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AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

Professor Bruce Robinson
Chair, MBS Review Taskforce

By Email: mbsreviews@health.gov.au

AMA response to the Report from the Allied Health Reference Group

The AMA appreciates the opportunity to respond to the report and recommendations from the Allied Health Reference Group (AHRG).

Overall, the AMA believes that the MBS Review Taskforce in making its recommendations to Government should be focussed on ensuring the centrality of GP care and that the continuity and coordination of patient care is enhanced and well supported.

General comment

The AMA acknowledges the nine broad themes outlined on page 9 of the report that the AHRG has attempted to address with its recommendations. These being to:

- Ensure that clinical services align with best-practice guidelines.
- Increase access to allied health in primary care.
- Ensure that the list of eligible allied health professionals (AHP) under the MBS reflects contemporary practice.
- Facilitate group-based allied health therapy where clinically appropriate.
- Ensure that patients with an Autism Spectrum Disorder (ASD), Pervasive Developmental Disorder (PDD), Complex Neurodevelopmental Disorder (CND), or disabilities have adequate access to high-quality allied health services.
- Strengthen evidence base for the provision of allied health care in Australia.
- Improve access to allied health services in rural and remote areas.
- Change the delivery model and focus of allied health in Australian primary care.
- Improve communication between allied health professionals and other health care professionals.

The AMA agrees that measures across these themes need to be considered in order to ensure that patients can access appropriate care to improve their health, functionality, well-being and quality of life. However, the AMA does not believe in all cases that new or additional items under the Medicare Benefits Schedule (MBS) is the best way to address such issues, particularly those that arise from the underfunding of state/territory based programs or a maldistribution of the workforce.

The AMA also notes that while some of the recommendations cover chronic disease management in a general sense, other recommendations are more specific to an emerging and complex cohort of patients for whom there are significant barriers to equitable and timely care. While clinical guidelines are now in place we are yet to see under what model of care they could best be implemented.

Applied principles

In responding to the AHRGs recommendations the AMA has applied the following principles and encourages the MBS Review Taskforce to do the same:

- ASD and other neuro-developmental disorders require unprecedented collaboration between health, education, and disability sectors.
- The sharing of pertinent clinical and other information among these groups and with their families is an important aspect of improving care and reducing fragmentation.
- New clinical guidelines for ASD have been developed and research into the implementation of these guidelines is also underway. Results of this will continue to inform refinements to the provision of health, education and disability support care for those who are impacted.
- Early identification and intervention are vital and must be the priority.
- Workforce issues must be recognised. A limited number of paediatricians, child psychiatrists, and clinical psychologists work specifically in the area of ASD. Barriers to access are magnified for children living in rural and remote areas.
- MBS items will not address systemic (state/territory) underfunding (and related workforce) issues e.g. Recommendation 3 for improved access to prosthetic and orthotists services.

Response to Recommendations:

<u>Recommendation 1 Access to comprehensive Assessment Item</u>

The AMA has no objection to the introduction of an Assessment Item for AHPs with the restrictions proposed, as it aligns with standard practice when seeing a new patient for the first time.

The AMA acknowledges that a thorough initial assessment by allied health is not only required under various professional standards, but also helps the AHP to capture information pertinent to the patient's care. It is vital that relevant clinical and management information collected by the allied health professional during an assessment is shared with the referring and any other treating medical practitioner.

The AMA estimates introducing an AHP assessment item would require funding of an extra $4 million if the new item was priced at $90[1]. This assumes the assessment item would be in addition to the current number of allied health services (AHS) claimable under a GP management plan and team care arrangement.

[1] MBS statistics 2017-18 – allied health services divided by 3 multiplied by $90

The AMA supports reviewing the use of the new item in 12 to 24 months to identify and analyse any abnormal claiming patterns and the recovery of any confirmed inappropriate claims.

Recommendation 2 Expand allied health involvement under team care arrangements

The AMA has no objection to modifying the number of AHS accessible for patients stratified by the complexity of their care requirements under a GP Management Plan. This would ensure that access to Commonwealth funded AHS is more aligned with the patient's health care needs.

The AMA understands that not all patients with a Team Care Arrangement (TCA) access their full quota of allied health items, while there are others who would benefit from access to additional services. Pooling the number of available services and assigning them according to need is a more equitable approach.

