



## **ENHANCED PRIMARY CARE**

### **FINAL REPORT**

**A JOINT PROJECT BETWEEN THE AUSTIN AND REPATRIATION  
MEDICAL CENTRE, THE NORTHERN DIVISION OF GENERAL  
PRACTICE AND THE NORTH EAST VALLEY DIVISION OF GENERAL  
PRACTICE**

**PROJECT CATEGORY:                    EFFECTIVE DISCHARGE**  
**PROJECT NAME:                        ENHANCED PRIMARY CARE**  
**DEMONSTRATION PROJECT**

**PROJECT COMMENCEMENT DATE: 12 November 2001**  
**REPORT DUE DATE:                    12 November 2002**  
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**THIS PROJECT WAS JOINTLY FUNDED BY THE DEPARTMENT OF HEALTH AND  
AGING (DH&A) AND THE VICTORIAN DEPARTMENT OF HUMAN SERVICES (DHS).**  
**PROJECT MANAGEMENT WAS THE RESPONSIBILITY OF THE GENERAL  
PRACTICE DIVISION OF VICTORIA (GPDV).**

## **EXECUTIVE SUMMARY**

**At the Austin & Repatriation Medical Centre the EPC project was conducted between November 2001 and November 2002. The project team consisted of a project manager (EFT 0.8) and a GPLO (EFT 0.2). To improve collaboration between the project partners, the project team was based in the North East Valley Division of General Practice located on one of the A&RMC campuses. The project achieved all of the aims stated in the funding submission:**

- **Strengthened relationships between the Medical Centre and GPs**
- **Increased awareness of Enhanced Primary Care principles and process in the Medical Centre**
- **Increased awareness of Enhanced Primary Care hospital discharge items principles and process within the partnering divisions and their constituent GPs**
- **Increased usage of hospital discharge item numbers**
- **Improved GP participation in hospital discharge planning for select patients.**

**The project team decided to test the EPC process in different units to assess its potential across the hospital. At the hospital level, EPC is relatively untested. EPC was the most successful in units where the staffing was stable and where there was already good understanding of referral process and availability of community service providers. EPC also worked best in areas where there was time for good discharge work up of patients.**

**GPs were generally responsive to collaborative discharge planning with the medical centre for complex patients. Particularly, they were enthusiastic about the improved quality and clarity of discharge information;**

- **Treating hospital team details**
- **Treating community team details**
- **Medical plan for the future**
- **Telephone discussion with the hospital medical staff.**

**The project team initially promoted the project widely across the Medical Centre. 8 areas were then targeted for involvement.**

- 1.0 Palliative Care Liaison – EPC introduced at point of discharge for patients referred from medical and surgical units for advice. 26 care plans constructed with good feedback about process and outcome from GPs. This unit will be EPC sustainable in the future.**
- 2.0 Pain Management Service – A consultancy service within the hospital. Patient requirements are very complex. Chronic abdominal pain patients have significant medical interventions and as such, the EPC item descriptors did not facilitate discharge care planning or case conferencing. 1 EPC case conference and 2 care plans attempted. EPC is a useful tool for this group of patients and should be pursued in the long term. The item number descriptors may need some revision to accommodate the complexities of these patients.**
- 3.0 Renal Unit – Primary care issues in this unit are prominent. Patients are involved with hospital-based units for many years, often on a weekly or more frequent basis and switch alliances from the GP to the hospital staff. EPC discharge care planning was introduced at the point of vascular access surgery. The care plans were not successful as they could not be organised during a short length of stay (48 hours). However, the role of the GP has been enhanced by the inclusion of a GP presentation in the patient education seminars run by the unit. Patient needs are complex and may be better coordinated through guidelines and shared care arrangements using community care plans rather than hospital based. 8 care plans were commenced.**
- 4.0 Cardiac Respiratory Medicine – Generally unsuccessful during the life of this project, however, a process has been set up for inclusion in a concurrent project. These patients have very complex and multidisciplinary problems and would benefit greatly from a coordinated approach to management facilitated by the use of EPC. 1 case conference held with good feedback from all concerned.**
- 5.0 Complex Discharge Team – Accepts referrals from all around the Medical Centre. 12 care plans completed and 4 case conferences attempted without success (due to patient condition changes). This unit has the ability to seed the EPC process throughout the Medical Centre. Sustainable use of EPC by this team.**
- 6.0 Psychiatry Banksia House – 2 case conferences successfully conducted. 20 care plans completed in a 1-month trial period. This unit was used as a trial for roll out across the rest of the Mental Health Clinical Service Unit (CSU). Good outcome from the use of EPC process in this unit. Negotiations and education process for the CSU continuing. It is expected that EPC process will be sustainable in the long term.**

- 7.0 Rehabilitation Hospital – Already had some exposure to the EPC process. The discharge practice on this campus sophisticated and involved good communication with community service providers, however the contact tended not to be coordinated and was discipline specific. The project team was unable to provide sufficient resources for the introduction of EPC discharge process on this campus, but this should be a future pursuit with the assistance of the Hospital Primary Care Liaison Unit (HPCLU).**
- 8.0 Aged Care Rehabilitation Service – Concurrently conducting a review of their own internal documentation. EPC process developed to compliment this review but relatively untested at time of report. Potential for development of a sustainable process in the future. The complex discharge team has the ability to assist the HPCLU to achieve this.**

**In the long term, the use of EPC principles and improved collaboration with community partners will be common practice at the Austin & Repatriation Medical Centre. The process has been seeded across many units and continues to be pursued in others. With the introduction of an automated patient management system (Medtrak) over the next 2 to 3 years, the EPC process can be included in routine practice in all areas for appropriate patients**

## 2.0 AIMS AND OBJECTIVES OF THE EPC PROJECT

In the original funding submission to the Department of Human Services, 6 aims were listed:

- Strengthen relationships between GPs and A&RMC staff, both individually and collectively, through the use of EPC Items for discharge planning for inpatient services
- Improve awareness amongst A&RMC staff of the availability and value of EPC items for discharge planning for inpatient services
- Improve awareness amongst NDGP and NEVDGP GPs of the availability and value of EPC items for discharge planning for inpatient services
- Increase usage of the EPC items for discharge planning for inpatient services by A&RMC staff and local GPs (for patients with complex care needs and chronic medical problems)
- Improve the involvement of community service providers, specifically GPs, in discharge planning

The original submission proposed that 15 units / areas would be using EPC discharge planning principles and processes within the project lifetime. This figure was reduced to 8 units / areas in the 6 month report for several reasons:

- The project team needed to develop a process for the application of relatively untested EPC descriptors in a large acute public hospital and then develop an education programme for the medical centre staff.
- Several projects were running concurrently at the medical centre and the project team was wary of creating complexity with overlapping projects.
- The medical centre has three campuses and it was difficult for the project team to devote adequate time across all 3 (needing to map current processes, develop a system, educate all staff, trial process etc)
- Some areas / units were reluctant to embrace EPC into the current discharge process
- It was recognised that a sustainable process required intense engagement with particular units rather than broad spectrum (and more superficial) contact across the hospital.

A further objective identified was to test the ease of use and efficacy of the MBS EPC hospital discharge item numbers as they are applied across the medical centre. A decision was made by the project team to build on existing discharge processes rather than concentrate energy on improving the base system first and then introducing EPC. Concurrent with the EPC project, the Austin & Repatriation Medical Centre was engaged in a major review and upgrade of IT patient services and records and therefore, any permanent posting of the developed EPC process would need to be timetabled into the IT agenda for the future. This has implications for sustainability in the short term, however in the long term, it means that certain units will have gained significant EPC experience and knowledge by the time the discharge planning process goes “on line”.

### 3.0 SUMMARY OF PROJECT ACTIVITY

MONTH	ACTIVITY PROPOSED	ACTUAL ACTIVITY	COMMENTS
November - December	Recruitment of 10 units into project Identify key staff as drivers in each unit Ascertain staff knowledge of EPC Determine possible barriers / enablers to project success Evaluate GP knowledge of EPC discharge items Advertise project to GPs	<ul style="list-style-type: none"> <li>Set up hospital project advisory committee with terms of reference, executive support etc</li> <li>Researched EPC structure and hospital discharge item numbers.</li> <li>Establish contacts within the HIC to get accurate interpretation and advice</li> <li>Developed educational package for hospital staff (including EPC information for consultants to use in private practice)</li> </ul>	<ul style="list-style-type: none"> <li>There was limited knowledge of EPC in general or the project specifically among staff and much time and effort was devoted to the development of written / presentation and other educational material for dissemination. Staff were addressed on an individual, professional group, management group and at the work unit level.</li> <li>Significant amount of time was devoted to mapping out the admission / discharge processes in chosen units / wards in order to make small and targeted changes to current work practices rather than imposing another layer of activity. The aim of mapping was to present a visual framework for discussion, look at mutual benefits to involved parties, and to determine the best point for insertion of EPC discharge processes into the unit structure. (This process was presented to the national GPLO conference on the Gold Coast on 3<sup>rd</sup> March 2002. Refer appendix for sample maps.)</li> </ul>
December - January	Attend unit meetings etc to get input from all staff levels to determine best way of introducing process into unit practice.  GP education	<ul style="list-style-type: none"> <li>Survey of hospital staff re knowledge of EPC</li> <li>Met with senior medical staff for education / support for project in units</li> <li>Audit of files to ascertain level of documentation which might be related to project processes</li> <li>Interview patients / carers as to their understanding of discharge liaison with GPs</li> <li>Survey GP practice staff to determine how project might be adapted for GPs and practice management (eg appointments etc)</li> </ul>	<ul style="list-style-type: none"> <li>One case conference was conducted in January for a patient in an acute medical ward to trial the system and determine ease of use / appropriateness of case conference. GP and staff follow up very positive.</li> <li>Develop basic written education package, presentation material and draft paperwork for consideration by units. Paperwork which featured hospital input and recommendations and summary of contact with the GP was more acceptable to hospital staff than paperwork which appeared to benefit the GP (with details of item numbers, billing, etc)</li> </ul>
January - February	Finalise protocols and processes to proceed and sign off 5 units	<ul style="list-style-type: none"> <li>Initiate process to get paperwork accepted by the Medical Records committee – advice from Health Information Manager was to “frame” the documents as correspondence and file in the correspondence section of the patient medical record file</li> <li>Consultation at the ward clerk level to provide education about administrative and medical record requirements.</li> <li>Commence education of staff in Primary Care Liaison Unit about project and enlist support for continuing project development and probable continuation of principles after the project life.</li> </ul>	
February - March	Roll out case conferencing and care planning within these 5 units	<ul style="list-style-type: none"> <li>Select initial 5 units for engagement and develop process for and with these units – palliative care referrals, renal unit, psychiatry, aged care rehabilitation, amputee rehabilitation</li> </ul>	Continuing to devote time to education, including to GPs through divisional board reports, written information in divisional newsletters and formal presentation at the divisions’ CME evenings.

