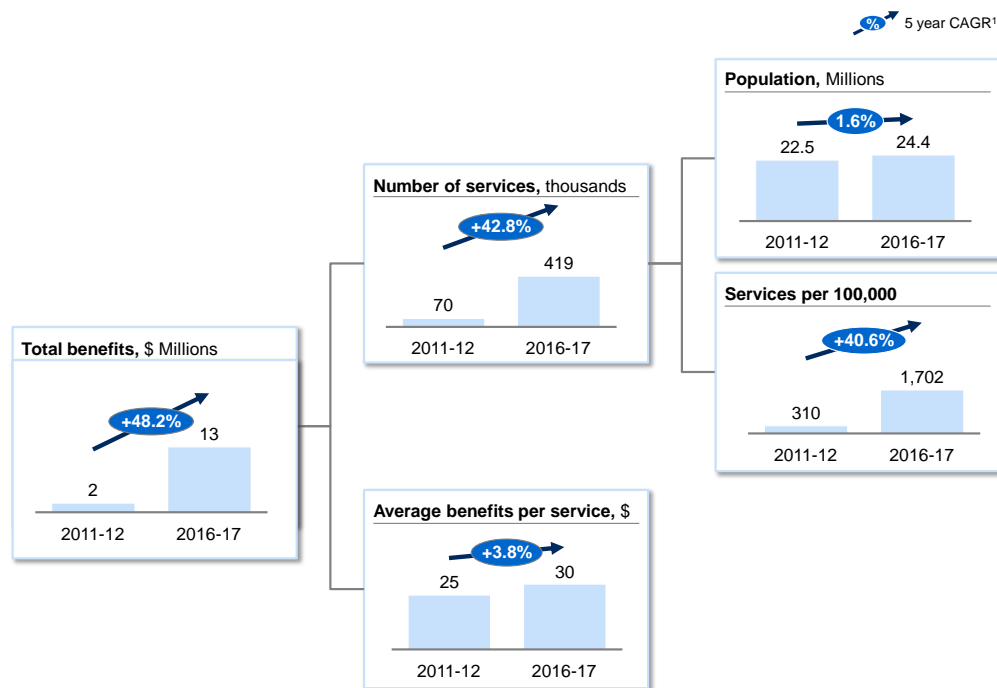
3.3 Areas of responsibility of the Reference Group

The Reference Group reviewed 10 MBS items under *Category 8 Miscellaneous Services; Group M14 NPs 82200–82225*. These items cover professional attendances and telehealth



services and are time tiered. In 2016/17, these items accounted for approximately 419,000 services and \$13 million in benefits. Over the past five years, service volumes for these items have grown at 42.8 per cent per year, and average benefits per service have increased by 3.8 per cent compounded annually (Figure 1). In 2016/17, attendance by a participating Nurse Practitioner (NP) lasting at least 20 minutes had the highest service volume, accounting for approximately 133,000 services.

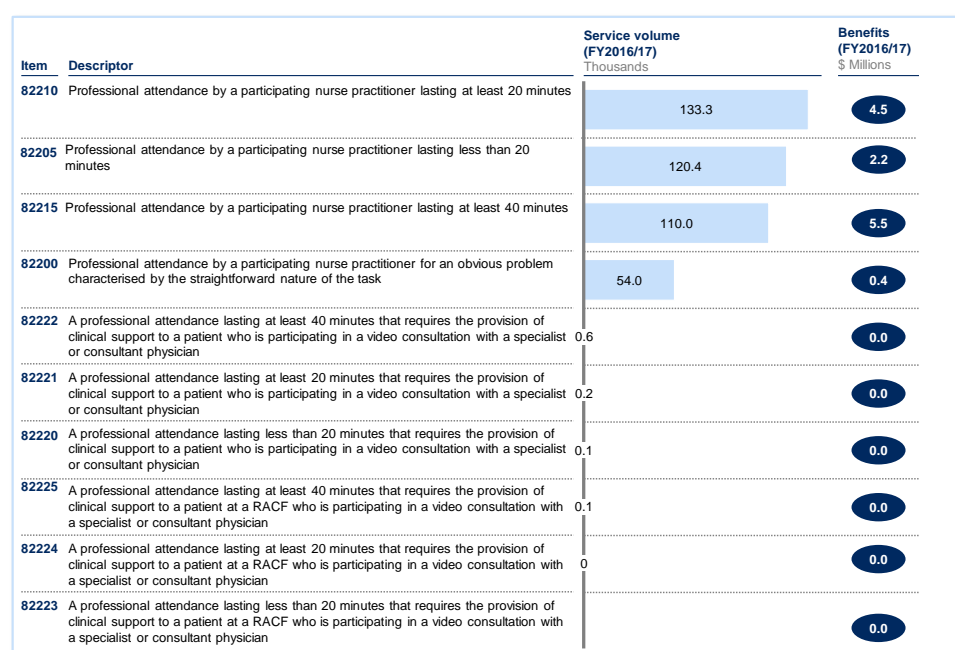
Figure 1: Drivers of benefit growth, 2011/12 to 2016/17



¹ Compound Annual Growth Rate
SOURCE: MBS data, 2011/12 – 2016-17



Figure 2: In-scope items by service volume, 2016/17



SOURCE: MBS data, 2011/12 – 2016-17



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3.4 Summary of the Reference Group's review approach

The Reference Group completed a review of its items across four full 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 identified through peer-reviewed nursing and medical journals and other sources, such as government reports and professional societies.



4 Main themes: nurse practitioners

4.1 The role

Consistent with international experience, the NP role was implemented in Australia to improve the flexibility and capability of the nursing workforce and enable new ways of addressing identified service gaps across Australia's health care system. This initiative was driven by a clear need to improve access to care for marginalised, underserved and vulnerable populations.

An NP is a registered nurse (RN) whose registration has been endorsed by the Nursing and Midwifery Board of Australia (NMBA) under the *Health Practitioner Regulation National Law 2009* (the National Law). Endorsement as an NP signifies that the RN has completed the prescribed education and has the requisite experience to practise using the title of nurse practitioner, which is protected under the National Law. To be eligible for endorsement, an applicant must meet the NMBA's *Registration Standard: Endorsement as a Nurse Practitioner*. The minimum educational preparation for NPs is completion of a master of NP program, accredited by the Australian Nursing and Midwifery Accreditation Council (ANMAC) and approved by the NMBA.

4.2 The scope of practice

All health practitioners, including NPs, are expected to practice within the scope of health care delivery in which they have been educated and deemed competent. The scope of practice of the NP builds upon RN practice, enabling NPs to autonomously and collaboratively manage complete episodes of care, including wellness-focused care, as an independent primary provider of care or as part of a collaborative team.

NPs use primary and secondary health promotion and disease prevention principles in their care, as well as advanced, comprehensive assessment techniques in the screening, diagnosis and treatment of diverse acute and long-term health conditions. NP practice is evidence-based and includes the ability to request and interpret diagnostic tests; prescribe therapeutic interventions, including the prescription of medicines; and refer to other health care professionals. Collaborative and integrative in their approach, NPs use skilful and empathetic communication to facilitate person-centred care through the holistic and encompassing nature of nursing. NPs also evaluate care provision to enhance safety and quality within health care.



NPs practise in all clinical areas, across metropolitan, rural and remote Australia, in both the public and private sectors. With appropriate education and training, an NP can provide health care services across a broad context as a primary care provider for a patient. Alternatively, an NP may have more specialised education and training to provide expert care in a particular clinical specialty, such as emergency medicine, palliative care or renal medicine. While the role is clinically focused, NPs are also expected to actively participate in research, education and leadership in clinical care.

After extensive formative work demonstrating the ability to safely and effectively translate the NP role to the Australian context, the NP title was formalised and protected in Australia in 1998 through the *Nurses Amendment Act 2003* (NP Act). The first NPs were authorised to practise in New South Wales in 2000.

Since 2000, the Australian nursing profession has established the necessary professional and regulatory requirements to support the role, including:

- Professional standards for practice (1) (2) (3).
- The NMBA registration standard for endorsement under s95 of the National Law (4).
- NP course accreditation standards developed by the ANMAC (5).
- Professional representation through the Australian College of Nursing Practitioners.

In addition, NPs were admitted as eligible Medicare providers with the ability to participate in both the MBS and PBS in 2010 (6), enabling consumers to access rebates when choosing an NP as their health care provider. NP eligibility to participate in the MBS and the PBS is enabled by the *Health Legislation Amendment (Midwives and NPs) Act 2010*.

4.3 Differences between a registered nurse and a nurse practitioner

The NP role builds on the RN scope of practice. Table 2 broadly outlines the educational, professional and experiential requirements of the RN and NP scope of practice.

Table 2: Registered nurse and nurse practitioner scope of practice

	Registered nurse (RN)	Nurse practitioner (NP)
Practice requirements		
Title protection?	Yes	Yes



	Registered nurse (RN)	Nurse practitioner (NP)
Regulation	Regulated under the National Registration and Accreditation Scheme (NRAS) by the NMBA Registration (RN): NMBA	Regulated under the NRAS by the NMBA Endorsement (NP): NMBA State/territory-based authorisation to account for jurisdictional legislation/policy where relevant (e.g. Poisons and Therapeutic Goods Acts). A total of three years full-time equivalent (FTE; 5000 hours) experience working at the advanced practice level (7) is required prior to endorsement by the NMBA.
Regulatory standards and guidelines	Registered Nurse Standards for Practice (8) NMBA Code of Conduct for Nurses (9)	Registered Nurse Standards for Practice NMBA Code of Conduct for Nurses NP Standards for Practice (9) Safety and Quality Guidelines for NPs (10)
Mandated collaborative arrangements	No	Legislated as a requirement for patient access to MBS and PBS rebates for NP services (11)
Requirements for entry into degree program	Completion of secondary education	Bachelor of nursing Postgraduate qualification at Australian Qualifications Framework (AQF) Level 8 in a relevant clinical specialty area
Experiential requirements for entry into degree program	N/A	Current general registration as an RN A minimum of two years FTE as an RN in a specified clinical field and two years FTE of current advanced nursing practice in this same clinical field
Length of education program	Three years FTE with 800 supervised clinical practice hours	Additional one to two years FTE with 300 integrated professional practice hours in addition to 5000 hours (equivalent to three years FTE) required for endorsement
Level of educational program	AQF Level 7: bachelor's degree program	RN education program + AQF Level 9: master's degree program
Scope of practice		
Formal diagnosis	No	Yes



	Registered nurse (RN)	Nurse practitioner (NP)
Prescribing	No, although allowed to supply and/or administer under limited protocol in some public-sector settings (nurse-initiated medicines, standing orders and protocols)	Yes
Request/interpret diagnostic pathology	No, although some public-sector roles facilitate access to limited diagnostic pathology under the authority of a medical practitioner.	Yes
Request/interpret diagnostic imaging	No, although some public-sector roles facilitate access to limited diagnostic imaging under the authority of a medical practitioner.	Yes
Referral to medical specialists	No	Yes
Referral to allied health	Limited to within the public sector (e.g. nurse to physio referral for in-patients)	Yes, however NP referrals to allied health care are not currently subsidised by the MBS
MBS subsidy for services	No	Yes, for time-tiered professional attendances; telehealth; limited, simple, basic point-of care pathology; and limited plain-film X-Rays and ultrasounds
PBS subsidy for eligible prescribed medicines	No	Yes, with limitations.
MBS subsidy for therapeutic and diagnostic procedures	No	No
Admission rights	No	Yes, depends on local policy



5 Recommendations

5.1 Introduction

The Reference Group's recommendations are organised into four themes:

- Supporting comprehensive and coordinated care for people with long-term health conditions and Aboriginal and/or Torres Strait Islander peoples (Section 5.2).
- Enabling nurse practitioner care for all Australians (Section 5.3).
- Addressing system inefficiencies caused by current MBS arrangements (Section 5.4).
- Improving patient access to telehealth services (Section 5.5).

A table summarising the list of items considered by the Reference Group can be found in Appendix A.

5.2 Supporting comprehensive and coordinated care for people with long-term health conditions and Aboriginal and/or Torres Strait Islander peoples

Case Study – Aboriginal and Torres Strait Islander Health

Susan is an NP working in an Aboriginal Health Service (AHS) in remote Queensland. She provides comprehensive primary and secondary health promotion and disease prevention and management services for consumers, many of whom have complex health requirements that are strongly influenced by the social determinants of health. Susan's primary health care services are augmented by the fact she has expertise in the assessment and management of people with kidney disease and diabetes. Many of her clients would greatly benefit from subsidised allied health services. In addition, many of her clients would benefit from enrolment in the Closing the Gap scheme, which provides subsidised prescriptions for Aboriginal and Torres Strait Islander clients.

Susan has infrequent and irregular access to a GP in her remote clinic. Although Susan has independently developed comprehensive management plans for her complex clients, which include referrals to allied health professionals, she is unable to appropriately operationalise them because NP referrals to allied health professionals are not currently available for rebate under the MBS. Her patients cannot afford to see the allied health specialists privately at the AHS, and the AHS cannot continue to provide these services without income generated by subsidised allied health appointments. In addition, current Department of Health policy precludes her from enrolling patients in the Closing the Gap scheme or accessing its initiatives, which results in her patients paying higher out-of-pocket costs.



1.1.1 Recommendation 1 – Enable patients to access MBS rebates for long-term and primary care management provided by NPs

The Reference Group recommends enabling patients to access MBS rebates for long-term and primary care management provided by NPs as follows:

- a. amending the item 701, 703, 705 and 707 descriptors to include NPs as eligible providers, with proposed item descriptors (using item 701 as an example) as follows:

Items 701 – example descriptor

Professional attendance by a medical practitioner (other than a specialist or consultant physician), or a nurse 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.

- b. amending the item 715 descriptor to include NPs as eligible providers, enabling Aboriginal and/or Torres Strait Islander patients to access MBS rebates for health assessments performed by NPs, with the proposed item descriptor as follows

Items 715

Professional attendance by a medical practitioner (other than a specialist or consultant physician), or a nurse 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.

- c. amending the item 721, 723 and 732 descriptors to include:
 - i. NPs as eligible providers, enabling patients to access MBS rebates for the preparation and review of chronic care management plans and the development of team care arrangements by NPs
 - ii. an appropriate title that captures the intent of the chronic care management plans and team care arrangements (for example, Patient-centred Management Plan, Chronic Disease Management Plan),,and
 - iii. with proposed item descriptor (using item 701 as an example) as follows:

**Item 721**

Professional attendance by a medical practitioner (other than a specialist or consultant physician), or a nurse 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.

Note: The Reference Group notes that this recommendation may need to be amended to reflect proposed changes by the GPPCCC.

- d. amending the item 729 and 731 descriptors to include NPs, enabling patients to access MBS rebates for an NP's contribution to a multidisciplinary care plan, with proposed item descriptor (using item 729 as an example) as follows:

Item 729

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), or a nurse practitioner, for preparation of a chronic disease management plan for a patient (other than a service associated with a service to which any of items 735 to 758 apply)

Note: The Reference Group notes that the GPPCCC referred a question on case conferencing to the Reference Group. See Appendix D for the Reference Group's response to the GPPCCC.

- e. amending the item 2700 and 2701 descriptors to include NPs as eligible providers,
- f. that no MBS item or otherwise subsidised activities relating to the planning, coordination and management of long-term health conditions (for example, Closing the Gap initiatives, Home Medicines Reviews [HMRs], integrated team care) should result in greater disadvantage for Aboriginal and/or Torres Strait Islander patients seeking and choosing an NP to manage their chronic health condition, and
- g. that any future iterations of MBS items, Commonwealth-subsidised models of care, or funding arrangements relating to the primary care management and coordination of long-term health conditions should consider that an NP may be a patient's preferred primary care provider, as a safe and effective alternative to a GP.

1.1.2 Rationale 1

This recommendation focuses on ensuring high-value care for patients with long-term, chronic health conditions and Aboriginal and/or Torres Strait Islander peoples. It is intended



to avoid fragmentation, delays and other inequities in care for patients whose primary health care provider is an NP. It is based on the following.

