

# Better Connections-Better Care



Supporting improved inter-agency care planning

Barwon South West Region

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Primary Health Integration

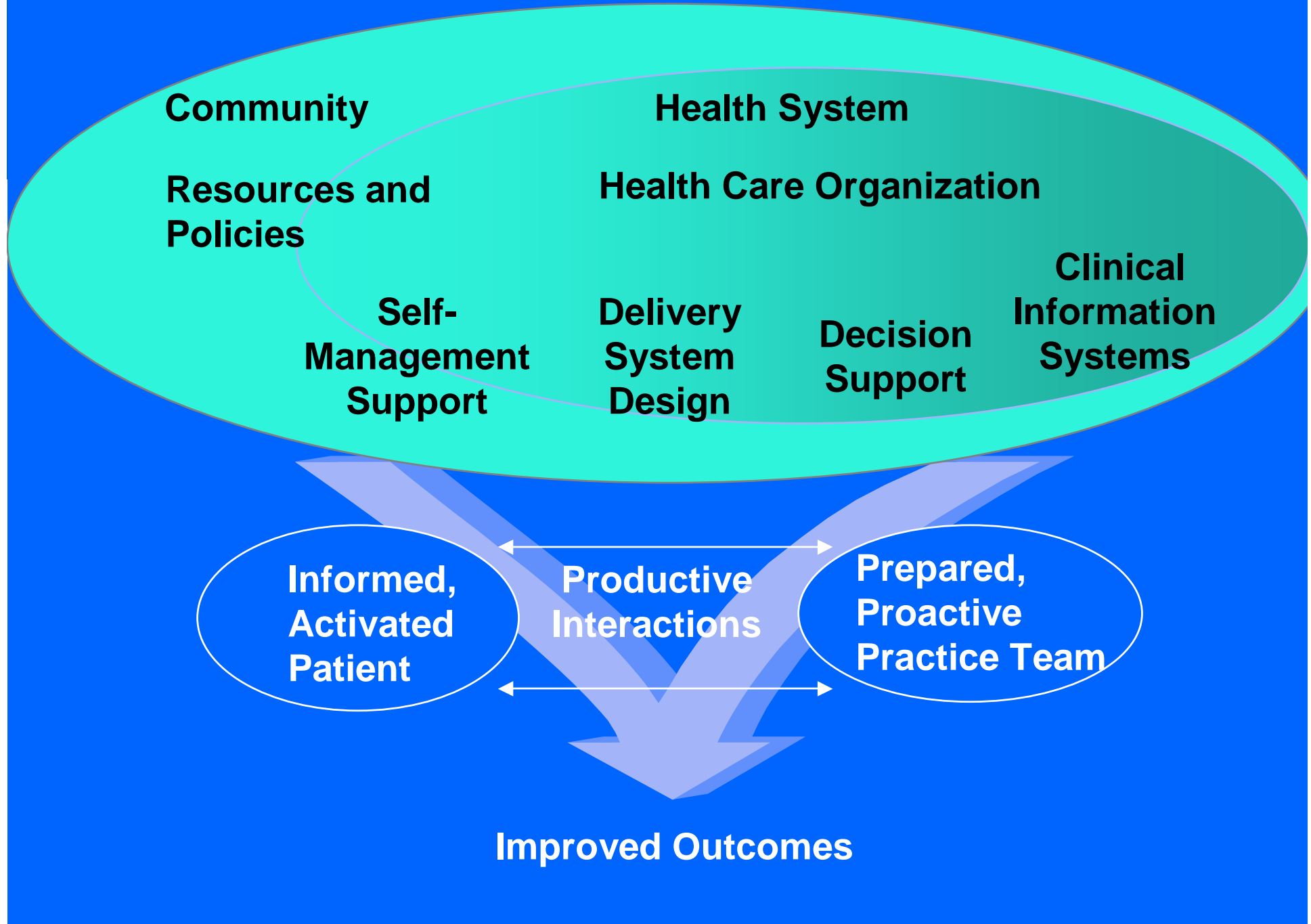
