

# Better Connections-Better Care



Supporting improved inter-agency care planning

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# 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**

**Resources and  
Policies**

**Health System**

**Health Care Organization**

**Self-  
Management  
Support**

**Delivery  
System  
Design**

**Decision  
Support**

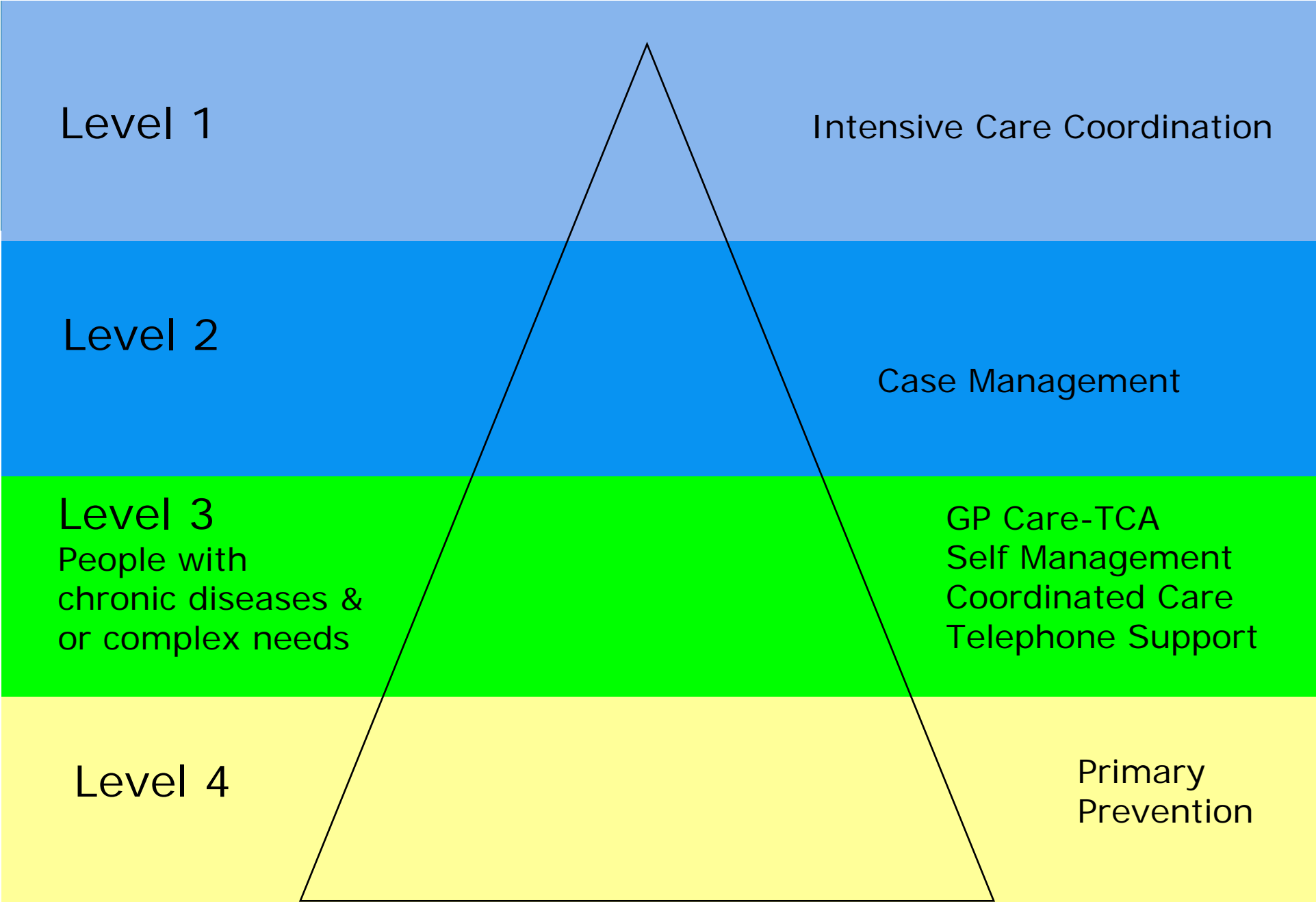
**Clinical  
Information  
Systems**

**Informed,  
Activated  
Patient**

**Productive  
Interactions**

**Prepared,  
Proactive  
Practice Team**

**Improved Outcomes**



Level 1

Intensive Care Coordination

Level 2

Case Management

Level 3

People with chronic diseases & or complex needs

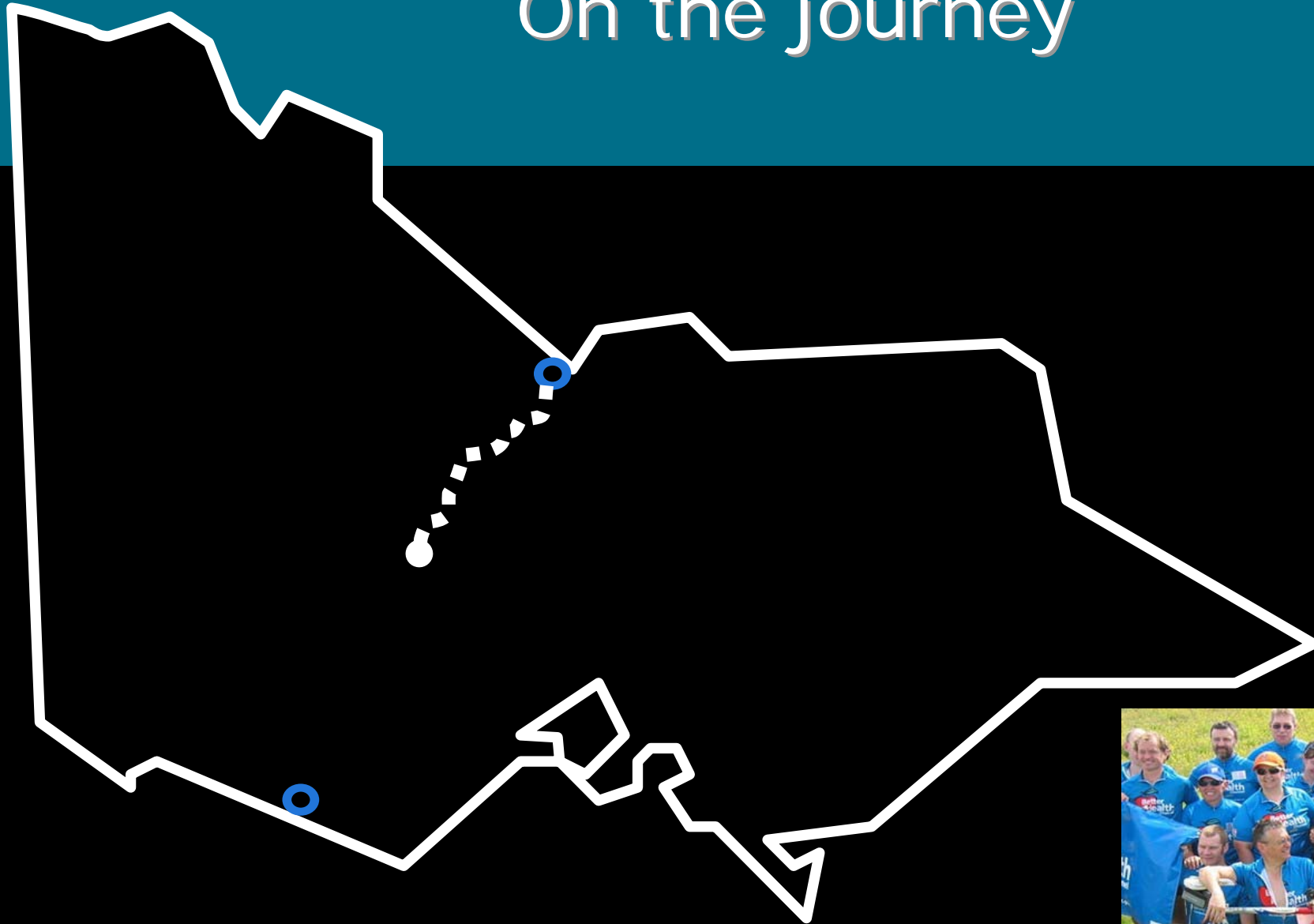
GP Care-TCA  
Self Management  
Coordinated Care  
Telephone Support

Level 4

Primary Prevention

Levels of chronic and complex care management

# On the journey



# The Vision



Consumers are supported to achieve their goals

Everyone with chronic and complex care needs has a care plan

# Why?

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



# How is it going?



The direction  
The supports  
The relationships

The systems  
The tools  
The people



# Progress in Gippsland

- HARP Care Coordinators
- Better Health in Gippsland Project
- CDM Resource Kit
- La Trobe Community Health Service plans to address EICD-appointment of Key Workers

# Progress in Gippsland

- 2007-Victorian Service Coordination Practice Manual
- 2007-S2S e-referral
- Gippsland Region Integrated Cancer Services-hand held record

# Processes & practices required

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

# 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

Would the person benefit from a Coordinated Plan?

