

# SESAHS STRATEGIC PLAN

WORKING with GPs

to IMPROVE

1998

2000

CONTINUITY of CARE



**WORKING WITH GPS  
TO IMPROVE  
CONTINUITY OF CARE**

**SESAHS STRATEGIC PLAN**

**1998-2000**

# Foreword

I am very pleased to be presenting this first strategic plan for General Practitioner Liaison in SESAHS. This document brings together the past experience of the hospitals and General Practitioners in our Area and highlights the integral role played by GPs in enhancing the public health system.

This plan builds on activities of proven value and suggests new ideas for improvement in the continuum of care in our Area.

I commend it to you.

Deborah Green  
**Chief Executive Officer**

October 1998

# Acknowledgements

The ideas expressed in this paper have been formally and informally discussed with numerous General Practitioners, local and interstate Directors of Divisions of General Practice, local hospital administrators and clinicians.

In particular, the author would like to acknowledge Mr Gawaine Powell Davies, Integration SERU Coordinator and Ms Jane Lloyd, GP and Hospital/Acute Care Network Coordinator for Integration SERU, for making the relevant SERU documents available during the preparation of this paper.

Prepared by Dr Sylvia Jacobson, SESAHS GP Liaison Coordinator, Clinical Services Policy and Planning Unit.

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# Executive Summary

**The recommendations** for the way forward in SESAHS for improving continuity of care and integrating GPs into hospitals **originate from:**

- Experience gained in South Eastern Sydney Area Health Service and the former Eastern and Southern Sydney Area Health Services
- Reviewing the initiatives, projects and programs that have been trialed over the last 5-6 years by Area Health Services, Divisions of General Practice and Academic Departments of General Practice
- Recommendations from NSW Health Services' "Vision & Strategic Plan", the NSW Health Taskforce on General Practice and the Integration SERU's "GPs and Hospitals Working Together" and
- Consultation with Divisions of General Practice, Integration SERU, Area health staff and state and interstate Divisions & Departments of General Practice

**The main barriers** that have been identified to improving continuity of care in SESAHS are:

- Communication with GPs at the time of admission and discharge as well as notification of procedural bookings and in the event of death
- Hospital systems functioning as secondary and tertiary institutions poorly linked to primary health carers especially GPs
- Differences in culture between hospitals and GP practice
- Funding arrangements of GPs

**SESAHS plans to**

- Improve communication with GPs and promote the concept of continuity of care
- Raise the profile of GPs in its hospitals and community health services
- Promote a change in culture within Area facilities to improve the appropriate inclusion of GPs in the processes of continuity of care.
- Fund GP involvement (eg hospital GP liaison, patient discharge planning)
- Encourage accessibility of GPs
- Encourage networking
- Evaluate the effectiveness of its strategy.

**Effective strategic planning** requires inclusion of the *Cochrane Collaboration on “Effective Professional Practice”* (CCEPP) which highlights the need to combine dissemination of information with one or more of the following:

- ensuring participation of stakeholders/opinion leaders in development of strategies (clarifying purpose/priorities)
- educational programs
- reminders
- audit and feedback
- rewards and penalties

# 1.0 Introduction

During the past six years in the healthcare system in Australia there has been a strong emphasis from governments, Area Health Services and Divisions of General Practice on improving the working relationship between hospitals, community health services and general practitioners.

South Eastern Sydney Area Health Service (SESAHS) has been particularly committed to this goal with GP consultation and inclusion at all levels of planning and services.

Across the country numerous pilot programs/projects to promote hospital-GP integration have been trialled and evaluated. The Integration Support and Evaluation Resource Unit (SERU) has reviewed these and produced the document *“From Projects to Programs: GPs & Hospitals Working Together”*, which provides an overview of currently accepted practice and aims to support the development of quality GP and hospital projects/programs.

The working relationship that has been established between the Area Health Service and the Eastern Sydney, South Eastern Sydney, St George and Sutherland Divisions of General Practice as well as individual GPs has highlighted that the culture differences between hospital based services and that of general practice has significantly contributed to the difficulties experienced in achieving a seamless process between hospital and community care. The inclusion of GPs in a consistent and meaningful way during health service planning is encouraged and GP input has proven to be of significant value in the development of future directions for services in the Area.

With the benefit of the recent document *“From Projects to Programs: GPs & Hospitals Working Together”*, the report *“General Practice, Changing the Future Through Partnerships”* and the experience of the SESAHS GP Liaison Coordinator, it is timely now to provide our hospitals and community health services with a document from which to move forward in the process of improving hospital-GP relationships and facilitating continuity of care in South Eastern Sydney.

This document although at times repetitive, highlights that the same or similar issues have been identified for over 10 years in numerous and varied settings.

It is envisaged that this strategic plan will be used as a working document by all the hospitals and community health services across SESAHS to implement the changes necessary for self sustaining, significant changes in GP-hospital communication.



## 2.0 Background

All the policies, papers, recommendations and initiatives in relation to promoting a collaborative approach between hospitals and GPs to health service delivery, have focussed on:

- **improving communication with GPs**
- **including GPs in the planning of health services and**
- **the role of GPs as primary care providers .**

This chapter attempts to provide an overview of some of the major recommendations and reports of the NSW State government.

### 2.1 History

Since the mid 80's General Practitioners have been acknowledged as the primary health carers and have been seen as providing longitudinal and holistic care for patients and their families. As well they have been in the best position for participating in health promotion and screening programs. However for many years GPs, governments and area health services have been raising questions about poor communication between GPs and hospitals.

