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Royal Australian College *of* General Practitioners

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24 May 2021

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Medical Benefits Division
Department of Health
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By email: pcs@health.gov.au

Dear Mr Balodis

Proposed new Medicare Benefits Schedule (MBS) item/s for nicotine smoking cessation

The Royal Australian College of General Practitioners (RACGP) thanks the Department of Health (the Department) for the opportunity to provide feedback on proposed new MBS items for nicotine smoking cessation.

The RACGP is Australia's largest general practice organisation, representing over 41,000 members working in or towards a career in general practice. General practitioners (GPs) are at the frontline of Australia's healthcare system. Each year, GPs provide more than 160 million general practice services to more than 22 million Australians, with almost nine in 10 people consulting a GP.[i]

Work of the RACGP in the area of smoking cessation

The RACGP supports our members to undertake smoking cessation consultations through the development of clinical guidelines. We first developed *Supporting smoking cessation: A guide for health professionals* in 2011. Since then, there have been two minor updates in 2012 and 2014. The second edition is the most comprehensive update and brings the guideline in line with new modalities of smoking cessation. It also incorporates GRADE – Grading of Recommendations, Assessment, Development and Evaluation – a new approach to assessing clinical evidence and drafting practice recommendations. The second edition of the guideline was funded in part by the Department and VicHealth.

Position on the creation of new MBS items

The RACGP generally does not support the introduction of single disease focussed MBS items, as they are not consistent with the generalist approach to care GPs are trained to provide. These items represent fragmentation of MBS funding rather than comprehensive primary care. A greater priority for allocation of health funding should be supporting patient access to comprehensive, continuous general practice care, where a patient and their GP can determine which assessments and interventions are required to support the patient to remain well.

However, the Department has advised that temporary items are proposed to assist with awareness of new guidelines and regulations relating to liquid nicotine, including the prescribing of e-cigarettes. Over time, it is expected that GPs would incorporate new treatment strategies into their regular consultations, consistent with how support for nicotine cessation is provided now. The RACGP would be less concerned about these new items if they were temporary, however it is unclear how long they will be in place before expiring. We also question whether this approach – to familiarise practitioners with new guidelines and interventions before they resume regular consultations – will create confusion.

Rather than basing the new MBS item/s on item 699 (heart health assessment), the RACGP instead recommends they be managed under similar arrangements to items 721 and 732 (General Practitioner Management Plans [GPMPs]), with standard time-based consultations being used for interim follow-up visits either face-to-face or via telehealth. The new services appear similar to GPMPs in scope, as they require consent and a written plan and involve managing nicotine smoking cessation as a standalone issue.

Terminology

We note that members had differing views on the correct terminology to describe these types of encounters, with suggestions including “smoking cessation”, “nicotine cessation” and “nicotine smoking cessation”. This may be due to ambiguity around what is involved in each encounter and what the items are intended to achieve.

It was noted that “nicotine smoking cessation” is a more specific description for smoking cigarettes than “smoking cessation” but misses those using nicotine containing vaping products because they are not technically smoking. The item descriptors/explanatory note should make it clear that the item/s can also be used for habitual nicotine use including all forms of inhaled nicotine, as people using nicotine products need support to prevent switching back to cigarette use.

For the purposes of this submission, the RACGP has used the term “nicotine smoking cessation”.

Comments provided by our members in response to the consultation questions are provided below in Appendix A. Appendix B outlines suggested amendments to the draft item descriptor, and Appendix C outlines suggested amendments to the draft explanatory note.

The RACGP looks forward to contributing to further discussions around the development of these MBS items. Please contact Leonie Scott, National Manager – Policy and Advocacy, on (03) 8699 0031 or via leonie.scott@racgp.org.au if you have any questions or comments regarding our submission.

Yours sincerely

Dr Karen Price
President

Appendix A: Member feedback on consultation questions

Questions regarding the draft item descriptor

What would be the optimum number of GP encounters required for this episode of care?