# Inter-agency care planning

## What is it?

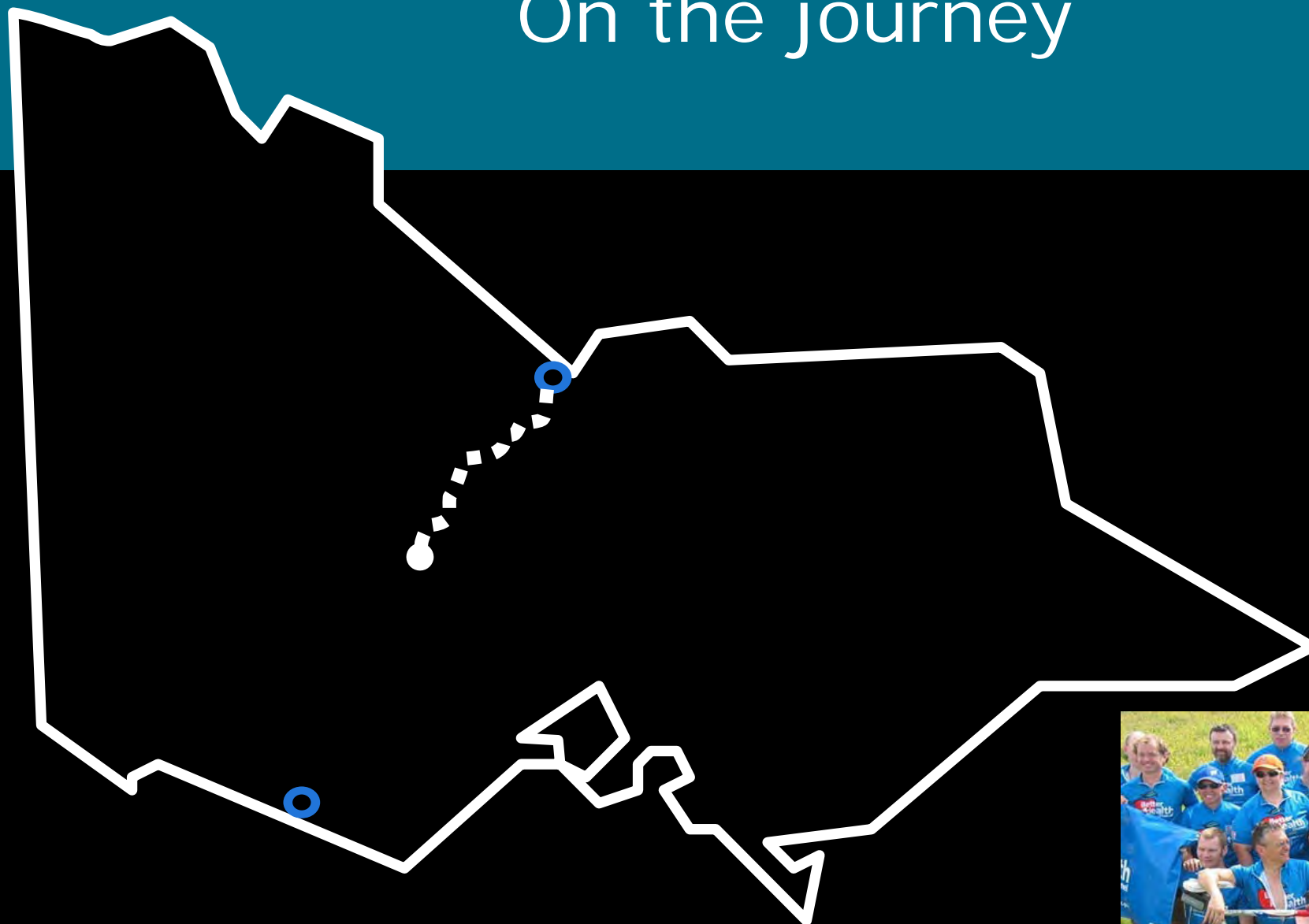
- Consumer has complex or multiple needs
- More than one agency
- Needs of consumer
- Carer, practitioners and GP
- Options worked through to an agreed strategy

