

hospital



GP



 Better Care

The Enhanced Primary Care National Demonstration Project:

St Vincent's Health site

2001-2002

Partner organisations:

St Vincent's Health

Inner Eastern Melbourne Division of General Practice

Melbourne Division of General Practice

Otway Division of General Practice

Project Officer and author

Dr Clare Carberry

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MEMBERS OF THE STEERING COMMITTEE

Peter Hunter	Medical Director Aged & Continuing Care St Vincent's Health
Neth Hinton	Operations Director Aged & Continuing Care St Vincent's Health
Anne Murphy	Consumer representative
Peter Sherwen	VMO Caritas Christi Palliative Care
Stephanie Mavrodoglos	Representing Inner Eastern Melbourne Division of General Practice
Clara Mandaletti	Representing the Melbourne Division of General Practice
Michael Nolan	Representing the Otway Division of General Practice
Silvio Pontonio	Group Manager Continuing Care active (Nov 2001- April 2002)
Mary Doyle	Manager ALERT active May - Nov 2002
John Belfrage	Manager Inner Melbourne Post-Acute Care Program

Acronyms

EPC	Enhanced Primary Care
MBS	Medical Benefits Scheme
MDT	Multi-disciplinary team meeting
GP	General Medical Practitioner
HMO	Hospital Medical Officer
NUM	Nursing Unit Manager
PO	Project Officer
PSC	Patient Services Clerk

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Executive summary

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

Aim of the project

To promote joint care planning and enhance information exchange between St Vincent's Health staff and general medical practitioners (GPs) using the Enhanced Primary Care (EPC) Medical Benefit Scheme (MBS) discharge items.

The project endeavoured to:

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

Scope of the project

The project had three patient category target areas:

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

Rationale for selected patient categories

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

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

Project Outcomes

1. A functioning EPC discharge process (supported by policy) in the Aged Care service area (three wards) indicated by:
 - A regular number of approximately three EPC care plans or case conferences per ward, per week at the conclusion of the project.

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

Project failures

The project failed in the cardiothoracic unit.

Key findings from the project evaluation

GP data:

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

Staff data:

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

Patient data:

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

Recommendations

1. Extend the EPC items to patients who are residents of Commonwealth funded care facilities (nursing home and hostels).
2. Change the patient consent requirements.
3. Acknowledge the significant investment made by hospitals when introducing EPC discharge processes by supplying targeted funding to ensure that such 'beginnings' can be sustained in the longer term.
4. Such National Demonstration projects need to be funded for a minimum of eighteen months to two years to maximise the possible outcomes for the investment made.
5. That feedback from patients and their families is sought by hospital staff about the affect on the post-discharge care experience of the changes brought about through this project. An appropriate question or questions could be included in the usual post discharge follow-up phone call/contact.
6. That junior medical staff are provided with appropriate leadership and mentoring as regard the process and relational aspects of practice.

Learnings from the project

1. *Why was the project successful in the Aged Care service area at St Vincent's Health?*
 - a. Strong and enduring endorsement from the Aged Care Executive members of the health service: the project was important.
 - b. Medical leadership and senior medical ownership of the project (which involved **active** encouragement and support of junior medical staff).

- c. Impressive and unified leadership by nursing staff across the Aged Care service area.
 - d. Tremendous commitment from the staff at all levels to quality patient care.
 - e. Engagement and support for the project from key allied health staff.
 - f. Changed processes were embedded into usual ward routines.
 - g. The importance of good community care as a necessary part of good hospital care was an integral element of the 'culture' of this service area.
 - h. Ownership of the project by staff at all levels developed over time.
 - i. Organisational pride: leading the field.
2. *Why was the project moderately successful in the Palliative Care service area at St Vincent's Health?*
- a. In principle endorsement rather than strong, active endorsement from the Executive members representing the health service.
 - b. The project was perhaps less of a priority than in the Aged Care service area.
 - c. In principle support rather than strong, active support from most senior medical staff.
 - d. Individually shaped medical involvement in EPC work.
 - e. Generally, poor take-up (ownership) by junior medical staff (HMO1 & 2s).
 - f. Patchy engagement of allied health staff.
 - g. Lack of ownership of the project.
 - h. **Strong nursing leadership in one ward resulted in the most significant achievements coming from this service area.**

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

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

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

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

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

- a. Strong support (which included action) from the Executive members of the health service representing this service area.

- b. Medical leadership and support for the project.
- c. In principle support from key nursing staff.
- d. Good support from allied health staff.

**Overview of the national EPC demonstration project
St Vincent's Health site**

Introduction

The Medicare Enhanced Primary Care (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 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 (quoted directly from the *Guide for Patients and Carers, General Practitioners, Hospital Clinicians, Allied Health and Community Care Providers*. Commonwealth Department of Health and Aging, 2001).

The Victoria Department of Human Services in conjunction with the Commonwealth Department of Health and Aging jointly funded four EPC national demonstration projects in 2001. St Vincent's Health and partners: the Inner Eastern Melbourne Division of General Practice, the Melbourne Division of General Practice and the Otway Division of General Practice were successful tenderers. This document reports on the project and its outcomes.

Scope of the project: an elaboration

The project followed the original project submission in regard to patient categories (aged, palliative and rural). However, choosing a strategy to 'target' rural patients was challenging.

Many units receive rural patients for tertiary care, but some units receive high numbers of rural patients for example neurosurgery, gastrointestinal and cardiothoracic. In addition, there are key rural towns or areas where an established referral pattern of patients to St Vincent's occurs. It was for this latter reason that in the planning stages of the project the Otway Division of General Practice was invited to become a partner in the project submission: in 2000-2001, a significant number of patients had been admitted from that area.

Finally, after significant deliberation, which involved review of current referral patterns from the Otway area, and examination of the percentage of rural patients in other units, the cardiothoracic unit was chosen because of its singular pattern of having rural patients as its principal patient base (2001-2002). Not only would such a choice allow appropriate targeting of rural patients, but would take the project into the heart of an acute surgical ward.

How would the processes developed in the sub-acute area translate into the fast pace, short stay common to the surgical ward?

Attendance at team meetings and interviews with staff from the cardiothoracic unit revealed that their rural patients constituted a group with chronic and complex care needs: elderly patients with co-morbidities, often either living alone or being a carer for another person.

Actions taken

The principles of action for change

The approach employed can be described in seven steps:

1. **BUILDING TRUST AND CONFIDENCE:** Getting to know the staff and ward processes ('being around', attending meetings).
2. **BUILDING ON THE PAST AND PRESENT:** Learning what works well ('being around' listening, observing, talking with staff).
3. **DEVELOPING COMPETENCY:** Education about EPC and its relation to hospital discharge processes (groups of staff, one to one throughout wards).
4. **SMALL GROUNDED STEPS INFORMED BY THOSE WHO WOULD LEAD CHANGE:** Listening to staff, their fears and concerns about change and about what could work (sharing and discussing ideas with staff, getting their responses/reactions).
5. **DOING THE DOABLE:** Being guided by the demands of the EPC project, and the above points.
6. **WORKING TOGETHER:** Working with staff closely as the new processes and forms were developed, trialed and implemented (seeking feedback, criticism, being available for 'troubleshooting').
7. **GETTING THE JOB DONE SATISFACTORILY:** Having faith in the project process in difficult times (asking for help to solve problems, persistence, seeking authoritative assistance occasionally).

Phase one action: process mapping

A breakfast forum, which attracted over one hundred guests, was held in the first three weeks of the project. Although a number of attendees were from relevant community organisations, including GPs, most of those present were hospital employees and senior executive staff. The evaluation of the forum revealed that it raised the profile of the project with those who attended, and provided valuable information about the role of EPC MBS items in the discharge setting.

A variety of methods were employed to assess the discharge processes in a number of units. The units selected were those that were directly involved in the project for example, Aged Care and Palliative, or those units that regularly refer clients to these units. For example, the four special medical wards were included because they refer patients frequently to the Aged Care units. It is worthy of note that surgical units were not included in the process mapping exercise.

The methods employed were:

- Individual interviews with the Nursing Unit Managers (NUMs).
- Participant observation of multidisciplinary team meetings.
- Survey of NUMs regarding discharge processes.

- Review of discharge documents including an audit of approximately eighty patient files.

The findings of this process mapping exercise revealed that:

- Discharge processes were fairly consistent throughout the units involved in the process mapping exercise. Notable aspects of the discharge processes relevant to GPs were:
 - Regular faxing to GPs on admission of shared clients by the majority of the 11 units surveyed.
 - Organisation-wide processes for ensuring and checking GP details in patient files.
 - Phone contact (not uncommonly) with GPs on admission or during the in-patient stay.
 - Discharge summary (computer generated) sent within 24-72 hrs by the majority of units.

Multidisciplinary team (MDT) meetings were part of the discharge planning process in all the units studied. There was a difference between the acute and sub-acute area in the status of the MDT team meetings as well as in their format, process and outcomes.

Analysis of responses

Although there was some variation, the discharge processes in the sub-acute area were generally of a high standard (Sullivan, Irwin and Street, 1995). Two of the defining differences between the MDT meetings observed in the acute and sub acute area appeared to be the:

1. Use of patient records and
2. Documentation during the meeting.

The short time frame, the fast pace of the acute MDT meetings and the whereabouts of the record (xray, theatre) appeared to preclude such activity. Another interesting difference between team meetings was:

3. Decision making and planned action processes.

In the acute setting but less so in the sub-acute area, although patient issues were raised and discussed, decisions and actions related to the issues raised were not always consistent. That is, if "x" number of issues were raised, not all "x" were addressed. Another issue that appears to distinguish acute and sub-acute discharge planning observable at the MDT meetings was:

4. Clear delegation of a discharge co-ordinator in the sub-acute area.

It appears that the NUM carries the chief discharge coordination role in the acute units.

One tentative conclusion, given some support by the NUMs at a acute NUM meeting held to discuss the results from the process mapping, is that a good deal of discharge planning occurs informally on rounds, and in discussions when relevant people are available. Therefore, what is observable at the MDT meeting is not the sum of discharge planning that occurs around a patient admission. However, a 'trail' of discharge process activity was not easily identifiable at times. For example, although all NUMs claimed that GPs were regularly contacted, there was no evidence of such contact recorded in the patient files when the

project officer audited them. In addition, one HMO1 on an acute ward commented that while there was an intention to contact GPs, the 'hit' rate (actual contact) was about 4/10. He explained that sometimes making the phone call, just 'fell off the end of the day' meaning that one ran out of time, and on other occasions, when the phone call was actually made, the GP was unavailable. This frank comment was supported by the comments of a number of other HMOs interviewed.

On review of the discharge documents, including the audit of approximately eighty patient files it appeared that:

5. There was poor alignment between the discharge records currently in use and the requirements of the EPC discharge work.
6. None of the discharge forms in use at the commencement of the EPC project included a formal discharge care plan.

The mal-alignment of forms was a significant issue because extra work would be required by hospital staff arranging a discharge care plan or a case conference with the GP. This problem was one of a range of disincentives for hospital staff at the commencement of the EPC project.

Another disincentive was the imbalance in financial reward for resource investment. The GP was rewarded via the EPC MBS items, but the hospital received no extra funding for the extra resources required to improve the quality of the discharge processes.

Outcome of the process mapping exercise

A recommendation from the project officer to the EPC project Steering Committee was made that changing the discharge documentation and the system that supported it was required. The Steering Committee supported the recommendation.

Another two recommendations from the project officer to the EPC Steering Committee that were similarly supported were that:

1. Care planning rather than case conferencing be the main focus of activities in the first instance, and that
2. Telephone contact rather than face-to-face or facsimile be the medium for GP/hospital staff interaction.

Phase two: the action

The MDT meeting and the electronically produced discharge summary already in place at St Vincent's Health provided a structure and process onto which the EPC processes could be grafted.

Because a key element of EPC work is the involvement of multi-disciplinary staff in conjunction with medical staff, the development of a system that could accommodate multiple users contributing to a discharge summary was paramount. The electronic discharge summary in use throughout the organisation at the time that the project commenced permitted only one user at a time, and was restricted to use by medical staff only. Therefore, a discharge summary was developed in template form that would permit multiple users to access to the document.

In the first instance, a discharge summary/care plan template (Appendix D) was used during the course of the project while a more comprehensive database was constructed. The use of the template permitted a trial of both the processes and the multi-disciplinary (MD) discharge summary/care plan. Therefore, the particular features of the database and the reports it generated were closely aligned to the needs of users on the ward. In addition, as a result of feedback via the evaluation process operative during the course of the project, the needs of GP recipients also shaped the development of the forms generated by the database.

The EPC processes that were developed during the project (modified to suit the particular nuances of each ward) are described below.

The EPC process at ward level: Aged Care

The multi-disciplinary team meeting was chosen as the best place to identify patients for EPC. In the early stages of the project the team leader was charged with the responsibility of posing the question as to whether GP involvement through case conferencing or care planning would benefit the patient. Later in the project, a decision was taken that all patients destined for a 'discharge home' would be eligible for an EPC care planning or case conferencing process unless there were reasons not to proceed for example, the patient did not give consent. When a patient was flagged for an EPC item, a process was set in train to ensure that action was taken. The following steps outline the action:

1. On admission, a fax-back is faxed to the GP notifying the GP of the admission of the patient; The fax-back contains an invitation to the GP inviting her/him to return the fax indicating that he/she is interested in participating in a discharge care plan or a case conference.
2. GP interest in participating in an EPC care plan/case conference is registered at the weekly multi-disciplinary team meeting.
3. All patients destined for a discharge 'home' are flagged as 'EPC' and that label is placed against the patient name on ward patient list.
4. Relevant staff including the designated discharge co-ordinator is involved or informed of the team decision.
5. Patient information (Refer to Appendix I) is given to the patient and discussed. Consent is requested for GP involvement, and the patient response is recorded (MD discharge summary/care plan).
6. The plan of discharge care is discussed with the patient.
7. Phone call with the GP is booked in conjunction with the relevant medical staff and other staff who are required to be present.
8. Relevant staff members are informed to fill in the discharge care plan before the link up with the GP in the case of care planning.
9. Relevant staff members are organised to be present for the GP link-up for case conferencing.
10. GP contribution is noted in either the discharge care plan table or the case conference form.

11. Discharge summary/care plan or case conference document is despatched to the GP.
12. Discharge summary/care plan is despatched to other health care providers involved in the care plan for example Royal District Nursing Service (with patient permission).
13. A copy of the document is kept in the patient's file.
14. A copy of the discharge summary/care plan (or case conference form) is provided to the patient and/or family.

Outcomes

Indicators

1. Number of EPC discharge items used:
 - a) Aged Care services (across three wards) 3 x 3 EPC care plans (routinely) per week with occasional case conferences being conducted.
 - b) Palliative (two wards) occasional use of the EPC care planning item.
 - c) Cardiothoracic: no EPC work was undertaken.

It is worthy of note that the majority of GPs did not claim a discharge EPC MBS item number although they were entitled to do so (Refer to the evaluation data in Appendix A).

2. Unexpected outcomes:

- a) MD discharge summary/care plan used as the standard discharge summary

Aged Care Service Area

A decision was taken in the Aged Care service area to use the MD discharge summary/care plan for all patients whether an EPC process was in place or not. The use of this document extended into a fourth ward - the awaiting placement ward.

The use of this document throughout the service resulted in an improvement of information being communicated to community providers involved in patient care. Informal feedback from community providers was very positive. This response was reinforced by the feedback from GPs. (Please refer to the GP fax-back and interview evaluation in particular: Appendix A).

Palliative Service Area

A decision was taken in one of the wards of the Palliative service area to use the MD discharge summary/care plan for all patients who were discharged whether an EPC process was in place or not.

