The Royal Women's Hospital

Enhanced Primary Care Demonstration Project

Final Report
February 2003

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1. Executive Summary

The Enhanced Primary Care (EPC) Demonstration Project at The Royal Women's Hospital (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 are North West 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 General Practitioners (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 and Women with Individual Needs. In total, the nineteen care plans and two case conferences were generated from these units.

The project was withdrawn from the Fetal Management Unit in November 2002.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

Some of the key learnings from this project are:

- 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 consenting 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 a gap in communication with community providers is identified as a problem by core members of a unit, 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.

The key recommendations are:

Commonweatlh:

- For hospital initiated discharge care plans or case conferences, the definition of chronic be reduced to a period of 3 months to capture the complexities of the immediate post-discharge period
- A GP should be eligible to participate in a discharge care plan with two other medical specialists of different disciplines
- Consideration to the inclusion of GP involvement in patient management, not necessarily discharge, to assist in determining ongoing management of a complex patient

State:

- Twelve months is insufficient time to plan, implement and embed change in process in a large organisation

Hospital:

- The RWH implement notification of a patient's GP of their admission to hospital
- Position descriptions and roles of clerical staff aligned so GP details are routinely captured and documented
- Extension to existing computer technology (CLARA) to enable autofaxing to the GP in the outpatient setting/change in patient management/alteration to care or change in a patient's condition
- Develop and undertake Key Performance Indicators to routinely assess communication with GPs
- Recognition that a short term project such as this is one step in a process of cultural change which requires much longer term organisational commitment.

The EPC process is just one means of communication with GPs. This project has highlighted to hospital staff the importance of appropriate communication with community providers. GPs have indicated their delight at improved communication with hospitals. The project team believe that this project has contributed significantly to the entire continuum of communication with GPs.

Aims and Objectives of the Project

The project seeks to improve the hospital discharge planning process at The Royal Women's Hospital (RWH) by facilitating General Practitioner (GP) involvement through the use of Enhanced Primary Care (EPC) Medicare Benefits Schedule Book (MBS) item numbers. The aims are specifically expanded 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

These aims have been revised slightly from those in the original submission. This was due to an improved understanding that to facilitate discharge planning with GPs, hospital staff require little knowledge of the EPC MBS item numbers, but rather require an improved understanding of the benefits of GP involvement in the discharge planning process (see section 4.8).

The Divisions of General Practice collaborating in this project are North West Melbourne, Western Melbourne, Melbourne and Ballarat and District. These urban divisions represent the major catchment area of patients attending the RWH. In addition, Ballarat and the surrounding district have a high number of referrals from rural Victoria.

2. Intended and Actual Scope of the Project

The original submission of the project had four target areas within the hospital:

Table 1. Intended Scope of the Project

	Women's Alcohol & Drug Service (ADS)	**Fetal Management Unit (FMU)**	**Neonates**	**Oncology**
Service	Specialist antenatal service for pregnant women with complex drug & alcohol problems.	Statewide service for women who have an abnormality detected in their unborn baby.	One of four neonatal intensive care units in Victoria.	Statewide service for women with benign, pre-malignant and malignant conditions
Medical Disciplines Involved	Obstetricians, Psychiatrist, Paediatrician, Midwives, Social Workers.	Obstetricians, Paediatricians, Geneticists, Sonographers, Social Workers, Midwives	Paediatricians, Nursing Staff, Social Work.	Gynaecological Oncologist, Medical Oncologist Nursing Staff, Physiotherapist, Social Worker.
Other Comments	Women who are stabilised on methadone with good social support are referred to mainstream antenatal services.	Unit deals with abnormalities detected in the baby in advanced pregnancy (18–20 week)	There is a great deal of pressure for a limited number of neonatal intensive care beds in Victoria.	Breast Unit also has inpatients in this unit, but is not supported by resident medical officers

The project was extended in the second six months following discussions with hospital management. These units had a self-identified a gap in communication with community providers and were keen to be involved when they heard of the project through the hospital education that was provided as part of the project.
The new units recruited into the project were:

	Diabetic Clinic	**Young Mother's Clinic**	**Women with Individual Needs**
Service	Specialist clinic for women with diabetes prior to pregnancy or who develop diabetes in pregnancy (gestational diabetes mellitus - GDM)	Provides care and education for young pregnant and parenting women of < 19 years of age	A mobile clinic for women who are intellectually disabled
Medical Disciplines Involved	Obstetricians, Endocrinologists, Diabetes Educator, Midwives	Midwives, Obstetrician, Peer Educator, Social Worker, Dietician, Education Support Worker, Drug and Alcohol Worker	Midwife, Social Worker, other staff as necessary
Other Comments	Clinic consults with approximately 55 patients per year with Type I and II diabetes and approximately 200 patients with GDM. 15% of patients with GDM go on to have an impaired Glucose Tolerance Test post natally. These are the two groups of women targeted for EPC discharge planning	Approximately 120 women attend the clinic per annum. Any woman who is <19 years of age is offered this antenatal service	A low volume clinic which cares for approximately 40 patients per year. These women often have complex medical and psychosocial needs and require multidisciplinary coordinated hospital and community care

3. Actions Taken, Outcomes and Key Learnings

4.1 Women's Alcohol and Drug Service

The Women's Alcohol and Drug Service (WADS) provides an Outreach Service in the antenatal and postnatal period for women with complex drug and alcohol problems. All clients are case managed by a counsellor and a midwife.

The service is the major statewide provider of training for similar services. As such, it provides both education and mentoring for other drug and alcohol services involved in antenatal care. This training role has increased during the term of the project with a commensurate decrease in direct patient care, with patient numbers decreasing from 120 to 60 clients per year.

Actions Taken	Outcomes
1. Analysis of pathways and points of communication to community providers via interview with staff and patients	1. The service has strong/ongoing relationships with a core group of GPs. This includes routine telephone communication with GPs prescribing methadone.
2. Staff survey undertaken to evaluate communication with GPs and the benefits of communicating with GPs (Appendix 1)	2. Results showed that all staff surveyed frequently communicated with a GP to inform them of patient outcomes and gain information from the GP about the patient. 100% staff felt that the benefit of the communication was for the patient and hospital staff, whilst 80% felt the benefit of the communication was for the GP. (see Appendix 1b)
3. Patient survey undertaken to get a "snap-shot" of attitudes to two-way communication between hospitals and GPs (Appendix 2)	3. Results of patient survey were that 67% of patients had a GP, and 80% of all patients were happy for transfer of medical information between GP and hospital. 60% patients were in agreement with discharge planning and no patients disagreed with it (see appendix 3 for full results).
4. Staff education surrounding role of the GP and the project purpose and process via attendance and presentation at team meetings and individual consultation with staff. (see section 4.8)	4. EPC process to be written into the unit's orientation package - Education of midwives in inpatient areas to familiarize them with guidelines so that congruent with care given when admitted
5. Guidelines and protocols developed for routine care planning - Tools developed (Appendix 4) - Assistance with logistics of individual cases	5. Guidelines for routine care planning was trialled for 3 months for all women being: - discharged antenatally post methadone stabilisation - discharged postnatally - The staff felt that discharge planning with GPs via the EPC process was a paper burden and did not generally enhance patient outcomes. However, they could see that there are situations where more formal discharge

Actions Taken	Outcomes
	planning could be useful. Consequently the level and method of communication with a GP is the decision of the case managers. This will range from a minimum of individual case discussion with a GP to case planning via EPC if there is a perceived clinical benefit. Guidelines for flagging the patient for enhanced GP communication have been formulated by the staff and include: - a new GP for the client, or - a major change in the client's condition. - As a result of HIC requirements, the process and paperwork needed to be largely duplicated. The additional documentation was an added burden on staff with little or no measurable enhancement of communication or patient outcomes. The reasons the HIC compliant documentation was not incorporated into existing WAD paperwork was because of the highly sensitive nature of aspects of the Individual Treatment Plan, which staff were reluctant to routinely share with community providers.
6. External Agency Liaison and education	6. Education of staff at medical centre at Dame Phyllis Frost Centre (Women's Prison, Deer Park, Victoria) - Incorporation of education about care planning and case conferencing with GPs into the WADS training modules- used when training other services providing care for pregnant women with drug and alcohol problems 4 care plans and 1 case conference generated.

Key Learnings

- Units that have existing comprehensive communication with GPs and other community providers may see little benefit to more formal discharge planning with GPs particularly where they can perceive no change in patient care or outcomes.
- Paperwork and additional documentation required is an additional burden on hospital staff

4.2 Oncology

The Oncology/Dysplasia Unit provides a multidisciplinary, integrated inpatient/outpatient service for women with benign, pre-malignant and malignant conditions. About 18 months ago, the unit implemented a "Primary Nursing" model, whereby one member of the nursing staff is allocated a patient and acts as their primary hospital care provider and coordinator. This aims to enhance continuity of care and improves the discharge planning process. Nursing and clerical staff turnover has increased substantially over the duration of the project. The Breast Unit is a small unit which is not supported by resident medical staff. It has a consultant breast surgeon once per week and a full time breast care liaison nurse.

Approximately 85% of patients have a documented GP who receives an electronic discharge summary. The unit reports that resident medical staff have routine telephone communication with GPs.

