ENHANCED PRIMARY CARE

GUIDE FOR WORKERS INVOLVED IN INDIGENOUS HEALTH

ON ENHANCED PRIMARY CARE HEALTH ASSESSMENTS, CARE PLANS AND CASE CONFERENCES

MEDICARE

HEALTH ASSESSMENTS, CARE PLANS AND CASE CONFERENCES

AN INFORMATION KIT FOR WORKERS INVOLVED IN INDIGENOUS HEALTH

Introduction

The Medicare Enhanced Primary Care (EPC) Items provide Medicare rebates for services provided by doctors undertaking health assessments, care planning and case conferencing services. These Medicare Items are part of the EPC Package, which aims to improve the quality of primary health care provided to older Australians (health assessments) and people with chronic conditions and complex care needs (care planning and case conferencing).

The aim of this Kit is to provide workers involved in Indigenous health with information about the Medicare EPC Items to assist you in promoting quality use of these items within Indigenous communities. The Information Kit contains this booklet in addition to resource material including:

- fact sheets to guide discussions on health assessments, care planning and case conferencing;
- case studies;
- posters;
- proformas; and
- a resource/contact list.

Please use the information and materials contained in this kit and feel free to adapt them to your local circumstances and needs. A feedback sheet for providing comments and suggestions about how the information and material can be improved is attached.

Health assessments

What is a health assessment?

A health assessment is an in-depth look at health issues affecting a patient's daily life. It provides an opportunity for a doctor and a patient to work together to identify problems and conditions that can be prevented or that can be treated to improve the patient's health and quality of life.

What are the benefits of health assessment services?

Benefits for the patient

Health assessments improve patient's health and quality of life by identifying any health problems that can be prevented or better managed.

Benefits for the Doctor and Health Workers

Health assessments provide the doctor and health workers with up-to-date information about the patient's medical condition and health care needs. This information helps the doctor or health worker to manage or improve the patient's health and well being.

Who can have a health assessment?

Any person who is 55 years or older (75 years and over for non-Aboriginal and Torres Strait Islander people) can have a health assessment each year. A person does not have to be sick to have a health assessment. Health assessments are voluntary and a person does not have to agree to an assessment if they don't want to have one.

Who can do a health assessment?

The patient's usual doctor does a health assessment. The doctor may arrange for someone else, such as, an Indigenous Health Worker or nurse, to gather some of the information that is required.

The doctor must be satisfied that the person collecting the information needed for the health assessment has the necessary skills, expertise and training. The doctor must also be consulted on any issues arising during the information collection. The doctor must see the patient in person as part of the health assessment.

How is a health assessment done?

Before undertaking a health assessment the doctor should ensure the person understands what is involved and agrees to have a health assessment.

A health assessment must include all of the following activities:

1. **Measurement of the patient's blood pressure, pulse rate and rhythm.**
   Control of blood pressure reduces the risk of serious health problems. If the assessment identifies a problem with the patient's blood pressure, a follow up consultation with the doctor may be necessary to determine further management.

2. **An assessment of the patient's medication.**
   This should include a review of medications taken including medicine bought over the counter, prescriptions from other doctors, medications prescribed but not taken, interactions and a review of indications. Side effects and interactions of medications occur more frequently for people in the age group eligible for health assessments and at a lower dosage than in younger adults.

3. **An assessment of the patient's continence (bladder control).**
   Continence problems are under-reported and are a major cause of reduced quality of life in this age group. Continence problems are usually easily identified by direct questioning and, when first diagnosed, can often be better managed. If continence problems are identified, a follow up consultation should be arranged to determine further management.

4. **An assessment of the patient's immunisation status for influenza, tetanus and pneumococcus.**
   Vaccinations for influenza, tetanus and pneumococcus prevent unnecessary sickness and even death from vaccine preventable diseases.

5. **An assessment of the patient's physical function, including the patient's activities of daily living and whether or not the patient has had a fall in the last three months.**
   An assessment of activities of daily living (how the patient manages their day-to-day activities) involves examining how the patient manages in their environment. It gives an indication of the patient's level of physical functioning and how this may affect the patient's ability to undertake normal activities.

   The patient should be asked whether they have had a fall in the previous three months. A recent fall for people in the age group eligible for a health assessment is the strongest predictor of future fall related injury.

6. **An assessment of the patient's psychological function, including the patient's cognition and mood.**
   An assessment of the patient's cognition (the patient's understanding, thinking patterns and memory) is important because unrecognised dementia is common in the age group of people who are eligible for a health assessment. Identifying this can often improve quality of life.

