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GP Clinics and Hospital Emergency Departments

Introduction

The Victorian state government is concerned about the increasing demands on public hospitals, which are reported to be growing consistently at 3-4% per annum, both in Victoria and other states. (Emergency admissions for 12 metropolitan Melbourne major hospitals are increasing at higher rates of 7-8% per annum).[1]

The Department of Human Services (DHS) has allocated the Hospital Demand Management (HDM) strategy $582 million over 4 years ($125 million in 2001-02), to develop and implement targeted strategies to tackle the problems of access to emergency and elective services – in particular for emergency services in the major metropolitan hospitals.[2] One component of the HDM strategy is the Hospital Admissions Risk Program (HARP) with an allocation of $150 million over 4 years. HARP aims to avoid unnecessary use of emergency departments (EDs) and inpatient services in the hospitals involved in the HDM strategy, through implementing models of care that better manage emergency presentations and emergency admissions to public hospitals. Alternative models involve the hospital and the community.[3] Although the HDM and HARP strategies mainly target the major hospitals in metropolitan areas with emergency departments, HARP funding was also provided in 2001-02 to four regional hospitals: the Bendigo, Ballarat, LaTrobe Valley and Goulburn Valley Hospitals.

DHS is not prescriptive about particular strategies to be funded. The department produced a background paper as a first step in building an evidence base around emergency demand focused preventive initiatives. The paper outlines the HARP strategy and, among other things, provides broad description and overviews of relevant literature reviews. One of the strategies outlined in the paper is the establishment of GP clinics in or beside hospital emergency departments. GPDV board has grave concerns about this particular strategy, unless they operate only on an after-hours basis.

GPDV's concerns about the establishment of GP clinics in or beside hospital emergency departments relate to:

- encouraging consumer behaviour which may ultimately increase hospital demand;
- the evidence of effectiveness of hospital-based GP clinics.

GPDV board invites comments from divisions on GP clinics, or more general GP/hospital coordination issues. Contact Louise Willis (03 9341 5208; l.willis@gpdv.com.au) or Lenora Lippmann (03 9341 5114; l.lippmann@gpdv.com.au).

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[1] Emergency Demand Coordination Group, Department of Human Services, March 2002, *Hospital Admission Risk Program (HARP) Background Paper.* Available at www.health.vic.gov.au/hdms/harpbgpap.pdf , p.9.
[2] *Hospital Demand Management Strategy*, www.health.vic.gov.au/hdms/hdmstrat.htm , accessed April 2002.
[3] *HARP Background Paper*, p.12.

GP/hospital strategies in HARP

The HARP background paper lists some types of initiatives that promote greater integration of GPs and hospital services, drawing on literature reviews about GPs and hospitals[4]. These include:

- working partnerships between GPs and hospitals
- broad prevention of acute care (through shared care of people with chronic illness and case management etc.)
- managing transitions of care (through discharge planning, communication etc.)
- shifting care (through GP involvement in ambulatory care programs; after-hours care; GP involvement in EDs etc).

The paper suggests that although evidence about effectiveness of these strategies is not conclusive, it is worth promoting these initiatives with the aim of contributing to a body of evidence that will indicate their efficacy.

GPDV believes that although this is true for most of the strategies listed, the establishment of GP clinics in EDs is an exception.

Encouraging consumer behaviour which has the potential to increase hospital demand

In the context of after-hours primary medical care, it is widely accepted that services should include a process for sending a summary of the after-hours consultation to the usual GP (where the patient has one) and referring the individual back to the usual GP where appropriate. The aim of this process is to increase the continuity (and thereby quality) of care, but it also reinforces the notion that a general practice setting is the appropriate place to seek primary medical care. Pressure on hospitals increases when people see hospital emergency departments as their first port of call whenever they need medical care.