Actions Taken	Outcomes
1. Ongoing education and consultation with medical and nursing staff including breast care liaison nurse regarding the role of the GP and the process of EPC via attendance at discharge team meetings, individual discussion, nursing staff inservice (See section 4.8)	1. Greater understanding developed on psychosocial issues affecting women in this unit that affect care in the community and are relevant to GPs. - Due to clerical and nursing staff turnover unit there is inconsistency in knowledge of the EPC process. - A few senior medical staff to act as advocates and create momentum for change
2. Staff survey undertaken to evaluate communication with GPs and the benefits of communicating with GPs	2. Results of the staff survey were that 85% staff surveyed had communicated with a GP (generally to inform them of patient outcomes). 80% staff felt that the benefit of the communication was for the hospital staff, whilst 100% felt the benefit of the communication was for the GP and the patient. (see Appendix 1b)
3. Patient survey undertaken to get a “snap-shot” of attitudes to two-way communication between hospitals and GPs	3. Results of patient survey were that 100% of patients had a GP, and 100% were happy for transfer of medical information between GP and hospital. 85% patients were in agreement with discharge planning. (see appendix 3 for full results)
4. Extensive discussions with Head of Unit to gain support for the project.	4. There was little sense of ownership over the project and concerns about the additional time required by staff for patient benefits that were unable to be measured in the remit of the project. Head of Unit support for the project gained late in project.
5. Development of guidelines - Tools developed (Appendix 4)	5. Care planning is routine for: - All patients going home for palliative care

Actions Taken	Outcomes
- Assistance with logistics of individual cases	- All patients who will have chemotherapy - Inclusion of consent forms and patient information sheets for planning with GPs in major surgery admission packs - To facilitate the logistics of the EPC process a recommendation to add GP name and "checkbox" to ward list complete care plans at multidisciplinary team meetings where all staff are present
6. Redesign of care maps	6. Revised care maps being developed in consultation with nursing staff and clinical service support officer to include discharge planning with the GP on day one of admission. Seven care plans have been generated from this unit.

Key Learnings

- A sense of ownership with a desire for the project to succeed is needed to ensure active support from Department Heads and Unit Managers.
- The active support of Department Heads and Unit Managers is imperative for the successful incorporation of increased GP involvement in the discharge planning process
- There are added difficulties in incorporating GPs in the discharge planning process when there is a high turnover of staff largely due to education and training issues
- To assist the sustainability of EPC it is beneficial to have a Unit Manager's delegated staff member to assist in the day to day overseeing of discharge planning with GPs by flagging patients and ensuring education of new staff members.
- Because hospital staff often work in a subspecialist area with a disease focused model of care, it is often difficult for hospital staff to understand the broader psychosocial consequences of a disease. Consequently, they have little understanding of the role of the GP and how their inclusion in the discharge planning process can benefit patients.

4.3 Fetal Management Unit

The Fetal Management Unit (FMU) is a specialised multidisciplinary unit for women who have had an abnormality detected in their unborn baby. It is a once weekly outpatient clinic. There is close liaison within the multidisciplinary team, the woman and her family, in order to determine the diagnosis, prognosis and management. All women and families are offered counselling.

There are severe time pressures, both in terms of resolving complex issues in a timely fashion with a high patient load and limited resources.

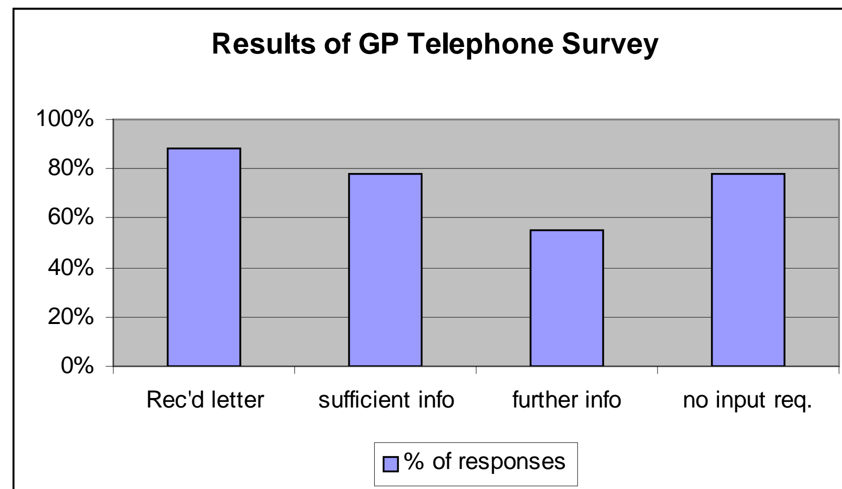
Actions Taken	Outcomes
1. Ongoing education and consultation with medical staff and midwives regarding the role of the GP and the process of EPC via attendance at multidisciplinary team meetings, Individual discussion, ward inservice for midwives(see section 4.8)	1. Improved understanding of the role of the GP
2. Staff survey undertaken to evaluate communication with GPs and the benefits of communicating with GPs	2. Results of the staff survey showed that 100% staff surveyed regularly communicated with a GP to inform them of patient outcomes and to receive information from the GP about the patient. 100% staff felt that the benefit of the communication was for the hospital staff, the GP and the patient. (see appendix 1b)
3. Patient survey undertaken to get a "snap-shot" of attitudes to two-way communication between hospitals and GPs	3. Results of patient survey were that 91% of patients had a GP, and 95% were happy for transfer of medical information between GP and hospital. 82% patients were in agreement with discharge planning. (see appendix 3 for full results)
4. Audit of medical records to determine frequency of documentation of GP details	4. Summary of audit – 28 records audited – 61% had GP details documented; 96% had a letter or discharge summary; 32% were rural patients
5. Development of process and guidelines for suitable patients for care planning	5. Initial care planning guidelines developed: ➢ shared maternity care with a GP ➢ fetal abnormalities with genetic basis ➢ fetal abnormalities with ongoing problems for the baby ➢ rural patients. - Staff felt EPC was additional work that was not sustainable in their current administrative and medical resource climate. The unit has good communication with GPs and it was felt that EPC with GPs would not result in improved patient outcome. Consequently a telephone survey was undertaken to establish the level of GP satisfaction with communication.

Actions Taken	Outcomes
6. Telephone survey of GPs to determine level of satisfaction with current communication	6. Summary of telephone survey (n=9) – see Chart 1
7. Meetings with Director of FMU	7. Discussions surrounding viability of project in FMU. Main barrier identified as time resource, already have good communication with GPs and it is not clear that increased communication enhances patient care or outcomes. - All correspondence to GPs will include an invitation to contact a nominated person if they have any enquiries - Withdrawal of project from FMU in November 2002 1 case conference was undertaken.

Key Learnings

- Where comprehensive communication already exists between a unit and community providers, it is very difficult to convince staff to take on extra paperwork and duties where there is little measurable benefit to patient care and outcomes.
- Adequate resourcing is needed to undertake care planning with GPs
- The active support and endorsement from senior medical staff is imperative to move forward
- In areas which consists of highly specialised multidisciplinary medical and allied health services, the role of the GP in ongoing patient management and support in the community may not be obvious or seem of secondary importance to the immediate medical needs of the patient
- The applicability of EPC care planning/case conferencing in the antenatal period is unclear. This is due to the HIC definition of complex and chronic.

Chart 1
Fetal Management Unit



This telephone survey indicated that GPs had, in most instances, received a letter from FMU, and they were generally happy with the amount of information they received. The further information the GPs would have liked was more frequent updates. Whilst most GPs did not have the opportunity to have any input regarding their patient, they were happy with this outcome. General comments were that "personal communication such as a phone call is very beneficial" and "good communication between a hospital and the community is imperative".

4.4 Neonates

The Intensive and Special Care Nurseries are the largest in Victoria with 58 cots. Care is provided for neonates and their families in a multidisciplinary environment with integrated services. This is a high volume unit with approximately 1500 admissions per year of which about 90% are from mothers who have given birth at this hospital. Both the Medical and Nursing Directors head both the Neonatal Intensive Care Units (NICU) at the RWH and The Royal Children's Hospital (RCH) (both part of Women's and Children's Health Service).

The main communication with GPs is by means of a patient held discharge summary. A select few consultants in the unit regularly have telephone communication with a GP prior to a baby being discharged home. GP details have not been recorded either in the patient's medical record or on the hospital database. Approximately 50% of discharges are to a community hospital, where discharge planning utilising the EPC item numbers is not applicable. GPs have been notified of the baby's admission to the unit only via the electronic discharge summary of the mother.

Actions Taken	Outcomes
1. Ongoing education and consultation with medical staff and midwives regarding the role of the GP and the process of EPC via Individual discussion, ward inservice (See section 4.8)	1. Staff found it difficult to see the patient benefit of GP involvement
2. Staff survey undertaken to evaluate communication with GPs	2. Results of the staff survey were that 40% staff surveyed had communicated with a GP generally to inform them of patient outcomes. 80% staff felt that the benefit of the communication was for the GP and the patient and 40% felt it is beneficial for staff (see appendix 1b))
3. Parent survey undertaken to get a "snap-shot" of attitudes to two-way communication between hospitals and GPs	3. Results of parent survey were that 60% of patients had a GP, and 90% were happy for transfer of medical information between GP and hospital. 90% patients were in agreement with discharge planning. (Appendix 3)
4. Analyzing GP communication at the unit and NICU at RCH	4. Identification that the frequency of communication with GPs was substantially lower at RWH compared to NICU at the RCH
5. Audit of medical records to determine frequency of documentation of GP details	5. Results of audit showed that 4% (1/30) had GP details documented, 90% (27/30) had a copy of letter or discharge summary; 80% discharged to another hospital, and 20% discharged home.
6. Uncovering process of transfer of mother's GP details to that of the baby (Two separate databases in use)	6. For babies whose mother has a documented GP, the transfer of these GP details to the baby remains unresolved. Hospital executive are currently undertaking an industrial relations framework for resolution in an attempt to incorporate this into the position description of clerical staff
7. Development of admission notification process and protocol to GP	7. Routine GP notification of all babies at 7 days post admission. Computerized template developed for notifying GP of admission.

