

Medicare Enhanced Primary Care (EPC) Discharge Items - Information Kit

The Australian Health Ministers' Advisory Council (AHMAC) raised concerns earlier this year regarding the low uptake of the EPC MBS items for discharge care planning and case conferencing, and the difficulties in implementing these services. One strategy to address these concerns and increase uptake is the preparation of guidance for practitioners, hospital staff and allied health and care providers on using the EPC MBS discharge services.

An 'Exposure Draft' of such guidance has now been prepared and a copy is attached for your information and use. This Exposure Draft draws on comments and suggestions from a range of stakeholders and is being released in a simple format (booklet, fact sheets and proformas) for ease of dissemination and flexibility in use. The kit will be widely distributed for use in consultation and development work and as a supporting document for local forums and demonstration projects on use of the EPC discharge items.

The information kit contains:

- a booklet with general information and case studies;
- 10 Fact Sheets designed to provide information targeted to the needs of specific users, including general practitioners, patients and carers, hospitals and allied health professionals, and to explain different aspects of EPC discharge services; and
- proformas for an EPC discharge care plan and for a summary of an EPC discharge case conference (the fact sheets and proformas have been consolidated into one document for ease of transmission).

The kit can be used either as provided or adapted to local needs and local circumstances. Users of the kit are encouraged to integrate it into their local practices.

The information kit is presented as an Exposure Draft with the purpose of generating comments and suggestions based on actual experience in using EPC discharge services, which will be used to develop final EPC discharge guidance in mid-2002. Any comments and suggestions regarding this information kit should be made to the EPC Implementation Team, Department of Health and Ageing (contact Martin Mullane on 02 6289 7184 or Phoebe Baker on 02 6289 8735). Comments can be made at any time up to 15 March 2002, when detailed preparation of final guidance will commence.

Please contact Phoebe Baker by COB Friday 17 December if you need hard copies of the documents. Please let her know if there are any other people whom you think would benefit from receiving this information.

EXPOSURE DRAFT

THE ENHANCED PRIMARY CARE MEDICARE ITEMS

FOR DISCHARGE CARE PLANNING AND CASE CONFERENCING

**Guide for Patients and Carers, General Practitioners,
Hospital Clinicians, Allied Health and Community Care
Providers**

**[Where adapting this guidance material for local use and circumstances include
Hospital(s) name(s) & contact details for EPC discharge issues]**

December 2001

INTRODUCTION

This booklet forms a part of a kit intended to provide relevant information on the Medicare Enhanced Primary Care (EPC) discharge items. The booklet contains general information and an overview of the items, including the rationale behind their introduction, the benefits of EPC discharge planning services, the Medicare requirements for use of the EPC items, and case studies to illustrate key elements of EPC discharge care planning.

The information kit also contains 10 individual fact sheets designed for different stakeholders and explaining different aspects of the EPC discharge services. These fact sheets are intended to provide a simple format for disseminating information tailored to specific target groups or to specific aspects of EPC discharge care planning as follows:

FACT SHEET 1	General information
FACT SHEET 2	Information for patients and carers
FACT SHEET 3	Information for GPs
FACT SHEET 4	Information for hospitals
FACT SHEET 5	Information for allied health professionals
FACT SHEET 6	Preparing and contributing to a discharge care plan – at a glance
FACT SHEET 7	Flow Chart for Care Planning
FACT SHEET 8	Organising and participating in a discharge case conference – at a glance
FACT SHEET 9	Flow chart for case conferencing
FACT SHEET 10	Medicare Benefits Information

Sample proformas for EPC discharge care planning and case conferencing are also included in the kit. These proformas may be used as provided or adapted to local needs.

The information kit is presented as an Exposure Draft with the purpose of generating comments and suggestions based on actual experience in using EPC discharge services, which will facilitate the development of the final guidance.

This booklet and the fact sheets are designed to be used and adapted to local circumstances, including to support specific projects funded to demonstrate use of the EPC discharge services. All users are encouraged to integrate this kit into their local practices and to make any suggestions for improvements.

Any comments and suggestions regarding this information kit should be made to the EPC Implementation Team, Department of Health and Ageing (contact Martin Mullane on 02 6289 7184 or Phoebe Baker on 02 6289 8735).

MEDICARE EPC DISCHARGE ITEMS

The Medicare EPC discharge items provide Medicare rebates for EPC discharge care planning and EPC case conferencing services. They were introduced in November 1999 as part of the Enhanced Primary Care (EPC) Package. These items provide an ideal opportunity for greater involvement of GPs, allied health professionals and other care providers in planning for the post-discharge care needs for patients with chronic medical conditions and complex care needs.

EPC discharge care plans and case conferences differ from other EPC items in that they are available to patients in hospital and are focused on their post discharge care needs. EPC discharge care planning and case conferencing services provide flexibility in addressing discharge care needs. While EPC discharge care planning focuses on the management of longer-term needs, discharge case conferencing can allow GPs to address immediate, shorter term and more urgent needs of patients being discharged from hospital.

EPC discharge services are targeted at a specific category of patients – those with chronic conditions and complex needs requiring coordinated care from a team of health and care providers. They are not intended for patients being discharged from hospital with health and care needs that can be addressed by routine medical care.

EPC discharge care planning

An EPC discharge care plan is a comprehensive, longitudinal plan for the care of an individual patient, with at least one chronic or terminal medical condition and multidisciplinary care needs, being discharged into the community from a hospital or day hospital facility.

The planning process generally includes the following steps:

- a) Identifying and describing:
 - relevant diagnosis, prognosis and /or other problems relating to the patient;
 - specific medical treatments and medications required;
 - other care and self management techniques (where appropriate); and
- b) identifying the patient's multidisciplinary care needs through a biopsychosocial assessment covering:
 - the patient's general health and review of relevant medical history and problems;
 - medication review (where appropriate);
 - physical and mental functioning;
 - the social needs of a patient including the adequacy and suitability of practical support; and
 - the impact of the chronic condition(s) on quality of life; and
- c) inviting contribution from the relevant identified health and other service providers in establishing management goals in relation to the identified problems and needs (EPC discharge services can only be provided by a multidisciplinary team, which must comprise at least three health or care providers); and
- d) preparing a written document (the plan) outlining the outcomes of the planning process, including:
 - the patient's health and care needs;
 - the outcomes and management goals being sought;
 - the kinds of treatment, health services and health care that the patient is likely to need on discharge from hospital;
 - any other service or support the patient is likely to need;
 - arrangements, such as appointments, medication lists, planned investigations, that have been made to meet the treatment, services, and care needs of the patient; and

- how and when the plan will be reviewed.

EPC discharge case conferences

An EPC discharge case conference is a meeting of health and care providers to plan for the immediate care needs of an individual patient with a chronic condition and complex needs being discharged into the community from a hospital or day hospital facility. At the case conference, the multidisciplinary case conferencing team:

- discusses a patient's medical history, diagnosis and current condition
- identifies the patient's multidisciplinary care needs;
- assesses whether previously identified outcomes (if any) have been achieved;
- identifies outcomes to be achieved by members of the case conference team providing care and service to the patient;
- identifies tasks that need to be undertaken to achieve these outcomes, and allocates those tasks to members of the case conference team; and
- agrees on appropriate review arrangements.

BENEFITS OF EPC DISCHARGE SERVICES

Benefits for care providers

By involving a multidisciplinary team in the coordination of care and services required by the patient, EPC discharge care planning and case conferencing can help to share the load of caring for the patient and meeting the patient's needs. Without a coordinated, team approach, the burden of care can fall unfairly and unequally on one party only.

Benefits for patients and carers

Discharge care planning has the potential to greatly enhance continuity of care following discharge for a chronically ill patient with complex care needs, by enabling all parties involved in the care of the patient to consult together in planning for effective ongoing patient care. This helps ensure that care providers are in a better position to provide appropriate care and support to the patient.

A care plan is likely to facilitate coordinated follow-up action by clearly articulating:

- the patient's care needs and the outcomes being sought;
- how these needs will be met;
- self-management techniques and home management strategies to give the patient more control of his/her condition; and
- details of all care and service providers who will be involved in the care of the patient, and of arrangements for the provision of their care and services.

As a copy of the plan is given to the patient and carer, it can be:

- read and absorbed within the patient's own time;
- referred to from time to time and in discussing matters of concern with providers; and
- a very important way of transferring information gathered in the discharge process from the hospital to the community.

Benefits to GPs

GPs and others involved in providing care to the patient will benefit by having

- greater involvement in the on-going care of the patient; and
- up-to-date information about the patient's medical condition and health and care needs on discharge; and
- up-to-date information about other providers involved in the care of the patient.

