

Dear Professor Fassett

Re: Rebuilding Tasmania's Health System — Supplement No.3 – Building a Stronger Community Care System.

We write in response to the above document released by the Minister for Health in late 2014<sup>1</sup> as a supplement to the Green Paper 'Delivering Safe and Sustainable Clinical Services'.

We are a group of clinicians with leadership and liaison responsibilities in THO South at the all-important hospital-community inter-face. We therefore fully agree with the intent of the report and will support all reasonable policy and operational changes that improve the patient journey. We acknowledge that this is a complex aspect of health that challenges us in Tasmania, and every other health system, particularly due to the increased needs of those with chronic diseases, ageing and deteriorating health at the end of life.

We would, however, like to challenge some of the data and foundational assumptions in the document.

1. 'Inappropriate' attendances at DEM RHH.

We would recommend caution in accepting the statement: '[I]n the period 2009-2013, 43.1 per cent of all Emergency Department ED presentations were potentially avoidable' (p3), without further scrutiny.

Audits of RHH ED attendances show an average of 10% of daily attendances may have been suitable for treatment in a GP Surgery using the ACEM definition of a GP patient. This is consistent with presentations to other tertiary EDs in Australia<sup>2</sup>

Furthermore, studies have shown that these patients do not significantly contribute to ED congestion or burden, they account for <5% of ED LOS<sup>3</sup> and a very small proportion of ED costs<sup>4</sup>.

Attempts to address this group of patients for the RHH will not alleviate the true ED crisis, namely that of ED overcrowding.

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<sup>1</sup> Undated, accessed 8/1/15 at [www.dhhs.tas.gov.au/onehealthsystem](http://www.dhhs.tas.gov.au/onehealthsystem).

<sup>2</sup> Nagree, Camarda, Fatovich et al. Quantifying the proportion of general practice and low-acuity patients in the emergency department. *Med J Aust* 2013;198: 612-615.

<sup>3</sup> Schull, Kiss, Szalai. The effect of low-complexity patients on emergency department waiting times. *Ann Emerg Med* 2007; 49:257-264.

<sup>4</sup> Baggoley. Primary care patients – what's the problem? *Emerg Med Australas* 1998; 10: 95-100

<sup>5</sup> Hoot, Aronsky. Systematic review of emergency department crowding: causes, effects and solutions. *Ann. Emerg. Med.* 2008;52: 126-136

ED overcrowding, which has clearly been shown to result in increased patient morbidity and mortality, results from the situation where demand for inpatient beds exceeds supply and patients stay in ED as “boarded” patients resulting in “access block”<sup>5</sup>. It is not due to low complexity patients attending an ED instead of a GP surgery.

Whilst RHH ED staff will continue to ensure patients understand when their presentation would have been better managed in a GP surgery and will facilitate on going management in this system there is a concern that the inaccurate assessment of the burden that low acuity patients place on the ED will lead to misguided and wasteful strategies to reduce ED overcrowding.

It is certainly true that community-based alternatives for acute episodes in specific sub-groups of patients require further exploration and development. It is important to ensure that attendances for patients who require palliative care should be closely monitored (see below), especially the clinically inappropriate transfer of dying patients from residential care facilities.

## 2. Palliative Care

We have internally audited our ED attendances, and can report that in 2012, 80% of patients known to the specialist palliative care service had no DEM attendances.(Bannink, unpublished) We now intend to obtain resources to audit the attendances of all patients within one year of death in Southern Tasmania.

Emergency Departments have an important role to play in selected palliative care patient episodes such as fracture, bowel obstruction, oncological emergencies, and where specialist input or investigation is required, especially after hours when other medical assessment may be hard to obtain and unable to solve the problem anyway.

Two major recent Australian reports have detailed the challenges of dealing with dying.<sup>2 3</sup> Health expenditure tends to rise as death approaches, and in the US it is estimated that 32% of Medicare expenditure is on those in the last two years of life (<http://www.dartmouthatlas.org/data/topic/topic.aspx?cat=1>).