In 1988 in the *Policy Statement for General Practitioner Involvement in Larger Hospitals within the Area Health Service*<sup>1</sup> it was raised that GPs were isolated and had very little contact with the University Teaching Hospitals. The major issues which were identified included:

- Poor verbal and written communication between hospital staff and the patients nominated GP including information on patient admission, discharge or death thus not encouraging the concept of continuity of care.
- Patients are discharged earlier from hospital but GPs are not given adequate information from the hospital to be able to provide the best quality care to their patients.
- Junior Hospital Doctors (Interns and RMO's) have minimal contact with and understanding of General Practice. They are not taught the importance of the GPs' role in the continued management of patients and they see hospital residency as having limited relevance to GP training despite the fact 50% of them will become GPs .
- GPs are isolated from the wider medical community with lack of opportunities for continuing education.
- Many hospital doctors, many patients and even some GPs hold the GP in poor regard resulting in greater reliance on specialists and hospitals. This has financial implications for hospitals, GPs and the Medicare system.

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<sup>1</sup> Goldstein S. et al. 'Policy Statement for General Practitioners Involvement in Larger Hospitals within the Area Health Service' Eastern Sydney Area Health Board (October 1988)

## ***2.2 History of NSW Health Department Policy Directions***

A NSW Health policy document entitled “***NSW Health Outcomes & Resource Distribution***” was intended to provide a useful overview of the initiatives for change arising out of the Minister’s “*Economic Statement for Health*”<sup>2</sup>.

The policy highlights include:

- In the area of primary care, health services are currently exploring the development of arrangements whereby general practitioners may manage specific health issues with GPs assuming responsibility for aspects of the management of disease-specific programs which have discrete budget allocations. A number of NSW pilot projects to improve the outcomes of diabetes care are currently considering the appropriateness and effectiveness of such arrangements.
- A key area for change is to better integrate the role of the primary care providers with the public health system over time. General practitioners are currently being involved in policy development in this area by NSW Health and the NSW General Practice Advisory Committee has recently commissioned a discussion paper on strategies for better integration for the future.

It also makes reference to managers in the NSW Health system having to employ effective methods for engaging GPs on health services issues.

In August 1989, the Department of Health distributed a circular<sup>3</sup> which outlined procedures to improve communication between hospitals, community health and GPs. Ideas included noting patient’s GP prominently in the medical record, conferring with GPs regarding ongoing management of their patients, promoting communication with GPs and encouraging patients to find a regular GP.

In April 1997, NSW Health Department circulated to Area Health Services the “***General Practice Advisory Committee Review of the Recommendations of the 1994 Health Taskforce on General Practice***”<sup>4</sup> which highlighted amongst other issues:

- Policies for developing directories of local public health service
- Identifying the role of the general practitioners with hospitals and community health services in relation to continuity of care
- GP involvement in undergraduate education, training and clinical experience of community based care

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<sup>2</sup> ‘NSW Health Outcomes and Resource Distribution’ Christine Giles Presentation to the ‘Managing Health Care and Competition’ Conference, 4 March 1997

<sup>3</sup> Department of Health NSW, Circular No:89/117 ‘Procedures for Liaison with General Practitioners by Community Health Services and Hospitals’ (August 1989)

<sup>4</sup> General Practice Advisory Committee (1997) Review of the recommendations of the 1994 NSW Health Taskforce on General Practice, NSW Health

The outcome from the second NSW Health/General Practice Forum “**Collaboration for Integration**” held in May 1997 were four resolutions:

- mechanisms to involve funding mechanisms be established to facilitate collaboration between General Practice and NSW Health services
- formal local structures be established for collaboration between Area Health Services and Divisions of General Practice.
- a recommendation be put to the Minister that GP members be included on Area Health Boards to put the GP view and give the AHS view back to GPs
- consumers views in collaboration will be explored

### ***2.3 NSW Health Department Initiative***

In February 1997, the “***Integration of General Practice & NSW State Health Services: A Vision & Strategies Plan***” was prepared by consultants Dr James Wall & Mr Paul Harney. The study was commissioned as a result of the forum “Integrating Care in NSW” which identified the need for the Divisions of General Practice, the Area Health Services and the NSW Health Department to develop a vision and strategic plan (Appendix 1). It was prepared after surveys and interviews with GP, Area and public sector representatives.

#### **The study showed that:**

Over 80% of ALL respondents agreed that the key elements shaping future health care service delivery in NSW should include:

- Integrated health care delivery
- GP involvement in all levels of decision making
- Higher levels of continuity of care
- Reducing duplication of services
- Improved access to health services
- Benchmarking effective use of resources (financial, physical & human)
- Joint planning between Area Health Services and Divisions of General Practice
- Encouragement of diverse integration initiatives
- Establishing of achievable strategic goals over the next 1-5 years by NSW Health, Area Health Services and Divisions of General Practice.

Over 90% of heads of Divisions of General Practice and CEOs of Areas/District Health Services agreed that:

- Divisions of General Practice, Area Health Services and NSW Health should establish mechanisms to coordinate, monitor and evaluate integration initiatives in NSW
- The existing separation of NSW health services and GP services limits the quality of care to patients and constrains improvements in quality of care.

## **Conclusions of the study included:**

### (i) Experience of Integration

There is a long way to go before any one of the Divisions of General Practice and Area Health Services in NSW successfully establish continuity of care at the personal and the divisional level. Participants indicated a readiness for change and a willingness to move toward integration of services.