Benefits to the hospital

Effective discharge planning can help support earlier discharge from hospital and potentially reduce the rate of unnecessary readmissions. This can contribute positively to hospital performance measures and to the management of demand growth at the tertiary level. Coordinating the delivery of services to meet post-discharge care needs can impact significantly on patient recovery and potential for independent living in the community.

Benefits to the community

Improving communication processes surrounding the discharge of patients with chronic conditions and ongoing multidisciplinary care needs will help to ensure that such patients are discharged into the community with appropriate access to required services.

EPC DISCHARGE SERVICES AND MEDICARE BENEFITS

Medicare benefits are available for services provided by **medical practitioners**. Services provided by allied health professionals or other service providers are not covered under Medicare. In some cases such providers may be salaried employees of hospitals or other organisations. In other cases services may be covered under private health insurance for patients with private health cover. Before an EPC discharge service is provided, the patient must be made aware of any out-of-pocket expenses which may be incurred as a result of the service.

The level of the Medicare rebate for a particular item depends on whether the service is an in-hospital or an out-of-hospital service.

In-hospital services

Medicare benefits are not payable for in hospital services provided to **public patients**. A **public patient** is an eligible person who receives or elects to receive a public hospital service free of charge.

In-hospital services provided to a **private patient** attract a Medicare rebate of 75% of the Medicare Benefits Schedule fee. The balance (25 % of the schedule fee) and amounts above the Medicare Benefits Schedule fee may be claimable from the patient's private health fund or self-funded. A **private patient** is a person who elects to be treated as a private patient. Private patients may be patients in a private hospital, or patients who elect to be responsible for fees relating to hospital charges.

Out-of-hospital services

Out-of-hospital services attract a Medicare Rebate at 85% of the Medicare Benefits schedule fee for both private and public patients.

The discharge items are categorised as follows:

In-hospital services:	Out-of hospital services:
<ul style="list-style-type: none">• Preparing a discharge care plan• Organising and coordinating a discharge case conference.	<ul style="list-style-type: none">• Contributing to a discharge care plan being prepared by someone else• Participating in a discharge case conference organised by someone else.
<i>These services are part of in-hospital care and are available to private patients only.</i>	<i>These services complement hospital discharge services and are available for public and private patients.</i>

Medicare Eligibility Requirements (see also MBS book, November 2001)

To be payable under Medicare, the following requirements must be met:

- The patient must be a person with at least one chronic medical condition, that has been present or is likely to be present for at least six months (or is terminal) and multidisciplinary care needs;
- The discharge care plan must be prepared by and the discharge case conference must be organised and coordinated by the medical practitioner providing in patient care or by hospital staff designated to manage discharge care planning - these items are available to private patients only;
- The care planning or case conferencing team must include the person preparing the plan and at least two other health professionals or care providers, from different disciplines. Each member of the multidisciplinary team must provide a different kind of care or service to the patient. In addition to the patient's usual GP, one of the other health professionals on the team may be a medical practitioner, normally a consultant physician or specialist; and
- The patient must consent to the discharge care planning or case conference and to the involvement of his or her usual GP.

Medicare benefits are available for one discharge care plan for each eligible hospital admission. A discharge care planning service should not be provided on the same day as a discharge case conferencing service. A discharge care plan may be reviewed (by the medical practitioner who prepared it) once in any three-month period but not within one month of the plan being prepared.

RELEVANT ISSUES

The patients usual GP

EPC services should generally only be undertaken by the patient's usual GP. This means the GP, or a GP working in the medical practice, that has provided the majority of medical services to the patient over the previous twelve months, and/or will provide the majority of services over the coming twelve months.

The patient's usual GP can prepare a discharge care plan and organise and coordinate a discharge case conference, if the patient is a private patient and their usual GP is providing in-patient care to that patient in a fully private capacity. The patient's usual GP may contribute to a discharge care plan or participate in a discharge case conference for a *public or private patient* at the invitation of the hospital.

Visiting Medical Officer (VMO) arrangements

Visiting medical practitioners are employed to provide services for and on behalf of a hospital under VMO arrangements. Accordingly, services provided by a VMO do not attract Medicare benefits, except where the doctor provides them in a fully private capacity, separate from any VMO arrangements.

Patient consent

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

- the patient/carer is informed of the planned discharge care plan or case conference service and what is involved;
- the patient is informed that his or her medical history, diagnosis and care preferences will be discussed with other care providers;
- the patient (and their carer where appropriate) has the opportunity to specify any information that he/she wants conveyed or withheld from other providers; and
- the patient is advised of the fee and Medicare rebate for the case conference and of any other costs involved, ie for allied health services.

Care planning

Although Medicare benefits are available for a discharge plan to be prepared for each hospital admission, this may not be necessary or appropriate for all admissions. It may be more useful to review any previous discharge plan, where members of the multidisciplinary team are already in place. A review process can be more efficient than developing a new plan and can assist in determining whether failure to meet some outcomes may have contributed to the current admission. Where the patient's medical condition or care needs have changed significantly since the last admission it may be appropriate to prepare a new discharge plan relating to discharge needs for that admission.

FACILITATING THE USE OF THE EPC DISCHARGE ITEMS

Hospitals

Hospitals can play a significant role in promoting the use of the Medicare EPC discharge items by incorporating them into their practices and ensuring there are procedures and systems to support their use. For example, hospitals can ensure there are standard procedures for:

- recording key information, such as the patient's usual primary care provider(s), informal carer on admission;
- documenting an *estimated* date of discharge within 24 hours of a patient's admission;
- identifying patients, on admission or soon thereafter, who already have multidisciplinary care being provided or who would benefit from EPC discharge care planning on discharge into the community;

- providing eligible patients and their carers with information about discharge care planning (eg see fact sheet on *Information for Patient's and their Carers*, which can be adapted to local needs);
- gaining and recording patient consent to proceed with a discharge case conference or a discharge care plan;
- gaining and recording patient consent to invite the patient's usual GP to contribute to a discharge care plan or participate in a discharge case conference in the case of public patients;
- establishing information requirements and developing effective communication processes and mechanisms to facilitate required communication, particularly with GPs, allied health professionals and other service providers within their catchment area.

Incorporating this type of discharge care planning into hospital practices is likely to be more effective where local experience and existing relationships in the provision of discharge services are taken into account.

Allied Health and Community Care Providers

Addressing the needs of a patient with a chronic medical or terminal condition and complex care needs requires a multidisciplinary approach. However, these services have historically worked with minimal interaction. A coordinated approach based on the EPC MBS items for discharge case conferencing and care planning can improve functional outcomes by promoting effective communication, and can help empower patients to manage their symptoms, like pain, more effectively.

Allied health and community care providers interested in participating in EPC discharge care planning should ensure that GPs and hospital staff in their area are aware of their interest and availability.

Informal carers

With increasingly shorter hospital stays, the successful outcome of the patient's return home will frequently depend upon the support carers can provide. Yet often they are not well informed, consulted or offered support as part of the discharge planning process.

A patient's informal carer may have an integral role in the patient's post-discharge care and will also have valuable contribution to make in planning the discharge care needs of the patient. It is important that the informal carer is consulted and involved in discharge care planning wherever possible and as soon as possible and kept informed throughout the process.

A patient's informal carer can be included as an additional member of a discharge care team, however, informal carers do not count towards the minimum of three health or care providers necessary for payment under Medicare.

Consultant physicians

There are separate MBS items for case conferencing by consultant physicians. While these items are not part of the EPC package, they take into account appropriate linkages with the EPC MBS items. The Medicare requirements are similar to those applying to the GP items, including which services may be provided to private and to public patients, excepting that:

- the multidisciplinary team must involve the consultant physician plus three other care providers, each from a different discipline; and

- GP case conferencing items have three time tiers (at least 15 but less than 30 minutes; at least 30 but less than 45 minutes; and at least 45 minutes). Consultant physician items have two time tiers (at least 30 but less than 60 minutes, and more than 60 minutes).

PRINCIPLES OF EPC DISCHARGE PLANNING

The following principles underpin the use of the EPC MBS items for discharge care planning and discharge case conferencing.

For patients with chronic conditions and complex needs, requiring care and treatment from multiple health and care providers:

- Discharge planning is an integral part of the patient's hospital care, and is a shared responsibility of all health and care providers involved in their care.
- The patient's discharge needs should be identified as early as possible, following admission.
- The involvement of a patient's usual doctor is essential for the smooth transition of the patient back into the community.
- The patient and his or her carer(s) should be consulted and kept informed at all stages of the discharge process, and advised of the care and treatment that will be required after leaving hospital.
- Discharge from hospital should be timely and linked to appropriate and available health and community based services.
- Hospital-based discharge planning should be coordinated by a designated person/staff with:
 - up to date knowledge, including knowledge of
 - the services available in the community;
 - referral procedures; and
 - average waiting times; and
 - a strong ability to liaise (and forge links) with service providers, health professionals, patients and carers.

