GP Liaison THO-South

Response to the DHHS Green paper Delivering Safe and Sustainable Clinical Service, December 2014

This response is from the perspective of our particular roles as GP Liaison Officers within the THO-South and as General Practitioners in the private sector. We have a broad range of exposure to the health sector in our work as, in addition to our position within THO-South, we variably work in General Practice including community and residential Aged Care, the After Hours Services, the Sexual Assault Forensic examination service, and as teachers of medical students and General Practice Registrars. We also regularly work with Tasmanian Medicare Local on Health Pathways working groups. These activities give us cross-sectorial insight and the ability to note recurring issues and themes. We therefore provide this feedback which we believe is constructive and solution oriented as well as perhaps correcting some misconceptions that seem to have crept into the document.

We have responded to this paper in conjunction with the Directors of Palliative Care and Emergency Department regarding “Supplement 3 -Building a stronger Community Care System” and we have provided comments to the Musculoskeletal, Emergency Medicine and Child Adolescent Mental Health Service Clinical Advisory Groups.

This response touches on details involved with the community-hospital interface.

As part of our work as GP liaison officer we try to enhance continuity of care for patients across the primary and tertiary sector and also facilitate and improve access and utilisation of hospital services and communication between and within sectors. We find the ability to improve continuity of care, communication, and utilisation is often diminished by particular interpretations of Privacy Laws and by concerns over public perception rather than patient care.

Much of our comment in this response is founded in these essential needs which are articulated in the Executive Summary but solutions are not directly found within the substance of the report. In fact General Practice which is described as the corner stone of Health care is hardly mentioned throughout the documents. Yet improved links with General practice will greatly facilitate improvements in health care in Tasmania.¹

Recommendation 1

That the State government acknowledges that General Practice is the corner stone of primary health care and improving health outcomes requires working with the central premise of general practice as the patient’s health care home.²,³

That the State government implements strategies to enhance the cross-sectorial interaction with general practice
Enhancing Continuity of care across the Health sectors

The Green Paper refers to poorer outcomes for hospitalized patients in terms of Safety (p 12 Fig 1.2.2 and 1.2.4). Adverse events commonly occur at times of transitions of care (including at times of clinical hand over from shift to shift, unit to unit within the hospital and when transitioning care from hospital to community). At the hospital-community interface communication of the patient’s recent health events, history, medications, short and longer term needs are essential. We have found there are various impediments that occur to good communication in the current system. These include perceived issues of patient privacy. Recent advice to Patient Information Management Service (PIMS) at the THO-South from the Crown Law that the Personal Information Protection Act 2004 Tas Schedule 1, Section 2 part 1 precludes Discharge Summaries being sent to the Current General Practitioner without express permission from the Patient where the patient was not directly referred for admission by the General Practitioner. However the Act has further advice in Schedule 1 Section 2 part 4 that states that Personal information may be disclosed in other circumstances (indicated in red below), this latter section seems to allow for the Discharge summaries to be sent without express permission of the patient if this has been unable to be obtained.

See Personal Information Protection Act Schedule one Section 2 part 4.

“4) A personal information custodian that provides a health service to an individual may disclose health information about the individual to a person who is responsible for the individual if

- (a) the individual is

  -(i) physically or legally incapable of giving consent to the disclosure; or(ii) physically unable to communicate consent to the disclosure; and

(b) The natural person providing the health service for the personal information custodian is satisfied that the disclosure

  - (i) is necessary to provide appropriate care or treatment of the individual; or

  -- (ii) is made for compassionate reasons; and(c) the disclosure is not contrary to any wish

  - (i) expressed by the individual before the individual became unable to give or communicate consent; and

  (ii) Of which the natural person is aware, or of which he or she could reasonably be expected to be aware; and...

We contend that it is our experience that patients do expect the hospitals to communicate with their General Practitioner, that they see it as necessary to provide ongoing care and if that if they have not expressly at any time said not to communicate information that it should be done as a matter of course. Just as sending of discharge summaries to the PCEHR is an Opt-out model, so should the sending of
Discharge summaries to the General Practitioner be an Opt-out model and that this should be articulated in the expectations to the State Health Practitioners by the DHHS in the Service Agreements.

**Recommendation 2**

I. That the Service Agreements between the DHHS and DHHS Health Practitioners and Hospitals require that discharge summaries with advice about dates of admission, reason for admission, relevant procedures, diagnoses, discharge medication, and discharge arrangements be sent in a timely fashion (on the day of discharge or at a maximum of 48 hours from discharge) as a matter of course. Requiring patients to purposefully Opt-out of this communication if they do not want it.

II. The outpatient and inpatient service providers are regularly required to report on the number, quality and timeliness of discharge summaries.