*Victorian Service Coordination Practice Manual 2007, p22*

# Chronic Care Model



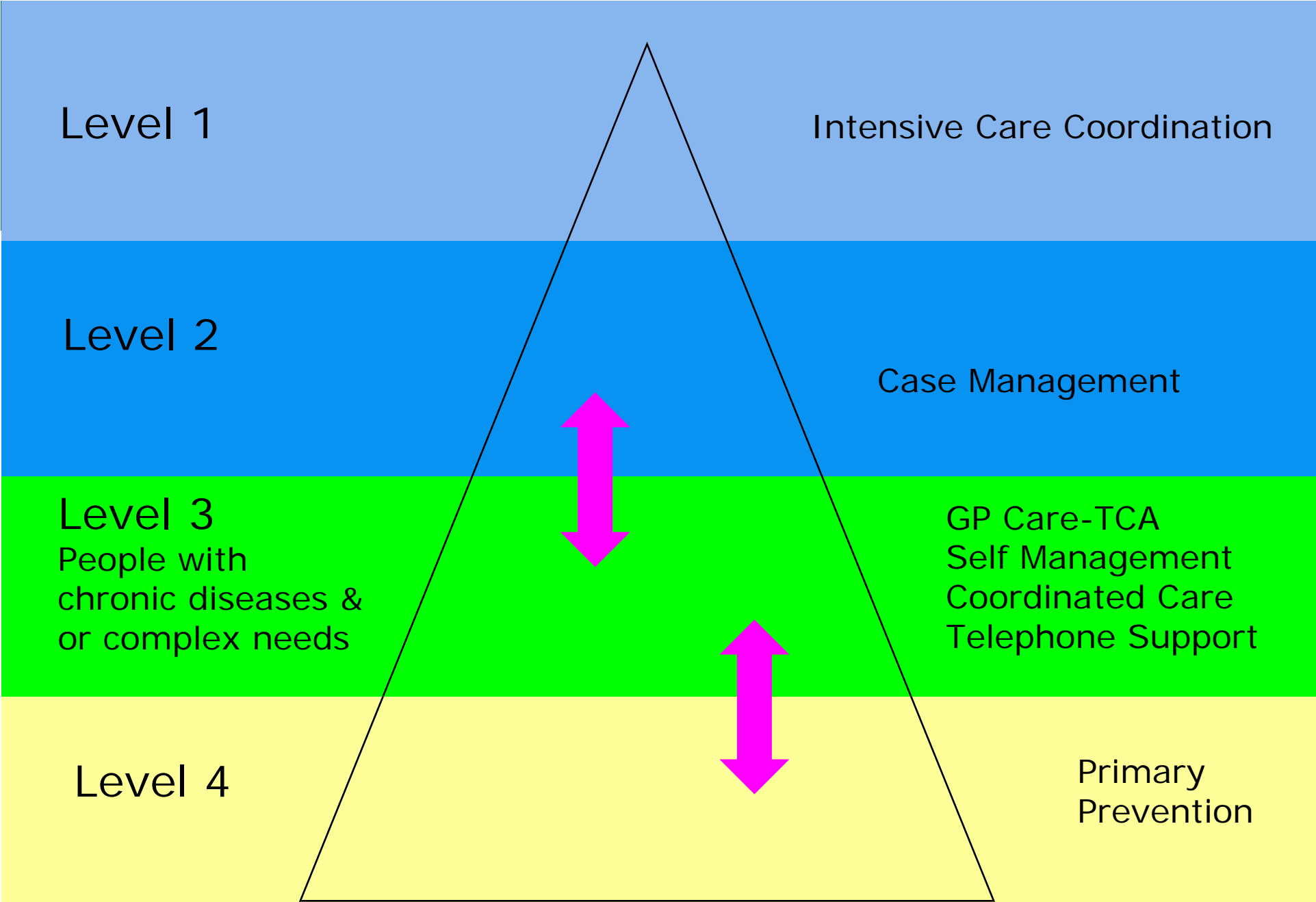
# On the journey



# Why?

- Growing demand
- Together we do better
- Better health outcomes
- Improved quality of care
- Efficient use of limited resources





