
1159

Final Decision Analytic
Protocol (DAP) to guide
the assessment of
palliative medicine
professional attendance
items

June 2012

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MSAC and PASC

The Medical Services Advisory Committee (MSAC) is an independent expert committee appointed by the Minister for Health and Ageing (the Minister) to strengthen the role of evidence in health financing decisions in Australia. MSAC advises the Minister on the evidence relating to the safety, effectiveness, and cost-effectiveness of new and existing medical technologies and procedures and under what circumstances public funding should be supported.

The Protocol Advisory Sub-Committee (PASC) is a standing sub-committee of MSAC. Its primary objective is the determination of protocols to guide clinical and economic assessments of medical interventions proposed for public funding.

Purpose of this document

This document is intended to provide a decision analytic protocol (DAP) that will be used to guide the assessment of an intervention for a particular population of patients.

The protocol guiding the assessment of health interventions are typically developed using the widely accepted “PICO” approach. The PICO approach involves a clear articulation of the following aspects of the question for public funding the assessment is intended to answer:

- P**atients – specification of the characteristics of the patients in whom the intervention is to be considered for use
- I**ntervention – specification of the proposed intervention and how it is delivered
- C**omparator – specification of the therapy most likely to be replaced by the proposed intervention
- O**utcomes – specification of the health outcomes and the healthcare resources likely to be affected by the introduction of the proposed intervention

However, as discussed in detail on p15 below, in the case of palliative medicine professional attendance items, PASC resolved that the adoption of the standard PICO approach was not appropriate as an assessment focussed on such an approach may be so narrow that it would not be informative to MSAC.

Summary of key matters for consideration by the applicant

The PASC requests that the applicant note the following issues and address these issues in its assessment:

- The wording of the items to be proposed should include some specification of the services that are expected to be delivered in a structured palliative medicine attendance for complex assessment and management of, and in a review of, a patient requiring palliative care services (i.e., to ensure that the intervention delivered under the MBS item is as described in the section titled "Intervention - Description" on pp.11-13 below and as required to satisfy the Palliative Care Australia standards). The wording for MBS Items 132 and 133 should be modified so that the specific services that are expected to be delivered in a palliative care setting are reflected.
- The assessment should present the overall body of evidence that could inform a judgement as to the overall comparative effectiveness, safety and "value" (both to patient and carer) of a model of care involving structured palliative medicine attendances for complex assessment and management of patients and for follow-up review of these patients. Where information was available to allow a comparison of such a model of care versus alternative models of care (e.g., the model of care that prevailed at the time the initial items for palliative care were made available on the MBS, or a model of care involving unstructured attendances that respond to issues as they are raised by a patient), then the assessment should include such comparative analyses.
- On the basis of the likely claims of potential clinical superiority for the proposed model of care compared with alternative models of care, PASC considered that an assessment should present appropriate comparative cost-effectiveness analyses. Although incremental cost-effectiveness ratios based on quality-adjusted survival (i.e., results of comparative cost-utility analyses) are considered desirable for decision-making, PASC noted that it is important to recognise that there is often trade-off between the most appealing outcome upon which to base the economic evaluation from a theoretical point of view and the degree of uncertainty in the estimate of incremental cost-effectiveness generated. Extrapolation of outcomes beyond the evidence in this setting of palliative care is likely to be associated with the introduction of considerable uncertainty in estimates of incremental cost-effectiveness that may be generated. Given the difficulties that are likely to be encountered in extrapolating from other outcomes to impact on quality of life, PASC considered that the presentation of other types of economic analyses (e.g., cost consequences and cost-effectiveness analyses), in addition to cost-utility analysis (if it can be conducted), would be appropriate in the case of structured palliative medicine attendances for complex assessment and reviews.
- Broader considerations besides the impact on a palliative care patient's quality-adjusted survival could be taken into account in an assessment supporting the availability of additional palliative medicine MBS items. For example, an economic analysis may also incorporate costs and benefits associated with transfer of services delivered under the public system to the private system and also costs and benefits associated with expansion of availability of palliative medicine services. Also, impacts of a change to the model of care on carers of patients should be considered.

Purpose of application

An application requesting the listing of four time-tiered professional attendance (consultation) items on the MBS, that are intended to allow for preparation and review of complex treatment and management plans by palliative medicine specialists, has been progressed by the Department of Health and Ageing (DoHA) in consultation with the Australian & New Zealand Society of Palliative Medicine (ANZSPM).

