

## Introduction

Improving communication about the care of clients shared between community health services, general practitioners (GPs), and general practice more broadly, will enhance the quality of care and experience of clients, particularly those with chronic or complex conditions.

Feedback regarding shared clients is an essential element in the communication between multiple providers of client care. It needs to be part of a communication loop that continues at appropriate points of the intervention process over the course of a client's treatment from referral to discharge.

Consistent, timely and appropriate feedback to GPs (or other members of the general practice team such as the practice nurse) is necessary for maintaining high quality multidisciplinary care for clients and for forming a solid working relationship between providers based on trust and good communication. Lack of appropriate feedback to GPs impacts on the quality of relationships and care across the board, so it is important that a statewide approach sets the standard for feedback to GPs.

These guidelines provide advice to community health services about how, when and what client feedback is, and the information a GP requires to add value in the care of their client.

They were developed after analysing existing resources from the primary health sector and extracting key elements that support quality GP feedback. The contents of the guidelines were tested in 2009 through the Plan, Do, Study, Act (PDSA) general practice engagement projects focusing on feedback to GPs.

Importantly, these guidelines have been created within the broader context of improving multidisciplinary care, which includes improving the quality of referrals from GPs and the quality of feedback from GPs. They will feed into the revision of the Service Coordination Tool Templates and complement the service coordination initiative in the primary care partnerships strategy to support the continuing development of an effective primary care system in Victoria.

## Why is feedback necessary?

Feedback supports a quality team approach to care and should be part of the communication between multiple service providers regarding clients in common.

Communication and feedback from community health professionals to GPs is vital as it:

- enables relevant effective primary health support to be provided
- reduces confusion for the client and garners confidence in the health service
- facilitates follow through of management by the GP
- is essential to avoid treatment mishap, particularly in regard to medication
- reduces the risk of duplication of management plans, tests and personal history information provided by the client
- increases the chances that the client follows up on necessary steps
- facilitates continuity of care so that the client's care is not fragmented
- acts as a positive promotional mechanism for the service and raises the standard of professionalism.

Communication from GPs to community health professionals regarding shared clients should be encouraged whenever appropriate.

# When should feedback be provided?

Subject to the client's consent,<sup>1</sup> feedback from community health professionals to GPs should occur whether the client was initially referred by the GP or self-referred.

Client consent is required for the sharing of information. In some instances, clients may refuse to give consent. If this occurs, information cannot be shared unless:

- it is necessary to lessen or prevent a serious and imminent threat to an individual's life, health, safety or welfare
- a serious threat to public health, safety or welfare exists. (Health Records Act 2001)

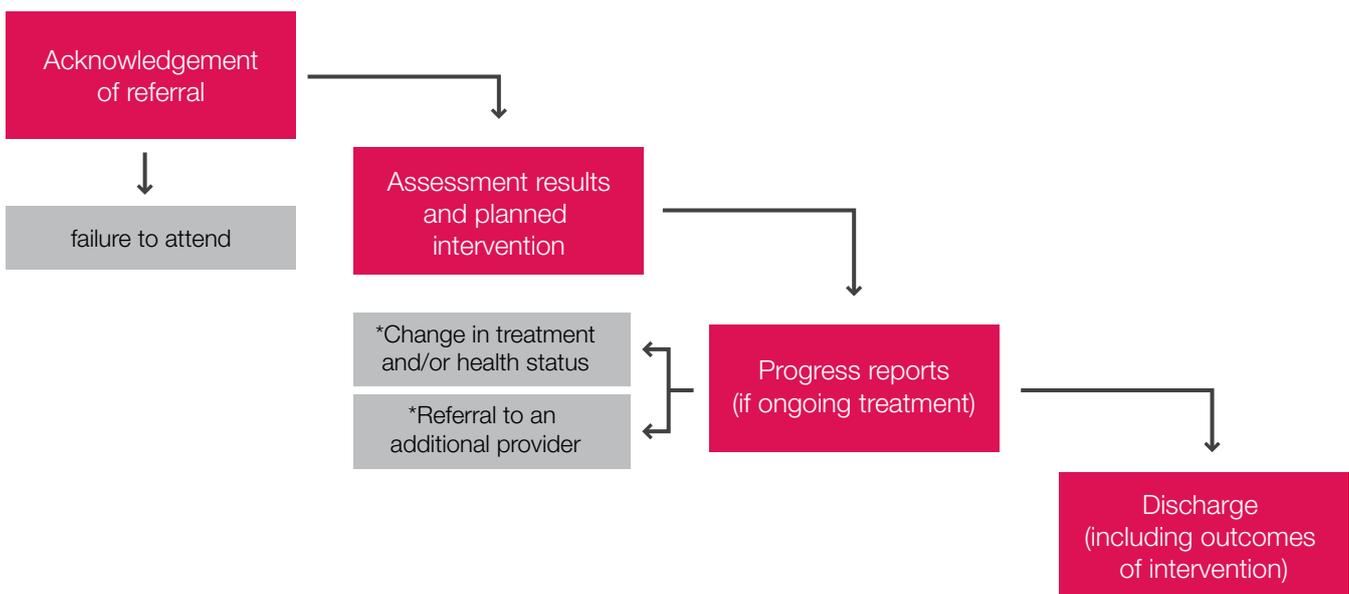
Feedback from community health professionals to GPs should occur with regard to:

- acknowledgement of referral
- outcomes from assessment/re-assessment and planned interventions for the client
- change to a person's condition or status, or change in treatment
- referral to an additional service provider
- periodic progress
- discharge or end of course of care (including outcomes of treatment)
- notice of failure to attend by a referred client.

The regularity of progress reports should be determined through local agreement between the general practice and the community health service involved in the client's care. Agreements may be made through an informal arrangement between individual practitioners or ideally, may be a formalised agreement developed through local divisions of general practice and primary care partnerships regarding whole client groups, for example, clients with type 2 diabetes.

Diagram 1 sets out the potential junctures for providing written feedback to GPs. While the acknowledgement of referral and discharge report are generally one-off occurrences, assessment results, planned interventions and ongoing progress reports may occur multiple times over a client's course of care.

**Diagram 1. Trigger points for providing written feedback to GPs**



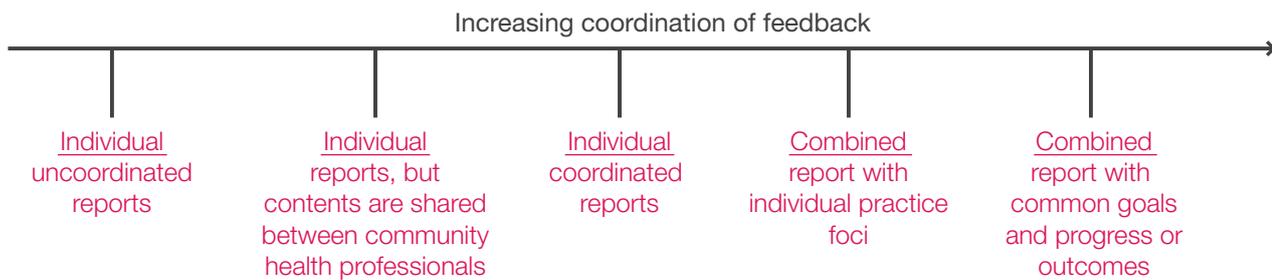
\* These events would prompt a feedback report to the GP.

<sup>1</sup> For further information on privacy and consent, refer to the website at <http://www.health.vic.gov.au/pcps/coordination/privacy.htm>

## Who should provide feedback?

When a client receives services from a community health multidisciplinary team, the process of feedback becomes more complex. Ideally, the team should identify an agreed key worker to coordinate the feedback to the client's GP, creating one report with individual input from each service provider, or one comprehensive report with a common intervention plan and/or progress report. Similarly, one discharge report could be generated covering outcomes from all interventions.