MONTH	ACTIVITY PROPOSED	ACTUAL ACTIVITY	COMMENTS
March - April	Ongoing negotiation with next 5 units planned 6-month report due to DHS by May 12, 2002	<p>Significant work in developing a comprehensive GP education program with the 2 GP divisions and the renal unit, including guidelines for GP renal failure management, GP seminar, GP clinical attachments</p> <p>Plan EPC seminar for senior staff at A&amp;RMC to review current progress and set priorities for next 6 months</p> <p>Cultivate interest in additional units</p> <ul style="list-style-type: none"> <li>• Complex discharge coordinator</li> <li>• Pain management</li> <li>• Cardio respiratory medicine</li> <li>• Orthopaedics</li> <li>• General medical</li> <li>• Medical assessment and planning unit</li> </ul>	<p>2 case conferences conducted by discharge coordinator to trial process for acute units.</p> <ul style="list-style-type: none"> <li>• 1 case conference did not qualify under EPC descriptors as discharge was not yet planned and the GP was present at a family meeting mid admission to look at discharge possibilities – see case study in appendix.</li> <li>• 1 case conference funded through the hospital in the home programme. Patient changed GPs and descriptors not clear about eligibility for billing if a new GP involved.</li> </ul> <p>Approval from senior medical staff to care plan renal patients undergoing vascular access surgery in conjunction with the vascular and renal units.</p> <p>Development of the process to fit with the various practices in the units chosen taking much longer than expected due to the complexities of the descriptors, time pressures of GPs and hospital staff and the complexities of unit process</p>
April - May		<ul style="list-style-type: none"> <li>• Ensure that the paperwork and education activities developed for the project comply with MBS May 2002 schedule supplement</li> <li>• Commence review of Care plans / case conferences conducted so far</li> <li>• Realistic review of commitment to engage with 15 units: concentrating on developing a sustainable process in smaller number of units currently involved</li> <li>• Work with team in acute medical assessment unit (very short stay) to develop process for using EPC at discharge.</li> <li>• Develop ways for GPs to identify patients who would benefit from EPC discharge processes – link information about project with GP notification of admission and trial for 1 month</li> <li>• Develop process in target units</li> </ul>	<ul style="list-style-type: none"> <li>• Palliative Care Unit liaison nursing staff commenced care planning for all patients going home with community palliative care services</li> <li>• Mother baby and mood/eating disorders unit (Banksia House) attempting to care plan / case conference all discharges in May</li> <li>• Aged care unit agree to trial EPC discharge case conferencing</li> <li>• Complex discharge team adopts process. This team becomes independent in EPC process in short time.</li> <li>• Preliminary talks with Royal Talbot Rehabilitation Hospital (RTRH) with view to commencing EPC process in rehabilitation hospital</li> <li>• Renal EPC targets patients at the point of vascular access surgery</li> <li>• Pain management service expresses interest. (Joint project developed with NEVDGP to adapt community EPC process in tandem with discharge EPC project with the pain management service at the A&amp;RMC</li> </ul>
May - June	Review findings of first three month trial Modify process accordingly Feedback to units preparing to be in	<ul style="list-style-type: none"> <li>• Continue with education of Banksia House staff and support during month of EPC care planning trial and review plans generated by this process</li> <li>• Support palliative care liaison nurses</li> </ul>	45 staff and community provider representatives took part in primary care seminar in May at the A&RMC. Activity was based around trying to work out ways in which awareness of the role of GPs and primary care providers

MONTH	ACTIVITY PROPOSED	ACTUAL ACTIVITY	COMMENTS
	trial	<ul style="list-style-type: none"> <li>Conduct seminar with senior medical centre staff to further publicise the project, gain support and gain ideas for the continued direction of the project</li> </ul> <p>Submit 6-month report</p>	<p>could be raised at the medical centre. The Directors of acute and ambulatory programmes took recommendations back to the medical centre's senior medical staff for consideration</p> <p>6-month report was submitted, including a recommendation that the EPC project team review the initial submission to reflect the difficulties encountered when trying to enlist 15 units into the EPC process</p>
June - July	Roll out to next 5 units and commence preparation to last 5 units	<p>Commenced working with the pain management team at their request – reviewing long stay patients with chronic abdominal pain</p> <p>Review of activity in the renal unit</p> <p>Start to follow up GPs involved in the EPC discharge process at A&amp;RMC</p> <p>Notification of admission survey to GPs members of the NEV DGP and the NDGP, one month trial (see appendix)</p> <p>Trial EPC case conferencing process in aged care rehabilitation unit</p>	<p>One case conference organized in aged care rehabilitation for complex patient discharge. GP able to assist with setting up of community supports and to provide information about the ability of patient's wife to cope with discharge demands. Follow up with hospital team revealed enthusiasm for the process (but comments about the time commitment predominant). The consultant reported that, from a medical perspective the case conference was too time consuming since the patient's needs were all in the allied health and nursing category. GP comments were very positive in terms of the improved handover of the patient's needs (medical discharge summary, on its own, not adequate in this case). At time of report writing (November), this client remains at home well supported and has not represented to the medical centre since discharge in early July</p>

MONTH	ACTIVITY PROPOSED	ACTUAL ACTIVITY	COMMENTS
July - August		<p>Audit palliative care process and feedback</p> <p>Commence negotiations with Aged Care rehabilitation to introduce care plan and case conferencing process formally</p> <p>Start to educate staff in the Hospital Primary Care Liaison Unit (HPCLU) about the EPC process in discharge planning – including issues of sustainability of process in currently targeted units and roll out to further units across the medical centre</p> <p>Analysis and follow up of 182 patients nominated for discharge planning by GPs through the notification of admission survey. All units contacted to notify of GP interest in discharge planning. EPC team offered to ad hoc care plan. No EPC uptake from this opportunistic strategy (see appendix).</p>	<p>GP notification of admission survey revealed:</p> <ul style="list-style-type: none"> <li>• GPs enthusiastic about working with hospital for complex/complicated patients at any stage of admission</li> <li>• GPs able to identify patients who are at risk of delayed discharge or readmission / A&amp;E representation</li> <li>• The medical centre is able to more easily work with a GP who responds to notification of admission than trying to chase up a reluctant GP for input into patient care. (See Appendix)</li> </ul> <p>The aged care rehabilitation asks for a delay in the introduction of the EPC process due to an internal review of their team meeting and patient review paperwork and process</p> <p>Palliative Care Liaison staff using the process well. GPs have indicated satisfaction with the improved discharge information (mainly the details of the hospital team and referred community providers list accompanying the medical discharge summary) but request a phone call from the treating registrar / resident at the time of discharge to discuss future medical management in more detail. This information passed on to the liaison nursing staff.</p>
August - September		<p>ARCHI conference presentation (see appendix)</p> <p>NDGP Board presentation</p> <p>Attempts to reintroduce the EPC process at Royal Talbot Rehabilitation Centre – abandoned in favour of emphasising sustainability of other sectors</p>	<p>Staff at Royal Talbot have well-established process involving GP communication at time of or near to patient discharge. In 2001 the then A&amp;RMC GPLO set up a system for EPC case conferencing. One case conference was conducted.</p>
September - October	Roll out to next 5 units making total of 15 units involved	<p>NEVDGP Board presentation</p> <p>Meetings with the HPCLU and IT department re changes to automatic notification of admission letter based on GP survey</p> <p>Integration of EPC into HARP projects</p>	<p>Notification of admission scheduled for inclusion in new IT system at A&amp;RMC around March 2003. To remain the responsibility of the divisions until then.</p> <p>3 HARP funded projects at the A&amp;RMC, each with capacity to include EPC discharge processes. Education given to each of the project managers for future EPC involvement between the medical centre and GPs. One HARP project focuses on chronic disease management (and there is now enthusiasm from the cardio respiratory team for using EPC)</p>

MONTH	ACTIVITY PROPOSED	ACTUAL ACTIVITY	COMMENTS
October - November	Evaluation / ongoing support and finalise sustainability Report writing	Audit Complex discharge team (CDT) process  Arrange for process guidelines and paperwork to be available through the hospital intranet  Continue to work with aged care rehabilitation through direct contact and the complex discharge team  Presentation to A&RMC Mental Health Services Clinical Service Unit of results of the Banksia House Trial, to progress EPC discharge care planning to other areas within the psychiatry clinical services unit  Hand project over to staff in the Hospital Primary Care Liaison Unit for continued monitoring	12 care plans constructed by the CDT up until November 2002. Good feedback from GPs about the process, particularly regarding the comprehensive information and the phone call from the registrar and / discharge coordinator.
Throughout the project	Monthly project groups meetings	Presentation of progress to other pilot projects and the GPDV	Clearing house for ideas and provided a structure for capitalising on other project learnings. Experience of and support from other project workers invaluable in terms of efficiency of process development, collective learning and organisation
	3 monthly meetings with stakeholders	Advice to stake holders regarding project progress	Provided valuable feedback and consultation loop with stakeholders (DH&A, DHS, GPDV) and the EPC implementation team.