Establishing a GP clinic in or beside a hospital emergency department could appear an attractive option, as it seems to offer the promise of diverting patients who require general practice services and "mistakenly" present to ED, to the general practice where they are thought to belong. However, to the person presenting, there may be little apparent difference between the ED or a GP clinic that operates alongside it. The existence of a GP clinic is likely to undermine the message that a hospital is **not** the place to seek primary care medical services, and may actually encourage the public in the long term to seek out hospital-based services.

Evidence of effectiveness of GP clinics

The current Commonwealth Request For Tender for a stocktake of the general practice/emergency department interface may provide valuable information on what models and practices are likely to be effective. The successful tenderer is expected to report by mid-August this year.[5]

The draft HARP background paper states that there is good supporting evidence for the strategy of "GPs in emergency departments." (It is worth noting that while GPs may make

[4] Section 4.1.5, *The GP/hospital interface.* The section draws especially on Centre for General Practice Integration Studies, 2001, *GP-hospital integration: what have we learnt*?
[5] RFT – 119/0102. See www.health.gov.au/tenders.htm for more information.

fewer admissions, and order fewer tests, than junior hospital staff in EDs, the presence of senior staff in EDs also tends to reduce admissions.[6]) While discussing GPs working in emergency departments, the paper also discusses the establishment in Victoria of GP clinics beside Emergency Departments, as though this diversion is part of the same strategy.[7] It is important not to conflate these two different strategies. Establishing a GP clinic that operates in or near a hospital, with different funding and billing arrangements is not the same thing as altering staffing arrangements in Emergency Departments. The supporting evidence in the background paper appears to be evidence for the latter, rather than the former.

It is also important that policy makers realise that identifying those ED patients who might appropriately be diverted to a primary care setting is more complex than simply sending all triage category 4 and 5 patients to a GP. For one thing, some of these patients still require admission. One study suggests that 10% of cases deemed 'GP substitutable' actually required hospitalisation.[8] The DHS background paper says:

> *In Victoria, some metropolitan health services have made arrangements with GP groups to set up general practice clinics near the hospital ED. This enables many triage Category 4&5 patients to have the option of faster and more appropriate care in a general practice setting* (p.50)

But, as acknowledged elsewhere in the paper (e.g. p. 48), there is doubt and debate about what constitutes "inappropriate" presentation. One of the literature reviews cited in the DHS paper concludes that "no valid and reliable method exists to define inappropriate care at an ED."[9] The same NZHTA paper argues that "without a valid and reliable measure of inappropriate ED attendance, the absolute effectiveness of interventions to reduce these attendances cannot be accurately assessed." Clearly, more work needs to be done to define, and identify, inappropriate attendance.

As part of a program of work on after-hours GP services, GPDV is attempting to quantify after-hours ED presentations that might be appropriately dealt with in a primary care setting instead. This involves setting criteria, based on the currently used VEMD (Victorian Emergency Minimum Dataset) data fields, to identify the group. We need to examine referral status, departure status, time of arrival and departure, as well as triage category. Our criteria for those patients who might have been appropriately dealt with in a primary care setting include self-referred, walk-in walk-out, and Category 4 and 5 patients who leave within twelve hours.

This type of information may be valuable for service planning, but still does not mean that clinicians can easily identify patients who might be appropriately diverted at the time that they present to ED.

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[6] "Good evidence exists (from RCTs) that among effective interventions for reducing admissions are …the placement of GPs and the ED… The provision of senior staff in the ED… [is] also probably effective at reducing admissions." New Zealand Health Technology Assessment, 1998, NZHTA Report 6, *Acute medical admissions: a critical appraisal of the literature.* http://nzhta.chmeds.ac.nz/acute.htm , accessed March 2002.

[7] *HARP Background Paper*, p.50

[8] Ieraci et al, 2000, "Emergency medicine and 'acute' general practice: comparing apples with oranges", Aust. Health Review, 23:2 pp152-161, cited in Centre for General Practice Integration Studies, 2001, *GP-hospital integration: what have we learnt*?, Appendix 3, p.71.

