Better Connections-Better Care

Supporting improved inter-agency care planning

Grampians Region

Linda Pandita
Care Planning Project Manager
Primary Health Integration

Department of Human Services

Victoria
The Place To Be

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

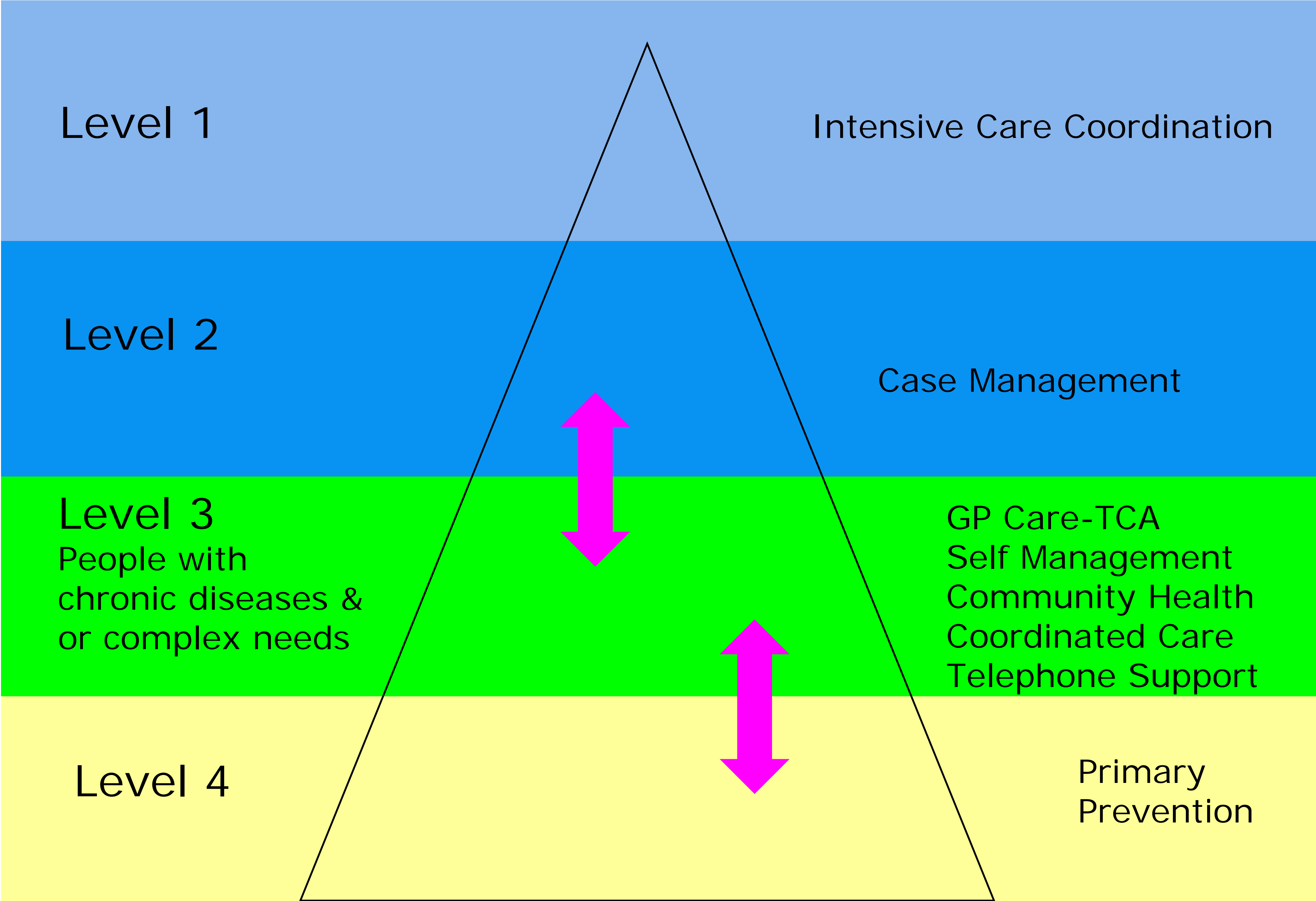
Victorian Service Coordination Practice Manual 2007, p22

Chronic Care Model
Community
Health System
Resources and Policies
Health Care Organization
Self-Management Support
Delivery System Design
Decision Support
Clinical Information Systems
Informed, Activated Patient
Productive Interactions
Prepared, Proactive Practice Team
Improved Outcomes

