

Involving GPs in safe referral home

A final report on four Victorian enhanced primary care discharge demonstration projects



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Executive summary

Four Enhanced Primary Care (EPC) discharge demonstration projects of 12 months duration were funded by the State and Commonwealth Governments in Victoria during 2001-2002. These four projects were conducted by partnerships of hospitals in collaboration with divisions in their catchment areas. The four hospital sites were the Austin Health (previously Austin and Repatriation Medical Centre), Central Gippsland Health Service, the Royal Women's Hospital, and St Vincent's Health. Each of the projects tried to institutionalise systems for General Practitioner (GP) involvement in discharge planning for patients with chronic and complex conditions using the EPC discharge care planning items from the Medicare Benefits Schedule.

During the course of the projects there appeared to be seven building blocks for GP involvement in discharge planning for those with complex needs. These building blocks are:

1. Processes that encourage patients to nominate a GP
2. GP name to be on the patient file
3. Access to up to date GP contact details
4. Designated discharge coordinator at unit level
5. Process for routine notification of admission and/or discharge to GPs
6. All staff see their job includes safe referral home
7. Senior and junior medical staff respect the GP role.

Without these building blocks in place, hospitals could not institutionalise systems for GP involvement in discharge planning for those with complex needs.

The projects also showed that GPs welcomed involvement in discharge planning for patients with complex needs but did not necessarily claim the EPC items. For hospital staff, intensive support was required to introduce and maintain systems for GP involvement in discharge planning. Many were unhappy about asking patients to consent to the GP billing for their involvement. While they found the process time consuming when it became routinised, hospital staff found that the GP response exceeded expectations and that GPs provided valuable information about family capacity and community supports available. Doctor-to-doctor contact was vital.

Care-planning provided more flexibility for all parties than case conferencing. The term 'EPC' was not helpful in engaging hospital staff but the term 'safe referral home' and 'involving GPs in discharge planning' did facilitate staff interest in the projects. While feedback from patients was limited, the vast majority agreed that discussion between the hospital and their GP was valuable for planning their discharge home, that they felt well looked after, and valued a good relationship with their GP.

Embedding EPC compliant discharge processes was more likely to be successful in hospital units where:

- Most building blocks were in place
- Staff were stable
- The consultant and unit manager provided active support for GP involvement in discharge planning
- Communication with community providers was problematic for hospital staff in some way
- Staff were willing to incorporate more formal discharge processes into ward procedures
- Patients had a longer than average length of stay, and
- Patients had complex needs and required a focus on their needs at home.

No conclusion could be drawn as to whether all these factors needed to be present for successful GP involvement in planning or whether success could occur with only some of these factors present.

The four projects increased awareness and knowledge among relevant hospital staff and GPs about the EPC Medicare items related to discharge planning and coordination. This is manifest in the higher take up per capita of these items in Victoria than in Australia as a whole. In terms of patient groups it became clear that the frail elderly, those with palliative care needs, people with psychiatric/social issues, and those with multiple medical and social problems could benefit from GP involvement in discharge planning. To overcome the logistical barriers to hospitals and GP linkages in discharge planning and coordination in a sustainable way the projects found that they needed to:

- Attend to the building blocks noted above
- Focus on care-planning rather than case conferencing
- Use information technology systems to facilitate coordinated communication
- Clarify responsibilities of all hospital staff in relation to discharge coordination
- Engage the ward clerks to set up GP phone contact, and
- Ensure there was a doctor-to-doctor phone conversation in the process.

Recommendations to the Commonwealth include:

- That EPC education for GPs and hospital staff be continued
- That eligibility and requirements for the items be streamlined to improve their usability.
- That research be undertaken to assess the effect of GP involvement in discharge planning on patient care

Recommendations to the State include:

- That the General Practice Liaison Officer (GPLO) function be supported.
- That Key Performance Indicators (KPIs) be collected to encourage hospitals to assess their communication with GPs.

Recommendations for hospitals include:

- That they promote safe referral home to their staff as part of the hospitals' job.
- That they work with divisions to continue education about GP involvement in discharge planning.

Recommendations for divisions include:

- That they continue to work with hospitals to maintain and develop GP involvement in discharge planning for patients with complex needs.

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The author would like to thank Vivien Adler and Gill Smith from the Department of Human Services for their active support and interest in the EPC Discharge Demonstration projects. Their commitment to working in partnership with GPDV and funding our coordination role was of great benefit to the projects which each found the change process challenging. Dr John Stanton was also instrumental in facilitating the initial discussions between GPDV and the department that led to the development of the projects. At the Commonwealth level the projects benefited from the input of Peter Broadhead, Michelle Roffey, Martin Mullane, and Dianne Petchell.

In addition the demonstration projects were greatly enhanced by the skill, humour, and persistence of the project officers in each site and the part-time GPLOs in three of the sites. The Austin Health the team was Lee Stamford and Dr Jenny Bocquet; at Central Gippsland Health Service (CGHS) the team was Rob Herni and Carol Barker; at the Royal Women's Hospital (RWH) the team was Robyn Bradley and Dr Ines Rio; and at St Vincent's Health the team was Dr Clare Carberry and Dr David Isaac. The executive sponsors at each hospital site also provided a vision for the projects and some essential leadership in encouraging cultural change in senior hospital staff. These sponsors included Dr Craig White at Austin Health, Ros Hunter at CGHS, Dr Chris Bayley at the RWH, and Dr Peter Hunter at St Vincent's Health.

Lenora Lippmann

Integration Team Leader
GPDV

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Abbreviations

| | |
|-------------|--|
| APCL | Acute Primary Care Liaison |
| CGHS | Central Gippsland Health Service |
| DHS | Department of Human Services (Victoria) |
| DoHA | Department of Health and Ageing (Commonwealth) |
| EDS | Effective Discharge Strategy |
| EPC | Enhanced Primary Care |
| GPDV | General Practice Divisions Victoria |
| GPLO | General Practice Liaison Officer |
| GPR | Statewide GP database |
| HMO | Hospital Medical Officer |
| IT | Information Technology |
| KPI | Key Performance Indicator |
| LGAs | Local Government Areas |
| MBS | Medicare Benefits Schedule |
| PCP | Primary Care Partnership |
| RWH | The Royal Women's Hospital |

X Involving GPs in safe referral home

Glossary

assessment: a decision-making method based on collecting, weighing and interpreting relevant information about the patient. Assessment is not an end in itself, but part of a process of delivering care and treatment. It is investigative, using professional and interpersonal skills to uncover relevant issues and to develop a care plan.

carer: someone (usually a family member) who provides support to children or adults who have a disability, mental illness, chronic condition or who is frail aged. Carers can be parents, partners, sons, daughters, brothers, sisters or friends of any age.

clinical guidelines: systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.

community: A person's normal residence, whether an independent house, a supported residential service or an aged residential facility.

comprehensive assessment of older people: A multidimensional process designed to assess an older person's functional ability, physical health, cognitive and mental health and socio-environmental situation

department: Department of Human Services

discharge case conference: an EPC discharge case conference is a discussion between at least two members of the acute or sub acute multi-disciplinary team with the patient's general medical practitioner prior to the patient's discharge from the acute or sub acute setting. This discussion focuses on immediate, urgent needs of the patient on discharge into the community and can occur by telephone or face to face. To be eligible for GP reimbursement a multidisciplinary case conference needs to take at least 15 minutes.

discharge care plan: an EPC discharge care plan is a plan of care prepared by a multidisciplinary care planning team which includes relevant hospital staff, the patient's general medical practitioner and other relevant health and community care providers prior to the patient's discharge from the acute or sub acute setting. An EPC discharge care plan focuses on the long term care needs of a patient on discharge from the hospital into the community.

