AMA Victoria's response to the Exposure Draft of the Drugs, Poisons and Controlled Substances Regulations 2017

20 April 2017

The Australian Medical Association (Victoria)

Introduction

AMA Victoria welcomes the opportunity to provide feedback to the *Exposure Draft: Drugs, Poisons and Controlled Substances Regulations 2017* (the regulations).

The proposed regulations will replace the *Drugs, Poisons and Controlled Substances Regulations 2006*.

The proposed regulations have partially restructured the existing regulations but introduce some limited amendments. AMA Victoria broadly supports the amendments to the regulations, with the exception of section 53.

Section 53 describes circumstances in which a pharmacist may supply a Schedule 4 medicine, or Schedule 8 controlled drug contrary to instructions on prescription. AMA Victoria is strongly opposed to this proposed amendment.

The AMA holds the position that only medical practitioners are trained to make a complete diagnosis, monitor the ongoing use of medicines and to understand the risks and benefits inherent in prescribing. Only medical practitioners currently meet the high standards required by the NPS MedicineWise *Prescribing Competency Framework* in order to safely prescribe independently.[1]

AMA Victoria submits that sections 53(2) and 53(3) of the regulations be removed.

AMA Victoria submits that national model regulations should be adopted to regulate medicines and poisons listed in the Poisons Standard. AMA Victoria supports an ongoing process of consultation for incorporating specific changes identified by stakeholders to the existing regulations.

Prescription Medication and Public Health Concerns

Recent Coronial findings in Victoria and New South Wales have repeatedly recommended changes to the way drugs of dependence are prescribed, monitored and regulated. The changes are expected to strengthen accountability and duty of care and make the health system less fragmented and medical practitioners more aware of medication historically prescribed to the patient.

In April 2017, the Coroners Court of Victoria released statistics that 477 Victorians died of a drug overdose in 2016. This number is expected to rise to 500 as investigations are finalised. Victoria's overdose rate has been steadily rising since 2010, up almost 40% from 342 to 477.[2] Misuse of prescription medication is a contributing factor to deaths by drug overdose in Victoria.

The Coroners Court of Victoria highlights the contribution of medication in deaths. More than 70% of Victorian overdose deaths involve the use of multiple drugs. Of the 190 overdose deaths involving heroin in 2016, more than three-quarters also involved other drugs.[3] Benzodiazepines were the most frequent contributing pharmaceutical drug group to Victorian overdose deaths, followed by opioids, then antidepressants.[4]

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[1] The AMA, "AMA Position Statement: Medicines", 2014.

[2] The Age, "Drug overdose deaths rise in Victoria", 2017.

[3] The Age, "Drug related deaths have seen a 'significant jump' since 2014", 2017.

[4] Coroners Court of Victoria, "Summary of coronial recommendations on drug harm reduction", 2017.

Further, non-fatal overdose is a significant cause of hospital admissions, and misuse of drugs and associated costs may increase in future given that national trends show an increase in more widespread prescription of opioids. The *Regulatory Impact Statement* accompanying the amended regulations reports that the current annual cost of hospitalisations associated with the toxic effects of drugs in Victoria has been estimated at around $8.6 million.[5]

Drugs of Dependence

A 2015 study published in the *Medical Journal of Australia* reports that codeine-related deaths have doubled from 2000 to 2009.[6] Some drug seeking people will turn to codeine to negate withdrawal effects. There is currently a proposal to up-schedule codeine from a Schedule 3 medicine to a Schedule 4 medicine, due to take effect in 2018.

Looking to the future, the Victorian Government has anticipated that the most likely next amendments to the regulations will concern the introduction of real-time prescription monitoring (RTPM).

If codeine is included in monitoring through RTPM, AMA Victoria anticipates that this should replace MedsASSIST, a real-time monitoring system for codeine sales established by the Pharmacy Guild of Australia. AMA Victoria submits that monitoring of codeine must be functional and integrate with general practitioner (GP) medical software.

AMA Victoria also supports including the most problematic Schedule 4 medicines, including opioid analgesics like codeine, as well as benzodiazepines, pregabalin (Lyrica) and quetiapine (Seroquel) in monitoring through RTPM.

AMA Victoria supports Project Stop, a decision-making tool for pharmacists aimed at preventing the use of pseudoephedrine based products to manufacture methamphetamine.

