

**Review of Strategic Possibilities for  
Hospital—GP Collaboration to improve  
Continuity of Patient Care**

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# ABSTRACT

The purpose of this review of current levels of collaboration between Royal Melbourne Hospital (RMH) and General Medical Practitioners (GPs) is to identify strategic options for collaborative endeavours to improve the continuity of patient care. The review was undertaken in response to initiatives by the Divisions of General Practice yet also seeks to respond to the imperatives for the hospital system which arise from governmental initiatives, particularly the formation of hospital networks.

The paper reviews the Australian literature and recent initiatives which seek to improve collaboration between hospitals and GPs. The goals and strategies identified in the review of the literature are then used as a basis to assess current hospital performance and to identify joint strategies to be implemented in the next two years.

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# Chapter 1

## Executive Summary

### Background

Strengthening and broadening the primary care base has been a key Commonwealth Government strategy in its endeavours to make health services more responsive to the needs of local communities. The establishment of the Divisions of General Practice has been the cornerstone of this process, although this has been supplemented by other initiatives to make better use of community based services. This has been done in order to reduce the demand on tertiary care services and to better meet the needs and preferences of consumers. The Commonwealth's Continuity of Care Pilot Projects and the State Government's Hospital in the Home initiative are important examples of this developing emphasis. This vision is reflected in the State Government planning documents *Victoria's Health to 2050 and Developing Melbourne's Hospital Network*.

At the same time funding models designed to encourage technical efficiency and an increasing concern with allocative efficiency and equity, have put pressure on major hospitals to look beyond their walls. The pressure is not only to establish linkages that will facilitate expeditious discharges, but also to justify services in terms of their benefits for the day to day lives of individuals and for the overall health status of the community.

It was against this background that the Royal Melbourne Hospital Board of Management decided to establish a Department of Community Health with the brief to:

- improve linkages with the general community and community based service providers; and
- find ways to better define, and respond to, the health needs of the community.

Within this process linkages with General Practitioners, and in particular, with the Divisions of General Practice, are vital. Hence the first two functions of the Department of Community Health in the proposal accepted by the hospital's board were:

- to foster links with the Divisions of General Practice, to ensure appropriate clinical linkages and a productive clinical relationship between these providers and the hospital; and
- to develop a model of patient care, with an emphasis on continuity of care, through linkages with community based service providers and primary care givers.

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## Purpose

In view of these issues it is imperative that the hospital approaches the task of collaboration with all community based service providers with a commitment to ensuring continuity of care for all patients throughout a full episode of illness and beyond.

From this perspective the purposes of this discussion paper are as follows:

- 1 to review the Australian literature and recent Australian and local initiatives to improve hospital-GP liaison;
- 2 to propose a conceptual framework to guide the development and evaluation of GP-hospital liaison projects to improve continuity of care;
- 3 to summarise the current performance of the hospital in terms of continuity of care issues and the strategies that are being developed to improve performance;
- 4 to identify 'strategic' opportunities and priorities for joint projects between RMH and the Divisions of GP and to suggest strategic options for the RMH-Divisional collaboration over the first two years;
- 5 to suggest strategic options for the development of continuity of care activities within the hospital.

It is not a purpose of this paper to discuss the actual form of the agreement between the hospital and the divisions of general practice.

## Outline of Discussion Paper

Following the introductory and methodological sections, the discussion paper proceeds in four sections.

- 1 **GP activities:** A review of the literature relating to GP-Hospital liaison and of recent Australian and local initiatives.
- 2 **Hospital activities:** Examination of RMH's efforts and performance in relation to continuity of care issues.
- 3 **Key issues in GP Hospital collaboration:** Relating RMH's current approaches to continuity of care to the priorities expressed by GPs and State and Federal Governments.
- 4 **Future options:** Strategic options for GP-hospital collaboration in ensuring continuity of care.

### 1 GP Activities

This section begins with a review of the literature that describes a hierarchy of models for GP involvement in hospitals. Examples of each model can be found in Australia although GP wards are generally only found in local community hospitals rather than in large, teaching hospitals.

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The findings and recommendations of a national process to develop standards for the evaluation of GP-hospital projects are briefly presented.

Two local initiatives are discussed. The first, a program initiated by the Melbourne Division of General Practice to forge agreements for collaboration with four main hospitals, is one of the reasons for preparation of this review. The second, a survey of local GPs on how RMH and St. Vincent's Hospital perform on admission and discharge issues, highlights the issues that are of importance to GPs and identifies many areas requiring improvement. The need for further studies to provide a baseline to use in evaluating initiatives to improve the performance of the hospitals is discussed.

## **2 Hospital Activities**

This section has two aims. It first attempts to develop a picture of the success of planning for continuity of care from the perspectives of stakeholders within the hospital. It was considered that input from GPs who are working within the hospital and can therefore offer a dual perspective would be particularly valuable. Therefore interviews were conducted with 13 key informants; four GPs working within the hospital and the nurse directors of each clinical business unit and of ICU. These interviews produced a picture of scattered, ad hoc attempts to deal with continuity of care issues and to involve GPs in care. Such attempts are often thwarted however by the lack of a consistent approach across the hospital.

All of the GPs felt there was scope for increasing the number of GPs appointed to the hospital in various positions. They varied in their views about the feasibility and desirability of GPs prescribing treatment for hospitalised patients.

Further consultation with hospital administration and medical staff will take place around the findings of this review.

The second aim of this section is to review the most important projects currently underway within the hospital in relation to continuity of care. In this discussion the hospital Quality Assurance (QA) program is treated as one project although clearly it involves many activities. Findings of particular relevance are highlighted, although the review of QA activities was hampered somewhat by the confidentiality guidelines that currently apply.

Other important projects that are discussed are:

- discharge notification review committee;
- managed care;
- joint projects with community health centres;
- pre-admission clinics;
- directory of services.

This review of current projects confirms that there is considerable activity occurring within the hospital to improve admission and discharge practices and to address issues related to continuity of patient care

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more generally. Once again, however, it seems that both monitoring and planning have proceeded in an ad hoc manner. At present there is no forum for sharing information or for coordination of activities designed to improve the continuity of patient care across a whole episode of 'illness'. Various flow charts relating to patient movement through the system have been developed (Attachment H), and there have been some attempts to standardise parts of the process. None-the-less, considerably more needs to be done.

If the hospital is to meet the challenge of providing integrated, patient oriented care three issues seem to be of particular importance:

- the need for coordinated planning and monitoring of continuity of care activities;
- a commitment to implementation of projects beyond the conceptual stages;
- the need to draw extensively on the expertise of GPs and other community service providers.

The imperative in this regard will become considerably greater with RMH becoming part of the Western Hospital Network.

### **3 Key Issues in GP Hospital Collaboration (Bringing Them Together)**

This section seeks to highlight both the differences and the common ground between the objectives of GPs and the hospital. A collaborative response to current changes in healthcare in Australia is essential in order to achieve excellent continuity of care. The flow chart on page 40 highlights the concerns of GPs and hospital responses (however partial) at various stages in an episode of patient care. The hospital needs to become more consistent, however, in its efforts to achieve continuity of care. Excellence in admission and discharge planning should be considered important for everyone, not just for people who are likely to present problems to the hospital. There are examples of excellent practice within the hospital—mechanisms need to be found to highlight and disseminate these practices.

### **4 Future Options**

Possibilities for future action are discussed within three broad areas.

- (A) Improving communication between the Hospital and GPs as regards individual patients.
- (B) Making best use of the specialist knowledge of GPs in the areas of continuous care and community based care.
- (C) Developing a coordinated hospital strategy to improve continuity of care.

Within each area three types of suggestion are presented:

- 1 Proposals for immediate action where problems and solutions are reasonably well known.
- 2 Suggestions for further study or for pilot projects.
- 3 Suggestions for monitoring activities.

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## A Proposed Strategic Activities on Communication Regarding Patient Care

### Immediate Action

- 1 The directory should be completed giving due consideration to the findings of the Hospitals-GP survey.
- 2 The joint initiative of the Pre-admission Best Practice Demonstration Project and the North-West Melbourne Division of General Practice, investigating standardised referral forms, should be supported and extended.
- 3 A working party, including at least one general practitioner, should be established to implement the recommendations of the *Notification of Discharge Review Committee* immediately.
- 4 The MURMA meetings should be continued.

### Further Studies and Pilot Projects

- 1 There should be a survey of HMOs to identify practical issues related to communication and discharge. This process should result in recommendations from HMOs to any committee looking at discharge planning.
- 2 Identify and describe examples of best practice in discharge planning and communication from hospital services and departments. Actively seek dissemination of these practices. (One example might be the Palliative Care Service.)
- 3 Mechanisms need to be put in place to gain a consensus within the hospital on acceptable standards and protocols for communication with GPs at the time of admission and discharge. (This would need to be supported by ongoing QA assessing compliance eg the extent to which GPs are noted in the history and on bed cards and ongoing monitoring of discharge communication.)
- 4 A pilot project should be conducted with a relevant population on one or two units to facilitate GP involvement with their patients whilst they are in hospital. (? Essendon surgical). The progress of this project should be monitored by regular qualitative review with the GPs involved and by a comprehensive survey of the patients affected.
- 5 There should be a formal review of the Hospital in the Home, Affiliated General Practitioners Program within six months of the commencement of the program.

### Monitoring

1. Work with the divisions of general practice to develop means for monitoring the standard of discharge communication and planning. This would be most effective if done across a number of hospitals (to allow comparison). A one off project assessing rural discharges could be organised in collaboration with the RACGP sentinel practice project or the Rural Practice Centre. Results should be circulated to hospitals and all GPs.

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## **B Optimal Use of GP Specialist Knowledge**

### **Immediate Action**

- 1 Form a group for GPs working in the hospital.
- 2 GPs should be included in advisory role on committees related to continuity of care (part of recognition of specialist knowledge). eg managed care, notification of discharge, protocol development working groups, Hospital in the Home, pre-admission clinics, homeless, etc. Mechanisms for GP appointment and remuneration need to be identified.
- 3 Agreements for formal relationships between the hospital and the divisions of general practice should be made, giving due consideration to the findings of this review paper.

### **Further Studies and Pilot Projects**

- 1 GPs should be included in the process of setting directions for the RMH Department of Community Health. (One possibility is to develop a reference committee for the Department, to meet every six months and containing a mix of GPs, CHCs, consumer and hospital representatives, with the brief to assist the department in the task of improving continuity of care and identifying and responding to community health needs.)
- 2 Mechanisms for GPs to give advisory input to the Hospital Network Board of Directors should be established.
- 3 Do a feasibility study for GP affiliation with outpatients and pre-admission clinics.
- 4 Seek to identify two or more areas where appointment of GP medical officers could be beneficial to patient care processes. These should be selected on the basis that an episode of care typically extends far beyond the period of hospitalisation. eg nephrology, orthopaedics.
- 5 An appropriate schedule should be developed for payment of GPs appointed to advisory and clinical positions within the hospital and for the recognition of higher qualifications.

### **Monitoring**

- 1 The steering committee for the GP-hospital agreement should be presented with a summary of continuity of care initiatives within the hospital at least annually. The purposes of this review would be:
  - to provide expert guidance for the hospital's ongoing planning regarding continuity of care;
  - to monitor the level of consultation with community based service providers in planning activities.

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## **C A Coordinated Strategy to Develop Continuity of Care for the Hospital Network**

The hospital must be committed to developing mechanisms to ensure coordination of efforts to improve continuity of care and to ensure that examples of excellent practice in this regard are identified, developed and disseminated.

A body needs to be established with the mandate to pursue these tasks. Any body that receives this mandate must meet two requirements:

- a requirement to ensure representation and involvement of all sections of the hospital;
- a requirement to have a workable unit which has the mandate and is accountable to ensure that tasks are done.

A dual structure involving a steering committee and a work-team is probably appropriate. The steering committee should have broad and authoritative representation. It may be appropriate to establish a work-team with resources contributed from the Department of Community Health, the Quality Resource Centre, and Managed Care to implement the required actions. This team would need to link with other teams across the network to ensure coordination and to address issues such as the flow of resources. For this reason it may be desirable for the steering committee to be drawn from all hospitals in the network and to report directly to the network CEO.

Similarly this team would need to maintain strong links with those whose responsibility it is to identify community health needs and gaps in current services. This latter task will be a priority for the network board and will be best achieved by collaboration with agencies operating close to the community, in particular general practice bodies, local government and community health centres, and through the coordination of the efforts of relevant hospital units (eg Corporate Planning, Department of Community Health and the Quality Resource Centre). While there is probably a need for each hospital in the network to address continuity of care issues on an individual basis, needs assessment is probably best done by one body on behalf of the whole network.

### **Immediate Action**

- 1 The hospital should establish a steering committee to oversee the coordination of efforts to improve continuity of care and to ensure that examples of excellent practice are identified, developed and disseminated throughout RMH.
- 2 A work team should be formed with a mandate and resources to assist the steering committee.

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## Chapter 2

### Background, Purpose and Methods

#### Background

Strengthening and broadening the primary care base has been a key Commonwealth Government strategy in its endeavours to make health services more responsive to the needs of local communities. The establishment of the Divisions of General Practice has been the cornerstone of this process, although this has been supplemented by other initiatives to make better use of community based services. This has been done in order to reduce the demand on tertiary care services and to better meet the needs and preferences of consumers. The Commonwealth's Continuity of Care Pilot Projects and the State Government's Hospital in the Home initiative are important examples of this developing emphasis.

At the same time funding models designed to encourage technical efficiency, and an increasing concern with allocative efficiency and equity, have put pressure on major hospitals to look beyond their walls. The pressure is not only to establish linkages that will facilitate expeditious discharges, but also to justify services in terms of their benefits for the day to day lives of individuals and for the overall health status of the community.

It was against this background that the Royal Melbourne Hospital Board of Management decided to establish a Department of Community Health with the brief to:

- improve linkages with the general community and community based service providers;
- to find ways to better define, and respond to, the health needs of the community.

Within this process, linkages with General Practitioners, and in particular, with the Divisions of General Practice, are vital. Hence the first two functions of the Department of Community Health in the proposal accepted by the hospital's board were:

- to foster links with the Divisions of General Practice, to ensure appropriate clinical linkages and a productive clinical relationship between these providers and the hospital;
- to develop a model of patient care, with an emphasis on continuity of care, through linkages with community based service providers and primary care givers.

Since the establishment of the Department, the release of two important State Government reports has paved the way for revolutionary changes, not only for Royal Melbourne Hospital, but for Victorian health services in general. *Victoria's Health to 2050* articulates the government's vision for the delivery of health services, a vision in which the majority of services are delivered in or near patients' homes, and in which the patient and their advocates have a much greater role in selection of treatments.

