VICTORIAN DIVISIONS FORUM

State and National Health Call Centres: implications for general practice

July 2006

Report to Divisions

On 4th June, Victoria's Nurse On-Call centre was launched. On 21st May, GPDV hosted a forum for Division Chairs about the Nurse On-Call centre, as well as the plans for a national health call centre network, which was announced by COAG in February. (COAG incorporates all levels of government in Australia).

At our Forum, 21 representatives from 17 divisions heard speakers from the contractor running Nurse On-Call, McKesson and from the Victorian Department of Human Services, about what the service is for and how it will work. Participants also heard a presentation from West Vic Division about their local after hours project which uses telephone triage by nurses as one component, but has very different objectives.

Following the presentations, there was a lively discussion about aspects of call centres, whether there would be or should be connections between a caller's usual GP and Nurse On-Call and what the impact on demand on general practice might be from the operation of the call centre.

PRESENTATIONS

The Victorian Picture: the health call centre – what's it all for?
Julie Baker, McKesson Asia-Pacific, and Janet Laverick, Primary Health Branch, DHS
Key points from the presentation and further questions and discussion:

- (DHS) The call centre is not expected to substitute services or divert people to other services (e.g. away from hospital Emergency Departments), but to provide a new service to the public.
- The public value such a service, and want reassurance about whether they need to seek further help. More health information enables more self management.
- The service is not about diagnosis, but about triage.
- McKesson has experience running health call centres in other states and territories in Australia and overseas.
- (McKesson) The nurses assess calls based on strict protocols, and give advice on when and where to seek further assistance if necessary (e.g. hospital within a certain time frame, GP within a certain timeframe etc.) Calls can be diverted to ambulance where necessary. Nurses can decide that a person needs a more urgent level of care than that recommended by the protocol, but cannot decide that a person needs less that what is recommended.
- The DHS Health Services Directory will be used as the source of information for local services to refer to.
- The call centre is based in Victoria. Some nurses will be able to work from home. There is capacity to switch calls across to other states where McKesson operates call centres at times of high demand (e.g. during a public health crisis), to ensure that demand is met.
- All nurses recruited are Division 1 nurses and are provided with six days' training (a combination of face-to-face and online) and take calls initially under very close supervision.
- There is ongoing quality assurance of calls.
- 80% of calls are to be answered within 20 seconds.
- The service is accessible through a 1300 phone number.
- There is no plan for communication back to a caller's regular GP.
- There is no plan for systematic evaluation of changes to service use on the rest of the health system including general practice due to operation of the call centre – this is outside the scope of the current project.

One slide was based on an **evaluation of the ACT service**, which surveyed a sample of callers about what services they would have accessed without the advice of Nurse On-Call and what services they were advised to access. This showed potential for changed service utilisation. The largest change was for self care (2% - 34%). There was a marked decrease in Emergency Department visits (47% - 7%), but an

increase in ambulances (0.2% - 3%), and an increase in seeing a GP/dr/other primary care provider urgently (6-19%) and seeing a GP/dr/other primary care provider not urgently (26%-37%).

This slide gave rise to a lively discussion about whether call centres might in fact increase the load on general practice, and concerns were expressed about the implications this might have on workload and therefore on workforce retention in areas of workforce shortage. But it was not clear how generalisable these results would be. It was also difficult to pinpoint the likely effect on general practice, when the category did not separate GPs from other doctors who might work in outpatients, for instance or other primary care providers. Julie Baker pointed out that the category could include obstetricians or midwives who provided primary care. Although there was general interest in what the effect might be on demand for general practice services, no organisation is currently planning to evaluate it, and it is unclear where resources for such evaluation would come from.

The presentation given by DHS and McKesson at the Forum is not publicly available through GPDV. For further information about the operation of the call centre, contact Julie Baker, McKesson (Julie.Baker@mckesson.com.au).

The Divisions' Picture: Phone advice in Victorian divisions' after-hours projects – what have we learnt?
Alicia McGrath (After Hours Project Officer) , Jane Measday (Senior Project Manager), Rob Grenfell (GP member of the board of management), West Vic Division of General Practice.

