Wellington Primary Care Partnership

The Client Journey

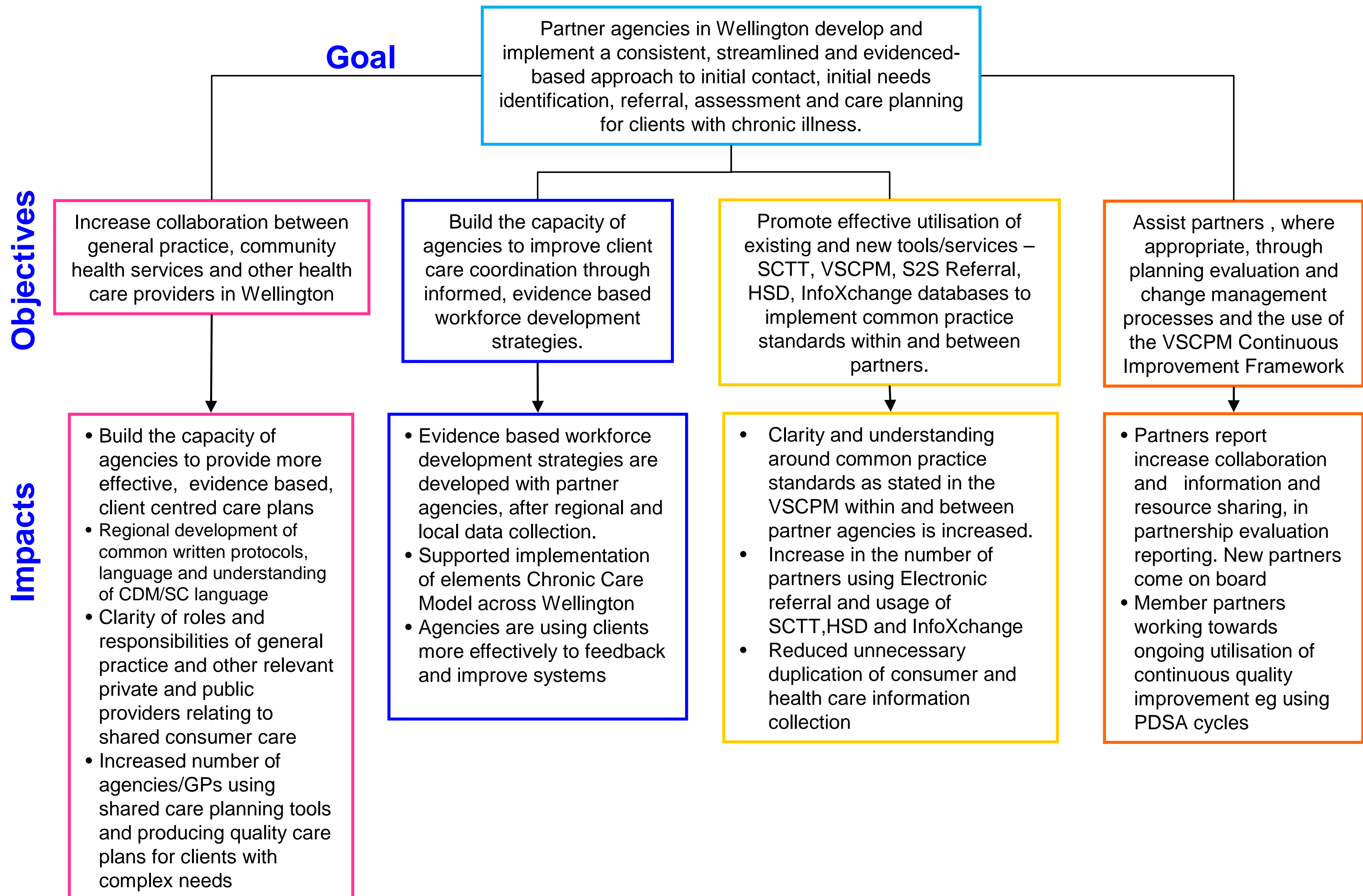
Improving Care Coordination

2009 – 2012

Version 1.0
November 2009

Prepared by: WPCP Staff and Member Agencies

Overview



Priority 1: The Client Journey – improving coordination of care

Goal
Partner agencies in Wellington develop and implement a consistent, streamlined and evidenced- based approach to initial contact, initial needs identification, referral, assessment and care planning for clients with chronic illness.