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The Metropolitan Hospitals Planning Board interim report, *Developing Melbourne's Hospital Network*, proposes a model in which networks of treatment facilities are developed, each involving a major tertiary centre, but with much of the routine acute and chronic care work devolved to secondary acute centres, community hospitals and community based providers. This model will provide both opportunities and challenges to the ability of health services to ensure continuity of care across a full episode of illness. The model will also pose challenges to GPs; on the one hand GPs will probably have an increasing role in the provision of acute services, on the other hand some GP case management functions are likely to be taken up by the networks or by third party case managers and brokers.

## Purpose

In view of these issues it is imperative that the hospital approaches the task of collaboration with all community based service providers with a commitment to ensuring continuity of care for all patients throughout a full episode of illness and beyond.

From this perspective the purposes of this discussion paper are as follows:

- 1 to review the Australian literature and recent Australian and local initiatives to improve hospital-GP liaison;
- 2 to propose a conceptual framework to guide the development and evaluation of GP-hospital liaison projects to improve continuity of care;
- 3 to summarise the current performance of the hospital in terms of continuity of care issues and the strategies that are being developed to improve performance;
- 4 to identify 'strategic' opportunities and priorities for joint projects between RMH and the Divisions of GP and to suggest strategic options for the RMH-Divisional collaboration over the first two years;
- 5 to suggest strategic options for the development of continuity of care activities within the hospital.

## Method

This review is viewed as the first stage of a four stage process of project development in the collaboration between RMH and the Divisions of General Practice and other community based providers. The four phases are:

- 1 Exploratory phase.
- 2 Detailing phase.
- 3 Pilot projects (implementation oriented).
- 4 Pilot projects (outcome oriented).

This report deals with the first phase of the process. The purpose of the exploratory phase is to gain a broad overview of current conditions in respect to hospital GP liaison. In particular the review examines current projects and data collection activities and seeks to identify problem areas that may be amenable

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to intervention. It is a necessary preliminary for targeting more intensive evaluation and data collection activities in later phases. The method generally involves strategic consultation together with a review of the qualitative and quantitative data available. In reviewing both interview data along with historical and policy documents it is necessary to develop sensitivity to the particular discursive and political issues that underlie the status quo in order to avoid naive investigations and recommendations.

## Data Collection Activities

The main components of the review are summarised in Table 1.

**TABLE 1** Summary of Data Collection

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■ **Surveys, policy documents, etc**

Policies audit

Notification of discharge review committee minutes

Managed Care Project minutes

QA/QI reports.

CHC minutes and other documents from Community Agencies.

GP survey

Literature review (complete)

Notes from divisional meetings on GP liaison (and other divisional minutes and working notes)

Report of the GP admission and discharge planning network

■ **Broad ranging interviews**

GP divisions

Key informants in hospital

■ **Entry process information (eg A & E referral sources)**

Pathways by which enter hospital

Function of pre-admission clinics

Outpatient clinic policies

■ **Basic indicators**

Analysis of reasons for readmission

Timing of discharge summaries

Timing of discharge letters

Time for elective admissions

Time for OP appointments

Time for OP waits

Routine tests (Pre-admission clinics)

■ **Identify relevant data sources**

Catalogue data sources located for ongoing evaluation purposes

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Guidelines for the wider use of information from quality assurance and other monitoring activities are in the process of development. Unfortunately the quantitative indicator data cannot be released at this stage until hospital policy in this regard is clarified.

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## **Outline of Discussion Paper**

The discussion paper proceeds in four sections.

The first section reviews the literature relating to GP-Hospital liaison and recent Australian and local initiatives. Findings of a survey of GPs in the RMH catchment are examined in order to identify issues of concern to GPs.

The second section examines the hospital's efforts and performance in relation to Continuity of Care issues.

The third section seeks to relate the hospital's current approaches to continuity of care to the priorities expressed by GPs and State and Federal Governments.

The final section suggests strategic options for GP-hospital collaboration in ensuring continuity of care.

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## Chapter 3

### GP Initiatives in Hospital Liaison

#### Review of the Literature

There are clear advantages in improving the interface between GPs and hospitals. There are benefits to the patient in terms of improved continuity, consistency and comprehensiveness of care<sup>1-8</sup>. GPs themselves benefit from reduced professional isolation<sup>1,5-8</sup>. The hospital sector and the community sector can benefit from a more rational use of resources and educational advantages stemming from GPs being excellent role models as providers of comprehensive care<sup>2-3,6-7</sup>. The general public benefit from increased access to an integrated health care system that provides high quality care<sup>3,7</sup>. There are also benefits to funding bodies in terms of cost, with GP involvement reducing demand for hospital beds, outpatient services, and so on<sup>2</sup>.

Until now, however, the integration of GPs with hospitals has been unsystematic and ad hoc. A variety of models have been advanced, but their documentation and evaluation has generally been poor. Ten such models are listed below. They are not exhaustive, nor mutually exclusive, and many of them overlap in terms of their implementation.

The first set have attempted to **standardise communication** between GPs and hospitals by: (1) developing referral protocols which can be used by all GPs referring patients to a given hospital<sup>9</sup>; (2) improving communication from the hospital to the GP on admission of their patients<sup>10</sup>; (3) improving communication at the point of discharge by optimising the quality and timeliness of discharge summaries<sup>11-14</sup> and adopting such strategies as computer generated letters or patient-held information cards<sup>14-16</sup>.

A second model, which **involves GPs prior to patient admission**, aims to reduce delays in admission and duplication of tests, and to promote patient education and satisfaction. Various projects have been developed which are located either in hospital clinics or general practices, and involve the use of proforma for history, examination and tests<sup>10</sup>.

Thirdly, there is the **involvement of GPs in meetings, case conferences and discharge planning**. A number of Divisions of General Practice have established projects where GPs become involved in the discharge planning process, either by visiting the hospital or being consulted on the phone. This enhances the planning process because the GPs often have a broader view of the social context of the patient, and can therefore determine the most suitable follow-up.

**GP follow-up of patients discharged from hospital** constitutes the fourth model. A significant proportion of patients requiring follow-up after discharge may not be seen by a GP<sup>11</sup>. This may lead to failure to detect complications, lack of support and unnecessary readmission<sup>10</sup>. Various projects have been put in place to formalise this follow-up.

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It has been said that the fifth model - **educational/clinical programs and other academic activities** - is the most traditional model for improving hospital-GP liaison<sup>2</sup>. It has changed over time, with GPs tending to prefer interactive learning through case discussions and clinical meetings rather than formal seminars. This version of the model also has the advantage that the education process becomes a two-way relationship, and allows GPs to provide valuable input for hospital doctors. The role of GPs as educators may also be developed more formally, with GP involvement in teaching medical students, resident medical staff and RACGP trainees, as well as research in both general practice and the hospital setting.

**Shared care** is the sixth model. The hospital and the GP share the care of a given patient, both acting independently but in cooperation. For example, in ante-natal shared care, the GP is responsible for the majority of ante-natal care, the consultant obstetric team at the hospital for the delivery and the post-natal hospital stay, and the GP for continuing post-natal care once the patient returns home<sup>17</sup>. Other areas in which shared care arrangements are common include psychiatry, drug and alcohol, palliative care and diabetes<sup>18-21</sup>. Shared care involves agreed roles and responsibilities of both parties, agreed protocols for management, a system of communication, and training and education of GPs. This model enhances the role of GPs, reduces the workload of the hospital and promotes continuity of care for the patient<sup>2</sup>.

The seventh approach is the **appointment of a GP liaison officer**. GP liaison officers may be involved in promoting a combination of the activities encompassed in the models noted above. Harris et al (1993) suggest that their role may include coordinating educational activities for GPs, encouraging and organising GP involvement in services such as shared care programs, and supporting GP input into planning, service development and discharge programs<sup>2</sup>.

Models 1-7 promote improved liaison between GPs and hospitals and make the patient's path between the hospital and the community smoother, but they do not actually involve GPs in the management of the patient during his/her hospital stay. The **appointment of GP affiliates or associates** is an alternative, which increases the involvement of GPs in hospital based treatment<sup>22</sup>. These GPs are recognised by the hospital by being given admitting rights. They may visit patients, and have complete access to patient records. In Australia there is no financial incentive for GPs to visit patients in hospital. This may be an impediment to the successful implementation of this model, although studies that have looked at reasons for non-use of hospital privileges have not found economic considerations to be a major influence<sup>5</sup>.

**GP wards** take the role of GPs in hospital inpatient care one step further still. This ninth model is more common in rural and/or small hospitals, and is based on the assumption that lower technology inpatient beds providing a relatively low cost alternative to more expensive beds in larger hospitals. Generally, a GP heads the ward, and it is largely staffed on a sessional basis by local GPs<sup>23</sup>.

**Departments of General Practice** constitute the final model, and have been described as the most comprehensive strategy for improving the interface between GPs and hospitals<sup>2</sup>. These are based

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within hospitals, and aim to involve a network of community based GPs<sup>24</sup>. As such, they provide a means by which many of the above models can be implemented in a coordinated manner.

It is difficult to determine the extent to which any of these models has been implemented in Australia, since documentation is poor. One study surveyed 102 hospitals regarding measures they had taken to involve GPs in public hospital services. Of the 95 that responded, 65% had appointed GP affiliates or associates, 32% had a department of general practice, 41% had a designated GP liaison position, 40% had formal GP shared care programs, and 14% had formal GP involvement in discharge planning<sup>2</sup>.

In a similar study, 310 hospital administrators were surveyed about GP involvement in their hospitals. 88% of hospitals responding to the questionnaire reported some structural involvement with GPs, although there was considerable variation according to hospital type. Over 93% of district hospitals reported GP involvement, in comparison to 87% of base hospitals and 66% of teaching hospitals. In district and base hospitals, GPs were most likely to be involved in inpatient care. In teaching hospitals, the most common GP involvement was in the emergency department<sup>25</sup>.

Even when the implementation of a given model has been documented, there has frequently been no evaluation in terms of process, impact, outcome or cost-effectiveness. The most extensive evaluation examined nine projects funded through the Commonwealth Government's General Practice Demonstration Grants Program to promote the involvement of GPs in the processes of hospital admission and discharge of their patients. This study had various pitfalls, but drew out several key issues that are relevant to the success of such models including the need for a GP liaison officer to drive the process and directing appropriate attention to logistics and incentives for participants<sup>26</sup>.

In addition to improving evaluative efforts in relation to the above models, there is a need to look at their relevance and usefulness in the current context of changes to the wider health system. As already noted in the previous section, financial incentives and changing views on appropriate ways for patients to receive care are strengthening and broadening primary care.

In Victoria, two recent policy documents focus on a new role for primary care providers in general and GPs in particular. *Victoria's Health to 2050*<sup>27</sup> describes the GP as central in smoothing the patient's path between acute care and both primary care and continuing care in the community. Likewise, the Metropolitan Hospitals Planning Board's interim report recommends the establishment of "networks of hospital services ... that can promote the better integration of acute care, extended care and psychiatric services along with an increase in the provision of locally available ambulatory care ... General practitioners would be closely linked into the network to promote continuity of care."<sup>28</sup> In the light of these clear policy directions, models which improve communication between the hospital and the GP and/or which make use of the specialist knowledge of GPs in the areas of continuous care and community based care are of greatest relevance.

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## Australian and Local GP Initiatives

### General Practice Admission and Discharge Planning Review Network

Over the course of 1994 a consultancy was conducted by the University of NSW School of Community Medicine and two collaborating divisions of general practice. The stated aim of the consultancy was:

to develop a consensus about key impact and outcome measures for use in the evaluation of General Practice Divisions' projects in hospital admission and discharge planning.

The project was carried out in five phases:

- Phase 1: Review the literature on existing related programs, their evaluation, and outcome measures used.
- Phase 2: Establish and disseminate an initial database of current projects and their evaluation. Establish a network of interested divisions, (*this network was subsequently called the "GP admission and discharge planning network"*).
- Phase 3: Send out pre-workshop reading and reference material. Plan, conduct and evaluate a workshop.
- Phase 4: Prepare a post-workshop report and disseminate to participants for review and consensus development.
- Phase 5: Prepare a final report including the consensus on impact and outcome indicators and recommendations for maintaining and developing the network.

A consensus was established regarding six key outcome areas for which standard indicators should be identified or developed:

- 1 integration of GPs in hospital care of patients;
- 2 maintenance of continuity and consistency of care;
- 3 maintenance of patients normal physical, mental and social functioning and their satisfaction with care;
- 4 improvement in the quality and efficiency of communication between GPs, hospital specialists and other health carers;
- 5 reduction in the demands on hospital care and improved efficiency of community care;
- 6 improved GP knowledge, skills and professional satisfaction (and an associated impact on costs within the health system).

A range of possible indicators for each objective was suggested which addressed the implications of the objective for:

- patients and carers;

- 
- service providers;
  - general practitioners;
  - other health professionals.

Some attempt was made to identify which indicators were thought to be of high priority.

### **Comment**

This report was a useful review of the state of play in hospital GP liaison within Australia. It also identified a broad range of outcome issues that could legitimately be targeted by GP-hospital projects. It is, however, our opinion that the report is disappointing in one regard and potentially dangerous in another.

The report is disappointing in that it fails to make recommendations about matching outcome measures to program type. The proposed indicators, taken together, would comprehensively monitor quality of admission and discharge planning and outcomes for any hospital, but this is a different issue to evaluating discrete projects. The danger lies in the failure of the report to point out that many programs act only at one or a few points in a process in which many elements must come together to achieve the desired goals. Many beneficial programs are unjustly abandoned because they have been evaluated in terms of rhetorically defined goals, which are influenced by many systems factors, rather than on the basis of the specific incremental changes that can be realistically expected. Measurement of patient clinical and functional outcomes is important, but such measures are unlikely to be affected by GP interfacing programs alone. On the other hand, the incidence of critical incidents that jeopardise patient outcomes, (eg communication of drug orders or critical test results), may well be ameliorable to the impact of a targeted project.

Achieving the six global objectives identified above requires strategic action at multiple points in the system and really requires careful analysis of the system as a whole. Table 2 lists benefits commonly claimed for improved GP-hospital liaison categorised by stakeholder groups and the time, in relation to a hospitalisation episode, when the benefit would be experienced. This framework can be useful in identifying the realistic goals of particular programs and in identifying sequences of short term or intermediate goals that are necessary conditions of achieving the ultimate goals. Attachments C, D and E are three models that demonstrate the value of thinking in terms of immediate, intermediate and ultimate objectives and of systems analysis.

### **Melbourne Division of General Practice Hospital Liaison Project**

The Melbourne Division of General Practice received funds in 1994 to negotiate agreements for formal collaboration with four hospitals; Royal Melbourne Hospital, St. Vincent's Hospital, The Royal Childrens' Hospital and the Mercy Hospital. Each of these four hospitals has a GP attached to the hospital in some capacity who undertook to liaise with the Division. A GP divisions' hospital committee was set up which

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had representation from the Northwest, Inner Southeastern and the Central Highlands Divisions. This committee approached the four hospitals to set up meetings with management to establish Heads of Agreement arrangements to govern their formal collaboration. At this stage an agreement has been finalised with one hospital. The details of the agreement with Royal Melbourne Hospital are still being negotiated. It is a major purpose of this review to suggest strategic options for the RMH-divisional collaboration over the first two years of the agreement.

