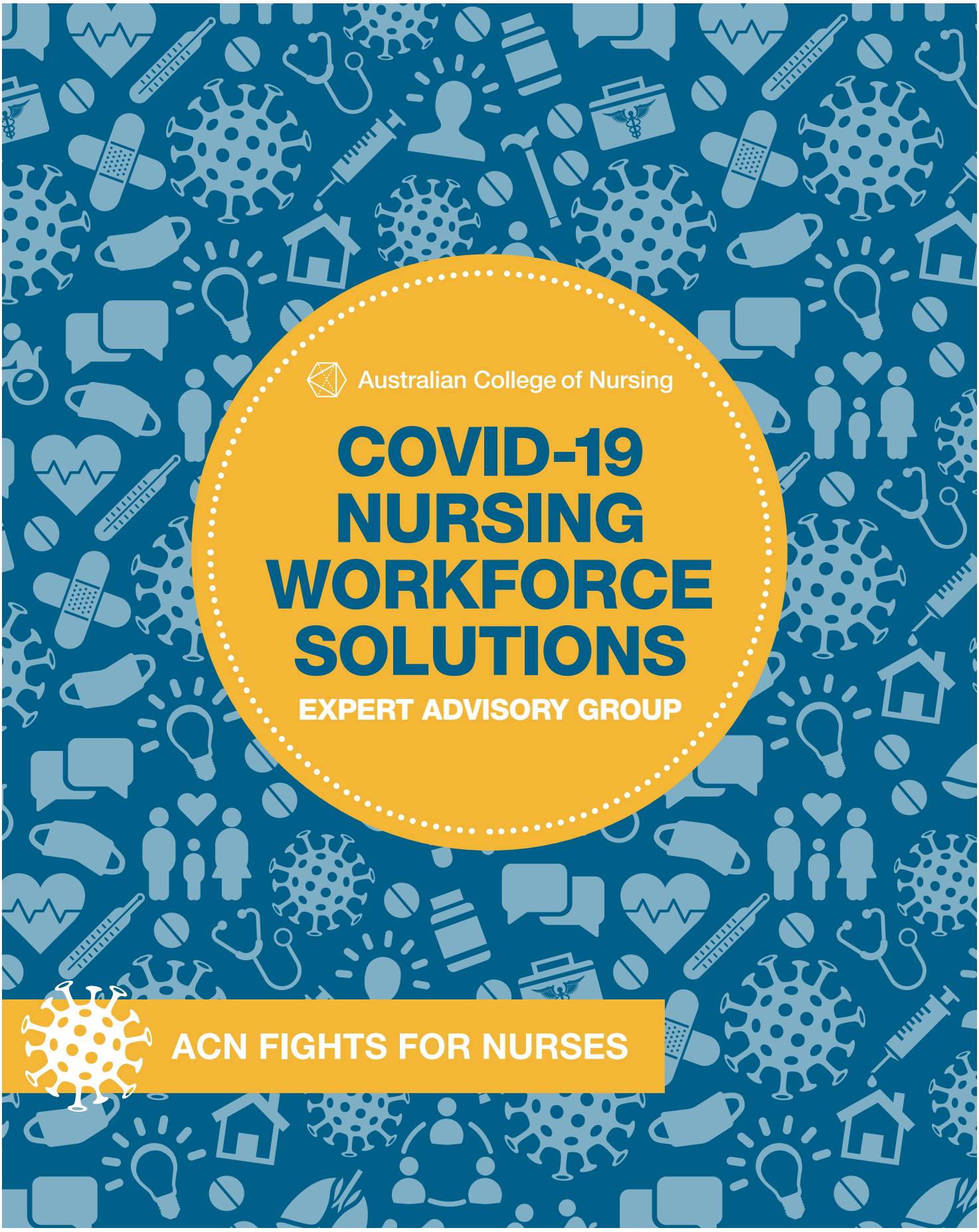

SUPPORTING DOCUMENTATION

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STATEMENT

Nurses are a crucial part of the health workforce solution to the impending COVID-19 pandemic. While nurses working in hospitals will support the sick who require acute care, nurses working in the community and primary health care (PHC) sector will be vital in reducing the spread of infection, supporting people to manage chronic health conditions and keeping people out of hospital where possible. As the health and economic crisis escalates, unemployment will rise potentially affecting two million Australians, hospitals will reach capacity and General Practitioners in rural and metropolitan communities will be redirected to acute care settings, or in the case of fly-in-fly-out doctors, will be unable to travel entirely. For the protection and health of the broader community, it is crucial to eliminate all barriers that restrict nurses working to their full scope of practice.