Further information

Further information can be obtained from:

- EPC explanatory notes in the Medicare Benefits Schedule book, November 2001 (Department of Health and Ageing, 2001)
- the Department of Health and Ageing Website
www.health.gov.au/hsdd/primcare/enhancpr/enhancpr.htm
- the Medicare Enquiry Line on 13 20 11
- RACGP Standards and Guidelines for the Enhanced Primary Care MBS items, checklists and proformas (available on the RACGP website: www.racgp.org.au)
- State Based Organisations and local Divisions of General Practice.

CASE STUDY 1: Discharge Care Planning

Mr Roberts is a 73-year-old widower who lives on his own. Mr Roberts has a history of Chronic Obstructive Pulmonary Disease (COPD), Hypertension and Non Insulin Dependent Diabetes (NIDDM). His diabetes control has deteriorated since his wife died and it is thought to be due to an irregular diet. He is frequently hospitalised for acute exacerbation of his COPD. This is his 3rd admission this winter. Mr Roberts would benefit from a discharge care plan in view of his chronic conditions, need for care and treatment from multiple health and care providers, and his frequent hospital admissions. The overall purpose of the plan is to provide better-coordinated care, to assist him to more effectively manage his health and to prevent unnecessary readmissions.

On admission to hospital Mr Robert's details, including the name of his usual GP, are referred to the hospital's discharge planner attached to the thoracic unit. The hospital and the local Division of General Practice have established arrangements for interested GPs in the Division to participate in EPC discharge services. The hospital maintains a list of GPs who are willing to contribute to EPC discharge services for their eligible patients being discharged from hospital, one of whom is Mr Roberts GP.

The discharge planner visits Mr Roberts and explains how he may benefit from an EPC discharge planning service, what is involved and which health and care providers could be included in a discharge care plan team. Mr Roberts agrees to have a discharge care plan developed, to the involvement of his GP, and to the sharing of his medical information with the members of the team.

In consultation with the Registrar managing Mr Roberts' in-patient treatment, the discharge planner prepares a draft EPC discharge plan which is faxed to Mr Roberts' GP and to the other members of the discharge planning team. The discharge planner then phones Mr Roberts' GP to discuss the draft plan, and to confirm Mr Roberts' health care needs, management goals, the treatments and services required and arrangements to provide them. The plan is finalised with the input from the GP and other members of the team and copies provided to Mr Roberts and the team (*see next page*).

PC Multidisciplinary Discharge Care Plan

GP Prepares

Review

GP Contributes

Discharge Care Plan 722

728

728

Patient's GP: Mr George Practitioner

Mr John Roberts	DOB	26
/06/1928		
33 Roberts St, Robertsville		
Carer: None		

Patient's Carer: None

Contact details _____

Previous Discharge/Community Care Plan?

Yes Date 27/6/01

No

Relevant History/ Diagnosis from Bio-psychosocial Assessment of Patient

COPD, Hypertension, NIDDM, Benign Prostatic Hypertrophy

Current medications

Enalapril 5 mg (morning)

Metformin HCL 500mg twice daily

Seretide 2 puffs twice daily

Atrovert 2 puffs four times daily

Multidisciplinary Discharge Care Planning Team

Name	Discipline	Contact	Agreement Obtained (date/method)	Providers Comments
Mr George Healer	GP			
Ms Pauline Islet	Diabetic Educator			
Ms Olive Longarms	Outreach nurse			
Mrs Jackie Pulser	Pulmonary Rehabilitation Program, Discharge Planner.			

I agree to my GP Preparing/Contributing a discharge care plan for me.

I agree to my GP sharing medical or other information with the identified Health Care Providers.

I do/ do not have any information that I want withheld from other participants (if information to be withheld please specify: _____)

I am aware that there is a fee for my GP's involvement in the preparation of this Care Plan for which a Medicare rebate will be payable.

Patient's Signature _____ Date ____/____/____

EPC Multidisciplinary Discharge Care Plan

Patient's Name: Mr H. Roberts

DOB: 26/6/1928

I agree to the above care plan and have received my copy.

Patient's Signature _____

Date _____

Care Plan Review date: _____

Problems/ Needs Identified from bio-psychosocial assessment	Management Goals	Treatment Plan (Tasks/treatments to meet goals)	Person responsible for care	Contact Details
Chronic obstruction pulmonary disease	<ol style="list-style-type: none"> 1. Prevent exacerbations and hospital admissions 2. Improve baseline lung function 	<ol style="list-style-type: none"> 1. Initial medication and post discharge education 2. Pulmonary rehabilitation and education about self management of problem 3. Assess for Home Medicines Review (HMR) and immunisation 4. Fluvax yearly and check pneumovax status 	<p>Outreach Nurse</p> <p>Pulmonary Respiratory Nurse</p> <p>GP</p> <p>GP</p>	
Diabetes control	BSL with insulin limits or Stable HbA1c	<ol style="list-style-type: none"> 1. Education about management and monitoring of diabetes 2. Diet advice and follow-up 	Diabetic Educator	
Hypertension	Maintain BP below 140/85	<ol style="list-style-type: none"> 1. Enalapril 2. Diet modification to reduce weight 3. Exercise 	GP Diabetic Educator	
Polypharmacy	Minimise to necessary medications	<ol style="list-style-type: none"> 1. Review for HMR 2. Dosette Box 	GP	

CASE STUDY 2: Discharge Case Conference

Mrs Morgan is 44 years old, single with two teenage children. She has a history of depression, including a previous suicide attempt, and analgesic abuse. She has been admitted into hospital for a left mastectomy and axillary clearance. She will be in hospital for three days and will be discharged home with drain tube in situ. Mrs Morgan became quite depressed whilst in hospital. Ward staff had concern about possible risk of self-harm following discharge and arrangements were made for her to be seen by the psychiatry unit. Pain management has also been difficult following her operation. The Breast Care Nurse and hospital social worker agreed that Mrs Morgan's has complex health and care needs arising from her multiple chronic conditions and urgent and acute post-discharge needs.

The Breast Care Nurse contacted Mrs Morgan's GP and confirmed that she would be available later that day to participate in a discharge case conference to address Mrs Morgan's immediate care needs on discharge from hospital.

Organising the case conference

- The Breast Care Nurse sought and obtained Mrs Morgan's consent for her to:
 - Organise and coordinate a discharge case conference;
 - To involve Mrs Morgan's usual GP in the case conference; and
 - To share information concerning Mrs Morgan's health and care needs with the GP, hospital social worker and Psychiatry Registrar.
- Confirmed the availability of the GP and the hospital social worker;
- Arranged for the meeting to take place by teleconference later that afternoon, prior to Mrs Morgan's planned discharge the following day; and
- Faxed the details of Mrs Morgan's situation and an outline of the issues to be discussed to the GP.

At the case conference:

- The Breast Care Nurse outlined the situation – including:
 - the procedure used in the removal of the breast, the staging and prognosis;
 - the status of Mrs Morgan's wound;
 - the medication being given to Mrs Morgan; and
 - what Mrs Morgan had been told about her condition.
- The GP raised concern about Mrs Morgan's;
 - previous history of analgesic abuse;
 - past history of depression; and
 - lack of family support.
- Given the identified risk of self harm and lack of social support which was confirmed by the GP, it was felt that she would benefit from regular contact with the social worker and initially home visits would occur but ongoing management would be through the Out-Patients Department. The GP would visit her at home to monitor analgesic requirements and reinforce the need to move towards non-narcotic pain management.
- The social worker undertook to visit Mrs Morgan at home following discharge and arrange support for her children and access to counselling to help with her depression.
- A plan to monitor and address these problems was developed (*see summary of case conference on following page*).

Please use I.D. label or block print

Summary of the Discharge Case Conference

Date: 21/11/2001 Start Time: 10.00 Finish Time: 10.28

Surname : Morgan	MRN
Given Name: Pauline	
DOB 11/03/1957	Sex: Female
Doctors name Dr M Lindfield	

Items

Duration of meeting	15-29 mins	30-45 minutes	>45 minutes
GP coordinates and prepares	746 <input type="checkbox"/>	749 <input type="checkbox"/>	757 <input type="checkbox"/>
GP contributes:	768 <input checked="" type="checkbox"/>	771 <input type="checkbox"/>	773 <input type="checkbox"/>
		30-60 mins	> 60 mins
Consultant Physician coordinators & prepares		809 <input type="checkbox"/>	811 <input type="checkbox"/>
Consultant Physician participates		813 <input type="checkbox"/>	815 <input type="checkbox"/>

INTERPRETER REQUIRED? No COPY /SUMMARY TO PATIENT OR OTHER SERVICE PROVIDERS Yes

IDENTIFIED PROBLEMS	MANAGEMENT GOALS	MANAGEMENT STEPS/ACTIVITIES	CARE PROVIDER DETAILS	DISCUSSED WITH CARE PROVIDER date etc
Wound Management after the mastectomy	No infection Wound healing satisfactorily	Regular review at home	Breast Care Nurse	21/11/2001
Depression	Treat Depression	Supportive counselling Paroxetine	Social worker GP	21/11/2001
Pain Management	Patient to remain pain free	Monitor narcotic analgesic use Reduce narcotic analgesic use over agreed timeframe	GP Social worker	21/11/2001

CONSENT TO PROCEED WITH DISCHARGE CASE CONFERENCE VERBAL CONSENT Yes Date: 19/11/2001

My GP/ Discharge Coordinator has explained the purpose of the Discharge Case Conference and I give/my carer gives permission to discuss the above issues, with the providers listed. I am aware that there is a fee for my GP's involvement in this Discharge Case Conference, which is rebatable from Medicare.