The objectives defined by the GP hospitals committee for the various agreements are attached in Attachment B. The weightings given to the objectives by each of the four hospital liaison representatives are indicated. As with the GP survey, (next section), admission and discharge arrangements are consistent priorities. Other priorities vary considerably.

St. Vincent's Hospital has received funding for the appointment of a half time GP liaison officer. That hospital therefore, already has a number of projects in place, and it would be worthwhile for RMH to take account of their experiences.

### **Melbourne and Northwest Divisions - 'Survey on Communication and Liaison Between Hospitals and GPs'**

In late 1993, the Royal Melbourne Hospital and St. Vincent's Hospital agreed to fund a survey of GPs within their catchment to ascertain their opinion on hospital performance in a number of areas, and to get feedback on a number of proposed patient care initiatives. Despite a number of methodological problems, the survey was able to confirm a widely held perception that GPs experience a range of difficulties getting access to hospital services for their clients and that discharge communication is inadequate often enough to be a problem. The implementation of the recommendations arising from the survey is a priority for the divisions involved (Attachment A). The survey results and recommendations have been carefully considered in formulating the suggestions for action at the conclusion of this report.

### **Other Divisional Projects**

There are a number of other projects, initiated by one or other of the Divisions of General Practice, which involve significant collaboration with the RMH. These projects are simply listed at this point. The hospital's part in these collaborative projects is mentioned later.

- 1 Homeless persons' programs  
A number of groups have commenced programs to provide better health care to homeless persons. These groups include the Melbourne Division of General Practice, the Royal District Nursing Service (RDNS) and St Vincent's Hospital.
- 2 Share Care Projects

**TABLE 2 Potential Benefits of Improved GP-hospital Liaison**

Group	Immediate	Short-term	Long-term
<b>Patients</b>	Less distressing hospitalisation.	Better supports post-hospitalisation	Improved functional, affective and symptomatic outcomes (Receive treatment appropriate to long-term aspirations and social situation)
	More informed decision-making in the hospital	Fewer symptoms and complications	
	Less duplication of assessments and tests	Sense of direction	More confidence in the health system
<b>Carers</b>	Less distress	Less distress and burden	Less distress and burden
<b>GPs</b>	More continuity and control of care	Better able to meet patients needs	More effective
	Learning	Fewer problems and complications to deal with.	Improved knowledge base Increased satisfaction
<b>Hospital staff</b>	Better informed	Smoother discharge	Increased awareness of holistic issues
	Patient better informed and more able to co-operate/ participate.	Fewer readmissions	Increased satisfaction
		Better continuity of plans	Free up resources Increased trust
<b>Hospitals and the health system</b>	Appropriate referrals	Earlier/smoothier discharges	Less mis-utilisation of services
	Less duplication of tests	Fewer readmissions	
<b>The General Public</b>	Decreased costs		Decreased costs
			Increased skills and knowledge among GPs

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## Chapter 4

### Hospital Activities for Liaison and Continuity of Care

#### Section A Interviews with Hospital General Practitioners

There are currently five general practitioners working in various roles in Royal Melbourne Hospital. Intensive interviews were conducted with four of these practitioners loosely based on the schedule in Attachment F. Interviewees were encouraged to develop issues that they considered to be important apart from the schedule. As a second round a draft report was fed back to the interviewees to seek their comment or further input. Because of the relatively unstructured nature of the interviews, summaries of individual interviews are presented rather than a question by question synthesis. Summaries of each interview were negotiated with the interviewees and an overall summary concludes the section.

The interviewees occupy the following positions in the hospital:

- 1 GP consultant to Medical Unit B;
- 2 Palliative Services Coordinator;
- 3 Director of Staff Clinic;
- 4 GP consultant to the HIV/AIDS Service.

The GP consultant to the diabetes unit has thus far been unavailable for interview.

(NB: in all interview reports comments that come directly from the interviewee or are summarised from the interviewee are reported in a serified font.)

#### Interview 1 - GP Consultant to Medical Unit B

This interviewee brought two perspectives to the interview; the first is as a GP practising in the hospital; the second is as the president of a division of general practice. This broader focus carries over into his hospital work in that he considers that he has two roles within the hospital; firstly as a clinician, and secondly as a representative of general practice within the division of medicine. As a result of these multiple perspectives, this doctor was able to comment on a number of wider issues affecting GP hospital relations, including the potential impact of current trends in government policy.

#### Interview Report

##### On Current Role in the Hospital, Impact and Problems

Essentially there are two roles.

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**Clinical role** involving:

- session in medical outpatients and audit;
- auditing discharge plans and input into discharge planning issues;
- training medical students.

This position was developed after an approach to the hospital by the incumbent.

Impacts:

- improved planning for patients in his care;
- training of medical students and other staff;
- increased awareness in this unit and the division of medicine generally about the role of GPs;
- improved general quality of discharge planning through auditing and use of examples of poor planning.

Problems:

- cultural ethos that does not recognise a role for GPs (many other hospitals have a stronger GP presence);
- no actual resistance from staff within the hospital;
- unproductive exchanges comparing incidents of bad hospital communication at discharge with incidents of poor GP communication at referral;
- insufficient training of undergraduates about GP roles and elements of the episode of care which occur outside the hospital;
- post-graduate qualifications of GPs not recognised by RMH.

Possibilities for extension of this role to other areas of the hospital:

- highly desirable (particularly to work on problem solving in the surgical division);
- each unit should employ a GP;
- having particular GP positions is probably more realistic at the moment than expecting GPs to come in and visit their patients (although this may change once the GP role is recognised and they are given the right to make management decisions and reimbursement issues are sorted out).

**Administrative/advisory role** including:

- participation as a member of the division of medicine;
- teaching.

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Impacts:

- GP perspective presented;
- some increased appreciation of the GP role.

Problems:

- still grossly insufficient GP participation in policy development and planning (eg No GP input into standard discharge form);
- Hospital needs to be willing to pay GPs for their involvement on committees, etc. (GPs do not get the same benefits from these inputs that the honoraries do);
- the Department of Community Health could be a problem. The hospital thinks it is getting sufficient GP input through the Department, yet there is a risk of the DCH becoming as distant from GPs as any other department. The hospital still needs to consult with GPs.

### **General Issues About the Hospital's Liaison with GPs**

Communication (regarding patients):

- communication from RMH does seem to have improved over the last few months (especially the medical units);
- surgical units never ring the GP to notify them that their patient has been admitted;
- if surgeons contact GPs at the time of discharge they often issue orders in a demeaning way (eg instructing the GP to look after dressings);
- the Accident and Emergency Department does not contact GPs

Communication (general):

- GPs are made to feel unwelcome if they come into the hospital, communication with HMOs is difficult and there is no recognised right for them to care for their patients;
- there is no GP involvement in the orientation of new residents.

### **General Comments**

If the hospital feels it needs to change there is no point in looking outwards, it needs to look inwards to see what can be changed inside (particularly at the attitudes and awareness of staff).

It is futile comparing the failings of the hospitals and those of GPs (eg poor discharge communication versus poor referral communication). GPs and hospitals need to look to the common ground, the patient, and see how they can do better.

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The Commonwealth and the State Governments are close in their perspectives in that both would like to see a devolution of services into the community. If GPs and hospitals are going to deal constructively with forces for change (eg casemix, Hospital in the Home) they need a vision of the underlying forces and requirements that are leading to these changes. There is a need to define the cutting edge for those who want change.

Hospitals appear unwilling to shift their philosophical ground.

## **Interview 2 - Coordinator of Palliative Care Services**

This interviewee also brings multiple perspectives to the interview. As well as practicing as a GP in the hospital he is also the Medical Director of the Melbourne City Mission Hospice Service.

### **On Current Role in the Hospital, Impact and Problems**

Current clinical and administrative role involves:

- coordinating palliative care services in the department of haematology and oncology;
- facilitating access to the hospital for oncology and palliative care patients;
- maintaining links with the Melbourne City Mission Hospice Program and other community based services;
- training GPs and registrars in palliative care.

This role includes seeing referrals from all over the hospital for palliative care. The aim of the service is to get people back into the community wherever possible. This doctor also represents the hospital at the Northern Palliative Care Forum.

The special contribution a GP can bring to this role is the ability to focus on what can be achieved in the community, and, on the basis of experience caring for people in the community, to make judgements on whether it is realistic for particular patients to be cared for at home.

Impacts:

- increased recognition of the role of palliative care and issues relating to pain control in many areas of the hospital;
- some changes in medical practice - eg use of subcutaneous infusions for pain control;
- these impacts mostly affect nurses and junior medical staff—surgeons never get to see it;
- able to counsel some GPs who ring up with complaints about the hospital (eg regarding changes of medication);
- establishment of discharge protocols and discharge communication protocols on the unit and mechanisms to ensure these are carried out.

- 
- the parent unit must contact the GP and the palliative care liaison nurse checks that this has happened;
  - phone call to the domiciliary service;
  - fax 5 pages of information to the domiciliary service;
  - fax a letter and discharge summary to the GP at the time of discharge;
  - discharge planning facilitated by:
    - getting multi-disciplinary involvement quickly;
    - cross referring to Aged Care Services where appropriate;
    - established contacts with community service providers.

Problems:

- acceptance of GP background within the hospital in particular acceptance of the idea that GPs have “specialist” expertise that is important;
- there is no pay structure for GPs working in the hospital (current structure relates to registrars and visiting medical officers);
- both of these indicate that the GP role is generally undervalued.

Possibilities for extension of this role to other areas of the hospital:

- this issue is important; most patients live and work in the community, but none of the hospital medical staff work in the community;
- possible areas where this could be introduced first are aged care, psychiatry and hospital in the home;
- there should be a GP appointed for the outpatient clinics;
- more realistic to have GP appointments for particular areas than to invite every GP to be involved with their patients in hospital.

General Issues About Hospital Liaison With GPs

*Communication Between the Hospital and GPs*

Problems on the hospital side:

- TIME - so much is left to the resident and registrars;
  - a liaison position might help;
  - some units have to phone the GP;
  - faxing a letter to the GPs is probably the best approach, most GPs have faxes.

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### *Other Opportunities for GPs to be Involved in the Hospital*

Problems are:

- time involved for GPs;
- lack of mechanisms by which GPs are recognised and payed as legitimate practitioners in the hospital (? problem in the culture of medical schools);
- problems with structures for GPs relating to the hospital (ie problems with the ability of divisions to represent their members and also non-member GPs);
- it is not feasible for the hospital to pay GPs to visit their patients;
- the system of payment of GPs involved in Hospital in the Home is too difficult.

### **Interview 3 - Director of Staff Clinic**

The nurse for the staff clinic also attended this interview in which issues relating to health promotion were covered in addition to GP issues.

### **Interview Report**

#### **On Current Role in the Hospital, Impact and Problems**

Role is to provide primary care services and occupational health services to people working at RMH and their families.

This role is extended to include:

- involvement with occupational health and safety issues;
- infection control committee;
- best practice project steering committee.

Impacts:

- mainly relate to occupational health;
- marginal impact on perceptions of GP roles.

Problems:

- attitudes within the hospital (GPs are perceived as being 2nd rate doctors. There is likely to be an increased appreciation of GPs under the casemix funding system);
- no Division of General Practice within the hospital (ie no forum for GPs working within the hospital).

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There are advantages to working as a GP in a hospital environment, particularly the ready availability of resources (eg dietitians, interpreters, specialists) and the opportunity for informal contact with hospital staff.

### **General Issues About Hospital Liaison With GPs**

Communication between the hospital and GPs:

- communication is the number one priority particularly as casemix results in more acute patients being discharged into the community;
- need to let GPs know the waiting times and interests of different surgeons and physicians;
- phone call to the GP at the time of admission and discharge is important;
- divisions could look at medical record issues for patients who have a number of GPs (eg patient held records).

Other opportunities for GP participation in the hospital:

- MURMA meetings and other educational opportunities;
- provide opportunities for GPs to work in outpatient areas (will help increase skill levels);
- some units should have GPs appointed to the unit;
- an in-house division of GPs may facilitate GP input into decision making;
- GPs should be able to be involved with their own patients - this requires a defined role, parking facilities, consideration of time and resolution of remuneration issues.

Current obstacles to GPs being involved with their patients include:

- the lack of a defined role for GPs that leads to them feeling funny and to a lack of credibility on the wards;
- lack of a supportive and friendly environment;
- some GPs are fearful of being found out as not knowing much (ie like reliving their medical student experiences).

Suggest a pilot project on one unit where GPs are issued with hospital ID and parking permits and mechanisms for ease of involvement are put in place.

### **Interview 4 - Medical Consultant for HIV and Infectious Diseases**

This doctor works in a nearby general practice that has a particular focus on servicing the gay community and on sexually transmitted diseases. He is active in a number of community service roles and in lobbying for issues important to the gay community.

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## Interview Report

### On Current Role In the Hospital, Impact and Problems

Current clinical role:

- one session per week in the outpatient department as a specialist in infectious diseases;
- participate in audit session on the unit each week.

Other roles:

- HIV care committee - a committee of review to improve services to patients and ensure services are patient centred. Tasks include policy review and acting on letters from patients;
- lecture FRACGP students on STDs.

Special contribution as a GP:

- more in touch with needs of GPs. Extra effort to write a letter back to the GPs rubs off on other physicians;
- very aware of services and other GPs working in the HIV area—provide network information to other physicians;
- visit own patients in the hospital after clinical session.

Problems:

- not really any problems.

Advantages:

- GPs have a bit of an inferiority complex. Amazed how quickly picked up knowledge about infectious diseases;
- get better service from the hospital when you know who to contact and when you are known by hospital staff;
- much easier to visit patients having a hospital ID and being known;
- easier to get patients in.

Possibilities for extension of this role to other hospital areas:

- GPs with particular interests could be beneficially employed in a number of other areas (eg dermatology, psychiatry, cardiology, respiratory med., gastroenterology, paediatrics, Hep C and others). HIV and palliative care may be special areas where GPs are important to act as a conduit between the hospital and the community.

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Benefits of visiting own patients in hospital:

- continuity of care;
- GP gets a feel for what they're in for;
- patient feels good that they're being followed up;
- hospital staff value GP visits—sometimes asked by the Professor on the medical unit to visit particular patients.

### **General Issues About Hospital Liaison with GPs**

Communication between the hospital and GPs:

- notification of admission and discharge is most important. These are good (ie a phone call is made) about half the time;
- letters vary in quality. Letters from surgical units are much worse than those from medical units;
- difficult to get patients in. Avoid outpatients where possible.