## 4.0 ACTIONS TAKEN, OUTCOMES, KEY LEARNINGS AND SUSTAINABILITY ISSUES BY UNIT

### 4.1 PALLIATIVE CARE LIAISON NURSES

DESCRIPTION	ACTIONS TAKEN	OUTCOMES	KEY LEARNINGS	SUSTAINABILITY
<p>2 liaison nurses take referrals from hospital units.</p> <p>These patients are assessed and either referred on to the palliative care registrar for advice or the nurses advise on continuing care and discharge issues.</p> <p>If the patient goes home with supports then the palliative care nurses commence an EPC care plan</p> <p>GPs who have patients admitted to the palliative care inpatient unit are invited to EPC care plan by the unit. This process has been established for some time, uptake is negligible. GPs however are involved throughout the admission</p>	<p>Palliative care clinical team educated about process and asked about applicability to their unit.</p> <p>Liaison nurses educated about the process and paperwork developed.</p> <p>There already exists extensive paperwork in this unit. Development for this project was complimentary to current process. Paperwork included the regular discharge summary to accompany care plan document.</p> <p>Process for case conferencing also developed however family meetings are held regularly to discuss patient/carer wishes and do not involve the GP. Under the item number descriptors, EPC rebate for GPs is applicable if discharge is planned and the hospital communicates this to the GP. At the time of family meetings, discharge and future care is not yet decided; patient may not be discharged and therefore GP not remunerated</p>	<p>26 care plans completed during survey period – GPs billed for only 7 of the these for a variety of reasons</p> <ul style="list-style-type: none"> <li>➤ Altruistic</li> <li>➤ Unsure of EPC process</li> <li>➤ No time or not yet got around to it</li> <li>➤ Have had problems with billing previously</li> </ul> <p>Of the GPs who billed, 6 GPs had no problems and 1 GP stated that he had problems with the HIC (resolved using item number 728)</p> <p>Liaison nurses have continued to use care planning process since the survey period for patients going home with supports</p> <p>Quality Assurance report written about the process and discussed with the liaison nurses. They will take to the Cancer CSU quality committee for discussion</p>	<p>GPs have appreciated the additional information such as the community providers involved in continuing care.</p> <p>GPs feel that these patients are complicated and therefore require phone contact with the hospital medical staff as well as a discharge summary. Phone call is not currently routine.</p> <p>GPs require continued update with regards the EPC process</p> <p>Community palliative care agencies want to be more involved in hospital referral process and EPC care plan.</p> <p>There is already good awareness of the role of GPs by the cancer services unit, however when patients are admitted under a more general unit then the role of the GP in continuing care may not necessarily be considered</p> <p>A major review of discharge processes in cancer wards started in October 2002. EPC information has been passed on to assist.</p>	<p>The palliative care liaison nurses will continue to care plan appropriate patients and induct hospital medical staff into process as appropriate</p> <p>EPC process to be considered in review of discharge practices on cancer wards</p>

## 4.2 PAIN MANAGEMENT SERVICE

DESCRIPTION	ACTIONS TAKEN	OUTCOMES	KEY LEARNINGS	SUSTAINABILITY
<p>The pain management service is a hospital wide consultancy service run by the department of anaesthesia that accepts referrals for acute, chronic and cancer pain management. Recommendations are made to parent unit</p> <p>A senior clinical nurse is part of the team</p> <p>The patients chosen for EPC Discharge process are a group of chronic abdominal pain patients who have frequent admissions to acute hospitals</p> <p>Team case conferencing occurs weekly to discuss both inpatients and outpatients. GPs currently not included</p> <p>GP is seen as integral in the maintenance and support process in the community and in the continuing management of medication use and prescription</p> <p>A member of the pain management team has an association with a programme currently running with a division of general practice utilizing community care plans at a regional clinic</p>	<p>Audit of patient sample looking at hospital admission and readmission and use of community services</p> <p>Development of a protocol for care planning and case conferencing in the unit</p> <p>Discussions with the pain management clinicians and the divisions of general practice to develop a plan for GP education (based on a needs analysis survey of GPs by the pain management physicians at Barbara Walker Pain Clinic) to enhance pain management in the community</p> <p>Active assistance organising care plans and case conferences at the A&amp;RMC</p>	<p>Patient sample audit revealed:</p> <ul style="list-style-type: none"> <li>• This group of clients has very complicated medical needs over a long period of time</li> <li>• Multiple hospital admissions each year</li> <li>• Medication management is critical</li> </ul> <p>1 EPC case conference was attempted but converted to a care plan. 1 care plan organised but did not proceed under EPC descriptor guidelines (team consisted of 3 specialist physicians and the GP), however, the GP remained fully informed about the patient progress and management recommendations via <u>numerous</u> phone discussions</p>	<p>Collaborative management of chronic pain patients can be done using the EPC process at both a community and hospital level. Composition of the clinical team may need to be discussed at a HIC level given that in many cases all of the team members are doctors with different specialties working with the GP.</p> <p>Units which consult to other hospital units have difficulty organising EPC activities which involve a patient's parent unit as part of continuing patient management</p>	<p>Remains long term endeavour</p>

### 4.3 RENAL UNIT

DESCRIPTION	ACTIONS TAKEN	OUTCOMES	KEY LEARNINGS	SUSTAINABILITY
<p>This unit takes referrals from a wide section of Victoria for patients with chronic and acute renal problems.</p> <p>This service covers busy in-patient and out patient units, community based dialysis units, dialysis training, home dialysis and transplant services.</p> <p>Patients are often involved with the unit for a lifetime and often develop primary care dependency on the unit – audit revealed 14% of all requests by renal patients in the hospital dialysis unit to staff involved primary care issues that could have been handled by the GPs</p>	<p>Extensive process of mapping patient flow from initial GP referral through to end of association with unit (see appendix)</p> <p>GPs and hospital staff were asked how the process could be improved and how the 2 sectors might help each other with patient management</p> <p>Development of a GP training program. Patient management guidelines and GFR calculators distributed to GPs at a seminar organised by the local divisions of general practice</p> <p>GP now presents at the patient/carer/family renal education program at the medical centre</p> <p>Process developed to commence EPC care plan at the time of preadmission clinic attendance for vascular surgery (i.e. early in clinical care pathway prior to development of primary care dependency.).</p>	<p>8 patients approached for consent to the process at preadmission clinic</p> <ul style="list-style-type: none"> <li>• 2 refused to be involved in the process – no reason given</li> <li>• 6 consented to the process</li> </ul> <p>Care plans did not proceed on the ward due to very tight time constraints (average length of stay approximately 48 hours)</p>	<p>In order to use EPC discharge items, the project team targeted patients at the time of vascular access. The average length of stay for this procedure is about 48 hours; this was not enough time to construct a care plan with the large number of community and hospital service providers.</p> <p>Where EPC discharge process depends on the coordination and cooperation of staff across unit boundaries, it may be more difficult to progress.</p>	<p>EPC use in renal disease might be better suited very early on in the patient disease process under shared care arrangements, disease management guidelines and community EPC care plans (incorporating ACTIVE participation of GP, community care agencies and hospital units)</p> <p>Successful share care arrangements for very ill patients are dependent on the development of trust and relationship between care providers, and on clarity of provider roles. EPC project work attempted to build relationships between local GP's and the renal unit via the divisions.</p> <p>Reduction of patient dependency on renal units is a very long term project</p>

#### 4.4 CARDIAC / RESPIRATORY MEDICINE

DESCRIPTION	ACTIONS TAKEN	OUTCOMES	KEY LEARNINGS	SUSTAINABILITY
<p>Patients in this disease category have chronic conditions often with multiple co morbidities and often fall into the aged care category</p> <p>Many patients have multiple readmissions to the A&amp;RMC, often for short periods of time.</p> <p>Patients are usually admitted to the general medical units through the accident and emergency department</p>	<p>Discussions with consultant medical staff about assisting them by introducing EPC discharge practices for this group of patients</p> <p>Discussions with Nurse Unit Manager of the medical assessment unit about the process and development of appropriate supporting procedure and paperwork for the process</p> <p>EPC project team kept in touch with the ward nurse unit manager to support any future EPC case conferences or care plans.</p>	<p>Limited enthusiasm for the process in this area.</p> <p>One case conference was held in the medical assessment ward. Patient had multiple medical and social problems. The patient has since remained out of hospital (8 months) with community support.</p>	<p>The hospital is currently undergoing a rebuilding programme and the ward infrastructure did not support a case conference (phone point access in meeting rooms, access to good speaker phone, meeting room in close proximity to the ward).</p> <p>Where infrastructure, ward processes, staff, paperwork or time constraints do not appear to support the introduction of EPC, alternatively funded projects may provide a later impetus for successful introduction of EPC.</p>	<p>During the life of the project, this area was not "EPC" successful. In recent weeks, the units have received additional funding (DHS HARP). Discussions with the chronic disease management project worker have been held to educate about the use of EPC discharge practices to work with GPs and support patients in the community.</p> <p>Through this project there appears to be good support at a senior clinical level for the introduction of EPC at both a hospital and community level over the next 2 to 3 years.</p>

## 4.5 COMPLEX DISCHARGE TEAM

DESCRIPTION	ACTIONS TAKEN	OUTCOMES	KEY LEARNINGS	SUSTAINABILITY
<p>Commenced in 2001, this team is under the Aged Care Services clinical services unit.</p> <p>The team is currently expanding to include 3 discharge coordinators, 1 medical and 1 surgical discharge coordinator.</p> <p>The team works across the Repatriation and Austin campuses and has a good understanding of available brokerage and community services.</p> <p>The focus is on clients with multiple and complex discharge issues and the need for continued support to remain at home</p>	<p>Collaboration with the coordinators to develop a process for discharge case conferencing and care planning.</p> <p>Education about the EPC process</p> <p>Initial case conferences were organised by the EPC team as a coaching exercise.</p>	<p>High-level understanding and rapid acceptance of the process.</p> <p>The coordinators were quick to become independent in setting up case conferences and care plans</p> <p>EPC process and paperwork now used by the team routinely to achieve effective discharge.</p> <p>12 care plans successfully completed with good feedback from hospital staff, GPs and community providers involved. Participants particularly cited the improved clarity of information received (both by phone and written care plan document).</p> <p>GPs overwhelmingly applauded the quality of the discharge work up by the complex discharge team and the community handover. 0 of the 12 patients had since been readmitted to an acute facility at the time of follow up</p>	<p>The team has good coverage over the medical centre and staff in the various units work well with the discharge coordinators.</p> <p>Using this avenue, EPC discharge process can be seeded across many hospital units.</p> <p>The complex discharge team members already have extensive experience working with community providers and GPs. The EPC discharge process complimented and enhanced the already established discharge process</p>	<p>Potential for good use of EPC in the long term with a wide cross section of patient type. Some support from the HPCLU will be required from time to time.</p> <p>The complex discharge team coordinators will use EPC processes for all clients whose they facilitate.</p> <p>The medical and surgical unit coordinators will use EPC for patients who have unplanned readmissions to the various medical and surgical units</p>

