

DRAFT

Care Planning



Building a regional framework for moving forward

Discussion Paper

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Introduction

This document has been compiled to provide a framework to support discussion around care planning as we move towards a more integrated system of care planning and care coordination in the Region. It builds on work previously undertaken by Inner East Primary Care Partnership (IEPCP), Outer East Health and Community Support Alliance (OEHCSA), Hume Region Primary Care Partnerships and HACC agencies, Central Victorian Health Alliance Primary Care Partnership, HARP (Eastern Health), other PCP agencies and the Department of Human Services.

The discussion paper also articulates factors influencing the decision making for the adoption of greater efficiencies in current care planning practice. It summarises and pulls together some of the threads of multifaceted and complex care planning issues. It does not endeavour to provide solutions to the significant issues relating to systemic change required to enhance the current system. In depth work and dialogue is required to deal with many of the elements described in this document.

However, as an aid to further dialogue, several recommendations for moving forward are articulated in the [Recommendations](#) section of the document.

It is hoped that this discussion paper will lay the groundwork to develop a regional approach to care planning that will encourage greater collaboration and agency support for a more integrated system of care planning.

Terminology

Language plays an important role in influencing the mutual understanding and application of key service coordination concepts. Use of diverse care planning, care coordination and case management terms, in addition to varied interpretations of the *Better Access to Services: A Policy and Operational Framework* (BATS) language continues to highlight the complexity associated with this element of service coordination.

According to BATS, care planning is a process of deliberation that incorporates a range of existing activities and includes the continuum of navigational and supportive functions such as **care coordination, case management, referral, feedback, review, re-assessment and monitoring**. Care planning involves the judgment/determination of relative need as well as competing needs, and assists consumers to come to decisions that are appropriate to their needs, wishes, values and circumstances.¹

Care planning facilitates a consistent, planned approach to the management of appropriate care for consumers with chronic diseases and multiple or complex needs often requiring complex care arrangements. *Care in Your Community* proposes that integrated chronic and complex care includes: consistent approach to case management, care coordination and key worker arrangements.² This carries with it the notion of continuity of care, coordination of care, disease management, good communication among caregivers, smooth transfer of information and records, elimination of duplicate testing and procedures.³

The above highlights the different uses of terminology to describe similar care planning and care coordination concepts and processes. Therefore, for the purpose of clarity in this document Care Planning will be understood within the context of the BATS strategy. Likewise, care coordination will be understood as the 'range of services required by the consumer are coordinated so that they are delivered in the most efficient and effective way to meet individual consumers' needs'.⁴

Other items relating to terms and definitions also appear later in this document in the section [Terms and Definitions](#).

¹ State of Victoria, *Better Access to Services – A Policy and Operational Framework*, June 2001, Victorian Department of Human Services

² State of Victoria 2006, *Care in Your Community, A Planning Framework for Integrated Ambulatory Health Care*, Victorian Department of Human Services, 2006

³ *Review of Integrated Care Literature*- Prepared by Clare Keating, Effective Change Pty Ltd for Whitehorse Community Health Centre, May, 2006 - Shortell et al cited in Leatt, P, Pink, G and Guerriere, M Towards a Canadian Model of Integrated Healthcare, *Integrated Health Care Vol 1 No 2* 2000

⁴ State of Victoria, *Better Access to Services – A Policy and Operational Framework*, June 2001, Victorian Department of Human Services

Background

There has been much work undertaken over the last four years to further advance care planning and integrated chronic disease management in the region by both the OEHCSA and IEPCP and other PCP agencies. Service coordination has set the platform of initially a regional protocol and more recently a statewide protocol that has built common agreed approaches to intake, assessment, care planning and referral.

In 2005 the IEPCP convened a Care Planning Working Group to identify care planning gaps and address interagency and cross-disciplinary issues affecting coordinated care for clients with complex needs and to provide opportunities for capacity building and sustainable reform. An extensive snapshot of the level of funded and unfunded case management within the region was also undertaken to capture information about consumers requiring care planning. Agencies participating in the Working Group also adopted a set of care planning definitions (see [Terms and Definitions](#)) for the purpose of establishing a common understanding and to form a foundation for subsequent discussions. Key findings are located in the Situational Analysis section of this document.

The next three years will continue the work to further embed a common agreement for care planning and chronic disease management across sectors. Care planning is one of the key service coordination focus areas for further development and implementation in the IEPCP and OEHCSA 2006-09 Community Health Plans. Both PCPs will work together on developing a regional care planning approach that will inform member agency activity in this important area. Currently there are numerous approaches, guidelines, projects and programs that all need to be integrated to create an integrated informed approach for the Eastern Regions. This work will also inform the statewide approach that remains underdeveloped. The key pieces of work that will provide an essential backdrop to this work are:

- Victorian Service Coordination Practice Manual
- HARP Guidelines (Eastern Health)
- Chronic Disease Programs that are operating from Community Health Services in the EMR
- Local IEPCP and OEHCSA service coordination work that has been completed in particular the Eastern region Electronic Service Coordination System
- Client Self Management Theory
- Clinical Governance work that is being undertaken in the region
- Local GP work to date
- Commonwealth GP items that focus on care planning, case conferencing and chronic disease
- Eastern Service Coordination System (e Referral)

The Central Victorian Health Alliance PCP has also undertaken in depth work around care coordination developing a care coordination continuum, care coordination pathways, identifying and articulating various care coordination models and a process for the conduct of care coordination meetings. This work is reflected in this document and is re presented as a platform for discussion.

Context

System

Care Planning occurs within a complex and whole system of care that includes primary and secondary health care, health and social care, statutory and independent sectors⁷. It requires appropriate organisational structures that promote care planning and appropriate care coordination while being supportive of the diversity of organisational cultures that exist in a health system that encourages collaboration.

A quality care planning system provides a crucial platform of support for consumer care streamlines agency systems and facilitates pathways between services within the wider service system. Ensuring appropriate consumer navigation through and within the system to receive appropriate care coordination is vital. A quality care planning system is also supported by the foundation of common service coordination practice that encompasses consistent application of all the facets of service coordination from which agencies can coordinate service delivery for the benefit of consumers.

Care planning may be seen as a step in the process of health systems and health care delivery becoming more cohesive and seamless. From the patient perspective, particularly those with complicated and on-

⁷ *Review of Integrated Care Literature*- Prepared by Clare Keating, Effective Change Pty Ltd for Whitehorse Community Health Centre, May, 2006

going needs which are part-medical, part-physical, part psychological and part-social, receiving care across home, community and institutional settings⁸, care planning and appropriate care coordination between services enhances quality care and provides a level of service more sensitive to the personal circumstances and wishes of consumers. This is consistent with state and federal policy directions.

Care planning requires a robust and flexible system to meet consumer needs for consistent and accessible coordinated care. Impacting upon care planning are the differing federal and state systems particularly affecting GP participation in care planning. State and federal systems need not be mutually exclusive but can co-exist working together to ensure continuity of care planning and care coordination. Such co-existence encourages flexibility of service provision, better coordination between service providers and continuity of care for consumers.

Where a consumer has complex and multiple needs and requires the services of more than one agency, it is expected that a Service Coordination Plan (*also see section on Service Coordination Planning Tool*) will be developed. The Service Coordination Plan should draw together existing care plans and build aspects of coordination and communication⁹ within and among agencies providing care to consumers with complex and multiple needs.

The further embedding of care planning requires agencies to review their internal systems addressing how consumers move into and within their agency, how the Service Coordination Plan is implemented and utilised as well as undertaking external service system review, such as examining who are key referral partners and the effectiveness of referral pathways to and from those services.

Care planning is both an interagency, cross-disciplinary and an intragency activity requiring whole-of-system solutions and strong commitment to collaboration and cooperation within and between agencies and GPs to deal with the complexities and challenges. Importantly, care planning and integrated chronic disease management are inexorably linked. Integrated chronic disease management must be supported by good care planning systems and practice.

Policy

The *Better Access to Services: A Policy and Operational Framework* (BATS) encourages agencies to align practices, processes, protocols and systems to achieve “functional integration”. Functional integration means that agencies remain independent of each other as entities but work in a cohesive and coordinated way to ensure that consumers get access to the services they need as quickly as possible without unnecessary barriers or duplication.¹⁰

The BATS strategy “is the core driver of reforms in the primary care sector, aiming to achieve a cohesive and coordinated system that promotes seamless and integrated service responses for consumers.”¹¹ The BATS strategy sets out the policy and operational framework which places consumers at the centre of service delivery and ensures that they have access to the services they need, opportunities for early intervention, health promotion and improved health and care outcomes,¹² ie. Service Coordination (SC). Care Planning is integral to SC and to providing reliable and systematic coordinated care for consumers.

Current policy context at state, federal and international levels also consistently highlights the importance of providing good SC to underpin consumers’ continuum of care as they move between services and sectors.

This commitment is affirmed in other key health industry policies, including but not limited to:

- *Growing Victoria Together*¹³: This provides a whole of Government policy framework, which integrates and shapes the policies and plans for the future of Victoria’s health services.
- *A Fairer Victoria*¹⁴: A long-term action plan by the Government to tackle disadvantage and increase opportunities for all Victorians. It highlights the need for locally appropriate policy responses and flexible ways of delivering services. One of the key platforms of A Fairer Victoria is to reduce

⁸ *Review of Integrated Care Literature*- Prepared by Clare Keating, Effective Change Pty Ltd for Whitehorse Community Health Centre, May, 2006 Community Health Centre, May, 2006

⁹ Primary Care Partnerships, *Victorian Service Coordination Practice Manual*, Draft 2006

¹⁰ Ibid.

¹¹ State of Victoria, *Better Access to Services – A Policy and Operational Framework*, June 2001, Victorian Department of Human Services

¹² Ibid.

¹³ State of Victoria (2001), *Growing Victoria Together: A Vision for Victoria to 2010 and Beyond*, Victorian Department of Premier and Cabinet

¹⁴ State of Victoria (2005), *A Fairer Victoria, Victorian Government’s Social Policy Action Plan*, Victorian Department of Premier and Cabinet

barriers and improve access to quality services, particularly for disadvantaged groups in the community.

- '*Care in Your Community Framework*'¹⁵ – which highlights that 'there will be a consistent, planned approach to developing the infrastructure for the delivery of integrated health care, including information and communications technology (ICT), standard tools and protocols ...' . This framework is aligned with the government's *Growing Victoria Together* agenda and *A Fairer Victoria* policy, *Care in Your Community*. It builds on existing policy directions to provide a coherent whole-of-health framework for the delivery of integrated, community-based health care. Delivery of health care is to be integrated and coordinated around 'the needs of people, rather than service types, professional boundaries, organisational structure, program funding or reporting requirements.'
- *The Interim Guidelines for the Early Intervention in Chronic Disease in Community Health Services (2005)*¹⁶ require that comprehensive and robust practices, processes, protocols and systems (PPPS) are in place as part of the service coordination strategy, to minimise fragmentation across the service system and ensure that clients receive appropriately coordinated and integrated services in a timely, efficient and seamless manner.
- *The Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services – October 2006 (DHS)* highlights the strategic relationship of care planning to integrated chronic disease management (ICDM) stating "Service coordination provides an essential platform for ICDM. Its focus is on consistent approaches to initial contact, initial needs identification, assessment, care planning and referral across PCP member agencies. Common service coordination practice provides the foundation from which agencies can coordinate service delivery for the benefit of their clients."¹⁷ The document encourages the development of additional local agreements consistent with the Statewide PPPS to enhance ICDM within the context of care planning. For example, local protocols could be developed for:

- agreement and definition around which consumers will receive a multi agency care plan and have a key worker
 - systems to support the nomination of a key worker and development/review of a care plan
 - agreement around levels of written service outcome communication required by agencies¹⁸
- This would incorporate work with PCP member agencies, particularly GPs, to develop and define local agreements and systems to:
- identify clients with chronic disease who require cross disciplinary/multi-agency (including GP) care planning
 - initiate and coordinate care planning for people with chronic disease¹⁹

- *Related Commonwealth government initiatives* such as the "*The Way Forward*"²⁰ also reflect alignment with service coordination principles.

