Enhancing Hospital & GP
Linkages in Discharge Planning

A JOINT INITIATIVE BETWEEN
CENTRAL GIPPSLAND HEALTH SERVICE
AND
THE EAST GIPPSLAND DIVISION OF GENERAL PRACTICE

Jointly funded by the Department of Health and Ageing
and the
Victorian Department of Human Services

ENHANCED PRIMARY CARE
HOSPITAL DEMONSTRATION PROJECTS

FINAL REPORT

February 03

Project Manager: Rob Herni
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Executive Summary

Central Gippsland Health Service (CGHS) in partnership with the **East Gippsland Division of General Practice (EGDGP)** commenced the Enhanced Primary Care (EPC) Hospital Demonstration Project in February 2002, to conclude in February 2003. The project team consisted of 2 part time Project Workers, with support from the EGDGP project worker, (EFT.2).

The project generally achieved the aims of the project as stated in the funding submission which were to:

- **maximise the take up of the new EPC Medicare Benefits items**
- **improve linkages between GPs and Hospitals**
- **increase GP involvement in discharge planning and care coordination**
- **achieve better outcomes for patients with chronic and complex conditions**

This project will assist in meeting needs particular to the Wellington region, a large rural area serviced by a range of centralised services, with outreach to isolated areas. An invitation to be involved in the project was made to all GPs within the EGDGP.

This project builds on CGHS improvements to their discharge processes that will ensure a smooth, timely and safe transition from hospital to home with the adoption of effective models of care which enhance communication between acute and community care providers.

The project has enhanced the already sound relationship between CGHS with Wellington and East Gippsland Shire based GPs. GPs were generally enthusiastic about collaborative discharge planning with CGHS, (a practice of long standing with staff of the Community Care Services sector for clients with chronic and complex needs), but somewhat reticent about the practice of claiming EPC Medicare Benefits Scheme (MBS) items for such services.

EPC MBS item uptakes have not significantly increased in the Wellington/East Gippsland area, with few GPs claiming the items. It is believed that this will change with the roll out of effective discharge planning strategies and the position of the dedicated discharge planner. The new Discharge Planning Coordinator will coordinate communication between the GP and the Hospital on behalf of the client and assist in presenting discharge and care conferencing documentation conducive to claiming EPC MBS items.

GPs have welcomed the many CGHS initiatives aimed at assisting in the admission and discharge processes, especially:

- The increased level of awareness of the importance of the GP in the patient discharge planning process for patients with chronic and complex conditions
- The improved communication between Hospital and GP
- The introduction of the GP identification card
- The "your patient in hospital" admission advice
- Standardised formats for discharge plans and case management
- Patient advice literature, GP EPC education materials
- The standardised electronic discharge summary
- Production of proformas which are GP-friendly to use

The project outcomes relied heavily on the active participation of the EGDGP and their role in the education of members of that division, including the staging of lunchtime educational meetings with GPs at their clinics. These meetings and the education of the GP through this process were not successful, as the EGDGP was not able to provide the staff or make the appointments as planned.

The project team consequently provided much of the education material in written format and conducted an evening dinner and EPC forum for Wellington based GPs, their clinic managers and relevant CGHS staff. The project team brought together CGHS staff to fully brief them on the aims and objectives of both the Effective Discharge Planning and Enhanced Primary Care Demonstration

projects. This meeting invited attendees to speak about their roles within CGHS and proved pivotal to the success of both projects
Central Gippsland Health Service has an enviable record in communicating with GPs and other Health Professionals. The EPC project has provided the tools to further enhance the process of communication and together with the appointment of a dedicated Discharge Planning Coordinator will do much to further improve patient care at CGHS.

CGHS is committed to the practice of Effective Discharge Planning and has demonstrated this commitment by the appointment of a dedicated Discharge Planning Coordinator. This appointment, together with the written discharge planning procedures now in place, will ensure that the uptake of EPC MBS items by GPs involved in the discharge and case conferencing of their clients will increase over the next 6 months. The project time period of 12 months is insufficient to adopt change in the processes in a large organisation and especially when considering the enormous geographic area in question.

Aims and Objectives of the Project

In the original funding submission these were stated as such:

> "To maximise the take up of the new EPC Medicare Benefits items, to improve linkages between GPs and hospitals, increasing GP involvement in discharge planning and care coordination and achieving better outcomes for patients with chronic and complex conditions."

Through the project, CGHS and EGDGP objectives were to:

- Build more coordinated working relationships between CGHS, the EGDGP, Wellington GPs and community service providers
- Develop a new streamlined system incorporating Care Planning, Case Conferencing and discharge systems. This will complement current discharge planning projects
- Develop and implement an educational process regarding appropriate use of EPC items, via sessions held at GP Clinics and workshops with other service providers
- Increase information provided to GPs on patient admission to Acute services
- Work with patients and families to inform them and involve them in the project, with a view to improving health outcomes
- Increase GP involvement in discharge planning by developing meeting options including teleconferencing and electronic information
- Evaluate and provide reports for project outcomes
- Ensure sustainable processes to ensure ongoing improved linkages between CGHS and GPs for patients with chronic and complex conditions
- Provide a comprehensive report to assist other services to implement similar systems

Project Steering Committee

At the commencement of the project a steering committee was formed to oversee the progress and provide assistance where necessary. The committee membership included representatives from all stakeholder groups across the organisations involved.

Terms of Reference:

Goal:

The goal of the Steering Committee will be to provide guidance, support and active involvement in the development, implementation and evaluation of the project.

Objectives:

1. To ensure that the project addresses the project goals and objectives.
2. To strategically explore project activities.
3. To provide input into decision making relating to achievable outcomes.
4. To provide advice to the project in relation to targets and linkages.
5. To explore future funding options.

Membership:

The Steering Committee comprises:-

- Leona Mann – CEO, CGHS
- John Lewis – EO, EGDGP
- Sarah Roberts – Project Officer, EGDGP
- Dr David Monash – Chairman EGDGP
- Helen McAdam – CGHS Director, Community Care Services
- Denise Bromiley – WPCPG
- June Maxfield – CGHS Community Care Services
- Ros Hunter – CGHS Director, Clinical Services- Nursing
- Dr Michael Langford – CGHS Director, Medical Services- Medical
- Wendy Harwood – Nurse Manager, Patient Services
- Dr Iain Miller – Surgeon

In Attendance

- Rob Herni – Project Manager
- Carol Barker – Project Officer, Discharge Liaison Officer

Meeting Procedures

Quorum: a Quorum will be 5.

