

5. Integrated care enablers

5.1 Introduction

A range of things is needed to underpin the development of integrated community-based health care. To deliver person and family centred care, and plan on an area basis for population health needs, Victoria's health system needs:

- approaches to **funding models** and reporting that provide appropriately structured incentives to support person-centred care and provide health care providers with flexibility to address area-based planning priorities
- a **workforce** that is structured to provide person-centred care in community settings
- different organisations and professions need **integration tools** - a standard environment to work within which supports trust, understanding and effective communication - including common language and common approaches to information sharing
- an **information management** environment that supports effective, informed decision making, reduces administrative overheads, supports information sharing (allowing information to lead/follow people as they move through the system) and collaboration between providers, consumers and carers
- the delivery of integrated health services in a community setting requires a range of autonomous organisations to work together in **partnership**.

The current funding model for Metropolitan, B and C hospitals is based on reward for patients admitted. Whilst this funding model remains there is an incentive to continue to focus on patient throughput, which results in maintaining high bed occupancy in order to remain financially viable. Programs such as Hospital in the Home, which are leading the way and providing evidence for the Ambulatory Care Model, are funded as an adjunct to the Acute funding structure at a lesser rate. This maintains focus on inpatient care and ambulatory care as secondary.

Otway Health Service

5.2 Funding models

The way in which funding is provided structures the approach that health service providers take to the delivery of health care. Funding arrangements provide incentives for providers to work in particular ways. To effectively support systemic change, funding approaches and structured incentives should provide a stimulus rather than a barrier to doing things differently.

In Victoria, nationally and internationally, a range of approaches have been taken to use funding more flexibly to support a person-centred approach to health care. In Victoria, some key examples are:

- Coordinated care trials (CCTs), which involved coordination of funding between State and Federal Governments to provide care from a pooled funding source for particular cohorts of people.
- Multi-Purpose Services (MPSs), involving pooled funding arrangements for agencies delivering a range of services, taking in both State and Commonwealth sources of revenue.
- Small Rural Health Services funding arrangements and work through the department's Flexible Funding initiative allow services to use funds flexibly to support innovative approaches to service delivery.
- The Sub-acute Ambulatory Care Services (SACS) Framework consolidates funding streams across sub-acute services and includes standardised accountability and reporting processes.

The above examples are limited trials (in the case of CCTs), or focus on single agencies or single programs. This means that, while these initiatives provide significant benefits to health care providers and the people that use their services, they remain islands of flexibility, unable to connect up and extend their benefits to the health care system as a whole.

An important threshold that needs to be crossed in Victoria is a move to a flexible funding approach that allows separate organisations working together to use existing funding streams more flexibly to package care in a way that meets an individual's needs in community and home-based settings.

There are a number of anomalies in the way that health care services are funded that work counter to the vision and principles of Care in your community. Some key areas are:

- Outpatient services are funded on a unit price basis, which does not support continuity of care and does not match the arrangements for similar services.
- Current casemix arrangements promote hospitalisation and do not provide enough flexibility or incentives to consider alternative approaches to care.
- Funding along program lines has created a range of funding streams which complicates service delivery and reporting and reduces flexibility, including the ability to substitute care across program boundaries to better meet the needs of individuals.

Issues currently facing outpatients centre on evolving models of care, such as multidisciplinary clinics, the need to improve timeliness and accessibility of services, and scheduling and waiting list times.

A major issue that underpins all proposals for any change to outpatients is the need for patient level unit record data and costing systems, consistent across the state. Any changes would also need to be approached within the context of the current Australian Health Care Agreement with the Commonwealth, which specifies directions for national minimum datasets with patient level data.

The Department of Human Services will examine alternatives to casemix funding for people with chronic conditions. These alternatives will provide incentives to substitute inpatient care with community-based health care services, to provide people with appropriate packages of care to maximise their health outcomes and reduce the risk of unplanned hospital admissions.