An assessment of the patient's mood (how the patient is feeling) should examine whether the patient seems depressed. The use of a formal depression scale such as the Geriatric Depression Scale may help you to identify this.

7. **An assessment of the patient's social function, including the availability and adequacy of paid and unpaid help, and whether the patient is responsible for caring for another person.**
   The availability and adequacy of paid and unpaid help, if needed or wanted, is the central component of an assessment of the patient's social support. This is because people's social networks tend to become smaller as they age and the role of formal support services may need to increase correspondingly.

   It is important to identify whether the patient is responsible for caring for another person. Being a carer for another person can significantly affect the physical and psychological health of the patient and may substantially reduce opportunities for the patient to maintain social networks. If the patient is identified as being a carer, the doctor should evaluate the effect of this role on the patient's health and functioning, and provide information about local carer support services, including regular or emergency respite care.

8. **The health assessment should also cover matters that may be of particular relevance to the patient.**
   Medical literature and consensus medical opinion support the following additional components for inclusion in a health assessment:

• Multi-system review; • Fitness to drive; • Hearing; • Vision; • oral health; • diet and nutritional status; • smoking status;	• foot care; • sleep; • need for community services; • home safety; • cardiovascular risk factors, including blood pressure; and • alcohol use.

9. **Keeping a record of the health assessment with the patient's records.**

10. **Offering the patient a written report about the health assessment and talking to the patient about the recommendations and matters covered in the health assessment.**

11. **Offering a copy of the health assessment report (or relevant extracts) to the carer, where the patient has an informal or family carer, with the patient's agreement.**

12. **Keeping patients informed about their health assessment**

Doctors should establish a register of patients who have had annual health assessments and remind registered patients when their next health assessment is due.

What are the Medicare Items for health assessment services?

The Medicare Items for health assessment services provided to a person of Aboriginal and Torres Strait Islander descent are:

- Item 704 if the health assessment is done at the Doctor's surgery; or
- Item 706 if all or part of the health assessment is done in the patient's home.

Equivalent Medicare Items for non-Aboriginal and Torres Strait Islander people are:

- Item 700 if the health assessment is done at the Doctor's surgery; or
- Item 702 if all or part of the health assessment is done in the patient's home.

Want to find out more?

Contact the Aboriginal and Torres Strait Islander Medicare inquiry line on 1800 **556 955;** or visit the Department of Health and Ageing Enhanced Primary Care website at: www.health.gov.au/epc

Care planning

What is a care plan?

An EPC care plan is a thorough, long-term plan for the care of a patient who has at least one chronic medical condition and complex care needs. A care plan is a way of organising the care and treatment needed by the patient.

A care plan clearly describes the:

- patient's health and care needs;
- what needs to be achieved for the patient;
- actions that will be taken to achieve these;
- self-management techniques and home management strategies that will give the patient more control of their condition; and
- details of the health and care providers who will provide care or services to the patient; and
- arrangements for these care and services to be provided.

What are the benefits of care planning services?

Benefits for patients and carers

Care planning allows the doctor, the patient and those involved in caring for the patient, to plan and then manage the health and care services a patient needs. This helps to improve the quality of care provided to a patient with complex care needs.

Because a copy of the care plan is given to the patient and carer, the patient can read and absorb it in their own time. The patient also has something to keep that lists all their health and care needs, and the services that are going to be provided to help them to look after themselves.

Benefits for health care providers

Care planning helps to share the load of caring for a patient, because it involves a team-based management of the patient's complex care needs. Without a coordinated, team approach the burden of caring for the patient can fall unfairly and unequally on one person only.

Benefits for Doctors and Health Workers

Doctors, health workers and others involved in providing care to the patient will benefit by having:

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

Who can have a care plan?

Care plans are available for people of any age who have at least one chronic medical condition and complex care needs requiring multidisciplinary care from a doctor and at least two other care providers. For example, a patient with diabetes and kidney disease causing complications which need to be managed with the assistance of a health care team.

A **Community care plan** is prepared for a person who lives at home in the community.

A **Discharge care plan** is prepared for a person who is being discharged into the community from a hospital or day hospital facility.

Doctors can also contribute to care plans for people in a **Residential Aged Care Facility**.

What is a chronic condition?

A chronic condition is a condition that has been, or is likely to be, present for at least six months or that is terminal.

Who can prepare a care plan?

An EPC care plan can be prepared by the patient's usual doctor and a multidisciplinary care planning team.