Other policies and requirements impacting on care planning include:

- Victorian Service Coordination Practice Manual (PPPS)
- HACC Requirement Guidelines
- Eastern HARP Guidelines
- VHA clinical governance initiative (includes credentialing, scope of practice etc.)

¹⁵ State of Victoria 2006, *Care in Your Community, A Planning Framework for Integrated Ambulatory Health Care*, Victorian Department of Human Services, 2006

¹⁶ State of Victoria, *The Interim Guidelines for the Early Intervention in Chronic Disease in Community Health Services (2005)*, Department of Human Services

¹⁷ State of Victoria, *Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services – October 2006*, Department of Human Services

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ Commonwealth of Australia, 2004, *A New Strategy In Community Care, The Way Forward*, Australian Government, Department of Health and Aging

The following diagram featured in the *Victorian Service Coordination Practice Manual* depicts the resources and tools that support effective service coordination including care planning and care coordination with the BATs featured as the foundation of service coordination.



Situational Analysis

Currently the system is fragmented with a diversity of care plan options, care planning practices, multiple federal and state funding streams and requirements, placing additional pressure on agencies to sort through the care planning maze adding to the complexity of ensuring good care coordination for consumers.

Care planning at all levels encompasses care coordination, case management, referral, feedback, review, re-assessment, monitoring and exiting. According to the *Victorian Service Coordination Manual*²³ the key features of care planning include:

- Nomination of key worker/case coordinator for the consumer (one contact person instead of several)
- Incorporation of the continuum of care management for consumers where a consumer requires multiple services or has complex or special needs.
- Acknowledgement of the potential contribution of self management to effective care
- Provision of effective monitoring (formal and informal) of consumers' health and wellbeing
- Formal evaluation of the effectiveness of services being delivered, eg. regular reviews
- Requirement that referral information is received and acted upon by practitioner to whom referral is made
- Requirement that feedback is provided to the referrer.

²¹ *Review of Integrated Care Literature*- Prepared by Clare Keating, Effective Change Pty Ltd for Whitehorse Community Health Centre, May, 2006

²² *Ibid.*

²³ *Victorian Service Coordination Manual*, Primary Care Partnerships, Prepared by Juliet Frizzell, Effective Change and Dr. Ro Saxon, HDG Consulting

- Facilitation of collaborative care planning with GPs maximising opportunities inherent in the Federal government's Medicare Benefits Schedule items
- Use of the Service Coordination Plan Template for consumers with complex and multiple needs who require the services of more than one agency.

Although these facets of care planning and care coordination are being undertaken within the system there is still much work to be done to systematise and further embed quality care planning and coordination practice within the region. We cannot make the assumption that care planning is currently being done well within all or even most agencies.

Currently care planning occurs:

- across all service types eg, HACC, Community Health, Disability, Acute, Mental Health, Alcohol and Drugs, etc.
- internally within an agency and/or across a multi-disciplinary team and across multiple agencies,
- at different levels eg. around life stages, health status, or a particular issue,
- across a range of timeframes e.g. short term, long term,
- utilising agency specific documentation and tools, and
- utilising a range of different approaches e.g. self management both formal and informal.

Primary services provided include: CACPs, EACH, HACC, HARP-TRAAC, Flexible programs, Linkages, PAV, DVA Home Care, Early Choice, Community Mental Health

What is happening to those waiting for services?

The findings of the research done by the IEPCP indicated that some consumers are receiving:

- No services
- Some or minimal HACC
- Support by informal carers/families
- Some respite access
- Limited support by service providers as part of overall service provision

This has implications affecting unfunded case management, resourcing and identification of service gaps.

Key issues – Intra-agency

Several key issues impacting on care planning, care coordination and case management were identified in the course of the mapping process undertaken by the IEPCP. These are reflected in the table below.

FACTOR	ISSUES
<i>Resources and/or increased funding for:</i>	<ul style="list-style-type: none"> • Strengthening service coordination systems <ul style="list-style-type: none"> ○ Assessments ○ Home visits ○ Follow ups ○ Raising targets for existing care
<i>Personnel</i>	<ul style="list-style-type: none"> • Key worker – roles and responsibilities • Workloads – on current personnel undertaking/monitoring referrals/assessments • Workforce: <ul style="list-style-type: none"> ○ development ○ credentialing ○ qualifications ○ skills
<i>Systems management (eg. client data base management system)</i>	<ul style="list-style-type: none"> • Limitations of current systems • Prioritisation of waiting list times • Longer term provision verses episodic services for clients with long term issues > impact on waiting lists • Data collection limitations and improvements • Linkages to broader computer system networks (intra-agency/inter-agency)
<i>Communication</i>	<ul style="list-style-type: none"> • Infrequent intra-agency (also inter-agency) case conferencing • Communications: GPs and service agencies
<i>Intra-agency (also inter-agency)</i>	<ul style="list-style-type: none"> • longer term care needs to be considered – eg. chronic condition management programs

Key Inter-agency System Issues

FACTOR	ISSUES
<i>Consumers</i>	<ul style="list-style-type: none"> • Lack of awareness of available services • Consumer difficulty negotiating/understanding the health service system • Consumer unwillingness to accept previously offered services/formal case management • Ensuring consumer ability to access appropriate case/care management • Consumers may fall between service eligibility gaps - needs not seen as 'urgent' or assessed as 'at risk' therefore ineligible for funded CM
<i>Systems Management</i>	<ul style="list-style-type: none"> • Multiplicity of programs/short term interventions <ul style="list-style-type: none"> • Confusing for clients • Confusing for service providers – to understand programs limitations • Services not flexible enough • Wide range of agency internal care planning practices • The degree to which multi agency care planning is already core practice or not • The various modes and levels of funding received by agencies for assessment, care planning & case management • Capacity to uniformly determine respective roles in care coordination and subsequent roles and responsibilities of Key Worker(s) • Limitations in follow up practices to ensure implementation/establishment of appropriate care strategies • Discharge planning • Workforce development
<i>Information and Communication</i>	<ul style="list-style-type: none"> • Between services/clients – challenging <ul style="list-style-type: none"> ◦ to keep information flowing ◦ to monitor/manage client waiting for package • lack of consistency in practice and process for transfer of information and documentation • limitations of common information systems/transfer of information/record data, etc. • infrequency of interagency case conferencing • communication with GPs • need for communication protocols describing communication systems where organisations have common clients • Lack of a centralised system of information to provide service providers with information on availability of community packages • Commitment to open communications and use of SCTT • Networking opportunities to break down barriers

Service Coordination Plan – Tool Templates

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. Full implementation of service coordination requires reviewing current practice around the utilisation of the current Service Coordination Plan tool and ensuring full usage to assist in care coordination. In fact this tool is currently the least utilised of the SCTT tool suite. This was confirmed in the service coordination quality review of agencies in the IEPCP conducted earlier in 2006.

In accordance with the *Victorian Statewide Practice Manual* a Service Coordination Plan ([Appendix 1](#)) should be completed for those consumers with multi-agency involvement and complex needs. Generally, consumers who should have a Service Coordination Plan are those who:

- are being seen by more than one agency and more than one discipline;
- have multiple issues and problems that need to be addressed concurrently; and
- are likely to be better off if the care and services they receive are coordinated across all agencies over time.²⁴

The development, documentation and monitoring of Service Coordination Plans is integral to successful care planning and appropriate care coordination processes. The *Chronic Disease Management Program*

²⁴ Primary Care Partnerships, *Victorian Service Coordination Practice Manual*, Draft 2006

Guidelines 'recommends that where cross-disciplinary/multi-agency care planning occurs it is preferable that the Service Coordination Plan form (SCTT tools) be used.'²⁵

Care Planning Continuums and Models

Care Planning/Care Coordination Continuums

Several sources describe care planning and care coordination occurring as a continuum. Consideration is given to the various ways of describing a continuum of care illustrating the varying levels of care planning/care coordination. These are more fully described following **Diagram 1** which also highlights the interrelationship between care planning and care coordination, agencies and consumers, care plan development and the elements contained within each continuum.

Systems Continuum

Levels of care planning and care coordination for consumers requiring chronic and complex care management may be viewed as a continuum from several perspectives. For example, from a **systems** perspective which incorporates:

- Agencies
- Resources
- Workforce

Central to this continuum of course is the consumer.

Prevention to Treatment Continuum of Care

The management of chronic and complex conditions according to the *Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services*²⁶ encompasses a continuum of care from **prevention through to treatment** and care management/care coordination. The levels of chronic and complex care prevention and management include the following elements²⁷:

Prevention (eg. obesity reduction, smoking cessation – programs such as Diabetes Prevention Program)

- risk reduction for consumers with high risk factors for developing chronic disease

Planned, managed and proactive care (programs such as EliCD)

- Assessment & care planning
- GP care
- Self-management interventions
- Access to mainstream health services and community programs
- Generic telephone advice
- Planned review, recall and reminders
- Ongoing management and monitoring

Intensive Care Coordination (programs such as HARP CDM, services such as CHS, HACC, etc.)

- Comprehensive assessment and care planning
- Specialised medical and GP management
- Package of services
- Continuous, frequent interventions

²⁵ State of Victoria, *Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services – October 2006*, Department of Human Services

²⁶ State of Victoria, *Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services – October 2006*, Department of Human Services

²⁷ Ibid.

- Linkage to ongoing monitoring and maintenance

Care Coordination Process Continuum

The notion of a continuum can also be used to describe some of the elements of the care coordination process such as how information can be shared, who can facilitate care and when.

The Central Victorian Alliance (*The Care Coordination Process at a Glance, October 2006*)²⁸ describes the care coordination process continuum at a **process &/or practice level** as consisting of the **sharing of information between services when** there is.....

No 'facilitator' (key worker/case manager)	Interim 'facilitator' (key worker/case manager)	A nominated 'facilitator' (key worker/case manager)
Team shares information between itself	Team sends information to an interim facilitator	Team sends information to a nominated facilitator
<ul style="list-style-type: none"> • Multiple needs, but straightforward • Able to communicate in a coordinated manner without key worker • A comprehensive/single multi-disciplinary plan is not required 	<ul style="list-style-type: none"> • Multiple &/or complex needs • A comprehensive/single multi-disciplinary plan is required • An ongoing key worker or case manager is not available • Interim worker initiates care coordination and an ongoing facilitator • Hands over to ongoing worker when available 	<ul style="list-style-type: none"> • Multiple &/or complex needs • A comprehensive/single multi-disciplinary plan is required • An ongoing key worker or case manager is available • Ongoing worker facilitates care coordination • The role is regularly reviewed: ie. transfer to another nominated key worker if needed; transfer between case management and key worker as required

Who can facilitate care coordination **when**.....