Effective Discharge Strategy (EDS): the strategy was funded by the Department of Human Services for a period of 5 years from 1998/1999 to improve discharge practices from public hospitals.

evidence-based practice: a process through which professionals use the best available evidence, integrated with professional expertise, to make decisions regarding the care of an individual. It requires practitioners to seek the best evidence from a variety of sources; critically appraise that evidence; decide what outcome is to be achieved; apply that evidence in professional practice; and evaluate the outcome. Consultation with the client is implicit in the process.

General Practice Liaison Officer: anyone, regardless of professional background, who is employed specifically for the purpose of improving communication and transfer of information between general practitioners and hospitals, for the ultimate benefit of patient care.

Health Service: the acute, sub-acute and primary care campuses of a Health Service, as well as the additional services that it provides in the community. The term 'Health Services' is capitalised in this paper to differentiate it from general health care and ongoing support community services delivered by various providers in the community.

hospital: acute or sub-acute inpatient facilities.

older people-friendly hospitals: Health Services that promote an attitude of catering for the specific needs of older people and that have modified their environment, and their staff expertise and mix, to reflect this attitude.

ongoing community support services: are supportive care services such as assistance with personal care, homecare meals and home maintenance. These services are provided in the person's home and are ongoing. Community support services are aimed at promoting independence and maintaining the person in the community.

Primary Care Partnership (PCP): are groups of primary care providers that have formed voluntary alliances in their local communities. PCPs aim to improve the health and well-being of their catchment's population by better coordination and planning and service delivery in response to identified needs.

post acute care: the service provided to people after a hospital admission or emergency department presentation. It provides time-limited, individually tailored packages of supportive care to assist people to recuperate in the community.

sub-acute care: goal-oriented, time-limited interventions, generally provided in a multidisciplinary environment to patients who require evaluation, treatment and management for post-acute or chronic conditions.

transdisciplinary assessment: an assessment tool that any trained member of a multidisciplinary team can use. Where the assessment flags specific issues, the appropriate professional will then provide specialist intervention.

1. Setting the context

The important role that community providers, including GPs, play in the health care of patients is increasingly recognised by hospitals. This has been supported by State and Commonwealth Government policies in the last five years.

In 1998 the Victorian State Government introduced the Effective Discharge Strategy (EDS). This was a five-year multi-faceted strategy that adopted a systematic approach to understanding, measuring, and improving discharge planning processes and their outcomes. Key activities included the development of discharge improvement plans by Victorian public hospitals, patient record audits, development of performance indicators and special projects, such as the development of the state-wide GP data-base known as the GPR.

In 1999 the Commonwealth Government introduced the Enhanced Primary Care (EPC) package of initiatives to ensure that, where possible, health care is community-based, increasingly focussed on prevention, and better coordinated and directed to finding new and more effective ways to manage chronic illness. This package included funding for:

- the Coordinated Care Trials
- investigation of effective falls prevention
- chronic disease self management, and
- new Medicare Benefits Schedule (MBS) item numbers that would enable GPs to be reimbursed for the time they spent in coordinating the care of patients with chronic conditions and complex multi-disciplinary care needs. These MBS items became known as EPC items.

In Victoria, divisions of general practice were funded by the Commonwealth Government through General Practice Divisions Victoria (GPDV) for 18 months to educate GPs on the use of the EPC items. However the divisions tended to focus firstly, on health assessments for the elderly and then, on community care planning. Education about GP involvement in discharge planning was difficult without the buy-in of hospitals. This was particularly necessary for the EPC discharge items relating to the public sector because reimbursement is only available for GPs to contribute to a discharge care plan or participate in a discharge case conference at the invitation of the hospital in the case of public patients.

The items provided an opportunity for hospitals and GPs to work more actively together in discharge planning without the GPs being financially disadvantaged. However, usage of the discharge items since their introduction has been low. In Victoria the Second Effective Discharge Patient Record Audit found that hospitals scored poorly in the area relating to involvement of community service providers. However, even though the overall score of 51 per cent was low, a high proportion of the contacts (91%) were with GPs. (Second Effective Discharge Patient Record Audit, June 2000, page 69). This information indicated there was room for hospitals and GPs to work more collaboratively to deliver effective discharge for hospital patients and to use the new MBS items more widely.

A number of reasons could be attributed to the low involvement of GPs in discharge planning. Knowledge of the new MBS items was not widespread throughout hospitals and GPs. It was not widely understood which patients could most benefit from a coordinated approach. Communication between hospitals and GPs was and is affected by logistical problems including the lack of, or incompatible telecommunications facilities, lack of information about discharge procedures, and time pressures. There was also a need for better mutual understanding of the roles of hospital discharge staff and GPs.

The eligibility criteria for the EPC discharge items are specific and include the following:

- these items are available to patients with a chronic condition and complex multidisciplinary needs before the patient is discharged from hospital;
- Medicare benefits for the items for a GP preparing a discharge care plan and for organising a discharge case conference are only available to private patients;
- in the case of public patients, the patient's usual GP must be invited by the hospital to contribute to a discharge care plan or participate in a discharge case conference;
- for the purposes of these items, the patient's usual general practitioner is defined as the medical practitioner or a practitioner working in the medical practice that has provided the majority of services to the patient over the previous twelve months and/or will be providing the majority of services to the patient over the coming twelve months; and
- the patient must consent to the GP being involved and to the GP billing them for the GP's participation. The guidelines also require that the patient be given the opportunity to specify any information to be excluded from consideration.

Eligible patients are only those with at least one chronic medical condition and complex care needs, with chronic being a condition that exists or is likely to exist for six months or more, or is terminal. Those being discharged to a residential aged care facility or transferred to a regional hospital are not eligible. The type of information to be included in a care-plan or in a case conference write-up is specified in the guidelines.

Within this context GPDV, the peak body for divisions of general practice within Victoria, held discussions with the Department of Human Services to see if there were some way of encouraging the use of the discharge items. These discussions resulted in the development of the demonstration projects for using the new EPC MBS items to improve linkages between hospitals and general practitioners in discharge planning and coordination. While the idea for the projects came from GPDV and the department, the Commonwealth Department of Health and Ageing (DoHA) was keen to encourage use of the discharge items and offered to fund two of the proposed EPC discharge demonstration projects in Victoria.

In May 2001, the Victorian Department of Human Services and the (then) Commonwealth Department of Health and Aged Care, in association with GPDV, invited submissions from hospitals, jointly with one or more division(s) of general practice, for the funding of four projects throughout Victoria. These projects were expected to develop and implement sustainable processes to ensure improved linkages between hospitals and general practitioners for patients with chronic and complex conditions. It was hoped that a range of different settings would be included in the demonstration sites including specialist, community, and rural hospitals. Projects were expected to be completed within 12 months. To promote statewide support and coordination, and consistency and learning from the four projects GPDV was to be the statewide coordinator.

The invitation to submit stated that the demonstration projects should be designed to address some of the identified barriers to GP involvement in discharge planning so that hospitals and GPs develop and maintain effective working relationships. The aim of the demonstration projects was to develop a variety of service models for show-casing the use of the new EPC MBS items to improve linkages between hospitals and GPs in discharge planning and coordination in Victoria.