Signed: Date: __/__/__ Signature of GP/ Discharge Coordinator: _____ Date __/__/__

CASE STUDY 3: Discharge Case Conference

Mr Jones is a 59 year-old Aboriginal man suffering from advanced renal failure requiring dialysis, diabetes (IDDM), hypertension, and prostate disease. His condition requires peritoneal dialysis and he was admitted to hospital to stabilise his renal function. Mr Jones has indications of poor nutrition, poor hygiene and poor short-term memory. His major medical problems seem to be difficulty in controlling his diabetes, managing his dialysis and alcohol use. He lives alone in his house but is regularly visited by his 36 year-old son. His son lives close by, has visited his father in hospital and is keen to help keep him out of hospital.

A case conference to discuss the management of Mr Jones' discharge care needs was organised by the hospital discharge coordinator. The case conference team included Mr Jones' usual GP, an Aboriginal Community Health Worker, and a Community Nurse. The nature of the case conference was explained to Mr Jones and to his son, and they agreed to this discharge service being provided and to information about Mr Jones' condition and health care needs being discussed by the case conference team.

Mr Jones' son met the discharge coordinator at the hospital and participated in the case conference as Mr Jones' family carer, with the GP, the Aboriginal Community Health Worker and the Community Nurse participating by telephone. The participants acknowledged that the complexities of Mr Jones' conditions meant that he may need to consider residential care in the near future, as living alone at home may not be viable in the longer term. However, given the commitment of Mr Jones' son, and the support that could be provided by the Aboriginal Community Health Worker, the case conference team decided that Mr Jones could be discharged to his home on trial with increased social and nursing support. This would include training and support by the team in:

- self-care techniques;
- the management of his peritoneal dialysis;
- improved diabetes control; and
- appropriate health and hygiene practices.

The team also agreed that Mr Jones should be assessed by the local Aged Care Assessment Team to identify whether he needs to move into residential care in the medium term.

The Aboriginal Community Health Worker took responsibility to manage Mr Jones as his case manager. She would monitor Mr Jones at home and liaise regularly with his GP and his son. Mr Jones' son would arrange to take Mr Jones to see his GP regularly. Mr Jones and his son agreed to these arrangements.

Outcomes:

- The need for extended Acute Hospital in-patient admission has been avoided.
- Mr Jones has agreed to an ACAT assessment and to consider relocating to permanent residential care when a bed becomes available.
- Mr Jones GP has been able to manage Mr Jones with the multidisciplinary support arranged.
- There has been a coordinated approach and improved communication as all involved in the care of Mr Jones, including his son as the family carer, are aware of his needs and of each others role.

EXPOSURE DRAFT
Medicare EPC Discharge Items

Please use I.D. label or block print

Summary of the Discharge Case Conference

Date: 19/11/2001 Start Time: 12.00 Finish Time: 10.43

Surname : Jones	MRN
Given Name: Humphrey	
	Sex: Male
Doctors name Dr M Lindfield	

Items

Duration of meeting 15-29 mins 30-45 minutes >45 minutes

GP coordinates and prepares 746 749 757

GP contributes: 768 771 773

30-60 mins > 60 mins

Consultant Physician coordinators & prepares 809 811

Consultant Physician participates 813 815

INTERPRETER REQUIRED?

COPY /SUMMARY TO PATIENT OR OTHER SERVICE PROVIDERS

IDENTIFIED PROBLEMS	MANAGEMENT GOALS	MANAGEMENT STEPS/ACTIVITIES	CARE PROVIDER DETAILS	DISCUSSED WITH CARE PROVIDER date etc
Diabetes	Controlled BSL	Diet Advice Regular Monitoring of Blood sugar level Review by nephrologist, ophamologist, dietician and podiatrist to occur in 12 months	Aboriginal health Worker Community Nurse GP	19/11/2001
Renal Failure	Maintain renal function	Management of peritoneal dialysis Enalapril and appropriate diet (referral to dietician)	Community Nurse GP	19/11/2001
Hypertension	Maintain blood Pressure below 130/80	Enalapril	GP	19/11/2001
Difficulties managing Activities of Daily Living	Regular meals Improved hygiene Improve living conditions	Monitor food availability and intake Ensure food available on weekends, visit daily and undertake regular washing and cleaning	Meals-on-wheels Son	19/11/2001

EXPOSURE DRAFT
Medicare EPC Discharge Items

CONSENT TO PROCEED WITH DISCHARGE CASE CONFERENCE VERBAL CONSENT

 Yes

Date: 17/11/2001

My GP/ Discharge Coordinator has explained the purpose of the Discharge Case Conference and I give/my carer gives permission to discuss the above issues, with the providers listed. I am aware that there is a fee for my GP's involvement in this Discharge Case Conference, which is rebatable from Medicare.

Signed: Date: __/ __/ __ Signature of GP/ Discharge Coordinator: _____ Date __/ __/ __

EXPOSURE DRAFT
Medicare EPC Discharge Items

Medicare EPC Discharge Items

<i>FACT SHEET 1</i>	<i>General information</i>
FACT SHEET 2	<i>Information for patients and carers</i>
FACT SHEET 3	Information for GPs
FACT SHEET 4	Information for hospitals
FACT SHEET 5	Information for allied health professionals
FACT SHEET 6	Preparing and contributing to a discharge care plan – At A Glance
FACT SHEET 7	Flow Chart for Care Planning
FACT SHEET 8	Organising and participating in a discharge case conference - At A Glance
FACT SHEET 9	Flow chart for case conferencing
FACT SHEET 10	Medicare Benefits Information

Proformas to support EPC Discharge Care Planning and Case Conferencing are also attached.

EXPOSURE DRAFT
Medicare EPC Discharge Items

General Information

Introduction

The EPC discharge care planning and case conferencing items were introduced in November 1999 as part of the Enhanced Primary Care (EPC) Package. Their objective is to enable GPs, other health professionals and service providers to work together in planning for the care needs of patients with chronic conditions and multidisciplinary needs who require ongoing care after discharge from hospital.

What is an EPC discharge care plan?

An EPC discharge care plan is a comprehensive, longitudinal plan for the care of an individual patient returning to the community after discharge from hospital.

What is an EPC discharge case conference?

An EPC discharge case conference is a meeting of health and care providers to plan for the immediate care needs of an individual patient being discharged into the community from a hospital or day hospital facility. While care planning is a longitudinal approach to management, case conferencing involves immediate management plans, to address shorter term or more urgent needs, or to reach consensus about discharge care.

Who is eligible to receive these services?

A patient of any age being discharged from hospital, who has a chronic medical condition and multidisciplinary care needs involving at least two other health professionals or service providers, is eligible for EPC discharge services.

Who can prepare a discharge care plan or organise a discharge case conference?

An EPC discharge care plan or case conference may be prepared or organised by the medical practitioner providing in-patient care, in the case of a private patient, or by hospital staff with responsibility for discharge planning, in the case of public patients. At least two other health professionals or care providers, each providing a different kind of service to the patient, must be involved in the preparation of an EPC discharge care plan or case conference.

The patient's usual GP can **prepare** an EPC discharge care plan and **organise and coordinate** an EPC discharge case conference for a **private** patient under his or her care. As public hospitals are funded under the Health Care Agreements to provide discharge services for public patients, in the case of a **public patient**, the patient's usual GP may **contribute** to the preparation of a discharge care plan, or **participate** in a discharge case conference **at the invitation of the hospital**.

Who can contribute to a discharge care plan or case conference?

A medical practitioner or an allied health professional or community care provider who will be providing care or treatment for the patient can contribute to a discharge care plan or participate in a discharge case conference. This includes pharmacists, physiotherapists, community nurses, occupational therapists, psychologists, Aboriginal health workers, probation officers, social workers, mental health nurses, home help, meals on wheels, and day care staff. Where a care plan is being prepared by a person other than the patient's usual GP it is advisable to involve the patient's usual GP.

Are Medicare benefits payable for these services?