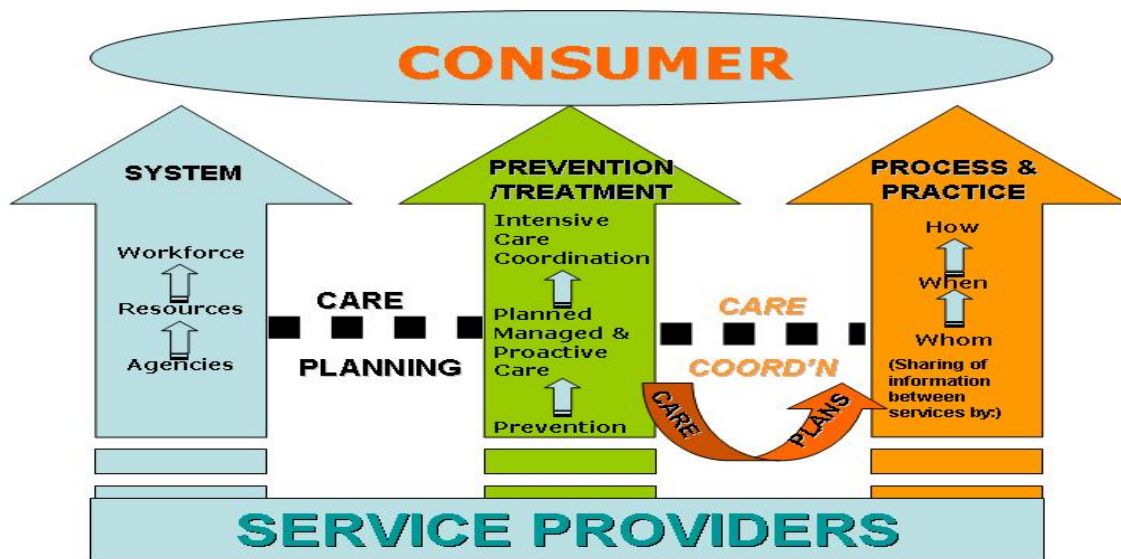
Generalist service when.....	Specialist services when.....	Dedicated case management services when.....
Less complex	Moderately complex	Very complex
Infrequent changes		Frequent changes
Infrequent advocacy		Frequent advocacy
<ul style="list-style-type: none"> • Works within own service boundaries • Not across services or sectors 	<ul style="list-style-type: none"> • Case management related to their own service system • Often time limited service 	<ul style="list-style-type: none"> • No service boundaries • Works across sectors

Within the care continuum care plans are developed which includes client goals and needs, self-management strategies, carer needs, ongoing proactive monitoring, regular review mechanisms and appropriate recommendations from evidence based clinical guidelines. Care plans are developed with active participation by consumer and carer, relevant community services/agencies, including GPs, and are shared by all parties involved in providing care. In turn, key worker/care coordinators are oriented to and use assessment tools, documentation processes, care planning, Victorian Service Coordination Practice Manual and Chronic Disease Management Medicare items²⁹.

²⁸ Central Victoria Health Alliance, *Care Coordination Process At A Glance*, Central Victoria Health Alliance Primary Care Partnership, October 2006, Catherine Fuller, Service Coordination Project Manager. Used with permission

²⁹ State of Victoria, *HARP Chronic Disease Management Guidelines*, Eastern Health, Department of Human Services

Diagram 1: Care Planning/Care Coordination Continuums



Care Coordination Models³⁰

The work of Central Victorian Health Alliance PCP (CVHA PCP) is most informative in identifying various care coordination models. They define care coordination as “a multidisciplinary process that requires a **cross agency team approach**. A team approach involves **shared responsibilities** and **collaborative monitoring and planning**. A **Key Worker** or Case Manager may be required to facilitate this ‘teamwork’ where there are multiple and complex needs. Care coordination can be undertaken using a variety of models to suit the service system’s nuances.”

It should be noted that Key Worker/Care Coordinator and Case Manager are not mutually inclusive terms. The Key Worker may not be a Case Manager and conversely a Case Manager may not necessarily be the Key Worker. The roles and responsibilities of the Key Worker need to be clearly articulated and may differ considerably from that of the Case Manager. However, there may be occasions when these two distinct roles are undertaken by the same individual. The Key Worker in the above rendering is viewed as a ‘facilitator’ to enhance a coordinated team approach to care planning on behalf of a consumer(s) where a multidisciplinary and/or multi agency approach is required. This issue requires more discussion and articulation around systems to support the nomination of a key worker.

The CVHA has articulated a number of models in the following table.

Model	Description
‘Allocation’	<ul style="list-style-type: none"> • A select service group or agency has a process to identify potential persons who would benefit from a ‘team approach’. • Consent is gained to nominate the person to the ‘team meeting’. • Assessment and care details are discussed (service level and gaps). The need for coordination is identified – if none, services etc. are readjusted. • If coordination is needed a Key Worker is allocated (this presupposes that there are systems, agreements and processes in place to allow the appropriate appointment of a Key Worker so that there is clarity around the role and responsibilities of that person and/or agency). • The Key Worker takes on responsibility for developing a multidisciplinary plan using assessments and plans from the relevant team member(s).

³⁰ Central Victoria Health Alliance, *Care Coordination Process At A Glance*, Central Victoria Health Alliance Primary Care Partnership, October 2006, Catherine Fuller, Service Coordination Project Manager. Used with permission.

Model	Description
'Clinic'	<ul style="list-style-type: none"> • A 'clinic' is organised within a team of practitioners. • Assessments and plan developed by practitioners are part of the clinic. • Assessments and plans are fed into a central 'Team Meeting' process and a multidisciplinary plan is developed by a nominated practitioner.
'Shared Care'	<ul style="list-style-type: none"> • 2 services share the monitoring of 1 individual plan or issue (eg. Physio & Strength Training leader). • An assessment or secondary consult service does the assessment and develops the plan and the service provider implements the plan. • Occasionally 2 or more services undertake joint assessments and develop a joint plan for the service provider to implement.
'Specialist Team'	<ul style="list-style-type: none"> • 2 or more services are involved in the 'team' focussing on a special area of care (eg. chronic illness, housing, mental health). All team members have a separate service delivery role: do their own assessments and plans. • Assessments and plans are shared at a 'Team Meeting': ± single multidisciplinary plan.
'Case Conference'	<p>A 'facilitated' meeting (face-to-face and/or teleconference) where the team share assessments and plans so as to develop a single multidisciplinary plan.</p>
'Case Management'	<ul style="list-style-type: none"> • Is required when a person has multiple and complex needs that can not be addressed individually by the services involved. • A dedicated Case Manager facilitates the 'team-work' process. (In some cases this person would or could also be referred to as the 'Key Worker'. Further discussion may be required around the terminology described in this model) • The Worker is able to work outside own agency: a cross-agency advocate.

GP Care Planning/Care Coordination Model

GPs have a central role in providing well coordinated care for consumers with chronic and complex diseases. They have a primary responsibility for medical management of those consumers. According to the *Chronic Disease Management Guidelines for Primary Care Partnerships and Community Health Services* the Australian Government has encouraged GPs to take a multidisciplinary proactive approach to chronic disease through the provision of reimbursement arrangements through MBS and the Practice Incentives programs (PIP).³¹ The multidisciplinary interventions are required to complement medical management provided by GPs.

The GP care planning/care coordination model for the management of eligible consumers places GPs in the central or lead care coordination role (this is not a case management) operating within the context of Care Plan (CPs) development, Team Care Arrangements (TCAs) and Managed Plans (MPs). Some interesting work in developing an effective GP care planning TCA arrangement has been undertaken in a collaborative arrangement project between Brunswick Community Medical Clinic and Moreland Community Health Service in conjunction with an aged care service provider in the Hume Moreland Primary Care Partnership. A flowchart of demonstrating the process for this TCA arrangement is available in [Appendix 2](#).

GPs can contribute to a plan developed by another service provider. TCA's provide access for client to MBS funded allied health services. Other service providers can suggest GP development of a TCA to support client access to private allied health. The GP acts as the link person in the discussion process (case conferencing). Face to face consultation with providers is considered ideal but rare due to time constraints and other limitations. Case management by service provider may fit into a TCA. Additionally, the observance of response time protocols is considered essential to the care planning process by GPs.

The Centre for General Practice and Integrations Studies³² has identified four essential components for better management of chronic disease³³ which directly impacts care planning and care coordination:

³¹ State of Victoria, *Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services – October 2006*, Department of Human Services

³² Centre for General Practice Integrations Studies, [Hhttp://www.cgpis.unsw.edu.au](http://www.cgpis.unsw.edu.au)H

- Effective teamwork
- Information management/information technology (IM/IT) maturity
- Appropriate business systems
- Effective linkages with external services³⁴

Several enablers for effective GP care planning have been identified including:

- Sufficient practice staff
- Adoption of sustainable systemic approach
- Practice nurse involvement and rapport with GP
- Use of electronic care plan forms
- Effective and efficient recall systems

Several barriers have been identified by GPs in relation to care planning with service providers including:

- Waitlists for HACC funded services
- Limited understanding of MBS within allied health
- Accessing of allied health choice
- Feedback from providers to GP

The engagement of GPs through the DGPs in activities such as development of local agreements for the identification of clients requiring cross-disciplinary and multi-organisation care planning is primary. The management of interfaces, building effective linkages and potential for dual planning processes between GPs and other service providers will form a strategic platform for ongoing discussion around care planning and care coordination between GPs, GP Divisions and service providers in the region.

Regional Care Planning Framework/Model

Although several care coordination models have been identified, in considering the issue of care planning from a system perspective, a cohesive regional approach to care planning should be underpinned by a framework or set of guiding principles and agreements which are adopted and implemented into day to day agency practice. These would be flexible enough to accommodate the variety of care planning models outlined above, flexible enough to meet differing agency requirements and the variety of existing practices. Consideration to how this would be accomplished will need to be undertaken.

Factors influencing Care Planning/Areas for Consideration

Terms and Definitions

Language is a most critical area for dialogue and agreement in care planning. Clearly articulated understandings around common sets of terms, definitions and the key tasks they describe is vital for establishing and building workable multi-agency and multidisciplinary systems and agreements.

There is currently a range of terminology (also see page 3 – [Terminology](#)) and language used to describe a number of activities, roles, responsibilities and practices that broadly come under the heading of 'Care Planning'. The work undertaken in the Hume Region (2003) on developing definitions based on thorough research for Care Planning, Care Coordination and Case Management to explore the use and understanding of these terms has proven to be most valuable.

In June 2003 the Hume Region PCPs and HACC agencies conducted an extensive literature review and the IEPCP also undertook a supplementary literature review on care planning. The Hume Region review was conducted around terminology and definitions of care planning, care coordination and case management. The review findings informed the agreements reached around terminology for the IEPCP.

The definitions and key tasks drawn from this work in the Hume Region include modifications formally agreed to by the IEPCP Care Planning Working Group in 2005. These definitions and key tasks were

³³ State of Victoria, *Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services – October 2006*, Department of Human Services

³⁴ Ibid.

adopted for the purpose of establishing a foundation for common understanding and to form a platform for ongoing discussions relating to service coordination/care planning by Inner East PCP service providers. Key to the adoption of these definitions³⁵ is that they allow differing models of care planning. For discussion purposes the following table has been compiled comparing the terminology adopted by the IEPCP Care Planning Working Group in 2005, those terms & definitions utilised in the Statewide Service Coordination Manual and those outlined in the HARP Chronic Disease Management Guidelines.

³⁵ *ACKNOWLEDGEMENT:* The original definitions were sourced from: *HACC Care Coordination, Care Planning and Case Management Project Report, Hume Region, June 2003*, Telos Consolidated 2003 (HACC, PCPs). They were then modified and adopted by the IEPCP Care Planning Working Group, September 2005.

