Developing Care Plans between General Practice and Community Health:

How we did it and what we learnt

A collaboration between Brunswick Community Medical Centre and Moreland Community Health Service

Auspiced by Hume Moreland Primary Care Partnership
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INTRODUCTION

The Hume Moreland Primary Care Partnership received funding through the 2004/05 GP Service Coordination Small Grants round to create, document, implement and disseminate a good practice model of service coordination between General Practice and Community Health.

The project built upon a number of service coordination and integration activities undertaken by Moreland Community Health Service (MCHS) and the co-located Brunswick Community Medical Centre (BCMC), which is operated by St Vincent's Health.

The early stages of the project concentrated on developing and implementing strategies to improve the level of knowledge and general communication between staff of the two services. It included provision of service information through existing websites, brochures and newsletters; orientation programs for new staff; initiatives such as tours of the major MCHS sites for BCMC GPs; and, attendance at each other's staff meetings. Although not covered in this manual, these activities were an important foundation and precondition for the care planning phase of the project.

There were two significant developments that influenced the way in which this project addressed the issue of care planning. The first was the introduction in July 2005 of the new Medicare Chronic Disease Management items, especially the Team Care Arrangement items. The second was the experience of the Interagency Care Planning Protocol Pilot Project undertaken by PCPs in the North West Region during 2005, especially the issues identified at the post trial meeting with General Practice Divisions Victoria (GPDV) in November 2005 around the existence of two care planning systems which do not interface - one used by DHS funded member agencies of PCPs and the other used by GPs as part of the Medicare system.

We realised that our project was potentially well placed to undertake some work that would progress the final resolution arising from that meeting: "There needs to be further exploration of the opportunities for interfacing the two care planning systems to maximise best care for the client group."

We decided to explore whether it would be possible to set up an integrated care planning system for a specific group of people, namely the residents of Stewart Lodge, a large Supported Residential Service (SRS) in Brunswick, which would meet the needs of the client group and the two services.

Following is a map of how we did this and the resources we identified that assisted the process. By sharing our story we hope to encourage other GP practices and primary care agencies to develop joint care planning arrangements for the benefit of shared clients with complex needs.

WHO WAS INVOLVED IN THE PROJECT ?

A variety of individuals representing varying disciplines and agencies were involved in the care planning project and the development of the care planning processes. This included PCP staff and staff from the North West Metropolitan Division of General Practice, as well as staff at MCHS and BCMC as detailed below.

Brunswick Community Medical Centre

Brunswick Community Medical Centre is operated by the St Vincent's Health Network and is primarily a bulk billing service for patients with a valid Medicare card. It has 5 GPs, a sessional psychiatrist, 2 practice nurses and a part time practice manager. The practice is also supported by the equivalent of 2 reception positions.

BCMC is a family medical practice, co-located with MCHS in Brunswick. The centre has special interests, ranging from women's health to mental health, to paediatrics and geriatric care. BCMC offers a comprehensive GP service including: acupuncture; cryotherapy; immunisations; women's health; minor surgical procedures; pathology collection; psychologists; and, psychiatrists. BCMC operates 6 days per week with some later night sessions during the week.

Staff involved in the project included:

- one of the GPs who regularly visits Stewart Lodge;
- a practice nurse;
- the practice manager; and,
- the senior receptionist.

Moreland Community Health Service

Moreland Community Health Service was formed in 1993 through the amalgamation of the former Coburg Community Health Centre, Brunswick Community Health Centre and Co-Care (Youth and Disability Health Service). It operates from 8 sites in the City of Moreland and in the northern suburbs of Melbourne and is the third largest community health service in Victoria.

MCHS provides a range of services including: dental; allied health; generalist and specialist counselling programs; aged and disability services; case management; family and carer support programs; social support programs for people with a mental illness; as well as, health promotion programs.

Moreland has a diverse population of around 140,000. A high proportion of residents were born overseas, and nearly half rely upon Government benefits for most of their income. Services provided attempt to reflect this make-up including employment of bilingual staff.

