



General Practice/Hospitals Transfer of Care Arrangements – 2013

1. Introduction

As the population ages and the incidence of chronic disease increases more patients are suffering from multiple chronic conditions which complicate their care needs.

Patients are relying more than ever on their general practitioner (GP) to co-ordinate their care needs, particularly around the time of hospital admission and discharge. To this end, patients quite rightly expect that important relevant information is communicated expeditiously between the medical professionals caring for them.

Appropriate and effective transfer of care arrangements are not an issue solely for patients with chronic disease; they are important for any patient who receives care both from their GP and in a hospital. Doctors can provide the best possible care when good communication exists between all treating medical practitioners at all stages of care, starting from the community setting, right through to acute or sub-acute care, and subsequent return to the community.

Appropriate and effective transfer of care arrangements between GPs and hospitals provide substantial benefits. When appropriate and effective transfer of care practices are put in place and followed, not only are hospital readmissions reduced and adverse events minimised, overall the patient, their families, the doctors and other health practitioners involved in providing care have a much more satisfactory and positive experience.

This position statement outlines requirements for appropriate and effective transfer of care arrangements. The principles outlined for GPs and hospitals are applicable to other areas of the health system including rehabilitation, residential aged care and community care.

2. Continuity of care between general practice and hospitals

Continuity is a key tenet of quality care. The key to continuity of care between GPs and hospitals is comprehensive, accurate and timely two-way communication regarding admission, treatment and patients' on-going care needs.

When a GP initiates a referral to hospital, he/she has a responsibility to provide, where appropriate, comprehensive referral letter/s containing up-to-date summaries, and sufficient information to enable appropriate assessment and management while the patient is in hospital.

Equally, when a patient is discharged from hospital, the GP will need a comprehensive transfer of care plan/summary, which would enable the GP to continue providing high quality care for the patient after they are discharged.

As much as possible, a patient's experience through the health system, particularly from care by a GP in the community to hospital and then back to the GP, should be as seamless as possible,

with the patient experiencing continuity and consistency in the care and treatment. However, this can only happen when health infrastructure and systems support good communication between all treating medical practitioners, and when doctors in hospitals and in general practice make transfer of care arrangements a priority for their patients.

3. Transfer of care and patient safety

Delayed or inaccurate communication between treating medical practitioners (GPs and hospital-based physicians) during transfer of care may negatively affect continuity of care and contribute to adverse events.¹

Accurate and timely hospital transfer of care summaries are integral to ensuring optimal on-going care of patients. If relevant information and appropriate follow-up arrangements are not made at the time of discharge, there is potential for the safety of the patient (and the medico-legal safety of the treating medical practitioners) to be put at risk.

National Safety and Quality Standards for Health Services (*Safety and Quality Improvement Guide Standard 6: Clinical Handover*)² requires clinical leaders and senior managers of health service organisation implement documented systems for effective and structured clinical handover (defined as the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis). The intention of the standard is to ensure there is timely, relevant and structured clinical handover that support safe patient care.

4. Appropriate and effective transfer of care arrangements

Appropriate and effective transfer of care arrangements are more than just a GP sending a referral letter to the hospital and, in return, the hospital sending on a transfer of care summary (discharge summary) when patient leaves hospital.

When a GP initiates a referral to hospital, he/she should communicate with the hospital by phone if appropriate and provide details in writing detailing:

- the main presenting problem and past interventions;
- other medical conditions and medical history that will have an impact on the patient's care in hospital;
- a medication history and details of reactions to medications;
- results of recent investigations;
- family and social circumstances;
- knowledge of any treatment being provided by other health practitioners; and
- any other issues that the GP considers relevant.