The decision to use the more comprehensive document was taken to improve the quality of information going to community providers after initial positive anecdotal feedback from the field (principally, from the community palliative nursing services).

b) Development of ward policy and protocol to support EPC processes

Aged Care Service Area (Refer to Appendix C)

c) EPC working party

Aged Care Service Area

A working party was set up to monitor and support the implementation of the database, quality issues, staff training and maintenance of EPC processes.

Because the database was ready for implementation in the Aged Care area in the very last weeks of the project, the working party, unsupported by the project officer, assumed responsibility for the education, upskilling of staff and troubleshooting in regards to the new database once the term of the project had expired.

The workers involved (NUMs and Allied Health Chiefs/staff) prepared manuals and worked as 'super-users' to support other staff in the transitional stage.

As is often the case, medical staff could not afford a representative to the working party. This is common in both hospital and community practice. The effect of this phenomenon is that medical staff members are not involved in the genesis and ownership of many ward-based initiatives. If the nursing staff do not take responsibility for 'training' the junior medical staff in many of the process aspects of ward routine there appears to be a gap in their capacity to function as full members of the multi-disciplinary team. For this reason, the project officer prepared a guide for medical staff (Appendix E) to assist them familiarise themselves with the database in preparation for use.

It is important to note that throughout the project it appeared that junior medical staff lacked the practical support of seniors in relation to process issues that the other health professions (nursing/allied health) afforded their junior members.

Performance

The targets for the project were:

1. The development of a process to support the use of the EPC item numbers in discharge processes for eligible patients at St Vincent's Health.
2. The implementation of that process.

Targets were comprehensively achieved in the Aged Care service area.

Targets were partially achieved in the Palliative Care service area.

Targets were not achieved in the Cardiothoracic service area (However, refer to Appendix B).

In addition, there was no 'roll out' to other areas of St Vincent's Health beyond the three areas named in the project submission (Aged Care patients, palliative care patients and rural patients).

Key benefits to patients

As no patient data was gathered, the benefits to patients involved in this project cannot be reported.

Patient data was not gathered because the project time frame was too short to collect credible patient data (See recommendation 5 in the Executive Summary).

Key learnings (hospital perspective)

Refer to relevant sections of the Executive Summary.

Conclusion: the project officer 'summing up'

The EPC National Demonstration project achieved a modicum of success. The list below reflects what the project officer believes to be the most important factors that contributed to that success.

- Senior medical leadership, which manifested as engagement, commitment and action.

When present, the medical leadership had the effect of giving credibility to the project and the project officer. In addition, this leadership lent support to the efforts of the senior nursing staff. Finally, the senior medical leadership assisted junior medical staff adapt to the new requirements by making it clear that this aspect of medical practice was important (communicating well with GPs and other community providers).

- Nursing leadership, and the belief by nursing leaders in the value of the project. The project was embraced as an opportunity to improve the quality of patient care and outcomes.
- Some particularly outstanding practitioners in the medical, nursing and allied health disciplines who championed the project goals with great gusto.
- An administrative staff work culture that was patient focussed.
- An organisational culture where quality was an important value.

APPENDIX A: Evaluation of the EPC demonstration project
St Vincent's Health

Evaluation of EPC discharge process and the multi-disciplinary discharge summary

If you take it from the perspective that up until recently there was nothing like this happening, it has to be said that it is a huge advance on what existed before. The quality of the St V's one is by far the best. It is a credit to St V's that it has made such advance in such a short time (GP respondent).

This process formalises what we have been doing informally for a long time. I'm in favour of that. I have another patient who is flagged for a care plan. I will get more accustomed to the process and know what I should be asking and contributing with more practice (GP respondent).

It was a little overwhelming. I just don't have time. It is great idea though. I've had a patient in Bethesda and she was sent home with nothing. No food in the cupboard, no district nurse, nothing. This patient has had much better care. I hope it continues, as it just does take us a little time to get used to it (GP respondent).

The GPs: Evaluation process

Engaging the general medical practitioners (GPs) in the evaluation process of the EPC project had two foci. First, GPs who participated in discharge care plans/case conferences with the staff of St Vincent's Health were invited to participate in a telephone interview. The chief aim of the interview was to provide an opportunity to the GP to appraise the:

- EPC process, and
- The multi-disciplinary (MD) discharge summary.

Second, between August and December 2002, for all patients leaving the Aged Care units of St Vincent's Health a short 'fax-back' evaluation survey accompanied each discharge summary. Telephone interviews and a fax-back survey were chosen as the evaluation tools because anecdotal reports suggest that both methods are time efficient and are acceptable to GPs.

For the telephone interview, a set of questions were prepared by the Project Officer (PO) and General Practice Liaison Officer (GPLO) and approved by the project Steering Committee. The GPLO interviewed two GPs to trial the evaluation questions: the responses from these first interviews have not been included in this summary. The fax-back survey, based on the interview questionnaire and similarly approved, was designed to gather specific information about the modifications that had been made to the discharge summary.

Feedback from the GP respondents was used to modify the multi-disciplinary (MD) discharge summary/care plan during the project. Therefore, the discharge document that GPs were appraising in November 2002 was a refined version of the document that other GPs had commented on during June-July 2002. In addition, feedback from hospital staff was used to develop the discharge document during the same period. In this way the evaluation process informed the development of the products from the project: the EPC process, and the discharge database.

Description of the interview process and sample

The interviews were pre-arranged with each GP after verbal consent was secured. Each respondent was asked to have the patient's discharge summary available to him or her during the interview. The interviews lasted approximately 10-15 minutes. One GP was not interested to participate in the evaluation process. In total, 52 GPs participated. Only 50 questionnaire transcripts were used in this analysis because during two of the interviews it became apparent that the complete requirements of the EPC discharge process had not been met.

Fifty does not represent the total number of GPs involved in EPC discharge care plans/case conferences at St Vincent's Health during the period of the project. For the last three months of the project approximately 3 EPC care plans/case conferences per week were being undertaken by the three Aged Care units. Reasons why all GPs involved in EPC care plans/case conferences were not involved in the evaluation interview process were:

- a. Tracking of EPC care plans/case conferences in the early stages of the project was difficult.
- b. GPs who had been interviewed once were not approached a second time.
- c. A number of cases, which had been identified as having had an EPC process undertaken, were found, on investigation not to have met the requirements of EPC. For example, some patients who were discharged to nursing homes and hostels were included. This group of patients is not eligible for EPC discharge care plans/case conferences.

The evaluation involved GPs whose patients were in-patients of one of the three St Vincent's Health Aged Care units. Although the two palliative units of St Vincent's Health were involved in the project, very few formal care plans or case conferences were undertaken. Therefore, only two GPs were interviewed whom had patients discharged from the palliative units. The fax-back evaluation sheet was used only in the Aged Care units.

The majority of GPs interviewed had been involved in the discharge care planning process as care planning rather than case conferencing. Care planning was the EPC process most fully developed and most commonly employed by St Vincent's staff.

The interview method

The interviews were conducted using a conversational methodology (Holstein & Gubrium, 1997). This approach maximises respondent engagement, reflection and contribution (Burgess, 1982; Burgess, 1984; Holstein & Gubrium, 1997). With regard to questions 6 & 7 the respondent was asked to 'rate' the MD discharge summary. A qualitative rating scale was prepared – excellent, good, average and poor – but was used only occasionally to prompt or guide respondents.

The interviewer decided not to lead (or possibly truncate) the response by automatically providing the respondent with a prepared rating list. One possible negative effect of this approach is that it reduces the uniformity of responses.

The rationale for using the scale on a 'prn' basis was to enhance respondent reflection and to generate grounded respondent ratings, which is consistent with the conversation style of interview. This approach facilitated the collection of 'rich' data. For example, to any one question a respondent often made a number of points. The various points help understand the rating proffered. The exemplar below was given in response to the question in which the respondent was asked to rate the layout of the MD discharge summary/care plan document (Q7).

Exemplar:

Too many compartments. If problems arise we can refer back to it. You need information in case the patient runs into problems. A bit too much however. You know us GPs, anything more that a little information and we are in trouble. We don't have the time. It's okay.

In the quotation above, the respondent replies in an indirect fashion, but arrives at the rating after considering 'pros and cons'. The respondent acknowledges that the document and the information it supplies is an important resource for the longer term care of the patient. However, the amount of information is problematic and the respondent implies that the document could be at risk of not being fully read because of the time pressures on GPs. Therefore, to one question, four points, all of which provide us with useful information have been made. We understand why the rating is okay, and not good or excellent.

However, one outcome of the conversational interview approach was that, on some occasions, respondents did not answer questions directly. In these cases a 'no definite response' or 'no clear rating' has been recorded. It appeared that some respondents did not respond directly to questions for a number of reasons. Either they:

- a. Took the opportunity to speak on some other aspect of the EPC discharge process
- b. Provided an answer to another question, or
- c. Elaborated on an answer to a previous question.

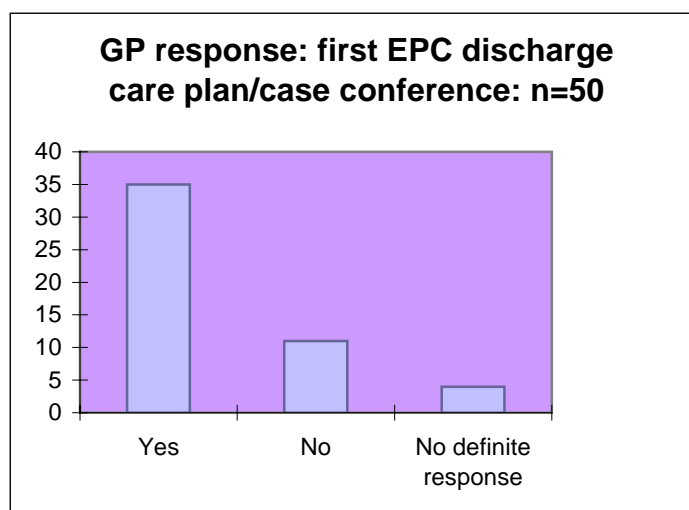
On such occasions, the interviewer made a judgement not to press the respondent for a direct answer because the response provided was valuable in itself, and the limitation on time required that the interview proceed. On other occasions it was judged that to pull the respondent back to the specific question could have threatened the conversational flow of the interview.

As noted above, although a rating scale of excellent/very good/good/average/poor had been prepared for the interviews, it became apparent after the first few interviews that GP respondents were ready to offer their own descriptors especially for the ratings other than excellent, very good or good. Three GPs used a numerical rating scale 6/10, 7/10 and so on. Others used terms such as 'outstanding', 'fine', 'thorough', 'comprehensive', 'adequate' and 'reasonable'. Therefore, each of the rating terms used to report the data from the interview rating questions represents a composite. Ratings of fine and thorough were categorised as good, 'outstanding' as excellent, and so on. 'Reasonable' rather than average, was the term most commonly used to describe the rating category less than good.

Data: the GP telephone interviews

1 Was this the first discharge care plan/case conference that you have undertaken?

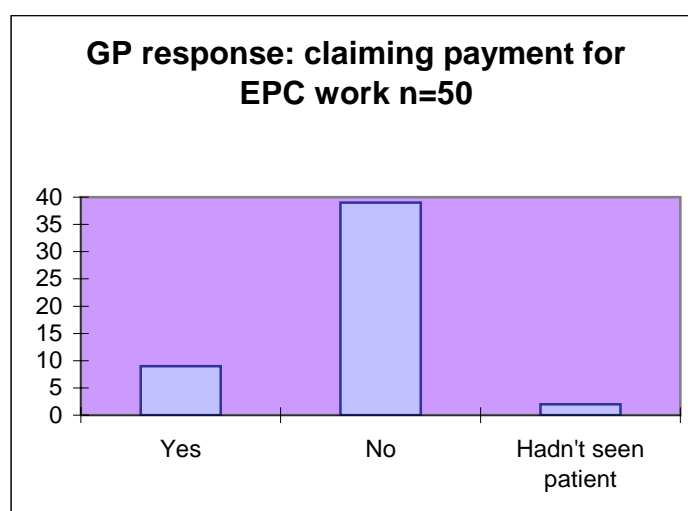
Yes	No	No definite response
35	11	4



The data reveals that involvement in EPC discharge processes was not common amongst the GPs interviewed.

2 Have you claimed an MBS EPC item number for your involvement in the discharge care plan/case conference process?

Yes	No	Hadn't seen patient
9	39	2



The most prominent themes emerging from GP comments to the first two questions was that:

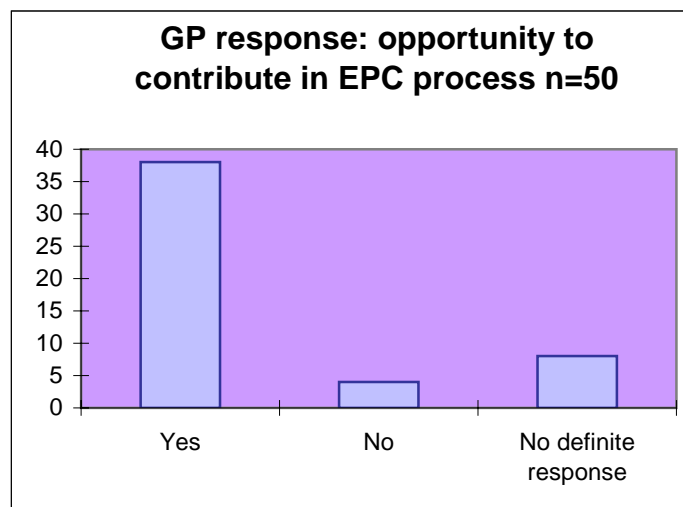
1. GPs were not aware that what they were involved in was an EPC discharge process
That is, the interaction was not clearly 'flagged' as constituting EPC discharge work that could attract payment, and
2. Most GPs were not interested in billing for their involvement.

Three other themes that emerged from responses to question two were that:

- a. There was a low level of knowledge in the GP community about EPC discharge items
- b. That a small group of GPs objected strongly to the EPC initiative perceiving it to be an attempt by government to interfere in medical practice, and
- c. The associated paperwork and bureaucracy was a deterrent to involvement in EPC related work.

3 Involvement in the EPC discharge process requires that you make a contribution to the care plan/case conference. Were you given an opportunity to contribute?

Yes	No	No definite response
38	4	8



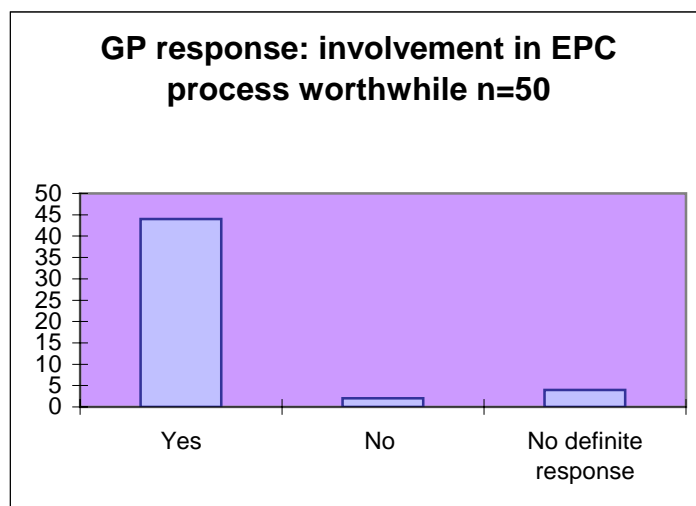
This question was designed to gauge how successfully the hospital staff (usually the unit's resident medical officer) created a dialogue with the GP. That is, how did the hospital staff provide the GP with an 'opening' to make comment, query, offer suggestions, or provide extra information on the proposed care plan.