### (ii) Major Changes

There was almost universal agreement that GPs should be the central co-ordinators of primary patient care.

### (iii) Funding

Strategies to share successful projects and initiatives should be developed, creative solutions to funding issues should be sought and GPs should be adequately reimbursed for activities such as lecturing and committee participation .

### (iv) Major Obstacles

More than 80% of ALL respondents believed that the major obstacles to integration were:

- GPs not being seen as pivotal in primary care delivery
- Funding structures as they exist
- Constraints on funding in the present climate
- Attitudes and beliefs of public health sector professionals based on their past experiences
- Professional boundaries are too isolating

### (v) Information Services /Health Promotion

The strategies to improve communication with GPs which received strong support included:

- Regular meetings between NSW Health, Area Health Services and Divisions of General Practice (96%)
- Directories of local health services for GPs (94%)
- A state wide system which notifies GPs of patient admission and discharge within a realistic timeframe (90%)
- A common health promotion plan jointly developed by Divisions of General Practice and Area/District Health Services (90%)
- A community directory for distribution to health consumers ( 88%)
- A communication mechanism to keep GPs updated on current policies and activities of the Health Department (88%)

### (vi) The role of the General Practitioners

The role of the GP as the central coordinator of comprehensive health care to individuals, families and communities has to be carefully worked through with other health professionals and managers. The clarification of the various responsibilities and roles played by those involved in health care is a key strategy for future integration of services.

(vii) Accountability/Best Practice

The interview feedback indicated that the key to successful coordination, support and evaluation of the integration of services is a collaborative endeavour among the key stakeholder groups; Divisions of General Practice, Area Health Services and NSW Health.

*The NSW Department of Health General Practice Advisory Committee (GPAC) suggestions regarding this report were that:*

- GPAC should be enhanced by extending its linkages with relevant NSW Health management, representatives and other organisations. It is essential that these linkages are echoed by local structures comprising of Divisions and Area Health Services.
- General Practitioners should receive adequate monetary compensation for work that they undertake in the development, organisation and provision of integrated health care.

## ***2.4 Commonwealth Initiative***

The Minister for Health and Family Services asked the General Practice Strategy Review Group to review the progress of the General Practice Strategies recommended by the Commonwealth Government for implementation over the last few years. This review group was also requested to identify achievements and areas for improvement and to provide advice on future directions.

From July 1997 the General Practice Strategy Review Group consulted across all States and Territories and released its recommendations in March 1998 in a report "*General Practice, Changing the Future Through Partnerships*".

This report includes amongst numerous recommendations, clear statements that:

- general practice embrace the team approach to ensure GPs' central role in the coordination and integration of health care
- GPs have a recognised role in the planning and development of health services
- GPs be active participants in the ongoing evaluation of the effects of policy implementation

## ***2.5 Funding***

GPs are remunerated under a Commonwealth fee for service agreement which is based on the content of face to face patient services and the time taken to perform the service. The Commonwealth does not pay for visiting patients in hospital, attending case conferences or involvement in health planning or policy forums.

The Australian Health Ministers Advisory Council (1993) identified establishing and maintaining appropriate remuneration levels for general practitioners working in public hospitals as a major issue.

States are responsible for hospital care and community health whereas the Commonwealth is responsible for primary medical care. So at this time hospitals would need to fund GP involvement in hospital care. Difficulties with this form of commitment arise because of funding constraints in State Health.



## 3.0 Current Status in SESAHS

### 3.1 GP liaison role

In 1992 a GP Liaison Officer was appointed under the Community Health Services & Programmes Management structure in Eastern Area Health Service. The role focused on networking extensively within the hospital and community health services, raising awareness of issues related to GPs and promoting the inclusion of GPs in planning of relevant services. At the same time good links were established with local GPs.

At that time, there were no Divisions of General Practice in the Eastern Suburbs but a few GPs were expressing interest in establishing them. The GP Liaison Officer worked closely with these GPs initially in establishing the Eastern Sydney and South Eastern Sydney Divisions of General Practice with a potential membership of 350 and 250 GPs respectively. The Eastern Sydney Area Health Service assisted these Divisions in their formative stages with administrative support, photocopying, mailing etc.

During the process of networking within the Area Health Service, with GPs and their representative bodies, the GP Liaison Officer gained a sound understanding of the issues for these groups, one of which is communication between them.

In 1993 a survey was undertaken in conjunction with the Area Quality Assurance Co-ordinator of all the GPs in the Area to assess their perceptions of the communication with the local hospitals. This included questions on discharge summaries, phone calls at time of admission, discharge or death of a patient as well as telephone access to hospital staff.

The results indicated communication rarely occurred regarding a patient's admission, deterioration in conditions or death while in hospital.

Discharge summaries were received by over 80% of GPs but there were significant complaints that these were illegible and contained inadequate information.

In 1994, a similar survey was undertaken to determine GPs level of satisfaction with the services offered by Community Health Services & Programmes. Included in this survey were questions devoted to the level of satisfaction or usefulness of the monthly mailout and GP Liaison newsletter.

The conclusions and recommendations from this survey indicated that there was a need for better information about the locations and range of services available to the local community and the GPs who care for them. It was also apparent that some communication problems between GPs and community health staff needed addressing. The GPs indicated that the information sent to them was useful.

These surveys highlighted some of the fundamental issues that needed addressing for continuity of care and a seamless health care service. The GP Liaison Officer brought the issues to the attention of senior clinical and management staff in various forums with the intention of promoting change.