[9] New Zealand Health Technology Assessment Clearing House, 1998, NZHTA Report 8, *Emergency Department Attendance: a critical appraisal of the key literature*, Executive Summary. http://nzhta.chmeds.ac.nex/emergency.htm , accessed March 2002.

After hours services

Primary care services in-hours and out-of-hours operate in quite different contexts. In most areas, there are GP services available during GP working hours, making a GP clinic at a hospital an undesirable alternative, from the point of view of hospitals, for the reasons given above, as well as of private GPs and of divisions of general practice. However, the difficulties that consumers experience in accessing GP services after hours suggest that after-hours GP clinics in or beside emergency departments may be one of the alternatives that might address demand for after-hours services. The HARP background paper discusses in-hours and after-hours services as though they are synonymous, but we suggest that different solutions may be required, depending on a range of factors including when the ED presentations occur, and what other services are available.

There is scope to support and reinforce the primary care role of GPs in an after-hours, hospital-based GP clinic, through the use of clearly defined protocols for feedback to a patient's regular GP, or assistance in identifying a local GP when a patient does not already have one. GPs also tend to welcome the location of after-hours services on the neutral ground of a hospital.

There may also be difficulties in diverting after-hours patients to primary care, as they may be likely to perceive their needs as urgent (otherwise they would not be seeking care outside of usual hours) even if clinicians believe their medical needs to be those that require primary care treatment rather than hospital treatment. An after-hours, hospital-based clinic could help provide education about appropriate use of services while providing assurance to those who perceive their needs to be more urgent that they may be medically.

Anecdotal evidence

Conversations with divisions of general practice that have some experience of GP clinics in hospitals reveal a range of practical problems that must be overcome when clinics are established, if they are to work effectively. These include:

- Good communication between a hospital ED and GP clinic is necessary, along with clear arrangements for referral between the two. The physical placement of a GP clinic in a hospital does not automatically mean that co-ordination is achieved. Awareness of opening hours, of what activities will be carried out in the GP clinic at particular times, protocols for referral and shared medical records, are necessary if the two are to function in an integrated way.
- Recruitment of GPs can be a problem, particularly if there is a perception that the hospital clinic is competing with existing general practices in the area. (This perception is less likely to arise in the context of a hospital after-hours GP clinic that refers patients, and sends summaries back to the usual GP; but is very likely to arise if a hospital GP clinic operates during usual hours of opening.) Some divisions are supportive of after-hours GP clinics being located in hospitals, but would oppose the extension of such clinics to operate at all hours.
- The question of funding for the general practice clinic is also an issue. In the past, some GP clinics have been unable to make the necessary investments in IM IT systems to meet quality standards, and ensure good communication back to the patient's regular GP. If the GP clinic has a private billing model (which anecdotal evidence suggests is necessary for

the clinic to break even) then it may not address one of the issues that gives rise to GP clinics in the first place: some patients will still see the ED as preferable because hospital care is free of charge to them. If, on the other hand, a clinic bulk-bills, it is more likely that GPs whose practices do not universally bulk-bill will see it as unwelcome competition, and therefore refuse to support it.

GPDV's work on GP/hospital interface

Of the broad GP/hospital interface strategies listed in the discussion paper, and referred to earlier in this paper (ie working partnerships; broad prevention of acute care; managing transitions of care; and shifting care), GPDV has concentrated on the third area, managing transitions of care, in its efforts to facilitate GP-hospital integration. This has been done through:

- the establishment of the statewide GP contact database for hospitals to use in the transmission of information about admission, discharge and ED presentations (currently 55 hospitals have signed agreements to use the GP Registry);
- negotiating with DHS to promote divisions' identified minimum requirements for the transfer of patient information as part of its Effective Discharge Strategy;
- negotiating for Commonwealth and State funding for four demonstration projects to increase hospitals' use of the enhanced primary care (EPC) MBS discharge planning items. These projects are now operational.