#### 4.6 PSYCHIATRY – BANKSIA HOUSE

DESCRIPTION	ACTIONS TAKEN	OUTCOMES	KEY LEARNINGS	SUSTAINABILITY
<p>The Banksia House Unit has expertise in the management of</p> <ul style="list-style-type: none"> <li>• Mood disorders</li> <li>• Eating disorders</li> <li>• Mother and baby psychiatry</li> </ul> <p>Staffing in the unit is generally stable with well-defined expertise.</p> <p>Discharge processes are well known to staff and there is good knowledge of supportive community psychiatry services in the community.</p> <p>GPs are not necessarily included in the discharge and follow up process</p> <p>There is limited hospital follow up of this group of clients through outpatients, - aim is to refer them back to the community services for continuing management.</p> <p>Case conferencing process is already established, multidisciplinary community team structure (DHS, psychiatrist, maternal and child health district nursing etc) however, GP rarely invited to participate.</p>	<p>Discussions with staff regarding current processes, attendances at team meetings.</p> <p>Mapping of the current process</p> <p>Development of an EPC structure to include the GP as part of the continuing care plan</p> <p>1 month trial of care planning / case conferencing in May 2002</p> <p>Purchase of a speaker phone to facilitate case conferences</p>	<p>Staff developed good understanding of the process.</p> <p>Consent not an issue as the staff reported that it reinforced to the client their involvement in the continuing care arrangements.</p> <p>20 care plans and 2 case conferences completed</p> <p>The feedback from GPs was positive, especially when the registrar telephoned the GP to discuss, rather than using the fax for GP participation. Some of the care plans were not as well developed as others. This related to a change of staffing mid trial. The EPC team was unaware of the staffing change and therefore did not provide adequate education for the covering registrar.</p> <p>Nurse unit manager keen to further develop the process at Banksia House. Quality assurance team examining ways to roll out process across psychiatry units.</p> <p>Psychiatrist involved in 1 case conference was denied payment by HIC – since resolved (HIC computer not allowing 2 similar item numbers billed for same patient on same day, GP payment accepted first)</p>	<p>EPC served as a catalyst for the inclusion of GPs in continuing management of this group of patients</p> <p>EPC works well when there is already good understanding of community processes and services.</p> <p>There were some difficulties with HIC payment – this was eventually resolved but the medical staff concerned indicated that they would be less enthusiastic to be involved in EPC activities in the future.</p> <p>Medical staff require specific education and information about the EPC hospital discharge items if they are to use them in the future.</p>	<p>There is good potential for the EPC process to be used routinely in the long term. Where the process can be further refined to fit a general psychiatry model, then it may roll out to psychiatry generally in the medical centre.</p> <p>With the introduction of the new Better Outcomes in Mental Health initiative, GPs will be more involved in the mental health care of their patient in the community. GP involvement though EPC during the hospital stay will enhance continuing care through these new item numbers.</p>

## 4.7 REHABILITATION HOSPITAL

DESCRIPTION	ACTIONS TAKEN	OUTCOMES	KEY LEARNINGS	SUSTAINABILITY
<p>Royal Talbot Rehabilitation Hospital is a separate campus of the A&amp;RMC and is a specialist rehabilitation service for adult clients.</p> <p>In patients, Rehabilitation in the Home, outpatient services are run from RTRC.</p> <p>Very experienced and stable staff</p> <p>Sophisticated and well developed team review system</p> <p>GP is contacted at discharge with good exchange of information. Discharge information is comprehensive and often there are 1 or 2 phone calls to the GP from the hospital registrar to discuss the plan of care for the client.</p> <p>1 care plan using EPC guidelines conducted in 2001 with the help of the (then) GPLO</p>	<p>Attendance at team meetings, file review, discussions with senior medical staff about the process</p> <p>Adaptation of the EPC process to suit RTRC conditions.</p>	<p>Staff not enthusiastic about process for 2 main reasons</p> <ul style="list-style-type: none"> <li>• Additional consent needed for the process</li> <li>• Already well-understood process of discharge. Tends to be discipline specific</li> <li>• There is a process for community referral / handover used that is efficient for the staff</li> </ul> <p>No progress made at the RTRC at the time of reporting</p>	<p>Where comprehensive paperwork and referral system already exists, it is difficult to convince staff to try a change in practice that may only benefit the GP.</p> <p>In subacute areas where patient association is long term and the need for specialist services is high, hospital out patient attendance may overshadow the activity of community provider's ability to support the patient in the community.</p> <p>Challenges exist in providing adequate support to geographically separated campuses. Project staff need to be available intensively to support to staff during the introduction of major changes to process / discharge practices.</p>	<p>In the long term, the use of EPC discharge processes will provide efficiencies for both GP and hospital staff.</p>

## 4.8 AGED CARE REHABILITATION

DESCRIPTION	ACTIONS TAKEN	OUTCOMES	KEY LEARNINGS	SUSTAINABILITY
<p>2 units on the Repatriation campus provide in patient rehabilitation for aged care patients in the region.</p> <p>Geriatrician or neurologist is team leader and allied health / nursing staff are experienced.</p> <p>The unit has support from the acute units at the medical centre who provide the main referral base.</p> <p>At the time of the EPC project, the Aged care rehabilitation units were conducting their own review of case conference / team meeting paperwork. (The EPC team was initially unaware of this process.)</p> <p>The aged care complex discharge team also service this unit.</p> <p>An NDHP4 project involving ortho geriatric patients commenced in 2002</p>	<p>File audit, team meeting attendance, discussions with staff and senior medical staff.</p> <p>Development and trial of a process for case conferencing and care planning.</p>	<p>1 case conference conducted.</p> <ul style="list-style-type: none"> <li>• Patient outcome very successful and has not been re admitted at the time of report.</li> <li>• GP positive about the information handover process</li> <li>• GP offered additional information regarding need for home supports for the patient and his wife</li> <li>• Allied health staff at the A&amp;RMC positive about the opportunity to provide information about current and future patient management</li> </ul> <p>Process for using EPC principles developed for the unit but not adopted at this stage.</p>	<p>The value of case conferencing with GPs and other community care providers sometimes varies according to the profession of the hospital staff involved.</p> <p>The value of the case conferencing process for GPs may be underestimated by hospital staff</p> <p>For a busy overloaded HMO contact with the GP is difficult to prioritise at discharge.</p>	<p>Strong chance that the EPC process will be used by the unit in the future for 3 main reasons</p> <ul style="list-style-type: none"> <li>• The complex discharge team will use the process with the staff for all patients referred from the unit.</li> <li>• The revised unit discharge and team meeting paperwork utilizes many of the EPC discharge planning requirements and will be very easily adaptable for EPC care planning</li> <li>• The ortho geriatric project worker will incorporate EPC processes into the discharge planning and care pathway of this group of patients.</li> </ul> <p>The hospital primary care liaison unit has been asked to continue working with aged care rehabilitation unit to promote the use of EPC</p>

## 5.0 KEY LEARNINGS OVERALL

- EPC worked best in the sub-acute areas where there was already good understanding of community referral issues and services and the staff perceived there was adequate time to organise these services.
- GPs are enthusiastic to work with the hospital in the care of their complex patients and cite good practice rather than remuneration as the key driver for this. (However, they were thankful to be able to receive payment for providing this service.)
- GPs are able to identify the patients who would benefit from discharge care planning with the hospital
- Improving the awareness of the role GPs play in the community by hospital staff is a continuing (and sometimes slow) process
- GP engagement with the hospital staff varies over the period of an in-patient episode of care and is not just related to discharge. The EPC process only recognises GP input around discharge issues.
- Workload, idiosyncratic unit practices and organisational differences often make contact between the hospital and GPs problematic.
- The EPC item number descriptors are at times inflexible with respect to the needs of specific groups of patients
- EPC can be an effective tool for organising discharge information for and with the GP and other community care providers.
- It can be a challenge involving private allied health service providers in the EPC discharge process, as it is only the GP (or certain specialists) who can be remunerated for their involvement
- Introducing EPC processes into a large medical centre is a long term endeavour due to the complexities of
  - The EPC process itself, including the item number descriptors, billing procedures for the GPs and private medical consultants,
  - The work systems in a hospital and the varied practices between units in the same hospital.
  - Time pressures
  - Different funding streams

## 6.0 RECOMMENDATIONS

### 6.1 COMMONWEALTH

- The Item numbers should be made more flexible to accommodate the range of patient circumstances encountered in hospital
- Patients who come from (and/or are discharged to) nursing homes into hospital for management of an acute medical episode should be eligible for EPC discharge items to develop a care plan to manage future acute episodes without hospital readmission
- Patients who require coordinated care from a team which is all medical (e.g. surgeon, physician, infectious diseases, GP) should be eligible for EPC discharge planning
- Consideration should be given to the development of longitudinal care pathways and shared care guidelines for patients with very long term disease (e.g. renal failure) so that the patient, the GP and the hospital are involved in good care coordination from the commencement or identification of the condition or disease process
- GPs should be considered for remuneration for their active involvement in patient management at any time during the inpatient episode of care.
- Consideration should be given to the issue of a separate consent process for EPC activities in hospital given the privacy guidelines introduced across the country in the last 12 months. Hospitals have completed extensive reviews of the privacy policy and consent process to accommodate these changes. EPC consent adds another layer to the process.
- The EPC item number billing process should allow for processing for non attendance of patients after hospitalisation (e.g. deceased, referred for nursing home care, patient unreliability, etc) if the GP has been actively involved in care planning

## 6.2 STATE

- Development of baseline KPIs centred around discharge liaison with community providers and facilitation of EPC activities
- The 4 EPC projects in Victoria have been collectively meeting monthly. This process has facilitated regular sharing of information, project worker support and problem solving and has improved the efficiency of the projects. The state should give consideration to developing this management process for similar project groups
- For this project, there was active involvement of a GPLO. This facilitated dialogue with senior hospital medical staff. Consideration should be given to supporting the role of the GPLO in public hospitals as an active organisational driver of acute / primary care integration.
- The project team, whilst paid by the A&RMC, were based in the NEVDGP. This facilitated smooth dialogue with the divisions and the divisions were treated as active participants in the process. Where projects are funded to address cross sector issues then serious consideration needs to be given to the issue of equity and active inclusion of project partners, rather than deliverables being simply hospital-based.

## 6.3 HOSPITAL

- For complex patients a hospital medical staff member should routinely contact the patient's GP as part of discharge information handover
- EPC processes be included in future discharge planning, especially through the HARP funded projects
- Future patient system IT development include EPC as part of the discharge process
- One of the strengths of this project was its engagement with the local divisions of general practice in a truly bilateral attempt to bridge the acute/primary interface. Such collaborative efforts are strengthened by the auspicing function of the Divisions of GP. This model should be considered for future collaborative projects between the hospital and community sectors.
- A GPLO component was funded as part of this project. Allocation of GPLO organisational capacity to future projects of this type should enhance effect.
- Several projects were concurrently running at the time of the EPC project. The hospital should give consideration to the development of an internal process for coordinated project management, development and support
- The commitment to developing EPC processes across the medical centre should continue, building on the considerable amount of activity and knowledge generated from this project in particular areas.
- EPC worked best in units where the knowledge of community referral and services is high and where clients are managed for multiple problems (rather than an exacerbation of one of multiple conditions as may be the case in acute admission units). Therefore it is a recommendation of this project that the medical centre develop a more coordinated approach to the safe referral home of acute, short stay patients.
- The medical centre should consider working with the divisions of general practice to develop a process for the dissemination of information and education to GPs about future EPC and integration initiatives

## 6.4 GPDV

- The role of the GPDV in coordinating the 4 projects was pivotal in maintaining momentum for EPC in the hospitals. Consideration should be given to developing a model for project management of like projects as part of future project funding rounds.

## 6.5 LOCAL DIVISIONS

- Collaboration needs to continue with the A&RMC on a framework for building on the EPC processes developed through this project to maintain the momentum for the development of coordinated discharge planning
- Where they are partners in funded projects the local divisions should continue to take an active role in the project development and dissemination of outcomes.