Pharmacist Supply of Schedule 4 (Medicine) and Schedule 8 (Controlled drug) Contrary to Prescription

Section 53 of the regulations outlines circumstances under which a pharmacist may supply a Schedule 4 medicine or Schedule 8 controlled drug contrary to prescription (refer ***Appendix 1***).

Section 53(1) provides that a pharmacist may supply a Schedule 4 medicine or Schedule 8 controlled drug contrary to instructions written on the prescription if the supply is consistent with a further verbal or written instruction issued by the prescriber.

AMA Victoria submits that a medical practitioner must always be consulted and issue verbal or written instructions before a pharmacist can supply medicines contrary to prescription. This is key to safety and risk management.

Patient request to depart from instructions on prescription

Section 53(2)(a) of the amended regulations however goes on to specify that a pharmacist may supply a Schedule 4 medicine or Schedule 8 controlled drug contrary to prescription, if a departure from instructions is requested on behalf of the patient.

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[5] Victorian State Government, "Regulatory Impact Statement: Proposed Drugs, Poisons and Controlled Substances Regulations 2017", 2017.

[6] NPS Medicinewise, "Codeine-related deaths: a cause for concern", 2015.

AMA Victoria submits that this is dangerous and will result in more morbidity, deaths and lack of integration and accountability in care.

It is a stark and notable contradiction to repeated Coroners' recommendations and the development of RTPM to better inform medical practitioners in prescribing safely and appropriately, and for pharmacists to monitor dispensing frequency.

Supply of medicines contrary to prescription may also contravene an existing permit, and/or opiate contract in place.

Schedule 4 medicines are prescription only medicines and there is a reason why these medicines are classified as Schedule 4 - specifically these medicines are drugs with both therapeutic properties but also side effects and harms. For some individuals and in some circumstances, these can include severe morbidity and even death. Similarly, Schedule 8 controlled drugs are subject to a range of controls due to additional risks such as dependence.

Section 53(2)(d) of the regulations goes on to say that the supply must not result in the medicine or controlled drug being provided in a quantity that is greater than the quantity requested by the patient (if any) under this very section 53(2)(a). AMA Victoria believes that this is an inadequate safeguard. The primary concern here is that the patient may request a clinically inappropriate, or dangerous, quantity of drugs.

Psychiatrist members of AMA Victoria report that patients with psychiatric illness often seek drugs of dependence. Some of these patients are at high risk of suicide.

Structures are put in place by psychiatrists such as more frequent pick-up of medication, for example weekly small quantities of medication at a time, to ensure therapeutic benefit optimisation but also to minimise risks. These are done on careful consideration of the patient's history, prior treatment and clinical formulation.

Often these patients give a convincing presentation to the pharmacist. Or else, they may appear significantly distressed. Only the prescribing doctor is able to assess whether the request for adjusting doses or quantity supplied is feasible for the patient's specific situation.

As with the risk of 'doctor shopping', there is a real risk that a patient will find a pharmacist who is prepared to make adjustments to prescription medication in line with the patient's wishes. This may lead patients who seek drugs of dependence to gravitate towards pharmacists more willing to comply with the patient's desires.

AMA Victoria reiterates that pharmacists should never be able to alter Schedule 4, or Schedule 8 prescriptions without further verbal or written instructions issued by the prescriber.

Unreasonable difficulty or inconvenience to the patient

The proposed changes would allow a pharmacist to supply a Schedule 4 medicine or Schedule 8 controlled drug contrary to a prescription, if requested by the patient on the grounds that the prescribed medication would impose an unreasonable difficulty or inconvenience to the patient.

AMA Victoria submits that this safeguard of s53(2)(b) is open to abuse by drug-dependent patients. Drug dependant patients frequently present convincing arguments to obtain a drug of addiction.

As mentioned in the previous section, 'doctor shopping' is a common problem and this includes stockpiling prescriptions from dozens of doctors. Some patients may sell legal prescription medicines on the black market, while others collect the medicines for personal use.

The risk with pharmacist supply of medications contrary to prescription is that it may support a culture and expectation of providing relatively non-urgent medication to people who struggle with drug addiction.

