



Medicare Benefits Schedule Review Taskforce

Report from the Wound Management Working Group

June 2020



Important note

The recommendations from the Wound Management Working Group (Working Group) were released for public consultation in November 2019.

The Working Group considered feedback from the public consultation and made changes to a number of recommendations as is reflected in this report.

The final recommendations from the Working Group and feedback from the public consultation will be provided to the Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) for consideration before the Taskforce makes its final recommendations to Government.



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1. Executive summary

The Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) is undertaking a program of work that considers how more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also seek to identify any services that may be unnecessary, outdated or potentially unsafe.

The Taskforce is committed to providing recommendations to the Minister for Health (the Minister) that will allow the MBS to deliver on each of these four key goals:

- Affordable and universal access
- Best practice health services
- Value for the individual patient
- Value for the health system.

The Taskforce has endorsed a methodology whereby the necessary clinical review of MBS items is undertaken by clinical committees and working groups.

The Wound Management Working Group (the Working Group) was established in 2018 to make recommendations to the Taskforce on the review of MBS items in its area of responsibility, based on rapid evidence review and clinical expertise.

The Working Group was also asked by the Taskforce to consider broader issues in relation to chronic wound management, raised by the Minister.

The recommendations from the Working Group were released for stakeholder consultation in November 2019. The Working Group considered feedback from stakeholders and has provided recommendations to the Taskforce in a Review Report. The Taskforce will consider the Report from the Working Group and stakeholder feedback before making recommendations to the Minister for consideration by Government.

1.1 Key recommendations

The Working Group made a number of recommendations to improve the management of both acute and chronic wounds in Australia. These recommendations will encourage and enable cost-effective evidence-based wound management, thereby increasing patient safety and improving health outcomes for patients, while providing value for the patient and the Australian healthcare system. The recommendations of the Working Group are expected to



support comprehensive best practice wound management, while enabling viable and futureproof provision of wound care services.

Key recommendations include the following:

- **Support provision of best practice chronic wound management within primary care.**
 - The Working Group recommends a stepped care approach to support the provision of best practice, comprehensive and team-based wound management within primary care. This involves holistic medical oversight, while supporting multidisciplinary team care, including mandatory education of GPs, practice nurses and Aboriginal and Torres Strait Islander Health Practitioners and Aboriginal Health Workers. The approach supports evidence-based diagnosis and treatment of wounds, including assessment and management of underlying risk factors and comorbidities, with regular reviews and referral for expert review when a wound is not healing adequately.
 - These recommendations include the following;
 - New MBS items for a GP to undertake an initial assessment and review of a chronic wound or wound deemed at high risk of becoming chronic.
 - New MBS items for short term treatment of a wound deemed eligible for a GP assessment. MBS subsidised treatment may be performed by a practice nurse or an Aboriginal and Torres Strait Islander Health Practitioner or appropriately trained Aboriginal Health Worker in an Aboriginal Medical Service. These items are to allow treatment for 4 weeks, to a maximum of 10 services after the claiming of the initial or review assessment items.
 - Increased number of MBS rebateable allied health services under Chronic Disease Management items, and inclusion of nurses as part of the care planning team for the purpose of Team Care Arrangement items.
 - Indexation and uncapping of the Workforce Incentive Program (WIP) for general practices in relation to Standardised Whole Patient Equivalent (SWPE) measures.
 - Investigations into an appropriate funding model for the use of remote and non-face-to-face services (real time or asynchronous) and potential for funding of certain podiatry interventions and appliances.
 - These recommendations will stimulate and enable provision of accessible evidence-based wound care, improving patient safety and outcomes, while optimising use of health system resources by targeting MBS funding towards improved patient outcomes.



- **Support provision of best practice chronic wound management in residential aged care facilities and the broader health system**
 - Within RACFs the Working Group recommends supporting appropriate education and training of staff, improving access to expert wound care, and reviewing current funding mechanisms, in order to improve provision of evidence-based wound care for residents.
 - The Working Group also recommends addressing broader health system issues in prevention and management of chronic wounds, including development of feedback mechanisms for patients transitioning between healthcare sectors with chronic wounds. This recommendation is to ensure continuity of care and improve wound outcomes for patients.
- **Create new items for venous compression bandaging and wound debridement procedures**
 - Create a new item for venous compression bandaging for patients with venous leg ulcers and two new items for simple conservative sharp or mechanical debridement and ultrasonic debridement, accessible to appropriately trained healthcare practitioners. Inclusion of these items will enable provision of affordable, universal and timely access to evidence-based wound management.
- **Development and provision of appropriate training, credentialing and accreditation of healthcare professionals involved in the provision of wound management services**
 - The Working Group recommends the development of appropriate wound care training, credentialing and accreditation for a number of healthcare providers, including nurses, Aboriginal and Torres Strait Islander Health Practitioners, Aboriginal Health Workers, Nurse Practitioners, GPs and pharmacists. These recommendations include defining and credentialing what constitutes a specialist wound care practitioner.
 - Education, training and credentialing are essential in enabling provision of evidence-based wound management services and is integral to the success of the proposed model in improving patient safety. These recommendations will assist healthcare providers to correctly diagnose and manage chronic wounds, incorporating early intervention and attention to underlying causes and prevention, while recognising the need for early referral when appropriate.
- **Remove the restriction prohibiting practitioners from charging for the cost of a wound dressing applied during a bulk-billed consultation**
 - The Working Group recommends introducing an exemption to the restriction prohibiting practitioners from charging for the cost of a wound dressing applied



during a bulk-billed consultation, in line with the current exemption for vaccinations. This recommendation will assist in the sustainable provision of wound care services within general practices by assisting in the provision of a financially viable wound care service, thereby increasing patient access.

- **Development of a Commonwealth-funded consumables reimbursement scheme**
 - The Working Group recommends a scheme be developed for patients with a chronic wound. This recommendation focusses on removing barriers and ensuring adequate access to quality wound care products for key target groups.
- **Update current MBS wound items**
 - The Working Group recommends updating the current MBS wound items to be consistent with modern best practice and enable provision of evidence-based, financially sustainable wound management

1.2 Consumer impact

All recommendations have been summarised for consumers in Appendix A – Summary for consumers. The summary describes the medical service, the recommendation of the clinical experts and rationale behind the recommendations. A full consumer impact statement is available in Section 9.

Both consumers and providers are expected to benefit from these recommendations because they address concerns regarding patient safety, access and quality of care, and because they provide a mechanism for which evidence-based wound management can be provided in the primary care setting.

The Working Group's recommendations to ensure health professionals are appropriately trained and credentialed in the provision of evidence-based wound management will, in particular, positively affect consumers as it will improve wound outcomes and reduce length of treatment, thereby reducing out of pocket costs and impact on quality of life for patients.

Inclusion of items for GP assessment of a wound will increase appropriate diagnosis and treatment, including earlier review of current treatment and referral for specialised review when required. The inclusion of a nursing item to treat the wound ensures that patients receive evidence-based wound management at reduced cost.

Recommendations regarding the cost of wound care consumables are in line with reducing cost of wound care for consumers and, together with the proposed model, will improve patient outcomes by shortening healing times.



The Working Group's recommendations enable provision of an improved essential health service to patients who are often disadvantaged and currently may be financially liable or unacceptably inconvenienced in seeking wound management services.



2. About the Medicare Benefits Schedule (MBS) Review

2.1 Medicare and the MBS

2.1.1 What is Medicare?

Medicare is Australia's universal health scheme that enables all Australian residents (and some overseas visitors) to have access to a wide range of health services and medicines at little or no cost.

Introduced in 1984, Medicare has three components:

- free public hospital services for public patients
- subsidised drugs covered by the Pharmaceutical Benefits Scheme (PBS)
- subsidised health professional services listed on the MBS.

2.2 What is the MBS?

The MBS is a listing of the health professional services subsidised by the Australian Government. There are more than 5,700 MBS items that provide benefits to patients for a comprehensive range of services, including consultations, diagnostic tests and operations.

2.3 What is the MBS Review Taskforce?

The Government established the Taskforce as an advisory body to review all of the 5,700 MBS items to ensure they are aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also modernise the MBS by identifying any services that may be unnecessary, outdated or potentially unsafe. The Review is clinician-led, and there are no targets for savings attached to the Review.

2.3.1 What are the goals of the Taskforce?

The Taskforce is committed to providing recommendations to the Minister that will allow the MBS to deliver on each of these four key goals:

- **Affordable and universal access**—the evidence demonstrates that the MBS supports very good access to primary care services for most Australians, particularly in urban Australia. However, despite increases in the specialist workforce over the last decade, access to many specialist services remains problematic, with some rural patients being particularly under-served.



- **Best practice health services**—one of the core objectives of the Review is to modernise the MBS, ensuring that individual items and their descriptors are consistent with contemporary best practice and the evidence base when possible. Although the Medical Services Advisory Committee (MSAC) plays a crucial role in thoroughly evaluating new services, the vast majority of existing MBS items pre-date this process and have never been reviewed.
- **Value for the individual patient**—another core objective of the Review is to have an MBS that supports the delivery of services that are appropriate to the patient’s needs, provide real clinical value and do not expose the patient to unnecessary risk or expense.
- **Value for the health system**—achieving the above elements of the vision will go a long way to achieving improved value for the health system overall. Reducing the volume of services that provide little or no clinical benefit will enable resources to be redirected to new and existing services that have proven benefit and are underused, particularly for patients who cannot readily access those services currently.

2.4 The Taskforce’s approach

The Taskforce is reviewing existing MBS items, with a primary focus on ensuring that individual items and usage meet the definition of best practice. Within the Taskforce’s brief, there is considerable scope to review and provide advice on all aspects that would contribute to a modern, transparent and responsive system. This includes not only making recommendations about adding new items or services to the MBS, but also about an MBS structure that could better accommodate changing health service models.

The Taskforce has made a conscious decision to be ambitious in its approach, and to seize this unique opportunity to recommend changes to modernise the MBS at all levels, from the clinical detail of individual items, to administrative rules and mechanisms, to structural, whole-of-MBS issues. The Taskforce will also develop a mechanism for an ongoing review of the MBS once the current review has concluded.

As the MBS Review is clinician-led, the Taskforce decided that working groups and clinical committees should conduct the detailed review of MBS items. The working groups and committees are broad-based in their membership, and members have been appointed in an individual capacity, rather than as representatives of any organisation.

The Taskforce asked the working groups and committees to review MBS items using a framework based on Professor Adam Elshaug’s appropriate use criteria (1) . The framework consists of seven steps:

1. Develop an initial fact base for all items under consideration, drawing on the relevant data and literature.



2. Identify items that are obsolete, are of questionable clinical value¹, are misused² and/or pose a risk to patient safety. This step includes prioritising items as “priority 1”, “priority 2”, or “priority 3”, using a prioritisation methodology (described in more detail below).
3. Identify any issues, develop hypotheses for recommendations and create a work plan (including establishing working groups, when required) to arrive at recommendations for each item.
4. Gather further data, clinical guidelines and relevant literature in order to make provisional recommendations and draft accompanying rationales, as per the work plan. This process begins with priority 1 items, continues with priority 2 items and concludes with priority 3 items. This step also involves consultation with relevant stakeholders within the committee, working groups, and relevant colleagues or Colleges. For complex cases, full appropriate use criteria were developed for the item’s explanatory notes.
5. Review the provisional recommendations and the accompanying rationales, and gather further evidence as required.
6. Finalise the recommendations in preparation for broader stakeholder consultation.
7. Incorporate feedback gathered during stakeholder consultation and finalise the Review Report, which provides recommendations for the Taskforce.

All MBS items will be reviewed during the course of the MBS Review. However, given the breadth of and timeframe for the Review, each working group and clinical committee has to develop a work plan and assign priorities, keeping in mind the objectives of the Review. Working groups and committees use a robust prioritisation methodology to focus their attention and resources on the most important items requiring review. This was determined based on a combination of two standard metrics, derived from the appropriate use criteria:

- Service volume.
- The likelihood that the item needed to be revised, determined by indicators such as identified safety concerns, geographic or temporal variation, delivery irregularity, the

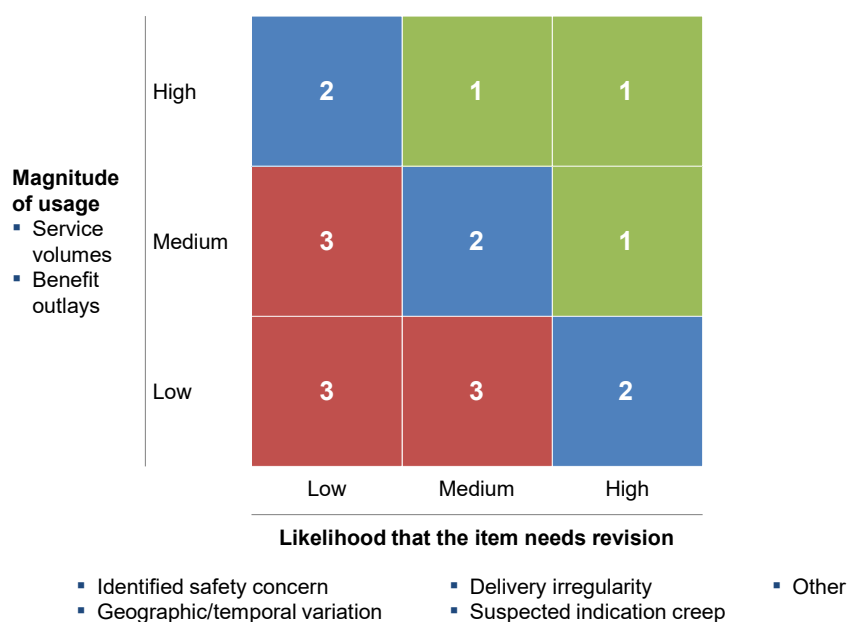
¹ The use of an intervention that evidence suggests confers no or very little benefit on patients; or where the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of the intervention do not provide proportional added benefits.

² The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.



potential misuse of indications or other concerns raised by the clinical committee (such as inappropriate co-claiming).

Figure 1: Prioritisation matrix



For each item, these two metrics were ranked high, medium or low. These rankings were then combined to generate a priority ranking ranging from one to three (where priority 1 items are the highest priority and priority 3 items are the lowest priority for review), using a prioritisation matrix (Figure 1). Clinical committees and working groups use this priority ranking to organise their review of item numbers and apportion the amount of time spent on each item.



3. About the Wound Management Working Group

The Working Group was established in November 2018 to make recommendations to the Taskforce on the review of MBS items within its remit, based on rapid evidence review and clinical expertise.

3.1 Wound Management Working Group members

The Working Group consists of 11 members, whose names, positions/organisations and declared conflicts of interest are listed in Table 1.

Table 1: Wound Management Working Group members

Name	Position/organisation	Declared conflict of interest
Dr Simon Torvaldsen (Chair)	General Practitioner, Perth; Member of the General Surgery Clinical Committee	Provider of MBS items in scope for the Working Group; Chair of the AMA WA Council of General Practice; Member of the Federal AMA Council of General Practice; Member of WA Council of RACGP
Natalie Cooper	Community Pharmacist; Associate Lecturer in Pharmacy Practice, University of Tasmania	Nil
Deb Garvey	Independent Nurse Practitioner in private practice, rural Victoria	Provider of MBS services
Terrie Ivanhoe	Nurse Practitioner (remote health and chronic disease – Aboriginal health); Chronic Disease Coordinator, Nganampa Health, NT	Nil
Dr Dan Kennedy	Plastic and Reconstructive Surgeon in private/public practice, Brisbane; Consultant Plastic Surgeon at Mater Adults Hospital; Member of the Plastic and Reconstructive Surgery Clinical Committee	Provider of MBS items in scope for the Working Group; Clinical trainer and educator for Galderma Australia Pty Ltd; Shareholder in a private hospital; Consultant with the Australian College of Rural and Remote Medicine, including telehealth services; President



Name	Position/organisation	Declared conflict of interest
		of the Australian Society of Plastic Surgeons
Dr Tammy Kimpton (Taskforce ex-officio)	General Practitioner, rural NSW; Member of the Taskforce	Provider of MBS items in scope for the Working Group
Prof Anthony Lawler	Emergency Medicine Specialist; Chief Medical Officer, Tasmania and regulator of service providers; Co-Chair of the Specialist and Consultant Physician Consultation Clinical Committee	Jurisdictional Employee in Tasmania
Alison Marcus	Consumer; Member of the Colorectal Surgery Clinical Committee; Member of the Diagnostic Imaging Clinical Committee	Nil
Dr Jenny Prentice	Nurse Consultant (wound, ostomy care), Perth; Editor, World Council of Enterostomal Therapists Journal; Member of the Diabetic Foot Australia Steering Committee	<p>Credentialing coordinator and Chair Clinical Governance Committee for Wound Innovations; Developer of Wound Innovations Online Education modules; Nurse Specialist Wound Skin Ostomy Care with Hall & Prior Aged Care Group</p> <p>Director private company (Trojan Health) providing wound, management services, clinical, audit and education.</p>
A/Prof Peter Thursby OAM	Vascular Surgeon (Retired); Surgical lecturer and examiner, Concord Hospital, Central Clinical School, University of Sydney; Examiner, Royal Australasian College of Surgeons; Chair of the Vascular Prosthesis Clinical Advisory Group; Member of the Vascular Surgery Clinical Committee	Member of the Australian and New Zealand Society for Vascular Surgery MBS Review Group; Former Affiliation with Avant Indemnity Insurance
Dr Stephen Yelland	General Practitioner, Gold Coast, QLD	<p>Provider of MBS items in scope for the Working Group; Compliance issues related to claiming of item 30023;</p> <p>Director of a private company (Wound Busters) providing wound management and education.</p>



3.2 Conflicts of interest

All members of the Taskforce, clinical committees and working groups are asked to declare any conflicts of interest at the start of their involvement and reminded to update their declarations periodically. A complete list of declared conflicts of interest can be viewed in Table 1 above.

It is noted that the majority of the Working Group members share a common conflict of interest in reviewing items that are a source of revenue for them (i.e. Working Group members claim the items under review). This conflict is inherent in a clinician-led process, and having been acknowledged by the Working Group and the Taskforce, it was agreed that this should not prevent a clinician from participating in the review.

3.3 Areas of responsibility of the Working Group

The Working Group was established as an independent expert working group to provide advice regarding existing MBS items for the management of acute wounds and consider broader issues around the management of chronic wounds.

The Working Group differs from other clinical committees established under the auspices of the MBS Review Taskforce in that the Working Group was asked to consider the management of chronic wounds, for which there are no specific MBS items. The Working Group was tasked with assessing the overall existing infrastructure and services as they relate to the management of wounds in primary care.

The Working Group identified the following key issues in wound management:

- Inconsistent standards of care between providers, including a skills deficit in clinicians and health professionals, particularly in diagnosis and management of wounds.
- High costs and lack of supports for clinicians, including inequitable access to advice and products and lack of reimbursement for wound care costs.
- Poor co-ordination between health professionals in the management of wounds, including both prevention and treatment.
- High out of pocket costs for patients.

The Working Group considered and discussed potential solutions aligned with these identified issues to produce recommendations that will:

- improve patients' experiences of care by addressing access to timely and affordable quality services;
- reduce overall disease burden and improve health outcomes for Australians;



- improve provider satisfaction through sustainable and meaningful work, including a quality improvement culture and opportunities for leadership; and
- optimise health system resources by reducing avoidable demand for acute care and repeat services for sub-optimal treatment.

3.4 Summary of the Working Group's review approach

The Working Group completed a review of its items across six full working group meetings. During these meetings it developed the recommendations and rationales contained in this report, based on evidence and collective clinical experience.

