

POSITION STATEMENT

General Practice/Hospitals Transfer of Care Arrangements

2023

This position statement outlines requirements for appropriate and effective transfer of care arrangements between the GP and the hospital and vice versa. The principles outlined for GPs and hospitals (public as well as private) are also applicable to other areas of the health system including rehabilitation, step down facilities, residential aged care and community care.

1. Introduction

- 1.1. As the population ages and the prevalence of chronic disease increases patients are relying more than ever on their general practitioner (GP) to manage and co-ordinate their care needs (including access and navigation to other providers) in order to achieve optimal health outcomes and to minimise risks. This is particularly relevant and of great significance when a patient has had hospital care. To this end, patients and GPs expect that relevant information about the treatment they have received or will receive is communicated expeditiously between all medical professionals caring for them.
- 1.2. Doctors are able to provide the best possible care to their patients when good communication exists between all treating medical practitioners at all stages of care, spanning across community settings and particularly between the community and acute or subacute hospital care.
- 1.3. 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 adverse events minimised, hospital readmissions reduced, and efficiencies made¹, but also the patient, their families, the doctors and other health practitioners involved in providing care have a much more satisfactory and positive experience^{2,3}.

1 Hall KK, Shoemaker-Hunt S, Hoffman L, et al. Rockville (MD): Agency for Healthcare Research and Quality (US); 2020 Mar.

2 Continuity and coordination of care: a practice brief to support implementation of the WHO Framework on integrated people-centred health services. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO. Sourced from: <http://apps.who.int/iris/bitstream/handle/10665/274628/9789241514033-eng.pdf?ua=1>

3 Newnham H, Barker, A, Ritchie E, Hitchcock K, et al. Discharge communication practices and healthcare provider and patient preferences, satisfaction and comprehension: A systematic review, *International Journal for Quality in Health Care*, Volume 29, Issue 6, October 2017, Pages 752–768, <https://doi.org/10.1093/intqhc/mzx121>

2. Continuity of care between general practice and hospitals

- 2.1. Continuity of care is a key tenet of quality care and positive patient experience. The key to continuity of care between GPs and hospitals is comprehensive, accurate and timely two-way communication regarding the admission process, the in-patient treatment and the patients' on-going care needs once discharged from hospital.
- 2.2. When a GP initiates a referral to hospital, they have a responsibility to provide a comprehensive referral containing up-to-date health status and diagnoses, current medication list, the relevant investigation results and other relevant information including the details of relevant other healthcare practitioners involved in care to enable appropriate hospital access, assessment and management.
- 2.3. Equally, when a patient has received hospital care, the GP needs timely and comprehensive communication about the care provided, including transfer of care arrangements in order to enable the GP to continue providing high-quality care for the patient.
- 2.4. The entire process of a patient's experience - from care provided by a GP in the community to hospital care and then appropriate and timely handover back to the GP - should be as seamless as possible. The patient should be assured of continuity and consistency in their care and treatment and share understanding and clarity about ongoing responsibilities. 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

- 3.1. Delayed or inaccurate communication between treating medical practitioners (GPs and hospital-based doctors) during transfer of care may negatively affect continuity of care and contributes to adverse events.⁴
- 3.2. Accurate and timely hospital transfer of care information is 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. Studies have shown that inadequate discharge arrangements can lead to costly and unnecessary hospital readmissions, preventable adverse events and drug-related errors^{5,6} For example, a study on the timeliness of discharge summaries showed that the absence of a discharge summary was associated with a 79 per cent

4 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.

5 Earl T, Katapodis N, Schneiderman S. Care Transitions. In: Hall KK, Shoemaker-Hunt S, Hoffman L, et al. *Making Healthcare Safer III: A Critical Analysis of Existing and Emerging Patient Safety Practices* [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2020 Mar. 15. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK555516/>.

