Protocol and Guidelines
South East HCP Interagency Care Planning Project

BACKGROUND

As part of the continuous improvement of Service Coordination, South East Healthy Communities Partnership (SE HCP) identified the need to develop an Interagency Care Planning protocol. A project was funded to work with key stakeholders to build on Care Planning protocols developed elsewhere and review them to meet the needs of consumers and the local service system.

At project commencement in October 2006, mapping of Interagency Care Planning practice identified that only four of the nine agencies/programs who completed the mapping survey had been involved in Interagency Care Planning. The agencies acknowledged current practice was informal and generally involved knowing that another agency was providing service to a consumer and coordinating visits to avoid services arriving at the same time. If an agency changed or ceased their service provision to a consumer this was not always communicated to other agencies involved.

The SCTT Service Coordination Plan had not been used by any of the agencies for Interagency Care Planning. Two programs had received a GP Team Care Arrangement from a consumers doctor but this was used as a referral and the process did not actively engage with them.

A workshop of reference group members and others reviewed protocols developed elsewhere and used these protocols as the basis for developing a protocol related to the local service system. Following the workshop the draft protocol and guidelines were further modified by the project reference group and then feedback was sort from the SE HCP Chronic Care Alliance and Committee of Management. Following endorsement by the COM the protocol trial will be from May - August 2007. A post trial review will revise the protocol and a report of the post trial findings will be circulated

AIM OF PROTOCOL

An agreed process, for agencies/GPs providing care to a consumer with complex and or chronic needs to work together with the consumer to achieve better outcomes for the consumer and improved communication and service coordination between agencies/GPs.

Note: Agencies may choose to use this protocol for **Intra-agency** care planning when 3 or more services within an agency are working with complex clients

The project acknowledges work done on Interagency Care Planning by:

- **Central Victorian Health Alliance, Primary Care Partnership and**
- **North West Cross Alliance PCPs: Service Coordination Protocol Project**

and uses work from those projects in the development of this draft protocol.

Interagency Care Planning

Version Number: 1.2
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Statement of Outcomes

Consumers with chronic and or complex conditions with services from 3 or more agencies experience greater involvement in planning their care needs, have a central point of contact and improved coordination of services to meet their needs. Participating service providers communicate and work as a team to meet the needs of these consumers.

PROCEDURES:

Step 1

Identify the need for an Interagency Care Plan during Initial Needs Identification/assessment/review. (see Guidelines: Target Group).nb The worker who identifies the need with the consumer does not automatically become the care coordinator/key worker.

(*For the purpose of the trial of the protocol please also review current consumers who fit within the target group to ensure there is sufficient use of the protocol during the trial period.)*

Step 2

Check if an interagency care plan exists and seek consumer consent. Discuss with consumer whether an interagency care plan is in place and if so seek consent to contact service to become part of that process.
If no plan in place, discuss with consumer the purpose and benefits to them of an interagency care plan and seek agreement to commence process.

Step 3

With consumer **identify participants** (current and/or future) to be involved in developing the ICP using the Service Coordination Plan (SCP) in the SCTT and whether consumer has preference for care coordinator/key worker. (see Guidelines: Care Coordinator/Key Worker pg 6)
Ask consumer to complete SCTT consent form for sharing of information and document consumer agreement to the SCP process in agency consumer management system.

Step 4

Worker who has identified need for SCP **communicates with identified participating services including GP** (who is invited to contribute to the SCP and or a case conference) by phone/fax/e-referral and **arranges time** for case

conference/teleconference/exchange of written documentation (or combination) to develop plan and appoint care coordinator/key worker.

Step 5a

At case conference/teleconference all participating services and consumer/carer **develop SCP and Care coordinator/key worker is appointed** (see Guidelines: The Plan pg 4) With the consumer/carer, the Care coordinator/key worker checks the plan to ensure it meets consumers needs and personal goals and **distributes** to other participants.

Step 5b

If written exchange of information, **Care coordinator/key worker appointed** following phone discussion and they with consumer **develop SCP** on behalf of team members and document and **distribute** SCP to all participants.