The ability to flexibly package care for individuals and their families is most important when people need a range of health and care services delivered in a coordinated way. Clearly not all people need this kind of approach all the time. Flexible funding needs to include mechanisms to assess a person's risk and capacity that can be used as a trigger for flexible application of funding to maximise people's capacity to remain in, or return to, community-based settings, where appropriate. While this kind of enrolled population approach currently exists within individual programs, the challenge is to apply it systematically to improve the way that care is packaged across a range of relevant program funding streams. As stated earlier (see 4.4.1 above), the department will integrate across programs that target the needs of people with chronic disease and complex care needs. At the same time, planning networks will be encouraged to propose systematic approaches to flexible funding for defined populations, as a part of integrated area-based planning.

Key actions

- In 2006, undertake a review of outpatient funding arrangements. The outpatient funding review will focus on developing a model that encourages best practice models and transparency in delivery of outpatient services.
- Trial alternatives to casemix funding in 2006-07, and consider the feasibility of extending this approach to other health services, commencing in 2007-08.
- Support and encourage the development of flexible funding approaches as a key outcome of trial area-based planning activity in 2006, including reallocation of WIES to community-based service delivery priorities, based on proposals developed and agreed by planning networks.

5.3 Workforce

Moving to increasingly deliver care in community-based settings under more flexible, person-centred arrangements will have implications for long-term workforce planning and strategy, the mix of skills and competencies needed in the workforce, the environments in which people work, and the numbers and distribution of the workforce.

Because of the complex and highly interdependent policy, funding and regulatory arrangements impacting on the health workforce, many aspects of reform require change to be addressed at a national level. At the same time, there remains much that the Victorian Government can do, and is doing, to address workforce issues that impact on the integrated delivery of community-based health care services.

Health Ministers recently agreed to a National Health Workforce Strategic Framework that sets out seven principles for improved health workforce outcomes at a national level. Victoria has adopted this framework, and added an eighth principle on the promotion of workforce quality and safety (see box).

Victorian Human Services Workforce Strategic Framework: Summary of principles

- 1 Ensure and sustain self-sufficiency in workforce supply
- 2 Workforce distribution optimises access and is aligned with need
- 3 Ensure attractiveness of workplaces
- 4 Ensure workforce is skilled and competent
- 5 Optimal use of skills and workforce adaptability
- 6 Policy and planning to be informed by best evidence and linked to requirements
- 7 Stakeholders to work collaboratively
- 8 Promote workforce quality and safety

In pursuing workforce strategies, it is important to have a clear sense of longer-term workforce goals (including modelling future supply and demand), and to take short-term action on key areas of workforce development that can lead to near-term outcomes.

In a highly competitive health workforce market, Victoria must take care that short-term initiatives undertaken independently of other jurisdictions, do not erode Victoria's competitive advantage in attracting and retaining health professionals.

While there is plenty happening in Victoria and nationally on the health workforce front, the challenge will be to bring relevant aspects of this work to bear in a strategic way on the goal of increasing the capacity to deliver health care in community-based settings. This involves planning for and developing the future workforce, and putting in place initiatives that create appropriate incentives and opportunities for the current workforce.

5.3.1 Systematic workforce planning

Workforce planning information needs to feed into the area-based planning process, so that as the service system evolves, so too does the workforce delivering those services. In turn, the outcomes of area-based planning, aggregated at a state level, need to inform the priorities for State Government managed and funded workforce development activity.

It will also be important for capital planning priorities to be informed by workforce requirements, not at an organisational structural level, but based on an analysis of the local health care system, the preferences of the local community, and a streamlined, integrated approach to the delivery of care, centred around users of health care services, their families and carers.

5.3.2 Work design

Through its Better Skills, Best Care strategy, the Department of Human Services is already undertaking specific work design projects that explore the potential to extend the capacities of clinicians to provide care in community-based settings, including work on new and amended roles to support delivery of services in superclinics.