Other opportunities for GPs to be involved in the hospital:

- outpatient clinics are a good place to start;
- sessional GPs in accident and emergency;
- more educational activities;
- more potential for GPs to visit their patients and to interact with medical and nursing staff (though probably not appropriate for the GP to prescribe treatment).

Problems are:

- GPs don't know their way around;
- lack of ID;
- no defined role (GPs do not fit into the hospital);
- no reimbursement (the hospital cannot realistically pay this).

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## **Section B      Review of Hospital Activities Related to Admission and Discharge Planning**

There have been a number of initiatives at the RMH over the last few years to examine the quality of discharge planning and to find ways to improve it. This process has been given new urgency since the advent of case-mix funding. This review seeks to describe the current state of play regarding discharge planning and to identify opportunities created by the current environment of change, to improve communication and collaboration between the hospital and GPs.

The review looks at two areas:

- 1      the current state of formal discharge planning;
- 2      projects and initiatives impacting on admission and discharge planning:
  - i      quality assurance in discharge planning;
  - ii     the discharge notification review committee;
  - iii    managed care;
  - iv     collaborative continuity of care research projects;
  - v      Hospital in the Home;
  - vi     hospital directory for GPs;
  - vii    homeless persons protocols.

The methods used in this review included:

- 1      review of relevant documents;
- 2      in depth interviews with the Nursing Directors of each Clinical Business Unit, and directors of special programs.

### **1      The Current State of Formal Admission and Discharge Planning**

#### **1.1    Interviews with Nurse Directors of Clinical Business Units**

##### **1.1.1    Method**

All Nurse Directors of Clinical Business Units (NDBUs) were interviewed over a six week period. The interview schedule is attached as Attachment G but the format of the interview was left very flexible and, as with the GP interviews, the nurses were encouraged to expand upon areas they considered to be of importance. For the purposes of making clear the current situation with discharge planning, I have chosen to present the results summarised by question and to summarise miscellaneous comments at the end. The nurse directors were asked to provide copies of any formal discharge protocols in use on the wards for which they were responsible.

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## 1.1.2 Results

### *Standard Discharge Protocols*

In special areas or for client groups where discharge planning is generally recognised of being a major issue of concern the NDBUs thought that discharge planning was done well. This included rehabilitation, psychiatry (and psych. patients generally), aged care, palliative care, most neurology and to a lesser extent cardiac surgery. In each of these areas multidisciplinary input is routine. Linkages and outside referrals are less standard for rehab. and neurology than the other areas, therefore more effort needs to be put in to identifying the appropriate community resources.

In the general medical and surgical wards standard discharge protocols are generally not used although some wards have developed conventions that work reasonably well. Most wards have a copy of the booklet "Guide to Discharge Planning" but all NDBUs were convinced that no-one uses it. Where critical pathway maps are being developed as part of the managed care project, these build in discharge planning activities.

Communication with GPs was considered to be erratic by all units except psychiatry and rehab. The only mention of GPs on the managed care plans developed to date is a "letter for GP," at the time of discharge.

### *Current Projects Related to Pre-admission and Admission*

Pre-admission clinics are currently available for some elective surgical patients and are being sought for cardiac surgery. Pre-admission clinics are used predominantly by those who have their surgery at Essendon.

Most units have no specified requirement to contact the GP in either the protocols for pre-admission clinics or the admission protocols. Exceptions are palliative care and some surgical units where GPs are notified when bookings are made.

A number of units have done quality assurance activities related to admission processes. Where the findings have been made available these are summarised in the next section.

### *Current Projects Related to Discharge Planning and Post-Discharge Care*

Discharge protocols for aged care and for the homeless will be standardised across the hospital. Interns will have to record contact with GPs.

The Department of Psychiatry offers a telephone support service to GPs that includes providing advice on where to refer emergency cases. Psychiatry is also developing community teams for crisis management and for rehabilitation. Some other areas, eg dialysis, have special programs for post discharge care.

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The nursing division is working on a strategic plan that may lead to the introduction of primary care nursing if the cost implications can be resolved. A primary care nurse would be responsible to ensure that all aspects of a patient's care, including discharge planning, are kept on track and s/he may be made responsible to make a follow-up phone call. Introduction of the Health Assessment Model in June 1995 should help identify people with special discharge planning needs.

The Intensive Care Unit has appointed a liaison nurse to assist with adequate debriefing of the patient and family and to help ensure appropriate continuity of care on the wards after discharge from the intensive care unit.

Neurosciences and orthopaedic surgery are negotiating with rehab and after care facilities to improve ease of transfer. There have been complaints from these facilities when the hospital then refuses to take patients back if they become acutely ill.

The stroke team seeks to enhance all aspects of stroke planning including discharge planning. Sometimes there is conflict between the stroke team's plans and the desire of the parent unit to get the patient out quickly.

#### *Difficulties Organising Discharges and Transfers*

*(NB. Many issues related to problems in organising discharges and transfers were identified in the review conducted by the notification of discharge working group and are discussed in that section on page 34.)*

Timing of medical decisions was considered a major problem particularly on surgical units where the timing of ward rounds and the irregularity of consultant hours can lead to decisions about discharge being made suddenly and at the last minute.

There is frequent difficulty finding rehab. beds or services able to cope with patients with special needs (eg head and neck surgery patients who require tracheostomy care). Similarly a lack of community supports prevents many people being discharged home. This is a problem with rehab patients from some regions that have no facilities for community based rehab.

Waiting for transport, medications, test results can all delay discharge.

'Boarder' situations (one unit's patient located in another unit's ward) create a difficulty for planning care including discharge planning, (there is little interward communication).

#### *General Comments on the Quality of Discharge Planning*

Some DRGs have high readmission rates and we should look at these to identify problems with discharge planning.

'Linkages' program has been relatively ineffective.

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There is a general notion that discharge planning is an activity of the last 24 hours. In the US expected length of stay is defined in advance and the whole team and the patient are notified. Not defining length of stay in advance increases problems with social factors limiting discharge.

The issue of linking with community carers should be addressed with all patients [? not just high risk].

Informal systems of discharge planning work for about 50% of people.

RMOs take a social history but then usually do not do anything about it.

Multi-disciplinary discharge planning could be improved by working on selected multidisciplinary QA projects in which discharge planning is a significant issue.

#### *Potential for Increasing GP Involvement in the Hospital*

Nurses will not have a problem so long as the GPs have ID.

Medical staff acceptance of a GP role would depend on how it was presented. In particular it would depend on the GPs having a clearly defined role.

There is most potential for GP involvement in pre-admission work-ups and follow-up.

### **1.1.3 Summary of Interview Findings**

It is clear that issues related to admission and discharge planning are considered important across the hospital and that in many areas there has been a substantial commitment, including the commitment of resources, to address these issues. However, efforts to address these issues have, in the past, proceeded in a rather ad hoc manner, heavily dependent on the commitment and initiative of staff within particular units and departments. Unfortunately it seems that the impetus behind many of these initiatives has often not been maintained. One can speculate that this might be due to staff movements or due to a lack of resources or due to difficulty maintaining different policies on different wards and units. It is hoped that recent initiatives in hospital wide strategic planning will help address these problems.

It is important to note that collaboration between units raises particular problems. This is not only the case with 'boarder' situations but has been noted with respect to the communication between inpatient and outpatient services and in the work of special services such as the stroke unit. This situation raises concerns about the hospital's ability to respond to the proposals of the Metropolitan Hospitals Planning Board—if coordination cannot be achieved across the current range of RMH services, it is going to be very difficult to achieve affective coordination across multiple sites and thus to meet the intention of the MHPB vision.

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## 2 Projects and Initiatives Impacting on Admission and Discharge Planning

### 2.1 Quality Assurance in Admission and Discharge Planning

#### 2.1.1 Introduction and General Comments

There have been numerous quality assurance studies done relating to discharge planning. In general these have been implementation studies conducted by nurses and looking at nursing compliance with a particular ward or unit's policies. There were however two studies of particular relevance to the issue of hospital-GP relationships. Permission to mention the main findings of these studies has been obtained from the units concerned.

#### 2.1.2 Overview of Relevant Quality Assurance Studies

At this stage it is only possible to present an overview of the types of quality assurance activities relevant to continuity of care that have been completed in the last few years. Details of the studies are unavailable because of confidentiality guidelines. It is clear, however, that there has been a substantial amount of work in the area. Mechanisms to allow this body of knowledge and experience to be drawn upon more widely within the hospital should be developed in the interest of coordination of hospital efforts and of efficiency.

**TABLE 3 Nursing Division QA Related to Admission and Discharge Processes**

Study Type	1988	1989	1990	1991	1992	1993	1994
Evaluation of dis/adm planning & specific problems				2	1	2	
Evaluation of standard care plans or protocols	1	1		2			
Patient satisfaction (general)		1		1	1	5	
Patient satisfaction with information				1	4	2	
Patient education and knowledge		2	3	9		5	
Communication				1	1		
Compliance with adm/disch procedures	1						
Total	2	4	3	16	7	14	

#### 2.1.3 Audit of Communication With Inpatients Personal Doctors (Dr Robert Fraser — Study conducted on one medical unit, 1992)

##### *Methods and Results*

In this study GPs were contacted regarding 143 patients admitted to the unit over a three month period. GPs were asked to complete a short mail questionnaire on the adequacy of communication from the

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hospital. Two further questions were asked regarding any comments the patients may have made about the hospital and mechanisms for facilitating GP visits to their patients in hospital.

Replies were received from 61% (83) of the doctors contacted.

In general the handwritten letters sent with patients who were discharged to the community were delivered and were considered legible and of acceptable to good quality. No mention is made of the time that elapsed before the patient presented to the GP. No mention is made of communication to the GP regarding patients who are transferred to other institutions.

Of major concern was the finding that for the three patients who died, in no case had the GP been notified of the death, or received a discharge summary or the post mortem report, despite the fact that it was unit policy that all of these should occur.

There were substantial delays in receipt of the typed discharge summaries for many patients, however the quality of the reports was considered to be good. Inclusion of negative test results in the report was valued. The importance of quick dispatch of these summaries (eg to avoid GPs duplicating tests) was emphasised.

Phone contacts were generally considered adequate and appropriate and were valued by doctors for complex patients and when patients are transferred to another facility. Some difficulty contacting registrars and getting through the switchboard were noted.

There was a very high rate of completion of the typed discharge summaries and most were correctly addressed. Those that did not arrive were presumably lost at either end or in the post.

### **Comments on This Study**

The findings of this study give a somewhat different view of the quality of discharge communication than the Melbourne Division GP survey. One obvious possible reason is that this unit is atypical of the hospital as a whole (one respondent suggested this). Another reason may be that the hospital's performance in this regard has deteriorated as throughput pressures have increased. A third possibility is that although the proportion of cases where problems arise is small, when multiplied across a number of units and then a number of hospitals, the absolute number of cases can still amount to a significant problem to GPs.

It is also important to note that this study supports the finding of the Melbourne Division's survey with respect to notification of deaths, and that it does not address the issue of notification of admissions at all.

None-the-less combining the two surveys suggests, on the one hand, that relatively modest failures in performance on the part of the hospital can create significant problems for GPs, and on the other, that HMOs generally make a considerable effort to communicate. Communication is limited not only by constraints of time but by systems constraints such as the unavailability of test results or histories. Both

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of these issues are likely to become more critical as pressure on throughput increases and simply asking people to do better without addressing issues at a systems level is unlikely to be successful.

## **2.2 The Discharge Notification Review Committee**

### **2.2.1 Introduction**

In May, 1994 a quality improvement team was set up as a result of discharge planning issues identified in the patient satisfaction survey conducted in October 1993. The specific finding of concern was that only 76% of patients reported that they were happy with the amount of warning they were given about their discharge from hospital whereas 11½% were dissatisfied. Given the wellknown tendency for patient satisfaction surveys to under-report problems this result was considered very important.

A form of structured brainstorming producing a product called an affinity diagram was conducted; this diagram is included as Attachment I. The seeding question for this exercise was, "What are the problems/issues related to late notification of discharge?"

### **2.2.2 Findings and Recommendations**

A broad range of problems was identified that relate the problem of discharge notification to issues that involve not just discharge planning but planning the process of care as a whole from pre-admission stages forward. Categories of problems included:

- the priority given to discharge planning;
- patient complexity;
- social problems;
- systems problems that initially delay discharge and then cause a hurried discharge;
- bed-blocking;
- the lack of a defined pathway including an expected length of stay;
- coordination and communication within the unit;
- wait time or unavailability of community supports or placements.

Some of these issues had an indirect effect in that where beds are clogged up, other patients may be forced out in a rush in order to get new patients in.

The proposed strategies for dealing with these problems included measures to:

- specify expected length of stay as close to the time of admission or before wherever possible and notify patient and relevant others;
- identify people at high risk of extended length of stay;
- facilitate early discharge planning;

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- ensure prompt and appropriate contact with GPs and involve GPs in the discharge planning process for complex patients;
  - define ideal pathways for patient management through their hospital stay;
  - standardise discharge planning;
  - monitor the discharge planning process.

Funds are currently being sought from the Department of Health and Community Services to pilot this project in one medical and one surgical business unit.

### **Comments on Project**

The recommendations of this project give formal recognition of the need to contact the GP at the time of admission for all inpatients except day cases. It also includes several mechanisms to facilitate early notification of discharge. Standardisation of the path of care and early identification of people at risk should facilitate the ability of medical staff to get discharge summaries including test results out quickly. The ability of the working party to implement the recommendations will clearly be affected by the ability of the hospital to resolve continuity of care issues more generally. Substantial consultation with GPs (and preferably GP representation on the working party) will be necessary to ensure these broader issues are duly considered.

## **2.3 Managed Care**

Managed care is a popular term with a wide range of usages. Within the hospital managed care refers to the process of determining standard care pathways for specific conditions or procedures. These pathways define what should be done for each patient on each day of their stay and incorporate patient education and discharge planning activities. Currently critical pathways have been developed for four conditions with another four under development.

### **Comments**

The process of developing critical pathways for each condition is time consuming and it will be some time before large numbers of patients are affected by the managed care project. None-the-less the pathways which are developed first will probably set the pattern for future developments. It is therefore probably appropriate that these tools be subject to GP review, firstly to ensure adequate reference to communication issues but also to improve the handling of discharge planning issues generally.

## **2.4 Joint 'Continuity of Care' Research Projects**

The Department of Community Health liaises regularly with the community sector, in particular those agencies in Melbourne's west with which we have patients/ clients in common. A major issue identified by the community sector, in particular by the Community Health Centres has been concern over

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discharge planning and continuity of care as practised by Royal Melbourne Hospital and other hospitals across Melbourne.