Chairperson: The Chairperson nominated and elected by the Steering Committee is John Lewis.

Meeting Times/Dates and Venue: To be conducted at 12 Noon, on the 3rd Friday of each month, in the Boardroom of CGHS.

Meeting Papers: Will be forwarded to the Chair 10 working days before the scheduled meeting for distribution to Committee members 5 working days prior to the meeting.

Business Processes:

The Steering Committee will conduct its business via:

- Face to face business on a regular basis
- Special meetings relating to an issue which has been identified as requiring Steering Committee input
- Teleconference
- Access to a documented report by the project manager

Tenure of the Steering Committee:

Tenure of the Steering committee will be for the duration of the project, currently funded for October 2001 to October 2002

Work Plan for Project Design and Implementation of Enhanced Hospital Discharge Planning and GP Linkages

This Work Plan outlines the:-

Project Management Structure,
Operational Framework, including Operational Policies, Protocols and Processes
The change management framework including the education, communication and planning strategies.
Priorities and Timelines. A – completed by 31 May 02, B – completed by 2 August 02, C – completed by 30 October 02

Work Item	**Priority**	**Completion Date**
Project Management Structure		
Project Management Group: • Prepare documentation for and develop Terms of Reference • Prepare documentation for the development of meeting procedures, meeting schedules and conflict resolution processes • Identify and track funding levels and ongoing key stakeholder support. • Prepare Hospital/GP Service Linkage Protocols • Provide written progress reports to the management group on monthly basis.	A A A A	Completed Completed Completed Completed Completed
Steering Committee: • Prepare the Terms of Reference • Prepare the meeting procedures, meeting schedules and conflict resolution • Provide written progress reports to the Project Management Group	A A	Completed Completed Completed
Operational Framework: 1. Develop Operational Policies, Protocols and Processes 2. Develop Service Delivery Model **3.** Develop Information Management/Communication Strategy Plan	B B B	Completed Completed Completed
Develop Operational Policies, Protocols and Processes • Produce a flow chart of the existing Intake/Discharge Protocols. • Produce service provider questionnaire to determine content of discharge plan. • Review and revise intake documentation. Note future requirements of both the project outcomes and BATS initiatives. • Identify opportunities to improve the relationship between intake/ward staff and internal/external service providers, inc GP's • Develop protocols ensuring adherence to established and proposed policies. • Develop processes to incorporate care planning and care conferencing.	A A A – B A – B A B	}Not }proceeded with Completed Completed Completed Completed
Develop Service Delivery Model • Produce a flow chart of proposed Intake /Discharge model. • Develop Intake Checklist in consultation with staff. • Identify and recommend HR requirements.	B B B	Completed Completed Completed

Develop Information Management/Communication Strategy Plan		
• Identify and recommend electronic communication options, including IM/IT currently available and adaptable to the project. • Develop proformas for patient information transfer	A A	Completed. Completed.
Change Management Frame Work		
Develop education strategy • Produce Project Information material for Hospital Staff, Patients, Carers, VMO's and GP's. • Develop Staff Information Session, formal and informal • Develop satisfaction questionnaire for patients and carers	B B B	Completed Completed Due for completion mid 2003
Develop and Implement Communication Strategy • Letters to all GP's on GPR • Personal visits to relevant GP Practices • Briefing sessions with all ward staff and outreached locations. • Briefing sessions with community providers, possibly in forum format. • Produce information letters to all admitted patients, explaining discharge and confidentiality requirements.	A A A A A	Completed Completed Completed Completed W in P- linked to PCP

Actions Taken & Outcomes

1. Nominated Doctor Advice Card

Throughout the project it became evident that in order to improve and facilitate communication with the GP and to ensure the accurate collection of GP information by hospital patient admitting staff, it was necessary for the patient to identify their GP.

Whilst the question of a patient not being able to identify his/her GP was not a major problem for CGHS patients (as in Metro Regions) it nevertheless made the task of admitting a patient and advising the GP of that patient's admission, more difficult.
It was found that:

- GP details needed to be collected and verified as correct,
- There are a number of patients without an identified GP (attend Clinics),
- The profile of the GP could be raised,
- The value of the role of the GP could be raised in the treatment and discharge of the patient.

This project provided an excellent opportunity to promote the "My Nominated Doctor" concept.