In addition “The service models to be developed should demonstrate:

- Effective means for informing relevant hospital staff and GPs about the new MBS items.
- Effective systems and processes for overcoming logistical barriers to hospital and GP involvement in discharge planning and coordination.
- Effective use of the EPC Medicare items to improve linkages between hospitals and GPs in discharge planning and coordination.” (Invitation for Submission, May 2001)

It was expected that the demonstration projects would result in:

- “Increased awareness and knowledge among relevant hospital staff and GPs about the EPC MBS items related to discharge planning and coordination.
- Identification of patient groups that will benefit from GP involvement in discharge planning.
- Development and implementation of systems and processes that overcome logistical barriers to hospitals and GP linkages in discharge planning and coordination, and
- Sustainable increase in involvement of and referrals to GPs for discharge planning and coordination through the use of the EPC MBS items.”(Invitation for Submission, May 2001)

Twenty-three submissions for the demonstration projects were received with the four successful applicants being:

- Austin Health with North East Valley Division of General Practice and Northern Division of General Practice.
- Central Gippsland Health Service and the East Gippsland Division of General Practice.
- The Royal Women's Hospital and Melbourne, Western Melbourne, North West Melbourne, and Ballarat and District Divisions of General Practice.
- Sisters of Charity Health Service (now known as St Vincent's Health) in association with Melbourne, Inner Eastern Melbourne, and Otway Divisions of General Practice.

In the body of the following report the projects are referred to through use of the name of the hospital concerned for example, the Austin Health project. This is to improve legibility and by no means downplays the role of the collaborating divisions. It does recognise that the focus of the change in all four projects was predominantly the hospitals concerned rather than the general practices in the catchment areas.

The starting time for each project depended on the hospital's capacity to recruit appropriate project staff. The Austin Health and St Vincent's projects started in November 2001, while the Royal Women's and Central Gippsland projects started in January and February 2002, respectively.

2. Overview of the project settings

Each of the demonstration projects had similar aims that can be summarised as follows:

- To strengthen the relationship between the health service and GPs.
- To increase awareness of the EPC discharge items in the health service and among local GPs.
- To increase usage of the EPC discharge item numbers.
- To improve GP participation in hospital discharge planning and care coordination.
- To improve patient involvement in discharge planning.

Austin Health project

Austin Health is located in the north eastern suburbs of Melbourne. It is a large teaching hospital with 840 beds and three campuses including a rehabilitation centre. Some of the services provided have a statewide catchment and some focus primarily on the local population. The health service averages around 65,000 separations a year.

Austin Health had worked closely with the two divisions of general practice since 1996. This relationship was documented with one division through a signed memorandum of understanding between the hospital and the division. One outcome of this relationship was that Austin Health employed a GPLO for 8 hours a week for 18 months prior to this project's implementation. She had worked closely between the two divisions and the hospital. The GPLO had been instrumental in getting the statewide GP database (GPR) utilised within the hospital and facilitating the enhancement of the automated FAX system of GP notification of patient admissions, discharges and deaths. The GPLO had also undertaken substantial education of the senior and junior medical staff around the GP role, and had provided some protocols and education about the use of the EPC case conferencing items. This provided a positive relationship base between the hospital and the divisions.

Although they were employees of the hospital the part-time project worker and part-time GPLO employed for the project were housed in the offices of one of the partner divisions, offices which are located on hospital grounds. They reported both to the Austin Health/GP Liaison Group and to the Boards of Management of the two divisions. Thus the divisions were closely involved in the project.

Austin Health planned to work on EPC implementation with 15 units where patients had complex medical conditions. However in practice they focussed on 8 units as follows:

1. Aged Care Rehabilitation Service
2. Cardiac Respiratory Medicine
3. Complex Discharge Team
4. Pain Management Service
5. Palliative Care
6. Psychiatry Banksia House
7. Rehabilitation Hospital
8. Renal Unit

Central Gippsland Health Service project

CGHS is an integrated regional health service in eastern Victoria, covering a population of approx 48,000 spread over 11,000 square kilometres in South East Gippsland and Wellington local government areas (LGAs). It has 110 acute beds, 209 aged residential beds, 89 independent living units, and comprehensive community care services. Many of its facilities are located in Sale, with a population of approx 15,000. Outreach services are offered to a range of small towns.

The CGHS project was distinctive in that it was located in a rural area and although local GPs have admitting rights, most patients are under the care of in-hospital doctors and visiting specialists. In addition, both CGHS and the division were very involved in the Wellington Primary Care Partnership (PCP) and hoped to use this project to complement the work being done through the PCP to better coordinate referrals and care.

The boundaries of the CGHS and its partner division, the East Gippsland Division of General Practice do not coincide. Approximately half the division's GPs are located within the CGHS catchment area, and the main office of the division is located in Bairnsdale, one hour from Sale. Although the Division and the health service had cooperated through the PCP structure the relationship historically was sound but not strong. Relationships with the GPs located in Sale were well established. CGHS was committed to increased automation of patient information but at the time of the project there was no automatic notification to the GPs that their patients were admitted, discharged, or dead.

The focus of the project was on the two acute wards of the Sale facility, and an invitation to be involved in the project was made to all GPs within the division catchment.

The Royal Women's Hospital project

The Royal Women's Hospital (RWH), Women's and Children's Health is located in Carlton in Melbourne. The RWH is a large specialist teaching hospital with 213 beds and an average of 21,000 separations per year. As a tertiary referral centre the RWH cares for women from both urban and rural areas.

The RWH has had a GPLO for many years and a strong working relationship with affiliated shared care GPs. However as a statewide specialist hospital it relates to GPs who are geographically dispersed. Consequently relationships with 30 geographically delineated divisions are not easy to develop. In recognition of this the Women's and Children's Health Service have a 'Heads of Agreement' with the peak body for Victorian divisions, GPDV, as a means for improving communication with GPs and divisions.

Thus the hospital had an organisational commitment to improving communication with community providers, and had good communication with some GPs. It had drafted a Community Practitioners Communication Policy as well as draft formats for use of the EPC MBS items. The hospital had incorporated the GPR into its electronic information system.

A distinctive feature of the project was the inclusion of a regional division, Ballarat, to test out how EPC processes might work with GPs located at some distance from the RWH.

The RWH project aimed to focus on four specialised units as follows:

1. Women's Alcohol and Drug Service
2. Oncology
3. Neonatal, and
4. Fetal Management

In fact the demonstration project covered these four units but was withdrawn from the Fetal Management Unit after ten months because of resource issues in that unit. It was extended to include the Diabetes Clinic, Young Mothers Clinic, and Women with Individual Needs team.

St Vincent's Health project

St Vincent's Health includes eight separate facilities in the Melbourne metropolitan area. This project aimed to include four of those facilities as follows:

| | |
|----------------------------|---|
| St Vincent's Hospital | a major tertiary teaching hospital in Fitzroy serving the inner north and east of Melbourne and much of country Victoria. |
| Caritas Christi Aged Care | a sub acute assessment unit in Fitzroy, co-located with the hospital |
| St George's Health Service | a specialist regional aged care service provider located in Kew, including extended care and rehabilitation beds. |
| Caritas Christi Hospice | a provider of regional palliative care services, operating from Fitzroy and from Kew. |

Thus some of the services provided have a statewide catchment and some focus primarily on the local regional population. As a tertiary referral centre St Vincent's Health has a substantial number of patients from rural areas in some units. It has 571 beds and an average of about 50,000 separations per year.

During the course of the project a restructure of the health service took place which aimed to introduce consistent quality practices across previously separately managed campuses under the Sisters of Charity umbrella. Each campus, however, did have a history of commitment to improving communication with GPs. St Vincent's Hospital had had a part-time GPLO for many years and had used the Effective Discharge Strategy resources to substantially improve their transmission of medical discharge summaries to GPs and utilised the Statewide GPR. In recent years St Vincent's Health had worked closely with Melbourne and Inner East Melbourne Divisions to improve the relationship between the health service and local GPs. However its linkages with rural divisions were weak.