The review drew on various types of MBS data, including data on utilisation of items (services, benefits, patients, providers and growth rates); service provision (type of provider); patients (services per patient); and additional provider and patient-level data, when required.

The MBS items that relate to the treatment of patients with chronic wounds are not exclusively for the use of patients with chronic wounds. Accordingly, Medicare utilisation data was of limited use to the Working Group for the review of chronic wound management.

The review therefore drew on relevant literature and clinical guidelines sourced from medical journals and other sources, such as professional societies. The models of care were compared to existing funding arrangements, including, but not limited to the MBS.

In August 2019, the Working Group held a stakeholder roundtable to facilitate discussion and input into the development of recommendations regarding chronic wound management in Australia. This roundtable was attended by a number of stakeholders, including the Australian Medical Association (AMA), Wounds Australia, the Royal Australian College of General Practitioners (RACGP) and the Pharmacy Guild. Attendees represented a range of medical and allied health specialities, including nursing, medical specialists, pharmacy, residential aged care, nurse practitioners, podiatrists, dietitians, rural, remote and Indigenous practitioners, as well as researchers receiving funding under the Medical Research Future Fund (MRFF).

Public consultation on draft Working Group recommendations was undertaken between November 2019 and February 2020. The Working Group considered feedback from the public consultation and made changes to a number of recommendations as is reflected in this report.



4. Wound care in Australia

The care of wounds is both an important and costly aspect of health care in Australia due to both the frequency and complexity of clinical presentations involving wounds.

Wounds can be broadly classified as acute or chronic based on the duration of the wound and the aetiology underpinning its development. Various definitions exist relating to the chronicity of wounds. However, generally speaking, acute wounds occur as a result of either trauma or surgery and generally follow an orderly predictable course of healing. Chronic wounds, on the other hand, mainly begin as acute wounds. An acute wound becomes a chronic wound when the anticipated stages of healing do not occur as timely as expected, resulting in protracted wound healing that impairs anatomical integrity and functionality (2). For the purpose of this report, the term “chronic wound” refers to those that do not progress through the healing process in a timely manner and includes, but is not limited to: pressure injuries, venous leg ulcers and arterial ulcers, as well as wounds that continue to require treatment beyond routine aftercare post-surgery or post-suturing of a wound.

Australian data is limited on the incidence and prevalence of chronic wounds within all healthcare settings, however particularly within the primary care setting (3) (4). The majority of chronic wounds in Australian hospitals and residential aged care facilities (RACF) consist of pressure injuries (84%), venous leg ulcers (12%), diabetic foot ulcers (3%) and arterial insufficiency ulcers (1%) (5) (6) (7) (8) (9). Approximately 450,000 Australians currently live with a chronic wound, directly costing the Australian healthcare system around AU\$3 billion per year (10) (5) (6) (11) (12). In hospital and residential aged care settings in Australia in 2010-11, the direct health care costs of pressure ulcer, diabetic ulcer, venous ulcer and artery insufficiency ulcer was found to be approximately US\$2.85 billion (4). While there is large uncertainty around these estimates (4), with inconsistency across sources and lack of literature, this is equivalent to approximately 2% of the total national health care expenditure (2) (13) (11).

Chronic wounds are most prevalent among people aged over 60 years and those with chronic health problems such as diabetes, obesity and cardiovascular disease, all of which are increasing in prevalence (10). Most chronic wounds are linked to at least one of these chronic diseases, particularly diabetes and peripheral vascular disease (6). The magnitude of



these health conditions places wound management at the forefront of health policy decisions in Australia.

The burden of chronic wounds

Chronic wounds present a significant health and economic burden to the Australian healthcare system, providers of healthcare services and patients themselves (2) (6) (13) (14) (15) (16) (12) (4) (17). This burden is often underestimated as available data is largely limited to hospital and residential care facilities. Chronic wounds may also be considered merely as complications of other comorbid conditions, or a normal part of aging and therefore not accurately reflected in data regarding overall burden of disease (11). However, chronic wounds have been shown to impact severely upon quality of life, reduce an individual's capacity to work and are associated with increased social isolation (9) (11).

The burden to healthcare services is significant in terms of both human and financial resources. The actual costs associated with the management of chronic wounds transcend those described above which do not include general practice and community nursing costs (6). Additionally, these figures do not reflect costs associated with severely reduced quality of life, loss of mobility, decreased functional ability, loss of participation in the work force and associated income, and after discharge wound care costs which are often borne by the patient (6) (15) (11) (18) (19). These costs are likely to grow with the increasing prevalence of chronic wounds due to an aging population and the rise in the prevalence of chronic diseases (6) (14) (18).

Despite the immense financial implications and impact on quality of life, chronic wounds remain an under-funded and under-recognised public health issue (6) (16).

Evidence shows the majority of chronic wounds are not properly diagnosed or treated and most healthcare providers receive little or no formal wound care training (10) (6). Inconsistencies in wound management practice and the use of outdated methods contribute to high costs and poor patient outcomes (13). With this in mind, key obstacles in the provision of evidence-based practice in wound management include limited education and training among health professionals, lack of awareness and support to invest in optimal clinical care, and the inadequate reimbursement and high costs associated with providing the best available wound care services (10) (6) (15) (11).

Appropriate funding and enhanced education in primary care may improve the uptake of evidence-based practice which would result in faster wound healing and better outcomes for patients (6).



The importance of evidence-based practices in wound care

Evidence clearly demonstrates that implementation of evidence-based wound care is cost-effective and coincides with both monetary savings and improved health outcomes for patients (5) (6) (13) (14) (11) (20) (21). Despite the obvious benefits of providing evidence-based wound care, the majority of Australians with chronic wounds do not receive evidence-based treatment (6) (15) (11). The widespread adoption of evidence-based practices in wound care depends highly on both adequate reimbursement and improved clinician and health provider training (6).

There has also been a lack of focus on wound management education and training within medical and nursing undergraduate and post-graduate training programs, contributing to the poor management of a large number of chronic wounds (22) (23).

If a patient receives evidence-based care, most venous leg ulcers (80%) will heal within 24 weeks. However, at present, 70% of these patients do not receive best practice wound care and instead, suffer from recurrent leg ulcers for 15 or more years (10) (5) (15). As 3% of the population aged over 60 years is affected by leg ulcers (10), it is imperative that future wound care policies support and encourage the provision of evidence-based practices in the treatment of these wounds through a payment or rebate structure which encourages provider upskilling in current best practices in wound management.

Poor treatment of wounds in the primary care sector can result in extended healing times, high recurrence rates and hospitalisations due to infections and other complications (6). Such adverse effects dramatically increase the burden to patients and the Australian healthcare system as the per-day cost of providing care within the hospital setting is dramatically higher than within the primary care sector.

Timely and accurate diagnosis of wounds, particularly those which are non-healing or not responding to existing management, is crucial in order to ensure the treatment applied is appropriate for the wound and its underlying cause. For example, the application of compression bandaging to leg ulcers caused by venous insufficiency is necessary to promote healing by controlling associated peripheral oedema (24). Conversely, inappropriate application of compression can result in limb ischaemia (25) (26).

The expertise and skill associated with wound management must therefore be highly emphasised, as care must be adapted to each individual patient with careful consideration given to underlying disease. Malignant wounds are frequently overlooked or misdiagnosed as another wound type which can lead to inappropriate treatments being applied. Additionally, the malignant transformation of ulcers has been reported in a number of types of chronic, non-healing wounds such as venous stasis ulcers, chronic pressure ulcers, fistulae, burns and scars (27). Inappropriate management can significantly impede wound



healing, resulting in poorer outcomes for patients and increased wound duration and costs (28).

Financial cost to general practices and patients

The observed high cost of wound care to the Australian healthcare system is under-representative of the total financial burden of this important public health issue as the majority of chronic wound care is managed in primary care, where financial data is lacking (6) (13). Funding for wound care outside of the hospital setting is available through claiming MBS items, including the care provided by General Practitioners (GP), medical specialists and nurse practitioners (6), and through direct payments to practices through the Practice Incentives Program (PIP). In the general practice setting, the Medicare rebate for a base level consultation may cover the cost of GP time, however additional costs associated with nursing time and wound care consumables are often borne by the practice or patient (6) (13). It is estimated that patients with a venous leg ulcer aged 60 years and older pay AU\$27.5 million out-of-pocket expenses each year (6) (21).

According to the Bettering the Evaluation and Care of Health (BEACH) program, in 2010-2011, the application of wound dressings was the second most frequently recorded procedure in general practice and the second most common procedure performed by practice nurses (29). In 2012 the General Practice Nurse National Survey Report run by the Australian Medicare Local Alliance (AML Alliance) found that 93% of practice nurses undertook wound management tasks either weekly or daily (30).

Wound management, including application of wound dressings, is a task frequently performed in general practice (31) (6). In Australia, practitioner time contributes a greater proportion to the cost of wound care than the cost of the consumables used. However, this varies widely, and the cost of consumables may be considerable (13). Lack of adequate reimbursement for contemporary wound management products outside of aged care facilities and the acute hospital system results in high out-of-pocket costs for patients with chronic wounds (6). Time taken for the wound to heal, time spent with health professionals and dressing changes are significant drivers of cost in the care of leg ulcers and other chronic wounds (14) (32).

There is little support for primary care practices to invest in optimal wound care practices, as often the practice stands to lose money from the treatment of chronic wounds. A cross-sectional study involving 18 general practices from the Sunshine Coast Clinical Research Network found that for most episodes of wound care, the total cost to the practice was greater than the total income, resulting in a net financial loss to the practice (13). This study



highlights a need to review the funding of wound care, so that general practice is able to adequately care for high risk patients, through financially sustainable provision of best practice wound care services, ensuring affordability to patients and practices. As wounds are already poorly managed in many cases (70% of venous leg ulcers do not receive best care due to a skills deficit in clinicians), there is presently little support for healthcare providers to upskill through greater education and training (10) (6).

The high cost of some consumables and budgetary restrictions on practices may encourage practitioners to use less appropriate dressings if they present a lower cost burden, leading to poor management of the wound, prolonged healing times and increased burden on the patient and the healthcare system (13). With the current financial pressures to both practice and patient, GPs face a dilemma in either choosing more affordable, low quality dressings or higher quality dressings that may present a cost barrier to patients (13). The use of inappropriate but more affordable dressings has been shown to increase the risk of complications in the long run, further reducing quality of life and financial burden on patients (6).

Some populations stand to be more adversely affected by the absence of evidence-based care of wounds. For example, lack of equitable access to services and consumables, as well as the disproportionately higher prevalence, morbidity and mortality of chronic diseases among Indigenous Australians leads to this population being highly affected by chronic wounds (6).

Wound management in Residential Aged Care Facilities (RACFs)

Chronic wounds also represent a major health burden in RACFs, with residents often entering RACFs with one or more chronic conditions and multiple chronic and complex wounds (33) (34) (35) (36).

Residents are also commonly readmitted to RACFs after discharge from a tertiary care setting with new pressure injuries, deterioration in existing pressure injuries and other chronic wounds (34) (37) (38).

The elderly in general are at increased risk of impaired skin integrity due to age related changes to the skin, frailty, malnutrition, incontinence, immobility and impaired cognition (39) (40). Worldwide the management of wounds in an aging population is a growing burden and major problem. Surgical Site Infections (SSIs) are a particularly important in patients greater than 60 years of age, with this cohort carrying the highest prevalence of these hospital acquired infections (41). Pressure injuries and venous insufficiency, peripheral arterial disease and peripheral neuropathy (secondary to diabetes) that result in chronic wounds increase morbidity and mortality (42) (43) (44) (45).



The Aged Care Funding Instrument (ACFI) provides funding for treatment of chronic wounds and complex skin integrity management for care recipients. ACFI claims must include a diagnosis, a directive (given by a registered nurse, medical practitioner or allied health professional acting in their scope of practice), a wound assessment and a record of treatment (46).

Multidisciplinary team care

The management of wounds includes a multitude of healthcare providers (6), including GPs, practice nurses, Nurse Practitioners, community nurses, community pharmacists, medical specialists and allied health professionals such as podiatrists and dietitians. Uncoordinated care, inappropriate self-management of wounds and diffusion of responsibility among the range of health care providers involved leads to poor continuity of evidence-based treatment and preventative care (15) (6). Conversely, improved coordination of care between health care providers with appropriate skills and training, as well as patient education regarding appropriate self-care, will support improved health outcomes and reduced complications (6) (15).

Prior to 2012, practice nurses provided MBS rebateable services on behalf of medical practitioners specifically for wound care (item 10996). However, this MBS item was replaced with the Practice Nurse Incentive Scheme (PNIP) in January 2012, providing a consolidated funding model for all services performed by a practice nurse, including wound care (13). It is unclear what effect this has had on the management of wounds in general practice, however it is possible that the broadening of nurses' roles may have resulted in a reduced focus on wound care (13).

Benefits to patients from improvements in wound management

Investment in improving wound management has the potential to save costs overall and improve the quality of life of vulnerable Australians (6) (20). Interventions to improve patient outcomes carry an initial cost, however studies assessing the cost-effectiveness of guideline-based interventions strongly support the benefits of evidence-based wound care, appropriate education and effective collaborative multidisciplinary care (6). These interventions have led to a reduction in health care costs associated with overall reduced demand in health services, across primary, residential and acute care settings (6) (14). The main driver for these savings would be that wounds are healed earlier, reducing the rate at which services are accessed and the potential for infection and other complications to occur (6) (14).

Improved wound management within primary care has the potential to achieve the goal of reducing the incidence of venous leg ulcers by 50% in 10 years (31). Australian research has



demonstrated that investments in provision of accessible and effective evidence-based care, as well as appropriate research and development may save up to 70% of all diabetes-related foot disease hospitalisations and amputations (47). Provision of optimal evidence-based care, rather than usual care, could save the Australian taxpayer \$2.7 billion over 5 years (17) (5), not to mention the direct benefits to patients.

Through supporting enhanced provision of evidence-based and appropriately targeted therapies for the management of chronic wounds, report recommendations are expected to support reductions in hospitalisations, enhancement in recovery and reduced risk of chronicity of wounds. The Australian healthcare system stands to generate significant financial savings by improving health system efficiencies and optimising the use of health researches for both patients and providers.

Current funding streams for wound treatment

Wound care services provided in general practices are currently funded through billing of MBS standard consultation items and, for eligible Indigenous patients, MBS item 10989 (which is for wound treatment provided by an Aboriginal and Torres Strait Islander Health practitioner). Financial incentives under the PNIP can also be accessed by eligible practices to subsidise cost of employment of practice nurses, who play a pivotal role in providing wound care services in general practices.

Where eligible, patients with chronic conditions can also receive up to five allied health services per annum (or 10 per annum for eligible Indigenous patients), which may include wound management services where appropriate.

The Aged Care Funding Instrument (ACFI) provides some funding for residents within RACFs, including the management of chronic wounds.

State and territory governments are important funders of wound care services through public hospitals and community services, however, services provided and eligibility requirements vary greatly across and within jurisdictions. Many Primary Health Networks have identified wound management as a priority and are using their flexible funding to support wound management in their regions.

Currently, wound dressings may be subsidised for eligible patients in specified circumstances only, such as programs supported by the Department of Veterans' Affairs or delivered within RACFs.

Payment for wound care products is currently excluded from both the MBS and the Pharmaceutical Benefits Schedule (PBS) and medical practitioners are prohibited from



charging patients an additional fee to cover the costs of wound consumables where the service has been bulk-billed to Medicare.

Chronic wound management is an Australian Government Priority

The Australian Government acknowledges a need to improve wound management in the primary health care sector. Several activities are already underway to inform the Government's consideration of options, including:

- investing \$2 million to fund a primary health care wound management pilot project;
- consideration of wound management by the MBS Review Taskforce; and
- prioritisation of wound management in the new health system's translation program under the Medical Research Future Fund (MRFF).



5. Recommendations - Chronic Wound Management

Management of chronic wounds within Australia involves several levels of the healthcare system:

- **Primary care services:** These services are largely GP based, they include practice nurses and other community health services, but may also include Aboriginal Medical Services and other rural and remote services. These services must be skilled and resourced sufficiently to manage the large majority of patients.
- **Specialist community-based services:** These services could include multidisciplinary wound clinics, specialised nursing or other multidisciplinary services involving allied health. Appropriate standards and accreditation must apply. A minority of patients will require these services.
- **Tertiary level services:** This includes hospital inpatient and outpatient services, and medical and surgical specialists. Only a small proportion of patients will require these services.

With approximately 450,000 cases of patients with wounds in Australia each year, by necessity the vast majority must be managed by primary care providers, largely in the general practice setting. However, some wounds require additional services to those commonly provided within the general practice setting, and any model for improved wound care in general practice must integrate well with these services, such as community nursing, allied health (e.g. podiatry) and residential aged care. Some wounds may also require specialist input and primary care providers must recognise the need for early referral and access to a specialist wound care practitioner. The Working Group recognise the importance of a multidisciplinary team care approach in the management of chronic wounds and have taken this into account in making recommendations to improve patient outcomes.

This report focusses on the primary care model of wound management due to the high potential for increased cost-efficiency and reduced burden to patients associated with improved prevention and treatment of wounds in this setting. There is currently no specific model aimed at reducing the burden of chronic wounds; however, the vast bulk of wound management can be provided in community settings utilising existing infrastructure. The model outlined below has the potential to improve quality of life for consumers and



generate significant savings for consumers and taxpayers in excess of the investment required.

The Working Group also made specific recommendations to improve the management of chronic wounds in RACFs, addressing the considerable impact of chronic wounds in this vulnerable population. The Working Group notes the below recommendations have the flexibility to address care needs in a number of remote settings, however understand that the MBS may not be an appropriate funding mechanism in all settings.

An underlying principle of the primary care model is, where the patient is reasonably able to contribute to the cost of care, this not be discouraged, however no patient should be unduly disadvantaged by cost. It is essential that patients have access to affordable best-practice wound management services.

The principle behind the primary care model is to inspire and reward quality care and promote patient-centred, integrated care. An essential element is to encourage and support comprehensive and team-based care, including appropriate assessment and management of wound aetiology, including underlying risk factors and comorbidities, as part of best practice chronic wound management. Education and upskilling are significant components as evidence shows that these are vital to improving outcomes. It is important that the model be flexible, has minimal administrative burden and maximises patient access to services. To demonstrate cost effectiveness it should reward outcomes, not just service provision. Such a model is in line with provision of high value healthcare by improving performance through engaging healthcare providers with evidence-based wound management education through a financial incentive (48).

In line with these principles, the Working Group recommends provision of wound care products to key target groups (see Recommendation 24) and a mandatory education component (see Recommendations 16-19), particularly for GPs and practice nurses. These recommendations are patient-centred, and aim to improve safety and convenience, while ensuring sustainability, high quality and cost containment.

The Working Group recommends a stepped care approach for wound management in primary care, whereby GPs are upskilled to correctly diagnose and manage chronic wounds and those at high risk of becoming chronic, with referral to appropriate specialist wound care practitioners when required (see Recommendation 7). Within general practice, this model includes:

- an initial GP assessment of the wound
- a defined period of treatment of the wound by a practice nurse, Aboriginal and Torres Strait Islander Health Practitioner or appropriately trained Aboriginal and Torres Strait



Islander health worker within Aboriginal Medical Services. Referral to an allied health professional or specialist wound care provider may also be appropriate at this stage

- a subsequent GP review of the wound and reassessment of required services; and
- an additional defined period of treatment by a practice nurse where a wound has not healed and requires further treatment. When a wound is observed to not be healing adequately consultation with or referral to a more specialised wound care provider should occur. Specialised wound care providers may include medical, nursing and allied health practitioners who have undertaken advanced education and clinical training in wound care.