Tasmania has taken up these challenges, and has recently embarked on a policy consultation process to improve care and decision-making entitled ‘Healthy Dying’ (<http://www.dhhs.tas.gov.au/palliativecare>).

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<sup>2</sup> Hal Swerissen and Stephen Duckett, 2014, Dying Well. Grattan Institute <http://grattan.edu.au/wp-content/uploads/2014/09/815-dying-well.pdf>.

<sup>3</sup> Australian Commission on Safety and Quality in Health Care. *Safety and quality of end-of-life care in acute hospitals: a background paper*. Sydney: ACSQHC, 2013.

The findings are now being collated, but whilst the title itself may need some modification in the light of public opinion that was ambivalent about the term 'healthy' dying, there is broad and strong support for a concerted effort to bring about lasting changes to our community and health service responses to death and dying.

'Goals of Care' has provided a framework for decision-making and limitation of medical treatment.<sup>4</sup>

We urge support for GPs, community nurses and allied health staff to discuss Goals of Care and to continue to do Advance Care Directives and palliative care planning for those patients with chronic diseases who are deteriorating in their last one to two years of life, including communication skills support and training.

### 3. General Practice

Both the National Health and Hospital Reform Commission (2009) (Commission, 2009) and the National Primary Health Care Strategic Framework (2013) (Australia, 2013) promote the need for a community care, with general practice as the central pillar of health care and main portal to the rest of the system. However the supplement does not really seem to articulate this central role of GPs in the provision of health care in the community. The reader could be forgiven for thinking that the GP is but one of a string of providers, rather than the central coordinating figure in the patient's health care. If it is Tasmania's intention to move away from this basic principle of Australian health care provision, the public should know this, and we doubt that the community would be happy with such a move. We do of course recognize that nursing and allied health roles continue to change and expand for the benefit of all. We support nurse practitioners and the extended roles of paramedics and each disciplines working at the peak of their abilities and cope..

Given the continued erosion of federal GP funding, increased demand and expectation, and the ever-increasing bureaucratic burden that GPs carry, it has never been more important for GPs and their practices to be supported.

We believe that there is a need to restate the GP role, and to urgently explore new mechanisms for a sustained conversation between GPs and the THOs/THS. With the demise of Divisions of General Practice, and the different role of Medicare Locals that prevented them acting as a conduit for GPs, we believe that the communication and policy gap is growing. The impending change from Medicare Locals to Public Health Networks is an opportunity to ensure greater general practice involvement and better links with the THS, but cannot alone fill the gap that we see.

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<sup>4</sup> Thomas et al, MJA 201 (8) · 20 October 2014, doi: 10.5694/mja14.00623.

We propose that consideration be given to the suggestions below under “strategic outcome 2 “ of the National Primary Health Care Strategic Framework.

- A GP network to open up a true two-way street between hospital and home care, perhaps an expansion of the already existing GP liaison services and linkages with the proposed new PHN reference groups.
- Exploration of appropriate ‘demonstration’ public-private partnerships.
- More robust GP and community health premises and service co-location projects, the proposed new ICCs for Glenorchy and Kingborough should be built with this in mind to develop linkages with all the surrounding practices rather than the collocation of a single practice as is the case with Clarence.
- Access to the DMR for GPs ‘registered’ with THS.
- Development of secure bidirectional email linkages with general practice.
- More phone and email communication between hospital doctors and GPs.
- Supervision of discharge summary delivery with education of Interns/RMOs/Consultants on the value of timely communication.
- Better access for GP trainee experience in hospital settings, where training regulations permit it.
- Well-developed innovative community care models for specific targeted patient groups based on local and international experience.
- Exploration of a CAG to cover general practice, community services, linked to a broader chronic diseases group. We do not believe that the need for general practice involvement in all CAGs negates the need for a specific grouping to fill the present vacuum in representation.

Clearly we have much to learn in order to improve patient journeys, and there is no room for complacency.

However, we would urge care in assuming that hospital ‘avoidance’ is achieved simply by adding capacity in non-medical and non-clinical assistance in the community. A more targeted approach is needed, and we are happy to contribute to this from the hospital and hospital-community inter-face where we all work.

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