Actions Taken	Outcomes
	Completion of this letter is the responsibility of the medical staff (Appendix 5)
8. Development of process to improve capture of GP details	8. Inclusion of GP details letter in parent admission pack (given to all parents - Appendix 6). Successful negotiation as to who will enter these details into the database. Process developed so these details are entered into baby's database
9. Development of process and guidelines for suitable patients for care planning	9. Development of criteria for routine care planning for patients: - discharged home for palliative care or with home oxygen - likelihood of significant neurological disability - mother of baby has drug related problems - < 27 weeks gestation and an inpatient beyond due date
10. Identification of a person who has the authority and enthusiasm to drive discussion, negotiation and change.	10. Continuing meetings with Director of Special Care Nursery (SCN) to find a way forward. This resulted in: - Improved cooperation between senior staff of the neonatal unit and other hospital staff resulting in a clearer vision of the importance of aligning the position descriptions and responsibilities of administrative staff to ensure there are not gaps in data collection, documentation and verification - Increased communication between the neonatal unit and other units and hospital areas
11. Gaining patient consent, particularly regarding billing issues was found to be a major barrier. Assistance given in gaining patient consent so care plans could be developed	11. Patient consent gained without incident 4 care plans completed – Jan 2003

Key Learnings

- The basic platform for GP communication needs to be resolved before more enhanced communication is achievable. This include the capturing and documenting of GP details and the GP directly receiving a discharge summary
- In highly specialised areas where there has historically been limited contact with primary health care providers, the staff have not valued the role of the family doctor and are unlikely, in the short term, to see the benefit of GP involvement
- Implementation of change in culture and practice in such environments is likely to take considerable time and resources
- In close knit units, communication through one delegated person with line authority may be successful in implementing increased communication with GPs
- If staff do not feel communication with a GP is of benefit to them they are less likely to embrace it
- Hospital staff have difficulties with consenting patients for a process that may incur costs. They do not see it as their role.

4.5 Diabetic Clinic

The Diabetic Clinic is a multidisciplinary team who manage the antenatal care of women with diabetes prior to pregnancy or women who develop diabetes in pregnancy (gestational diabetes mellitus – (GDM)).

The unit has self identified concern surrounding the appropriate community follow up of women who have had GDM with an impaired post natal glucose tolerance test. These women would account for approximately 10% of all those with GDM.

Actions Taken	Outcomes
1. Consultation with all medical staff (obstetricians and endocrinologists), midwives and diabetes educator to gain support for increased communication with GPs (see section 4.8)	1. Although undertaking the EPC process is extra work, the staff (especially the diabetes educator) felt it very important to ensure adequate community follow-up of this group of patients. - Identification of a champion in the unit who values discharge planning with GPs to facilitate and coordinate EPC
2. Education of the process of care planning with GPs	2. Greater understanding achieved by hospital staff of the EPC process and familiarisation with documentation
3. Development of guidelines for routine care planning with a GP	3. Routine care planning with their GPs for all patients with: - diabetes prior to pregnancy - an impaired post natal glucose tolerance test are to have
4. Assistance in development of care plans and identification of a suitable GP for women as required.	4. 2 care plans have been completed.

Key Learnings

- Long-term follow-up in the community for some conditions such as gestational diabetes can be enhanced by the EPC process
- When a gap in communication with community providers is identified as a problem by core members of a unit, it is likely EPC will be successfully incorporated into communication with GPs and be sustainable

4.6 Young Mother's Clinic

A specialised, multidisciplinary antenatal service for women <19 years of age. The clinic has approximately 120 patients per year, of whom about 50% have a GP. Feedback has previously been received by the clinic coordinator that GPs were not aware that their patient had attended the Young Mother's Clinic and the unit felt there was a need for increased communication with GPs.

Actions Taken	Outcomes
1. Consultation and education of clinic coordinator on the EPC process and importance of the role of the GP (see section 4.8)	1. Identification of gap in GP communication
2. Development of "Notification of Clinic Visit" to inform GPs of a woman's attendance, including communication that a letter from the medical staff will follow and an invitation to the GP to be involved in care planning. (Appendix 7)	2. With patient consent, from October 2002, "Notification of Clinic Visit" form faxed to the GP of all new clients attending the clinic (N=20) - Fax back received from 4 GPs who would welcome involvement in care planning with their patients. 2 care plans generated

Key Learnings

- The EPC process is welcomed where there are self identified gaps in communication with community care providers
- GPs are well placed to identify patients who will most benefit from hospital initiated care plans. This can be done through a notification of admission/attendance and has the flow-on effect of being time efficient for hospital staff.
- Notification of admission/attendance also allows GPs to indicates their interest in involvement and billing arrangements
- When a gap in communication with community providers is identified as a problem by core members of a unit it is likely EPC will be incorporated into communication with GPs and be successful and sustainable

4.7 Women with Individual Needs

This antenatal care option commenced in January 2002 (initially as a funded project of the Department of Human Services Maternity Services Project). The arm involved in this project is a mobile antenatal service for women with special learning needs, acquired brain injury and intellectual disabilities. The staff involved became aware that many of the women they cared for had poorly coordinated community supports and felt that involvement in the EPC project may provide an avenue of linking women with GPs postnatally. Approximately 30 women per year are seen by the clinic.

Actions Taken	Outcomes
1. Education of staff about the importance of the role of the GP (See section 4.8) and EPC processes	1. Staff welcome any extra resources to assist in the community linkage of this complex group of patients
2. Development of "Notification of Clinic Visit Proforma" to inform GPs of a woman's visit. (Appendix 8)	2. Project has had x3 new patients since the project was commenced in this area. None of these women had a GP, but plans are in place to assist them in finding a suitable one
3. Development of a method of assisting women to find a GP	3. Get yourself a GP campaign (see section 4.9)

Key Learnings

- The awareness of the value of a GP has been heightened through discussions with staff. The GP can be a valuable addition to the other community providers required to assist these complex care women.
- EPC is applicable if a patient is intending to consult with a chosen GP for the next 12 months post hospital discharge, even if she has not previously consulted with that GP
- It remains to be seen whether GPs who do not know a patient will wish to be involved in the discharge planning process.
- Discharge planning with a GP is especially useful for hospital staff if the patients are highly complex and are low in numbers
- Hospital contact is a window of opportunity for women to be encouraged and assisted in finding a regular GP
- Hospital staff should be provided with the resources to assist a woman in finding a regular GP (see section 4.10)

4.8 Hospital Staff

Education of hospital staff took place over the entire project and included presentations at team meetings, presentation to senior hospital management and individual case discussion.

It became clear that the main issues to be addressed were:

- The role of the GP and the broader psychosocial consequences of a woman's/baby's health problem. This was especially true in sub-specialist areas where the staff had difficulty understanding the relevance of the GP
- Promoting that communication with a patient's GP is beneficial for the patient and the hospital staff (as opposed to just the GP)
- Promoting and encouraging all aspects of communication with GPs
- Discussing EPC as the more intensive element in the continuum of communication with GPs
- Not using the term EPC, but rather discussing "GP integration into the discharge planning process", "handover of the patient to the community provider" or "safe referral home"
- Promoting that most people have a GP and would like the hospital to have appropriate communication with them
- Promoting the profile of the GP

It also became clear that to facilitate discharge planning with GPs, hospital staff require little knowledge of the EPC MBS item numbers, but rather require an improved understanding of the benefits of GP involvement in the discharge planning process. It was found to be counterproductive to emphasis MBS item numbers and payment to the GP.

A staff survey was conducted following involvement in discharge planning with GPs (Appendix 10). The results showed that 100% staff agreed or strongly agreed:

- The care planning documentation is easy to understand
- The clinical information discussed was relevant to future patient management
- Welcomed future participation in care planning

80% staff agreed or strongly agreed that:

- The process was easy to follow
- The GP was able to provide useful information about the patient
- The process will improve patient management
- The patient will be well managed by the GP

Interestingly, only 40% staff agreed or strongly agreed that the process has increased their rapport with other health professionals at the hospital. The main reason for this was that other health professionals did not provide input into the care plan.

4.9 General Practitioners

Anecdotal evidence suggests that GPs are not familiar with the process of being involved in hospital initiated care plans

Actions Taken	Outcomes
1. Needs analysis of GPs via GP Focus groups	1. Both metropolitan and rural focus groups held. - All GPs were aware of the aims of EPC and most had individual experience with EPC through health care assessments and community care plans - All the GPs were enthusiastic about increased communication with hospitals in general and involvement in discharge planning for their patients with complex and chronic problems. They saw hospital initiated discharge care planning as a potential "portal into the hospital" which they had been "trying to get in for years". They spoke of their frequent frustrations in trying to deal with hospitals in gaining more information about their patient's hospital stay. - They felt they could have a positive influence on their patient's management during their hospital stay and in discharge planning - They felt they knew which of their patient's were likely to have ongoing complex problems - They overwhelmingly felt they should be notified of their patient's admission to hospital - All the GPs would bulk bill for the service and felt that most other GPs would also bulk bill The main motivation for involvement is to: - improve ongoing patient management - improve continuity of care - improve the way hospitals regard GPs Major barriers identified by the GPs were: - logistics of coordinating the plan between hospital and community providers - potential breadth of time consuming tasks they may be expected to perform - difficulties associated with becoming proficient with EPC process (such as paperwork compliance and billing) with limited experience. They felt this would be compounded by the different documentation of hospitals and the low patient numbers involved Through discussions with GPs, it appears a significant percentage did not apply for the MBS rebate as they were either unaware they were involved in a rebatable service or could not be bothered with the additional paperwork
2. Education of GPs on EPC discharge care planning via: - Informing GPs of project at Shared Care Education sessions (Appendix 9) - Newsletter to Shared Maternity Care Affiliates - Division fax-out/newsletter - Division education sessions	2. 9 Shared Care Education sessions have been held during the course of the EPC project where the project was presented and information sheets were distributed. - Flier distributed to 592 SCA - Successful discussion about incorporation of hospital initiated EPC into Divisional education