- The burden of chronic illness is growing in Australia, placing increasing pressure on the health system. This pressure is particularly felt within the following populations:
 - Aboriginal and/or Torres Strait Islander peoples: Chronic diseases were responsible for 64 per cent of the total disease burden among Aboriginal and/or Torres Strait Islander peoples in 2011. (12) There is a high burden of avoidable death among Aboriginal and/or Torres Strait Islander peoples.
 - Homeless populations: People experiencing homelessness are less likely to access primary and preventive health services. (13) This increases the risk of later-stage diagnosis of disease (14), poor control of manageable conditions (for example, hypertension, and diabetes) and hospitalisation for preventable conditions (for example, skin or respiratory conditions).
 - Aged care: Care is provided not only in RACFs but increasingly in the home and community setting. Many of the residents of aged care facilities have complex health care needs. While the RACF population is growing rapidly, the number of GPs providing care in these facilities may be declining. (15)
- All patients, but particularly the marginalised groups outlined above, should be supported and enabled to access health care provided by appropriate models of care, including NPs (16). There are specific considerations for the Aboriginal and Torres Strait Islander Health Assessment Item 715. It is specifically focused on Aboriginal and/or Torres Strait Islander populations and is conducted across the lifespan of patients. When a medical practitioner conducts an item 715 health assessment service, it enables several important, subsidised health services. These services help mitigate the risk of developing chronic health conditions, assist with the early identification of such conditions, improve the quality of preventive care provided, and reinforce the requirement for multi-level care for this vulnerable population. This includes access to:
 - Culturally appropriate care using subsidised enhanced follow-up services offered by nurses and Aboriginal and Torres Strait Islander health practitioners. These services are rebated through MBS item 10987.
 - Subsidised enhanced care services using allied health and Aboriginal and Torres Strait Islander health workers. These services are rebated through MBS items 81300–81360. In many instances, income generated from nurses, Aboriginal and Torres Strait Islander health practitioners, and allied health workers through use of these items is not only used to pay for their professional services, but also supports Aboriginal Community Controlled Health Centres and Aboriginal Health Services.



- Closing the Gap initiatives, including integrated team care funding through primary health networks, medication supply subsidies and practice incentive program payments that enhance service delivery for all Aboriginal and/or Torres Strait Islander peoples. Importantly, practice incentive payments relating to the item 715 health assessment support ongoing infrastructure and human resource requirements for the delivery of health care for Aboriginal and/or Torres Strait Islander peoples. Excluding NPs from these initiatives results in significant disadvantage for Aboriginal Health Services using the services of NPs.
- NPs working with Aboriginal and/or Torres Strait Islander peoples, whether in metropolitan or remote health services, are unable to provide these subsidised health services because they are not considered eligible providers under MBS item 715. They are unable to facilitate subsidised allied health care, culturally safe Aboriginal and Torres Strait Islander health worker support, or Closing the Gap pharmaceutical rebates for their patients. The lack of access to these rebates results in patients receiving no clinical care, or little or fragmented clinical care, and in further marginalisation of an already vulnerable group.
- NPs in Australia provide high-quality case management, care planning and care facilitation services for people with long-term health conditions. Their ability to diagnose, request and interpret diagnostic investigations, prescribe medicines and initiate referrals to other health professionals means they are well placed to serve as a primary provider of care for people with long-term health conditions.
- Inequity in funding mechanisms should not prevent people from receiving comprehensive, evidence-based care. Current MBS restrictions limit patient choice and result in fragmented care. They also prevent health services from optimising NPs—an underutilised resource in Australia's health care system.
- Patients who choose an NP as their health care provider are unable to access MBS rebates and as a result are limited in their choice of provider. This is particularly problematic where access to a medical practitioner is limited, and for marginalised and vulnerable populations.
- Current restrictions result in fragmented and delayed care for NP patients, as the NP must refer a patient to a GP for a Chronic Disease Management Plan, Mental Health Treatment Plan or health assessment to be rebated under the MBS. While MBS data cannot indicate why a referral occurred (and whether it represented high- or low-value care), recent attendance data shows that same-day attendances with a GP following an NP attendance are higher for health assessment and GP Management Plan items than for general GP attendances (Figure 3). These restrictions unnecessarily limit a patient's choice of provider in the management of their long-term health. These restrictions also



create a financial disadvantage for health services that employ NPs to meet the needs of their communities.

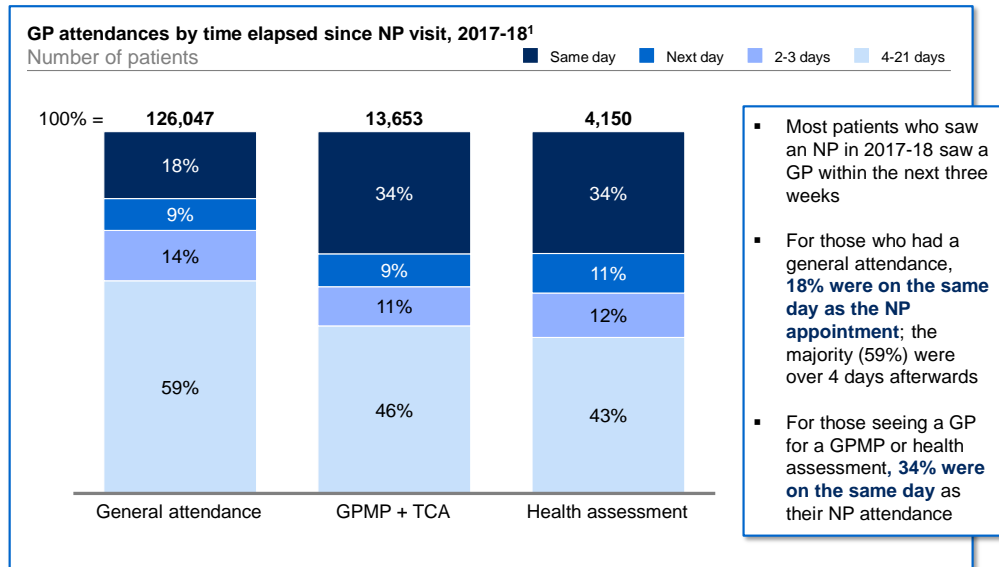
- This recommendation may also have advantages from a system efficiency standpoint. Increasing point-of-care access to NPs will remove the need for onward referral for additional MBS services. This will reduce the current duplication and fragmentation experienced by many patients, particularly Aboriginal and/or Torres Strait Islander peoples and those from marginalised communities, improving system efficiency.

Figure 3: Distribution of same-day attendances

CHRONIC CARE MANAGEMENT

The percentage of same-day GP appointments for chronic care and health assessment items are higher than for general attendances

PRELIMINARY



¹ Excludes telehealth NP attendances. Within the MBS sections, General = A01 + A02; GPMP + TCA = A15; Health assessments = A14

SOURCE: MBS data, 2017

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Case Study – Residential Aged Care Facilities

Mark is an NP providing comprehensive clinical services to older people living in RACFs across the metropolitan area of Adelaide. He routinely sees residents who would not otherwise have access to timely primary care. A typical day may require Mark to assess, diagnose and treat minor or acute illnesses or injuries including infections, wounds, behavioural and psychological symptoms of dementia, musculoskeletal injuries and mental health episodes, or to provide end-of-life care. This can involve a range of interventions and care coordination; prescribing, titrating and/or ceasing medicines; ordering diagnostic investigations; and directly referring patients to other health professionals.

However, residents can experience delays in receiving necessary diagnostic investigations as current MBS rules do not enable NPs to initiate many common diagnostic imaging tests otherwise subsidised in primary health care, such as ultrasounds and X-rays. This leads to fragmented and unnecessary duplication of services, either requiring a second attendance by a GP, or worse, an unnecessary transfer to an emergency department.



Some residents may not have access to a GP who conducts comprehensive medical assessments or team care arrangements, including accessing allied health services. Residents then do not have their chronic health conditions proactively assessed and monitored for early signs of deterioration, increasing the incidence of acute events and hospitalisation or reducing their overall quality of life. Residents and RACF staff have asked Mark to assist in the provision of comprehensive health assessments, chronic disease management, case conferences and advance care planning. However, the allocated times for NP professional attendances (i.e. MBS items 82200–82215) are not practically useful for this care.

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

The Reference Group recommends enabling patients to access MBS rebates for NP services in aged care settings, particularly:

- (i) Health assessments, which are available for residents of RACFs and those aged over 75
- (ii) Health assessments for Aboriginal and/or Torres Strait Islander peoples
- (iii) Managing chronic disease
- (iv) Contributing to a multidisciplinary care plan, particularly for residents of RACFs (item 731), and
- (v) Developing a Mental Health Treatment Plan.

Notes:

1. *This recommendation mirrors most of the recommended changes made at Recommendation 1.*
2. *This recommendation also reinforces the importance of Recommendation 5 which proposes a new item for an NP professional attendance lasting for at least 60 minutes.*

5.2.1 Rationale 2

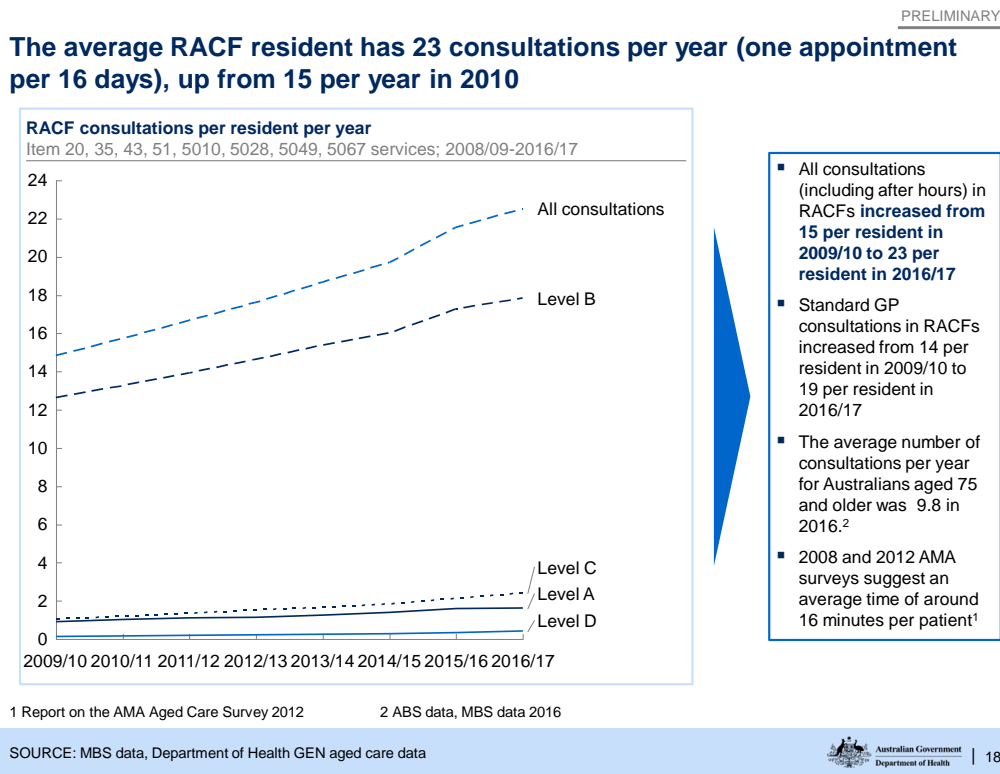
This recommendation reiterates recommendations made elsewhere in the report to emphasise the importance of ensuring access to universal, affordable and coordinated care for long-term health conditions for patients receiving aged care services in residential and community settings. It is based on the following:

- Increasing levels of frailty and complexity in physical and mental health in aged care settings requires access to continuity of care from appropriately qualified clinicians.
- Ninety-seven per cent of permanent RACF residents (as of 30 June 2017) had medium or high-level needs for complex health care services, and 85 per cent had one or more diagnosed mental health or behavioural condition (17).



- There are limitations on the availability of primary care service provision in the aged care sector. Although MBS data shows increasing visits per patient in RACFs since 2010 (Figure 4), a recent survey of Australian GPs highlighted that over 35 per cent of the respondents who currently visit patients in RACFs intend to either not take on any new patients in RACFs, decrease their visits or stop visiting RACFs altogether (15).

Figure 4: Residential aged care facility visits by GPs



- Many patients cannot continue to receive services from their usual GP after moving into an RACF, either because they have moved outside the GP practice's boundaries, or because the GP is unable or unwilling to visit RACFs (15).
- In the absence of timely, accessible primary care, these older people are often transferred to hospital emergency departments for treatment and/or admission. Delayed intervention may also result in avoidable deterioration in the older person's health status and the subsequent need for more intensive use of health resources.
- Consumer representatives on the Reference Group also emphasised the limits this imposes on an older person's access to responsive, appropriate, quality primary care and the commensurate increase in stress for family carers and residential aged care staff.
- Permanent residents in RACFs or those receiving Home Care Packages (HCPs) in their homes cannot currently access MBS rebates for comprehensive medical assessments,



Chronic Disease Management Plans or other common MBS services when these are provided by an NP.

- NPs are effective providers of preventive and long-term care in the aged care sector. For example, a study funded by the Department of Social Services, which reviewed 30 organisations using different NP models of care (18), found that NPs:
 - Spent more time with patients than GPs, and were more accessible and able to initiate more timely care.
 - Visited elderly people in their homes and thereby increased access to care for those who were not mobile or able to drive themselves to services.
 - Were able to review medicine regimes and, in some cases, reduce unnecessary polypharmacy.
 - Played strong coordination roles in bringing together health professionals and family members, and provided valuable translation of information into language the elderly person and their family could understand.
- In addition, economic efficiencies were gained through reductions in unnecessary transfers to acute health facilities, ambulance costs, hospital bed days and therefore hospital costs. The study estimated that extending the tested models of care to all aged care settings would have saved \$97 million in 2013/14 from reductions in hospital bed days alone (18).

5.2.2 Recommendation 3 - Enable Domiciliary Medication Management Reviews (DMMRs) and Residential Medication Management Reviews (RMMRs) to be initiated by NPs

The Reference Group recommends:

- a. enabling patients to access MBS rebates for NP-requested medication management reviews (MMRs) and DMMRs, through items 900 and 903
- b. that the same rules that apply to GP-requested medication reviews should apply to NP-requested reviews, including gaining consent from the patient or carer, giving results to the patient, and developing a plan to assist the patient with managing the medication
- c. access to rebates for NP-initiated medication reviews should apply to both the NP and the pharmacy components of these reviews (whether via the MBS or a Sixth Community Pharmacy Agreement)
- d. Pharmacist reports should be supplied to the NP where they are the patient's lead clinician, and



- e. a copy of the DMMR/RMMR should be uploaded to My Health Record, with permission from the patient (or legal substitute decision-maker).

5.2.3 Rationale 3

This recommendation focuses on increasing access and reducing fragmentation of care. It is based on the following:

- There are a significant number of hospital admissions due to medication-related misadventure. In its 2013 literature review on medication safety, the Australian Commission on Safety and Quality in Health Care stated: “Medication-related hospital admissions have previously been estimated to comprise 2 per cent to 3 per cent of all Australian hospital admissions, with rising estimates of prevalence when sub-populations are studied. For example, 12 per cent of all medical admissions and 20 per cent to 30 per cent of all admissions in the population aged 65 years and over are estimated to be medication-related.” (19).
- Increased use of DMMRs/HMRs and RMMRs can improve medication management and reduce hospital admissions by providing comprehensive care and risk management.
- These reviews are sometimes overlooked, delayed or prevented where access to a GP is limited.
- Enabling rebates for NP-requested MMRs will assist with reducing the delays in care noted above, medication misadventure and the risk of medication-related hospital admissions.
- Enabling rebates for NP-requested MMRs will also help to ensure continuity of care for patients.
- A patient’s risk increases when they see multiple providers who may prescribe medications. It is essential that the patient has a lead clinician acting as care gatekeeper to help manage and coordinate their health (including management of medications), and to seek further advice as needed.
- This is particularly true for marginalised groups who have trouble accessing GP care and are often treated by NPs, providing consistency in care giving and building trusting relationships is a key concern for these groups.
- This is also true for patients in outer rural and remote areas, who may not have regular access to a GP. Some primary care clinics are managed by an NP, who functions as the senior/lead clinician and the consistent point of contact for patient care and chronic disease management coordination.