The multidisciplinary care planning team must include the patient's usual doctor and at least two other health professionals or community service providers. Only one of the other members of the team may be another doctor (usually a specialist or consultant physician). Each member of the care planning team must contribute to the plan and provide a different type of service to the patient.

Examples of health professionals who could be included in a care planning team include:

Allied Health Professionals		Community Service Providers
Asthma educators Audiologists Dental therapists Dentists Diabetes educators Dieticians Indigenous Health Workers Mental health workers Occupational therapists Optometrists	Orthoptists Orthotists or Prosthetists Pharmacists Physiotherapists Podiatrists Psychologists Registered nurses Social workers Speech pathologists	Education Providers Meals on Wheels Home Help Home Nursing Personal Care Workers Probation Officers Chaplain

Can a person who looks after the patient as their carer be involved in care planning?

Involving the person who takes care of and supports the patient can be beneficial. The patient's carer can give more information about:

- the patient's circumstances;
- the amount and type of support they gives to the patient; and
- if they will be able to continue giving the patient that level of support and care.

The patient and their carer do not count towards the minimum three members of the multidisciplinary team.

How is a care plan prepared?

Care planning involves:

1. **Identifying the patient's need and eligibility for a care plan and the other health and care providers who should be involved.**

2. **Asking the consent of the patient to prepare a care plan:**
   In asking the consent of the patient, the Doctor should:
   - explain to the patient:
     - what a care plan is and how the patient will benefit from one;
     - who will be involved in the care planning;
     - what information will be shared with others;
     - payment arrangements including any possible costs;
   - give the patient the opportunity to specify any information that they:
     - do not want to be passed on to some or all members of the care planning team; or
     - would like to be passed on to some or all members of the care planning team; and
   - record the patient's agreement, if it is given.

3. **Identifying the patient's care needs through an assessment covering:**
   - the patient's general health;
   - a review of relevant medical history and problems;
   - a medication review (if appropriate); and
   - the impact of the patient's chronic condition(s) on their of life.

4. **Inviting health and care providers who will be involved in providing treatment, or care to the patient to contribute to the care plan by:**
   - establishing management goals in relation to the identified problems and needs of the patient;
   - identifying specific medical treatments and other health and care services needed;
   - making arrangements on how these services will be delivered and when;

- documenting these arrangements in the care plan; and
- agreeing on when the plan will be reviewed.

5. **Discussing the care plan with the patient.**

6. **Preparing a written document (the plan) outlining the outcomes of the planning process including:**
   - the patient's health and care needs;
   - the outcomes and management goals being sought;
   - the kinds of treatment, health services and health care that the patient is likely to need;
   - any other service or support the patient is likely to need;
   - arrangements (such as appointments or medication lists) that have been made to meet the treatment, services and care needs of the patient; and
   - how and when the plan will be reviewed.

7. **Giving a copy of the care plan to:**
   - other members of the multidisciplinary care planning team; and
   - offering a copy to the patient and, where appropriate and if the patient agrees, the patient's carer.

8. **Keeping a copy of the care plan on the patient's medical record**.

What happens when a Doctor contributes to a care plan?

A patient's doctor can contribute to a care plan if they have been asked to contribute by the person who is preparing the care plan. A doctor can contribute to a care plan in person, or via telephone or videoconference. A doctor can also contribute in writing or by email or fax.

When a Doctor contributes to a care plan they may:

- prepare a part of the plan that relates to the treatment, service or care that they will give to the patients; or
- give advice to the person who prepares the care plan.

If a doctor contributes to a care plan, they should put a copy of the completed plan on the patient's medical record.

What happens in a review of a care plan?

A doctor can review a care plan that they have prepared. When reviewing a care plan, the doctor must:

- record the patient's agreement to review the care plan;
- consider whether the arrangements made in the care plan for treatment, service and care have been carried out;

- consult with other members of the original care plan team to consider whether different arrangements need to be made to achieve the management goals mentioned in the original care plan;
- discuss the review of the care plan with the patient (and the patient's carer, if appropriate);
- prepare a revised care plan if different arrangements need to be made;
- offer a copy of relevant parts of the revised care plan (if there are any) to the patient (and to the patient's carer, if appropriate and with the patient's agreement); and
- provide copies to the health professionals who, under the revised plan, will give the patient treatment, services and care mentioned in the care plan.

A care plan can be reviewed 3 months after it was prepared.

How many care plans can be prepared for a person?
It is recommended that a care plan be prepared only once a year. A new plan can be prepared after six months if the patient's usual doctor thinks there has been a significant change in the patient's condition or care support arrangements since the development of the previous care plan.