Table: Terminology and definitions adopted by IEPCP Care Planning Working Group 2005, Statewide Service Coordination Practice Manual and HARP Chronic Disease Management Guidelines - Comparative Table

Terminology	Adopted Definition by IEPCP Working Group (2005)	Key Tasks	Statewide Service Coordination Practice Manual (2006) ³⁶	HARP Guidelines ³⁷
Care Planning	Care Planning is a dynamic, consultative process that includes the client, the family and appropriate service providers in the identification and assessment of clients needs, from which a care plan is developed, that includes goals and actions aimed at achieving desired/optimal outcomes.	<ul style="list-style-type: none"> • Assessment of short term and long term client needs • Prioritising of client needs and goal setting to meet such needs • Exploring the most appropriate and cost effective way of meeting client needs • Developing a Care Plan specific to the services of the agency, noting other agencies involved, The circulation of this Plan will depend on current individual agency practices • Implementing the Care Plan • Ongoing assessment and review of client needs and appropriate revision of the Care Plan 	A process of deliberation that incorporates a range of existing activities such as care coordination, case management, referral, feedback, review, re-assessment and monitoring. Care Planning involves the judgement/ determination of relative need as well as competing needs, and assists consumers to come to decisions that are appropriate to their needs, wishes, values and circumstances.	A process to outline how the issues identified in an assessment or review of the client's needs are to be best managed. This may involve linking into a range of existing services, how self management and education are to be provided and involves setting up communication between the General Practitioner and other people involved in providing care to the client. Care planning involves balancing competing needs, and assisting consumers to come to decisions that are appropriate to their needs, wishes, values and circumstances.
Care Coordination	Care Coordination is a process that implements care plans, ensuring that agencies plans are coordinated and are implemented in a client focused, flexible and timely manner. It is acknowledged that some clients will choose to coordinate their own care, The care plan is dynamic in response to the client's needs and may alter during the work with the client.	<ul style="list-style-type: none"> • Implementation of Care Plans, particularly through each agency involved coordinating their own service(s)/program(s) • Agencies ensuring that the care is meeting the client's needs through effective monitoring and review of Care Plans • Liaising and communicating with other service providers and client/carer • planned exit to other services/systems eg. ACAS, case management or residential services 	The range of services required by the consumer is coordinated so that they are delivered in the most efficient and effective way to meet an individual consumer's needs. Care coordination enables continuity of care, avoids duplication of services and ensures that meeting consumer needs is paramount over the needs of individual services providers and is not hampered unnecessarily by program boundaries,	The term "care coordination" has been used as the generic term for the multitude of coordinating roles in existence for people with chronic and complex needs. This includes case management, care management, service coordination and key worker roles. Within Levels 1 and 2 it is understood that the intensity of care coordination will vary depending on the client's needs. In some instances clients may need significant input from the care coordinator while others may need more emphasis on referral to appropriate services. The decision to use one generic term has been made to create consistency across HARP CDM and in recognition of the fluctuating and diverse needs of clients.

³⁶ Victorian Service Coordination Manual, Primary Care Partnerships, Prepared by Juliet Frizzell, Effective Change and Dr. Ro Saxon, HDG Consulting

³⁷ State of Victoria, HARP Chronic Disease Management Guidelines, Eastern Health, Department of Human Services

Terminology	Adopted Definition by IEPCP Working Group (2005)	Key Tasks	Statewide Service Coordination Practice Manual (2006) ³⁸	HARP Guidelines ³⁹
Case Management	Case Management encompasses the tasks of Care Planning and Care Coordination and as such is based on a comprehensive assessment of the client's complex needs. The Case Manager ⁴⁰ , as a central point of contact and identified key worker, liaises with the client and services to provide holistic care, problem solving and advocacy on behalf of the client. This process will proactively respond to and plan for client needs, activate appropriate resources in consultation with the client, carers and other service providers, and, ensure that the client is aware of all options and is able to make informed choices.	<ul style="list-style-type: none"> • being the lead agency • assessing client and carer/family needs using the social model of health • developing/updating the Care Plan and developing future goals • problem solving, trouble shooting, responding to crisis • negotiating and facilitating service provision • liaising with service providers • monitoring the client's wellbeing, needs, care and the effectiveness of services • advocacy and mediation • planning of care within available resources, sourcing additional funds • empowering clients and/or families to make informed choices • referring to other agencies • identifying the need for specialised training that may arise due to a client's specific needs • developing an ongoing care plan or exit/discharge plan 		"Case management" refers to programs such as Linkages, Community Aged Care Packages (CACPs) and Extended Aged Care at Home (EACH) Packages. HARP CDM may refer clients to existing case management services as required.

³⁸ *Victorian Service Coordination Manual*, Primary Care Partnerships, Prepared by Juliet Frizzell, Effective Change and Dr. Ro Saxon, HDG Consulting

³⁹ State of Victoria, *HARP Chronic Disease Management Guidelines*, Eastern Health, Department of Human Services

⁴⁰ *Case Manager/Care Manager*: where the term Care Manager is utilised it is understood to be Case Manager.

Other related care planning terminology and definitions

These have been derived from a variety of sources as indicated and demonstrate the diversity of care planning/care coordination terminology usage.

Terminology	Definitions
Care Coordinator/Key Worker/Case Coordinator/Case Manager ⁴¹	A nominated Worker who has responsibility of ensuring that the care plan is implemented, and that reviews and reassessments are undertaken at the appropriate times by the relevant service providers. (Also see notes on Care Coordination Models)
Care Plan ⁴²	The outcome of assessment and care planning process that documents the services to be provided. It specifies service type, levels and frequency of service provision.
Case Conferencing ⁴³	MBS Item allowing GPs to be involved in real time discussion with other practitioners (minimum 2) via telephone, video conference, face to face to develop care plans for consumers. This MBS Item enables a GP to contribute to the development and review of Service Coordination Plans.
Case Management ⁴⁴	The activities undertaken by one central person who assumes overall responsibility for the care plan, in order to streamline interface between service system and the consumer and carer. Activities may include some or all of the following: <ul style="list-style-type: none"> • Assessment • Care Plan development • Referral and/or feedback • Implementation of the care plan, including liaison with service providers • Monitoring • Review • Re-assessment • Exiting and discharge • Management of brokerage funds <p>Additional case management key tasks may also include⁴⁵:</p> <ul style="list-style-type: none"> • Advocacy and mediation • Development of client exit plan • Negotiation and facilitation of service provision
Case Management arrangements	Features of care management arrangements most commonly cited include: <ul style="list-style-type: none"> • Case / care management plan • Joint care planning • Individualised service planning
Comprehensive Assessment ⁴⁶	An extensive process of enquiry that gathers information about medical, physical, social, cultural and psychological dimensions of need and assess restorative options and capacity for improvement. It occurs where consumers have multiple, complex, or unclear needs or with consumers who require long-term and/or intensive service provision.
Contribution to a Care Plan ⁴⁷	MBS Item enabling a GP to contribute to another practitioner's care plan.
General Practice Management Plans	MBS Item allowing GPs to assess, identify needs, set agreed management goals, identify consumer actions, treatment and ongoing management and documenting GPMP for consumers with chronic (or terminal) medical

⁴¹ *Victorian Service Coordination Manual*, Primary Care Partnerships, Prepared by Juliet Frizzell, Effective Change and Dr. Ro Saxon, HDG Consulting

⁴² Ibid.

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ *HACC Care Coordination, Care Planning and Case Management Project Report*, Hume Region, June 2003, Telos Consolidated 2003 (HACC, PCPs).

⁴⁶ State of Victoria, *Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services – October 2006*, Department of Human Services

⁴⁷ *Victorian Service Coordination Manual*, Primary Care Partnerships, Prepared by Juliet Frizzell, Effective Change and Dr. Ro Saxon, HDG Consulting

Terminology	Definitions
(GPMP) ⁴⁸	conditions once every two years or less if clinically required. GPMPs allow GPs to prepare care plans for eligible consumers where the involvement of other health or care providers is not required.
Integrated Care ⁴⁹	Care provided to a client that is coordinated and connected across the continuum of services and among providers in all sectors and levels.
Linkage	Occurs between existing organisational units. It aims at an adequate referral of patients to the right unit at the right time and good communication between the professionals involved in order to promote continuity of care.
Self Management ⁵⁰ (Self Managed Care)	Involves [the person with the chronic disease] engaging in activities that protect and promote health, monitoring and managing of symptoms and signs of illness, managing the impacts of illness on functioning, emotions and interpersonal relationships and adhering to treatment regimes.
Shared Care	<p>This is a term used in the AOD sector. Shared care arrangements are made by GPs with other services providers to provide quality general practice care for deal consumers with AOD problems.</p> <p><i>"Shared care ensures that people who need ongoing services from GPs and other service providers receive the most effective combination of care (Penrose-Wall et al., 2000, p. 6)</i></p> <p>Shared care:</p> <ul style="list-style-type: none"> • is multidisciplinary and multi-agency • includes prevention and treatment • is fundamental to effective harm minimization
Team Care Arrangements (TCA)	<p>Team care may involve multiple practices or multiple organizations that allow different professionals to discuss referrals and negotiate agreement around division of labour.⁵¹</p> <p>MBS Item funding GP involvement in the development and review of care plans with other practitioners.</p> <p>Available for consumers chronic and complex needs requiring ongoing care from a multidisciplinary team of their GP and at least two other health or care providers.⁵²</p>

Other terminologies which are utilised within the system and are interchangeable with other more commonly used terms are care management, lead agency and strategic alliances or care networks.

Any relabelling of care planning/care coordination terminology would require significant consideration. Continued debate around terminology is essential to establish a set of common understandings for all associated care planning terminology within service coordination.

Integrated Chronic Disease Management (ICDM)

As previously mentioned care planning facilitates a consistent, planned approach to the management of appropriate care for consumers with chronic diseases and multiple or complex needs often requiring complex care arrangements. *Care in Your Community* proposes that integrated chronic and complex care includes a "consistent approach to case management, care coordination and key worker arrangements".⁵³

⁴⁸ Whitehorse Division of General Practitioners, Power Point Presentation

⁴⁹ State of Victoria, *Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services – October 2006*, Department of Human Services

⁵⁰ Flinders university Model of Chronic Condition Self Management [Hhttp://som.flinders.edu.au/FUSA/CCTU/Self-Management.htm](http://som.flinders.edu.au/FUSA/CCTU/Self-Management.htm)

