South East Healthy Communities Partnership

E - CARE COORDINATION

Case Study

CASE STUDY TITLE

Keeping the focus on consumer goals

December 2011

DETAILS OF ORGANISATION CONTACT	
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Case Study Title	E-Care Coordination 'Keeping the focus on consumer goals'

SUMMARY/ABSTRACT

South East Healthy Communities Partnership's Active Service Model E-Care Coordination Project builds on work undertaken by a consortium of 9 Primary Care Partnership's in the E-Care Planning Project (2011).
This project has aimed to develop;

- an e-care coordination governance model;
- agreed practices, processes, protocols and systems;
- functional specifications; and
- identify learnings that can be used statewide.

SEHCP's ASM Project aims to achieve functional integration between services involved in the care coordination of HACC eligible consumers in the South East through the development and implementation of an E-Care Coordination Protocol, Pathway and use of the S2S e-care coordination module. The benefit of this is that stakeholders involved in the consumer's care will have access to, with the consumer's consent, care coordination information through an encrypted messaging system and central data repository. The system also enables new practitioners to be invited to participate in the consumer's care and will provide review and recall functions.

Throughout the project 6 agencies have worked together to develop the SEHCP ASM E-Care Coordination Protocol which is based on the Victorian Service Coordination Practice Standards for Interagency Care Planning and incorporates Active Service Model Principles. The Plan Do Study Act cycle of care has been used as a continuous improvement approach in the application of the protocol.

Implementation has included: establishment of the governance structure, review of agency staff roles, setting up change management teams within agencies, auditing of agency e-care coordination readiness, facilitating training, and putting a robust communication and monitoring strategy into place.

To date, thirty three staff have been trained to use the S2S e-care coordination module and thirteen staff in Plan Do Study Act. Seven e-care coordination plans have been developed.

A final evaluation report will be available for dissemination in May 2012. The report will include information from consumer, practitioner and agency perspectives.

BACKGROUND	
Name Of Project	South East Healthy Communities Partnership Active Service Model E-Care Coordination Project
Aim of project / Focus of project	Based on the Active Service Model Principles and underpinned by the Victorian Service Coordination Practice Standards the overall aim of the project is to achieve functional integration between services involved in the care coordination of HACC eligible consumers in the South East through the development and implementation of an E-Care Coordination Protocol, Pathway and use of the S2S e-care coordination module.
Program Logic expectation(s)	It is expected that by developing agreed e-care coordination protocols, pathways and systems, and putting them into practice services will be able to focus more efficiently on supporting consumers, in this case HACC eligible consumers with multiservice involvement, to achieve their goals, resulting in enhanced well-being. **Indicators** • Consumers and carers with multiservice involvement are identified at the initial assessment stage. • Consumers and carers experience coordinated delivery of services and a continuum of care. • Consumers and carers have confidence in the advice, support, treatment, and care coordination they are receiving. • Consumers and carers receive care and support that is appropriate to their cultural background, circumstances, needs and preferences. • Consumers and carers actively participate in the development of their own care plans and in the delivery of their care. • Consumers and carers have confidence in the way their health and care information is collected and shared. • Sharing of quality consumer health and care information in accordance with the Victorian Service Coordination Practice Manual and privacy requirements. • Sharing of quality service information with consumers and carers and within and between agencies. • Reduce unnecessary duplication of consumer health and care information collection. • Reduce unnecessary duplication of screening and assessment processes. • Clarity of roles and responsibilities of general practice and other relevant private (e.g. private allied health) and public providers relating to shared consumer care. • Increase the levels and quality of shared care and care planning between general practice, other private services and other publicly funded providers. • Feedback to GPs is embedded as part of service delivery.

BACKGROUND

Background

In 2008 SEHCP developed and trialled an Interagency Care Planning Protocol. The aim of the Protocol was to develop an agreed process for agencies and GPs providing care for consumers with complex needs to work together to achieve:

- better outcomes for the consumer; and
- improved communication and service coordination between all involved in the careplan.