PASC noted that the comments received from the ANZSPM during the public consultation period on this DAP did not appear to be supportive of the time-tiered items that had been proposed by the Department and instead reiterated the ANZSPM's position that its preference was for the addition of items that are similar to MBS Items 132 and 133 that are available to consultant physicians to allow for complex assessment and management of patients (requiring an attendance \geq 45 minutes) and for follow-up review of these patients (requiring an attendance \geq 30 minutes) to ensure that treatment and care plans are kept aligned with the changing needs of the patient and their caregiver/s and family and the changing phase of the patient's illness. A set of items for attendances at consulting rooms or in a hospital and a set for attendances at a place other than consulting rooms or hospitals) were proposed.

PASC determined that the DAP should be revised so that the intervention of interest related to structured palliative medicine attendances (either in consulting rooms, hospitals, or other places) for complex assessment and management of patients and for follow-up review of these patients, as requested by the ANZSPM, rather than the time-tiered items proposed in the Consultation DAP.

Background

Current arrangements for public reimbursement

For a medical practitioner to be recognised by Australian Medical Council and Medicare Australia as being a palliative medicine specialist s/he must be a fellow of the Australasian Chapter of Palliative Medicine (FACHPM).

There are currently six palliative medicine professional attendance items available on the MBS:

- three items for professional attendances at consulting rooms or hospital (Items 3005, 3010, and 3014); and
- three items for professional attendances at a place other than consulting rooms or hospital (Items 3018, 3023, and 3028); PASC noted that the schedule fees for attendances in these locations are between 21% and 85% higher than for attendances in doctors' rooms or in hospital.

In addition, there are twelve palliative medicine items for case conferencing:

- three time-tiered items for organisation and co-ordination of a community case conference by a palliative medicine specialist (Items 3032, 3040, and 3044)
- three time-tiered items for participation in a community case conference by a palliative medicine specialist (Items 3051, 3055, and 3062)

- three time-tiered items for organisation and co-ordination of a discharge case conference by a palliative medicine specialist (Items 3069, 3074, and 3078)
- three time-tiered items for participation in a discharge case conference by a palliative medicine specialist (Items 3083, 3088, and 3093).

Details of these items (as per the May 2012 edition of the MBS) are provided in Table 1.

Table 1: Current MBS item descriptors for professional attendance items available for palliative medicine specialists

| Category 1 – Professional attendances |
|---|
| <p><u>MBS Item 3005</u></p> <p>MEDICAL PRACTITIONER (PALLIATIVE MEDICINE SPECIALIST) ATTENDANCE - SURGERY OR HOSPITAL</p> <p>Professional attendance at consulting rooms or hospital by a consultant physician or specialist practising in the specialty of palliative medicine, where the patient was referred to him or her by a medical practitioner.</p> <p>- INITIAL attendance in a single course of treatment</p> <p>Fee: \$148.10 Benefit: 75% = \$111.10 85% = \$125.90</p> <p>(See para A48 of explanatory notes to this Category)</p> |
| <p><u>MBS Item 3010</u></p> <p>- Each attendance (other than a service to which item 3014 applies) SUBSEQUENT to the first in a single course of treatment</p> <p>Fee: \$74.10 Benefit: 75% = \$55.60 85% = \$63</p> <p>(See para A48 of explanatory notes to this Category)</p> |
| <p><u>MBS Item 3014</u></p> <p>- Each MINOR attendance SUBSEQUENT to the first in a single course of treatment</p> <p>Fee: \$42.20 Benefit: 75% = \$31.65 85% = \$35.90</p> <p>(See para A48 of explanatory notes to this Category)</p> |
| <p><u>MBS Item 3018</u></p> <p>MEDICAL PRACTITIONER (PALLIATIVE MEDICINE SPECIALIST) ATTENDANCE – HOME VISIT</p> <p>Professional attendance at a place other than consulting rooms or hospital by a consultant physician or specialist practising in the specialty of palliative medicine, where the patient was referred to him or her by a medical practitioner.</p> <p>- INITIAL attendance in a single course of treatment</p> <p>Fee: \$179.70 Benefit: 85% = \$152.75</p> <p>(See para A48 of explanatory notes to this Category)</p> |
| <p><u>MBS Item 3023</u></p> <p>- Each attendance (other than a service to which item 3028 applies) SUBSEQUENT to the first in a single course of treatment</p> <p>Fee: \$108.70 Benefit: 85% = \$92.40</p> <p>(See para A48 of explanatory notes to this Category)</p> |
| <p><u>MBS Item 3028</u></p> <p>- Each MINOR attendance SUBSEQUENT to the first in a single course of treatment</p> <p>Fee: \$78.25 Benefit: 85% = \$66.55</p> <p>(See para A48 of explanatory notes to this Category)</p> |