Legal prescription drugs can be oversupplied and AMA Victoria submits that this legal safeguard of 'difficulty' or 'inconvenience' to the patient is insufficient to prevent the practice of doctor shopping and protect patient safety.

AMA Victoria submits that pharmacists should never be able to alter Schedule 4, or Schedule 8 prescriptions without further verbal or written instructions issued by the prescriber.

Assessment of acceptable risk to the health and safety of the patient

At s53(2)(c), the pharmacist must be satisfied that they have taken all reasonable steps to ensure that supply of the Schedule 4 medicine or Schedule 8 controlled drug as requested by the patient would not represent an unacceptable risk to the health and safety of the patient.

Pharmacists do not hold the training or the skills to alter medication, as pharmacists do not know why a specific drug is being supplied to the patient and lack in-depth knowledge of the patient's medical history, pharmaceutical interactions and allergies to date.

Prescribing requires more than a knowledge of adverse events, doses, optimal routes, drug-drug and drug-food interactions, pharmacokinetics and pharmacodynamics.

Medical practitioners are the only health professionals trained to fully assess a person, initiate further investigations, make a diagnosis, and understand and recommend the full range of clinically appropriate treatments for given conditions.

Further, supplying a medicine contrary to prescription interferes with the therapeutic relationship between doctor and patient.

Patient safety and quality outcomes depend on a medical diagnosis of the patient to assess whether it is appropriate to continue, alter the dose, change or cease the prescription medicine.

Pharmacists by their own admission are not trained to do that.[7]

As the practitioner with prescribing rights, doctors bear the duty of care and responsibility for decisions they make regarding medicines, including informing the patient and gaining consent.

[7] Hoti K, Sunderland B, Hughes J & Parsons R., "An evaluation of Australian pharmacists' attitudes on expanding their prescribing role", *Pharm World Sci.* 2010.

Patient medication safety and efficacy depends on review by a doctor before the next prescription is issued. This is why PBS requirements limit the number of prescription repeats that can be written.

Under the proposed changes, a GP may be totally unaware of amounts dispensed and this may pose a risk to patient health and safety if medication is altered. If a GP issues a prescription with "dispense sufficient for 1 week at a time" – this annotation then becomes totally meaningless and takes the GP out of the loop if a pharmacist is able to supply medication contrary to instruction.

Concerning urgent prescription arrangements, the 2009 AMA Victoria survey[8] reported that GPs prefer to review the patient's clinical condition before issuing an 'urgent' prescription. At the very least, GPs will review the patient's file before authorising a pharmacist to dispense a medication by telephone.

Doctors place a high value on the professional role of pharmacists and are committed to working with pharmacists to improve the medication management of patients and their clinical outcomes. AMA Victoria supports pharmacists as part of the multidisciplinary team in patient care, in particular supporting medication reviews in general practice.

Conflict of Interest

If pharmacists could supply medication contrary to prescription, AMA Victoria believes that this represents a potential conflict of interest since pharmacists derive a direct income from the sale of medicines.

This has been supported by a *Choice* study in 2017 that reported many mystery shoppers, across 240 Australian pharmacies, were being directed by pharmacists to non-evidence based, over the counter complementary medicines and provided with non-evidence based information about their efficacy.[9]

AMA Victoria submits that there should be a clear separation between the prescribing and dispensing of medicines. This removes any potential conflict of interest in deciding the most appropriate treatment for patients, for example which brand of medicine to supply.

Medico-legal and Ethical Issues

Under the amended s53 of the regulations, the pharmacist (who has no prescribing rights) will be making a not dissimilar decision about whether or not to supply a medicine, continue a medicine, and in what quantity to supply the medicine.

This raises medico-legal questions around who then bears the legal liability for the dispensing of Schedule 4 medicines and Schedule 8 controlled drugs without an updated prescription.

AMA Victoria submits that doctors should not shoulder the responsibility for a decision that they have not been involved in and that pharmacists should never be able to alter Schedule 4, or Schedule 8 prescriptions without further verbal or written instruction issued by the prescriber.

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[8] AMA Victoria, "AMA Survey on Pharmacists' Request for Scripts", 2009.

[9] Choice, "Is your pharmacist giving you the right advice?" 2017.

AMA Victoria supports adhering to the existing hierarchical tenets of patient management.