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

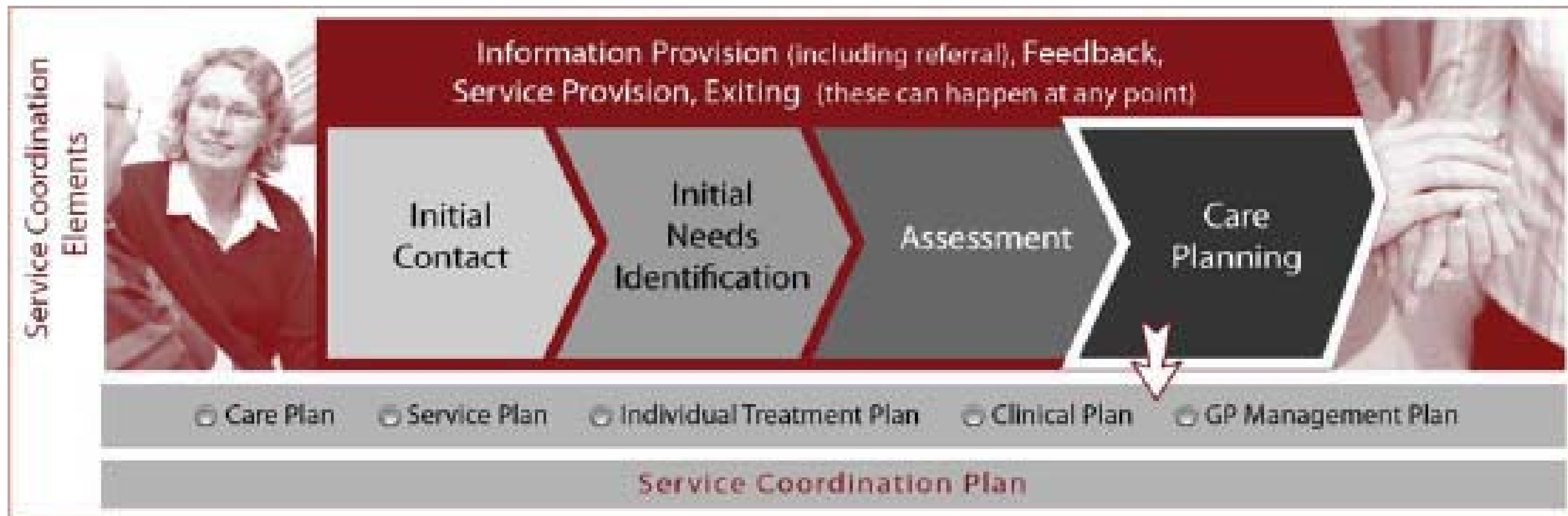
Consumers are supported to achieve their goals

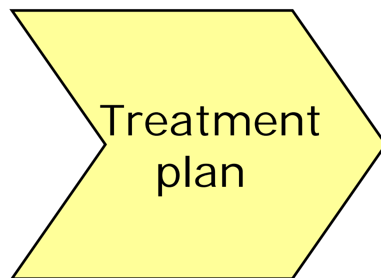
Everyone with chronic and complex care needs has a care plan

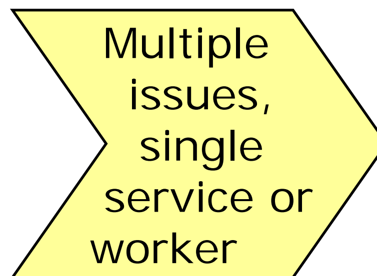
Processes & practices required

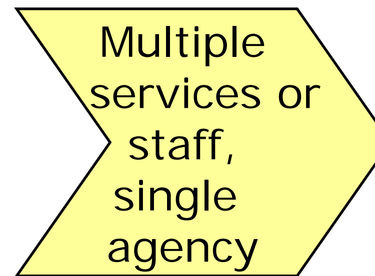
- Agreed protocols
- Trust between agencies
- Feedback & communication
- “Key worker” with appropriate skills
- Business practices and systems
- Support the consumers