Table 1: Current MBS item descriptors for professional attendance items available for palliative medicine specialists

| Category 1 – Professional attendances |
|--|
| CASE CONFERENCE ITEMS |
| <p><u>MBS Item 3032</u></p> <p>CASE CONFERENCES - PALLIATIVE MEDICINE SPECIALIST</p> <p>Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines</p> <p>(See para A48 of explanatory notes to this Category)</p> <p>Fee: \$136.50 Benefit: 75% = \$102.40 85% = \$116.05</p> |
| <p><u>MBS Item 3040</u></p> <p>Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines</p> <p>(See para A48 of explanatory notes to this Category)</p> <p>Fee: \$204.80 Benefit: 75% = \$153.60 85% = \$174.10</p> |
| <p><u>MBS Item 3044</u></p> <p>Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE, where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines</p> <p>(See para A48 of explanatory notes to this Category)</p> <p>Fee: \$272.95 Benefit: 75% = \$204.75 85% = \$232.05</p> |
| <p><u>MBS Item 3051</u></p> <p>Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE, (other than to organise and to coordinate the conference) where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines</p> <p>(See para A48 of explanatory notes to this Category)</p> <p>Fee: \$98.05 Benefit: 75% = \$73.55 85% = \$83.35</p> |
| <p><u>MBS Item 3055</u></p> <p>Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE, (other than to organise and to coordinate the conference) where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines</p> <p>(See para A48 of explanatory notes to this Category)</p> <p>Fee: \$156.35 Benefit: 75% = \$117.30 85% = \$132.90</p> |
| <p><u>MBS Item 3062</u></p> <p>Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE, (other than to organise and to coordinate the conference) where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines</p> <p>(See para A48 of explanatory notes to this Category)</p> <p>Fee: \$214.65 Benefit: 75% = \$161.00 85% = \$182.50</p> |

Table 1: Current MBS item descriptors for professional attendance items available for palliative medicine specialists

| Category 1 – Professional attendances |
|--|
| <p><u>MBS Item 3069</u></p> <p>Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines</p> <p>(See para A48 of explanatory notes to this Category)</p> <p>Fee: \$136.50 Benefit: 75% = \$102.40 85% = \$116.05</p> |
| <p><u>MBS Item 3074</u></p> <p>Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines</p> <p>(See para A48 of explanatory notes to this Category)</p> <p>Fee: \$204.80 Benefit: 75% = \$153.60 85% = \$174.10</p> |
| <p><u>MBS Item 3078</u></p> <p>Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE, where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines</p> <p>(See para A48 of explanatory notes to this Category)</p> <p>Fee: \$272.95 Benefit: 75% = \$204.75 85% = \$232.05</p> |
| <p><u>MBS Item 3083</u></p> <p>Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines</p> <p>(See para A48 of explanatory notes to this Category)</p> <p>Fee: \$98.05 Benefit: 75% = \$73.55 85% = \$83.35</p> |
| <p><u>MBS Item 3088</u></p> <p>Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines</p> <p>(See para A48 of explanatory notes to this Category)</p> <p>Fee: \$156.35 Benefit: 75% = \$117.30 85% = \$132.90</p> |
| <p><u>MBS Item 3093</u></p> <p>Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE, where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines</p> <p>(See para A48 of explanatory notes to this Category)</p> <p>Fee: \$214.65 Benefit: 75% = \$161.00 85% = \$182.50</p> |

The ANZSPM claims that management of palliative medicine patients has become more complex since initial items for palliative care were introduced. A complex assessment and management plan are required, for example, to comply with palliative care capability and quality framework service provision (such as Palliative Care Australia standards) and to comply with medical developments in palliative medicine (such as advanced care planning and end-of-life decision making). It is claimed that preparation of a treatment and management plan typically takes around 60 minutes. In November 2007, items as shown in Table 2 were introduced that allow for complex assessment and management of patients however these items (MBS item 132 and follow-up review item 133) are restricted such that they are only available to consultant physicians (i.e., to fellows of the Royal Australian College of Physicians [FRACPs]). A minority of palliative medicine specialists hold such a fellowship; the majority are fellows only of the Australasian Chapter of Palliative Medicine (AChPM). The ANZSPM provided advice that, as of December 2010, there were 282 recognised palliative medicine specialists. Of these, 6% hold FRACP only, 26% hold FRACP and FACHPM and the remaining 68% hold FACHPM only. Thus, only a minority of palliative medicine specialists are able to claim these items. This inconsistency in access to MBS complex assessment and management items causes some concern among the palliative medicine practitioner base and the ANZSPM has expressed that it believes these items should be available to all palliative medicine specialists whether they hold FRACP, FACHPM or FRACP & FACHPM. The proposed items are intended to address this inconsistency. It was noted by PASC that MBS items 132 and 133 are limited to services delivered in the surgery or hospital. The proposed items are not restricted to professional attendances in these settings but permit professional attendances in all settings (i.e., including homes and residential aged care facilities). PASC considered that, given the poor health status of patients requiring palliative services, it was appropriate that differential MBS palliative medicine items should be available for delivery of medical services in settings other than the consulting rooms or hospital setting (e.g., to include nursing home, hospice or patient's own home).