In the interests of patient safety and quality of care, supply of medicines contrary to prescription should only occur with the verbal or written agreement of the patient's medical practitioner.

AMA Victoria submits that:

1. **Section 53(2) and 53(3) of the regulations be removed.**
2. **Pharmacists should dispense Schedule 4 medicines and Schedule 8 controlled drugs in accordance with the patient's prescription unless the pharmacist has discussed any requested changes with, and obtained the verbal or written agreement of, the patient's medical practitioner.**
3. **There should be a clear separation between the prescribing and dispensing of medicines.**
4. **This removes any potential conflict of interest in deciding the most appropriate medication treatment for patients.**
5. **National model regulations should be adopted to regulate medicines and poisons listed in the Poisons Standard. AMA Victoria supports an ongoing process of consultation for incorporating specific changes identified by stakeholders to the existing regulations.**

Other Matters:

Schedule 8 (Controlled Drugs)

Regarding Schedule 8 controlled drugs, the proposed regulations strengthen the provisions around:

- *Prescribing drugs of addiction*

The amended regulations provide that medical practitioners in Victoria must apply for a permit to administer, supply or prescribe drugs of addiction.

Medical practitioners should exercise caution when patients request prescriptions for specific drugs of addiction and consider the most clinically appropriate management of patient pain. Doctors must keep good records to ensure that drug dependent patients are easily identified.

If a practitioner prescribes opioid replacement therapy, under the revised regulations, the practitioner will be able to update their Schedule 8 register daily, instead of maintaining a continual balance.

AMA Victoria comment: AMA Victoria supports reducing compliance burdens. This is especially so as registered medical practitioners incur costs in making applications for Schedule 8 treatment permits to prescribe or supply certain controlled drugs for more than short-term use.

- *Single supply of Schedule 8 controlled drugs*

Under the amended regulations, medical practitioners writing prescriptions for a single supply of Schedule 8 controlled drugs will now be required to write explicitly that there are to be "no repeat" supplies.

AMA Victoria comment: Software used to generate computer-generated prescriptions already includes a statement to indicate that there are no repeats. AMA Victoria supports that handwritten prescriptions should include the same information.

- *Requirement to record a patient's date of birth for Schedule 8 prescriptions*

AMA Victoria comment: AMA Victoria supports that including the patient's date of birth for Schedule 8 prescriptions will assist in data matching for the implementation of RTPM.

- *Destruction of drugs*

Under existing regulations, there is a strong compliance burden for two authorised persons to be present when Schedule 8 controlled drugs or Schedule 9 prohibited substances are destroyed. Under the proposed regulations nurses, midwives and other practitioners acting alone will be able to destroy unused partial doses of solid-form (tablet or lozenge) Schedule 8 and 9 drugs.

AMA Victoria comment: AMA Victoria welcomes changes which will free up clinicians' time but supports that two practitioners (e.g. nurses and midwives) are required to destroy solid-form Schedule 8 and 9 drugs without a medical practitioner present.

- *Changes to the prescribed form*

For medical practitioners wanting to apply to the Department of Health and Human Services (DHHS) for a permit to provide pharmacotherapy, the prescribed form has been amended.

Prescribers can now include Aboriginal and Torres Strait Islander status as provided voluntarily by the pharmacotherapy client.

AMA Victoria comment: AMA Victoria supports this initiative and refers to its recommended minimum standards for forms (refer ***Appendix 2***).

APPENDIX 1

Drugs, Poisons and Controlled Substances Regulations 2017

SECTION 53

53 Circumstances in which pharmacist may supply Schedule 4 poison or Schedule 8 poison contrary to instructions on prescription

(1) A pharmacist may supply a Schedule 4 poison or Schedule 8 poison on a prescription or a copy of a prescription but contrary to the instructions written on the prescription if the supply is consistent with a further verbal or written instruction given by the prescriber.

(2) A pharmacist may supply a Schedule 4 poison or Schedule 8 poison on a prescription or a copy of a prescription but contrary to the instructions written on the prescription if—

(a) a departure from those instructions is requested by or on behalf of the person named on the prescription; and

(b) the pharmacist is satisfied that not to depart from the prescription as requested would impose an unreasonable difficulty or inconvenience on the patient; and

(c) the pharmacist has taken all reasonable steps to ensure that supplying the poison as requested would not represent an unacceptable risk to the health and safety of the patient; and

(d) the supply does not result in the poison being provided in a quantity that is greater than the quantity requested under paragraph (a) (if any).