Refer to Attachment 1

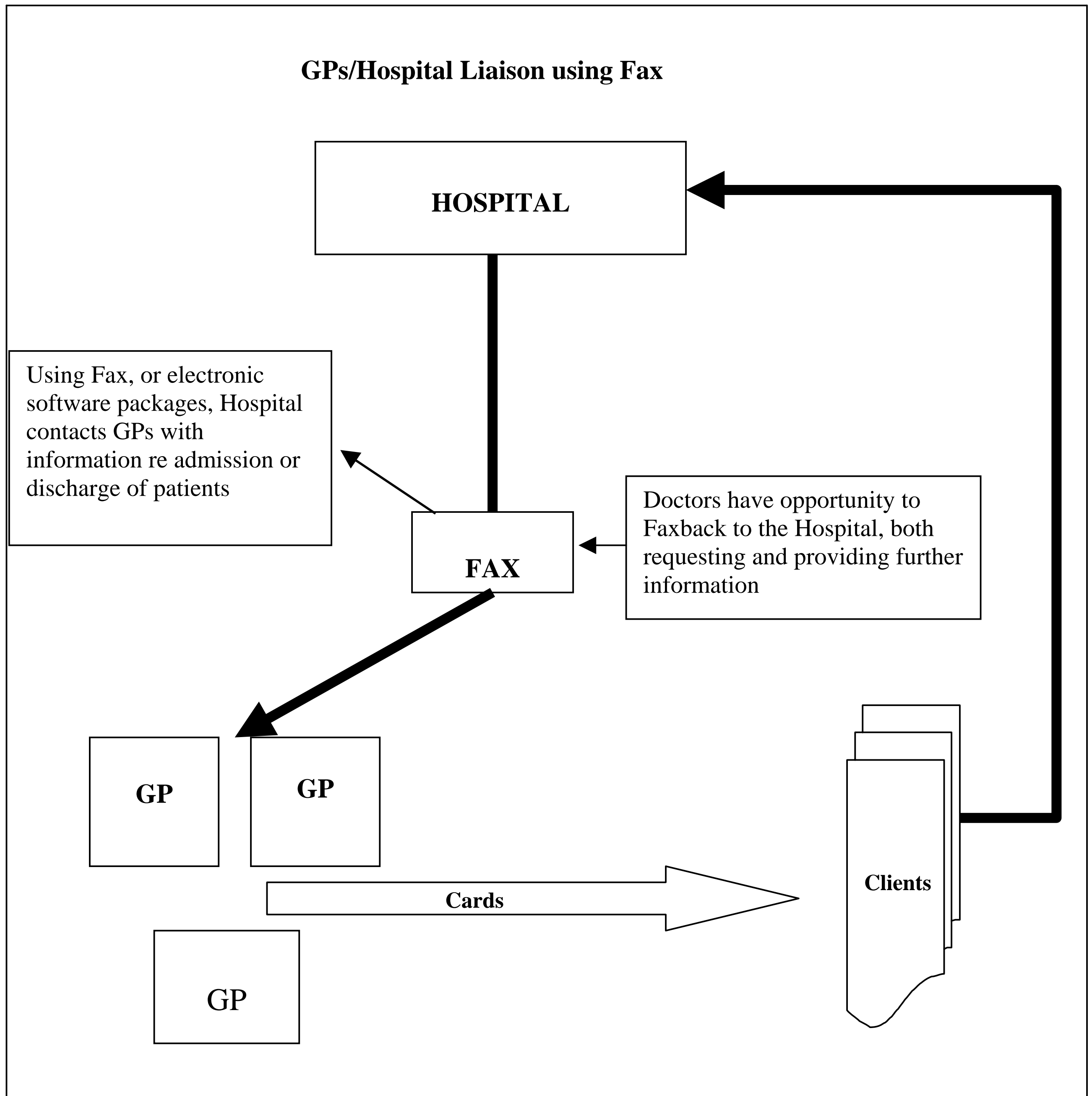
The project team embarked on the following:

- Provision of 500 "Nominated Doctor Advice Cards"(NDA), for each GP in the EGDGP register
- Production of leaflets explaining the EPC hospital discharge MBS items available to GPs
- Mailing of letters explaining the purpose of the NDA card
- Development of a Flow Chart depicting the process
- Provision of education for the Admission clerk
- Redesign of the admission pro forma to make the identification of the GP a mandatory field
- Organisation of print media releases explaining the NDA card and the necessity of being able to nominate a GP
- Improvement of the profile of the GP in the hospital.

The desired outcome of this initiative is the "your patient has been admitted to CGHS", which is now faxed to the nominated GP on the admission of a patient.

Refer to Attachment 2

NDA Card Use Flowchart



Hospital Admission Process

- A more streamlined process for admitting patients to hospital was devised and now operates well within CGHS.

Refer to Attachment 3

2. Project Media Coverage & Public Awareness

The EPC project group identified a number of problems that could be addressed by both Media Releases and the production of Patient **Information Pamphlets**.

The pamphlets are:

- "Involving my GP in my Hospital Care"
- "Involving my GP in a Discharge Case Conference"

The media releases focused on the local print media in East Gippsland Shire, Wellington Shire and Latrobe City, coinciding with the issuing of Doctor Advice Cards to all medical clinics in the region. This article received front-page placement in some of the region's papers and explained the purpose of the card in the improvement of patient care.

Both are designed to provide information and encouragement to the patient or their families to seek more information during and following a hospital admission.

Refer to Attachment 4a & 4b

The Nominated Doctors Advice cards, the EPC Hospital Discharge Items for GPs and the information pamphlets were distributed to Doctors and Clinics. Members of the project team attended this in the Wellington region and members of the GP divisional staff carried out in the East Gippsland Region.

Where possible, education in the use of the above was conducted.

3. Doctor Awareness of the EPC MBS Items

Information was provided to GPs in print form, supported with a campaign by the EGDGP to meet with and provide education to the GP and Clinic managers during their regular clinic meetings or during their lunch hours. This campaign did not achieve its outcome.

A Dinner meeting at Powerscourt Guest House, together with a professional presenter presiding over a "Hypothetical" proved more successful, but was still only attended by 5-6 GPs. The relevant hospital staff normally involved in the discharge process including the newly appointed Discharge Planning Coordinator (by any other name) provided a most enlightening overview of the discharge process and the roles GPs are expected to provide in the post hospital care of their patients. Very clearly, the process of claiming MBS items for their role in the Discharge Planning and Case Conferencing process was not very high on their agenda.

Improved Discharge Summaries and Case Conferencing proformas, together with early notification of the meeting, agenda of the meeting and limiting the time of the meeting will assist the GP in their endeavours to participate. Discussions with GPs and clinic managers have all indicated their desires to participate in such meetings.

The outcome of these initiatives is the recognition of the availability of the MBS items and the willingness to take up the items when presented in a "easy to use format" by the CGHS discharge planning coordinator.

4. Charging the EPC MBS Items

The project steering committee discussed the need for patients to be prepared for discharge planning and case conferences, but generally objected to the notion that fees would be discussed by the treating hospital staff. The EGDGP undertook to address this issue and ensure that all discharge planning meetings and case conferences would be bulk billed by the participating GPs. **This would mean "no cost" to the patient.**

We reported early in the project that the ability of GPs to charge for their time in participating in these processes was not being taken up. This has not changed and whilst a number of case conferences have

taken place (mainly by the CGHS community services department) only a few GPs have charged the eligible MBS items for their participation.

Outcome:

The appointment of a dedicated Discharge Planning Coordinator and this person's ability to track the patient through the admission, treatment and post discharge procedures, together with the availability of well designed proformas will see a marked increase in the take up of MBS items by members of the EGDGP.

5. Development of Proformas

A range of new proformas was developed for use within the hospital to assist with organisation of care planning and case conferencing with the GP's.

