Better Connections-Better Care

Supporting improved inter-agency care planning

Southern Metro Region

Linda Pandita
Care Planning Project Manager
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

Community

Health System

Resources and Policies

Health Care Organization

Self-Management Support

Delivery System Design

Decision Support

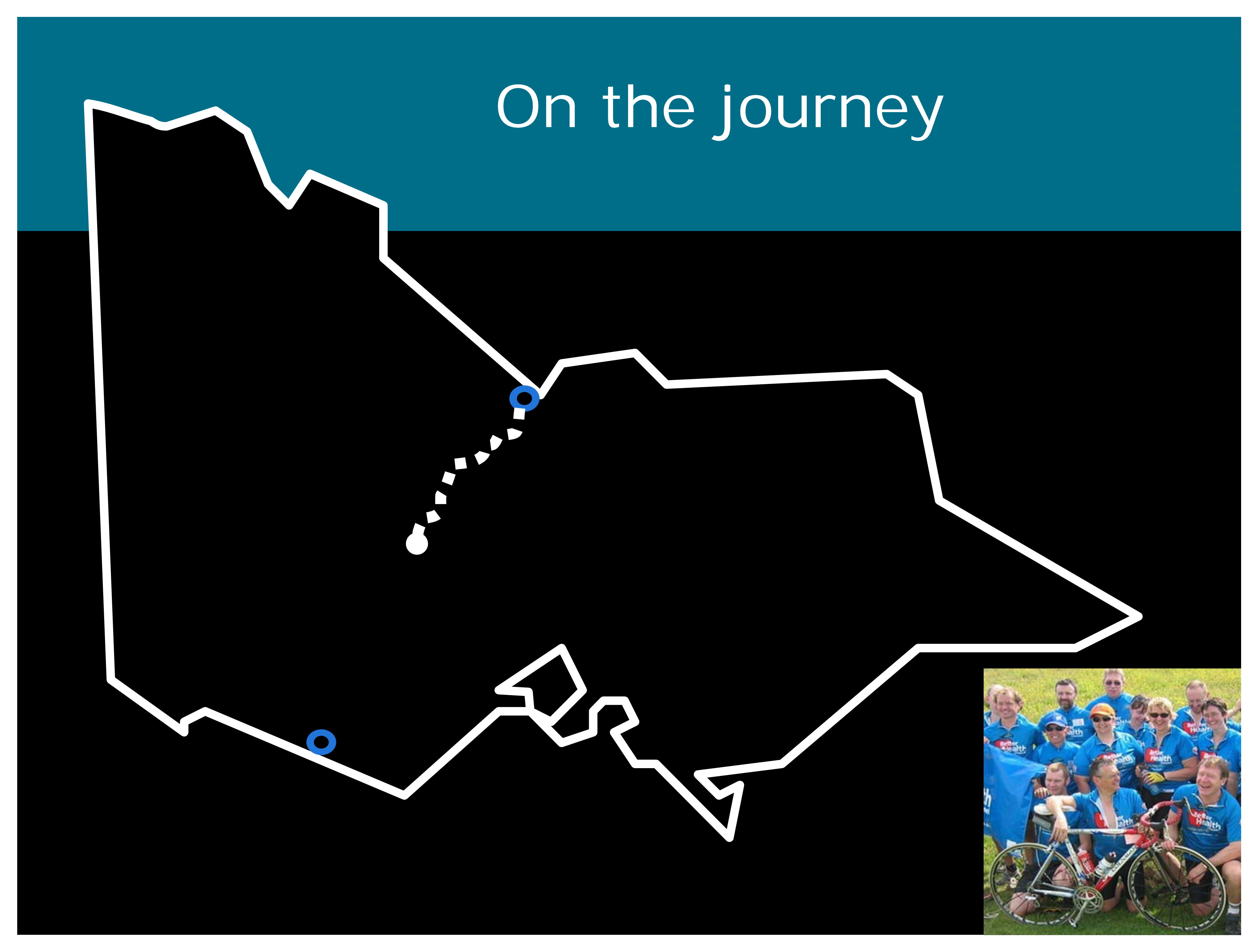