Actions Taken	Outcomes
3. Advocating for GPs in areas seen as problems e.g. - GPs who are sharing the care of antenatal women whose pregnancies become high risk are not always notified that their patient has ceased shared care - Increasing the profile of the GP as the central community provider	3. Inclusion of section for notifying GP of cessation of shared care in the new patient held Pregnancy Record (distribution to commence in March 2003) - "Get yourself a GP" campaign (see section 4.10)
4. Experiential survey of GPs who have been involved in a discharge care plan or case conference (n=17) (Appendix 10)	4. 10 GP surveys were completed. Overall, 80% felt the hospital provided adequate information about the patient, the documentation was good, the process ran smoothly, and they were more likely to contact the unit about this and other patients. 100% GPs would welcome future participation in discharge planning. Only 30% GPs felt they required further information about EPC.
5. Patients were surveyed following involvement in the EPC process (Appendix 11). Four surveys were returned.	5. Results showed that the 100% patients agreed or strongly agreed that: - adequate information was provided by the hospital about the process, - the benefits of discharge planning were explained to them - patients were happy for their GP and hospital to share information - patients felt it is helpful to plan for their discharge - patients understood that their GP would bill them in their usual way Whilst 75% patients were satisfied with the summary of the decisions reached, one patient stated that she wasn't asked what she wanted included or informed of the outcome of the conference. She stated that she "would have been interested in both of these".

Key Learnings

- GPs welcome enhanced communication with a hospital about their complex and chronic patients
- GPs have experienced frustration trying to get more information about their patient's hospital stay and discharge plan and view EPC as a potential way for improvement
- GPs are able to reliably and easily predict which of their patients are going to have complex care needs on discharge
- GPs expect to be notified of their patient's admission to hospital
- It is likely EPC can consolidate relationships with GPs, such as affiliation (e.g. shared maternity care). In this situation, the hospital is more likely to value their role and be involved in ongoing education, feedback and support
- GPs require continued updates on the EPC process
- It is difficult to become proficient/experienced with a process which occurs infrequently and has differing documentation between hospitals
- The majority of GPs are likely to bulk bill for their involvement in hospital initiated EPC
- As major providers of GP education, the Divisions of General Practice have a useful role in educating and supporting GPs and their practice staff in the use of EPC

4.10 "Get Yourself a GP" Campaign

Throughout the project, it became clear that to improve and facilitate communication with GPs, the continuum of communication with GPs needed to be realised (see section 4.8). This continuum ranges from the minimum of a discharge summary to more intensive communication such as GP involvement in discharge planning utilising the EPC process.

It was found that;

- GP details needed to be collected and confirmed more routinely
- There were a number of women without GPs (about 25%)
- The profile of GPs needed to be raised
- The value of the role of the GP needed to be raised.

It was felt that the EPC project provided an excellent opportunity to promote the concept of women having a GP in their local community. Consequently, the aims of the "Get Yourself a GP" Campaign were to:

- Encourage women to advise staff of their GP details
- Remind staff to ask about GP details
- Encourage women to ask about finding a GP
- Assist staff in helping a woman find a GP
- Improve the profile of the GP in the hospital setting
- Highlight and remind the staff and patients of the important and central role of the GP

Actions Taken	Outcomes
1. Proposal submitted to hospital management	1. Approval to undertake the campaign in August 2002
2. Extensive research taken to identify a suitable database to support the campaign	2. Better Health Channel utilised following some minor changes. "Find a GP" icons put on all relevant PCs in the hospital.
3. Source illustrator. Consumer feedback sought prior to proceeding	3. Illustration approved by consumer groups as being suitable for different age groups, cultures and medical conditions
4. Development of tear off sheet for GP details	4. Opportunity for women to easily notify staff of GP details.
5. Organise education and logistics: - Plan implementation including consultation with all unit managers - Training of medical and nursing staff - Incorporation of training in orientation programs for medical and nursing staff	5. Education flier distributed to all medical staff and unit managers (See Appendix 11) - Successful implementation of campaign with placement of posters and staff training in December 2002. Follow-up training to be conducted in February 2003.

Actions Taken	Outcomes
- Organising suitable computers, printers and connections	

Key Learnings

- Prominent campaigns such as "Get Yourself a GP" are useful at a number of levels (from reminding staff to ask about GP details to reinforcing the role of the GP in the community)
- Consumer feedback is important to ensure the posters are user friendly and deliver a clear message
- Implementation of a campaign such as this requires a broad and coordinated approach. This includes consultation with unit managers, medical staff and clerical staff to determine how best to incorporate it into current work practices, education of staff and implementation in consultation with Information Management.

4.11 Other

Description/Current Situation	Actions Taken	Outcomes	Key Learnings
Consultants, in particular Paediatricians, are not aware of the availability of an MBS item number for case conferencing in private practice.	- Development of "Consultant Pack" for case conferencing utilising MBS item numbers	- Well received by relevant consultants	Some relevant specialists e.g. Gynaecology oncologist are not eligible for this item number
Not all senior hospital management staff were aware of the project and it was felt there was a need to increase its profile.	- Presentation to Senior Hospital Management about the project in general and the importance of communicating with GPs and other community providers to provide a safe referral home.	- Improved understanding of the project and the value of GPs and greater discussion about encouraging EPC at the RWH	Senior medical staff support is required to incorporate EPC and GP communication into hospital policy and protocols
There is some duplication in the information gained on some discharge forms. Amalgamation of documentation in collaboration with Post Acute Care(PAC)/Effective Discharge Strategy(EDS) and Women's Social Support Services(WSSS) to develop a suite of discharge planning forms.	1. Presentation at Medical Records review committee 2. Consultation with EDS/PAC Steering Committee 3. Consultation with users of forms in the hospital 4. Redesign of paperwork in draft forms	1. Agreement that minimisation of the number of forms is good and will await draft 2. Full endorsement/support for the change 3. Support for change and welcome more streamlined documentation 4. Development of a suite of forms for discharge planning in consultation with PAC, WSSS and EDS coordinators	Hospital staff feel it unreasonable to duplicate information on different purpose documentation. Change in paperwork to decrease such duplication is well received by all staff. Consultation with all stakeholders is helpful in identifying duplication and commonalities with existing documentation. The discharge assessment screen (a tool of the EDS) measures 4 risk factors which are: - living alone - caring for others - use of community services - ability to manage self care If a patient has one or more risk factors they are flagged for more comprehensive discharge planning. Through hospital education it is hoped this process may also be used to identify patients eligible for EPC.

5.Conclusions

5.1 Major Achievements

- Improved communication with GPs:
  - Generation of 19 care plans and 2 case conferences in 6 different areas
  - Development of guidelines where care planning is routine in particular circumstances in oncology, neonatal, WADS and diabetes units.
  - Modification of nursing care maps in oncology so that early consideration is given to discharge planning with the GP
  - Introduction of "Notification of Attendance" proforma to GPs in Young Mother's Clinic and Women with Individual Needs Clinic Project
  - Introduction of a mechanism for GPs to notify hospital of potentially suitable patients for EPC in Young Mother's Clinic and Women with Individual Needs Project
  - Introduction of GP notification of admission for babies hospitalised over 7 days in neonatal unit
  - Process to define the work descriptions of clerical staff clearly outlining that the capture and checking of GP details is part of their role
- Successful implementation of "Get yourself a GP" Campaign"
- Improving the profile of the GP to hospital staff and their understanding of the role of the GP
  - Good communication is routine in some areas (eg Fetal Management Unit)
  - Self identification of Young Mother's Team wanting involvement in EPC project
- Integration of information about EPC and communication with GPs into education of external providers (WADS)
- Integration of GP into the Effective Discharge Strategy discharge planning – this work continues towards the development of more integrated tools to identify woman and babies in need of enhanced discharge planning and the development of combined Key Performance Indictors

5.2 Critical Issues

- Routine collection and documentation of a patient's GP details
- Hospital staff, in particular senior clinical staff need to:
  - Value the role of the GP
  - Perceive GPs as being able to add value to the community care of women and children
  - Regard appropriate communication with a patient's GP and discharge planning as an essential and integral part of their patient care
- Hospital staff perception of the need for improved communication with GPs
- Hospital staff need to regard EPC as:
  - A useful part of the spectrum of options available for communication with GPs
  - Productive use of time in terms of organisation and paperwork for the patient and staff benefits
  - Able to be done within their resources
- EPC must be incorporated in routine process to ensure sustainability and uptake

5.3 Success Factors

- Appropriate education of hospital staff:
  - For all levels of staff in participating units
  - Surrounding the role and value of the GP in discharge planning
  - Around discharge planning with communication to a patient's GP as being a core responsibility of hospital staff
  - Regarding EPC as part of the continuum of possible methods and depths of communication with a GP
  - EPC being referred to as "GP Integration into Discharge Planning", "Safe referral home" or "Handover to GP"