A range of the pilot projects currently funded may be more broadly applicable to ambulatory care services, and thus assessment of the potential for these to shape future directions in ambulatory care workforce will be undertaken, also taking into account the findings of the first round of area-based planning. This will be important for rural areas where a more limited range of health care services is available locally. There is a need for practitioners in rural settings to be able to provide the broadest possible range of care locally, supported where necessary by back-up arrangements with other health services, remote guidance and support from specialist clinicians, access to clinical decision support, and access to flexible training and education options.

A focus will be given to new and expanded roles for allied health professionals, as well as allied health assistant and support worker roles in community settings and in rural areas.

5.3.3 Case management

In the shorter term, further work on case management arrangements (including funding mechanisms) will be undertaken to examine ways in which existing case management, care coordination and key worker arrangements can be extended and integrated. This work will focus on how this key component of an integrated service system can work more effectively as an integral part of the broader health care workforce.

5.3.4 Competency-based training

Other short-term work will explore the need and scope for statewide, competency-based approaches, including in the areas of referral practice and protocols (see Section 5.4 Integration tools), working with carers, integrated health promotion, supporting prevention and early intervention initiatives (including work coming out of the Council of Australian Governments (COAG) agenda), and the development of shared care arrangements.

5.3.5 Placement opportunities and development programs

New starters joining the health care workforce will be provided with structured development programs that increase their experience across a range of care settings,

support the development of cross-sector links, and help them to build networks across a number of agencies within their local catchment.

Area-based plans need to identify where such workforce programs are expected to make the greatest impact on identified priorities, and the agencies that will be involved. In rural areas, this can form the basis for shared service arrangements under which scarce staff resources are shared across agencies and settings to maximise efficiency, skills development and recruitment and retention prospects.

The department will also explore opportunities to expand the range of settings for undergraduate placements to increase students' exposure to integrated and/or multidisciplinary models of care delivery.

5.3.6 Academic research

Potential opportunities to develop research and education capacity and excellence in community settings and rural areas will be explored through the further development of concepts such as 'teaching community health services'.

Key actions

- From 2006-07, assess the potential applicability of funded workforce design pilot projects to priority ambulatory care services, and the degree to which these could support a widening of scopes of practice in community settings and rural areas.
- Develop a consistent statewide approach to case management, care coordination and key worker arrangements as part of a broader approach to the management of care for people with chronic and complex conditions, for introduction in 2007.
- Work with Vocational Education and Training (VET) providers to develop competency-based training to target skills development relevant to integrated health care delivery in community-based settings, with the first of these new training courses to commence in 2008.
- Commencing in 2006-07, establish new undergraduate clinical placement and development programs that increase opportunities to gain experience in community-based settings, particularly those with an emphasis on multidisciplinary workforce models.
- In 2006-07, explore options to raise the profile and build the evidence base around community-based modalities of care and improve the capacity to attract and retain high calibre staff, including the feasibility of increasing investment in academic and research activities in priority areas.

The development of joint assessment tools that are integrated and interactive across care sites will support continuum of care, avoid duplication and enhance communication and understanding across sectors. A flexible and open approach to common assessment tools will strengthen the service system and improve quality outcomes for clients.

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5.4 Integration tools

Work on business practice change will be driven at a local level by partnering on integration and the implementation of changes as a result of service and capital planning outcomes. However, there are many areas of practice where there is a high degree of commonality, and where common approaches to managing information can have significant benefits, by reducing duplication and administrative burden and by increasing the efficiency and effectiveness of information sharing.

Consumers are too often required to provide the same information at the various interfaces of the health system, are exposed to repeat assessments, diagnostics and/or other interventions.

The service coordination tool templates (SCTTs) are an initiative to collect and share information in a common form, based on people's initial contact with the service system. Their purpose is to broadly identify people's health care needs and support effective referral of people between agencies. There has been good acceptance of SCTTs and evidence of changed referral practice in some sectors such as community health and HACC. Other sectors, particularly GPs and acute care, have not widely adopted SCTTs for a number of reasons, including:

- the functionality of SCTTs in existing software could be improved
- the culture change, and business practice change required to implement service coordination across organisations is significant, and can be time and resource intensive.