Clinical Information Systems

Informed, Activated Patient

Productive Interactions

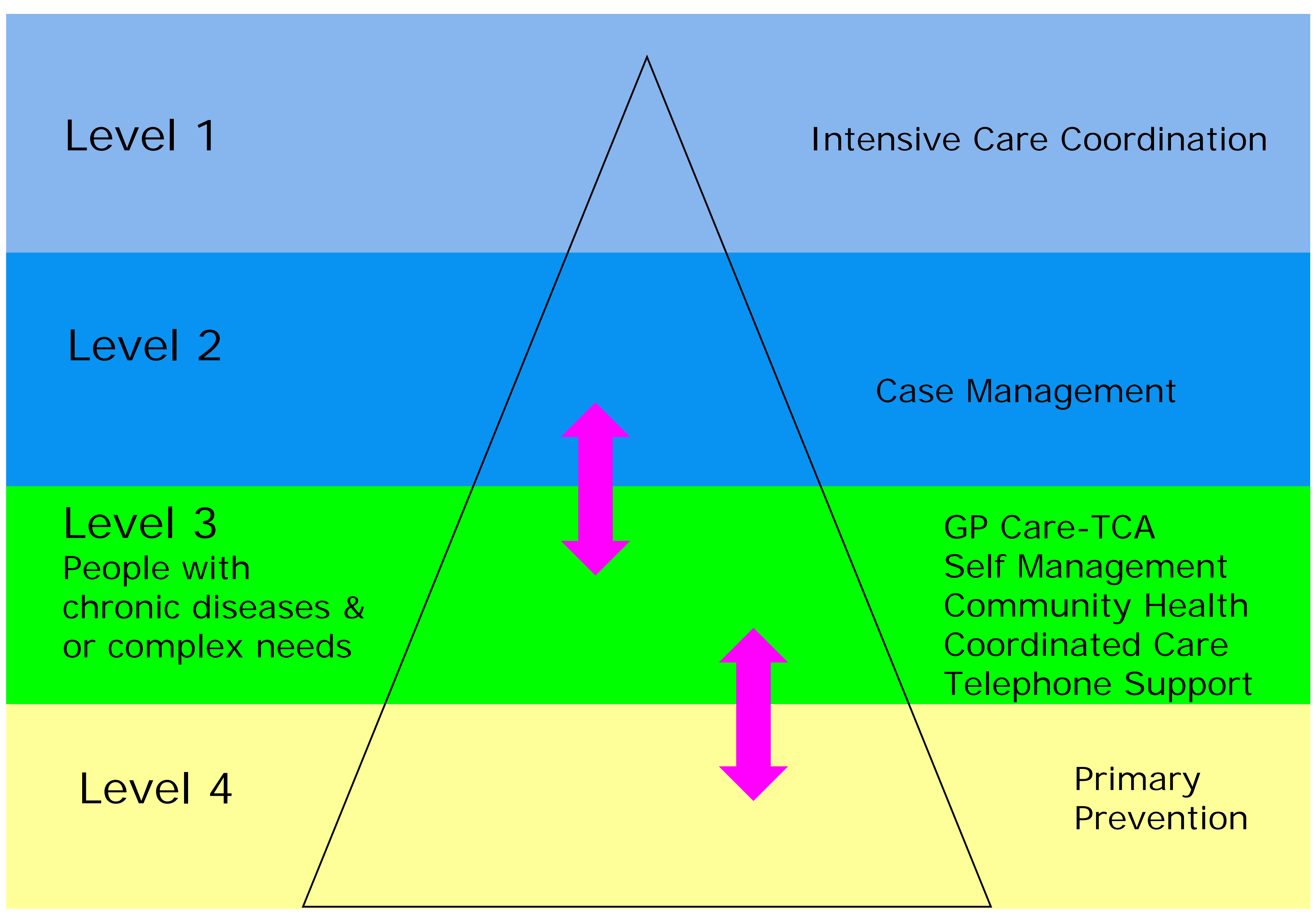
Prepared, Proactive Practice Team

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

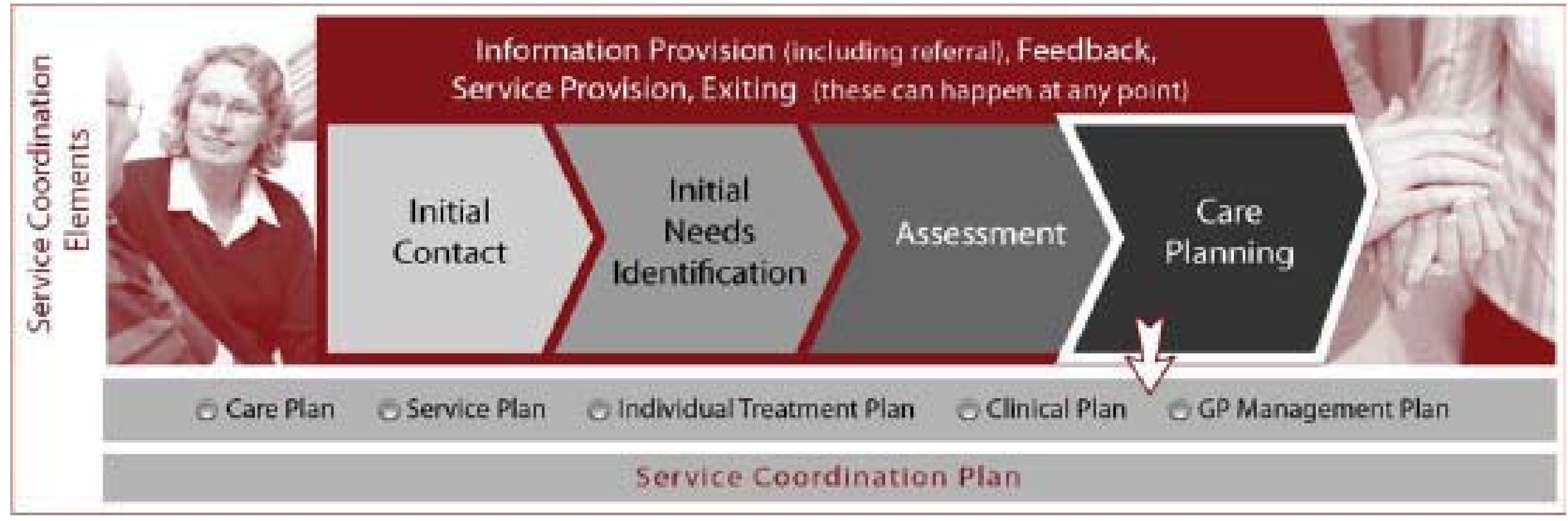
Consumers are supported to achieve their goals

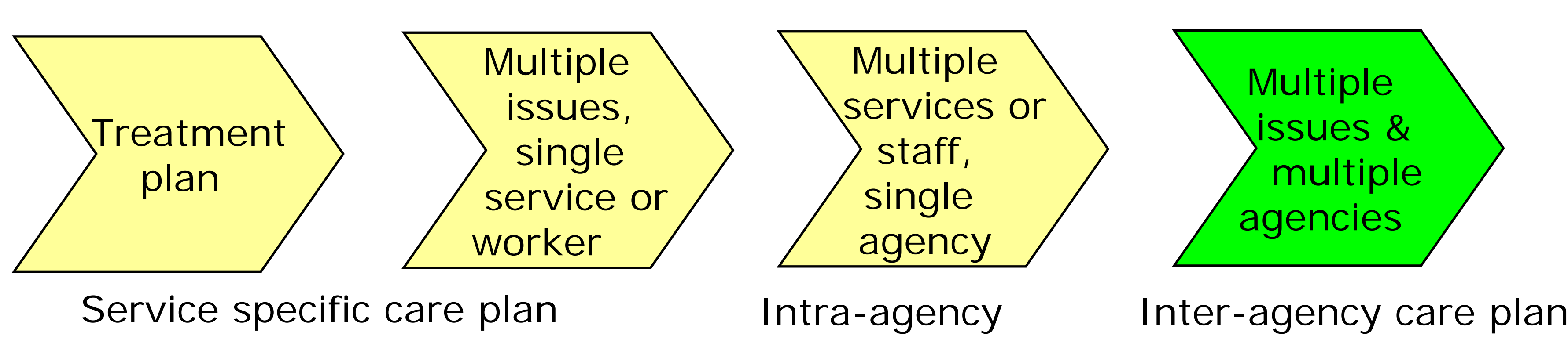
Everyone with chronic and complex care needs has a care plan