Although the majority of respondents answered positively to this question there was variation in the level of contribution from agreeing to the care plan proposed by the hospital staff (and the GP's role in it) to active participation with questioning and discussion. Some respondents talked positively about the invitation to contribute and gave examples of their contribution. Others said yes, they were given an opportunity but that they weren't well prepared to contribute because they were not clear that it was a care plan process in which they were involved.

Of those who said no to this question, two said they were just passive recipients of information. Another respondent said that it was unrealistic to contribute to the care plan as the GP had not been involved in the patient's recent in-hospital care and therefore was not in a position to make a meaningful contribution. Another GP said that he was simply being told by the hospital staff about the patient's discharge care plan and was not given an opportunity to contribute.

4 Do you think that involvement in the EPC discharge process was worthwhile?

Yes	No	No definite resp
44	2	4



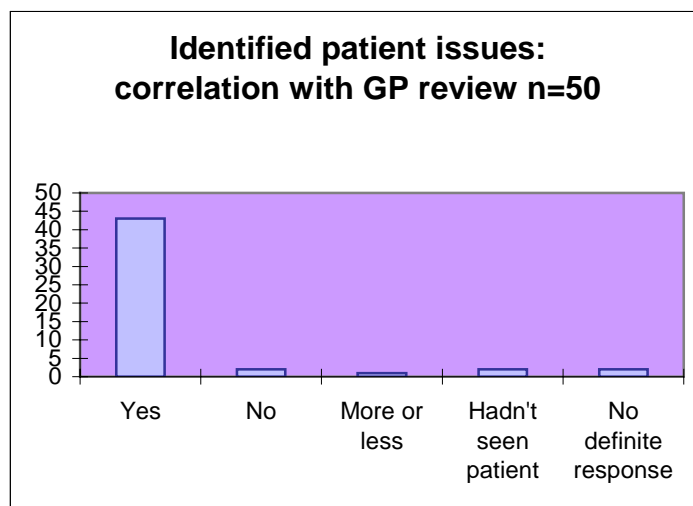
There were many favourable and encouraging comments from the GP respondents to this question. It was clear that GPs valued highly the information shared and the contact from the hospital. Regarding the latter point, comments were made that the contact from the hospital acknowledged the GP's part in the continuum of care. In addition, it gave the GP time to plan follow-up care, for example a home visit for the patient in the immediate post-discharge period.

However, those few GPs who responded negatively highlighted issues of interest. As noted above, one GP thought that the process was tokenistic, another commented that the exchange of information had not been satisfactory, and that many patient issues had been inadequately handled, if not ignored by the hospital staff. This respondent said that the role of the GP was not adequately acknowledged or valued in the care planning phone call with the effect that the contact was of little value.

Two respondents observed that the phone interaction could be replaced by a comprehensive discharge care plan faxed to the GP for comment prior to the patient's discharge. Another group of GPs said that it would be helpful to them to receive a written copy of the proposed care plan prior to the phone conversation with hospital medical staff. Most GPs acknowledged the difficulties of making phone contact for both hospital staff and themselves, but despite this said that personal contact was of tremendous value.

5 Did the discharge issues highlighted by the hospital staff correlate with your review of the patient post-discharge?

Yes	No	More or less	Hadn't seen pt	No definite resp
43	2	1	2	2

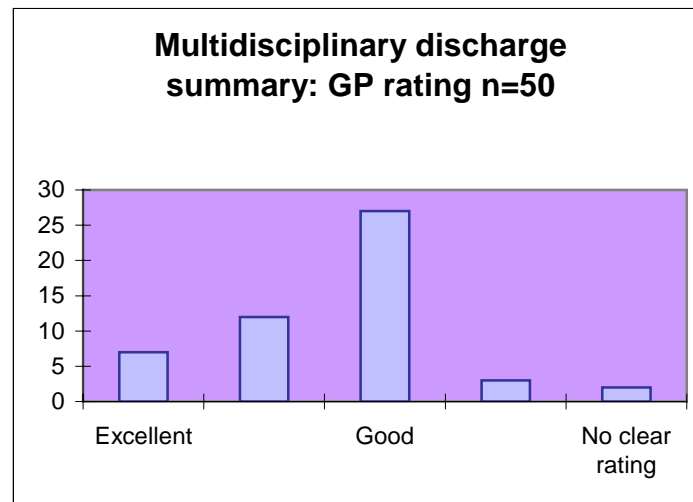


Given the uniformity of the positive responses to this question, it is perhaps of most value to examine the two negative responses. One GP (Dr Tom) said that he had been involved with the patient over a long period of time, therefore when he first saw the patient in the post discharge period he was shocked by the patient's status. Dr Tom thought that the discharge care plan prepared by the hospital staff was unrealistic given the home and social environment to which the patient was returning. Nevertheless, Dr Tom remained in close communication with the hospital staff during the immediate post discharge period and adjusted the care plan in an open and collaborative manner. Dr Tom explained the disparity between his and the hospital staff's assessment of the patient at discharge as due to their different roles in the care process. He had the benefit of knowing the patient over an extended period of time but the hospital staff only see the patient through a short-term episode of ill health, he said. Dr Tom was impressed by his interaction with the hospital.

The other dissenting GP to Q5 (Dr Cat) was not impressed by any part of the EPC process. Dr Cat was alarmed but not surprised by the disparity between the assessment of the patient at discharge and the care plan, and the patient's condition in the immediate post discharge period. Dr Cat, who had also treated the patient over an extended period of time, highlighted a number of omissions both from the medical report of the patient's condition at discharge and the care plan. He queried why the medications had been changed, and where they had not been changed why a different brand name drug had been dispensed to the patient. Dr Cat was highly critical of this practice, which he claimed was a common hospital practice. He would order a MBS item number 900 for a community pharmacy review in order to prevent the risk of the patient 'double dipping' or confusing the new hospital medications with the medications she had been taking before admission. Dr Cat said his contact with the hospital staff throughout the patient's admission was typical of the hospital staff attitude more generally where GPs are ignored and undervalued.

6. I would like your feedback about the multi-disciplinary discharge summary that you received. Overall, how would you rate it?

Excellent	V Good	Good	Reasonable	No clear rating
7	12	27	3	2



The majority of GPs rated the MD discharge summary positively. Even in cases where the GP was critical, sometimes, highly critical of aspects of the MD discharge summary, the overall rating was positive. Spontaneously, many GPs made comparisons with discharge summaries from other hospitals as part of the appraisal process. There was general consensus amongst GPs in the comments that accompanied their rating of the MD discharge summary:

- For patients with complex care issues, GPs preferred more rather than less information.
- Details of the patient's medications at discharge, and reasons for any alterations or additions to the medication regime were an essential component of a good discharge summary.
- The inclusion of pathology and other results relevant to the patient's post-discharge care was important.
- GPs valued concise summaries.
- GPs responded positively to the nursing and allied health contribution to the discharge summary.
- GPs valued the information about who else was involved in the patient's care post discharge (Discharge Care Plan table) and the provision of contact details.
- GPs valued the information (including contact details) of the hospital multi-disciplinary treating team.

It is friendly for finding information. It is not too busy. You can quickly select out individual parts; it's quite nice. Having all the names of the individual therapists is very

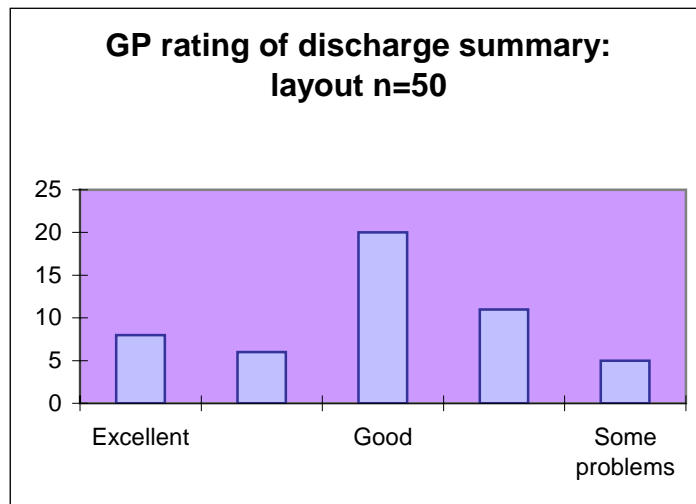
good. You know you can contact someone who knows about your patient if you need to. Not just a name like 'Alison' but the name and position is provided. It's very good.

- GPs did not like the use of acronyms.

7a In relation to the MD discharge summary, could you comment on the layout of the document?

The aim of question 7a-7d is to explore in more detail the overall rating of the MD discharge summary using the parameters: layout, ease of reading, amount of information and quality of information. It is worthy of note that although reduced, the positive response to the MD discharge summary is consistently maintained (at least 75% throughout). The number of 'reasonable' responses is increased, as is the acknowledgment of some problems.

Excellent	V Good	Good	Reasonable	Some problems
8	6	20	11	5



The problems that were identified by respondents were: the use of jargon and acronyms, and poorly filled out or incomplete sections. The need for succinct summary was again noted. One GP complained of receiving too many pathology reports.

I am impressed by the layout of the discharge summary. It is laid out nicely. It has all the results. It's excellent, nice, clear.

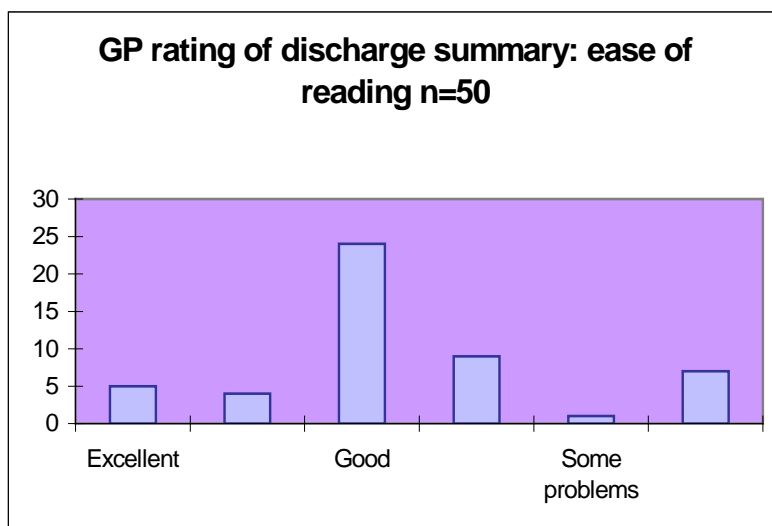
The tables are good.

Easy to find your way around, very good .

Could it be put more succinctly?

7b In relation to the MD discharge summary, could you comment on it in regard to ease of reading?

Excellent	V Good	Good	Reasonable	Some problems	No clear rating
5	4	24	9	1	7



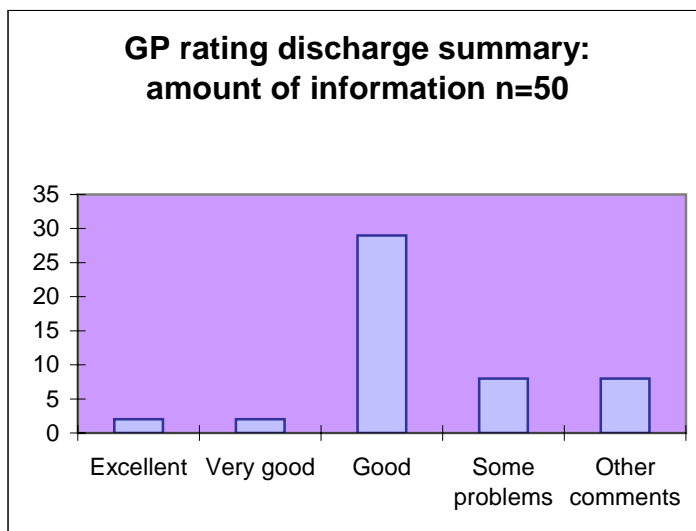
The main problem noted in relation to this question was the variable quality of the faxed copy. Typical comments were:

Fine it's printed, it's laid out well with good headings and it's broken up into different sections.

It's straightforward, readily accessible and legible.

7c In relation to the MD discharge summary, could you comment on it in regard to the amount of information?

Excellent	V Good	Good	Some problems	Other comments
2	2	29	8	8



The problems identified were:

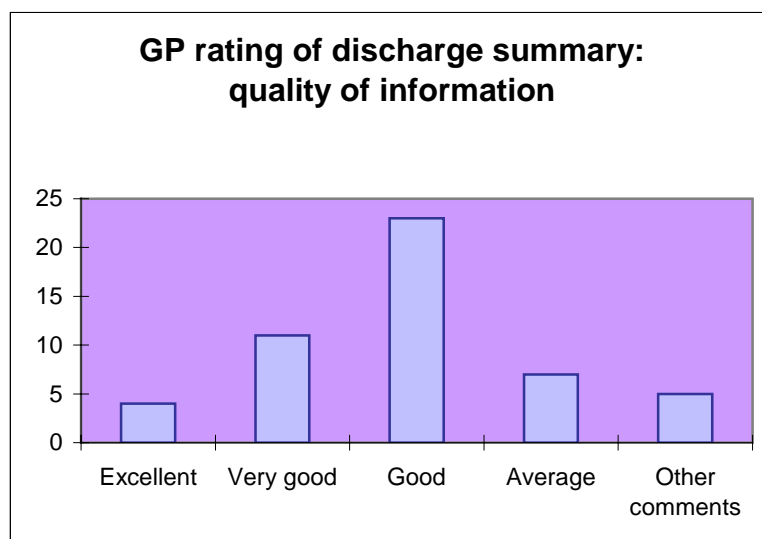
- Too much information.
- Lack of specific information.
- Lack of immediate relevance of some of the information.

I was looking for information about the operation, but there was no information about the operation. I suppose coming from the sub-acute area I can't expect that.

The above quotation was representative of comments made by a number of GPs whose patient had been in other acute surgical or medical units prior to their admission to the sub-acute unit. These comments by GPs are perhaps indicative of a failure of communication with the GP throughout the patient's journey in the acute and sub-acute settings.

7d In relation to the MD discharge summary, could you comment on it in regard to the quality of the information?

Excellent	V Good	Good	Average	Other comments
4	11	23	7	5



Some typical comments from respondents were:

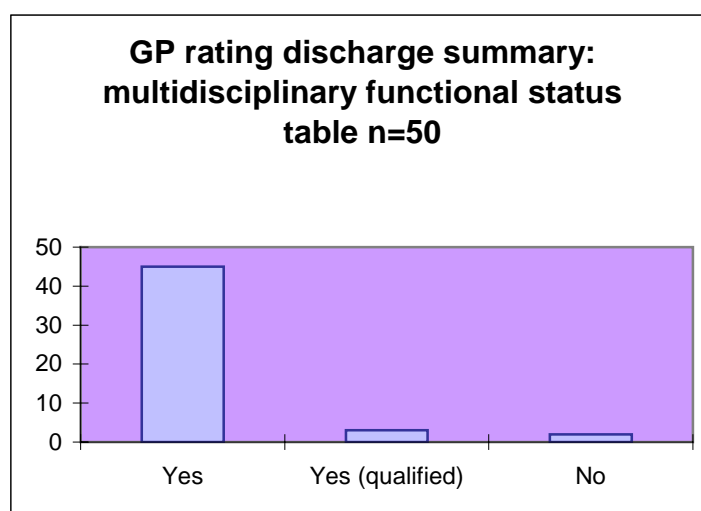
Perfectly adequate; this document adds to the notes I had jotted down during my conversation with the resident.

Everything you would hope for.

8 Was the information about the patient’s functional status of value to you in your role as a GP?

The inclusion of nursing and allied health information in the discharge summary is an innovation, which requires both the investment of hospital staff time and careful coordination. It was therefore important to gauge whether the effort was justified in terms of the usefulness of the information to GPs. Q8 in part, aims to assess the value of this information to GPs.