One of the mental health services offered at MCHS is a Psychiatric Disability Rehabilitation Support Service (PDRSS). PDRSSs support clients with a mental illness to gain or develop skills they may need to actively participate in daily life. Linx is a specialist team within the PDRSS program at MCHS. It is the role of the Linx staff at Stewart Lodge to support the residents. The Linx staff play a vital role in supporting the clients in making and attending appointments.

The main staff involved in the project from MCHS include:

- the Linx client support worker;
- the Manager, Psychosocial Rehabilitation & Youth Health Services; and,
- the Director of Clinical Services.

The Stewart Lodge residents

Stewart Lodge is a registered Supported Residential Service located in Brunswick. Supported Residential Services provide accommodation and care for people who need support in everyday life, for example, people who are frail or have a disability, and are generally private concerns. They do not receive any government funding but they must be registered with the State Government of Victoria.

Stewart Lodge has 80 residents who primarily require support due to chronic disability such a mental illness or brain injury. Most of the residents have been recipients of supported care for many years.

We chose this particular group of clients for a number of reasons:

- they are a defined group: resident turnover is low, with most of the 80 current residents already joint clients of the community health service and medical centre;
- residents all have chronic medical conditions, particularly mental illness, and therefore are eligible for a Medicare rebateable GP Management Plan. Most have complex needs and are eligible for a Medicare rebateable Team Care Arrangement if their GP decides that they require ongoing care from the GP and at least 2 other collaborating providers, each of whom provides a different kind of treatment or service to the patient.
- MCHS receives funding through the Psychiatric Disability Rehabilitation Support Services (PDRSS) and HACC for the Linx program to provide reasonably intensive on-site support to these clients;
- BCMC also has a strong commitment to meeting the medical needs of these clients, and runs regular GP clinics on site; and,
- there were already some joint systems in place between BCMC and MCHS (and some other players, including the Managers of the SRS and the Area Mental Health Services) to manage the physical and mental health needs of these clients, including a monthly case conference, a communication book and an annual round of physical health check-ups.

Taking all the above factors into account, we considered that there was a good chance of developing and testing a care planning system for these clients within a reasonably short period of time.

WHAT DID WE DO?

We began by identifying five key steps that were common to both the care planning process for Community Health Services and the Medicare Team Care Arrangement (TCA) guidelines for General Practitioners.

These were:
1. Determine the need;
2. Identify participants and obtain client agreement;
3. Develop the plan;
4. Document the plan; and,
5. Review the plan.

We used these steps as a road map against which we documented the precise processes which would need to be undertaken by the various players in the case of the client group in order to meet everyone's requirements. The document we developed was a flowchart as included in Appendix B.

This required the coordination of several key roles across the two organisations, primarily the practice nurse, the general practitioner and the Linx staff.

HOW DID WE DO IT?

Step 1: Determine the Need

The need for a care plan was determined as part of a process of annual health checks for the Stewart Lodge residents.

1.1 The practice manager identified and developed a spreadsheet of all Stewart Lodge residents who are also clients of BCMC.

1.2 BCMC made block bookings for a small group of Stewart Lodge residents, generally once per week. The Linx staff facilitated the appointments by transporting the clients to the clinic and supporting those that had consented to her involvement.

1.3 BCMC created a health assessment tool that was adapted from the GP Management Plan (MBS item no. 721) sample form no. 721 (Please see Appendix A for details on how to access these forms).

1.4 The practice nurse completed part of the health assessment tool first because this provided the GP with base information and saved the GP some time.

The practice nurse entered the information that she had collected onto the computer system so it was readily available to the GP highlighting patient issues identified. The practice nurse generally:

- completed the blood pressure, pulse, urinanalysis, weight, feet, footwear and vision checks;
- discussed with the patient about their perception of their own health needs and goals;
- discussed with the patient their nutrition, diet and exercise; and,
- observed mobility, vision and hearing.

1.5 The GP completed the health assessment and using the partially completed health assessment tool available electronically through Medical Director, the GP:

- completed a physical examination including skin, chest and heart;
- ordered any blood or other tests; and
- reviewed medications.

1.6 Immediately following the health assessment, the GP and practice nurse consulted with the Linx staff to verify the information they had gathered. The Linx staff had consent from the client for this process.