Objective 1

Objective	Key Partner Agencies	Evidence/Strategies	Predicted Impacts	Impact Indicators	Timelines
Promote effective utilisation of existing and new tools/services – SCTT, VSCPM, S2S Referral, HSD, InfoXchange databases to implement common practice standards within and between partners and systems.	Community and Women's Health East Gippsland Division GP Central Gippsland Health Service Ramahyuck Aboriginal Cooperative Dargo Bush Nursing GHA	**Evidence:** • DHS Program Logic – July 2009 • Feedback from Wellington PCP agency consultations: Jan – August 2009 • Feedback from Community and Women's Health Forums • DHS Better Access to Services Policy and Operational Framework and related documents. • DHS Gippsland Region Disability Services – Assistance with Planning - 2009 • DHS – Framework for Assessment in HACC – 2008 • Self management mapping • CDM/SC Survey 2009 **Strategy 1 - 5:** **1.** Agree to/discuss common practice SC standards through the effective use of the	• Common SC Practice Standards in IC, INI, referral, assessment and care planning established both locally and regionally • Improved communication between agencies, GP practices and private providers about consistent policy and process. • Reduction in unnecessary duplication of client health care information. Reduce unnecessary duplication of screening and	• Service coordination practice standards are integrated into policy, work plans and position descriptions.	June 2011
				• Increased use of Service Coordination Tool templates (SCTT) for referral in accordance with policy and the SCTT 2009 user Guide	Dec 2010
				• Increased use of InfoXchange and HSD	June 2011

<table>
<tr>
<td rowspan="6"></td>
<td rowspan="6">HACC Service providers in Wellington

Disability services

Regional Working groups

Gambler's Help - LCHS</td>
<td rowspan="6">Victorian Service Coordination Practice Manual (VSCPM), the use of SCTT 2009, Victorian Statewide Referral form (VSRF) with relevant partners
2. Develop processes and protocols to facilitate the sharing of relevant consumer health and care information via secure electronic systems. (S2S.) with new
3. Work with agencies to establish systems/protocols to ensure currency of data on HSD.
4. Promote the use of the Human Services Directory and the InfoXchange Service Seeker databases. Promote the use of the Care Planning Module and multidisciplinary, multi agency, client centred care planning in support of the Regional CDM plan.
5. Support the development of systems and processes to support the HACC Assessment Framework both locally and regionally (Regional Service Coordination priority)

<u>Key Tasks:</u>
1. Work with agencies to establish appropriate workforce development strategies to support strategy.
2. Work with agencies to establish a process for common SC practice based on the VSCPM 2009
3. Facilitate information sessions about the revised SCTT,S2S E - referral
4. Provide training and support for practitioners to improve the quality of information recorded on the SCTT and S2S</td>
<td rowspan="6">assessment processes.
• Providing network support to agency staff.
• Service data is relevant and current
• Increased effective use of Human Services Directory and the InfoXchange Service Seeker databases.</td>
<td>• Increased use of S2S internally and externally</td>
<td>Ongoing</td>
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<td>• Consumer satisfaction levels improve (Agency client satisfaction tools)</td>
<td>Annually</td>
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<td>• Improvements in service data reflected in improved service knowledge and appropriate referrals (as reported by agencies and reporting tools)</td>
<td>Annually</td>
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<td>• Sectors demonstrate improved communication and client centred planning (DOH SC /CDM surveys to agencies).</td>
<td>December 2011</td>
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<td>• Improvement in the quality of client data in the system.</td>
<td>Ongoing, monitored annually</td>
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<td>• Increased clarity and understanding around current practice standards as stated in the VSCPM</td>
<td>As above</td>
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		Evidence/Strategies (continued)		Impact Indicators (continued)	
		5. Promote and share best practice examples **6.** Advocate for agency support to effectively utilise S2S, **7.** Build capacity within organisations to regularly update service data. **8.** Build time in to WPCP meetings for robust discussion around SC issues.		within and between partner agencies (Regional evaluation)	