Yes	Yes (qualified)	No
45	3	2



The GP responses to this question indicate that the information provided by nursing and allied health staff was of value to them in their ongoing care of their patients.

Many GPs commented that this information would be an important resource to them in their ongoing care of patients. One GP observed that it was difficult for the GP to arrange a multidisciplinary assessment such as the one provided in the discharge summary, and that it was therefore very useful to as a baseline of the patient’s functioning:

It is valuable, especially the amount of information regarding independence. It is very important that I know whether the patient is able to get out to shop and that type of thing.

A number of GPs made particular note of the importance of the information on mobility. Three GPs, regarding their male patients, said that the information on continence was particularly useful, as their patients were often reticent on such issues:

Often patients like XXX wouldn’t tell you about his continence, mood and behaviour, useful. Yes, the information is very useful.

A number of GPs also commented on other new sections of the MD discharge summary: the discharge care plan table and the psychosocial section. On such occasions the comments were generally positive and related to the layout of the discharge care plan, the names and

contact details of those participating in the care plan and the assigned responsibilities of those involved. Two GPs commented when their role in the care plan as discussed during the telephone call had not been clearly enunciated in the care plan. Two GPs commented that the information in the psychosocial section of the discharge summary was not particularly valuable as they already had that information, but others commented specifically on its value:

This woman has a lot of issues. We are aware of things to a degree but it is great to have a social workers' assessment in the psychosocial section. It's valuable to have that there as background information. I may not use it all now, but it will be there in the future for reference.

Other comments of interest were:

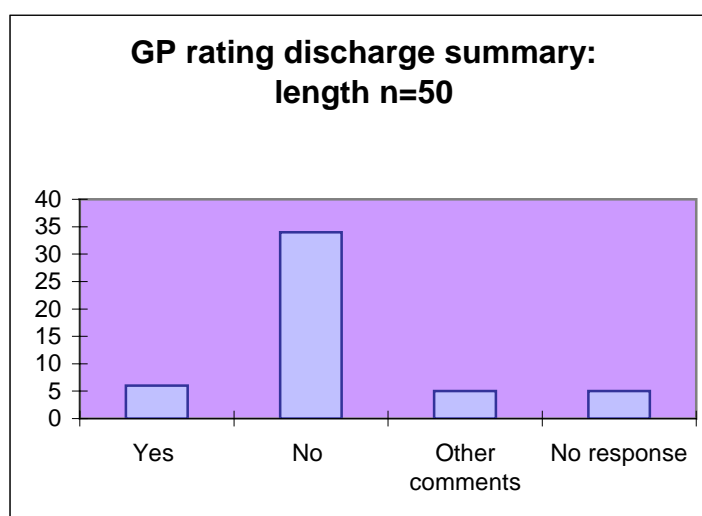
I think it is valuable. It is similar to what we are doing in our annual health assessments. Even if at this stage it educates us as to the language and terms that can be applied to assess a patient's function.

Absolutely, it means that you know what they are like when they come out. We have a truck load of part time doctors. If they have a clear layout of what the patient is like at discharge then it helps them when they are called on to see the patient. You can look back on it 18 months later. It's a level of documentation that doesn't get done in general practice. It's incredibly valuable both as a document for the future, a resource, and for the information that it gives you that is relevant right now.

Yes, because I know lack of time I am not able to go into this detail. You have done all that work. It makes my work easier. Then I can point out something specific, that she may not be able to tell me.

9 Was the MD discharge summary too long?

Yes	No	Other comments	No response
6	34	5	5



The 'other comments' category includes a range of observations. Some respondents noted that the MD discharge summary is long, but that length isn't necessarily a problem.

I'd rather have a longer document that you can manage with a highlighter than have to ring up people. You just can't manage to do that, realistically.

Long. It has lots of information, lots of bits and pieces. It has everything you could want. Someone has written a programme for this. It is aimed at the evaluation of an old person going somewhere. It is useful, but long.

A bit too much, that's not a criticism though. Everything one would need.

Of those who said that the MD discharge summary was too long, almost all (5 out of 6) rated the summary as 'good' overall. This small group of respondents made it clear that length was important. - the longer the document, the less likely they would be to read it.

Of the respondents who did not rate the summary as too long, a number warned against wordiness explaining that GPs would *'just gloss over it.'* In addition, the respondents observed that the use of acronyms was problematic. Amongst this group of respondents approximately a third noted that for patients with complex issues the detail provided was necessary:

No [it is not too long], not at all. You need the detail to continue the care. The detail adds to the length. If you value the information, you don't mind the length.

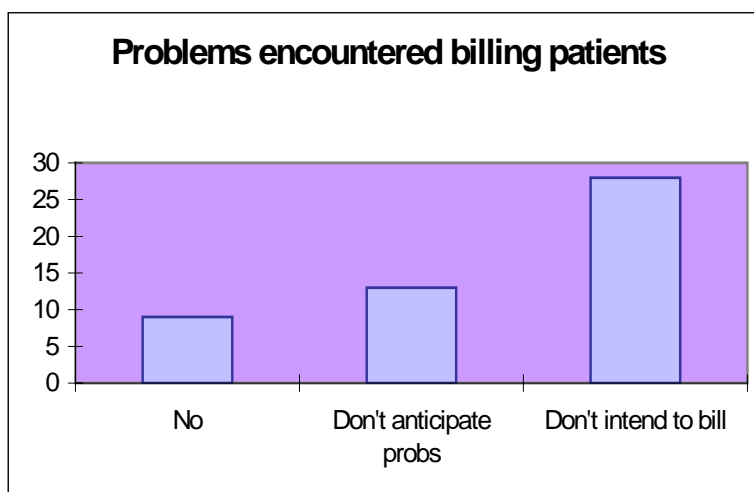
Three respondents mentioned that for patients with simple care issues, such detail would not be appropriate. Another sub-group of respondents in this category explained that the MD discharge summary was a resource. Another distinct sub-group answered 'no' to the question: 'Was the MD discharge summary too long?'

Repeatedly, GP respondents emphasised the need for simple writing and summary. If a document was succinctly written and clearly laid out, the length was less important:

Never a problem with the amount. It's about being able to get at it, what's most relevant.

10 Did you encounter any difficulties or problems with billing the patient for this service?

No	Not anticipated (qualified)	Don't intend to bill
9	13	28



Of those who said they would not bill for their involvement in EPC discharge work, the reasons offered were:

- Philosophical objections:

'Mine is philosophical issue. I have stayed clear of them totally. I think it is bullshit. It is the government dictating to us about what they want us to do, not what good care might demand.'

'EPC is just a waste of taxpayers money.'

- The paperwork involved is a hurdle:

'It's more documentation/paperwork. We are drowning in all this stuff.'

- No interest in billing for such work:

'It's work we've always done.'

- Not worth it:

'The \$28 from the government is dross.'

11 Have you any suggestions regarding the MD discharge summary?

- Evidence of patient and family input
- Direct contact phone numbers for treating team
- Executive summary on the first page (not just the summary of medical issues)
- Ensure that what is discussed in the phone call is included in the document
- Details of others who are involved in the patient's care
- Ensure that the document is complete, and signed
- Email the discharge summary/care plan

12 Have you any other general comments, or specific recommendations you would like to make regarding the Discharge Care Plan process?

- Keep the patient and family well informed throughout, especially when the patient is shifted from one unit to another.

'There should be someone in the hospital who follows/supports these patients and their families to explain things to them as they are shunted through the system, so that they understand clearly what is happening. The family comes to me and it is much harder from where I am.'

- Ensure that we receive information as the patient is shifted from one unit to another.
- Book resident phone calls with the GP so that patient consultations are not interrupted and the GP is ready with the patient's notes to hand, to discuss treatment and care issues.

'It is inappropriate to discuss other patients when seeing a patient. You need time to consider the patient's issues before contributing to the care plan, and privacy to discuss the issues.'

- Make sure that the summaries are succinct.
- Make sure that the phone call with the GP is clearly flagged as an EPC process

The interns should make it clearer that they are inviting your input. They have to understand why they are ringing, and give more opportunity to contribute.

- Improve notification of admission.

Representative comments GP respondents

The comments from GPs regarding the MD discharge summary/care plan and the EPC process were generally very positive. As noted above, there were negative comments regarding EPC as a government initiative, but otherwise GPs expressed support and approval for the initiatives generated from the EPC discharge project.

It's marvellous to get a thorough report.

It's good, very good. The telephone link-up was very good, brief to the point, goals were set. Contact has been good since

No major criticisms. I am quite impressed by it that the resident rang me before the patient was discharged. That was very good. It permits us to plan ahead and then receiving the summary before the patient comes in, not giving it to the patient. We don't have time to read it while the patient is here.

I think it has been handled very well. More information than usual, and being type written that's great. It's excellent really. The discharge care plan box, particularly the management plan, it's excellent really. If I have to ring up it's all there. Sometimes that's difficult but all the information with names is here. I could ring if I need to.

GP evaluation of multi-disciplinary discharge summary: Fax-back responses

The questions included on the fax-back evaluation form were a refined version of some questions used to guide the telephone interviews. For example, information from interview GP respondents had revealed that the nursing and allied health information was valuable to the GP at the time of the patient's discharge. However, GPs had explained that it was valuable because it could help in the ongoing management of the patient. In addition, GP respondents said that this information had a use beyond the present: it could be referred to as a baseline multi-disciplinary assessment of the patient's functioning. Therefore, in the fax-back evaluation two questions were asked: one that related to the value of the multi-disciplinary information, and another that probed for its usefulness in relation to ongoing patient management.

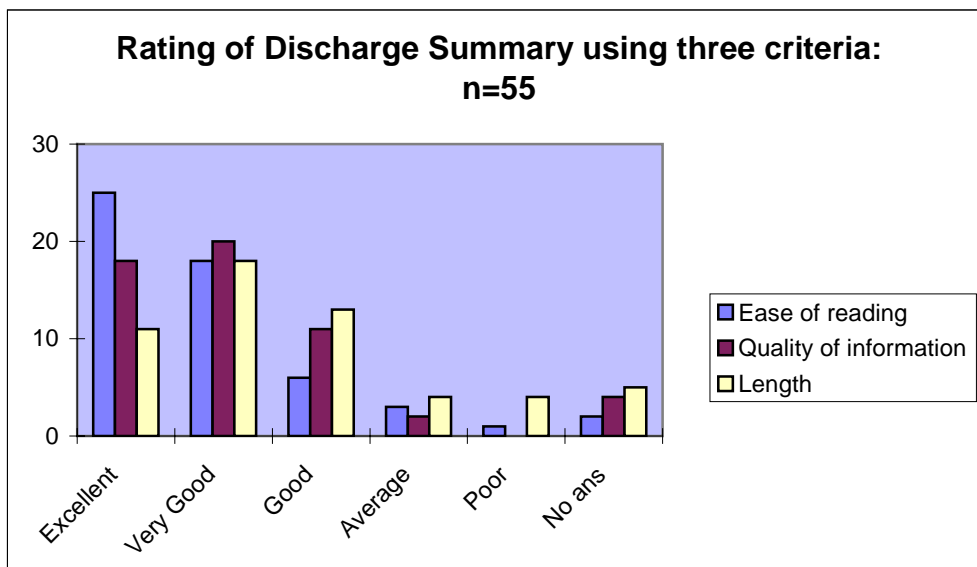
The fifty-five responses do not represent the total number of fax-back forms that were sent out. In total, approximately three hundred fax-back forms were despatched. There is no guarantee that all recipients of the fax-back form sighted it, given the administrative procedures of GP practices. In addition, over time some GPs would have received multiple copies of the evaluation form (different patients, patients who had been re-admitted) but they only needed to respond on one occasion. In this context, the response rate of fifty-five is considered to be a good response rate.

The fax-back responses do not require detailed analysis. Overall, the data from this source supports (triangulates) the data collected through the telephone interviews. However, the GPs responding via the fax-back consistently rate the MD discharge summary more highly than those who were interviewed. (Compare Q5 from the fax-back data with Q6 from the interview data.)

One explanation for this finding is that forty per cent of the interviews (20) were conducted between June and August when the early drafts of the MD discharge summary were being trialed. The fax-back evaluation of the MD discharge summary occurred at a later stage (August-December), when the document had been refined.

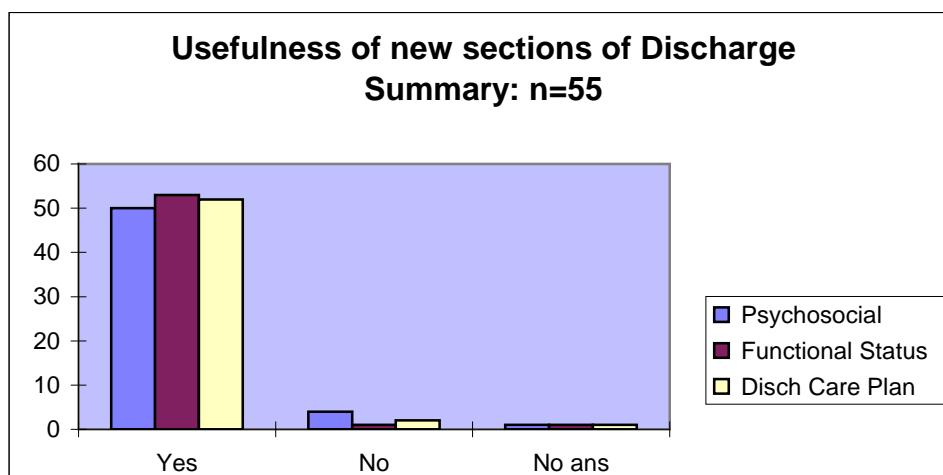
1. How would you rate the MD discharge summary in regard to:

		E	VG	G	Av	P	n/a
a)	Ease of reading	25	18	6	3	1	2
b)	Quality of information	18	20	11	2	0	4
c)	Length	11	18	13	4	4	5



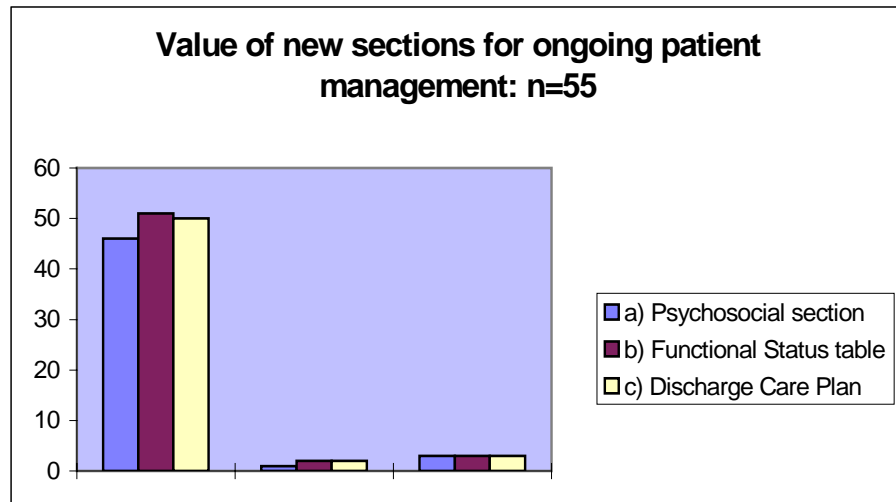
2. Is the information contained in the following sections of the discharge summary useful?