6 Schwarz CM, et al (2019) A systematic literature review and narrative synthesis on the risks of medical discharge letters for patients' safety. *BMC Health Services Research* (2019) 19:158 <https://doi.org/10.1186/s12913-019-3989-1>

increase in the risk of readmission within 7 days and a 37 per cent increased risk of readmission within 28 days.⁷

- 3.3. Numerous studies have shown that a review post discharge with the patients GP within two to four weeks of hospital discharge reduces the incidence of emergency department presentation and re-admission rates by 50 per cent^{8,9,10,11}. This reduces bed demand on the tertiary health system, fiscal cost to the society, and would reduce access block and ramping.
- 3.4. It is logical to reduce the burden on our public hospitals, that an active policy and funding to achieve this action be considered by governments, both federal and state in a collaborative manner. This should at a minimum be applied to complex patients where the cost benefit ratio would be in 'orders of magnitude'.
- 3.5. National Safety and Quality Standards for Health Services (Communicating for Safety Standard)¹² requires that 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 supports safe patient care.

4. Appropriate and effective transfer of care arrangements

- 4.1. 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.
- 4.2. GP referral to hospital
 - 4.2.1 When a GP initiates a referral to hospital, they should communicate with the hospital by most appropriate method (including phone) and provide the following details:

7 Li et al (2013) Timeliness in discharge summary dissemination is associated with patients' clinical outcomes. *J. Eval. Clin. Pract.*. 2013 Feb;19(1):76-9.

8 Vernon D, Brown JE, Griffiths E, Nevill AM, Pinkney M. Reducing readmission rates through a discharge follow-up service. *Future Healthc J.* 2019 Jun;6(2):114-117. doi: 10.7861/futurehosp.6-2-114. PMID: 31363517; PMCID: PMC6616175.

9 Mashhadi SF, Hisam A, Sikander S, Rathore MA, Rifaq F, Khan SA, Hafeez A. Post Discharge mHealth and Teach-Back Communication Effectiveness on Hospital Readmissions: A Systematic Review. *Int J Environ Res Public Health.* 2021 Oct 4;18(19):10442. doi: 10.3390/ijerph181910442. PMID: 34639741; PMCID: PMC8508113.

10 Leppin AL, Gionfriddo MR, Kessler M, Brito JP, Mair FS, Gallacher K, ... Montori VM. (2014). Preventing 30-Day Hospital Readmissions: A Systematic Review and Meta-analysis of Randomized Trials. *JAMA Internal Medicine.* 174: 1095-1107. <https://doi.org/10.1001/jamainternmed.2014.1608>

11 Chu D and Johnson T. Avoiding hospital readmissions: the models and the role of primary care. Evidence Brief no: 24 19 May 2022. Deeble Institute for Health and Policy Research. Sourced from: https://ahha.asn.au/system/files/docs/publications/hospital_readmissions_reduction_primary_care_role_0.pdf

12 Australian Commission on Safety and Quality in Health Care Communicating for Safety Standard, <https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard>

- a) demographic and contact information
- b) reason for referral to the health service
- c) relevant findings, investigations; medical summary, medicines and allergies
- d) infectious state (if relevant)
- e) knowledge of any treatment being provided by other health practitioners
- f) an Advance Health Care Plan (when appropriate)
- g) the person's need for interpreter and/or cultural support. Any disability support needs, including advocates and/or alternative decision makers
- h) where relevant, a copy of the GP Management Plan, Comprehensive Medical Assessment and Mental Health Treatment Plan with the permission of the patient.

4.3. General Practitioners: details and follow-up

- 4.3.1 Health service administrators must ensure the name and contact details of a patient's General Practitioner and/or practice is verified and updated on the patient record at each episode of care by the health service.
- 4.3.2 When a patient is admitted directly to a hospital via emergency department or outpatient clinic the details of the patient's GP must be recorded and, where appropriate, contact made with the general practice to obtain relevant medical history. Where a patient has complex care needs their GP must be directly involved in the planning for management and discharge of their patient. Hospitals must enable an admitted patient to be visited by their GP during their hospital stay.
- 4.3.3 Patients without a usual GP should be strongly encouraged to become a patient of a general practice (but this should not result in patients being "allocated" to a GP).
- 4.3.4 A copy of the discharge summary should be sent to the referring GP/general practice.