Are there standard formats for preparing a care plan?
You don't have to use a standard format when preparing a care plan. Some sample proformas have been included in this Kit to assist you. These can be adapted to meet your local needs and circumstances.

What is a discharge care plan?

A discharge care plan is a care plan developed for a person being discharged from hospital into the community. The conditions for discharge care planning are similar to those mentioned above.

What are the Medicare Item numbers for the different care planning services?

The appropriate Medicare Item number depends on the type of plan being developed and the work that the doctor does. A doctor can be responsible for preparing and reviewing a care plan, or they can be invited to contribute to the development and review of a care plan prepared by someone else.

The table below summarises the appropriate Medicare Item numbers for the different EPC care planning services:

720 – **Preparing** a community care plan; 722 – **Preparing** a Discharge Care plan; 724 – **Reviewing** a Community Care Plan or a Discharge Care plan 726 – **Contributing** to the development or a review of a community care plan prepared by another person;	728 - **Contributing** to the development or review of a Discharge Care plan prepared by another person. 730 - **Contributing** to the development or review of a care plan in a Residential Aged Care Facility.

Want to find out more?

You can contact the Aboriginal and Torres Strait Islander Medicare inquiry line on **1800 556 955** and, if you have access to the Internet, you could visit the Department of Health and Ageing Enhanced Primary Care website at: www.health.gov.au/epc

Case conferences

What is a case conference?

An EPC case conference is a meeting of health and care providers to plan for the immediate care needs of an individual patient with chronic conditions and complex health care needs. A case conference can help better organise the care a patient needs.

The outcomes of the case conferencing process are summarised in a written document that clearly describes:

- the patient's health and care needs;
- the outcomes being sought;
- the tasks and activities that will be done to achieve these outcomes;
- which members of the team will undertake which task; and
- whether previously identified outcomes have been achieved.

What are the benefits of case conferencing services?

Benefits for patients and carers

Case conferences provide the opportunity to coordinate an approach to managing the delivery of immediate services to a patient with complex care needs. Case conferencing allows the doctor, in consultation with the patient and those involved in caring for the patient, to discuss and then manage the immediate health and care services a patient needs.

As a summary of the case conference is given to the patient and carer, it can be read and absorbed within the patient's own time. The patient can also refer to the case conference summary when discussing matters of concern with providers.

Benefits for health and care providers

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

Benefits for Doctors and Health Workers

Doctors, Health Workers and others involved in providing care to the patient will benefit by having:

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

Who can have a case conference?

A person of any age who has at least one chronic medical or terminal condition and complex care needs requiring multidisciplinary care from a doctor and at least two other care providers.

A **Community case conference** is for an eligible person living in the community. A **Discharge case conference** is for an eligible person being discharged into the community from a hospital or day hospital facility. Case conferences can also be held for people in a **Residential Aged Care Facility.**

What is a chronic condition?

A chronic condition is a condition that has been, or is likely to be, present for at least six months or that is terminal.

Who can organise and coordinate a case conference?

To be paid under Medicare, the case conference can be organised by the patient's usual doctor and involve a multidisciplinary case conference team.

The multidisciplinary case conference team must include the patient's usual doctor and at least two other health professionals or community service providers. Each member of the case conference team must provide a different type of care or service to the patient. In addition to the patient's doctor, only one of the other members of the team can be another doctor, usually a specialist or consultant physician.

Examples of health professionals who could be included in a care planning team include:

Allied Health Professionals		Community Service Providers
Asthma educators Audiologists Dental therapists Dentists Diabetes educators Dieticians Indigenous Health Workers Mental health workers Occupational therapists Optometrists	Orthoptists Orthotists or Prosthetists Pharmacists Physiotherapists Podiatrists Psychologists Registered nurses Social workers Speech pathologists	Education Providers Meals on Wheels Home Help Home Nursing Personal Care Workers Probation Officers Chaplain

Can a person who looks after the patient as their carer be involved in the case conference?
Involving the person who takes care of and supports the patient can be beneficial. The patient's carer can give more information about the:

- the patient's circumstances;
- the amount and type of support they give to the patient; and
- if they will be able to continue giving the patient that level of support and care.

The patient and their carer don't count as one of the minimum three members of the team.

What happens in a case conference?