Note

Regulation 68 requires that the pharmacist notify the prescriber and make a record of the supply.

(3) A pharmacist may supply a Schedule 4 poison or Schedule 8 poison on a prescription or a copy of a prescription but contrary to the instructions written on the prescription if—

(a) at the time that the prescription is presented, it is not reasonably practicable for the pharmacist to comply with the instructions written on the prescription; and

(b) the patient consents to the departure from the instructions; and

(c) the pharmacist has taken all reasonable steps to ensure that supplying the poison in that manner would not represent an unacceptable risk to the health and safety of the patient.

Note

Regulation 68 requires that the pharmacist notify the prescriber and make a record of the supply.

APPENDIX 2

10 Minimum Standards of Communication between Health Services and General Practitioners and other Treating Doctors

AMA Victoria's 10 Minimum Standards for Communication between Health Services and General Practitioners and other Treating Doctors

February 2017

Introduction

This Standards document has been informed by the AMA Position paper General practice/hospitals transfer of care arrangements – 2013[1]. It has been developed by AMA Victoria's Section of General Practice and the AMA Victoria Policy Unit.

Purpose

AMA Victoria Section of General Practice has developed this **"10 Minimum Standards"** document to facilitate discussion with the Department of Health and Human Services Victoria, public and private hospitals, General Practitioners (GPs) and other treating doctors in order to drive key processes to enhance clinical safety, improve health outcomes, reduce avoidable hospital presentations, reduce risk, improve patient experience and improve resource efficiencies across our Victorian health system.

Context

For most patients who receive an episode of care from a health service, the episode comprises one part of their treatment, management, care or recovery journey. This is particularly the situation for people whose conditions are episodic, ongoing or 'chronic'.

For most patients in Australia, their General Practitioner is the main provider of ongoing health care. A person's General Practitioner plays a critical role in co-ordinating responses to their patient's health care needs, including making relevant referrals to specialist non-admitted care, admitted care, allied health care services and social support.. They also continue the patient's health care after any medical event or change that has resulted in a care episode in hospital. General Practitioners also work in tandem with medical specialists who medically manage and treat the patient in non-admitted care settings, such as health service specialist outpatient clinics and other health practitioners that work in outpatient health care services. This role of the patient's general practice to function as a health care home is important at many levels, well evidenced to improve health outcomes and supported by the Australian Medical Association.

In order that a patient's care is safe, effective and efficient, adequate and timely communication of information between all medical and health professionals, who provide care to the patient, is required. This needs to occur between all treating health practitioners at all stages of the patient journey; starting from the community setting, through to acute or sub-acute care, and on subsequent 'return' to the community and clinical handover back to a person's General Practitioner.

When appropriate and effective transfer of care practices between General Practitioners other treating doctors and health services and are undertaken, re-admissions are reduced and adverse events minimised. There is also an improvement in satisfaction and experience for patients, carers, families, doctors and other health practitioners.

Stakeholders

The most important stakeholder are patients, their carers and families as improved communication leads to better health outcomes and improved patient experience.

Practical examples include reducing the frequent need for patients to repeat fundamental information or undergo repeat investigations and preventing medicine mismanagement due to poor communication between providers.

The other major stakeholders of these requirements include General Practitioners/ other treating doctors, health services and health professionals.

For both health services, and General Practitioners, adherence to these Standards will help achieve and demonstrate performance against their respective Quality Standards by demonstrating the policies and systems required for good communication.

Government is also an important stakeholder as the outcomes of improved communication between General Practice and Health Services will improve efficiency and sustainability, increase patient and carer satisfaction and strengthen service performance.

Who do these Standards apply to?

These standards are principally concerned with health services, General Practitioner and other medical professionals. Health Services may be public or private. These Standards scope emergency care, admitted care and non-admitted care episodes[1]

[1] See Glossary at end of this document.

THE 10 STANDARDS IN SUMMARY

Standard 1: Referral information from a practitioner to a health service

A referral to a health service from a General Practitioner includes information for an assessment of the need for care in their setting, triage, and the requirements for the patient's access to the health service.