**The GP Liaison Officer became a contact person for Area Health staff, Divisions of General practice and local GPs. Requests from Area staff included advice on how to consult appropriately and work with GPs. From these introductions, many worthwhile projects developed such as Mental Health, and Older People's Shared Care projects, Cervical Screening and Post Natal Depression Programs.**

**The Divisions of General Practice accepted the GP Liaison Officer position as a helpful link in making contact for them within the Area and providing them with relevant information about the Health Services.**

The GP Liaison Officer initiated regular seminars for GPs to which Area Health staff were invited providing opportunities for GPs and Area Health staff to meet. These have proved most successful with between 40 and 70 people attending each meeting, 10-20 percent being Area Health staff mainly from Community Health Services.

There is a monthly newsletter/mailout to GPs in which information on current public health matters, community resources, Area Health Services and facilities and educational activities are included.

In October 1995, after the amalgamation of Eastern & Southern Sydney Area Health Services, the GP liaison role was extended across the South Eastern Area with the St George and Sutherland Divisions of General Practice, Area facilities and services being included in the brief.

**The role of the GP Liaison Officer has evolved in response to the needs and changes of the Area Health Service and those of the Divisions of General Practice and now includes advice on planning and delivery of current programs and services. The role is that of a consultant often acting as a facilitator of new initiatives in relation to improving communication with GPs.**

In 1996 the GP Liaison Officer's line of reporting was transferred to the Director of Clinical Services and is now titled **GP Liaison Co-ordinator, with responsibility for:**

- Networking broadly across the Area and amongst GPs
- Facilitating GP/hospital liaison meetings
- Raising profile of GPs at all levels across the Area
- Participating in design and evaluation of surveys of GPs in relation to communication with hospitals and community health service
- Editing monthly GP Liaison Newsletter/mailout
- Organising GP Seminars and participating with the organisation of other relevant educational programs
- Encouraging hospitals to look at strategies to improve communication with GPs including improved discharge summaries
- Facilitating the introduction of members of the Divisions of GP to Area Health staff
- Consulting to hospitals and Area services on the planning and development of improved GP-hospital integration initiatives
- Participating in the development of Shared Care Projects
- Acting as resource person for GPs
- Liaising with the University of NSW to develop an academic Department of General Practice

In 1992 the AMA, the Royal Australian College of General Practitioners and Commonwealth Government agreed to endorse the concept of Divisions of General Practice as independent, formal networks of General Practitioners. Divisions would enhance the involvement of general practitioners in health decision making at the local level, health promotion, shared care programs, continuing medical education, undergraduate education

In South Eastern Sydney Area there are four Divisions of General Practice: Eastern Sydney, South Eastern Sydney, St George and Sutherland Divisions, all of whom have established links and networks within their relevant hospitals and community health services.

**The link between the Liaison GP Co-ordinator and the four Divisions of General Practice is close and the Liaison GP Co-ordinator takes on the responsibility of following through recommendations, requests and information between the Divisions and the Area administration. These issues are addressed at a monthly meeting of the South Eastern Sydney General Practice Advisory Committee (SESGPAC).**

### ***3.2 Progress of SESAHS towards continuity of care***

GPs through the Divisions of General Practice are represented at meetings and forums across the Area. There has been a marked shift in awareness of the role of GPs and the value of consulting with them and gaining their perspective on the organisation and delivery of services.

Divisions of General Practice have gained understanding of the issues for the Area Health Service and the lines of communication have improved significantly. Co-operative initiatives between the Divisions of GP and Area Health services include:

- Shared Care Programs –Antenatal, Mental Health, Diabetes, Older Peoples Programs (SCOPP)
- Eastlink – a direct enquiry line for patient pathology, radiology and nuclear medicine results with direct access to the Ward Information System(W.I.S.); a facsimile service for transmission of results to participating doctors and a contact for consultative specialist services(Appendix 2)
- Trialing and proposed implementation of DOCFACS (Doctor Facsimile System) in the major Area hospitals
- GP representation on advisory committees, strategic planning working parties and at planning forums
- Co-ordination of GP education programs across the Area
- The establishment of the SESGPAC (South Eastern Sydney General Practice Advisory Committee)
- Health Promotion Programs
- Immunisation

### ***3.3 Communication-the core issue related to continuity of care***

**The main issue for GPs is still communication with the hospitals followed by communication with community health centres. Despite continuous efforts from the Divisions of General Practice and the GP Liaison Co-ordinator, the quality of hospital discharge summaries, the frequency of phone calls regarding patients' admissions and discharge status or notification of death has not significantly changed on most sites within the Area. Telephone access to hospital clinicians remains difficult.**

**The commitment of senior clinical and administrative staff to improving communication between hospitals and GPs is often much higher than that of more junior staff who are delegated the responsibility of providing the communication.**

The understanding of the role of general practitioners in the community is often not adequately understood and/or respected by those responsible for promoting and executing the steps necessary for exchange of adequate admission and discharge information to GPs.