Medicare benefits are available for EPC discharge services provided by GPs (there are also separate Medicare items which cover discharge case conferencing by consultant physicians). The level of the applicable Medicare rebate depends on whether the service claimed is for organising, or for

EXPOSURE DRAFT
Medicare EPC Discharge Items

participating in, a discharge care plan or case conference. The EPC discharge items are categorised as follows:

- Preparing a discharge care plan and organising and coordinating a discharge case conference are treated as in-hospital services (provided as part of in-hospital treatment); and
- Contributing to a discharge care plan prepared by someone else and participating in a discharge case conference organised and coordinated by someone else are treated as out-of-hospital services.

In line with funding arrangements for public hospitals, in-hospital services are provided free of charge to public patients. Private patients can claim 75% of the MBS schedule fee for in-hospital services from Medicare and the remaining 25% of the schedule fee from their private health insurer or self fund. Out-of-hospital services are available to both public and private patients and attract a rebate of 85% of the Medicare Benefits Schedule fee.

Eligible patients are entitled to one EPC discharge plan for each hospital admission and one review of the plan in any three month period (but not within one month of preparing a discharge care plan). Patients are also entitled to one discharge case conference for each hospital admission, but not in conjunction with preparation of a discharge care plan.

Benefits for patients and carers

A written care plan is beneficial to patients and their carers, by:

- facilitating coordinated follow-up action;
- identifying the patient's care needs and how they will be managed;
- being able to be read and absorbed within the patient's own time, and referred to as necessary, particularly in discussing treatment or matters of concern with providers;
- addressing self-management techniques and home management strategies to give the patient more control of his/her condition;
- containing the details of all care providers, making ongoing communication easier; and
- putting care providers in a better position to provide appropriate care and support to the patient.

Benefits to GPs

GPs and others involved in providing care to the patient will benefit by having

- greater involvement in the on-going care of the patient; and
- up-to-date information about the patient's medical condition and health and care needs on discharge; and
- up-to-date information about other providers involved in the care of the patient.

Benefits to the hospital

Effective discharge planning can help support earlier discharge from hospital and potentially reduce the likelihood of readmission. This can contribute positively to hospital performance measures and to the management of demand growth at the tertiary level. Coordinating the delivery of services to meet post-discharge care needs can impact significantly on patient recovery and potential for independent living in the community.

Benefits to the community

Improving communication processes surrounding the discharge of patients with chronic conditions and ongoing multidisciplinary care needs will help to ensure that such patients are discharged into the community with appropriate access to required services.

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Medicare EPC Discharge Items

Information for Patients and Carers

What is an EPC discharge care plan?

An EPC discharge care plan is a comprehensive plan for the care of a hospital patient who will need on-going care from his or her GP and at least two other health or care providers after being discharged from hospital.

The plan must be in writing and should contain the following information:

- a) your health and other care needs;
- b) what your doctor and the other health and care providers aim to achieve;
- c) the medical treatment, health and other care services you are likely to need;
- d) who will provide the treatment, care and other services; and
- e) when the plan will be reviewed.

Who would benefit from an EPC discharge care plan or case conference?

If you are being discharged from hospital and have a chronic condition (for example, diabetes, arthritis, disability or asthma) and will need the care of your GP and at least two other health workers or care providers (for example: a physiotherapist, community nurse, or other community care providers) you may benefit from an EPC discharge plan or case conference.

How will I benefit from an EPC discharge care plan or case conference?

Discharge planning and case conferencing provide the opportunity for the health and care providers involved in caring for you to plan your care in a coordinated manner, in consultation with you. A discharge plan should improve your access to effective and appropriate services required to meet your ongoing needs.

- As the plan is in writing you will be able to:
 - read and absorb the information and to refer to it from time to time as you need;
 - refer to it in discussing your health needs and matters of concern with your health and care providers.
- Your discharge plan will also contain information about:
 - scheduled appointments; and
 - self- management techniques and home management strategies, where appropriate, for ensuring you are more in control of your condition.

Who prepares the discharge care plan?

Your GP or hospital staff with responsibility for discharge planning will prepare the plan with your assistance and in consultation with the other formal health professionals and care providers involved in caring for you. As a care plan is an important part of your care, it is advisable that your usual GP is involved. If someone other than your GP is organising your discharge care plan, this person will, with your permission, invite your GP to contribute to the care plan.

If you would like your carer, another family member, or someone else to be present for the care plan appointments, please tell your GP beforehand.

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Medicare EPC Discharge Items

What if I do not want my personal information to be disclosed to others?

Your GP, or other person who may be organising your care plan, will offer you the opportunity to add any information to the discussion or to indicate any information you do not wish disclosed to any or all members of the care planning team.

How is the plan prepared?

Your GP must obtain your consent before preparing or contributing to your discharge care plan. You can tell your doctor about any aspects of your health you do NOT want discussed with the other providers. If you agree to a care plan being prepared, then with your help, your GP and the other members of the care planning team will:

- assess your health and care needs, including medical, physical, psychological and social needs;
- identify the results to be achieved through the care plan;
- identify the health and care services you will require and the arrangements for providing them.

Your GP and the other members of the care planning team will make a plan for your care. Once the plan has been developed, your GP or other person preparing the plan will discuss the plan with you and offer you (and with your agreement, your carer) a copy of the plan.

Are there any costs to me?

Medicare pays a rebate for your GP to prepare or contribute to a discharge care plan. In some cases there may be additional costs involved for other providers contributing to the care plan. Your GP or other person organising the care plan should advise you of any costs. If in doubt, ask your GP about any fees involved.

Any services to be provided by specialists or other health professionals that are recommended as part of the care plan may be charged separately.

If you are a private patient and your GP organises your care plan or case conference you are entitled to a Medicare rebate of 75% of the Medicare Benefits Schedule fee for these items. If you have private insurance hospital cover, you can claim the remaining 25% of the schedule fee from your private health fund. You may also be able to claim charges above the schedule fee from your private health fund.

If your GP contributes to your discharge care plan or case conference, you are entitled to an 85% Medicare rebate, as with other Medicare GP services.

How long does a planning session take?

Preparing a discharge care plan may take 15-20 minutes of your time, and your GP may need a further 15-30 minutes, depending on the complexity of your health needs and circumstances.

You can obtain further information about discharge care planning:

- from your GP
- from hospital staff with responsibility for discharge planning
- or by phoning the Medicare enquiry line on 13 20 11 for the cost of a local call.

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Medicare EPC Discharge Items

Information for General Practitioners

EPC Discharge Care Planning

What is an EPC discharge care plan?

A hospital discharge care plan is a comprehensive longitudinal plan for the care of an individual patient returning to the community after discharge from hospital. The plan identifies the arrangements made to meet the patient's health and care needs and should include:

- f) an assessment of the patient and their health care needs;
- g) management goals with which the patient agrees;
- h) an assessment of the treatment, health care and other services the patient is likely to need on discharge from the hospital;
- i) arrangements for the provision of the treatment and other care services identified as needed for the patient; and
- j) arrangements for the review of the plan.

Who is eligible for these services?

Any patient being discharged from a hospital or day care facility into the community, who:

- has a chronic medical condition (present or likely to be present for at least six months), or a terminal condition ; AND
- requires multidisciplinary care from a GP and at least two other health care providers from different disciplines.

Who can prepare a discharge care plan?

To be eligible for payment under Medicare, the discharge care plan:

- must be prepared by the medical practitioner providing in-patient care (for private patients only) or by other health care providers involved in the care of the patient (such as hospital staff with responsibility for discharge planning)
- for public patients the patient's GP may contribute to a discharge care plan prepared by relevant hospital staff or another health or care provider; and
- the care planning team must include at least two other health care providers. Each of the members of the team must provide a different kind of care or service to the patient.

Note

- Other than the patient's usual GP, one other medical practitioner may participate in a care planning team, normally a specialist or consultant physician.
- As in-hospital services, including discharge services, are provided free of charge to public patients, a GP can prepare and coordinate a discharge care plan for a private patient under his or her care but may only contribute to the discharge plan of a public patient, at the invitation of the hospital.
- The patient's informal carer should be involved in discharge planning where possible, including as an additional member of the discharge planning team where this is appropriate. The patient, and/or their carer, do not count towards the minimum three members required to constitute the care planning team.

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Medicare EPC Discharge Items

Information for General Practitioners

EPC Discharge Case Conferencing

What is an EPC discharge case conference?

An EPC discharge case conference is a meeting of health and care providers to plan for the immediate care needs of a patient being discharged into the community from a hospital or day hospital facility.

What is the purpose of an EPC discharge case conference ?

The purpose of a discharge case conference is to provide an opportunity to coordinate the management of the health and care needs of a patient with a chronic or terminal condition and multidisciplinary care needs, in consultation with two or more health professionals or service providers. The discharge case conference team identifies and discusses the care goals of the patient and identifies the immediate management actions required to address the patient's needs.