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



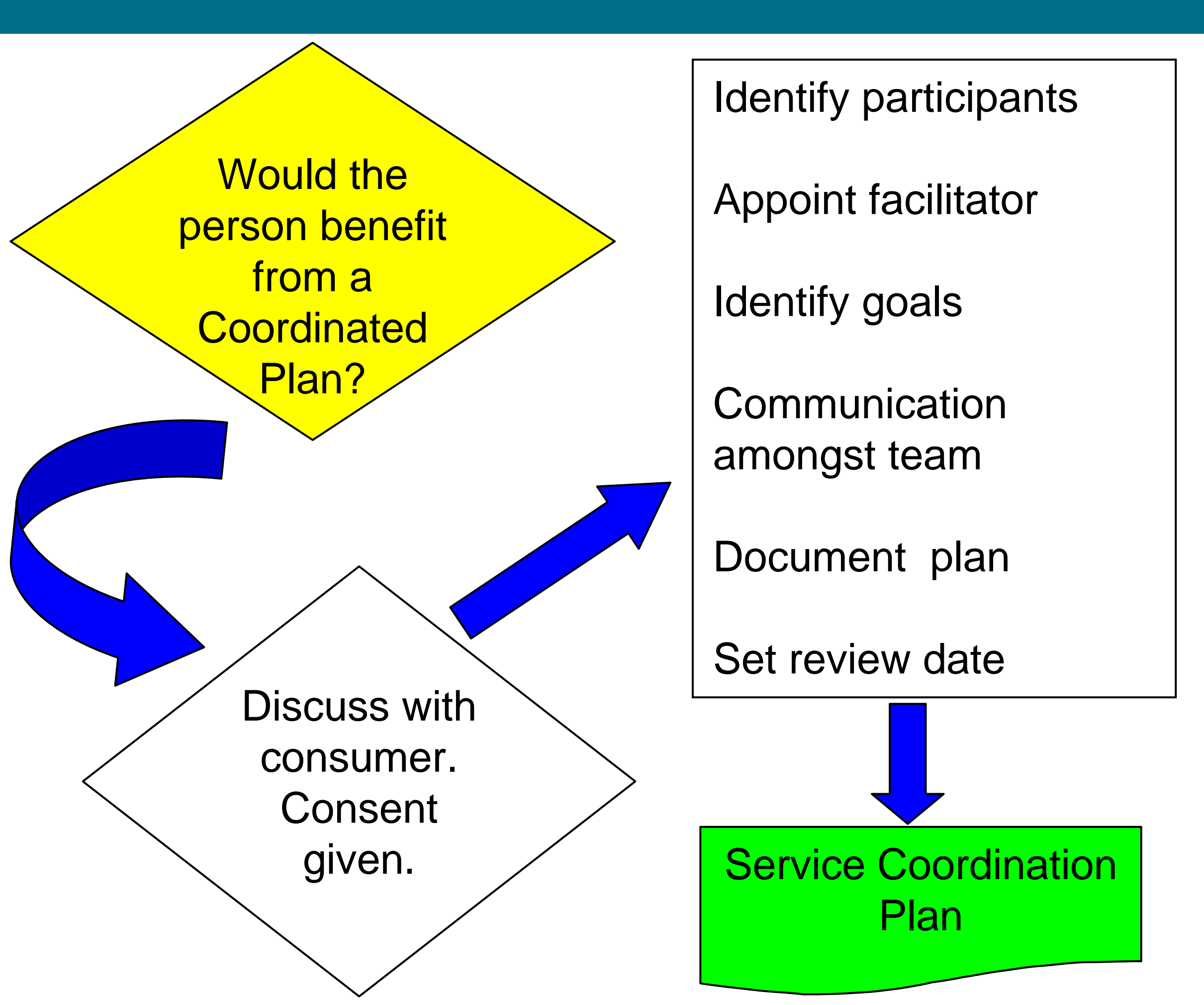


Inter-agency Care Planning

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

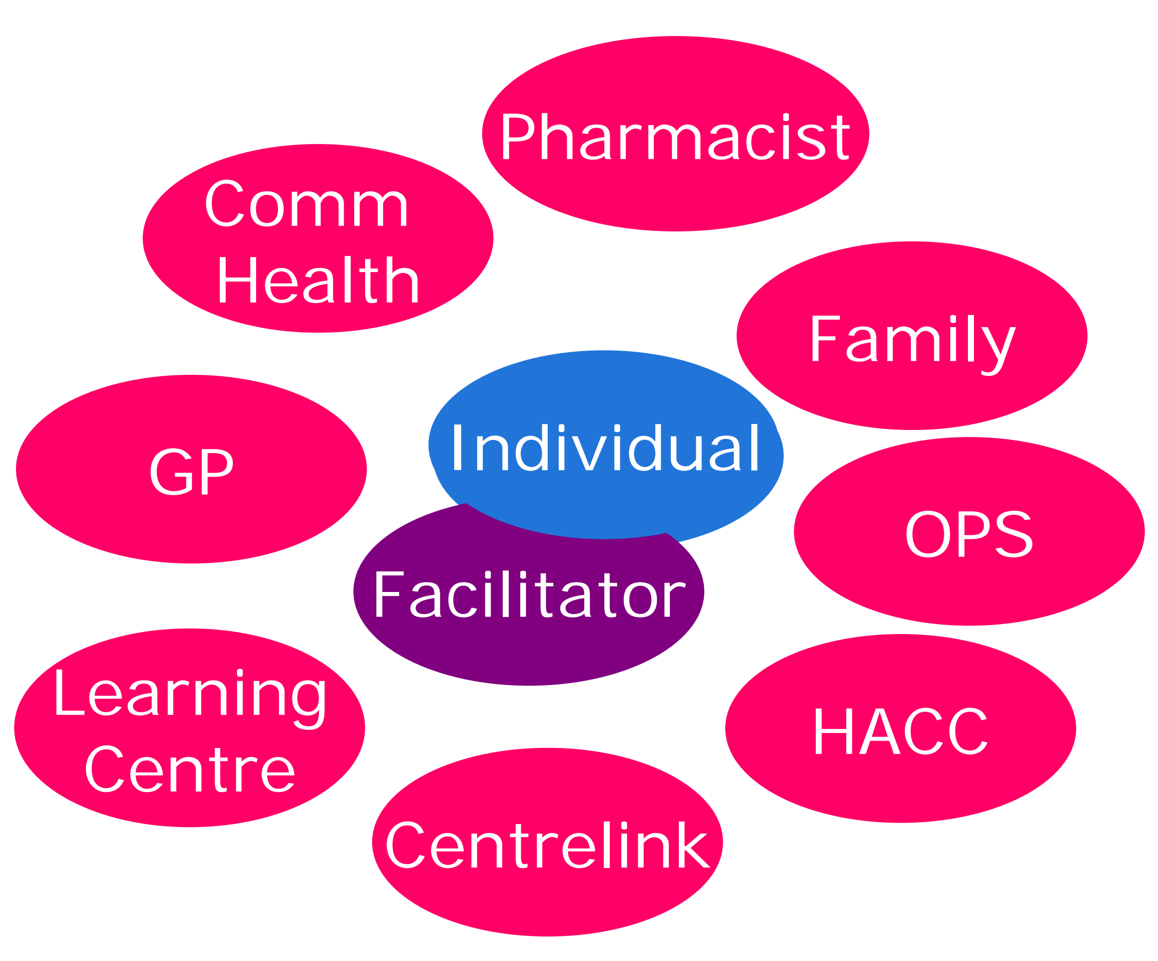
Involvement

Care Plan

Monitor & Review

Impact

Lifestyle



Connected support team

How is it going?