#### **Initiatives to address these problems have included:-**

- Medical Records administrators telephoning GPs if a patient has died
- DOCFACS or similar program implementation
- Quality Assurance program for discharge summaries
- Divisions of General Practice in conjunction with Emergency Departments designing a referral form for GPs sending patients to hospital
- Accreditation of GPs to hospitals
- Current GPs names be accurately recorded in the medical record and clearly displayed above the patient's hospital bed
- More Shared Care Programs
- GP membership of hospitals' Medical Records Committees

The GP Liaison Co-ordinator and representatives from the Divisions of General Practice have continually attempted to raise awareness of issues related to communication from hospitals. Forums and meetings where this has been addressed include:

- Interns orientation days
- Meetings with interns during the year
- Medical registrars meetings
- Dept of Medicine Divisional meetings
- Grand Rounds
- Medical Records Committees
- Executive Directors meetings
- Hospital/GP Liaison meetings
- Peri-operative services
- Other relevant forums

**The overwhelming feedback from GPs indicates that the initiatives and strategies listed above have not had a significant impact in changing the culture of hospitals in relation to communicating with GPs. This document provides the Area facilities and services with strategies that are focussed on initiating a culture change towards improved communication with GPs.**

It is acknowledged that there are a small number of services across the Area who have attempted with varying success to assist GPs with the ongoing management of their patients by providing legible, accurate written discharge summaries or telephonic communication at the time of their patients' discharge.

### ***3.4 Effective use of medicines***

There is mounting evidence that many adverse events are preventable if the communication between health care providers is improved.

SESAHS is committed to improving the quality use of medicines and have identified that to achieve this it is essential to implement the strategies to improve communication with general practitioners.

“The Manual of Indicators for drug use in Australian hospitals”<sup>5</sup> has included an impact indicator addressing general practitioners' satisfaction with information provided by the hospital regarding discharge medications. **Since communication regarding medications is an integral part of discharge information, monitoring this indicator could provide valuable feedback regarding the success of discharge communication strategies.** (Appendix 3)

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<sup>5</sup> NSW Therapeutic Assessment Group 'Manual of Indicators for drug use in Australian hospitals', (April 1998)



## 4.0 Principles for Strategic Planning

### *4.1 Key areas that have been identified by representatives of Area Health Services and Divisions of General Practice to form the basis of a Strategic Plan:*

Key Results Areas	Strategic issues
<b>Planning</b>	<ul style="list-style-type: none"> <li>• Need for a cohesive approach to planning for integrated service delivery</li> <li>• Need to develop specific integration plans for critical health service delivery areas</li> </ul>
<b>Ownership</b>	<ul style="list-style-type: none"> <li>• Need to build commitment amongst key stakeholders, taking account of the particular needs of urban and rural areas in implementing the integration process</li> <li>• Need to involve all key stakeholders in decision making</li> <li>• Need to collaboratively develop a system of clinical and non clinical health providers and managers</li> <li>• Need to overcome the physical and cultural isolation of participants in the health care system</li> <li>• Need to utilise all forms of communication, media and networks to promote and maintain understanding across professions and organisations</li> </ul>
<b>Funding</b>	<ul style="list-style-type: none"> <li>• Need to better utilise existing funding systems and to initiate new approaches to fund the integration plan</li> </ul>

<p><b>Roles and Responsibilities</b></p>	<ul style="list-style-type: none"> <li>• Need to redefine roles and responsibilities of all health providers and managers in the light of an integrated health delivery system</li> <li>• Need to identify knowledge and skills necessary for competence and effectiveness for all professionals and managers in redefined roles</li> <li>• Need to create a system of evaluation that supports improvements to quality of care and efficiency</li> </ul>
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Decisions regarding necessary resources, establishment of responsibilities and accountabilities and timelines depend upon the deliberations of individual Area Health Services and Divisions of General Practice.

#### ***4.2 The foundations of effective GP - hospital integration projects and programs require:***

- **Agreement**

Hospitals, Divisions of General Practice and other groups/stakeholders should aim to reach an agreement on how the project/program will be conducted.

- **Management**

A joint committee including GPs, hospital, community and consumer groups should be established to manage projects.

- **Systems to sustain improvements**

Sustaining change within hospitals requires performance measures for hospital divisions or units. It may also involve quality assurance measures and regular feedback to staff.

Sustaining changes in collaboration with General Practices is equally important. Hospitals rely on GPs to provide up to date practice details (including all GPs who work in the practice, phone and fax numbers, e-mail addresses and change of address) and to transfer patient information on request, as well as being accessible to discuss cases. These responsibilities are for GPs to consider.

- **Information Systems**

Programs and projects need to be compatible with existing systems.

When planning information systems it must be taken into account that although there are an increasing number of GP practices becoming computerised, it is still the minority of GPs that use computers for clinical information and only a few GPs have internet/e-mail connections.

## 5.0 Models and Outcomes for Planning GP – Hospital Communication

The Integration and Support Evaluation Resource Unit (SERU) was established in 1996 by the Commonwealth Department of Health and Family Services to provide support to Divisions of General Practice on the integration between GPs and the broader health system. Three other SERUs were also established at this time. They include the Public Health and Health Promotion Seru, Education Seru, and Access Seru. The Integration SERU provides evaluation support and advice to Divisions and the Commonwealth, as appropriate.

SERUs are part of an infrastructure support network within the Commonwealth Department of Health and Family Services General Practice Strategy. This strategy commenced in 1991 and includes the Divisions and Project Grant Program (DPGP), the Rural Incentives Program (RIP), the Better Practice Program (BPP) and the General Practice Evaluation Program (GPEP).

The Divisions have undertaken approximately 1000 projects, of which over 450 have focused on integration between general practitioners and the broader health system but limited research is available about what does and does not work in integration projects. This gap is being addressed by the Integration SERU through the following strategies:

1. Development of “*From Projects to Programs, GPs and Hospitals Working Together: A Guide for Divisions of General Practice*<sup>6</sup>”. Included in the potential users of this document are Area and District Health Services
2. Coordination of a National Meeting on GP-Hospitals working together to identify effective structure and processes to enable GPs, hospitals and community health services to work in a more integrated way to improve patient care and health outcomes
3. Following up the recommendations from the National Meeting
4. Supporting Divisions to improve evaluation of GP projects

The models and outcomes in this chapter are essentially taken from the “*Guide*” and intended to provide ideas that may assist Area facilities and services in planning strategies to address GP-hospital communication.

