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ISSN 1839-6348

Issue 27  
January 2013

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# Communication between health professionals across sectors

Bringing disparate activities and services into a coherent system requires well-resourced communication. The World Health Organization<sup>1</sup> defines health services integration as:

*bringing together common functions within and between organisations to solve common problems, developing commitment to a shared vision and goals and using common technologies and resources to achieve these goals.*

This *RESEARCH ROUNDup* explores strategies that enable interactive, timely, two-way exchange of pertinent clinical information between care providers across primary, acute and specialist settings.

## Communication

Improving communication between acute and primary care has been on the health reform agenda for almost 20 years, since the inception of the Divisions of General Practice (DGP) in 1995. In 2008, 63 out of 119 Divisions reported that 76% of GPs were satisfied with the agreed discharge information from hospitals. These data may be misleading as GP-hospital integration was a non-mandatory performance indicator in the national performance framework.<sup>2</sup> There is scope for more current evaluation of satisfaction.

Communication can be both vertical (between settings eg. hospital to GP) and horizontal (across providers eg. GP to Allied Health professional). Most hospital episodes begin and end with care in the community, so communication strategies are relevant to providers across sectors and levels. Barriers between health care sectors persist as services like hospitals provide specialised acute care to high needs patients with little input from primary health care (PHC) providers.<sup>3</sup> Poor communication across and between the sectors has often made it more difficult for hospitals, GPs and other health professionals to offer cohesive care to their patients, or to work together to address health problems in the community. The quality of communication between different parts of the health system has considerable implications for patients, the health care system and health care costs.<sup>4</sup>

## PHC-Hospital Interface

A report<sup>3</sup> on improving GP-hospital integration outlined four main purposes, specifically to:

- ⇒ prevent the need for acute care
- ⇒ shift care to the most appropriate setting
- ⇒ improve transitions of care, and
- ⇒ build better working relationships between GPs & hospitals.

Over a decade later the need to improve integration between primary/acute and specialist care remains a challenge.<sup>2</sup> The interface between primary and acute care is complex. Research indicates that transitions between health settings are a potentially vulnerable time for patients. Information exchange during this period is central to improving patient safety and health outcomes.<sup>5,6</sup>

At the GP-hospital interface, information is exchanged in multiple directions. Research predominantly focuses on

discharge from acute to primary care<sup>5,7,8,9</sup> and referral from primary to acute/specialist care (eg. for a planned procedure or specialist referral). Equally important, but less researched, is communication with GPs: 1) when a patient presents through the Emergency Department of a hospital; and 2) in the event of a routine or scheduled procedure resulting in problems or unexpected referrals usually within the hospital, especially referrals to the intensive care unit. These events are important to GPs, as medical decisions of a long-term nature (eg. starting dialysis in a geriatric patient) will ultimately be managed by PHC providers.<sup>10</sup> Less literature examines the role of other non-GP health professionals (eg. nurses, allied health) following hospitalisation.<sup>11</sup>

A meta-analysis<sup>12</sup> to evaluate two-way communication exchange identified interactive communication as most effective - that is

*two-way purposeful interaction whether face-to-face or telephone, joint video-conferencing involving the patient, primary care physician and specialist (p 249).*

In chronically ill patients, this study found that initiatives aimed at enhancing the **quality of information exchange** had larger effects on patient outcomes than those that did not. Types of communication included patient consultations, regular specialist attendance at PHC team meetings, telepsychiatry with PHC providers, scheduled telephone discussions, and shared electronic progress notes. There is benefit to interventions comprising multiple strategies ie. procedures for discharge communication, use of an Enhanced Primary Care discharge plan, agreed formats and arrangements to fax information to the GP for review and provide copies to the patient and other service providers. Health outcomes and patient satisfaction significantly improved when GPs made appointments for the patient to attend within seven days of discharge.<sup>13</sup> These strategies rely on infrastructure for providers and patients (ie. shared records, technology) as well as system-wide agreements (ie. multidisciplinary teams, funding, joint planning).