As soon as a patient is admitted to hospital, planning for transfer of care arrangements should commence. The hospital should ensure it has up-to-date contact details for the patient's usual GP

¹ Kripalani et al (2007) Deficits in communication and information transfer between hospital-based and primary care physicians: Implications for patient safety and continuity of care. *AMA*. 2007; 297(8):831-841. doi:10.1001/jama.297.8.831

² Australian Commission on Safety and Quality in Health Care (2012) Standard 6: Clinical Handover, http://www.safetyandquality.gov.au/wp-content/uploads/2012/10/Standard6_Oct_2012_WEB.pdf

and general practice. Communication with a patient's GP during hospital admission should occur when necessary.

During transfer of care, the patient's GP will need to have:

- a summary of the patient's diagnosis and treatment course in hospital including reasons for changes to medications (If a medication requiring PBS Authority is started in hospital and the GP is to continue prescribing the same, then the reason for the PBS Authority should be stated);
- a summary of all test results conducted in hospital;
- details of follow up appointments;
- details of any allied health and support services provided to the patient while in hospital;
- a list of medications to be administered following discharge, including details of the supply given to the patient by the hospital;
- details of arrangements for allied health care following hospitalisation; and
- support and care arrangements for family members and carers.

Wherever possible, the patient's GP should be contacted (verbally or by other secure means) to discuss the patient's progress and treatment in hospital, and to ensure that timely arrangements are made for a transfer of care appointment for the patient with their GP. In this regard, a phone call to the patient's GP during transfer of care can be useful contact from hospital. However, verbal contact during the hospital admission should occur only when deemed necessary. Further, the hospital should provide adequate supplies of medication to last until the patient can obtain an appointment with their GP.

With regard to transfer of care arrangements for outpatients, clear advice on assessment and recommended management should be given after each outpatient visit, otherwise there is a risk of confusion of such aspects as drug doses, the current plan and so on.

5. Local Hospital Networks and Medicare Locals

The establishment of Local Hospital Networks (LHNs) and Primary Health Care Organisations known as Medicare Locals (MLs) provides an environment to support good transfer of care arrangements in the health system.

MLs have been established to improve primary health care delivery and to tackle local health care needs and service gaps while working closely with LHNs to make sure that primary health care services and hospitals work together effectively.

MLs and LHNs should have formal engagement protocols and some common membership in governance structures, and work together where possible in areas such as assisting with patients' transitions out of hospital and, where relevant, into aged care.³ In this regard, MLs and LHNs could fund appropriately skilled GPs and hospital specialists to devise collaborative pathways for transfer of care ensuring that best practices are implemented.

³ National Health and Hospitals Network Agreement, http://www.federalfinancialrelations.gov.au/content/other_related_agreements/NHHN_Agreement.pdf.

While some MLs/LHNs have commenced work on improving care pathways across various part of the health system in their areas, this is not happening consistently across Australia and there is scope for this to be applied across the country.

6. Patient centred medical home

The patient centred medical home (PCMH) model of primary care is presently being considered by the Government as a way to support quality general practice, especially to enable well-coordinated multi-disciplinary care for patients with chronic and complex diseases.

The PCMH has gained traction in the United States and other countries such as Canada, France, the UK, the Netherlands, Sweden and New Zealand and, has demonstrated outcomes that: improved quality measures; reduction in avoidable hospital admissions, emergency department use; and reduced overall costs.^{4,5}

While the PCMH could be considered simply as an extension to the Australian concept of the “family doctor” or the “usual GP” (as the basis for a trusting relationship between doctor and patient that fosters long-term quality care), the full implementation of the PCMH model in the Australian context should provide an environment that supports good transfer of care arrangements between general practice and hospitals.

7. E-health

Information technology and e-health have the potential to improve transfer of care arrangements. A well-developed and clinician-friendly e-health system would go a long way to improving the communication between the various parts of the health system. However, it is paramount that the content of e-health records is accurate, reliable and meets clinical needs, otherwise the e-health records will not be used, and potential benefits from a well-developed system will be lost. To this end, e-health records must be (re)structured to engender trust.

While there is the potential for e-health to improve transfer of care arrangements, transfer of care summaries must be provided directly to the patient’s doctor as separate entities. Information technology and e-health systems may assist this process, for example, by enabling information to be transferred more quickly, but should not be used as a replacement for direct point-to-point communication to the patient’s doctor.