The review, treatment and/or referral cycle continues repeatedly as appropriate until the wound is healed. Services supported under this cycle should also accommodate arrangements to allow patients who move practices during the course of treatment, where appropriate.

The Working Group recommends review of this model two years after implementation. Review of the proposed model should include consideration of the most appropriate mechanism to support various healthcare providers in the provision of comprehensive and team-based care. This includes assessment and management of underlying risk factors and comorbidities as an essential element of best practice chronic wound management.

Review should also include monitoring of patient outcomes and out of pocket costs, as well as changes in evidence and improvements in healthcare technologies.

5.1 Primary Care Model

5.1.1 Recommendation 1: GP Initial wound assessment

Create a new item for the initial GP assessment of a chronic wound or a wound at high risk of becoming chronic.

In order for a general practitioner to claim this item a wound must be deemed chronic at time of presentation (present for at least 4 weeks), or at high risk of becoming chronic. Clinical criteria for claiming this item are specific and aim to restrict claiming to those who will most benefit from these services.

The categories of people eligible for wound assessments include the following;

- (i) *Patient whose wound has been present for greater than 4 weeks at time of presentation, or;*
- (ii) *Patient with a wound, and any one or more of the following factors:*



- a. Patient with a past history of wound taking more than 4 weeks to heal; or*
- b. Presence of concurrent comorbidity significantly affecting wound healing, such as diabetes mellitus, limb paresis, neuropathy or peripheral vascular disease; or*
- c. Presence of local wound-related factors, such as evidence of venous insufficiency, ankle or foot deformity or oedema; or*
- d. Concurrent medication use significantly affecting wound healing (for example long term or high dose corticosteroids); or,*
- e. Patient is of Aboriginal or Torres Strait Islander descent; or,*
- f. Age of patient greater than 75 years.*

The Working Group considers this assessment equivalent to the relevant time-based health assessments.

The Working Group recommends that consideration be given to the development of a risk assessment tool, similar to the Australian cardiovascular risk charts (49), to classify patients whose wounds are deemed at high risk of becoming chronic. When developed, this risk assessment tool could replace specified criteria within item descriptor and simplify the process of determining a wound at high risk of becoming chronic.

A proposed descriptor for the new item and more detailed information regarding examples of relevant assessments to undertake, including prevention and appropriate treatment of underlying illnesses is at Appendix B.

Claiming of this item will trigger eligibility for the following:

- Access to the proposed practice nurse items below for 4 weeks to a maximum of 10 services (see Recommendation 3)
- Access to the GP wound assessment review item below, able to be claimed after 2 weeks and ideally within 4 weeks of the initial assessment (see Recommendation 2)
- Access to the proposed new wound debridement items (see Recommendation 10)
- Access to the proposed additional allied health services (see Recommendation 5)
- Access to a wound consumables scheme (Recommendation 24)

In order for practitioners to claim this item they must have undertaken appropriate wound-specific training (see Recommendations 16-19).

The Working Group recommends associated Explanatory Notes remind practitioners that:

- time spent by the nurse providing wound care cannot be included in GP consultation time. This is in line with the recommendation regarding updating the Explanatory Notes for acute wound MBS items.



- where a practice nurse provides ongoing wound management, the medical practitioner is not required to see the patient during each subsequent visit, but should be able to be contacted if required.

The Working Group recommends that the Department work with key stakeholders in the development of appropriate education and training in wound management, which a GP is required to undertake prior to claiming the proposed new item (Recommendation 19).

The Working Group understands that this wound assessment item and subsequent practice nurse items may not be accessible to all relevant patient groups, including those requiring community nursing services and patients within residential aged care, and notes it is important that vulnerable patients are not disadvantaged. The Working Group recommends that consideration be given to patient groups who are unable to present to a general practice for wound assessment and subsequent nursing treatment. The Working Group recommends that the effect of the proposed model on these patient groups should be monitored following implementation, with consideration given to improving the proposed model.

In the process of this assessment, practitioners are required to maintain adequate documentation, including wound measurements, to assist in subsequent reviews of the wound. It is strongly encouraged that, whenever reasonable, practitioners take calibrated photographic evidence at each point of assessment.

5.1.2 Rationale for Recommendation 1

This recommendation focuses on supporting comprehensive and team-based care within the primary care setting, whereby underlying risk factors and comorbidities are assessed and managed as an essential element of best practice wound management. This recommendation will improve access to affordable and universal best practice wound management, while achieving improved value for the patient and the health system overall. This recommendation will also improve patients' quality of life and reduce out-of-pocket costs.

It is based on the following:

- There are a number of factors contributing to poor management of wounds within Australia. This recommendation is in line with assisting GPs to correctly diagnose and appropriately manage wounds which are chronic or at high risk of becoming chronic.
- Appropriate, evidence-based wound care in a GP-based primary care setting with early intervention and attention to underlying causes and prevention represents the most cost effective intervention to reduce the burden of disease and minimise total costs to the health care system (50) (31) (6).



- Due to the very large number of chronic wounds in Australia, treatment in a primary care setting is the only realistic option for the vast majority of chronic wounds and is considered the most cost effective and appropriate option (7).
- Patients eligible for this service have been clearly defined to include those with a wound(s) deemed chronic at time of presentation and those with a wound(s) deemed at high risk of becoming chronic. A wound that is present for four to six weeks is commonly expressed as a marker of wound chronicity (51), however targeting this item only to patients whose wound has been present for an extended period of time may introduce a perverse incentive to delay appropriate assessment and management of the wound and underlying risk factors.
- As such, the Working Group recommends this item also be accessible to patients with a wound, who fall into one or more categories putting them at high risk of the wound becoming chronic. This encourages and supports the assessment and management of aetiological factors causing the wound and/or delaying healing. The age of a patient is an important factor as the ability of a wound to heal diminishes with age. Persons 65 years and older account for 85% of non-healing wounds in the United States (52). There are also a number of other factors which may put a patient at high risk of a wound becoming chronic, such as concurrent comorbidities, clinical wound-related factors, concurrent medication use and their environment. It is important that the criteria for a patient accessing this wound assessment are well-defined so as to ensure access is targeted to those most at risk.
- General practice is the main primary care model that has the infrastructure, care model and skills base to be cost-effectively empowered to provide optimal primary care-based wound management
- The Working Group agreed that suitable education is required for GPs and other healthcare workers regarding appropriate wound care. Education and upskilling are integral to the model of care, as there is robust evidence to show that increased skill in wound care is the major factor in ensuring rapid healing and best outcomes. Suboptimal management of chronic wounds is a major problem and this recommendation will work towards addressing this issue.
- The recommendation to mandate appropriate training (see Recommendations 16-19) is to ensure that providers have the necessary skills to make use of appropriate products and are familiar with appropriate assessment, diagnosis and management of chronic wounds, including when to refer to a subspecialty.
- Inclusion of a comprehensive wound assessment checklist is to enable practitioners to accurately diagnose wound types and therefore initiate appropriate treatment with minimal delay. This is especially important in the diagnosis of varying types of leg ulcers



(venous, arterial or mixed venous/arterial), as well as determining malignancy of the wound.

- The inclusion of this item on the MBS will reduce hospital admissions, improve GP skills and training in wound care, and encourage GPs to provide this service to patients. It is aimed at supporting appropriate wound management within the primary care setting, and ensuring subsidised wound care activity is targeted towards the delivery of evidence-based, outcomes focussed wound care.
- In combination with the cost of consumables recommendations below (see Recommendations 23 and 24), as well as the review and treatment items (Recommendations 2 and 3), this recommendation will enable general practices to provide a financially viable, multidisciplinary, best clinical practice wound management service.

5.1.3 Recommendation 2: GP wound assessment review

Create a new item to account for a GP to undertake a comprehensive review assessment of a chronic wound or a wound at high risk of becoming chronic.

The purpose of this item is to provide a mechanism for the treating GP to undertake a comprehensive review of the wound and the Working Group recommends that progression of wound healing be reviewed multiple times prior to the claiming of this item.

In order for practitioners to claim this item they must have undertaken appropriate wound-specific training and have access to the patient's initial and, if undertaken, subsequent wound assessment documentation and treatment regime. This review should occur at least two weeks after the initial assessment by the general practitioner to give sufficient time for interventions such as compression therapy and the use of appropriate wound dressings to have a positive effect.

As part of this review a number of steps need to be taken to encourage appropriate management of wounds. This checklist will assist in an evidence-based review of wound management and encourage practitioners to refer appropriately. Further detail on what is required for assessment and review will need to be determined, with the potential for development of guidelines and resources to supplement education in practices.

Claiming of this item will enable the following:

- Access to the proposed practice nurse items below for an additional 4 weeks to a maximum of a further 10 services



- Access to a subsequent GP wound assessment review item, able to be claimed after 2 weeks and ideally within 4 weeks of the previous review.
- Access to the proposed new wound debridement items

Under most circumstances the GP is expected to consult with a specialised provider (see Recommendations 7 and 22) on or before four weeks (i.e. claiming of this item) if the wound is not observed to be healing adequately with current treatment.

As such, the Working Group recommends that an Explanatory Note be created, stating that consultation with or referral to an appropriate specialist or specialised wound care service is expected when clinically indicated, and if the wound is not healing adequately after four weeks of treatment (based on consensus and best practice).

The Working Group recommends that referral for specialist review and assessment may include where appropriate, the utilisation of remote and non-face-to-face services (real time or asynchronous) (see Recommendation 8).

An appropriate descriptor for this review assessment will need to be developed in line with the initial assessment item.

Assessments and Next Steps

A practitioner must perform a number of assessments in the claiming of this item. Specific criteria will need to be further determined and developed, however may include the following:

- Observed size reduction of wound (e.g. reduction of 25% [measuring greatest and least dimensions] over 4 weeks indicates adequate healing for treatment of a venous leg ulcer, however any reduction in size can be indicative of wound healing for other wounds)
- Observed progression of the wound bed through the phase of healing, e.g. from inflammatory phase into granulation phase. This includes reduction in exudate (colour, amount, odour), localised erythema or inflammation at per-wound margins, as well as reduction in wound pain.
- Management of oedema
- Improved circulation

Referral to a specialist may be necessary if the following is occurring (53):

- The wound is rapidly deteriorating
- The wound is large or complex



- Patient is at risk of amputation
- Inadequate management of peripheral vascular disease (e.g. if the Ankle Brachial Pressure Index [ABPI] is less than 0.5 or abnormally high, the patient should be referred)
- The wound may require specialised therapy, e.g. hyperbaric therapy, topical negative pressure
- The wound shows irregular appearance or location (possibly suggesting malignancy)
- The wound not healing adequately despite best practice
- Recurring wound with no obvious cause
- Persistent wound pain despite optimal management
- Multiple co-morbidities

5.1.4 Rationale for Recommendation 2

This recommendation focuses on provision of accessible best practice wound care services while ensuring value for both the patient and the health system overall.

It is based on the following:

- Ensuring wounds are reviewed according to guidelines and within appropriate timeframes is instrumental in reducing the burden of chronic wounds in Australia. This item will assist clinicians in the appropriate review of wounds to ensure that initial diagnosis and treatment provided is appropriate and improving wound outcomes for patients. This review assessment will also provide clinicians with a trigger point for escalation, assisting clinicians in the decision to refer patients to an appropriate specialist if the wound is deemed to not be healing to an acceptable level within a certain timeframe.
- This review assessment will also support provision of wound care services appropriate to the patient's needs, providing real clinical value and not exposing the patient to unnecessary risk or expense.
- The review aspect of the new wound treatment cycle is aimed at targeting MBS rebateable services to treatment that is shown to be beneficial and improves patient outcomes. The model supports and strongly encourages timely consultation with or referral for specialist or specialised wound care service review and assessment of the initial diagnosis and treatment when a wound is not healing adequately with current treatment. This recommendation, in combination with increased GP education and



training (Recommendation 19), will ensure subsidised wound care activity is targeted towards the delivery of evidence-based, outcomes focussed wound care. This will lead to improved wound healing and quality of life for patients in a timely manner.

- While the GP wound assessment review item would ideally be provided within 4 weeks of the previous review, this item may be claimed after this time where clinical circumstances dictate.
- Utilisation of telehealth has been proven to be beneficial in a number of clinical situations, including in the provision of remote specialist wound consultations (54) (55) (56) (57) (58). The Working Group considers the use of remote and non-face-to-face (real time or asynchronous) services an ideal treatment modality in referral for specialist or specialised wound care service review, when face-to-face services are not possible or appropriate (see Recommendation 8).

5.1.5 Recommendation 3a: Practice Nurse wound treatments

Create two new items for wound management services provided by a practice nurse on behalf of and under the supervision of a medical practitioner, with the below criteria. One item would be for treatment under 20 minutes in duration and one for treatment over 20 minutes in duration. These items should also be available for wound management services provided by Aboriginal and Torres Strait Islander Health Practitioners or appropriately trained Aboriginal Health Workers within Aboriginal Medical Services. (Refer to Appendix C for proposed new item descriptors)

Criteria for accessing the proposed new items are as follows;

- These items are claimable after the initial assessment of a chronic wound or the review assessment of the same wound and are available for 4 weeks to a maximum of 10 services. Prior to 4 weeks, the medical practitioner should undertake a review of the wound to assess healing.
- These items can only be claimed by a medical practitioner where wound management (other than normal aftercare) is provided to a patient by a nurse on behalf of the medical practitioner.
- Either of these items can be claimed only once per patient visit, even if more than one wound is treated during the same patient visit.
- For the purpose of these items a practice nurse means a registered or enrolled nurse who is employed by, or whose services are otherwise retained by a medical practitioner or their practice. This includes a health service in relation to which a direction made under subsection 19(2) of the Health Insurance Act 1973 applies. Aboriginal and Torres



Strait Islander Health Practitioners or appropriately trained Aboriginal Health Workers are those employed within Aboriginal Medical Services.

- The practice nurse, Aboriginal and Torres Strait Islander Health Practitioner or Aboriginal Health Worker providing wound management under these items must be appropriately trained and credentialed to treat wounds.
- The medical practitioner under whose supervision the treatment is provided retains responsibility for the health, safety and clinical outcomes of the patient.
- The medical practitioner does not need to be present during the treatment of the wound. However, the medical practitioner must conduct an initial assessment of the patient and appropriate subsequent reviews (including under a distance supervision arrangement if the medical practitioner is not physically present) in order to give instruction in relation to the treatment of the wound.
- Where a practice nurse provides ongoing wound management, the medical practitioner is not required to see the patient during each subsequent visit but should be able to be contacted if required.
- Where the medical practitioner also provides a service to the patient in addition to the treatment by the practice nurse (i.e. not routine wound care, or services outside the scope of the item descriptor), the medical practitioner is able to claim for the professional service they provide to the patient.

The Working Group recommends the Schedule fees for these items take into consideration the previous item for provision of wound management services provided by a practice nurse, corrected for CPI increase, and also taking into consideration a relative increase for support evidence-based wound care and value for the patient and the healthcare system.

The Working Group recommends that the Department work together with key stakeholders in the development of appropriate training and credentialing required prior to practice nurses claiming the proposed new items. This training must be widely acceptable and accessible to nurses, particularly in the context of remote area nursing (Recommendations 16 and 17).

The Working Group notes the draft recommendation from the Aboriginal and Torres Strait Islander Reference Group to expand provider access for MBS item 10989 (wound treatment provided by an Aboriginal and Torres Strait Islander Health Practitioner) to include appropriately trained Aboriginal and Torres Strait Islander health workers and nurses (when provided in Aboriginal and Torres Strait Islander primary health care). Item 10989 does not require healthcare providers to undertake additional training and credentialing in wound management and should not be co-claimed with the proposed new items.



Consideration should be given to prevent and monitor for inappropriate co-claiming of these items, such as in combination with current wound management MBS items or GP consultation items, when not clinically required.

5.1.6 Rationale for Recommendation 3a

This recommendation focuses on ensuring patient access to best practice wound management services within a collaborative team care environment. The aim is to inspire and enable provision of evidence based best clinical practice, within an affordable and accessible setting to patients.

It is based on the following:

- The Working Group considered many aspects of wound management within the primary care setting. One of these aspects is the provision of wound care services by practice nurses. Prior to 2012 practice nurses could access an MBS item specifically accounting for wound care services provided by a practice nurse (item 10996), however this was replaced with the PNIP in January 2012, providing a consolidated funding model for all services performed by a practice nurse, with no wound-specific reimbursement for nursing time (13). It is unclear what effect this has had on the management of wounds in general practice, however it is suggested that nurses may now have a reduced role in wound care following the removal of item 10996 (13) (31).
- The Working Group considered the following two options for adequately remunerating and enabling provision of best practice wound management services by practice nurses:
 - Block or bundled funding
 - Fee for service
- The Working Group considered the merits and disadvantages of both funding mechanisms and recommended the fee for service model for a number of reasons, including the ability to drive appropriate care, mandate appropriate training and credentialing and allow utilisation of a simple and easily understood mechanism for funding wound services provided by a practice nurse.
- The Working Group considers a fee for service model that complements existing non-MBS payment structures as administratively simpler than block funding for wound care, for both general practices and in remote settings. Different wounds require different intensity of medical and nursing treatment, and a block payment model for all wounds will not allow the flexibility required for the provision of timely and appropriate wound care activities. The fee for service model ensures a patient rebate is paid for services which are actually provided to the patient, compared to a block payment which would see the same rebate paid for patients requiring a variable number of services i.e. the



rebate would be the same for a patient requiring four nursing visits and a patient requiring ten visits.

- This model also enables flexibility for the cases when a different GP is required to supervise nursing care provided on different occasions over the four week treatment cycle.
- The Working Group acknowledges that this funding approach may need to be revisited in the future if a bundled payment model, similar to that used under the Health Care Homes trial, is implemented nationally.
- The proposed new items enable and encourage service provision and health care expertise in excess of that currently subsidised by the WIP (previously PNIP), and introduces a mixed funding model for practice nurses which incentivises and supports specific quality activities, both in training and clinically.
- This recommendation will see the re-introduction of specific items for nurses to provide treatment of wounds in the practice setting. A distinction from the previous item is that, in order for nurses to be able to perform these services and claim these items, they will be required to undertake appropriate wound management training, credentialing and associated continuing professional development.
- The additional incentive of MBS subsidised treatment available only to practice nurses, Aboriginal and Torres Strait Islander Health Practitioners and Health Workers who have undertaken additional training and credentialing will encourage both GPs and these providers to upskill in the provision of evidence-based wound management services. This is a factor essential to improving the management of wounds in Australia.
- Inclusion of unregulated health care workers in this recommendation aims to improve provision of quality care in a setting where currently there can be a lack of services, training and regulated service providers. These workers often provide wound care services in these settings and it is important that they are upskilled in wound management.
- Inclusion of these items is intended to support upskilling of practice nurses, while supporting appropriate wound management within the primary care setting, providing maximum flexibility to adjust to changing circumstances and evidence. This recommendation will reduce hospital admissions, improve nursing skills and training in wound care, and encourage GPs to provide this service to patients by reducing the financial burden on practices.
- In the primary care setting, the time and financial burden for practices is considerable, particularly the burden on nursing resources. In combination with the cost of consumables recommendations below, this recommendation will enable medical



practices to provide a financially viable, multidisciplinary, best clinical practice wound management service, which is easily accessible for patients.

5.1.7 Recommendation 3b: Workforce Incentive Program (previously PNIP)

The Working Group recommends the WIP be uncapped in relation to SWPE measures relating to practice size. The Working Group also recommends that the WIP be indexed in line with indexation of the MBS.