5.3 Enabling nurse practitioner care for all Australians

5.3.1 Recommendation 4 – Significantly increase the schedule fee assigned to current MBS NP professional attendance items to more appropriately reflect the complexity of care provided

The Reference Group recommends significantly increasing the schedule fee assigned to current MBS NP professional attendance items (items 82200, 82205, 82210 and 82215).

5.3.2 Rationale 4

This recommendation focuses on ensuring that attendance items reflect best practice and enable the provision of high-quality care to underserved populations. It is based on the following:

- This will enable patient access and choice, and promote workforce sustainability in the primary health care setting.
- Current research highlights the role of NPs as providers of high-value primary care.
- There is a need to improve access to high-quality primary care in Australia, particularly in rural and remote areas, and for marginalised and vulnerable populations.
- In a recent study of GP clinics in northern New South Wales, almost 20 per cent of general practices could not offer an appointment, and less than 50 per cent could offer a same-day appointment (20).
- There are fewer MBS primary care attendances in rural and remote areas, compared to the rest of Australia (Figure 5).

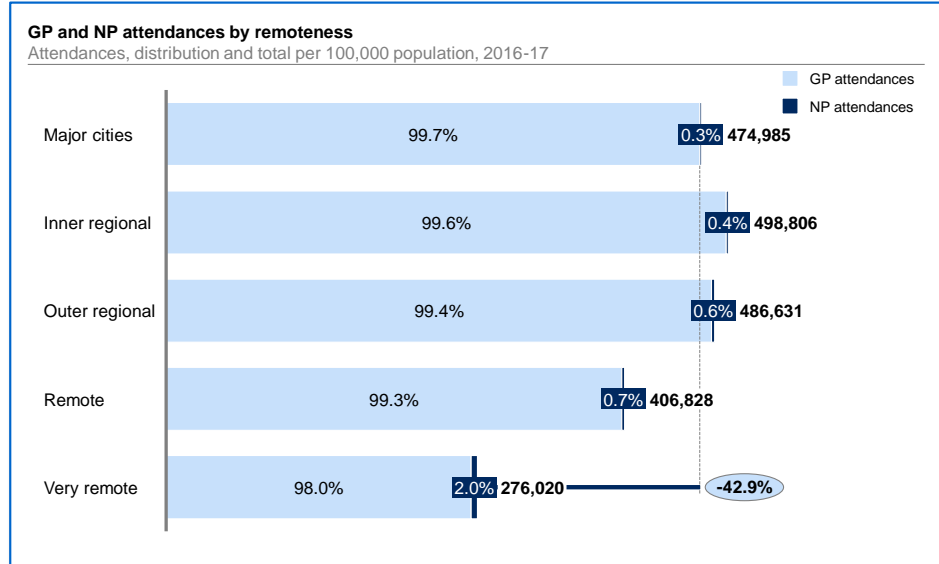


Figure 5: MBS attendances by primary care providers, by remoteness area

IN-SCOPE ITEMS

PRELIMINARY

1 Combined NP and GP attendances show fewer MBS primary care attendances in remote and very remote areas



SOURCE: MBS data 2016/17

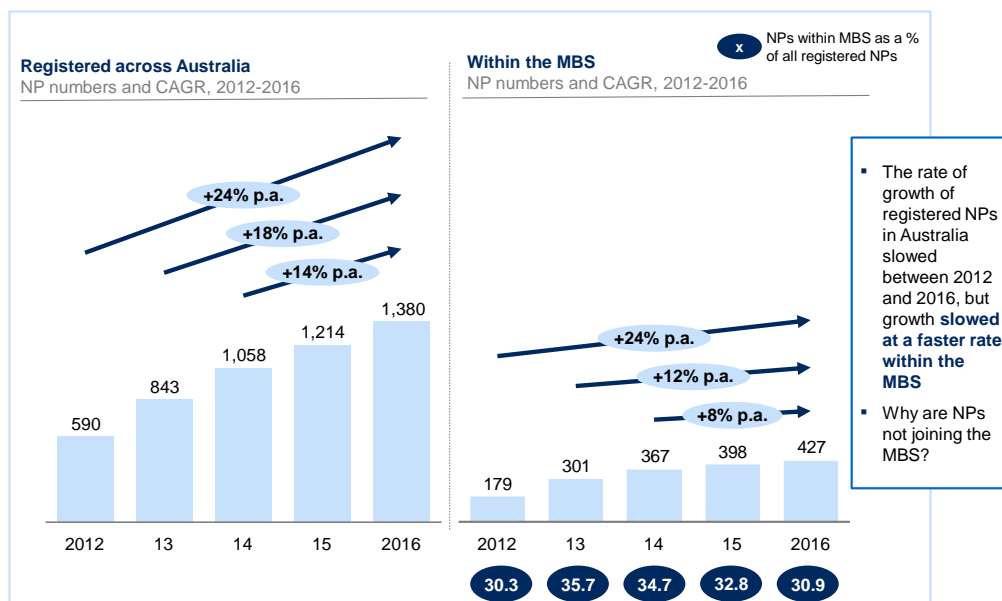
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Figure 6: Growth in NPs in Australia and within the MBS

IN-SCOPE ITEMS

A While the number of MBS-registered NPs is growing, it is not keeping pace with the overall growth in registered NPs across Australia



SOURCE: Nursing and Midwifery Board of Australia Registrant Data, as of March, 2012-2016; MBS data, 2012-17

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- In Australia, the NP workforce is growing, but the rate of growth is slowing. Growth of the NP workforce within the MBS is slowing more dramatically, and from a much smaller base (Figure 6).
- Financial sustainability has been identified as a major limitation for NP models of care in private practice settings, particularly when relying on a bulk-billing fee model (21).
- The majority of NP models of care find it difficult to cover the cost of providing care without charging patients out-of-pocket fees. This is counter-intuitive for NPs who are working to provide services to underserved and marginalised populations, and unnecessarily burdensome for the communities they serve. The combination of low MBS rebates and low out-of-pocket fees makes it difficult for most NP models of care to cover their costs, creating a disincentive for any employer wishing to engage an NP, such as an Aboriginal Medical Service (Figure 7).
- In a mixed-methods evaluation of NP models in aged care, a key challenge was the financial sustainability of private practice NP models due to the low MBS schedule fee assigned to NP professional attendance items. Thirty per cent of NP-led services ceased to operate due to financial non-viability (3).

Figure 7: Bulk-billing and out-of-pocket rates

	% of attendances	% bulk billed	Average OOP ¹
Short attendance	26%	99.4%	\$11.16
Attendance < 20 minutes	32%	94.5%	\$24.99
Attendance < 40 minutes	29%	94.3%	\$30.02
Attendance > 40 minutes	13%	91.9%	\$54.03
Weighted average	100%	94.4%	\$37.5

¹ OOP = Out-of-pocket. Calculated from the subset of services that had an out-of-pocket fee

SOURCE: MBS data, 2016-17

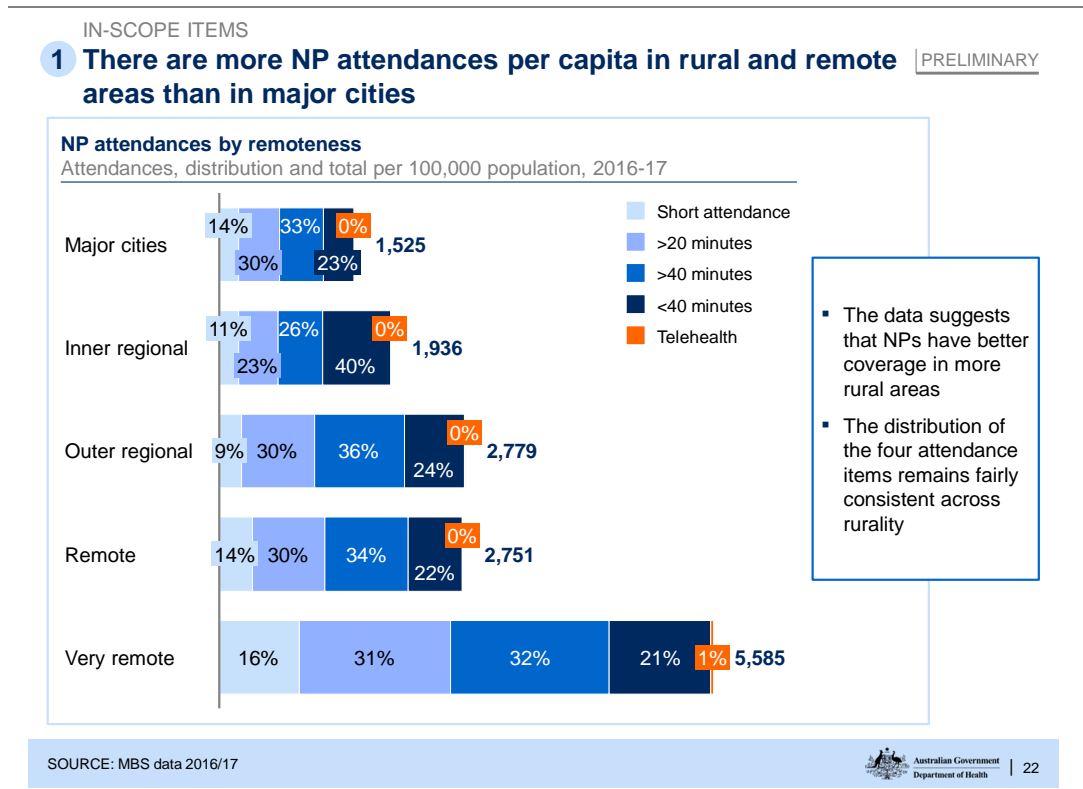
- Significantly increasing rebates for NP professional attendance items will improve patients' ability to access NP services and, in turn, improve their care provider choices.
- This recommendation will improve NPs' ability to cover the costs of care provision, leading to a more financially viable model that allows them to provide services in the



primary care setting, including to underserved and marginalised populations such as Aboriginal and/or Torres Strait Islander peoples, rural and remote populations, the homeless and aged patients. It would also support the rate of growth of this provider group.

- This recommendation may particularly improve rural and remote patients' access to and choice of primary care provider. MBS data shows that NPs provide a relatively high percentage of MBS services in rural and remote areas (Figure 8).

Figure 8: NP attendances by remoteness area



- This recommendation will also improve equity within the MBS fee structure, aligning NP rebates more closely with those for other practitioners with similar qualifications, expertise and experience.
- NPs receive half the per-minute rate of clinical psychologists, despite comparable levels of education (master's level) and comparable advanced practice experience requirements. The per-minute rate for a clinical psychologist providing a 50-minute session is \$2.49, compared to \$1.24 a minute for a 40-minute attendance by an NP (assuming the minimum appointment time for each provider; MBS, 2018).
- The NP per-minute attendance rebate rate is also less than half of the rebate rate for GPs for a 40-minute attendance, despite often undertaking similar activities during professional attendances, with evidence to suggest comparable outcomes (22) (23).



- The Reference Group recognises that this recommendation will only partially solve the issue of limited access to NP care. However, it is a vitally important component. Other recommendations in the report address additional barriers to access.

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

The Reference Group recommends creating a new MBS item for longer NP attendances to support the delivery of complex and comprehensive care, with the proposed item descriptor as follows:

New Item 822AA

Professional attendance by a participating NP lasting at least 60 minutes.

5.3.4 Rationale 5

This recommendation focuses on ensuring that attendance items reflect best practice and enable the provision of high-quality care to underserved populations. It is based on the following:

- The current time-tiered items for NP attendances do not reflect best practice. A range of care often needs to be provided in attendances lasting more than 60 minutes. For example:
 - Palliative care: These attendances often last for at least an hour due to the complexity of the care provided, which cannot be postponed or broken down into multiple shorter attendances. This can include a combination of pain and symptom management, psychosocial support, prescribing or adjusting multiple medications, referral to other health professionals and some procedural activities (such as insertion of urinary catheters).
 - Health care services for Aboriginal and Torres Strait Islander peoples: Many Aboriginal and/or Torres Strait Islander peoples have more than one chronic disease. Monitoring activities, engaging in a culturally safe way (which guides the location of the attendance, and the additional family, kin and community involved) and providing education on treatment and management, taking language and literacy difficulties into account, can be time-consuming to achieve the best outcomes for the patient.
 - Care for patients with dementia: Patients with dementia have cognitive impairments that make clinical assessment, shared care planning and procedural care more complicated. Longer consultation times are needed to deliver effective,



best-practice care. This is relevant not just for formal cognitive screening/testing, but also for the more routine primary care attendances.

- Specialist wound care: Consultations frequently take 60 minutes or longer to undertake various chronic wound assessment/treatments, including ankle-brachial pressure index measurement, chronic wound debridement and effective patient education.
- Diabetes care: A specialist diabetes NP would require over 60 minutes with a patient to download and interpret data from a continuous blood glucose monitor then initiate treatment changes, including patient education. Similarly, starting a patient on an insulin pump routinely takes more than one hour.
- The length of attendances is affected by several factors, including patient age and socioeconomic status. Longer attendances are also an inherent consequence of the increasing burden of chronic disease (24).
- The cost of providing longer attendances is difficult for NPs to meet without charging high out-of-pocket costs or spreading care over multiple, shorter visits. This means that while there is a need for these services, patients are unable to access them.
- The patient rebate for an attendance of at least 40 minutes (item 82215) is already too low to be financially viable. This item cannot sustainably cover an attendance of over 60 minutes.

5.3.5 Recommendation 6 – Enable patients to access MBS rebates for after-hours or emergency care provided by NPs to facilitate care provided in the most appropriate settings and in a timely manner

The Reference Group recommends:

- a. enabling patients to access MBS rebates for after-hours or emergency care provided by NPs
- b. modifying MBS items that support patient access to emergency and after-hours assessment and treatment by vocationally qualified GPs and GP registrars to include care provided by NPs, examples of item numbers that should be revised include:
 - (i) Items 761–769 for professional attendance (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)
 - (ii) Items 772–789 for 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) by a medical practitioner—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, and

(iii) Items 585–600 for urgent attendance after hours,

and

- c. applying the restrictions, controls and requirements that were introduced to MBS emergency and after-hours care in March 2018.

5.3.6 Rationale 6

This recommendation focuses on ensuring that timely, high-quality care is available to patients in the right location at the right time. It is based on the following:

- The MBS acknowledges the need for after-hours and emergency care through the existence of items that reimburse this care when provided by medical practitioners.
- The Reference Group feels that this recommendation would particularly benefit patients who require care but do not have access to readily available health practitioners after hours—for example, those in RACFs, hostels, or palliative or community nursing services.
- There are currently no MBS rebates for patients who receive emergency or after-hours assessment and care from an NP, even when the NP may be best placed to provide this care (e.g. for geographical reasons, or because of a pre-existing role in caring for the patient).
- This results in reduced access to timely, appropriate assessment and treatment. This could prevent patients from seeking the necessary care (leading to worsening health issues), or prompt them to seek care within emergency departments where their needs may be a lower priority.
- Enabling patients to access these rebates when an NP is providing care would have beneficial outcomes for patients. In particular, the Reference Group believes this change would offer patients an alternative to seeking care at emergency departments, and would have a positive effect on:
 - Achieving the goals of the Closing the Gap strategy.
 - The quality of palliative and end-of-life care.
 - Access to timely care for residents of RACFs.



5.3.7 Recommendation 7 – Enable patients to access MBS rebates for NP care received outside of a clinic setting

The Reference Group recommends enabling patients to access MBS rebates for NP care received outside of a clinic setting by creating new items for NP professional attendances (items 822BB, 822CC, 822DD and 822EE) with the proposed descriptors (using an attendance of less than 20 minutes as an example) is as follows:

New Items – Example descriptor

Professional attendance by a nurse 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, for an attendance on one or more patients at one place on one occasion.

Note: The Reference Group notes that these items could parallel the existing GP professional attendances for out-of-rooms visits.

5.3.8 Rationale 7

This recommendation focuses on ensuring that appropriate and sustainable primary care is available to all Australians in the right location at the right time. It is based on the following:

- Enabling rebates for care received in out-of-rooms or out-of-clinic settings would parallel the structure of GP professional attendance items.
- This structure would enable more precise records to be maintained (through MBS item number tracking) on how frequently NP services are provided in non-clinic settings.