Case conferencing involves all the activities described below:

1. **The doctor decides that the patient would benefit from a case conference and is eligible, and the health and care providers who should be involved.**

2. **Asking the consent of the patient to undertake a case conference:**
   In asking the consent of the patient, the doctor should:
   - explain to the patient:
     - what a case conference is and how the patient will benefit from one;
     - who will be involved in the case conference;
     - what information will be shared with others;
     - the payment arrangements including any possible costs; and
   - give the patient the opportunity to specify any information that they:
     - do not want to be passed on to some or all members of the case conference team; or
     - would like to be passed on to some or all members of the case conference team; and
   - record the patient's agreement if it is given.

3. **Hold the case conference (in person, by phone or videoconference) and, with other members of the team,:**
   - discuss the patient's problems, care needs and goals;
   - discuss the outcomes being sought;
   - agree on the care needs of the patient and what needs to be achieved for the patient;
   - allocate tasks to members of the team; and
   - agree on how and when the tasks will be reviewed.

4. **Preparing a written summary outlining the outcomes of the case conference including:**
   - start and finish times, and who participated;

- the outcomes and recommendations;
- the tasks allocated to members of the team and arrangements to undertake them; and
- how and when the outcomes of the case conference will be reviewed.

5. **Giving a copy of the case conference summary to:**
   - other members of the multidisciplinary case conference team;
   - the patient and, where appropriate and if the patient agrees, the patient's carer; and
   - discuss the outcomes of the case conference with the patient.

6. **Keeping a copy of the summary of the case conference on the patient's medical record.**

What happens when a Doctor participates in a case conference team?

A patient's usual doctor can participate in a case conference team at the request of the person who is organising the case conference. A doctor's participation can be done by a variety of means including a face-to-face meeting; by telephone or videoconference.

If a doctor participates in a case conference, they should request a copy of the case conference summary, or the part of the summary that relates to their specific contribution, and put this on the patient's medical record. The doctor must document their contribution to the case conference on the patient's medical record.

If a doctor participates in a case conference held in a residential aged care facility it must be at the request of the residential aged care facility. The doctor's contribution should be documented in the summary of the case conference and a record of this contribution should be included on the resident's medical record.

What is a discharge case conference?

A discharge case conference is held for a person being discharged from hospital into the community. The conditions for discharge case conferencing are similar to those mentioned above.

What are the Medicare Item numbers for the different case conference services?

The appropriate Medicare Item number depends on the type of case conference being held and the work that the doctor does. It also depends on the amount of time the doctor spends performing the service. A doctor can be responsible for organising the case conference or they can be invited to participate in a case conference that has been organised by someone else.

The table below summarises the appropriate Medicare Item numbers for the different EPC case conferencing services:

740 - **Organising** a community case conference that goes for 15-29 minutes; 742 - **Organising** a community case conference that goes for 30-44 minutes; 744 - **Organising** a community case conference that goes for 45 minutes or longer; 746 - **Organising** a discharge case conference that goes for 15-29 minutes; 749 - **Organising** a discharge case conference that goes for 30-44 minutes; 757 - **Organising** a discharge case conference that goes for 45 minutes or longer; 734 - **Organising** a case conference in an aged care facility that goes for 15-29 minutes; 736 - **Organising** a case conference in an aged care facility that goes for 30-44 minutes; 738 - **Organising** a case conference in an aged care facility that goes for 45 minutes or longer;	759 – **Participating** in a community case conference that goes for 15-29 minutes; 762 – **Participating** in a community case conference that goes for 30-44 minutes; 765 – **Participating** in a community case conference that goes for 45 minutes or longer; 768 – **Participating** in a discharge case conference that goes for 15-29 minutes; 771 – **Participating** in a discharge case conference that goes for 30-44 minutes; 773 – **Participating** in a discharge case conference that goes for 45 minutes or longer; 775 – **Participating** in a case conference in an aged care facility that goes for 15-29 minutes; 778 – **Participating** in a case conference in an aged care facility that goes for 30-44 minutes; and 779 – **Participating** in a case conference in an aged care facility that goes for 45 minutes or longer.

Want to find out more?

You can contact the Aboriginal and Torres Strait Islander Medicare inquiry line on **1800 556 955** and, if you have access to the Internet, you could visit the Department of Health and Ageing Enhanced Primary Care website at: www.health.gov.au/epc

HEALTH ASSESSMENTS

What is a health assessment?
A health assessment is where you and your Doctor check out all the things that affects your day to day well being.

How will I benefit from a health assessment?
Having a health assessment means your Doctor can look at all the things that affect your well being and give you advice on how to keep well.