5.1.8 Rationale for Recommendation 3b

This recommendation focuses on supporting provision of more equitable access to services to patients of all general practices.

It is based on the following:

- The WIP-Practice Stream provides incentives to support all eligible general practices to engage the services of nurses, Aboriginal and Torres Strait Islander Health Workers and Health Practitioners and a range of allied health professionals.
- The incentive payment a general practice receives depends on the size of the practice, the type of eligible health professional/s engaged, number of hours health professionals have worked over the quarter, type of practice and the practice location.
- Practice size is measured by the SWPE and is based on MBS billed care provided by all general practitioners in a practice. The maximum incentive payment under the WIP is capped at 5000 SWPE (equivalent to five full time GPs).
- This means that general practices which employ greater than the equivalent of five full time GPs will not receive additional funding under the WIP, resulting in patients of these larger practices potentially receiving a lower level of team based care from additional healthcare providers.
- Removing the cap for maximum incentive payments under the WIP will ensure eligible general practices employing greater than the equivalent of five full time GPs are appropriately supported to engage the required level of services of nurses, Aboriginal and Torres Strait Islander Health Workers and Health Practitioners and a range of allied health professionals.
- This will result in more equitable access to services for patients who visit larger practices.
- Indexation of this payment in line with the MBS will ensure appropriate remuneration and support for eligible practices and health care providers.



5.1.9 Recommendation 4: Nursing care under team care arrangements

The Working Group recommends that practice nurses who have undertaken the additional training and credentialing be considered part of the care planning team for the purpose of Team Care Arrangements and any future item incorporating Team Care Arrangements.

This would mean that the practice nurse is included as one of the three practitioners required in order to claim for the facilitation of team care planning.

5.1.10 Rationale for Recommendation 4

This recommendation focuses on enabling best practice wound management through multidisciplinary team care.

It is based on the following:

- Under current arrangements practice nurses are generally not considered part of the care planning team and therefore cannot be included as one of the three practitioners required in order to claim for the facilitation of care planning.
- The Working Group suggest that, in the context of chronic wound management, practice nurses who have undertaken additional training be considered part of the care planning team, to better facilitate care planning and improve outcomes for patients with chronic wounds. In the context of enhanced wound care provision, the skill set and services provided are in addition to current standard of care and are different from those provided by any other members of the care team. Although ultimately under the supervision of the GP, the proposal is that the nurse operate autonomously to a degree (the expectation is that the GP will not see the patient at every nurse visit).
- This recommendation will facilitate patients with chronic wounds accessing allied health services, where specialist care is not required (the advanced wound care being provided by the upskilled General Practice) but the services of an allied health practitioner (eg podiatrist) are required. Access to such allied health care can under some circumstances, provide improved outcomes and lower overall costs, so consideration must be given to a mechanism to enable this. Under the model proposed, the GP, practice nurse and Allied health practitioner would be working together as a genuine multidisciplinary team and it is felt that the inclusion of the upskilled practice nurse is justified.



5.1.11 Recommendation 5: Increased access to allied health services

Increase the number of allied health services available under Team Care Arrangements (TCA), and any future item incorporating TCAs, for patients with chronic wounds or wounds deemed at high risk of becoming chronic.

The Working Group recommends an increase in the number of allied health services available under a GP chronic disease management plan (GPMP) or TCA for patients eligible for the GP wound assessments and nursing treatment.

Consideration should be given to developing a mechanism to ensure mandatory reassessment of the wound by a patients referring GP. This may include reassessment after accessing the first five allied health services, and before a patient is eligible for accessing additional allied health appointments.

5.1.12 Rationale for Recommendation 5

This recommendation focuses on ensuring that the MBS provides equitable access to best practice wound management services, including appropriate multidisciplinary care.

The Working Group recognises the importance of ensuring that patients with chronic wounds have access to appropriate and affordable allied health services. This would better assist practitioners to address underlying conditions and prevent the development of, or deterioration of chronic wounds. It is based on the following:

- Under the current Chronic Disease Management items consumers are eligible for accessing 5 MBS-subsidised allied health appointments. The Working Group considers that this number is often insufficient for appropriate wound management, prevention and treatment.
- This is in line with the draft recommendation made by the Allied Health Reference Group (AHRG) to increase the number of allied health appointments under Chronic Disease Management items by stratifying patients to identify those with more complex care requirements. The AHRG states that the set of five MBS-funded allied health appointments is often insufficient to adequately treat patients with chronic conditions. Patients who require more than five allied health appointments are often not adequately supported by other sources of funding, including states, territories and PHNs and this can lead to demand-driven waiting times restricting patient access.
- As mentioned above patients with chronic wounds often have a number of chronic conditions and would benefit from accessing a number of different allied health professionals, including podiatrists, occupational therapists, dietitians, physiotherapists, and in certain situations, orthotists and prosthetists.



5.1.13 Recommendation 6: Podiatry interventions and appliances

The Working Group recommends that research be undertaken to determine the cost-effectiveness of certain podiatry interventions and appliances in the management of chronic wounds.

The Working Group recommends that evidence-based podiatry interventions and appliances, particularly appropriate offloading devices, should be considered for inclusion in the development of a consumables scheme (Recommendation 24) or an alternative device funding scheme.

5.1.14 Rationale for Recommendation 6

This recommendation focuses on ensuring access to best practice wound management services.

It is based on the following:

- Treatment of chronic wounds requires a multidisciplinary team, with a number of health professionals providing essential services contributing to evidence based wound care along the care continuum.
- The Working Group and stakeholders identify podiatry as one area which has the potential to improve outcomes for patients with chronic wounds associated with the foot, including services and appliances such as appropriate offloading, customised pressure alleviation devices, orthoses, total contact casting and medical grade footwear.

5.1.15 Recommendation 7: Referral when required

The Working Group recommends that improvement in a wound must be observed, or consultation with or referral to an appropriate specialist or specialised wound care practitioner should take place.

Strong emphasis and clear guidance on appropriate referral should be provided in an education program for treating practitioners (Recommendation 19).

The Working Group considers it very important that a wound be referred for expert assessment if it is observed not to be healing adequately with current treatment, independent of the setting in which the wound is being treated. This includes, but is not limited to primary care, residential aged care and community nursing.



This recommendation has been embedded, through introduction of an Explanatory Note, into the proposed GP primary care model, with a trigger point for referral (when required) at the review assessment undertaken by a GP (see Recommendation 2).

5.1.16 Rationale for Recommendation 7

This recommendation focuses on ensuring appropriate and timely access to best practice wound management services.

It is based on the following:

- Appropriate prevention, diagnosis and treatment of wounds is essential to reducing the burden of chronic wounds in Australia. Australian research shows that access to wound management expertise can promote evidence based wound care and lead to improved health for patients and efficient use of health resources (15).
- Given the majority of patients with chronic wounds do not receive evidence based wound management (6) (10) the Working Group considers it essential that providers of wound management services are aware of the requirement to refer patients to specialist practitioners when appropriate. Strongly encouraging referral when a wound has not improved as expected will assist clinicians to provide evidence-based wound management, independent of the setting in which the wound is treated.
- This recommendation should be read in combination with additional training required prior to accessing new MBS items (Recommendations 1, 2 and 3) and defining and supporting access to specialist or specialised wound practitioners (Recommendations 14 and 22). Together these recommendations will enable primary care providers to better recognise the requirement to refer for expert advice, and be able to identify those practitioners with appropriate skills to provide a recognised expert wound care service.
- This recommendation is in line with provision of evidence-based wound management and will enable clinicians to determine wounds which are not responding adequately to current treatment, including appropriate reassessment of initial diagnosis and management (53).
- This will contribute towards patients receiving evidence-based wound management in a timely manner, resulting in reduced wound healing duration and improved health outcomes for patients, as well as reduced costs for patients and providers (28), while ensuring MBS subsidised treatment is targeted towards treatment which is producing outcomes for patients.



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

The Working Group recommends that where appropriate, consideration should be given to the use of remote and non-face-to-face services (real time or asynchronous) and an appropriate funding model investigated.

Ideally a healthcare provider would attend a patient face-to-face, however, the Working Group agrees that telehealth may be an appropriate alternative in many situations, particularly to assist referral to a specialist or specialised wound care service practitioner.

Obtaining an expert/specialist opinion is one situation that the Working Group recommend is well suited to asynchronous telehealth. This would increase access to specialist services and in many cases be more convenient for the patient, without any reduction in clinical value.

This treatment modality may be appropriate in a number of situations, including rural and remote settings and RACFs, as well as to assist established teams working within different locations. This recommendation is not limited to patients located within rural and remote settings.

5.1.18 Rationale for Recommendation 8

This recommendation focuses on increasing access to best practice wound management services, including value for the patient and the health system.

It is based on the following:

- Telehealth should not be a substitute for face-to-face care, however can play an important role in the management of chronic wounds.
- Utilisation of remote and non-face-to-face services has been proven beneficial in a number of clinical situations, including in the provision of remote specialist or specialised wound care practitioner consultations (54) (55) (56) (57) (58). These services have been used for a number of years in remote areas in Australia, addressing many of the key challenges to providing health care in Australia.
- Telehealth is a recognised modality of providing equitable access to wound care expertise. Use of telehealth has been observed to reduce hospitalisations, improve wound healing, reduce cost of care and assist with facilitating inter-professional practice between GPs, allied health, specialists and the acute sector (59) (60) (61) (62) (63) (64), and should be considered in a number of situations, including RACFs. [The recent response to the COVID-19 pandemic has proven how telehealth can be used to improve or maintain patients access to services.](#)



- This recommendation is in line with the General Practice and Primary Care Clinical Committee (GPPCCC) draft recommendation supporting flexible access to services, including utilisation of asynchronous and non-face-to-face technologies.

5.2 Procedure-specific wound management services

5.2.1 Recommendation 9: New item for venous compression bandaging

Create a new item for venous compression bandaging for the management of venous leg ulcers resulting from chronic venous insufficiency.

Table 2: Item introduction table for new item for venous compression bandaging

Item	Descriptor
New item 1	The application of graduated compression therapy to manage venous hypertension and peripheral oedema associated with venous leg ulcers resulting from chronic venous insufficiency, up to 18 weeks of therapy, after an appropriate assessment has been undertaken to exclude significant arterial disease

Proposed new Explanatory Notes:

- *Up to 18 weeks of a system of graduated compression therapy (normally 20-40mmHg) is designed to heal an existing lower leg ulcer.*
- *Graduated compression therapy must involve a recognised elastic or inelastic system.*
- *Individually measured compression stockings can be used to help prevent ulcer recurrence in patients with previously healed ulcers.*
 - Access to these may be provided under the suggested consumables scheme (see Recommendation 24).
- *Appropriate vascular assessment should include vascular disease history and examination and may include an ABPI, Doppler study or toe pressure.*

The Working Group recommends that this item not be claimed in conjunction with the proposed practice nurse treatment items (Recommendation 3), with the Schedule Fee appropriately accounting for a complete medical service, including any required dressing change.

The use of this item is restricted to health care clinicians who have proof of competency based on the completion of appropriate training. To this end, the Working Group recommends that practitioners who have undertaken relevant training (both theoretical and clinical) should be eligible to access this MBS item. This would include GPs, podiatrists,



practice nurses, clinical nurse specialists and nurse practitioners who have undertaken appropriate training.

The use of three layered tubular bandage compression therapy will not generate use of this item number.

5.2.2 Rationale for Recommendation 9

This recommendation focuses on ensuring affordable and universal access to appropriate best clinical practice.

It is based on the following:

- Effective venous compression bandaging is essential in effective treatment of venous leg ulcers and leads to improved, more rapid healing of these wounds. Provision of compression therapy to manage the peripheral oedema from chronic venous insufficiency is in line with Cochrane Level 1 evidence for the management of venous leg ulcers (24).
- Up to 18 weeks of a recognised system of graduated compression therapy has been shown to heal an existing venous leg ulcer (65).
- Compression bandaging is a specific and time-consuming task requiring specific skills and relatively expensive consumables.
- Appropriate vascular assessment is required prior to compression to confirm the leg ulcer is venous, not arterial in origin (66).
- Inclusion of this item will enable effective treatment of venous leg ulcers within an appropriate setting and is in line with providing patients with affordable and universal access to evidence-based wound management.
- Currently patients may be required to regularly visit expensive specialist wound clinics, making treatment inaccessible to many. Inclusion of this item within the MBS will ensure patients have access to evidence-based wound management, greatly reducing inconvenience and improving patient safety as well as reducing overall costs in many cases.
- This item is restricted to a recognised elastic or inelastic system of graduated compression therapy, as gold standard treatment for venous leg ulcers (24). Although a potentially effective method of initiating compression, the use of three layered tubular bandage compression therapy does not generate the use of this item number as its level of complexity and associated labour intensity requirements are significantly less than non-elastic bandage systems.



5.2.3 Recommendation 10: New wound debridement items

Create new items to account for wound debridement procedures performed within primary care, including specialist wound clinics.

Table 3: Item introduction table for new items for wound debridement procedures

Item	Descriptor
New item 2	Simple conservative sharp or mechanical debridement of more than 5 minutes duration of a wound macroscopically contaminated with extensive devitalised tissue and exudate to be closed by a method other than primary intention. Maximum of 6 debridements in a 4-week period.
New item 3	Ultrasonic Debridement of more than 5 minutes duration of a wound macroscopically contaminated with extensive devitalised tissue and/or exudate to be closed by a method other than primary intention. Maximum of 6 debridements in a 4-week period.

- Proposed Explanatory note for ultrasonic debridement is as follows:
 - *Treatments should reflect the principles of aseptic technique.*

These items would be claimable after the initial GP wound assessment item has been claimed, similar to the restrictions placed on wound management services provided by a practice nurse (see Recommendation 3).

These items account for the debridement of any wound regardless of chronicity and should not be claimed in conjunction with the proposed practice nurse treatment items (Recommendation 3). As such, the Working Group recommends that the Schedule Fees appropriately account for a complete medical service, including any required dressing change.

The Working Group recommends that the Schedule fee for providing ultrasonic debridement of a wound should take into account the significant costs associated with consumables and equipment required when providing this service, as well as time taken to support debridement of these wounds, when required.

The Working Group recommends that practitioners who have undertaken relevant training (both theoretical and clinical) should be eligible to access these MBS items. This would include GPs, podiatrists, practice nurses, clinical nurse specialists and nurse practitioners who have undertaken appropriate training.

5.2.4 Rationale for Recommendation 10

This recommendation focuses on ensuring affordable and universal access to appropriate best clinical practice.

It is based on the following:



- The Working Group considered the current debridement item 30023 to be specific to the tertiary care sector, presumably in operating theatres, due to the specification of the type of anaesthesia. This is appropriate, however the Working Group recommended two additional items be created for debridement procedures performed within specialised clinics or primary care settings.
- The Working Group did not include specification of type of anaesthesia used as this will be up to the discretion of the treating clinician.
- These two new item numbers are to recognise and encourage debridement of wounds as an essential part of evidence-based wound management (67) (68) (69). Effective management of chronic wounds involves tissue debridement, inflammation and infection control, moisture balance and epithelialisation of wound edges (TIME) framework and effective debridement when clinically indicated can significantly reduce wound healing time and total treatment costs (70).
- Ultrasonic debridement in particular has been shown to improve wound outcomes, including decreased exudate and slough by enhancing the inflammatory response and hastening proliferation. This decreases patient wound pain and improves healing in wounds of various aetiology (71) (72) (73) (74) (75). The Working Group note the extra costs and components required for practitioners to perform ultrasonic debridement compared to simple conservative sharp or mechanical debridement. These include additional cost of equipment, consumables and an appropriate space to manage aerosolisation.
- For these reasons, the Working Group has recommended a separate item number for ultrasonic debridement, with a higher rebate in comparison to simple mechanical debridement.
- These procedures are currently performed in practices, however to date have not been included within the MBS.
- These items will enable the effective treatment of wounds within an appropriate setting and are in line with providing patients with affordable, universal and timely access to best practice wound management.

5.2.5 Recommendation 11: Negative pressure wound therapy

The Working Group recommends that future consideration be given to the development of an MBS item for negative pressure wound therapy (NPWT).



5.2.6 Rationale for Recommendation 11

This recommendation focuses on ensuring access to best practice wound management services.

It is based on the following:

- This is an advanced treatment option that has been shown to promote mechanisms that support wound healing, including increased perfusion to the wound and surrounding area, reduced oedema, stimulation of granulation tissue formation and reduction in exudate and infectious materials (70) (76).
- The use of NPWT within the community setting is expanding due to the availability of more portable NPWT devices and consideration should be given to the development of a specific MBS for this procedure. This recommendation is in line with providing access to best clinical care.
- As this is an extensively used and effective therapy wound management that has not been previously funded in the MBS, an MSAC application may be required.

5.3 Additional Residential Aged Care Facilities considerations

While the Working Group recognises wound management within RACF may not be funded through the MBS, management of wounds in this setting represents a significant cost and is an issue that must be addressed as part of a plan to better manage wounds in Australia.

The elderly in general are at increased risk of impaired skin integrity due to age related changes to the skin, frailty, malnutrition, incontinence, immobility and impaired cognition (39) (40), with residents often entering RACFs with one or more chronic conditions and multiple chronic and complex wounds (33) (34) (35) (36).

The Working Group recognises the considerable impact of chronic wounds in this vulnerable population. As indicated above, RACFs form an important part of a continuum of care for the aged. Therefore, the management of residents with wounds as they intersect with different health service providers irrespective of where or how the wound was acquired is a common issue and one that requires better application of evidence-based inter-professional practice and continuity of wound care.

The Working Group's specific recommendations relating to RACFs aim to reduce the burden of poorly managed chronic wounds on both residents and the health system. A number of other recommendations from the Working Group may also indirectly improve wound management within RACFs, such as education programs and defining a specialised wound care provider.



5.3.1 Recommendation 12: Education and training of RACF staff

The Working Group recommends that consideration be given to including mandatory quality indicators for education and training of RACFs staff, including the management of skin injuries, chronic wounds and ulcers, in accreditation and monitoring processes of RACF under the Aged Care Quality Standards.

RACF staff include registered and enrolled nurses, assistants in nursing, personal care workers and Aboriginal and Torres Strait Islander health practitioners and health workers.

5.3.2 Rationale for Recommendation 12

This recommendation focuses providing affordable and universal access to best practice wound management services to residents of RACFS.

It is based on the following:

- Mechanisms of accreditation should drive an increase in best practice wound management. Current Standards provide a framework to illustrate the model for escalation of care. However, developing the capacity to recognise trigger points for referral, including outlining clinical parameters, is important for improved wound management.
- Staff knowledge of the principles and application of wound management or maintenance of healthy skin in the case of non-registered caregivers within Australian RACFs has been shown to be less than optimal (77) (78) (79) (80). Unregulated healthcare workers, in collaboration with appropriate registered practitioners, play an important role in patient care (81), particularly pressure ulcer prevention and skin care (82). It is important that these workers undertake appropriate education and training, including understanding of their own competency and responsibilities (83). Additional education and training leads to observed increases in knowledge that improved clinical practices, including earlier recognition and reporting of impaired skin integrity, reduced prevalence of pressure injuries and skin tears and better product choices resulting in substantial cost reductions (77) (78) (79) (80).

5.3.3 Recommendation 13: Review funding for chronic wounds in RACF

The Working Group recommends a review of funding for the management of complex wounds in aged care, for example via the Aged Care Funding Instrument.



This should include consideration of both time and personnel required in caring for complex wounds, including complex venous, arterial and diabetic and neuropathic foot ulcers in residents, as well as the provision of appropriate consumables.