**Diagram 2. Different levels of coordinated feedback provided to a GP**



## What should be included in the feedback?

Feedback from community health professionals to GPs should be concise and relevant to the GP's care of the client and no longer than one single-sided page. The feedback should include:

- client identification details
- referral details including reason for referral
- clinicians involved in client's care, reason for involvement and contact details of providers.

Depending upon the nature of the report, information may also include:

- assessment/re-assessment findings and planned interventions in summary
- outcomes of the service provided
- issues or recommendations that may require follow up by the GP.

A sample feedback template, which includes the key elements identified for quality feedback, is provided in Appendix 1.<sup>2</sup> Additional resources are available in Appendix 2.

## How should feedback be provided?

Feedback can be written or verbal, although written feedback is the recommended mode as it provides an accurate record of care that can be referred to as required. For this reason, when verbal feedback is given, it should be recorded in written form as soon as the community health professional can do so. If urgent medical or psychological concerns are held about a client, the community health professional should contact the GP directly by phone, then follow up with written communication. The judgement about what is urgent is a matter for clinical opinion.<sup>3</sup>

Written communication to the client's usual GP should be provided via secure fax, post or secure messaging. If the referral was made by a GP other than the client's usual GP, a discussion should take place with the client as to whether communication should also be addressed to their usual GP, highlighting the matter of continuity of care.

Feedback may be given to the client to pass on to the GP. While it is important to involve the client in their care, it is also essential that the community health professional communicates directly with the GP.

<sup>2</sup> The sample template is based upon two existing forms: Patient feedback report, Bentleigh Bayside Community Health and Bayside General Practice Network and Health professionals feedback report, Ballarat and District Division of General Practice and Ballarat Community Health Centre

<sup>3</sup> GPV position statement feedback to GPs about patient care, 2010, General Practice Victoria, available online at: [http://www.gpv.org.au/files/downloadable\\_files/Resources/20100303\\_Feedback%20to%20GPs\\_FinalLL.pdf](http://www.gpv.org.au/files/downloadable_files/Resources/20100303_Feedback%20to%20GPs_FinalLL.pdf)

## Communication requirements in team care arrangements

The team care arrangements (TCA) item under Medicare is available for use by GPs for the care of clients with a chronic or terminal medical condition and complex care needs. *Complex care needs* means that the client requires ongoing care from a multidisciplinary team consisting of their GP and at least two other health or care providers.

The GP requires communication from any health care provider who forms part of the TCA to:

- confirm agreement to the TCA plan outlined and their contribution to it
- notify any change to the TCA plan
- request additional TCA sessions
- notify if the client has discontinued care.

If claiming under Medicare:

- where an allied health professional provides a single consultation to the client under a referral, they must provide a written report back to the referring GP after the service
- where an allied health professional provides multiple consultations to the same client under the one referral, they must provide a written report back to the referring GP after the first and last service only, or more often if clinically necessary.

Written reports should include:

- any investigations, tests or assessments carried out on the client
- any treatment provided
- future management of the client's condition or problem.

For further information, visit [www.health.vic.gov.au/communityhealth/downloads/factsheet06.pdf](http://www.health.vic.gov.au/communityhealth/downloads/factsheet06.pdf) and [www.medicareaustralia.gov.au/provider/business/education/files/2248-quick-reference-guide-for-allied-health-professionals.pdf](http://www.medicareaustralia.gov.au/provider/business/education/files/2248-quick-reference-guide-for-allied-health-professionals.pdf).

## Communication requirements with mental health care plans

The GP mental health care items under Medicare are available for use by GPs when undertaking early intervention, assessment and management of clients with mental disorders. Management may include the preparation of a GP mental health care plan. Where a GP mental health care plan has been completed and claimed on Medicare, a client is eligible for referral to Medicare-rebateable allied mental health services, such as psychological therapy or focused psychological strategy services.

On completion of a course of treatment (maximum of six services), allied mental health professionals must provide a written report to the referring medical practitioner, which should include information on:

- any assessments carried out on the client
- any treatment provided
- recommendations on future management of the client's disorder, including whether an additional course of treatment is required.

For further information, visit [www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-programs-amhpm-pdf-factsheet](http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-programs-amhpm-pdf-factsheet).