Table 2: Current MBS item descriptors for items available for complex assessment and management of patients in surgery or hospital settings

| Category 1 – Professional attendances |
|---|
| <p><u>MBS Item 132</u></p> <p>The title would need to be changed to:</p> <p>PALLIATIVE MEDICINE SPECIALIST - REFERRED PATIENT TREATMENT AND MANAGEMENT PLAN, SURGERY, HOSPITAL OR HOME</p> <p>Professional attendance of at least 45 minutes duration for an initial assessment of a patient with at least two morbidities (this can include complex congenital, developmental and behavioural disorders), where the patient is referred by a medical practitioner, and where</p> <ul style="list-style-type: none"> a) assessment is undertaken that covers: <ul style="list-style-type: none"> - a comprehensive history, including psychosocial history and medication review; - comprehensive multi or detailed single organ system assessment; - the formulation of differential diagnoses; and b) a consultant physician treatment and management plan of significant complexity is developed and provided to the referring practitioner that involves: <ul style="list-style-type: none"> - an opinion on diagnosis and risk assessment - treatment options and decisions - medication recommendations <p>Not being an attendance on a patient in respect of whom, an attendance under items 110, 116 and 119 has been received on the same day by the same consultant physician.</p> <p>Not being an attendance on the patient in respect of whom, in the preceding 12 months, payment has been made under this item for attendance by the same consultant physician.</p> <p>Fee: \$259.00 Benefit: 75% = \$194.25 85% = \$220.15</p> <p>(See para A12 of explanatory notes to this Category)</p> |

Table 2: Current MBS item descriptors for items available for complex assessment and management of patients in surgery or hospital settings

| Category 1 – Professional attendances |
|---|
| <p><u>MBS Item 133</u></p> <p>CONSULTANT PHYSICIAN (OTHER THAN IN PSYCHIATRY) REVIEW OF REFERRED PATIENT TREATMENT AND MANAGEMENT PLAN - SURGERY OR HOSPITAL</p> <p>PALLIATIVE MEDICINE SPECIALIST - REVIEW OF REFERRED PATIENT TREATMENT AND MANAGEMENT PLAN, SURGERY, HOSPITAL OR HOME</p> <p>Professional attendance of at least 20 minutes duration subsequent to the first attendance in a single course of treatment for a review of a patient with at least two morbidities (this can include complex congenital, developmental and behavioural disorders), where</p> <ul style="list-style-type: none"> a) a review is undertaken that covers: <ul style="list-style-type: none"> - review of initial presenting problem/s and results of diagnostic investigations - review of responses to treatment and medication plans initiated at time of initial consultation comprehensive multi or detailed single organ system assessment, - review of original and differential diagnoses; and b) a modified consultant physician treatment and management plan is provided to the referring practitioner that involves, where appropriate: <ul style="list-style-type: none"> - a revised opinion on the diagnosis and risk assessment - treatment options and decisions - revised medication recommendations <p>Not being an attendance on a patient in respect of whom, an attendance under item 110, 116 and 119 has been received on the same day by the same consultant physician.</p> <p>Being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under item 132 by the same consultant physician, payable no more than twice in any 12 month period.</p> <p>Fee: \$129.65 Benefit: 75% = \$97.25 85% = \$110.25</p> <p>(See para A12 of explanatory notes to this Category)</p> |

Intervention

Description

The AChPM proposed that an assessment supporting MBS listing of items that would allow for preparation and review of complex treatment and management plans by palliative medicine specialists should be submitted to MSAC.