Some Community Health Centres have taken the initiative to set up joint projects with hospitals and other community based providers (eg; RDNS and welfare agencies). Examples of substantial systems change projects currently underway in the west include:

- a a joint research project run by Western Hospital and Keilor Community Health Service to investigate service gaps for patients recently discharged from two particular hospital wards (medical and surgical) into the area covered by the postcode for Keilor;
- b a research project entitled *Managing Care*, being undertaken by consultants on behalf of Doutta Galla Community Health Service, examining the role of Community Health Centres in relation to post-discharge health services.

As a parallel to these examples, Brunswick Coburg Community Health Centre is developing a proposal to run a research project in conjunction with the Royal Melbourne and North West Hospitals as well as other community based health service providers to examine discharge planning issues in relation to elderly clients discharged to the postcodes of Brunswick and Coburg.

## **2.5 Hospital in the Home**

The Hospital in the Home is a clinical program for patients who require acute inpatient services, but who, by virtue of being medically stable, can and prefer to be managed at home. The program is being administered by the Department of Community Health. Both the North West Melbourne and Melbourne Divisions of General Practice are participating in the development of the program.

All GPs are notified when their patients are discharged to Hospital in the Home, and consulted about discharge planning. GPs are being encouraged to become more integral members of the Hospital in the Home staff by becoming Affiliated General Practitioners with the Program. Affiliated GPs undertake to participate in training regarding the clinical procedures used in Hospital in the Home. Affiliates will be recognised, for the program, as members of staff at RMH and will be able to do home visits and receive fee for service payment from the hospital. They will also be able to prescribe drugs through the hospital pharmacy.

The Hospital in the Home program is a pilot project and it is anticipated that arrangements between the program and GPs will be further developed over the pilot period. None-the-less it is expected that this project will increase recognition of the importance of the GP role within the hospital and assist in defining the role of the community-based doctor in the multidisciplinary team.

## **2.6 Pre-admission Clinics**

The Preadmission Clinic was developed as part of the Coordinated Surgical Service at Essendon campus in 1992. It has evolved to the point where it now manages the continuum of services from referral through to booking, screening, surgical treatment and discharge. The hospital has been

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awarded a National Demonstration Hospitals Program Grant to extend this program to the Parkville campus and to disseminate this approach to a number of collaborating hospitals.

The program is seeking to improve communication and collaboration with GPs in a number of ways:

- ensure GPs receive advance notification of planned admission dates and are notified if these are changed in any way;
- develop mechanisms to ensure that test results obtained by GPs are used and that test results are not repeated.

In order to achieve the latter program staff are collaborating with the North-West Region Division of General Practice to develop a standard referral form for use by GPs (Attachment K). Obtaining widespread use of this form will require ongoing collaboration with several GP divisions. (A sidelight to this project was that when the hospital tried to contact GPs for comment they found that less than half of GPs in the division had fax machines.)

## **2.7 Directory of Services**

The Department of Community Health is currently collating a directory of the services at RMH to distribute to GPs.

The primary aim of producing the directory is to increase the ease with which GPs are able to access the hospital's services and specialists. In keeping with this aim the content of the directory includes information on:

- each department and service within the hospital;
- specialists working within the hospital;
- services that can be accessed by GPs for non-inpatients;
- direct phone numbers for each department/service and where possible for each specialist;
- referral processes.

### **Comments**

The initial survey for collation of the directory drew a response rate of 25%. This low response rate is of concern not only as regards the practical task of collating the directory but also as an indicator of the level of commitment within the hospital to facilitating GP access. For the directory to be of value other issues related to the efficiency with which GPs can access medical staff within the hospital need to be addressed. Issues that were highlighted in the GP survey included the long waits just to get past the RMH switchboard and the failure of HMOs or specialists to return calls. Obviously directory entries that simply refer GPs to the main switchboard are of limited value. One of the RMH GP interviewees suggested that an indication of the particular interests of various specialists would be of value.

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## **2.8 Homeless Persons Protocol Review**

Some GPs in the Melbourne Division of General Practice provide medical services to homeless people. This group contains large numbers of people with complex needs related to psychiatric and substance abuse problems and other general health problems. Discharge planning for this particularly vulnerable client group is very important, as are the relationships between hospital and community based health and welfare service providers who work with this group.

The aim of the review is to improve discharge planning process by examining and modifying existing protocols in order to better meet the needs of this population. This will occur against a background of data collection and educational activities designed to enhance the hospital staffs' understanding of the health and welfare needs of this client group. As well as integrating the experience already accumulated within the hospital this process will draw upon the experiences gained by the Melbourne Division of General Practice, the RDNS and St Vincent's Hospital in their programs to service the homeless.

## **3 Summary of Hospital initiatives in Continuity of Care**

This review of current projects confirms that there is considerable activity occurring within the hospital to improve admission and discharge practices and to address issues related to continuity of patient care more generally. Once again, however, it seems that both monitoring and planning have proceeded in an ad hoc manner. At present there is no forum for sharing information or for coordination of activities designed to improve the continuity of patient care across a whole episode of 'illness'. Various flow charts relating to patient movement through the system have been developed (Attachment H), and there have been some attempts to standardise parts of the process. None-the-less considerably more needs to be done.

If the hospital is to meet the challenge of providing integrated, patient oriented care three issues seem to be of particular importance:

- the need for coordinated planning and monitoring of continuity of care activities;
- a commitment to implementation of projects beyond the conceptual stages;
- the need to draw extensively on the expertise of GPs and other community service providers.

The imperative in this regard will become considerably greater with the formation of the hospital networks.

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## Chapter 5

### Key Issues in GP–Hospital Collaboration

Figure 1 summarises the previous discussion by looking at each stage of patient care within a total episode of illness and highlighting issues of concern raised in the GP survey on the one hand and hospital activities on the other. This diagram demonstrates that, while there is clearly awareness of most of the issues of concern to GPs within the hospital there has, to date, been little coordinated effort to address these issues. It is equally clear that the focus of hospital efforts is on issues that will increase throughput, while the GPs' main concerns are getting patients into the hospital and communication.

Increasing throughput will make it easier to get patients in. However there is a danger that the relationship between hospitals and GPs could become one merely of convenience to the hospitals (eg hospitals instructing GPs to do certain tests for certain patients, contacting GPs about patients who are hard to get out and so on), rather than a partnership that is considered important for all patients. Such an approach would be short sighted as there are many ways in which a generally strong partnership between the hospital and GPs could enhance throughput. These range from better patient preparation for hospitalisation to prevention of unplanned readmissions, and to an increased skill level amongst community practitioners. In short there is an imperative to develop partnerships with GPs that recognise their skills and move beyond the hospital telling them what to do.

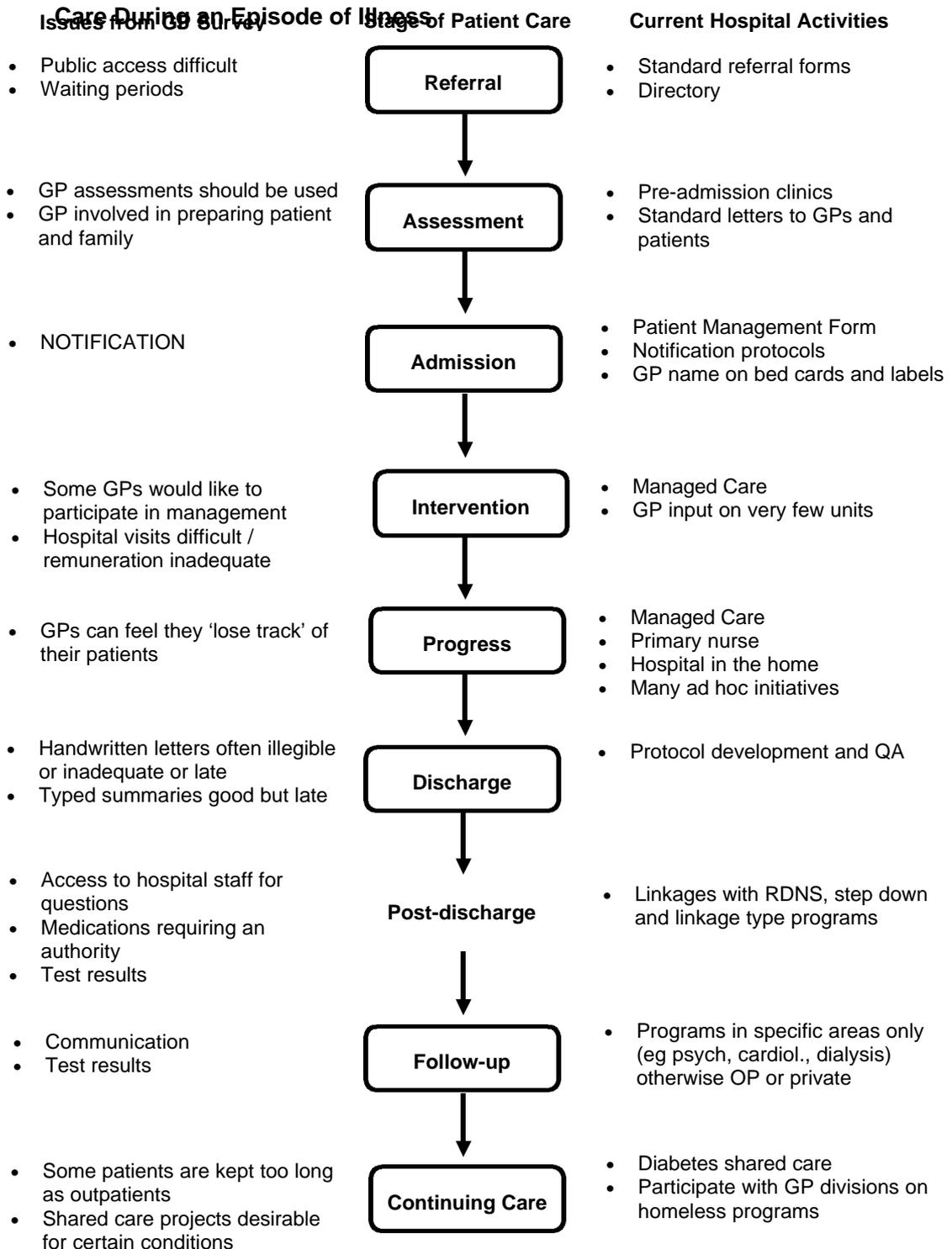
Similarly there is a need for GPs to define their role in ensuring adequate continuity of care and, as for the hospital, this may mean clearly specifying standards of practice. Some recent papers by GPs reveal a tendency to demand consistency from the hospitals whilst rejecting the possibility of consistency amongst GPs because they are all “individual practitioners”. In terms of continuity of care one part of achieving consistency will involve defining the limits of the case management and care brokerage role that GPs should have and for which they should be held accountable. It will also involve their participation in developing models of case management and care brokerage for clients with complex care needs.

As stated by one GP interviewed for this report:

*It is futile comparing the failings of the hospitals and those of GPs (eg poor discharge communication versus poor referral communication). GPs and hospitals need to look to the common ground, the patient, and see how they can do better.*

An essential element of achieving a patient focus is to adopt the perspective of a full episode of illness and to coordinate efforts within this general framework.

**FIGURE 1 Summary of GP Issues and Current Hospital Activities at Each State of Patient**



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## Chapter 6

### Strategic Options

#### Summary and Possibilities for Strategic Action in the Development of Hospital GP Relationships

Possibilities for future action are discussed within three broad areas.

- A Improving communication between the Hospital and GPs as regards individual patients.
- B Making best use of the specialist knowledge of GPs in the areas of continuous care and community based care.
- C Developing a coordinated hospital strategy to improve continuity of care.

Within each area three types of suggestion are presented:

- 1 proposals for immediate action where problems and solutions are reasonably well known;
- 2 suggestions for further study or for pilot projects;
- 3 suggestions for monitoring activities.

#### A Communication Regarding Patient Care

In respect to communication, the primary task of the collaboration should be to seek to identify ways and means of notifying General Practitioners of their patient's admission to hospital, involving them in discharge planning, as resources allow, but in all cases, communicating to them a timely summary on discharge which contains information needed for ongoing care and in particular:

- i access information for any outstanding results;
- ii clear statement of management issues;
- iii details of medication (with special attention to medications requiring an authority); and
- iv where appropriate, details of any community support services arranged or needing to be arranged.

Further objectives of the collaboration as regards communication relate to the sharing of information and expertise and enhancing GPs' access to the hospital.

#### Immediate Action

- 1 The directory should be completed giving due consideration to the findings of the Hospitals-GP survey.

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- 2 The joint initiative of the Pre-admission Best Practice Demonstration Project and the North-West Region Division of General Practice, investigating standardised referral forms, should be supported and extended.
  - 3 A working party, including at least one general practitioner, should be established to implement the recommendations of the *Notification of Discharge Review Committee* immediately.
  - 4 The MURMA meetings should be continued.

### **Further Studies and Pilot Projects**

- 1 There should be a survey of HMOs to identify practical issues related to communication and discharge. This process should result in recommendations from HMOs to any committee looking at discharge planning.
- 2 Identify and describe examples of best practice in discharge planning and communication from hospital services and departments. Actively seek dissemination of these practices. (One example might be the Palliative Care Service.)
- 3 Mechanisms need to be put in place to gain a consensus within the hospital on acceptable standards and protocols for communication with GPs at the time of admission and discharge. (This would need to be supported by ongoing QA assessing compliance eg the extent to which GPs are noted in the history and on bed cards and ongoing monitoring of discharge communication.)
- 4 A pilot project should be conducted with a relevant population on one or two units to facilitate GP involvement with their patients whilst they are in hospital. (? Essendon surgical). The progress of this project should be monitored by regular qualitative review with the GPs involved and by a comprehensive survey of the patients affected.
- 5 There should be a formal review of the Hospital in the Home, Affiliated General Practitioners Program within six months of the commencement of the program.

### **Monitoring**

Work with the divisions of general practice to develop means for monitoring the standard of discharge communication and planning. This would be most effective if done across a number of hospitals (to allow comparison). A one off project assessing rural discharges could be organised in collaboration with the RACGP sentinel practice project or the Rural Practice Centre. Results should be circulated to hospitals and all GPs.

## **B Optimal Use of GP Specialist Knowledge**

GPs generally accumulate considerable expertise about the effects that illness has on peoples' lives and families and the psycho-social issues that can create and maintain illness. They also have an extensive knowledge of community facilities. In circumstances where an increasingly large proportion of the patients seen in hospitals are people with acute problems related to chronic conditions, it is clear that GPs have a great deal to offer in terms of formulating strategies for patient management. GPs can

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have this input in four ways; by involvement with their own patients who are in hospital, as appointees to suitable hospital staff positions, by providing input to policy making bodies, and through education.

### **Immediate Action**

- 1 Form a group for GPs working in the hospital.
- 2 GPs should be included in advisory role on committees related to continuity of care (part of recognition of specialist knowledge). eg managed care, notification of discharge, protocol development working groups, Hospital in the Home, pre-admission clinics, homeless, etc. Mechanisms for GP appointment and remuneration need to be identified.
- 3 Agreements for formal relationships between the hospital and the divisions of general practice should be made, giving due consideration to the findings of this review paper.