The systems
The tools
The people

The direction
The supports
The relationships

Care Planning Progress-Southern Metro

- Kingston Centre-Southern Health-patient centred care, goal setting and introduction of Key Liaison role.
- Alfred social work-care planning for HIV positive, complex clients
- Motivational interviewing and self management training

Care Planning Progress-Southern Metro

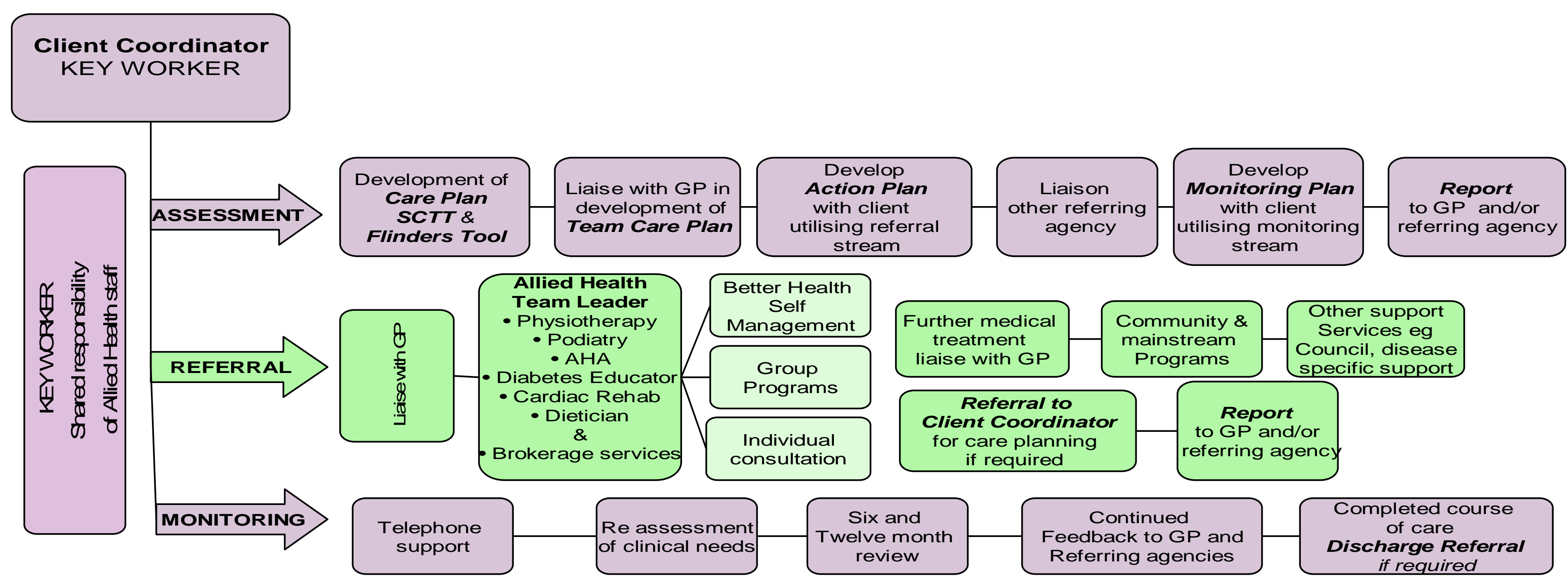
- South East HCP-interagency care planning protocol pilot.
- Inner South Community Health Service-staged care planning for hard to engage clients/introduction of Healthsmart
- GP's increasing use of TCA's & other MBS items e.g. ISEPICH project
- Improved communication of care plans using e-referral systems

Care Planning Progress- Southern Metro

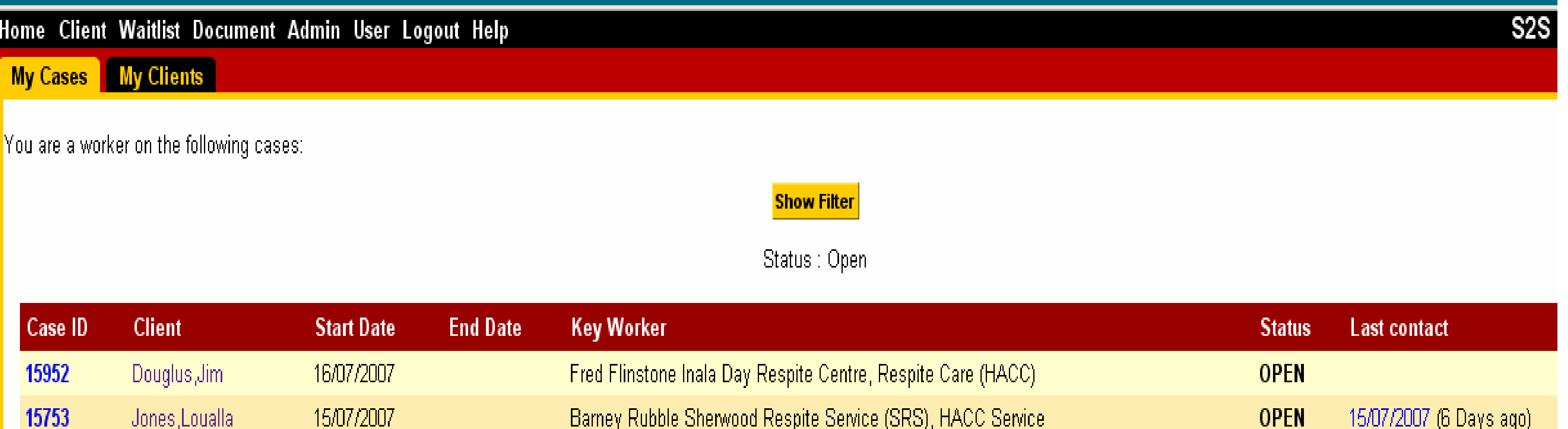
- Better Living Better Health Care coordinators and-Introduction of HMS-Client management system for clients with chronic conditions
- Victorian Service Coordination Practice Manual
- Frankston Community Health-key worker role and shared GP Liaison role

Frankston Community Health Service

Aim to integrate care planning and key worker roles:



S2S system Care Planning Module-Health worker view



Home Client Waitlist Document Admin User Logout Help S2S Refe

View Case | Edit Case | Compressed

Current Client : **Mitzi Roberts**
This page allows a new case to be created.