The application for an assessment submitted to PASC provided a general description of the proposed intervention. The application notes that palliative medicine is the study and management of patients with active, progressive, far advanced disease, for who the prognosis is limited and the focus of care is quality of life. It also notes that an assessment of a patient by a palliative medicine specialist would involve: ascertainment of a patient's current active medical problems and recording of the patient's past medical history, conduct of a medication review, making advanced care planning arrangements, assessment of current and previous physical and psychological function. A management plan would be developed, based on information provided by the history and examination of the patient, with the plan being explained, and/or provided to the patient, or where appropriate, to their family or carer(s). The palliative medicine specialist treatment and management plan should address any specific questions and issues that were raised by the referring practitioner. A written report of the assessment, including the management plan, should be provided to the referring practitioner within a maximum of two

weeks after the assessment. More prompt verbal communication may be appropriate. The palliative medicine specialist would then provide follow-up review, treatment and management (via a number of consultations, as required).

Further detail on various aspects of the proposed intervention are provided as follows. PASC noted that, ideally, the MBS listing would outline the services that are expected to be delivered in the preparation of a complex treatment and management plan.

HISTORY

The palliative medicine specialist treatment and management plan should encompass a comprehensive patient history, which addresses all aspects of the patient's health, including psychosocial history, past clinically relevant medical history, any relevant pathology results if performed, and a review of medication and interactions. There should be a particular focus on the presenting symptoms and current difficulties, including precipitating and ongoing conditions. The results of relevant assessments by other health professionals, including GPs and/or specialists, including relevant care plans or health assessments performed by GPs under the Enhanced Primary Care and Chronic Disease Management, should also be noted.

EXAMINATION

A comprehensive medical examination means a full multi-system or detailed single organ system assessment. The clinically relevant findings of the examination should be recorded in the management plan.

DIAGNOSIS

This should be based on information obtained from the history and medical examination of the patient. The list of diagnoses and/or problems should form the basis of any actions to be taken as a result of the comprehensive assessment. In some cases, the diagnosis may differ from that stated by the referring practitioner, and an explanation of why the diagnosis differs should be included. The report should also provide a risk assessment, management options and decisions.

MANAGEMENT PLAN

- *TREATMENT OPTIONS/TREATMENT PLAN*
The palliative medicine specialist treatment and management plan should include a planned follow-up of issues and/or conditions, including an outline of the recommended intervention activities and treatment options. Consideration should also be given to recommendations for allied health professional services, where appropriate.
- *MEDICATION RECOMMENDATIONS*
Provide recommendations for immediate management, including the alternatives or options. This should include doses, expected response times, adverse effects and interactions, and a warning of any contra-indicated therapies.
- *SOCIAL MEASURES*
Identify issues which may have triggered or are contributing to the problem in the family, workplace or other social environment which need to be addressed, including suggestions for addressing them.

- *OTHER NON-MEDICATION MEASURES*

This may include other options such as any rehabilitation recommendations and discussion of any relevant referrals to other health providers.

- *INDICATIONS FOR REVIEW*

It is anticipated that the majority of patients will be able to be managed effectively by the referring practitioner using the palliative medicine specialist treatment and management plan. If there are particular concerns about the indications or possible need for further review, these should be noted in the palliative medicine specialist treatment and management plan.

- *LONGER TERM MANAGEMENT*

Provide a longer term palliative medicine specialist treatment and management plan, listing alternative measures that might be taken in the future if the clinical situation changes. This might be articulated as anticipated response times, adverse effects and interactions with the palliative medicine specialist treatment and management plan options recommended under the palliative medicine specialist treatment and management plan.

- *CARER SUPPORT PLAN*

Provide appropriate support, training and resources to ensure that carers are able to carry out their end of life care responsibilities effectively. Provide care and support to deal with bereavement and grief.

- *BEREAVEMENT PLAN*

Provide bereavement support to all relevant family members, both before and after the patient's death, to support them through the acute phase of grief. This will include routine and ongoing risk assessment and establishment of partnerships with local community networks to enhance bereavement support. People with complicated grief or prolonged needs may need to be referred to specialist bereavement counselling or psychiatric service.

- *SPIRITUAL ASSESSMENT*

Ensure that spiritual support through pastoral carers, as appropriate, is arranged.

Although the ANZSPM advised that the usual time needed to conduct an assessment and draft a management plan is around 60 minutes, it also advised that both initial and follow-up consultations may be either shorter or longer, depending on a patient's needs and depending on the patient's health status. On this basis, DoHA (representing the applicant) suggested that the application should request MBS listing of a set of time-tiered items (as opposed to items specifically allowing for the preparation and review of complex treatment and management plans), with specialists being able to bill the relevant item based on the time spent with patients. It was suggested that the proposed time-tiered items would allow FACHPMs to have access to adequate reimbursement for the activity of preparing and reviewing complex treatment and management plans as would be provided by MBS item 132 and follow-up review item 133 (detailed in Table 2) which are available to consultant physicians (i.e., to FRACPs).