How does a case conference take place?

A case conference can be conducted face-to-face, by a teleconference, video-conference or a combination of these. All members of the case conference team must be in contemporaneous simultaneous communication during the case conference.

Who is eligible for an EPC discharge case conference?

A patient of any age who is being discharged from a hospital or day hospital facility into the community and who;

- a) suffers from at least one chronic medical condition (present or likely to be present for at least six months), or a terminal condition; AND
- b) requires care from at least two health professionals or service providers each of whom is from a different discipline.

What happens at a case conference?

The discharge case conferencing team discuss the patient's health and other care needs and;

- identify the outcomes to be achieved; and
- identify the tasks that need to be undertaken to achieve these outcomes ;
- assess whether previously identified outcomes (if any) have been achieved ;
- allocate responsibilities to each member of the team; and
- agree on a review date (where necessary).

Who can organise a discharge case conference?

To be eligible for payment under Medicare, the discharge case conference:

- must be organised by the medical practitioner providing in-patient care (for private patients only) or by other health care providers involved in the care of the patient (such as hospital staff with responsibility for discharge planning)
- for public patients the patient's GP may participate in a discharge case conference that has been organised by relevant hospital staff or another health or care provider
- the case conferencing team must include at least two other health care providers. Each of the members of the team must provide a different kind of care or service to the patient.

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Medicare EPC Discharge Items

- If you are interested in participating in EPC discharge case conferencing ensure that hospital staff in your area are aware of your interest and have an agreed method to contact you regarding your involvement.

Who can participate in a discharge case conference?

- the patient's usual GP, if invited by the hospital or other provider organising the conference;
- any health or care provider who will be providing care to the patient after being discharged from the hospital;
- the patient and/or the patient's family carer, where possible and appropriate.

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Medicare EPC Discharge Items

Information for Hospitals

EPC Discharge Care Planning

Introduction

The EPC discharge care planning and case conferencing items were introduced in November 1999 as part of the Enhanced Primary Care (EPC) Package. Their objective is to enable GPs, other health professionals and service providers to work together in planning for the care needs of patients with chronic conditions and multidisciplinary needs who require ongoing care after discharge from hospital.

Incorporating EPC discharge planning into hospital practices

Hospitals can play a significant role in promoting the use of these items by incorporating them into their practices and ensuring there are procedures and systems to support their use. For example, hospitals can ensure there are standard procedures for:

- identifying patients who may benefit from EPC discharge planning services as early as possible;
- informing relevant providers and patients and carers about the discharge planning items;
- obtaining the details of the patient's usual primary care provider(s) on admission;
- obtaining the patient's consent to a discharge care plan or discharge case conference and to involving their usual GP in this service;
- estimating the date of discharge as early as possible; and
- developing a network of contacts with local GPs, allied health professionals and community health and care support services.

Patient consent

Discharge care planning and case conferences must be undertaken with the consent of the patient and/or carer. Hospitals can facilitate the discharge process by identifying eligible patients and assisting with gaining their consent for discharge planning or case conferencing services as early as possible.

The process of gaining patient consent includes:

- informing the patient and/or carer of the need for a discharge plan and/or case conference;
- advising the patient and/or carer about:
 - the purpose, benefits, and expected outcomes of a case conference or care plan;
 - who will be involved in the preparation of a discharge plan or in a case conference and why;
 - the fee for the case conference or care plan;
 - the Medicare rebate payable; and
 - any other costs involved, ie for allied health services;
 - information that will be divulged to other care providers and providing the opportunity to add to that information or to specify any information he/she would not like to be divulged; and

This process can be facilitated by agreeing arrangements with GPs (eg through local Divisions of General Practice) for obtaining patient consent, and developing standard forms to be signed by the patient and/or carer to verify that consent has been given.

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Medicare EPC Discharge Items

Involving the patient's usual GP

It is important to involve a patient's usual GP in planning for the discharge care needs of the patient. Hospitals can facilitate this by putting in procedures for:

- identifying the patient's usual GP on admission;
- obtaining and recording the patient's consent to the GP being involved;
- inviting a patient's usual GP contribute to a discharge care plan or participate in a case conference; and
- providing feedback on the outcomes of a discharge care plan or case conference to the patient's usual GP.

Involving the patient's informal carer

With increasingly shorter hospital stays, the successful outcome of the patient's return home will frequently depend upon the support carers can provide. Yet often carers may not be well-informed, consulted or offered support as part of the discharge planning process.

It is important that the patient's informal carer is involved in the discharge planning process, wherever possible. The hospital can identify what the carer can and cannot do to help in the patient's recovery and if they are available. It may also be necessary to advise the patient's carer on aspects of the patient's care needs post-discharge.

Involving Allied Health and Community Care Providers

Patients with chronic conditions and multidisciplinary care needs require an interdisciplinary approach with input from multiple services. Historically, these services have often worked in parallel with only minimal interaction. Hospitals can play an important role in developing effective communication links to involve allied health and community care providers through discharge planning.

Planning for discharge on admission

The discharge care needs of a patient with a chronic condition and multidisciplinary care needs should be addressed as early as possible, following admission. This will allow more time for organising a care planning or a case conference team and thus minimise barriers to successful implementation of post-discharge care arrangements.

Discharge coordinator

The use of a designated person to act as a 'discharge coordinator', can greatly enhance the effectiveness of discharge planning. The 'discharge coordinator' should have adequate clinical knowledge, extensive knowledge of health and care services available within the community, the capacity to liaise effectively with other care providers, including GPs, hospital clinicians and other allied health professionals; and skills in assessing patient needs, organising and communicating.

Medicare Benefits

Medicare benefits are available for GPs' involvement in EPC discharge services. These apply to services by medical practitioners in preparing a discharge care plan, organising a discharge case conference, contributing to a discharge care plan and participating in a discharge case conference. As public hospitals are funded under the Health Care Agreements to provide discharge services for public patients, Medicare does not provide rebates for GPs preparing/organising EPC discharge services for public patients, as these services are expected to be provided as part of hospital care.

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Medicare EPC Discharge Items

Support material for EPC Hospital Discharge Items

Further information can be obtained from:

- EPC explanatory notes in the Medicare Benefits Schedule book, November 2001 (Department of Health and Ageing, 2001);
- the Department of Health and Ageing Website
www.health.gov.au/hsdd/primcare/enhancpr/enhancpr.htm;
- the Medicare Enquiry Line on 13 20 11;
- RACGP Standards and Guidelines for the Enhanced Primary Care MBS items, checklists and proformas (available on the RACGP website: www.racgp.org.au); and
- State Based Organisations and local Divisions of General Practice.

EXPOSURE DRAFT
Medicare EPC Discharge Items

Information for allied health and community care providers

EPC Discharge Care Planning

What is an EPC discharge care plan?

A hospital discharge care plan is a comprehensive longitudinal plan for the care of an individual patient returning to the community after discharge from hospital. The plan identifies the arrangements made to meet the patient's health and care needs and should include:

- a. an assessment of the patient and their health care needs;
- b. management goals with which the patient agrees;
- c. an assessment of the treatment, health care and other services the patient is likely to need on discharge from the hospital;
- d. arrangements for the provision of the treatment and other care services identified as needed for the patient; and
- e. arrangements for the review of the plan.

Who is eligible for these services?

Any patient being discharged from a hospital or day care facility into the community, who:

- has a chronic medical condition (present or likely to be present for at least six months), or a terminal condition; AND
- requires multidisciplinary care from a GP and at least two other health or care providers from different disciplines.

Who can prepare a discharge care plan?

To be eligible for payment under Medicare, the discharge care plan:

- must be prepared by the medical practitioner providing in-patient care (for private patients only) or by other health care providers involved in the care of the patient (such as hospital staff with responsibility for discharge planning)
- for public patients the patient's GP may contribute to a discharge care plan prepared by relevant hospital staff or another provider; and
- the care planning team must include at least two other health care providers. Each of the members of the team must provide a different kind of care or service to the patient.

If you are interested in participating in EPC discharge care planning ensure that GPs and hospital staff in your area are aware of your interest and availability. If you provide discharge planning services for your clients, it may be appropriate for their GPs to participate.

Note

- Other than the patient's usual GP, one other medical practitioner may participate in a care planning team, normally a specialist or consultant physician.
- As in-hospital services, including discharge services, are provided free of charge to public patients, a GP can prepare and coordinate a discharge care plan for a private patient under his or her care but may only contribute to the discharge plan of a public patient, at the invitation of the hospital.
- The patient's informal carer should be involved in discharge planning where possible, including as an additional member of the discharge planning team where this is appropriate. The patient, and/or their carer, do not count towards the minimum three members required to constitute the care planning team.