1.7 A GP Management Plan was then developed for each client with the GP confirming the plan with the client at a subsequent consultation at Stewart Lodge. A claim was then made for Medicare Item 721 – Prepare a GP Management Plan.

1.8 The practice nurse and GP discussed the need for a care plan using the TCA Medicare item depending on the outcome of the GP Management Plan and client agreement.

Step 2: Identify Participants and Obtain Client Agreement

2.1 Based on the areas for intervention identified in the GP Management Plan, service providers who could contribute to a TCA and provide appropriate, affordable and accessible services to the client were identified.

2.2 The GP discussed the plan with the client and ensured the client gave his/her consent before these agencies were contacted.

2.3 The practice nurse generally did the investigating as to availability of identified services, waiting times and fees.

Step 3: Develop the Team Care Arrangements

3.1 In most cases the practice nurse contacted the identified service providers and obtained their agreement and input to the TCA. These service providers could be private or publicly funded services depending on the urgency of the need, availability and waiting times for services, and the length of time the client might need to access the service.

Step 4: Document the Team Care Arrangements

4.1 The practice nurse and the GP documented the TCA including: goals, collaborating providers, treatment/services they have agreed to provide, client actions and consent, and a review date. Templates that can be used for this process are available as identified in Appendix A.

4.2 The practice nurse sent a copy of the TCA, Victorian Statewide Referral Form and any other relevant documentation to public service providers included in the TCA and to the Stewart Lodge manager for inclusion in the client file (accessible by clients). (The Victorian Statewide Referral Form is the GP version of the Service Coordination Tool Templates (SCTT). The GP referred the client to private allied or dental using the required Medicare referral forms and a copy of the TCA and any other relevant documentation.

4.3 BCMC claimed Medicare Item 723 – Coordinate Team Care Arrangements.

4.4 The plan was recorded electronically on Medical Director so it was easily accessible for review and amendment within the practice.

4.5 The Linx staff assisted the clients to attend any external appointments set up as part of the care plan.

Step 5: Review the Team Care Arrangements

5.1 The TCA review date was established by the GP when developing the plan with the client. This was normally set at 6 months. The review details were entered onto the recall system in place at BCMC.

5.2 The practice nurse and or the GP consulted with the participating providers to review the client progress.

5.3 The GP reviewed the TCA with the client.

5.4 The practice nurse documented any agreed changes to the TCA and sent copies to the participating service providers and the Stewart Lodge manager.

5.5 Claimed Medicare Item 727- Coordinate Review of Team Care Arrangement.

Case Study

John is a 63 year old man residing at Stewart Lodge who has a long term mental illness and a history of supported residential care. An appointment is made for him to come into BCMC for a health screen. He is accompanied by the Linx support staff. John initially sees the practice nurse who completes parts of the health screen including: blood pressure, pulse, urinanalysis; feet and footwear; weight, nutrition, teeth, diet and exercise; mobility, vision and hearing; and, his perception of his own health needs and goals. Issues identified by the practice nurse is that John: was concerned that he was underweight which may be associated with apparent dental problems; has large calluses on both feet and uses a chisel to remove irritating skin; has a long history of smoking and consumes about 25 each day; and, is at high risk of the flu and has had no recent flu injection.

John continues his health screen with the GP who has available the information gathered by the practice nurse on their computer system. The GP completes: an extensive physical examination including skin, chest heart; orders tests including glucose levels, HbA1c, cholesterol, and microalbuminuria; and, reviews Johns medications and requests a list of all medications from the pharmacist. Issues identified by GP include: an active skin rash; unstable diabetes and a lack of antibodies for HepB.

As John is not able to accurately articulate all relevant health and lifestyle details, he consents to the Linx support staff to meet with the GP and practice nurse to contribute information that includes that John: eats a large varied diet; exercises regularly; struggles to put on weight; maybe being bullied over food; maintains good hygiene; and, manages all his daily living tasks with minimal input. He has limited understanding of the impact and management of his diabetes.