Any funding model in the RACF setting should be specific to wound management, encourage best care, and include access to an advisory service and adequate consumables. This model should also encourage use of evidence based practice within RACFs, including the appropriate level of nursing staff for wound care and wound based education and training requirements of RACF staff.

5.3.4 Rationale for Recommendation 13

This recommendation focuses on providing universal access to best practice wound management services.

It is based on the following:

- Residents are often admitted to RACFs with multiple painful chronic wounds. In addition, these residents may have multiple comorbidities affecting their predisposition to the development of chronic wounds and skin tears. The elderly, increasingly, are the recipients of surgical procedures and are at high risk of post-operative complications (84).
- Delayed wound healing is common among the elderly due to their comorbid status, the effect of polypharmacy, being poor surgical candidates or determining the wound status as being non-healable, rather than being undertreated, toward end stages of life (33) (34) (85) (59) (84).
- In addition, residents with advanced dementia have a greater predisposition to developing chronic wounds, and may require far more intensive wound management interventions than in patients with normal cognition, due to agitation or aggression (86). As a result, the number of staff required to assist with wound management procedures increases. Further, wound management procedures in this cohort of residents may consume one or more hours, particularly when multiple wounds are involved.
- Currently, the ACFI as it relates to wound management does not cater for these 'real time' variables, when accounting for the cost of providing best practice wound care. This likely increases the total costs of managing chronic wounds in RACF due to delayed healing or non-healing of wounds (87).
- Under current arrangements RACFs are unable to charge consumers for dressings and related medical devices (e.g. heel elevators), as funding for these consumables must be covered under current funding arrangements.



- A revised funding model should consider the costs of all wound management consumables, such as cleansing solutions, primary and secondary dressings. These include the dressing product in direct contact with the wound bed and the dressing that covers this, as well as fixation methods and bandaging. As twice daily moisturising significantly reduces the incidence of skin tears in the aged (88), consideration of this along with the use of tubular bandaging to reduce skin trauma when prescribed by a GP, nurse practitioner or clinical nurse consultant in wound management should also be investigated (38).

5.3.5 Recommendation 14: Access to wound care experts in RACFs

The Working Group recommends improved access to wound experts, including service teams (on-site or telehealth-enabled, where appropriate), to assist RACF staff to provide evidence-based wound management of chronic wounds for residents.

This should take into account existing services (variable across States and locations) that currently support RACF staff through provision of expert wound care services and should aim to complement and expand upon existing care, as well as support and upskill RACF staff.

The model for such a service may parallel the Government's existing [Dementia Management and Advisory Services \(DBMAS\) program](#), which provides assessment, clinical support, short term case management and mentoring/clinical supervision of care providers within RACF.

5.3.6 Rationale for Recommendation 14

This recommendation focuses on providing universal access to best practice wound management services.

It is based on the following:

- As the Working Group has recommended (see Recommendation 7), improvement in a wound should be observed or the patient referred to an appropriate specialist or specialised wound care practitioner. A wound may be classified as non-healing after appropriate assessment (84), as is often the case with malignant wounds or wounds that arise during end stages of life. For instance, malignant wounds (fungating or ulcerating) seldom heal yet require specific treatment to ameliorate symptoms such as pain, bleeding, exudate and malodour. These wounds are often challenging to manage due to their location, frequency of dressing changes and amount of dressing products used at any one time to manage the wound (43) (45). As such, ensuring access to wound experts when appropriate is an essential element in any setting in which a wound is being managed. This is particularly the case in RACFs where RACF staff have various levels of skills and experience in wound management (40).



- Telehealth is a recognised modality of providing equitable access to wound care expertise (see Recommendation 8) (59) (60) (61) (62) (63) (64).
- This recommendation should be read in line with Recommendation 22, defining credentialing requirements of those specialised in wound management.

5.3.7 Recommendation 15: Hospital acquired wounds

The Working Group recommends that the Federal Government work with the Safety and Quality Commission and the Aged Care Quality Commission to improve the management of patients being discharged from private and state-based hospitals with hospital acquired wounds, often with insufficient or no documentation of the presence of the wound(s). Mechanisms should be developed to monitor and provide feedback on wounds incurred in the hospital system in order to improve provision of care and prevention of wounds in this setting.

For the purpose of this recommendation, hospital acquired wounds include pressure injuries, skin tears, surgical site infections (SSIs) and unhealed ulcers.

This recommendation should include patients discharged to the community, as well as to RACF, and may take into account the potential for cost-shifting associated with the treatment costs of these wounds being transferred to other services and the potential establishment of appropriate penalties (87). Definitions of referral pathways should also be considered.

Consideration should be given to developing appropriate feedback mechanisms to institutions to improve wound prevention and management for any episode of care, with collection of appropriate data and documentation being an important factor in enabling improved multidisciplinary communication within and between health care sectors, and ensuring continuity of a patient's care.

The Working Group also recognises the importance of developing a more integrated model of care for people moving between state and federally funded care programs in achieving optimal outcomes for patients, including those with chronic wounds. To this end, the working group supports consideration of this issue in ongoing negotiations with jurisdictions on the National Health Reform Agreement.

5.3.8 Rationale for Recommendation 15

This recommendation focuses on data-driven quality improvement and clinical accountability for wound management across residential, community and acute care



settings. This will identify responsibilities for care, while feedback mechanisms will contribute to improved prevention and patient outcomes.

It is based on the following:

- Surgical site infections (SSIs) and pressure injuries are common post-operative surgical complications (89) with most occurring post discharge at considerable cost to patients or accepting health services (90). There are no mandatory reporting requirements for SSI's in Australian acute care facilities (41), and there is no national process for tabulating reported SSIs. Earlier post-operative discharge to the community (a person's home or community health provider) or a RACF means the substantial cost of managing these conditions is borne by the individual or healthcare provider, should they occur (91). Similarly, mandatory reporting of hospital acquired SSI's and pressure injuries that occur post discharge is not required, by GPs, RACFs and other healthcare providers therefore the actual occurrence (incidence) of SSI's and pressure injuries post discharge is not known.
- Documentation and appropriate treatment of SSIs is particularly important in patients greater than 60 years of age, with this cohort carrying the highest prevalence of these hospital acquired infections (41).



6. Recommendations – Education, credentialing and accreditation

The recommendations regarding appropriate training modules for education, credentialing and accreditation are an integral part of the proposed model.

Appropriate prevention, diagnosis and treatment of wounds is essential to reducing the burden and chronicity of wounds and the Working Group considers it essential that education and upskilling are part of the model of care. There is robust evidence to show that increased skill in wound care is the major factor in ensuring rapid healing and best outcomes (7) (92).

While a range of health practitioners, including general practitioners, have varying levels of skills in wound management, there is significant opportunity to improve practitioners' competencies for providing evidence-based wound care to patients. It is likely that more consistent and optimised approaches to wound care could produce cost savings that would offset the cost of upskilling (50) (7). The Working Group recognises that different health practitioners have proportionate requirements for additional education and training, based on entry level competencies. As such, the Working Group have recommended that the Department work with key stakeholders in the development of appropriate education, training and credentialing, in order to address identified knowledge gaps in the various professions involved in the management of chronic wounds. The Working Group recommends that any education module should be ethical, consistent, accessible and straightforward.

6.1.1 Recommendation 16: Nurse training and credentialing

The Working Group recommends that the Department work together with key stakeholders in the development of appropriate training for nurses, and for credentialing in wound management, required prior to practice nurses being able to provide services under the proposed new items.

Completion of this training, along with determined necessary Continuing Professional Development (CPD) will be a mandatory requirement for claiming the proposed nursing items.



6.1.2 Rationale for Recommendation 16

This recommendation focusses on providing accessible best practice wound management services and improve the value of wound services provided to achieve improved value for the health system and patients.

It is based on the following:

- Nurses play a critical role in the management of wounds and it is essential that nurses are appropriately skilled in providing these services. Mandating education of nurses in the provision of the above nursing wound items will encourage nurses to upskill, leading to improvements in wound management. This recommendation will improve access to best practice wound management and increase the value of providing these services for both the healthcare system and the patient.

6.1.3 Recommendation 17: Aboriginal and Torres Strait Islander Health Practitioner and appropriately trained Aboriginal Health Worker wound management training and credentialing

The Working Group recommends that the Department work together with key stakeholders in the development of appropriate training and credentialing for Aboriginal and Torres Strait Islander Health Practitioners and appropriately trained Aboriginal Health Workers in wound management. This training and credentialing would be required prior to claiming the proposed new items for short term wound treatment in an Aboriginal Medical Service.

Completion of this training, along with determined necessary CPD will be a mandatory requirement for claiming the proposed new wound treatment items.

6.1.4 Rationale for Recommendation 17

This recommendation focuses on providing accessible best practice wound management services to achieve improved outcomes for patients and value for the health system.

It is based on the following:

- Aboriginal and Torres Strait Islander Health Practitioners and Aboriginal Health Workers play a critical role in the management of wounds. It is essential that these healthcare providers are appropriately skilled in providing these services.
- Mandating education of these providers prior to being eligible for funding under the above wound treatment items will encourage these providers to upskill, leading to improvements in wound management.



- Aboriginal and Torres Strait Islander peoples generally suffer a disproportionate burden of illness, including social disadvantage, when compared with the general population (31). This recommendation will support best practice wound management by providing healthcare providers with skills and knowledge to manage wounds and associated chronic conditions in a vulnerable population, with a disproportionate burden of disease.

6.1.5 Recommendation 18: Nurse Practitioner training and credentialing

The Working Group recommends that the Department work together with key stakeholders in the development of appropriate training and credentialing for Nurse Practitioners wanting to specialise in the provision of specialist wound management services.

6.1.6 Rationale for Recommendation 18

This recommendation focusses on providing accessible evidence-based wound management services.

It is based on the following:

- Nurse Practitioners work autonomously and collaboratively with other practitioners and play a critical role in the diagnosis and treatment of people of all ages with a variety of acute or chronic health conditions (93).
- This recommendation will enable provision of accessible evidence-based wound management services by practitioners who are capable of providing high quality, patient centred care.

6.1.7 Recommendation 19: General Practitioner training

The Working Group recommends that the Department work with key stakeholders in the development of appropriate training which a GP is required to undertake prior to claiming the proposed new items.

This may require GPs to complete a training module similar to that required for preparation of a GP Mental Health care plan, with a similar investment of 6-8 hours. Completion of this training would be a mandatory requirement for claiming the wound assessment items. Similarly, there would need to be liaison with key stakeholders to ensure that continuing wound care education is made widely available to GPs.



6.1.8 Rationale for Recommendation 19

This recommendation focusses on providing accessible best practice wound management services and improving the value of wound services provided to achieve improved value for the health system and patients.

It is based on the following:

- GPs play a critical role in the management of wounds and it is essential that these practitioners are skilled in correct diagnosis and appropriate management of wounds within the primary care setting.
- Improvements in evidence-based knowledge and skills amongst healthcare providers have been observed where innovative wound management training has been implemented (6). Evidence clearly demonstrates that implementation of evidence-based wound care coincides with improved health outcomes for patients (5) (6) (14) (11) (21). As such, the Working Group recommends building upon the skill base of GPs, with additional training in wound management to improve wound outcomes for patients.
- The Working Group believes that to date there has been generally insufficient education regarding wound care provided during training of primary care providers, including GPs. The Chronic Wounds Solutions Collaborating Group's Call to Action highlighted an urgent need for improved education and training of health professionals in order to increase uptake of evidence-based practice (11).
- An education and training needs analysis undertaken in 2013 concluded that healthcare providers with the highest need for more wound management education and training appear to be those working in primary care, such as practice nurses and GPs, as well as those working in RACFs (94).
- This recommendation will support GPs to identify wounds which are not healing as would be expected and enable early referral to minimise any delay in appropriate treatment.
- This recommendation will improve access to best practice wound management and increase the value of providing these services for both the healthcare system and the patient. This will reduce out-of-pocket costs for patients, as well as reduce the impact of wounds on a patient's quality of life.



6.1.9 Recommendation 20: Practice accreditation

The Working Group recommends that subsidised wound consumables be provided only to practices accredited or registered for accreditation against the Royal Australian College of General Practitioners (RACGP) Standards for general practices.

The Working Group also recommends that consideration be given for the Department to work with key stakeholders in the development of wound management criteria to add to the current RACGP accreditation standards in general practices. This could include factors such as ensuring access to practice nurse continuing professional development in wound care, as well as safe storage of products.

6.1.10 Rationale for Recommendation 20

This recommendation focusses on increasing access to appropriate education, as well as ensuring safe storage and management of government supplied consumables. It is aimed at supporting provision of best practice wound management within the primary care setting.

It is based on the following:

- Addition of criteria relevant to wound management will assist with the provision of best practice wound management, increasing the value of these services for the individual patient and the health system as a whole. These criteria will increase access to appropriate wound management and encourage practices to maintain these minimum standards in the provision of these services.

6.1.11 Recommendation 21: Pharmacist education

The Working Group recommends that training be made available for pharmacists to encourage best practice wound management.

6.1.12 Rationale for Recommendation 21

This recommendation focusses on improving appropriate multidisciplinary team care in the management of wounds in the primary care setting.

It is based on the following:

- Community pharmacies are often the first port of call for those with a wound, therefore appropriate training is required, particularly for the management of minor wounds, product use and appropriate referral for medical assessment.
- This recommendation will improve patient access to best practice clinical care.



6.1.13 Recommendation 22: Specialised wound care providers and services

The Working Group recommends that the Department work with key stakeholders to define and credential those appropriately qualified to provide a specialised wound care service.

These healthcare providers may include appropriate medical specialists, GPs and other providers who have undertaken advanced education and clinical training in wound care.

The Working Group also highlights the important role that Primary Health Networks (PHNs) can play in the development of appropriate clinical referral pathways for providers. This service can assist linking primary care providers with appropriate private and publically funded specialised wound care providers and services.

6.1.14 Rationale for Recommendation 22

This recommendation focuses on providing accessible best practice wound management services and improving outcomes for patients the health system.

It is based on the following:

- The Working Group considers it essential that specialist wound care providers have the necessary skills and expertise to provide a specialised wound care service. This recommendation will ensure that those who are appropriately trained and credentialed to provide this service are clearly defined, ensuring adequate (specialist level) standards of care for patients.
- This recommendation would also assist primary care providers to recognise those practitioners with appropriate skills to provide a recognised specialist wound care service, including establishment of an accurate diagnosis of the aetiology of the wound and appropriate subsequent evidence based treatment (53) (32). Involvement of a healthcare provider with advanced practice wound care expertise is associated with increased use of evidence based guidelines and reduced time to healing, leading to significantly less use of health services for those with chronic leg ulcers (15). Appropriate use of these services through increased adoption of evidence-based care has the potential to produce significant savings for patients and the healthcare system, including improved healing rates and reduced healing time (14) (32).
- Although many healthcare providers provide an effective wound management service, if the wound is observed not to be healing adequately, the patient should be referred to an appropriate wound care specialist, for review and expert advice (see Recommendation 7).
- This recommendation will assist primary care providers identify wound care specialists, enabling appropriate referral and expert advice in the assessment and review of chronic



wounds. Appropriate diagnosis and treatment is essential in improving wound outcomes for patients, and defining and identifying providers of specialised wound care may reduce wait times for patients, reduce adverse outcomes and enable provision of evidence-based wound care in a timely manner.

- This recommendation is in line with the stepped care approach, linking patients with best practice evidence based care through various members of the healthcare team. Defining these providers may also contribute to improved communication between healthcare providers and reduced confusion for patients.

7. Recommendations – Addressing the cost of wound care consumables

The total cost of providing wound care services within primary care is considerable, and it is often not financially viable for medical practitioners to provide complete care, including consumables, in the current framework (13). There are multiple factors contributing to this situation, with the cost of consumables being a very significant one. It is important to note that a large proportion of patients with chronic wounds are frail and/or elderly, often with limited income and requiring that services be delivered with little or no out of pocket expenses. In this context, it is especially important that the financial viability of bulk-billed services be maintained, including consideration of cost of consumables.

The recommendations addressing cost of consumables must be read in conjunction with the above recommendations regarding improvements in comprehensive multidisciplinary wound management, education and provision of best practice wound care, including the following;

- Wound assessment and review by a GP who has undergone appropriate wound management training; and,
- Provision of wound care by highly skilled and credentialed practice nurses and other providers.

The Working Group made the following recommendations to address the cost of consumables.



7.1 Remove bulk-billing restriction on charging the cost of wound care consumables to the patient at the same time as a bulk-billed consultation

7.1.1 Recommendation 23: Remove bulk-billing restriction

The Working Group recommends introducing an exemption to the restriction prohibiting practitioners from charging for the cost of a wound dressing applied during a bulk-billed consultation, mirroring the current exemption for vaccinations (See MBS Explanatory Note GN.7.17).

The Working Group recommends that the fee charged to the patient can only be for products used in the treatment of the wound (i.e. the additional charge must only be to cover the supply of the wound dressing, in line with Explanatory Note GN.7.17) and an Explanatory Note should be created clarifying that wound care products cannot be billed in advance of treatment.

This recommendation should be read in conjunction with Recommendation 24, to develop a Commonwealth-funded consumables scheme.

The Working Group recommends that this recommendation be subject to review following implementation, to monitor use and any unintended consequences.

7.1.2 Rationale for Recommendation 23

This recommendation focuses on removing barriers and enabling access to quality wound care products.

It is based on the following:

- The Working Group considered the current prohibition (with the exception of vaccines) on raising an additional charge/s for a bulk-billed service. Where an attendance is bulk billed and a wound dressing is required, this leads to either less than optimal dressing selections at the point of care, sending patients to the pharmacy with a higher cost for dressings, or the GP absorbing the sometimes-considerable cost. An alternative is to not bulk bill the service, which can result in higher out-of-pocket costs for the patient.
- The price of dressings can be a significant factor impacting the ability of a practice to absorb the cost of a complete wound care service in a bulk-billing scenario. For example, the MBS rebate for standard GP level B consultation is \$38.20 (correct as of July 2019). Many common and small dressings are equivalent to 10-20% of the MBS rebate alone, while treatment systems for venous leg ulcers often exceed the above rebate value. The alternatives are to either not bulk-bill the service, or to send patients to a third party to obtain their own dressings. These approaches can result in



considerable costs to the patient and there is a risk that this will deter or delay their access to quality treatment.

- This recommendation would enable practitioners to use their discretion to bulk-bill an attendance item and separately charge the patient for the supply of wound care consumables, resulting in a much smaller up front payment. This option would be in addition to the current options of:
 - the practice absorbing the cost of wound care consumables in order to bulk-bill an attendance item, which is often insufficient to cover the cost of the service; or,
 - sending patients to a third party (e.g. community pharmacy) to purchase their own dressings; or,
 - charging the patient a private fee that incorporates the cost of both the service and required wound care consumables. This can result in a significant upfront fee to the patient.
- The Working Group acknowledge that allowing practitioners to charge patients for the cost of wound care consumables at the same time as a bulk-billed attendance will reduce cost for providers, however may not reduce costs for some patients. This recommendation will assist in the sustainable provision of wound care services within general practices, thereby increasing patient access. The complementary introduction of a national wound consumables scheme (Recommendation 24) is required to reduce out of pocket costs for patients.

7.2 Develop a scheme to subsidise the cost of consumables for specific patient groups

7.2.1 Recommendation 24: Development of a wound consumables scheme

The Working Group recommends that a Commonwealth-funded wound consumables scheme be developed to ensure defined patients have access to appropriate and evidence-based wound care products with reduced out-of-pocket costs. Eligible patients are those who meet the minimum eligibility requirement for, and have been assessed by a GP under the suggested new item for GP wound assessments (Recommendation 1).