**SAFE REFERRAL HOME  
PROCESS FOR CARE PLANNING AND CASE CONFERENCING WITH GPs**

**1. DISCHARGE PLAN**

Determine

- Discharge needs
- Community services required.
- Availability of community services, use of PAC etc to bridge time gap
- Would patient needs be best catered for by a case conference or a care plan? (See table)

<b>CARE PLAN</b>	<b>CASE CONFERENCE</b>
A written plan of patient’s future needs where all the care providers are identified and agree what care is provided and by whom. Must involve at least 3 care providers (not counting family member / carer and only 2 Doctors – one usually the GP and the other providing a different type of care)	A formal face-to-face or phone conference involving the GP / relevant hospital staff and relevant community providers for at least 15 minutes. Gives the team members the opportunity to discuss in detail the relevant issues associated with discharge and continuing care needs. Must involve at least 3 care providers (not counting family member / carer and only 2 Doctors – one usually the GP and the other providing a different type of care)

**2. COMMENCE MULTIDISCIPLINARY PLAN DOCUMENT**

- Patient consent – Give patient / carer copy of information brochure
- Plan participants to be determined

**3. SEND FAX TO GP**

- GP involvement in discharge care plan / GP involvement in discharge case conference

**4. ORGANIZE**

CARE PLAN	CASE CONFERENCE
<p><b>FORMULATE CARE PLAN</b></p> <ul style="list-style-type: none"> <li>• Medical staff contact GP and discuss relevant discharge issues and document GP agreement on the plan (this should take about 10 minutes)</li> <li>• Team members to contact appropriate community service providers</li> <li>• Use problem / action list to discuss issues with future service providers</li> </ul> <p>Document in the care plan</p>	<p><b>ORGANIZE CASE CONFERENCE</b></p> <ul style="list-style-type: none"> <li>• Phone GP and other relevant community service providers to organize a mutually convenient time for the conference</li> <li>• Fax to GP (and others) the partially completed “Safe Referral Home Multidisciplinary Care Plan or Case Conference” so that all participants can keep a record of the conversation</li> <li>• Organize room / speaker phone / conference call</li> </ul>

**5. DISCUSS WITH THE PATIENT / CARER**

- When plan completed the team coordinator / “Link Person” should explain to the patient / carer what to expect in the future
- Provide a copy of the plan / case conference summary to the patient

**6. PROVIDE COPIES OF THE PLAN TO**

- GP
- All participants
- Attach relevant medical summaries / referral letters as necessary

# **CONSENT TO PROCEED WITH AN ENHANCED PRIMARY CARE (EPC) DISCHARGE CASE CONFERENCE OR CARE PLAN WITH A GENERAL PRACTITIONER**

## **ISSUES TO BE CONSIDERED BY STAFF**

**The patient should be clearly informed of what is involved in an EPC discharge case conference or care plan and their consent obtained prior to providing this service. The means of obtaining the patient's consent should be consistent with practice in obtaining consent to other medical services and ensure that:**

- Discuss with the patient (or carer if the patient is unable to consent) that you would like to organise a meeting with the hospital staff and their GP (and other community providers if appropriate)**
- Explain the purpose of the meeting. There is a patient information sheet to give to the patient detailing this.**
  - Make sure the patient / carer understands the purpose of the conference, confidentiality issues and that they have the right to specify which information (if any) they request be withheld from other participants**
  - Ask if there is any information that they wish to be withheld from the GP (or other community providers who will be involved in the meeting)**
  - Arrange for them to speak to their GP prior to the case conference if they wish to discuss any information they do not want discussed at the meeting**
- Advise the patient / carer that the GP will bill them for the service in the “usual way”**
  - Record verbal or written consent on the “Discharge Case Conference” proforma.**

*It is often very helpful to reassure the patient / carer that this process will make their transition home smoother and that information discussed with the GP will assist in future management*

For further information contact Lee Stamford (project officer – EPC) on extension 4333

## APPENDIX 2 PATIENT INFORMATION

**Would I Benefit From A Care Plan or a Case Conference?**

**Talk to one of your hospital care team members. If you have a condition that is chronic (eg. arthritis, heart or lung condition or diabetes), and you use or will need other services such as home help, therapy or nursing then you may benefit from this process.**

**Care plans and case conferences help to coordinate the care you receive more effectively – which will help you cope better with your medical condition.**

**Will There be Any Costs to Me?**

**If your GP bulk bills these services are free. If not he or she will charge you a fee for these services and you can claim a Medicare rebate.**

### Further Information



**Lee Stamford**  
Project coordinator  
9496 4333



**Your hospital care team member**

The hospital liaison for this project is Lee Stamford  
Phone 03 9496 4333

Should you require further information you may also contact your GP, or phone the Medicare enquiry line: 13 20 11 for the cost of a local call

**Produced by:**  
**© Lee Stamford**  
**project officer, EPC**

July 2002  
Date for review: October 2002

# ***Involving My GP in My Hospital Care***

CLINICAL SERVICES UNIT

# ***Planning and Discharge Case Conferencing***

INFORMATION FOR PATIENTS  
AND FAMILIES ABOUT  
DISCHARGE SERVICES

## ***Discharge Care***

THE A&RMC & ROYAL TALBOT HOSPITAL ARE PROUD TO BE WORKING WITH GPs TO PROVIDE COORDINATED CARE

### **How is my GP Involved?**

At the Austin & Repatriation Medical Centre we are working hard to provide you with coordinated care and services. Your local doctor (GP) plays an important part in your management, particularly around the time you are ready to leave the medical centre and go home.

The federal Government has introduced a range of services under Medicare, which link your GP in with your hospital care. The hospital will work with GPs so that you receive the best care for your condition.

The unit looking after you will normally send a discharge summary to your regular GP.

However, if you need care or services from a number of other healthcare workers then your GP can participate in a discharge case conference or a care plan with the hospital.

### **What is a Care Plan?**

**A discharge care plan is a written plan of your future care needs. It is based on information from your GP, other workers such as physios, council services, nurses etc and hospital staff. It outlines the care or services you would benefit from after you return home. You will also have input into the plan. Your GP will review the plan at a later**

**stage with you and other service providers involved.**

**You will receive a copy of the plan so that you also have a clear idea of the management of your condition.**

**What is a Discharge Case Conference? At a case conference your hospital team will discuss your current and future care needs with your GP and others who will be involved in your continuing care. Your GP has the choice of either coming into the hospital or using a conference phone for the meeting. The case conference will give your GP and continuing care team a very clear understanding of your situation and will allow him / her to organise and review your care when you return home.**

**YOU MUST GIVE YOUR CONSENT BEFORE A CARE PLAN OR CASE CONFERENCE WITH YOUR GP CAN PROCEED**

**For consent you should:**

- **Be informed of who should participate**
- **Understand the type of information about you and your condition that will be discussed**
- **Consider whether there is any information you DO NOT want to be discussed as part of this process and discuss this with your hospital care team member**
- **Understand that your GP will bill you in the usual manner. A Medicare rebate is payable to you**

**YOU MAY HAVE A COPY OF THE CARE PLAN OR CASE CONFERENCE NOTES. ASK A MEMBER OF YOUR HOSPITAL CARE TEAM IF YOU ARE NOT AUTOMATICALLY OFFERED ONE.**

# Further Information

**If you have any questions contact:**

- **The Unit Manager on your ward**
- **A member of your hospital care team**
- **Lee Stamford, Project Officer, 9496 4333**
  - **Your GP**

**Produced by: © Lee Stamford**

Date produced: February 2002

Date for review: June 2002

# *Involving My GP in a Discharge Case Conference*

Information for patients and families

**At the Austin & Repatriation Medical Centre**

**we are working hard to provide you with  
coordinated care and services.**

**When you leave hospital, your GP will play an**

**important role in working with you to  
continue this care.**

## **What is a Discharge Case Conference?**

**A meeting between your GP, other community professionals and the hospital team to:**

- **Ensure your GP has the most up to date knowledge about your care whilst in hospital**
- **Give your GP the opportunity to discuss aspects of your management with the hospital care team and to make staff aware of any other issues which might impact on your continuing care in the community**
- **To identify supports or services that may be required after you leave hospital**
- **To ensure your GP is aware of any goals or plans that the hospital has made with you, for your ongoing care and management**
  - **To facilitate a smooth transition home**
- **In some cases, to involve your GP in your transition to other care facilities**

**Who would be present at this Discharge Case Conference?  
The participants at the case conference will be members of your hospital care team, your usual GP and other care**

**providers who will be involved in your care after you leave hospital.**

**This may include:**

- **Hospital consultant or registrar**
  - **Social worker**
  - **Physiotherapist**
  - **Community nurse**
- **Team leader or hospital liaison person**
  - **Occupational therapist**
  - **Dietitian**
  - **Community services coordinator**

**How are My Views and Concerns Represented?  
Before the case conference can proceed we must obtain your consent.**

**The case conference organiser will discuss with you who will be involved in the meeting and the type of information that will be discussed.**

**Your GP will discuss the outcomes of the case conference with you at your first visit after leaving hospital. However, you may also choose to be present at the case conference.**

**Discuss this with a member of your hospital care team.**

## About Consent

**You will be asked to agree to the case conference being organised and conducted. Before giving your consent you should:**

- **Understand the purpose of the meeting**
- **Be aware of who will be there and what will be discussed**
- **Consider any information you would like excluded from discussion**
- **Know that the GP will bill you in the normal manner for his / her participation in the case conference**

**Discuss with a member of your hospital care team any other aspects of the case conference which may concern you**



## ENHANCED PRIMARY CARE HOSPITAL DISCHARGE ITEMS FOR GPs

### MULTIDISCIPLINARY DISCHARGE CASE CONFERENCE

#### PARTICIPATING IN A DISCHARGE CASE

#### CONFERENCE MBS ITEM No 768, 771, 773

- A case conference addresses the immediate care needs of a patient being discharged into the community from hospital or a day hospital facility and WHO IS NOT a care recipient in a residential aged care facility
  - The patient has 1 or more chronic medical conditions (lasting or expected to last for 6 months) or a terminal condition and complex care needs
  - The conference may be conducted face-to-face, by a teleconference, video conference or a combination of these
- PRIOR TO PATIENT DISCHARGE**
- At least 3 care providers must be involved. (this may include a GP and another medical practitioner - usually a specialist and with different involvement to GP)
  - The conference discussion assesses previous outcomes/identifies problems /outcomes to be achieved/tasks to be undertaken/responsibilities to be allocated/review plans discussed

#### GP RESPONSIBILITIES

- Ensure patient consent (including billing information) has been obtained
- Must be present for the whole case conference and record time start/finish and other participants' details in patient file (minimum 15 mins for conf).