Levels of chronic and complex care management

# The Vision



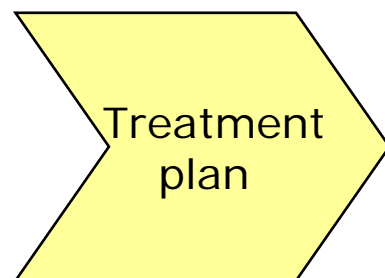
Consumers are supported to achieve their goals

Everyone with chronic and complex care needs has a care plan

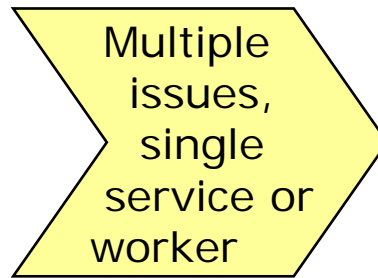
# Processes & practices required

- Agreed protocols
- Trust between agencies
- Feedback & communication
- “Key worker” with appropriate skills
- Business practices and systems
- Support the consumers

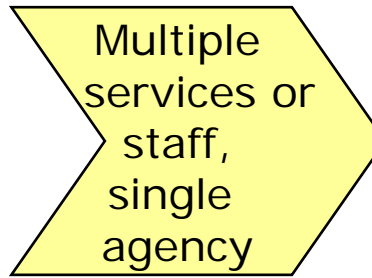
# Building on assessment and goals



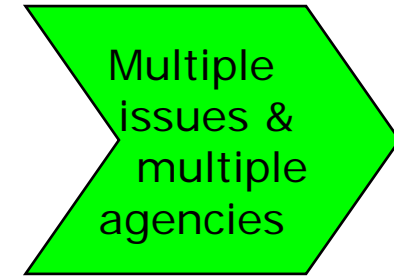
Service specific care plan



Intra-agency



Inter-agency care plan

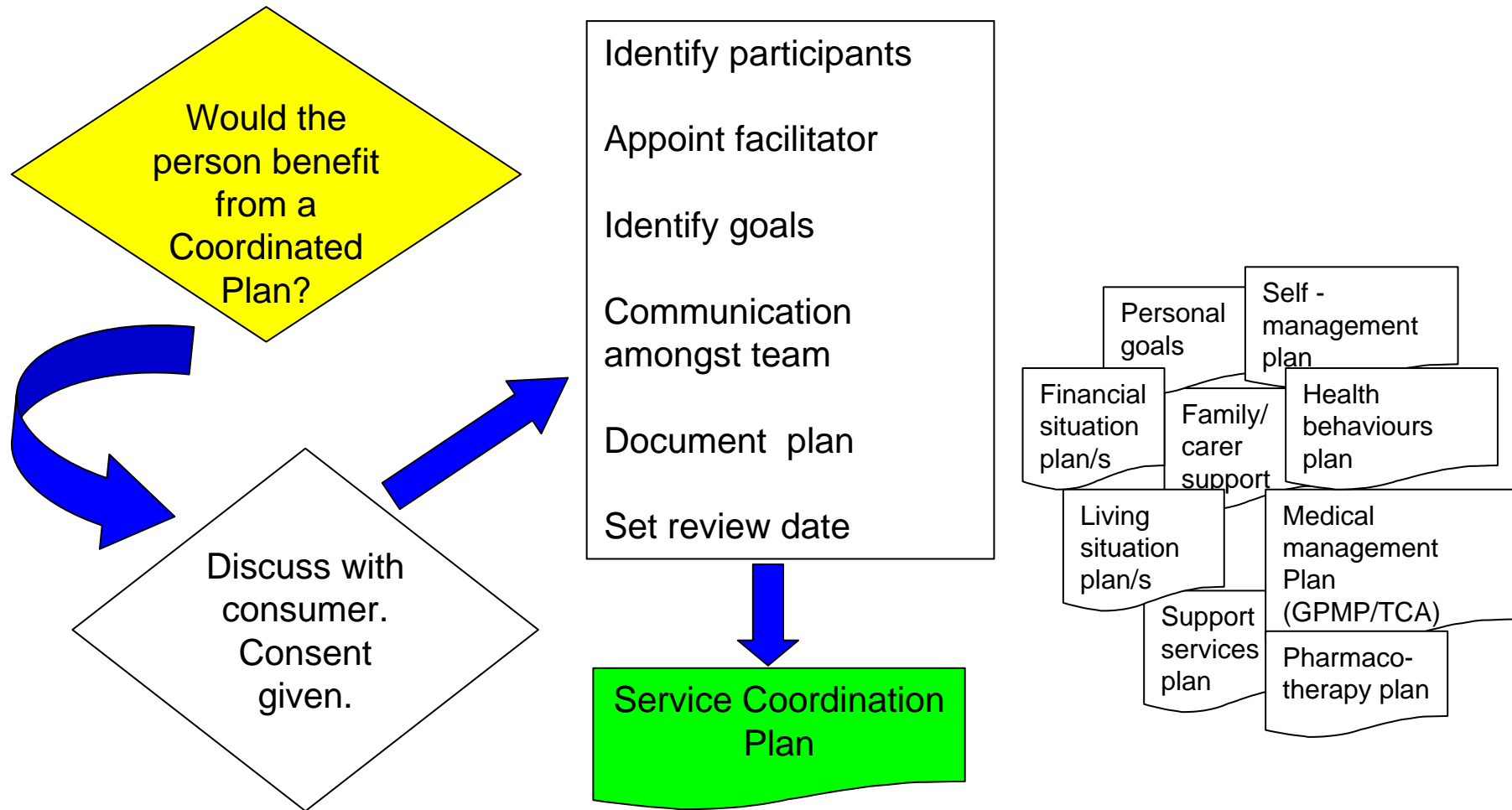


# Inter-agency Care Planning

Outcome – one plan or linked plans

- Engagement and empowerment of the consumer
- Social, emotional and health needs
- Synthesis of multiple goals
- Based on assessment
- Coordinated scheduling of services
- Documentation, monitoring and communication

# Process for inter-agency care planning



# Principles of Self-Management

Knowledge  
Involvement  
Care Plan  
Monitor & Review  
Impact  
Lifestyle



Connected support team

# How is it going?



The direction  
The supports  
The relationships

The systems  
The tools  
The people

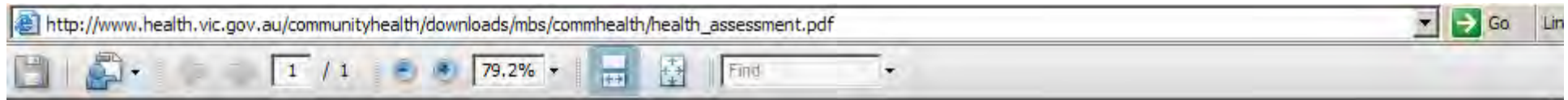


# MBS Project

- Focus on CDM prevention and management MBS item numbers
- Phase 1 (**published**) – Resources to enhance understanding of new MBS item numbers
- Phase 2 (**coming**) – Examples of service models, & business case for change in CH to assist change management



# MBS Project



## Health assessments Summary of MBS item numbers

Service type	Older age health assessment		Aboriginal and Torres Strait Islander (ATSI) health check				Refugee and Other Humanitarian Entrants (R&OHE) Health Check		Health Assessment for People with an Intellectual Disability		Medical assessment for residents of an aged care facility
