General practice and primary care: making a difference at the coalface of wound management in Australia

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ABSTRACT

Over one third of Australia's medical workforce works at the primary care level in the General Practice setting[1]. This large component of the work force is the gate keeper for our medical system and is ideally placed to provide best evidence management to patients suffering Venous Leg Ulcers [VLUs] to improve patient well being while healing the wound.

Primary care in general has the potential to achieve the goal of reducing the incidence of VLUs by 50% in 10 years. There are many challenges to achieving this goal which will be explored in this paper with suggested actions to maximise this potential.

GENERAL PRACTICE AND PRIMARY CARE

General practice is central to our primary health care system and provides the point of access for patients into a system that is one of the most effective ways to deliver health services to people with chronic wounds.

In the role of gatekeeper general practice has a profound influence on both health outcomes and health expenditures. The role of the GP is becoming increasingly important as the population ages with the consequent increase in the burden of chronic disease.

GPs understand and accept their responsibility in the primary care system, perceiving themselves to be the central co-coordinator for patient care as Wiese *et al* reported[2].

One needs to remain aware that general practice differs from specialist care in that it deals with more with problem complexes rather than with established diseases[3].

VLUs are the most common chronic wound problem seen in general practice and GPs are involved in the diagnosis and management of over 90% of VLUs[4,5].

The complexity of VLUs require accurate diagnosis, assessment and management which are well within the scope of the well trained GP. GPs can also provide cost effective management through referral to specialists, pathology, diagnostics, the public and private hospital systems and utilise the long standing collaboration with community nursing, aged care and allied health.

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GENERAL PRACTICE NURSES

With the emphasis upon chronic disease management in recent times there has developed a growing and vital role for the general practice nurse (GPN). The number of GPNs has grown over the years. In 2012 it was estimated that 63.5% of all general practices employed a nurse, with a total of 10,693 nurses, an increase from 2009 of 20%. In practices employing a nurse there is an estimated average of 2.7 nurses per practice[6].

As GPN numbers grow, the role of the practice nurse is expanding. An Australian study described six roles of nurses in general practice: patient carer, organiser, quality controller, problem solver, educator and agent of connectivity[7].

The *General Practice Nurse National Survey Report*[8] reported individual tasks undertaken by nurses. Two of the five most frequent clinical tasks undertaken by nurses involved wounds:

- Wound management — 93.1%
- Assistance with minor surgical procedures — 86%

The future will most likely see fostering of the nurse's roles and broadening of their tasks, especially within wound management.

MEDICARE LOCALS

Medicare locals (MLs) are regional primary health care organisations playing a key role in planning and coordinating primary health care services. MLs are evidence that Australia's health system is being recalibrated by shifting the emphasis of care from the hospital sector and placing it more towards the primary health care sector. MLs are working with primary health care professionals, to introduce new models of health care delivery through expanded multidisciplinary health care teams. More specifically, they can play a major role in enhancing wound management in primary care[9].

GP-SUPPORTING ORGANISATIONS

There is a wide range of organisations that support general practice in Australia. There are several major bodies, whose support and collaboration to lobby government is essential for major changes to occur with VLU management, and these are:

- The Australian Medical Association (AMA) is the peak medical organisation in Australia representing the profession's interests to government and the wider community.
- The Royal Australian College of General Practitioners (RACGP) which is committed to ensuring high-quality clinical practice, education and research for Australian general practice.
- The Rural Doctors Association of Australia (RDAA) which advocates for quality medical care for Australians living in rural and remote communities and on behalf of practitioners working in those areas.

THE CHALLENGES TO PRIMARY CARE WOUND MANAGEMENT

Despite the many advances in the understanding of wound healing, the growing research, the many new products and devices and the capacity of primary care to deal with chronic disease, many Australians are not given an opportunity to improve their wellbeing and are thus left suffering from wounds for many months or years. There are three main challenges in primary care that need to be addressed to correct this:

1. Increase wound awareness in community, government, and the medical profession
2. Educate GPs and GPNs to improve the practice of evidence-based wound management
3. Facilitate financial support of all aspects of wound management on a national level.

WOUND AWARENESS: THE HUMAN AND FINANCIAL COST

The morbidity caused by VLUs and the impact on society's most vulnerable, the elderly and those in the lower socio-economic community, does not seem to have made a great impact with the general public, governments, and even the medical profession at large. At this time of "Closing the Gap" Aboriginal peoples and Torres Strait Islander peoples, in particular, must be considered as they generally suffer a disproportionate burden of illness and social disadvantage when compared with the general population.

EVIDENCE-BASED WOUND MANAGEMENT: EDUCATION AND EXPERTISE

Wound management education starts poorly at medical schools[10] and then fails to grab any momentum right through to graduation and beyond. GPs acknowledge wound management is a knowledge and skill gap and many have a lack of confidence managing wounds[11]. GPs have to rely upon continuing medical education (CME) to upskill themselves. With the plethora of medical problems facing GPs[12],

wound management is not always on their agenda. Outside formal CME activities, access to guidelines, pathways and education resources is limited and fragmented[13]. In particular, with VLUs and mixed arterial/VLUs, GPs have identified particular areas of weakness in:

- performing ABPIs
- using compression therapy
- knowledge of wound products, pharmaceuticals, and devices[11].