To inform this scheme, further research will be required to determine cost-effectiveness (incorporating economic modelling) of certain products for which a Commonwealth-funded consumables reimbursement scheme would provide most value.

Research could for example include the following wound types or patient groups:



- Compression bandaging for venous leg ulcers.
- Consumables for non-healable wounds. These are wounds that financially disadvantage particularly vulnerable patients.
- Patients with recalcitrant lower leg ulcers (venous, arterial, or mixed).
- Patients with diabetic and neuropathic foot ulcers.
- Patients with pressure injuries.
- Patients with Surgical Site Infection (SSI) and chronic wound dehiscence.

7.2.2 Rationale for Recommendation 24

This recommendation focuses on removing barriers and ensuring adequate access to quality wound care products for patients with chronic wounds.

It is based on the following:

- A scheme for provision of consumables for a defined population is a logical way to subsidise consumable costs (31). This type of scheme can enable close control of consumables used and facilitation of best practice. It provides much better control, including an educational element, compared with a simple monetary subsidy.
- Development of this scheme will ensure patients who are unable to afford wound care consumables, or are likely to be greatly impacted by the cost of consumables, are able to access evidence-based wound care. This recommendation is in line with the principles of Medicare and the MBS Review Taskforce, providing value for the individual patient and the healthcare system, while contributing to ensuring no patient is unable to access evidence-based wound care due to cost.
- The Working Group advises that the Department of Veterans' Affairs Repatriation Pharmaceutical Benefits Scheme, which provides concessional wound dressings on prescription through pharmacy, would be an inappropriate model for a Commonwealth-funded consumables scheme due to the volume of wounds treated nationally, the potential for additional burden upon patients and overall model costs.



8. Recommendations – Current MBS items

The Wound Management Working Group reviewed recommendations from the General Surgery Clinical Committee (GSCC) and the General Practitioner and Primary Care Clinical Committee Phase 1 (GPPCCC) in regard to 13 acute wound items, with minor amendments to the recommendations of the GSCC.

The GSCC reviewed the following 12 MBS items: 30023, 30024, 30026, 30029, 30032, 30035, 30038, 30042, 30045, 30049, 30064 and 30068.

The GPPCCC reviewed the following 8 MBS items: 30026, 30029, 30032, 30035, 30038, 30042, 30045 and 30049.

Both the GPPCCC and the GSCC recommended increase in the Schedule fees of items within scope.

For in scope items, the GPPCCC stated that “provision of this service in the primary care setting is just as safe and effective as in the Emergency Department and may be more cost effective”. It also stated that “the current MBS fee for wound repair may be inadequate for financially sustainable provision of this services in the primary care setting”, prompting some practices to redirect consumers to Emergency Departments. This is consistent with the literature, suggesting that the current fees are often inadequate to cover the supplies and additional resources required in providing these services (13).

The GSCC also suggested that many wounds can be appropriately managed in primary care, with this setting being the most cost-effective option and the preference of most patients. However, that there is a financial disincentive to providing these services in primary care due to high costs and insufficient rebates.

These recommendations to increase the Schedule fees are in line with improving access to appropriate clinical best practice, as well as reducing out-of-pocket costs for the consumer and increasing value for the health system overall. The Working Group considered that the proposed new rebates fairly and accurately reflected the total cost of providing these services, which are currently undervalued in the MBS.

8.1.1 Recommendations for multiple items

The Working Group agreed with the following recommendations from the GSCC:



- Removal of the aftercare component from these items as the aftercare component of treating wounds is highly variable and not currently accounted for in the fee structure of these items. Removing this component from these items will allow for appropriate remuneration of services provided.
- Re-word the Explanatory Notes to ensure that they clearly explain that GPs can claim for a consultation in conjunction with a procedure that has not been pre-arranged. This is to remove confusion for practitioners and allow for appropriate remuneration of services provided.
- Update the Explanatory Notes to remind practitioners that a Medical Practitioner can only claim for the time they spend with the patient and not include time spent with the nurse.
- Revision of all items covering wounds on the face or neck to reflect a wound length definition of three centimetres, and retain the current length definition for wounds not on the face or neck of seven centimetres.
- Change the definition of “deeper tissue” in relevant item descriptors to “*deep tissue including fascia or muscle, but not including subcutaneous tissue*”.

8.2 Wound on the face or neck (items 30032, 30035, 30045 and 30049)

Table 4: Item introduction table for items 30032, 30035, 30045 and 30049

Item	Descriptor	Schedule fee	Services FY2017/18	Benefits FY2017/18	Services 5-year annual avg. growth
30032	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, small (not more than 7 cm long), superficial (Anaes.)	\$82.50	34,336	\$2,380,858	4.68%
30035	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, small (not more than 7 cm long), involving deeper tissue (Anaes.)	\$117.55	8,529	\$841,759	-19.31%
30045	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, large (more than 7 cm long), superficial (Anaes.)	\$117.55	1,135	\$112,277	-7.02%



Item	Descriptor	Schedule fee	Services FY2017/18	Benefits FY2017/18	Services 5-year annual avg. growth
30049	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, large (more than 7 cm long), involving deeper tissue (Anaes.)	\$185.60	585	\$81,702	-16.04%

8.2.1 Recommendation 25

The Working Group recommendations align with the recommendations of the GSCC. These recommendations are as follows:

- Items 30032 and 30045: Amend item descriptors to reflect a wound length of three centimetres rather than seven centimetres and exclude aftercare in these items.
 - Proposed item descriptors are as follows;
 - *Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, small (not more than 3cm long), superficial, excluding aftercare (Anaes.)*
 - *Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, large (more than 3cm long), superficial, excluding aftercare (Anaes.)*
- Items 30035 and 30049: Amend the item descriptors to reflect a wound length of three centimetres rather than seven centimetres, exclude aftercare in these items and define “deeper tissue” as “*deep tissue including fascia or muscle but not including subcutaneous tissue*”.
 - Proposed item descriptors are as follows:
 - *Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, small (not more than 3cm long), involving deep tissue including fascia or muscle but not including subcutaneous tissue, excluding aftercare (Anaes.)*
 - *Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, large (more than 3cm long), involving deep tissue including fascia or muscle but not including subcutaneous tissue, excluding aftercare (Anaes.)*



8.2.2 Rationale for recommendation 25

This recommendation focuses on improving access to best practice, ensuring consistency within the MBS and providing clarity to providers and patients.

It is based on the following:

- **Reduction from seven centimetres to three centimetres:** The reduction of the length of wound included in this item is important in recognising the complexity of facial wounds and the distinction between wounds on the face compared to those on the body. A seven centimetre wound on the face is very substantial and the reduction in length to three centimetres is a more accurate reflection of the clinical distinction between a small and large wound. These lengths are also consistent with the categories used for scar revisions.

The face is a cosmetically important and complex structure. Repair of even small facial wounds is significantly more complex than elsewhere on the body. The higher fee better reflects the higher degree of expertise required to perform facial surgery.

It is expected that many facial wounds greater than seven centimetres will require referral to a plastic surgeon (noting that in regional areas this may not always be possible). However, wounds greater than three centimetres are often repaired by GPs.

- **Include definition of deeper tissue in descriptors:** Currently the definition of deeper tissue referred to in these items, is defined within the Explanatory Notes TN.8.6 as “all tissues deep to but not including subcutaneous tissue such as fascia and muscle”. Defining ‘deep’ within these descriptors removes confusion and will enable practitioners to accurately claim these items.
- **Exclude aftercare:** The level of aftercare required for these wounds is inconsistent. Some wounds will require multiple subsequent attendances for aftercare, but other wounds may not require any aftercare. Sometimes the doctor performing the wound repair may perform the aftercare, sometimes this is not the case. This recommendation will allow flexibility in the provision of aftercare, in line with providing affordable and universal access to clinical best practice by reducing out-of-pocket costs and enabling clinicians to provide an appropriate level of care to each patient. This recommendation will enable appropriate reimbursement for services provided.



8.3 Wound not on the face or neck (items 30026, 30029, 30038 and 30042)

Table 5: Item introduction table for items 30026, 30029, 30038 and 30042

Item	Descriptor	Schedule fee	Services FY2017/18	Benefits FY2017/18	Services 5-year annual avg. growth
30026	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, small (not more than 7 cm long), superficial, not being a service to which another item in group t4 applies (Anaes.)	\$52.20	96,322	\$4,184,895	-4.88%
30029	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, small (not more than 7 cm long), involving deeper tissue, not being a service to which another item in group T4 applies (Anaes.)	\$90.00	26,804	\$2,015,129	1.37%
30038	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, large (more than 7 cm long), superficial, not being a service to which another item in group t4 applies (Anaes.)	\$90.00	7,939	\$594,920	-4.05%
30042	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, other than on face or neck, large (more than 7 cm long), involving deeper tissue, other than a service to which another item in group T4 applies (Anaes.)	\$185.60	4,120	\$571,430	-3.36%

8.3.1 Recommendation 26

The Working Group recommendations align with the recommendations of the GSCC. These recommendations are as follows.

- Items 30026 and 30038: Amend item descriptors to exclude aftercare.
 - Proposed item descriptors are as follows:
 - *Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, small (not*



more than 7 cm long), superficial, not being a service to which another item in group T4 applies, excluding aftercare (Anaes.)

- *Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, large (more than 7 cm long), superficial, not being a service to which another item in group T4 applies, excluding aftercare (Anaes.)*
- Items 30029 and 30042: Amend item descriptors to exclude aftercare and define deeper tissue as “*deep tissue including fascia or muscle but not including subcutaneous tissue*”.
 - Proposed item descriptors are as follows:
 - *Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, small (not more than 7cm in length), involving deep tissue including fascia or muscle but not including subcutaneous tissue, not being a service to which another item in Group T4 applies, excluding aftercare (Anaes.)*
 - *Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, other than on face or neck, large (more than 7cm in length), involving deep tissue including fascia or muscle but not including subcutaneous tissue, not being a service to which another item in Group T4 applies, excluding aftercare (Anaes.)*

8.3.2 Rationale for Recommendation 26

This recommendation focuses on improving access to best practice and providing clarity to providers and patients.

It is based on the following:

- **Include definition of deeper tissue in descriptors:** Currently the definition of deeper tissue, referred to in these items, is defined within the Explanatory Notes TN.8.6 as “all tissues deep to but not including subcutaneous tissue such as fascia and muscle”. Defining ‘deep’ within these descriptors removes confusion and will enable practitioners to accurately claim these items.
- **Exclude aftercare:** The level of aftercare required for these wounds is inconsistent. Some wounds will require multiple subsequent attendances for aftercare, but other wounds may not require any aftercare. Sometimes the doctor performing the wound repair may perform the aftercare, sometimes this is not the case. This recommendation will allow flexibility in the provision of aftercare, in line with providing affordable and universal access to clinical best practice by reducing out-of-pocket costs and enabling



clinicians to provide an appropriate level of care to each patient. This recommendation will enable appropriate reimbursement for services provided.

8.4 Wound of soft tissue (items 30023 and 30024)

Table 6: Item introduction table for items 30023 and 30024

Item	Descriptor	Schedule fee	Services FY2017/18	Benefits FY2017/18	Services 5-year annual avg. growth
30023	Wound of soft tissue, traumatic, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.)(Assist.)	\$326.05	36,308	\$6,380,500	-0.01%
30024	Wound of soft tissue, debridement of extensively infected post-surgical incision or Fournier's Gangrene, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.)	\$326.05	1,863	\$356,894	1.47%
30229	Muscle, excision of (extensive) (Anaes.)(Assist.)	\$272.95			

8.4.1 Recommendation 27

The Working Group recommendations largely align with the recommendations of the GSCC, with an additional amendment to item 30023. These recommendations are as follows.

- Item 30023: Amend the item descriptor to include foot, better describe “deeper tissue” and support appropriate use of this item, as well as excluding aftercare. The Working Group amended this recommendation slightly to include necrosis, as well as to restrict claiming of this item to one debridement per operative field. An explanatory note should be created to define degloving (traumatic stripping of the skin and subcutaneous tissue away from the deep fascia to create a flap or an undermined pocket), and clarify that the 15cm measurement refers to an averaging of diameters (as per skin cancer measurements).
 - Proposed item descriptor is as follows:
 - *Debridement and/or repair of a wound with macroscopic, visual contamination or necrosis at the time of presentation that penetrates the deep fascia or, degloving of an area greater than 15 cm in diameter, or*



involves subcutaneous muscle on the face, or exposes tendons or neurovascular structures in the hand or foot, and the procedure is being performed under general, regional anaesthesia or procedural sedation, excluding aftercare (Anaes) (Assist.)

- Item 30024: Combine item 30229 with item 30024 and amend descriptor to better describe this significantly complex procedure and current best practice. Exclude aftercare from this procedure
 - Proposed item descriptor is as follows:
 - *Necrotising infections requiring excision, under general, regional anaesthesia or procedural sedation, excluding aftercare (Anaes.) (Assist.)*
 - Increase fee to be commensurate with item 30375 (\$521.25).

8.4.2 Rationale for Recommendation 27

This recommendation focuses on improving access to appropriate clinical care, while providing clarity to providers in the appropriate use of items

It is based on the following.

- **Item 30023:** The Working Group agreed with the majority of the recommendations of the GSCC, with one amendment. The recommendations of the GSCC more accurately describe the intention of the item, will support appropriate use and reduce variability in billing for patients.

The Working Group considered both recommendations regarding item 30023 and 30024 and considered that one subset of wounds had been inadvertently excluded in the proposed recommendations. These wounds are those that have dehisced with a necrotic edge, but have not yet shown necrotising infection, therefore do not meet the requirements for either item 30023 or item 30024. Inclusion of the term necrosis in item 30023 will ensure all such types of wounds have been accounted for.

The Working Group noted cross-specialty input suggesting potentially inappropriate claiming of this item. The Working Group agreed that this item should be restricted to one claim per operative field to support appropriate care and claiming of this item. One operative field is defined by the Working Group to be one set of drapes, or one limb.

- **Item 30024:** The change in wording better aligns this item with current best practice and will clarify the procedure covered by this item. It accounts for necrotizing fasciitis, which is a life-threatening condition where any delay can result in much greater tissue loss. This procedure often requires extensive excision and laying open of tissue that can take significantly longer to perform than that covered by item 30023. The



recommended fee increase will bring the Schedule fee of this significantly complex procedure into line with a comparable emergency laparotomy.

- Exclude aftercare:** The level of aftercare required for these wounds is inconsistent. Some wounds will require multiple subsequent attendances for aftercare, but other wounds may not require any aftercare. Sometimes the doctor performing the wound repair may perform the aftercare, sometimes this is not the case. This recommendation will allow flexibility in the provision of aftercare, in line with providing affordable and universal access to clinical best practice by reducing out-of-pocket costs and enabling clinicians to provide an appropriate level of care to each patient. This recommendation will enable appropriate reimbursement for services provided.

8.5 Foreign body removal (items 30064 and 30068)

Table 7: Item introduction table for items 30064 and 30068

Item	Descriptor	Schedule fee	Services FY2017/18	Benefits FY2017/18	Services 5-year annual avg. growth
30064	Subcutaneous foreign body, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes.)	\$109.90	33,041	\$3,055,760	-21.33%
30068	Foreign body in muscle, tendon or other deep tissue, removal of, as an independent procedure (Anaes.) (Assist.)	\$276.80	4,446	\$911,975	-6.14%

8.5.1 Recommendation 28

The Working Group recommendations align with the recommendations of the GSCC. These recommendations are as follows:

- Items 30064 and 30068: Remove aftercare component from these items and retain original descriptors.
 - Proposed item descriptors are as follows:
 - Subcutaneous foreign body, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure, excluding aftercare (Anaes.)*
 - Foreign body in muscle, tendon or other deep tissue, removal of, as an independent procedure, excluding aftercare (Anaes.) (Assist.)*



8.5.2 Rationale for Recommendation 28

This recommendation focuses on ensuring affordable and universal access to appropriate best clinical practice.

It is based on the following:

- The level of aftercare required for these wounds is inconsistent. Some wounds will require multiple subsequent attendances for aftercare, but other wounds may not require any aftercare. Sometimes the doctor performing the wound repair may perform the aftercare, sometimes this is not the case. This recommendation will allow flexibility in the provision of aftercare, in line with providing affordable and universal access to clinical best practice by reducing out-of-pocket costs and enabling clinicians to provide an appropriate level of care to each patient. This recommendation will enable appropriate reimbursement for services provided.

8.6 Repair of full thickness laceration of ear, eyelid, nose or lip (item 30052)

Table 8: Item introduction table for item 30052

Item	Descriptor	Schedule fee	Services FY2017/18	Benefits FY2017/18	Services 5-year annual avg. growth
30052	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.)	\$254.00	1,502	\$299,565	3.04%

8.6.1 Recommendation 29

- Add an Explanatory Note to item 30052 to define a full thickness laceration of an ear, eyelid, nose or lip:
 - Proposed new Explanatory Note is as follows:
 - *Full thickness laceration is defined as follows: Ear lacerations are of both anterior and posterior skin and cartilage. Eyelid lacerations are of skin, cartilage and mucosa. Nasal lacerations are full thickness including lining. Lip lacerations are of skin, muscle and vermilion/mucosa*



8.6.2 Rationale for recommendation 29

This recommendation focuses on improving the MBS by better describing the intention of the item.

It is based on the following:

- MBS data shows that approximately 70% of claims of this item in FY2017/18 were claimed by GPs. As this is a complex procedure, involving all layers of the ear, eyelid, nose or lip it would be expected that the majority of services would be performed by surgical specialties. This data suggests that this item is being claimed for simple repairs of these structures, rather than the full thickness repairs, which is the intention. As such, the Working Group recommends the addition of an explanatory note defining what is classified as a full thickness laceration in these organs. This recommendation will enable practitioners to better understand the intention of the item and enable them to claim appropriately.



9. Impact statement

Both patients and clinicians are expected to benefit from these recommendations because they address concerns regarding patient safety and quality of care, and they take steps to ensure the MBS provides value to the patient and the healthcare system. Patient access to evidence-based services was considered for each recommendation. The Working Group also considered the impact of each recommendation on providers to ensure that any changes were reasonable and effectively enabled provision of sustainable wound care services in primary care, including RACFs.

This report represents a comprehensive and team-based approach to managing problems in the provision of wound care services in Australia and reflects up to date, evidence-based practice in a model easily understood and accessible to both patients and providers.

The anticipated outcomes of these changes align with the Taskforce's goals of affordable and universal access to best practice health services that provide the greatest possible value for the individual and the health system.

These changes are expected to provide both patients and clinicians with a number of benefits including:

- Reduce overall disease burden and improve health outcomes for Australians while optimising health system resources by reducing avoidable demand for acute care and repeat services for sub-optimal treatment;
- Improve patients' experience of care by addressing access to timely and affordable quality services through financially sustainable holistic medical oversight of multidisciplinary evidence-based wound management services within primary care, including RACFs;
- Inclusion of new items for wound debridement and venous compression bandaging, allowing patient access to contemporary best practice procedures;
- Development and encouraged uptake of education for healthcare providers, increasing confidence in the provision of these services and improving safety and health outcomes for patients. This will improve provider satisfaction through sustainable and meaningful work, including a quality improvement culture and opportunities for leadership;
- Removing the restriction prohibiting practitioners from charging for the cost of a wound dressing applied during a bulk-billed consultation, assisting in provision of financially



viable wound care services for providers and reducing out-of-pocket costs for patients; and,

- Development of a Commonwealth-funded wound consumables reimbursement scheme, allowing access to evidence-based care for key target groups.