Objective 2

Objective	Target Group	Evidence/Strategies	Predicted Impacts	Impact Indicators	When
Support agencies, through planning evaluation, change management processes and the ongoing utilisation of the VSCPM Continuous Improvement Framework	Central Gippsland Health Service Yarram and District health Service Ramahyuck Aboriginal Cooperative Bush Nursing Centres Disability Services HARP/ICOP Staff EIiCD	**Evidence:** • DHS Program Logic –July 2009 • Feedback from WPCP agency consultations – Feb – August 2009 • Feedback from Community and Women's Health Forums • DHS Better Access to Services Policy and Operational Framework and related documents. • VSCPM Continuous Improvement Framework. • Information from "Lean Thinking" Forum **Strategies 1 - 6:** • Facilitate change through a PDSA approach using the CDM Resource Kit, VSCPM Continuous Improvement Framework and other relevant tools. • Explore professional development options with agencies to assist with implementation of change management and the continuous improvement	• Stronger partnerships between agencies, GPs and private providers. • Increased consistent understanding of the 6 elements of the Chronic Care Model • Agency specific and catchment strategies developed to better engage with vulnerable groups • Increased capacity of agencies to manage change • Increase in evidence based planning • PDSA cycles are used to trial changes in agencies • The number of agency staff involved	• Chronic Care Model elements embedded into standard agency processes as measured by ongoing continuous improvement. (indicated through annual DOH survey).	Ongoing
				• Increased number of agencies adopting regionally agreed standards as per VSCPM (measured as above)	Ongoing and measured annually

	Workforce Development Working Group	framework. (particularly agencies with EIiCD Funding) • Provide ongoing intra agency leadership and facilitate agreed mechanisms for change and post change support • Promote the use of relevant data to set priorities • Build new and strengthen current partnerships to build agency capacity to change both across and between agencies. **Key Tasks for strategies 1-6**: • Provide ongoing training and discussion opportunities around the CDM Resource kit • Provide on going support for agency workers involved in the change process through the Wellington CDM Network • Participate in the review, development and implementation of the regional EIiCD workforce development and the Regional CDM training plans. • Source relevant data and supporting research to support member agencies to work from a strong evidence base. • Share examples of best practice through networks and newsletters and other channels of communication. • Provide and create opportunities for new partnerships between community health sectors, private providers and GPs • Ongoing consultation, both formally and informally, with key players in agencies to monitor processes and support needs.	in continuous improvement is increased • Partner agencies report increased collaboration and information and resource sharing, in partnership evaluation reporting • Member agencies working towards continuous quality improvement eg using PDSA cycles	• Client satisfaction improved (indicated by Agency Client Satisfaction Surveys)	Ongoing and measured annually
				• Regional training plan developed and implemented.	June 2010

		Strategy 7: • Work with agencies and clients to ascertain particular needs of vulnerable and hard to reach groups within and across current systems in Wellington. **<u>Key tasks strategy 7:</u>** • Work with agencies to collect client identified data/evidence which identifies and addresses local issues for service access for clients in the most need in Wellington • Use client and carer information and collaborate with key stakeholders, to more clearly identify particular client service gaps. • Review Operational Plan to accommodate strategies to address service gaps.	• Ensure agency staff are aware of the local barriers to service access for some client groups. • Develop strategies with agencies to address gaps in client service	• Clients and carers receive care and support that is appropriate to their cultural background, circumstances, needs and preferences (Agency planning documents and identify gaps, Client Satisfaction Surveys)	Ongoing
				• Agencies respond to the needs of their client groups (measured as above)	Ongoing