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Medicare EPC Discharge Items

Information for allied health and community care providers EPC Discharge Case Conferencing

What is an EPC discharge case conference?

An EPC discharge case conference is a meeting of health and care providers to plan for the immediate care needs of a patient being discharged into the community from a hospital or day hospital facility.

What is the purpose of an EPC discharge case conference ?

The purpose of a discharge case conference is to provide an opportunity to coordinate the management of the health and care needs of a patient with a chronic or terminal condition and multidisciplinary care needs, in consultation with two or more health professionals or service providers. The discharge case conference team identifies and discusses the care goals of the patient and identifies the immediate management actions required to address the patient's needs.

How does a case conference take place?

A case conference can be conducted face-to-face, by a teleconference, video-conference or a combination of these. All members of the case conference team must be in contemporaneous simultaneous communication during the case conference.

Who is eligible for an EPC discharge case conference?

A patient of any age who is being discharged from a hospital or day hospital facility into the community and who;

- suffers from at least one chronic medical condition (present or likely to be present for at least six months), or a terminal condition ; AND
- requires care from at least two health professionals or service providers, each of whom is from a different discipline.

What happens at a case conference?

The discharge case conferencing team discuss the patient's health and other care needs and;

- identify the outcomes to be achieved; and
- identify the tasks that need to be undertaken to achieve these outcomes ;
- assess whether previously identified outcomes (if any) have been achieved ;
- allocate responsibilities to each member of the team; and
- agree on a review date (where necessary).

Who can organise a discharge case conference?

To be eligible for payment under Medicare, the discharge case conference:

- must be organised by the medical practitioner providing in-patient care (for private patients only) or by other health care providers involved in the care of the patient (such as hospital staff with responsibility for discharge planning
- for public patients the patient's GP may contribute to a discharge care plan prepared by relevant hospital staff or another provider); and
- the case conferencing team must include at least two other health care providers. Each of the members of the team must provide a different kind of care or service to the patient.

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Medicare EPC Discharge Items

If you are interested in participating in EPC discharge case conferencing ensure that GPs and hospital staff in your area are aware of your interest and availability.

Who can participate in a discharge case conference?

- the patient's usual GP, if invited by the hospital;
- any health or care provider who will be providing care to the patient after discharge from the hospital;
- the patient and/or the patient's family carer, where possible and appropriate.

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Medicare EPC Discharge Items

PREPARING AN EPC DISCHARGE CARE PLAN

Establish patient need and eligibility for a discharge case conference

Assess the patient's diagnosis and prognosis to determine if he/she will have on-going care needs after discharge into the community. Confirm patient is eligible for Medicare services, and has a chronic (or terminal) condition and multidisciplinary care needs. Confirm no previous discharge care plans prepared for this admission.



Identify providers who can best meet the patient's specific needs and goals

Identify providers who are required and available to meet the post-discharge needs of the patient (drawing on local knowledge, contacts, registers of service providers etc). The multidisciplinary care plan team should be determined by the patient's post discharge needs, including medical, physical, psychological and social needs. Where possible, involve the patient's usual GP (if you are not the patient's usual GP).



Discuss with the patient and obtain their consent

- Discuss the purpose, benefits and implications of the discharge care plan with the patient (and their carer as appropriate);
- Explain who will be involved and why;
- Inform the patient that his or her medical information will be discussed with other care providers;
- Ask the patient if there is any information (medical or personal) that he/she does not want divulged to all or to specific members of the discharge planning team;
- Advise the patient of any additional costs that he or she might incur;
- Ask the patient for his or her consent for you to:
 - proceed with the discharge care plan; and
 - invite his or her usual GP to participate (if applicable, eg where the hospital is organising the case conference);
- Record the patient's consent in the patient's file, if given.



Assess patient's needs and consult other providers contributing to the discharge care plan

- Assess patient and identify problems and needs; agree goals with patient;
- Contact providers to discuss the care plan and provide them with adequate information to understand the patient's needs ;
- Develop management plan with tasks and services to be provided by members of team
- Record their agreement to provide services;
- Clarify any costs involved; and
- Agree on a review date (if appropriate)



Document the discharge care plan

- Prepare a document in writing containing the details of the care plan;
- Provide a copy of the plan and evidence of the contribution made by members of the team to the patient (and their carer if appropriate); place a copy of the plan in the patient's records;
- Discuss the outcomes and recommendations in the care plan with patient (and their carer if appropriate) and gain agreement to its implementation; and
- Provide a copy of the plan or relevant sections of the plan to the persons who will provide the treatment and care specified in the plan.



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Medicare EPC Discharge Items

When reviewing the discharge care plan

Record the patient's agreement to the review. Consider whether arrangements for treatment, service and care have been carried out, and whether different arrangements need to be made, in consultation with the care planning team.

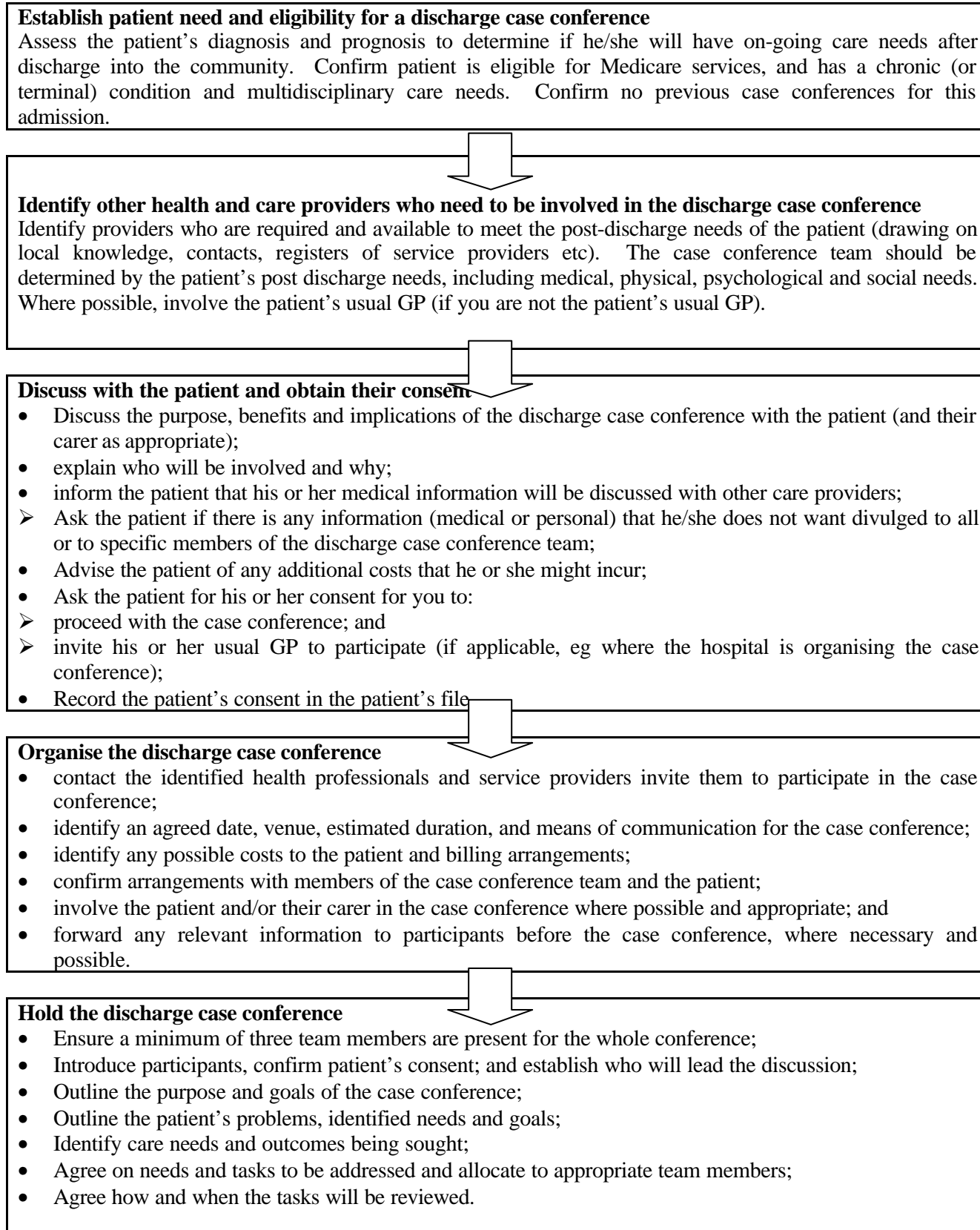
Discuss the outcomes of the review with the patient (and their carer if appropriate). Distribute copies of the revised plan (if any) to the patient and members of the care planning team.



If claiming a Medicare service for preparing a discharge care plan, submit a Direct Bill form, otherwise issue an account to the patient (rebates for preparing a discharge care plan are available for GP services to private patients only).