		Yes	No	n/a
a)	Psychosocial section	50	4	1
b)	Functional Status section	53	1	1
c)	Discharge Care Plan	52	2	1



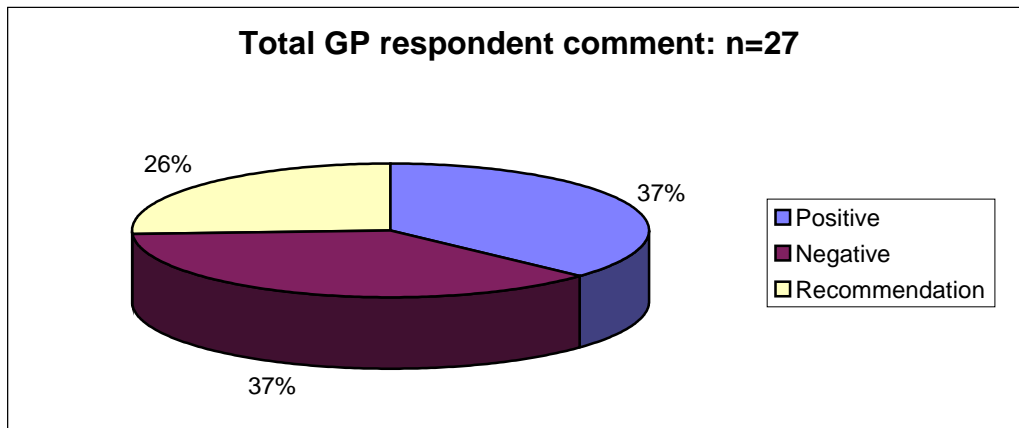
3. Do you think the information supplied in the following sections could assist you in the ongoing management of the patient?

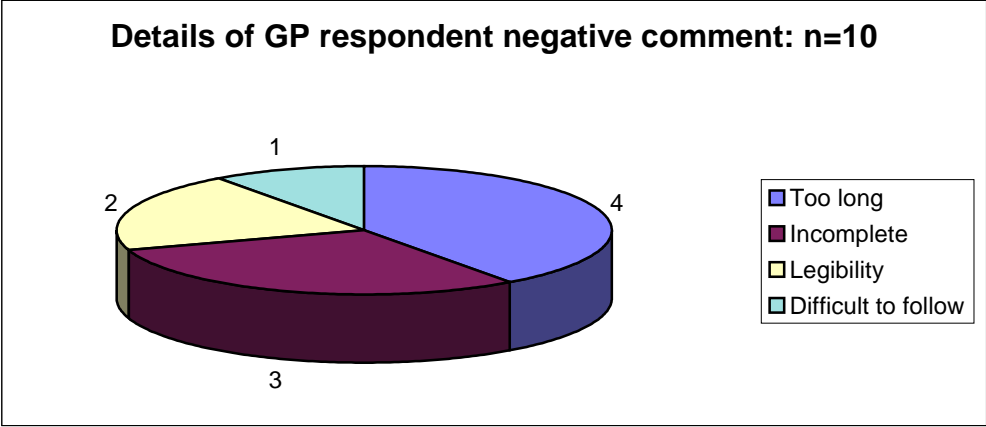
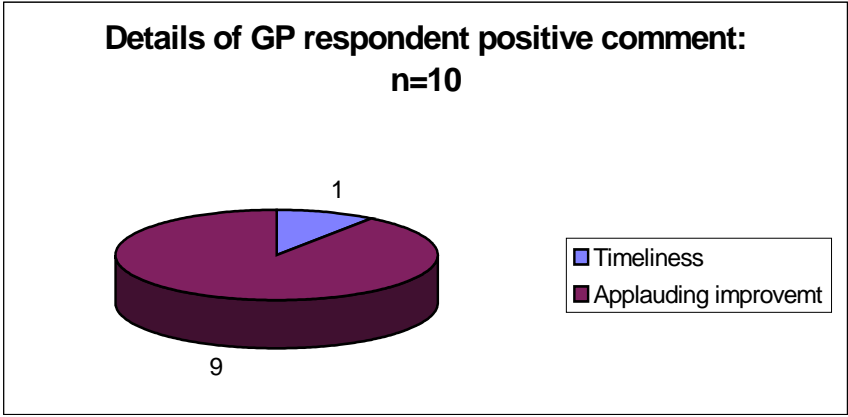
		Yes	No	n/a
a)	Psychosocial section	46	6	3
b)	Functional Status section	51	1	3
c)	Discharge Care Plan	50	2	3



4. How could the MD discharge summary be improved?

27 of 55 respondents made comments	Pos	Neg	Rec
	10	10	7





Recommendations

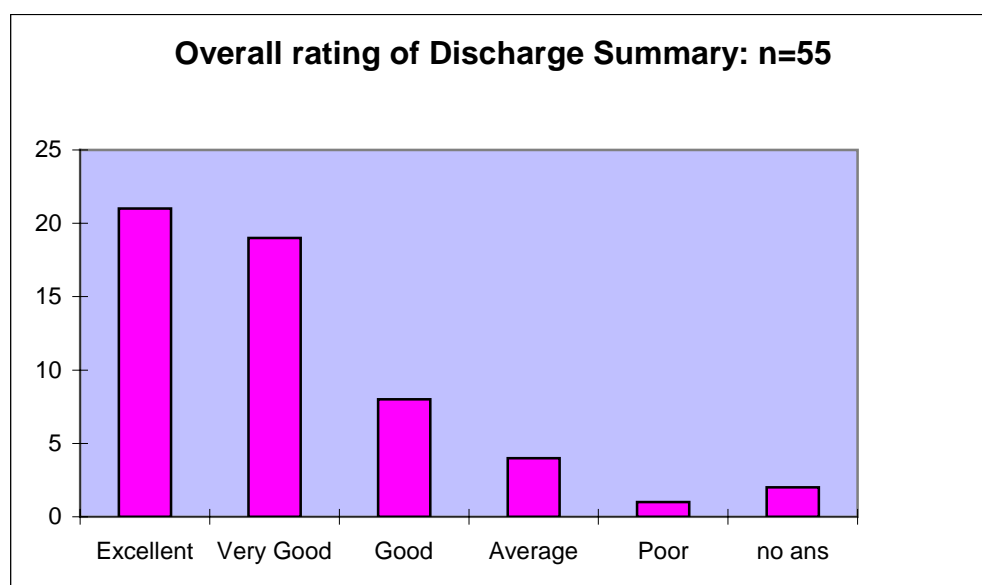
Apart from comments about layout, for example the order of information where there were five comments made, each of the following suggestions was mentioned by one respondent.

- a) Avoid acronyms
- b) Fax the Discharge Summary at the time of discharge
- c) Email the Discharge Summary
- d) Use a database to produce the Discharge Summary
- e) Improve communication with relatives
- f) Personal contact with GP to hand-over information at discharge is very important
- g) Offer care plan workshop to the divisions of General Practice

However, a number of these comments were repeated by other GPs during interviews.

5. Overall, how would you rate the MD discharge summary?

	E	VG	G	Av	P	n/a
	21	19	8	4	1	2



Sub-acute staff evaluation of the MD discharge summary

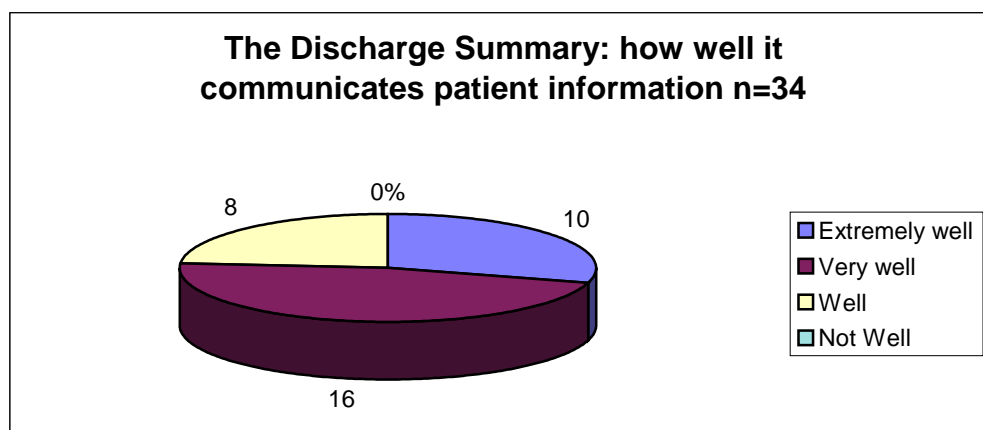
Three methods of data collection from the staff involved in the EPC process were employed.

1. A questionnaire was made available to staff in the last weeks of the project (November 2002). All staff that contributed to the discharge summary was encouraged to fill in the evaluation form anonymously and fax it through to the project officer. The questionnaire respondents were a mixed group, ranging from those who had been contributing to the MD discharge summary for six months, to others who were just beginning to make contributions to the MD discharge summary. Thirty-four evaluation forms were received.
2. Two focus group interviews were conducted during the same period. The staff invited to attend the focus group interviews were those more senior staff members who had a leadership role in their units and who had been closely involved in the implementation of the of the EPC project in either the Aged and Palliative areas. Steering Committee members were also invited to participate in these focus groups: three members participated. In total, twelve people participated in the two focus group interviews.
3. Face to face, or telephone interviews were conducted with ward medical staff (HMO1s and HMO2s) during the course of the project. The project officer briefed each resident and registrar for each ward (five wards) at the beginning of his or her rotation. Permission to approach them for a short interview at the conclusion of their rotation was requested at this time. On most occasions, the interview was conducted with the resident (HMO1) who is usually solely responsible for the discharge summary. In those cases where the registrar (HMO2) shared the responsibility for the discharge summaries he/she was interviewed as well. In total, twelve interviews were conducted. Three of the interviews were with HMO2s and nine with HMO1s. In addition, at the conclusion of the project, interviews were undertaken with the administrative staff, the Personal Services Clerks (PSCs) of the three Aged Care wards.

The staff questionnaire data:

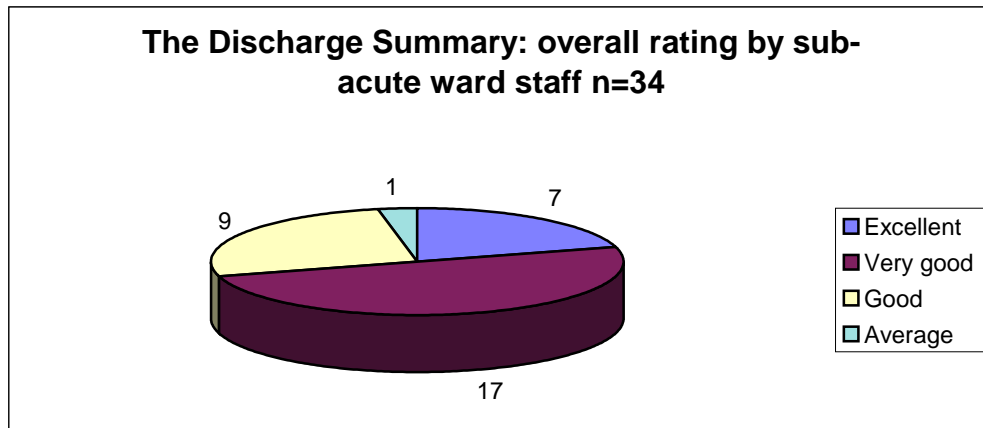
1. **How well do you think the MD discharge summary communicates patient information to GPs and other community providers who receive it?**

	EW	VW	W	Av	NW	Total
	10	16	8			=34



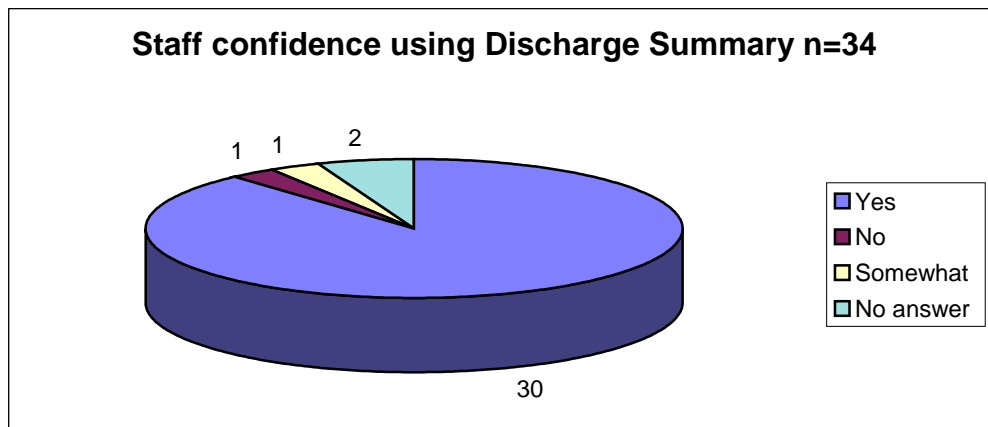
2. Overall, how would you rate the MD discharge summary?

	E	VG	G	Av	P	Total
	7	17	9	1		=34



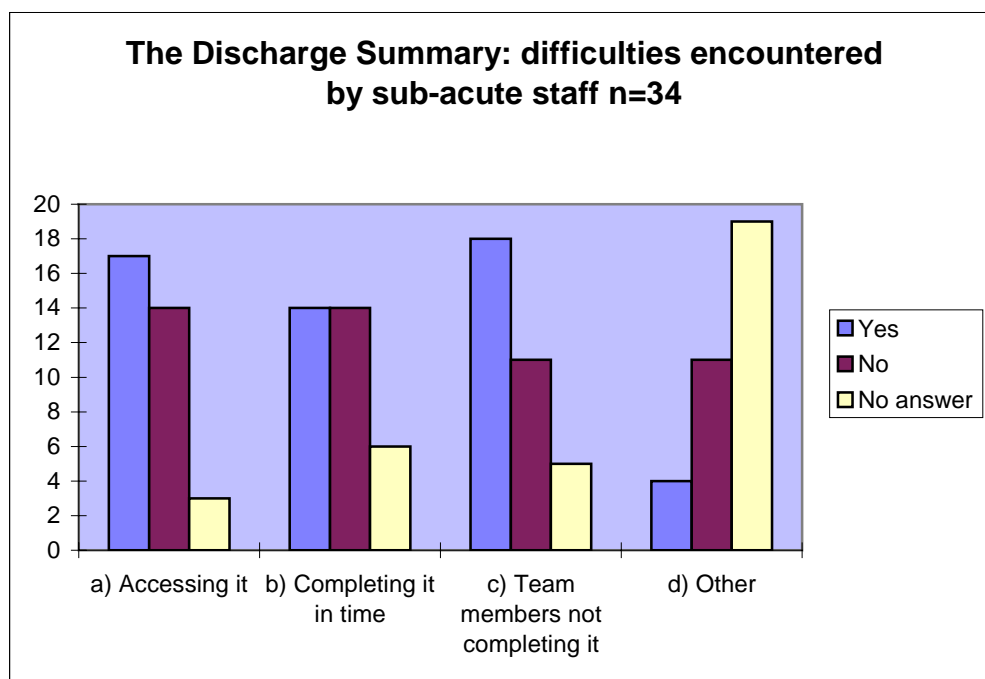
3. Do you feel confident using the MD discharge summary?