Participants in care planning process

Key Worker?	Name	Role	Role in Team	Service
	Barney Rubble	Case manager		Sherwood Respite Service (SRS) HACC Service

Add Workers

Name:
Agency:
Service:

Name	Role	Service
Amodha Ratnayeke	Medical practitioner	Infoxchange, General Medical Service
Amodha Ratnayeke	Referral coordinator	Infoxchange, General Medical Service
Barney Rubble	Case manager	Sherwood Respite Service (SRS), HACC Service
Bart Infoxchange	Service coordinator	City Homelessness Hub (CHH), Family Support
Betty Rubble	Case manager	Burremah Place Respite Services, District Nursing
Fred Flinstone	Case manager	Inala Day Respite Centre, Respite Care (HACC)
Goofey Infoxchange	Case worker	Down Town Homelessness Hub (DTHH), Homelessness Support Servi
Grumpy Infoxchange	Administration worker	City Homelessness Hub (CHH), Family Support
Happy Infoxchange	Intake worker	City Homelessness Hub (CHH), Support and Advocacy
Homer Infoxchange	Case worker	Acme Boarders Association (ABA), Tenancy Management

Rows 1 - 10 from 16

Participants

Name

Role

Add another Participant | Delete

Case Details

Access Level: Standard

Start date: 21/8/2007

End date:

Review date: 21/11/2007

Case description:

Key Worker view

Referral ID: 16476 **From:** Ph: (03) 9418 7417 Health Service,

Client: Mrs Marge Simpson 02/07/1930 Female
Address: 23 Grove prd, Oakleigh, 2135

To: District Nursing, Burremah Place Respite Services

Date/Time: 21/08/2007 20:16

Referral Notes:

Please let me know if you are willing to assist me in the care planning for my client Marge Simpson.

1.Set up Service Coordination Plan to access appropriate services

2.Link client with community services.

3.Provide chronic illness self management strategies. I have set up a case for this client and have given all of you access.

Please complete the care plans for your roles in the system Thank you Dr AR

Home Client Waitlist Document Admin User Logout Help S2S Refe

Incoming Sent Open Draft Search

Below is a list of referrals you have sent. When the referral has been acknowledged by both the receiver and yourself it will no longer appear here. View the referral details by clicking on the **REFERRAL ID** number.

You can find a referral on this page by pressing **CTRL+F** on your keyboard. Type the name or **Referral ID** you are searching for, then press **ENTER**.

Sent Referrals

REFERRAL ID	CLIENT	DATE/TIME	STATUS
15749	Loualla Jones, 09/07/1930	15/07/2007 12:29	ACTION INITIATED
16472	Marge Simpson, 02/07/1930	21/08/2007 20:16	NEW
16474	Marge Simpson, 02/07/1930	21/08/2007 20:16	ACKNOWLEDGED
16476	Marge Simpson, 02/07/1930	21/08/2007 20:16	ACKNOWLEDGED

Home Client Waitlist Document Admin User Logout Help S2S Refe

View Case | Edit Case | Compressed

Current Client : **Mitzi Roberts**

This page allows a new case to be created.

Participants in care planning process

Key Worker?	Name	Role	Role in Team	Service
	Barney Rubble	Case manager		Sherwood Respite Service (SRS) HACC Service

Add Workers

Name:

Agency:

Service:

Name	Role	Service
Amodha Ratnayeke	Medical practitioner	Infoxchange, General Medical Service
Amodha Ratnayeke	Referral coordinator	Infoxchange, General Medical Service
Barney Rubble	Case manager	Sherwood Respite Service (SRS), HACC Service
Bart Infoxchange	Service coordinator	City Homelessness Hub (CHH), Family Support
Betty Rubble	Case manager	Burremah Place Respite Services, District Nursing
Fred Flinstone	Case manager	Inala Day Respite Centre, Respite Care (HACC)
Goofey Infoxchange	Case worker	Down Town Homelessness Hub (DTHH), Homelessness Support Servi
Grumpy Infoxchange	Administration worker	City Homelessness Hub (CHH), Family Support
Happy Infoxchange	Intake worker	City Homelessness Hub (CHH), Support and Advocacy
Homer Infoxchange	Case worker	Acme Boarders Association (ABA), Tenancy Management

Rows 1 - 10 from 16

Participants

Name

Role

Add another Participant | Delete

Case Details

Access Level: Standard

Start date: 21/8/2007

End date:

Review date: 21/11/2007

Case description:

Home Client Waitlist Document Admin User Logout Help S2S Refe

View Action Plan | Edit Action Plan | Compressed

Action Plan Details:

Date: 21/8/2007

Review date:

Issue:

Goal:

Action/s:

Responsibility:

Outcome score: Goal not achieved

Outcome comment:

Date completed:

Home Client Waitlist Document Admin User Logout Help S2S Refe

View Case | Edit Case | Compressed

Current Client : **Marge Simpson**

This page displays a created case.

Participants in care planning process

Key Worker	Name	Role	Role in Team	Service
	Betty Rubble	Case manager	District Nurse	Burremah Place Respite Services , District Nursing
	Homer Infoxchange	Case worker	Tenancy Support Worker	Acme Boarders Association (ABA) , Tenancy Management
	Barney Rubble	Case manager	HACC worker	Sherwood Respite Service (SRS) , HACC Service
Yes	Amodha Ratnayeke	Medical practitioner	Case Coordinator & GP	Infoxchange , General Medical Service

Case Details

Case ID: **16435**
Access Level: Case Workers Only
Start date: 21/08/2007
Review date: 21/11/2007
Case description: Marge is socially isolated, has a poor nutritional intake and has a number of surface wounds that are neglected and does not manage medications. She requires support with finding suitable accommodation. May need assistance with personal care and meals.