### **The issues addressed in the document relevant to this plan include:**

- Systems to Sustain Improvements (Appendix 4)
- Evaluation (Appendix 4)
- Advantages of GP Involvement in hospitals (Appendix 5)
- Barriers to GP Involvement in hospitals (Appendix 6)

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<sup>6</sup> Lloyd J. & Mira M. ‘From Projects to Programs, GPs & Hospitals Working Together: A Guide for Divisions of General Practice’, Integration Support and Evaluation Resource Unit (SERU), University of NSW. (July 1997)

- National & State Key Policies and Initiatives (Appendix 7)
- State Perspectives (Appendix 8)  
State Programs of particular interest are:  
*Hospital Liaison GPs (WA)*  
*Hospital Integration Project - GP Liaison (VIC)*  
*Agreement between Area Health Services & Divisions (NSW)*

## **5.1 General Models of GP roles in hospitals**

**The role of GPs is changing due to casemix and developments such as early discharge and hospital in the home projects/programs and this requires efficient hospital/GP communication systems.**

### **5.1.1 GP liaison roles in hospitals**

The employment of GPs in liaison roles within hospitals and community health services may be useful in:

- establishing improved systems for two way communication between GPs and hospitals
- educating GPs and hospital staff about each others' services
- identifying and if necessary modifying clinical guidelines for local circumstances
- monitoring and evaluating communication between GPs and hospitals
- discharge planning for patients with complex needs
- facilitating involvement of GPs in the hospital

**GP hospital liaison workers should not duplicate or replace the “normal” activities of hospital staff in discharge planning or discharge communication. Rather, they are in a position to provide a much clearer community perspective to decisions made in hospitals and promote the culture changes necessary to promote safe transfer of patients between the hospital and the community.**

### **5.1.2 GP consultants**

In some cases, GPs act as consultants, providing care for patients in hospital. Such care should be subject to the usual accreditation or delineation of clinical privileges procedures, peer review and evaluation and monitoring. Where it is provided as a replacement, or a supplement to specialist medical care in hospitals, it should be carefully evaluated for cost benefit and appropriateness of patient care.

### **5.1.3 Appointment of GP affiliates or associates (Harris, Fisher & Knowlden 1993)<sup>7</sup>**

GP affiliates or associates are recognised by the hospital, they may visit patients, read and make annotations in the medical records and use hospital services such as libraries. GPs may or may not have general admitting rights. In this model GPs are not usually paid for their hospital work.

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<sup>7</sup> Harris MF, Fisher RR, Knowlden SM. Improving general practitioner involvement in urban hospitals Department or Divisions of general practice. *The Medical Journal of Australia* 1993; 158: 304-7

## 5.1.4 GP role in continuity of care

Other roles emphasise GPs' contribution and efforts towards ensuring **continuity of care**.

- *Emergency/primary care*

Employment on a part time or sessional basis to see primary care patients presenting to the hospital.

- *Prevention of admission*

This involves assessing patients who present to hospital or who are likely to need hospitalisation, and arranging supportive care (medical, nursing, allied health) to prevent admission (e.g. falls, varicose ulcer etc.).

- *Pre admission*

Communicating information on patients' history, background and stability of co-morbidities, etc. Assessing, educating and possibly carrying out investigations with patients prior to admission (based in GPs' practices).

- *Discharge Planning*

Participating in discharge planning meetings (in person or via telephone)

- *Ambulatory care, hospital in the home, post acute and transitional care*

GPs participate in case conferences in person or via telephone prior to patients' discharge. GPs can also be involved in home visits and providing medical support to home nursing teams.

- *Follow up care*

Providing follow up, continuing care in the community after discharge with feedback to hospital teams.

## 5.2 Opportunities for better integration of GPs in hospitals

### 5.2.1 Pre-admission

Projects may include:

- Referral form from GP to Emergency with fax back form to the GP
- GPs completing a preoperative form

### 5.2.2 Intra-Hospital care

Intra-hospital care may involve:

- GPs acting as consultants to patients in the wards
- GPs having visiting rights to inpatients, GPs name on the bed and in notes etc.

- Working with hospitals to improve the appropriateness of care for certain groups (e.g. ATSI or NESB people)
- GPs presenting to junior hospital staff on continuity of care issues (junior doctors often have had little or no contact or experience with community medicine and GPs)

While the latter two are seldom undertaken as separate projects they are important mechanisms for improving access to appropriate hospital care by patients. The involvement of GPs as consultants in hospitals is generally funded by the hospital with the GP providing management of co-morbidity which might otherwise involve a more expensive consultant (e.g. management of a skin condition).

### 5.2.3 Discharge communication & planning

Since previous surveys, the issues related to GP-hospital communication may have changed and it may be worthwhile determining from GPs the current problems with discharge communication.

