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Attention: Mr Roland Balodis

AMA Supplementary Submission to Wound Management Working Group

Thank you for inviting the AMA to provide a submission in response to the Draft Report from the Wound Management Working Group (WMWG). The AMA generally welcomes the recommendations of the WMWG as they aim to improve support for high quality wound care within a GP-led team-based approach to care.

Current MBS arrangements fail to recognise the importance of wound care and the demonstrated improvements that it can make to a patient's health as well as the cost savings it can deliver to the health system by promoting timely healing of wounds and avoiding unnecessary complications.

Recommendation 1: GP Initial Wound Assessment

The AMA supports the stepped approach to wound care and the concept of having an MBS item that provides access to additional services that will support wound treatment and healing. However, the AMA has some concerns with the Recommendation 1 as proposed.

The first of these is in relation to the categories of people eligible for wound assessments. The list provided at page 30 of the report would restrict the wound assessment item to patients aged over the age of 75. The AMA suspects that this restriction is connected to the current target groups for health assessments. However, given the rationale and evidence presented on page 32 that in the US patients over 65 account for 85% on non-healing wounds the AMA suggest that, if an age restriction is be applied, over 65 would be a more appropriate for the purposes of a wound assessment.

The AMA notes that the WMWG considers the proposed assessment equivalent to the relevant time-based health assessments (p31). However, the minimum time in the proposed descriptor at Appendix B is "lasting at least 20 minutes" and includes developing a management plan, initiating investigations, management and referrals as necessary. This would suggest that rather than a health assessment item per se this item is more akin to a Health Assessment, GP Management Plan and Team Care Arrangement combined. The fee for it should reflect the work involved.

For the sake of clarity about the purpose of this item the AMA suggest that the title of this proposed item be amended to a GP Wound Assessment and Team Care Plan.

On another matter the AMA wants to be sure that there is clarity around when nurse time can be counted and when it cannot for an item claimed by a GP. While the AMA agrees that nurse time spent with the patient cannot be counted towards the time taken for a GP consultation, the precedent established in the MBS for Health Assessment items does allow for this time to be counted. This was something the AMA strongly and successfully advocated for when the Health Assessment items were streamlined and which is reflected in the quote below from the 2014 Fact Sheet titled Medicare Health Assessments: MBS Items 701-707 and 715.

> "The time needed to undertake the aspects above of the health assessment by the practice nurse or Aboriginal and Torres Strait Islander health practitioner may be added to the time taken by the GP to complete the assessment."

The AMA notes that where the GP Wound Assessment and Team Care Plan is claimed the WMWG proposes that this will unlock up to 10 wound treatment items (available for a time limited period of 4 weeks) provided by practice nurse who is appropriately trained and credentialed to treat wounds. The AMA supports this proposal as a mechanism for ensuring quality wound care is a viable proposition for general practices, although any move to change the Workforce Incentive Payment should be avoided so that as not to undermine this change.

The AMA notes that when the Practice Nurse Incentive Program (as it was called then) was introduced that a range of services, including wound care performed by an Aboriginal and Torres Strait Islander health practitioner were retained alongside the incentive payment to ensure the health needs of Indigenous communities could be supported. The AMA suggests that given the current health and economic burden of chronic wounds that a similar approach should be taken.

Recommendation 2: GP wound assessment review

The AMA supports the introduction of a new item for a wound assessment review.

While it could be argued that the wound review could be incorporated into the existing review item for chronic disease management and team care arrangements (MBS item 732), the AMA advises that having a specific MBS item will be fundamental to the accountability of services unlocked as part of the treatment cycle. From a compliance perspective it will more efficient if practice nurse and allied health services as part of wound treatment cycle can be directly linked to the assessment or review item.

The descriptor of review item will also need to make it clear that specialist referral is required if the wound is not showing adequate signs of improvement as outlined on page 35.

Recommendation 3: Practice Nurse wound treatments

The AMA supports the introduction of the proposed wound management services provided for and on behalf of a medical practitioner by a practice nurse or Aboriginal and Torres Strait Islander Health Practitioner or Aboriginal Health Worker who is appropriately trained and credentialed to treat wounds. This would not only be an investment in frontline care provided through general practice but would encourage upskilling.