Compression therapy is not performed in general practice as frequently as evidence-based medicine advises[14-16]. A report by Finlayson *et al.* reported only 11% of patients presenting with a VLU to two specialised wound clinics had any form of compression therapy in the previous 12 months[5].

Despite nurses taking an increasing role in wound management in general practices, Weller *et al.* reported knowledge of VLU management is suboptimal and current practice does not comply with evidence-based management guidelines[17]. Some possible solutions may be forthcoming with:

- the Wound CRC education project and the development of the Wound Education Hub, a plan for effective delivery of wound management education and training to medical and nursing students, providers and patients
- the development of a national curriculum for all Australian medical and nursing schools
- implementation in clinical practice of published VLU guidelines and pathways[16].

ACCESS TO SPECIALISED WOUND CLINICS AND PROVIDERS

In many areas of Australia there are problems with the availability and accessibility of specialised wound management clinics and providers. There is a lack of knowledge of specialised clinics and providers, no credentialling system to recognise specialisation outside of wound nurse practitioners and vascular surgeons, difficulties of geographical location, and an inability to afford the services and ongoing care, all of which contribute to a lack of specialised support for VLU patients and their primary providers. Even if accessible, there can be a reluctance for primary providers to refer even when a need is identified[17]. For those practising in rural and remote areas, the answer may lie in teleconferencing[18]. VLU management can be enhanced by:

- promoting the message that referring for specialised management will assist healing[5,16]
- secondary-level speciality clinics run by appropriately trained GPs and/or nurses that have the potential to fill referral gaps in the community, break down GPs' reluctance to refer, provide education, and encourage evidence-based management
- credentialling and maintaining a database of clinics and wound providers
- Department of Health (DOH) changing the definition of "specialist" to recognise wound nurse practitioners and other wound specialists to allow Medicare billing for teleconferencing.

FINANCIAL BURDEN OF VLU MANAGEMENT

General practice is a private business. The major financiers are DOH, the Department of Veterans' Affairs (DVA), the patient and the practice itself. GPs have to use the item numbers available to them through the consultation and investigation process and through chronic disease management. Despite no direct funding for a wound procedure there are specific item numbers for chronic disease management (CDM) care plans that are an ideal Medicare-funded process to enhance the whole-care approach to patients suffering from a VLU[19]. Of equal importance, care plans can be used to identify patients at risk and prevent VLUs. Care plans use the training of the GP and nurse to provide general medical advice to the patient and specifically give advice about skin care, compression garments, and calf muscle exercises. They also allow referral to allied health professionals.

Lateral thinking by general practices with the use of care plans have the potential to be extremely effective in reducing the incidence of VLUs in 10 years' time.

The impact of the Practice Nurse Incentive Payment (PNIP) implemented in 2012 remains to be seen. It was aimed to assist practices to employ more nurses and "consolidate practice funding arrangements into a simplified, single funding stream" and "support an expanded and enhanced role for nurses in general practice". However, the use of the nurses is entirely up to the practice and not necessarily to provide wound procedures. In Whitlock *et al.*'s study[20] on wound management costs in general practice, the nurses reported they had a reduced role in wound management compared with that under the previous fee-for-service arrangements (item 10996). When fully evaluated next year it will be interesting to see if wound management has been enhanced.

The wound procedure still remains the costly process to general practices. A dilemma arises frequently for non-DVA patients about who pays for the dressings and products. Does the practice absorb the cost? Does the patient buy the dressing? In Whitlock *et al.*'s study the total cost of care was greater than the total income and patients only paid for dressings in 3.6% of occasions[20].

Unfortunately, a ruling from DOH complicates the funding of dressing costs. A general practice is not allowed to charge for a dressing if the consultation is bulk billed. The irony of this is that this rule does not apply with vaccinations. If most patients with a VLU are over 65 years old and in a lower socio-economic group, most GPs will probably be inclined to bulk bill the consultation/dressing. However, if the practice has to absorb the cost, then it is unlikely modern, more effective, though more expensive dressings will be used, including compression products. Using cheaper dressings and particularly avoiding compression products will not support the delivery of best practice wound management.

VLU management can be enhanced now by:

- encouraging practices to use the PNIP to enhance use of the nurse in wound management
- making good use of care planning in treatment and prevention
- a change of policy from DOH regarding bulk billing and payment of products
- private health funds providing more support for outpatient wound management.

In the future, care of people with VLUs would be fostered by:

- specific Medicare item number for wound management
- recognition of 'woundology' as a specialty to allow teleconference billing
- national subsidy scheme for reimbursement of compression therapies and products.

CONCLUSION

Reducing the incidence of VLU by 50% in 10 years will have untold benefits for patients and our health system. The future of chronic disease management lies in the hands of primary care, of which general practice is central. VLUs are complex, chronic problems commonly managed in the everyday life of a general practice. General practice and primary care are at the coalface of VLU diagnosis and management and the onus falls on general practice to go beyond its already effective role in chronic disease and deal effectively with the problem of VLUs. This can be done by addressing the challenging areas of wound awareness, education and expertise, and financial costs. Many individuals involved with managing VLUs, and organisations such as the AWMA and the Wound Co-operative Research Centre, are already at work addressing the challenges. The call from primary care and patients is for understanding, collaboration and commitment from other influential bodies such as the medical organisations and DOH to assist in making significant change.

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