Benefits reported by agencies and consumers included:

- Families were now aware that all services were working from the one plan and felt supported;
- there was now consistency in messages for the consumer;
- all service providers came together at one time which resulted in improved understanding of what each agency could provide and how the services could work together to meet the consumer's needs;
- there was value in having an opportunity to meet face to face and establish relationships with workers from other agencies;
- the SCTT Service Coordination Plan (now known as Care Coordination Plan) was useful and met needs;
- liaison with GP's improved;
- there was a reduction of duplication of services; and
- joint discussion occurred regarding careplan review timeframes.

One of the barriers reported included:

- Careplans not being available electronically for all to use.

Whilst there has been gradual improvement in intra agency careplanning over the past 3 years, results from the 2010 Statewide Primary Care Partnership Service Coordination Survey still suggests a low rate of care coordination plans being documented for consumers with complex needs who are receiving more than two services. Providing copies of careplans to GP's (with consumer consent) also rates below state average.

In 2011 SEHCP, as part of a consortium of 9 PCP's across the state, commenced participation in a trial of an electronic care coordination system that could be used effectively at practice level. The trial has included working towards the establishment of a statewide e-care Coordination Protocol and the development and use of an e-care coordination system.

The local trial "cluster" focused on agencies and consumers involved in the SEHCP Making a Move – Falls Prevention Project. A protocol was developed and initial training on the electronic system provided. This training session gave valuable feedback in identifying suggestions for modification of the system for broad use.

SEHCP's Active Service Model Project builds on the initial trial learnings and has enabled an expansion in the number of services and consumers benefiting from service coordination.

Objectives

SEHCP Strategic Plan incorporates four strategic intent statements one of which is for consumers to have a seamless journey through the service system.

The overall strategic outcome that the partnership is for "a responsive Service system where agencies work together to respond to consumer needs and support their community".

Aligning with the strategic plan, the project objectives are to:

- Engage and empower consumers to be involved in care coordination plans and making decisions about their care;
- provide a platform for strengthening partnerships between services;
- develop an agreement between project participants on the care pathway and e-care coordination systems incorporating Active Service Model principles; and
- build staff knowledge, skills and confidence in using care coordination and e-care coordination processes and systems.

IDENTIFIED PARTNERS		
Partner Organisation	**Roles and responsibilities with regard to the project**	**Contact details *(name, position)***
City of Greater Dandenong	Steering Group	Mary Rydberg Manager Community Care & Library Services
City of Casey	Steering Group	Jo Smale - Manager Aged and Disability
Southern Health: Cardinia Casey Community Health & Greater Dandenong Community Health	Steering Group	Deborah Stuart - Director Community Services
RDNS: Berwick and Springvale	Steering Group	Karen Atley - Client Services Manager Berwick
Kooweerup Regional Health Service	Steering Group	Terrona Ramsey - Chief Executive Officer/Director of Nursing
mecwacare	Steering Group	Vicky Carmody - General Manager Home Nursing and Care Services

IDENTIFIED PARTNERS		
Participant Organisation	**Roles and responsibilities with regard to the project**	**Contact consumer details *(name, position)***
City of Greater Dandenong	Working Group/Change Leader Participant in training and E-Care Coordination Plans	Lenna Popovski Ian Stevenson, Anna Lew Ton, Mary Johnson, Kristy Rowe, Anne Hyde (HACC Assessment Officers)
City of Casey	Working Group/Change Leader Participant in training and E-Care Coordination Plans	Anna Makadonskaya Eve Lavelle, Sussy Vasquez-Lozano, Paula Kaoud, Sharon Fisher (HACC Assessment/Coordinators)
Southern Health: Cardinia Casey Community Health Southern Health: Greater Dandenong Community Health	Working Group/Change Leader Participant in training and E-Care Coordination Plans Participant in training and E-Care Coordination Plans	Belinda Ogden Anne Rigby (Chronic Disease Coordinator) Nanda Viswanathan, Maryann Dcosta (Team Leader & PAG Coordinator), Diane Hoey, Mary Garret Bronwyn Davies (SW/Team Leader), Marilyn Rodgers-Wilson, Sophie Reese(SW), Elizabeth McCartin (SW), Therese Turner (OT), Jill Reese
RDNS: Berwick and Springvale	Working Group/Change Leader Participant in training and Care Coordination Plans	Paul Ryan Karen Atley (Client Services Manager), Angela Skelton (Operations Manager), Alicia Jolly, Fiona McLean (Operations Manager)
Kooweerup Regional Health Service	Working Group/Change Leader Participant in training and Care Coordination Plans	Marie Eisma Kerrie Chrimes (District Nurse NUM), Vivian Knapp
mecwacare	Working Group/Change Leader Participant in training and Care Coordination Plans	Karen O'Bryan Vanessa Sach and Mary McBride (HACC Assessment Officers)
Lime Management Group	Project management & consultancy	Heather Lawson - Director, Linda Pandita - Consultant/Project Manager
Infoxchange Australian	Training and support	Amodha Ratnayeke - Manager Online Applications
Gill & Wilcox	Plan Do Study Act Training	Marie Gill - Consultant