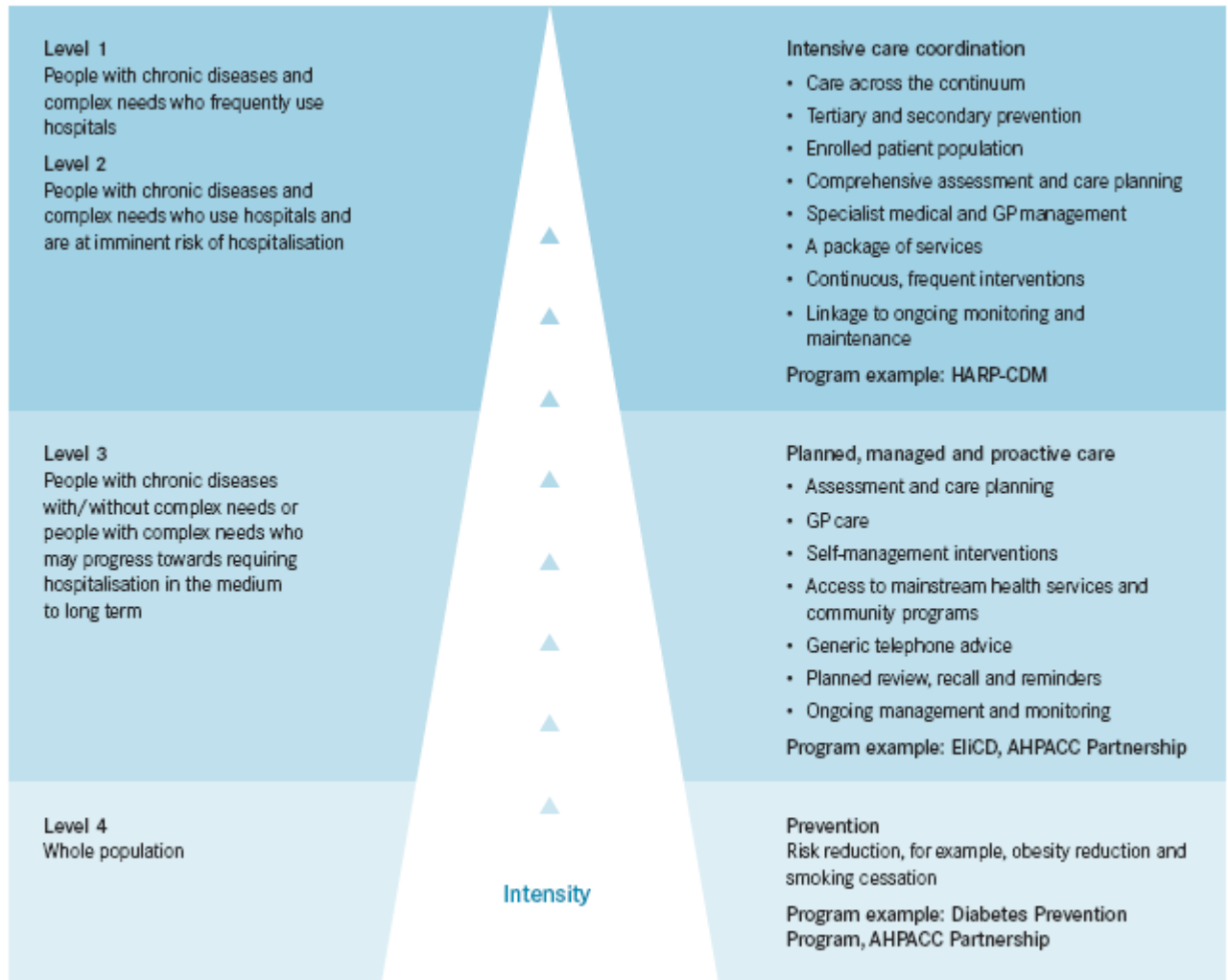
⁵¹ *Victorian Service Coordination Manual*, Primary Care Partnerships, Prepared by Juliet Frizzell, Effective Change and Dr. Ro Saxon, HDG Consulting

⁵² Whitehorse Division of General Practitioners, Power Point Presentation

⁵³ State of Victoria 2006, *Care in Your Community, A Planning Framework for Integrated Ambulatory Health Care*, Victorian Department of Human Services, 2006

Chronic disease management encompasses a continuum of care from prevention through treatment and care management for consumers with chronic disease. The *Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services* provides the levels of chronic and complex care prevention and management which is useful in our consideration of ICDM impacts upon care planning and care coordination illustrated in the following diagram.

Diagram 2: Levels of chronic and complex care prevention and management⁵⁴



PCPs have received core funding for ICDM to build on existing service coordination work. Service coordination provides an essential platform for ICDM. Guiding principles that undergird local ICDM work include:

- providing person centred care, including support for carers and/or families of people with chronic disease
- recognising that consumers are active partners in the management of their chronic disease
- increasing choice and control
- providing the right care in the right place at the right time
- proactively promoting health
- targeting population subgroups of greatest need
- building whole of service system response⁵⁵

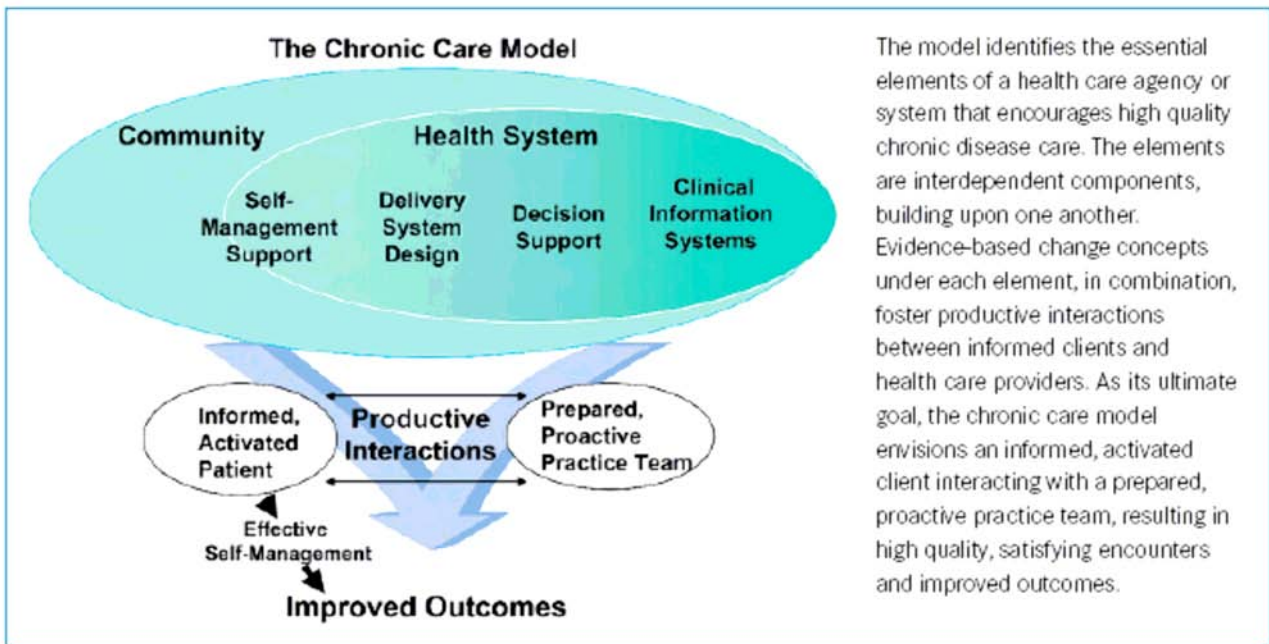
The challenge for the service system is to improve integration and continuity of care for consumers over time, through different stages of disease progression. The PCPs are encouraged to base their ICDM work upon the Wagner Chronic Care Model (**Diagram 3**) – a systems-based model endorsed by the World Health Organisation which articulates the essential elements for improving care in health systems at the

⁵⁴ State of Victoria, *Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services* – October 2006, Department of Human Services

⁵⁵ Ibid.

community, organisation, practice and clients levels. This model can be applied to a variety of chronic diseases, health care settings and target populations.⁵⁶

Diagram 3: The Chronic Care Model⁵⁷



Self-Management

Effective chronic disease management is undergirded by evidence-based self-management interventions, such as the Flinders University Model of self managed care, delivered by suitably trained health care providers and/or consumers. Self-management interventions aim to place the consumer in control of their life and assist them to be as independent as possible.⁵⁸

Self-management enables the consumer/carer to work in partnership with their health care provider to:

- Know their condition and various treatment options
- Negotiate a plan of care
- Engage in activities that protect and promote health
- Monitor and manage the symptoms and signs of their condition(s)
- Manage the impact of the condition(s) on physical functioning, emotions and interpersonal relationships⁵⁹

Self-management enhances the ability of the client to deal with all that a chronic disease entails, including symptoms, treatment, physical and social consequences, and lifestyle changes⁶⁰

Existing evidence based self-management interventions include:⁶¹

- Flinders Model⁶²
- Stanford Model⁶³

⁵⁶ Ibid. (for more information about the Wagner Chronic Care Model)

⁵⁷ State of Victoria, *Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services – October 2006*, Department of Human Services

⁵⁸ Ibid.

⁵⁹ *Flinders university Model of Chronic Condition Self Management* [Hhttp://som.flinders.edu.au/FUSA/CCTU/Self-Management.htm](http://som.flinders.edu.au/FUSA/CCTU/Self-Management.htm)

⁶⁰ State of Victoria, *Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services – October 2006*, Department of Human Services

⁶¹ Ibid.

⁶² *Flinders university Model of Chronic Condition Self Management* [Hhttp://som.flinders.edu.au/FUSA/CCTU/Self-Management.htm](http://som.flinders.edu.au/FUSA/CCTU/Self-Management.htm)

⁶³ *Standford Chronic Disease Self-Management Program* [Hhttp://patienteducation.stanford.edu/programs/cdsmp.html](http://patienteducation.stanford.edu/programs/cdsmp.html)

- Self Management 5As (Kaiser Permanente)⁶⁴
- Telephone coaching⁶⁵
- Motivation interviewing for behaviour change (Prochaska and DiClemente Model)

In relation to care planning agencies need to facilitate processes to address and support self-management interventions. For example:

- how consumers who need self-management are identified
- who provides self-management interventions
- how good self-managers are supported
- determination of who provides ongoing management and review
- how are consumers linked back into the system if issues are identified in the review

Discussion within the region about the differing roles such as acute sector role, GP role, CHS role, and other service providers in self-management would also be useful.

Care Plans

Care plans are primarily utilised to promote consistency of planning and delivery of care, provide effective communication tools and encourage best practice.⁶⁶ Consistent consumer focused practice and approaches to the development and sharing of care plans is vital to improving and providing better outcomes for consumer care. This requires higher levels of collaboration and communication between service providers and consumers.

Care plans are undergirded by coordinated care strategies developed and implemented by service providers. They are based upon:

- A set of common practices, processes, protocols and systems for sharing of consumer and service information and include use of service coordination tools, recall and reminder and feedback systems as outlined in the Victorian Service Coordination Practice Manual
- Adherence to consumer consent and privacy standards
- Best practice clinical guidelines including multidisciplinary pathways between service providers/sectors
- Training for service providers, including GPs, in best practice guidelines and coordinated care⁶⁷

To enable greater access to services and improvements in care coordination, centrally coordinated care pathways and the development and utilisation of multiagency/multidisciplinary care plans and require:

- identification of clear entry points for consumers
- cooperative approaches to the development and documentation of care plans in and among service providers/sectors
- shared and agreed expectations across services/sectors
- clarification of the care coordination/key worker role across agencies
- agreement around shared and dedicated resources allocated to the care coordination/key worker role
- agreed use of common referral tools including Service Coordination Plan, e referral and pathways
- building on existing relationships⁶⁸

However, within the region, as mentioned previously, the current system is fragmented with a diversity of care plan options, care planning practices, multiple federal and state funding streams and requirements, placing additional pressure on agencies. Further discussion is required around the development and implementation of multiagency/multidisciplinary care plan development and implementation of care coordination best practice.

⁶⁴ <http://jenny.ipro.org/attachment.php?attachmentid=1322&d=1146597543>

⁶⁵ Linder H, Menzies D, Kelly J, Taylor S, Shearer S, (2003) *Coaching for behaviour change in chronic disease: A Review of the literature and implications for coaching as a self-management intervention*, La Trobe University, *Australian Journal of Primary Care*, Special Issues, The Management of Chronic Diseases in Primary care Settings, Vol 9, Numbers 2&3 2003

⁶⁶ State of Victoria, *Improving Chronic Disease Care: Learnings from the Integrated Disease Management Projects*, December 2005, Department of Human Services

⁶⁷ Ibid.

⁶⁸ Ibid.