Standard 2: General Practitioner Details

The name and contact details of a patient's General Practitioner and/or practice is verified and updated on the patient record at each episode of care by the health service.

Standard 3: Supported Access to a General Practitioner

When patients do not have a regular General Practitioner, the health service has a process to support patients to locate a General Practitioner and/or practice and to attend for follow-up care.

Standard 4: Timely Communication

The health service has a system for timely communication directly to a patient's General Practitioner and other treating doctor(s) on the conclusion of every episode of care, after sentinel events and periodically during ongoing care.

Standard 5: Handover back to a General Practitioner

The health service provides General Practitioners with clear and appropriate information to support safe and meaningful clinical handover of patient care.

Standard 6: Information Transmission

The health service has secure and reliable electronic systems to send and receive information to and from the Health Service and General Practitioners and other treating doctor(s).

Standard 7: Outpatient services intake and appointment systems

Specialist Outpatient Services have transparent intake and appointment systems that provide appropriate information and notifications to patients, General Practitioners and other treating doctor(s).

Standard 8: Outpatient Services Communication

There is a system for ongoing and timely clinical communication about patient care between a health care service's Specialist Outpatient Services, other ambulatory and day services and the patient's General Practitioners and other treating doctor(s).

Standard 9: Discharge Planning Processes

The health service has discharge care planning processes for patients with complex needs that involves their General Practitioner and other treating doctor(s).

Standard 10: Managing Quality

These standards are incorporated into the Policies and Quality Systems of General Practices and Health Services.

THE 10 STANDARDS IN DETAIL

Standard 1: Referral information from a practitioner to a health service

A referral to a health service includes information for an assessment of the need for care in their setting, triage, and the requirements for the patient's access to the health service.

Elements of this information include, where appropriate to the needs and circumstance of the patient:

- demographic and contact information.
- reason for referral to the health service.
- findings, investigations; medical summary, medicines and allergies.
- an Advance Health Care Plan (when appropriate).
- the person's need for interpreter and cultural support.
- any disability support needs, including advocates and/or alternative decision makers.

Supporting standards and corroborating guidelines for this Standard are:

- The RACGP Standards for general practices (4th edition) Criterion 1.5.2 Clinical handover[2].
- The RACGP Standards for general practices (4th edition) Criterion 1.6.2 Referral documents[2].

Standard 2: General Practitioner Details

The name and contact details of a patient's General Practitioner and/or practice is verified and updated on the patient record at each episode of care by the health service.

The preferred criteria is the name of the General Practitioner, while the minimum criteria is the name of the practice.

Standard 3: Supported Access to a General Practitioner

When patients do not have a regular General Practitioner, the health service has a process to support patients to locate a General Practitioner and/or practice and to attend for follow-up care.

Minimum criteria for the process includes:

- Relevant staff have access to up to date contact details for General Practitioners for their catchment area.
- Assistance is available for the patient to choose a General Practice and to make a follow up appointment.

Standard 4: Timely Communication

The health service has a system for timely communication directly to a patient's General Practitioner and other treating doctor(s) on the conclusion of every episode of care, after sentinel events and periodically during ongoing care.

Criteria for timely formal communication:

Circumstances	Timing
• Unplanned inpatient admission • Discharge from an inpatient admission • After attendance at an emergency department or short-stay setting • On patient death or other sentinel events	Within 24 hours
• Initial Specialist outpatient consultation • Changes in health status or medication at a specialist outpatient service • Discharge from Specialist outpatient clinic	Within 7 days

Standard 5: Handover back to a General Practitioner

The health service provides General Practitioners with clear and appropriate information to support safe and meaningful clinical handover of patient care.

Supporting standards and corroborating guidelines for this Standard are:

- National Safety and Quality Health Service Standards Standard 6 – Clinical[3].
- AMA Position Statement - General Practice/Hospitals Transfer of Care Arrangements – 2013[1].

Standard 6: Information Transmission

The health service has secure and reliable electronic systems to send and receive information to and from the health service and General Practitioners and other treating doctor(s).

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

Standard 7: Outpatient services intake and appointment systems

Specialist Outpatient Services have transparent intake and appointment systems that provide appropriate information and notifications to patients, General Practitioners and other treating doctor(s).