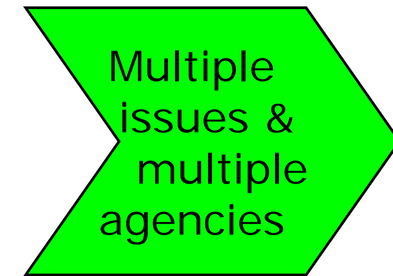
Building on assessment and goals











Service specific care plan

Intra-agency

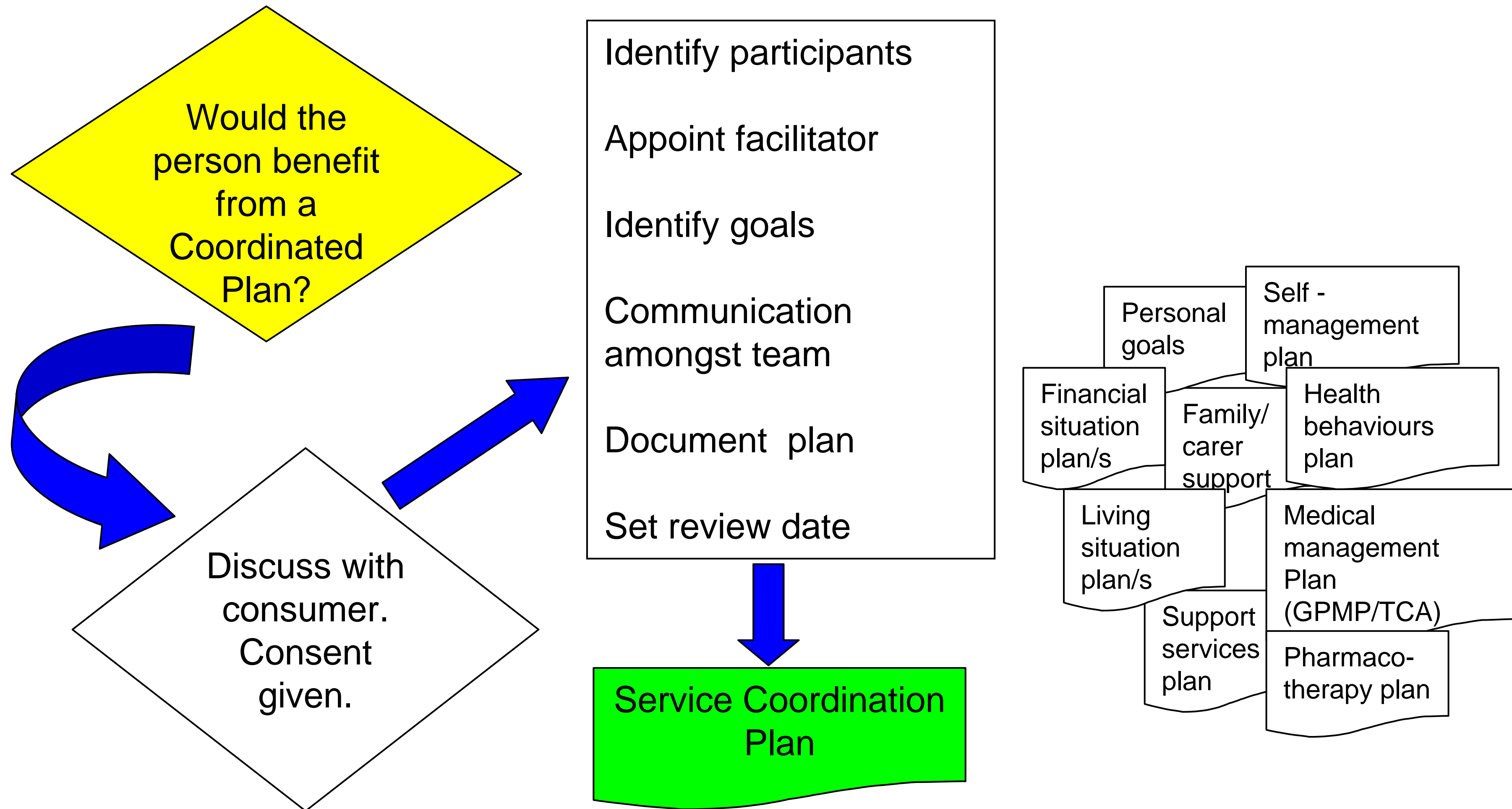
Inter-agency care plan

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

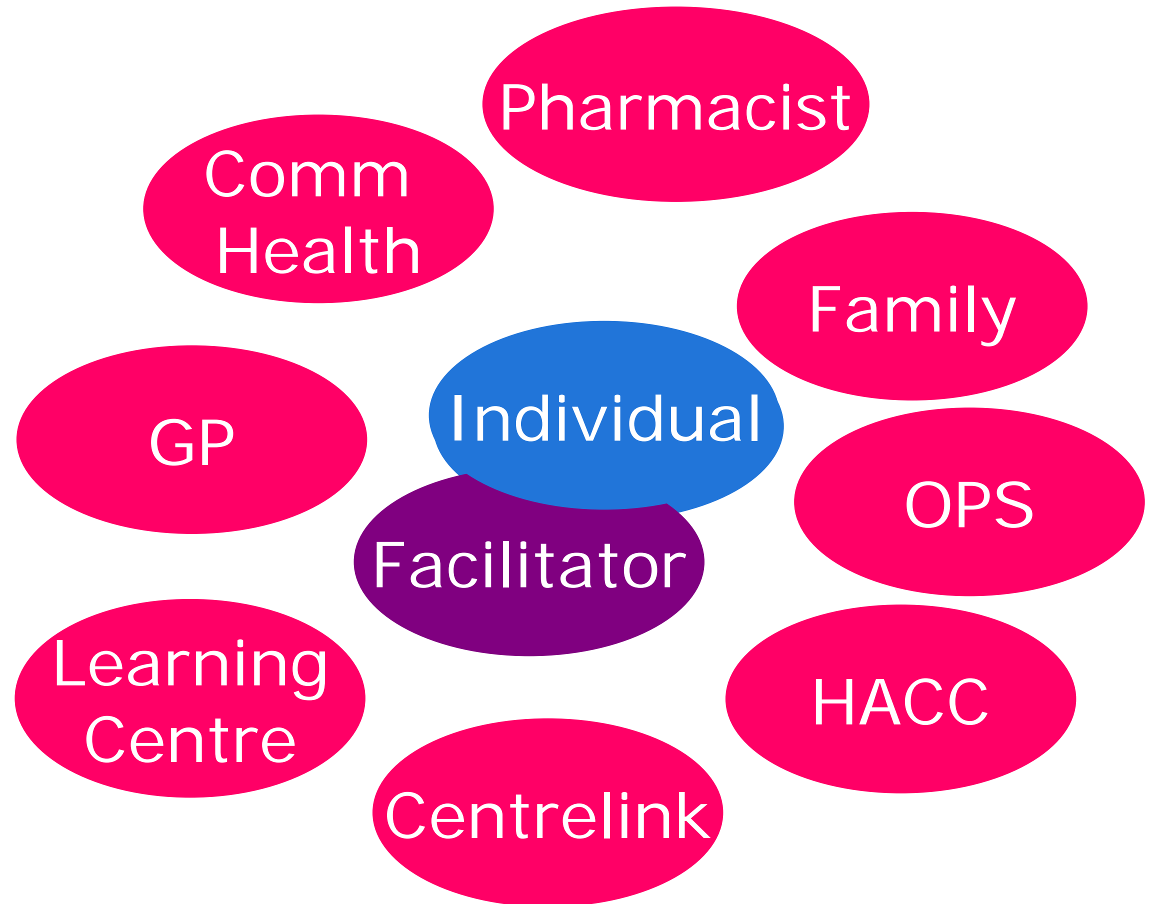
Involvement

Care Plan

Monitor & Review

Impact

Lifestyle



How is it going?

The systems
The tools
The people

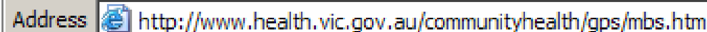
The direction
The supports
The relationships

Medicare Benefits Scheme 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

Address http://www.health.vic.gov.au/communityhealth/gps/mbs.htm Go



State Government of Victoria, Australia, Department of Human Services

Victorian Government Health Information

Health Home | Main A to Z Index | Site Map | Search Health | About Health | Links

Community Health

Health > Community health home > General Practitioners > Medicare Benefits Schedule Project

- **Community health home**
- Community health services
- Aboriginal health
- Chronic disease management
- Counselling
- General practitioners
- Community Health Services Strategy
- Medicare Benefits Schedule Project
- Primary Health Branch related work
- DHS GP Position Statement
- Resources & links
- Health promotion
- Service provider information
- Publications
- Contacts

Medicare Benefits Schedule Project

The Department of Human Services Primary Health Branch is working to provide information and support to Victorian primary health care agencies who may be looking to build or extend evidence-based models of care that incorporate recently introduced MBS item numbers. These item numbers have a particular focus on the prevention or management of chronic disease and mental health conditions. Summaries of these items and their business rules have been developed as the first stage of the project.