Client eligibility	For clients aged 75 years or over, living in the community		Client is an Aboriginal or Torres Strait Islander aged 0-14 inclusive	Client is an Aboriginal or Torres Strait Islander aged 15-54 inclusive	Client is an Aboriginal or Torres Strait Islander aged 55 years or over		Client is a refugee or other humanitarian entrant who has arrived in Australia in the last 12 months		Client is a person with an intellectual disability <sup>1</sup>		For clients who are permanent residents of a Commonwealth-funded Residential Aged Care Facility
Relevant MBS Item Number	Health assessment provided in a consulting room (also known as 75+ health assessment) #700	Health assessment provided outside consulting rooms, hospitals and residential aged care facilities #702	ATSI child health check #708	ATSI adult health check #710	ATSI older person's health check provided in a consulting room #704	ATSI older person's health check provided outside consulting rooms, hospitals and residential aged care facilities #706	Refugee and other humanitarian entrants health check provided in a consulting room #714	Refugee and other humanitarian entrants health check provided outside consulting rooms, hospitals and residential aged care facilities #716	Annual health assessment for a person with an intellectual disability, provided in a consulting room #718	Annual health assessment for a person with an intellectual disability, provided outside consulting room, hospitals and residential aged care facilities #719	Comprehensive medical assessment <sup>3</sup> (also known as CMA) #712