- GPs are likely to view nicotine smoking cessation as a series of ongoing consultations rather than single episodes of care.
- At a minimum, an initial encounter and at least two follow-up encounters are needed.
- It is difficult to nominate an optimum number of encounters required to achieve nicotine smoking cessation. Nicotine is an addiction and people will make multiple attempts to quit, will relapse to smoking again and make further attempts to quit. People might quit for days, weeks, months or years and then relapse again. There may be multiple conversations between a GP and patient about quitting before a quit attempt, and these could occur every week or every month.
- Aboriginal and Torres Strait Islander patients (as well as other patients in rural and remote areas, and those of low socioeconomic status) are more likely to smoke, but also more likely to have other life circumstances that make smoking harder to stop. Therefore, the optimum number of encounters for the "average" patient may not be the optimum number for those who most need nicotine smoking cessation advice.
- People with significant morbidity (ie enduring mental illness, substance dependency and previous failed attempts at quitting) may need eight consultations for each quit attempt – initial consultation, one-week consultation, then weekly to monthly until cessation. Patients with lower complexity will likely require up to six consultations – initial consultation, one-week consultation, one-month consultation, then every 1–2 months until completion of treatment at 3–6 months.
- It is critical that flexibility is provided, as patients will require different interventions depending on their circumstances at a particular point in time. For example, sometimes a brief intervention is required, and other times motivational interviewing would be more appropriate.

What may be involved with each encounter?

- A consultation devoted to nicotine smoking cessation should follow the RACGP's *Supporting smoking cessation: A guide for health professionals*.
- A list of the types of interventions that GPs provide when supporting patients to quit smoking is included below. Not all these interventions will occur in one consultation or in the order listed. Some may also be revisited in subsequent consultations.

Initial encounter

- Ask about and document the smoking and/or nicotine use status of the patient
- Assess nicotine dependence (eg how many minutes until first cigarette after waking?) Smoking within 30 minutes indicates nicotine dependence
- Assess and address barriers to quitting
- Explore the benefits of quitting (including non-health related benefits)
- Offer nicotine smoking cessation assistance and, if the person is willing to accept the offer, affirm and encourage them
- Agree on a quit plan, including a quit day, strategies for managing smoking triggers, barriers to success and mobilising social support
- Discuss methods to quit smoking, including use of nicotine replacement or medication as well as behavioural and psychology methods
- Recommend pharmacotherapy if nicotine dependent

- If prescribing pharmacotherapy, provide information of both benefits and potential risks and ensure the prescription meets legal requirements
- If the patient is not ready or unsure, use a motivational approach, explore barriers and review at future visits
- Arrange follow-up encounters

Follow-up encounters

- Review progress and problems
- Evaluate whether goals have been achieved and reframe or reset goals if necessary
- Encourage continued use of pharmacotherapy
- Monitor and manage medication side effects
- Congratulate and encourage

The length of time required for each encounter?

- Members suggest that a minimum of 20 minutes would be required for the initial encounter. Follow-up encounters would likely last less than 20 minutes.
- Some consultations which assess a patient's readiness to quit and provide a brief intervention only (eg if someone is in the pre-contemplative stage) will be short encounters (or, more likely, parts of other encounters). The draft item descriptor indicates that this item is not designed to be available for this type of encounter. For a more substantive nicotine smoking cessation encounter, where the patient has expressed a desire to quit smoking now, an encounter could last anywhere between 10 and 30 minutes. A 15–20 minute encounter may be fairly standard, however 10 minutes would be sufficient for many encounters.
- The time needed for a consultation will also be dependent on paperwork requirements.

Does this (draft item descriptor) sufficiently outline the framework required to initiate patient engagement?

- Nicotine smoking cessation is an ongoing process and both initial and follow-up encounters are required.
- As noted above, the RACGP recommends the items be managed under similar arrangements to items 721 and 732, with standard time-based consultations being used for interim follow-up visits either face-to-face or via telehealth.

Is this requirement fit for purpose, including for the provision of telehealth services?

- The RACGP strongly supports the availability of telehealth item numbers, including for nicotine smoking cessation.
- It was announced in the 2021–22 Federal Budget that smoking cessation consultations would be exempt from the existing relationship requirement for MBS-funded telehealth services provided by a GP (where patients are required to access telehealth from their usual practitioner). While we welcome the decision to exempt certain services from this requirement, our members have expressed serious concerns about the exemption for smoking cessation. Accessing this type of care from a patient's usual GP is critical to engaging, influencing and supporting the patient to give up nicotine. There is a risk that an exemption will result in online-only services fragmenting care.
- The existing relationship requirement needs to be flexible where there are significant access barriers. Examples include patients in remote areas who may have difficulty accessing a GP on a regular basis, and patients with severe mental illness or itinerate lifestyles.

What should be required of the service as a matter of law (ie the item descriptor), and what should be considered guidance on service delivery (ie the explanatory notes)?

Refer to Appendices B and C.

Does this align with clinical guidance? Should this specify referral to services such as Quitline?

- The item descriptor could include references to possible referral options such as Quitline, however the wording should make it clear that there are other services available. Referral should not be seen as essential but rather an option if the patient wants and needs it.
- Specific advice about services to use impinges on clinical autonomy, where a GP and patient agree on what will work in their particular circumstances for that particular patient.
- Evidence for nicotine smoking cessation interventions and clinical guidelines are subject to change, and the item descriptor and explanatory note should state that the latest accepted guidelines should be followed (rather than contain the guidelines themselves).