The EPC discharge demonstration project at St Vincent's Health had three areas of focus:

- Aged Care services
- Palliative Care
- Rural Discharges to the Otway region.

3. Project outcomes

a) Summary of number of care plans and case conferences

In each of the demonstration sites it was difficult to track how many actual care plans or case conferences involved GPs and which of these would be eligible for an EPC reimbursement from Medicare. As three of the four sites had statewide catchments, local take-up rates for EPC were not helpful. The figures in the table below are an estimate of the uptake of the EPC items at the four sites in the 12-month demonstration period.

Table 1:
Number of care plans and case conferences undertaken in demonstration sites

| | Care plans | Case conferences | Total |
|---------------------|------------|------------------|-------|
| Austin Health | 68 | 8 | 76 |
| CGHS | NA* | NA* | NA* |
| RWH | 19 | 2 | 21 |
| St Vincent's Health | ** | ** | ~ 110 |

**CGHS did not count the number of care plans or case conferences undertaken because they were only undertaken on a trial basis.*

*** A breakdown of the total is not included because St Vincent's automated their processes so that a care plan or case conference was considered for all patients in three wards as they were being discharged. Some GPs were not able to participate, some patients declined so most eligible patients on these wards had a care plan with a GP contribution, but not all.*

From these figures it is clear that care plans were attempted far more often than case conferences. Case conferences were found to be logistically difficult to organise, as all parties need to be available at the same time. Care plans, on the other hand, require all parties to input into the one plan but this can be done at different times.

The number of EPC discharge care plans and case conferences claimed in the Victorian demonstration projects appears to have contributed to a Victorian upward trend in the use of these items, stronger than the national trend, and against the Victorian trend for community EPC items. The table below indicates the uptake of the EPC items in Victoria compared to the uptake in Australia as a whole.

Table 2:
Number of claims per month for all community and discharge care planning and case conference items, Victoria and Australia, July 01- June 02 compared to July 02-April 03.

| Time period | Number claims per month for all community care planning & case conference items (av) | Number of claims per month for all discharge care planning & case conference items (av) |
|---------------------------|---|--|
| Australia 2001–2002 | 22,541 | 260 |
| Australia 2002–April 2003 | 18,971 | 267 |
| Variance | -16% | +3% |
| Victoria 2001–2002 | 5,010 | 91.5 |
| Victoria 2002–April 2003 | 3,569 | 105 |
| Variance | -29% | +15% |

b) Changes in hospital practices

As can be seen from the overview of the projects outlined above, each of the demonstration sites was at different stages of development in the communication between the hospital and GPs. In trying to achieve GP involvement in discharge planning each of the projects found they needed to address some basic building blocks before that could occur. Table 3 outlines the building blocks and the changes the projects made to ensure the building block was in place.

Table 3:
Building blocks for GP involvement in discharge planning and changes to hospital practices to achieve the building blocks

| Building blocks | Changes in hospital practice to achieve the building blocks |
|--|--|
| 1. Patient to nominate a GP for continuing care | <ul style="list-style-type: none"> • The establishment of a ‘Get Yourself a GP’ campaign’ (RWH) • Distribution of nominated Doctor Advice Cards to all general practices (CGHS) |
| 2. GP name on patient file | <ul style="list-style-type: none"> • Review of job descriptions at admission and ward clerk level (RWH, CGHS) |
| 3. Hospital to have up to date contact details for GPs | <ul style="list-style-type: none"> • Incorporation of the GPR into the hospital information system at the ward level (St Vincent’s, CGHS) |
| 4. Designated person at ward level responsible for discharge | <ul style="list-style-type: none"> • Senior level review of admission & discharge responsibilities and processes, with documented changes (Austin Health, CGHS, RWH, St Vincent’s) |
| 5. Hospital to have a mechanism for notifying GPs of admission | <ul style="list-style-type: none"> • GP communication built into the automated system (Austin Health, St Vincent’s, CGHS) and/or discharge • ‘Notification of attendance’ proforma to GPs for specialised outpatient services (RWH) • Computer generated notification of admission to GPs for babies hospitalised beyond 7 days (RWH) |
| 6. Hospital staff to see job includes safe referral home | <ul style="list-style-type: none"> • Incorporation of the GP role in patient brochures and education (Austin Health, CGHS, RWH, St Vincent’s) |
| 7. Medical staff to see value of the GP role | <ul style="list-style-type: none"> • Hospital based medical education includes attention to GP role (Austin Health, St Vincent’s, RWH) |

Each project received senior level commitment to promoting a cultural shift in thinking about the role of the hospital. This manifested itself in terms of senior sponsorship of staff education about safe referral home, senior endorsement to changes in discharge processes, and changes in job descriptions of ward clerks. Three of the projects had GPLOs who played a key role in educating medical staff about the role of a GP and why communication from the hospital was needed.

Beyond the 'building blocks'

- At Austin Health a GP now presents at the patient /carer /family renal education program on a routine basis. A GP training program has been developed around renal care.
- CGHS has appointed a dedicated Discharge Planning Coordinator.
- The RWH has included information about EPC and communication with GPs into their education of external providers of alcohol and drug services.
- St Vincent's Health, where many of the building blocks were in place before the EPC project began, has changed the discharge summary format for the aged care and palliative care units from a hospital medical summary to a multi-disciplinary discharge summary designed to include input from the GP. A discharge database was developed to produce a range of discharge documents. By the end of the project this was being used to facilitate the compilation of approximately three EPC care plans or case conferences per aged care ward per week. The database was also being used regularly in one palliative care unit.

c) Benefits for hospitals and patients

Three of the four projects sought feedback from hospital staff involved in care plans and case conferences, and one project also sought feedback from patients involved. The following summary was compiled from this feedback.

Hospital/patient feedback

Positives

- The GP was 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.
- The Division was able to help locate a GP willing to look after a discharged person with very complex needs who did not have a regular GP.
- The well-coordinated care plans prevented readmission.
- The EPC process complemented and enhanced the discharge process.
- It was helpful to get patient consent to continuing care arrangements.
- Allied health (in the hospital) were very positive about the opportunity to provide information in regards to current and future patient management.
- GPs are able to identify patients with complex needs who could benefit from care planning.
- GP involvement ensures adequate community follow-up.
- The EPC process facilitated reviews of documentation. In all sites there has been a reduction in 'double-up' and the number of forms used at discharge. Now information is seen to be more combined and structured.

- Hospital staff felt that the EPC process enabled them to get to know the GPs and establish important and valuable rapport with them.
- Although time consuming, the EPC process improves the quality of discharge information.
- There was a consistently positive response from staff regarding the importance of good communication at discharge with all carers involved in the patients care post discharge.

Doubts

- Staff felt discharge planning with GPs via the EPC process was a paper burden and did not generally enhance patient outcomes (Royal Women's Alcohol & Drug Service).
- Because hospital staff often work in a sub-specialist area, it is sometimes difficult for them to fully appreciate the broader psychosocial consequences of an illness that may manifest or develop after discharge. So they may have little understanding of the role of the GP and how their inclusion in the discharge planning process could benefit patients.
- EPC is additional work. In units that have communication with GPs EPC was not perceived to result in improved patient outcomes.
- Some hospital staff were concerned that they appear to do most of the work involved with care plans and case conferences, but that it is the GP who gets paid for their time.