5.4 Addressing system inefficiencies caused by current MBS arrangements

5.4.1 Recommendation 8 – Remove the mandated legislated requirements for NPs to form collaborative arrangements

The Reference Group recommends removing the mandated requirement for NPs to form collaborative arrangements, in accordance with the *National Health (Collaborative arrangements for NPs) Determination 2010*.

5.4.2 Rationale 8

This recommendation focuses on the provision of affordable, universal and high-value care for patients, particularly in underserved areas. It is based on the following:



- A collaborative arrangement is defined as an arrangement between an eligible NP and a specified medical officer that must provide for consultation, referral and transfer of care as clinically relevant (25).
- The Reference Group noted that this recommendation has implications for NP participation in the PBS.
- Collaborative arrangements have become an impediment to growth of the NP role in improving access to quality care for all Australians. This was a key finding of the National Health and Hospitals Reform Commission (26). NPs have also reported that collaborative arrangements work against true collaboration (27) (28).
- Some of the reasons for this are:
 - Collaborative arrangements can be difficult to develop, particularly in rural and remote areas (27). The availability and accessibility of medical practitioners with whom an NP can establish the mandated collaborative arrangement—when this is the selected form of collaboration—remains a challenge in some rural and remote locations, reducing patient access to NP care. In addition, difficulty recruiting a medical practitioner to collaborate with (when that is the selected mechanism) and resistance to NP referrals has been reported by some NPs in primary care.
 - Requiring an NP to establish a collaborative agreement makes them dependent on the willingness and availability of medical practitioners to participate (when this is the selected form of arrangement), but there is no requirement for medical practitioners to do so.
 - Collaborative arrangements can affect perceptions of the autonomy of NPs as legitimate health care providers.
- The original reasons behind establishing collaborative arrangements, such as avoiding fragmented care (29) (30), do not justify the continued requirement for these arrangements.
 - Collaborative arrangements for NPs were introduced in 2010 via the *National Health (Collaborative arrangements for NPs) Determination 2010*, as a prerequisite to an NP providing health care services subsidised by the MBS (11). This was a ministerial determination made at the time of the legislative amendments to allow patient access to rebates through the MBS for NP services. Neither the presence nor the effectiveness of collaborative arrangements has been monitored by the Department or the DHS since implementation of the determination in 2010.
 - Experience over the last 18 years shows that NPs effectively collaborate without formal agreements. Collaboration is already required formally within NPs' standards of practice.



- Collaboration is ingrained in nursing philosophy and is represented in the NMBA standards for practice for both RNs and NPs. Both sets of standards are grounded in actual (as opposed to aspirational) practice and are evidence-based (31). To meet the standards of practice (against which nurses are audited), collaborative practice must occur. A separate mandated collaborative arrangement is not required.
- There is no evidence to suggest that collaborative arrangements increase collaboration between NPs and medical practitioners.
- Collaborative arrangements are not required in comparable countries. For example, mandated collaborative arrangements are not required for NPs practising in New Zealand.
- Medical practitioners do not face increased liability by working with NPs in the absence of collaborative arrangements. Conversely, collaborative arrangements may expose medical practitioners to increased liability (32).
- Nurses and midwives are the only health professionals required by law to establish an arrangement with a medical officer in order to participate in the MBS.

Case Study – Diagnostic Imaging 1

James practises as an NP in an urban homelessness clinic in the Australian Capital Territory. He is the sole health provider in a bulk-billing clinic and provides comprehensive primary health care services across the lifespan of clients.

A typical day requires James to assess, diagnose and manage long-term health conditions in his population, such as diabetes, depression, drug and alcohol dependence, and hypertension. James assesses and manages acute, minor illnesses and injuries such as upper respiratory tract and skin infections, sexually transmitted infections, musculoskeletal conditions and wounds. He provides a wide range of preventive health care services, including routine vaccinations and lifestyle modification interventions, such as smoking cessation counselling and nutrition advice.

James also cares for people with complex health requirements. However, he is frequently required to refer clients to a general practice, as current MBS rules do not enable him to initiate many common diagnostic imaging tests otherwise subsidised in primary health care, such as ultrasounds and X-rays. This causes frustration for clients, whose care experience becomes fragmented. It also involves unnecessary duplication of services. Although the general practice is willing to see patients referred by James, the practice often does not have an appointment available for several days. Clients are frustrated because they know James is sometimes able to initiate an investigation, while at other times he needs to refer them to a general practice—a visit that may not always be bulk billed. As a result, clients attending the homelessness clinic often do not continue to seek treatment for their problems, or end up attending the local public hospital emergency department to obtain imaging requests that could have been requested in James' homelessness clinic.



Case Study – Diagnostic Imaging 2

Susan is a primary healthcare nurse practitioner who has a 15-minute appointment booked with a male university student that she has not seen before. The student is presenting for a sick certificate, as he has been unable to attend exams due to recurrent severe headaches. He had previously been seen by other practitioners in the clinic for similar headaches.

At first glance the student appears to be a fit and healthy 19-year-old. Susan conducts a comprehensive assessment and notes that the patient has hearing loss in his left ear and has a mild ptosis of his left eye. Concerned, Susan conducts a thorough review of his previous visits. On each occasion the patient was advised to take Panadol and given a medical certificate. However, on review of his record Susan notices the patient has several untranslated medical records imported into his file that were in French. Luckily Susan has a rudimentary understanding of French and becomes increasingly concerned when she discerns the patient was given a diagnosis of neurofibromatosis many years ago after having his hearing evaluated as a child in France.

Susan calls a local neurology team, as she is suspicious the patient may have progression of his disease due to the constellation of his symptoms. After discussing the case over the phone, the neurologist identifies she would like to see the patient early the following week, but would like him to have an MRI performed prior to his appointment. Susan can request the MRI but the test will not be subsidised by the MBS if requested by a nurse practitioner, resulting in significant out of pocket expenses for her patient. The patient doesn't feel comfortable going to another health provider that he doesn't know for an imaging request. Ultimately, the patient has his appointment with the neurologist, but didn't have an MRI to review at his appointment. This resulted in significant delays as the patient had to then be referred for the MRI and return to the specialist appointment, which eventually revealed progression of extensive schwannomas and bilateral acoustic neuromas.

5.4.3 Recommendation 9 - Remove current restrictions on MBS-rebated diagnostic imaging investigations when requested by NPs working within their scope of practice

The Reference Group recommends:

- a. removing current restrictions on diagnostic imaging investigations subsidised under the MBS when requested by NPs working within their scope of practice
- b. in particular, restrictions should be removed from the following items, which serve as exemplars:
 - (i) Ultrasound investigations.
 - General: Items 55028, 55032, 55038, 55048, 55054 and 55065.
 - Cardiac: Items 55113, 55114, 55115, 55116 and 55117.
 - Vascular: Items 55238, 55244, 55246, 55248, 55252, 55274, 55276, 55278 and 55292.
 - Obstetrics/gynaecology: Items 55700, 55703, 55704, 55706, 55707 and 55718.



(ii) Diagnostic radiology investigations.

- Head: Items 57901, 57902, 57903, 57912, 57915, 57921, 57924, 57927, 57933, 57945, 57960, 57963, 57966 and 57969.
- Spine: Items 58100, 58103, 58106, 58108, 58109, 58112, 58115, 58120 and 58121.
- Alimentary tract and biliary system: Items 58903 and 58909.
- Localisation of foreign body: Item 59103.
- Breasts: Items 59300 and 59303.
- Tomography: Item 60100.
- Fluoroscopic exam and report: Items 60506 and 60509.

(iii) Computerised tomography imaging examinations.

- Items 56001, 56007, 56016, 56022, 56030, 56101, 56107, 56220, 56223, 56233, 56301, 56307, 56409, 56412, 56501, 56507, 56619, 56801, 56807, 57007, 57341, 57350, 57360 and 57362.

(iv) Magnetic resonance imaging examinations.

- Items 63551, 63554 and 63560.

(v) Nuclear medicine imaging items.

- Items 61307, 61348, 61421, 61425, 61449, 61473 and 61505.

(vi) Other Diagnostic Procedures and Investigations

- Items 12306, 12312, 12315, 12321, 12320 and 12322

5.4.4 Rationale 9

This recommendation focuses on reducing fragmentation in care. It is based on the following:

- The Reference Group notes that this recommendation is not about increasing the NP scope of practice, as NPs can request any diagnostic investigation within their individual scope of practice outside the MBS. NPs are a safe and effective health workforce, with a demonstrated ability to adapt and respond to gaps in health service delivery, traverse the boundaries of health settings, and provide affordable, accessible health care for marginalised and vulnerable populations in primary and community health care.
- Enabling patients to access an MBS rebate for diagnostic imaging investigations requested by an NP would have positive outcomes for patients. Currently, patients only receive MBS rebates for a limited number of diagnostic imaging investigations



requested by an NP. In the event that a rebate is not available for a diagnostic imaging service when requested by an NP, patients must either:

- Be referred to a medical practitioner (where available) in order to receive the rebate for diagnostic imaging services. This creates barriers to the provision of timely and appropriate health care and results in the costly duplication of services, delays and fragmented episodes of care (27) (21).
- Forego the MBS rebate to which they are entitled and pay the full, unsubsidised cost for the diagnostic imaging service. This is an inequitable transfer of cost to the patient, who would not be required to pay the full cost if the service was provided by a GP.
- Decide not to undertake diagnostic testing (for example, if they are not able to afford the required imaging services). This may affect patient outcomes.
- This recommendation will enable NP models of care to provide more timely and efficient health care by enabling them to work to their full potential. It will also reduce the challenges of fragmentation and duplication of care, inequitable cost burdens, and the risks of increased morbidity and/or mortality outlined above. This is particularly true in areas where NP models have been established to address existing health workforce and service delivery shortages. Allowing NPs to work to their full potential is associated with higher supply in rural and primary care health professional areas (33).
- The recommendation may also assist with the development and implementation of NP models of care that align with the original intent of the role by:
 - Supporting the provision of flexible and responsive care that adapts to identified needs in marginalised and vulnerable communities.
 - Supporting NP workforce sustainability.
 - Better enabling NPs to align their practice with supporting evidence-based guidelines in clinical care.
 - Promoting timely and effective referrals to medical specialists and consultant physicians, resulting in improved patient access to informed, specialised medical care.

5.4.5 Recommendation 10 – Enable patients to access MBS rebates for procedures performed by an NP working within their scope of practice

The Reference Group recommends:

- a. enabling patients to access MBS rebates for procedures performed by an NP by changing the restrictions for diagnostic and therapeutic procedures that can be



performed by GPs to also include NPs who are working within their scope of practice
, and

b. in particular, NPs need to be able to request and/or perform the following:

(i) Category 2 – diagnostic procedures and investigations.

- Item 11506: Spirometry – measurement of respiratory function before and after inhalation of bronchodilator.
- Item 11700: 12-lead electrocardiography, tracing and report.
- Item 11610: Measurement of ankle-brachial indices and arterial waveforms
- Item 73811: Mantoux test.
- Item 73839: Quantitation of HbA1c performed for diagnosis of diabetes in asymptomatic patient at high risk.
- Item 73840: Quantitation of glycosylated haemoglobin performed in the management of established diabetes.
- Item 73844: Quantitation of urinary microalbumin as determined by urine albumin excretion on a timed overnight urine sample or urine albumin/creatinine ratio as determined on a first morning urine sample in the management of established diabetes

(ii) Category 3 – therapeutic procedures.

- Item 14206: Implanon insertion (hormone or living tissue implantation by cannula).
- Item 30062: Implanon removal including suturing.
- Item 30003: Dressing of localised burn.
- Item 30071: Diagnostic biopsy skin or mucous membrane.
- Item 30216: Aspiration of haematoma.
- Item 41500: Foreign body ear – removal of (by means other than simple syringing).
- Item 30023: Deep or extensively contaminated wound including suturing under anaesthesia.
- Item 30026: Suture < 7cm superficial not face.
- Item 30029: Suture < 7cm deep not face.
- Item 30032: Suture < 7cm deep face.
- Item 30038: Suture >7cm superficial not face.



- Item 30042: Suture >7cm deep not face
- Item 30052: Suture eyelid/nose/ear.
- Item 30061: Foreign body superficial – Removal of (inc. Cornea/Sclera).
- Item 30064: Foreign Body Subcutaneous – Removal of.
- 30071 Diagnostic Biopsy skin or mucous membrane.
- Item 30219: Haematoma, Furuncle, Abscess, and Lesion – Incision with drainage of.
- Items 31356–31376: Removal of skin lesions.
- Item 41500: Foreign body ear – removal of by means other than simple syringing.
- Item 41659: Foreign body nose – removal of by means other than simple probing.
- Item 42644: Foreign body Cornea/Sclera – removal of imbedded.
- Item 47915: Ingrowing nail of toe, wedge resection for, with removal of segment of nail, ungual fold and portion of the nail bed.
- Item 35503: Insertion of Intra-uterine contraceptive device (IUD).
- Item 36800: Catheterisation of the bladder.

5.4.6 Rationale 10

This recommendation focuses on reducing fragmentation in care. It is based on the following:

- This change should expand (rather than replace) the current list of procedures for which rebates already exist for NP-performed procedures.
- Under current MBS rules, rebates for most diagnostic and therapeutic procedures are not available to patients when those procedures are performed by an NP.
- NPs perform a variety of diagnostic and therapeutic procedures across all care settings, in accordance with their scope of practice.
- As with diagnostic imaging referrals, the lack of MBS rebates for diagnostic and therapeutic procedures performed by NPs can increase out-of-pocket costs for patients, perpetuate inefficiencies through duplication of care, and blur care accountability. It also imposes an unnecessary limitation on the NP workforce.



- Currently, the person receiving a procedure performed by an NP is required to pay the full cost of a procedure (without an MBS rebate), in addition to the professional attendance fee.
- Duplication, delays and inefficiencies can be created when a patient is referred to a medical practitioner for a procedure in order to be able to access the MBS rebate to which they are entitled. This practice also blurs accountability for care and limits the role of NPs as autonomous and independent health providers.
- Research in primary care has found that duplication of services (attributed to the inability of NPs to perform or request diagnostic and therapeutic items subsidised under the MBS) interrupts workflow and delays patient care (21). For example, patients may be referred to other services, including emergency departments, for some procedures because there is no adequate MBS rebate to support patients accessing this care from an NP.
- The ability to facilitate access to MBS rebates for diagnostic and therapeutic procedures performed by NPs will support more affordable, equitable and accessible care in primary health, community, rural and remote, and residential aged care settings. Vulnerable health patients are particularly affected by the lack of MBS rebates for care provided by NPs (18).
- This recommendation will also increase the financial viability of NP services by better recognising the broad range of services that NPs are able to provide. This will enable more equitable and accessible health services (18).
- Access to MBS rebates for items performed by NPs may be cost-neutral because duplication of services would be eliminated. Access to health care for the most vulnerable patients would also be improved.
- Other benefits of this recommendation may include increased professional colleague and patient satisfaction with the type of care provided, a decrease in patient waiting times due to improved access, and increased productivity as NPs are able to contribute to the overall provision of health care services (21) (22).

5.5 Improving patient access to telehealth services

5.5.1 The role of telehealth

The Reference Group acknowledged that the role of non-face-to-face communications is an increasingly important one in health services and patient care. For NPs acting as a primary care giver, as well as those in more specialised roles, telehealth offers an opportunity to provide high-value care to patients who may not be able to see their health provider in person.



The Reference Group noted that the long-term solution for telehealth support, as part of a comprehensive suite of health services, may not be through a fee-for-service MBS. However, it felt it was important to include actionable, shorter-term recommendations for specific items, both existing and new, that could address the current service gap in telehealth.

The Reference Group considered various restrictions on proposed telehealth items in order to ensure that they are not abused, and that telehealth is only used when it is a mechanism for providing high-value care to a patient. These included:

- **Rurality:** Ensure that patients who use telehealth services are not easily able to access a relevant health provider for a face-to-face consultation.
- **Usual practitioner:** Ensure that patients receive telehealth support from a provider who is focused on the patient and is providing telehealth support because it is the best medium available (rather than being focused on telehealth and providing a service to a patient simply because the option is available).
- **Follow-up care:** Ensure that patients only receive telehealth support when the attendance is in relation to a clinical issue already discussed at a face-to-face consultation.
- **Patient-side support:** Ensure that, where relevant, an appropriate practitioner is physically in attendance with the patient during their telehealth consultation.

