

Delivering clinical case management for frequent callers to ambulance services

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Ambulance services in England are playing an increasing role in the provision of care. Their role has changed from one of picking up patients in the community and dropping them off at an emergency department (ED) to more advanced care models. These now include the provision of clinical advice over the telephone (hear and treat), the treatment of patients on-scene (see and treat) and the more traditional conveyance to the ED.¹ These changes have been occurring during a prolonged period of increased demand on all areas of emergency care, including a 47% rise in ED attendance over 15 years.² Further, it is known that frequent users of healthcare use a disproportionate amount of resources.³

CLINICAL CASE MANAGEMENT FOR FREQUENT CALLERS

The paper by Edwards *et al*⁴ provides one of the first examples of delivering interventions for frequent callers to an English ambulance service and is one of few publications on the topic internationally.⁵ There are three notable findings that are discussed in this commentary:

1. Frequent callers were found to be heterogeneous with 95 (86%) falling within more than category
2. Ten different types of interventions were used, although 90 (82%) patients received five or fewer
3. The interventions as a whole showed a reduction in median calls from five per month preintervention to zero per month postintervention.

These findings are of importance for both research and practice. First, the heterogeneous profile of patients within this study suggests that, similar to frequent users of the ED,⁶ there are potential

subgroups of frequent callers. However, there is still much research to be done before they can be fully identified due to the paucity of research within ambulance services.⁵

Second, that there were 10 intervention types demonstrates the complexity of care associated with this group of patients who may require the support of various health and social care services. While this potentially serves as a note of caution, complexity should be sought to be understood rather than avoided. Indeed, this could serve as an opportunity for ambulance services that have been recognised as being able to coordinate and lead the integration of health and social care services,⁷ which coincides with perspectives on transforming the healthcare system for the delivery of more integrated care.⁸

Third, the reduction in calls is a promising indication that, from an ambulance service perspective, providing interventions can reduce service usage and possibly free up resources that are needed elsewhere. Nevertheless, caution should be noted when interpreting the impact of clinical case management. As Edwards *et al* have acknowledged, the lack of a control group means that reductions in usage cannot be fully attributed to the interventions. Roland and Abel⁹ have recently cautioned against ignoring regression to the mean; given that patients were registered for up to 24.5 months at the maximum end of the range, it is entirely possible that this contributed to the result. Further research would provide an insight into the extent regression to the mean has impacted on the study outcome.

WHAT DOES QUALITY MEAN TO FREQUENT CALLERS?

There is a risk that frequent callers, once identified by ambulance services, are simply passed to another service¹⁰ so that budgetary rather than patient needs are met. As such, it must be remembered that

many patients will be frequently calling ambulance services because they are not receiving adequate care, as opposed to calling for vexatious reasons.⁶ Qualitative research is needed to identify outcomes that are of importance to frequent callers and understand the mechanisms by which interventions for frequent callers work.

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