The AMA accepts that time tiered items as proposed will help support the treatment of wounds of varying complexity and number.

From a compliance and evaluation perspective the AMA notes that it is easier to track the usage of a service when it has an MBS item. Data on the usage of wound care items will not only provide an indicator as to the need for wound care but will help track healing periods or referrals to wound care experts.

Recommendation 4: Nursing care under team care arrangements

The AMA supports the inclusion of practice nurses who are trained and credentialled for wound care as a team member for the purposes of case conferencing with either allied health providers or other specialists to discuss the patient's multidisciplinary care needs. This support also extends to the inclusion of an Aboriginal and Torres Strait Islander Health Practitioner or Aboriginal Health Worker who is appropriately trained and credentialed to treat wounds.

Recommendation 5: Increased access to allied health service

The AMA notes the proposal to increase the number allied health services for patients with chronic wounds or wounds deemed at high risk of becoming chronic. The AMA recommends this proposal should be referred to the General Practice Clinical Care Committee (GPCCC) for comment.

Recommendation 6: Podiatry interventions and appliances

The AMA has no objection to research being undertaken to determine the cost-effectiveness of certain podiatry interventions and appliances in the management of chronic wounds. Deepening the evidence-base for effective wound care can only facilitate better wound treatment pathways and enhance patient outcomes.

Recommendation 7: Mandatory referral

In the interests of patient care, where a patient has a wound that is not improving in line with the criteria outlined on page 35, we support the development of treatment pathways that enable access to advice from an appropriate specialist wound care practitioner to assist GPs in managing a patient's care, unless doing so would not be efficacious or in the patients best interest. These pathways need to be flexible and recognise the GP as being in the best position to determine whether or not this support is required. In line with Recommendation 8 the

AMA would expect that access to a specialist wound care practitioner could be provided via means other than a face-to-face attendance as this may not always be a practical or feasible option for the patient.

The AMA recommends that consideration be given to the development of National Chronic Wound Management Standard to help ensure that appropriate protocols and processes a followed across all health care sectors, including aged care. The AMA would want to be involved in the development of such a standard.

Recommendation 8: Remote and non-face-to-face services (real time or asynchronous)

The AMA agrees that telehealth services are an important tool in ensuring patient access to necessary care outside of face-to-face services. Certainly, access to such services for rural and remote patients would see members of the health team on the ground better supported with access to expert opinion to facilitate the delivery of quality wound care.

The AMA has welcomed the recommendations of the GPPCCC to grant GPs access to telehealth items. The AMA maintains that telehealth must be an adjunct to normal care which is provided by the usual GP.

Access to specialist opinion provided remotely and asynchronously has always been a service that the AMA has supported. Despite there being no funding under Medicare for these services, the AMA List of Medical Services and Fees has always recognised the value these services.

To this end the AMA supports consideration of how such services could be funded to support wound care.

Recommendation 9: New item for venous compression bandaging
Recommendation 10: New wound debridement items

The case for these new items has been effectively made and the AMA supports the introduction of these new items.

The AMA notes the proposed exclusion of three layered tubular bandage compression therapy from the venous compression bandaging item and the reasons why. However, given there is evidence of its potential effectiveness and efficacy, we suggest that it should be supported as a treatment option that can be provided under a for and on behalf of practice nurse item.

Recommendation 11: Negative pressure wound therapy

The AMA agrees that future consideration be given to the development of MBS item for negative pressure therapy.

Recommendations 12 to 15: Grouped under Additional Residential Aged Care Facilities considerations

The AMA supports the recommendations on the basis they are aimed at reducing the burden of poorly managed chronic wounds on both residents and the health system. These recommendations support universal access to best practice wound care for residents and enhanced accountability around the prevention and management of wounds across the health sector.

Further to recommendation 12 the AMA's position is that any medical care, including wound care, must be done by trained medical staff such as enrolled nurses and registered nurses.

