Government of South Australia
SA Health

**TO:** **Negotiation representatives of the RDASA and AMA (SA Branch).**

**FROM:** **Peter Chapman, Chief Medical Advisor, CHSA**

**SUBJECT:** **Updated version of the tiered approach to the provision of Emergency Department on-call services**

**DATE:** **Friday 18 December 2009**

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**PROPOSAL:**
A tiered approach is promoted as the most accurate means of responding to the level of burden placed on rural GPs in providing on-call services for Country Health SA Hospital facilities where the basis of payment is the traditional fee for service model.

**BACKGROUND:**
It is recognised that being on call, especially at weekends, is for many GPs an onerous task. While the level of burden varies between individual GPs, the cumulative affect is generally influenced by the following variables:

- Emergency Department patient volumes;
- local health facility service profile; and
- proximity of the local health facility to higher level support services.

At the last three meetings of the negotiation teams, the concept of a tiered approach has been explored as a means of better representing CHSA's service needs with that of meeting the individual needs of GPs who provide the on call service. To that end, it is proposed that a three-tier approach be adopted along with suitable compensation to match the assessed level of burden that applies.

**A TIERED STRUCURE**
<u>Tier One</u>
This tier is applicable in those locations where Emergency Department patient volumes are low; there is usually only one or possibly two resident GPs and low volume uncomplicated obstetrics may be a feature of the service provided.

The expectation is that the GP is available to the hospital to all triage categories. Where it is not possible for the GP to attend immediately for triage one or two patients, as is currently the case, the patient will be

managed remotely by telephone contact between the GP and hospital nursing staff with attendances at the hospital as appropriate.

As is currently the case, triage one or two patients will require their initial management to be provided by the nurse, with remote telephone support being provided by the GP until their arrival at the hospital. If retrieval of the patient is required, support continues to be provided by the GP in conjunction with Medstar until the arrival of the retrieval team.

As is currently the case in some situations, dependent on local availability, paramedics may be involved in the provision of support for the patient, especially where no medical cover is available.

The activity volume for this tier would normally be less than 1500 presentations per year with a usual mix of a maximum of one per month of triage one category. These hospitals usually do not have emergency theatre capacity.

Tier Two

This tier is applicable in those locations that generally have higher Emergency Department patient volumes than tier one locations, there is a minimum of two doctors on call and they offer a 24/7 procedural service including complicated obstetrics. They do not feature resident specialist services and the GPs must be available within 40 minutes of being contacted. This enables, for example, the service criteria for caesarean category one sections to be achieved.

On-going and regular teaching of under and post-graduate student's takes place in these locations.

Tier Three

This tier is applicable in those locations that routinely experience high patient volumes in the Emergency Department and feature one or more of the following criteria:

- have a minimum of three doctors on call each night for emergency, obstetrics and anaesthetics,
- offer emergency caesarean service,
- receive inter-hospital emergency transfers from hospitals in the cluster or region, and
- may have resident specialists.

The GPs providing the on call emergency service are usually very busy on any given night due to patient workload and higher-level acuity of presentations; they frequently spend extended periods at the hospital and must be able to attend within 20 minutes of being contacted and are expected to see a significant proportion of all presentations.

## APPLICATION OF THE STRUCTURE

Application of a differential payment

Given the increasing level of burden based on patient volume, level of acuity and immediacy, the rate of on call payable increases from tier one through to tier three.

The following table outlines the proposed application of the tiered model by location:

PROPOSED APPLICATION OF THE THREE TIER MODEL

| **Tier One** | | **Tier Two** | | **Tier Three** | | Excluded by virtue of no medical presence |
|---|---|---|---|---|---|---|
| Balaklava | Mannum | Angaston/Tanunda | | Berri | | Marree |
| Bordertown | Meningie | Clare | | Ceduna | | Oodnadatta |
| Burra | Orroroo/Booleroo | Coober Pedy | | Gawler | | Woomera |
| Central Yorke | Penola | Crystal Brook | | Mount Barker | | |
| Cleve | Peterborough | Eudunda/Kapunda | | Mount Gambier | | |
| Cowell | Port Broughton | Jamestown | | Murray Bridge | | |
| Cummins | Quorn | Kangaroo Island | | Naracoorte | | |
| Elliston | Renmark | Loxton | | Port Augusta | | |
| Gumeracha | Riverton | Millicent | | Port Lincoln | | |
| Hawker | Southern Yorke | Roxby Downs | | Port Pirie | | |
| Karoonda | Strathalbyn | Waikerie | | Victor Harbour | | |
| Kimba | Streaky Bay | Wallaroo | | Whyalla | | |
| Kingston | Tailem Bend | | | | | |
| Lameroo/Pinnaroo | Tumby Bay | | | | | |
| Laura | Wudinna | | | | | |
| Leigh Creek | | | | | | |