- Record GP contribution to case conference and other relevant information from the case conference and subsequently record details of treatment/services provided. Discuss with patient.

#### HOSPITAL RESPONSIBILITIES

- Identify suitable patients as early as possible before discharge
- Inform relevant providers/patients/carers about discharge planning
- Obtain and record patient consent to a multidisciplinary discharge care plan or case conference and to involving their usual GP in this service
- Estimate date of discharge as early as possible
- Ensure accurate current GP details are recorded and invite the GP to participate in discharge planning

The A&RMC is using EPC discharge items to actively discharge plan with patients' GPs.  
Local Division of Geriatrics

### MULTIDISCIPLINARY DISCHARGE CARE PLAN

#### PARTICIPATING IN A MULTIDISCIPLINARY

#### DISCHARGE CARE PLAN MBS ITEM No 728

- The patient has 1 or more chronic medical conditions (lasting or expected to last for 6 months) or a terminal condition and complex care needs WHO IS NOT a care recipient in a residential aged care facility
- A multidisciplinary discharge care plan is a written plan addressing the discharge needs of a patient and involves collaboration with at least 3

different care providers (may include the *GP* and 1 other medical practitioner - usually a specialist and with different involvement to *GP*)

- The plan covers assessment (of current and future needs)/management goals (with patient agreement)/arrangements for service provision/review arrangements and is organised **PRIOR TO DISCHARGE**
- Copies of the relevant parts of the plan should be kept by team participants
- The patient should be offered a copy of the completed care plan.

#### **GP RESPONSIBILITIES**

- Ensure patient consent (including billing information) has been obtained
- Discuss patient needs/management/goals/service you will provide with the person preparing the plan
- Contribute in relation to care/treatment/service provision
- Record *GP* contribution to the plan and other relevant information in the patient file - discuss with patient

#### **HOSPITAL RESPONSIBILITIES**

- Identify suitable patients as early as possible before discharge
- Inform relevant providers/patients/carers about discharge planning
- Obtain and record patient consent to a multidisciplinary discharge care plan or case conference and to involving their usual *GP* in this service
- Estimate date of discharge as early as possible
- Ensure accurate current *GP* details are recorded and inviting the *GP* to participate in discharge planning



**SAFE REFERRAL HOME  
ENHANCED PRIMARY CARE  
MULTIDISCIPLINARY CARE PLAN  
OR CASE CONFERENCE**

<b>PATIENT LABEL OR</b>	
Last Name	_____
First Name	_____
UR	_____ DOB _____
Address	_____

For GPs – This document has been prepared by the A&RMC to assist you in the continuing care of your patient. Your participation in this process may qualify as an MBS EPC item. Consult your local division of general practice or the MBS guidelines for further information on EPC item numbers. Care Plan item 728, Case conference item 768/771/773

**DETAILS**

Participating Unit _____ Coordinator _____ Phone _____ Fax _____	GP name _____ Phone _____ Fax _____
This plan faxed to GP on     /     / Phone call follow up to GP: Yes/No   Date   /   / By whom: _____	Out-Patient Appointments: Clinic                             Date   /   / Clinic                             Date   /   / GP                                 Date   /   /

**PARTICIPANTS / SERVICE PROVIDER CONTACT DETAILS POST DISCHARGE**

Discipline	Name	Contact Details

**AUTHORITY / CONSENT TO PROCEED** (To be completed by hospital)

The purpose of this plan has been explained to me / my carer. I/my carer give permission for the preparation of the plan and for the discussion of my medical history, diagnosis with the providers listed above, including my GP.

I/my carer have been asked if any medical/personal information should be withheld from discussion with the participants and this has been taken into account.

I understand that I/my carer may have input into the document.

I am aware that my GP will bill me in the normal manner for his/her participation in the care plan.

SIGNATURE OF PATIENT / CARER / VERBAL \_\_\_\_\_ DATE   /   /

SIGNATURE OF WITNESS \_\_\_\_\_ DATE   /   /

DESIGNATION \_\_\_\_\_

**SUMMARY**

**EXPECTED DISCHARGE DATE   /   /**

**PRINCIPAL DIAGNOSIS AND OTHER SIGNIFICANT HEALTH PROBLEMS**

**MULTIDISCIPLINARY PLAN**

**WRITTEN MEDICAL DISCHARGE SUMMARY: TO FOLLOW / ATTACHED** (circle as appropriate)  
**ALLIED HEALTH LETTER / SUMMARY ATTACHED / TO FOLLOW**

**PATIENT NAME** \_\_\_\_\_

**UR**

**NUMBER** \_\_\_\_\_

**MULTIDISCIPLINARY PLAN**

<b>PROBLEM</b>	<b>GOAL / PLAN OF ACTION / TASK / RECOMMENDATIONS</b>	<b>SERVICE PROVIDER RESPONSIBLE</b>	<b>DATE NOTIFIED DISCUSSED</b>

**INPATIENT SERVICES RECEIVED**

DISCIPLINE	NAME	CONTACT DETAILS
<b>FURTHER COMMENTS</b>		
<b>GP INPUT</b> Care Plan <input type="checkbox"/> Case Conference <input type="checkbox"/> (Time started ..... Time ended.....)		

**COPY OF CARE PLAN GIVEN / SENT TO:**  
 GP  PATIENT  OTHER (specify)





**FAX: GP INVOLVEMENT IN DISCHARGE CARE PLAN**

TO \_\_\_\_\_ FROM \_\_\_\_\_

**FAX NO** \_\_\_\_\_ **FAX** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**NO PAGES** \_\_\_\_\_ **DATE** \_\_\_/\_\_\_/\_\_\_

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Dear Dr. \_\_\_\_\_,

Your patient, M. \_\_\_\_\_, currently on Ward \_\_\_\_\_ will soon be discharged from the A&RMC and has been identified as having complex and chronic discharge needs. The hospital is currently in the process of utilising EPC discharge items to establish more effective discharge planning and communication with GPs and provide patients with coordinated care.

As part of discharge planning we invite your participation in a Discharge Care Plan, to define ongoing care needs and management.

As part of this process, we will

- ◆ Provide you with a copy of the care plan for your consideration and input prior to discharge.
- ◆ The care plan will contain details of patient consent to the process
- ◆ Provide contact details of the treating team and of their involvement with the patient’s care needs.
- ◆ Provide you with additional information that may assist you in the management of your patient.
- ◆ A member of the hospital team will telephone you to discuss your input into the continuing management of your patient.

We look forward to working with you in the future.

Thankyou

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Using the MBS EPC items, GPs are now able to claim reimbursement for involvement in discharge care planning (MBS Item 728). The information in this fax is confidential and intended for the nominated recipient only. Discharge case conferencing and care planning at the A&RMC is facilitated by Lee Stamford, project worker, and Dr. Jenny Bocquet, GPLO EPC. They can be contacted on 9496 4333.



**FAX REQUEST FOR GP INVOLVEMENT IN DISCHARGE CASE CONFERENCE**

TO \_\_\_\_\_ FROM \_\_\_\_\_

**FAX NO** \_\_\_\_\_ **DATE** \_\_\_ / \_\_\_ / \_\_\_

**NO PAGES** \_\_\_\_\_

Dear Dr. \_\_\_\_\_,

M. \_\_\_\_\_ is currently an inpatient at the A&RMC and has nominated you as the regular GP. As part of discharge planning we invite your participation in a Discharge Case Conference, to discuss ongoing care needs and management.

The hospital will obtain patient consent as outlined in the MBS guide. This and details of the conference participants will be provided to you at the time of your involvement.

We would welcome your participation in the case conference, either in person or by phone at a mutually agreeable time for all participants. It is envisaged that it will take 15 to 30 minutes. A member of the hospital care team will ring your practice to arrange an appointment time should you be interested in participating in this forum.

Using the MBS EPC items, GPs and certain types of consultants are now able to claim reimbursement for involvement in case conferencing and care planning.

The A&RMC and the associated divisions of general practice will provide you with further information when the case conference is being more formally organised.

Please return phone or fax your reply to:

Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

The information in this fax is confidential and intended for the nominated recipient only. Discharge case conferencing and care planning at the A&RMC is facilitated by Lee Stamford, project worker, and Dr. Jenny Bocquet, GPLO EPC. They can be contacted on 9496 4333.

## APPENDIX 5 - CASE STUDIES

### Mr E.L.

**Mr E.L. is an 89 year old gentleman with multiple medical and mobility problems. He lives with his wife in their own home. His wife is also elderly but remains the main carer. The couple have (some) local council supports – home help and personal care weekly. These had been organised by the medical centre on previous admissions. Mr E.L.'s GP had regular contact with this couple but had not been given the opportunity to be involved in Mr E.L.'s plan of care until this admission.**

Mr E.L. was admitted in April 2002

- Diagnosis of urinary retention / CCF / MRSA Sepsis
  - 7 admissions in past 18 months
  - Wanted to stay at home with wife
  - Admitted for rehabilitation in May
    - Discharged home in July

**The discharge coordinator wanted to keep Mr E.L. safely at home for as long as possible (as per Mr E.L.'s wishes) but was unsure of how to actively involve the GP. Mr E.L.'s discharge needs were complex and the support services arranged to assist this couple to live at home were now greatly increased.**

An EPC discharge care plan was commenced. The discharge coordinator originally offered the GP a case conference, however the GP opted for a discharge care plan. (It was easier in this case for the GP to be involved through fax and a series of shorter phone calls than in a structured case conference). Discharge coordinator decided to use the EPC discharge process to assist the GP to coordinate services.

### THE PROCESS

- The discharge coordinator arranged a meeting with all of the community service providers to construct a plan of care for Mr E.L.
- The discharge coordinator and the registrar developed the future medical management plan. The registrar discussed options for care with the GP and the GP agreed to assist Mr E.L. and his wife to remain at home for as long as possible.
- The discharge coordinator faxed the care plan to the GP and followed up with a phone call to discuss Mr E.L.'s plan for the future.

Mr E.L. was transferred home in July 2002 with regular GP follow up (hospital back up if needed) and coordinated support services. He is currently awaiting linkages funding for case management. At the time of this report (November 2002), Mr E.L. has remained out of hospital since his transfer home. The hospital team, given Mr E.L.'s complexity, did not expect this.