### **Further Studies and Pilot Projects**

- 1 GPs should be included in the process of setting directions for the RMH Department of Community Health. (One possibility is to develop a reference committee for the Department, to meet every six months and containing a mix of GPs, CHCs, consumer and hospital representatives, with the brief to assist the department in the task of improving continuity of care and identifying and responding to community health needs.)
- 2 Mechanisms for GPs to give advisory input to the Hospital Network Board of Directors should be established.
- 3 Do a feasibility study for GP affiliation with outpatients and pre-admission clinics.
- 4 Seek to identify two or more areas where appointment of GP medical officers could be beneficial to patient care processes. These should be selected on the basis that an episode of care typically extends far beyond the period of hospitalisation. eg nephrology, orthopaedics.
- 5 An appropriate schedule should be developed for payment of GPs appointed to advisory and clinical positions within the hospital and for the recognition of higher qualifications.

### **Monitoring**

- 1 The steering committee for the GP-hospital agreement should be presented with a summary of continuity of care initiatives within the hospital at least annually. The purposes of this review would be:
  - to provide expert guidance for the hospital's ongoing planning regarding quality of care;
  - to monitor the level of consultation with community based service providers in planning activities.

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## **C A Coordinated Strategy to Develop Continuity of Care for the Hospital Network**

As previously noted the performance of the hospital in ensuring continuity of care has been patchy. A coordinated approach will be essential within the hospital networks to ensure that the flow of both patients and resources works effectively across the network and into the community. At the same time the regional basis for the networks provides greater opportunities than have previously been available to make health services responsive to the health needs of the community.

A priority for the hospital must be to develop mechanisms to ensure coordination of efforts to improve continuity of care and to ensure that examples of excellent practice in this regard are identified, developed and disseminated. Clearly a body needs to be established with the mandate to pursue these tasks. Any body that receives this mandate must meet two requirements:

- a requirement to ensure representation and involvement of all sections of the hospital;
- a requirement to have a workable unit that has the mandate and is accountable to ensure that tasks are done.

A dual structure involving a steering committee and a work-team is probably appropriate. The steering committee should have broad and authoritative representation. It may be appropriate to establish a work-team with resources contributed from the Department of Community Health, the Quality Resource Centre, and Managed Care to implement the required actions. This team would need to link with other teams across the network to ensure coordination and to address issues such as the flow of resources. For this reason it may be desirable for the steering committee to be drawn from all hospitals in the network and to report directly to the network CEO.

Similarly this team would need to maintain strong links with those whose responsibility it is to identify community health needs and gaps in current services. This latter task will be a priority for the network board and will be best achieved by collaboration with agencies operating close to the community, in particular general practice bodies, local government and community health centres, and through the coordination of the efforts of relevant hospital units (eg Corporate Planning, Department of Community Health and the Quality Resource Centre). While there is probably a need for each hospital in the network to address continuity of care issues on an individual basis, needs assessment is probably best done by one body on behalf of the whole network.

### **Immediate Action**

- 1 The hospital should establish a steering committee to oversee the coordination of efforts to improve continuity of care and to ensure that examples of excellent practice are identified, developed and disseminated throughout RMH.
- 2 A work team should be formed with a mandate and resources to assist the steering committee.

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## References

- 1 Schattner P and Dunt D (1989) "General practitioner involvement in non-procedural medicine in public hospitals in Melbourne, Australia" *Family Practice*, 6(2): 141-145
- 2 Harris MF, Fisher RR and Knowlden SM (1993) "Improving general practitioner involvement in urban hospitals: Departments or divisions of general practice" *The Medical Journal of Australia*, 158: 304-307
- 3 Goldman LM (1986) "General practitioners and hospitals". In Andersen N, Bridges-Webb C and Chancellor A *General Practice in Australia*, Sydney University Press: Sydney
- 4 Lynn K (1990) "Surgical patients need their family doctors" *Canadian Family Physician*, 36: 1247-1248
- 5 Johnston MA, Tweedie T, Premi JN and Shea PE (1980) "The role of the family physician in hospital: Use of hospital privileges" *Canadian Family Physician*, 26: 215-220
- 6 Turgeon SA (1984) "The role of the family physician in the hospital" *Canadian Family Physician*, 30: 2313-2315
- 7 Stevens JA (1973) "Hospital care from general practitioners" *The Medical Journal of Australia*, 1: 403-407
- 8 Barber JH, Bain DJ, Bassett WJ and Haines AJ (1972) "General practitioner ward in a district" *British Medical Journal*, 4: 27-30
- 9 Divisions and Projects Grants Program (1992) *Application Guidelines*
- 10 Frith J (1994) *GPs and Hospitals*, School of Community Medicine, University of New South Wales: Sydney
- 11 Temple J (1988) "General practice follow-up of patients discharged from hospital" *The Practitioner*, 232: 148-152
- 12 Bado W and Williams CJ (1984) "Usefulness of letters from hospitals to general practitioners" *British Medical Journal*, 288: 1813-1814
- 13 Finau SA (1986) "Communication between hospital and general practitioner: A study of a rural area" *Community Health Studies*, 10(2): 205-209
- 14 Castleden WM, Stacey MC, Norman PE, Lawrence-Brown MMD and Brooks JD (1992) "Members of the Department of General Surgery, Fremantle Hospital" *Medical Journal of Australia*, 157: 380-382
- 15 Kendrick AR and Hindmarsh DJ (1989) "Which type of hospital discharge report reaches general practitioners quickly" *British Medical Journal*, 298:362
- 16 Sandler DA, Heaton C, Garner ST and Mitchell JRA (1989) "Patients' and general practitioners' satisfaction with information given on discharge from hospital: Audit of a new information card" *British Medical Journal*, 299:1511-1513

- 
- 17 Bull M (1989) "GP obstetrics: Making the most of shared care" *The Practitioner*, 233:211-215
  - 18 Drummond DC, Thom B, Brown C et al (1990) "Specialist versus general practitioner treatment" *Lancet*, 336: 915-918
  - 19 Kendric T, Sibbald B, Burns T and Freeling P (1991) "Role of general practitioners in care of long term mentally ill patients" *British Medical Journal*, 302: 508-510
  - 20 Copperman H (1988) "Domiciliary hospice care: Survey of general practitioners" *Journal of the Royal College of General Practitioners*, 38: 411-413
  - 21 Powell J (1991) "Shared diabetes care" *The Practitioner*, 235: 761-762
  - 22 Montalto M, Gunesekera and Sanderson (1994) "The use of inpatient admission privileges by members of a Division of General Practice" *Australian Family Physician*, 23(3): 453-461
  - 23 Sullivan J (1994) "How I established a general practice unit" *General Practitioner*, 2(6): 4-8
  - 24 Royal Australian College of General Practitioners (1984) *Guidelines for Establishment of Departments of General Practice in Hospitals*, Royal Australian College of General Practitioners: Melbourne
  - 25 School of Medical Education, University of New South Wales (1993) *General Practitioners in Hospitals*, Report prepared for the Australian Health Ministers' Advisory Council Medical Workforce Group on Hospital Training and Career Development, Australian Government Publishing Service: Canberra
  - 26 Lesley P (1993) *Preliminary Report: Lessons from GP Demonstration Grants*, Deloitte Touche Tohmatsu: Melbourne
  - 27 Health and Community Services Victoria (1995) *Victoria's Health to 2050*, Health and Community Services, Melbourne
  - 28 Metropolitan Hospitals Planning Board (1995) *Interim Report: Developing Melbourne's Hospital Network*, Metropolitan Hospitals Planning Board, Melbourne

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# ATTACHMENT A

## Recommendations of the Hospital–GP Survey

The survey recommendations have been grouped into the following domains:

- A problems GPs have in making referrals to the hospitals;
- B issues surrounding notification of the GP by the hospital;
- C issues concerning verbal liaison by the hospitals with the GP;
- D issues concerning written liaison by the hospitals with the GP;
- E GP attitudes to the hospitals' proposed initiatives.

EACH RECOMMENDATION IS LINKED TO DATA FROM THE BODY OF THE REPORT. THE NUMBER OF THE SUPPORTING DATA IN THE SURVEY REPORT IS SHOWN IN BRACKETS.

### **A Recommendations Concerning Problems for GPs Making Referrals to the Hospitals**

- Both hospitals need to be clear about where they want to position themselves with respect to the private system and their GP referral base and consider the incentives for change. (A2, A3, B3)
- The hospitals need a clear strategy to deal with non-emergency, yet reasonably urgent, outpatient referrals which are a major frustration for GPs. (A2, A3)
- The hospitals should examine the length of current waiting lists, identify those which are excessively long and plan strategies to address these. These strategies should be circulated to referring GPs. (A3)
- RMH should address problems with its switchboard. (B1)
- RMH should consider publication of a Directory of Services to assist GPs to call relevant departments directly and improve knowledge of hospital clinics. SVH will need to update its directory. (B6, B1)
- Publication of a dedicated telephone number for GPs making clinic appointments to reduce the time taken for the majority of GPs who phone on behalf of their patients. (A2, C3)

### **B Recommendations on Notification of the GP by Hospitals Concerning Patients**

#### **1 Notification by the Emergency Department.**

- Notification of the GP of a patient's admission or non-admission when referred to the Emergency Department. (B7, F3.4)
- Notification of the GP of a patient's self referred attendance at the Emergency Department, providing the patient consents to this. (B8, F3.4)

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- Development of systems for GP notification in the above cases involving fax, telephone or “next day” mail. This could involve collaboration with the Divisions of General Practice who have the capacity to greatly increase the numbers of GPs with a fax through bulk purchases arrangements. (B7, B8)

## **2 Notification of inpatient admission.**

- Develop systems for using information technology, fax or “next day” mail for notification of the patient’s GP of admission in all cases. (D2, F3.1)
- Educate resident medical staff concerning the importance of a phone call to the GP to both notify the admission of their patient and to collaborate over the past history and discharge needs. GP involvement in medical orientation is one possible strategy. (D2, D6, F3.4, F4.3)

## **3 Notification about major change in patient’s status (particularly death) while in hospital.**

- Speedy notification of a patient’s death whilst in hospital by fax, phone call or “next day” mail. (D4, F3.4)

## **C Recommendations Concerning Verbal Liaison by the Hospitals with the GP**

- The hospitals, in conjunction with private specialists and GPs, should develop and publicise strategies to deal with GPs’ needs for telephone consultation and advice. (A1, B3)
- The hospitals should initiate as routine procedure that junior medical staff phone the GP to notify admission, to collect details of the patient’s past medical and social history and to assess the patient’s needs after discharge. (B5, D2, D3, D4, D5, D6, F3.4, F4.3)
- Community support services arranged by the hospital should routinely liaise with the GP over the care of their mutual patient. (F4.7)
- As a means of highlighting the importance of liaison, the hospitals should identify the GP’s name on their patient’s bed card and other relevant documentation in the patient record. (F3.2)
- In order to facilitate the visiting of patients in the hospital by those GPs wishing to do so, the hospitals and GP Divisions should look at ways of overcoming problems with parking where this is a barrier as well as remuneration for the GP’s time. (D5, F3.6)
- The hospitals should address the GPs’ concerns over premature patient discharge through better liaison strategies noted above. (E5, F4.5, F4.3, F4.4)
- The hospitals should address the issue of consulting the GP before a patient they have referred is referred on to another specialist. (F3.5)
- The hospitals and Divisions of General Practice should collaboratively develop “best practice” strategies for the management of public patients requiring urgent admission. (A4)

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## **D Recommendations Concerning Written Liaison by the Hospitals with the GP**

- The hospitals need to rectify the frequent problem of illegibility of the interim discharge summary. (E1)
- The hospitals should address the problem of the final discharge summary arriving “too late to . (E2)
- Both hospitals, but particularly RMH, should address the problems associated with access by the GP to outstanding results. A uniform procedure between the two institutions would be desirable and could then be publicised to all GPs. (E3)
- The hospitals should tackle the delays in GPs receiving letters from outpatient departments. (B4, B5)

## **E GP Attitudes to the Hospitals’ Proposed Initiatives (Not Covered Elsewhere)**

### **1 Pre-admission assessments.**

- The hospitals should develop systems which include the GP in the pre-admission work-up of elective patients. (F1)

### **2 Outpatient shared-care programs.**

- In collaboration with GPs, the hospitals should gradually expand the range of chronic medical conditions available through outpatient shared care programs. (F2.2, F2.2)

### **3 Early discharge programs.**

- With respect to early discharge, (and in addition to phone liaison), the hospitals should develop written discharge protocols to accompany the patient home. (F4.7)
- The hospitals should utilise the services of GPs in the management of early discharge patients provided the hospital medical consult the GP from the time of admission as to his/her role and availability to home visit. (F4.2, F4.3, F4.4)

## ATTACHMENT B

### Objectives of Affiliation Between the Hospitals and the Divisions of General Practice

Table 1 :  
Objectives of New Hospital-GP Arrangements  
 Priorities 4 August 1994 (C means Current)