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## General Practice Liaison

In Australia, a state-wide General Practice Liaison (GPL; 2001) program was undertaken focusing on systems change and improvements at the interface between hospitals and general practice. This was identified as a successful model of GP-hospital integration, fostering connections and relationships, and leading to successful partnerships and service integration; the framework was refined in 2007.<sup>19</sup> The GPL program spans a number of health sectors, Commonwealth and State governments. This initiative achieved significant changes in the areas of information flow, processes of care, relationships and communications providing a model for communication at the GP-hospital interface.

## The Reformed Australian Context

From July 2012, the peak bodies responsible for improving primary and acute care integration are Medicare Locals (MLs) and Local Hospital Networks (LHNs). A National Performance and Accountability Framework has been established,<sup>14</sup> which includes facilitating integration between the PHC and hospital sectors; and improving measurement and performance across hospital and PHC services over time. MLs and eHealth have the role of cultivating communication and continuity of care to ensure GP, PHC and hospital care are better integrated by improving acute/PHC information exchange.<sup>6</sup> To date only one performance indicator specific to communication between acute/PHC interfaces exists. Both Swiss and US collaborators<sup>15</sup> affirm that indicators, like benchmarking, are invaluable to improved communications across health services. The current LHN indicator relates only to follow-up within the first seven days of discharge from a psychiatric admission (6.2.1.7).<sup>14</sup> A Lead Clinician Group (LCG) is responsible for assisting integration of services at the local level. Although in the early stages (agreed by COAG in December 2011), current indicators require refinement because unless transition issues (eg. communication) appear in institutional or practice quality standards, they will take lower priority than items for which organisations are held accountable. The quality of transitions across health settings is a telling indicator of the integration of the health system as a whole.

## Mechanisms to improve communication at the interface

### eHealth

Whilst still in the early stages of implementation (July 2012), the personally controlled electronic health record (PCEHR) has been championed as a mechanism to facilitate the seamless communication of patient information from one healthcare provider to another. Each health professional's preference and resources will play a part in the utilisation of the Australian PCEHR to its full potential. In a qualitative study of communication between PHC and acute care, the general consensus from Swiss GPs was that they were not concerned about how the information was conveyed (email, fax or phone) as long as the communication happened. Despite facilitating information exchange between PHC providers and subspecialists, e-technologies for referrals are prone to coordination breakdown.<sup>16</sup> Barriers to the use of electronic health record-based referrals include: lack of both an institutional referral policy and standardisation in certain referral procedures; ambiguity in roles and responsibilities; and inadequate resources to adapt and respond to referral requests.<sup>16</sup>

### Minimum communication standards

Recently, a set of minimum communication<sup>10</sup> to be used by hospital staff as a guide to specify minimum expected standards has been proposed:

- ⇒ *admission* (notification copy is sent to both patient & GP)
- ⇒ *during hospitalisation* (information sent to GP after emergency admission, when complications/unexpected events occur, when patient is referred to another clinic, and when long-term decisions are made, or if death occurs)
- ⇒ *at discharge* (short letter sent to GP day after discharge).

However passive guidelines have been shown to have little influence on referral practices. Organisational (eg. valuing teamwork and innovation)<sup>17</sup> and financial<sup>15</sup> factors are more likely to influence behavioural shifts around communication; although the evidence is still sparse and organisational measures of clinical quality might be an artefact of good teamwork and quality communication.<sup>18</sup>

## Conclusions

Communication strategies at the interface between the PHC and acute care sectors require system and structural support, reinforced by benchmarks for minimum required communication between sectors. The quality of transitions between sectors is central to integrated care for service users. Organisations need to be accountable for these transitions on the basis of clear policies, well-defined roles and responsibilities for key personnel, standardised procedures and interactive communication protocols, and adequate technical and human resources in place to provide support.

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