Community providers

Positives

- Coordinated discharge planning improved the clarity of information received (for patients with complex discharge needs).

d) GP response

Three of the four projects sought feedback from GPs involved in discharge care planning or case conferences. For instance St Vincent's followed up over 50 GPs involved in discharge planning through phone interviews and surveys. Despite expectations that GPs might be difficult to engage, these three projects found the GP response very positive as can be seen from the following summary.

- GPs applauded the quality of discharge work up and community handover.
- There was a consistently positive response from GPs to the introduction of a multi-disciplinary discharge summary. GPs responded positively to the nursing and allied health contribution.
- GPs valued the information on the hospital multi-disciplinary treating team with contact details.

- The EPC compliant discharge summary contains more information and is longer than the usual summary. While GPs value concise summaries, for patients with complex care issues, GPs preferred more rather than less information.
- The contact with the hospital acknowledged GPs are part of the continuum of care.
- Personal contact was of tremendous value. GPs valued direct personal contact with hospital staff to discuss both the admission and the discharge of shared patients.
“The telephone link-up was very good, brief to the point, goals were set. Contact has been good since, as I can ring if I need to.” (Report from St Vincent’s Health)
- The EPC compliant process meant the GP received the summary before seeing the patient. This gave the GP time to plan follow-up care, eg a home visit for the patient in the immediate post-discharge period.
- Details of the patients’ medications at discharge and reasons for any alterations or additions were an essential component of a good discharge summary.
- The coordinated discharge plan provided an important resource in their ongoing care of patients.
- It is difficult for a GP to arrange a multi-disciplinary assessment and so the comprehensive discharge summary was very useful as a baseline of the patient’s functioning.
- It was valuable to have information on independence, mobility, and continence.
“It’s incredibly valuable both as a document for the future, a resource, and for the information that it gives you that is relevant right now. Also useful for part time doctors seeing patients without much background information.”
- GPs valued the information about who else was involved in the patients care post discharge and the provision of contact details.
- GPs valued notification of a patient’s admission, in addition to prompt notification of a patient’s discharge.

The majority of GPs did not claim payment using the EPC MBS discharge item numbers for their involvement in discharge care planning/case conferencing. (St Vincent 39 out of 50 interviewed GPs had not claimed). GPs were often not aware that they were involved in an EPC discharge process, and most GPs were not interested in billing for their involvement. There was a low level of knowledge about EPC discharge items.

A small group of GPs strongly objected to the EPC initiative as an attempt by government to interfere in medical practice. Associated paperwork and bureaucracy were a deterrent to involvement in EPC related work and \$28 was seen to be not worth the trouble.

e) Units where successful/not successful

Table 4:
Number of care plans and case conferences undertaken by type of unit¹

| | Austin Health | RWH | St Vincent's Health | Total |
|-----------------------------|---------------|-----------|---------------------|-------------|
| Aged Care | 0 | - | ~ 100 | ~ 100 |
| Palliative care | 26 | - | ~ 10 | ~36 |
| Psychiatry | 22 | - | - | 22 |
| Complex discharge | 16 | - | - | 16 |
| Renal | 8 | - | - | 8 |
| Oncology | - | 7 | - | 7 |
| Alcohol & drug | | 5 | | 5 |
| Neonates | | 4 | | 4 |
| Pain management | 3 | - | - | 3 |
| Diabetes | - | 2 | - | 2 |
| Young Mum's | - | 2 | - | 2 |
| Cardiac respiratory | 1 | - | 0 | 1 |
| Fetal management | - | 1 | - | 1 |
| Rehabilitation | 0 | - | - | 0 |
| Women with individual needs | - | 0 | - | 0 |
| | 76 | 21 | ~ 110 | ~207 |

¹Central Gippsland Health Service could not provide any figures re attempts at care plans or case conferences involving GPs so it not included in this table.

As can be seen from Table 4 above, the units where GP involvement in discharge planning was most successful were:

- Aged care at St Vincent's Health.
- Palliative care psychiatry, and complex discharge at Austin Health.
- Some of the specialised supports at the RWH.

The project workers reported that the EPC processes were sustainable in each of these units.

All the patients in these units have complex needs so it is possible for systems involving GPs in discharge planning to be routinised. This was best exemplified in the aged care units at St Vincent's Health.

Some success was achieved in disease specific units such as renal (Austin Health), and oncology (RWH). While within such units patients have repeated contacts with the hospital, each contact may be relatively short and focussed on a procedural intervention. When hospital staff work in a sub-specialist area, it is sometimes difficult for them to fully appreciate the broader psychosocial consequences of an illness that may manifest or develop after discharge. Consequently, they may not be fully aware of how the inclusion of a patient's GP in the discharge planning process can benefit. With these patients, a shared care model of care may produce a more coordinated approach to care over a longer time frame than can be achieved through the use of EPC care planning items in isolation.

Some success was also achieved in units that went across wards (like the pain management unit at Austin Health, and some of the specialised units at the RWH) where patients had longer length of stay and substantial complexity. There seems to be great potential for patient benefits in these types of units. However the logistics of organising input from a range of dispersed players is difficult, and sufficient staff and technology resources are required.

At three of the demonstration sites there were attempts to involve GPs in discharge planning in the surgical and medical units where the patients have a short length of stay. Despite the complexity of patient needs, these attempts were not successful. In these units, hospital staff's focus is on acutely ill people in hospital for a relatively short intensive period. Therefore the unit managers believed that present staff resources could not support the increased workload the changes in practice would require.

The three projects that included rural GPs in their consideration were not successful in engaging them in discharge planning. For the two city hospitals it was hard to identify such a small group of patients, while for the rural hospital, existing structures focussed on case conferences for complex patients and it was difficult to engage rural GPs in such time restricted events.

Other units where EPC compliant processes for GP involvement in discharge planning were not successful were ones where there was already good informal communication with community providers (for example, Alcohol and Drug Service at the RWH, and at the Rehabilitation Hospital at Austin Health). In these units the formalisation of processes was seen to require resources without additional patient outcomes.

At Austin Health, on notification of admission, GPs were asked to notify the hospital of those patients they thought could benefit from GP involvement in a discharge care-plan. GPs responded to this survey very well and identified patients with complex needs. However the hospital did not have the capacity to respond to this scattered identification of patients. Thus this approach was not successful.

f) Characteristics of settings where EPC has most potential for sustainability

The units where GP involvement was most likely to be sustained beyond the life of the project exhibited the following characteristics:

- Strong and enduring endorsement from senior members of the health service that GP involvement in discharge planning for complex patients is important.
- Leadership by nursing staff.
- Staff commitment to quality patient care.
- Engagement of key allied health staff.
- Changed processes are embedded into usual ward routines.
- The importance of good community care as a necessary part of good hospital care is seen as an integral element of the culture of the ward.

g) Summary of key learnings

- The basic platform for GP communication needs to be resolved before more enhanced communication is achievable. This includes capturing and documenting GP details for all patients, and the GP directly receiving a discharge summary.
- EPC is most successful in sub-acute units where the staffing tends to be more stable, there is time for good discharge work up of patients, and there is already good understanding of community referral issues and services.
- When core members of a unit identify a gap in communication with community providers as a problem, it is likely the EPC process will be successfully incorporated into communication with GPs and will be sustainable.
- GPs are generally enthusiastic about increased communication with hospitals and involvement in collaborative discharge planning for complex patients. GPs cite good practice rather than remuneration as a key driver for this.
- GPs are very positive about the improved quality and clarity of discharge information and the phone discussion with hospital medical staff.
- GPs often do not claim the EPC discharge items.
- While hospital staff are not initially enthusiastic about involving GPs in discharge planning because of the extra work entailed, when processes are routinised hospital staff find that GP input into discharge planning is very valuable – and beyond their expectations.
- Care planning is much more useful than case conferencing for discharge planning with GPs.

