*Policy Issues Paper no. 18*
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# After Hours General Practice Services

This paper describes some of the issues arising in the implementation of the Commonwealth's after hours program with implications for State and/or Commonwealth policy. It was developed in preparation for a meeting in May of the Victorian Advisory Committee on General Practice (VACGP), convened by the Commonwealth Department of Health & Ageing (DoHA).[1] Except for minor revisions, this is the paper presented to the VACGP meeting. We are circulating the paper to our member divisions – and other interested stakeholders – to inform divisions about the detail of some of the issues we are discussing at the state level, on their behalf.

This paper very briefly describes GPDV's activities and then foreshadows some of the policy issues that GPDV's after-hours program has identified as matters requiring Commonwealth and State government attention. Key points/suggested solutions are highlighted in italics, and where we suggest that either the Victorian Department of Human Services (DHS) or the Commonwealth Department of Health & Ageing (DoHA) should take action, we have indicated the appropriate department in the margin. Discussion points made at the VACGP meeting, or developments since, are included in boxed text.

If you have any questions or comments you would like to make on the issues raised in the paper – or related issues, please contact Nicole Petterson (n.petterson@gpdv.com.au) or Louise Willis (l.willis@gpdv.com.au). The paper is also available at www.gpdv.com.au/policy.

## BACKGROUND

### Introduction

GPDV's after-hours program is funded by the DoHA under the National After Hours Primary Medical Care Initiative. Its aim is to develop proposals for the greater involvement of divisions of general practice and GPs in the provision of more effective after-hours medical services. Similar programs are being run in all states and territories. The current phase of the initiative follows on from a round of national trials that were funded from 1999 to explore different local models for delivering after hours primary care services. In Victoria, the Central Grampians trial, involving West Vic Division of General Practice, was funded.

In December 2001, Nicole Petterson was appointed as GPDV's after-hours program officer for a period of 12 months. The Program will provide recommendations to DoHA and DHS about:

- the future role for Victorian divisions of general practice within a collaborative framework for the development of more effective after-hours primary medical care services in Victoria;
- the requirements for implementing the suggested divisional role, including collaborative agreements, proposed roles of DoHA and DHS, source of funds and other resources, etc;
- a proposed implementation strategy and timeframe.

[1] As well as representatives of State and Commonwealth health departments responsible for primary care, the VACGP also includes representatives from the Rural Doctors Association Victoria (RDAV), Rural Workforce Agency Victoria (RWAV), Royal Australian College of General Practitioners (RACGP), Australian Medical Association (AMA), General Practice Divisions Victoria (GPDV) and the Health Issues Centre. The VACGP provides an opportunity for State and Commonwealth to consider together the way the policies of the two levels of government are played out at the level of general practice, through divisions.

**GPDV's program to May 2002**

- Established an after hours reference group.
- Workshop for divisions and projects considering an after hours project.
- Development of standards and benchmarks for after hours primary medical care services.
- Establishing a framework for the collection of data on the current state and models of after hours care in Victoria and commencement of data collection.
- Supporting communication and information flow between projects.
- Contributions to a support kit for projects.
- Establishing relationships with service providers and stakeholders.

**GPDV plan to December 2002**

- Complete data collection.
- Workshop on the role of call centres in Victoria (May 29th)
- Continue to build relationships.
- Identify and support potential for integration and collaboration between services.
- Develop recommendations as above.

## POLICY ISSUES FOR VACGP

### 1. Call centres / triage function

**Standards and accreditation**

Nurse triage/advice (which may or may not be provided in a call centre) exists in many after-hours service delivery settings, both formally and informally. In this paper when referring to nurse triage and advice, we mean a situation without a doctor on-site, and where nurses also make a judgement about whether they alone can manage patients until a later time when they may or may not need to see a doctor.

There are examples of call centres with nurse triage/advice both in Western Australia and the ACT. The Central Grampians after-hours trial in Victoria saw the implementation of telephone nurse triage supported by formalised protocols but not in a call centre environment. This has markedly reduced the after hours workload on GPs in the area, has met with a positive community response and has not been associated with any negative health outcomes.