By working together, community health services and GPs/general practices can enhance client/patient access to services by constructing new models of care that incorporate MBS-rebateable services where appropriate.

To find information relevant to your needs, select from the following options:

- **Are you in community health?**
- **Are you in general practice?**

Hint: you can find the pages by googling "MBS Project"

Example of information on website

Care planning and case conferencing
Summary of MBS item numbers

Service type →	Care Planning prepared by a GP Chronic Disease Management (CDM) Items		Case Conferencing prepared by a GP				GP contribution to a care plan prepared by another provider Chronic Disease Management (CDM) Items		GP participation in Case Conferencing organised and coordinated by another provider				Practice nurse or registered Aboriginal Health Worker monitoring and support
Patient eligibility →	Patient has a chronic or terminal medical condition and is living in the community	Patient has a chronic or terminal medical condition **and** complex care needs and is living in the community	Patient has a chronic or terminal medical condition and is living in the community	Patient has cancer and is living in the community	Patient is a resident of a Common-wealth funded Residential Aged Care Facility (RACF)	Patient is an in-patient being discharged from a hospital or day hospital facility into the community	Patient is nc a resident of a Common-wealth funded Residential Aged Care Facility (RACF)	Patient is a resident of a Common-wealth funded Residential Aged Care Facility (RACF)	Patient has a chronic or terminal medical condition and is living in the community	Patient has cancer	Patient is a resident of a Common-wealth funded Residential Aged Care Facility (RACF)	Patient is an in-patient being discharged from a hospital or day hospital facility into the community	Patient has a chronic and /or terminal condition, has a GPMP, TCA or Multi-disciplinary EPC Care Plan in place, and is not an admitted patient of a hospital
Relevant MBS Item Number →	GP Management Plan (GPMP) #721 Review of GP Management Plan #725	Team Care Arrange-ments (TCA) #723 Review of Team Care Arrange-ments #727	Organise and coordinate a Community Case Conference 15–30 mins #740 30–45 mins #742 >45 mins #744	Lead and coordinate a Case Conference of at least 10 mins duration where there are at least four medical practitioners from different areas of practice and, in addition, allied health providers #871	Organise and coordinate a Case Conference in a RACF 15–30 mins #734 30–45 mins #736 >45 mins #738	Organise and Coordinate a Discharge Case Conference 15–30 mins #746 30–45 mins #749 >45 mins #757	Contribution to a Care Plan, or a review of a Care Plan, being prepared by another provider[1] #729	Contribution to a Care Plan, or a review of a Care Plan, being prepared by the RACF or hospital from which the resident is being discharged #731	Participation in a Case Conference 15–30 mins #759 30–45 mins #762 >45 mins #765	Participation in a Case Conference of at least 10 mins duration and where there are at least four medical practitioners from different areas of practice and, in addition, allied health providers #872	Participate in a Case Conference in a RACF 15–30 mins #775 30–45 mins #778 >45 mins #779	Participate in a Discharge Case Conference 15–30 mins #768 30–45 mins #771 >45 mins #773	Provision of monitoring and support for people with a chronic disease, on behalf of a GP #10997

MBS items

- Care Plan prepared by GP-GPMP/TCA
- Case conference prepared by GP
- GP contribution to a care plan by another provider
- GP participation in case conference organized by another provider
- Practice Nurse or Aboriginal Health Worker monitoring or support

Inter-agency Care Planning Progress-Grampians Region

- Central Victorian Health Alliance-
  Care Coordination Pathway

- The Grampians Health Information and Communications Technology Alliance-development of a shared electronic care planning model.

Inter-agency Care Planning Progress-Grampians Region

- Increase in number of agencies and staff using e referral system which can be built on for care planning

- Self management and care planning training

- Victorian Service Coordination Practice Manual

- Other

Successful strategies for improved 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.