## Health assessments

### Summary of explanatory notes and web links

	Older Age Health Assessments #700, #702	Aboriginal and Torres Strait Islander (ASTI) Health Checks #704, #706, #708, #710	Refugee and Other Humanitarian Entrants (R&OHE) Health Check #714, #716	Health Assessment for People with an Intellectual Disability #718, #719	Comprehensive Medical Assessment (CMA) #712
Steps that must be taken to claim the Medicare item	<ul style="list-style-type: none"> <li>Medical component, including blood pressure, medications, immunisation</li> <li>Physical component, including activities of daily living and mobility</li> <li>Psychological component, including cognition and mood</li> <li>Social component, including adequacy of social support, carers and formal help arrangements</li> </ul>	<ul style="list-style-type: none"> <li>Taking the client's medical history</li> <li>Physical examination</li> <li>Undertaking or arranging any required investigations</li> <li>Assessing the client, using the information gained from medical history, physical examination and investigations</li> <li>Making or arranging necessary interventions and referrals</li> <li>Documenting a simple strategy for the good health of the client</li> </ul>	<ul style="list-style-type: none"> <li>Taking the client's medical history</li> <li>Physical examination;</li> <li>Undertaking or arranging any required investigations</li> <li>Assessing the client, using the information gained from medical history, physical examination and investigations</li> <li>Making or arranging any necessary interventions and referrals</li> <li>Developing a plan</li> </ul>	<ul style="list-style-type: none"> <li>Medical component, including blood pressure, medications, immunisation</li> <li>Physical component, including activities of daily living, exercise opportunities, reviewing growth and development, sexual activity, nutritional status</li> <li>Preventive component including cancer screening, checking risk factors for osteoporosis, thyroid disease, dysphagia, gastro-oesophageal disease</li> <li>Psychological component, including cognition and mood</li> <li>Social component, including social support, carers and help arrangements</li> <li>Dental component</li> </ul>	<ul style="list-style-type: none"> <li>Taking a detailed relevant medical history and conducting comprehensive medical examination</li> <li>Developing a list of diagnoses or problems based on history and examination</li> <li>Providing a written summary of the outcomes of the CMA for the resident's records to inform the provision of care for the resident by the residential aged care facility (RACF) and reviewing pharmacist</li> </ul>
Medicare rules relating to frequency of service	Once per client for any 12-month period	#704/706 every 12 months, #708 every 9 months, #710 every 18 months	Benefits are available on one occasion only	Once per client for any 12-month period	Once per client for any 12-month period
Role of the GP	<ul style="list-style-type: none"> <li>Determining client eligibility, gaining consent and initiating service, if appropriate</li> <li>Central coordinating role, including at least one client consultation</li> <li>Medical components that cannot be delegated</li> </ul>	<ul style="list-style-type: none"> <li>Determining client eligibility and initiating the service, if appropriate</li> <li>Central coordinating role, including at least one client consultation</li> <li>Medical components that cannot be delegated</li> </ul>	<ul style="list-style-type: none"> <li>Determining client eligibility and initiating the service, if appropriate</li> <li>Central coordinating role, including at least one client consultation</li> <li>Medical components that cannot be delegated</li> </ul>	<ul style="list-style-type: none"> <li>Determining client eligibility and initiating the service, if appropriate</li> <li>Central coordinating role, including at least one client consultation</li> <li>Medical components that cannot be delegated</li> </ul>	<ul style="list-style-type: none"> <li>To provide all services. The GP may be assisted by a practice nurse</li> <li>The client's usual GP may delegate the provision of a CMA to a medical locum, who would provide a written summary of CMA outcomes</li> </ul>
Roles that can be performed by practice nurses (PNs) or Aboriginal health workers (AHWs) on behalf of and under the supervision of the GP	<ul style="list-style-type: none"> <li>Explaining the item and any fees</li> <li>Information collection, including taking or reviewing medical history</li> <li>Investigations for which the PN/AHW is qualified</li> </ul>	<ul style="list-style-type: none"> <li>Explaining components of the item and any fees to the client, and obtaining client consent</li> <li>Information collection, including taking or reviewing medical history</li> <li>Investigations and interventions for which the PN/AHW is qualified</li> </ul>	<ul style="list-style-type: none"> <li>Explaining components of the item and any fees, obtaining client consent</li> <li>Information collection, including taking or reviewing medical history</li> <li>Investigations and interventions for which the PN/AHW is qualified</li> </ul>	<ul style="list-style-type: none"> <li>Explaining components of the item and any fees to the client, and obtaining client consent</li> <li>Information collection, including taking or reviewing medical history</li> <li>Investigations and interventions for which the PN/AHW is qualified</li> </ul>	Practice nurses can assist the GP in obtaining information relevant to the CMA for the GP's consideration, in taking the resident's history and in the examination, but cannot replace the GP's involvement in any components of the CMA
Main information	Older Age Health Assessments: <a href="http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-epc-bfthasmmnt.htm">www.health.gov.au/internet/wcms/publishing.nsf/Content/health-epc-bfthasmmnt.htm</a>				