However there are clear benefits in having agreement on:

- the type of information that will be collected and shared for particular purposes
- what this information means (common language and definitions)
- common data standards (a standard way of representing the information to support information exchange between ICT systems).

Service coordination aims to place consumers at the centre of service delivery - ensuring that they have access to the services they need, opportunities for early intervention and health promotion and improved health outcomes. Service coordination is facilitated by PCPs, where agencies come together to agree on how they will coordinate their services so that consumers experience a health system that works together.

Agencies that have successfully implemented service coordination understand that using the tool templates is one part of service coordination, but examining and modifying current practice is equally important. In fact, full implementation of service coordination requires revision of client intake processes, including eligibility and risk assessment criteria, an examination of referral mechanisms, and a systematic approach to the management of waiting lists.

Particularly for people with chronic disease or complex care needs, but also for the episodic care needs of people who are generally well, planning and managing care effectively involves cooperation and the sharing of information between numerous providers across agency boundaries. To support this business need it will be valuable to have agreement about the type of information to be collected and shared, its meaning, and underpinning data standards for 'personal' information; referral information, hospital admission and discharge information; and assessment information.

5.4.1 Personal information

The major benefit of the SCTT for service providers is that it provides a common structure for collecting client information. This, in itself, has significantly increased the effectiveness of referral practices between agencies. A limiter, however, has been that the SCTT has been seen as aged care focused and not adaptable to the needs of other client groups.

The SCTTs are currently being revised to incorporate the needs of different practitioners. This review aims to make the SCTTs suitable for use by agencies that may provide services to a range of client groups. The revision aims to improve the tool templates to support better identification of, and service responses to, the needs of a range of client groups. Making the tools more useful for collecting information from various client groups will mean more agencies can implement them. This will improve coordination of services across a greater diversity of human service providers.

5.4.2 Referral information

To date, e-referral (electronic referral) has been implemented in more than 80 agencies across Victoria. Current e-referral activity has been underpinned by the inclusion of the SCTTs in 30 client management software applications. The next step is the development of business rules to guide the implementation of messaging standards for the tools, which will enable health services to use electronic messaging to exchange information without having to re-enter client data.

GPs, as primary care providers, can significantly influence referral patterns. It is therefore essential that their needs are incorporated.

5.4.3 Hospital admission and discharge information

Many hospitals have invested in the development of processes that streamline admission and discharge information. However, to date there are no minimum information and communication standards or uniform or compatible ICT across the sector, particularly at the hospital/GP interface. The development of statewide practices, processes, protocols and systems (PPPS) for service coordination, and the introduction nationally of event summary templates for discharge and referral, will begin to address this issue.

As the system strives towards 'continuity of care' the process of discharge should become obsolete. The effective interface of services and the smooth transition of people between services are essential to achieve person-centred care.

5.4.4 Outpatients

One of the key areas of action will be to improve the efficient and systemic functioning of the significant resource represented by outpatient clinics in hospitals.

In part this is an issue of the workforce arrangements in outpatients, including a lack of clarity about the role and practices of specialist clinicians and the lack of consistent work practices and protocols relating to referrals, transfer of duty of care, and shared care or care planning arrangements with other providers, including GPs. An important area to target as part of broader work on policy settings for outpatient services will be the level of integration between outpatient clinics and GPs and other health care providers.

5.4.5 Assessment information

The process of assessment can significantly influence an individual's health and social outcomes. Standardised clinical protocols and data collection can enhance clinical care and improve the quality, efficiency, effectiveness and equity of care.