Should this include requirements to discuss and record possible risks associated with treatment, for example the use of e-cigarettes, for the purposes of indemnity insurance?

- Members report that recording risks of treatment is not routinely done by GPs and they are not specifically instructed to do this with other MBS items. GPs discuss the pros and cons of treatment options but do not record or transcribe consultations because this would increase the cost of the service significantly without improving the substance of the consultation.
- There is emerging but uncertain evidence about e-cigarettes and their efficacy in smoking cessation. The RACGP is cautious about their role in cessation, however, notes e-cigarettes are widely available to consumers, despite it being illegal in Australia to sell e-cigarettes that contain nicotine. There are also concerns about vaping as a gateway to smoking among children.

Questions regarding the draft explanatory note

Is there an appropriate claiming interval or frequency limit? Would Maximum lifetime claims (to align with enabling a 14-month supply of liquid nicotine) be appropriate?

- Our members advise that nicotine cessation is a gradual process that requires multiple consultations. The process typically involves short-term follow-up care to assess the impact of interventions (eg a step down nicotine patch used in a fortnightly cycle).
- Nicotine addiction is difficult to treat and relapse in smokers is common, with many needing multiple attempts to quit. Enforcing lifetime limits on access to nicotine smoking cessation strategies would equate to poor patient care.
- Members have questioned why the 14-month supply of liquid nicotine is different to the prescribing of any other Schedule 4 (S4) medications or addictive medications, where regular monitoring of the condition and assessment of side effects would be required by the prescriber. It is unclear how this length of time has been selected.
- The intent of the item is to achieve nicotine cessation, however long-term (ie >12-week) nicotine replacement suggests a different emphasis on harm minimisation. Harm minimisation will be an appropriate goal for a very small number of patients who are likely to need regular support similar to Medically Assisted Treatment for Opioid Dependence (MATOD) programs.

Are there other resources that should guide the explanatory note or be included in any fact sheets associated with a potential item?

- Useful links include:

    - Pharmaceutical Benefits Scheme (PBS) criteria for prescribing
    - Telephone coaching services (often state-run) – for example https://www.icanquit.com.au/
    - NPS MedicineWise – Prescribing changes for nicotine vaping products
    - NPS MedicineWise – Nicotine vaping products: practice implications of scheduling changes

Would it be beneficial to add a weblink or additional information regarding the supply pathway and legal requirements of prescribing? In the notes, or in fact sheets/via MBS Online?

- This may be useful, particularly if there are different requirements to usual PBS prescribing (eg for e-cigarettes) or if there are state differences in prescribing.
- Members note that while providing links to further information is appropriate, GPs rarely access MBS item descriptors as part of their daily workflow. The Department should therefore consider how this information can be disseminated to GPs through other channels.

Is this (information provided in the draft explanatory note) appropriate and sufficiently clear advice on co-claiming?

- The information is clear, however it should be noted that smoking cessation conversations often arise as a result of people attending consultations for health problems caused by smoking. There may be issues of capacity in many Aboriginal and Torres Strait Islander health services, as well as other practices in areas of deprivation (where there are more smokers). Eleven per cent of GPs work in the most deprived areas of Australia; 24% in the least deprived.[ii] Those 11% are managing patients with greater multimorbidity, disability and mental health issues, as well as fewer community resources. It is likely that the inability to co-claim items will disadvantage patients in areas where this type of care is most needed.
- The draft explanatory note states that “if the patient has a separate medical issue requiring immediate management, a longer attendance item may be billed in place of as to facilitate both the nicotine smoking cessation service and review of the other health-related issue”. Our members advise that this stipulation is not consistent with the rest of the MBS. If patients need additional services that are unrelated to nicotine smoking cessation, the patient should be able to claim an appropriate rebate for these additional services.
- Currently almost all nicotine smoking cessation consultations will take place as part of other consultations. The opportunity to discuss nicotine smoking cessation often arises in the context of other health issues that people have (eg heart disease, chronic obstructive pulmonary disease [COPD]), that run in their family (eg otitis media) or in the context of mental health issues or other substance use. The prevalence of multimorbidity and complex health conditions among Aboriginal and Torres Strait Islander people means it is unlikely that many Aboriginal health services will have the capacity to run separate consultations to discuss nicotine smoking cessation.
- It would be useful to link to the Services Australia education guide on billing multiple MBS items, as this includes scenarios related to co-claiming and will help GPs to meet their compliance obligations.