## **FOLLOW UP SURVEY**

- **Patient comments**
  - **Happy to be home**
  - **Feels very well looked after**
  - **Good relationship with GP**
  
- **GP Comments**
  - **Impressed by degree of patient work up for discharge**
  - **Confident that information from hospital was appropriate. The information was much more comprehensive than the usual**
  - **No problems with involvement in future care plans**
  - **Prefers care plan to case conference due to time commitment and need to be available at a specific time.**
  - **No problems with HIC billing but needed to get extra information about the hospital discharge item numbers from the EPC project team first**
  
- **Hospital Staff Comments**
  - **Case conference would have been more efficient for them (hindsight), however the response and the cooperation of all the team members in supporting Mr E.L. gave the process credibility**
  - **The response of the GP exceeded hospital staff expectations**
  - **The doctor to doctor contact was integral in gaining GP commitment**
  - **GP has hospital back up but not using it**

In Mr E.L.'s case, the care plan was used to both educate the GP about future medical management strategies and to provide all continuing support team members with a network for communication. The GP was able to provide additional input through his knowledge of the patient's family to ensure that services organised were appropriate.

Mr E.L. is currently very well maintained at home.

## **MISS A.B.**

Miss A.B. is a 19 year old student who suffered a brain injury, and required continuing assistance with all activities of daily living. Discharge was problematic for several reasons:

- She lived out of the usual A&RMC catchment area and therefore the staff were less well informed of community support services in the area
- She required assistance with all activities of daily living
- She was originally assessed as low level residential care classification.
- Her parents were reluctant to place their daughter in a residential care facility
- She was awaiting a place in a slow to recover rehabilitation facility.

The ward staff organised a family meeting with Miss A.B.'s parents and the GP was invited. The GP came in to the meeting (about an hour's drive from his practice), was able to support the family and suggest ways in which community support services might be accessed and coordinated to assist the family to look after Miss A.B. at home until a rehabilitation place became available. The family meeting lasted approximately 1 hour.

Miss A.B. was transferred home once the appropriate services were set up. The GP was unable to access the EPC discharge case conferencing item number (773) for his services in this case. The GP assisted the hospital team by supporting the family and locating future services for this young lady. The GP coordinated a community EPC care plan for Miss A.B. on her transfer home.

## **MS G.B.**

Miss G.B. is a 28 year old woman admitted with a diagnosis of postnatal depression. She has a 15 month old baby and lives at home with her partner. Prior to this admission, Ms G.B. was under the care of a psychiatrist and a GP. She also saw the maternal child health nurse and received assistance from a psychiatry day care worker.

Prior to Ms G.B.'s referral back to community care, the treating unit organised a discharge case conference. (The unit often organised discharge case conferences to fully inform the main continuing care providers, but did not regularly use the EPC item numbers to facilitate the participation of community medical care providers.)

The EPC project team assisted with case conference organization. The private psychiatrist, representatives from the Department of Community child protection services, the psychiatric day care worker and the maternal and child health nurse came in and the GP was present by phone.

Feedback from the hospital staff was positive. There was good exchange of information between the hospital and continuing care providers. The private psychiatrist and the GP were fully informed about the future care strategies for this woman, and the GP was confident he was now aware of all the issues involved in this woman's care. (Previously, he was not aware of the supports this woman received).

The case conference worked to ensure that all the community care providers and the client had the same information and were able to work together to assist the client to remain in the community with her family.

The GP successfully claimed for his participation under the MBS guidelines. The psychiatrist however had her claim rejected by the HIC. This was due to a problem with the computer recognising 2 similar claims for the same client on the same day and the psychiatrist has subsequently received payment for her participation in a discharge case conference.



# NOTIFICATION OF ADMISSION SURVEY OF GPs IN THE NORTHERN AND NORTH EAST VALLEY DIVISIONS OF GENERAL PRACTICE

**JUNE 2002**

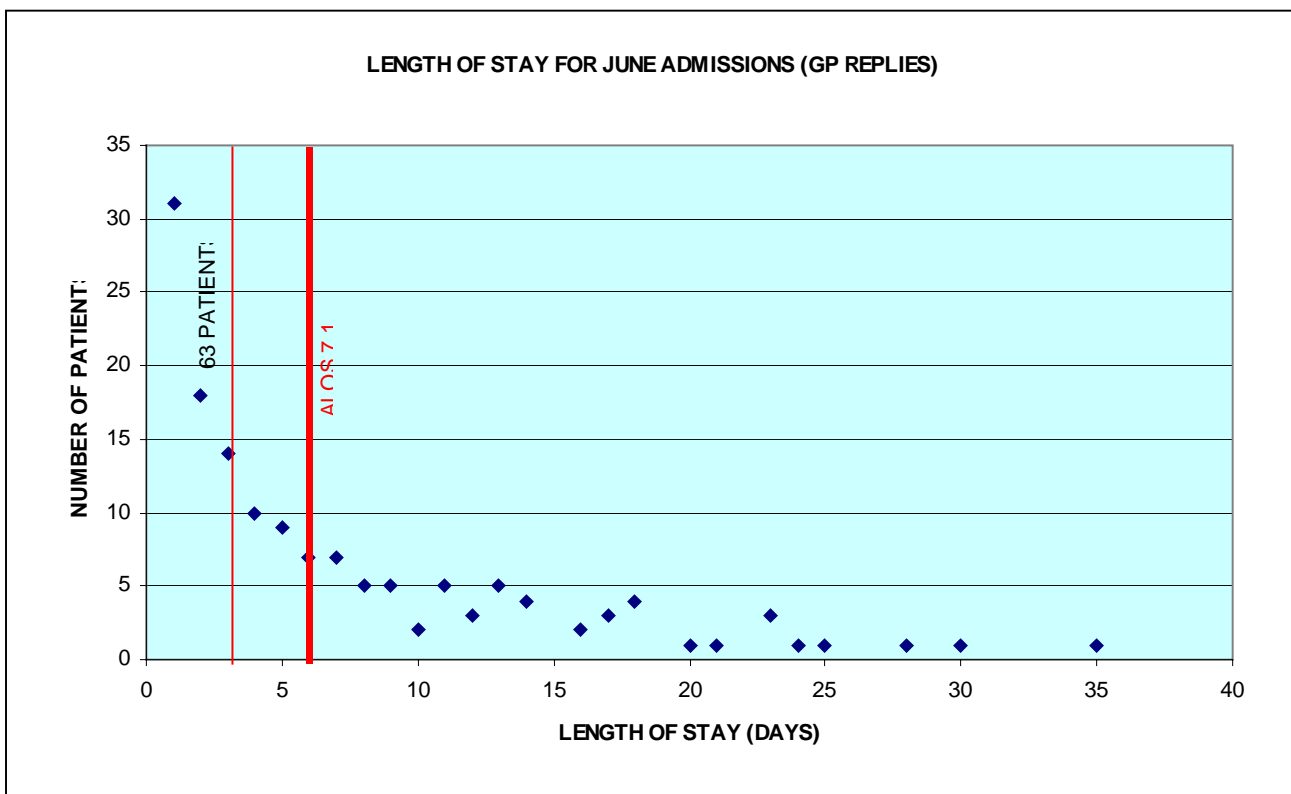
For the month of June, GPs in the NDGP and NEVDGP were sent additional information with the usual notification of admission.

GPs were offered the opportunity to care plan / case conference with the hospital and to fax back their indication to do so. Response was overwhelming and raised GP expectations beyond the EPC project team’s capacity.

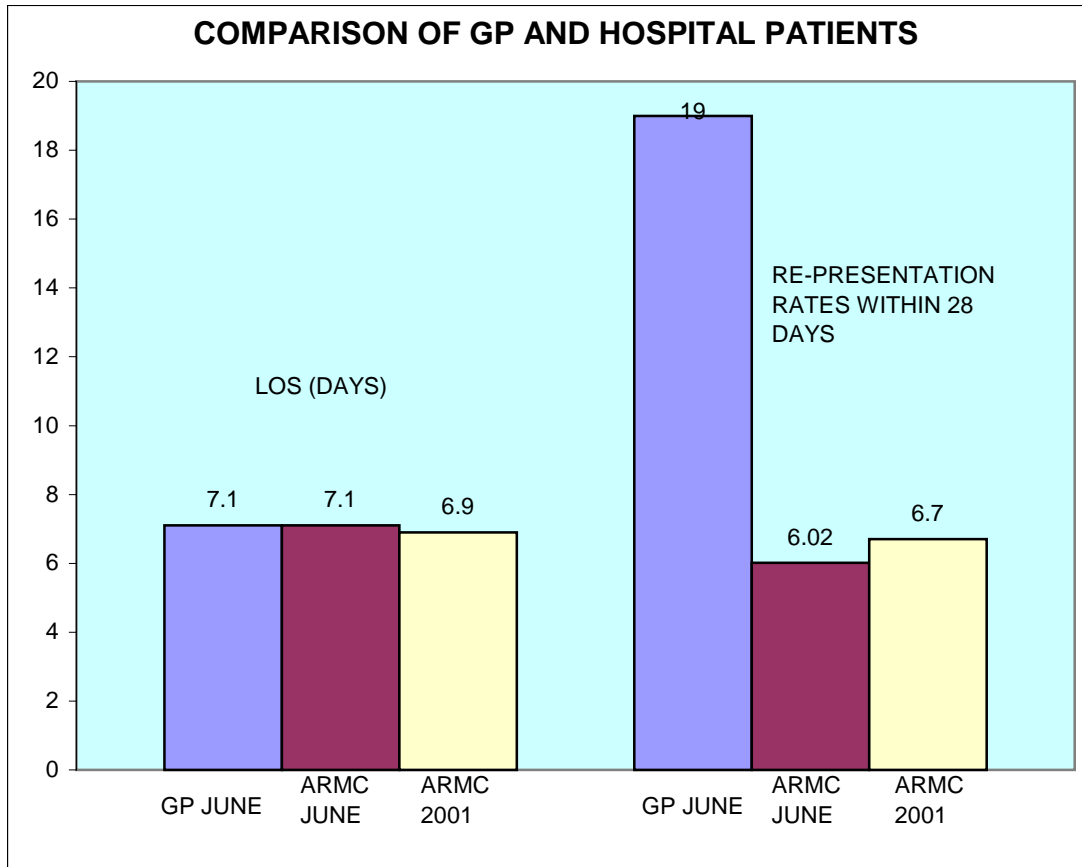
**RESULTS:**

Response from 82 GPs for 128 patients {representing approximately 34% of June admissions (for GPs in the divisions)}

- Each patient was followed up through the HMO / registrar / NUM to highlight the need to liaise with GPs. This had varying success according to the length of stay of the patient.
- All GPs responding were sent additional information relating to the EPC hospital discharge items specifically
- Additional findings are that 92% GPs will negotiate a home visit in the first week post discharge as part of the care plan
- 90% of GPs are willing to bulk bill for hospital EPC items
- From the survey we were also able to look at the type of patient the GP was flagging and while most of the patients fitted in to the longer stay category, there was a group at the short stay end (ALOS to 3 days) which were worth looking into.