The GP discusses the possibility of developing a GP Management Plan and Team Care Arrangements with John as they are concerned that he requires some assistance to manage his diabetes in particular. John consents to this action and agrees to meet with the GP again to confirm any test results and the plan. A **GP Management Plan** is developed**.**

The GP meets with John the following week and explains the outcomes of the health screen and associated tests. They agree that John would benefit from: a Diabetes 12 month cycle of care; referral to a diabetes educator; a dental review; podiatry assessment; HepB and flu vaccinations; medication for skin rash; monitoring of his meals and making Sustagen available; a request to the Pharmacist to complete a medication review; and encouragement to reduce or cease smoking. John provides his consent to the GP Management Plan and for identified services to be contacted to contribute to a Team Care Arrangement plan. A **claim** is made to Medicare for **Item 721 – Prepare a GP Management Plan** and a date is entered onto the recall system to review the plan.

The practice nurse identifies accessible private podiatry who are registered with Medicare, as public services have long waiting times and John's needs are not urgent. The provider is contacted and they nominate services they could provide to John and contribute to the setting of goals on the TCA. The practice nurse also negotiates with the diabetes educator and dental service at Moreland Community Health Service for appropriate services for John and contribution to the TCA. Appointments are also made for the vaccinations and diabetes management program at BCMC. The Linx service is included in the TCA to monitor meals and encourage the cessation of smoking.

The TCA is documented by the practice nurse using templates loaded onto the BCMC computer system and includes details such as: goals, collaborating providers and the treatment/services they have agreed to provide, client actions and consent, and a review date. Using the Referral for Allied Health Services under Medicare Form a referral is made to the podiatry provider and includes a copy of the TCA. Dental and diabetes services at Moreland Community Health Service are also organised using the Victorian Statewide Referral Form and a copy of the TCA. Both forms are integrated into the BCMC computer system and auto populates some data. A copy of the TCA is also provided to John, the Linx service and the pharmacist. The Linx staff follows up with making and attending all the appointments with John. BCMC **claim Medicare Item 723 – Coordinate Team Care Arrangements**.

The recall system reminded BCMC to arrange a review appointment with John 6 months later. Prior to the appointment the practice nurse contacted the collaborating providers to review Johns progress and an appointment was made to review Johns diabetes. John had attended two dental and three podiatry appointments and would require annual review by these services. The diabetes educator and review appointment indicated that John was better managing his diabetes, had maintained his exercise and good eating but had not managed to stop smoking.

John attended the appointment with the GP and practice nurse, again supported by the Linx staff. John's skin rash had healed, his vaccinations had been completed and dates set for repeats. All agreed that an annual dental review, and 6 monthly podiatry and monitoring of his diabetes would be beneficial. Changes to the TCA were documented by the practice nurse and copies were distributed to the collaborating providers, the Linx service and John. BCMC **claim** Medicare **Item 727- Coordinate Review of Team Care Arrangement** and **Item 725 Review of a GP Management Plan**.

WHAT DID WE LEARN ?

Like most projects or pilots unexpected barriers and enablers emerged. Following are the most prominent issues and how we went about addressing them.

Enablers: Practice Systems

Sufficient practice staff

One of the enablers for BCMC was that they had sufficient practice staff (a practice manager as well as two practice nurses, although only one was working on this project) to manage the administrative aspects of what is quite a complex process.

Adopting a sustainable systemic approach

BCMC took a lead role in instigating and managing the TCA process. This was accepted by all involved players and appears to be dependent on the practice having sufficient staff and strengthening relationships with staff from MCHS.

BCMC was also able to develop roles for the practice nurse and other practice staff which reduced the direct GP time needed to implement the process.

Adequate IT

Having access to electronic templates through Medical Director and being able to develop supplementary forms to suit the client group streamlined the efficiency of the process. The IT system was able to support the use of the full range of Medicare items including being able to auto populate the GP Management and TCA forms. BCMC also had a system in place to manage client recalls

Enablers: Service Providers

Facilitated client involvement

The existence of MCHS Linx staff at Stewart Lodge was a key to the success of this care planning project. They were able to facilitate attendance at all appointments, including transport, and provide accurate information to the care planning team, when the client consented.

The Linx staff also followed up all appointments with allied health and acted as a conduit for feedback. This was vital as many of the residents of Stewart Lodge would not have been able to do this on their own.