West Vic after hours service aims to address problems of:

- workload pressures
- (relating to difficulties in) retention of GPs
- 1 funded ED
- Inconsistent after hours service and advice.

The model provides:

- On-call arrangements for GPs in each town
- Telephone nurse triage
- Feedback to GPs and agreed process for patients to be seen by a GP in the morning
- Quality processes including nurses and GPs to improve service

Outcomes:

- 61% of clinical calls are handled by the triage nurse. 49% over the phone, 12% were asked to attend ED and were attended by a nurse.
- Accessible, affordable ($4 per head of population)
- Professional respect between doctors and nurses
- High GP satisfaction rate

The service has different aims and objectives from the health call centres under discussion (see slide in presentation for more detail). The existence of a statewide, or national, health call centre – providing only telephone advice, but not direct health services where necessary - would **not** remove the need for the WestVic after hours service. They both use telephone triage as one component, but this is not a valid argument for having only one or the other (just as it is not a valid argument to have only hospitals or a call centre, because they both use triage advice as a component.)

There was some discussion of this point, especially because there were concerns that the Commonwealth is likely to stop funding local after hours services if and when a national telephone health call centre network is established. Funders might see the triage component in after hours primary care models and confuse it with health service delivery. If existing funding is withdrawn, there will be no services for a health call centre to refer to in some areas. Service closure, and greater demands on those services remaining would be likely to exacerbate the GP workforce problem.

SUMMARY & WHERE TO FROM HERE?

- There was a question about whether the Health Services Directory will incorporate information about after hours arrangements, to allow Nurse On-Call to give accurate information to callers.
- A clear communication strategy to GPs is needed (including articles in division newsletters) – simply sending brochures directly to practices is ineffective. GPDV could assist DHS with this.
- There were concerns about potential impact on general practice service utilisation (and in turn its potential to exacerbate workload problems leading to workforce shortage), but there are no plans to evaluate service utilisation.
- The conclusion seemed to be that Nurse On-Call will operate quite separately from general practice services, and will not offer entry to health services, but merely suggest the appropriate service for the caller to contact. The disadvantage of this scheme is that triage assessment done by Nurse On-Call will not be used by the other health care care settings that callers will be referred to, so patients need to go through the process again and may or may not access the service they need. Advantages are that the lack of coordination will mean that there are no medico-legal issues which can arise where a transfer of care takes place, and any existing funding for after hours general practice services is less likely to be threatened, because it will be clear that the two services are quite different (advice about who to approach for care on the one hand; health service delivery on the other).

A background paper on Health Call Centres and two presentations from this Forum are at www.gpdv.com.au under "Events", "View Previous Events" and "GPDV Quarterly Forum - May 2006".

HOT TOPIC

Supervision of Division 2 nurses

Nathan Pinskier (Monash Division) raised the hot topic. He was concerned about the current legal requirement that Division 2 nurses be supervised by Division 1 nurses and not GPs. In essence, the argument is that GPs should be able to supervise Division 2 nurses, because GPs are highly trained and therefore competent to supervise nurses. Practices that have Division 2 nurses for whatever reason – cost or availability – would be at risk without supervision arrangements in place for Division 1 nurses.
In discussion, it was suggested that the issue of professional supervision is a separate issue to that of management, and that the professional supervision arrangements are able ensuring that that nurses work within their scope of practice. Possibilities for indirect supervision were also raised (for example, a practice employing a Division 2 nurse who is supervised by a Division 1 nurse in a neighbouring practice. Some participants were interested in exploring the division role in supporting indirect supervision arrangements.

GPDV will continue to address supervision arrangements for nurses as one of the components of the Nursing in General Practice Program by working with nursing program staff in divisions.

The next GPDV Forum will be held on Sunday 20th August 2006. The topic for discussion will be governance of divisions, and of GPDV, including issues about the structure and membership of boards: GP members only? non-GPs?; succession planning in the context of elected boards; pros and cons of limited tenure for directors; how to resolve tensions between board member's role as director and the need for the board to receive input as representatives of a constituency. Contact Eliza Sanneman at GPDV for more details (9341 5200; e.sanneman@gpdv.com.au)