The AMA expects though, that this approach would work better under a medical home model of care. Different levels of access across different complexity stratifications is not something that the AMA believes the current MBS payment infrastructure could manage without the creation of a multiple item numbers for each tier of access. Adequately funding general practices to provide or access AHS based on patients' stratified needs may be a more manageable. Alternatively, taking a Treatment Cycle approach, such as outlined in the *Review of DVA Dental & Allied Health Arrangements Final Report – May 2018* may be another. This approach would ensure:

- the GP is central to the patient's care;
- communication between the allied health provider and the GP;
- a defined treatment goal and cycle of care;
- review of patient progress against treatment plan; and
- access to additional services, if recommended by the AHP, and as determined appropriate by the GP.

The AMA has long advocated that access to AHS funded under the MBS should be via the GP Management Plan (GPMP) with the Review item providing additional access to AHS if required. The TCA item has placed an additional administrative burden on GPs and does not align with standard referral practice and the clinical flow of care. The AMA notes that the General Practice and Primary Care Clinical Committee (GPPCCC) has recommended combining the GPMP and the TCA. Given this is in line with AMA advocacy the AMA was supportive in its response to the committee's recommendations, supporting the GPMP along with voluntary patient enrolment as the access point.

The AMA supports the proposal to pilot and phase in any implementation of this recommendation in order to assess its effectiveness in improving patient outcomes and reducing the downstream costs of poorly or under managed conditions.

Recommendation 3 Improve access to orthotic or prosthetic services

The AMA in principle is concerned about expanding access to the MBS to non-regulated health professionals.

In the AHRG's rationale for this recommendation (on page 30) the specific gap the AHRG is seeking to fill is the assessment for suitability of orthoses or prostheses, yet the proposed item descriptor makes no reference to this. The AMA would have expected to see the words "to assess their suitability for orthoses or prostheses" in the first sentence of the descriptor. Furthermore, the rationale also notes that patients who cannot pay for these services have access to publicly funded services through the public hospital system. Thus, indicating that the barrier to accessing care is not so much the lack of services subsidised by the MBS, but the underfunding of public hospital orthotic and prosthetic services across Australia. With only 220 private practising providers (according to Allied Health Professions Australia) it is questionable whether the introduction of an MBS item will address the problem and unlikely that the inequities of access, particularly in rural and remote areas, will be addressed even if there was a relevant MBS item.

The AMA suggests that considering other options outside of the MBS would be more appropriate. However, should the MBS Taskforce recommend an orthotic or prosthetic service, the AMA would suggest that as per GPPCCC Recommendation 2, that only patients who have a nominated GP or general practice (i.e. have voluntarily enrolled) would be eligible for such services if part of their Chronic Disease Management Plan.

Recommendation 4 Incentivise group therapy for chronic disease management

Given the centrality of general practice to patient care and established *Standards for General Practices*, it would make more sense to incentivise accredited general practices under the Practice Incentive Program to organise group sessions in consultation with the allied health providers who either work within the practice or with whom the practice has a working relationship.

The AMA supports enhancing patient access to group sessions, where appropriate, as the evidence suggests group sessions enhance patient access and provide a more efficient way to work with patients experiencing the same condition. The cross-peer education and group support increasing patient satisfaction, and no doubt, their engagement in managing their condition[2]. However, while there are patients who will benefit from group sessions, not all will, and the AMA believes it is important that patients, upon GP referral, should first be assessed as to their suitability for group sessions. Incentivising group therapy should not come at the expense of the needs or care of individual patients.

[2] Egger G, et al. *Shared medical appointments. An adjunct for chronic disease management in Australia?* Australian Family Physician. Volume 43, No.3, March 2014 Pages 151-154

Recommendation 5 Understand the effectiveness of group allied health interventions

The AMA supports evidence-based medicine and would support a systematic review to ascertain where group sessions deliver high value care and to inform future considerations around access to group sessions and funding models that would best facilitate and support them.

The AMA would expect that access to group session services would be in line with the key attributes of a patient-centred medical home[3] being:

- Continuity,
- Coordination,
- Comprehensiveness,
- Accountability,
- Accessibility, and
- Patient-centred.

Recommendation 6 Improved access to paediatric allied health assessments

The AMA notes that in October 2018 a new *National Guideline for the Assessment and Diagnosis of Autism Spectrum Disorders in Australia* was produced by the Cooperative Research Centre for Living with Autism (Autism CRC) and later endorsed by the NHMRC. These guidelines recommend changes to the way ASD is managed in order to stop the current fragmented approach from the health, education and disability sectors. The Guidelines recommend a family-centred approach. Any changes to the MBS relating to ASD should recognise that this is a developing area where ongoing refinements are likely to ensure those with ASD are receiving appropriate and tailored care.

Recommendation 7 Improve access to complex paediatric allied health assessments for children with a potential ASD, CND or eligible disability diagnosis

This recommendation is consistent with the National Guidelines which acknowledge that diagnosis may be informed by a range of allied health professionals, and that a proper assessment may need to take place over more than two attendances. Assessment services are not funded by NDIS, so the MBS is important in facilitating access.