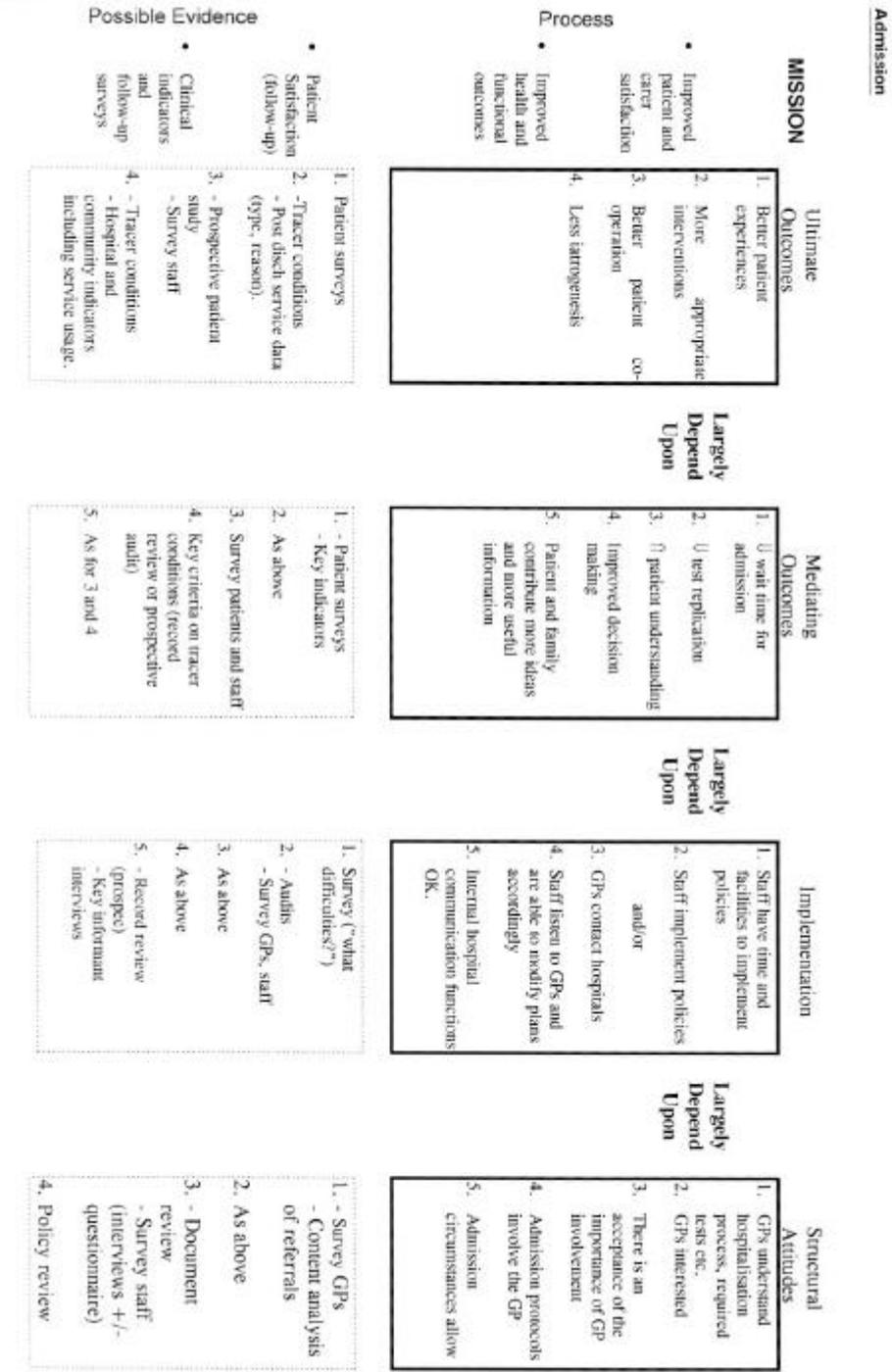
Hospital-GP collaboration domains	Mercy	RCH	RMH	StV's
Shared cared by areas eg diabetes oncology	X 2	2	1 1	1 C
Preadmission planning liaison protocols	2 2 2	1	3 3 3	1
Admission arrangements	1	1		1
Assignment of GPs to administration patient care committees departments ...	2 2 2	1	3 1 3	2
Inpatient liaison with GPs	2	1	1	1
Pre-discharge planning protocols	1 1	1	1 3	1 C
Outpatient arrangements	2	1	2	?
GP case management	2	XX	3	3
Community-based supports eg "Hospital in the Home" HACC	2	3	1	1 C
(Any necessary) readmission priorities	2	1		1
Review of Quality Assurance Continuing Medical Education & other education programs	2 2	HVD C	3 1 3	2
Research and projects collaboration	2	2	2	3
Services to GPs eg sterilization of instruments	X	3		1
GP participation in orientation: Hospital staff inservice: Interns and Registrars	1 1	HVD C	1 2	1
Hospital visits to GPs	2	3		
<i>Hospital visits BY GPs</i>				2
Ongoing liaison between the Hospital and Divisions and periodic collaboration review	2	1	3	2

Table 2 :  
**Means of Achieving Hospital-GP Objectives**  
 Priorities 4 August 1994 (C means Current)

Hospital-GP collaboration processes	Mercy	RCH	RMH	StV's
Hospital requesting GPs to be nominated by (or through) Division to Hospital Committees	3	1	2	1 C
Information dissemination about Hospital services	2	1	3	1 C
Reskilling of GPs individually, or volunteer groups	2	2		1
Wards	2		3	
Clinics	2		1	
Departments	2		3	
...				
Regular updates in (a) Hospital publications	2	1		2
(b) <i>Melbourne GP</i> about Hospital-GP collaboration	2			
Private Hospital services to be advertised in <i>Melbourne GP</i> other Divisional Newsletters	3 3	1		
Mechanisms for shared project development	3	3 ?	1	2 ?
implementation	3		1	
evaluation	3			
Hospital resources for agreed-upon Division activities	3	3		
Budget holding by Division and/or identified GP group practices on behalf of patients for necessary medical, and hospital services	X	X		
GPs in Emergency Departments				1 C

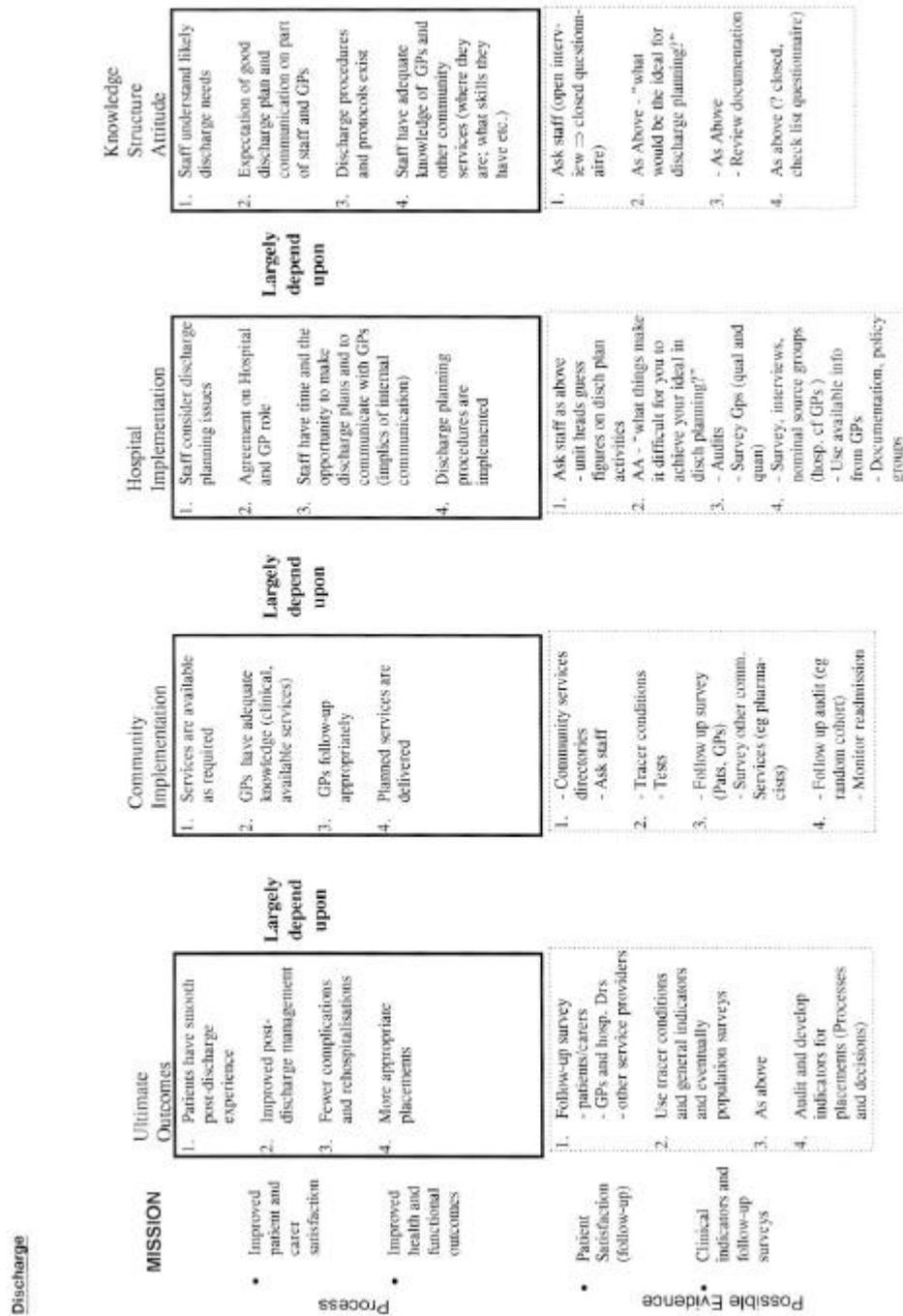
# ATTACHMENT C

## Preconditions for Achieving Improved Admission Related Outcomes



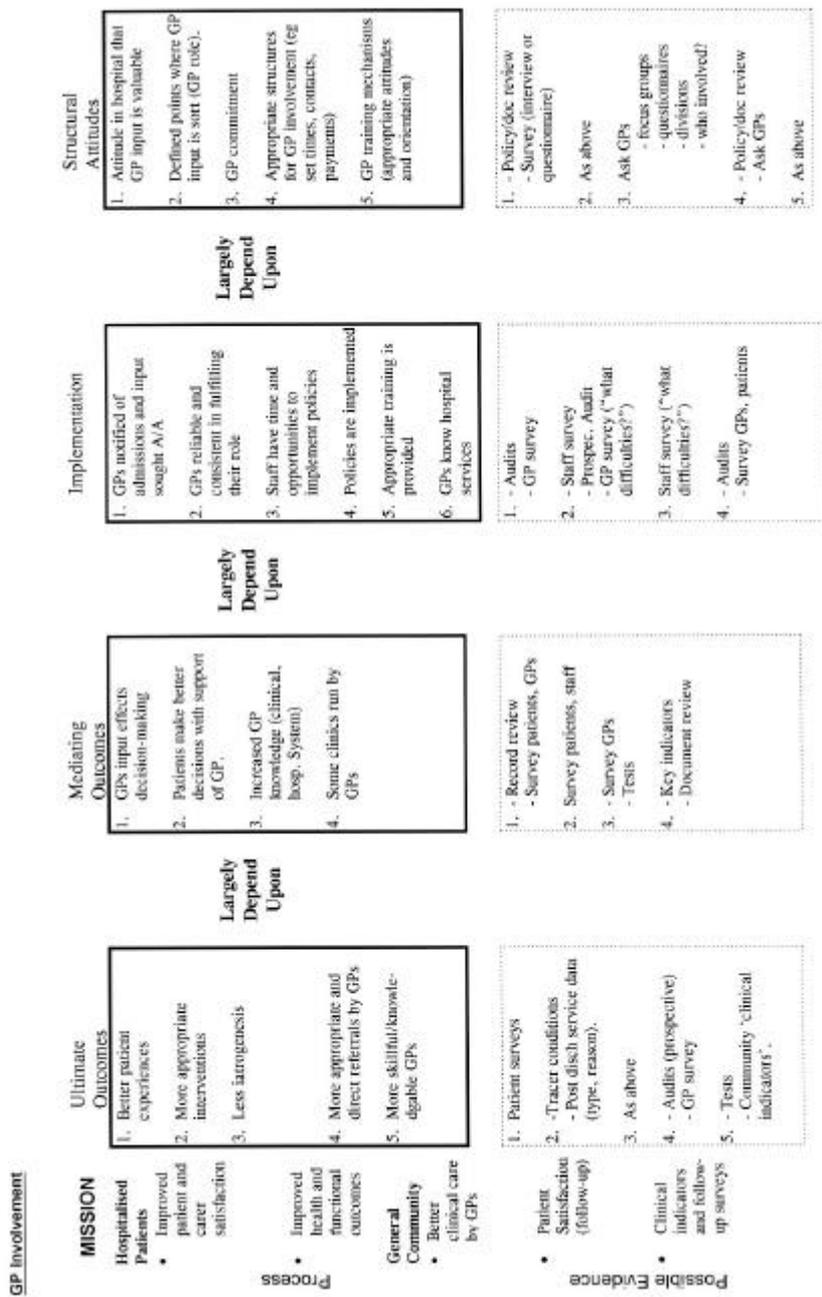
# ATTACHMENT D

## Preconditions for Achieving Improved Discharge Related Outcomes



# ATTACHMENT E

## Preconditions for Achieving Better Integration of GPs in Hospitals



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# ATTACHMENT F

## Interview Schedule for GPs in the Hospital

Please explain your role within the hospital.

Does your role ever extend beyond this? Special tasks, different times.

Is there scope to extend this sort of role to include other GPs in other areas of the hospital?

What are the main difficulties you face to fulfilling your role in the hospital?

Do you feel you have had an impact on either practices or attitudes within the hospital?

Do you have any aspirations regarding further changes you would like to see?

What are the main obstacles to increasing GP involvement in the hospital?

- Hospital side
- GP side

What would you see is the most urgent change necessary to improve the effectiveness of the hospital's interactions/relationship with GPs?

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# ATTACHMENT G

## Interview Schedule for Hospital Key Informants

Do you use any standard discharge protocols?

Copies?

How effective do you think communication with community service providers (eg GPs) is on your unit? (As appropriate).

What scope is there for GPs to become more involved in patient care? (As appropriate)

Are you doing any work specifically to address issues of continuity of care?

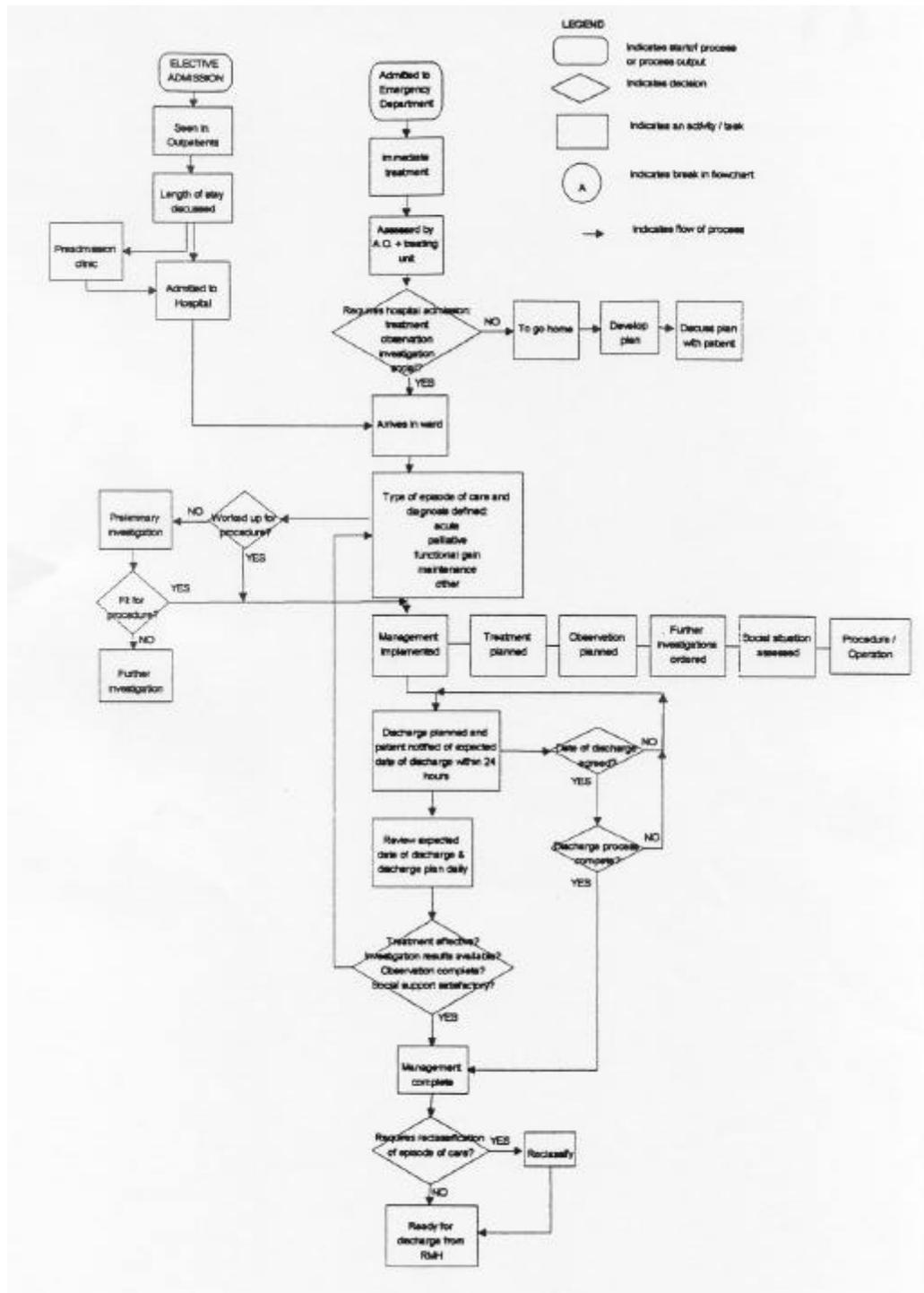
- Pre-admission or at the time of admission:
- Post-discharge:

Do you have any common problems related to organising discharges or transfers?