Team approach

The GP, practice nurse and Linx staff worked as a team to ensure that the client received a thorough assessment and was able to make informed decisions about their care plan. Many of the Stewart Lodge residents were not always able to provide reliable information on their health and well being so this was supplemented by the Linx staff.

Quicker access to private allied health and dental using MBS items

Once appropriate services were located, clients were able to get quicker access to private allied health and dental using the MBS items as part of their Team Care Arrangement than if they had used public services. This reduced the pressure on the publicly funded system, allowing priority for those clients who were going to need

this support beyond what the MBS items allowed. (That is, more than 5 allied health or 2 dental visits in one year).

It was decided during the project that clients requiring referral to allied health or dental would be streamed in one of three ways:

- direct to private providers for those clients who had been identified as having short term or infrequent need for the service;
- given priority access into the public system for clients who were likely to have an ongoing or frequent need to access services; or,
- a mixture of private and public.

We have learnt that private Medicare registered providers do not have to be members of the TCA team and can be receive direct referrals as long as the need is identified in a TCA. – "Please note also that an allied health provider does not necessarily need to be a member of the TCA team for the GP to be able to refer patients to them. A GP can refer patients to AHPs who are not members of the TCA team as long as the referral is for services that are recommended in the patient's TCA". See page 14 of the FAQs on the Commonwealth website for further clarification.

Building relationships

MCHS and BCMC deliberately chose to build on good practice already occurring between the two and strengthen relationships to maximise client outcomes. This can be an undervalued process but frequently results in the development of goodwill and trust. There was a shared commitment by staff to meeting the needs of highly disadvantaged clients in their locality. This has been the fundamental factor which has motivated staff to bear with the slow and tedious process of trying to make their two very different organisational, financial and technical systems interact.

The second part of the relationship building for BCMC was to develop connections and an understanding with local private providers to facilitate client referral and support. Again this takes time but is well worth the effort.

Barriers: Systems

Systems development for the practice

Developing sustainable systems within general practice takes time. Designating who performs what role, adopting suitable tools, learning to use existing software and/or upgrading to new software all take an enormous amount of time and energy.

BCMC staff all agreed that the effort to establish the systems was well worth the investment. The system they employ now runs smoothly and assists in generating income for the practice as well as providing a comprehensive service to vulnerable clients.

Understanding how to use the MBS Items

It also took some investment by the practice, and support from the Division of General Practice, to understand and integrate the new MBS items into existing practices and systems. Staff needed to learn how to work within the MBS guidelines and make use of the chronic disease items cost efficient for the practice at the same time. This involved developing systems that facilitated this practice.

Integrating IT systems and software

This is a barrier that is still present and may take some time to resolve. It would be easier if client information could be transferred and shared with all Team Care Arrangement participants (or at least those from BCMC and MCHS) in a secure electronic environment. This is not possible at present as the software and systems used by the two services do not integrate with each other and data is not transferable from one system to another. Until this issue is resolved all information is being transferred manually.

There are areas of duplication of information in the Statewide Referral Form and the TCA Template such as medications, allergies and basic demographics. General Practice Divisions Victoria and the Primary Health Branch of DHS will provide some guidance and advice on this in the near future.

Barriers : Service Providers

Waitlists for HACC funded services

The residents of Stewart Lodge are limited in their ability to pay for services so rely on HACC funded or no gap private services. Many of the HACC funded services in the Moreland area, especially for services such as dental and podiatry, have long waiting lists that make them difficult to access .

Locating private allied health registered for Medicare rebate

General Practitioners are able to refer clients to limited private allied health and dental services registered for a Medicare rebate. The clinic had difficulty in locating private providers who were: a) registered with Medicare; b) understood and agreed to participate in the Team Care Arrangement; and, c) were affordable and accessible for the Stewart Lodge residents.

The Divisions of General Practice were able to provide lists of Medicare registered private allied health practitioners and the clinic then had to invest time in establishing a relationship with some of these providers.

Availability of affordable dentistry

Affordable dentistry proved a particularly difficult service to locate in both the public and private sectors. BCMC and MCHS were able to negotiate a priority system for the Stewart Lodge residents, especially in accessing urgent dental services. BCMC referred other clients to private providers.