Objective 3					
Objective	**Target Group**	**Evidence/Strategies**	**Predicted Impacts**	**Impact Indicators**	**Who/Timelines**
Build the capacity of agencies to improve client care coordination through informed, evidence based workforce development strategies.	CGHS EGDGP General Practices YDHS Private Providers in Wellington Regional Working Groups. Ramahyuck Aboriginal Cooperative Member agencies	**<u>Evidence</u>** • DHS Program Logic – July 2009 • Feedback from Wellington agency consultations April 2009 • On going Agency Consultation • Feedback from Community and Women's Health Forums • DHS Better Access to Services Policy and Operational Framework and related documents. • DHS Gippsland Region Disability Services – Assistance with Planning - 2009 • DHS – Framework for Assessment in HACC – 2008 • Self management mapping • SC/CDM Survey 2009 • Wagner framework **<u>Strategies</u>** **1.** Keep agencies informed of regional and statewide opportunities for workforce development **2.** Consult with PCP agencies to inform workforce development directions to support improved care coordination. **3.** Ensure that workforce development opportunities are shared across the region **4.** Provide leadership for joint strategic planning and evaluation around evidence based practice	• Increased consistent knowledge and understanding of SC standard practice and the Chronic Care Model • A more informed sector through broader access to knowledge and evidence based information. • Increased shared planning around Workforce Development in the catchment.	• Partnerships are strengthened and matured through shared workforce development (partnership tool completed annually)	Ongoing
				• Increased level of participation and advisory skill of consumer and carer (Agency consumer data).	June 2010
				• Care is streamlined and client focussed (Reported though DOH annual survey)	Ongoing, annually
				• Evidence based workforce development strategies are developed with partner agencies, after regional and local data collection in line with regional training plan.	June 2010 with annual review

		Key Tasks/Principles: • Ongoing communication with key partners to determine current and future workforce development needs • Ensure post training support processes are in place before any catchment training is rolled out • Build the capacity of partners to better measure service system improvements. • Encourage agencies to showcase their work through building the capacity of staff to research, evaluate and present findings • Review regional CDM training plan with CDM workers to ensure it meets the needs of Wellington partners • Work with agencies to develop client and carer upskilling processes • Provide opportunities for interagency networking and partnership building.		• Agencies are using clients more effectively to feedback and improve systems (As reported by Agencies)	Ongoing
				• Increased shared knowledge of care coordination progress catchment wide and regionally (indicated by increased opportunities for agency staff participation in shared learning forums).	Ongoing

Objective 4

Objective	Target Group	Evidence/Strategies	Predicted Impacts	Impact Indicators	Who/When
Facilitate greater collaboration between general practice, community health services and other health care providers in Wellington	Community and Women's Health East Gippsland Division of GP Practice Nurses Private Providers including Diabetes Educators Central Gippsland Health Service Ramahyuck Aboriginal Cooperative Dargo Bush nursing GHA HACC services in the catchment	**<u>Evidence:</u>** • General Practice Engagement in Chronic Disease Management – A Resource for Primary Care Partnerships • DHS Program Logic – July 2009 • Feedback from Wellington agency consultations – April 2009 • Feedback from Regional audits • Gippsland E- referral Forums and User Groups • National E- Health Initiatives • Feedback from Allied Health/GP sessions (ABHI) **Strategy 1:** **1.** Promote the effective use of Statewide Referral form (VSRF) with the Division of General Practice, with Wellington Practice Managers, and other relevant GP staff where possible and appropriate. **Key Tasks Strategy 1:** • Work with East Gippsland Division of General Practice to develop a possible action plan to: ○ Support EG DGP and GPs to embed the VSRF in GP Practices in Wellington and East Gippsland as the standard form for referrals to agencies	• Increased GP use of the VSRF and electronic referral (Argus S2S) in Wellington • Increased GP access to information about services offered locally and knowledge about how to access these services • Reported improvement in partnership strength and usefulness between GPs and other health providers Local data collected and disseminated to agencies • Local pathways determined by GPs and other providers	• Argus/S2S usage increased in general practices in the Wellington catchment (feedback from EGDGP and S2S referral figures)	Ongoing
				• Improved quality of GP referrals to agencies (ie electronic, using VSRF and containing appropriate information) (As reported by GPs and other service providers)	Ongoing and to be completed by June 2012
				• GPs in Wellington are referring to a broader range of services/agencies (See S2S data)	Ongoing
				• Increased quantity and quality of referral feedback to GPs and agencies	Reported annually
				• Increased GP involvement in	December 2010, reviewed in 2011 Operational Plan