8. AMA position

While some policy and infrastructure measures have been put in place to improve transfer of care arrangements between general practice and hospitals, the AMA considers that more can be done in this area:

⁴ Beal, C. et al (2007) “Closing the divide: How medical homes promote equity in health care” results from the Commonwealth Fund 2006 Health care Quality Survey, The Commonwealth Fund, 2007

⁵ Deloitte (2008) The Medical Home: Distributive Innovation for a New Primary Care Model

General practice

- GPs should 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 patient.⁶
- GPs should be able to initiate contact with hospital staff to obtain progress reports on their patients while they are in hospital, including anticipating times when their patient will need a post-discharge appointment.
- Where possible and appropriate, GPs should be able to be e-credentialed to access local hospital electronic health records.
- General practices should be able to use local hospital specialists for training in the particular care needs of local population groups with particular medical conditions (e.g. diabetics, pregnancy).

Hospitals:

- If a patient that is referred by a GP to the hospital receives unanticipated care, the patient's GP should be promptly notified.
- Patients admitted to hospital need to nominate a GP/general practice for follow up care. Patients without a usual GP should be strongly encouraged to become a patient of a general practice.
- When a patient is admitted to hospital, the details of the patient's GP should be recorded and, where appropriate contact be made with the general practice to obtain relevant medical history, particularly if this was not provided at admission.
- GPs should be able to visit their patients in hospital during their hospital stay.
- When the patient's condition is complex or follow up needs to be provided urgently, a phone call should be made to the patient's general practice to notify of the transfer of care and make an appointment with the GP. A message should be left with the practice if the usual GP not available.
- Transfer of care summaries should be made available to the GP within 24 hours.
- Transfer of care summaries must be accurate and comprehensive. They must include a full medication list including reasons for stopping/starting medication and reason for any medication which will subsequently require PBS Authority script.
- Hospitals should supply sufficient medication to last until post-discharge appointment with a patient's GP (supply dictated by appointment time).
- In addition to transfer of care 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.
- Hospital Outreach/Hospital in the Home Services should report to the GP progressively.
- There should be GP representation within individual hospital management structures (e.g. Board director or governance or management committees) to ensure general practice issues are regularly discussed and to provide an appropriate forum for any concerns experienced by local GPs in their dealings with hospitals to be raised and addressed. GP

⁶ This may include (but not be limited to) presenting complaint and the reason for the referral, relevant current clinical information including allergies and drug sensitivities, relevant past history, current medications (and past medications) and results or relevant and recent tests and investigations.

position must represent General practice and should be subject to performance review and accountability.

- Adequate funding should be provided for the establishment and maintenance of GP Liaison Officer (GPLO) Positions and this role needs to be widely publicised and utilised. The GPLO role, job description and accountability however, need review and mechanism should be put in place to ensure the GPLO liaises with General Practice and not just with hospital.
- For outpatients, clear advice on assessment and recommended management should be given after each outpatient visit.

Financial support for appropriate transfer of care

- The MBS fee structure needs to recognise the time and complexity involved for treating medical practitioners to communicate transfer of care arrangements.
- Hospital funding and budgets need to reflect the time needed for hospital staff to produce high quality and timely transfer of care reports.
- GPs should be represented on hospital committees and should be funded to undertake this work.

Key performance indicators (KPIs)

- Part of improving transfer of care arrangements revolved around changing the culture within hospitals, KPIs could be useful in effecting this change. KPIs may include:
 - Percentage of discharge transfer of care documents reaching the GP within 24 hours.
 - Satisfaction with the standard of information provided in transfer of care summaries.
 - Percentage of letters to GPs after Outpatient appointment within a week.
 - Percentage of patients' files with GP and general practice name clearly marked.
 - Percentage of patients where GP is included in discharge planning.

The AMA Council of General Practice (AMACGP) has principal carriage of this *General Practice/Hospitals Transfer of Care Arrangements Position Statement*.