In this document we use the term 'PHC nurses' to refer broadly to nurse practitioners, registered and enrolled nurses working outside the acute hospital setting. This includes, for example, nurses employed in community health, general practice, non-government organisations, rural and remote settings and various other non-hospital facilities (e.g. detention settings, boarding houses).

The solutions recommended in this document are focused on releasing the current funding constraints on the clinical practice of registered nurses, as the largest group of nurses, and nurse practitioners, as advanced level practitioners. This will ensure that these nurses can respond to the crisis by keeping our most vulnerable and at-risk patients out of hospitals to support Stage 2 social distancing or self-isolation measures.

Whilst ACN are not putting enrolled nurses forward for consideration in the Medicare item number funding recommendation at this time, we acknowledge the significant role that enrolled nurses play in the delivery of health care in all settings throughout Australia.

SOLUTIONS

For PHC nurses to optimally contribute to the pandemic response, the following actions are required:

1. **Facilitate nurses working to their full scope of practice by removing funding constraints.**

   Removing funding barriers to the delivery of nursing care will promote nurses to work to their full scope of practice[1-3] outside the hospital setting.

   a) In relation to nurse practitioners, either

      i. Immediately implement the 14 recommendations of the Medicare Review Taskforce - Nurse Practitioner Reference Group Report[4] enabling nurse practitioners to provide emergent care to the broader community, including residential aged care, or

      ii. Provide nurse practitioners immediate access to the same item numbers that general practitioners currently have access to and remove the requirement under Health Insurance (Midwife and Nurse Practitioner) Determination 2011 for general practitioner collaboration. This will reinforce the delivery of emergent care to the broader community, including residential aged care.

   b) Amend Section 84AAF of the National Health Act 1953 to provide registered nurses with access to Medicare Provider Numbers.

   c) Provide registered nurses with access to the existing nurse practitioner Medicare item numbers:

      a. 82200 - professional attendance short
      b. 82205 - professional attendance <20 minutes
      c. 82210 - professional attendance ≥20 minutes
      d. 82215 - professional attendance ≥40 minutes

      with a 100% loading for after hours and in-home consultations.

   d) Work collaboratively with the Australian College of Nursing to determine the need for additional Medicare item numbers and funding of nursing services as the pandemic unfolds.

2. **Allow patients to be cared for in their homes, both face-to-face and via teleconference, through the fleet of primary and community health nurses.**

   Considering recently announced Stage 2 social distancing and self-isolation measures, care will need to be quickly transferred to people's homes, rather than attending GP practices and hospitals. This will be further compounded if there are reduced numbers of medical practitioners in the community as they are redeployed to support the hospital system.

3. **Ensure nurses (including those working in rural and remote settings, community health, non-government organisations etc) have ready access to personal protective equipment (PPE) to ensure that they remain safe.**

EVIDENCE FOR SOLUTIONS

1. **Facilitate nurses working to their full scope of practice by removing funding constraints.**

   The Australian Primary Health Care Association states: "Nurses working to their full scope of practice as part of an interdisciplinary team can enable more integrated, efficient and accessible health care"[5]. When working to their full scope of practice, PHC nurses provide health assessment, triage and referral, management, self-management support/education, health promotion and health system navigation/co-ordination of care[1,2]. These activities embrace acute presentations, chronic conditions and opportunistic screening to improve health outcomes within the community and reduce the number of people going to hospitals. Ensuring that nurses work to the extent of their scope of practice improves patient outcomes, enhances productivity and is better value for money for health services[3,5].

   Australian research has consistently demonstrated factors that constrain PHC nurses from working to their full scope of practice[6,7]. A key barrier that could be rapidly addressed to facilitate PHC nurses working to their full scope of practice is the constraints of the current Medicare funding structure. Nurses should be given access to Medicare Benefits Schedule (MBS) items as an equal and valued member of the health care team. In many instances nurses are limited in MBS items they can utilise. Inadequate or unequal compensation as a result of unequal access to MBS items may result in loss of the nursing workforce in primary care (particularly nurse practitioners) through poor retention and attraction rates stemming from inequalities, if this issue is not addressed.