Refer to Attachments 5a-f

Key Learnings

- **Relationships between CGHS and GPs in the Wellington area generally very good.**
- **Acute wards routinely discuss discharge with the relevant GPs.**
- **GPs generally respond well to the requests for assistance/input into discharging planning for their patients.**
- **GPs generally do not charge for their time in discharge planning and case conferencing however, they will take up the items if the discharge planning coordinator presents the paperwork in easy to use format.**
- **The use of the Nominated Doctor Advice card served to improve relationships between all GPs and the health services in the Wellington and East Gippsland Shires.**
- **GPs with admitting rights to CGHS are often not eligible to charge the MBS Items.**
- **Doctors have welcomed the "your patient admitted advice" form, now routinely faxed on patient admission.**
- **Doctors approve of the discharge summary presented in electronic format.**
- **Doctors are not easily accessed for educational purposes.**
- **Doctors require all written material in single page format.**
- **Acute care staff does not need the burden of more paperwork.**
- **Hospital staff should not be expected to "sell" discharge planning to patients where there are costs applicable.**
- **Acute care staff believes the liaison/communication with GPs is good.**

Summary

Effective Discharge Planning Links to GP Linkages

The project team has revised the CGHS Policy and Procedures to ensure:

- that the option of communication with the GP from early patient admission advice to case conferencing are clearly the responsibility of the Discharge Planning Coordinator.
- that patients with complex and chronic care needs are identified early and that their possible post discharge care and discharge date are communicated early to the community providers, including the patients GP.
- that the computer generated discharge summary is meaningful, comprehensive and received in a timely manner by the GP.
- that the carers and family of patients are involved or are given the opportunity to be involved in the discharge process.

How the Discharge Planning Coordinator provides the links between GP and CGHS

- The appointment of the dedicated discharge planner will provide a constant conduit between the hospital and the GP.
- The Discharge Planning Coordinator will provide the GP with early advice re discharge plans and the need for care plans.
- The Discharge Planning Coordinator will provide the GP with the paperwork necessary to substantiate and identify the MBS items to be claimed.
- This paperwork will represent auditable "proof of participation" in the discharge plan or case conference.
- The Discharge Planning Coordinator will arrange the discharge planning meetings and Case Conferences in consultation with the clinic managers to ensure optimum effort for the GPs time inputs.
- The Discharge Planning Coordinator will ensure that all paperwork necessary for the meetings are prepared and in place in a timely manner.
- The Discharge Planning Coordinator will explain to the patient, carers and family the purpose of the meetings.

Conclusions

Major Achievements:

- Improved communication with GPs
    - Generation of some Care plans – including plans not claimed as MBS items
    - Development of the "Nominated Doctor Advice" Card
    - Introduction of the "Patient Admission Advice"
    - Introduction of the "Patient Discharge Notice"
    - Improved Discharge Planning Practices involving the GP
    - Education for clerical staff to ensure the GP is seen to be important in the patient hospital stay.
- Successful dinner meeting to bring the GPs and Hospital staff together to discuss the role of the GP in the patient discharge process.
- Improving the already high profile of the GP within CGHS.
- Integration of the GP into the Effective Discharge Planning strategy by virtue of written procedures for discharge planning.
- Production of educational material for patients, families and health professionals outlining the role of the GP in the discharge planning process.
- Production of the EPC MBS items checklist as a guideline to GPs in the claiming of MBS items.
- The appointment of a skilled person to the position of Discharge Planning Coordinator to assume responsibility for the introduction and continuation of the processes set in place for "Enhancing Hospital and GP Linkages in Discharge Planning."

Recommendations

Commonwealth:

- GPs to be eligible where the patient is discharged to an alternative "home" situation, such as nursing home or hostel
- Consideration be given to alternative measurement of success other than the "uptake of EPC MBS items"
- That the GP divisions are responsive to providing EPC MBS item information to the GP in an easy to follow manner.

State:

- Extension of project time lines to enable hospital processes to be set in place. Up to 24 months would be ideal.
- That the EDS project be more closely aligned to the EPC Demonstration Hospital project to further work towards a process of total "management of patient hospital care involving the GP where applicable and practicable".
- The development of Key Performance Indicators for safe referral home and the coordination of discharge planning with GPs.

Hospital:

- That CGHS continue with the now routine GP notification of a patient's admission.
- That CGHS continue to advise Community Care Service providers of the patient's hospital admission.
- That the electronic discharge summary module be implemented as soon as possible.
- That the position of Discharge Planning Coordinator be made permanent and that the performance of the incumbent be reviewed 6 monthly against the position description.
- Install the GP register on selected computers, eg Admission, Acute Wards, and Community Care Services.
- Highlight the importance of discharge planning into the hospital education procedure to ensure all staff accepts responsibility for their role in the process – that discharge planning is a core part of the clinical staff's role.
- Educate Medical Officers on the importance of discharge planning, the timely completion of the discharge summary and their relationships with the patient's GP.
- Discharge planning training must be part of the orientation program.

Evaluation of Project

The original submission called for a formal external evaluation to assist in the preparation of a final report available to all other services.

This is not complied with, as the project team believes that the project is only now into the operative stage. The appointment of the Discharge Planning Coordinator, together with the agreed to procedures for discharge planning at CGHS will provide the outcomes desirable to the project.

The project evaluation together with a review of the uptake of EPC MBS items in the catchment area can be completed by end September 03. This task can be coordinated by the Discharge Planning Coordinator and can be part of the Discharge Planning Coordinator position performance evaluation.

Anecdotally, CGHS Community Care Services and ACAS have conducted a number of Case Conferences involving the GPs, for discharged patients from the hospital.

Refer to Attachments 6a & b

A*TTACHMENT 1*

Enhancing Hospital & GP
Linkages in Discharge Planning

Date …………………….

Dear

Re Nominated Doctor Advice Card

Attached to this letter is a card that can make a big difference to your health care.

Please keep the card with your Medicare card so that I will be notified in the event of your treatment by emergency services or your admission to hospital.

By notifying the hospital of my details, as shown on the card, you will assist the hospital to promptly notify me of your admission and discharge.

Prompt notification will assist me and my colleagues to provide you with better health care through better knowledge of your health status.

So, please sign and keep this card with you at all times and assist us to help you when you need it most.

Yours sincerely

(General Practitioner)

Front of Card

Nominated Doctor Advice
If I require Medical care please notify

GP Name …………………………….
Address ………………………………
Phone …………………………………
Fax ……………………………………

I consent to my doctor supplying all necessary information for my ongoing care.

