AUSTRALASIAN
MEDICAL SERVICES COALITION

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Professor Paul Kelly,
Chief Medical Officer,
Department of Health.

4th January 2021

Dear Professor Kelly,

Re: Paradigm Shift to New COVID-19 Normal & Prioritised Testing for Vulnerable Groups

Australasian Medical Services Coalition Ltd (AMSC) is a non-profit organisation supporting all health professionals, and advocates for minority and disadvantaged groups. We represent all 15 Ahpra-registered professions and Medicare Australia-recognised healthcare professional groups. AMSC's mission is to support ethnically diverse populations by delivering strong health outcomes. AMSC and its members have been supporting various communities in NSW through its medical and allied health platforms. More information about AMSC is available from our website: www.amsc.org.au

We recognise the enormous pressure regarding the current lack of resources in testing and wish to offer our assistance in this time of need.

We consider that there needs to be a paradigm shift to the triage of resources in the new COVID-19 standard healthcare setting.

With the change in the definition of close contacts and reduction in quarantine/isolation requirements, there will be a significant reduction in the daily PCR testing requirements but a corresponding increase in rapid antigen testing (RAT) requirement for work clearance. We anticipate the lack of availability of both types of test kits in the short term. There are currently long queues, and testing centres turn patients away due to limited resources and large numbers of people presenting.

As such, vulnerable groups at higher risk of contracting COVID-19 and getting sicker from it will have difficulty accessing testing services during these trying times and delay treatment, resulting in higher morbidity.

After extensive discussion with many of our frontline doctor members who are keen to contribute actionable solutions, AMSC proposes the following for consideration in the transition to the new model:

1. GPs / Specialist GPs who are familiar with patient history are in the best position to triage patients.

This is further aided by the risk stratification already utilised in the national COVID-19 vaccine rollout. Patients also have easier access to their own doctor for advice. High-risk patients (see 2.) will be referred for testing, while mild cases will be reassured and managed directly, preserving resources for those in need.

2. Consideration for specialised home collection services:

For patients who are at high risk (elderly over 65 years of age, immunocompromised, chronic disease sufferers, pregnant, unvaccinated, socially disadvantaged, including those who are unable to afford RAT or unable to leave the house) and highly suspicious of testing positive, we recommend direct provision and home visit collection of PCR test kits via the pathology provider specifically prioritised for URGENT testing.

This has been trialled in a limited and serendipitous outpatient capacity out of necessity, with a 100% yield on PCR test results (see attached DHM letter). It is an extension of existing home pathology services, which will greatly increase test yield and reduce transmission risk.

This model will also reduce the probability of a positive case standing in queue for hours and potentially spreading the disease. Furthermore, the patient may be turned away if tests are not available or subject to batch or delayed testing due to the number of tests performed. In many cases, vulnerable groups may skip testing altogether due to difficulty of access and have higher morbidity or transmit the disease further to other vulnerable groups.

3. Where PCR testing is not indicated but patients are still vulnerable or socially disadvantaged (e.g., pensioner) and unable to afford RAT, RATs can be provided through local respiratory centres or pathology collection centres based on a referral provided by the patient's

usual GP (the definition of usual GP can be the one that is defined for items 721-732: “The patient's "usual GP" means the GP, or a GP working in the medical practice, who has provided the majority of care to the patient over the previous twelve months and/or will be providing the majority of GP services to the patient over the next twelve months. The term "usual GP" would not generally apply to a practice that provides only one specific CDM service”). Positive RATs can then be progressed to urgent PCRs with direct notification to DOH if positive.

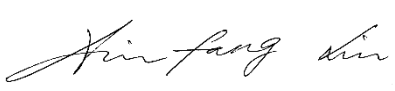
Furthermore, under this new proposed model, COVID-19 testing can be performed only with a GP referral (whether by telehealth or in-person consults) for all patients as pop-up PCR test centres are eventually phased out. It will work in synergy with accessing emergency services if acute clinical deterioration occurs.

This closes the gap for GPs currently not having medical records of patients who test positive independently, are treated in hospital and require further outpatient follow-up, which can then be handed back to GPs, thus reducing workload for the DOH. In most cases requiring only outpatient treatment, the results will be available directly to the GP, who will manage the patient at home.

In the transition period to this model, the above recommended model of having GP referrals for COVID-19 testing can be trialled by having priority access to pathology laboratories for urgent cases mentioned in point 1 above.

We anticipate that these services will require new Medicare item numbers.
AMSC sincerely hopes that these suggestions are of assistance as they are based on the experiences of frontline healthcare workers. We are happy to have an in-depth discussion on the practical aspects of the proposal if it is of merit to the DOH.

Kind Regards,



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