The Department of Human Services recognises the need for a range of common tools suitable for assessment at different levels of breadth and intensity. Work with the Commonwealth and other states and territories is developing a national standard data specification for assessment for entry to basic care services at a low level of intensity. States and territories will be able to build on this specification so that it aligns with their specific service systems. The Department of Human Services is also considering testing the use of a comprehensive assessment tool (such as the InterRAI suite of tools) that could be used statewide, with an initial focus on aged and disability services. The critical issue with moving towards standardisation in this area is that it is supported by electronic client management systems that can easily collect, store and transmit relevant information between service providers. Standardisation in both of these areas will be accompanied by agreed protocols to support the sharing of information.

Key actions

- By mid-2006, complete the first cycle of review of SCTTs to accommodate the needs of health service providers.
- By mid-2006, begin trialling a statewide comprehensive assessment tool (such as the InterRAI suite of tools) and protocols to support sharing of assessment information (as part of the revised SCTTs).
- By mid-2006, complete the development of a statewide PPPS for service coordination that will provide a single, consistent approach to coordinating people's health care and sharing health information, including across the interface between hospital and community-based health care services.
- By December 2006, develop agreed interagency business practice and statewide information standards to support the rollout of e-referral to all health service providers.
- As part of broader work on outpatient departments, partner with health services to develop a consistent statewide approach to business practice change focusing on capacity to integrate effectively with other parts of the health care system. This work to be completed by end 2006, allowing for phased introduction of new approaches from 2007-08.
- By mid-2006, implement an assessment framework for basic community care, including defining the roles of assessment agencies and their relationships with other agencies.
- By January 2007, implement a common structure for collecting assessment information at the point that people first seek community care.
- By 2008, implement a change process that removes 'discharge' and achieves transition to a person-centred approach in the way people move through the system.

5.5 Information and communications technology

By bringing flexibility in information management, ICT will allow new approaches to community-based care delivery to be achieved.

Integrated, ubiquitous information management systems are a vital component in achieving the business change goals of delivering care in community-based settings. This is because a key cause of discontinuity of care is lack of current or complete information about people's recent care history.

The Department of Human Services has a role to play in driving statewide approaches to ICT capacities that support the business requirements of integrated community-based care services. In some cases (the development of electronic health records, for example) this role is carried out through participation in national agendas, in particular the work being carried out through the National Electronic Health Transition Authority. This means that progress is often dependent on a number of factors, not always within the department's direct control. Table 1 sets out the ways that ICT capacities can support the business requirements of community-based health care, indicates what the department is currently doing, and sets out the challenges that remain.

5.5.1 Health Assist Line

The HAL, due to commence operation in 2006, will play an important role in supporting an integrated service system. By providing health advice and information about services to callers, it will improve community knowledge and understanding of the health care system. By providing triage and referral it will support more appropriate use of health care services, including directing people to appropriate community-based services.

As *Care in your community* continues to develop, the HAL can continue to support changing needs. In the area of chronic disease and complex care management, the service can provide a first point of contact for people with chronic conditions and complex needs and provide them with additional support through outbound recall and reminder calls.

The HAL will receive call traffic formerly going to hospital EDs. Many of these and other calls received by HAL will relate to primary care matters. Within a systems approach to episodic and urgent primary care, the HAL will triage callers to community-based health care services as appropriate, supporting diversion away from EDs and substitution of more appropriate care options.

5.5.2 Event summaries/electronic health records

The development of event summaries and, ultimately, full electronic health record architecture will mean that all health care services can have access (with consent) to the information they need to deliver coordinated care to people with chronic conditions and complex care needs. For an enrolled population, this access could be extended to the HAL service, allowing this service to be a first port of call for condition management. Summary records can be stored centrally and kept up-to-date with summaries of recent events in a person's care. Victoria is continuing to work with other jurisdictions on the development of a national electronic health record architecture. The implementation of HealthSMART applications through a shared services model will support authorised access to patient information across the public health sector.

5.5.3 Electronic referral

A statewide electronic referral architecture will be developed in alignment with national directions, allowing referrals to and from all types of services in all locations in Victoria. In the longer term, electronic referrals can be linked to scheduling and waiting list management systems and to detailed client records and event summary information to provide an integrated picture of the range of options available to people needing care.