Name of Patient …………………………….
Signature ……………………………………

Back of Card

Nominated Pharmacy Advice
If I require Medical care please notify

My Local Pharmacy ………………..
Address ……………………………..
Phone ……………………………….
Fax …………………………………..

Name of Patient ……………………………………….

Signature ……………………………………………...

ATTACHMENT 2

A Joint Initiative between Central Gippsland Health Service and the East Gippsland Division of General Practice

Doctor Information:

Attach
GP Label

Patient Information:

Attach
Patient Label

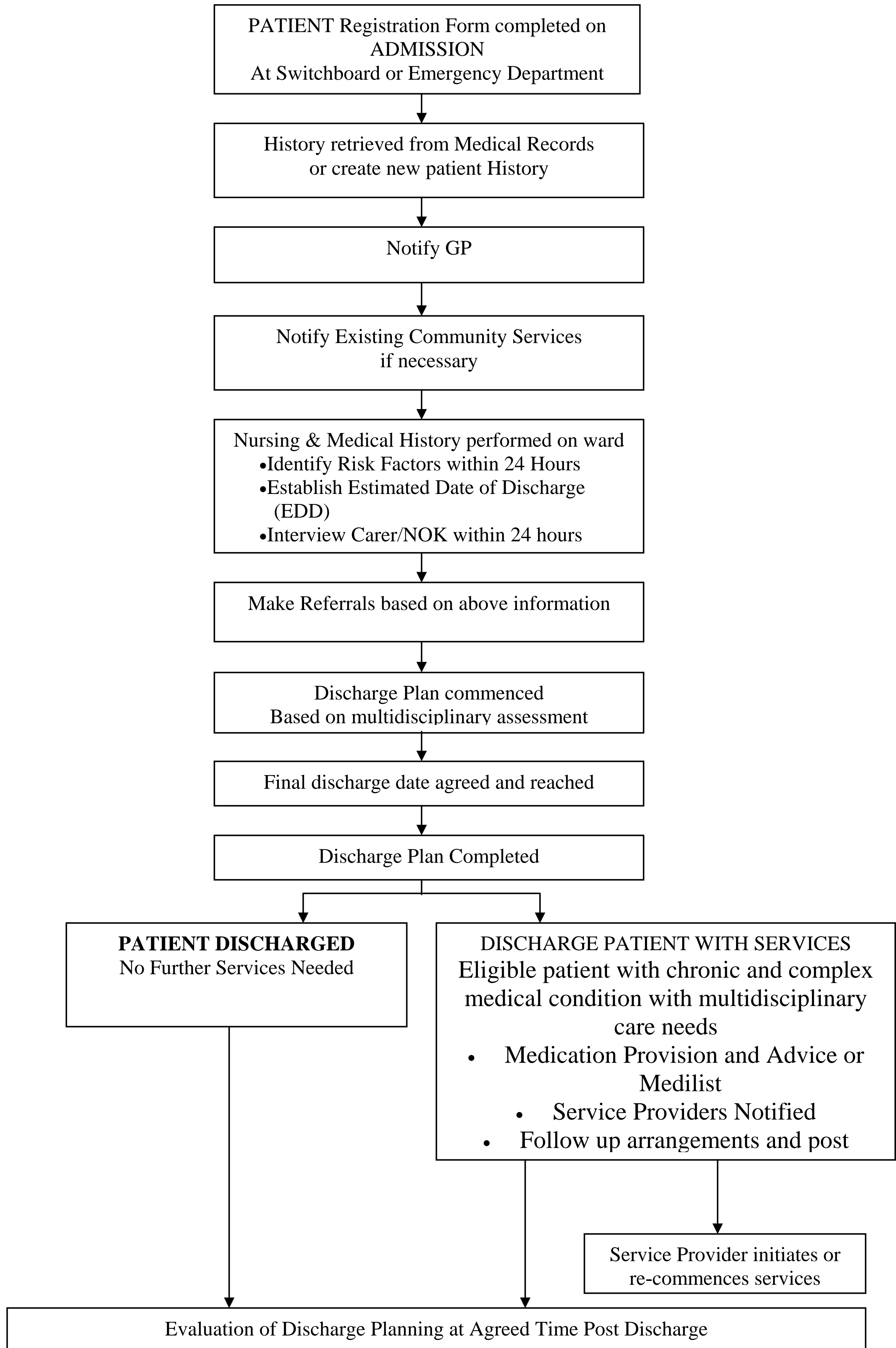
PLEASE BE ADVISED THAT THE ABOVE PATIENT HAS BEEN ADMITTED TO Central Gippsland Health Service, Guthridge Parade, SALE.
Phone: 51438600

For further information regarding this patient please contact the admitting VMO.

Please Note:

- The patient has consented to this information being communicated to you.

ATTACHMENT 3 **Flow Chart of Admission Process**



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 which 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

Carol Barker
Discharge Liaison Officer
51 438442

Sarah Roberts, EGDGP
51 530383

The hospital liaison for this project is Carol Barker
Phone 51 438442

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

We gratefully acknowledge the assistance of
Lee Stamford
Project Officer, A&RMC
June 2002

Involving My GP in My Hospital Care

INFORMATION FOR PATIENTS AND FAMILIES ABOUT DISCHARGE SERVICES

THE CENTRAL GIPPSLAND HEALTH SERVICE ARE PROUD TO BE WORKING WITH GPs TO PROVIDE COORDINATED CARE

At the Central Gippsland Health Service 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 hospital and go home.

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

How is my GP Involved?

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 and hospital staff and 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. Your GP has the choice of either coming into the hospital or using a conference phone for the meeting. This will give your GP 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

Hospital staff will explain the procedure to you. You should discuss any concerns about the process then ask a member of your hospital care team.