	Yes	No	Somewhat	n/a	Total
	30	1	1	2	=34



4. Have you encountered any difficulties/problems with the MD discharge summary?

Yes	No	n/ans	Total
a) Accessing it (Incl access to computers)	17	14	3 =34
b) Completing it in a timely fashion	14	14	6 =34
c) Team members not completing it	18	11	5 =34
d) Other	4	11	19 =34



There were twenty responses to this question (some respondents made more than one point):

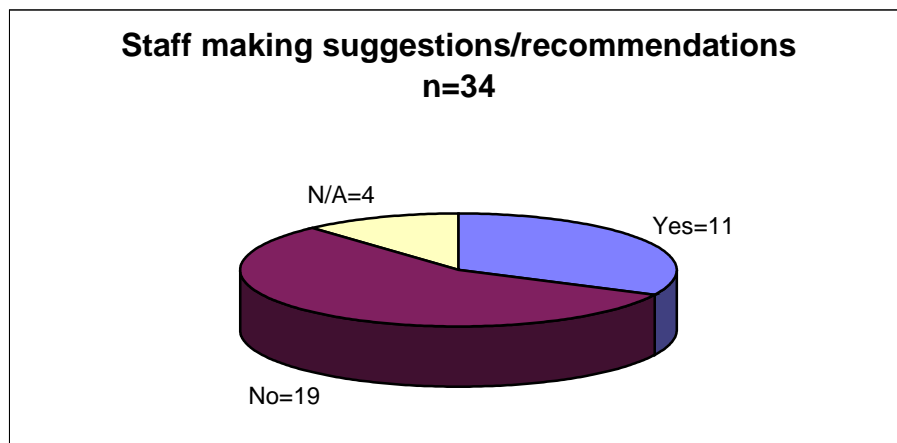
- Coordination of timing for users wanting to access MD discharge summary/care plan.
- Problems with the template (because of 'one user' access at a time) x4.
- Lacks necessary sections (not explained).
- Allied health staff members are often late in making entries.
- The discharge coordinator often does not fill in the appropriate sections
- Allied health staff need to complete their sections prior to discharge x3
- Difficulty with the font: sometimes two fonts in the one document.
- There are not enough computers x3.
- Difficulty completing it on time when there are patients discharged with little notice.
- Difficulties for part-time staff completing the MD discharge summary in a timely manner.
- Some medical staff members are difficult to motivate.
- We need systems in place to ensure that the document is completed.
- SVHM access for St George's and Caritas Christi staff (organisation-wide connectivity issues).
- Work pressures: large number of patient discharge summaries to be completed.

- Some weekend staff members do not have computer password access x2.
- Team members may not be available to complete the MD discharge summary when the patient is being discharged.

The three principal problems that are highlighted by staff in response to Q4 are supported by other data: the interview data from the patient services clerks and the data from the focus group interviews.

5. Summary of the suggestions and recommendations from staff.

Yes	No	n/a	Total
11	19	4	=34

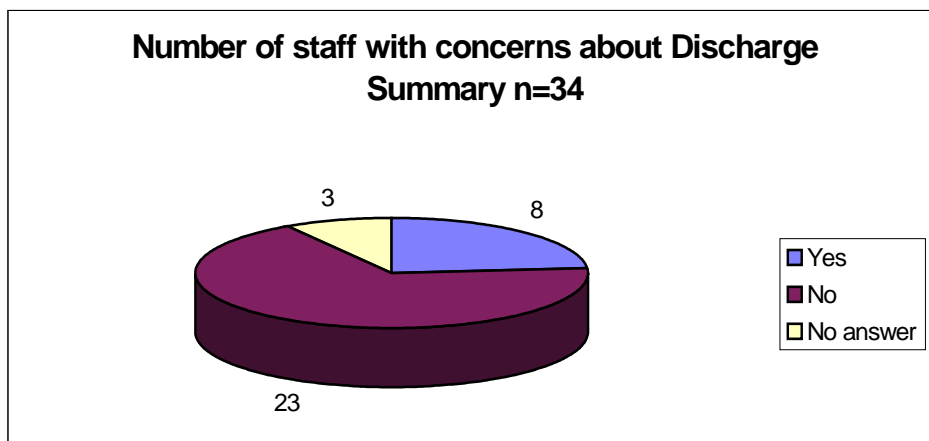


Eleven respondents responded to this question:

- The MD discharge summary/care plan should be provided to the patient and family as well.
- To improve quality of work practice, responsible staff members should complete their section prior to or on the day of discharge.
- Patient shouldn't be discharged until the document is complete and despatched.
- Should be 'patient and family friendly'. In addition, the MD discharge summary should be concise, simple and 'to the point'.
- It would be useful to have an allied health review to ensure that the A/H sections are useful.
- Each worker to complete his or her section only, not the sections of other workers.
- Need for:
 - Policy & protocol development to ensure compliancy
 - Continued training and updates
 - Orientation for all new staff (especially rotating medical staff)
- Increase access to computers
- Facilitate access for St George's and Caritas Christi staff.
- Excellent
- Need more practice

6. Have you any concerns about the MD discharge summary?

	Yes	No	n/a	Total
	8	23	3	=34



Eight respondents added comments to this question:

- It's hard to know when the document has been completed by all disciplines.
- Adequate training will be required for staff using the new database.
- Password access needs to be available to all staff members who make entries in the MD discharge summary/care plan.
- Some staff members fill in the sections of others.
- Database may not allow adequate flexibility.
- It is too long.
- Logging on is problematic.
- One comment was illegible.

Nursing and allied health reflection on the EPC project: The focus group interviews

Description of the focus group process

Two focus groups were conducted. Eight people attended the first focus group, which was conducted at the St George's Hospital campus Kew. Four people attended the second group conducted at the St Vincent's Hospital campus. Staff members were formally invited to attend the interviews and times were selected to maximise participation.

Staff members were provided with prompts to consider beforehand. The prompts required staff to consider:

- Early attitudes toward the project
- Present issues/achievements
- Recommendations.

Prompts were used to ensure that the interviews were focussed.

Palliative staff members were represented at both meetings. For the most part more senior staff members attended the focus group interviews, for example unit managers, allied health heads.

The group interviews lasted approximately one hour. A facilitator known to all staff conducted the group interviews. The meetings were not tape-recorded. Rather, throughout the group interviews a member of the Executive administrative staff took notes using a word processor. Speakers were not identified. The notes were delivered to the project officer in electronic format for analysis.

Major themes discerned from the focus group interviews

- *Benefits:* This project was worthwhile because it:
 - Improved discharge planning
 - Streamlined and improved discharge documentation
 - Increased awareness amongst staff of discharge planning
 - Improved team communication about discharge planning
 - Increased understanding of each other's roles
 - Changed documentation
 - Put the GP 'on the map'. 'The EPC discharge process brought things [information] to the team.'
 - It has reduced 'double-up' and the number of forms used at discharge. 'Now information is combined and structured ... no-one is left in the dark.'
 - Positive feedback from the field about the changed documentation.

- *Problems:*
 - Initial cynicism: 'Projects come and go', either nothing eventuates or people revert to old habits.
 - IT issues were multiple especially in the early stages of the project for example, access to computers, access to the discharge template, problems with the discharge template. 'People were almost ready to give up'.
 - Getting staff 'up to par' (computer skills, EPC process); developing and maintaining staff enthusiasm.
 - The process took a long time to develop. There was a lack of clarity in the beginning. There were problems for staff more generally understanding what EPC actually was.
 - Poor IT support for staff not on the St Vincent's Hospital site specifically poor IT functioning at the St George's Hospital site.
 - Some GPs don't understand the EPC process, which makes it difficult for hospital staff. More education of GPs is required.
 - GP gatekeepers (clerical staff) can stall the EPC process.
- *Concerns:*
 - Providing adequate discharge information while adhering to principles of the new privacy legislation.
 - Sustaining the project: 'initiatives can be forgotten'. Rotating staff and changing systems makes it difficult to sustain change. Ongoing education and support is required.
- *Recommendations:*
 - Ensure that clear protocols are developed and staff educated regarding dissemination of patient information from a database.
 - Support for staff (availability of education and in-servicing) as the database is introduced onto the wards during the next months.
 - Extend EPC to patients who are residents of nursing homes and hostels.
 - Improve IT infrastructure to support such changes to practice. Develop acceptable encryption processes so that the MD discharge summary can be emailed.

HMO interviews: Reflection on the EPC project

Description of the interview process

Once the EPC process had been initiated all HMO staff involved were briefed in both the Aged Care and Palliative areas (five units) during their first week, and then at the conclusion of their tenure an informal interview was conducted. The concluding interview was usually conducted on a face-to-face basis, but on four occasions it was conducted using the telephone. In addition, some interim opportunistic interviews were undertaken to gauge how the EPC process was developing.

The questions asked of the HMOs were:

1. What is your opinion of the EPC discharge process?
2. Do you think it is a valuable process?
3. Have you experienced any problems?
4. What is your opinion of the MD discharge summary/care plan?
5. Can you make any suggestions or recommendations to improve the EPC process or the MD discharge summary/care plan?

The PO took notes of the informal interview. Any recommendations from the HMOs were considered by the project Steering Committee and where appropriate implemented or trialed.

Overall, the HMOs were supportive of the EPC process. That is, for most HMOs improving the quality of discharge information to GPs, and ensuring direct contact with the GP to discuss the discharge care plan was viewed as reasonable and in the interests of patient care. There was some variation in the responses with some HMOs being thoroughly committed to the process while others supported the idea in theory but observed that when they were busy it was not a high priority.

There was one dissenting view. One HMO claimed that:

EPC does not enhance what we are doing for the patient. Planning discharge can be difficult. The GP does not need the information that we are asked to supply in the discharge summary/care plan.

The consultant attitude to the EPC discharge process appeared to be an important factor in how pro-actively the HMOs assumed the associated extra work tasks.

Major themes discerned from the HMO interview data

1. *Clarification* of the EPC discharge process & care plan:
 - Different interpretations amongst the consultants, registrars and residents regarding what constitutes an EPC discharge care plan.
 - There were different views amongst residents and registrars as to what constituted GP involvement or contribution.
2. *Process issues*: All interviewees observed that coordination of multiple staff members within a tightly limited timeframe was challenging. The HMO is the person who signs the

discharge summary before its despatch, so they were keen to see that the document was complete.

3. *Format*: MD discharge summary. Particularly in the first weeks and months, residents commented on the layout and sequence of the discharge summary. Their comments guided the development of the document.
4. *Phone contact* with GP: positives and negatives
 - Making contact with the GP can be extremely difficult.
 - One respondent observed that she had learnt how to approach and talk to the GP. She commented that there is nothing in their medical course to prepare them for this aspect of the job.
 - Handing over patient issues is more effective when talking to GP.
 - Getting to know the GPs and establish rapport with them is important and valuable.
 - The HMO often had to educate the GP about EPC. This was considered inappropriate.
 - Some tension can occur during the interaction with the GP. Some GPs are not receptive to the approach by the hospital staff. Occasionally GPs are rude.

One resident (HMO1) observed that as junior medical staff they are not guided nor prepared as to how to manage the 'relationship' side of medical practice: inter-relating with other health professionals, including medical practitioners. This resident had developed confidence in conversing with GPs as a result of the EPC process.

One registrar (HMO2) observed that in a slightly more senior position, registrars receive little preparation as to how to mentor residents in this aspect of medical practice. This registrar concluded that it was a personal, ad hoc thing. He said that it was his father, a businessman, who had taught him the importance of interpersonal relationships in the work context and about how to manage these relationships.
5. *Consent*: securing patient consent for a GP service is problematic. There was a lot of dissatisfaction registered by HMOs about the consenting process. They did not think that it was appropriate for hospital staff to be requesting patient consent on behalf of the GP. In addition, it was judged to be repetitive in the context of the hospital's patient consenting process.
6. *Incompleteness* of the MD discharge summary is a problem:
 - It is difficult for the HMO to discuss the care plan adequately with the GP when allied health and/or nursing staff have not completed their sections.
7. *Time*: It is time consuming, but worth it:
 - EPC process improves the quality discharge information, which is often an underestimated aspect of practice:

Even if it is not funding that we [the hospital] receive for doing this work, but the recognition that it is an important part of our job (HMO).

8. *Security*: Safety of medical information. There was concern expressed that other staff could inadvertently change medical instructions for example, discharge medications
9. *Value* of multi-disciplinary team input to discharge summary/care plan

10. *Ownership* of the process by the multi-disciplinary team is essential.

- All the work could be lost if it is not recorded and passed on.
- The geriatric setting demands this level of interaction.

There have been big positives: extra attention is now paid to the phonecall to the GP. The effect of the project has been to improve the discharge process and the information going to GPs (HMO2).

It is anomaly that we do all the work, but it is the GP who is funded for it. I don't begrudge them the money, it probably makes up for other areas where they are underpaid, but it is strange (HMO).

PSC interviews: Reflection on the EPC project

Description of the interview process

The ward administrative staff members, the Personal Services Clerks (PSCs), are key 'players' in smooth ward processes. Their role in the EPC discharge process, although slightly different in each ward, was very important.

One PSC from each of the three Aged Care wards was interviewed at the conclusion of the project. The interviews were informal and conversational. The project officer took notes during the interviews.

Major themes discerned from the PSC interview data

1. Change or development of Patient Services Clerk role: increased responsibilities.

The PSCs observed that their role was changing, as they were often required to remind (and to coordinate) staff to fill in the discharge summary. They were the ones who saw whether the MD discharge summary was complete.

2. Compliance of multi-disciplinary staff, especially Allied Health staff.

It was observed by the PSCs that generally medical and nursing staff members were compliant. However, even after having expended a lot of energy with reminders, allied health staff often did not respond.

3. Co-ordination of staff input so that the MD discharge summary was complete so that it could be despatched in a timely fashion.

It's a difficult position to be in 'on their backs' but you know you have to get the summary out promptly. I understand how pressured they are, but every time? I end up getting snappy.

4. Understanding of the EPC process by Allied Health staff.

The PSCs offered explanations as to why sections of the Allied Health staff consistently did not fill in the MD discharge summary: was it not a priority for them? They observed that all the staff members were very busy, but despite this others managed to fill it in.

5. Improved discharge process and dispatch of MD discharge summary/care plan.

The information was better and because it was a shared responsibility it was not left to the HMO to organise it all. It was observed that previously patient files would 'hang around' the ward for days [sometimes weeks] waiting for the resident to write up the discharge summary. GPs would ring in and complain:

It is now a driven priority. You don't want to be the one holding it up, so it drives the prompt despatch (PSC)!

6. The PSCs concurred with other staff that involving the GP in discharge planning and organising comprehensive discharge information was a time consuming process (more so for them when other staff did not 'pull their weight'). However, there was general support and approval for the outcomes: better information to support the ongoing management of patient care in the community.

APPENDIX B: Cardiothoracic Unit - Recommendations

EPC Project: Recommendations Cardiothoracic Unit

The Enhanced Primary Care (EPC) Project has been conducted between November 2001 and November 2002 at St Vincent's Health. The overarching aim of the project was to further develop communication processes between hospital staff and patients' GPs. Specifically, the aim was to involve GPs in patient discharge planning.

The Project Officer's recommendations after consultations with Mr Tony Wilson (Cardiothoracic Surgeon) and David Clark (NUM Cardiothoracic Unit) are listed below. The recommendations document discussion as to how an initiative to improve communication with GPs could be implemented in the Cardiothoracic Unit in a realistic and staged manner.

1. Faxed notification of the patient's GP (& physician) of planned admission date.

Staff member responsible: Waiting List Officer

Action Required:

- a) Check whether the PAS system is presently generating this report.
 - b) If so, develop a process with the waiting list clerk to ensure that the fax is despatched to the GP/physician routinely.
 - c) If not, use the attached draft notification document and develop a process with the waiting list clerk to ensure that the fax is despatched to the GP/physician routinely.
2. Prepare a one page fax-back proforma that asks specific questions of the patient's GP re matters that could affect the post discharge recovery of the patient.

In addition, this fax-back could ask the GP to indicate whether they would be interested to participate in an EPC care plan/case conference (See attached sample).