   The newly introduced Workforce Incentive Payment (WIP), like the Practice Nurse Incentive Payment before it, "does not cover the full cost of engaging an eligible health professional"[8]. The costs to general practices of employing nurses are further offset through a combination of specific items of service and efficiencies in patient care. As the nature of service delivery in general practice changes, so too will the claimable activities undertaken by nurses. To retain nurses in general practice it is essential that these changes do not impact on remuneration for these nurses or their job security.

   Nurse Story: *Jo was employed as a registered nurse in a general practice. Her role was to undertake health assessments (items 701, 703, 705, 707, 715, and 10987), chronic disease management (10997), and management plans (721, 732). Since the COVID-19 outbreak the practice has decided that patients should not attend the practice for these assessment visits at present as they are vulnerable and at risk. As this work is no longer required at the practice, Jo has had her working hours reduced. The provision of time tiered Medicare item numbers would allow Jo to provide an enhanced level of service to patients in their home 24/7, over and above what is usually provided.*

   PHC nurses working to their full scope of practice have the capacity to provide a range of vital health services that would normally be provided in the general practice setting to people within the community during periods of self-isolation or social distancing. For example, many PHC nurses are accredited nurse immunisers. Establishment of provider numbers for nurses would allow them to work directly in the community to deliver important immunisations, such as influenza and pneumococcal, to vulnerable populations. Additionally, during this pandemic, it is important that high quality management of chronic conditions and health promotion continue, to avoid future growth in chronic disease and avoidable hospital admissions. PHC nurses are well placed to provide assessment, self-management support, health education, triage and referral for patients in the community, thereby reducing presentations to Emergency Departments.

   Nurse role solution: *Cindy is an accredited nurse immuniser. Currently she works in a general practice and provides immunisations as part of a flu clinic run by the practice. Each patient also briefly sees the General Practitioner during their visit to order the immunisation. As a registered nurse and an accredited nurse immuniser, Cindy is educated and prepared to provide immunisations and nursing services. If funding models were adapted Cindy would be able to consult with elderly patients in their own home. Not only could she provide immunisations (e.g. influenza, pneumococcal) but she could also assess how the person was coping during the current COVID-19 social distancing measures and isolation, evaluate their current health, ensure that they had sufficient medications and identify any referral needs.*

   In a potentially overloaded system, Cindy could provide care that helped her patients avoid Emergency Departments admissions by delivering care in the patient's home.

2. **Allow patients to be cared for in their homes, both face-to-face and via teleconference, through the fleet of primary and community health nurses.**

   Innovative models of care are required allowing nurses to engage in more home visits and telehealth consultations to provide care in the community where it is needed. This will help people to avoid hospital and general practice visits.

   Several innovative models of care currently exist in specific areas that provide exemplars of how nurses could add value to health care through community-based outreach and delivery of health care. These include the Nurse Navigator model in Queensland[9-11] and the national Department of Veterans' Affairs program. The success of these programs demonstrates that they are feasible, cost-effective and positively impact health outcomes. Upscaling these programs provides an opportunity to provide greater access to health care in the community and reduce visits to hospital.

   Ensuring that there is a strong PHC nursing workforce is important to strengthen the multidisciplinary PHC team to address the growing health needs in the community, reduce the spread of COVID-19 and influenza, support people to manage existing chronic health conditions and keep people out of hospital where possible. PHC nurses are skilled in coordinating care and helping people to access the right services[2]. This is important as health systems are likely to be stretched and people are likely to need assistance in navigating the changing system. Having skilled nurses working directly with people in their home or within community settings, including rural and remote Australia, will significantly increase people's access to the health care that they need.

3. **Ensure nurses have ready access to personal protective equipment (PPE) to ensure that they remain safe.**

   Some 9% of COVID-19 cases in Italy[12] are reported to be among health care workers. Australian PHC nurses are currently experiencing challenges in obtaining regular supplies of adequate personal protective equipment for use in their workplaces. While this is clearly an outcome of the rapidly evolving situation, it is vital that PHC health professionals have access to the kinds of equipment advocated by the WHO to reduce their risk of exposure and infection. Minimising the risk of transmission to health care professionals is vital if we are to sustain effective health care delivery in Australia.