Ultimately, the Reference Group decided against identifying the specific conditions associated with these dimensions, as several exceptions could be found for each of them. Some suggestions are included with each of the recommendations below, as a starting place for implementation.

5.5.2 The advantages of telehealth

For patients, the main benefit of using telehealth services is increased access to health care, with non-inferior outcomes, where clinically appropriate. Evidence for this includes the following:

- Surveys have consistently found high patient satisfaction with telehealth consultations (34) (35) (36).
- Compared to usual care, a range of telehealth interventions have been found to produce at least equivalent outcomes in the management of asthma (37) (38), blood pressure (39) and depression, and in overall quality of life (40).

A systematic literature review of telehealth services in rural and remote Australia reviewed models of care and factors influencing success and sustainability. Funding for general



medical and other practitioners for the provision of telehealth services is limited or non-existent (41).

In a study in the United States, the transaction costs of in-clinic consultations and telehealth presentations were compared for chronic pain management provided by community-based providers including NPs, primary care physicians and physician assistants. Although similar in terms of cost, telehealth consultations demonstrated preliminary evidence for improved patient satisfaction with treatment, improved provider satisfaction with the consultation process, reduced wait times and reduced health care utilisation (42).

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

The Reference Group recommends:

- a. adding GPs as eligible participants in NP patient-side telehealth services (items 82220, 82221 and 82222)
- b. including all Aboriginal and/or Torres Strait Islander peoples, not only patients of Aboriginal Medical Services or Aboriginal Community Controlled Health Services with a 19(2) exemption, and
- c. amending the item descriptors along the lines of the following example:

Item 82220 – example text

A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating NP that requires the provision of clinical support to a patient who:

- a) is participating in a video consultation with a specialist, consultant physician, or general practitioner; and
- b) is not an admitted patient of a hospital; and
- c) is located:
 - (i) both:
 - (A) within a telehealth eligible area; and
 - (B) at the time of the attendance - at least 15 kms by road from the specialist, consultant physician or general practitioner mentioned in paragraph (a); or
 - (ii) in Australia if the patient is of Aboriginal or Torres Strait Islander descent.



Note: The Reference Group recognises that this item would require GPs to have access to reimbursement for telehealth service provision, whether through an MBS item number or a different funding model.

5.5.4 Rationale 11

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

- Telehealth services provide high-quality care options for Australians.
- GP-to-patient telehealth items with an NP on the patient side would help to fill current access gaps and allow for the provision of clinically effective, high-value services to patients, including:
 - GPs as eligible telehealth providers will increase patient access to primary care, particularly in remote areas where such access is more limited. NPs are well placed to support these telehealth services due to their relatively higher presence in remote areas (compared to GPs).
 - GPs would also decrease wait times to see the GP (by enabling consultation at the time of need), minimise cost for the patient (by mitigating the need to travel to the GP) and enhance buy-in from remote sites (43).
 - Limiting the video telehealth attendance to clinical support with a specialist or consultant physician restricts patient access to health care providers when an NP is seeking consultation with a patient and a GP. Often it is more appropriate, cost-effective and efficient to consult with a collaborating GP, rather than a specialist or consultant physician, especially for people who are geographically marginalised (living in Modified Monash Model areas 4 to 7), people in aged care and people in palliative care who are being managed at home.
- The current structure of telehealth items limits NP uptake. A survey of 73 NPs who work in primary care and access the MBS indicated that only 12 per cent had ever used telehealth items. It identified the requirement to have a specialist or consultant present as the main reason for non-use of telehealth items (44). MBS data showed that there were only 1,033 telehealth rebate claims in 2016/17 (less than 0.3 per cent of NP services for the year).
- GP telehealth items enable collaborative relationships between NPs and GPs, as NPs support from the patient side to facilitate care.
- The Royal Australian College of General Practitioners has developed clinical guidelines to enable the implementation of video consultations in general practice. These guidelines provide valuable insight and strategies to mitigate risk (45).



- Access to telehealth items for Aboriginal and/or Torres Strait Islander peoples in all regions, from urban to remote, may help to improve uptake of services where low cultural safety limits their ability to access services.

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

The Reference Group recommends adding patients in community aged care settings to residential aged care telehealth items (82223, 82224 and 82225) with the proposed descriptors as follows:

“... patients in receipt of, or assessed as eligible for, Government-funded Home Care Packages.”

5.5.6 Rationale 12

This recommendation focuses on increasing access to, and use of, telehealth services for patients who face difficulties accessing their primary health provider despite living in urban areas. It is based on the following:

- NPs often provide services to older people living in RACFs and those who are still living at home but in receipt of (or assessed as eligible for) Government-funded HCP.
- Patients receiving funding through the HCP program have similar levels of frailty and dependence to those living in residential aged care. Despite living in urban areas, they often have mobility and illness limitations, which impede their ability to access medical and nurse practitioner services.

5.5.7 Recommendation 13 – Create new MBS items for direct NP-to-patient telehealth consultations

The Reference Group recommends:

- a. creating new MBS items for direct NP-to-patient telehealth consultations (items 8222A, 8222B and 8222C) with the proposed descriptors (using item 8222A as an example):

**New Item 8222A – example text**

A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating NP practising in MMM 2-7 that requires the provision of clinical support to a patient who:

- a) is participating in a video consultation with the NP; and
- b) is not an admitted patient; and
- c) is located:
 - (i) both:
 - (A) within an MMM 2-7 area; and
 - (B) at the time of the attendance - at least 35 kilometres from the NP's location (a); or
 - (ii) in Australia if the patient is of Aboriginal or Torres Strait Islander descent.

- b. these items should parallel the time-tiers of existing patient-side items (i.e. less than 20 minutes, at least 20 minutes and at least 40 minutes), and
- c. there should be no requirement for any particular health service professional to be patient-side.

5.5.8 Rationale 13

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

- Telehealth services are high-quality care options for Australians.
- Telehealth sessions between an NP and a patient will improve access to timely care, reduce fragmentation, reduce or avoid the need for patients to be transferred to access required care, and allow for clinically effective, high-value services for patients. For example:
 - Telehealth services could be used for managing a patient who may already have medications/dressing available, to triage for the need for a physical consult, and/or to follow up on a face-to-face consult.
 - Telehealth services can increase access for patients in isolated areas. For example, a patient based at a cattle station will require access to care for an initial contact, for urgent or emergent care, or for follow-up care. If provided face to face, patients would face barriers including cost, travel and time away from community.



- Telehealth consultations can help improve access for patients with physical disabilities (who may find it difficult to get to an NP's office) and for patients with intellectual disabilities (who may not respond well to unfamiliar surroundings).
- Telehealth consultations can support NPs in providing primary care across the aged care sector. Enabling aged care nurses to access the support of NPs, particularly after hours, would further enhance NPs' contribution to improving health outcomes and avoid deterioration in health status for older people.
- The Reference Group acknowledges that there could be benefit in a patient-side attendance by an RN, an Aboriginal and Torres Strait Islander health worker or health practitioner, an allied health professional, an enrolled nurse, or other health care providers.

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

The Reference Group recommends allowing telehealth consultations to take place via telephone where clinically appropriate (i.e. without requiring a video connection) (items 82220, 82221, 82222, 82223, 82224, 82225, 8222A, 8222B and 8222C).

5.5.10 Rationale 14

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

- Requiring video connections between patient and practitioner has been shown to limit patient access to telehealth services (46) (47).
- Patients may be unable to undertake video communication due to:
 - Poor internet connections, often due to remoteness.
 - Lack of access to necessary technology.
 - Lack of understanding of or comfort with technology.
- Telephone communication for telehealth services offers non-inferior outcomes, where clinically appropriate (47) (48).



6 Impact statement

Both consumers and NPs are expected to benefit from the recommendations in this report. In making its recommendations, the Reference Group's primary focus was ensuring consumer access to high-quality primary care services. The Reference Group also considered the effect of its recommendations on NPs and other health professionals to ensure that they were fair and reasonable.

Patients will benefit from the Reference Group's recommendations through improved access to continuity of primary care models and higher quality clinical services, particularly in aged care, chronic disease management, and rural and remote areas. This includes:

- **Affordable, accessible primary care of choice.**
 - Significantly increasing patient rebates for services provided by NPs will improve patient access to primary care, lower costs for consumers, enable patient choice and establish access where no care options exist. This will be particularly beneficial for underserved and marginalised populations such as Aboriginal and/or Torres Strait Islander communities, the homeless and socially isolated people.
 - Consumers want real choice in their primary health care. This is not currently available consistently across Australia. In some rural and remote areas, there are few health service delivery options available.
 - Aboriginal and/or Torres Strait Islander peoples have expressed the importance of receiving primary care "on country" to feel culturally safe and to maximise their health outcomes. Inadequate MBS rebates to support access to NP services on country means that patients must often travel to seek primary care and/or experience unreasonable delays in receiving care. This can result in further deterioration of their health and/or an inability to seek the care they require. The poor outcomes that result for Aboriginal and/or Torres Strait Islander peoples who face barriers to care are preventable and could be improved by broadening access to NP services, particularly for people with chronic illness and disease.
 - Recommended changes to telehealth services seek to improve access to care by broadening the types of providers who are eligible to participate in telehealth, as well as the modes of communication that are used. These changes will provide increased opportunity for patients to receive affordable, high-value and best-practice primary health care from the practitioner of their choice.



- These changes will also improve the care experience for patients in rural and remote regions, who will be able to engage and develop a relationship with their chosen primary health care provider without travelling long distances.
- There is limited subsidised access to health care in high-priority areas that are often serviced by NPs, including aged care, mental health, palliative care and chronic disease management. This is due to the restricted number of MBS rebates available to patients when NPs provide or initiate services. Improving support for NP services through the MBS for people living in residential care will reduce unnecessary deteriorations in health status, which often occur for older Australians who experience delays in receiving care. In palliative care, changes to support NP services will provide a foundation to support improved end-of-life care and make a meaningful difference to quality of life for many Australians.
- Significantly increasing the MBS rebate for NP attendances and providing MBS rebates for NP home visits and outreach work will improve access for vulnerable patients who need timely, affordable care in non-traditional environments. Such care is often provided opportunistically, rather than through traditional visits to a general practice or consulting room. Provision of such care within the community will reduce unnecessary costs, fear and disruption for consumers, as well as any unintended consequences of emergency or hospital care.
- Allowing patients who live in residential aged care facilities (RACFs) and those who receive Commonwealth-funded community aged care in the home in all areas (Modified Monash Model areas 1–7) to access rebates for telehealth services will mean that they can be treated in their own home without the disruption, confusion, discomfort or distress of unnecessary transfer to hospital.
- **High-value, best-practice health care.**
 - Improving patient access to MBS items for services provided and initiated by NPs will maximise choice, reduce fragmentation and duplication for consumers, and reduce current inefficiencies and improve cost-effectiveness across Australia's health system.
 - The recommendations in this report support the provision of high-quality care to patients by removing artificial barriers to real collaboration between service providers, and by recognising the value of NP attendances (which last at least 60 minutes in some circumstances).
 - The recommendations will also enhance continuity of care provided by NPs, who provide high-value care to patients, as highlighted by national and international research cited throughout the report. Enabling consumers to access appropriate MBS rebates for NP services will limit the unnecessary duplication of services,



fragmentation of care, and other inefficiencies currently experienced by NP patients within existing MBS arrangements.

- Building trust with a known primary care professional reduces patients' apprehension and increases their confidence in the care provided. Patients will benefit from the availability of MBS rebates for health assessments and chronic care and team care arrangements undertaken by an NP, as well as case conferences coordinated by an NP, because they will no longer have to attend multiple appointments with another practitioner, who may not be their primary care provider, in order to receive the rebates to which they would otherwise be entitled.
- Similarly, being able to access MBS rebates for diagnostic imaging and procedures performed by NPs will assist patients in avoiding the inefficiencies, cost and inconvenience of visiting additional providers.

The Reference Group's recommendations will benefit NPs by enshrining a more accurate representation of their scope of practice in the MBS, and through increased financial recognition of the care they provide. More broadly, NPs will benefit from increased choice in working models as NP care becomes a financially and structurally viable option.

Consumers, NPs and the Australian health care system will benefit from overall increased investment in NP continuity of primary care, as recommended in this report. These benefits will accrue from high-quality, cost-effective health outcomes that benefit families and the community.



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8. Glossary

Term	Description
AHS	Aboriginal Health Services
ANMAC	Australian Nursing and Midwifery Accreditation Council
AQF	Australian Qualifications Framework
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	Department of Health
DHS	Department of Human Services
DMMR	Domiciliary Medication Management Review
FTE	Full-time equivalent
GP	General practitioner. GP is used within this report to refer to vocationally registered GPs and GP registrars who are appropriately supervised and are skilled and qualified to provide comprehensive primary care.
GPPCCC	General Practice and Primary Care Clinical Committee
HCP	Home Care Packages
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.
HMR	Home Medicines Review



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.
Minister, The	Minister for Health
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.
MMR	Medication management review
MSAC	Medical Services Advisory Committee
National Law	Health Practitioner Regulation National Law 2009
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.
NMBA	Nursing and Midwifery Board of Australia
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).
NP	Nurse practitioner
NRAS	National Registration and Accreditation Scheme
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.



OOP	Out-of-pocket payment. These are health care payments that consumers are expected to make themselves (i.e. an amount not rebated by Medicare).
PBS	Pharmaceutical Benefits Scheme
PCRG	Primary care reference group
RACF	Residential aged care facility
Reference Group, The	Nurse Practitioner Reference Group of the MBS Review
RMMR	Residential Medication Management Review
RN	Registered nurse
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).
Taskforce, The	MBS Review Taskforce
Underserved	People who may not be able to gain entry to and receive care and services from the health care system. Factors influencing this ability include geographic, architectural, availability, transport and financial considerations, among others. Someone who is underserved may not necessarily receive less care, but they cannot receive it whenever or wherever they need it.



Appendix A Full list of in-scope items

Item	Description	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
82200	Professional attendance by a participating NP for an obvious problem characterised by the straightforward nature of the task	9.60	53,990	\$442,762.00	85.71%
82205	Professional attendance by a participating NP lasting less than 20 minutes	20.95	120,414	\$2,152,151.20	23.74%
82210	Professional attendance by a participating NP lasting at least 20 minutes	39.75	133,334	\$4,523,977.20	50.76%
82215	Professional attendance by a participating NP lasting at least 40 minutes	58.55	109,966	\$5,547,413.10	63.87%
82220	A professional attendance lasting less than 20 minutes that requires the provision of clinical support to a patient who is participating in a video consultation with a specialist or consultant physician	28.30	109	\$2,610.95	55.47%
82221	A professional attendance lasting at least 20 minutes that requires the provision of clinical support to a patient who is participating in a video consultation with a specialist or consultant physician	53.70	244	\$11,138.60	161.38%
82222	A professional attendance lasting at least 40 minutes that requires the provision of clinical support to a patient who is participating in a video consultation with a specialist or consultant physician	78.95	593	\$39,819.95	105.96%
82223	A professional attendance lasting less than 20 minutes that requires the	28.30	0	\$0	N/A



Item	Description	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5- year annual avg. growth
	provision of clinical support to a patient at a RACF who is participating in a video consultation with a specialist or consultant physician				
82224	A professional attendance lasting at least 20 minutes that requires the provision of clinical support to a patient at a RACF who is participating in a video consultation with a specialist or consultant physician	53.70	5	\$228.25	20.11%
82225	A professional attendance lasting at least 40 minutes that requires the provision of clinical support to a patient at a RACF who is participating in a video consultation with a specialist or consultant physician	78.95	82	\$5,506.30	82.96%



Appendix B Full list of recommendations

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

The Reference Group recommends enabling patients to access MBS rebates for long-term and primary care management provided by NPs as follows:

- a. amending the item 701, 703, 705 and 707 descriptors to include NPs as eligible providers, enabling patients to receive MBS rebates for health assessments performed by NPs, with proposed item descriptor (using item 701 as an example) as follows:

Items 701 – example descriptor

Professional attendance by a medical practitioner (other than a specialist or consultant physician), or a nurse 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

- b. amending the item 715 descriptor to include NPs as eligible providers, enabling Aboriginal and/or Torres Strait Islander patients to access MBS rebates for health assessments performed by NPs, with the proposed item descriptor as follows

Items 715

Professional attendance by a medical practitioner (other than a specialist or consultant physician), or a nurse 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.