- Senior medical leadership is a key factor in the successful implementation of GP involvement in discharge planning for complex patients. An organisation culture that values quality and is concerned about safe referral home is also a great facilitator of such involvement.
- Units that have existing comprehensive communication with GPs and other community providers may see little benefit to more formal discharge planning with GPs.
- Public hospital staff have difficulties with having to obtain consent from patients for a process that may incur costs for patients.
- The use of the term 'EPC' is not meaningful for hospital staff and not necessarily welcomed by GPs.

4. Processes to embed use of EPC

Statewide

The staff of the four demonstration projects met monthly with each other through the coordination of GPDV. The main benefits of forming this projects group were that it:

- Enabled the projects to learn from each other and share resources developed,
- Provided moral support for project workers undertaking challenging change management in hospital environments that were variously receptive to GP involvement in discharge planning, and
- Acted as a clearinghouse for issues arising with eligibility for EPC and an avenue for taking up issues with the Commonwealth and the Health Insurance Commission.

In addition the projects group met with the key Commonwealth and State stakeholders on a quarterly basis so that these stakeholders had a good understanding of the difficulties and benefits entailed in getting the EPC discharge items to work.

Hospital

a) Preparation

Each of the four demonstration projects developed the following:

- A combined hospital/division steering committee.
- A substantial understanding of the rules re use of EPC items.
- A mapping of current admission and discharge processes in relevant units.
- An educational package and multiple deliveries for hospital staff individually, at unit level, and at management level.
- Documents/templates that fulfil EPC requirements for patients, GPs, hospital staff.
- Contact with GP practices to ascertain how best to involve GPs in discharge planning and acceptable wording re billing arrangements.

b) Engagement

In addition, to elicit the support of key players the projects:

- Held focus groups of GPs.
- Met with division boards, wrote in division newsletters, and presented at division education events.
- Worked with the division to overcome any barriers identified within the general practices, and progress any opportunities arising.
- Interviewed patients and carers about their attitude to their GPs involvement in discharge planning, and to issues around consent.

- Met with senior medical staff to ascertain how EPC might help their units' functioning.
- Conducted senior sponsored hospital staff education about GP involvement in discharge planning.
- Consulted the health information manager about how to incorporate the paperwork into the patient file.
- Consulted the ward clerks about how to incorporate the requirements into their work practices.
- Identified key local champions of GP involvement in discharge planning.
- Worked with senior management to overcome any barriers identified within the hospital, and progress any opportunities arising.
- Established regular communication mechanisms with key people in each unit targeted.
- In consultation with units developed process and paperwork for involving GPs in discharge for each unit, starting with education of all parties and individual trials of collaborative care-planning and case conferences to see what worked best.
- Following trials, sought feedback from all parties about what was working and what not, and modified processes accordingly.

c) Implementation

In terms of implementation the projects each developed different processes in each unit to fit with that unit's work practices, patient needs, and staffing. The report on St Vincent's project (Appendix C) outlines the procedure developed for St Vincent's Aged Care Services.

In brief, each unit had to identify people responsible for each of the following steps:

- Contact GP on patient admission to invite involvement in discharge planning (often by faxback).
- Record whether GP is interested in being included.
- Check whether patient is eligible for EPC item and record.
- If eligible and GP interested, seek patient consent, including patient pamphlet in appropriate language. Family member to be approached if patient unable to consent. Discuss patient needs on discharge and record.
- Record outcome of request for patient consent.
- A week before the discharge date, ring the GP to book a time for the HMO to phone to discuss discharge care-plan. Notify the team of the time booked.
- Before the GP phone call, all members of team enter information in the discharge summary in regards to the current status and plan for future. (For case conference all relevant team to be present).

- With semi completed care plans, the HMO should phone the GP, seek input and provide feedback about care-plan. Record GP input and agreements in regards to post discharge care.
- Finalise discharge care plan, send to GP, send the plan to other relevant community service providers, place a copy in patient file, give a copy of the care plan to the patient and explain it.
- The GP should bill the patient on their next contact.

Such processes worked best when they were linked to the hospital information technology (IT) system and the delegation of responsibilities complemented existing job descriptions.

Summary of key learnings

- Improving the awareness of the role GPs play in the community by hospital staff is a continuing and slow process.
- Workload and unit practices often make contact between the hospital and GP problematic.
- Introducing EPC processes into a large health service is a long-term endeavour due to the complexities of the work systems in a hospital, time pressures, and the requirements of the EPC items themselves.
- Paperwork which features hospital input and recommendations, and summary of contact with the GP is more acceptable to hospital staff than paperwork which appears to benefit the GP.
- IT systems and constant internal and external drivers for GP involvement in discharge planning for those with complex needs are required to establish and maintain EPC discharge compliant processes.

5. Common issues arising

With EPC descriptors

From the projects' point of view, working in a hospital setting to integrate the use of a specified set of new GP reimbursement arrangements created a number of difficulties. In general terms the four projects found that institutions such as hospitals find it difficult to adopt systems that cater for a narrow range of their customers/clients/patients. In those units where a larger number of patients were eligible for EPC items systems were more likely to be incorporated into ongoing practice.

It was easier to engage staff if the EPC items were seen to be useful for a range of high need patients requiring GP involvement in discharge arrangements. Thus the projects found that there was pressure to expand the range of patients eligible for the discharge items. Consequently throughout their operation the projects raised a number of issues of interpretation of the eligibility requirements with the Department of Health and Ageing and the HIC, and in some instances the projects adopted slightly different interpretations of the guidelines.

The four projects struggled with the EPC eligibility criteria in that they all found high need patients they felt could benefit from an EPC discharge plan or conference who did not fit the descriptors.

²*Commonwealth Department of Health and Ageing (May and November 2001, May and November 2002): Medicare Benefits Schedule Book, Canberra*

- According to the Medicare Benefits Schedule Book the EPC discharge items are only meant to be used for patients being discharged into the community. However, for patients with complex needs there was often a need for GP input around the pros and cons of the patient going home or to another setting. This is particularly relevant where the patient may need rehabilitation, nursing home type care or palliative care. Also when the patient was first admitted it was often important to have GP input to know what has been tried previously and what other factors might be impinging on the patient's health, that is before discharge home was planned.
- According to the Medicare Benefits Schedule Book² the EPC discharge items are only meant to be used when the patient is being discharged home. This means that when a patient is discharged via a base hospital or sub-acute facility an EPC item cannot be used. However the trail of information from the ward of origin through the other facility to the GP is often very poor.
- Some units, such as the pain management team and the infectious diseases team at Austin Health, had trouble with the EPC requirements for the involvement of a multi-disciplinary team. Patients seen by these teams are generally high need, with chronic and complex problems and are being seen by a team of two or three specialist physicians and the GP. While an EPC multidisciplinary team can include multiple specialists or consultant physicians, only one specialist or physician can count as one of the minimum three members of the multidisciplinary team. This is because an EPC care planning or case conferencing team must be multidisciplinary and not just comprise medical expertise. This meant that some of these patients who could have benefited from an EPC discharge plan or case conference were not eligible to receive one.