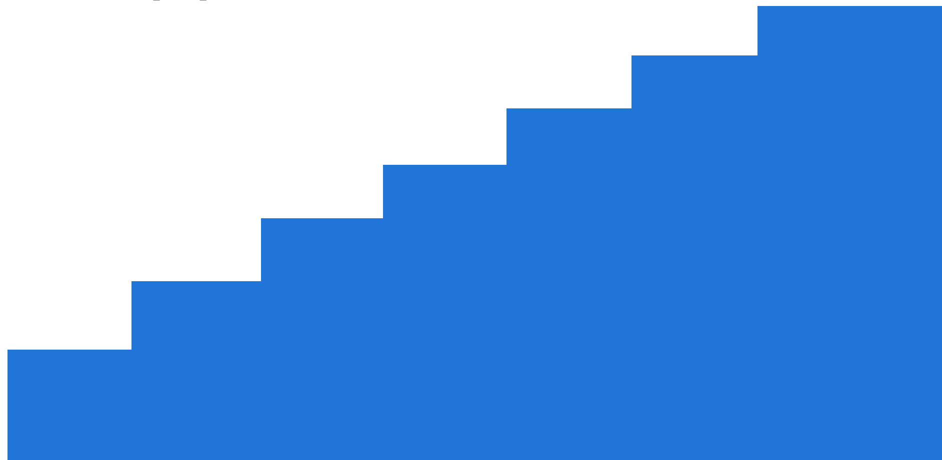
Time for revision

- Care planning advisory group
- Consultations
- Via the internet

https://www.health.vic.gov.au/pcps/coordination/sctt_survey.htm

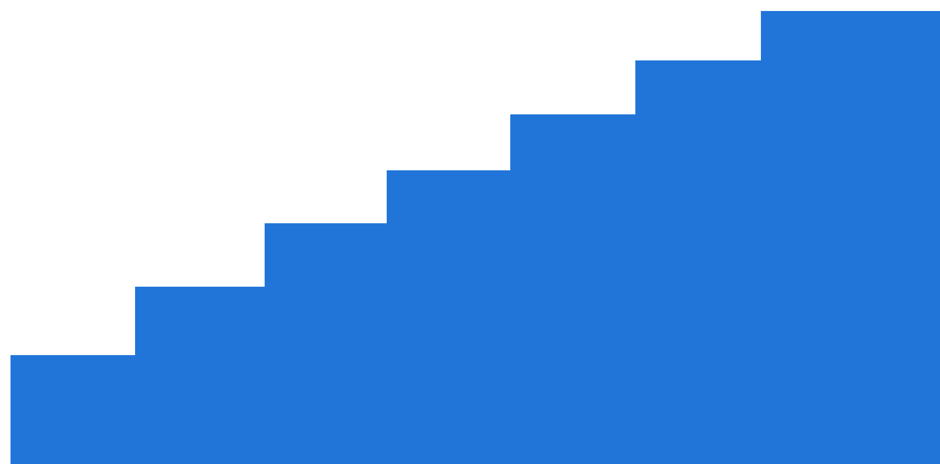
Seven steps to effective inter-agency care planning...

- 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 Grampians Region -build relationships

- Forums for relationship building-complex care network, service liaison meeting
- Work to build trust between agencies and establish MOU's
- Develop a "Better Care" group to include AOD workers, intake workers, non govt agencies and discharge coordinators-address service coordination and inter-agency care planning
- Engage with agencies who have not yet been included in partnerships

Next steps for Grampians Region -tools and systems

- Improve IT connectivity, quality and usability
- Build on e referral implementation
- Support and progress GICTA work

Next steps for Grampians Region -tools and systems

- Evaluation and review of current inter-agency care planning systems
- Initial needs assessment to become issues based rather than solution focused

Next steps for Grampians Region -processes

- Build care planning into quality improvement frameworks
- Formalize and strengthen shared protocols for intra and inter-agency care planning
- Establish agency MOU's which reflect service coordination principles and participation

Next steps for Grampians Region -support for staff

- Advocate for increased resources to gatekeeper roles e.g. ACAS
- Continual education of how to work together on interagency care planning
- Provide training in using IT systems, MBS items, engaging with GP's
- Clarification and understanding of roles
- Education about other agencies- what they offer and how they work
- Improve skills in working with complex clients

Next steps for Grampians Region -support for consumers

- Avoid "ownership" of clients
- Improve self management skills
- Support clients in driving and owning their own health care
- Look at appointment of key workers based on clients perspective/preference rather than agency needs

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