Staff member responsible: NUM & multidisciplinary team

Action Required:

- a) NUM to coordinate multidisciplinary team to brainstorm key discharge issues relevant to this particular patient group. The aim of the questions asked of the GP should provide information that adds to the usual discharge screen information collected routinely in the pre-admission clinic. The questions should be specific to potential discharge issues for patients undergoing cardiac surgery and should be based on the knowledge of the treating team: medical/nursing and allied health.
- b) One person from the team could be nominated to draft a set of questions (3-4) to be approved by the team. The document would then be prepared as a fax-back form (Refer to sample attached).
- c) The waiting list clerk would fax the discharge fax-back proforma with the notification of planned patient admission.
- d) When faxes are returned a process for acting on them needs to be developed eg who takes responsibility for the fax? Where is it filed? Who presents and acts on the information?

3. The key post discharge issues identified by the team in the preparation of the fax-back proforma (above) could be used to prepare new resident medical staff to better identify potential patient discharge problems in the pre-admission clinic.

Staff member responsible: Consultant in liaison with medical & multidisciplinary team.

The role of the senior medical staff in 'setting the scene' for junior medical staff is very important and cannot be underestimated. The outcomes of the Enhanced Primary Care (EPC) project in the sub-acute area clearly show that where senior staff emphasise the importance of the role of the GP in the post discharge period, and the importance of good communication throughout the episode of care, junior medical staff generally respond with positive and committed action.

4. If a GP is to be formally involved in an EPC discharge care plan or case conference, patient consent (verbal) for GP involvement should be secured and recorded at the time the patient is seen in pre-admission clinic.

Staff member responsible: resident medical officer

5. Making contact with the GP before discharge of patient.

Staff member responsible: Resident (supported by PSC/NUM?)

Talking to the GP is often difficult because of the dyssynchronous routines of hospital and GP practice. However, data from the EPC project suggest that for both the GP and the hospital staff, making contact is valuable.

One strategy that has been used in the subacute area is a pre-arranged phone booking with the GP to discuss the patient's discharge needs. The Patient Services Clerk (PSC) makes the phone booking shortly after admission of the patient in consultation with the unit's medical staff.

Another option is that a senior member of the nursing staff discusses the patient's discharge needs with the GP in the case that the medical staff members are unavailable.

6. Development of an information table/doc for the GP. A need for such 'ready-to-hand' easily accessible and pertinent information has been identified in the EPC project. This document could accompany the discharge summary and could highlight key stages in the patient's recovery/GP role during the first weeks-months post discharge.

Staff member responsible: Medical staff/Multidisciplinary team

- a) Contact David Isaac, the GPLO at St Vincent's

7. To commence the initiative, develop a timeframe and target rural patients.

Staff member responsible: NUM/ANUM

- a) Identify the referring physicians and their GP base in the Albury/Wodonga area
- b) Identify the local Divisions of General Practice in the area and undertake a site visit?

APPENDIX C: EPC Aged Care ward policy

St Vincent's Health Aged Care Services

Clinical Policy and Procedure Manual

Section: Clinical, Continuum of Care

Subject: Involvement of GPs in Discharge Care Planning (EPC)

Background

The Enhanced Primary Care (EPC) project operated throughout St Vincent's Health Aged Care Services during 2002. The aim of the project was to improve continuity of care for patients with chronic and complex care needs being discharged home. Improving two-way communication with GPs was a central focus of the project

Engaging GPs in discharge planning has been facilitated by the introduction of a new group of Medical Benefit Scheme Items given the title 'Enhanced Primary Care'. GPs can now claim payment for involvement in indirect patient care such as discharge care planning and case conferencing. However, GPs are dependent on an invitation from the hospital to participate in discharge planning. Once it is confirmed that the GP will participate in the care planning or care conferencing process, the onus is upon the hospital to supply the GP with evidence that the patient has consented to the GP's involvement and provide documentation of the issues discussed and agreements made.

Purpose

To ensure continuity of care for patients by improving the quality and regularity of communication between hospital staff and GPs.

Definitions

A Discharge Care Plan is a plan of care negotiated with the patient's general medical practitioner and other community care providers by hospital staff prior to the patient's discharge from the acute or sub-acute setting.

A Discharge Case Conference is a discussion between at least two members of the acute or sub-acute multidisciplinary team with the patient's general medical practitioner prior to the patient's discharge from the acute or sub-acute setting. The case conference outcomes usually inform the discharge plan developed for and with the patient. For example, a case conference can involve the GP via telephone when discussion about the most appropriate 'level of care' for a patient is undertaken.

Process

- 1 When the patient is admitted:
 - a **A member of the unit's medical staff** makes contact with the patient's GP within 48hrs of admission to discuss the patient's condition (including pre-morbid status), and to seek the GP's involvement in discharge planning.
 - b Where applicable, the **Patient Services Clerk (PSC)** faxes the 'notification of admission' fax-back, which notifies the GP of the patient's admission and invites the GP to participate in discharge planning.
 - c On receipt of the fax-back the PSC attaches it to the patient's team meeting record sheet.
- 2 At the team meeting:
 - a **The person 'scribing' at the team meeting** registers the GP's expression of interest re participation on the patient's discharge care plan

- b **The person chairing the team meeting** asks the group if the patient is eligible for an EPC discharge care plan/case conference. **Any team member** can identify the patient as eligible for a discharge care plan or teleconference.

To be eligible for a discharge care plan/conference the patient must have chronic and complex care issues that require multidisciplinary input. **At present, (10/02) patients who have been admitted from and are returning to a Residential Facility are not eligible for EPC. Similarly, patients who are discharged to a Residential Facility are not eligible for EPC.**

- c **The person who is 'scribing' at the team meeting** flags the patient for an EPC discharge care plan by recording it on the team meeting sheet.
- 3 Once a patient has been identified for an EPC care plan/case conference the patient's verbal consent must be secured. **The HMO staff or other nominated staff is** responsible for explaining the process and securing patient consent. At times, **the discharge co-coordinator** may request patient consent. The person who gains consent gives a patient information pamphlet to the patient. In the case that a patient is not able to give consent, a family member can be approached.
 - 4 **The person who secures patient consent** makes an entry into the discharge summary by ticking the appropriate box on the template that patient consent has been given.
 - 5 Approximately one week before the planned discharge date **the PSC** after liaising with the resident (and any other staff who may need to be involved), rings the GP's surgery and books a time for **the HMO** to ring the GP to discuss the discharge care plan.
 - 6 **The PSC** emails all staff involved in the patient's care of the telephone appointment time and date.
 - 7 **Each staff member involved in a patient's care** makes written entries into the patient's discharge summary, specifically the functional status table and discharge care plan before the time of the telephone call to the GP.
 - 8 **The HMO** rings the patient's GP at the pre-arranged time and discusses the multidisciplinary care plan. **The HMO** seeks GP input and feedback about the care plan.
 - 9 **The HMO** makes an entry into the discharge summary which identifies that the GP has participated in a care plan or case conference.
 - 10 In addition, **the HMO** enters any input from the GP and any agreements regarding post discharge care that have been entered into by the GP.
 - 11 Once the discharge summary has been finalized and checked by **the discharge coordinator or the NUM, the PSC** faxes it to the GP.
 - 12 **The discharge coordinator** provides the patient with a copy of the patient Discharge Care plan and ensures that it has been explained in a manner to assist the patient's understanding of issues.
 - 13 Where a case conference has been conducted (via telephone or in person) the substance of the case conference discussion needs to be entered onto the case conference form by **the discharge coordinator**, and a copy of the same faxed by **the PSC** to the GP.

APPENDIX D: Multi-disciplinary discharge summary template & SAMPLE

St Vincent's Health
DISCHARGE SUMMARY & CARE PLAN

Affix patient id
to each page

Patient Information

Patient Name: Elizabeth Bain	Date of Birth: 2 nd September 1927
Patient UR: 123456	Phone Number: 9853 4502
Address: 5 Kinswhit Street Melwell 2769	Primary Language: English
Interpreter required: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

GP Details

GP: Dr Bernard Holsworthy	Telephone: 9282 7491
Address: 499 Melwell Rd Melwell 2544	Fax: 9282 7493
	Email:

Admission and Discharge Information

Referred By: St Agnes Hosp	Treating Team:	
	Nursing Unit Manager:	J. Smith
	Dietitian:	D. Jones
Admission date to acute: 24/06/02	Occupational Therapist:	M. McTee
Admission date to sub-acute: 27/07/02	Physiotherapist:	M. Ulter
Sub-acute unit: St George's Heale REHAB	Social Work:	V.Ting
Discharge Date: 25/8/02	Speech Pathologist:	A. Wise
Discharge Destination: Home	Nursing staff:	R. Hodge
Consultant: Peter Hunter	Locum staff:	

Primary Diagnosis at Discharge	Other Diagnoses/Problems or Complications
L MCA infarct	Hypertension TIA Ex smoker L TKJR 2002 Ca bladder 1999

Admission and In-patient Management Issues: Progress and Procedures

Mrs. Bain was transferred from St Agnes's Hospital where she was admitted following a fall out of bed. She presented with R facial droop, expressive dysphasia and R hemiparesis. MRI revealed an acute L MCA infarct in L frontal lobe/L temporal lobe and internal capsule. Carotid doppler showed no significant stenosis. When Mrs. Bain arrived at SGHS sh required Ax2 for all transfers and mobilisation and was incontinent of urine.

During her stay she was reasonably stable from a medical point of view although teary at times and anxious. She was treated with aperients for constipation and antibiotics for a UTI. Occasional incontinence was managed with tofranil and trimethoprim (E Coli UTI) with good result.

From a nursing point of view, Mrs. Bain improved from needing full nursing care to managing personal tasks with some assistance and prompting, continent, and able to transfer with her husband's assistance.

She has been started on secondary prophylaxis against further CVAs. If perindopril is well tolerated, Coversyl plus may be considered as it has recently been shown to be good secondary prophylaxis.

Significant Investigations during Admission

SEE ATTACHMENT AT BACK

Results Pending

nil

Allergies:

Penicillin

Morphine

Functional Status at Discharge (include details of equipment/aids)	
Total Barthel Score on Admission: 63 Total Barthel Score on Discharge: 84	
Mood & Behaviour	Alert and orientated Name & Position: J.Smith RN d
Continence	Continent of urine and faeces Continent of urine and faeces In the day time (and occasional prompt is required) however she does have some urinary incontinence night. Name & Position: M Hodge RN D
Continence Management Aids	Pads Pads green Tena during the dayMaxi pads at night and she requires assistance to put these on. Maxi pads go on at 2200 after toileting .Off at 0600 and toileted again. Name & Position: M Hodge RN D
Personal care tasks	Moderate assistance with personal care Requires assistance to ambulate to shower, mod assist to wash self, including assist to stand at bar to attend to perineum. Use short, clear instructions. Dressing with set up and mod assist to affected side. Name & Position: M.McTee (
Domestic & Community tasks	Assisted with all tasks Name & Position: M.McTee (
Home Set-up & Equipment	Home assessmt completed/setup with equipment Home Modifications under-way. Some equipment in situ in home environment. Requires 53cm high over-toilet frame and Kingston chair. Comfortable, adjustable high-back chair from YYYY Medical h been delivered. Works by ZZZZZ Industries to complete home modifications prior patient' s discharge. Name & Position: M.McTee (
Gait	Gait aid: stick Four point stick Name & Position: M. Ulter (

Gait ability	Supervision Endurance 150m+. To use four point stick & AFO. Name & Position: M. Ulter (
Bed Transfers	Assistance Mod assistance required to transfer lower limb onto bed. Name & Position: M. Ulter (
Sit to stand transfers	Assistance Name & Position: M. Ulter (
Communicatⁿ & Cognition	Mod communication problems Still receiving ongoing speech therapy to improve verbal communication. Moderate receptive and mod-sev expressive dysphasia. Requires short simple questions / commands. Expressive language improving however makes sound errors and uses jargon words. Name & Position: A. Wise Speech Pathologist
Hearing	No issues Name & Position: A. Wise Speech Pathologist
Swallowing	Mild oral phase difficulties. Requires soft diet cut up Name & Position: A. Wise Speech Pathologist
Food Consistency	Normal diet cut-up Soft meats Name & Position: A. Wise Speech Pathologist
Nutrition	Normal Low fat (weight control) finely cut up, needs lipped plate. Feeds herself, good intake. Name & Position: D. Jones (Dietitian)
Medication Management	Websterpack RDNS to support family at home Name & Position: M Hodge RN D
Wound Care	Location: Skin folds abdomen and groin. Dressing Regime: Dry thoroughly and apply emollient cream e.g. sorbolene and glycerin Name & Position: M Hodge RN D

Psychosocial

Assessment: Mrs Bain previously lived with her husband, independent with all aspects of living. Previously no services received.

Family/Supports: Very supportive husband and daughter, both willing to assist Mrs Bain extensively especially in her first month at home, with daughter moving in to attend to care needs.

Community: Mrs Bain will require rise and retire assistance and personal care, referral to linkages made. Home help and in-home respite has been arranged through DVA.

Other Comments: High level ACAS approval for respite care.

Name & Position: V Ting (Social worker)

DISCHARGE CARE PLAN

Discharge Issues	Management Goals & Treatment Plan	Appointment/ Visit details (Names and Contact Details Community Providers)
GP contribution Case conf <input type="checkbox"/> care plan <input checked="" type="checkbox"/> N/A <input type="checkbox"/> GP confirmed care plan, providing information about the limits to the husband's ability to care for wife	To prevent secondary hypertensive complications. Supervision and monitoring of hypertension and secondary prophylactic medication. GP to liaise with cardiac unit if nec.	GP will home visit on pt's return home 25/8 and review regularly. GP Name: Dr Holswor
1. Reduced independence: supervision required for gait, assistance with bed transfers	To ensure safe ambulation. Family educated to assist with transfers and supervise mobilisation program. Referral made to physiotherapist to optimise function & maintenance of current physical status. Name & Position: M. Ulter (Physiotherapy appt arranged with Melwell CRC 1 st appt 10am Thursday 29/8/02 with Simon tel: 9885 6752.
2. Personal care 3. Continence 4. Skin integrity 5. Medication	To maximize her own self care within her limitation. To remain socially continent. To prevent skin breakdown Name & Position: M Hodge RN D	Referral has been made for Linkages Package on discharge. Contact no. 8282 7412 Sean Papas. RDNS from Melwell will attend commencing pm 25 Sept. Contact no. 9854 0926 RDNS to support/educate husband and daughter in dispensing meds
6. Home support 7. Personal care	To maintain normal rise and retire patterns and personal hygiene & care Referral to linkages made. Home help and in-home referral has been made through DVA. Name & Position: V Ting (Social worker)	Home help and in-home respite have been arranged through DVA H/H 1st visit 26/8 Contact Anne 9250 7841
8. Home Modifications & equipment set-up	To support patient and family to manage in the home environment. Review alterations and products in situ. Name & Position: M.McTee (OT Cynthia Brode will ring family arrange a post discharge home visit.
8. Communication difficulties (dysphasia) expressive and receptive disorder	To continue and maintain regular speech. Speech Pathology treatment arranged to improve receptive expressive language Name & Position: A. Wise Speech Pathol	CRC Melwell to continue therapy for 4 weeks Referral has been made and 1st appointment to follow physio appt on 29/8. Contact Kylie @ the CRC on 9295 6952 if nec.