Discuss with consumer. Consent given.

Identify participants  
Appoint facilitator  
Identify goals  
Communication amongst team  
Document plan  
Set review date

Service Coordination Plan



# Successful strategies for health outcomes

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

# Successful strategies for patient satisfaction

- Relationships between service providers
- Support for clinicians
- 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.

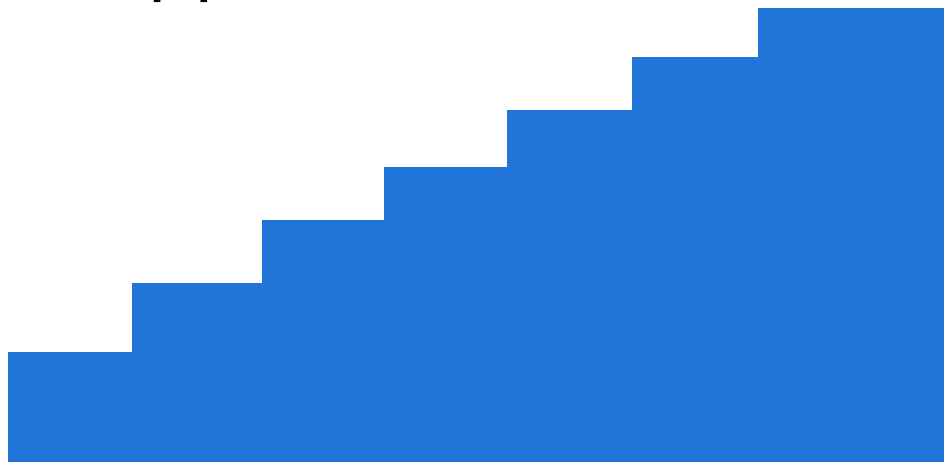
## **Time for revision**

- 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)

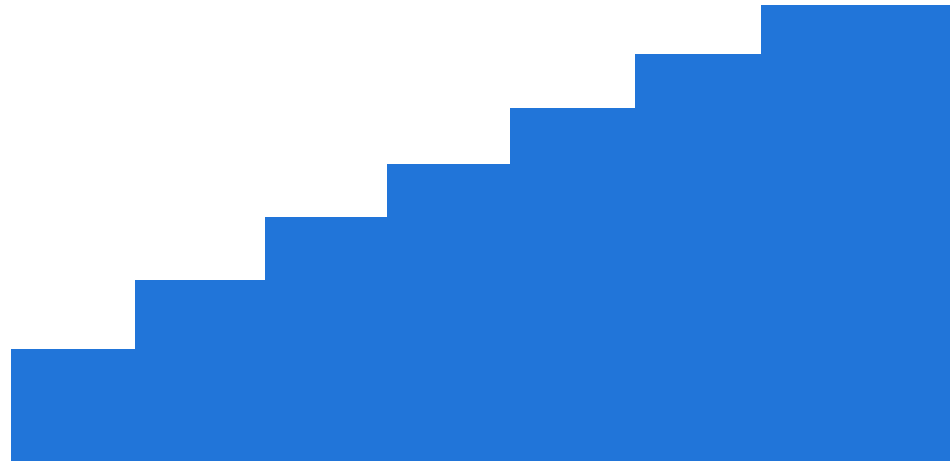
# Seven steps to effective inter-agency care planning...

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



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

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



## Next steps for Gippsland- build relationships

- Engage with General practices ?  
Remuneration for participation
- Provide information to GP's about agencies
- Tap into existing networks of agencies and focus on inter agency care planning
- Arrange local service expos-tag onto Seniors expo or careers expo

## Next steps for Gippsland- tools and systems

- Encourage use of VSRF as referral
- Establish central intake @ West Gippsland HCG & shire of Baw Baw
- Prepare for Infoxchange link with Argus-develop consistent key message

# Next steps for Gippsland- tools and systems

- Agree on common tools
- Influence DHS to develop a nursing care profile (PAC, RDNS etc.
- Request care planning module in S2S
- Develop electronic discharge plans

# Next steps for Gippsland- processes

- Review care pathways for people with mental health issues and streamline

## Next steps for Gippsland- support for staff

- Build on S2S-train more staff, use leaders & champions to encourage others
- Provide training and support to practice nurses in S2S, MBS, agency/service information

## Next steps for Gippsland- support for consumers

Target inter-agency care planning to support ATSI people, young struggling families, D& A clients, people with mental health issues and no case managers, remote area clients, cancer clients who are not pall care eligible, CALD groups, those needing services across geographical areas

# 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)