#### ◇ Content

**The literature suggests that the following information should be included in discharge summaries:<sup>8</sup>**

- ranking of diagnosis in order of importance
- significant results of examination and investigations, both positive and negative
- information given to patient and/or carer about diagnosis and prognosis
- suggested or made arrangements for follow up
- relevant social factors
- degree of certainty of diagnosis
- prognosis
- adverse inpatient events such as cardiopulmonary arrest
- community services arranged
- clinical management (other than coded procedures)
- history of drug reaction or allergies
- details of drugs at discharge
- drugs given at hospital, other than drugs at discharge
- functional ability (activities of daily living); recommended lifestyle changes
- hospital extension for clinician contact
- name of hospital clinician whom GP can contact for advice

The results of a study by Balla & Jamieson (1994) recommended that discharge summaries include:<sup>9</sup>

- specific plans after discharge
- reasons for altering medications
- information given to the patient and family about the illness
- summary of the case by the consultant

<sup>8</sup> Solomon JK, Maxmell RB, Hopkins AP. Content of a discharge summary from a medical ward: views of general practitioners and hospital doctors. *Journal of the Royal College of Physicians of London* 1995; 29, 4: 307-10.

<sup>9</sup> Balla JI, Jamieson WE. Improving the continuity of care between general practitioners and public hospitals. *Medical Journal of Australia* 1994; 161: 656-9.

#### ◇ **Promptness**

The necessity for early communication with GPs varies from patient to patient; at the hospital level it is usually easier to have a set goal e.g. GPs should receive the discharge letter within 48 hours. It may be appropriate to also have a mechanism for more rapid delivery of information in certain cases e.g. a fax or telephone call.

#### ◇ **Legibility**

It is essential that, where hand written letters are used that they be legible. Some problems may be overcome by simply arranging that the top copy of a triplicate form be sent to the GP rather than the last copy. The writer of the letter must be identifiable i.e. s/he should print her/his name.

**It may be worth considering developing a structured letter. The main advantage of structured letters is that the information is easier to comprehend and differentiate. Rawal, Barnett and Lloyd (1993),<sup>10</sup> identified the following advantages of structured letters:**

- the reader can see at a glance main problems/what's happened
- they are shorter
- GPs can transfer information easily to computerised patient records
- issues related to confidentiality, security and patient permission of medical records/discharge summaries need to be addressed

#### ◇ **Quality assurance**

Medical staff who are responsible for discharge communication usually rotate between units (and often hospitals). To change this behaviour a strong commitment is required from senior hospital doctors and hospital administration.

- Measures which may help this process include:
- senior doctors insisting that the discharge summary be used as the information source at case reviews etc.
- incorporating timely transfer of discharge summaries to GPs in the standards and protocols of the hospital education programs for hospital staff
- positive feedback from GPs who receive quality discharge summaries
- regular audit of discharge communication and feedback to staff involved (Appendix 9)

### ***5.3 Early discharge, post acute care, transition care, ambulatory care and hospital in the home projects***

Early discharge, ambulatory care and hospital in the home projects usually aim to facilitate the early transition of patients from hospital to home by providing continuity of care with an emphasis on pre and/or post discharge planning. All attempt to improve continuity of hospital with community care and provide more intensive medical and nursing support to patients who would otherwise be kept in hospital. Early discharge, transitional care and hospital in the home projects rely on greater GP involvement and improved discharge planning.

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<sup>10</sup> Rawal J, Barnett B, Lloyd BW. Use of structured letters to improve communication between hospital doctors and general practitioners. *British Medical Journal* 1993; 307; 6911:1044

### 5.3.1 Benefits

These projects can be of significant benefit to all stakeholders.

Benefits include:

- accelerated recovery - patients are likely to have early post operative mobility with rehabilitation in their own home (Farnworth, Kenny & Shiell 1994)<sup>11</sup>
- reduced length of stay (Farnworth, Kenny & Shiell 1994)<sup>12</sup>
- reduced time between admission and surgery (Farnworth, Kenny & Shiell 1994)<sup>13</sup>
- in an emergency (Frith 1996)<sup>14</sup>
- less inconvenience with reduced travel and waiting times
- improved GP involvement in admission and discharge planning (Frith 1996)<sup>15</sup>
- improved understanding of roles and communication between the GPs and the hospital staff (Frith 1996)<sup>16</sup> and
- increased patient satisfaction
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### 5.3.2 Barriers

The main barriers to these programs are:

- the dual funding system
- the possible reticence of hospital specialists to transfer care to a GP

## 5.4 *Opportunity for Divisions*

The Divisions of General Practice now provide an infrastructure which can support initiatives in hospitals.

Currently the service needs of hospitals for junior medical staff exceed the future training opportunities for specialists and GPs. Moreover, hospitals do not necessarily provide suitable training for such junior doctors but prioritise their service needs. An alternative to this is to encourage GP participation in hospitals in a way which strengthens the role of generalist medical staff. This can be facilitated through the Divisions of General Practice.

## 5.5 *After hours & primary care*

GPs are well placed to provide the majority of these services.

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<sup>11</sup> Farnworth MG, Kenny P, Shiell A. The Cost and Effects of Early Discharge in the Management of Fractured Hip. *Age and Ageing* 1994; 23: 190-4

<sup>12</sup> Ibid

<sup>13</sup> Ibid

<sup>14</sup> Frith J. Evaluation of St Vincent's Hospital and Eastern Sydney Division of General Practice Project 'Early Discharge Project Stage 3'. School of Community Medicine, University of New South Wales, 1996.

<sup>15</sup> Ibid

<sup>16</sup> Ibid

## ***5.6 Outcomes of the continuity and consistency of patient care between general practice and hospitals***

Listed below are examples of programs to improve the continuity of care between General Practice and hospitals.