Contact with GP: GP participated in CARE PLAN

HMO name: Josie Sutcliffe

Transfer Nursing Home: Not applicable

Signature:

Patient consent for GP involvement:

Date: 25/08/02

Patient & family aware of disch plan:

Attachments

Pathology results

Patient Name: Elizabeth Bain

Patient UR: 123456

Medications at Discharge				
Drug Name	Dose	Route	Frequency	Quantity Supplied
Folate	5mg	O	Daily	3/7
Phenytoin	330mg	O	Mane	3/7
Citalopram	20mg	O	Mane	3/7
Nulax	1 tab	O	Mane	3/7
Polytears	2 drops	Both eyes	QID	3/7
Multivit	1tab	O	Daily	3/7
Asasantin	1 tab	O	BD	3/7
Simvastatin	10 mg	O	Nocte	3/7
Perindopril	2 mg	O	Mane	3/7
Tofranil	10 mg	O	Nocte	3/7

HMO name:

Josie Sutcliffe

Signature:

Date:

25/08/02

St VINCENT'S HEALTH DISCHARGE SUMMARY & CARE PLAN

Patient Information

Patient Name:

Date of Birth:

Patient UR:

Phone Number:

Address:

Primary Language:

Interpreter required: Yes No

GP Details

GP: y

Telephone:

Address:

Fax:

Email:

Admission and Discharge Information

Referred By: Click and Select

Treating Team:

Nursing Unit Manager: Click and Select

Dietitian: Click and Select

Admission date to acute:

Occupational Therapist: Click and Select

Admission date to sub-acute:

Physiotherapist: Click and Select

Sub-acute unit: Click and Select

Social Work: Click and Select

Discharge Date:

Speech Pathologist: Click and Select

Discharge Destination:

Nursing staff:

Consultant: Click and Select

Locum staff:

Primary Diagnosis at Discharge	Other Diagnoses/Problems or Complications

Admission and In-patient Management Issues: Progress and Procedures

Significant Investigations during Admission

SEE ATTACHMENT AT BACK

Results Pending

Allergies:

Functional Status at Discharge (include details of equipment/aids)	
Total Barthel Score on Admission:	
Total Barthel Score on Discharge:	
Mood & Behaviour	Alert and orientated Name & Position:
Continenence	Continent of urine and faeces Name & Position:
Continenence Management Aids	Nil required Name & Position:
Personal care tasks	Click and select Name & Position:
Domestic & Community tasks	Click and Select Name & Position:
Home Set-up & Equipment	Click and Select Name & Position:
Gait	Click and select Name & Position:
Gait ability	Click and Select Name & Position:
Bed Transfers	Click and Select Name & Position:
Sit to stand transfers	Click and Select Name & Position:
Communicationⁿ & Cognition	Click and Select Name & Position:
Hearing	No issues Name & Position:
Swallowing	 Name & Position:
Food Consistency	Normal Name & Position:
Nutrition	Normal Name & Position:
Medication Management	Websterpack Name & Position:
Wound Care	Location: Dressing Regime: Name & Position:

Psychosocial

Assessment:

Family/Supports:

Community:

Other Comments:

Name & Position:

DISCHARGE CARE PLAN

Discharge Issues	Management Goals & Treatment Plan	Appointment/ Visit details (Names and Contact Details Community Providers)
GP contribution Case conf <input type="checkbox"/> care plan <input type="checkbox"/> N/A <input type="checkbox"/>	.	GP Name:
1.	Name & Position:	
2.	Name & Position:	
3.	Name & Position)	
4.	Name & Position:	
5.	Name & Position:	

Contact with GP: Click and Select

HMO name:

Transfer Nursing Home: Not applicable

Signature:

Patient consent for GP involvement:

Date:

Patient & family aware of disch plan:

Recipients of Disch Summ.:

Attachments

Pathology results

MEDICATIONS

Patient Name:

Patient UR:

Medications at Discharge				
Drug Name	Dose	Route	Frequency	Quantity Supplied

HMO name:

Signature:

Date:

APPENDIX E: Aged Care Database suggestions & guide for medical staff

The Aged Care Discharge Database

Medical staff

Staff were involved in the development of the Access Database as part of the Enhanced Primary Care (EPC) Project during 2002. The aim of the EPC project was to further develop communication processes between the St Vincent's ward staff and patients' GPs. GPs could be invited to participate in EPC discharge care planning or telephone case conferencing with the aim of improving continuity of information and service to patients.

The database has been designed to produce many reports required for discharge: a GP discharge summary, a residential care summary, a patient summary and a notification of death summary to mention a few. Patient information entered once into the database will be used in those various reports.

Accessing the database

There is a distinct medical 'front end' to the database, which secures the information that medical staff enter. That is, other users cannot gain access to the principal medical sections for data entry, namely the Medication tab and the Inpatient Progress & Management tab.

To gain access to the medical front end of the database, medical staff will need to have a St Vincent's email address with user name and password.

Medical staff will use their St Vincent's user name and password to access the database once senior supervising medical staff have forwarded a formal request to IT. The pathway to the database is: M drive/EPC Discharge/Front End/Medical

The permissions for access to the database must be arranged before rotating medical staff commence duty in the Aged Care Service area.

Organising the permissions to access to the database

The senior medical staff member who is responsible for the orientation of new medical staff could organise the permissions through IT either on a yearly basis after the new year's medical schedule is released or prior to the commencement of a new staff member.

IT must to be notified when a rotating medical staff member has completed their rotation and the permission needs to be rescinded.

Optimal use of the database: Preparation of new medical staff

It is important that new medical staff are introduced to the database and shown how to use it. When compared to other discharge summaries for example, the one produced by the JadeCare database also used at St Vincent's Health, the reports from the Aged Care DB are distinctive.

- The discharge summaries and referral documents are designed to report the care needs of patients with complex needs: contributions from the multidisciplinary team are included in the discharge summary

- However, the DB also has the capacity to produce a simple report for a patient with simple discharge needs.
- Another feature of the Aged Care discharge summary produced from the database is that it is structured to provide appropriate documentation to the GP in the case that the GP is involved in a discharge care plan or case conference process.

APPENDIX F: Notification of admission fax-back

St Vincent's Health
Notification of Admission

To: Dr _____ **From:** Cardiothoracic Unit Waiting List Officer

Fax no: _____ **Fax no:** 9288 4669 **Date:** _____

Dear Doctor

This is to inform you that the planned admission date for:

D.O.B: _____ to the Cardiothoracic Unit at St Vincent's Hospital is _____.

Should you wish to make contact with the medical staff, please ring the hospital on 03 9288 2211 and ask for one of the HMOs to be paged for you. In addition, you can contact the Nursing Unit Manager, David Clark on telephone: 9288 4621, pager no. 640.

The names of the unit's HMOs are: Dr _____ (Pager no. _____)

and Dr _____ (Pager no. _____).

GP FAX-BACK

Did you know that at St Vincent's we want to involve GPs in the discharge planning of their patients?

Would you like to participate in the discharge care planning of the patient named above?

Please indicate your interest by ticking the appropriate box below and **FAX BACK THE FORM**

I am interested in participating in:

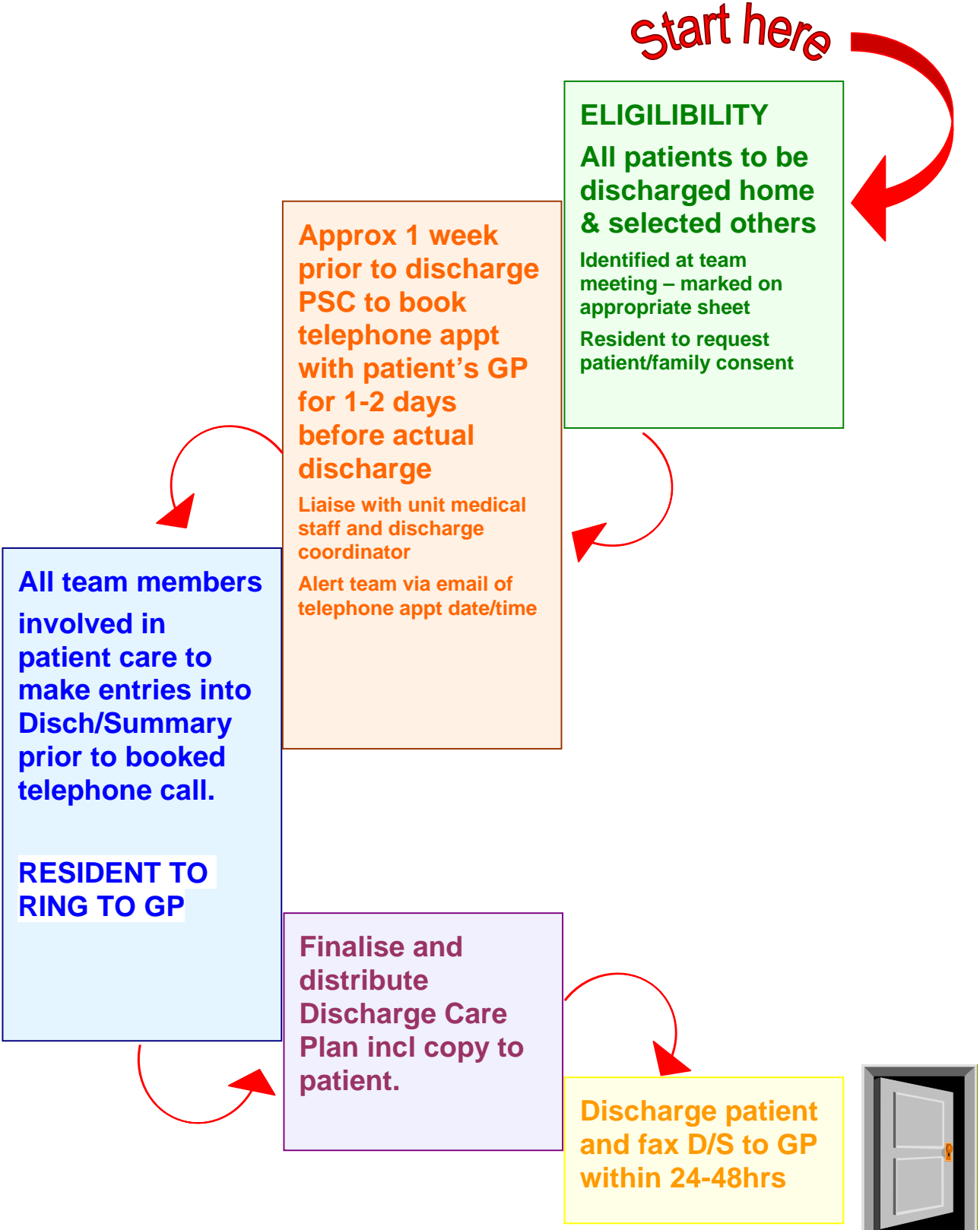
An Discharge Care Plan YES NO

An Discharge Case (Telephone)conference YES NO

*You can charge MBS item number 728 for participation in a discharge care plan, or number 768 for participation in a teleconference.

APPENDIX G: Evaluation forms & other materials

**EPC DISCHARGE CARE PLAN
PROCESS FLOW CHART**



ENHANCED PRIMARY CARE (EPC) PROJECT

The New Discharge Summary: Evaluation Questionnaire

PLEASE RETURN TO CLARE CARBERRY ON FAX 3205 BY MONDAY 25TH NOVEMBER

Where appropriate please indicate your response by marking a box.

1. How well do you think the new discharge summary communicates patient issues to GPs and other community providers who receive it?

Extremely well Very Well Well Average Not well

2. Overall, how would you rate the new discharge summary?

Excellent Very Good Good Average Poor

3. Do you feel confident using the new discharge summary?

Yes No

4. Have you encountered any difficulties/problems with the new Discharge Summary?

- | | | |
|--------------------------------------|------------------------------|-----------------------------|
| a. Accessing it | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b. Completing it in a timely fashion | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c. Team members not completing it | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d. Other | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Comment: _____

5. Have you any suggestions, or specific recommendations regarding the new Discharge Summary OR your role in contributing to it?

Yes No

Comment: _____

6. Have you any concerns about the new Discharge Summary?

Yes No

Comment: _____

Hospital + GP = BETTER CARE

GP EVALUTION: TELEPHONE INTERVIEW QUESTIONS

Introduction, reason for phone call, aim of evaluation process

1. Was this the first Discharge Care Plan that you have undertaken?
2. Have you claimed the MBS EPC item no 728 as a result of your involvement in the care plan?
3. Have you any suggestions regarding ways of improving the process eg time of phone call, length of phone call?
4. Involvement in the Discharge Care Plan process requires that you make a contribution to the care plan. Were you given an opportunity to contribute to the care plan?
5. Was the communication that occurred with the hospital staff, through the Discharge Care Plan process, adequate?
6. Do you think that involvement in the Discharge Care Plan was worthwhile?
7. Did the discharge issues highlighted by the hospital staff correlate with your review of the patient post-discharge?
8. Did you receive the discharge summary?
9. Did you receive it via: fax, mail or the patient/carer?
10. I would like your feedback about the Discharge summary that you received. Overall, how would you rate it: Click and Select?
11. In relation to the discharge summary, could you comment specifically on the following features, again using the same terms: poor, average, good, excellent
 - a. Layout Click and Select

GP EVALUTION: TELEPHONE INTERVIEW QUESTIONS

- b. Ease of reading Click and Select
 - c. Amount of information Click and Select
 - d. Quality of information Click and Select
12. Was the information about the patient's functional status of value to you in your role as a GP?
- a. If yes, why?
 - b. If no, why not?
13. Is the discharge summary too long?
14. Did you encounter any difficulties/problems with billing the patient for this service, or asking the patient to sign the Medicare form?
15. Have you any other general comments, or specific recommendations you would like to make regarding the Discharge Care Plan process?

FAX-BACK FORM FAX: 9288 2091

**GP EVALUATION OF THE AGED
CARE SERVICES DISCHARGE**

There are three new sections in the discharge summary we are sending you: a psychosocial section, a functional status table, and a discharge care plan table.

We would value your feedback. Could you please respond to the questions and fax the form back?

16. How would you rate the Discharge Summary in regard to:

	<i>Excellent</i>	<i>V good</i>	<i>Good</i>	<i>Average</i>	<i>Poor</i>
a. Ease of reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Quality of information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Length	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comment _____

b. Is the information contained in the following sections of the summary useful?

	<i>Yes</i>	<i>No</i>
a. Psychosocial section	<input type="checkbox"/>	<input type="checkbox"/>
b. Functional Status section	<input type="checkbox"/>	<input type="checkbox"/>
c. Discharge Care Plan	<input type="checkbox"/>	<input type="checkbox"/>

Comment _____

c. Do you think the information supplied in the following sections could assist you in the ongoing management of the patient?

	<i>Yes</i>	<i>No</i>
a. Psychosocial section	<input type="checkbox"/>	<input type="checkbox"/>
b. Functional Status section	<input type="checkbox"/>	<input type="checkbox"/>
c. Discharge Care Plan	<input type="checkbox"/>	<input type="checkbox"/>

Comment _____

d. How could the discharge summary be improved?

Comment _____

e. Overall, how would you rate the Discharge Summary:

<i>Excellent</i>	<i>V good</i>	<i>Good</i>	<i>Average</i>	<i>Poor</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you would like to make further comment add an extra page or telephone Clare Carberry direct on 9288 2177.

Thank You

FAX BACK 9288 2091

Hospital + GP = BETTER CARE

TOOL USED FOR AUDIT OF STANDARD DISCHARGE SUMMARY

Category	Rating	Comment
1. GP details present/absent		
2. Correct GP details correct or not		
3. No of pgs (total)		
4. No of pgs (path reports)		
5. Length of prose summary (lines)		
6. Unnecessary words, phrases (scale 1-5)		
7. Diagnoses		
8. Treatment		
9. Outcomes		
10. Present status/ongoing medical needs (each item present/absent)		
11. Summary of nursing/allied health care needs at discharge if any (each item present or absent)		
12. Discharge plan present or absent		
13. Medications present/absent		
14. Services post discharge present/absent		
15. Role of GP post discharge specified present/absent		
16. Name HMO present/absent		
17. Signature and date present/absent		
18. Evidence of phone contact with GP (Yes/no)		
19. Comment		

APPENDIX H: Poster Hospital + GP = BETTER CARE

hospital + GP

= Better Care

APPENDIX I : Patient Information

Appendix J: The discharge database frames and reports