This review has sought to provide patients with improved access to evidence-based wound care, for all wound types, as well as considering the financial sustainability of these services for healthcare providers. The recommended changes are also aimed at reducing out-of-pocket costs for patients. Value for the health system was given high priority by improving wound management in primary care. The changes are anticipated to reduce patient presentation to tertiary services, optimising use of health resources through careful focus and targeting of recommendations towards patients most affected by chronic wounds. These recommendations enable provision of accessible care at reduced cost to the Australian healthcare system through the appropriate and timely management of wounds which are chronic, or at risk of becoming chronic.

The Working Group believes that these changes will benefit patients by improving the value, completeness and access to evidence-based care. Clinicians will benefit from access to appropriate wound care education, rational Medicare services and an enhanced ability to offer the best care to all patients.



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11. Glossary

Term	Description
ABPI	Ankle Brachial Pressure Index
AHRG	The Allied Health Reference Group of the MBS Review
CAGR	Compound annual growth rate or the average annual growth rate over a specified time period.
Change	When referring to an item, 'change' describes when the item and/or its services will be affected by the recommendations. This could result from a range of recommendations, such as: (i) specific recommendations that affect the services provided by changing item descriptors or explanatory notes; (ii) the consolidation of item numbers; and (iii) splitting item numbers (for example, splitting the current services provided across two or more items).
CPD	Continuing Professional Development
Delete	Describes when an item is recommended for removal from the MBS and its services will no longer be provided under the MBS.
Department, The	Australian Government Department of Health
DHS	Australian Government Department of Human Services
FY	Financial year
GP	General Practitioner
GPPCCC	The General Practice and Primary Care Clinical Committee of the MBS Review
GSCC	The General Surgery Clinical Committee of the MBS Review



High-value care	Services of proven efficacy reflecting current best medical practice, or for which the potential benefit to consumers exceeds the risk and costs.
Inappropriate use / misuse	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
Low-value care	Services that evidence suggests confer no or very little benefit to consumers; or for which the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of services do not provide proportional added benefits.
MBS	Medicare Benefits Schedule
MBS item	An administrative object listed in the MBS and used for the purposes of claiming and paying Medicare benefits, consisting of an item number, service descriptor and supporting information, schedule fee and Medicare benefits.
MBS service	The actual medical consultation, procedure or test to which the relevant MBS item refers.
Misuse (of MBS item)	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
MRFF	Medical Research Future Fund
MSAC	Medical Services Advisory Committee
New service	Describes when a new service has been recommended, with a new item number. In most circumstances, new services will need to go through the MSAC. It is worth noting that implementation of the recommendation may result in more or fewer item numbers than specifically stated.
No change or leave unchanged	Describes when the services provided under these items will not be changed or affected by the recommendations. This does not rule out small changes in item descriptors (for example, references to other items, which may have changed as a result of the MBS Review or prior reviews).
NPWT	Negative pressure wound therapy



Obsolete services / items	Services that should no longer be performed as they do not represent current clinical best practice and have been superseded by superior tests or procedures.
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Network
PNIP	Practice Nurse Incentive Program
RACFs	Residential Aged Care Facilities
Services average annual growth	The average growth per year, over five years to 2014/15, in utilisation of services. Also known as the compound annual growth rate (CAGR).
SSU	Short Stay Unit
SWPE	Standardised Whole Patient Equivalent
The Working Group	The Wound Management Working Group of the MBS Review
The Taskforce	The MBS Review Taskforce
Total benefits	Total benefits paid in 2017/18 unless otherwise specified.
TCA	Team Care Arrangement
WIP	Workforce Incentive Program



Appendix A Summary for consumers

This table describes the medical service, the recommendations of the clinical experts and why the recommendations have been made.

Recommendation 1: Create a new item for the initial assessment of a wound by a general practitioner

Item	What it does	Working Group recommendation	What would be different	Why
New item	This item is for a consultation with an appropriately trained general practitioner for the initial assessment of a wound which has been present for greater than 4 weeks or is deemed at high risk of becoming chronic (not healing within the expected timeframe or is taking an extended time to heal).	Create a new item for the initial assessment of a wound which has been present for 4 weeks or is considered at high risk of becoming chronic (not healing within the expected timeframe or takes an extended time to heal).	There would be a specific item for general practitioners to claim in the initial assessment of a wound. The doctor would be required to undertake appropriate training in wound management prior to claiming this item.	Currently there is no specific item within the MBS for the management of a chronic wound. This item will ensure patients have access to evidence-based wound care, including appropriate prevention, diagnosis and treatment of wounds within an easily accessible setting. This item is intended to increase access for patients, reduce out-of-pocket costs, improve quality of life and reduce the impact of chronic wounds in Australia.



Recommendation 2: Create a new item for the review assessment of a wound by a general practitioner

Item	What it does	Working Group recommendation	What would be different	Why
New item	This item is for a follow-up consultation with an appropriately trained general practitioner for the review of a wound which has been present for greater than 4 weeks or is deemed at high risk of becoming chronic (not healing within the expected timeframe or takes an extended time to heal).	Create a new item for the review assessment of a wound which has been present for 4 weeks or is considered at high risk of becoming chronic (not healing within the expected timeframe or takes an extended time to heal).	There would be a specific item for general practitioners to claim in the review assessment of a wound. The doctor would be required to undertake appropriate training in wound management prior to claiming this item.	<p>Currently there is no specific item within the MBS for the management of a chronic wound. This item will ensure patients have access to evidence-based wound care, including appropriate prevention, diagnosis and treatment of wounds within an easily accessible setting. The review item will ensure that patients are provided with timely and appropriate wound management and early referral to a specialist wound care provider, when a wound is deemed not to be healing as expected.</p> <p>This item is intended to increase access for patients, reduce out-of-pocket costs, improve quality of life and reduce the impact of chronic wounds in Australia.</p>



Recommendation 3a: Create new items for wound management services provided by a practice nurse, Aboriginal and Torres Strait Islander Health Practitioner or appropriately trained Aboriginal Health Worker

Items	What they do	Working Group recommendation	What would be different	Why
New items	These items are for wound management services provided by a practice nurse, Aboriginal and Torres Strait Islander Health Practitioner or appropriately trained Aboriginal Health Worker.	Create new items for the provision of wound management services provided by an appropriately trained practice nurse, Aboriginal and Torres Strait Islander Health Practitioner or Aboriginal Health Worker within Aboriginal Medical Services. These items will be claimable for 4 weeks to a maximum of 10 services after the initial assessment of a chronic wound or the review assessment of the same wound.	There would be specific items for the management of a wound by appropriately trained practice nurses or Aboriginal and Torres Strait Islander Health Practitioner or Aboriginal Health Worker within Aboriginal Medical Services. One item would be for attendances lasting less than 20 minutes and one item would be for attendances lasting more than 20 minutes.	<p>Currently there is no specific incentive within the MBS for health workers to provide, and upskill in, wound management services. Block funding is available for any work performed by practice nurses within general practice; however, a gap was identified in the provision of wound care services by these qualified health care workers.</p> <p>These items will increase access for patients, reduce out-of-pocket costs, improve quality of life and reduce the impact of chronic wounds in Australia.</p>



Recommendation 3b: Uncapping and indexing the Workforce Incentive Program (WIP) in line with the MBS

Item	What it does	Working Group recommendation	What would be different	Why
N/A	The WIP provides targeted financial incentives to general practices and general practitioners. This includes the practice stream, which provides incentives for eligible general practices to engage the services of nurses, Aboriginal and Torres Strait Islander Health Workers and Health Practitioners and a range of allied health professionals.	The Working Group recommends that the WIP be uncapped in relation to practice size (measured using MBS billed care provided by all general practitioners in a practice). The Working Group also recommends that this incentive be indexed in line with the MBS.	<p>The maximum incentive under the WIP would no longer be capped at the equivalent of five full time GPs. This would mean that larger practices would receive additional funding to the maximum incentive currently available under the WIP (currently capped at the equivalent of five full time GPs).</p> <p>This incentive payment would also be indexed in line with indexation of the MBS.</p>	This recommendation aims to ensure equitable access to multidisciplinary healthcare services for patients who visit larger general practices



Recommendation 4: Include nursing care under team care arrangements

Item	What it does	Working Group recommendation	What would be different	Why
Multiple	Chronic Disease Management items, including those for undertaking team care arrangements assist GPs to develop a targeted plan to manage a patient's ongoing or chronic condition, including referrals to allied health professionals when appropriate	The Working Group recommends that practice nurses who have undertaken the additional training and credentialing (Rec 16) be considered part of the care planning team for the purpose of Team Care Arrangements	When GPs facilitate planning to develop a targeted plan to manage a patient's ongoing care needs, a GP must consult with at least two collaborating providers, each of whom provides a different kind of treatment or service to the patient. This recommendation would include practice nurses who have undertaken additional training and credentialing in wound management to be considered one of these collaborating healthcare providers.	<p>This recommendation will better assist clinicians to facilitate care planning and improve outcomes for patients with chronic wounds.</p> <p>This recommendation is expected to increase access to best practice care for patients, reduce out-of-pocket costs, improve quality of life and reduce the impact of chronic wounds in Australia.</p>


Recommendation 5: Increase the number of allied health services available under Chronic Disease Management items for those patients with chronic wounds

Item	What it does	Working Group recommendation	What would be different	Why
721 and 723	<p>GP management plans (GPMs) currently allow for a maximum of five Medicare rebateable allied health appointments.</p> <p>GP management plans aim to develop a targeted plan to manage a patient's ongoing or chronic condition. The plan can incorporate referrals to allied health services such as podiatry and dietetics, and the package can be reviewed to identify progress.</p>	<p>Increase the number of allied health appointments under Chronic Disease Management items (team care arrangements) for patients who have a Chronic Disease Management plan and whose wound has been assessed under the proposed initial or review wound assessment.</p>	<p>Access to allied health appointments would be increased for patients with a wound which has been present for 4 weeks or is considered at high risk of becoming chronic. These patients are those whose GP has undertaken an initial or review assessment of the wound, and consider additional allied health appointments appropriate.</p>	<p>This recommendation focuses on ensuring patients with chronic wounds have access to high-quality, high-value care. This recommendation would better assist healthcare providers and patients address underlying conditions and prevent the development of, or deterioration of chronic wounds.</p> <p>The Working Group identified patients with chronic wounds as those with a complex condition, likely to require more than five allied health services from a number of allied health professionals, including podiatrists, dietitians, occupational therapists, physiotherapists, and in certain situations orthotists and prosthetists.</p> <p>This recommendation will contribute towards improved wound management for patients, reducing the impact of chronic wounds of quality of life.</p>



Recommendation 6: Investigate the cost effectiveness of podiatry interventions and appliances

Item	What it does	Working Group recommendation	What would be different	Why
N/A	<p>Podiatry involves the professional care and treatment of people's feet.</p> <p>Podiatrists play a key role in the management and treatment of a number of chronic wounds associated with the foot and use various effective interventions and appliances.</p>	Investigate the cost effectiveness of podiatry interventions and appliances	Evidence would be available to guide the potential for value to the patient and the health system of certain podiatry interventions and appliances.	<p>Some podiatry appliances and interventions are funded through various sources, however this is inconsistent and the Working Group consider it appropriate for additional investigations to be undertaken to explore the cost-effectiveness of these services and products.</p> <p>This recommendation is in line with provision of accessible evidence-based wound management for patients, with reduced financial burden.</p>

**Recommendation 7: Referral when a wound is observed not to be healing adequately**

Item	What it does	Working Group recommendation	What would be different	Why
N/A	-	Improvement in a wound should be observed under current treatment, or the patient referred for expert review to a healthcare practitioner with specialised skills in wound management.	In combination with other recommendations of the Working Group, this recommendation will assist GPs and other healthcare providers to identify when a patient requires more specialised wound care or review.	<p>This recommendation will ensure patients with chronic wounds have access to timely and affordable evidence based wound management services and will improve outcomes for patients by encouraging appropriate review of initial wound diagnosis and treatment.</p> <p>This recommendation is intended to contribute towards patients receiving best practice wound management, reduced out-of-pocket costs, improved quality of life and reduced the impact of chronic wounds in Australia.</p>


Recommendation 8: Utilisation of remote and non-face-to-face services (real time or asynchronous)

Item	What it does	Working Group recommendation	What would be different	Why
N/A	Remote and non-face-to-face services (real time or asynchronous) include flexible communication, whereby patients have access to healthcare providers when unable to attend in person. This may occur at the same time, such as telehealth or video-consulting, or at a different point in time, such as secure email	Where appropriate, consideration should be given to the use of these services and an appropriate funding model investigated.	<p>Access to GPs and other healthcare providers via flexible communication will modernise the delivery of primary health care, and assist in the provision of specialised wound care.</p> <p>Although telehealth should not be a substitute for face-to-face care, this recommendation would support the use of these services when appropriate.</p>	<p>This recommendation focuses on increasing access to best practice wound management services for patients. This will particularly support those in rural and remote communities and residents in RACFs, who may be unable to attend a GP or specialist in person.</p> <p>This recommendation is consistent with the principle of equitable access and would mean that people living in rural and regional areas could avoid the costs and inconvenience associated with travelling long distances to see a healthcare provider.</p> <p>Patients living in aged care facilities would have easier access to GP and specialised wound care services that do not require face-to-face consultations.</p>



Recommendation 9: Create a new item for venous compression bandaging

Item	What it does	Working Group recommendation	What would be different	Why
New item	Venous compression bandaging is an effective and evidence-based treatment for venous leg ulcers caused by venous insufficiency by improving blood flow and reducing oedema (a collection of excess watery fluid in the tissues of the body).	Create a new item for the provision of venous compression bandaging in the management of venous leg ulcers.	There would be a specific item for appropriately trained healthcare providers to claim for applying venous compression therapy to venous leg ulcers.	<p>Currently there is no specific item within the MBS for provision of venous compression bandaging. This is an essential and evidence-based component of the management of venous leg ulcers; however, it is time-consuming and requires specific skills and often expensive consumables. Inclusion of this item will provide an incentive for practitioners to upskill in this procedure and improve access to appropriate evidence-based wound care for consumers.</p> <p>This item will increase access for patients, reduce out-of-pocket costs, improve quality of life and reduce the impact of chronic wounds in Australia.</p>



Recommendation 10: Create two new items for the debridement of macroscopically contaminated wounds using ultrasonic and simple conservative sharp or mechanical debridement techniques

Items	What they do	Working Group recommendation	What would be different	Why
New items	Debridement of a wound allows improved wound healing through the removal of contaminated material, such as dead tissue, which can slow the healing process. Debridement can be done in a GP clinic using an ultrasound machine or using sharp or mechanical techniques. These procedures may or may not require anaesthesia.	Create two new items for the debridement of wounds that can be seen to be contaminated (e.g. with dead tissue) that can be done in primary care. One item would be for ultrasonic debridement (using an ultrasound machine) and the other for simple conservative sharp or mechanical debridement. Both items would be for services taking at least 5 minutes.	There would be two new items for the debridement of macroscopically contaminated wounds by appropriately trained healthcare professionals.	Debridement of contaminated wounds can improve healing and result in better outcomes for the patient. There are currently no MBS items to reflect debridement of a wound that can be undertaken in a primary care setting (e.g. general practice). These items will enable the effective treatment of wounds within an appropriate setting and are in line with providing patients with affordable, universal and timely access to best practice wound management.


Recommendation 11: Future consideration be given to MBS items for negative pressure wound therapy

Item	What it does	Working Group recommendation	What would be different	Why
N/A	Negative pressure wound therapy (NPWT) is an advanced treatment option that has been shown to promote mechanisms that support wound healing, including increased perfusion (blood flow and delivery of oxygen) to the wound and surrounding area, reduced oedema (collection of excess watery fluid in the tissues of the body), stimulation of granulation tissue formation (new connective tissue) and reduction in exudate (fluid or ooze produced from damaged tissue) and infectious materials.	Consideration be given to the development of an MBS item for NPWT.	In the future, there would be a specific item for appropriately trained general practitioners to claim for NPWT.	<p>Currently there is no specific item within the MBS for provision of NPWT. The use of NPWT within the community setting is expanding and may warrant the development of a specific MBS item for this procedure in the future.</p> <p>This recommendation is in line with providing access to best clinical care and introducing this item will increase access for patients, reduce out-of-pocket costs by reducing healing times and improve quality of life.</p>


Recommendation 12: Include mandatory quality indicators for education and training of Residential Aged Care Facilities (RACFs) staff

Item	What it does	Working Group recommendation	What would be different	Why
N/A	This recommendation would focus on ensuring RACF staff undertake appropriate education and training in wound management.	The Working Group recommends that accreditation and monitoring processes in RACF include mandatory quality indicators for education and training of RACF staff in the management of skin injuries, chronic wounds and ulcers.	<p>RACFs staff include registered and enrolled nurses, assistants in nursing, personal care workers and Aboriginal and Torres Strait Islander health practitioners and Aboriginal health workers.</p> <p>This recommendation would ensure that every caregiver in RACFs have a basic level of education and training in appropriate prevention and management of chronic wounds and relevant skin conditions.</p>	<p>RACF staff include a number of workers who have variable experience and knowledge in appropriate wound management. It has been shown that some staff within RACF have insufficient knowledge in the principles and application of appropriate wound management and prevention.</p> <p>This recommendation would ensure that RACF staff are appropriately educated and skilled in wound management, to provide evidence-based care to residents.</p> <p>This recommendation is intended to improve the prevention and management of wounds in RACFs, thereby improving quality of life for residents.</p>


Recommendation 13: Review funding for chronic wound management in RACFs

Item	What it does	Working Group recommendation	What would be different	Why
N/A	Funding is available for residents of RACF for the management of complex wounds.	The Working Group recommends that this funding be reviewed to include both the time and personnel required, as well as the provision of appropriate consumables.	Funding is currently available for wound management in RACFs, however this funding does not take into account all aspects of best practice care. Review of this funding would enable consideration of real time variables, to account for the whole cost of managing chronic wounds in this population.	<p>This recommendation would enable provision of best practice wound management to residents of RACFs, thereby reducing the impact of chronic wounds in this population. This is likely to reduce the total costs of managing chronic wounds in this population and improve health of residents by preventing and reducing the time for wounds to heal.</p> <p>This recommendation will increase access to evidence-based care for patients, improve quality of life and reduce the impact of chronic wounds in Australia.</p>



Recommendation 14: Improve access to wound care experts in RACFs

Item	What it does	Working Group recommendation	What would be different	Why
N/A	-	The Working Group recommends improving access to wound expertise within RACFs, in line with the recommendation regarding mandatory referral (Rec 7), when appropriate.	In combination with other recommendations of the Working Group, this recommendation will help RACF staff to identify and ensure residents of RACFs have access to wound care expertise when required and without unnecessary delay.	<p>This recommendation will improve access to wound management expertise, promoting evidence based wound care, leading to improved health for patients and efficient use of health resources.</p> <p>It is important that patients have access to timely and affordable evidence based wound management services, improving outcomes for patients by assisting appropriate review of wound diagnosis and treatment.</p> <p>This recommendation is intended to contribute towards patients receiving best practice wound management, improve quality of life and reduce the impact of chronic wounds in Australia.</p>


Recommendation 15: Improve the management of patients discharged from hospitals with hospital acquired wounds