- It was not clear whether pregnancy related complexities were eligible for EPC discharge items, as pregnancy is not a chronic medical condition as there may or may not be ongoing health ramifications.
- The consultant case conferencing items are only available to consultant physicians and consultant psychiatrists. Other specialists, for example, neurosurgeons and gynaecologists, were less likely to be interested in learning about the care planning and case conferencing items in their public sector capacity if they could not use them in their private work. This was problematic when they had a contribution to make to a patient's future care. The possibility of claiming the items in their private work would make these specialists more interested in being involved in collaborative discharge planning in their public work.³
- Hospital staff were often unhappy about asking patients' consent to GP billing arrangements. They did not see this as their job.
- It was not clear to GPs (or the project workers) what they should do about claiming reimbursement if the patient did not attend the GP after hospitalisation if the GP had been involved in the patients care planning. This non-attendance might result from death, relocation to a nursing home, or patient mobility.⁴
- It was a challenge to involve private allied health service providers in the EPC discharge process because of remuneration issues.

Within hospitals

In the hospital settings common difficulties that arose for the four projects were as follows:

- Staff did not see the value in adding to their existing heavy workloads by involving the GP.
- Staff were uncomfortable with gaining patient consent to their GPs involvement and particularly to being billed.
- As noted above hospital systems are geared to applying the same systems to all patients within a ward. It was difficult to establish a system for a small proportion of patients for whom EPC discharge items might be applicable.
- The IT systems were not in place to facilitate recording and communication.

In two of the demonstration sites major upgrades of IT patient information systems were in train. During the limited time span of the project the IT system could not provide direct transfer of patient discharge summaries from the hospital to the GPs in one setting, and was in various stages of operation in different units within the other setting. A third site also was experiencing changes in the operation of the IT system which meant processes could not be duplicated across similar units. In each case project workers worked to ensure that EPC processes could be incorporated into the new systems as they came on stream but an interim process had to be developed.

³ The Department of Health and Ageing has noted that the EPC items are focused on primary care and allow reimbursement for GP involvement in care plans and case conferences. Reimbursement is available to physicians and psychiatrists for case conferences through the relevant consultant physician and consultant psychiatrist items which are complementary to the EPC items.

⁴ The Department of Health and Ageing has answered this by saying that the GP can send in the claim form with a note saying the patient is unable to sign.

- The physical infrastructure did not support a case conference (phone point, access to meeting room in close proximity to unit, access to good speaker -phone).

Division involvement

From the point of view of division involvement in these projects common difficulties that arose were as follows:

- There was key staff turnover.
- The demonstration hospitals' patient population was seen to be a tiny proportion of their GPs' workload (RWH specialist units, St Vincent's Health rural division partner).
- By the time the demonstration projects started division funding for EPC education had finished and so divisions had variable commitment to continuing education for GPs about EPC.

Other

EPC discharge items are only one tool available for promoting GP hospital partnerships in the care of patients with complex needs.

6. Recommendations

Commonwealth

Although the EPC discharge items were designed for one specific target group of patients (those with complex and chronic conditions with multi-disciplinary care needs being discharged home) the projects found that when it came to implementing the items from a hospital perspective there were other high need complex patients for whom GP involvement in discharge care planning or case conferencing would be beneficial. Hence the project teams recommended the following:

- Eligibility for EPC discharge services should be expanded to include patients who come from or are going to residential care facilities, patients who require a multi-medical team (each providing a different service to the patient), and patients for whom discharge home has not yet been decided.
- For hospital initiated discharge care-plans or case conferences, consideration should be given to deleting the requirement for a 'chronic' condition and instead, only requiring complexity in the patient's condition.
- Consent arrangements, particularly with respect to GP billing of the EPC discharge items should be reviewed to take into account the role of public hospital staff.
- Consideration should be given to incentives for shared care arrangements for patients with long-term disease.
- Funding should be provided for continuing EPC education for GPs and hospital staff.
- Research should be undertaken to assess the effect of GP involvement in discharge planning on patients and their families.

State

- The GPLO function should be supported as a key driver of collaborative arrangements between GPs and hospitals for coordinated patient care.
- Key performance indicators should be collected and published to encourage hospitals to assess their communication with GPs.
- All hospitals should be encouraged to notify GPs of their patients' admission to hospital.
- Change management projects such as these should be funded for at least eighteen months, and coordinated through a suitable third party to facilitate information sharing, problem solving and the efficiency of such projects. The third party is a valuable facilitator of communication between the projects, between the two levels of government, and between the two sectors.

Hospitals

- Senior hospital personnel should promote safe referral home to their staff as part of the hospitals' job.
- Hospitals should work with divisions to continue education about GP involvement in discharge planning.
- Hospitals should align position descriptions so that GP details are routinely documented and accessible.
- Hospitals should establish patient information systems to enable automatic communication with GPs from all units of the hospital.
- For complex patients, a hospital medical staff member should routinely contact the patient's GP as part of discharge information handover.

Divisions

- Divisions should continue to work with hospitals to maintain and develop GP involvement in discharge planning for patients with complex needs.

Appendix 1: Executive summary of each project

Austin Health, Northern Division of General Practice and North East Valley Division of General Practice:

At Austin Health 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 Austin Health campuses. The project achieved all of the aims stated in the funding submission:

- Strengthened relationships between the health service and GPs
- Increased awareness of Enhanced Primary Care principles and process in the health service.
- Increased awareness of EPC 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 was 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 health service 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 health service.

Eight areas were then targeted for involvement:

Palliative Care Liaison – EPC introduced at point of discharge for patients referred from medical and surgical units for advice. Twenty-six care plans were constructed with good feedback about the process and outcomes from GPs. This unit will be EPC sustainable in the future.

Pain Management Service – A consultancy service within the hospital. Patient requirements were 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. One EPC case conference and two care plans were attempted. EPC was found to be a useful tool for this group of patients and should be pursued in the long term. However, the item number descriptors may need some revision to accommodate the complexities of these patients.

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 eight care plans initiated at this stage were not successful, however, as they could not be organised during a short length of stay (48 hours). Despite this, the role of the GP has been enhanced by the inclusion of a GP presentation in the patient education seminars run by the unit. Overall, the needs for this patient group are complex and may be better coordinated through guidelines and shared care arrangements using community care plans rather than hospital based.

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 multi-disciplinary problems and would benefit greatly from a coordinated approach to management facilitated by the use of EPC. One case conference held with good feedback from all concerned.

Complex Discharge Team – Accepts referrals from all around the Medical Centre. Twelve care plans were completed and four case conferences attempted without success (due to patient condition changes). This unit has the ability to seed the EPC process throughout the health service. Sustainable use of EPC was demonstrated by this team.

Psychiatry Banksia House – Two case conferences were successfully conducted. Twenty care plans were completed in a one-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 outcomes were achieved from the use of EPC process in this unit. Negotiations and education processes for the CSU are continuing. It is expected that the EPC process will be sustainable in the long term.

Rehabilitation Hospital – Already had some exposure to the EPC process. The discharge practice on this campus was sophisticated and involved good communication with community service providers, however, the contact tended to be poorly 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).

Aged Care Rehabilitation Service – Concurrently conducting a review of their 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 Austin Health. 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 two to three years, the EPC process can be included in routine practice in all areas for appropriate patients.

Central Gippsland Health Service and East Gippsland Division of General Practice

Central Gippsland Health Service (CGHS) in partnership with the East Gippsland Division of General Practice (EGDGP) commenced the EPC Hospital Demonstration Project in February 2002. It was concluded in February 2003. The project team consisted of two part time project workers, with support from the EGDGP project worker, (EFT 0.2).

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 was intended to 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 built on CGHS improvements to their discharge processes to 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 long standing practice 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 strategy 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 six months. The project time period of twelve months was insufficient to adopt change in the processes in a large organisation and especially when considering the enormous geographic area in question.

Royal Women's Hospital, NorthWest Melbourne, Western Melbourne, Melbourne, and Ballarat and District Divisions of General Practice.