***With the increasing numbers of nurse-led telephone triage/advice services in Australia, standards and accreditation for telephone triage/advice (whether privately run, or run by other state-funded services or hospitals) will be vital to achieve consistency and ensure safety for consumers. Quality assurance programs should be an essential part of any service.*** **DHS DoHA**

DoHA representatives informed the VACGP meeting that development of standards and accreditation for call centres are being addressed as part of the Commonwealth Health Call Centre Program. GPDV welcomes this advice but believes DoHA and DHS will still need to consider standards and accreditation for telephone triage/advice services that are provided in settings other than call centres.

**Hospitals**

A nurse triage and advice function for after-hours services is often conducted informally in rural hospitals. This means that the service is highly variable depending on the experience and training of the nurse providing the service. Research in Australian and international emergency departments provides evidence that advice given by nurses without the backing of protocols can put patients at risk.[2] Agreement on, and adoption of, protocols for nurse triage/advice would be a

[2] Fatovich et al., "Emergency Department Telephone Advice", *MJA 1998;169:143-146.*
Verdile et al., "Emergency Department Telephone Advice", *Ann Emerg Med.1989; 18: 278-282.*

component of clinical risk management and if done at a statewide level, it has the potential to reduce duplication, as one set of protocols could be used (or adapted) rather than many different sets being developed at the local level.[3] (We would support consultation with local doctors before implementation of protocols, to ensure that local needs are being met, and to promote local ownership of protocols.)

Training is another important component of ensuring a high quality triage service. There is training available through the Collaborative Health Education and Research Centre (CHERC). Work is currently underway to accredit the training module as a unit in the Advanced Diploma of Nursing at La Trobe University.

***The commitment of DHS would be necessary if hospitals were to adopt formal protocols and training for nurses in EDs without an on-site medical officer. GPDV recommends that DHS consider these measures.*** **DHS**

**2. Areas of need: provider numbers**

Deputising services are currently eligible for special needs provider numbers. There are some areas in Victoria with poor access to after-hours primary care because of workforce shortages, where GP clinics may benefit from similar arrangements. Even in services where there is a high doctor: population ratio, there are often difficulties in maintaining after hours rosters/staffing levels. Areas that have workforce shortages in-hours often have magnified problems with workforce after hours. These areas tend to be associated with a high burden of disease, making more provider numbers necessary to facilitate access to GPs. **DoHA**

At the VACGP meeting, DoHA officers confirmed that special provider numbers are available for deputising services. GPDV welcomed this advice but maintains that that special provider numbers are still necessary for after hours settings other than deputising services, in areas of GP workforce shortage.

**3. Information to help implement trial findings**

The lack of availability of information on the five national after-hours trials hampers progress at the statewide level, as we look more closely at appropriate models, and negotiate with stakeholders on their implementation. There has been no release of a synthesis of findings of all the trials across Australia. Given the large investment of the Commonwealth over the past few years in developing approaches to the delivery of after-hours primary care services, we would welcome the opportunity to use the information that those trials provide, and to ensure that Victorian models are based on evidence of effectiveness rather than only on the local 'good idea'. We understand that there have been problems, such as having to make comparisons between trials that were conducted very differently, in the course of the national evaluation of Phase 1 (completed by some sites in September 2000 and by all sites by May 2001). We look forward to the public release of the evaluation in the very near future, along with the results of Blue Moon Consulting's consumer study. **DoHA**

After the VACGP meeting, the Blue Moon Consulting study was released.

In early September, the national evaluation had not been released.

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Aitken et al., "Telephone advice about an infant given by after hours clinics and emergency departments", *NZ Med J* 1995; 108: 315-317.

[3] There are protocols available which have been adapted to the Australian environment for both face to face and telephone nurse triage. For example: Robin Tchernomoroff (ed.), *Emergency Nursing Guidelines 2001, 3rd edition*, Victorian Department of Human Services; and those developed by the Central Grampians after hours trial.