Are areas within your unit currently working on developing clinical path maps? (As appropriate)

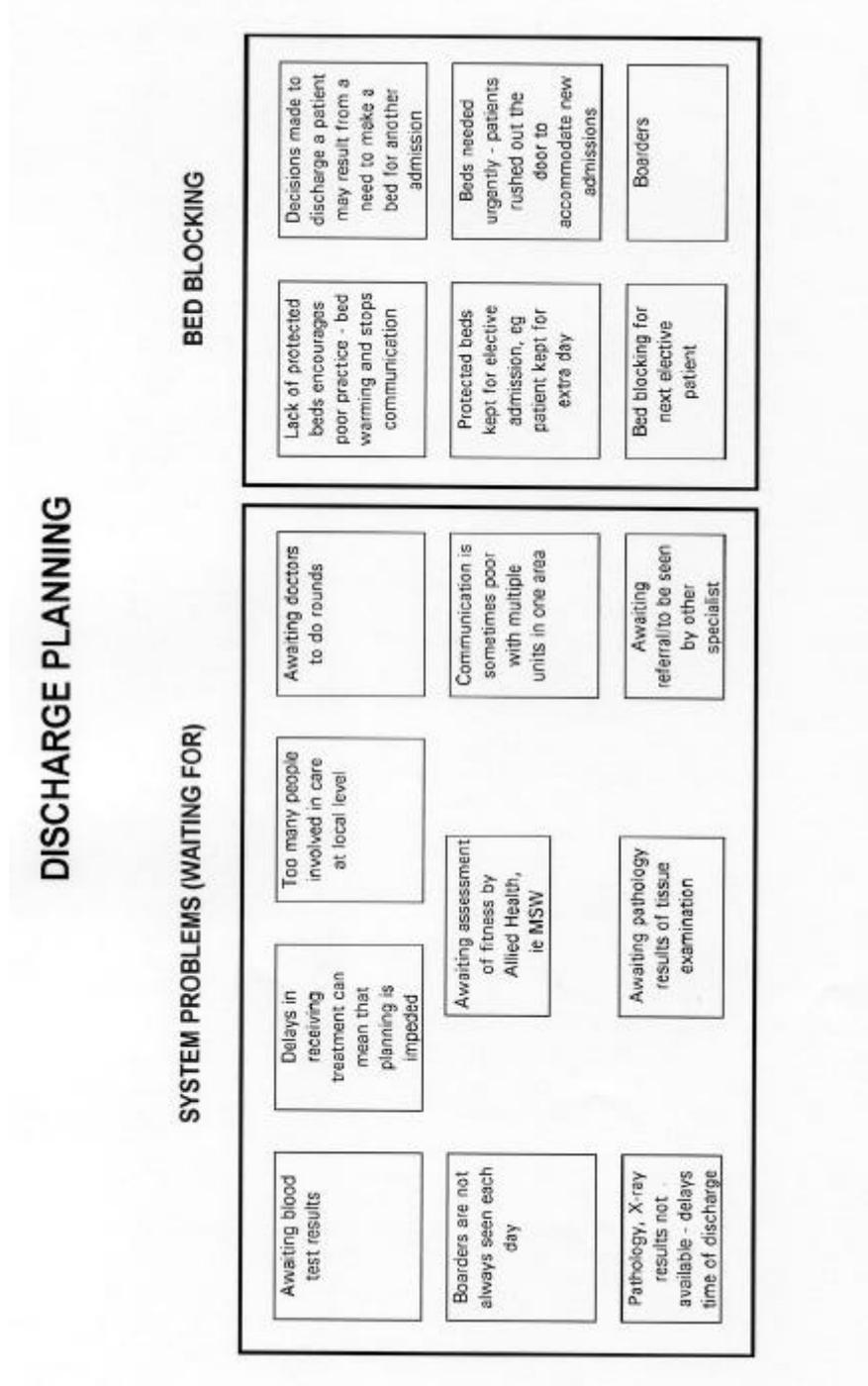
# ATTACHMENT H

## Ideal Flow Chart for Elective and Emergency Admissions

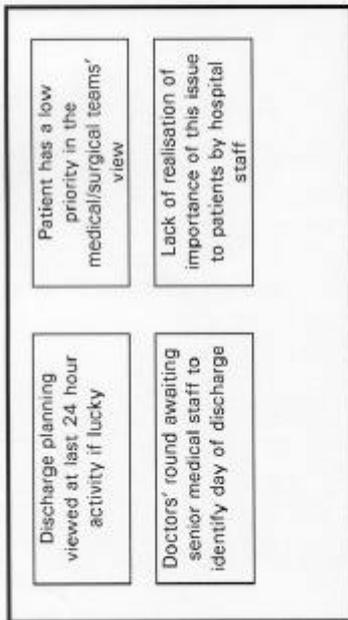


# ATTACHMENT I

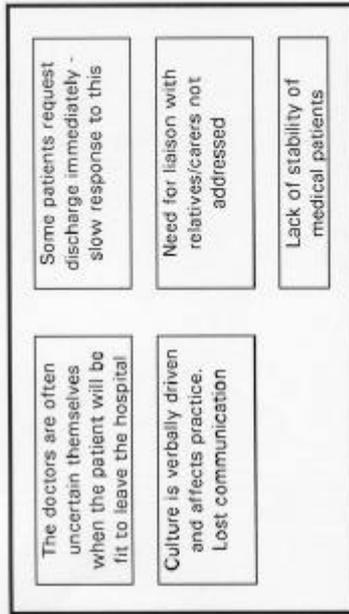
## Affinity Diagrams on Problems with Notification of Discharge



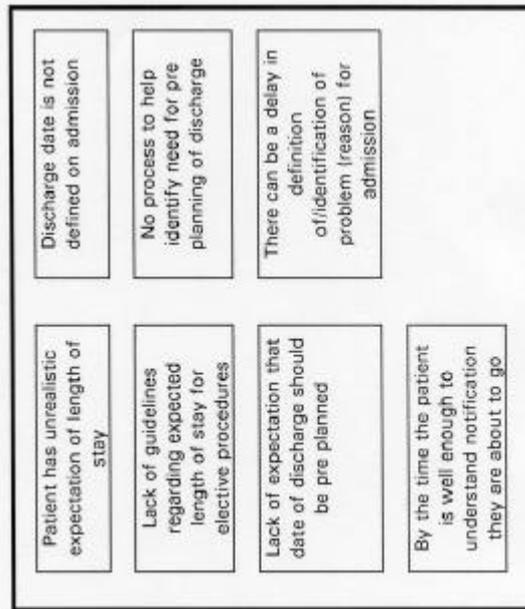
## PRIORITY



## PATIENT COMPLEXITY



## NO DEFINED PATHWAY



# ATTACHMENT J

## Proposed Patient Management Form

THE ROYAL MELBOURNE HOSPITAL	PATIENT IDENTIFICATION
Date: .....	UR No. ....
Consultant: .....	NAME: .....
Registrar: .....	
Intern: .....	
General Practitioner: .....	

---

**To be completed within 24 hours of admissions and weekly thereafter.**

- Why was the this patient admitted to hospital? **Brief statement:**  
.....  
.....
- What is the likely duration of admission? ..... days.
- Is the clinical database complete? YES  NO   
IF NOT, who will provide additional information? (Please tick the appropriate box)

Patient	<input type="checkbox"/>	Other Med. Practitioner	<input type="checkbox"/>
Family	<input type="checkbox"/>	Other Professional person	<input type="checkbox"/>
Other lay person	<input type="checkbox"/>		

- Are there "Risk Factors" for a prolonged stay? (ie more than 7 days) YES  NO   
IF YES, which risk factors are present?

<b>Physical Status</b>		<b>Home Situation</b>	
Age >75	<input type="checkbox"/>	Lives alone	<input type="checkbox"/>
Poor functional status before admission	<input type="checkbox"/>	Caregiver unable to cope	<input type="checkbox"/>
3 or more admissions over last 3 months	<input type="checkbox"/>	Alternative accommodation required	<input type="checkbox"/>
Communication difficulty	<input type="checkbox"/>	Unclear	<input type="checkbox"/>
Current medical condition(s)	<input type="checkbox"/>		
Other	<input type="checkbox"/>		

- Is this patient suitable for the Hospital in the Home Program? YES  NO
- What is your current plan? **Brief statement**  
.....  
.....
- Have the results of all **critical basic investigations** been seen by you? YES  NO   
If not, from which of the following have you not seen results from

Medical Imaging	<input type="checkbox"/>	Microbiology	<input type="checkbox"/>
Biochemistry	<input type="checkbox"/>	Other	<input type="checkbox"/>
Haematology	<input type="checkbox"/>		

- What action will you take if the result of the next **critical investigation** is:  
*Positive:* **Brief statement** .....  
.....  
*Negative:* **Brief statement** .....  
.....
- What is your plan if current treatment is **unsuccessful**? **Brief statement**  
.....  
.....
- Has the General Practitioner been informd of the admission? YES  NO

PATIENT MANAGEMENT

---

# ATTACHMENT K

## Proposed Standard Referral Form

**THE ROYAL MELBOURNE HOSPITAL**

Date.....

---

Dear.....

RE:.....

Purpose of Referral:  Opinion  
 Opinion and Surgical Management  
 Other reasons

Presenting Problem:.....

Other Problems:.....

Provisional Diagnosis:.....

Relevant Past History and Social Information (including language spoken)  
.....  
.....

Relevant Physical Examination:.....  
.....

**RECENT PATHOLOGY / RADIOLOGY RESULTS (PLEASE ATTACH PHOTOCOPIES)**

**KNOWN ALLERGIES:**.....

**MEDICATIONS (Current)**

DRUG	STRENGTH	DOSE	FREQUENCY	ROUTE	START DATE

Comments:.....  
.....

Office Stamp

Yours Sincerely,

Dr..... Please print

---

# ATTACHMENT L

## Protocol for Discharge Planning Follow-up Survey

### Background

Of recent times all hospitals have become increasingly concerned with issues related to efficient and effective discharge planning. No doubt the main motivation towards this recently, is the increasing pressure to constrain costs, in particular through the introduction of case-mix funding. However the corporatisation of hospitals and the need to develop a consumer focus has also played a substantial role. 'Consumers', in this sense, include, individual service users, funding agencies, referring practitioners and, most generally, the community that the hospital serves.

There is substantial anecdotal evidence from both GPs and community health centres of failures of discharge planning causing distressing and sometimes dangerous problems for patients. Furthermore there is informal, and more recently formal survey evidence, that GPs find it difficult to get timely, legible and adequate information from hospitals and that they encounter substantial difficulties when the need to contact the hospitals arises.

There are many activities currently underway within Royal Melbourne Hospital, within the GP divisions, and in the community health centres to try to enhance the adequacy of discharge planning and follow-up. The purpose of this study is to obtain baseline data on the adequacy of discharge planning and communication and the implementation of plans. A second purpose is to develop a method for monitoring these issues in the future.

### Proposed Method

#### Sample

It is proposed to draw a random sample of 60 patients discharged from RMH over a two week period who were inpatients for at least three days. The GPs of any patients who died within the two week period will also be contacted.

#### Data Sources

For each patient four data sources will be used:

- the patient record,
- the typing pool,
- an interview with the patient (7-10 days post discharge),
- an interview with the patient's doctor (7-10 days post discharge).

---

## Key Questions

Key questions related to each data source are as follows:

### Patient Record

- Is the GPs name noted?
- Is there evidence of contact with the GP at time of admission or discharge?
- What documentation exists regarding post discharge care needs and plans to meet these needs?
- Discharge destination and contact details.

### Typing Pool

- When was the formal discharge summary submitted for typing?
- When was it sent to the LMO?

### Interview with Patient

- Quality of explanations re treatment and plans?
- How adequately were their needs planned for?
- What problems did they experience following their discharge home?
- What services have they used?

### Interview with GP

- What role did they play in the patient's admission?
- Did they have contact with the hospital during the patient's stay?
- Were they notified of the patient's discharge? If so how promptly and how adequate was the information with which they were provided?
- What follow-up were they required to provide?
- Suggestions for improved communication and/or GP involvement.
- Details will also be recorded of any difficulties encountered identifying or contacting the GP

## Resource Requirements

### Time Requirements

- |   |        |
|---|--------|
| • Develop protocols and obtain ethical approval                         | 2 days |
| • Consultation on instruments, piloting and modifying.                  | 3 days |
| • Obtain sample   | 1 day  |
| • Organising access through medical records and typing pool information | 1 day  |
| • Obtain and review records 60*45 minutes                               | 6 days |
| • Pre-call to GP and GP interview 60*20 min.                            | 3 days |
| • Patient interviews 60* 30 min   | 4 days |

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• Data analysis and initial report.	4 days
• Dissemination, discussion and the development of recommendations.	4 days
• Preparation for publication.	TBN
<b>TOTAL</b>	Approx. 6 weeks

**Costs**

Staff costs approx \$4,800  
Other costs approx \$800  
*Total Cost of the Initial Survey approximately \$5,600*