	Yarram and District health Services Disability services	**Strategies 2 and 3** **2.** Facilitate the sharing of relevant consumer health and care information between GP and other service providers via secure electronic systems (S2S) **3.** Strengthen and build partnerships with the East Gippsland Division of GP and Practice staff, through shared planning and vision to increase effective communication between GPs and other service providers **Key Tasks Strategy 2 and 3:** • Support agencies in the uptake and effective use of Argus/S2S System for referrals to and from GPs – including running training for S2S users and new agencies coming on board. • Identify mixed models of care that utilise The Medical Benefits Scheme (MBS) services and other public and privately funded services • Increase understanding of the MBS and effective use of item numbers within the Primary Healthcare Sector and Private Providers • Implement the collection of local data which will clearly articulate what local health agencies/services and private providers can offer GPs and their clients (in particular those services where there is confusion eg HARP, EIiCD, ICOP etc.) • Verify known and potential pathways between services and GPs • Support the Regional GP Engagement project **<u>Strategy 4:</u>** **4.** To establish common care planning practices processes and language in line	• Increased understanding of the MBS and how it may be used within the primary health care sector including private providers • Increased understanding of TCAs in general practice and community health • Increased understanding of barriers to effective client centred care planning and feedback across services • Action plan to address issues is developed and implemented • Increased capacity of agencies to provide evidence based client centred care plans • Regional working groups establish agreed care planning practices, processes and language	coordinated care planning (Division data)	
				• Feedback to GPs embedded as a regular and systemic component of service delivery.	2010/2011
				• MBS education sessions delivered as part of the regional ICDM training plan.	June 2010
				• Increase in the number of TCAs produced in Wellington	June 2010
				• Services provide effective client centred care planning and feedback in and between agencies (As reported in DOH annual survey)	Ongoing 2009 - 2012
				• Action plan milestones are achieved and celebrated	Annually
				• Increase in the use of regionally agreed care planning practices, processes and language	December 2010

		with the Victorian Service Coordination Practice standards and related MBS items using the Victorian Continuous Improvement Framework		(measured through audit process)	
		Key tasks: • Work with EGDGP to provide education to non GP Providers to increase understanding of Team Care Arrangements.	• Regional care planning audits reveal current care planning arrangements and areas for improvement	• Regional care planning working group promote agreed care planning arrangements	June 2010
		• Discuss and define roles and responsibilities of key players in care planning. • Map current Wellington care plan arrangements as part of Gippsland wide audit. • Use regional audit data to initiate discussion with stakeholders • Develop regional and local action plan to improve the quality and frequency of client centred care planning. Support the work of the Regional Care Planning Working Group	• Care planning action plan implemented • Clarity of roles and responsibilities of general practice and other relevant private and public providers relating to shared consumer care • Increased number of agencies/GPs using shared care planning tools and producing quality care plans for clients with complex needs	• Care planning standards improved across Wellington and Gippsland (as benchmarked by VHA and GPV checklists)	Ongoing

Priority 2: Improve the health and wellbeing of communities most in need in Wellington; small & remote Indigenous socioeconomically disadvantaged

Goal
Service provision in Wellington caters for the needs of its diverse clientele and geographical locations, through client consultation and focus.

Objective 1

Objective	Target Group	Evidence/Strategies	Predicted Impacts	Impact Indicators	Who/When
The provision of coordinated best practice clinical care and support for self management for clients with chronic disease occurs across the service system.	Community and Women's Health East Gippsland Division GP Hospitals Aboriginal Health Organisations Bush Nursing Centres GHA HACC Disability services	**Evidence:** • DHS Program Logic – July 2009 • Feedback from Wellington agency consultations – April – August 2009 • Feedback from Community and Women's Health Forums • DHS Better Access to Services Policy and Operational Framework and related documents. • DHS Gippsland Region Disability Services – Assistance with Planning - 2009 • DHS – Framework for Assessment in HACC – 2008 • Self management mapping • *Closing the Gap* Report **Strategy 1** **1.** Provide a range of self management strategies within community health settings **2.**	• Increased understanding of self management and self management models across the catchment. • Increased demand for training and post training support. • Increased number of people trained in chronic disease management including self management models. • Improved community knowledge and understanding of Wellington health and community services • Self management principles and •	• Allied health and GPs refer into SM programs. (Self management programs have increased clientele.)	December 2010
				• Improved health literacy of consumers as reported by agency staff (and consumers).	June 2010
				• PCP Partner agencies evaluation shows improvement in client self-management	June 2012