Attachments

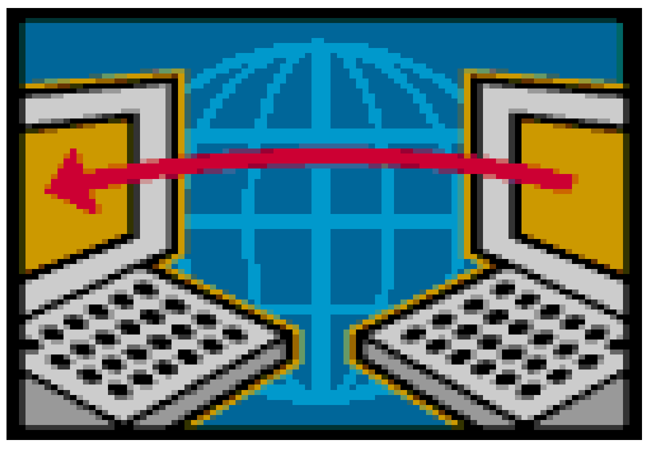
Label	Filename	Size
SCCT	Functional_Assessment_LO_6A.dot	228352
SCTT	Health_Conditions_LO_6A.dot	91648
SCTT	Living_and_Caring_LO_6A.dot	112128

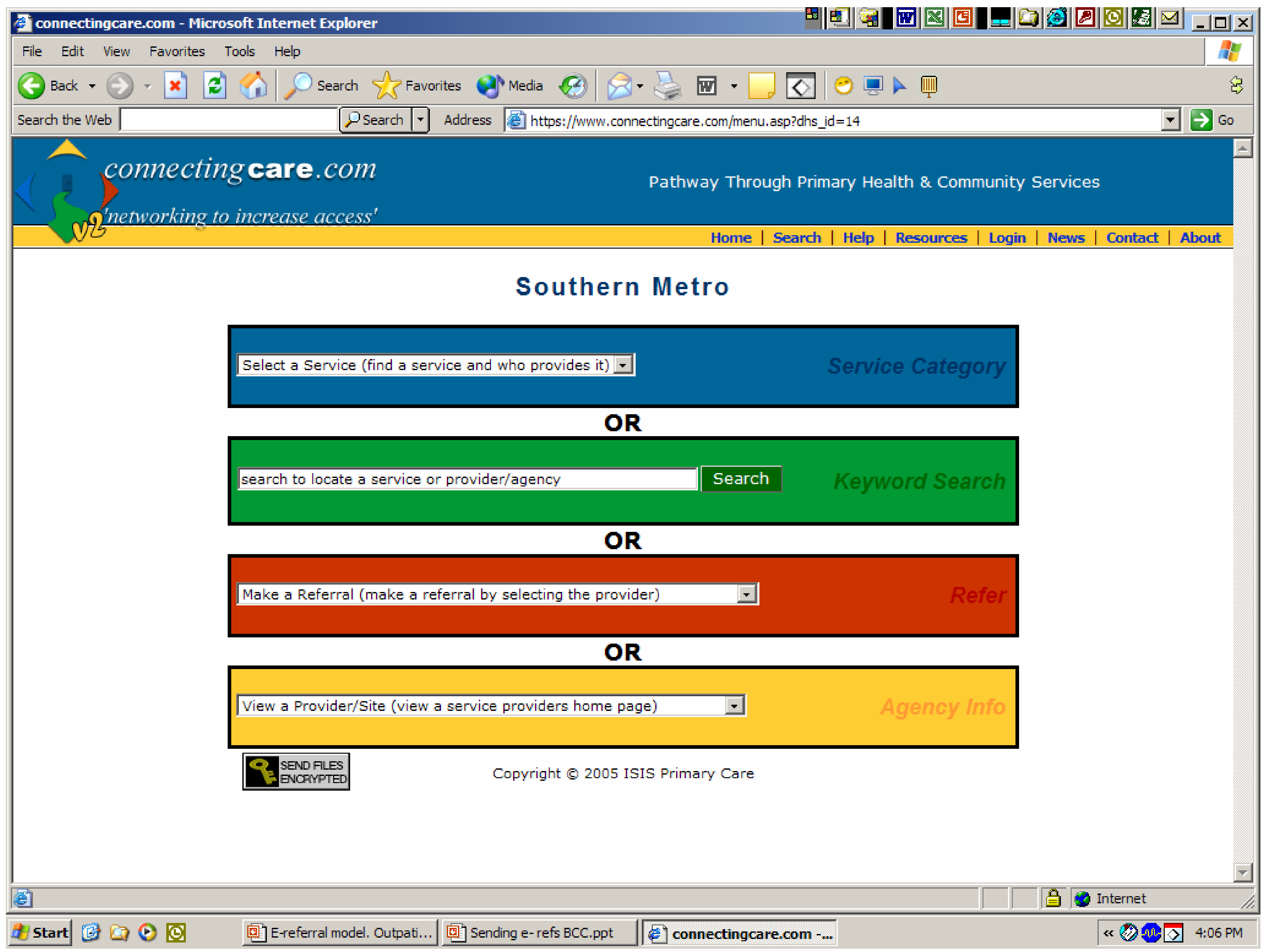
Action Plans

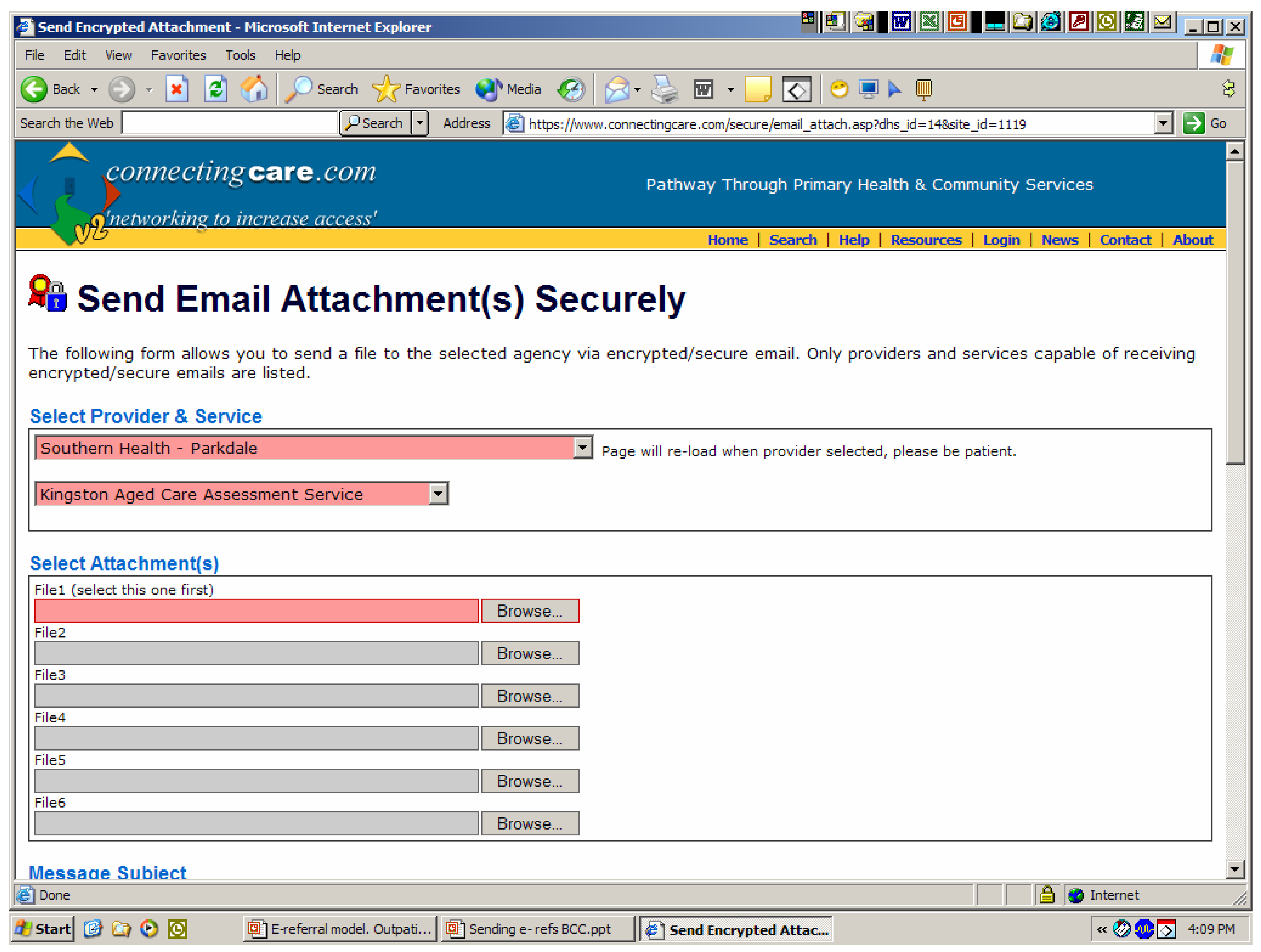
Action Plan ID	Goal	Worker	Service	Plan Date	Date Completed
16495	Improved control of asthma and wound management	Amodha Ratnayeke	Infoxchange , General Medical Service	21/08/2007	
16532	Secure supported accommodation	Homer Infoxchange	Acme Boarders Association (ABA) , Tenancy Management	21/08/2007	