- c. amending the item 721, 723 and 732 descriptors to include:
 - i. NPs as eligible providers, enabling patients to access MBS rebates for the preparation and review of chronic care management plans and the development of team care arrangements by NPs



- ii. an appropriate title that captures the intent of the chronic care management plans and team care arrangements (for example, Patient-centred Management Plan, Chronic Disease Management Plan), and
- iii. with proposed item descriptor (using item 701 as an example) as follows:

Item 721

Professional attendance by a medical practitioner (other than a specialist or consultant physician), or a nurse 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.

Note: The Reference Group notes that this recommendation may need to be amended to reflect proposed changes by the GPPCCC.

- d. amending the item 729 and 731 descriptors to include NPs, enabling patients to access MBS rebates for an NP's contribution to a multidisciplinary care plan, with proposed item descriptor (using item 729 as an example) as follows:

Item 729

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), or a nurse practitioner, for preparation of a chronic disease management plan for a patient (other than a service associated with a service to which any of items 735 to 758 apply)

Note: The Reference Group notes that the GPPCCC referred a question on case conferencing to the Reference Group. See Appendix D for the Reference Group's response to the GPPCCC.

- e. amending the item 2700 and 2701 descriptors to include NPs as eligible providers,
- f. that no MBS item or otherwise subsidised activities relating to the planning, coordination and management of long-term health conditions (for example, Closing the Gap initiatives, Home Medicines Reviews [HMRs], integrated team care) should result in greater disadvantage for Aboriginal and/or Torres Strait Islander patients seeking and choosing an NP to manage their chronic health condition, and
- g. that any future iterations of MBS items, Commonwealth-subsidised models of care, or funding arrangements relating to the primary care management and coordination of long-term health conditions should consider that an NP may be a patient's preferred primary care provider, as a safe and effective alternative to a GP.

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

The Reference Group recommends enabling patients to access MBS rebates for NP services in aged care settings, particularly:

- (i) Health assessments, which are available for residents of RACFs and those aged over 75
- (ii) Health assessments for Aboriginal and/or Torres Strait Islander peoples
- (iii) Managing chronic disease
- (iv) Contributing to a multidisciplinary care plan, particularly for residents of RACFs (item 731), and
- (v) Developing a Mental Health Treatment Plan.

Notes:

- 1. *This recommendation mirrors most of the recommended changes made at Recommendation 1.*
- 2. *This recommendation also reinforces the importance of Recommendation 5 which proposes a new item for an NP professional attendance lasting for at least 60 minutes.*

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

The Reference Group recommends:

- a. enabling patients to access MBS rebates for NP-requested medication management reviews (MMRs) and DMMRs, through items 900 and 903
- b. that the same rules that apply to GP-requested medication reviews should apply to NP-requested reviews, including gaining consent from the patient or carer, giving results to the patient, and developing a plan to assist the patient with managing the medication
- c. access to rebates for NP-initiated medication reviews should apply to both the NP and the pharmacy components of these reviews (whether via the MBS or a Sixth Community Pharmacy Agreement)
- d. Pharmacist reports should be supplied to the NP where they are the patient's lead clinician, and
- e. a copy of the DMMR/RMMR should be uploaded to My Health Record, with permission from the patient (or legal substitute decision-maker).

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

The Reference Group recommends significantly increasing the schedule fee assigned to current MBS NP professional attendance items (Items 82200, 82205, 82210 and 82215).



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

The Reference Group recommends creating a new MBS item for longer NP attendances to support the delivery of complex and comprehensive care, with the proposed item descriptor as follows:

New Item 822AA

Professional attendance by a participating NP lasting at least 60 minutes.

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

The Reference Group recommends:

- a. enabling patients to access MBS rebates for after-hours or emergency care provided by NPs
- b. modifying MBS items that support patient access to emergency and after-hours assessment and treatment by vocationally qualified GPs and GP registrars to include care provided by NPs, examples of item numbers that should be revised include:
 - (i) Items 761–769 for professional attendance (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)
 - (ii) Items 772–789 for 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) by a medical practitioner—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, and
 - (iii) Items 585–600 for urgent attendance after hours.
- c. applying the restrictions, controls and requirements that were introduced to MBS emergency and after-hours care in March 2018.

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

The Reference Group recommends enabling patients to access MBS rebates for NP care received outside of a clinic setting by creating new items for NP professional attendances (items 822BB, 822CC, 822DD and 822EE) with the following descriptor (using an attendance of less than 20 minutes as an example) is as follows:



New Items – Example descriptor

Professional attendance by a nurse 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, for an attendance on one or more patients at one place on one occasion.

Note: The Reference Group notes that these items could parallel the existing GP professional attendances for out-of-rooms visits.

Recommendation 8 – Requirement for NPs to form collaborative arrangements

The Reference Group recommends removing the mandated legislative requirement for NPs to form collaborative arrangements, in accordance with the *National Health (Collaborative arrangements for NPs) Determination 2010*.

Recommendation 9 - Remove current restrictions on diagnostic imaging investigations

The Reference Group recommends:

- a. removing current restrictions on diagnostic imaging investigations subsidised under the MBS when requested by NPs working within their scope of practice
- b. in particular, restrictions should be removed from the following items:
 - (i) Ultrasound investigations.
 - General: Items 55028, 55032, 55038, 55048, 55054 and 55065.
 - Cardiac: Items 55113, 55114, 55115, 55116 and 55117.
 - Vascular: Items 55238, 55244, 55246, 55248, 55252, 55274, 55276, 55278 and 55292.
 - Obstetrics/gynaecology: Items 55700, 55703, 55704, 55706, 55707 and 55718.
 - (ii) Diagnostic radiology investigations.
 - Head: Items 57901, 57902, 57903, 57912, 57915, 57921, 57924, 57927, 57933, 57945, 57960, 57963, 57966 and 57969.
 - Spine: Items 58100, 58103, 58106, 58108, 58109, 58112, 58115, 58120 and 58121.
 - Alimentary tract and biliary system: Items 58903 and 58909.
 - Localisation of foreign body: Item 59103.
 - Breasts: Items 59300 and 59303.



- Tomography: Item 60100.
 - Fluoroscopic exam and report: Items 60506 and 60509.
- (iii) Computerised tomography imaging examinations.
- Items 56001, 56007, 56016, 56022, 56030, 56101, 56107, 56220, 56223, 56233, 56301, 56307, 56409, 56412, 56501, 56507, 56619, 56801, 56807, 57007, 57341, 57350, 57360 and 57362.
- (iv) Magnetic resonance imaging examinations.
- Items 63551, 63554 and 63560.
- (v) Nuclear medicine imaging items.
- Items 61307, 61348, 61421, 61425, 61449, 61473 and 61505.

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

The Reference Group recommends:

- a. enabling patients to access MBS rebates for procedures performed by an NP by changing the restrictions for diagnostic and therapeutic procedures that can be performed by GPs to also include NPs, and
- b. in particular, NPs need to be able to request and/or perform the following:
 - (iii) Category 2 – diagnostic procedures and investigations.
 - Item 11506: Spirometry – measurement of respiratory function before and after inhalation of bronchodilator.
 - Item 11700: 12-lead electrocardiography, tracing and report.
 - Item 73811: Mantoux test.
 - Item 73839: Quantitation of HbA1c performed for diagnosis of diabetes in asymptomatic patient at high risk.
 - Item 73840: Quantitation of glycosylated haemoglobin performed in the management of established diabetes.
 - (iv) Category 3 – therapeutic procedures.
 - Item 14206: Implanon insertion (hormone or living tissue implantation by cannula).
 - Item 30062: Implanon removal including suturing.
 - Item 30003: Dressing of localised burn.
 - Item 30071: Diagnostic biopsy skin or mucous membrane.



- Item 30216: Aspiration of haematoma.
- Item 41500: Foreign body ear – removal of (by means other than simple syringing).
- Item 30023: Deep or extensively contaminated wound including suturing under anaesthesia.
- Item 30026: Suture < 7cm superficial not face.
- Item 30029: Suture < 7cm deep not face.
- Item 30032: Suture < 7cm deep face.
- Item 30038: Suture >7cm superficial not face.
- Item 30042: Suture >7cm deep not face
- Item 30052: Suture eyelid/nose/ear.
- Item 30061: Foreign body superficial – Removal of (inc. Cornea/Sclera).
- Item 30064: Foreign Body Subcutaneous – Removal of.
- 30071 Diagnostic Biopsy skin or mucous membrane.
- Item 30219: Haematoma, Furuncle, Abscess, Lesion – Incision with drainage of.
- Items 31356–31376: Removal of skin lesions.
- Item 41500: Foreign body ear – removal of by means other than simple syringing.
- Item 41659: Foreign body nose – removal of by means other than simple probing.
- Item 42644: Foreign body Cornea/Sclera – removal of imbedded.
- Item 47915: Ingrowing nail of toe, wedge resection for, with removal of segment of nail, ungual fold and portion of the nail bed.
- Item 35503: Insertion of Intra-uterine contraceptive device (IUD).
- Item 36800: Catheterisation of the bladder.

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

The Reference Group recommends:

- a. adding GPs as eligible participants in NP patient-side telehealth services (items 82220, 82221 and 82222)
- b. including all Aboriginal and/or Torres Strait Islander peoples, not only patients of Aboriginal Medical Services or Aboriginal Community Controlled Health Services with a 19(2) exemption, and
- c. amending the item descriptors along the lines of the following example:

**Item 82220**

A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating NP that requires the provision of clinical support to a patient who:

- a) is participating in a video consultation with a specialist, consultant physician, or general practitioner; and
- b) is not an admitted patient of a hospital; and
- c) is located:
 - (i) both:
 - (A) within a telehealth eligible area; and
 - (B) at the time of the attendance - at least 15 kms by road from the specialist, consultant physician or general practitioner mentioned in paragraph (a); or
 - (ii) in Australia if the patient is of Aboriginal or Torres Strait Islander descent.

Note: The Reference Group recognises that this item would require GPs to have access to reimbursement for telehealth service provision, whether through an MBS item number or a different funding model.

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

The Reference Group recommends adding patients in community aged care settings to residential aged care telehealth items (82223, 82224 and 82225) with descriptors as follows:

“... patients in receipt of, or assessed as eligible for, Government-funded Home Care Packages.”

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

The Reference Group recommends:

- a. creating new MBS items for direct NP-to-patient telehealth consultations (items 8222A, 8222B and 8222C) with the following type of descriptors (using item 8222A as an example):

**New Item 8222A**

A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating NP practising in MMM 2-7 that requires the provision of clinical support to a patient who:

- a) is participating in a video consultation with the NP; and
- b) is not an admitted patient; and
- c) is located:
 - (i) both:
 - (A) within an MMM 2-7 area; and
 - (B) at the time of the attendance - at least 35 kilometres from the NP's location (a); or
 - (ii) in Australia if the patient is of Aboriginal or Torres Strait Islander descent.

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

The Reference Group recommends allowing telehealth consultations to take place via telephone where clinically appropriate (i.e. without requiring a video connection) (items 82220, 82221, 82222, 82223, 82224, 82225, 8222A, 8222B and 8222C).



Appendix C Summary for consumers

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

Recommendation 1: Enable patients to access MBS rebates for long-term and primary care management provided by NPs

Item (s)	What it does	Committee recommendation	What would be different	Why
701, 703, 705, 707, 715	Professional attendance by a general practitioner (GP) to perform a health assessment.	Allow patients to access MBS rebates for a health assessment performed by a nurse practitioner (NP).	Patients could access an MBS rebate for health assessments completed by NPs. Currently, rebates are only available if the assessment is done by a GP.	This would improve patients' choice and enable more access to services to manage their long-term health, particularly in rural and remote areas where there is limited access to medical practitioners.
721, 723, 732	Attendance by a general practitioner for preparation of a chronic care management plan for a patient.	Allow patients to access MBS rebates for a chronic care management plan performed by a nurse practitioner.	Patients could access an MBS rebate for chronic care management plans completed by NPs. Currently, rebates are only available if the plan is done by a GP.	This would improve patients' choice and enable more access to services to manage their long-term health, particularly in rural and remote areas where there is limited access to medical practitioners.
729, 731	Contribution or review by a general practitioner to a multidisciplinary care plan prepared by another provider.	Allow patients to access MBS rebates for a multidisciplinary care plan performed by a nurse practitioner.	Patients could access an MBS rebate when a nurse practitioner contributes to or reviews their multidisciplinary care plan. Currently, there is no MBS rebate for an NP contribution to this kind of plan.	This would improve patients' choice and enable more access to services to manage their long-term health, particularly in rural and remote areas where there is limited access to medical practitioners.



Item (s)	What it does	Committee recommendation	What would be different	Why
2700, 2701	Professional attendance by a general practitioner for the preparation of a GP Mental Health Treatment Plan for a patient (between 20 and 40 minutes, or greater than 40 minutes).	Allow preparation of a Mental Health Treatment Plan by nurse practitioners working within their scope of practice.	Patients could access an MBS rebate for the preparation of a Mental Health Treatment Plan when this is done by a nurse practitioner.	This would improve patients' choice and enable more access to services to manage their long-term health, particularly in rural and remote areas where there is limited access to medical practitioners.

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

Items	What it does	Committee recommendation	What would be different	Why
Detailed in Recommendation 1	Professional attendances by a GP to perform health assessments, chronic disease management, multidisciplinary care and mental health plans.	Allow preparation of health assessments, chronic disease management, multidisciplinary care and mental health plans by a nurse practitioner in aged care settings.	Improve access to universal, affordable and coordinated care of long-term health conditions for patients receiving aged care services in residential and community settings.	Nurse practitioners can help meet the high demand for care in aged care settings. Without this, older people are often transferred to hospital emergency departments for treatment and/or admission.

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

Items	What it does	Committee recommendation	What would be different	Why
900, 903	Participation by a general practitioner in a DMMR for a patient living in a community setting or RMMR in a residential aged care facility.	Allow a nurse practitioner to request a DMMR or RMMR.	Patients would receive an MBS rebate when a DMMR or RMMR is requested by a nurse practitioner.	These reviews are sometimes overlooked, delayed or prevented where access to a GP is limited. Enabling rebates for NP-requested DMMRs and RMMRs would help to ensure continuity of care for patients whose lead clinician is an NP.


Recommendation 4: Significantly increase the schedule fee assigned to current MBS NP professional attendance items

Items	What it does	Committee recommendation	What would be different	Why
82200, 82205, 82210, 82215	Professional attendances by a participating nurse practitioner (time tiered).	Increase the schedule fee assigned to these NP attendance items.	This would improve patients' ability to access NP services and, in turn, their choice of care provider.	An increased rebate would improve NPs' ability to cover the costs of care. A more financially viable model will allow more NPs to provide services in the primary care setting, including to underserved and marginalised populations.

Recommendation 5: Create a new MBS item for longer NP attendances to support the delivery of complex and comprehensive care

Item	What it does	Committee recommendation	What would be different	Why
New Item 822AA	Professional attendance by a participating nurse practitioner lasting at least 60 minutes.	Create a new item.	This recommendation would ensure that attendance items reflect best practice and enable the provision of high-quality care to underserved populations.	Attendances lasting more than 60 minutes are often required for a range of care, including palliative, dementia, specialist wound and diabetes care, and health services for Aboriginal and/or Torres Strait Islander peoples.


