



## General Practice/Hospitals Transfer of Care Arrangements – 2018

### 1. Introduction

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 significant 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.

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, 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 adverse events minimised, hospital readmissions reduced, and efficiencies made, but also 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 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.

### 2. Continuity of care between general practice and hospitals

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.

When a GP initiates a referral to hospital, they have a responsibility to provide a comprehensive referral containing up-to-date summaries, current care plans or health check summaries, current medication list, the relevant investigation results and other relevant information to enable appropriate hospital access, assessment and management.

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.

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**

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.<sup>1</sup>

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. A recent study has shown that the absence of a discharge summary was associated with a 79% increase in the risk of readmission within 7 days and a 37% increased risk of readmission within 28 days.<sup>2</sup>

National Safety and Quality Standards for Health Services (*Safety and Quality Improvement Guide Standard 6: Clinical Handover*)<sup>3</sup> 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**

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.

#### GP referral to hospital

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:

- Demographic and contact information.
- Reason for referral to the health service.

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<sup>1</sup> 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.

<sup>2</sup> 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.

<sup>3</sup> 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](http://www.safetyandquality.gov.au/wp-content/uploads/2012/10/Standard6_Oct_2012_WEB.pdf).

- Relevant findings, investigations; medical summary, medicines and allergies.
- Knowledge of any treatment being provided by other health practitioners.
- An Advance Health Care Plan (when appropriate).
- The person's need for interpreter and cultural support.
- Any disability support needs, including advocates and/or alternative decision makers.
- Where relevant, a copy of the GP Management Plan, Comprehensive Medical Assessment and Mental Health Treatment Plan with the permission of the patient.

#### General Practitioners: details and follow-up

- 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.
- When a patient is admitted directly to a hospital via emergency department or outpatient clinic 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. A GP visit to their patients in hospital during their hospital stay should be encouraged.
- 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).
- A copy of the discharge summary should be sent to the referring GP/general practice.

#### Communication with a patient's GP

Timely, formal communication (which includes appropriate contact details) with a patient's GP should occur in the following circumstances and with the following timelines:

- Unplanned inpatient admission within 24 hours.
- Discharge from an inpatient admission within 24 hours.
- When necessary, during hospital admission.
- After attendance at an emergency department or short-stay setting within 24 hours.
- On patient death or other sentinel events within 24 hours.
- Initial Specialist outpatient consultation within 7 days.
- Changes in health status or medication at a specialist outpatient service within 7 days.
- Discharge from Specialist outpatient clinic within 7 days.
- Hospital Outreach/Hospital in the Home Services should report to the GP progressively (every week at a minimum).
- A handheld paper based clinical summary should be given to the patient particularly if seeing the GP for immediate follow up.

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 summary of the patient's primary and secondary diagnosis/es, complications, procedures and management;
- A summary of relevant investigations;
- Details of any allied health and support services provided to the patient while in hospital;
- Changes to medications, including clear documentation of reason for change;
- A list of medications to be administered following discharge, including their timeline and details of the supply given to the patient by the hospital;

- Any allergies, reactions or alerts;
- Details of arrangements for ongoing care, including details of any follow-up appointments and clarity about the care to be provided by various providers;
- Details of the information provided to the patient/family;
- Support and care arrangements for family members and carers;
- Details of follow up appointments, if any; and
- An Advance Health Care Plan (when relevant).

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.

#### Discharge planning and urgent/complex care

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.

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:

- 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.
- 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 post discharge appointment with the GP is made and communicated to the patient at the time of transfer.
- Outpatient appointment/s date/s (if required) scheduled prior to discharge.
- The ability for expedited re-assessment in the Emergency Department if the patient's medical condition deteriorates and warrants the patient's representation.
- A documented plan of care and support to be provided to the General Practitioner.
- 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.
- Post-Acute Care services and other supports are put in place prior to discharge.
- Easy and timely access to hospital-based specialists for General Practitioners for post discharge management discussions, advice and support.
- 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.
- 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.

#### Outpatient services communication

With regard to transfer of care arrangements for outpatients, clear advice on assessment and recommended management should be given after each outpatient visit.

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. It can be found at: <https://ama.com.au/article/10-minimum-standards-communication>.

## **5. Local Hospital and Primary Health Networks**

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.

LHNs and PHNs need to ensure that primary, secondary and tertiary health care services engage and work together effectively around patient need.

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, clarity in responsibility, minimisation of waiting lists, assisting with patients' transitions between sectors and, where relevant, into aged care.<sup>4</sup> In this regard, LHNs and PHNs could fund GP Liaison Officers (GPLOs) to devise collaborative pathways for improving discharge summaries, transfer of care and communication between hospital based doctors and a patient's the regular GP, ensuring that best practices are implemented.

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

## **6. Digital Health and My Health Record**

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.

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 easy upload and display of critical clinical information.

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. *My Health Record* allows uploaded information to a range of

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<sup>4</sup> National Health and Hospitals Network Agreement, [http://www.federalfinancialrelations.gov.au/content/other\\_related\\_agreements/NHHN\\_Agreement.pdf](http://www.federalfinancialrelations.gov.au/content/other_related_agreements/NHHN_Agreement.pdf).

potential health providers who may later have to care for a patient after transfer (this is called “point to space” communication).

GPs who use the *My Health Record* should consider uploading a Shared Health Summary for their patients 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.

Hospitals should upload to a patient’s *My Health Record*, transfer of care summaries to facilitate communication in circumstances of unanticipated care by doctors and health providers other than the patient’s usual GP.

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). These should interface with patient information management systems commonly used by General Practitioners and other treating doctors in private or community clinic settings.

## **7. Resourcing and Key performance indicators (KPIs)**

While some policy and resourcing has been put in place to improve transfer of care arrangements between general practice and hospitals, the AMA considers the achievements inconsistent with too many transfers not meeting best practice. The AMA regards this as a core area in the provision of health care that requires sufficient standards, investment, and accountability. In this context:

- 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.
- 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.
- 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 ensure general practice issues are regularly discussed and to allow for concerns of local GPs in their dealings with hospitals to be raised and addressed in an appropriate forum.
- 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.
- Improving transfer of care arrangements partly revolve around changing the culture within hospitals and 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' hospital records listing the patient's usual GP and general practice.
- 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*.

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