Key project stages and activities

Stage 1: Planning: *July-August 2011*

- development of steering group and working group;
- development of detailed project workplan and communication strategy;
- scheduling of meetings, training and workshops; and
- development of evaluation framework and tools.

Stage 2: Develop agreed pathways and protocols: *August-September 2011*

- working groups met regularly to build partnerships, understanding of care; coordination issues and agree on pathways and protocols; and
- each participating agency reviewed their internal roles and systems in relation to the building blocks for inter agency E-care-coordination.

Stage 3: Implementation: *October 2011-April 2012*

- Plan Do Study Act workshop resulting in implementation plans for each agency;
- change teams established in each agency;
- PDSA templates and tracking template used for monthly working group progress reports and planning;
- S2S E-Care Coordination training provided to care coordinators, allied health professionals, assessment officers and key workers from participating agencies; and
- training resources, presentations and case studies developed to support implementation.

Stage 4: Evaluation and monitoring: *October 2011-May 2012*

- Monthly meetings, telephone support, issues identification/troubleshooting and data collection;
- pre and post project staff survey to measure changes in knowledge and skill;
- telephone survey with sample of consumers.
- synthesis and analysis of data for evaluation report; and
- workshop including other key stakeholders to discuss key themes, validate findings, revise e-care coordination pathway and develop sustainability strategies.

Stage 5: Draft and final report: May 2012

- revision of E-Care Coordination pathway and procedure;
- document agreed sustainability plan;
- develop draft evaluation report, including case studies;
- presentation of draft report to Working group meeting for feedback;
- presentation of draft report to SEHCP for feedback; and
- develop final evaluation report.

Project Governance

The Project Steering Group, which consists of Managers from participating agencies, has responsibility for the oversight of the project. This group has made key decisions on the agreed protocol and reports back to the SEHCP Committee of Management via the SEHCP Executive Officer. The Project Working Group has included Practitioners from participating agencies who are responsible for leading the change management teams within their agency. The project governance model provides a partnership structure at both Manager and Practitioner levels to support the enhancement of interagency relationships, identification of emerging issues (i.e. workforce development) and facilitation of joint solution generation.

Incorporating Service Co-ordination Standards into the Project

The protocols and pathway developed are based on Victorian PCP Service Coordination Standards and the SCTT Care Coordination Tool which form the basis for the S2S e-care coordination module. Staff are required to have an understanding and experience in these areas in order to carry out their role as care coordinators.

Figure 1: Building Blocks of E-Care Coordination

Communication strategies

Working group members communicate with each other and the Project Manager at meetings, through email, phone and minutes. A monthly bulletin is produced and distributed by working group members to relevant staff within their organisation. Several power point presentations have been developed and used to train staff and keep the Steering Group informed. Monthly reports are tabled at the SEHCP Committee of Management and SEHCP Service Coordination & Integrated Chronic Disease Management Alliance meetings.

The Steering Group meets quarterly and the Working Group fortnightly. The Project Manager liaises regularly with SEHCP's Executive Officer.