As discussed in the section titled 'Purpose of application' on p.4 above, PASC noted that the comments received from the ANZSPM during the public consultation period on this DAP did not appear to be supportive of the time-tiered items that had been proposed by the Department and instead reiterated the ANZSPM's position that its preference was for the inclusion of items that are similar to MBS Items 132 and 133 that are available to consultant physicians to allow for complex assessment and management of patients (requiring an attendance \geq 45 minutes) and for follow-up review of these

patients (requiring an attendance \geq 30 minutes). A set of items for attendances at consulting rooms or in a hospital and a set for attendances at a place other than consulting rooms or hospitals) was proposed.

PASC determined that that the intervention of interest in the DAP should be structured palliative medicine attendances (either in consulting rooms, hospitals, or other places) for complex assessment and management of patients and for follow-up review of these patients, as requested by the ANZSPM, rather than the time-tiered items proposed in the Consultation DAP.

Prerequisites

REFERRAL

It is proposed that the patient must be referred for the intervention by a medical practitioner other than the palliative medicine specialist who is to provide the intervention. The referral process will be in accordance with the MBS G6.1 Referral of Patients to Specialist or Consultant Physician.

TRAINING

Palliative medicine specialist status can be achieved via two pathways. One pathway is through fellowship of the RACP followed by 3 years of advanced training in palliative medicine. A second pathway to specialist status in palliative medicine is through fellowship of the AChPM. This latter award requires completion of the same 3 year advanced palliative medicine curriculum training that is completed by those progressing through the RACP pathway. The FACHPM pathway is important in a specialty that, by its nature, is more attractive to doctors as they get older. Many general practitioners train to become specialists via the AChPM pathway. In summary, a specialist in palliative medicine may only be a FACHPM (meaning they are a palliative medicine specialist and perhaps a GP), or s/he may be both a FACHPM and FRACP (meaning they are a palliative medicine specialist and a consultant physician). ANZSPM estimates that the majority of specialists in palliative medicine in Australia have achieved specialty status through the FACHPM pathway. As noted on p.8 in the section titled "Current arrangements for public reimbursement", advice was provided to the PASC meeting by the ANZSPM that, as of December 2010, there were 282 recognised palliative medicine specialists. Of these, 6% are reported to hold FRACP only, 26% hold FRACP and FACHPM and the remaining 68% hold FACHPM only.

Co-administered and associated interventions

A referral from a medical practitioner is required prior to a professional attendance by a palliative medicine specialist. No other specific services are required to be administered prior to, with or following the proposed MBS items. However, follow-up services that might need to be rendered following a palliative medicine service would be discussed during the consultation and would be included in the treatment and management plan. A palliative medicine specialist may order various pathology tests or diagnostic imaging services during an initial or subsequent consultation (if a GP has not already done so) to assess patients at end of life who have complex, often interacting medical, physical and psychological problems, who are at significant risk of poor health outcomes.

Listings proposed for MSAC consideration

Proposed MBS listing

The MBS item descriptors proposed in the Consultation DAP are provided in Table 3. As discussed in the section titled 'Purpose of application' on p.4 above, PASC noted that the comments received from the ANZSPM during the public consultation period on this DAP did not appear to be supportive of the time-tiered items that had been proposed by the Department and instead reiterated the ANZSPM's position that its preference was for the inclusion of items that are similar to MBS Items 132 and 133 that are available to consultant physicians to allow for complex assessment and management of patients (requiring an attendance \geq 45 minutes) and for follow-up review of these patients (requiring an attendance \geq 30 minutes). PASC agreed that it would be appropriate for an application to propose two sets of items, each set similar to Item 132 and Item 133, for inclusion on the MBS – one set for attendances at consulting rooms or in a hospital and one set for attendances at a place other than consulting rooms or hospitals. PASC did not propose any specific wording for the two sets of items however PASC advised that the applicant should ensure that the wording of the items should include some specification of the services that are expected to be delivered in a complex assessment and in a review (i.e., to ensure that the intervention delivered is as described in the section titled "Intervention - Description" on pp.10-13 above). The wording for MBS Items 132 and 133 (as shown in Table 2) should be modified so that the specific services that are expected to be delivered in a palliative care setting are reflected.