4.4. Communication with a patient's GP

- 4.4.1 Timely, formal communication with a patient's GP (which includes appropriate contact details of relevant treating clinicians) should occur in the following circumstances and with the following timelines:
 - a) unplanned inpatient admission within 24 hours
 - b) discharge from an inpatient admission within 24 hours
 - c) when necessary, during hospital admission
 - d) after attendance at an emergency department or short-stay setting within 24 hours
 - e) on patient death or other sentinel events within 24 hours
 - f) initial specialist outpatient consultation within 7 days
 - g) changes in health status or medication at a specialist outpatient service within 7 days
 - h) discharge from specialist outpatient clinic within 7 days
 - i) Hospital Outreach/Hospital in the Home Services should report to the GP progressively (every week at a minimum)
 - j) a handheld paper based clinical summary should be given to the patient particularly if seeing the GP for immediate follow up.
- 4.4.2 During transfer of care back from hospital to community or residential aged care, the patient's GP needs to be provided with clear and appropriate information to support safe and meaningful clinical handover of patient care. This includes:

- a) a summary of the patient's primary and secondary diagnosis/es, complications, procedures and management
- b) a summary of relevant investigations
- c) details of any allied health and support services provided to the patient while in hospital
- d) changes to medications, including clear documentation of reason for change
- e) a list of medications to be administered following discharge, including their timeline and details of the supply given to the patient by the hospital
- f) any allergies, reactions or alerts
- g) details of arrangements for ongoing care, including details of any follow-up appointments and clarity about the care to be provided by various providers
- h) details of the information provided to the patient/family
- i) support and care arrangements for family members and carers
- j) an Advance Health Care Plan (when relevant).

4.4.3 Further, the hospital should provide adequate supplies of medication to last until the patient can obtain an appointment with their GP or a GP at their usual general practice. Efforts should be made prior to discharge to make a timely follow up appointment with the GP.

4.5. Discharge planning and urgent/complex care

4.5.1 As soon as a patient is cared for by a 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 and general practice.

4.5.2 The discharge care planning processes for patients with complex needs requires greater collaboration and planning between the hospital and a patient's GP and in addition to the above should include:

- a) Routine consideration for the need to undertake telephone, video conference or face-to-face case conferencing prior to discharge that includes the General Practitioner and/or referring doctor.
- b) 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 impending transfer of care and ensure that a post discharge appointment with the GP is made and communicated to the patient at the time of transfer.
- c) Outpatient appointment/s date/s (if required) scheduled prior to discharge.
- d) The ability for expedited re-assessment in the Emergency Department if the patient's medical condition deteriorates and warrants the patient's representation.
- e) A documented plan of care and support to be provided to the General Practitioner.
- f) GPs should be able to initiate contact with hospital staff to obtain progress reports on their patients while they are in hospital.
- g) Post-Acute Care services and other supports are put in place prior to discharge.
- h) Easy and timely access to hospital-based specialists by General Practitioners for post discharge management discussions, advice and support.

- i) 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 best practice.
- j) If a patient that is referred by a GP to the hospital receives unanticipated care or has a significant deterioration of their condition, the patient's GP should be promptly notified.

4.6. Outpatient services communication

- 4.6.1 With regard to transfer of care arrangements for outpatients, clear advice on assessment and recommended management should be given after each outpatient visit.
- 4.6.2 The AMA Guide *10 Minimum Standards for Communication between Health Services and General Practitioners and Other Treating Doctors* outlines ten minimum standards that should apply for communication between health services, GPs and other treating doctors.

5. Local Hospital and Primary Health Networks

- 5.1 The establishment of Local Hospital Networks (LHNs) and Primary Health Networks (PHNs) provides an environment to support best practice clinical handover and transfer of care arrangements.
- 5.2 LHNs and PHNs need to ensure that primary, secondary and tertiary health care services engage and work together effectively around patient need.
- 5.3 LHNs and PHNs should have formal engagement protocols and some common membership in their respective governance structures, and work together in areas such as hospital avoidance, clarifying areas of responsibility, minimisation of waiting lists, and assisting with patients' transitions between sectors and, where relevant, into aged care.¹³ In this regard, LHNs and PHNs could fund GP Liaison Officers (GPLOs) to develop and, as existing services are modified or new clinical streams developed, evolve collaborative pathways for improving discharge summaries, transfer of care and communication between hospital based doctors and a patient's regular GP, ensuring that best practices are implemented.
- 5.4 While the majority of LHNs/PHNs have implemented a mechanism for improving care pathways across various parts of the health system in their areas (eg. HealthPathways), this has not happened consistently across Australia and there is more to be done to see this delivered nationally. Ongoing evaluations of improvements to care pathways made and reporting of the findings should be undertaken and shared broadly with the health profession to inform further initiatives for realising the delivery of care that is integrated, seamless and coordinated.

