GPs and paediatricians Team up to improve kids’ primary care

In an Australian first, The Royal Children’s Hospital piloted an integrated model of care where paediatricians partnered with general practitioners to provide specialist care for children, upskilling primary healthcare providers and enhancing the quality of care delivered in the community to Victoria’s youngest patients.

## Background

Many caregivers seek paediatric care for their child from overcrowded emergency departments (EDs) or hospital outpatient (OP) clinics with wait times that are continually increasing. In 2017, The Royal Children’s Hospital’s (RCH) paediatric outpatient clinic wait times ranged from three to 18 months.

These children often present with relatively simple conditions that could be managed by their general practitioner (GP) in a primary care setting. Unnecessary referrals create a burden on the public healthcare system, with wide-ranging impacts on the delivery of timely, accessible and quality care.

Impacts include:

* creating overwhelming and unsustainable demand at public hospitals
* reducing access to public specialist care for children with complex conditions
* deterioration of a child’s health and increased school and parent work absenteeism due to prolonged waiting and travel times
* higher cost of care for the healthcare system, given the high cost of hospital versus primary care
* de-skilling GPs in the management of all but basic paediatric care.

The aim of the RCH’s innovation project was to reduce the number of children being referred to EDs and OP clinics at the RCH and the Sunshine and Werribee Mercy (ED only) hospitals.

To achieve this, the health service integrated paediatric specialists in a number of GP clinics, improving the quality of primary care delivered for common childhood problems and strengthening GP confidence and knowledge in paediatric care.

**Strengthening primary care to reduce paediatric outpatient and emergency department referrals**

**Lead** The Royal Children’s Hospital

**Partners** North Western Melbourne Primary Health Network, Werribee Mercy Hospital, Sunshine Hospital

**Duration** August 2017 – March 2019

**Key outcomes**

* Reduced referrals to hospital EDs from 19 per cent to 12 per cent
* Increased GPs’ confidence in managing child health issues
* Increased families’ confidence in their GP to provide general care for their child
* Achieved a variety of qualitative benefits for families (e.g. providing specialist care closer to home), improved the management of child health, and enhanced child health outcomes
* Demonstrated that at scale, the new model of care has the potential save families, hospitals and government more than $9,000 per year for every GP clinic running the model of care

## Key activity

* Five GP practices were recruited from the North Western Melbourne Primary Health Network via an expression of interest process. Two RCH paediatricians were integrated into the GP practices to work with the 49 participating GPs over eight months from April to November 2018.
* The GP-paediatrician integrated model of care involved:
	+ **weekly half-day co-consultation** **sessions based at the GP practice –** theGP and paediatrician would co-consult on approximately four to five paediatric patients per session, giving the GP an opportunity to learn directly from the paediatrician on how to manage common childhood conditions
	+ **monthly one-hour case study discussions –** the GP would present paediatric patient cases and receive immediate specialist advice about their management
	+ **phone and email support –** in betweenco-consultation and case study sessions, GPs had access to a dedicated phone number and email to receive same-day advice on paediatric patients.
* In response to interim feedback from participating GPs, the project was extended by four months (November 2018 to March 2019) with funding provided by the North Western Melbourne Primary Health Network (NWMPHN), and the co-consultation sessions reduced to a fortnightly frequency. All other elements of the model remained the same.

## Outcomes

* Over the 12-month project, 624 children were seen in GP-paediatrician co-consultations. 65 per cent required no further referral and returned to GP care. 23 per cent were asked to return for a follow-up co-consultation with the project paediatrician. Only 7 per cent required referral to a hospital OP clinic, with the remainder referred to a private paediatrician.
* Private paediatrician referrals decreased from 34 per cent to 20 per cent and ED referrals decreased from 19 per cent to 12 per cent.
* OP referrals decreased from 31 per cent to 28 per cent in the first six months but the decrease was not sustained as the project paediatrician left the practice. OP referrals had increased to 47 per cent by the end of the project.
* Unnecessary testing and prescribing by GPs for common conditions decreased. The proportion of children with bronchiolitis or bronchitis being prescribed unnecessary steroids or antibiotics decreased from 17 per cent to 9 per cent, and the proportion of infants with irritability, crying, reflux or unsettled behaviour being treated with acid suppression medications decreased from 29 per cent to 9 per cent.
* The model offered various other benefits, including:
	+ faster access for children needing specialist care
	+ convenience and comfort for families visiting their local GP instead of travelling to a hospital
	+ improved continuity of care for children being seen by their GP for more than basic healthcare
	+ improved equity of access for disadvantaged families by making paediatric advice available at their local GP clinic.
* A cost analysis showed that running the model at scale could potentially save families, hospitals and government more than $9,000 per year for every GP clinic running the model of care.

### Consumer experience

* All families interviewed who had attended a GP-paediatrician co-consultation for their child said they would recommend the service to other families.
* The proportion of caregivers who were ‘completely confident’ in their GP to provide general care for their child increased from 78 per cent to 94 per cent.
* More caregivers (76 per cent at project start to 90 per cent at project end) were confident in their GP to manage and coordinate the short- and long-term care for their child.

‘You don’t have to wait months. It’s now a better and quicker service.’

**– Caregiver**

‘It is good to actually have a paediatrician working local and [who] doesn’t have a 3–6 month waiting list … It’s so hard to get into paediatricians and [when you do], sometimes the problems have resolved … or they’ve gotten worse.’

**– Caregiver**

### Clinician experience

* All participating GPs said the model increased their professional knowledge and confidence in child health issues, and the majority (92 per cent) said the model was beneficial for paediatric patients.
* All GPs agreed the monthly case discussions were feasible, 92 per cent agreed email and phone support was feasible, and 75 per cent said the weekly co-consultations were feasible. Following the four-month project extension, 88 per cent of GPs agreed fortnightly co-consultations were feasible.
* Both project paediatricians considered the model of care feasible and acceptable, strongly agreeing it had strengthened their links with other health professionals and had been beneficial for paediatric patients.

 ‘The way the model is structured is ideal for learning at your workplace and at the same time providing quality care to your patients.’

**– Participating GP**

 ‘Working with local primary care providers is excellent. The GPs' knowledge of family and environmental context is very important and saves a lot time during paediatric consults (in contrast to seeing the kids in [the hospital OP clinic] with no background).’

**– Project paediatrician**



## Key learnings

* It was highly valuable to hold an early workshop where participating GPs, practice managers, administration managers and practice nurses could contribute to the model’s design. The workshop identified and solved problems the project team had not considered and ensured the model was more acceptable to practice teams. Partnering with the NWMPHN also allowed the project team to leverage its knowledge of primary care and maximise existing relationships, which strengthened the pilot.
* This model requires participants to change their normal ways of working. Involving all participants in project planning, setting clear expectations, managing changes, and allowing time for relationships to be built are key to successfully embedding the model in GP clinics. Families must also be supported throughout the process.
* Taking time to define roles and responsibilities and to appoint the right people in key positions can have a significant, positive impact on the model’s success. For example, the project paediatrician must not only be able to provide specialist paediatric care but be able to provide professional support and coaching to GPs as well.
* Immersing project team members at participating GP clinics during key stages of the pilot enabled intensive on-site support, coaching, and early identification and resolution of emerging issues. It also gave the project team insight into each practice’s individual culture.