## 4. Consumer information

There is a lack of awareness in the community about after hours primary care service availability[4], yet most people know where the nearest hospital is, which can sometimes result in general practice patients attending EDs.

It will be important to examine the opportunity for linking information provision for after-hours services with the PCPs' work developing local service directories; and also with the Commonwealth Carelink program. Although the then Minister for Ageing sent a letter to all GPs informing them about Carelink in October 2001, in which she said that some of the 60 Carelink centres that operate around Australia had contacted local divisions of general practice and local GPs in their area, there appears not to have been any ***systematic*** linkage of general practice and Carelink so far. **DHS** **DoHA**

Although there may be productive local links between PCP service directory work and after hours services in particular areas, there also needs to be consideration of these links between state and commonwealth strategies at a statewide level.
There was no discussion at the VACGP meeting of plans for any systematic linkage of general practice after hours services and Carelink.

At one point the State government planned to roll out a 24 hour telephone advice line as part of the PHACS/PCP strategy. Is DHS able to advise on the status of this plan? **DHS**

At the meeting, DHS advised that it no longer plans to implement a 24 hour telephone advice line as part of the PCP strategy.

## 5. Data and service planning

The paucity of data relating to after hours service usage limits our ability to plan services that address identified needs. This is one of the most significant – and frustrating – problems in attempting to address after-hours service delivery problems. Developing possible solutions – and even funding national trials – without documented evidence of the extent of the problem can give rise to models of service delivery that are out of all proportion to the problem of consumer access to after-hours services.

There is no adequate way of adequately determining those ED patients who required ED care and those who may have been more appropriately cared for in a GP setting.[5] The data of most interest relates to triage category 4 and 5, but this is a classification of urgency and does not equate to a presentation that could be dealt with in general practice. In fact a significant proportion of hospital admissions are believed to come from triage categories 4 & 5.

### Commonwealth

The Medicare Benefits Schedule (MBS) and the Practice Incentives Program (PIP) do not currently provide us with adequate accurate information about after hours consultations. Through the MBS, only home visits and the initial consult on reopening a surgery after hours are subject to a different claim number: a clinic that stays open late uses the same MBS items as they do throughout the day. The PIP gives information only on those practices registered for that Program.

[4] Blue Moon Consulting's presentation at National After-Hours Conference, 2001.
[5] For further discussion, see 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; and also GPDV, April 2002, *Policy Issues Paper no. 16: GP Clinics and Hospital Emergency Departments.* Available at at www.gpdv.com.au/policy

***The existence of a separate MBS item for all after hours services would allow us to find out how many people are seeking services out of hours and in what areas.*** If the Commonwealth introduced such an MBS item number, it would be able to track the need for after-hours services with much greater accuracy. **DoHA**

**State**

The State has stated its interest, most recently through the HARP program, in identifying those patients who present to hospital EDs but might be appropriately referred to primary care services. There may be different issues in identifying and referring patients in-hours and after-hours, because patients presenting to EDs at different times of day may have quite different motivations for going to a hospital rather than a GP. In any case, it is extremely difficult to obtain data across the state about after-hours ED presentations that might be referred to primary care, and that therefore might tell us where extended hours primary care clinics might be established most usefully, and at what hours they should operate.

DHS needs to examine ways to capture hospital data to provide this basis for service planning, (and this is particularly timely in the current context of the HARP strategy). For the GPDV project, we have looked at the Victorian Emergency Minimum Dataset (VEMD) data fields to see how to identify after-hours patients who might be able to be appropriately referred to general practice. Using the current data fields, we consider that those presentations that are walk-in (field: arrival transport mode), not referred by a health professional (field: referral source), treatment time less than 6 hours (field: first seen by doctor to departure time) could identify presentations that might be appropriately dealt with in a general practice setting. It would be far simpler and more accurate if the data fields were set up with this in mind as one of the purposes of the data collection. **DHS**

The rural contribution to the VEMD also needs to be considered, as not all hospitals currently contribute and smaller hospitals that often employ GPs in the ED may not contribute data. Although there would have to be considerable change in thinking by those collecting the data, there may be some simple steps to improve the quality of the data to identify individuals who would have been more ideally seen in a GP setting. **DHS**