	Regional Working Groups	**Key Tasks for Strategy 1** • Support the development of agreed regional SC/CDM common language and protocols • Support implementation of regional EICD/Workforce Development Plan • Provide ongoing post training support and peer learning opportunities as outlined in the regional workforce development plan. • Work with funded agencies to support EIiCD projects and training • Regional CDM SM Training Survey results will be analysed and used to develop training plan. • Specific training and post training support will be provided in SM courses such as Stanford, MI and HC along with other identified CDM topics. • Promotion of CDM self management programs to all sectors, to enhance the referral process • Further promote and encourage the use of the Chronic Disease Management Kit as a guide for trialling and implementing organisational change. • Formal and rigorous evaluation of SM programs/strategies and is completed and is part of on going program development and continuous quality improvement.	programs are embedded in agency protocols and processes. • Chronic disease management is part of agencies strategic plans. • Improved attendance and retention at SM programs. • Improved recruitment and retention in community programs and agency services. • Patient held records are utilised to encourage client centred care and self management. • Agency evaluation of SM work shows improvement in client understanding • The impacts of clinical care and support for self management are measured and monitored using agreed clinical and lifestyle indicators	practice	
				• Increase in the number of health sectors that engage individuals in the process of informed decision making about their health and the health of their families.	June 2012

Objective 2

Objective	Target Group	Evidence/Strategies	Predicted Impacts	Impact Indicators	Who/When
Improve agency awareness of indigenous health issues and barriers to access to services.	Community and Women's Health East Gippsland Division GP Hospitals Aboriginal Health Organisations Bush Nursing Centres GHA HACC Disability services Regional working groups	**Evidence:** • DHS Program Logic – July 2009 • Feedback from EG agency consultations – April 2009 • Feedback from Community and Women's Health Forums • DHS Better Access to Services Policy and Operational Framework and related documents. • DHS Gippsland Region Disability Services – Assistance with Planning - 2009 • DHS – Framework for Assessment in HACC – 2008 • Self management mapping **Strategy 1** To improve communication with_Ramahyuck and establish shared goals to reduce barriers to effective indigenous health care. **Tasks:** **1.** Initiate discussion with Ramahyuck as to the most effective way to improve communication and identify key issues and ways to support **2.** Research local indigenous identified health issues and barriers to accessing services **3.** Provide communication opportunities for partner agencies to discuss 'Closing the	• Increased knowledge and awareness of indigenous identified health issues and barriers to service access within partner agencies. • Agreed, client centred, evidence based strategies developed to address identified, local indigenous health issues	• Agencies strategic plans include strategies to address indigenous identified health issues	December 2010
				• Clients and carers receive care and support that is appropriate to their cultural background, circumstances, needs and preferences. (As indicated by service provider data on access to services)	Ongoing
				• Clients receive evidence based, culturally appropriate self management support.	Ongoing

		Gap' report. **4.** Provide leadership in the roll-out of cultural awareness training to agencies as required.			

APPENDIX

Acronyms

ABHI	Australian Better Health Initiative
AHW	Aboriginal Health Worker
CDM	Chronic Disease Management
CGHS	Central Gippsland Health Service
DHS	Department of Human Services
EGDGP	East Gippsland Division of General Practice
GHA	Gippsland Health Alliance
GPs	General Practitioners
HACC	Home And Community Care
HARP	Hospital Admissions Risk Program
HC	Health Coaching
HSD	Human Services Directory
IC	Initial Contact
ICOP	Improving Care for Older People
INI	Initial Needs Identification
MBS	Medicare Benefits Schedule
MI	Motivational Interviewing
PDSA	Plan, Do, Study, Act
PNs	Practice Nurses
S2S	Service To Service
SCTT	Service Coordination Tool Templates
SM	Self Management
TCA	Team Care Arrangement
VSCPM	Victorian Service Coordination Practice Manual
VSRF	Victorian Statewide Referral Form
WPCP	Wellington Primary Care Partnership
YDHS	Yarram & District Health Service