The EPC Demonstration Project at the RWH was conducted from 5 February 2002 until 31 January 2003. The project team consisted of a Project Officer (EFT 0.6) and a General Practice Liaison Officer (EFT 0.1). The collaborating divisions of general practice were NorthWest Melbourne, Western Melbourne, Melbourne, and Ballarat and District.

The project achieved the aims stated in the submission which were to:

- Improve the continuum of care from admission to post-discharge.
- Improve communication with GPs.
- Increase GP involvement in discharge care planning and case conferencing.
- Improve patient involvement in discharge planning.

The units initially involved in the project were:

- Women's Alcohol and Drug Service
- Fetal Management Unit
- Neonates and Oncology.

The project was extended in the second six months to include:

- The Diabetic Clinic
- Young Mother's Clinic
- Women with Individual Needs.

The project was withdrawn from the Fetal Management Unit in November 2002 as this unit had good communication with GPs and needed further resourcing to participate in such a project.

In total, nineteen care plans and two case conferences were generated from these units.

Some of the key learnings from this project were:

- The active support of department heads and unit managers is imperative for the successful incorporation of increased GP involvement in the discharge planning process.
- Where comprehensive communication already exists between a unit and community providers, it is very difficult to convince staff to take on extra work where there is little measurable benefit to patient care and outcomes.
- The EPC process should be discussed as one part in the range of communication with GPs.
- Hospital staff have difficulties with obtaining consent from patients for a process that may incur costs.
- The basic platform for GP communication needs to be resolved before more enhanced communication is achievable. These include the capturing and documenting of GP details and the GP directly receiving a discharge summary.
- When core members of a unit identify a gap in communication with community providers as a problem, it is likely the EPC process will be successfully incorporated into communication with GPs and will be sustainable.
- GPs were enthusiastic about increased communication with hospitals and to be involved in discharge planning for patients with complex care needs.
- Most GPs would bulk bill for their involvement in this service.
- GPs are able to reliably and easily predict which of their patients are going to have complex care needs on discharge.

St Vincent's Health and Inner Eastern Melbourne, Melbourne, and Otway Divisions of General Practice

“There have been big positives: extra attention is now paid to the phone call to the GP. The effect of the project has been to improve the discharge process and the information going to GPs” (Medical Registrar, HMO2).

Aim of the project

To promote joint care planning and enhance information exchange between St Vincent's Health staff and GPs using the EPC MBS discharge items.

The project aimed to:

- Upskill hospital medical, nursing, allied health and administrative staff in the use of the EPC MBS discharge items.
- Change care planning protocols and discharge planning processes so that the EPC discharge items could be employed.
- Invite GPs to participate in discharge planning using the EPC care planning and case conferencing item numbers for eligible patients.
- Gauge the success of the changes introduced through the project.

Scope of the project

The project had three patient category target areas:

1. Aged Care
2. Palliative Care
3. Rural (cardiothoracic)

The selection of the above patient categories was made on the basis of the requirement for the EPC MBS discharge items to be used with clients with chronic and complex care needs. In each of the selected categories it is common that patients have complex and chronic care needs.

The cardiothoracic unit was chosen as the site to 'target' rural clients because that unit is the only unit at St Vincent's Health where the rural admissions outnumber the metropolitan admissions.

Project outcomes

1. A functioning EPC discharge process (supported by policy) in the aged care service area (three wards) indicated by a regular number of approximately three EPC care plans or case conferences per ward, per week by the conclusion of the project.
2. A discharge database was developed during the project and at its conclusion was being used throughout the aged care service areas. The database produces discharge documents appropriate for EPC work including:
 - A multi-disciplinary discharge summary/EPC discharge care plan.
 - A patient discharge summary.
 - A residential care discharge summary.
 - An EPC case conference form.
 - Multiple other discharge referral forms (including a notification of death).
3. Development of materials for patients in five languages, which explain the EPC discharge process.
4. Upskilling of ward staff - medical, nursing, allied health and administrative - in the use of the database and EPC processes (Aged Care and Palliative).
5. Regular use of the multi-disciplinary discharge summary in template form in one of the palliative units.
6. Development of a palliative care discharge database based on the aged care database.
7. Development and distribution of a poster that promotes hospital/GP interaction in the interests of patient care.

Project failures

The project failed in the cardiothoracic unit.

Key findings from the project evaluation

GP data:

1. GPs value notification of a patient's admission, in addition to prompt notification of a patient's discharge.
2. GPs value direct personal contact with hospital staff to discuss both the admission and discharge of shared patients.
3. There was a consistently positive response from GPs to the introduction of a multi-disciplinary discharge summary. This discharge summary contains more information and is longer than the usual discharge summary.
4. GPs require comprehensive (but succinct) discharge information for patients with complex care needs.
5. The majority of GPs did not claim payment using the EPC MBS discharge item numbers for their involvement in discharge care planning/case conferencing (over time, it is possible that this finding could change).

Staff data:

1. There was a consistently positive response from staff regarding the importance of good communication at discharge with all carers involved in the patient's care post discharge.
2. Staff acknowledged that improving the quality of the discharge process is time intensive and that 'quality costs'.
3. Staff expressed the need for adequate support (upskilling/IT training/staff time) in their endeavours to improve and maintain the quality of discharge processes.
4. Staff acknowledged that the ebb and flow of constant staff movement (rotations, part time staff, shift work and usual staff turnover) could erode a quality process if it were not adequately supported and resourced.
5. Some medical staff (HMO1 and 2) acknowledged that they had little preparation for the 'relational' aspect of medical practice.

Patient data:

The project timeframe was too short to include patients in the evaluation (see below).

Learnings from the project

1. Why was the project successful in the Aged Care service area at St Vincent's Health?

- Strong and enduring endorsement from the aged care executive members of the health service that the project was important.
- Medical leadership and senior medical ownership of the project (which involved active encouragement and support of junior medical staff).
- Impressive and unified leadership by nursing staff across the aged care service area.
- Tremendous commitment from the staff at all levels to quality patient care.
- Engagement and support for the project from key allied health staff.
- Changed processes were embedded into usual ward routines.
- The importance of good community care as a necessary part of good hospital care was an integral element of the 'culture' of this service area.
- Ownership of the project by staff at all levels developed over time.
- Organisational pride in St Vincent's Health leading the field.

2. Why was the project moderately successful in the palliative care service area at St Vincent's Health?

- In principle endorsement rather than strong, active endorsement from the executive members representing the health service.
- The project was perhaps less of a priority than in the Aged Care service area.
- In principle support rather than strong, active support from most senior medical staff.
- Individually shaped medical involvement in EPC work.
- Generally, poor take-up (ownership) by junior medical staff (HMO1 and 2s).
- Patchy engagement of allied health staff.
- Lack of ownership of the project.
- Strong nursing leadership in one ward resulted in the most significant achievements coming from this service area.

The palliative service area showed great potential for realising many more changes and achievements. The short timeframe of the project denied the realisation of that potential.

3. Why did the project fail in the cardiothoracic service area at St Vincent's Health?

The project failed in the cardiothoracic unit because the unit manager believed that the present staff resources could not support the increased workload that the changes to practice would require.

However, the medical consultant, at the conclusion of the project remained interested in advancing efforts to improve communication and information between the hospital staff, GPs and rural consultants in the interests of patient care.

There was significant potential for development of the project had the timeframe been a little longer, because there existed:

- Strong support (which included action) from the executive members of the health service representing this service area.
- Medical leadership and support for the project.
- In principle support from key nursing staff.
- Good support from allied health staff.