What will happen during a health assessment?
Your Doctor will look at your blood pressure, the medicines you take, and the things you do from day to day. They may also test your eyesight and hearing.

Health assessments are voluntary and your Doctor will ask your permission before doing a health assessment.

Who will be at a health assessment?
Your Doctor will do the health assessment with you. A health worker or nurse may help your Doctor to collect some information.

Where will the health assessment happen?
A health assessment can be done at the Doctor's surgery, at your own home or a combination of both.

Will I have to pay anything?
If your Doctor bulk bills you won't need to pay anything. You may need to pay your Doctor extra if your Doctor does not bulk bill. Your Doctor will tell you if you have to pay any extra money.

Will my health assessment be used for anything else?
No. Your health assessment is a matter between you and your doctor.

For use on patient's medical record

Patient name:

Date of discussion:

Patient consent for a Health Assessment given: yes ☐ no ☐

CARE PLANS

What is a care plan?
A care plan describes your health and care problems and the treatment, care and services that you need. It tells you who will give you care and services and when they will be given. It also tells you when the plan will be looked at again to check if your needs have been met.

A discharge care plan is for people who are leaving hospital.

How will I benefit from a care plan?
You will benefit from care planning if you have an illness that lasts for a long time and many care needs. It allows your Doctor and all those who are looking after you to work together to give you the best care.

Because a care plan is written, you and those who are caring for you will have something to keep that lists all of your health and care needs and the things that are going to happen to help you to look after yourself.

How is the plan prepared?
Your Doctor will meet with you to talk about your health and care needs. This will help you and your Doctor to work out who can best help you. The Doctor will talk with these people about the services, care and treatment you need and find out when they can see you. Your Doctor will put all this information together and write a care plan for you.

Who will help my Doctor to make the care plan?
People who give the type of care and services that you need, for example, a health worker, nurse, physiotherapist, nutritionist or social worker may help your Doctor.

Will the Doctor keep me informed about what is happening?
Your Doctor will ask your permission before talking to any other people about your health problems and care needs. Your Doctor will also tell you what was agreed about your care and ask whether you are happy about this. You will be offered a copy of the care plan to keep when it is finished.

Can I ask someone to come with me when I see my Doctor to talk about my care plan?
Yes, you can take someone along, for example a family member or a friend.

Will I have to pay anything?
If your Doctor bulk bills you won't need to pay anything. You may need to pay your Doctor extra if your Doctor does not bulk bill. You may also need to pay other people who are going to help your Doctor to prepare the care plan. Your Doctor will tell you if you have to pay any extra money.

For use on patient's medical record

Patient name:

Date of discussion:

Patient consent for a Care Plan given: yes ☐ no ☐

CASE CONFERENCES

What is a case conference?
A case conference happens when your Doctor talks with other health and care professionals about your health problems and care needs. The people in a case conference will work out what things need to be done to improve your well being and how they can help you.

A discharge case conference is for people who are leaving hospital.

How will I benefit from a case conference?
You will benefit from a case conference if you have an illness that lasts for a long time and many care needs. It allows your Doctor and all those who are looking after you to work together to give you the best care.

Because the things that happen in a case conference are written down, you and those caring for you will have something to keep that lists all of your health and care needs and the things that are going to happen to help you to look after yourself.

What happens in a case conference?
Your Doctor will meet with you to talk about your health and care needs. This will help you and your Doctor to work out who can best help you. Your doctor will ask your agreement to discuss your health needs with these people. The Doctor will get together with these people to talk about the services, care and treatment you need and find out when they can see you if they need to. Your Doctor will also set up a time for the people to get together later on to check if your needs have been met.

Who will be with my Doctor in the case conference?
People who give the type of care and services that you need, for example, a health worker, nurse, physiotherapist, nutritionist or social worker may help your Doctor.

Will the Doctor keep me informed about what is happening?
Your Doctor will ask your permission before talking to any other people about your health problems and care needs. Your Doctor will also tell you what was agreed about your care and ask whether you are happy about this. You will be offered a copy of what happened in the case conference.

Can I ask someone to come with me when I see my Doctor to talk about the case conference?
Yes, you can take someone along, for example a family member or a friend.

Will I have to pay anything?
If your Doctor bulk bills you won't need to pay anything. You may need to pay your Doctor extra if your Doctor does not bulk bill. You may also need to pay other people who are going to be in the case conference. Your Doctor will tell you if you have to pay any extra money.

For use on patient's medical record

Patient name:

Date of discussion:

Patient consent for a Case Conference given: yes ☐ no ☐