Regarding recommendation 14 and access to wound care experts the AMA notes that the Royal Commission into Aged Care Quality and Safety is recommending the establishment of multi-disciplinary outreach health teams to provide service for people in residential aged care facilities. AMA members have reported where such teams already exist (NSW and VIC) they are helpful, particularly in wound management cases. Such teams should certainly include appropriate medical specialists, GPs and other providers who have undertaken advanced education and clinical training in wound care. Where such teams are utilised there should be appropriate mechanisms in place to ensure there is a process for clinical handover to ensure continuity of care.

To emphasise the importance of and need for Recommendation 15 the AMA notes that RACFs are now expected to report on three quality indicators, one of which is reporting any pressure injuries, and they are experiencing problems doing so where the patient has acquired a pressure injury while in hospital. The AMA is also aware that patients with multiple co-morbidities and with higher risks of pressure sores are being rejected by RACFs precisely because of the quality indicator reporting risk, as this may reflect poorly on the RACF.

Recommendations 16 to 22: Grouped under Education, credentialing and accreditation

The AMA acknowledges that more needs to be done to better support optimal wound care because of the significant impact of chronic wounds on patients, general practice resources the health system and the economy more broadly.

The inadequate resourcing to date of general practice when it comes to wound care has undoubtedly contributed to the barriers to optimal wound care, as GPs try to provide care while minimising the cost to patients.

If the new items proposed by the WMWG are adequately funded then we are confident that this would result in the upskilling of GPs and other providers of wound care. The AMA acknowledges the evidence that evidence-based wound care delivers effective care, savings and improved health outcomes and that appropriate training is needed to support this.

As per Recommendation 19 the AMA would expect the training for a GP to be no more time consuming than that required for the preparation of GP mental health treatment plan under MBS items 2715 and 2717. Where GPs already have extensive clinical training and expertise in chronic wound management there should be a mechanism for that to be recognised.

Wound training must support all providers who undertake it in meeting their continuing professional development requirements.

The AMA cannot state strongly enough that any training and credentialing of nurse practitioners under Recommendation 18 should not supersede the legislative requirement for nurse practitioners to be in a collaborative arrangement with a medical practitioner. As the AMA stated in its submission in response to the Report from the Nurse Practitioner Reference Group, the AMA does not support the removal of the requirement for collaborative care in the provision of services by Nurse Practitioners (NPs).

The AMA strongly believes that it would be a retrograde step for the safety and quality of patient care and for the efficacy of service provision if the requirement for collaborative arrangements between NPs and medical practitioners were abandoned. It would lead to greater fragmentation of care and increased costs to the health system overall. Without a mechanism that ensures medically qualified clinical oversight the risk for disjointed care, misdiagnosis and missed diagnosis, inappropriate or unnecessary testing or referral, and delayed treatment is greatly enhanced. The collaborative requirement is not a system inefficiency in the AMA's view but is rather a mechanism for ensuring our health resources are used effectively.

Recommendation 23: Remove bulk-billing restriction

This recommendation mirror's the AMA's April 2017 letter to Minister for Health calling for an exemption (like that for vaccines) to the restriction on charging for consumables when bulk billing a patient for wound care. The AMA fully supports this recommendation.

Removing this restriction for wound consumables is an important first step to improving patient access to appropriate wound care.

Recommendation 24: Development of a wound consumables scheme

The AMA supports this recommendation as it would, much like the supply vaccines to practices, provide a supply of consumables at a subsidised cost. Cost efficiencies could be achieved through the bulk purchasing and distribution of wound management consumables to practices for use with eligible patients. Minimising the cost of consumables and having a ready supply at the practice will provide greater patient convenience in accessing care but will also ensure that any out-of-pockets for eligible patients are minimal.

Recommendations 25 to 27: Grouped under Current MBS items

The AMA supports the removal of aftercare from the items outlined in Recommendations 25 and 26. Also supported are the amendments to MBS Items 30032 and 30045 and 30035 and 30049. The AMA has also agreed with the General Surgery Clinical Committee that wound items are undervalued. The recommended fee increases and removal of 'aftercare' in the item descriptor will ensure there is appropriate reimbursement for the consumer and minimise the burden on emergency departments and hospital operating rooms.

Yours sincerely

Dr Tony Bartone
President