Some work related to facilitating "working partnerships" has been done by the Southern Metropolitan Region Divisions of General Practice, who have developed minimum requirements for participation in HARP projects.

GPDV would be interested to receive divisions' comments on:

- The broad direction of GPDV's GP-hospital integration work: whether there is support for continued emphasis on the area of managing transitions of care or whether this direction should be altered (and if so, what the new focus should be)
- the draft minimum requirements for participation in HARP projects; and their potential applicability to other negotiations with hospitals, and other health services, to work together. (See draft on p.7.)

Draft position

- The establishment of GP clinics in or beside emergency departments is highly likely to reinforce a consumer view that hospital is the place to seek all medical care. If this occurs, it will ultimately increase hospital demand, rather than reduce it.

- A range of other strategies involving GPs, including all the others outlined in the HARP background paper, would be preferable ways to improve health outcomes while better managing demands on public hospitals.

- After-hours primary care services and in-hours primary care services operate in different contexts and should not be treated as synonymous. After-hours GP clinics in hospitals may be desirable, depending on the local circumstances, but the establishment of in-hours GP clinics is not supported.

- GPs working in emergency departments and the establishment of separate GP clinics in or beside emergency departments are two different strategies. Divisions might wish to consider negotiating with hospitals on the former rather than the latter.

- Identifying those patients who present to emergency departments but may be more appropriately managed in a primary care setting is complex. The research supports this position and there are suggestions that more work needs to be done to better identify these patients. It is important that policy-makers recognise that the solution is far more complex than simply diverting triage category 4 & 5 patients.

- GPs believe that continuity of care may be compromised if GP clinics are established at hospitals. Existence of these clinics may increase the likelihood that some patients will not have a regular GP. This would also be a barrier to implementation of the current Commonwealth strategies to implement population health approaches through general practice, through the Enhanced Primary Care (EPC) strategy and the Chronic Disease Management (CDM) initiatives, which require GPs to focus systematically on their own practice population.

GPDV invites comments from divisions on this draft position.

Minimum requirements for participation of General Practice in Hospital Admission Risk Program (HARP) and other hospital projects

DRAFT

Based on the draft by the Southern Metropolitan Region Divisions of General Practice, 18/3/02

Rationale

In the course of every day practice more than 95% of patients presenting to the average GP do not have chronic/complex conditions requiring hospitalisation or high level access to other community services. It is acknowledged that the remaining 5% do place demand on the acute sector and involve all providers in more complex care requiring coordination and continuity. It is imperative that divisions of general practice on behalf of their memberships only engage in proposals/projects that will clearly benefit patients and be relevant to general practice

Divisions of general practice will seek adherence to the following minimum requirements when consideration is being given to participation in any of the HARP initiatives:

- Evidence based initiatives that are relevant to the current health care setting, in particular to general practice and the community
- Projects/initiatives that operate according to best practice and quality improvement principles, i.e. quality medicine
- Consultation and timely involvement in planning of proposals and preparation of submissions. (NB Last minute letters of support will not be provided if this criterion is not met.)
- Any partnership with other agencies to be clearly defined and all parties to have a clear understanding of what the partnership implies.
- Opportunity for Divisions of General Practice to be the auspicing agency and manage the funds for projects
- Opportunities for a percentage of funding to be directed to allied health support and services within the general practice setting.
- Positions such as GP Consultant or GP Liaison within the hospital setting to be responsive to and regularly meet relevant divisions of General Practice.
- Selection processes for positions such as GP Consultant, GP Liaison and project staff to have divisional representatives on the selection panels.
- Appropriate remuneration for GPs working on joint initiatives and hospital projects.
- Consideration of and consultation about possible duplication of services provided in the community by general practice
- Acknowledgment that divisions are not primarily workforce agencies.

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