Other comments on the draft explanatory note

- The note states that the assessment "may include the identification of nicotine smoking cessation aids suitable for the individual, based on the clinical guidance made available by the provider's authority body". It does not specify what is meant by the "provider's authority body" (eg the RACGP, the Australian College of Rural and Remote Medicine [ACRRM]).
- The requirement to obtain consent is very bureaucratic. Nicotine smoking cessation will mostly occur in the context of an established relationship. Obtaining consent may be necessary if the service is provided by a new practice (especially if smoking cessation services are set up specifically to take advantage of the new item/s).
- If the nicotine smoking cessation item is added to the MBS as a health assessment, it is important that claiming the item does not prevent an Aboriginal and Torres Strait Islander health assessment (item 715) also being claimed. Currently there is a restriction on claiming both item 715 and item 699 (heart health assessment) for the same patient.
- The requirement to retain a copy of the nicotine cessation plan for two years will likely prolong consultations and make them exercises in completing paperwork rather than providing high-quality clinical care. Many patients accessing this service will have chronic diseases and mental health problems. Aboriginal and Torres Strait Islander patients will also have plans for preventive health, meaning patients will end up with multiple plans for different areas of their care. It would be more suitable to have a single plan covering aspects of care important to the patient, which is reviewed as circumstances change. There is also no template specified to develop the nicotine cessation plan.
- The note states that nicotine cessation services should not take the form of a health screening service. Our members observe that screening for tobacco use and providing assistance to quit is one of the most effective preventive interventions – see the RACGP Red Book for more information.

Appendix B: Draft item descriptor with suggested amendments

Note: The RACGP supports these items being managed under similar arrangements to items 721 and 732 (GPMPs). Smoking should be considered similar to a chronic disease because it requires very similar planned, proactive, structured and team-based support.

Suggested changes are in red text.

Professional attendance for nicotine smoking cessation assessment, advice and help by a general practitioner at consulting rooms lasting at least 20 minutes and must include:

(a) taking a patient history, aimed at identifying disease risk factors attributable to nicotine smoking and/or use and identifying barriers and enablers to cessation; and

(b) completing a patient nicotine dependence assessment, including where clinically appropriate a basic physical examination; and

(c) motivational interviewing to assist the patient to undertake cessation

(d) initiating interventions ~~and referrals~~ for the cessation of nicotine; and

(e) implementing a management plan for appropriate treatment; and

(f) providing the patient with tobacco and/or nicotine cessation advice and information, including addressing barriers to cessation; and

(g) providing referral(s) (if needed) for the cessation of nicotine

with appropriate documentation.

not to be co-claimed (normal same-day multiple attendance rules apply).

Appendix C: Draft explanatory note with suggested amendments

Suggested changes are in red text.

Nicotine smoking cessation counselling

Item XXX will support patients seeking assistance in nicotine smoking cessation to access health and counselling through a doctor in general practice.

The items will fund nicotine smoking cessation services lasting less than or at least 20 minutes, by a general practitioner (XXX). The new items will provide patients with a comprehensive assessment to determine nicotine dependence, identification of any physical, mental or lifestyle-related risks, and a management plan to aid nicotine smoking cessation. This may include the identification of nicotine smoking cessation aids suitable for the individual~~, based on the clinical guidance made available by the provider's authority body~~.

A general practitioner may use the Royal Australian College of General Practitioners (RACGP) resource Supporting smoking cessation: A guide for health professionals as a guide to complete this assessment and develop a management plan.

Nicotine smoking cessation items are not available to people who are in-patients of a hospital or care recipients in a residential aged care facility.

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

Nicotine cessation services should not take the form of a health screening service.

For the purpose of prescribing smoking and nicotine cessation medicines, including those only available through the Authorised Prescriber or Special Access Scheme, the practitioner must ensure they have met all the legislative requirements to provide a legal patient prescription.

A copy of the nicotine cessation plan must be retained for a period of 2 years after the date of service.

General practitioners should not conduct a separate consultation for another health-related issue in conjunction with smoking cessation counselling services unless it is clinically necessary. If the patient has a separate medical issue requiring immediate management, a longer attendance item may be billed in place of as to facilitate both the nicotine smoking cessation service and review of the other health-related issue.

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

References

[i] Department of Health. Annual Medicare statistics: Financial year 1984–85 to 2019–20. Canberra: DoH, 2020.
[ii] Australian Bureau of Statistics. Health and socioeconomic disadvantage. Canberra: ABS, 2010. Available at https://www.abs.gov.au/ausstats/abs@.nsf/lookup/4102.0main+features30mar+2010