ATTACHMENT 4b

Further Information

If you have any questions contact:

- The Unit Manager on your ward
- A member of your hospital care team
- Your General Practitioner
- Carol Barker, CGHS Discharge Liaison Officer 51 438442
- Sarah Roberts, East Gippsland Division of General Practice 51 530383

Involving My GP in a Discharge Case Conference

Information for patients and families

At the Central Gippsland Health Service 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

ATTACHMENT 5a

CENTRAL GIPPSLAND HEALTH SERVICE

PROCESS GUIDELINES

DISCHARGE CARE PLANNING AND CASE CONFERENCING WITH GENERAL PRACTITIONERS

- Identify eligible patient (chronic and complex medical condition with multidisciplinary care needs)
- Allocate coordinator for discharge planning process (if this is not the person who identified the patient)
- Send Fax to GP inviting them to participate (refer to Fax Request for GP involvement in Discharge Care Planning or Fax request for GP involvement in Case Conferencing)
- Obtain and document patient consent
- Develop list of diagnoses/problems. Identify health needs and establish goals with patient.
- Keep the summary in patient file
- Ensure the patient completes CGHS Patient Satisfaction Survey
- Evaluation of the process (from hospital viewpoint)

Discharge Care Plan	**Case Conference**
• Fax to GP "Enhanced Primary Care Discharge Care Plan and Case Conference" form for their contribution to understand the patient's anticipated post-discharge needs. • Contact the GP either by phone or fax to gain their input. • Finalise the discharge plan – it needs to include the goals of care, the timeframe for service delivery, services to be provided, and the names and contact details for all involved in the patient's ongoing care. • Fax final copy of the plan and the patient's consent to the GP and other providers. • Provide copy of the discharge plan to the patient.	• Phone GP to make mutually convenient time to hold the case conference when all the participants will be available. • Fax to GP the partially completed "Enhanced Primary Care Discharge Care Plan and Case Conference" form. • Allocate a room with a speaker phone • Hold the case conference noting start and finish times. • Identify health needs and outcomes to be achieved. • Develop agreed management plan identifying tasks and allocation of tasks to participants. • Provide copy of the summary to the patient or carer and other health care providers.

ATTACHMENT 5b

CENTRAL GIPPSLAND HEALTH SERVICE

FAX REQUEST
GENERAL PRACTITIONER
INVOLVEMENT IN CASE CONFERENCE

To:	**From:**
Fax No:	**Date:**

Re: Affix Patient Label	Admission Date: …/…../….. Admission Diagnosis: ……………………………..

The purpose of this fax is to gain your input regarding your patient. This is to discuss the care goals of your patient/client and identify immediate action required to address these needs. Your participation will be very welcome, either in person or by phone, in a **case conference.**

Details of the conference participants and management issues will be forwarded to you prior to the conference. Patient/client consent for your involvement will be obtained.

On the completion of the case conference we request that you, as their GP give the patient a copy of the case conference summary when next they visit you and place the documentation sent to you on the patient's medical record.
GP's are now able to claim reimbursement for their involvement in case conferencing and care planning using the MBS EPC item numbers.

Could you please indicate your interest in participating by faxing this form back to the number below by …./…../…..

Please contact me with any queries.

Name:…………………………………………. Phone: ………………………………

Return Fax Number: ………………….

I am able/not able to participate in the planned Case Conference.

Signed ……………………………

ATTACHMENT 5c

CENTRAL GIPPSLAND HEALTH SERVICE

FAX REQUEST
GENERAL PRACTITIONER
INVOLVEMENT IN DISCHARGE CARE PLANNING

To: **From:**

Fax No: **Date:**

Re: Affix Patient Label

Admission Date: …/…../…..

Admission Diagnosis:

……………………………..

The purpose of this fax is to gain your input regarding your patient's discharge back into the community.

Your patient has been identified as having complex and chronic care needs and we feel her/his care would be improved if you were involved in the discharge plan.

The discharge issues to be discussed are:

- Treatment Plan
- General Issues
- Psychological/Psychosocial Issues
- Ongoing Monitoring

Could you please indicate your interest in participating by faxing this form back to the number below by …./…../…..

On the return of this Fax we will gain patient consent. You will be contacted by phone/fax with time and date to contribute to the plan. **GP's are now able to claim reimbursement** for their involvement in the care planning and case conferencing using the MBS item numbers.

Please contact me with any queries.

Name:…………………………………………. Phone: ………………………………

Return Fax Number: ………………….

I am able/not able to participate in the planned Discharge Care Planning meeting

Signed ……………………………

ATTACHMENT 5d

CENTRAL GIPPSLAND HEALTH SERVICE

PATIENT INFORMATION SHEET

YOUR CASE CONFERENCE

Why do we need to plan for your return home from hospital?
It is important to organise a plan for when you go home so that you will stay well and have the services you need as soon as you get home.

What is a case conference?
It is generally a telephone conference between your GP and the hospital staff looking after you to:

- Give your GP the opportunity to make hospital staff aware of your medical history and any other issues which may impact on your care whilst in hospital or when you are discharged.
- To identify any supports/services that may be required after discharge from hospital.
- Make sure that your GP, hospital staff and other health professionals agree about who is going to provide various aspects of your ongoing care.

Who would be present at this Case Conference?
Your GP and at least two other health professionals from the hospital and community. They will discuss the best way to provide the services and care that you will need when you are ready to go home. You and your carer can be involved in this process.

How are my views/concerns represented?
In order to proceed with the case conference, we must obtain your consent or the consent of your carer. It is important to tell hospital staff if there are any things you DO NOT want discussed during the case conference. You will be asked by the hospital staff about what is important for you to be included in the case conference.

Can I be assured of Confidentiality?
Your personal information is treated with the strictest confidence

What happens after the Case Conference?
The hospital staff and your GP will discuss the recommendations of the case conference with you. You will be given a copy of the case conference summary.

Are there any costs involved for a Case Conference?
Your GP will bill you in the usual way for his/her participation in the case conference. You will be asked to pay this account OR sign a Medicare form when you next see your GP. A Medicare rebate is available for this service. Referrals to specialists or other health professionals that are recommended as part of the conference will be charged separately.

ATTACHMENT 5e

CENTRAL GIPPSLAND HEALTH SERVICE

PATIENT INFORMATION SHEET

YOUR DISCHARGE CARE PLAN

Why do we need to plan for your return home from hospital?
It is important to organise a plan for when you return home so that you will stay well and have services you need as soon as you get home.

What is a care plan?
It is a written plan of your future care needs for when you go home

- To identify any supports/services that you may need after discharge from hospital
- Make sure that your GP, hospital and any other health professionals agree about who is going to provide various aspects of your ongoing care.
- Your GP will review the plan at a later stage with you after you are at home. It is important to see your GP soon after your discharge home.

Who would be involved with this Care Plan?
Your GP and at least two other health professionals from the hospital and community would be involved. They will plan the best way to provide the services and care that you will need when you are ready to go home. You and your carer can be involved in this process.