16570	Ensure medication is taken daily, monitor successful healing of wounds	Betty Rubble	Burremah Place Respite Services , District Nursing	21/08/2007	
16634	Ensure client remains independent in own home as long as possible. Ensure appropriate services in the home is organised	Barney Rubble	Sherwood Respite Service (SRS) , HACC Service	21/08/2007	

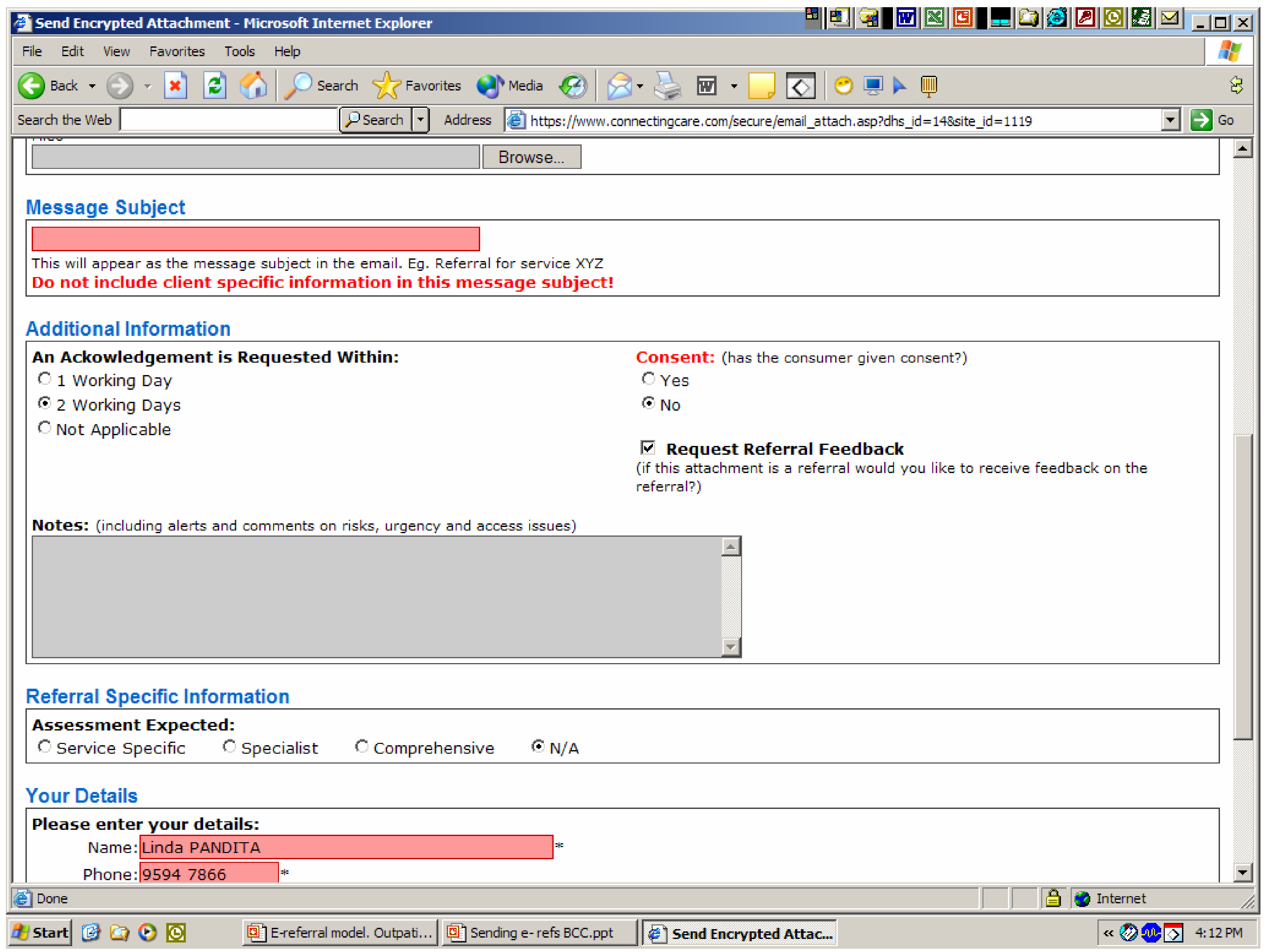
Connecting-care system

Care plans can be developed from agency software following case conference or meeting and sent as secure attachments to participants