FURTHER CONSIDERATIONS

Background

Until 2012, item numbers for the provision of defined nursing services in general practice were provided by the Medicare Benefits Scheme (MBS). These included immunisations, cervical smears and wound care, provided 'for and on behalf of' the GP[13]. Medicare provided remuneration to the general practice for each occasion of service. This funding model negatively limited the range of services that nurses in general practice provided[13,14].

The Practice Nurse Incentive Program (PNIP) was implemented from 1 January 2012. The PNIP, now replaced by the Workforce Incentive Payment (WIP), offsets employment of a registered nurse and enrolled nurse by accredited general practices through block incentive payments. These payments seek to support an "enhanced role for nurses working in General Practice"[13] as they do not specify the services to be delivered but rather allow individual practices to plan nursing services that best meet community needs. The value of these incentive payments is based on a combination of a practice's Standardised Whole Patient Equivalent value and the hours for which nurses are employed.

"Elements of the health system are failing for some consumer groups. These are the aged, those with multiple, chronic diseases and those who are marginalised and disadvantaged by geography, culture or poverty"[3]. ACN would argue that current funding models limit the potential for health professionals to deliver flexible health care and person-centred care[3]. We must not lose sight of this during the COVID-19 pandemic.

From the introduction of the PNIP in 2012, and at the commencement of the MBS Taskforce Review, nurses have argued "for the abolition of the remaining MBS item numbers allowing for the claiming of services provided by a nurse in general practice 'for and on behalf' of the GP, or 'under the supervision' of the GP"[13]. ACN did not support any item numbers for nursing services provided 'for and on behalf of', or 'under the supervision' of the GP. "As regulated health professionals, registered nurses are not 'supervised', nor do they provide care 'for and on behalf of' any other health care professional[13]. Nurses acknowledge that all health care is a collaborative endeavour focused on positive outcomes for individuals and groups"[13].

In addition to the lack of professional recognition afforded by 'for and on behalf of' item numbers, this funding structure negatively impacts collaborative multidisciplinary practice[15] and is inefficient. Requiring a doctor to be present to maximise funding claims when the service could effectively be delivered by a single health professional is not sustainable, particularly as our health system capacity is stretched and will continue to be over the coming months due to COVID-19.

Provider numbers

Provider numbers offer direct access to claiming Medicare rebates for eligible health professionals. Currently, nurses are the only health professional group that does not have access to a provider number. This means that nurses are only able to access Medicare rebates for services provided 'on behalf of, and under the supervision of medical practitioners. While nurses recognise that they practise within a multidisciplinary health care team, "as regulated health professionals, Registered Nurses are responsible and accountable to the Nursing and Midwifery Board of Australia"[16]. In the current funding system nurses' clinical practice is constrained and they are not able to work to the full scope of their practice[14,17]. Additionally, at present, collaboration between nurses and other health professionals is inefficient[14,15] as nurses require 'supervision' to maximise funding benefits rather than to add value to health care service delivery. These factors mean that in the current environment PHC nurses are not making the optimal contribution to health care.

Nurses are the largest health profession in Australia, comprising some 56% of the registered health practitioner workforce. As such the nursing workforce "plays a crucial role in determining national health outcomes" (p.8)[18].As our health system faces one of its greatest tests of capacity and potential significant workforce shortages, it is vital that nurses can provide services to the full extent of their scope, without being reliant upon the presence of others. Extending provider numbers to registered nurses would free these skilled health professionals to provide nursing care within the community to the full extent of their scope of practice without reliance on others.

Summary

- There is a need to extend provider numbers to registered nurses to provide direct access to claiming Medicare rebates without reliance upon other health professionals.
- Registered nurses are responsible and accountable to the Nursing and Midwifery Board of Australia for their practice.
- It is not the best use of the health care resources, including financial and human resources to rely on antiquated systems for consumers to access appropriate care. This is not acceptable during a pandemic crisis.

MBS Item numbers

Historically, the introduction of MBS item numbers for nursing services in general practice has resulted in prescriptive care, at times, directed to meet funding criteria. This has both narrowed the nursing role and constrained nurses from working to the full extent of their scope of practice[14]. It has also negatively impacted the provision of person-centred, holistic and comprehensive nursing care, and limited the full benefits of nursing services to consumers.