## Care coordination plan

For clients with complex needs who require services from multiple providers, the community health service should develop a care coordination plan using the care coordination plan template.<sup>4</sup> In most cases, a GP would be involved in a client's care and as such, should be provided with a copy of the plan and reviews of the plan as per the practice standards outlined in the Victorian service coordination practice manual (2007).<sup>5</sup> If the GP has not contributed to the care coordination plan, they could be invited to participate in a team approach and provided with a copy of the plan at that point.

4 Service Coordination Tool Templates 2009 user guide, 2009, Primary Health Branch, Department of Human Services, Victoria

5 Victorian Service Coordination Practice Manual: A Statewide Primary Care Partnerships Initiative, 2007, Department of Human Services, Victoria

# Appendix 1. Sample feedback report

## Feedback report

Dear *Dr Brown*

This report is to provide you with information about your patient who has been attending *Wellvale CHS* [Community Health Service]. I am available to discuss the patient with you or provide any further information should you require this. My contact details are at the bottom of this report.

Yours sincerely,

*Susan Smith*

### Patient details

Name: *Mr Bill Jones*

Address: *20 Town Street, Wellvale*

Date of birth: *01/06/1955*

Medicare No: *1234 56478 0*  
(where applicable)

### Referral details

Referred to: *Diabetes Educator*

Referred by: *Dr Phillip Brown (GP)*

Reason for referral: *Newly diagnosed diabetes type 2*

### Relevant assessments/tests and results:

*Mr Jones underwent a comprehensive assessment. Results indicated that he would benefit from diabetes education and support.*

### Planned interventions:

*Mr Jones to attend a diabetes education program.*

### Services provided:

*Mr Jones attended a six-week diabetes education program in June and July 2009 with his wife.*

### Outcomes:

*Mr Jones is now monitoring his BGLs.*

*He has increased his physical activity to include a 30-minute walk every 2–3 days.*

### Future management plan:

*Mr Jones has been added to the recall list for follow-up contact by a diabetes educator in six months.*

### Key issues:

*Mr Jones continues to smoke.*

### Recommendations/requests for GP follow up (if applicable):

*The benefits of smoking cessation will need ongoing reinforcement.*

### Further comments/referred on:

*Referred to a dietician at Wellvale CHS for discussion of diet and supermarket tour.*

### Service provider details:

Name: *Susan Smith*

Role: *Diabetes Educator*

Phone: *9222 6666*

Fax: *9222 6666*

Best times to contact: *Wednesday 9.00 am–2.00 pm and Friday 2.00 pm–5.00 pm.*

*(repeat the above box if there are multiple service providers)*

## Appendix 2. Examples of local feedback resources

| Who  | What   |
|--|--|
| Melbourne East General Practice Network            | Template letters and communication principles  |
| Wimmera PCP/West Vic Div                           | Diabetes self-management – general practice engagement map and template for feedback form.   |
| Ballarat and District Division of General Practice | Health Professional's Feedback Report Template   |
| Bendigo Loddon PCP                                 | Tools to support the service coordination processes: Proforma and checklists (feedback)  |
| Whitehorse Community Health Service                | EliCD best practice guidelines for communication between Whitehorse CHS and GPs including flowcharts<br>Good Life Club – communication templates<br>Good Life Club – case conference learnings, template and indicators for case conference  |
| Central Bayside Community Health Service           | Minimum standards for GP communication Powerpoint presentation on GP feedback PDSA cycle<br>Good Health for Life Program including: <ul style="list-style-type: none"> <li>• minimum standards for GP communication</li> <li>• supplementary information for referral template</li> <li>• referral feedback template</li> <li>• feedback following assessment letter template</li> </ul> |
| VHA  | Clinical indicators in community health (communication to general practitioner)  |
| Primary Health Branch, DHS                         | General Practice Engagement in ICDM Information resource includes examples from Whitehorse CHS and Better Health in Gippsland  |

Many of these resources can be found at: <http://www.health.vic.gov.au/communityhealth/gps/improving.htm>