How are my views/concerns represented?
In order to proceed with the care plan, we must obtain your consent or the consent of your carer. It is important to tell hospital staff if there are any things you DO NOT want discussed during the case conference. You will be asked by the hospital staff about what is important for you to be included in the case conference.

Can I be assured of Confidentiality?
Your personal information is treated with the strictest confidence

What happens after the Care Plan?
The hospital staff and your GP will discuss the recommendations of the discharge care plan with you. You will be given a copy of the care plan summary.

Are there any costs involved for a Care Plan?
Your GP will bill you in the usual way for his/her participation in the care plan. You will be asked to pay this account OR sign a Medicare form when you next see your GP. A Medicare rebate is available for this service. Referrals to specialists or other health professionals that are recommended as part of the conference will be charged separately.

ATTACHMENT 5f

<table>
<tr><td>Central Gippsland Health Service
ENHANCED PRIMARY CARE
DISCHARGE CARE PLAN & CASE CONFERENCE RECORD</td><td>Unit Record No.________________________
Surname:________________________
Given Names:________________________
D.O.B:________________Sex:______
Affix Patient Label</td></tr>
</table>

Discharge Care Plan / Case Conference Details (to be completed by hospital)	
Coordinator:	**GP Name:**
Phone:	**Phone:**
Fax:	**Fax:**
Patient's discharge address and phone no.(if different to above):	

Participants and Service Provider Details (including carer details) (to be completed by hospital)			
Name	**Position**	**Contact Details**	**Date**
	Referring Doctor		

Case Conference Use Only (to be completed by hospital):		
Date:	**Start Time:**	**Finish Time:**
Venue:	**Booked by:**	
GP Input / Action: (To be completed by GP at time of case conference OR use next page)		

Authority to Proceed with Care Plan or Case Conference (to be completed by hospital)	
The purpose of this care plan/case conference has been explained. I/my carer, give permission for it's preparation and for the discussion of my medical history and diagnosis, with the providers listed above. All participants are to retain confidentiality.	I am aware my GP will bill me in their usual way for their participation and that a Medicare rebate will be payable for this service. I/my carer have been asked if any medical/personal information should be withheld from other participants.
Signature: **Date:** **Patient / Carer / Verbal (please circle)**	**Witness:** **Date:**

Note: 1. GPs should refer to MBS schedule book for description of items and GP responsibilities
2. Hospital to file in correspondence section of medical record

Central Gippsland Health Service *ENHANCED PRIMARY CARE* **DISCHARGE** **CARE PLAN AND** **CASE CONFERENCE**	Unit Record No.________________________ Surname:____________________________ Given Names:_________________________ D.O.B:____________________Sex:______ Affix Patient Label

Patient Summary
Principal Diagnosis and Other Significant Health Problems:
Medications:

Aims and Outcomes			
Needs Identified	**Goal (including perceived goals of patient/family/carer)**	**Task/Recommendations**	**Review Date & Person Responsible**
1.			
2.			
3.			
4.			
5.			
6.			

Agreement
I understand the above care plan/case conference recommendations and agree to the outlined goals.
Patient/Carer signature: GP: **Other Health Professional:**
Appointment to see GP: Yes / No Date: / / 03

ATTACHMENT 6a

Case Study

Mrs B, 67 y.o. lady with advanced Parkinson's disease suffered epileptic seizures and collapse requiring admission to BRHS then transfer to CGHS on 5 June 02 under the care of a physician.

Presentation
A thin, frail lady lives alone in Mallacoota in a flat behind husband's house. This lady has difficulty caring for herself and requires 2nd daily Home Help, MOW and DNS. She walks with a frame but is unsteady on feet. The patient suffered recent delusions due to medications. Her nutritional status is poor.

Hospitalisation
The patient was admitted for review of medications and stabilisation of her chronic illness. During her stay in hospital she suffered complications requiring resuscitation, transfusion and transfer to Critical Care Unit.
Referrals were made to the Discharge Planner, Dietitian, OT, Physio, Speech Therapist and Social Worker.
This lady received an intensive period of care in hospital after transfer back to the Medical Unit. The family was involved in her discharge planning and at one stage Nursing Home placement was considered.
The patient eventually recovered and requested to return home. A family meeting was held to discuss the possibility of this. A Case Conference was then held to organise and plan for her discharge.

Case Conference
Present**: CGHS –** Physician, Nursing Unit Manager, Dietitian, OT, Physio, Social Worker and the patient.
Mallacoota – GP, Case Manager, Community Nurse, Physio, CHC Manager.
The conference was conducted by telephone linkup, one week prior to the patient's Estimated Date of Discharge.

Discharge Plan:
1. Return home to husbands care 14/8/02
2. To be visited by Case Manager and OT 15/8/02 to put services into place.
3. Dietitian to follow up regarding supplements after discharge
4. Pharmacist to arrange Dosettes for medications
5. Transfer and District Nurse information to be forwarded on discharge
6. Physio to be continued at home – arrangements made.

Discharge
The patient was discharged home on 14/8/02 with community services in place.
A post discharge appointment with the physician was arranged and attended.

Follow-up Phone Call
A follow-up phone call was made 1/10/02 to inquire about the patient's progress since discharge.
This lady is now managing well with husband cooking meals and providing daily care.
Home help continues four times per week. Weekly physio visits have ceased two weeks ago.

ATTACHMENT 6b

CASE STUDY 2

Mr S, a 55 y.o. man with Motor Neurone Disease lives at home with his son and daughter. His medical condition has been deteriorating gradually over the last six months and he is now confined to a wheelchair and has continual CPAP.

Community Care Services in place are:

- Visiting Nursing Service
- Home Care
- Respite Care
- Social Work (DHS)

A Case Conference was held on 29/8/02

Present:
- GP
- ACAT Member
- DHS Rep
- HC worker – CGHS
- Carer – Respite Centre Co-care
- Team Leader – Assessment and Care Coordination
- Service Coordinator
- Client's daughter
- Client

Outcome:

Services in place:
- HACC (HC) 1.5hrs F/N to continue
- Respite 2hrs F/N to continue
- Visiting Nurse twice weekly
- Co-Care 6hrs respite/week

Referrals to be made:
- Dietitian }
- Speech Pathology} sent 2/9/02

Application to be made:
- "Home First" Package through DHS
- "Making a Difference" program to provide services on a regular basis

GP to follow up "out of home" respite
Palliative Care Coordinator to be contacted
Motor Neurone Assoc. to be contacted.