# Care Planning Progress- Barwon South West

- Use of TCM-Client management system
- Between Barwon Health and Pathway
- S2S referral as a platform
- Chronic Disease management collaboration and relationship building
- Self management training

# Care Planning Progress- Barwon South West

- CGG and Diversitat-good inter agency care planning due to relationship building
- Corangamite Shire/Wannon PAC/Timboon Health-good practice
- Greater Geelong-care planning meetings
- GP's increasing use of TCA's & other MBS items

# Care Planning Progress- Barwon South West

- Developing plans for people with disabilities-Disability Home First-IPP
- Wisconsin-Donna McDowell
- Bellarine Community Health
- Bapcare case managers
- Child First
- ACAS Assessment officers
- HARP Care coordinators

# Successful strategies for health outcomes

- Relationships between service providers
- Arrangements for coordinating service provision
- Use of systems to support coordination

# Successful strategies for client satisfaction

- Relationships between service providers
- Support for clinicians/workers
- Communication between service providers
- Support for consumers/patients

# Strengthening relationships between service providers

- Strengthening the link between patient and primary health care providers, particularly for those with complex care needs
- Developing stronger networks of service providers

# Strengthening relationships between service providers

- Strengthening general practice multidisciplinary teams including the role of practice nurses in chronic disease management
- Co-locating general practice and other services
- Investing in systems to support co-ordination of care between co-located systems

# Supporting coordination of service provision

- Developing service networks and arrangements for improved access to allied health and other community based services for early intervention

# Systems to support coordination of care

- Develop systems for communicating or sharing information between primary health care and other service providers
- Create structures, particularly at a regional level, which are able to develop systems to support coordination of care

# Systems to support coordination of care

- Further developing tools (e.g. common assessments, care plans, decision supports) that can be used by a range of providers across both national and state funded services and integrated in the care provided by different services.

# Service Coordination Plan

A tool for inter-agency care planning built into software applications which forms part of the SCTT and is available for use by all.