III. That Resident Doctors at the Hospitals are given quarantined time to perform the duty of creating appropriate discharge summaries.

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**Access to Better services**

**Outpatient departments**

The clinicians and support staff work hard in the outpatient services and attempt to deliver timely, evidenced based holistic care. Much of the work in improving services and in providing services is not visible to the community or to other health professionals. Some transparency was provided in the South by the establishment of the Outpatient Website however this is not true throughout the state and waiting times for appointments are not yet visible on the site.

Provision of waiting times for appointment will allow clinicians and patients alike to understand the likely timing of an appointment for their condition and allow rational informed discussion between referrer and patient about appropriate care pathways for the patent, including alternative specialists (General Physician versus Neurologist), privately funded care, and possible management in the community sector or self-care.

Few clinics have developed active discharge policies from clinic and the frequent practice of junior doctors seeing follow up patients while the consultants see new patients discourages appropriate discharge of patients from clinics into community care with General Practitioners.

Recently the Electronic outpatient appointment summary (part of the HCS suite) has been developed in partnership with the three THOs and the TML. This system allows a summary of the appointment with clinical advice to be delivered into the patient’s General Practitioners software within minutes of the end of the consultation and allows for timely response from the GP. Unfortunately the teaching of the use of this technology has had to be subsumed into normal business resulting in a slower than desired uptake especially in the North. Clinicians’ insecurity with information management systems without training has also slowed uptake.
**Recommendation 3**

Outpatient Services

I. Resources be allocated to teach clinicians to use the outpatient appointment summaries and for the IT infrastructure to be provided to support this.

II. That consistent active discharge protocols be developed for each clinic type to encourage appropriate discharge of patients from clinic to free up spaces for more new patients and reduce waiting times for clinics.

III. Outpatient appointment times be published for each hospital on the outpatient clinic website.

Please note to complement these measures we fully support the publishing of the surgical waiting times for various surgeries for each hospital on a DHHS website.

**Secure electronic communication**

The IT infrastructure available to the clinicians and managers at the THOs is clumsy, lacks interconnection and often acts as a series of PDFs rather than integrated data and information. This creates clumsy systems with silos of disconnected information that limits efficiency. We note:-

The adoption of particularly the HCS system but also the Audit 4 systems at the RHH has shown the efficiency and security that can be achieved with appropriate software and infrastructure. ---Significant inefficiencies occur because the lack of a secure bidirectional electronic communication system between primary care (particularly General Practice) and acute health sector. Emails about patients cannot be sent between a GP and a THO south clinician due to lack of an encrypted email system (a requirement of AHPRA standards). Fax communication needs to be utilised instead resulting in frequent delays and often misplaced faxed documents.

-GPs and private specialists often lament their lack of access to their patient’s information on the DMR which causes delays in obtaining information.

**Recommendation 4**

I. That the DHHS expedite the purchase and commissioning of an integrated statewide electronic health record system which includes all aspects of care and management.

II. That the DHHS commission the development of a secure bidirectional electronic communication system between primary care (particularly General Practice) and the new THS

III. That the DHHS consider allowing accredited GPs and other appropriate health care providers access to the DMR.
**Shared care and Clinical Governance**

The Green paper makes reference to a *focus on hospital avoidance programs*. It is our experience (in trying to advance projects of this nature) that issues of Clinical Governance and interdisciplinary misunderstandings of clinicians’ capabilities are often road blocks to such initiatives. Strategic and high level discussion of these issues is required such that managers and clinicians can feel confident implementing hospital avoidance strategies. Clinical Advisory Groups would be ideal structures to examine these issues in individual areas of clinical care.

**Recommendation 5**

I. Clinical Advisory Groups meet to discuss clinical capabilities of the various professions engaged in care of a particular clinical issue and devise clinical governance pathways to aid decision making and resolve safety concerns.

II. That consideration is given to establishing educational requirements and training for clinicians to achieve in order to be allowed to participate in formal share-care arrangements, along the lines of antenatal share care, but expanding to such areas as home management of infections, post definitive oncology treatment and others.

In our discussions with our General Practice Colleagues in trying to enhance GP responsiveness to THO-South initiatives a frequent inhibitor of action are the Laws governing Medicare claims which GPs utilize. If a service has been charged under Medicare for a specific procedure, then another practitioner cannot charge for routine follow-up if the full Medicare fee was charged. This ruling has resulted in GPs not wanting to remove sutures post-operatively from RHH patients or follow up simple fractures treated at the hospital in case they are committing Medicare Fraud when billing.

**Recommendation 6**

I. The DHHS clarify and make public the Medicare components of surgical services, so that GPs would be able to undertake post-operative care without fear of Medicare sanctions.