The AMA acknowledges that the presentation or symptoms of ASD can vary widely in nature and severity, with variation apparent in individual cases, as well as in the same individual over time. Recognising that the severity of symptoms can be dynamic and change over time, and with the possibility of emerging symptoms, it is appropriate to support additional assessments by allied health professionals at appropriate times. As in any situation where care of the patient involves members of a multi-disciplinary team, relevant clinical and management information collected by the allied health professional during an assessment must be shared with referring and, if different, the treating medical practitioner

[3] https://www.aci.health.nsw.gov.au/nhn/patient-centred-medical-home-model/key-principles

In the interests of facilitating timely and accurate diagnosis for children with a potential ASD, CND or eligible disability diagnosis, the AMA supports increasing the number of assessment items from four per lifetime up to eight. The AMA supports also that the referring practitioner reviews the assessments between the first four and any additional assessment appointments. This supports continuity of care, coordinated care, and clinical stewardship.

In addition, the AMA believes the expanded access should be monitored and reviewed to determine its impact on delivering timely treatment and support and enhanced patient outcomes.

Recommendation 8 Encourage multidisciplinary planning for children with a potential ASD or eligible disability diagnosis

This recommendation appears to reflect the National Guidelines, which recognises that allied health professionals often undertake case conferences to determine whether a patient meets specific diagnostic criteria.

The AMA appreciates, especially where ASD is suspected, that it may be a non-GP specialist, such as a paediatric psychiatrist, referring the patient to appropriate allied health professionals as part of the assessment and diagnosis process. It is fundamental, however, that regardless of the make-up of the multidisciplinary team that the patient's usual GP be included and kept apprised of the progress towards diagnosis, diagnosis and treatment options as part of the patient's care plan. The GP regardless of what specialised treatment a patient with ASD or an eligible disability diagnosis may require, is the patient's primary and most accessible health care provider. The patient's GP will still be providing the patient's preventive care, such as immunisations, and managing any acute illnesses or injury that may arise, and needs to be across any specialist referred services/treatments the patient is undergoing and any medications they may be on in order to provide comprehensive and holistic care.

The AMA appreciates the AHRG's suggestion that new items for case conferencing are not necessary, but that up to two available assessment attendance items could be utilised for the purpose of case conferencing with the referring practitioner and other members of the multidisciplinary team. However, the AMA would note that MBS items are for specific purposes. The AMA would expect that in order to monitor the usage of services funded under Medicare that there should be greater clarity as to the service being provided. Thus, separate items for assessment attendances and separate items for participating in a case conference to discuss the patient's treatment plan for a diagnosed ASD, CND or eligible disability would be more appropriate.

Recommendation 9 in the GPPCCC Report calls for allied health professionals participating in case conferences to be eligible to claim for the service under the MBS. The AMA in its response on the GPPCCC recommendations had no objection to AHPRA registered allied health professionals privately practicing and who are a member of the patient's health care team being granted access to a rebate for participation in multi-disciplinary case conferencing.

Furthermore, the AMA would expect, and it is a requirement of MBS items 82000, 82005, 82010 and 82030, that if a patient is referred to an allied health professional for assessment and input that it would be provided in a written report back to the referring doctor. The referring doctor then using the allied health professional's assessment to inform their diagnosis. The AMA would not expect a case conferencing item for the allied health provider to be necessary to provide feedback on their assessment to the referring practitioner.

Recommendation 9 Improve access to M10 treatment items for group therapy

This proposal provides a flexible solution to enable a treating allied health provider to provide beneficial services to a patient either individually or within a group session. The proposal aligns with the AMA position statement *Autism Spectrum Disorder* recommendation that effective and evidence-based treatments should be instituted as soon as possible, and is supported by the AMA.

The AMA acknowledges it would be administratively simple to amend the current M10 treatment items to the service to be provided either individually or within a group session. However, the AMA is concerned that this would not provide a clear and ready indication of how these services are used. The AMA suggests, where possible and practical, that a range of group session items could be implemented, with the same overall total number of services, giving providers flexibility in using an individual or group item, while enabling effective data collection on usage. More wholesome data enables the ready determination of usage trends and identification of any emerging health system inequities, as well as enabling further analysis of the benefits of group sessions.

Recommendation 10 Improve access to M10 for patients with severe speech and language disorders

The AMA in principle has no objection to patients with severe speech and language disorders having improved access to subsidised services under the M10 group of items in the MBS, particularly as early identification and intervention enhances the patient's societal functionality and quality of life, improving their overall outcomes. The AMA notes though, that this would require a legislative change as the only eligible disabilities are currently sight and hearing impairment, cerebral palsy, Down syndrome and Fragile X syndrome.