¹³ National Health and Hospitals Network Agreement, http://www.federalfinancialrelations.gov.au/content/other_related_agreements/NHHN_Agreement.pdf.

6. Digital Health and My Health Record

- 6.1 Digital technology, including My Health Record, has the potential to support good transfer of care arrangements. Digital health systems which are interoperable, and which connect the various silos of healthcare can improve communication between doctors and health providers caring for patients transitioning across the health system. It is therefore important that there is a harmonisation of interoperability standards and other records-related requirements across jurisdictions, stronger compliance action to require software developers to comply with interoperability standards, and where necessary, funding to enable them to do so*.
- 6.2 Relevant clinical information uploaded to a patient's My Health Record prior to transfer may be important when it is accessed by other doctors and health providers caring for the patient afterwards. This may be particularly helpful when a patient attends hospital in an emergency, or when a patient is discharged from hospital and the treating GP who will take over care is unclear or unknown. However, it is paramount that the content of clinical information on a patient's My Health Record is accurate and relevant. This requires the My Health Record system to be designed to be usable and to facilitate the easy upload from, download to and display of critical clinical information in the GP's patient record.
- 6.3 Hospitals should upload transfer of care summaries to a patient's My Health Record, to facilitate timely communication including in circumstances of unanticipated care by doctors and health providers other than the patient's usual GP. My Health Record allows uploaded information to be accessible to a range of potential health providers who may later have to care for a patient after transfer (this is called "point to space" communication).
- 6.4 It is crucial that My Health Record does not replace direct communication with a patient's usual doctor known as "point-to-point" communication. While My Health Record can improve communication during transfer of care by providing instant access to patient records, transfer of care summaries must also be provided directly to a patient's usual doctor via systems such as secure messaging, fax or letter.
- 6.5 GPs who use the My Health Record should consider uploading a Shared Health Summary for all patients, particularly those who have serious or complex medical conditions and who are more likely to require unanticipated hospital admissions. Alternatively, these patients should be provided with a paper based medical summary to carry with them or store in a readily accessible place at home particularly if the patient has opted out of My Health Record.
- 6.6 Hospitals should have secure and reliable electronic systems to send and receive information to and from the Health Service and General Practitioners and other treating doctor(s). Interoperability standards that enable real time transfer of information pertaining to a patient's care must be introduced with appropriate compliance measures.

7 Resourcing and Key performance indicators (KPIs)

- 7.1 The AMA regards transfer of care as a core element of the provision of health care that requires sufficient standards, investment, and accountability. In this context:
- a) The MBS fee structure must recognise the required time and complexity involved for treating medical practitioners to communicate transfer of care arrangements in line with best practice.
 - b) Hospital funding and budgets need to reflect the time needed for hospital staff to produce high quality and timely transfer of care reports.
 - c) GPs should be represented on hospital committees and should be funded to undertake this work.
 - d) There should be GP representation within individual hospital management structures (e.g. Board Director, GP Liaison Officer, or membership of other governance or management committees such as Quality and Safety and Clinical Governance committees) to promote and improve collaboration with and understanding of issues impacting patient care for local GPs.
 - e) Adequate funding should be provided for the establishment and maintenance of general practitioners in the position of GP Liaison Officer (GPLO). This role must be widely publicised and utilised. PHNs should fund GPLO Networks within their jurisdictions thereby providing a platform for members to share ideas, learnings and solutions to support improvement at the local level.
 - f) Improving transfer of care arrangements partly revolves around changing the culture within hospitals and KPIs could be useful in effecting this change. KPIs may include:
 - a. percentage of discharge transfer of care documents reaching the GP within 24 hours
 - b. satisfaction with the standard of information provided in transfer of care summaries
 - c. percentage of letters to GPs after outpatient appointment within a week
 - d. percentage of patients' hospital records accurately listing the patient's usual GP and general practice
 - e. percentage of patients where the usual 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*.

See also:

* [AMA's 10 Minimum Standards for Advancing Digital Health in General Practice](#)

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