Table 3: Proposed MBS item descriptor for proposed palliative medicine services

| Category 1 – Professional attendances | |
|--|--|
| <p><u>MBS Item XXX</u></p> <p>Professional attendance by a palliative medicine specialist in the practice of his or her specialty, following referral of the patient to him or her by a practitioner - an attendance of not more than 15 minutes duration</p> <p>Fee: \$TBA Benefit: 75% = \$TBA 85% = \$TBA</p> | |
| <p><u>MBS Item XXX</u></p> <p>Professional attendance by a palliative medicine specialist in the practice of his or her specialty, following referral of the patient to him or her by a practitioner - - an attendance of more than 15 minutes, but not more than 30 minutes duration</p> <p>Fee: \$TBA Benefit: 75% = \$TBA 85% = \$TBA</p> | |
| <p><u>MBS Item XXX</u></p> <p>Professional attendance by a palliative medicine specialist in the practice of his or her specialty, following referral of the patient to him or her by a practitioner - an attendance of more than 30 minutes, but not more than 45 minutes duration</p> <p>Fee: \$TBA Benefit: 75% = \$TBA 85% = \$TBA</p> | |
| <p><u>MBS Item XXX</u></p> <p>Professional attendance by a palliative medicine specialist in the practice of his or her specialty, following referral of the patient to him or her by a practitioner - an attendance of more than 45 minutes duration</p> <p>Fee: \$TBA Benefit: 75% = \$TBA 85% = \$TBA</p> | |

TBA = to be advised. Fees will be calculated based on cost inputs for time-based professional attendances.

The application for an assessment did not provide an indication of the average likely frequency of patient review. Furthermore, the proposed items do not specify any criteria that need to be satisfied

to trigger an assessment or review by a palliative medicine specialist. In contrast, it was noted that only one MBS Item 132 and one MBS Item 133 is claimable in a 12 month period. PASC resolved that a limit of one attendance for complex assessment and two attendances for review per annum should be included with the item descriptors.

Although the proposed item descriptors do not specify the patient population to whom the items may be delivered, PASC considered it reasonable to assume that a palliative medicine specialist would only be attending to patients requiring palliative care. However, it noted that patients requiring palliative care are a heterogeneous group. Patients needing access to palliative care will have been diagnosed with a range of life-limiting illnesses that may include cancer, neurodegenerative disorders such as motor neuron disease and dementia, stroke, organ failure and multiple sclerosis. The population of patients requiring palliative care will include people of all ages who have active, progressing, advanced disease, for whom the prognosis is poor and the focus of care is the maximisation of the quality of remaining life. PASC agreed that no specification of the patient population to whom the items may be delivered needs to be included in the MBS item descriptors.

Clinical place for proposed intervention

The application for an assessment did not elucidate the clinical place for professional attendance by a palliative medicine specialist beyond stating that it occurs at the point at which a general practitioner makes a clinical judgement that such an attendance is necessary. PASC considered that the clinical place for professional attendance by a palliative medicine specialist does not require specification in the MBS item descriptor (i.e., no “triggers” to indicate that a professional attendance by a palliative medicine specialist is indicated need be specified in the item descriptor).

During the public consultation phase for the development of this DAP, PASC sought input from stakeholders to clarify whether there would be any change in the delivery of services as a result of the availability of the additional items, i.e., PASC sought clarification on whether the billing of the proposed new items would occur as a result of a shift of claims from existing palliative medicine items or not. ANZSPM reported that, although the billing of the proposed new items would occur as a result of a shift of claims from existing palliative medicine items, the management of palliative medicine patients had become more complex since initial items for palliative care were introduced on the MBS and the delivery of services over time has changed. In particular, a complex assessment and management plan are now required, for example, to comply with palliative care capability and quality framework service provision (such as Palliative Care Australia standards) and to comply with medical developments in palliative medicine (such as advanced care planning and end-of-life decision making). The ANZSPM claims that the conduct of complex assessments is associated with an improvement in quality of care and, presumably, a consequence of this would be an improvement in patient outcomes. In practice, for ethical reasons, palliative medicine specialists conduct complex assessments despite the fact that such assessments are not always adequately reimbursed (in particular where a palliative medicine specialist is not a FRACP).