The rationale provided for Recommendation 10 anecdotally indicates that the patient cohort does not have adequate access to allied health services through CDM plans and TCAs because they are not often considered (by the GP) to have a chronic condition. The AMA would suggest that some further research or investigation into whether this is the case and what might be behind any barriers to care would be prudent, before looking to amend the list of eligible disabilities. Currently, patients with a GPMP and a TCA would be eligible for up to 5 speech pathology services.

Medicare statistics currently show that out of the allied health services (10950-10970) that speech pathology (MBS Item 10970) accounts for 2.15 per cent of items claimed. Given, it is estimated that 7.7 per cent of people suffer a disorder related to voice, speech, language, or

swallowing[4], it would certainly appear that more could be done. The AMA would suggest that if children with such problems are predominantly under the care of a paediatric physician that this could be one barrier, as only the GP can prepare a GPMP and TCA which would provide access to subsidised speech pathology services. This highlights the importance of ensuring the GP remains a key member of the multidisciplinary care team when patients are referred for more specialised care. Ensuring that the Explanatory Notes in the MBS for the GPMP and TCA items include some examples of chronic conditions that include a speech disorder may also be another way to ensure greater clarity about eligible chronic conditions.

Recommendation 11 Improve access to the ASD and eligible disability assessment to people under 25

The AMA supports this recommendation. As noted within the relevant documentation, we are seeing an increasing number of ASD diagnosis in children and adolescents (aged from 13 – 25 years). It has also been recognised that periods of transition (for example between primary, secondary and tertiary education, and work) can have a significant impact on physical and mental health, and that transition planning can assist.

Further, without this change, the diagnostic process may be undermined for those children aged 13 and over and who can't afford out of pocket costs for allied health assessment services. Without access to this support the diagnostic process may be abandoned (which doesn't benefit anyone and may result in increased costs and reduced quality of life in the long term).

Recommendation 12 Improve allied health collaboration during assessments

While the AMA is supportive of measures to facilitate early identification and intervention of ASD and other eligible disabilities, these services should be coordinated by a central member of the patient's health care team. The AMA strongly believes this should be the GP working collaboratively and in consultation with other members of the multi-disciplinary team. The AMA would therefore suggest that it would be more appropriate to amend the eligible practitioners for purposes of M10 items to include GPs for pervasive developmental disorders, than to enable inter-disciplinary referral.

The AMA has supported aspects of GPPCCC Recommendations 2, 3, 7 and 9 which if implemented would ensure that general practice and allied health providers are better supported to work collaboratively and would provide funding to support the GP provide more flexible access to services such as referrals without a face-to-face consultation. The existing case conference items could readily be utilised by the GP to discuss the appropriate referrals with existing and intended members of the multi-disciplinary team.

[4] US Department of Health and Human Services. *Quick statistics about Voice, Speech, Language*. National Institute on Deafness and Other Communication Disorders: Sourced from: https://www.nidcd.nih.gov/health/statistics/quick-statistics-voice-speech-language

Recommendation 13 Support the codifying of allied health research and evidence

The AMA supports this recommendation and the collection of robust data to not only track utilisation but to enable further analysis as to effectiveness and efficacy of the services utilised.

Recommendation 14 Improve access to allied health services via telehealth

The AMA believes this recommendation should be for the short rather than the longer term, and supports allied health providers, subject to the proposed restrictions, being able to access telehealth items to enhance the delivery of patient care. Rural and remote communities already have very limited or no reasonable access to AHPs and enabling AHS via telehealth supports greater equity of care of access.

The AMA, however, notes there is an inconsistency with the restriction that the patient must be at least 35 kilometres by road from the allied health professional, compared to other telehealth items. For example, MBS item 99 only requires the patient to be at least 15 kilometres by road from the doctor. This restriction applying also to the related Nurse Practitioner MBS items 82220-82222. The AMA would advise that the same threshold distance of 15 kilometres should apply to any approved allied health telehealth services.

Recommendation 15 Non-fee-for-service allied health payment models

The AMA supports the proposal to undertake research into alternate funding models to fee-for-service to determine how allied health services could be better integrated in primary health care. While fee-for-service is an effective funding model for more acute services the AMA believes there is scope for blended funding arrangements for chronic and complex conditions, requiring comprehensive, integrated and well-coordinated care. This could include funding to support enhanced care for those patients anticipated to need a suite of allied health services, incentives for integrating allied health services into medical practices, or practice grants for innovative integrated models of care.