II. The DHHS fund pilot programs exploring private primary care-DHHS joint initiatives exclusive of Medicare funding that have appropriate clinical governance and occur in the community.

**Statewide website**

Health pathways in an excellent resource for use by GPs to look at the variety of clinical options in a particular disease state however the content of this site is not controlled by the DHHS and given the resource issues in the public sector the THOs/ THS need to develop clear guidelines of scope of the various services they offer and information they need to prioritise their patients. This has been partially developed at the THO-South as the Outpatientsouth website and includes advice on some statewide services. Planning is occurring to enable this site to become a state wide site. However there are issues about resourcing the extended development and maintenance of the site that have yet
to be addressed. It is possible this statewide site will be a catalyst for statewide agreements on requirements for referrals and also triaging protocols.

Outpatientsouth already has close interlinks with the HealthPathways site and where referrers find that the condition is outside the scope of the public services they can link back to the HP site and look for private options. It is the ideal site to house the clinic waiting times for appointments and potentially also the surgical waiting list times. Knowledge of waiting times will assist counselling of the patients on possible other options of care and may reduce demand or ensure the patient is referred to the right clinic in the right time frame.

It would assist in good patient referral, hand over and facilitate clinicians and the hospitals fulfilling their Duty of Care requirements.  

It is our contention that this information needs to be on a THS/THOs owned site to allow for rapid responsiveness to changes in information.

**Recommendation 7**

That the new THS support the moves to make the Outpatientsouth website statewide and provide ongoing support for the maintenance of this website as a source of guidance for referrers on scope of clinic services, pre-referral requirements and indicative waiting times for appointments.

In this response we have tried to provide constructive suggestions for the DHHS to embrace that would reduce inefficiencies, reduce recurrent “road blocks” to improvement, provide structure and opportunity for Improved services.

The Executive Summary of the Green paper says that the DHHS wishes to create an effective and responsive primary care sector by....

- Having a greater focus on primary and community care (We contend the mechanism for this are not evident in the Green paper), and the paper by hardly mentioning General practice has left out of much of the document the corner stone of primary care, the patient home that is the General practice and this needs to be addressed further in the White paper.
- Shifting the balance of care provision from the hospital to the community (We contend the mechanism for this are not evident in the Green paper), however our response has provided suggestions that will act as enablers for this to occur.
- Redesigning our clinical services. We have suggested measures and enablers that will drive and enhance this process.
- Strengthening public-private partnerships. We have given some insight above into common issues and discussed some solutions.
- Strengthening interstate partnerships (we have not addressed this.)

Our essential message is the Green paper is a start, and has provoked discussion however whilst professing to be encouraging community care it is a hospital centric document that has largely ignored
the cornerstone of primary care. This imbalance needs to be corrected in the white paper. No Health system will ever be holistically improved if General practice issues and concerns are not acknowledged and addressed.

To assist this aim we recommend further commissioning of direct GP involvement.

**Recommendation 8**

That the THS support mechanisms for ongoing primary care interaction with the acute and sub-acute services by:

I. Expanding the general practice involvement in CAGs by either using the existing GPLOs or paying outside GPs to attend. (Note all GP liaison officers are required to continue their work in General Practice).

II. Support and expand the existing GPLO network by ensuring that there is per capita representation in each of the regions

We note also that the social determinants of health have not been discussed in the Green paper and we encourage the Government to continue to consider the mantra “Health in all Policies” when creating policy

Our response has provided eight practical recommendations that will facilitate communication, address road blocks to improvement, improve transparency and provide data to improve outcomes. We hope to see some of these recommendations included in the White Paper and carried forward in policy and strategy, such that there are improved patient outcomes and interdisciplinary and inter-sectorial cooperation.

We encourage you to continue to remove political expediency from the solutions suggested in Health Care and instead truly put the health needs of the whole of the state at the forefront of policy and decision making in Health Care. This is truly consistent with the statements of the Hippocratic Oath which we believe all involved in Health Care should subscribe to.

Yours sincerely

Drs Elizabeth (Liz) Webber and Annette Barratt

References


2. The National Health and Hospital Reform Commission (2009), A Healthier Future for All Australians- Final Report of the National Health and Hospitals Reform Commission Commonwealth of Australia, ACT


6. Medical Board of Australia 2010 Good Medical Practice: *A Code of Conduct for Doctors in Australia (section 2)*
SUMMARY OF RECOMMENDATIONS

Recommendation 1

That the State government acknowledges that General Practice is the corner stone of primary health care and improving health outcomes requires working with the central premise of general practice as the patient’s health care home.\(^2,3\)

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