Urgent Care Project: Best Practice Review

Introduction

The aim of this review is to identify and create an inventory of all sources of best practice information around vertical integrated care models including similar organisations nationally and internationally, academic studies and central sources. The rationale behind this is to assist with the "design and test of a new urgent care system in Birmingham East & North and Solihull together with a reimbursement system which will incentivise providers in the best interests of patients."

Methods

To address these questions we have examined existing work that incorporates systematic reviews, trials and comparative studies and large observational studies, that has been undertaken locally, nationally and internationally from which we are able to learn from. "Urgent care was defined as the range of responses that health and care services provide to people who require-or who perceive the need for – urgent advice, care, treatment or diagnosis. People using services and carers should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need." The focus of this review was wide ranging across all sectors.

References can be provided to support all the statements below and will be available shortly at www.warwick.ac.uk/go/edwaits

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Improving patient flows – right place, right time

- High users of the ED are usually high users of primary care, it is not commonly substitution in this group.
- Good continuity of primary care reduces ED usage.
- Open access to primary care (including OOH) reduces ED attendance
- Walk-in centres & NHS Direct have not been demonstrated to change flows.
- Phoning for advice before going to the Emergency Department may reduce attendances.
- There is no evidence around the effects on waiting times of general practitioners working in emergency departments.
- Primary care filtering at the front door of the ED may reduce emergency department attendance but may be unsafe
- Triaging out of the emergency department can reduce numbers but more work is required to verify the safety of such systems.
- No evidence that NHS Direct significantly changes flows or reduces ED attendance
- It is possible to divert some 999 calls to advice lines but safety is not known.
- The role of paramedics/ECPs in either discharging patients from scene or deciding on appropriate destinations has not been adequately studied to confirm its safety and effectiveness, except in a specialist role with elderly patients combined with a prolonged training programme
- Specialist nurse care in heart failure, COPD and DVT can reduce hospital admissions.
- Nurse practitioners are safe and effective but their effect on flows is unknown
- The role of other health care professional in emergency care needs evaluation
- Patient education is of unproven benefit in most areas except chronic disease management.
- Attendance by the elderly, those with chronic disease and those with multiple attendances may be reduced by various interventions, trials are needed in this area, including the role of social workers.
- Senior staff may reduce admissions and delays.
- Triage is a risk management tool for busy periods; it may delay care.
- Fast track systems for minor injuries reduce waits.
- Observation wards may reduce length of stay and avoid admission.
- There is a lack of evidence of innovations in bed management.
- There is a lack of evidence about innovations to reduce delayed discharges from hospital.
- Co-payment systems reduce attendances but may equally reduce attendances by those requiring emergency care.
- There is no evidence on how reimbursement systems may help to incentivise best care in the NHS funding system.

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Reducing unplanned hospital admissions

A range of initiatives have been explored to identify initiatives that may reduce unscheduled admissions. Table 1, 2 & 3 summarises the evidence about the interventions which target the following four main areas: the way care is organised, specific programmes or methods of care, tools to facilitate more effective care and the strategies for involving people in their own care.

There is some evidence to suggest that the following initiatives may reduce unplanned hospitalisations and readmissions.

- Self-management education and self-monitoring
- Group visits to primary care for those with chronic disease
- Broad managed care programmes and care from specialist nurses
- Integrating social and health care
- Multidisciplinary teams in hospitals and after discharge
- Discharge planning
- Nurse –led clinics to review chronic disease patients and frequent users
- Telecare and Telemonitoring
- Short stay units and clinical decision units in the ED for specific conditions
- Hospital at home for children

There is some evidence that the following may reduce length of stay:

- Self-management education
- Telecare
- Multidisciplinary teams in hospital
- Discharge planning and bed management may reduce length of stay
- Home hospitalisation
- Educating professionals
- Specific Geriatric emergency departments

In addition these interventions may reduce length of subsequent hospital stays:

- Targeting people at high-risk
- Self-management education
- Telemonitoring
- Multi-disciplinary teams in hospital and after discharge
- Nurse-led clinics and nurse-led follow up
- Targeted assertive case management
- Targeted proactive home visits.

Lessons from Kaiser Permanente

(provided by Chris Crisafulli, KP South California)

KP has stated that their key successful changes were:

- Short stay and clinical decision units where patients can be worked up, observed and stabilized prior to discharge.
- Physicians trained and committed to low hospital utilization, i.e. higher rather than lower threshold for admitting a patient. One element that facilitates that is not to have a surplus of hospital beds available.
- Crisis team for psychiatric patients.
- Discharge planning

For patients coming to the emergency department:

- 50% of our ED visits are for low acuity injuries and illnesses. Of those 50% about 60% of them tried and were unable to get an appointment with their primary care physician. Having a primary care physician and being able to see that primary care physician is the most effective way to prevent ED visits. One of our strategies we employ in the winter time when we naturally expect more URI and therefore ED visits, is to open up more primary appointments.
- Having an efficient Fast Track system for the low acuity patients is an absolute must. Otherwise delays in discharge will clog up the ED.
- A state-of-the-art accredited nurse advice system called "KP OnCall". Algorithms allow RNs to recommend at least five dispositions; Home care, Urgent appointment in PC, Emergency visit or 911 ambulance pick-up. It allows us to direct patients to the appropriate level of care at the right time to the right place. This center serves over 4 million people. We are unsure of how many of our southern california population utilize this service but we do know that outside claims costs have been reduced.
- Three other important areas to focus on the reduction of Lab and Radiology turn around time and consultant response times.