Allied health understanding of MBS items

BCMC staff also found that many allied health staff in both private and public practice had had limited exposure to the MBS CDM items and how they worked, so they found they were often educating on the run. It is anticipated that this may change over time as more practitioners become aware of the items and the benefits of participating in Team Care Arrangements.

Feedback from providers

Communication and feedback to the GP is vital in supporting the client. Not all allied health providers were diligent in this process resulting in missed information and greater time involvement by BCMC staff in pursuing information.

WHAT DO YOU NEED TO CONSIDER?

If you are thinking about trialling care planning between GPs and other primary care providers, some major issues to consider are:

- Do you have a client group in common that you are motivated to work together for?
- Do you have a relationship or an opportunity to build a relationship with local providers including general practices?
- How well do you know the business of potential care planning partners? How can you find out who they are and get access to information about them?
- How can you put in place sustainable systems to undertake and record care planning?
- Do you have sufficient privacy and consent protocols in place to ensure client confidentiality and informed consent to participating in care planning?
- How do the Medicare Chronic Disease items support care planning? How can these be used?
- What do you need to consider in developing a GP Management Plan or TCA for a specific disease?
- How does the Medicare assisted access to private allied health and dental providers work and what do you need to do?
- What resources are available to assist, such as the Divisions of General Practice or your local PCP?

Resources to assist you in being informed about the above listed areas are located in Appendix A.

Other areas that General Practices may need to consider and that your local Division of General Practice may be able to assist you with are:

- Do you have sufficient staffing such as practice nurses to assist in administering the care planning process?
- How can you change the way you practice to maximise use of available resources, such as the role a practice nurse can play in the GP Management Plan or TCA?
- Do you have systems that can assist with care planning such as client recall and the ability to auto populate care planning templates?
- Where are the local private providers registered with Medicare, what are their costs and availability?
- What education, systems and other support are available?

CONCLUSION

At one level the care planning collaborative between MCHS and BCMC has been a logical and simple approach to improving relationships and maximising client care. However, it has also involved a choice to invest resources to develop sustainable systems and relationships between different parts of the service sector.

For the Stewart Lodge clients there have been many good outcomes including the detection of low levels of Vitamin D; improved dental hygiene; previously undetected serious medical issues for a couple of residents; and attention to the high need for appropriate foot care for many. For many of the residents it is the first time that they had undertaken a preventative approach to the care of their health rather than waiting for acute symptoms to arise. Subsequently a variation in programs for the residents developed such as a walking group to help combat the Vitamin D deficiency and improve people's general fitness.

Both BCMC and MCHS value the outcomes of this project and intend to build on the progress by offering the same service to other client groups including people with diabetes.

APPENDIX A: Useful Resources

- To locate the local Division of General Practice
  http://www.adgp.com.au/site/index.cfm?module=DIVISION&state_code=VIC

- For general information on the Medicare Chronic Disease items
  http://www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-programs-epc-chronicdisease

- For information on the Medicare Allied Health and Dental Care initiative
  http://www.medicareaustralia.gov.au/providers/forms/medicare.htm - allied health

- For a quick reference guide to the new Chronic Disease Management Items: Making the most out of your Practice:
  http://www.adgp.com.au/site/content.cfm?page_id=11619&current_category_code=934

- For care planning flowcharts and disease specific flowcharts:
  http://www.adgp.com.au/site/index.cfm?module=DOCUMENTS&leca=59

- For general Team Care Arrangements and GP Care Plan templates as well as chronic disease specific templates:
  http://www.adgp.com.au/site/index.cfm?module=DOCUMENTS&leca=59
  http://www.nrdgp.org.au/resources.html or
  http://www.monashdivision.com.au/resources/resources.htm

- To locate local allied health and other primary care agencies and providers:
  http://www.connectingcare.com/
  http://humanservicesdirectory.vic.gov.au/

- General information on Chronic Disease Management
  http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/Sharing+Health+Care+Initiative-1
  http://www.adgp.com.au/site/index.cfm?display=333

- For information on privacy and consent:
  http://www.health.vic.gov.au/pcps/publications/languages_privacy.htm

APPENDIX B: CARE PLANNING FLOWCHART