- Identification of “drivers” for the project
  - In the early implementation phase this was largely the project worker
  - A delegated staff member takes over the role of the "driver" from the project worker when established. It is necessary to have at least one staff member, with authority, who acts as a “champion” to promote the project, help establish it, and plan for its sustainability
  - Development of a project team in each participating unit to act as consultants
- Specific unit factors:
  - Unit staff identify a gap in communication with GPs
  - Units with a group of highly complex women/babies
  - The numbers of women/babies eligible for EPC are manageable and within the resources of the unit
  - Staff perceive discharge planning with GPs as beneficial to the patient or themselves
- Incorporation of EPC into routine care:
  - Identification of disease states and diagnoses rather than individual patients for whom EPC is applicable
  - Modification of care maps to include discharge planning earlier in hospital stay
  - Incorporation of EPC paperwork with other discharge planning documentation to avoid duplication and flag eligible patients
- Develop a mechanism, for example, a fax back form on admission notification so GPs may:
  - Flag eligible patients who may require more comprehensive discharge planning
  - Indicate their willingness to be involved
  - Indicate their preferred billing method
- Develop a culture and mechanism to assist women in finding a GP
- A patient’s regular GP is likely to be involved in hospital initiated discharge planning if invited

5.4 Identified Barriers

- Implementation of a change in culture and practice is likely to take considerable time and resources
- Hospital staffs understanding of the relevance, role and value of the GP
  - Many staff were not aware that the majority of patients have a regular GP
  - Some staff did not understand the role and value of the GP as a primary care provider for patients with a chronic and complex condition with multidisciplinary care needs
  - Many felt that GPs had little to offer their patients with specialist needs
  - Staff perceived EPC as being of value for the GP and not themselves or the patient
- Uptake of hospital staff responsibility for EPC, including:
  - Documenting and checking GP details
  - Flagging patients for enhanced communication with GPs
  - Contacting the GP
  - Consenting the patient
- Greater workloads, with no clear benefit for hospital staff, constitute a disincentive for staff involvement
- Limited hospital staff understanding of their role in discharge planning
  - Short rotation of resident medical staff resulting in difficulties with education about EPC process and documentation
  - A belief amongst some that discharge planning is not part of their role and they are not funded for it as part of patient care
  - Lack of resources for “additional” work
- Logistical difficulties including:
  - Organising 3 care providers to input into one care plan/case conference
  - Reduction in access to available telephone lines for other staff members during a case conference
- An active opposition to gaining patient consent regarding billing issues

6. Recommendations

6.1 Commonwealth

- Modification in eligibility definition for EPC discharge care plan/case conference:
  - The word "chronic" be removed or the definition be reduced from 6 months to 3 months to capture the complexities of pregnancy or the immediate post-discharge period
  - For hospital initiated care plans or case conferences (including community), the definition of EPC be extended to pregnancy related complex problems (without a timing definition)
  - GPs should be eligible to participate in a discharge plan where the patient is being discharged to a different health care facility (e.g. palliative care facility, community hospital or base hospital)
  - GPs should be eligible to participate in a discharge care plan with two other medical specialists (such as Oncologist and Palliative Care Physician)
  - Broader inclusion of medical/surgical disciplines eligible for consultant case conferencing, including gynecologist oncologists, urogynecologists
- Expansion of hospital initiated EPC:
  - Inclusion of GP involvement in patient management (not necessarily discharge) to assist in determining hospital and ongoing management of a complex patient
  - Consideration of incentives for hospital participation. (There was some resentment among staff that they were required to do extra work and GPs were financially rewarded.)
- Discussion with GP groups to modify payment to:
  - Remove the need for hospital staff to obtain consent regarding GP billing
  - Decrease the need for GPs to complete additional, unfamiliar documentation
  - Increase the likelihood of GPs receiving remuneration for their service (as it appears many are not applying for the rebate as they either are unaware they partook in a rebatable service or cannot be bothered with the additional paperwork)

6.2 State

- Extension of time line for the project
  - Adoption of change in culture and process, and establishing sustainability, in a large organisation takes longer than the time allocated. Consideration of a time period of 18 – 24 months
- Consideration of adopting a similar management process for projects of a similar nature, i.e. monthly meetings of project teams to share information and ideas, problem solving and project worker support.
- Reassessment of the remit and performance indicators of the Effective Discharge Strategy (EDS):
  - EDS is towards the end of it's 3-year duration. It seems to have had limited impact on hospital communication with GPs. Only one of the 4 key performance indicators is related to GPs, the provision of a timely and informative discharge summary.
  - EDS (or its successor) become more GP focused with indictors based on criteria such as percentage of patients with documented GP details, admission notification for GPs and contact with GPs during the hospital stay of patients with more than one at risk criteria.
- Development of Key Performance Indicators (KPIs) encompassing safe referral home and the coordination of discharge planning with GPs. These KPIs are linked to hospital funding and are available to GPs, GP groups and patients.

6.3 Hospital

- Implement routine GP notification of a patient's admission and through this:
  - Provide the GP with contact details of a central clinical person in the patient's care as a relevant contact for information or queries
  - Establish whether the GP feels EPC discharge planning is appropriate for the patient, their willingness for involvement and their preferred billing methods

- Extension of the Electronic Discharge Summary facility to provide for information regarding outpatient visits and change in patient condition or management to be autofaxed to the GP
- Develop means of having GP details documented accurately in the paper medical record
  - Many clinical staff report that it is an extra time burden to check CLARA for the patient's GP in order to get their contact details for communication
- Improve the capture, checking and documentation of GP details
  - The clear establishment and alignment of clerical staff position descriptions to ensure GP details are routinely collected and checked
  - Continue education for clerical staff of the importance and process of capturing GP details
  - Consideration that clerical staff management structure to changed to achieve consistency and alignment in duty expectation and improve education and training
- Development of a coordinated and consistent approach to discharge planning
  - Develop better integration of discharge planning projects and personnel – i.e. Effective Discharge Strategy, Post Acute Care, Enhanced Primary Care. This will avoid duplication of work and provide improved development and support.
- Develop and undertake KPIs across the hospital to routinely assess communication with GPs across different units enabling units to identify when and where they have gaps in communication with GPs
- Staff education:
  - Into the broader aspects of health and the value and role of the GP
  - That discharge planning is a core part of clinical staff's role
  - EPC processes to be included in staff orientation as part of a coordinated strategy to discharge planning and concept of "safe referral home"
  - In assisting patients to find a GP
- Suggestions for future similar projects:
  - It would have been helpful to have had both greater consultation and commitment from the involved services prior to commencement of this project, and to have had processes such as routine collection of GP details more established. However, it is recognised that these issues reflect the cultural change that this project has played a parting in driving. To await full implementation of these changes would have reduced the need for, and likely impact of the project.

6.4 Divisions

- Continued education of GPs in EPC processes, particularly hospital initiated care plans and case conferences.
- Develop increased connections with hospitals to assist in education, inform policy and assist in:
  - embedding the role, value and profile of GPs
  - improving continuity of care for patients between the hospital and community sector, including adoption of a coordinated approach to discharge planning
  - improving communication with GPs, including integrating GPs into discharge planning
- Continued involvement of relevant hospital staff in relevant Divisional Committees such as Divisional Continuity of Care Committees, Hospital Integration Forums and General Practice Liaison Officer meetings.

6.5 GPDV

The role of GPDV in coordinating the projects and chairing monthly meetings with the other demonstration projects was invaluable for the ongoing momentum, information sharing and support of the project. Similar project management design should be considered for similar projects in the future.

7. Appendices

7.2 Staff Survey

GP Integration Survey - Number One

March 2002

A 12 month project to improve linkages between hospitals and general practitioners in discharge planning and coordination is being conducted in oncology, fetal management unit, women's alcohol and drug service, and neonates. As a member of a project team attached to one of these units, you have been asked to complete this survey. All information will be used for evaluative purposes and your responses will remain anonymous.

Thank you for your participation.

Have you ever communicated with a GP about a specific patient on this ward/unit?

Yes ☐ No ☐

If yes, how often have you communicated with any GP in the past month?

- ☐ Never
- ☐ 1-3 times
- ☐ 3-5 times
- ☐ 5+

In general, what was the purpose of the communication? (more than one box may be ticked)

- ☐ Informing GP of patient outcomes
- ☐ Information from GP regarding the patient
- ☐ Involving GP in development of discharge plan
- ☐ Other (please specify)

In general, do you believe that involving the patient's GP in the above cases improved patient care?

Not Really 1 2 3 4 5 Most Definitely

Do you see communication with a patient's GP to be part of your role?

Yes ☐ No ☐

If no, whose role do you think it should be? …………………………………………

Do you think communication with GPs is regarded as important by other members of your unit?

Not Really 1 2 3 4 5 Most Definitely

Are the tools required for effective communication with GPs available?

	Yes	No	Don't Know
GP Details available			
Telephones			
Appropriate room			
Utilisation of central dictating service			
Electronic discharge summary			
Other (Clarify)			

What, if any policies/procedures/tools does the RWH have in place to support communication with GPs.

____
____

Please indicate on the scale below whether communication with a patient's GP is beneficial for the yourself, the patient, the GP.

For yourself/hospital staff
Not beneficial 1 2 3 4 5 Extremely beneficial

Why? ……………………………………………………………………….

For the Patient
Not beneficial 1 2 3 4 5 Extremely beneficial

Why? ………………………………………………………………………..

For the GP
Not beneficial 1 2 3 4 5 Extremely beneficial

Why? ………………………………………………………………………….

Have you got your own GP?

Yes □ No □

Do you encourage patients to have their own GP?

Yes □ No □

Do you have any comments about your experience as a health care provider with GPs?

____
____
____

Prior to this project, were you aware of the Federal Government initiatives of the enhanced primary care package which involves GPs in the discharge planning process and case conferencing of patients?

Yes □ No □

Discharge case conferencing and care planning is available for patients with a chronic or complex condition that is expected to last more than 6 months or is terminal and requires multidisciplinary care. On average, how many patients in your ward/unit do you think (best guess) would qualify over a one month period?