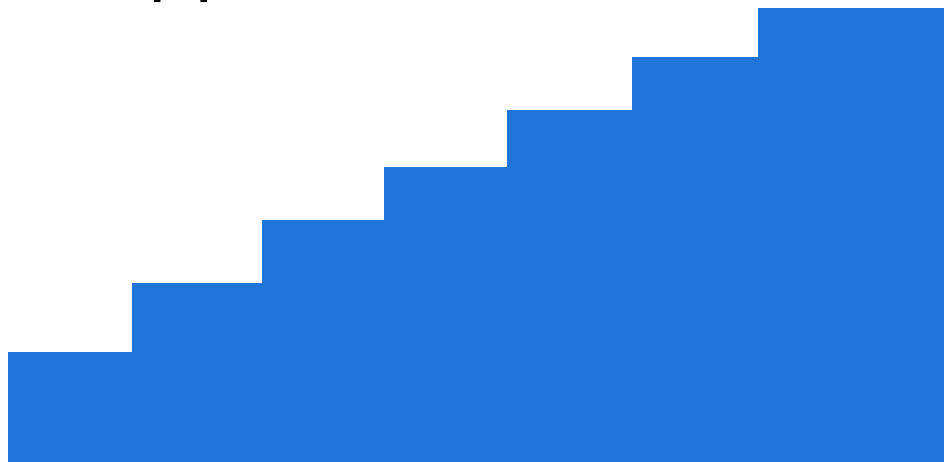
## **Time for revision**

- Care planning advisory group
- Consultations
- Via the internet

[https://www.health.vic.gov.au/pcps/coordination/sctt\\_survey.htm](https://www.health.vic.gov.au/pcps/coordination/sctt_survey.htm)

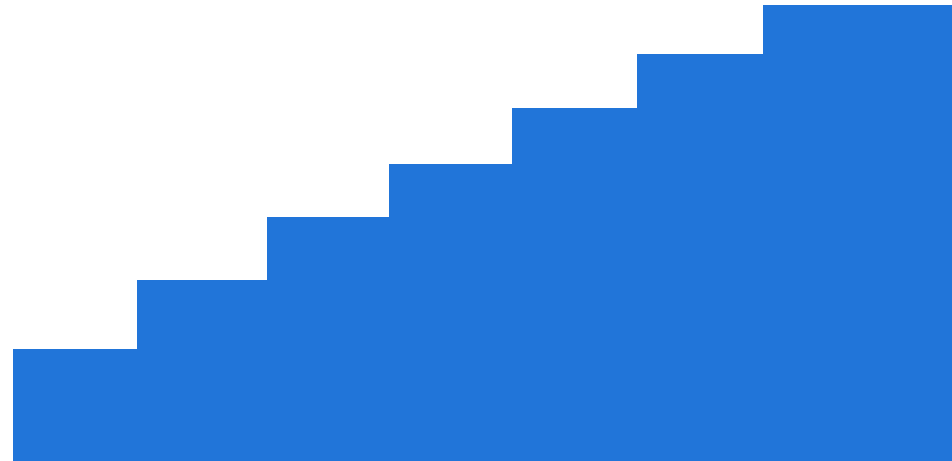
# Seven steps to effective inter-agency care planning...

- Relationships between service providers
- Systems to support coordinated care planning
- Tools to support coordinated care planning
- Support for consumers/clients and carers
- Support for workers



# Seven steps to effective inter-agency care planning...

- Discuss questions together in groups
- Share your knowledge
- Record the results
- Present results



# Next steps for Barwon South West-build relationships

- More forums (see recommended topics)
- Develop more collaboration between GP's and other services both health and welfare/support
- Develop better communication and sharing of client information between acute and community

# Next steps for Barwon South West-tools and systems

- Lobby for Fed/State lead in e-connectivity
- Common service directory, easy access, regional, up to date, with eligibility criteria listed
- Hand held records in absence of IT eg like maternal & child health booklet

# Next steps for Barwon South West-tools and systems

- SCTT interface/transferrable between IT systems
- Improve integration of IT systems
- Consistency in software
- Use consistent format/content of care planning tools

# Next steps for Barwon South West-processes

- Mandated SCTT or commitment from agencies to use it
- Implement simplified reporting systems
- Establish consistent, agreed processes to share care plans across multiple agencies and sectors, including GP's/acute/disability/welfare services

## Next steps for Barwon South West-support for staff

- Cross agency-education/training
- Build on PJB/S2S-train more staff, use leaders & champions to encourage others
- Regional e-newsletter to share inter-agency care planning and other work/SC practice
- Funding –key workers, provide capacity

# Next steps for Barwon South West-support for staff

- Provide training and support to practice nurses in PJB, S2S, MBS, agency/service information
- Training for all in SC, building relationships, use of tools and IT systems

# Next steps for Barwon South West-support for consumers

- Establish shared consumer/client training and education (self management, HP)
- Build on Client Centred care model

# Better Connections Better Care



Thankyou for participating-Lets keep working together  
Care Planning website

[http://www.health.vic.gov.au/pcps/coordination/care\\_planning.htm](http://www.health.vic.gov.au/pcps/coordination/care_planning.htm)