ATTACHMENT 7

CGHS GLOSSARY OF TERMS

ACAS	Aged Care Assessment Services	A co-located service at CGHS Community Care Services campus.
A&RMC	Austin & Repatriation Medical Centre	
ACHS	Australian Council of Healthcare Standards	An independent, not-for-profit organisation established in 1974, dedicated to improving the quality of health care in Australia through continual review of performance, assessment and accreditation.
ALOS	Average Length of Stay	
ANPAS	Antenatal Pre Admission Service	
ARCHI	Australian Resource Centre for Hospital Innovations	The ARCHI mission is to support and increase the implementation of effective and quality innovations in clinical care in the Australian healthcare sector. Through its website, newsletter, discussion groups, inquiry service and seminars, ARCHI helps to promote information sharing while preventing duplication of effort.
B of D	Burden of Disease	A study conducted by the DHS in 1996 due to steady increases in health expenditure in Australia despite cost-containment measures. Results of the study were used to plan future resource allocation.
BATS	Better Access to Services	A model that will enable people from across Wellington to have easier access to all primary health services, through a simplified and more coordinated referral and information sharing system.
BF	Breastfeeding	
BRHS	Bairnsdale Regional Health Service	
CCS	Community Care Services	A division of CGHS that provides integrated community health services.
CCU	Critical Care Unit	
CEO	Chief Executive Officer	
CGHS	Central Gippsland Health Service	
CNC	Clinical Nurse Consultant	
DHS	Department of Human Services	
DLO	Discharge Liaison Officer	
DNS	District Nursing Service	A CCS Nursing team that provides home-based nursing services to people throughout the catchment area.
DOB	Date of Birth	
DPC	Discharge Planning Coordinator	
DPU	Day Procedure Unit	
ED	Emergency Department	
EDD	Estimated Date of Discharge	
EDS	Effective Discharge Strategy	A five year initiative spanning from 1998/99 to 2002/03 funded by the Department of Human Services. The strategy represents a systematic approach to understanding, measuring and improving discharge processes and their outcomes.
EGDGP	East Gippsland Division of General Practitioners	An alliance of GPs in the East Gippsland Region established in 1993.
EO	Executive Officer	

EPC	Enhanced Primary Care	A package launched by the Federal Government in the 1999 Budget. The goal of the package is to improve the health and quality of life of older Australians and people with chronic and multidisciplinary care needs, through enhancing the quality of primary health care provided to these population groups.
EPC MBS Items	Enhanced Primary Care Medical Benefits Schedule Items	21 Items that came into effect on Nov 1 1999 which provide for three categories of GP activity: health assessments, care planning and case conferencing. The items are designed to support the role of GP's in the provision of coordinated, multidisciplinary health care.
EQuIP	Evaluation and Quality Improvement Program	A program that guides organisations seeking accreditation through a four-year program of self-assessment, organisation-wide survey and periodic review conducted by industry peers to meet ACHS standards.
EWNH	Evelyn Wilson Nursing Home	The Sale campus of the CGHS Residential Aged Care Services Division.
FPH	Fitzpatrick House	Private medical consulting rooms in Sale.
GA	General Anaesthetic	
GBH	Gippsland Base Hospital	The Sale campus of CGHS.
GEM	Geriatric Evaluation & Management	Sub-acute care of chronic or complex conditions associated with aging, cognitive dysfunction, chronic illness or disability. These conditions require inpatient admission for review, treatment and management by a geriatrician and multidisciplinary team for a defined episode of care.
GP	General Practitioner	
GPDV	General Practitioner Division of Victoria	
GPLO	General Practitioner Liaison Officer	
GPR	General Practitioner Register	An electronic register of Victorian GPs produced by DHS through the Effective Discharge Strategy.
HACC	Home and Community Care	The DHS HACC program funds more than 500 agencies to deliver basic maintenance and support services to older people, people with disabilities and their carers across Victoria.
HARP	Hospital Admission Risk Program	A commitment of $150 million over the four years to June 2005 has been made through the Hospital Demand Management Strategy. With these funds HARP will create additional capacity to treat, care for and proactively manage people in the most appropriate environment possible. It will support people's ability to remain in their normal living environment by emphasising an integrated approach to their care.
HCC	Health Care Card	
HIM	Health Information Manager	
HITH	Hospital in the Home	
HMO	Hospital Medical Officer	Resident medical officer working on short-term rotational basis following training.
INI	Initial Needs Identification	A tool implemented to enable more streamlined intake and improved service coordination for community care services clients.
IT	Information Technology	
LA	Local Anaesthetic	
LC	Lactation Consultant	
LGA	Local Government Area	
LOS	Length of stay	
LRH	Latrobe Regional Health	
M&CH	Maternal & Child Health	

Med	Medical Unit	
MMG	Maffra Medical Group	
MOW	Meals on Wheels	A volunteer service coordinated by the CCS Home Care service that provides meals in the community, prepared by the CGHS Catering division.
NOK	Next of Kin	
NUM	Nursing Unit Manager	
O & P	Obstetrics & Gynaecology Unit	
OH&S	Occupational Health and Safety	
OR	Operating Rooms	
OT	Occupational Therapy	
PAC	Post Acute Care	The Post Acute Care (PAC) Program was introduced in Victoria in 1996-97 to improve the transition from hospital to the community. It provides individually tailored packages of health and community care services to patients needing additional support, to assist them to recuperate following discharge from an acute public hospital. Services include home nursing, personal care, childcare, allied health services and home help.
PBS	Pharmaceutical Benefits Scheme	
PI	Performance Indicator	
RAI		
RN	Registered Nurse	
RWH	Royal Women's Hospital	
SIDS	Sudden Infant Death Syndrome	
Surg	Surgical Unit	
TOR	Terms of Reference	
VMO	Visiting Medical Officer	
WGHS	West Gippsland Health Service	
WIES	Weighted Inlier Equivalent Separations	
WPCP	Wellington Primary Care Partnership	A program designed to increase communication between primary care, community care services, GP's and the acute sector. Comprised of 33 member agencies within the Wellington Shire.