□ 1-3 □ 4-6
□ 7-9 □ 10+

Please indicate your: Position ……………………………………………………

Ward/unit …………………………………………………

7.3 Staff Survey Results

Results of Staff Survey on attitudes to communication with GPs – all units

Chart 2

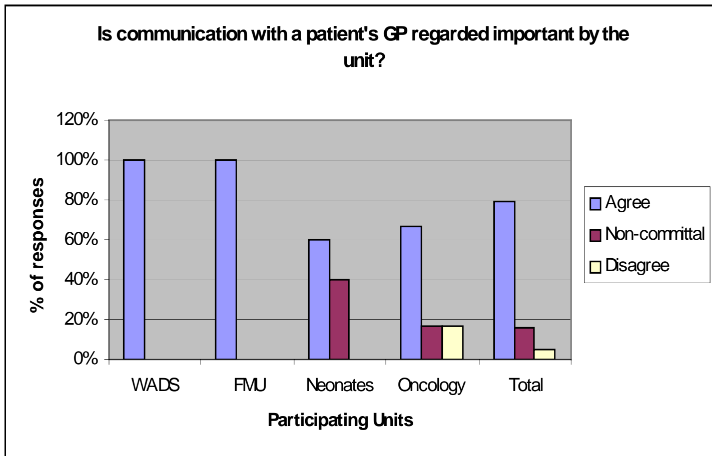


Chart 3

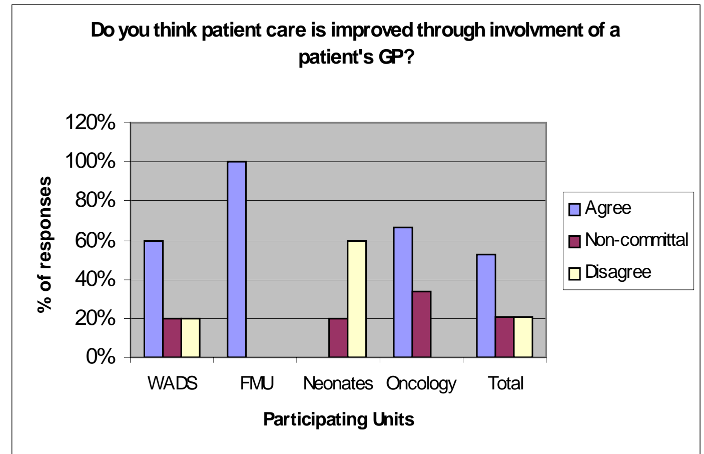
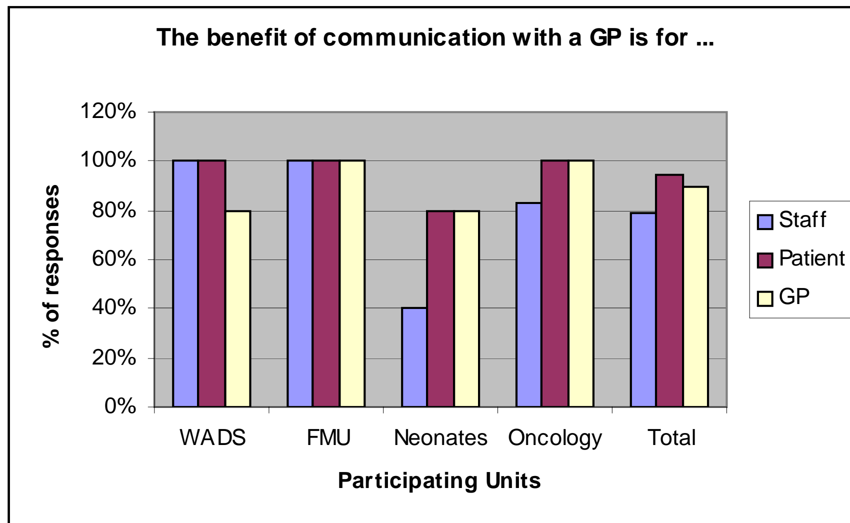


Chart 4



7.4 Initial Patient Survey

Patient Survey

Discharge Planning Process

The Royal Women's Hospital is committed to improve the process of women returning home following an admission/visit to the hospital. Could you please take a few moments to complete this short survey? It is completely confidential.

1. Do you have your own GP?

   Yes ☐ No ☐

   If yes, did your GP organise for your current hospital stay/visit?

   Yes ☐ No ☐

2. Would you be happy for a GP chosen by you to give the hospital information about you that would help in your care?

   Yes ☐ No ☐ Unsure ☐

3. Would you be happy for the hospital to give a GP chosen by you information about you that would help in your care?

   Yes ☐ No ☐ Unsure ☐

4. Some people think that discussion between the hospital and a patient's GP is valuable in planning their discharge home (eg organising home services, follow-up appointments with physiotherapists, social workers, doctors etc)? Do you agree with this statement?

   Don't agree 1 2 3 4 5 Agree Entirely

5. Which unit is looking after you?
   - ☐ Oncology
   - ☐ Neonates
   - ☐ WADS
   - ☐ Fetal Management

6. What is your age group
   - ☐ <20
   - ☐ 20-35
   - ☐ 35-50
   - ☐ >50

Thank you for your participation.

7.5 Results of Initial Patient Survey

Patient survey results

	WADS		FMU		Neonates		Oncology		Total	
Total Respondents	15		11		10		20		56	
Average Age Group	20-35		20-35		20-35		>50			
Own GP	10	67%	10	91%	6	60%	20	100%	46	82%
GP organised for hospital stay		0%	1	9%		0%	15	75%	16	29%
GP to hospital information	12	80%	10	91%	9	90%	20	100%	51	91%
Hospital to GP information	12	80%	11	100%	9	90%	20	100%	52	93%
Pt agreement with d/c planning	9	60%	9	82%	9	90%	17	85%	44	79%
Pt disagreement with d/c planning		0%	1	9%		0%	3	15%	4	7%

7.6 Care Planning / Case Conferencing Tools

Integration of General Practitioners

into the

Discharge Planning Process

Resource Kit

Contact: Robyn Bradley – EPC Project Officer (ext 2880)

Discharge Care Planning and Case Conferencing with General Practitioners

Process Guidelines

- ❑ Identify eligible patient (chronic and complex condition with multidisciplinary care needs).
- ❑ Allocate coordinator for discharge planning process (if this is not the person who identified the patient).
- ❑ Phone GP inviting them to participate in discharge planning. If GP requires it, send fax "Fax request for GP involvement in Discharge or Community Care Plan / Case Conference".
- ❑ Obtain and document patient consent (see "Gaining Patient Consent for Case Conferencing and Care Planning").
- ❑ Develop list of diagnoses/problems. Identify health needs and establish goals with patient.
- ❑ Identify two care providers to participate in the care plan/case conference (other than the GP).

Discharge Care Plans	Case Conferencing
❑ Fax to GP "Enhanced Primary Care Discharge Care Plan and Case Conference" form for their contribution. Provide GP with adequate information to understand the patient's anticipated care needs. ❑ Contact the GP by phone to gain their input. If phone contact is not possible, two way exchange of faxes is acceptable. ❑ Finalise the discharge care plan – it needs to include the goals of care, the timeframe for service delivery, services to be provided, and the names and contact details for all involved in the patient's ongoing care. ❑ Fax final copy of the plan and the patient's consent to GP and other providers. ❑ Provide copy of the discharge plan to patient.	❑ Phone GP to make a mutually convenient time to hold the case conference when all the participants will be available. ❑ Fax to the GP the partially completed "Enhanced Primary Care Discharge Care Plan and Case Conference" form. ❑ Allocate a room with a speaker phone. ❑ Hold the case conference noting start and finish times. ❑ Identify health needs and outcomes to be achieved. Develop agreed management plan identifying tasks and allocation of tasks to participants. ❑ Provide a copy of the summary to the patient/carer and other health care providers.

- ❑ Ensure the patient completes the "Royal Women's Hospital Discharge Planning Patient Survey"
- ❑ Keep the summary in the patient file – currently to be filed under correspondence.
- ❑ Evaluation of the process. Completion of the "Hospital Staff Experiential Survey".

PATIENT INFORMATION SHEET

DISCHARGE AND COMMUNITY

CARE PLAN / CASE CONFERENCING

Why do we need to plan for when you go home from hospital?

It is important to plan for when you go home so you will stay well and have the services you need as soon as you get home.

What is a Discharge or Community Care Plan / Case Conference?

A Care Plan is a written plan of your future care needs for when you go home.

A Case Conference is a meeting, generally a telephone conference, between your GP and the hospital staff looking after you.

The purposes of a care plan or case conference are to:

- To decide on which type of supports and services you may need when you are at home
- Make sure that your GP, hospital staff and other health professionals agree about who is going to provide various aspects of your ongoing care.

Who would be involved in this Care Plan / Case Conference?

Your GP and at least two other health professionals from the hospital. They will plan the best way to provide the services and care that you will need.

How are my views/concerns represented?

In order to proceed, we must obtain your consent. It is important to tell hospital staff if there are any things you DO NOT want discussed or communicated with the other people involved. You will be asked by the hospital staff about what is important for you to be included in the care plan / case conference.

Can I be assured of confidentiality?

Your personal information is treated with the strictest confidence.

What happens after the Care Plan / Case Conference?

The recommendations of the care plan/case conference will be discussed with you by the hospital staff and your GP. You will be given a copy of the summary.

Are there any costs involved for a Care Plan / Case Conference?

Your GP will bill you in the usual way for his/her participation. You will be asked to sign a Medicare form OR pay this account when you next see your GP. A Medicare rebate is available for this service.