Key actions

- Implement the Health Assist Line in 2006.
- Continue development work on the Human Services Directory and related information sources with the short-term goal of supporting the immediate requirements of the Health Assist Line in 2006 and, in the medium term, to support alignment with the development, at the national level, of a Health Provider Identifier to be rolled out in 2008.
- Commencing 2006-07, develop and implement a statewide electronic referral architecture, in line with national developments.

Table 1: Information management and information and communications technology directions

Business requirement	IM/ICT direction	Department of Human Services support	Challenge
Minimise duplication of data collection and burden of reporting	Shared electronic client records can be used across an organisation to minimise duplication of data collection and make the best use of available resources. Reports for performance monitoring can be derived from data collected for the primary purpose of supporting the delivery of care.	<p>Implementation of the Service Coordination Tool Templates and electronic referral has provided a foundation for sharing client information electronically.</p> <p>Future implementation of the Common Client Data Set will result in 'once only' collection of client demographic data for HACC, alcohol and other drugs services, ACAS and community and women's health.</p> <p>Future implementation of HealthSMART applications with statewide Shared ICT Services will provide a standards-based architecture for sharing electronic client health information.</p>	<p>Expand the implementation of the Common Client Data Set to a range of department program areas, including acute programs.</p> <p>Data provided to the department for reporting purposes is a by-product of data collected for the purpose of provision of client care.</p>
Support training and workforce requirements of service providers	<p>Technology can better support training and workforce requirements by linking services and clinicians to information or supporting system-wide approaches to training.</p> <p>Online training programs can be developed to facilitate individual self-paced training.</p>	<p>Providing access to up-to-date evidence-based guidelines through the Clinicians Health Channel.</p> <p>Connectivity to videoconferencing through the regional connectivity networks.</p> <p>The department has funded the development of a computer-based self-paced training resource to support agency training in service coordination and use of SCTTs.</p>	Training clinicians to effectively use online knowledge bases and videoconferencing.
Implement flexible and integrated models of care with services provided across a number of locations	<p>Use of mobile computing technology and wireless connectivity can support expanded mobile and outreach models of care and a flexible workforce that works across a number of physical locations.</p> <p>Currently RDNS uses mobile technology as part of day-to-day practice.</p>	<p>Implementation of broadband connectivity through regional ICT networks. Regional networks can support improved electronic referral arrangements, networked telephony services and videoconferencing for provision of services to remote sites.</p> <p>In 2004-05, the HACC program funded innovative use of mobile technology for assessment.</p>	Improved trust between service providers to provide streamlined access to services, coordinated care arrangements and sharing of client health and care information.
Greater focus on preventative health care	Electronic recall and reminder systems can be used to support early intervention strategies.	HealthSMART Patient & Client Management System (P&CMS) applications will include functionality for electronic recall and reminder systems.	Agency staff skilled to proactively use recall/reminder systems. Agency having the service capacity to respond to client need in a proactive manner.
Improve coordinated care for people with chronic and complex conditions	Electronic client records and electronic referral systems support timely and accurate referral processes. Electronic clinical support systems, including decision support systems, provide up-to-date evidence-based information to clinicians. Online applications can be used to support self-management.	HealthSMART P&CMS project includes support of all functions associated with the administration and management of patients and clients.	Coordinate care with private providers such as GPs and specialists. This means GPs having the capacity to participate in electronic referral, etc.
Improve waiting list management and booking of appointments	Waiting list management/electronic scheduling systems can provide waiting time information to allow people to choose where they prefer to wait or to receive a service on a 'first available' basis.	<p>The panel of P&CMS software applications includes waiting list management and appointment booking functionality at an agency level.</p> <p>The 'Your Hospitals' website provides 'time to treatment' information in relation to elective surgery and public dental services.</p>	Centralised waiting list management/electronic scheduling information that provides a single source for all community-based health services.