<b>Objective</b>	<b>Activities</b>	<b>Outcome</b>
Prevention of admissions	<ul style="list-style-type: none"> <li>• GP screening of elderly who present to emergency departments with a fall</li> <li>• Early intervention with GP and nursing care to prevent admissions</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced admissions</li> </ul>
Improving access to acute care services	<ul style="list-style-type: none"> <li>• GP run primary care services in hospitals</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced workload on emergency or outpatient services</li> <li>• Reduced investigations</li> </ul>
Development of more appropriate acute care services for disadvantaged groups	<ul style="list-style-type: none"> <li>• On call GP advocates for NESB or ATSI patients</li> <li>• Education of patients prior to admission</li> <li>• GP liaison officer</li> </ul>	<ul style="list-style-type: none"> <li>• More appropriate care</li> <li>• Improved patient satisfaction</li> </ul>
Improved continuity and consistency of care	<ul style="list-style-type: none"> <li>• GP liaison officer</li> <li>• Preadmission communication systems</li> <li>• GP hospital affiliates</li> <li>• Discharge communication systems</li> </ul>	<ul style="list-style-type: none"> <li>• Quality of communication</li> <li>• Consistency of care</li> <li>• Less duplication of tests</li> </ul>
Improved quality and efficiency of hospital care	<ul style="list-style-type: none"> <li>• GP preadmission assessment</li> <li>• GP consultations in hospital</li> </ul>	<ul style="list-style-type: none"> <li>• Improve patient health literacy (knowledge and self care skills)</li> <li>• Fewer adverse events</li> <li>• Reduced complications, delays, cancellations</li> </ul>
Improved post hospital care in the community and rehabilitation	<ul style="list-style-type: none"> <li>• GP involvement in ambulatory care/home hospital care</li> <li>• GP discharge planning</li> </ul>	<ul style="list-style-type: none"> <li>• Less stress on carers</li> <li>• Fewer complications/readmissions</li> <li>• Care consistent with guidelines</li> <li>• Patient functional health status</li> </ul>
Improved communication	<ul style="list-style-type: none"> <li>• GP database accessible to hospital</li> <li>• GPs on appropriate hospitals steering committees</li> </ul>	<ul style="list-style-type: none"> <li>• ready access to accurate GP contact details (phone, fax and address)</li> <li>• linkage of communication systems</li> </ul>



# 6.0 Recommendations and Strategic Directions for Improving Communication between GPs and SESAHS Facilities

Improved integration and communication of GPs with our health services will significantly contribute to maximising the effectiveness and efficiency of health care delivery in our Area. To ensure GPs' roles as the primary coordinators of comprehensive health care to members of our community is acknowledged and respected, a culture change within our facilities is essential. The following strategies are aimed at promoting these changes:

Key Result Areas	Strategies
1. Planning	<p>Improve quality of discharge summaries. This will require commitment from senior clinical staff as well as quality assurance programs</p> <p>Implement DOCFACS or a similar program - a secure facsimile system</p> <p>Develop protocols in Emergency Departments for telephonic, faxed or electronic information to be provided to GPs regarding their patients' admission and discharge clinical details</p> <p>EastLink – Encourage GPs to participate in this faxing facility from South Eastern Area Laboratory Services (SEALS)</p> <p>Electronic Transfer of Information - Participate in initiatives which include GPs in the sharing of clinical data via IT initiatives</p> <p>Encourage telephonic contact with GPs regarding relevant history and ongoing management.</p>
2. Raise Profile of GPs in Hospital	<p>Hospitals establish GP Liaison Positions to encourage and develop process for continuity of care</p> <p>Establish policy for GPs' names to be above their patients' beds in all SESAHS hospitals</p> <p>Special areas (e.g. Aged Care) to promote GP attendance at relevant case conferences</p> <p>GPs facilitate a teaching session twice yearly in Junior Medical Staff clinical training programs in all units with PGMC accreditation</p> <p>Review feasibility of establishing a Department of GPs across the Area.</p>

3. Fund GP Involvement	<p>To attend case conference</p> <p>Provide teaching to students/interns/RMOs</p> <p>Consult to AHS on planning &amp; advisory committees</p>
4. Encourage Accessibility of GPs	<p>Divisions to provide regular up-to-date lists of fax, phone, email and mobile numbers</p> <p>GPs to provide after hour numbers</p> <p>GPs to give patients business cards and suggest be kept with their Medicare card</p>
5. Encourage Networking	<p>Two Directors of Clinical Services to attend State /National forums on General Practice</p> <p>Each hospital to organise two opportunities per year for GPs and hospital staff together. (These may include tours of specialised services or new facilities, and inclusion of GPs at hospital social functions)</p> <p>GP Liaison Newsletter/Mailout monthly</p>
6. Community Health	<p>Develop policies on communication with GPs</p> <p>Implement QA program to monitor this communication</p>
7. Evaluation	<p>Develop appropriate evaluations tools to analyse the effectiveness of integration processes and projects</p> <p>Use Impact Indicator 8.3 (Appendix 1) from “Manual of Indicators for drug use in Australian hospitals”</p>
8. Roles and Responsibilities	<p>Clinical Directors responsible for monitoring outcomes of strategies</p> <p>Staff Specialists and VMOs responsible for implementation of strategies to improve discharge summaries</p> <p>IT Directors responsible for implementing discharge programs and electronic transfer of data</p>
9. Accountability	<p>Negotiations will occur to include all of the relevant strategies in the performance agreement of the Executive Directors of each hospital and the SESAHS GP Liaison Coordinator</p>

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