

General Practice and Public Hospital Integration

2006

The overriding aim of this Position Statement is to reflect general practice's views on what the profession believes is required in order to encourage better GP-public hospital integration.

Hospitals in the private and public sectors are organised and operate quite differently. This Position Statement addresses issues specifically related to public hospitals. It is acknowledged, however, that many of the statements within this document will apply to both public and private hospitals.

Issues relating to integration between general practice and private hospitals and consultants are covered in other AMA policies.

Continuity is a key tenet of quality care. In Australia general practitioners are the primary providers of continuous care for patients. Disruptions to continuity of care can, however, occur when health care services are also delivered to the patient through another provider, such as a hospital.

Appropriate integration of general practice and public hospital care can lead to improved patient health outcomes through better clinical management, improved continuity of care and reduced readmissions. High quality continuity of care requires that the care provided by hospitals be well coordinated with the patient's general practitioner.

Most hospital episodes begin and end with general practice. A general practitioner accompanies the patient on the journey that leads to admission to hospital and is responsible for the care of the patient on discharge. The patient's usual GP brings his/her knowledge of the whole person into consideration in planning and managing the patient's pre and post admission care.

General practitioners have a responsibility to establish within their practices systems and processes that improve communications with hospitals.

The increasing use of early discharge by the hospital sector highlights the critical need to improve GP hospital integration. Early discharge strategies have shifted acute care, with its associated complexity, to general practice. Importantly, the long-term management of people with chronic and complex conditions increasingly takes place in the community, under the care of general practice, and may include only occasional hospital admissions.

In spite of the benefits for patient care to be derived from GP-hospital integration, the barriers to improved communication and cooperation have continued to grow. Over the past decades, GPs have increasingly been excluded from the provision of hospital based care. Barriers between these two sectors have grown as hospitals have become focussed on providing acute care to high need patients with little input from GPs. In some places hospitals have become networked, creating a less locally focussed and more complex set of organisations for GPs to relate to.

Where several providers contribute to the care of a patient, access to meaningful and appropriate information is absolutely necessary to maintain quality continuity. The experience of Australian general practice in accessing timely and relevant patient information from hospitals is generally very poor. The provision of discharge summaries is

patchy at best in terms of quality and timeliness. There is a real concern around the absence of detailed information, such as discharge care plans, for example, accompanying a discharge summary. The absence of this additional information reduces the value of the discharge summary to the GP's capacity to provide the highest quality continuity of care for the patient following a hospital admission. The direct provision of information beyond the discharge summary is particularly important in relation to the discharge of patients to Residential Aged Care Facilities given the complexity of care involved.

It is the AMA's view that the transfer of a discharge summary to the GP must be a condition for patient discharge, that the overall quality of discharge summaries must be a basis for hospital accreditation, and that an appropriate body must be tasked with setting Australian standards for hospitals in relation to the provision of discharge information and summaries.

General practitioners have a responsibility to provide, where appropriate, comprehensive referral letters to public hospitals, containing an up-to-date summary and sufficient information to enable appropriate assessment and management.

The real beneficiaries from measures that improve GP and hospital integration are patients. It is thus essential that the links between GP and hospital care are strengthened and, where appropriate, are supported through adequate funding by State/Territory and Federal Governments. They must include but not be limited to the following:

Macro involvement

- GP representation within the hospital management structure. Every hospital in Australia must include a general practitioner on their major decision making body, such as their Board.
- Opportunities for hospitalist interface with general practitioners through existing GP forums or structures at the local level.
- Adequate funding for the establishment and maintenance of GP/Hospital Liaison Officer positions.
- Support for the formation and retention of academic GP Departments in hospitals.
- Inclusion of GPs in medical staff/advisory council meetings.

Information and Communication

- GPs must provide comprehensive, legible referral letters to public hospitals, containing an up to date summary and sufficient information to enable appropriate assessment and management of the patient¹.
- As a specific requirement of hospital accreditation the provision of timely, useful, detailed and legible² discharge information to general practitioners. As a condition of patient discharge it must be compulsory for the hospital to complete and transfer a discharge summary to the patient's GP.
- Discharge summaries must be accurate and comprehensive. They must include a full medication list, relevant tests that were carried out, and any follow up planned. Discharge summaries must be accompanied by detailed information relevant to the patient's post admission care that will contribute to the GP's ability to provide the care needed.

¹ The content of a referral may include the presenting complaint and the reason for the referral, relevant current clinical information including allergies and drug sensitivities, relevant past history, current medications, relevant history of past medications, and results of relevant and recent investigations.

² Concerns around the legibility of discharge summaries include the use of acronyms.

- Discharge summaries and accompanying information must not be hand written and if provided in hard copy they must be scannable.
- In addition to discharge summaries, direct communication with the patient's GP or GP practice prior to, or on the day of, discharge to a Residential Aged Care Facility is required.
- Development of an Australian Standard that informs hospitals and GPs of the minimum information sharing required on admission and discharge.
- Significant and meaningful investment by hospitals in information and communication technology that focuses on the opportunities provided by existing GP connectivity in relation to secure and efficient transfer of health information as appropriate.
- Hospital Outreach/Hospital in the Home Services should report to the GP progressively.
- GP driven education of doctors working in hospitals about the need to better communicate with patients' general practitioners to ensure the provision of quality care.
- Development of a remuneration structure that facilitates GPs and hospitals to better integrate care through case conferencing and discharge planning, including telephone consultations.
- Development of clear guidelines, by the Office of the Federal Privacy Commissioner, as to what information can be legally shared between hospitals and GPs.

Education

- More prevocational rotations through general practice: Doctors working in hospitals will have a better understanding of general practice and the critical need to share patient information to improve health outcomes.
- Adequate resourcing of GPs involved in this training related to pre vocational rotations.
- Increased role for GPs in bedside teaching, through their involvement in schools of medicine and appropriate recognition and remuneration for the teaching they provide.
- Initiatives aimed at informing GPs on broad processes, specialist structures and functions within public hospitals.
- Education of specialist colleagues and hospital management on the role of GPs.
- Provision of educational opportunities for GPs within public hospitals.
- Training and infrastructure support for Doctors in Training within public hospitals consistent with the aim of improving GP-public hospital integration.

Access

- Provision of opportunities for GP involvement in in-patient care and discharge planning where appropriate.
- Access for GPs to public hospitals including through visiting rights³,
- Remuneration for public hospital patient visits by general practitioners.
- GP hospital "accreditation" that is linked to visiting rights.

³ This might include, but not be limited, to such things as a clearly defined role for the GP in-patient care in hospitals, the GP's name on the patient bed to the provision of appropriate parking.

Cooperation

- Increased funding for additional transitional beds. Transitional beds are aftercare beds for step down. Care through this system must include input and integration with the patient's general practitioners.
- Cooperation between post discharge care by hospital nurses and GPs.
- Minimisation of red tape that gets in the way of good patient care.
- Provision of resources by public hospitals to general practices.
- Utilisation of GPs with special skills in some of the hospital's clinics.
- Indemnity by the public system for work undertaken by visiting GPs.