Effective Care Planning

Effective care planning encompasses a wide range of factors including:

- Agreement and adoption of appropriate care coordination and funding models
- Workforce development
- Information management systems
- Use of Service Coordination Plan and appropriate care coordination tools
- Quality and clinical governance support
- Viability and sustainability
- Risk management

Enablers to Effective Care Planning

A number of enablers for effective care planning have been identified through the processes undertaken in the region. These include but are not limited to:

- agreement and adoption of care coordination models that provide multidisciplinary and interdisciplinary support to consumers which enable management of their chronic and complex conditions
- maximised potential for consumer self management of chronic conditions
- embedding of multi agency/cross disciplinary care planning into day to day core work practices across all agencies
- funding models that provide incentives to support person-centred care
- workforce able to provide person-centred care
- integration tools, including common language and common approaches to information sharing
- information management environment that supports decision making, information sharing and collaboration, and partnerships between organisations⁶⁹
- comprehensive assessment information providing a solid foundation for effective care planning
- enhanced information and communications technology
- effective feedback and followup systems
- development of a regional case management strategy including development of protocols around review schedules for SC Plan, initiation of reassessments and provision of feedback to referral agencies
- cross agency team approaches which support consumer access to private allied health and to other services via GP coordination
- change of practice required to fully operationalise Service Coordination Plans
- adoption of an agreed set of principles to underpin practice containing. For example (this list is neither prescriptive nor exhaustive):

- consumer/carer is central and their needs will be foremost
- consumer/carer is involved in all stages of the service delivery with a choice to exit at any point in the service delivery process.
- consumer/carer consent will always be obtained for any referrals, consultations or work undertaken that involves interagency and intraagency (cross discipline) cooperation. The goal is to share necessary relevant information to achieve optimum service coordination for the consumer.
- agencies and staff undertaking service delivery will promote client autonomy, independence and right to services and advocacy for services.
- care coordination pathways/flowcharts, processes are developed as a guide and are not intended as prescriptive practice. They represent usual practice activities which may vary from consumer to consumer depending on their relevancy. Other practice activities not cited may be required.

⁶⁹ State of Victoria 2006, *Care in Your Community, A Planning Framework for Integrated Ambulatory Health Care*, Victorian Department of Human Services, 2006

- staged training and ongoing workforce development strategies for care planning
- whole of region staged change management strategy
- adoption of a regional agreement around nomination of and role and responsibilities of 'key worker'/ 'lead agency'
- development of effective communication and feedback systems to and through 'key worker' and between agencies and GPs
- agency/service provider use of well developed and clearly articulated care plans that incorporate the elements such as identified issues, goals, actions, target dates, agencies responsible for care and participant, regular review dates, planning method, checklists other appropriate and relevant information
- clearly defined policies and embedded practice in agencies/service providers around referral and feedback including universal agreement around use of Service Coordination Plan and other relevant SCTT tools and care planning tools
- appropriate consumer eligibility and prioritisation criteria for care planning
- firmly embedded referral practices and use of electronic referral system by service providers/practitioners
- provision of workforce training in use of electronic referral system
- strong commitment to internal and system wide continuous quality improvement
- focus by health care service providers on reduction of barriers to services affecting disadvantaged groups within the community
- fostering and building of strong partnerships/collaboration in implementing care planning initiatives, agreements, protocols, care plans in and among service providers, key agencies (eg. HARP, CHSS, GPs, etc.)
- development and implementation of shared goals by health care service providers
- adoption of regional agreement around who is responsible for updating of care plans
- processes of disseminating information and handling of out of date material
- early consumer involvement in care planning process
- appropriate processes to obtain consumer consent and privacy consistent with legislated standards
- use of service directories embedded in care planning/care coordination practices by service providers

Care Planning Quality and Clinical Governance Support

The implementation of clinical governance principles to ensure high quality clinical and health promotion services to consumers is well established in the acute health sector. It is likewise becoming increasingly important in the primary health care sector and other related sectors with the need for greater development, refinement and implementation of clinical governance principles being brought to bear by changes in policy directions around integrated chronic disease management, ambulatory care and other initiatives and programs that span the acute–primary interface.⁷⁰

According to the Australian Council on Healthcare Standards (ACHS, 2004)⁷¹ clinical governance is "the system by which the governing body, managers and clinicians share responsibility and are held accountable for patient care, minimising risks to consumers and for continuously monitoring and improving the quality of clinical care."

Dr. Cathy Balding, Director, Quality Works cited four principles guiding good clinical governance in a presentation to the VHA Clinical Governance Workshop in July 2006. They include:

- building a culture of trust and honesty;
- fostering of organisational commitment to continuous improvement;
- establishment of rigorous monitoring, reporting and response systems; and
- evaluation and responding to key aspects of organisational performance⁷².

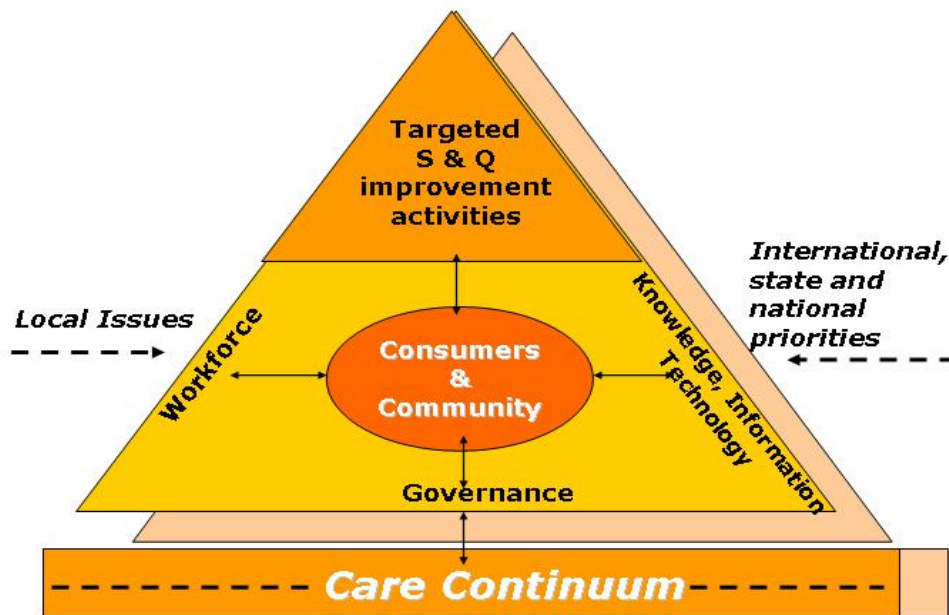
⁷⁰ Victorian Healthcare Association Ltd (VHA), Community Health Victoria (CHV), Community Health Victoria, *Clinical Governance Project Work Plan and Budget 2006-2007*

⁷¹ Victorian Healthcare Association Ltd (VHA), Community Health Victoria (CHV), Quote from presentation made by Dr. Cathy Balding, Director, Quality Works to the VHA Clinical Governance Workshop in July 2006

⁷² Ibid.

Dr Balding also provided a useful governance framework illustrating the relationship between the care continuum and the elements of quality and clinical governance impacting directly on consumers.

Diagram 4: Quality & Clinical Governance Framework⁷³



Quality and clinical governance support areas affecting care planning take into account the following:

- Care planning systems/structures that encourage and support best service coordination care planning practice
- Systems and practices that clarify the roles of all staff in achieving best service coordination care planning practice
- Incorporation of appropriate clinical governance and support, e.g.
 - Service guides
 - Risk assessment and prioritisation categories and tools
 - Other decision support tools and protocols
- Incorporation of quality measures/benchmarking to support continuous improvement, embedding of Statewide Service Coordination Practice Manual, quality assurance reviews and meeting of accreditation standards
- Development and embedding of evidenced based clinical indicators and robust systems to support and monitor clinical safety and quality Clinical Governance by:
 - managing risk through early identification and response
 - maintenance, monitoring and overviewing status of clinical safety and quality
- Development of care plans founded on sound assessment practices
- Incorporation of good consumer information management and data collection systems & practices that:
 - track consumer journey and service usage
 - support recall and follow up systems
 - allow for easy measurement of care planning demand, agency response, unmet need and service gaps
 - produce meaningful reports which inform care planning and resource allocation
- Maximisation of potential for quantitative outcomes such as:
 - increased capacity for collaboration and development of appropriate care plans
 - reductions in duplication of care plans, care planning activities and inappropriate or unnecessary service provision
 - allows for workload monitoring of staff resourcing care planning activity

Quality and clinical governance that supports care planning answers questions⁷⁴ such as:

⁷³ Victorian Healthcare Association Ltd (VHA), Community Health Victoria (CHV), Presentation at the *VHA Clinical Governance Workshop 4 July 2006*, Dr. Cathy Balding, Director Quality Works

- What are our high risk, high volume, high cost, high problem, high complaint areas? – and how are we addressing them?
- Are our key risks monitored, managed and minimised?
- Is our staff competent and credentialed to do what they do?
- Do we use correct and evidence based standards for our clinical care, staff safety and equipment?
- Are we reviewing and designing our systems to help work flow safely and efficiently?
- Are we including consumers in our improvement efforts?
- Are we reporting as required to external organisations on our dimensions of quality? – ACHS, DHS, etc – and learning from comparative data that we get back?
- Are we equipping and supporting staff to improve care and services?
- Do we have the right information to help us monitor and improve?
- Are we meeting state and national quality requirements?
- How safe are the people in our care?
- Are they better off because of our safety and quality program?

Viability and Sustainability

Frameworks and models enabling effective care planning/care coordination need to:

- Support agency implementation of policy directions around consumer centred care, broad and consistent needs identification, broad and specific assessment, information sharing, managing consumers with chronic and complex needs, facilitating continuity of care and provision of more integrated care.
- Maximise embedding of service coordination care planning across the agency and utilisation of tools such as Service Coordination Plan (SCTT), eReferral, electronic service directories etc.
- Address:
 - Demand Factors
 - Supply Factors
 - Cost Effectiveness
 - Resourcing
 - Evaluation/Continuous Improvement
- Be supported by appropriate resourcing model for infrastructure, staffing, case management, etc. that is linked to and can respond to changes in consumer needs and growth in agency program mix
- Be supported by appropriate infrastructure – IT, telecommunications, records management etc.
- Increase capacity to identify unmet need and advocate for/allocate appropriate resources accordingly
- Enhance care coordination practice and collaboration across all disciplines and between services
- Provide system wide solutions to care planning/care coordination issues

Risk Management⁷⁵

Effective risk management strategies which undergird the sustainability and viability of effective care planning and care coordination:

- Operate with fully documented care planning/care coordination system policies, practices and guidelines
- Support development of clearly articulated performance indicators, including policies dealing with breaches in protocols and practice
- Allow for clear identification of potential risks to consumers
- Allow for clear identification of potential risks to agency

⁷⁴ Ibid.