Table 1: Information management and information and communications technology directions (cont)

Business requirement	IM/ICT direction	Department of Human Services support	Challenge
Improve sharing of health and care information with consent	Universal electronic referral capability that allows secure referrals to and from all types of services in all locations in Victoria. Referrals can use information from scheduling and waiting list management systems and link to detailed client records and event summary information.	<p>As part of Primary Care Partnerships service coordination initiatives, the department has funded a range of e-referral projects. These projects have delivered secure e-referral using the statewide SCTTs. The agreed referral practice between PCP member agencies provides a platform for the introduction of electronic referral more broadly.</p> <p>Electronic messaging standards (using national HL7 standards) for the SCTTs have been developed. Further work is being undertaken to develop business rules for the use of these standards. Implementation of the HL7 standards in agency client management software applications will allow the exchange of SCTT data between client management software applications without the need to re-enter data.</p> <p>HealthSMART will provide an enterprise application integration (EAI) layer as part of the services to be made available through the Statewide Shared Services. To access the HealthSMART applications, agencies will connect to Statewide Shared Services via the Wide Area Network (WAN) links established in each region. The EAI layer will provide integration between HealthSMART software applications and other relevant agency legacy software applications. This allows for the sharing of patient, clinical and financial information between different systems, and ensures that information is kept current, accuracy is improved and data redundancy is reduced.</p>	<p>Including GPs in electronic processes for securely sharing client health and care information.</p> <p>Existing agency client management software applications need to move to HL7 compliance.</p> <p>Resources and effort need to be dedicated to change management as part of the introduction of new information systems.</p>
Improve communication between service providers	There are opportunities to build on the capacity provided by the rollout of broadband health ICT infrastructure; e.g. live video links, remote monitoring (including in the home) and remote diagnostics that support consultation and monitoring without consumers having to travel long distances or leave their home.	Broadband connectivity to prioritised state-funded health service providers is being implemented on a region-by-region basis. Local solutions have been developed in each region to meet short to medium term agency communication requirements. Some regions have already implemented video links and network telephony.	Including GPs as part of the regional electronic communication developments.
Provide decision support using up-to-date evidence-based information	System-wide evidence-based clinical systems, including decision support systems, could be implemented to support the delivery of quality and safe health care.	<p>The Clinicians Health Channel is a clinical information access portal. It is part of the Victorian Government Health Information Website and is made available by the Department of Human Services for the benefit of clinicians working in the Victorian public health sector. Since March 2000, the Clinicians Health Channel has provided access to the following resources, free of subscription costs:</p> <ul style="list-style-type: none"> • citation databases • detailed drug and prescribing information • clinical practice guidelines and a range of other information resources. <p>HealthSMART P&CMS applications will include functionality for electronic recall and reminder systems.</p>	Accessing and using decision support systems as part of a clinician's day-to-day practice.

Table 1: Information management and information and communications technology directions (cont)