Maintaining some MBS item numbers that include nurses has linked funding to the provision of specific services only. This perpetuates a model in a majority of instances whereby employers, who are often GPs, or practice managers, direct nurses to focus their role on activities which can be remunerated via Medicare. This means that the original intent of the PNIP, and now the WIP, to "enhance the role of nurses working in general practice"[13] has not been fully realised. The intent of the WIP to allow nurses to provide nursing services as required by the specific practice and its patients could be best achieved through broad item numbers, such as those afforded to nurse practitioners, that fund nursing services based on consultation duration rather than specific clinical tasks (e.g. pap smear, spirometry).

Nurses in general practice have long had access to MBS item numbers for telehealth but this is only when they are either with the patient at the practice or with the patient in the residential aged care facility and the medical specialist is on the other end of the conference. (Funding rules do not provide for a GP on the other end of a teleconference, although a GP can be with the nurse and the patient in person, enabling them to bill a higher amount). Providing registered nurses with access to additional items numbers would facilitate them to work to their scope of practice within the multidisciplinary team supporting people with or at risk of COVID-19.

In addition to their role in supporting people with or at risk of COVID-19, PHC nurses have the potential to play an important role in supporting the other aspects of the health of our community, including chronic disease management and prevention activities (e.g. influenza and pneumococcal immunisations). To achieve this in a sustainable manner, registered nurses require additional item numbers to facilitate nursing service delivery either via telehealth or outside of the general practice.

The negative impact of funding on nursing roles is also seen in relation to nurse practitioners. Nurse practitioners (NP) have been providing health care in Australia for 18 years and have been eligible providers within the MBS system for the past decade[4]. The Medicare Benefits Schedule (MBS) Review Taskforce4 have identified that:

> *"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" (p. 9).*

ACN has already made recommendations to Government about how the MBS system could be modified to address these issues[19].

Summary

Some 80 per cent of nurses in Australia are registered nurses[18] including around 2,000 nurse practitioners. Currently, the role of these health professionals is constrained by funding models that inhibit them working to the full extent of their scope of practice. Patients and communities suffer as a result.

Any consideration of new items numbers must consider the history of items constraining the nurses' role and focus on the introduction of broad item numbers, such as telehealth or time-based items, that allow nurses to deliver the nursing services they deem appropriate given the circumstances and condition of the individual patient. Our care should remain holistic and not transactional.

- There is a need to extend access to registered nurses to additional broad item numbers to cover the delivery of nursing services outside the general practice, either within homes or via telehealth, to facilitate nurses working to the full extent of their scope of practice and to optimise health care and health promotion in the community.
- It is essential to develop funding mechanisms to support teams of nurses, within the broader PHC multidisciplinary team, to provide assessment, triage and care directly to people in their own homes and via teleconferencing in order to facilitate the prevention of social isolation to manage ongoing chronic conditions and to provide health promotion.
- Recommendations have already been made to revise nurse practitioner access to the MBS to optimise their ability to provide care.

Review of Block Funding Programs

Funding of services in general practice should support integrated, multi-disciplinary person-centred care. Block funding was introduced to facilitate nurses working to their full scope of practice and without being directed by others to undertake only the aspects of nursing care for which the general practice can bill Medicare. However, the WIP, like its predecessor PNIP, only provides funding for a portion of nursing services. General practices achieve additional funding for nursing services through claiming other items of service such as health assessments (701, 703, 705, 707, 715, and 10987), chronic disease management (10997), antenatal care (16400), management plans (721, 732), team care arrangements (723), spirometry (11506), ECG (11700), and telehealth (10983, 10984) or through efficiencies achieved in the practice. As practices are forced to review the conduct of these items of service in the current environment of social isolation, there is a real risk to the funding of nursing in general practice. Of real concern is the impact this has on consumers, patients, families and communities including physical, mental and psychosocial health and well-being.

The current WIP block funding program ties the funding of nurses to the number of GPs in a practice, in order to access payment. While the number of GPs in a practice may be a proxy of practice population size, there is limited evidence for the efficacy of limiting nursing services based on GP numbers. Uncoupling the funding of nurses in general practice from GP numbers under the WIP, that is, removing the requirements around the GP : Nurse ratio would enable greater employment of nurses in general practice to provide services that better meet the needs of the community.

Summary

- There is a need to review WIP funding to address changing service delivery.
- Uncoupling WIP funding from GP: Nurse ratios would allow more registered and enrolled nurses to be employed within primary care to meet demand for services.

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