⁷⁵ Adapted from *Draft Risk Management Framework and Manual*, Whitehorse Community Health Service, 2006 and sourced from State of Victoria, *Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services – October 2006*, Department of Human Services

- Provide for clearly articulated risk management strategies and well defined, evidence based risk identification and prioritisation tools that are appropriate and available for identifying the clinical and psychosocial factors for a range of needs, disciplines & services. Addresses:
 - Clinical factors
 - Non clinical factors (program functions)
 - OH & S factors, e.g. crisis or critical incident management.
- Ensure appropriate identification and resolution to practice issues, guided by practitioners' clinical and professional expertise and agency policies
- Address additional risk factors relating to:
 - Information management
 - IT systems
 - Communications systems
 - Client records
 - Security management
 - Public liability
 - Internal and external emergencies
- Identify levels of threat posed to service provision and range of options for dealing with risk to agency e.g. of service interruptions
- Ensure appropriate consumer complaints/feedback mechanisms around care planning/care coordination
- Ensure periodic review, understanding and adherence to existing control measures, eg. management of crisis presentations
- Incorporate appropriate role statements and staff profiles to ensure that all staff have responsibility for embedding service coordination, and competent staff are employed with appropriate skills to match responsibilities
- Take into account human resource issues around:
 - Task breakdown, workflow and role delineation
 - Qualifications
 - Recruitment
 - Retention
 - Training
 - Backfill
 - Unplanned/extended leave
 - Job variety, satisfaction and stress management
- Support appropriate workforce development

Challenges for Regional Care Planning

Interface Issues

The importance of the interfaces between care planning and chronic disease management are very clear as previously outlined in this document. However, also strategically important is the building of appropriate system interfaces for:

- **dual planning processes (GPs/Agencies)** – need to avoid duplication – systematic involvement for General Practice is challenging. GPs are not mandated to use the Service Coordination Plan. Challenging for GPs who have other preferred formats recommended and promoted through Divisions. The GP contribution to other agency care plans may preclude some client access to Medicare rebateable private allied health and dental care services. Awareness of existing GP initiated care planning activity is required.
- **acute and private sector** – differences in systems and practice- including follow up, communications, staffing, referral practices, SCTT tool usage, discharge planning, etc. pose a challenge to managing care planning processes. It is becoming increasingly important to establish linkages and protocols that enable greater collaboration and to ensure smooth pathways between the sectors while taking into account differing organizational cultures and values. Particularly is this relevant to case management for consumers discharged from private sector to primary care sector. Consumers may readily fall through the gaps prior to being picked up by community

agencies. Often this can be an area of substantive unfunded defacto case management by community agencies. This provides even greater challenge for the arrangement of appropriate care plans which require a high degree of collaboration and facilitation within and between the acute and private sector.

- **acute–primary sector** – again, differences in systems and practice- including follow up, communications, staffing, referral practices, discharge planning, varied use of SCTT tools, service responsiveness, etc. pose a challenge to managing care planning processes which need substantive discussion and the development of appropriate pathways and protocols within the region.

Workforce Development

Credentialing and workforce development and training in respect to care planning are important considerations for the region. According to HARP Guidelines consumers/carers 'require healthcare providers with specific skills sets and experience. The selection of appropriate employees facilitates the provision of appropriate care and management. Clients require a team of professionals who are able to assess clinical status and detect disease exacerbation or crises in psychosocial issues as well as possess care coordination skills with an understanding of all internal and external supports and services available for clients.

Learning and development assists providers to provide quality care and management. Learning and development education also assists providers to continue to be competent in their practice.⁷⁶

Promoting and maintaining understanding of care planning within the individual agency requires workforce development which encourages staff to be committed to continuous improvement and consequently maintaining the impetus of care planning within the agency rather than allowing a shift in understanding to occur over time of what constitutes and undergirds care planning practice. Embedding the expectation of continuous improvement in care planning is essential to keeping the status of care planning fluid avoiding the consequences of status quo mentality creeping into the understanding and operationalising of care planning. This equally applies to the system as a whole. System wide strategies to maintain the impetus of interagency/multidisciplinary care planning are crucial. These issues require indepth discussion.

Change Leadership/Change Management

Change leadership or change management is a multi-faceted dynamic comprising both corporate and individual change leadership aspects. It is also multi layered involving organisational management at all levels. The engagement of corporate change leadership is vital to successful implementation and sustainable care coordination. A critical risk factor arises if change leadership is left to an individual without the strategic and visionary support of the whole of management.

In reality the change management process to embed appropriate whole-of-agency and whole-of-system care coordination models and approaches to care planning/coordination practices and process needs to be mutually owned. Practitioners and other staff can then provide clear whole-of-agency care planning/coordination that guide consultation, communication, care plan development, care coordination, review, implementation and evaluation processes within or across agencies. This process is no less important to accomplish system wide and sectoral change to ensure consumer access to appropriate services and care planning provision.

According to the findings of the *Improving Chronic Disease Care: Learnings from the Integrated Disease Management Projects, December 2005*⁷⁷ implementing and sustaining changes that support improvements in care coordination and care plan development are most successful when:

- changes are consistent with the agencies objectives and/or linked to existing services and partnerships
- a multifaceted approach is adopted
- existing reasources and strategies are adopted locally and integrated into agency practice

From December 2006 useful change management information, workplan and tools will be available in the newly developed service coordination resource *Service Access Models: A Way Forward Resource, Guide for Community Health Services*⁷⁸ and accompanying Toolkit which will be available on the DHS website.

⁷⁶ State of Victoria, *HARP Chronic Disease Management Guidelines*, Eastern Health, Department of Human Services

⁷⁷ State of Victoria, *Improving Chronic Disease Care: Learnings from the Integrated Disease Management Projects, December 2005*, Department of Human Services

Nomination and Role of Key Worker(s)/Care Coordinator

Defining the role of the key worker (or care coordinator) role as being substantially different from the case manager role may prove to be challenging. The role boundaries between these two are often somewhat blurred and that in essence the key worker is a pseudo case manager without the extra resources. The key worker role may also be seen as that of a coordination and facilitation role between agencies and services. Nomination processes for a key worker also need to be determined making a regional agreement for this issue fundamental to the care coordination process.

Terminology once again is an issue as the terms 'key worker' and 'care coordinator' are often used interchangeably. The question is, are their roles essentially the same? The previous work on definitions may prove to be a useful resource in determining key worker vs care coordinator terminology usage and role.

Essentially a key worker should be an appropriately qualified health professional. The role of the key worker needs to be clearly defined and delegated and may include elements such as:

- Coordination, communication and liaison with other health care providers and consumers/carers
- Ensuring a care plan is in place and in some cases development of the care plan
- Monitoring and review of care plan including regular collection and collation of clinical information
- Providing continuity of care
- Coordinating multidisciplinary case conferencing
- Ensuring ongoing followup with providers and consumers/carers
- Providing consumer/carer support ensuring appropriate service provision
- Making referrals to appropriate services/programs/community based activities
- Identification of consumer /carer self-management opportunities/interventions
- Provision of information to consumers/carers
- Access to specialist or multidisciplinary assessment and early intervention when risk of exacerbation or decline
- Planned reviews and proactive monitoring;
- Management of medication issues, in collaboration with GPs and pharmacists.
- Identification of potential risk management issues and proactive addressing of issues arising

Macedon Ranges Aged Care and Disability Planning and Advisory Network has done considerable work on developing a care coordination process. The Macedon Ranges model provides some useful insights as to how the nomination and allocation of a Key Worker may be handled. (see [Appendix 3](#))

Resources

Resourcing of role of key worker, particularly in light of the limitations linked to obtaining government funding, is a key issue confronting agencies subject to multiple funding streams and multiple quality system requirements. Reallocation of organisation resources may be required to successfully establish and support care planning practice. While this may pose initial challenges, resource allocation should be considered as part of an overall change management process.

The change management process usually relies on initially identifying the percentage of time that is used (and wasted) duplicating activity related to coordinating care plans within the agency and across agencies. This data may then be used to support reallocation of funding and other infrastructure resources required to support the key worker role.

While reallocation of resources may have variable impacts the overall improved efficiencies in the appointment of a key worker role should have the net result of increasing practitioner time for service delivery and improve the quality of care planning/care coordination for the consumer.

⁷⁸ State of Victoria, *Service Access Models: A Way Forward – Resource Guide for Community Health Services*, December 2006, Primary Health Branch, Department of Human Services

Recommendations

To facilitate movement towards an enhanced care planning system within the region the following recommendations are proposed (these recommendations are derived in part from the 2005 Care Planning Working Group findings).

1. Convene a regional reference group to oversee the further development and implementation of care planning/care coordination
2. From within the regional reference group, form a think tank or task force to support the development of a regional care planning framework and the necessary care planning /care coordination protocols/agreements in alignment with the Victorian Service Coordination Practice Manual.
3. Address topics including but not limited to:

Consumer

- Defining care coordination target group
- Role of consumer/carer in care coordination
- Consumer transition through continuum of care coordination and case management
- Care coordination consent/privacy issues
- Identification of consumers with complex needs
- Consumer transition between acute and/or post acute care and primary care agencies

System

- Conceptualisation of care planning/care coordination framework and models
- An implementation schedule and workplan
- Protocols for governing inter-agency/multidisciplinary care planning/care coordination
- Alignment with GPD activity
- Terminology and definitions
- Impact/relationship with chronic disease management

Governance

- Clinical governance in relation to care planning/care coordination
- Risk management relating to care planning/care coordination including clinical risk management

Agency Care Plans

- Documenting and managing care plan records
- Communication of care planning/care coordination information – consumers/agencies
- Processes for using, monitoring, reassessing and updating care plans
- Handling out of date care planning information (whose role, review methodology, decision making, feedback on altered care plans)
- The place of MBS care planning items
- Agency withdrawal of services
- Cross agency/multidisciplinary case conferencing coordination protocols/practice

Information Management

- Use of Service Coordination Plan (SCTT)
- SC Referral
- Use of GP Statewide Referral Form
- Use of E Referral system in care planning processes

Workforce

- Care coordination workforce development and credentialling
- Identification and nomination of key worker/care coordinator/lead agency including roles and responsibilities

Potential Deliverables

Potential deliverables would include but not necessarily be limited to the following:

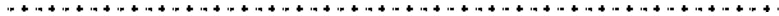
- Agreed regional framework for care planning/care coordination and care planning/care coordination models
- Development of regional protocols and agreement for care planning/care coordination collaboration

- Conduct of a time-limited trial to test protocols and agreements
- Evaluation of the protocols and agreements implemented during the trial
- Development of an electronic approach to care coordination (if considered desirable and feasible)

Next Steps

This discussion paper will be circulated in the region for feedback and comment.

A regional forum for OEHCSA and IEPCP service providers is also planned for early March 2007 when opportunity to be provided to determine the next steps to be taken in the region.



APPENDIX 1

Service Coordination Plan

Service Coordination Plan

Records the individual care plans of all workers/practitioners or agencies involved in a consumer's care to allow a coordinated approach to service delivery.

<p>Consumer</p> <p>Name:</p> <p>Date of Birth: dd/mm/yyyy / /</p> <p>Sex:</p> <p>UR Number:</p> <p style="text-align: center;">or affix label here</p>

Participants in Care Planning Process

Consumer: Yes No

I (consumer name) _____ have participated in the development of this plan.

Consumer signature: _____ Date: dd/mm/yyyy / /

Copy to consumer? Yes No

Details of Other Participants

Team members contributing to the development of this plan e.g. GP, health/community care providers, substitute decision maker, carer, family members, friends. Append sheet to specify any additional persons.

Name	Relationship to consumer	Contact phone number	Other relevant contact details	Copy of plan provided (yes/no)
	Key Worker			

Supporting Documentation

Document	Attached? Yes/No	Any relevant comments
Consumer details (CI template)		
Referral Information (e.g. S&R template, letters etc.)		
Needs Identification (e.g. screening or profiles)		
Individual Agency Assessments (full or summary)		
Individual Plans (Agency or Service Plans)		
Other (specify):		

Review date: dd/mm/yyyy / / Case Conference: No Yes

Service Coordination Plan

Records the individual care plans of all workers/practitioners or agencies involved in a consumer's care to allow a coordinated approach to service delivery.

<p>Consumer</p> <p>Name:</p> <p>Date of Birth: dd/mm/yyyy / /</p> <p>Sex:</p> <p>UR Number:</p> <p style="text-align: center;">or affix label here</p>

Consumer issue/problem:		
Goal:	Target date: dd/mm/yyyy / /	
Action/s to be taken:		
Responsible individual/s or service/s:		
Proposed start date: dd/mm/yyyy / /	Review date: dd/mm/yyyy / /	Issue resolved (date): dd/mm/yyyy / /

Consumer issue/problem:		
Goal:	Target date: dd/mm/yyyy / /	
Action/s to be taken:		
Responsible individual/s or service/s:		
Proposed start date: dd/mm/yyyy / /	Review date: dd/mm/yyyy / /	Issue resolved (date): dd/mm/yyyy / /

Append more sheets as necessary.