PASC considered that it would be futile to attempt a traditional HTA assessment that seeks to derive precise estimates of the comparative effectiveness, safety and cost-effectiveness of the proposed scenario, where MBS items for attendances for complex assessment (requiring an attendance \geq 45 minutes) and for follow-up review of these patients (requiring an attendance \geq 30 minutes) are

available, versus the current scenario, where currently available specific MBS palliative medicine attendance items are claimed, using the standard MSAC PICO plus economic evaluation approach as information to inform an approach as specific as this was unlikely to be available.

PASC recommended that the DAP should seek the presentation of the overall body of evidence that could inform a judgement as to the overall comparative effectiveness, safety and “value” (both to patient and carer) of a model of care involving structured palliative medicine attendances for complex assessment and management of patients and for follow-up review of these patients. Where information was available to allow a comparison of such a model of care versus alternative models of care (e.g., the model of care that prevailed at the time the initial items for palliative care were made available on the MBS, or a model of care involving unstructured attendances that respond to issues as they are raised by a patient), then the assessment should include such comparative analyses.

ANZSPM suggested that the number of services billed against the new items will occur as a result of a shift of claims from existing palliative medicine items (e.g. items 3005 and 3018) to the proposed items. ANZSPM predicted the following shifts in services:

- 40% of current palliative claims for MBS Item 3005 will shift to claiming under the new items (approximately 2,000 initial plans or patients attended to in hospital or consulting rooms)
- 75% of current palliative claims for MBS Item 3018 will shift to the new items (approximately 753 initial plans or patients attended to at home or in a residential aged care facility)
- 50% of palliative patients attended to in hospital or consultation rooms who receive an initial consult will require at least one review of their management plans (approximately 1,000 patients)
- 35% of palliative patients attended to at home or in a residential aged care facility will require at least one review of their management plans (approximately 350 patients)

ANZSPM concludes that 4,103 services will be claimed as a consequence of a shift from their current items to the proposed new items.

The application for an assessment stated that treatment and management plans are indicated for all patients who will experience expected death, including those at home and those in public and private hospitals, but claimed that there are, currently, not enough palliative specialists to service all potential patients. It also explained that the majority of palliative specialists work in the public hospital system such that it is reasonable to assume the majority of management plans are also created in public hospitals. PASC noted a claim was made by the ANZSPM that the availability of the additional proposed MBS items would encourage the provision of more consultations by palliative medicine specialists, especially in community care settings. PASC noted that an assessment of a model of care involving structured palliative medicine attendances for complex assessment and management of patients and for follow-up review of these patients should provide any evidence that is available to support this claim.

Clinical claim

PASC anticipated that an assessment considering the comparative effectiveness, safety and cost-effectiveness of a model of care involving structured palliative medicine attendances for complex assessment and management of patients and for follow-up review of these patients would claim that:

- Structured palliative medicine attendances for complex assessment and management of patients and follow-up review of these patients experience superior quality-adjusted survival compared with patients who are not managed by this model of care.
- Appropriate funding (via the listing of the proposed items) for services provided by palliative medicine specialists is likely to create a financial incentive for palliative medicine specialists to provide additional services to patients with terminal conditions in the community and this will have a positive impact on the Australian healthcare system.

Economic evaluation

On the basis of the likely claims of potential clinical superiority for the proposed model of care compared with alternative models of care, PASC considered that an assessment should present appropriate comparative cost-effectiveness analyses. Although incremental cost-effectiveness ratios based on quality-adjusted survival are considered desirable for decision-making, PASC noted that it is important to recognise that there is often trade-off between the most appealing outcome upon which to base the economic evaluation from a theoretical point of view and the degree of uncertainty in the estimate of incremental cost-effectiveness generated. Extrapolation of outcomes beyond the evidence in this setting of palliative care is likely to be associated with the introduction of considerable uncertainty in estimates of incremental cost-effectiveness that may be generated. Given the difficulties that are likely to be encountered in extrapolating from other outcomes to impact on quality of life, PASC considered that the presentation of other types of economic analyses (e.g., cost consequences and cost-effectiveness analyses), in addition to cost-utility analysis (if it can be conducted), would be appropriate in the case of structured palliative medicine attendances for complex assessment and reviews.

PASC noted that broader considerations besides the impact on a palliative care patient's quality-adjusted survival could be taken into account in an assessment supporting the availability of additional palliative medicine MBS items. For example, workforce issues that may be addressed by availability of additional MBS items could be addressed; an economic analysis may also incorporate costs and benefits associated with transfer of services delivered under the public system to the private system and also costs and benefits associated with expansion of availability of palliative medicine services. Also, the impact of a model of care involving structured palliative medicine attendances for complex assessment and management of patients and for follow-up review on carers of patients should be considered.