Recommendation 16 Enhance communication between patients, allied health professionals and GPs

The AMA has no objection to this proposal, with exception of the premise for 16 (c) being interdisciplinary allied health referrals, as per our comments on Recommendation 12.

Recommendation 17 Allow non-dispensing pharmacists to access allied health items

Rather than have specific MBS items, the AMA believes that services provided by non-dispensing pharmacists working within general practice should be funded as part of an additional overarching payment to practices participating in the Workforce Incentive Program (WIP). Specific MBS items are limiting in terms of the breadth and number of services that can be provided to the patient. The AMA's *General Practice Pharmacists – Improving Patient Care* proposal, developed in collaboration with the PSA, envisaged a diverse role for non-dispensing pharmacists employed by the practice, not necessarily best supported via fee-for-service items. They included:

- Medication management reviews conducted in the practice, an Aboriginal Health Service, the home or a Residential Aged Care Facility (RACF),
- Patient medication advice to facilitate increased medication compliance and medication optimisation,
- Supporting GP prescribing,
- Liaising with outreach services and hospitals when patients with complex medication regimes are discharged from hospital,
- Updating GPs on new drugs,
- Quality or medication safety audits, and
- Developing and managing drug safety monitoring systems.

Supplementary activities, depending on the needs of individual practices, could include activities such as patient education sessions, mentoring new prescribers and teaching GP registrars on pharmacy issues.

The PSA in their proposal *Integrating pharmacists into primary care teams* also envisaged a liaison role for general practice pharmacists with local community pharmacists to ensure continuity of care. The AMA expects also that as part of this liaison role the general practice pharmacist would facilitate quality referrals to services provided by community pharmacists under the 6th Pharmacy Agreement.

These activities mostly support the efficiency of the participating practice, along with the quality and safety of care.

The AMA is concerned that introducing MBS items for pharmacists could have the unintended consequence of incentivising practices who employ a non-dispensing pharmacist to focus their activities on only those that attract an MBS item. Thus, limiting the range of activities that the general practice pharmacists might provide. For example, when specific practice nurse items (10993-10999) existed in the MBS, one of the key complaints about them from general practitioners and practice nurses themselves was the items restricted the role that practice nurses could play within the practice. These items were subsequently deleted from the MBS with the introduction of the Practice Nurse Incentive Program (PNIP) in 2012, which was introduced to better support an enhanced role for nurses working in general practice. Both the AMA and the PSA drew on the PNIP as an appropriate model to support integrating pharmacists into general practice. The PNIP is now set to transition into the Workforce Incentive Program (WIP) from 1 January 2020 and will support all eligible practices to employ a pharmacist within the practice.

The AMA, as per its *Pre-Budget Submission 2019-20* and *Key Health Issues for the 2019 Federal Election* would prefer to see the existing caps on the number of incentives a practice is eligible for under the WIP lifted in order to support enhanced access to GP-led team based care for patients.

Recommendation 18 Expand the role of allied health in the Australian public health care system

The AMA recognises the complimentary role of allied health across the health system. This has been demonstrated in our support and advocacy for funding mechanisms to support multi-disciplinary health care teams and for practices to engage non-dispensing pharmacists and allied health workers within the practice team.

Preventative care is a fundamental part of the care that GPs provide on a daily basis, both personally and via referral. The AMA would agree that supporting patients with identifiable risks for chronic conditions to take action to reduce their risk and improve their health is vitally important. Better health outcomes for patients is a key tenet of the Quadruple Aim[5] which underpins the AMA's support for quality improvement measures, multi-disciplinary health care teams and the central role of general practice as patient's medical home.

The AMA is seeking to engage with Government to develop a long-term funding plan to better enable general practices to transform into patient-centred medical homes. Enabling the provision of a comprehensive range of services, including preventative measures, to reduce patients' need for more complex, high-cost health care, particularly for patients with or at risk of chronic disease.

Enhanced access to allied health services must be well coordinated by the usual GP to ensure it aligns with patients' health care objectives and is cost effective. The AMA wants to see a more robust funding model, that builds on existing fee-for-service arrangements, to enable patients to access improved care in the community. This might for example include enabling enhanced access to allied health services on a referral basis for those patients who formally nominated their usual GP and general practice.

Further information

Should you require any further information or clarification on the AMA's response to the Recommendations, please contact Michelle Grybaitis at mgrybaitis@ama.com.au.

Yours sincerely

Dr Tony Bartone
President

[5] Bodenheimer, T. and Sinsky, C. (2014) From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. Annals of Family Medicine, 12, 573-576.

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