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This information collected by:

Name:

Position/Agency:

Sign:

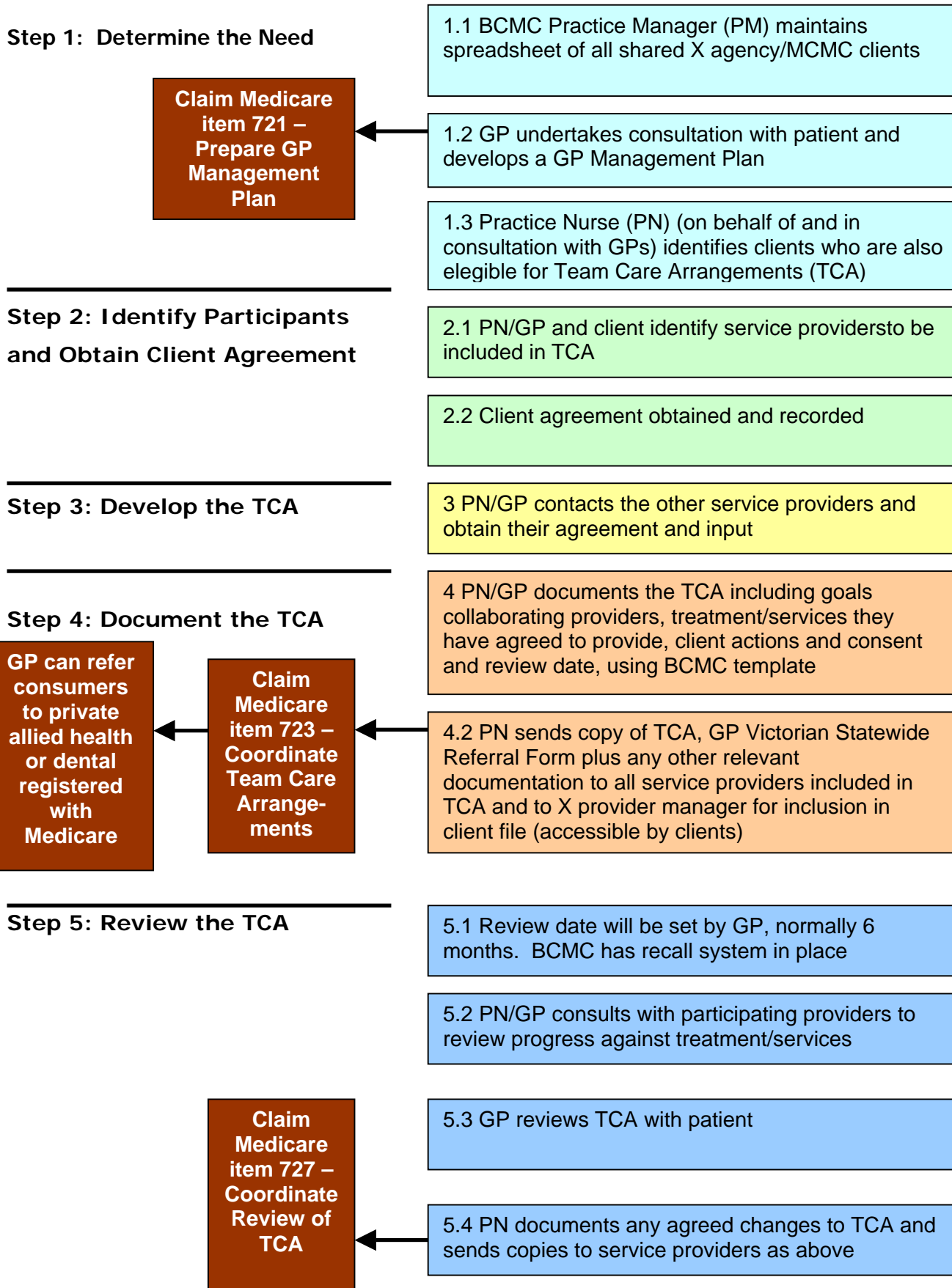
Date: dd/mm/yyyy / /

Contact number:

APPENDIX 2

Care Planning and Team Arrangements Flowchart

A collaboration between Brunswick Community Medical Clinic and Moreland Community Health Services, Hume Moreland Primary Care Partnership 05/12/2006 – Presentation at GPDV Forum 6/12/2006



APPENDIX 3

Macedon Ranges Care Coordination Meeting Process

Macedon Ranges Aged Care and Disability Planning and Advisory Network Care Coordination Meeting Process

The Model:

The Macedon Ranges Care Coordination meeting is a closed segment within the Aged Care and Disability and Planning Advisory Network's new meeting structure. This monthly client-focused segment promotes an inter-agency team approach. It aims to initiate service coordination for consumers with complex or multiple needs where the needs are currently not being met or where there is a lack of service coordination.

The meeting was restructured in September 2004 in recognition that the previous format did not meet the recently agreed Service Coordination Protocols of Privacy Legislation – primarily meetings were informal, instructured discussions amongst various service providers about clients on their lists with no structured outcomes. The meeting now has a structure that uses the CVHA and Loddon Mallee Service Coordination Protocols to inform its Terms of Reference. The new practices now meet agreed interagency Service Coordination and the Privacy Act.

This restructured meeting is now a closed meeting only discussing relevant clients, who all have consented to be on the allocation list (1-4 per month). There is a streamlined process where the focus is on client outcomes not service provider needs.

The outcome is better service coordination facilitated by non-case-management services: some clients only require services to share information; others need a Key Worker to facilitate coordination. For those clients designated or allocated a Key Worker, the meeting initiates the care coordination process. Service Providers in the person's team feedback information to the Key Worker. Then, together with the consumer and carer a 'multi-disciplinary' or 'team' Service Coordination Plan is developed. The outcome is improved consumer physical, social and emotional wellbeing.

The Changes:

The restructuring of a previous meeting, which took equivalent or more time, has proved both efficient and effective without adding onerous burdens upon workers. Only consenting clients who have met the identified criteria for Care Coordination are discussed at the meeting. The number of people discussed has reduced to 1 to 4 people per month, and one of 2 actions are set for each client discussed: either designating a Key Worker or improving feedback without a Key Worker. Clients are no longer brought up over and over again at monthly meetings, and there is no longer a lack of sharing of written information (plans or feedback).

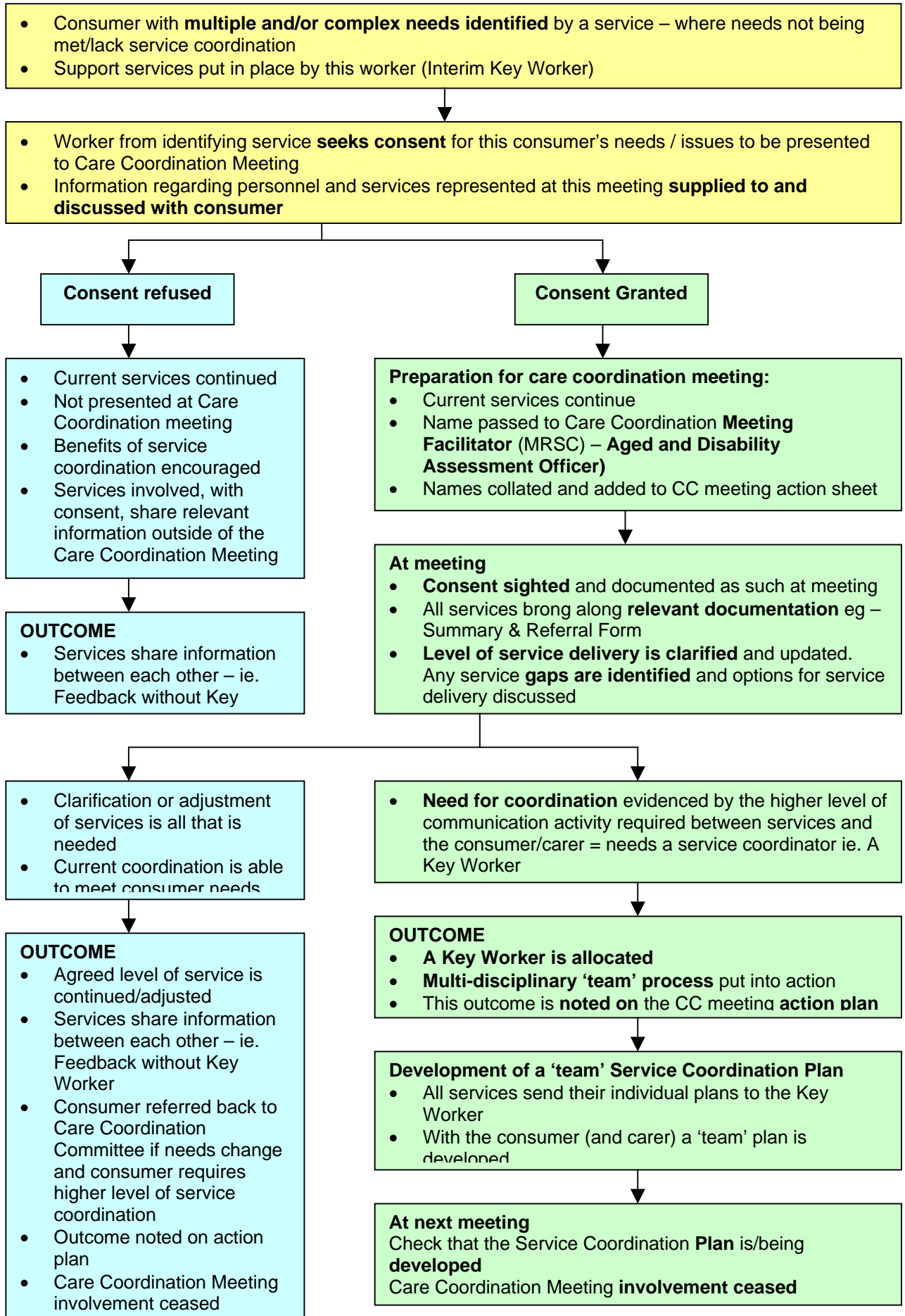
Service providers now adhere to both the agreed Service Coordination Protocols and Privacy Act. There is a commitment to the shared responsibility of exchanging written information to enhance service coordination, and improve outcomes for consumers.

To date, the meeting model has demonstrated that the process and designation of a Key Worker has improved Service delivery. Services have improved their practices for sharing client information. Service providers state that, even for those not designated a Key Worker, they are more informed and better able to plan and deliver relevant services. For those allocated a Key Worker as a coordinator of the 'team', and for whom multi-disciplinary Service Coordination Plans are developed, there have been positive outcomes reported. Situations that had been spiralling down have now been averted and improvements made to consumer's physical, social and emotional wellbeing.

The Outcomes:

Non-case-management services now act as Key Workers and develop multi-disciplinary or team care plans for clients (aged and disability sectors) who have complex/multiple needs and their situation requires coordination. This model has broadened the access consumers have to care coordination processes. Services state that they now know who else is involved and who to liaise with, as well as having an increases awareness of and understanding of services available. They also state that the structure is supportive and encourages workers to attempt the Key Worker role.

Macedon Ranges Aged Care and Disability Planning and Advisory Network Care Coordination Meeting Process⁷⁹



⁷⁹ Central Victoria Health Alliance, *Care Coordination Process At A Glance*, Central Victoria Health Alliance Primary Care Partnership, October 2006, Catherine Fuller, Service Coordination Project Manager. Used with permission.