**6. After-hours component in care plans**

There is evidence in the literature that targeted disease and access education can impact markedly on after hours service use.[6] ***Arrangements for after-hours care need to be included when templates and tools are developed for care plans. This includes PCP care plans, EPC care plans and discharge plans and those developed through the Chronic Disease Management initiatives (e.g. asthma and diabetes).*** **DHS DoHA**

**7. Practice Incentives Program (PIP) payments**

The current PIP payment rewards practices for providing after-hours coverage in three tiers:

1. ensuring patients have access to 24-hour care (this includes those practices that subscribe to deputising services)
2. on average, the practice covers at least 15 hours per week of its after hours care from within the practice
3. the practice provides 24-hour care from within the practice.[7]

[6] Greinder et al. Reduction in resource utilisation by an asthma outreach program. *Archives of Pediatric & Adolescent Medicine 1995 Apr;149(4): 415-420.*

[7] www.hic.go.au/ ; follow link to PIP Formula. Accessed April 2002.

Covering a share of after-hours work in a large group practice is rewarded through the PIP, but a solo GP who might be prepared to participate in co-operatives receives no PIP incentive to do so. Whereas if s/he personally provided all after-hours care, which may adversely affect the quality of care delivered throughout the day in some cases, the PIP pays an extra tier payment. There seems to be general agreement in informal discussions with GPs that participation in co-operative arrangements should be rewarded.

***It may be worthwhile to review the PIP after-hours payments, to provide some clarity about what sort of after-hours arrangements the PIP wishes to promote in general practice and review the incentives for GPs participating in co-operative after-hours arrangements***. **DoHA**

At the VACGP meeting, a DoHA representative did not indicate that any review of the after hours PIP payment arrangements is planned, but stated that GPs who participate in co-operatives may benefit in terms of lifestyle if not financially. This argument does not address the issues raised above: neither about what after hours arrangment the PIP is trying to promote; nor about recompense for doctors delivering after hours care through co-operatives (which applies especially to GPs in small or solo practices, and especially in rural areas, where deputising services are unavailable). ***GPDV would support a review for more equitable PIP payments.***

## 8. Hospital Emergency Departments and GP clinics

### Colocation

GPDV has concerns about the establishment of GP clinics in or beside hospital EDs where these clinics are intended to operate during usual hours of business. But the establishment of GP ***after-hours*** clinics near EDs may be a partial solution for after-hours access in some areas. Anecdotal evidence suggests that GP recruitment and continued participation in after-hours rosters is a barrier to the success of such projects, especially in areas of GP workforce shortage (which is a cause of increased pressure on the hospital ED in the first place) and compounded by the fact that GPs tend not to live in the local area. There is a similar pilot project currently running in the UK, but with GPs working in the ED rather than in a co-located, separate clinic.[8] It is worth running projects to see what GP-hospital models work best in Australia, which we hope the evaluation of some of the current HARP projects that include GP after-hours clinics will show.

***(For a fuller discussion of these issues, see GPDV's Policy Issues Paper no. 16.[5])***

### Funding

When we discuss the integration of hospital and GP services, the question of funding arises. A Victorian division board member who attended the national after-hours workshop recently said that an HIC representative at that event advised that GPs should not be billing GP items through the MBS if a state-funded hospital was providing funding – or providing in-kind support such as free or subsidised rent. There is a lack of clarity on the part of State and Commonwealth governments on this point that may impede efforts to establish and maintain GP clinics. **DoHA**

Subsequent to the meeting, DoHA circulated a short paper called *Consideration for the development of after hours primary medical care services*, which provides some clarification although it does not directly address the question of the level of in-kind support that a hospital can legitimately provide to a service that claims GP MBS items.

[8] The 12-month NHS Nu-Care Project was launched in April 2002 by the Harrow Primary Care Trust in the Accident and Emergency Department of the Northwick Park Hospital in North West London.