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Medicare EPC Discharge Items

ORGANISING AND COORDINATING AN EPC DISCHARGE CASE CONFERENCE



EXPOSURE DRAFT
Medicare EPC Discharge Items

Following the discharge case conference

- Prepare a written summary of the case conference including:
 - the day and time (start and finish) that the discharge case conference was held;
 - the details of each person that participated in the case conference;
 - the outcomes and recommendation of the case conference; and
 - the date of review to assess the achievement of stated goals.
- Discuss the outcome of the case conference with the patient and their carer if appropriate;
- Place a record of the case conference and outcomes in the patient's records;
- Give a copy to the patient's GP for the patient's records.

If claiming a Medicare service for organising and coordinating a discharge case conference, submit a Direct Bill form or issue an account to the patient (available for GP services to private patient's only)

PARTICIPATING IN A DISCHARGE CASE CONFERENCE

You may participate in a discharge case conference at the invitation of the person who is organising and coordinating it (eg where a hospital is organising a discharge case conference for a public patient). If you are invited to participate in a discharge case conference:

- You will be asked to:
 - contribute to the case conference in relation to the treatment, service or care that you will give the patient; and/or
 - give advice in relation to your area of expertise and/or knowledge of the patient.
- You should ensure that the patient has:
 - consented to the discharge case conference and your involvement; and
 - has been informed about any additional costs.
- Depending on the particular circumstances of the case, you may participate either via a face-to-face meeting with the case conference team, or by telephone or videoconference.
- You need to record in the patient's medical record the date, start and finish times and names of participants in the case conference.
- You should request (or if necessary prepare) a summary of the outcomes of the case conference or relevant extracts as they relate to your participation, to place in the patient's records.

Medicare Benefits entitlements

Medicare benefits are available for services provided by an eligible medical practitioner. Medicare items for participating in a discharge case conference are rebated at 85% of the Medicare Benefits Schedule fee.

Billing Arrangements

- **Medical practitioners**
Submit a Medicare direct bill assignment form or provide the patient with an account, as per normal billing arrangements.
- **Other health professionals and service providers**
If billing for your involvement in the discharge case conference, bill the patient or their insurance fund (where applicable) according to your normal billing practice.

EXPOSURE DRAFT
Medicare EPC Discharge Items

Medicare Benefits Schedule Information
General Practitioner EPC Discharge Items

Care Planning Items

Type of service	MBS Item No	Medicare Rebate Level	Patient eligibility
Prepare a Multidisciplinary Discharge Care Plan	722	75%	Private
Review a Multidisciplinary (Discharge) Care Plan	724	85%	Private
Attendance as a member of a care plan team to Contribute to a Multidisciplinary Discharge Care Plan or to a Review of a Discharge Care Plan prepared by another provider	728	85%	Private and public

Case conferencing Items

Type of service	MBS Item No	Medicare Rebate Level	Patient eligibility
Attendance as a member of a case conference team to organise and coordinate a Discharge Case Conference of at least 15 but less than 30 mins	746	75%	Private
Attendance as a member of a case conference team to organise and coordinate a Discharge Case Conference of at least 30 but less than 45 minutes	749	75%	Private
Attendance as a member of a case conference team to organise and coordinate a Discharge Case Conference of at least 45 minutes (and over)	757	75%	Private
Attendance as a member of a case conference team to participate in a Discharge Case Conference of at least 15 but less than 30 minutes	768	85%	Private and public
Attendance as a member of a case conference team to participate in a Discharge Case Conference of at least 30 but less than 45 minutes	771	85%	Private and public
Attendance as a member of a case conference team to participate in a Discharge Case Conference of at least 45 minutes (and over)	773	85%	Private and public

Consultant Physician Discharge Case Conferencing Items

Type of service	MBS Item No	Medicare Rebate Level	Patient eligibility
Attendance as a member of a case conference team to organise and coordinate a discharge case conference of at least 30 but less than 60 minutes.	809	75%	Private
Attendance as a member of a case conference team to organise and coordinate a discharge case conference of more than 60 minutes.	811	75%	Private
Attendance as a member of a team to participate in a discharge case conference of at least 30 but less than 60 minutes.	813	85%	Private and Public
Attendance as a member of a team to participate in a discharge case conference of more than 60 minutes.	815	85%	Private and Public

EXPOSURE DRAFT

Medicare EPC Discharge Items

Who is eligible for these items?

To be payable under Medicare, an EPC discharge care plan and an EPC discharge case conference must relate to a patient who has at least one chronic medical condition, or terminal condition, and multidisciplinary care needs involving a GP and at least two other health professionals and/or service providers. Different eligibility criteria apply:

- Items 722 and 728 for discharge care planning, and items 746 – 757, and 768 – 773, for discharge case conferencing, apply to a patient who **is** an in-patient of a hospital, day hospital facility and is **NOT** receiving care in a residential aged care facility.
- Item 724 for review of a community or discharge care plan, applies to a patient who is **NOT** an in-patient of a hospital, day hospital facility, or a residential aged care facility.

What is a chronic condition?

For the purposes of these items, a chronic condition is defined as a condition that has been, or is likely to be, present for at least six months. The items are also available to patients with a terminal condition.

Who can prepare a discharge care plan?

To be eligible for a Medicare rebate for preparing a care plan, the medical practitioner who is providing in-patient care must prepare the discharge care plan. This should generally be the patient's usual medical practitioner (private patients) or medical practitioner employed to provide services on behalf of the hospital (public patients). A patient's usual GP can contribute to a discharge care plan for public patient being prepared by hospital staff with responsibility for discharge services.

Who can contribute to a discharge care plan?

Contribution to a care plan must be at the request of the person who prepares the plan. The contribution may include preparation of a part of the plan that relates to the treatment, service, or care that the medical practitioner will give to the patient and giving advice to the person who prepares the plan.

What is a care planning and case conference team?

A discharge care planning or case conference team must include a medical practitioner and at least two other members, each of whom provides a different type of care or service to the patient. In addition to the patient's usual GP, one of the other members of the team may be a medical practitioner (normally a specialist or a consultant physician).

The patient's usual GP is the medical practitioner or a practitioner working in the medical practice that has provided the majority of services to the patient over the previous months and/or will be providing the majority of services to the patient over the coming twelve months.

What about the patient's usual GP?

A GP may prepare and review a discharge care plan and organise and coordinate a discharge case conference for a **private patient** under his/her care. Hospitals are funded under the Health Care Agreements to provide discharge services for public patients. Hence a GP may only contribute to the preparation and review of a discharge care plan or case conference for a **public patient** at the invitation of the person who prepares the plan.

How often can a care plan be prepared and reviewed?

A discharge care plan should be prepared **before** the patient is discharged from a hospital.

Medicare benefits are payable for one discharge plan for each hospital admission.

Medicare benefits are payable for one review of a discharge plan in any three month period (but not within one month of discharge). A discharge case conference can be provided for each hospital admission but should not be provided in conjunction with a discharge care plan.

EXPOSURE DRAFT
Medicare EPC Discharge Items

EPC Multidisciplinary Discharge Care Plan

Patient's Name _____

DOB _____

Identified problems/ Needs from bio-psychosocial assessment	Management Goals	Treatment Plan (Tasks/ treatments to meet goals)	Person Responsible for Care	Contact Details

I agree to the above care plan and have received my copy.

Patient's Signature _____

Date _____

Care Plan Review date: _____

**EXPOSURE DRAFT
Medicare EPC Discharge Items**

Please use I.D. label or block print

Summary of an EPC Discharge Case Conference

Date: / / Start Time: Finish Time:

Surname:	MRN:
Given Name:	
DOB:	Sex:
Doctors name:	

Items

Duration of meeting 15-29 mins 30-45 minutes >45 minutes

GP organises and coordinates 746 749 757

GP participates: 768 771 773

30-60 mins > 60 mins

Consultant Physician organises and coordinates 809 811

Consultant Physician participates 813 815

INTERPRETER REQUIRED?

COPY /SUMMARY TO PATIENT OR OTHER SERVICE PROVIDERS

INDENTIFIED PROBLEMS	MANAGEMENT GOALS	MANAGEMENT STEPS/ACTIVITIES	CARE PROVIDER DETAILS	DISCUSSED WITH CARE PROVIDER date etc

CONSENT TO PROCEED WITH DISCHARGE CASE CONFERENCE **VERBAL CONSENT**

Date:

My GP/ Discharge Coordinator has explained the purpose of the Discharge Case Conference and I give/my carer gives permission to discuss the above issues, with the providers listed. I am aware that there is a fee for my GP's participation in this Discharge Case Conference, for which a Medicare rebate is payable.

Signed: _____ Date: / / Signature of GP/ Discharge Coordinator: _____ Date / /