connectingcare.com - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Back Search Favorites Media
Search the Web Search Address https://www.connectingcare.com/menu.asp?dhs_id=14 Go
connectingcare.com
'networking to increase access'
Pathway Through Primary Health & Community Services
Home | Search | Help | Resources | Login | News | Contact | About
Southern Metro
Select a Service (find a service and who provides it)
Service Category
OR
search to locate a service or provider/agency
Search
Keyword Search
OR
Make a Referral (make a referral by selecting the provider)
Refer
OR
View a Provider/Site (view a service providers home page)
Agency Info
SEND FILES ENCRYPTED
Copyright © 2005 ISIS Primary Care
Internet
Start
E-referral model. Outpati...
Sending e- refs BCC.ppt
connectingcare.com -...
4:06 PM


Send Encrypted Attachment - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Back Search Favorites Media
Search the Web Search Address https://www.connectingcare.com/secure/email_attach.asp?dhs_id=14&site_id=1119 Go
connectingcare.com
'networking to increase access'
Pathway Through Primary Health & Community Services
Home | Search | Help | Resources | Login | News | Contact | About
Send Email Attachment(s) Securely
The following form allows you to send a file to the selected agency via encrypted/secure email. Only providers and services capable of receiving encrypted/secure emails are listed.
Select Provider & Service
Southern Health - Parkdale
Page will re-load when provider selected, please be patient.
Kingston Aged Care Assessment Service
Select Attachment(s)
File1 (select this one first)
Browse...
File2
Browse...
File3
Browse...
File4
Browse...
File5
Browse...
File6
Browse...
Message Subject
Done
Internet
Start
E-referral model. Outpati...
Sending e- refs BCC.ppt
Send Encrypted Attac...
4:09 PM



Send Encrypted Attachment - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Back Search Favorites Media
Search the Web
Search
Address
https://www.connectingcare.com/secure/email_attach.asp?dhs_id=14&site_id=1119
Go
Browse...
Message Subject
This will appear as the message subject in the email. Eg. Referral for service XYZ
Do not include client specific information in this message subject!
Additional Information
An Ackowledgement is Requested Within:
1 Working Day
2 Working Days
Not Applicable
Consent: (has the consumer given consent?)
Yes
No
Request Referral Feedback
(if this attachment is a referral would you like to receive feedback on the referral?)
Notes: (including alerts and comments on risks, urgency and access issues)
Referral Specific Information
Assessment Expected:
Service Specific
Specialist
Comprehensive
N/A
Your Details
Please enter your details:
Name: Linda PANDITA *
Phone: 9594 7866 *
Done
Internet
Start
E-referral model. Outpati...
Sending e- refs BCC.ppt
Send Encrypted Attac...
4:12 PM

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

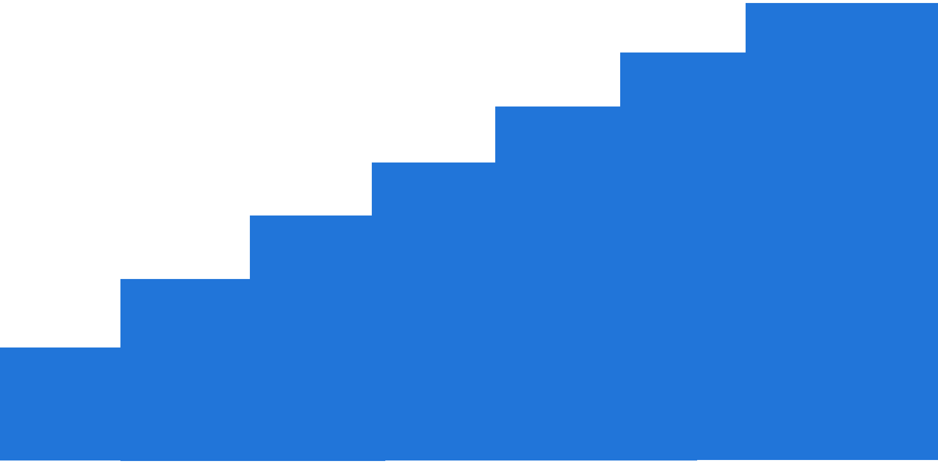
https://www.health.vic.gov.au/pcps/coordination/sctt_survey.htm

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 Southern Metro Region-build relationships

- Improve the interface with acute-discharge plans-share care plans with ED and preadmission
- Host forums for GP's and practice nurses
- Allocate time to develop relationships between leaders/agencies/staff/consumers
- Establish MOU's between agencies
- Build trust…

Next steps for Southern Metro Region -tools and systems

- Develop/build on shared Principles Protocols Practices and Systems
- Push for interoperability-eref interface between CC and S2S
- Auto-population of tools to and from client management systems
- Engage more agencies in e-referral
- Common standards and clinical indicators
- Educate re use of tools and templates

Next steps for Southern Metro Region -processes

- Advocate to DHS program areas for leadership guidelines, funding and policies to reflect need for inter-agency care planning
- Develop Southern Region service coordination for Palliative care group to work on care planning and coordination for palliative care clients

Next steps for Southern Metro Region -support for staff

- Develop and information kit about care planning-use forum Q's in meetings to get staff thinking about inter-agency care planning
- Include service coordination and care planning in orientation for all staff
- Develop a plan for implementation education and support of inter-agency care planning across sectors
- Establish clinical governance structure which supports inter-agency care planning
- Education re privacy for staff and consumers

Next steps for Southern Metro Region -support for staff

- Identify champions service coordination and care planning in each agency
- Provide cross sector training in inter agency care planning
- Recognition and reward for “key workers”
- Start small/focus on key agencies or client groups
- More forums like Better Connections Better Care

Next steps for Southern Metro Region -support for consumers

- Identification of key barriers to care planning from consumer perspective
- Advocate for more accommodation for homeless people in the area

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