Business requirement	IM/ICT direction	Department of Human Services support	Challenge
Improve client safety in the delivery of care	Shared electronic client records, decision support systems and searchable knowledge bases can be used by service providers to access up-to-date information about clients.	HealthSMART will provide information systems that actively support health care providers to: <ul style="list-style-type: none"> • increase the quality and safety of public health care and improve health outcomes • develop more consumer-oriented health care systems • increase the efficiency of health care provision • improve the management and use of resources within the public health care system • attract, retain and support a highly skilled workforce through the strategic application of ICT. 	Support for agencies in changing business processes. Training for practitioners to effectively use a range of electronic systems to support client care.
Support consumers navigate the service system	Consumers and service providers can be provided with up-to-date information about the range of services available to best meet identified client needs.	The Human Services Directory, sponsored by the Department of Human Services, provides an online resource for service providers and consumers to access detailed information about health, community and disability services. Consumers can access up-to-date, quality assured and reliable information through the Better Health Channel. The Better Health Channel includes a consumer friendly service directory based on the HSD database. The department has funded several PCPs to develop and implement e-referral systems. The e-referral systems are used by service providers to search for the most appropriate service to meet identified client needs and to support secure sharing of the SCTTs between agencies. Through the Department of Human Services, the Victorian Government is establishing a statewide health call centre telephone service that will provide 24 hour, 7 day a week access for Victorians to health information, advice and referral to health services. The service will be known as Health Assist Line.	Practitioners using the electronic service directories as day-to-day business tools. Implementing consistent practice between agencies in relation to service coordination, including referral processes.
Improve care planning	Shared electronic health records can be used as part of multidisciplinary care planning arrangements.	The SCTT implemented in agency software applications includes a Service Coordination Plan. The Service Coordination Plan can be completed for consumers with both multi-agency involvement and complex needs. This information can be shared, with consumer consent, using secure email. The SCTT will be fully implemented in the Health SMART P&CMS.	Involving GPs in multidisciplinary care planning arrangements.

5.6 Partnerships

The integrated service system is a complex mix of organisations, services, professional disciplines, and funding and governance arrangements. Even within the health sector, there is no one organisation that delivers the full range of services and interventions needed to support the needs of people with chronic illness or complex conditions. This is the case even for otherwise healthy people who need occasional access to health services. When the additional organisations and services needed to meet the psycho-social needs of individuals are taken into account, there is no way that a person-centred approach can be achieved without strong partnerships between organisations.

As noted in the area-based planning section, there are two core areas of partnership work needed to implement *Care in your community*: partnering around **integration** and partnering around **community-based service configuration planning**.

Partnering around **integration** is needed to deliver a person-centred approach to care on the ground. At the coordination level, this work will focus on the implementation of standardised approaches to hospital admission and discharge, the implementation of standardised referral practice, coordinated intake arrangements for community-based services, and the development of local protocols based on client/patient journey through the service system (including entry and exit arrangements for chronic and complex care programs). At the collaboration level, partnering will need to focus on resource sharing arrangements to support person-centred care (including sharing of staff, physical facilities and equipment and packaged funding of care delivery) and the development of team-based approaches to care.

Partnering in this area is already well developed in parts of the Victorian health care system through the PCP Strategy and HARP CDM. Partnering on integration for the implementation of *Care in your community* will need to build on both of these initiatives, increasing the reach of collaborative partnerships, both in terms of stakeholder commitment and impact on care delivery.

Workforce changes will also need to be managed through a collaborative partnership approach. As new roles appear in the workforce, and existing roles change or expand, practitioners involved in the delivery of health care across agencies and across disciplines need to be aware of the changes to ensure that their assessment and referral decisions are appropriate.

Partnering on **community-based service configuration planning** needs to focus on increasing the capacity of people to access services in community-based settings, increasing the number and type of services available in community settings, and increasing the number of people whose care is managed in the community. As noted in the section on area-based planning, partnering should be based on collaboration around the identification of service and facilities development priorities for each area. While the principal planning partners will be department-funded agencies, a range of other stakeholders (including GPs and other private providers) will also need to be involved. Local government has a key role to play in land use planning.

Primary Care Partnerships have tackled some of the inhibitors of better integration of ambulatory care services. While acute health services are members of PCPs, the lack of a clear mandate from the Acute Branch [sic] of DHS has inhibited extension of beneficial service integration work across the primary care sector to full implementation across the whole service system.

Melbourne Health

Co-location of services through capital planning does not ensure integration of services and seamless care for consumers. Recognition is required of the need for a higher level of sophistication with regards to partnering within the health sector. Partnering takes time and resources to develop. It requires "hard" skills such as planning and "soft" skills such as the ability to be able to sit with uncertainty and manage conflict. Examples of partnership development in the private sector show that partnering is developed over years, with a thorough exploration by potential partnering organisations of what it means for themselves and their clients before entering the partnership.

City of Whittlesea