Recommendation 6: Enable patients to access MBS rebates for after-hours or emergency care provided by NPs

Items	What it does	Committee recommendation	What would be different	Why
761, 763, 766, 769	A professional attendance (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 five minutes, five to 25 minutes, 25 to 45 minutes, and 45 or more minutes.	Allow treatment by a nurse practitioner.	Improve access to timely, appropriate assessment and treatment.	This would prevent patients from not accessing care (leading to worsening health issues), or seeking care within emergency departments where their needs may be a lower priority.
772, 776, 788, 789	Professional attendance (other than a service to which another item applies) at a residential aged care facility by a medical practitioner lasting less than five minutes, five to 25 minutes, 25 to 45 minutes, and 45 or more minutes.	Allow treatment by a nurse practitioner.	Improve access to timely, appropriate assessment and treatment.	This would prevent patients from not accessing care (leading to worsening health issues), or seeking care within emergency departments where their needs may be a lower priority.



Items	What it does	Committee recommendation	What would be different	Why
585–600	Professional attendance by a general practitioner on one patient on one occasion—each attendance (other than an attendance in unsociable hours) in an after-hours period.	Allow treatment by a nurse practitioner.	Improve access to timely, appropriate assessment and treatment.	This would prevent patients from not accessing care (leading to worsening health issues), or seeking care within emergency departments where their needs may be a lower priority.

Recommendation 7: Enable patients to access an MBS rebate for NP care received outside of a clinic setting

Item	What it does	Committee recommendation	What would be different	Why
New Items 822BB, 822CC, 822DD, 822EE	Attendance (other than at consulting rooms or a residential aged care facility or a service to which another item applies).	Create new items to cover care received outside of a clinic setting.	Allow patients to receive a rebate for out-of-rooms or out-of-clinic care from a nurse practitioner, similar to a GP.	This would provide appropriate and sustainable primary care to all Australians in the right location at the right time and would avoid unnecessary duplication and fragmentation of care.



Recommendation 8: Remove the mandated requirement for NPs to form collaborative arrangements

Items	What it does	Committee recommendation	What would be different	Why
All NP items	A collaborative arrangement is between an eligible NP and a specified medical officer that must provide for consultation, referral and transfer of care as clinically relevant (25).	Remove the legislative requirement for NPs to form mandated collaborative arrangements in accordance with the National Health Determination 2010 in order to participate in the MBS.	Where a mandated collaborative arrangement could not be formed, the provision of primary care would continue, avoiding fragmented care and unnecessary hospital admissions. There would be minimal risk to quality of care as NPs already collaborate effectively, as required formally within NPs' standards of practice.	Collaborative arrangements can be difficult to develop, particularly in rural and remote areas, due to the availability and accessibility of medical practitioners and their willingness to participate in these arrangements.

Recommendation 9: Remove current restrictions on diagnostic imaging investigations subsidised under the MBS when requested by NPs

Items	What it does	Committee recommendation	What would be different	Why
See Section 5.4.3 All diagnostic imaging investigations that can be requested by general practitioners.	Allows a patient rebate for diagnostic imaging.	Allow requests for diagnostic imaging by a nurse practitioner.	This would improve access to timely, appropriate diagnostic imaging as patients would not have to wait to see a GP to request diagnostic imaging and receive a rebate.	This would avoid unnecessary duplication and fragmentation of care for patients of nurse practitioners working within their scope of practice, who are functioning as an alternative to a medical practitioner.



Recommendation 10: Enable patients to access MBS rebates for procedures performed by an NP

Items	What it does	Committee recommendation	What would be different	Why
See Section 5.4.5 Category 2 – diagnostic procedures and investigations Category 3 – therapeutic procedures.	Allows a patient rebate for diagnostic and therapeutic procedures if requested by a general practitioner.	Allow requests for diagnostic and therapeutic procedures by a nurse practitioner.	This would improve access to timely, appropriate diagnostic and therapeutic procedures as patients would not have to wait to see a GP to receive these services and a rebate.	This would avoid unnecessary duplication and fragmentation of care for patients of nurse practitioners working within their scope of practice, who are functioning as an alternative to a medical practitioner.

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

Items	What it does	Committee recommendation	What would be different	Why
82220, 82221, 82222	A professional attendance by a participating nurse practitioner on the patient-side, supporting a patient who is participating in a videoconference with a specialist or consultant physician.	Expand the item descriptor to enable GPs to provide a telehealth consultation and include all Aboriginal and/or Torres Strait Islander peoples.	This would allow greater access to GPs for rural and remote communities that are typically serviced by NPs.	This would increase patient access to primary care and decrease wait times, particularly in remote areas where GP access is more limited.



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

Items	What it does	Committee recommendation	What would be different	Why
82223, 82224, 82225	A professional attendance by a participating nurse practitioner on the patient-side, supporting a patient who resides in a residential aged care service and is participating in a video consultation with a specialist or consultant physician.	Expand the item descriptor to include patients in receipt of, or assessed as eligible for, Liberal National Government-funded Home Care Packages.	This would allow greater access to, and use of, telehealth services for patients who are likely to find it difficult to access their primary health care provider despite living in urban areas.	Patients receiving funding through the Home Care Packages program have similar levels of frailty and dependence to those living in residential aged care.

Recommendation 13: Create new MBS items for direct NP-to-patient telehealth consultations

Item	What it does	Committee recommendation	What would be different	Why
New Items 8222A, 8222B, 8222C	A professional attendance by a participating NP practising in Modified Monash Model areas 2–7 that requires the provision of clinical support to a patient (various durations).	Create new items to support NP-to-patient telehealth services.	Patients would be able to access an MBS rebate for a telehealth (videoconference) consultation with a nurse practitioner.	Telehealth sessions between an NP and a patient would improve access to timely care, reduce fragmentation, and reduce or avoid the need for patients to be transferred to access care.

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

Item	What it does	Committee recommendation	What would be different	Why
82220, 82221, 82222, 82223, 82224, 82225, New Items 8222A, 8222B, 8222C	A professional attendance by a participating nurse practitioner that requires the provision of clinical support to a patient who is participating in a video consultation.	Allow items for telehealth consultations to take place via telephone where clinically appropriate, instead of by videoconference.	Patients who are unable to undertake video communication (for example, due to poor internet connections, lack of access, or poor understanding of the necessary technology) could still access telehealth services.	Requiring video connections between patient and practitioner has been shown to limit patient access to telehealth services. Telephone communication can offer comparable outcomes in some situations.



Appendix D Response to referred questions from the General Practice and Primary Care Clinical Committee

29 June 2018

Dear General Practice and Primary Care Clinical Committee,

The NP Reference Group (NPRG) of the Medicare Benefits Schedule (MBS) Review has reviewed the referred questions and recommendations from the General Practice and Primary Care Clinical Committee (GPPCCC). This note summarises the discussions, feedback, and recommendations of the NPRG to the GPPCCC on the two referred questions.

In general, the NPRG notes that

- The role of the NP (NP) has continued to evolve in its contribution to health service delivery, particularly to underserved and vulnerable populations, since its implementation in 2000 and since admission as eligible providers in 2010. Despite this, the role of NPs in delivering and managing health care often remains poorly understood.

To provide context to this response, the NP Reference Group (NPRG) is providing background information describing contemporary NP practice in Australia. This will provide Committee members, the GPPCCC and the Taskforce itself with clear and concise information to support the issues and proposed solutions identified by the NPRG, both in response to questions asked by the GPPCCC and issues raised by Ministers, other MBS Review Clinical Committees and stakeholders.

The purpose of this information is threefold:

- To provide a broad overview of the underpinning requirements for NP (NP) endorsement including education and practise requirements;
- To provide a broad overview of the practice differences between Registered Nurses (RN) and NPs; and
- To provide a summary of how issues relating to the interpretation and application of current Department of Health policy and relevant legislation are often a barrier for underserved populations seeking health care from NPs.

Background

Consistent with international experience, the NP role was implemented in Australia to improve the flexibility of the health care workforce and enable new ways to compliment traditional models of health care delivery. Driving this initiative was a clear need to improve access to care for marginalised, underserved and vulnerable populations.



NPs are registered nurses who have been endorsed by the Nursing and Midwifery Board of Australia (NMBA) to practice using an expanded and extended scope of practice. The Nursing and Midwifery Accreditation Council (ANMAC) provides a concise description of that scope of practice in their 2014 consultation document¹, which was used to inform academic programmes leading to NP endorsement:

The scope of practice of the NP builds upon registered nurse practice, enabling NPs to manage complete episodes of care, including wellness focussed care, as a primary provider of care in collaborative teams. NPs use advanced, comprehensive assessment techniques in screening, diagnosis and treatment. They apply best available knowledge to evidenced-based practice. NPs request and interpret diagnostic tests, prescribe therapeutic interventions including the prescription of medicines, and independently refer people to healthcare professionals for conditions that would benefit from integrated and collaborative care. They accomplish this by using skilful and empathetic communication with health care consumers and health care professionals. NPs facilitate person-centred care through the holistic and encompassing nature of nursing. Finally, NPs evaluate care provision to enhance safety and quality within healthcare. Although clinically focused, NPs are also expected to actively participate in research, education and leadership as applied to clinical care.

After extensive formative work demonstrating the ability of nursing to safely and effectively translate the NP role to the Australian context, the NP title was formalised and protected in Australia in 1998 through the *Nurses Amendment (NPs) Act*. The first NPs were authorised to practice in New South Wales in 2000.

Since 2000, the Australian nursing profession has established the necessary professional and regulatory requirements to support the role including:

¹ Australian Nursing and Midwifery Accreditation Council. (2014). Consultation Paper 2: Review of the NP accreditation standards (pp. 47). Canberra, ACT: ANMAC.



- Professional standards for practice^{2,3,4};
- NMBA Registration Standard for Endorsement under s95 of the National Law⁵;
- NMBA-approved NP Accreditation Standards for education courses accredited by Australian Nursing and Midwifery Accreditation Council (ANMAC)⁶;
- Professional representation through establishment of the Australian College of Nursing Practitioners; and
- An empirically-established framework to inform specialty clinical learning and teaching^{7,8,9}.

In addition, NPs were admitted as eligible Medicare providers with the ability to participate in both the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme in 2010¹⁰.

Differences between a registered nurse and a nurse practitioner

The NP role *builds upon* the RN scope of practice. The following table broadly outlines the educational, professional and experiential requirements of the RN and NP scope of practice:

² Australian Nursing and Midwifery Council. (2006). National Competency Standards for the NP (pp. 5). Canberra, ACT: ANMC.

³ Gardner, G., Carryer, J., Gardner, A., & Dunn, S. (2006). NP competency standards: Findings from collaborative Australian and New Zealand research. *International Journal of Nursing Studies*, 43(5), 601-610. doi:10.1016/j.ijnurstu.2005.09.002

⁴ Nursing and Midwifery Board of Australia. (2014). NP Standards for Practice. Retrieved from <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines/nurse-practitioner-standards-of-practice.aspx>

⁵ Nursing and Midwifery Board of Australia. (2016). Registration standard: Endorsement as a NP. Retrieved from <http://www.nursingmidwiferyboard.gov.au/Registration-Standards/Endorsement-as-a-nurse-practitioner.aspx>

⁶ Australian Nursing and Midwifery Accreditation Council. (2015). NP accreditation standards. Retrieved from <https://www.anmac.org.au/standards-and-review/nurse-practitioner>

⁷ Gardner, A., Gardner, G., Coyer, F., Henderson, A., Gosby, H., & Lenson, S. (2013). Educating for Health Services Reform: Clinical Learning, Governance and Capability (CLLEVER) Study. Retrieved from <http://thecleverstudy.blogspot.com.au/2013/06/welcome-to-cllever-study-cllever-study.html>

⁸ Helms, C., Gardner, A., & McInnes, E. (2017). Consensus on an Australian NP specialty framework using Delphi methodology: results from the CLLEVER 2 study. *Journal of Advanced Nursing*, 73(2), 433-447. doi:10.1111/jan.13109

⁹ Helms, C. (2017). Consensus on a Specialist Clinical Learning and Teaching Framework for Australian NPs. (PhD), Australian Catholic University, Canberra, ACT.

¹⁰ Australian Government. (2010). Health Legislation Amendment (Midwives and NPs) Bill (2010).



	Registered Nurse (RN)	NP (NP)
Practise Requirements		
Title Protection?	Yes	Yes
Regulation	<ul style="list-style-type: none"> Regulated under the National Registration and Accreditation Scheme (NRAS) by the NMBA <i>Registration (RN): NMBA</i> 	<ul style="list-style-type: none"> Regulated under the NRAS by the NMBA <i>Endorsement (NP): NMBA</i> <i>State/Territory-Based authorisation to account for jurisdictional legislation/policy where relevant (e.g Poisons and Therapeutic Goods Acts).</i> A total of three years' FTE (5000 hours) experience working at the advanced practice level¹¹ is required prior to endorsement by the NMBA
Regulatory Standards and Guidelines	<ul style="list-style-type: none"> Registered Nurse Standards for Practice¹² NMBA Code of Conduct for Nurses¹³ 	<ul style="list-style-type: none"> Registered Nurse Standards for Practice; NMBA Code of Conduct for Nurses; PLUS <i>NP Standards for Practice¹⁴; and</i> <i>Safety and Quality Guidelines for NPs¹⁵.</i>
Mandated Collaborative Arrangements	No	Legislated as a requirement for patient access to MBS and PBS subsidy for NP services ¹⁶ .
Educational Requirements for Entry into Degree Programme	Completion of secondary education	<ul style="list-style-type: none"> Bachelor of Nursing Postgraduate qualification at Australian Qualifications Framework (AQF) Level 8 in a relevant clinical specialty area

¹¹ Gardner, G., Duffield, C., Doubrovsky, A., & Adams, M. (2016). Identifying advanced practice: A national survey of a nursing workforce. *International Journal of Nursing Studies*, 55, 60-70.
doi:10.1016/j.ijnurstu.2015.12.001

¹² Nursing and Midwifery Board of Australia. (2016). Registered nurse standards for practice. Retrieved from <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>

¹³ Nursing and Midwifery Board of Australia. (2018). Code of conduct for nurses. Retrieved from <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>

¹⁴ Ibid.

¹⁵ Nursing and Midwifery Board of Australia. (2016). Safety and quality guidelines for NPs. Retrieved from <http://www.nursingmidwiferyboard.gov.au/Registration-and-Endorsement/Endorsements-Notations.aspx>

¹⁶ Australian Government. (2010). National Health (Collaborative arrangements for NPs) Determination (2010).



	Registered Nurse (RN)	NP (NP)
Experiential Requirements for Entry into Degree Programme	N/A	<ul style="list-style-type: none"> • Current general registration as a RN • A minimum of two years' full time equivalent (FTE) as a registered nurse in a specified clinical field and two years' FTE of current advanced nursing practice in this same clinical field
Length of Education Programme	3 years' FTE with 800 supervised clinical practice hours	Additional 1-2 years' FTE with 300 integrated professional practice hours in addition to 5000 hours (equivalent to 3 years EFT) required for endorsement
Level of Educational Programme	AQF Level 7: Bachelor's Degree Programme	RN education programme + AQF Level 9: Master's Degree Programme
Scope of Practice		
Diagnosis	No	YES
Prescribing	No, although allowed to supply and/or administer under limited protocol in some public sector settings.	YES
Request/Interpret Diagnostic Pathology	No, although some public sector roles facilitate access to limited diagnostic pathology under the authority of a medical practitioner.	YES
Request /Interpret Diagnostic Imaging	No, although some public sector roles facilitate access to limited diagnostic imaging under the authority of a medical practitioner.	YES
Referral to Medical Specialists	No	YES
Referral to Allied Health	Limited to within public sector (e.g. nurse to physio referral for inpatients.)	Yes, however NP referrals to allied health care not currently subsidised by MBS
MBS subsidy for services	No	Yes, for time-tiered professional attendances, telehealth, limited simple



	Registered Nurse (RN)	NP (NP)
		basic point-of care pathology, and limited plain-film X-Rays and ultrasounds.
PBS subsidy for eligible prescribed medicines	No	Yes, with limitations.
MBS subsidy for therapeutic and diagnostic procedures	No	No
Admission Rights	No	Yes, depends on local policy.

Scope of practice

With appropriate training a nurse practitioner can work as a primary care provider for a patient (eg in a Primary Care Practice) or a nurse practitioner may have the appropriate training to work as an expert in a discrete clinical area (e.g. in Emergency Medicine, Renal Medicine etc.)