Fax request for GP involvement in Discharge or Community
Care Plan / Case Conference

To: **From:**

Fax No: **Date:**

Dear Dr ________________________________

RE: Unit Record No.________________________ **Admission Date:** ___ / ___ / ___

Surname:______________________________ **Admission Diagnosis:**

Given Names:___________________________ ________________________

D.O.B:____________________Sex:_______

(Affix Patient Label)

The purpose of this fax is to gain your input regarding your patient. This is to discuss the care goals of your patient and identify actions required to meet these needs.

Your participation will be very welcome into your patient's future management by way of a:

❑ Discharge / Community Care Plan (circle applicable)

OR

❑ Discharge / Community Case Conference via telephone (circle applicable)

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

You will be contacted by telephone to contribute to the care plan / case conference.

GPs are able to claim reimbursement for their involvement in case conferencing and care planning with public hospital patients utilising the MBS EPC item numbers.

Could you please indicate your interest in participating by faxing this form back to the number below by **___/___/ 02**.

Please do not hesitate to contact me if you have any queries.

Name: ___________________________ Ward / Unit: ___________________________

Phone: ___________________________ Fax: ___________________________

GP signature to confirm acceptance to participate ________________________________

Thank-you.

Gaining Patient Consent for Case Conferencing and Care Planning

- ❑ Explain purpose, benefits and process of multidisciplinary care plans / case conferences to patient (ie. increased continuity of care, better communication between hospital and GP, plan for future care, have other community services required organised, safe referral home)

- ❑ Explain that personal information will be discussed with a minimum of 3 people including the patient's General Practitioner

- ❑ Ask the patient if there is any medical/personal information they do not want discussed at the conference

- ❑ Check with the patient that the GP listed in the patient file is the patient's usual GP

- ❑ Advise the patient that their GP will bill them in their usual way (ie. If the GP normally bulk bills the patient, they would do this for this service as well)

- ❑ Provide patient with a copy of the patient information sheet

- ❑ Respond to any patient or carer queries regarding the process

- ❑ Obtain and document the patient's consent to proceed with the case conference or care plan

The Royal Women's Hospital

DISCHARGE AND COMMUNITY CARE PLAN / CASE CONFERENCE

Unit Record No.____________________________

Surname:____________________________

Given Names:____________________________

D.O.B:____________________Sex:________

Affix Patient Label

Discharge and Community Care Plan / Case Conference Details (to be completed by hospital)

Coordinator:	**GP Name:**	**Other community provider:**
Phone:	**Phone:**	**Phone:**
Fax:	**Fax:**	**Fax:**

Patient's discharge address and phone number (if different to above):

Participants and Service Provider Details (including carer details) (to be completed by hospital)

Name	Position	Contact Details	Date

Case Conference Use Only (to be completed by hospital):

Date: **Start Time:** **Finish Time:**

Authority to Proceed with Care Plan or Case Conference (to be completed by hospital)

- The purpose of this care plan/case conference has been explained. I/my carer, give permission for it's preparation and for the discussion of my medical history and diagnosis, with the providers listed above.
- All participants are to retain confidentiality.
- I/my carer have been asked if any medical/personal information should be withheld from other participants

Applicable for Care Planning or Case Conferencing with General Practitioners only:

- I am aware my GP will bill me in their usual way for their participation and that a Medicare rebate is available for this service.

Signature: **Date:**

Patient / Carer / Verbal (please circle)

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

Trial August 2002

DISCHARGE AND COMMUNITY CARE PLAN / CASE CONFERENCE

The Royal Women's Hospital **DISCHARGE CARE PLAN**	Unit Record No.____________ Surname:____________ Given Names:____________ D.O.B:____________Sex:______ Affix Patient Label

Patient Summary

Principal Diagnosis and Other Significant Health Problems:

Medications:

Aims and Outcomes

Goal (including goals of patient/family/carer)	Task/Recommendations	Review Date & Person Responsible
1.		
2.		
3.		
4.		
5.		

Agreement

I understand the above care plan/case conference recommendations and agree to the outlined goals.

Patient/Carer signature: GP:

Other Health Professional:

Appointment to see GP: Yes / No Date: / /

Appointment to see other Community Health Professional: Yes / No Date: / /

Trial
August
2002

DISCHARGE CARE PLAN

7.7 Admission Letter – Neonates

<<Insert Date (format set)>>

<<Insert GP Name
and Address from Database>>

Dear Dr <<Insert Last Name from Database>>,

Re: <<Insert Baby Name, MRN, DOB, address from Database>>

I am writing to inform you that this infant is an inpatient in the Intensive and Special Care Nurseries at the Royal Women's Hospital. The provisional diagnoses are:
1.
2. (Registrar to complete ie. Not from database)
3.

<u>Neonatologist</u>: <<Insert from Database>>

<u>Case Manager</u>: <<Insert Paed A = Caroline Richardson, Paed B = Bev O'Sullivan>>

If you would like any further information, please do not hesitate to contact the Neonatologist or Case Manager through the hospital switchboard on 9344 2000.

Yours sincerely,

<<Insert Name and Title (Registrar, Fellow)>>

7.8 GP Details Letter – Neonates

Dear Parent(s)

Congratulations on the birth of your baby, and welcome to the Intensive and Special Care Nurseries at the Royal Women's Hospital.

We would like to inform your General Practitioner (GP) of your baby's admission to RWH and the care your baby currently requires, and then again when your baby is discharged home.

If you have a GP and are happy for us to write to him/her about your baby, please complete the details below and give this form to your baby's nurse or case manager.

If you do not have a regular GP and would like to, please ask your baby's doctor, nurse or case manager for more information on how to choose a GP. Remember that your GP can look after all members of your family and will know about other services in the community that may be of benefit to you.

GP Name: ____

Address: ____

____

Phone: ____

Bradma Label

7.9 Young Mother's Clinic Visit Proforma

THE ROYAL WOMEN'S HOSPITAL

Notification of Clinic Visit

To the Young Mother's Clinic

To:		**From:**	**Angela Steele** **Young Mothers Clinic Coordinator**
Fax No:		**Date:**	

Dear Dr ____

RE: Unit Record No.___________________________

Surname:_________________________________

Given Names:______________________________

D.O.B:________________________Sex:________

(Affix Patient Label)

The purpose of this fax is to advise you of your patient's first attendance at the "Young Mother's Clinic" at the Royal Women's Hospital today.

You will receive a letter from the doctor who saw your patient in due course. In the meantime, if you have any queries, please contact the Young Mother's Clinic Coordinator, Angela Steele, by phoning 9344 2189.

GP involvement in care planning at the Royal Women's Hospital

The Royal Women's Hospital is currently undertaking care planning for patients with complex and chronic conditions, requiring multidisciplinary care. Please complete and return this form if you wish to be involved in a hospital initiated EPC process for this patient.

- I am prepared to bulk bill for this service YES / NO
- I would like to be involved in a care plan for this patient YES / NO
- I require more information about the process YES / NO
- I/my practice has the capacity for home visits if needed YES / NO

Please fax back to: **Robyn Bradley**
EPC Project Officer
9344 2428 (fax)

For further information about EPC phone Robyn Bradley on 9344 2237

7.10 Women with Individual Needs Visit Proforma

Notification of Clinic Visit

for Women with Individual Needs

To: **From:** **Cherise Smith/Karen Graham**

Women with Individual Needs Project

Fax No: **Date:**

Dear Dr ______________________________________

RE: Unit Record No.______________________________

Surname:____________________________________

Given Names:________________________________

D.O.B:_________________________Sex:________

(Affix Patient Label)

The purpose of this fax is to advise you of your patient's clinic visit and subsequent assessment by the Women with Individual Needs project at the Royal Women's Hospital today.

You will receive a letter from the doctor who saw your patient in due course. In the meantime, if you have any queries, please contact, Cherise Smith or Karen Graham, Women with Individual Needs Project by phoning 9344 2558.

GP involvement in care planning at the Royal Women's Hospital

The Royal Women's Hospital is currently undertaking care planning for patients with complex and chronic conditions, requiring multidisciplinary care. Please complete and return this form if you wish to be involved in a hospital initiated EPC process for this patient.

- I am prepared to bulk bill for this service YES / NO
- I would like to be involved in a care plan for this patient YES / NO
- I require more information about the process YES / NO
- I/my practice has the capacity for home visits if needed YES / NO

Please fax back to: Robyn Bradley

EPC Project Officer

9344 2428 (fax)

For further information about EPC phone Robyn Bradley on 9344 2237

7.11 GP Information – Shared Care Meetings

For any enquiries regarding this project,
please contact:

Robyn Bradley
Project Officer
Royal Women's Hospital
132 Grattan Street
Carlton 3053
Phone: 9344 2880
Fax: 9344 2428
Email: bradleyr@cryptic.rch.unimelb.edu.au

This is a collaborative project incorporating the Melbourne, Western Melbourne, North West Melbourne and Ballarat and District Divisions of General Practice.

Discharge Planning

with the

Royal Women's

Hospital

The RWH is currently undertaking a project integrating General Practitioners into the Discharge Planning Process of patients with a chronic and complex condition and multidisciplinary care needs. The units involved in this project are:

- Oncology
- Neonates and special care nursery
- Women's Alcohol and Drug Service (specialist antenatal service for women with alcohol and drug problems)
- Fetal Management Unit (specialist service for management of women who have had an abnormality detected in their fetus)

Remuneration

The EPC package will reimburse you for your time spent contributing to a care plan or case conference using the Medicare Benefits Schedule.

The appropriate item numbers are 728, 768, 771 and 773.

Patient Consent

The hospital staff will obtain the patient's consent for your involvement in a care plan or case conference. The consent ensures patient confidentiality, addresses billing issues, and confirms that the patient has been asked if there is any information they wish to have withheld from other participants.

What is Care Planning?