Item	What it does	Working Group recommendation	What would be different	Why
N/A	-	The Working Group recommends that work be undertaken to improve the management of patients discharged from hospitals with wounds incurred in these settings. This may include developing feedback mechanisms and/or maintaining hospital responsibility for treating these wounds, despite being discharged from hospital.	This recommendation may assist in improving continuity of care for patients, while supporting and encouraging institutions, such as private and public hospitals, to invest in prevention and timely treatment of chronic wounds.	<p>Patients will often be discharged from hospitals with new wounds, with treatment responsibility often falling to the patient or accepting health service, such as RACFs.</p> <p>Improving the management of patients being discharged from hospitals with chronic wounds (with appropriate feedback mechanisms and/or treatment responsibility) will contribute towards reducing the number of wounds developing. This will also increase accountability for hospitals when patients develop preventable chronic wounds in this setting.</p> <p>This will lead to reduced number of chronic wounds for patients, while increasing access to timely treatment.</p> <p>This recommendation is in line with reducing the financial burden on patients, improving quality of life and reducing the prevalence and impact of chronic wounds in Australia.</p>

**Recommendation 16: Development of nurse training and credentialing in wound management**

Item	What it does	Working Group recommendation	What would be different	Why
N/A	This recommendation would focus on providing appropriate wound training and credentialing to nurses.	The Working Group recommends that the Department work together with key stakeholders in the development of appropriate training for nurses and credentialing be required prior to practice nurses claiming the proposed new items.	There would be new wound management training available for nurses that will give them the credentials to be able to claim the proposed nursing items.	<p>Nurses play a critical role in the management of wounds and it is essential that nurses are appropriately skilled in providing these services. Providing training and credentialing to nurses in relation to wound management will encourage nurses to upskill, leading to improvements in wound management.</p> <p>This recommendation will improve access to best practice wound management with appropriately trained and credentialed nurses.</p>



Recommendation 17: Development of Aboriginal and Torres Strait Islander Health Practitioner and appropriately trained Aboriginal Health Worker training and credentialing in wound management

Item	What it does	Working Group recommendation	What would be different	Why
N/A	This recommendation would focus on providing appropriate wound training and credentialing to Aboriginal and Torres Strait Islander Health Practitioners and appropriately trained Aboriginal Health Workers.	The Working Group recommends that the Department work together with key stakeholders in the development of appropriate training and credentialing for Aboriginal and Torres Strait Islander Health Practitioners and appropriately trained Aboriginal Health Workers. This training and credentialing would be required prior to these healthcare providers claiming the proposed new wound treatment items within Aboriginal Medical Services.	There would be new wound management training available for Aboriginal and Torres Strait Islander Health Practitioners and appropriately trained Aboriginal Health Workers that will give them the credentials to be able to claim the proposed wound treatment items within Aboriginal Medical Services.	<p>Aboriginal and Torres Strait Islander Health Practitioners and appropriately trained Aboriginal Health Workers play a critical role in the management of wounds and it is essential that these healthcare providers are appropriately skilled in providing these services. Providing training and credentialing in relation to wound management will encourage these healthcare providers to upskill, leading to improvements in wound management.</p> <p>This recommendation will improve access to best practice wound management, within a setting that is easily accessible for patients.</p>



Recommendation 18: Development of Nurse Practitioner training and credentialing in wound management

Item	What it does	Working Group recommendation	What would be different	Why
N/A	This recommendation focusses on providing wound management training to Nurse Practitioners.	The Working Group recommends that the Department work together with key stakeholders in the development of appropriate training and credentialing for Nurse Practitioners wanting to specialise in the provision of wound management services.	There would be new wound management training available for Nurse Practitioners that will give them the credentials to specialise in wound management.	<p>Nurse Practitioners work both independently and together with other practitioners and play a critical role in the diagnosis and treatment of people of all ages with a variety of acute or chronic health conditions.</p> <p>Providing training and credentialing to Nurse Practitioners in relation to wound management will further improve wound management service and increase accessibility to high quality care for patients.</p>



Recommendation 19: Development of General Practitioner training in wound management

Item	What it does	Working Group recommendation	What would be different	Why
N/A	This recommendation focusses on providing wound management training to GPs.	The Working Group recommends that the Department work with key stakeholders in the development of appropriate training which a GP is required to undertake prior to claiming the proposed new item.	GPs will have access to wound training, in the form of a 6-8 hour training module. Completion of this training would be a mandatory requirement for claiming the wound assessment items.	<p>GPs play a critical role in the management of wounds and it is essential that they have the highest possible level of skill in wound diagnosis and management.</p> <p>At present, there is limited education provided regarding wound care during training of GPs; more advanced training will help improve GP wound management.</p> <p>This recommendation will improve access to best practice wound management, reduce out-of-pocket costs for patients and reduce the impact of wounds on a patient's quality of life.</p>

**Recommendation 20: Practice accreditation**

Item	What it does	Working Group recommendation	What would be different	Why
N/A	This recommendation will target subsidised wound care consumables to general practices who meet the current accredited standards	The Working Group recommends that subsidised wound consumables be provided only to practices accredited or registered for accreditation against the Royal Australian College of General Practitioners (RACGP) Standards for general practices.		<p>The RACGP has developed the Standards for general practices (5th edition) with the purpose of protecting patients from harm by improving the quality and safety of health services.</p> <p>With the development of a subsidised wound consumables scheme, the supply of these consumables (such as bandages and dressings) may only be made available to general practices that are accredited under these standards</p>

**Recommendation 21: Development of pharmacist education in wound management**

Item	What it does	Working Group recommendation	What would be different	Why
N/A	This recommendation focusses on providing wound management training to pharmacists.	The Working Group recommends that training be made available for pharmacists to encourage best practice wound management.	There would be new wound management training available for pharmacists to improve multidisciplinary team care in the management of wounds in the primary care setting.	<p>Community pharmacies are often the first port of call for those with a wound, therefore appropriate training is required, particularly for the management of minor wounds, product use and appropriate referral for medical assessment.</p> <p>This recommendation will improve patient access to best practice clinical care.</p>



Recommendation 22: Define and credential expert or advanced practice wound care practitioners

Item	What it does	Working Group recommendation	What would be different	Why
N/A	This recommendation focusses on defining and credentialing those healthcare providers with appropriate skills to provide an expert, specialised wound care service.	<p>The Working Group recommends that the Department work with key stakeholders to define and appropriately credential expert or advanced practice wound care practitioners.</p> <p>The Working Group also highlights the important role Primary Health Networks can play in assisting GPs to determine appropriate specialised wound care providers to refer to, including in the development of referral pathways.</p>	<p>Healthcare providers who have skills and expertise to provide an expert wound management service would be defined and an appropriate credentialing pathway determined for those wanting to specialise in providing this service.</p> <p>Primary care providers would be able to easily identify those practitioners with appropriate skills to provide a recognised expert wound care service.</p>	<p>This recommendation will improve access to wound management expertise, promoting evidence based wound care and leading to improved health for patients and efficient use of health resources.</p> <p>This recommendation would also encourage those providers with an interest in wound management to upskill in order to provide this specialised service to patients.</p> <p>It is important that patients have access to timely and affordable evidence based wound management services, improving outcomes for patients by assisting appropriate review of wound diagnosis and treatment.</p> <p>This recommendation is intended to contribute towards patients receiving best practice wound management, reduce out-of-pocket costs, improve quality of life and reduce the impact of chronic wounds in Australia.</p>


Recommendation 23: Remove bulk-billing restriction on charging the cost of wound care consumables to patients

Item	What it does	Working Group recommendation	What would be different	Why
N/A	<p>This recommendation focuses on introducing an exemption to the restriction prohibiting practitioners from charging for the cost of a wound dressing applied during a bulk-billed consultation (when your doctor bills Medicare directly and accepts the Medicare benefit as full payment for their service resulting in no out-of-pocket expenses for the patient).</p>	<p>The Working Group recommends introducing an exemption to the restriction prohibiting practitioners from charging for the reasonable cost of a wound dressing applied during a bulk-billed consultation and recommends that the fee charged to the patient can only be for products used in the treatment of the wound.</p> <p>An Explanatory Note should be created clarifying that wound care products cannot be billed in advance of treatment.</p>	<p>This recommendation would enable practitioners to bulk-bill an attendance item and charge the patient the reasonable cost of wound care consumables (such as bandages and dressings).</p>	<p>Where attendance is bulk billed and a wound dressing is required, it can lead to less than optimal dressing selections, sending patients to the pharmacy for more expensive dressings, or the GP absorbing the sometimes large cost. One alternative is to not bulk bill the service, which can result in increased out-of-pocket costs for the patient.</p> <p>Introducing the recommended exemption will assist in the sustainable provision of wound care services within general practices and will reduce out-of-pocket costs and inconvenience for patients, by assisting in the provision of a financially viable wound care service, thereby increasing patient access.</p>


Recommendation 24: Develop a scheme to subsidise the cost of wound care consumables for specific patient groups

Item	What it does	Working Group recommendation	What would be different	Why
N/A	This recommendation focuses on developing a scheme to subsidise the cost of wound care consumables (e.g. dressings) to patients with a chronic wound.	<p>The Working Group recommends development of a Commonwealth-funded wound consumables scheme for patients with a chronic wound.</p> <p>To help inform implementation of this scheme, the Working Group recommends further research be conducted to identify wound types for which a consumables scheme would be most valuable, and which products should be subsidised</p>	The cost of wound care consumables would be subsidised for patients with a chronic wound.	<p>Development of the scheme will ensure patients who are unable to afford wound care consumables, or are likely to be greatly impacted by the cost of consumables, are able to access evidence-based wound care.</p> <p>This recommendation is in line with providing value for the individual patient and the healthcare system, while contributing to ensuring no patient is unable to access evidence-based wound care due to cost.</p>



Recommendation 25: Revise the descriptors for items for the repair of wounds on the face or neck to reflect a wound length of 3cm, exclude aftercare from the items and revise the definition of “deeper tissue”

Items	What they do	Working Group recommendation	What would be different	Why
30032, 30045, 30035 and 30049	These items are for the surgical repair of wounds on the face or neck.	<p>Revise the descriptors so the items can be used for repair of wounds more than 3cm long and so the items do not include the aftercare associated with the procedure. Additionally, the Working Group recommends the definition of “deeper tissue” be revised.</p> <p>This recommendation aligns with that of the GSCC.</p>	The items could be used for repairing wounds more than 3cm long instead of only those more than 7cm long. Aftercare would no longer be included in the items. Additionally, the definition of deeper tissue would be revised to include fascia or muscle but not the fatty tissue under the skin.	<p>Changing the length of the wound is aimed at better accommodating the size of the majority of wounds on the face and neck. Allowing the repair of wounds longer than 3cm to be claimed under the items better reflects the additional complexity associated with wounds in these areas.</p> <p>Removing aftercare from the items is intended to remunerate more appropriately for the procedure. Revising the definition of “deeper tissue” serves to clarify the services provided under these items.</p>



Recommendation 26: Revise the descriptors for items for repair of wounds not on the face or neck to exclude aftercare from the items and revise the definition of “deeper tissue”

Items	What they do	Working Group recommendation	What would be different	Why
30026, 30038, 30029 and 30042	These items are for the surgical repair of wounds not on the face or neck.	<p>Revise the descriptors so the items do not include the aftercare associated with the procedure. Additionally, the Working Group recommends the definition of “deeper tissue” be revised.</p> <p>This recommendation aligns with that of the GSCC.</p>	Aftercare would no longer be included in the items. Additionally, the definition of deeper tissue would be revised to include fascia or muscle but not the fatty tissue under the skin.	Removing aftercare from the items is intended to remunerate more appropriately for the procedure. Revising the definition of “deeper tissue” serves to clarify the services provided under these items.



Recommendation 27: Revise the descriptors for items for the surgical management of more extensive wounds to better reflect the service and exclude aftercare from the items

Items	What they do	Working Group recommendation	What would be different	Why
30023, 30024 and 30229	These items are for the surgical repair of more extensive wounds that are traumatic, extensively contaminated or involve the extensive excision of muscle.	<p>Revise the descriptor for item 30023 to include necrosis as an indication for the procedure and allow the items to include wounds on the foot. Restrict claiming of this item to once per operative field.</p> <p>Combine items 30229 and 30024, revise the descriptor for the item to better reflect current best practice and increase the fee for the new item.</p> <p>The Working Group recommends aftercare be excluded from the items.</p> <p>This recommendation largely aligns with that of the GSCC.</p>	<p>The descriptor for item 30023 would be revised to include necrosis as an indication and allow repair of a wound on the foot. This item would also be restricted to be claimed once per operative field.</p> <p>Items 30229 and 30024 would be combined into one item with a new descriptor and a higher fee.</p> <p>Aftercare would be excluded from both items.</p>	<p>Revising the descriptor for the items will clarify when it is appropriate to claim the items and better reflect current best practice. Combining items 30229 and 30024 serves to simplify the MBS and the increased fee will better reflect the complexity of the procedure.</p> <p>Removing aftercare from the items is intended to remunerate more appropriately for the procedure.</p>


Recommendation 28: Remove aftercare from the items for removal of a foreign body

Items	What they do	Committee recommendation	What would be different	Why
30064 and 30068	These items are for the removal of a foreign body from under the skin or deeper tissue (e.g. from a tendon or muscle).	Remove aftercare from the items but leave the descriptors otherwise unchanged. This recommendation aligns with that of the GSCC.	The items would exclude the aftercare associated with performing the procedure but would otherwise remain unchanged.	The descriptors for these items reflect current best practice and appropriately describe the service. However, removing aftercare from the items is intended to remunerate more appropriately for the procedure.

Recommendation 29: Add an Explanatory Note for the item for repair of a full thickness laceration of an ear, eyelid, nose or lip to better describe the procedure

Item	What it does	Committee recommendation	What would be different	Why
30052	This item is for the repair of a full thickness laceration of an ear, eyelid, nose or lip.	Add an Explanatory Note to the item to define what is meant by a “full thickness” laceration of the ear, eyelid, nose or lip.	The item would have an Explanatory Note to define what is meant by a “full thickness” laceration of the ear, eyelid, nose or lip.	The addition of an Explanatory Note is intended to clarify when it is appropriate to claim the item.



Appendix B Proposed descriptor for new item for GP initial assessment of wound and relevant clinical assessments for initial and subsequent assessments

Table 9: Proposed descriptor for new item for initial assessment of a wound by a general practitioner

Item	Descriptor
New Item	<p>Initial professional attendance for a comprehensive wound assessment by a general practitioner (who has undertaken wound care skills training) at consulting rooms lasting at least 20 minutes and which should include:</p> <ul style="list-style-type: none"> (a) collection of relevant information, including current medications, allergies, past medical history and taking a patient history aimed at identifying risk factors for delayed wound healing. Also a history of the wound itself such as mechanism, duration and symptoms; (b) a physical examination, which must include recording of wound characteristics and size, vascular assessment, presence or absence of infection, oedema, skin disease or neurological impairment; (c) where appropriate a functional, psychosocial, nutritional and/or quality of life assessments should be undertaken; (d) establish an appropriate diagnosis of wound, including aetiology where possible; (e) developing a management plan for appropriate treatment of the wound and any identified risk factors; (f) initiating investigation, management and referrals as necessary; (g) providing the patient with relevant health care advice and information, including prevention and modifiable lifestyle factors where possible; <p>with appropriate documentation</p>

In order to claim the proposed new GP initial assessment of a wound and review items a GP should undertake relevant assessments, such as the following:

Domain	Core Data Set items (93) (94) (95) (96) (97) (98) (99) (100)
General Health Information	Risk factors for delayed healing (systemic and local blood supply to the wound, susceptibility to infection, medication affecting wound healing, skin integrity)
	Co-morbid conditions



Domain	Core Data Set items (93) (94) (95) (96) (97) (98) (99) (100)
Wound: baseline information	Allergies or skin sensitivities
	Impact of the wound on quality of life (physical, social and emotional)
	Number of wounds and wound location
	Wound type/classification
	Wound duration
	Treatment aim / goals of care <ul style="list-style-type: none"> ○ Healable, non-healable, maintenance (51) ○ Short term goals of care <ul style="list-style-type: none"> ▪ Haemostasis, Bacterial balance, Moisture balance ▪ Debridement ○ Long term goals of care ○ Wound healing, Wound maintenance, Patient comfort ○ Functionality
	Planned reassessment date
Wound assessment parameters	Wound size (maximum length, width and depth)
	Undermining/tunnelling/sinus/fistula/cavity
	Category/classification <ul style="list-style-type: none"> ○ Pressure injury ○ Skin Tears ○ Burns ○ Tissue loss: superficial/partial thickness/ full thickness
	Wound Bed tissue type <ul style="list-style-type: none"> ○ Necrotic/eschar/sloughy/granulating /epithelializing ○ Hypergranulation ○ Exposed structures
	Wound bed tissue amount (expressed as a % of wound size)
	Description of wound margins/edges <ul style="list-style-type: none"> ○ Rolled / raised ○ Macerated ○ Dehydration/desiccation ○ Shape – linear/round/irregular
	Colour and condition of per-wound skin <ul style="list-style-type: none"> ○ Intact / fragile ○ Skin temperature (cooler, warmer, hot) in comparison opposite anatomical site ○ Sensory loss (such as via a simple two pinpoint discrimination test) ○ Oedema / induration ○ Dry or moist to touch ○ Maceration/excoriation ○ Hyperkeratosis ○ Callus ○ Eczema



Domain	Core Data Set items (93) (94) (95) (96) (97) (98) (99) (100)
	Foot Assessment or Neurovascular Assessment of the Foot <ul style="list-style-type: none"> ○ Sensory perception of the foot (such as use of a 10gm Semmes Weinstein monofilament, at least 4 spots identified)
Wound symptoms	Presence of wound pain - Application of pain scale
	Wound pain frequency/severity
	Exudate: Amount/ consistency/type/colour/ malodour
	Signs of infection <ul style="list-style-type: none"> ○ Localised/spreading/systemic (Cellulitis) (68)
	Whether a biopsy has been taken
	Functionality: Retained/impaired
Specialists	Vascular studies e.g Duplex ultrasound or hand held Doppler Ankle Brachial Pressure Indices
	Referrals <ul style="list-style-type: none"> ○ Wound specialists (medical/nursing) ○ Podiatry (Advanced Practice High Risk Foot) ○ Endocrinologist ○ Dietician ○ Infectious disease specialist



Appendix C Proposed descriptor for new items for wound management services provided by a practice nurse, Aboriginal and Torres Strait Islander Health Practitioner or appropriately trained Aboriginal Health Worker within Aboriginal Medical Services

Table 10: Proposed descriptor for new items for wound management services provided by a practice nurse, Aboriginal and Torres Strait Islander Health Practitioner or appropriately trained Aboriginal Health Worker within Aboriginal Medical Services

Item	Descriptor
New Item	<p>Treatment of a person's wound (other than normal aftercare) provided by a practice nurse, Aboriginal and Torres Strait Islander Health Practitioner or appropriately trained Aboriginal Health Worker within Aboriginal Medical Services, if:</p> <ul style="list-style-type: none"> (a) the treatment is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the person is treated within a general practice setting; and (c) the supervising medical practitioner has undertaken and claimed an initial wound assessment; and (d) the treatment is under 20 minutes in duration <p>This item is claimable for up to 10 services or up to 4 weeks subsequent to the initial assessment or review by the supervising medical practitioner (items XX or XX)</p>
New Item	<p>Treatment of a person's wound (other than normal aftercare) provided by a practice nurse Aboriginal and Torres Strait Islander Health Practitioner or appropriately trained Aboriginal Health Worker within Aboriginal Medical Services, if:</p> <ul style="list-style-type: none"> (a) the treatment is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the person is treated within a general practice setting; and (c) the supervising medical practitioner has undertaken and claimed an initial wound assessment; and (d) the treatment is over 20 minutes in duration <p>This item is claimable for up to 10 services or up to 4 weeks subsequent to the initial assessment or review by a medical practitioner (items XX or XX)</p>