The NPRG has developed feedback for both referred questions from the GPPCCC:

△ Rebates for non-doctor attendance at case conferences

— Context:

- The GPPCCC referred two questions relating to NP attendance at case conferences to the NPRG:
 - What does the evidence say about the benefit of NPs attending case conferences?
 - To what extent do NPs currently attend case conferences? What are the main barriers to attendance?
- Case conferences are understood to relate to items 735 to 880, and involve a minimum of three attendees. Currently, explanatory note AN.0.49 to these items notes that team members who may be included (although not rebated) in a multidisciplinary care team include a variety of allied health professionals, as well as registered nurses. This description is understood to include NPs.

— Suggestion:

- Include NPs in case conferencing MBS items 747, 750, 758 (participation as a member of a multidisciplinary case conference team in a case conference)

— Rationale (benefit of NP attendance at case conferences):



- Case conferencing is an effective means of promoting care coordination in a multidisciplinary team.
- The evidence demonstrates that Australian NPs facilitate continuity of care, reduce fragmentation, improve cost savings, improve access to timely medicines, enhance education opportunities and improve the capability of the multidisciplinary team through NP-led case conferencing and care coordination. Given the value of NP-led case conferencing, it follows that NP attendance at case conferences is also high value.
 - NP-led care coordination improves the capability of multidisciplinary teams, reduces fragmentation, and helps facilitate continuity of care (Allnut 2018)
 - NPs leading case conferencing and care coordination teams leads to cost savings, timely access to medicines, enhanced education for support staff and advance care planning (Johnston et al 2016, Chapman et al 2016)
 - NPs in Australia can provide effective case management for aged care patients, reducing declines in quality of life (Arendts et al 2018)
- Effective case conferencing and care coordination has the potential to improve outcomes for populations disproportionately affected by the social determinants of ill health. NPs often work with persons disproportionately affected by the social determinants of health.
- Case conferences are also relevant for a patient whose primary health provider is an NP; in these situations, it would be counter-intuitive and inefficient for the NP not to be recognised as such across relevant MBS items.

— **Rationale (current attendance and barriers):**

- In many instances, NPs are already participating in case conferences as autonomous care providers working in collaboration with other health practitioners, including GPs. However, case conferencing that is initiated, lead and/or attended by NPs in the primary health care sector is inhibited by the restrictive nature of the current MBS items available for professional NP attendances and the inability for NPs to use existing MBS case conferencing items, which would improve the ability of NPs to facilitate and coordinate care, particularly of people with chronic and complex or comorbid disease.
- The inability of patients to access MBS subsidy for services where NPs lead, initiate or attend case conference creates a significant barrier in the in the facilitation of care by NPs in the private sector. Most directly, this reduces access for patients to subsidised care by appropriately trained health professionals, and subsequently the continuity of their care where a NP is involved in or the main provider of health care for that patient. The result is unnecessary and repeated duplication and fragmentation of care.
 - Consumer representatives on the NPRG have also emphasized that the lack of an item number and the resulting limitations on access fails to recognise patient choice of health provider, and limits quality of care particularly where a NP provides care that is otherwise not available.
 - Chavez, Dwyer and Remelet (2016) find the reimbursement and NP acceptance are significant barriers to NP practice in aged care across various healthcare settings.
- Beyond this, the lack of recognition in this space contributes to a perception that NPs have a limited role in case conferencing and care management, and fails to recognise the



role of NPs as not only members of the multidisciplinary team, but may also be a patient's primary or sole health care provider. It also creates an unnecessary barrier in building collaborative care environments with other health care providers.

△ Addition of a care facilitation item as part of allied health services referred from a GP Management Plan

— Context:

- The GPPCCC referred two questions relating to NP attendance at case conferences to the NPRG:
 - Is there sufficient access to care facilitation services from NPs?
 - Is the benefit of care facilitation services from a NP equal to or greater than the benefit of an allied health appointment?
- The NPRG interpreted care facilitation to mean providing support and advice to a patient in navigating their healthcare choices to maximise their ability to manage and participate in their own care, together with assessing, planning, implementing and evaluating care in partnership with the patient to meet their care needs.
- The NPRG interpreted the second point as a question about the relative value of a care facilitation item alongside allied health referred items within the M3 section of the MBS review (items to which a patient can be referred by item 723 on team care arrangements). In other words, the question is asking whether a care facilitation item is equivalent in value to the existing allied health options available for a patient with five referred sessions from a 723.

— Suggestion:

- Create a care facilitation item for NPs (to which a patient can be referred via a 723) which would not count towards a patient's use of 5 referred allied health treatments.
- Recognise that the role of care facilitation is more extensive than a single session, in particular where management of health problems such as chronic wounds is required.
- Ensure that the NP item is not portrayed as an allied health item, as nursing is not considered an allied health profession. In addition, there is a risk that patient access to existing allied health items would be reduced if care facilitation by a NP was considered as allied health.

— Rationale:

- The NPRG believes there is insufficient access to care facilitation services initiated or provided by NPs. This is compounded by the lack of reimbursement available to subsidise care facilitation services led by an NP.
- Care facilitation session made available as part of a GPMP alongside referred allied health sessions would provide high value care. Additional access to care facilitation by NPs is a gap in the MBS and goes beyond an item within Allied Health items referred to by a GPMP, not least because multiple touchpoints may be required for effective care facilitation. However, there are circumstances where a care facilitation session as part of referred allied health sessions could provide high value care.
- More broadly, it is also necessary to recognise the variety of ways care facilitated by a NP may be utilised in the care of a patient. This includes either as an expert providing certain aspects of care or as a patient's primary care provider.



- In terms of comparing the relative value of a NP session, the net benefit of care facilitation services provided by a nurse is seen to be equal to that of a primary care provider or other allied health practitioner providing expert care. RCTs and other research demonstrate that there are no significant differences in outcomes for NPs and other primary care providers where the activity is in scope of practice for both practitioners (Laurent et al, 2004)
- Each profession provides a unique lens to the prevention and management of acute and long-term health conditions associated with care facilitation services, and should not be undervalued. The *complexity* of decision-making and breadth of scope including assessment of and management of complex health problems, diagnosis, referral and initiation of treatments (including medicines) provided by NPs must be considered and reflected in an assessment of where the reimbursement of a NP care facilitation item may fall in relation to other providers.
- While care facilitation services support high-value patient care, the NPRG does not consider that care facilitation services should reduce access to existing allied health services through GMPs. Given this, the NPRG is recommending that care facilitation be considered as a separate type of referred support under chronic care, and should not reduce the five available allied health sessions for patients with chronic care needs.



Appendix E Response to Stakeholder consultation feedback

29.7.2019

The Nurse Practitioner Reference Group (the Reference Group) met on separate occasions in July 2019 to review its recommendations to the MBS Review Taskforce on items in its area of responsibility, to review feedback received as part of the Stakeholder consultation process.

The Reference Group welcomed feedback on its recommendations, which were organised into four overarching themes:

1. Supporting comprehensive and coordinated care for people with long-term health conditions and Aboriginal and/or Torres Strait Islander peoples;
2. Enabling nurse practitioner care for all Australians;
3. Addressing systems inefficiencies caused by current MBS arrangements; and
4. Improving patient access to telehealth services by expanding the scope of providers eligible to participate in consultations, and by broadening modes of communication.

Analysis of Stakeholder feedback revealed wide-ranging and strong support for the Reference Group's recommendations, from professional organisations and consumer representative groups alike, including: Western Australia Primary Health Alliance, Headspace, Palliative Care Australia, Pharmaceutical Society of Australia, Royal Australian and New Zealand College of Psychiatrists, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, Australian College of Nurse Practitioners, Victorian Healthcare Association, Australian Nursing and Midwifery Federation, SA Health Nursing and Midwifery, Australian Primary Healthcare Nurses' Association, Consumer Health Forum of Australia, St John Western Australia, Allied Health Professions Australia, NSW Health, Hume Region Nurse Practitioner Collaborative, Home Nurse Services Pty Ltd, Refugee Nurses of Australia and the Australian College of Nursing. Additional feedback was also received from individual nurse practitioners (NP) and medical practitioners wishing to express their support for the Reference Group's recommendations.

Stakeholder feedback reinforced the restrictive nature of current MBS arrangements for NPs, and identified additional items relevant to primary healthcare that had not been initially considered by the Reference Group. Stakeholders supported the Reference Group's position that current MBS arrangements result in fragmentation in care, system inefficiencies and greater out-of-pocket costs for health consumers seeking care from NPs. Extensive case studies submitted by the Australian College of Nurse Practitioners (ACNP) further exemplify how MBS restrictions for requested diagnostic investigations, limitations with the current attendance items and procedures performed by NPs, who are working within their scope of practice, contribute to fragmentation of care, inefficiencies and duplication of services. Such restrictions not only create financial hardships for patients, but for health services targeting marginalised populations, such as those found in rural and remote areas, metropolitan homelessness services, and Aboriginal Community Controlled Health Services. The ACNP also highlighted the Australian Medical Association's 2017 Aged Care Survey, which identified the need for more experienced nurses, in the aged care sector - especially in light of the high proportion of general practitioners (GP) who had left, intend to leave, or intend to reduce their attendances to residential aged care facilities.

The Reference Group noted the submission from Consumers Health Forum of Australia who stated:



“The importance of NPs in settings where there are often problems with accessing other primary health care providers should not be underestimated. They play an important role in the provision of services in aged care, rural and remote Australia and working with Aboriginal and Torres Strait islander peoples. They should not be treated as a second best option but rather given the status that their training and scope of practice deserves”.

Additionally, the Consumers Health Forum of Australia state:

“For the health system to be sustainable we need to make sure that we reduce inefficiencies and duplication and allow all health professionals to work to their full scope of practice. Recommendations 8, 9 and 10 do exactly that and by doing this benefits consumers through more timely access. We believe that NPs can be trusted to always work within their scope of practice, understand their own limitations and will seek input from other clinicians when required, as well as refer on to a GP where required. The current restrictions on MBS rebated investigations ultimately disadvantage the consumer, who either has to forgo the MBS rebate or has to face the cost and inconvenience of going to a GP to get a referral.”

“We believe that the package of measures, if fully implemented ...would make a significant contribution to modernising our primary health care system”.

The Royal Australian and New Zealand College of Psychiatrists, also expressed support for

“an enhanced role for nurse practitioners as part of the MBS”

and that:

“mental health nurse practitioners are a significantly underutilised resource”.

The Victorian Healthcare Association (VHA) welcomed and supported all of the recommendations of the Reference Group. The VHA stated that:

“addressing some of the systematic blocks currently hindering the work of nurse practitioners is a key part of this efficiency drive, which is warmly welcomed by the VHA”.

The Reference Group also carefully considered feedback that was not fully supportive of its Recommendations. That feedback primarily focused on Recommendations 1, 8, 9 and 10; and was solely from medical colleges, medical associations, individual medical practitioners and in one case, a 4th year medical student.

The reference group identified four themes from these Stakeholder submissions:

1) That a need for expansion of NP services in primary care does not exist.

The Reference Group highlight a recently published cost-benefit analysis of NP models of care (Reference: Cost Benefit Analysis of Nurse Practitioner Models of Care Report. (2019) KPMG) commissioned by the Commonwealth Department of Health. The analysis identified the benefits of, and a need for expansion of NP models of care in aged care and primary care, especially in rural locations, where twice as many people do not have a GP compared to major cities, which increases to almost triple as many in remote locations (31.5% vs 11.1%). Additionally, patients are 2.5 and 15 times more likely to report “no GP nearby” as the reason for not attending a GP when needed, compared to those in major cities, 8.6% (rural) and 20.35% (remote) vs 3.4%(city). The report also highlighted the relatively poor access to primary care services in many Aboriginal and Torres Strait Islander populations, which is currently being addressed by a flexible and responsive NP workforce. This theme was bolstered by the fact that NP services currently performed in primary healthcare are invisible, with most being hidden by the current iteration of the MBS. This was further highlighted in the KPMG report, with a strong recommendation to develop robust systematic data



collection tools and methods to support the visibility and analysis of the Australian NP role (KPMG, 2019, p. 14).

2) A lack of understanding regarding the contemporary Australian NP scope of practice.

Submissions identified the mistaken belief that the MBS review was being used as a vehicle for expanding the NP scope of practice. The Reference Group highlight that current legislative and local authorisation processes already give Australian NPs the ability to practise safely and autonomously within their individual scopes of practice. Nurse practitioners working within their scopes of practice already request a broad range of diagnostic imaging tests. Nurse practitioners currently perform diverse primary healthcare procedures such as skin biopsies, spirometry, and intrauterine device insertions. The Reference Group has identified that health services or consumers choosing a NP as their healthcare provider are simply having costs shifted from the Commonwealth to the end consumer as a result of a lack of recognition by the MBS for services requested or performed by an NP. The Reference Group asserts that the recommendations reflect a patient subsidy issue, as opposed to a scope of practice issue.

3) The belief that mandated legislative requirements for collaboration are required for public safety.

Nurse practitioners are already required through their regulatory authority (the Nursing and Midwifery Board of Australia) to collaborate and create partnerships with other health providers, irrespective of legislated requirements to retain eligibility as MBS providers. This is determined through the *Nurse Practitioner Standards for Practice* (NMBA, 2014) and the *Code of Conduct for Nurses* (NMBA, 2018). The legislated requirement to demonstrate collaboration through the *National Health (Collaborative arrangements for nurse practitioners) Determination 2010* is therefore superfluous and representative of overregulation of the NP workforce. This is not consistent with the philosophy of “a minimum regulatory force that is appropriate to manage risks to the public” (AHPRA, 2019: <https://www.ahpra.gov.au/About-AHPRA/Regulatory-principles.aspx>). In addition, the Reference Group asserts that NPs are not restricted to practising with a mandated collaborative arrangement when providing non-subsidised primary healthcare services where they may practice to their scopes of practice (for which they are trained), and take personal and professional responsibility to form their own clinical partnerships with other health professionals, including medical practitioner colleagues. The Reference Group acknowledge the fact that NP have had legislative authority to practice autonomously and collaboratively in Australia for nearly 20 years, during which time the Reference Group are not aware of any NP held liable for working outside their scope of practice.

4) The claim that the NPRG recommendations will result in fragmentation of care.

This claim was not substantiated with supporting evidence. As identified in the NPRG report, and additionally in the independent *Cost-Benefit Analysis of Nurse Practitioner Models of Care* (KPMG, 2019), current restrictions to NPs practicing to their full scope of practice within the MBS currently results “*in duplication, fragmentation of care and inability to provide complete episodes of care*”, specifically identifying key contributors as: legislative collaborative arrangements, inability to refer to allied health professionals whose attendances attracts patient subsidies through the MBS, limited range of pathology and diagnostic imaging services and lack of access to health assessment and chronic disease management items (Pg. 95). This cost-benefit analysis reported that NPs provide high-value care with evidence that for every \$1 spent on NP services within the MBS, the benefit-cost ratio in aged care site was 12.4 and 5.5 in another site, 2.3 in dementia patients and 9.7 in one Aboriginal and Torres Strait Islander community (Pg. 94).



The Reference group also considered recommendations made in relation to NPs practising in the hospital perioperative environment (ACNP feedback, Pg. 28-29). The Reference Group acknowledge the importance and relevance of those recommendations, which were also discussed at the public consultation forum in Brisbane. The Reference Group notes those items are currently under consideration elsewhere by the MBS Taskforce and had not formally been reviewed as part of scope of the NPRG review.

Summary of main emendations to NPRG recommendations following consideration of feedback:

Duplicate item or items no longer on MBS schedule deleted:

- Item 31205: Removal of skin lesion (excluding warts and seborrheic keratoses) ≤ 10mm.
- Item 31210: Removal of skin lesion (excluding warts and seborrheic keratoses) 11-20mm.
- Item 31230:
 - Removal of skin lesion (excluding warts and seborrheic keratoses) from nose, eyelid, lip, ear, digit, genitalia.
 - Item 30067: Foreign Body Deep – Removal of.

Additional items added:

- 11610 Measurement of ankle-brachial indices and arterial waveforms
- 73844: Quantitation of urinary microalbumin as determined by urine albumin excretion on a timed overnight urine sample or urine albumin/creatinine ratio as determined on a first morning urine sample in the management of established diabetes.