Care planning is a written plan of your patient's future care needs after they are discharged from hospital. It identifies supports and services required and ensures that you and the hospital staff agree about who is going to provide various aspects of a patient's ongoing care. Following the patient's discharge, you should review the discharge plan and initiate a community care plan if there are clinical reasons to do so.

What is Case Conferencing?

A case conference is generally a telephone conference (or sometimes a face to face meeting) between you and the hospital staff looking after your patient. It gives you the opportunity to make hospital staff aware of your patient's medical history and any other issues which may impact on their care whilst in hospital. It also provides an opportunity to identify any supports or services that may be required by the patient when they are discharged.

What if I have a patient at the RWH who I think may benefit from discharge planning?

While the project is in it's pilot phase, if you have a patient you know is coming into hospital who has a chronic and complex condition with multidisciplinary care needs, you should contact Robyn Bradley (fax number 9344 2428) who will discuss it with the relevant hospital staff. GPs cannot initiate care plans and case conferences for public hospital inpatients.

7.12 Experiential Survey – GP, Staff and Patient

Royal Women's Hospital
Discharge or Community
Case Conferencing and Care Planning

GP Experiential Survey

We are interested in your opinions about your involvement in a case conference/care plan with the Royal Women's Hospital. Could you please take a few moments to answer this short survey?

Please indicate your response by marking the boxes below.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The hospital provided adequate information about the patient prior to the case conference/care plan.					
The documentation provided allowed good contribution to the case conference/care plan.					
The process ran smoothly at the designated time.					
The clinical information discussed was relevant to future patient management.					
There was good interaction between the participants.					
Following the case conference/care plan, I feel more confident in providing ongoing care to this patient.					
As a result of this communication, I am more likely to contact the unit with issues about **this** patient.					
As a result of this communication, I am more likely to contact the unit with issues about **other** patients.					
I feel my input earlier in the patient's admission would have been useful.					
I welcome future participation in case conferences / care plans.					
I/my practice staff require further education or information about EPC.					

Are there any ways in which the case conferences/care plans procedure could be improved to meet your clinical and/or logistic needs?

____

____

Any further comments?

____

____

Thank you for your time in completing this survey
Please return it by fax to Robyn Bradley - fax num (03) 9344 2156

Royal Women's Hospital
Case Conferencing and
Care Planning

Hospital Staff Experiential Survey

We are interested in your experience in case conferencing/care planning with a patient's GP. Could you please take a few moments to complete this short survey? General comments are also welcome.

Please indicate your response by marking the boxes below.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The documentation required for the case conference or care plan was easily understood.					
The process for case conferencing/care planning was easy to follow.					
The process ran smoothly at the designated time.					
The clinical information discussed was relevant to future patient management.					
The GP was able to provide useful information about the patient.					
I feel this process will improve patient management.					
As a result of this process, I feel confident that patient will be well managed by the GP.					
In general, has this been a positive experience in dealing with GPs in care planning.					
This process has increased the rapport between other health professionals and me.					
I would welcome future participation in case conferences/care plans.					

Are there any ways in which the case conference/care planning procedure could be improved to meet your clinical and/or logistic needs?

____

____

Who should be responsible for organising the paperwork and scheduling of the case conference/care plan?
Any further comments?

____

____

Which unit are you from? ______________________________

Thank you for your participation.

Please return to Robyn Bradley, Patient Representative Office, 1st floor via internal mail.

Royal Women's Hospital
Care Planning

Patient Survey

We are interested in your opinions about your GP's involvement in planning for your future care with the Royal Women's Hospital. Could you please take a few moments to answer this short survey?

Please indicate your response by marking the boxes below:

	Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
The hospital provided adequate information about involving my GP in my care plan.					
What was important for me was included in my care plan or case conference.					
The benefits of a care plan or case conference were explained to me.					
I was happy for my GP and hospital staff to share information about me.					
I think it is helpful to plan for my future care with my GP					
I understand that my GP will bill me in the usual way for his/her participation.					
I am satisfied with the summary of the decisions reached.					

Any further comments?

____

____

____

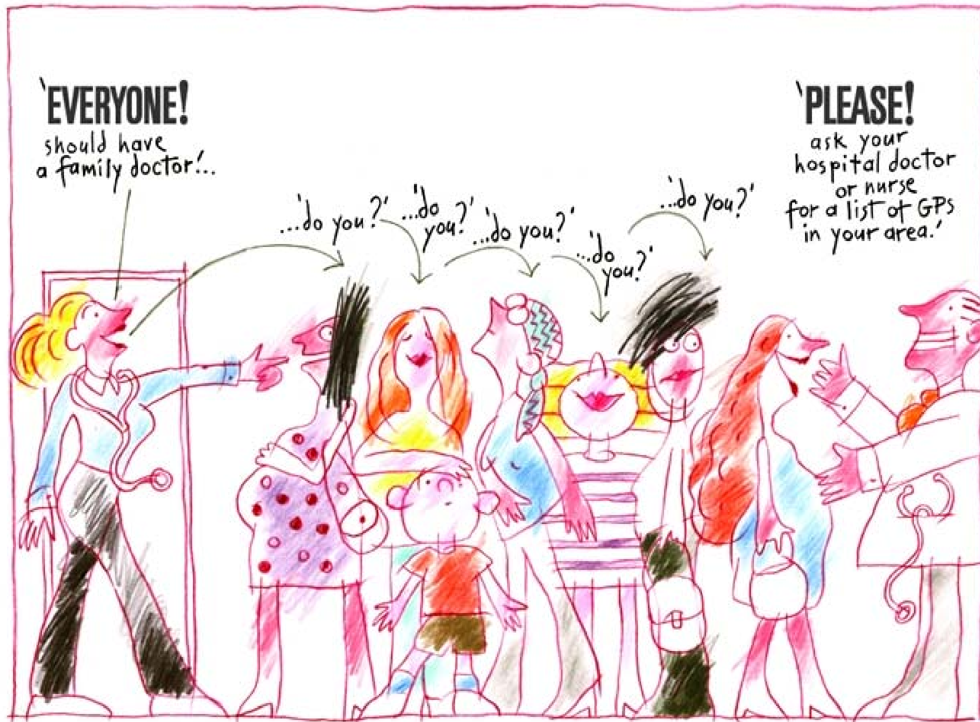
____

____

Thank you for your time in completing this survey
Please return it in the reply paid envelope provided or hand it to your nurse.

7.13 "Get Yourself a GP" Campaign Information Sheet

"GET YOURSELF A GP" CAMPAIGN



We are about to start a campaign to encourage women who have not identified a GP to nominate or find one, in the interests of their ongoing health care.

For women who do not have a GP, it will be the role of medical and midwives/nursing staff to access the "Better Health Channel Database" and print out the list of selected GPs. (See instructions below)

For women who have not notified the hospital of their current GP, a tear off sheet will be attached to the poster for them to complete and hand to staff.
Medical staff can now enter/change patient's GP details in Clara.

How to access database

- Click on the "Find a GP" icon on your desktop.
- A screen will appear which asks you to enter a suburb or postcode.
- Print the list of selected doctors and give to the woman.

Other methods to assist women select a GP

- Recommendation from family and friends
- Talk to their local Maternal and Child Health Nurse
- Yellow pages

Contact Chris Keck (page 3918) or Robyn Bradley (page 2880) with any queries

8. Vignettes

Case Study 1: EPC Eligibility

MD is a 32 year old primigravida who is 20 weeks pregnant. At her routine 18-week fetal anomaly scan multiple abnormalities were detected. She was referred to the Fetal Management Unit as an outpatient. A consequent amniocentesis showed a translocation between 2 chromosomes. The medical ramifications of this translocation are not clear. She and her partner have had extensive counselling. They have not decided whether they will terminate the pregnancy.

Issue:
This is clearly a complex problem. If the child is born there may be ongoing complex medical needs. There may also be genetic implications on future pregnancies, implications on other family members and ongoing counselling. All this will involve the GP.
However if the pregnancy is terminated, miscarries or results in a still birth, the HIC no longer regard the problem as chronic and the GP is not eligible for EPC MBS item number reimbursement.

Recommendation: The definition of EPC be extended to pregnancy related complex problems (without a timing definition).

Case Study 2: Staff resistance to consent for billing

When the first draft of the EPC documentation "GP Integration into Discharge Planning" was presented to the neonatal team meeting, all staff became resistant to the project when they realised they were expected to gain patient consent surrounding GP billing. They thought it unreasonable they were expected to discuss GP billing issues with the patient. They also felt it was unacceptable that public patients may incur costs whilst hospitalised.

Another area in the hospital suggested that if hospital staff received incentives as do GPs "we'd do hundreds of them".

Issues:

- Staff do not see it as their role and are philosophically opposed to consenting patients for billing, especially for an unknown amount by an outside provider
- Staff do not understand funding in General Practice and do not seem to understand that the payment the hospital receives for patient care includes discharge care planning

Recommendation: Staff education into the value of the role of the GP and that patient episode funding includes discharge planning

Case Study 3: GP communication

A GP complained to the GPLO about the following scenario.
DE was undertaking shared maternity care between the hospital and her GP. At 38 weeks gestation, the GP sent DE into the Emergency Department with a letter requesting investigation and management of a "small for dates" baby
The patient was assessed and an ultrasound organised for the following day. The patient's ultrasound suggested growth retardation and she was admitted for induction of labour. The woman delivered a healthy 3kg girl.
The GP did not receive any communication from the Emergency Department, results of the ultrasound, admission notification or a discharge summary.

Issues:

- There are many points where a GP should be notified of the outcomes of their patient's hospital encounter
- GPs expect to be notified of what happens to their patients and experiences such as the above influence their perception of the quality of hospital care

Recommendations: Routine mechanisms need to be developed in all departments to achieve a high level of communication with a patient's GP.