- 63 patients were admitted for a length of stay up to 3 days. (excluding day patients, renal, day oncology, psych). Of these patients, in the following month, 12 were admitted to A&E for 4 or more hours (2 represented twice). We are still looking into the possible reasons why, but these figures may indicate that GPs are able to recognize the more complex patients. We feel that a revised system of notification of admission may be worth pursuing here.



## **APPENDIX 7**

### **ABSTRACT FOR PRESENTATION AT ARCHI WORKSHOP AUGUST 29, 2002**

#### **OVERVIEW OF THE EPC PROJECT AT THE AUSTIN & REPATRIATION MEDICAL CENTRE**

##### **RECOMMENDATIONS FOR PROCESS OF IMPLEMENTATION REVIEW OF CARE PLANS AND CASE CONFERENCES TO DATE**

**Dr. Jenny Bocquet, GPLO and Lee Stamford, Project Worker**

The Austin & Repatriation Medical Centre is one of four centres in Victoria involved in a formal project aimed at the introduction of EPC discharge processes into hospital practice. The project is funded jointly by the Department of Health and Aging and the Department of Human Services for 12 months and is due to wind up in November 2002.

The project has had varying degrees of success. In the sub-acute areas, there is already a culture of organising community care and liaising with external services. These areas have been generally receptive to the idea of formal liaison with general practitioners but have been reluctant to change current practice to accommodate EPC into discharge systems. In the acute areas, the pace of admission and discharge or referral on seems faster and staff have received the idea of EPC with little enthusiasm. Finding the “champions” among the staffing groups was the first hurdle, but to get more cooperation the project team needed to provide full support and hard evidence for the need for change. As well, like all large organizations, there are many projects happening at the same time and staff tended to confuse one with the other.

The key factors in making EPC inroads have been

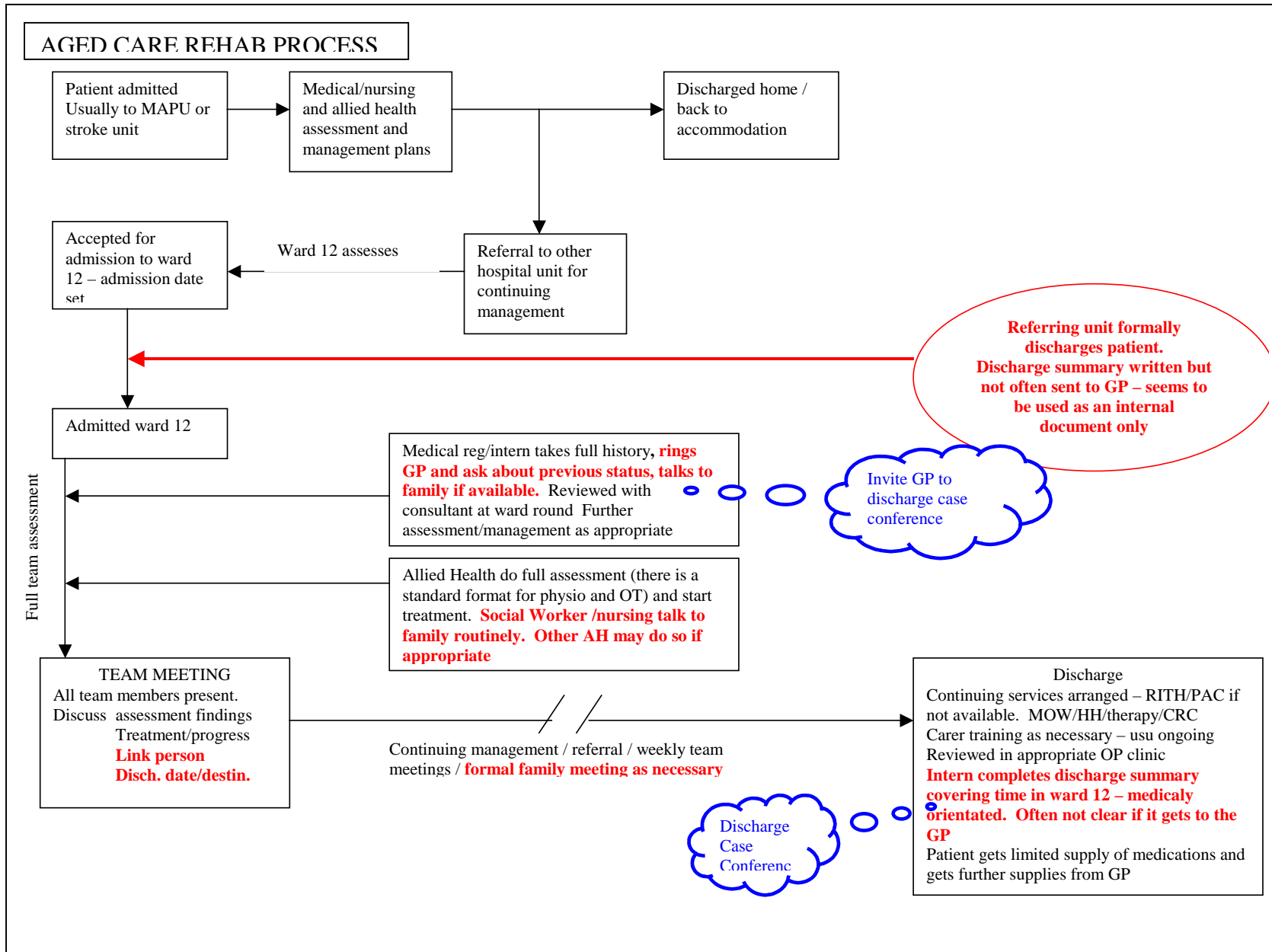
- Understanding the current ward / unit practices and finding areas for improvement based on the benefits to the ward / unit and the patient – not the GP! Look at the micro system/s. Most staff have a really good understanding of what goes on in their particular part of the process.
- Data collection, understanding and making this meaningful to the staff so that they can see the need for improvement and then see the results
- Pursuing spin offs that will assist the primary care cause in the hospital generally. The spin offs may not directly relate to the EPC project but do improve the quality of the information getting out to GPs
- Challenge the folklore – follow up on statements / comments and produce evidence for change
- Report your findings and results appropriately in the appropriate forum

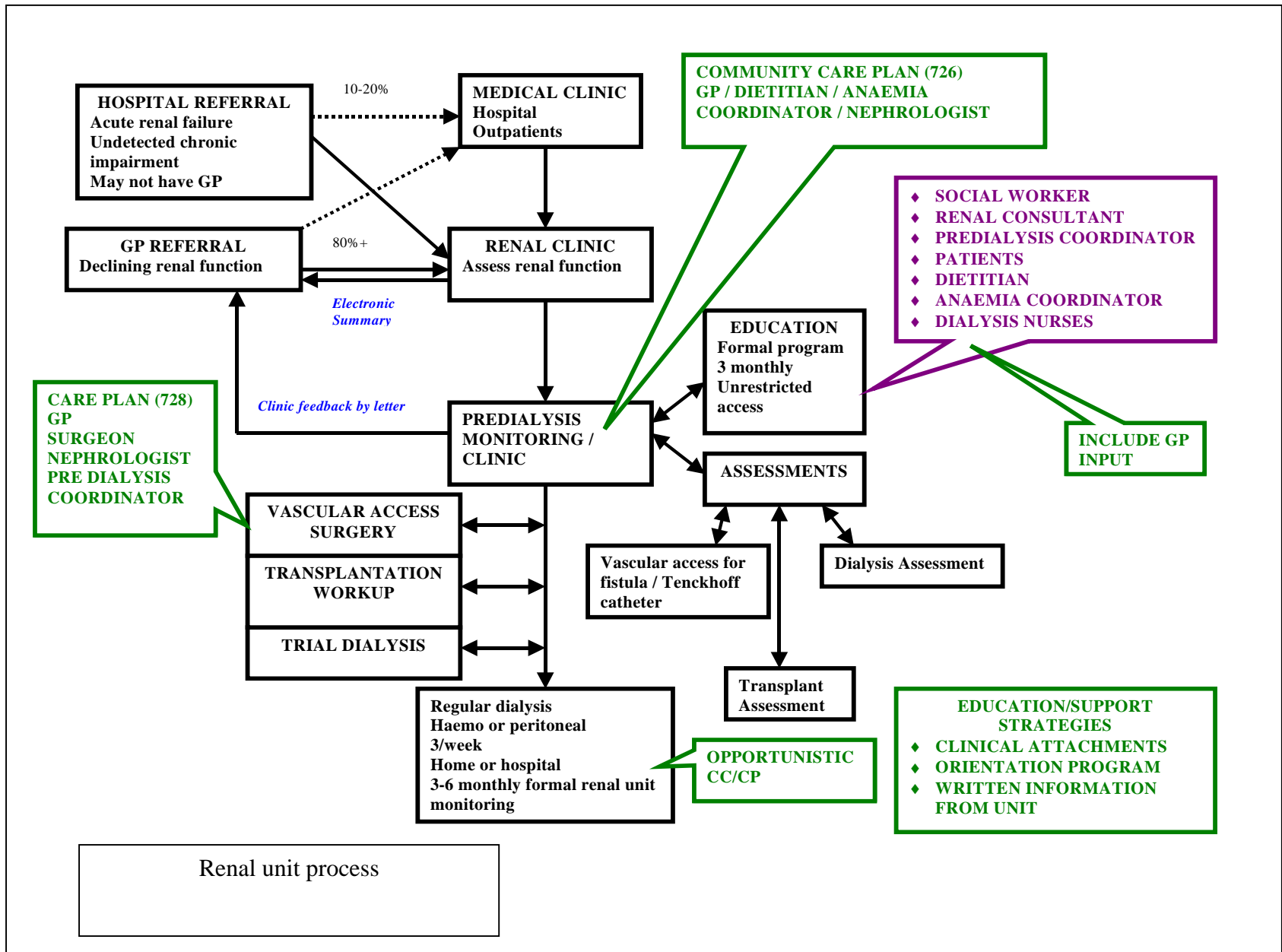
To date we have attempted 12 case conferences and 53 care plans. Most of these have been achieved in the last 2 months as the project team worked to make the process as user friendly in each area as possible. The areas using the process are not yet independent. Each EPC based activity has been followed up by questionnaire or interview and file audits have been completed. When the process runs smoothly the staff and GPs are overwhelmingly positive about the process, but the organization of

case conferences is still problematic, and with care plans, compliance with the item number descriptors can be challenging.

This presentation is designed to illustrate the processes used, the way that simple data collection has demonstrated the need for further work and will provide a review of the EPC activity to date.

# APPENDIX 8 – SAMPLE MAPPING





**BANKSIA HOUSE ADMISSION / DISCHARGE PATHWAY  
MOTHER & BABY (M&B) AND MOOD & EATING DISORDERS (M&ED)**