Minimum criteria include:

- a single point for referral to all specialist outpatient services.
- a publically available system that informs patients and referring doctors of the expected wait for various outpatient specialist services.
- a tracking system to enable patients and referring doctors to determine the prioritisation and status of a given specialist outpatient referral.
- clear, timely and responsive administrative and clinical processes, triggered by notification from a General Practitioner/referring doctor to review the scheduling of a patient's appointment according to clinical circumstances.
- referral from doctor acknowledged within 3 working days of being received.
- a patient's non-attendance of an appointment is notified to referring doctor within 3 working days.
- re-scheduling or cancellation of an appointment initiated by the patient or the health service is notified to a referring doctor within 7 working days.

Standard 8: Outpatient Services Communication

There is a system for ongoing and timely clinical communication about patient care between a health care service's Specialist Outpatient Services, other ambulatory and day services and the patient's General Practitioners and other treating doctor(s).

Minimum criteria include systems:

- for the receipt of updating advice from the General Practitioner or referring doctor about the patient's progress, changes in management, clinical condition or care requirements.
- to enable scheduled secondary consultation with or without the patient directly present at the health care service or general practice.
- to enable telehealth outpatient consultations from the General Practitioner's Clinic when the patient resides in a rural or aged care residential setting.

Standard 9: Discharge Planning Processes

The health service has discharge care planning processes for patients with complex needs that involves their General Practitioner and other treating doctor(s).

Minimum systems for discharge planning processes for patients with complex needs include:

- the ability to undertake telephone, video conference or face-to-face case conferencing prior to discharge that includes the General Practitioner and/or referring doctor.
- outpatients appointment date (if required) scheduled prior to discharge.
- the ability for expedited re-assessment in the Emergency Department if the patient's medical condition deteriorates and warrants the patient's re-presentation within 72 hours following inpatient discharge.
- a documented plan of care and support to be provided to the General Practitioner in addition to discharge summary if Post-Acute Care services are put in place.

Standard 10: Managing Quality

These standards are incorporated into the Policies and Quality Systems of General Practices and Health Services.

Minimum requirements include incorporation of requirements for:

- documentation of policies, procedures, systems and processes that support the attainment of these Standards.
- appropriate Quality Indicators for these requirements are developed, which enable performance monitoring and the measurement of performance improvement initiatives.

Glossary

Emergency Care:

Care provided in an emergency department or emergency treatment/care area

Admitted Care:

This includes hospital wards, hospital in the home, acute psychiatry, short stay units, day procedure units, day oncology, bed-based rehabilitation, bed-based Transition Care and other subacute care such as Geriatric Evaluation and Management and bed-based palliative care.

Non-admitted Care:

This includes Specialist Outpatient Services, rehabilitation services, community-based Transition Care Packages, community based Specialist Palliative Care and other recovery programs such as cardiac rehabilitation and respiratory rehabilitation programs.

References

[1] Australian Medical Association. 2013. AMA Position Statement. General Practice/Hospitals Transfer of Care Arrangements – 2013

[2] Royal Australian College of General Practitioners. 2010. Standards for general practices. 4th edition. Published October 2010 Updated May 2013, updated March 2015, updated July 2015

[3] Australian Commission on Safety and Quality in Health Care. 2012 National Safety and Quality Health Service Standards Standard 6 – Clinical Handover Safety and Quality Improvement Guide. https://safetyandquality.gov.au/wp-content/uploads/2012/10/Standard6_Oct_2012_WEB.pdf

[4] Specialist clinics in Victorian public hospitals: Access policy. August 2013 https://www2.health.vic.gov.au/getfile//?sc_itemid=%7BE6447CD4-2AD8-48B3-8760-08A028FC788E%7D

[5] Victorian public hospital specialist clinics. Discharge Guidelines. August 2010 https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Discharge%20guidelines

[6] Victorian Auditor – General's Report. Managing Acute Patient Flows. December 2008 http://www.audit.vic.gov.au/publications/2008-09/20081112-Managing-Acute-Patient-Flows.pdf

[7] Victorian Auditor – General's Report. Clinical ICT Systems in the Victorian Public Health Sector. October 2013 http://www.parliament.vic.gov.au/file_uploads/20131030-Clinical-ICT-Systems_ftGBLy2B.pdf