Consumer engagement

Feedback from consumers during the 2008 Care Planning Project provided important considerations for the development of the E-Care Coordination protocols. Consumers/Carers are involved in the development of each care coordination plan and are also invited to participate in case conferencing. Consumers/Carers will be invited to participate in the evaluation of the project in May 2012, which is likely to involve participation in focus group/s and/or individual interviews.

General Practice Engagement

Whilst the initial PCP Consortium E-Care Plan Project Trial local "cluster" made significant efforts to engage GPs through Monash Division of General Practice and Dandenong Casey General Practice Association it was identified that only GPs currently using Argus 5 to send and receive information, who demonstrated an interest in participating in the e-care coordination trial, could be considered.

Due to these challenges the Active Service Model Project has focused largely on incorporating the role of and communication with the GP into the e-care coordination pathway, rather than centre attention on using electronic systems. The pathway describes the process for inviting GPs to be part of a case conference and ensuring that the GP is provided with a copy of the care coordination plan.

RESULTS

Service improvement/ innovation and outcomes

Outcome measures:

- There is evidence of functional integration of e-care coordination across participating agencies;
- a care pathway and e-care coordination system that is well coordinated and reliable is operating and is sustainable;
- consumers are informed about care coordination options and processes (including who is responsible for what and their rights in relation to care coordination procedures and available services);
- services are working as a "virtual team" to support E-care coordination; and
- there is a high level of trust between services involved in the projects.

Initial data

- 12 Managers and Practitioners representing 6 agencies have been involved in steering committees and working groups.
- baseline data collected including agency survey, Vic Health Partnership's Analysis Tool, e-care coordination audit;
- e-care coordination protocol has been developed and endorsed by Management in the agencies;
- tracking and reflective practice tools developed and implemented;
- 33 staff have been trained to use S2S E-Care Coordination module;
- 13 practitioners have been trained in Plan Do Study Act
- 7 e-care coordination plans developed (1 month timeframe);
- agency position descriptions and processes have been reviewed;
- the project has been presented at SEHCP Annual Members Forum (68 attended); and
- presentations and case studies developed for change leaders to use for internal staff.

Note: Data reflects 5 months into a 10 month project

Status and sustainability

In April 2012 the E-Care Coordination Protocols and Pathway will be reviewed in line with feedback and evaluation outcomes. Participating agencies will be required to develop sustainability plans and encouraged to embed electronic care coordination into agency policy.

Critical to ongoing success will be:

- the commitment of agencies to ongoing protocol compliance and use of the S2S E-Care Coordination system;
- orientation and resourcing of training to new staff; and
- embedding care coordination into practitioner roles/position statements.

Additional agencies will be invited to participate in e-care coordination over time as part of service system change management.

CONCLUSIONS

Key success factors:

- building on previous service coordination work and learnings from the E-Care Plan Project developments;
- resourcing of dedicated Project Manager providing ongoing coordination and communications (provided by LIME Management Group and funded by Department Health – HACC Active Service Model Grant);
- agency Management and Practitioner commitment;
- use of PDSA process an tools to support implementation.

Key challenges:

- reluctance of some agencies/practitioners to take on Care Coordination role;
- multiple demands on practitioner time reduced time available for implementing change;
- lack of confidence/experience in using electronic systems in general;
- limited access to computers in some agencies; and
- key care team participants/some agencies unable to access the S2S E-Care Coordination module.

Limitations of the project:

- where agencies did not have the building blocks of serviced coordination/care planning/e-referral in place this limited or slowed progress towards achieving outcomes.

How activities and improvements will be sustained:

- agreed interagency protocols in place
- e-care coordination incorporated into internal agency protocols, position descriptions, performance measures and policy
- e-care coordination training resources developed and available for future use
- broaden participation in e-care coordination to more agencies.

Relevance of your findings to other areas of PCPs activity:

- the processes used to develop the protocol, pathway and the S2S electronic system have potential benefits for enhancing care coordination for a range of target groups, issues and program areas. For example: mental health, consumer with complex needs/chronic disease, problem gambling, refugee health, disability, youth, child and family.

REFERENCES

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