Step 6

Undertake **review** as per date set or when consumer/carer situation, goals, change using identified method (case conference, teleconference, written documentation or combination)

GUIDELINES

The Target Group

- People with chronic or complex conditions(see definitions pg 7) who have or need to have services from 3 or more service providers/programs
- Consumers who already have a case manager or care coordinator/ key worker are not excluded from the trial.

The Plan

1. Service Coordination Plan (SCP)

If the consumer appears to be in the target group, agency/provider asks:

- Is there an interagency care plan(ICP)? – if there is, with the consumers consent contact the agency that has done this to be included in the plan
- If no ICP, what other services are in place? – if there are multiple services and the person meets the criteria and agrees to have an Interagency Care Plan commence process.

2. GP Team Care Arrangement (TCA)

Eligibility criteria for MBS Chronic Disease Management - TCA items include:

- Chronic medical condition present for at least 6 months or terminal condition; and
- Complex care needs
- A need to see other providers on a regular, frequent and ongoing basis

This is a Medicare item number that can only be initiated by GP's that aims to encourage GPs to undertake a "shared care" approach to patients with chronic and complex health care needs. It is used for patients with chronic or terminal medical condition and who require ongoing care from a **multidisciplinary team of at least 3 health** or care providers (including their GP).

3. What to include when providing feedback for developing a SCP

Consumer Details including name, address, DOB, phone details
Assessment Summary Outcome

- Assessed problem or issues, assessment goals, Target/Review/end dates,
- Planned action or intervention, Services to be provided, Service or health information given to consumers
- Other relevant info eg admission/discharge date, referrals
- Consumer signature/consent(verbal) and date

Or **Discharge Plans** as per assessment summary +/- Referral Information
Or **Investigation Reports** eg Xray, pathology etc

4. What would you include in the Service Coordination Plan

The **assessed problem/s or issue/s**
Goal/s – clear, achievable and consumer focused (personal goals of the consumer)
Some or all of these goals may be used in the plan:

- **Safety and Protection** of consumer and/or support systems
- **Management of the episode**/acute event or post episode/post acute event (short time frame of days –weeks)
- **Functional gain** to improve or optimize levels of independence, wellness, quality of life (weeks to months)
- **Maintenance and support interventions** maintain levels of independence, wellness quality of life (weeks to months)
- **Prevention and early intervention** strategies

Target dates or anticipated review or end dates
Actions or Interventions

- Type of intervention – can be crisis, restorative or maintenance in nature or provide preventative, or safety related information
- Level of service intervention
- Frequency of the interventions

Responsible agency/service
You may also include an **emergency/crisis response plan**

5. Process for developing and reviewing a Service Coordination Plan

Involve the consumer/carer where possible and seek their consent to include relevant services in the development of the Service Coordination Plan and their agreement of the plan and for it to be distributed to the services involved.
Choose the most appropriate method or combination of methods that can be organized in a timely manner but *please note that the most comprehensive method to develop the plan is considered to be a face to face case conference*.

- **Case conference:** prior to meeting assessments and agency care plans provided to care coordinator for review with the consumer/carer. Check for unmet needs, duplication, lack of coordination. At the meeting use collaborative

problem solving and planning to resolve issues and action. Care coordinator to collate and distribute SCP to those involved following service and consumer/carer agreement.

- **Teleconference** as for case conference
- **Paper based by email, fax, post**, assessments and agency care plans provided to care coordinator for review with the consumer/carer. Check for unmet needs, duplication, lack of coordination. Problem solve and action plan through discussion with relevant services. Care coordinator to collate and distribute SCP to those involved following service and consumer/carer agreement

Timeframe for Trial

Development: Complete SCP within 4 weeks of agreement by consumer to be involved
Review: Aim for 6 weeks after commencement of SCP

Feedback

Need for all services included in the SCP to provide and receive regular feedback through the care coordinator /key worker via e-referral if available, otherwise fax.

Care coordinator/key worker

- If consumer has a **Case Manager/HARP Care Coordinator/HARP Service Facilitator** they would act as the care coordinator/key worker
- If consumer does **not have any of the above** discuss with the consumer who they would prefer to be their care coordinator/key worker.
- **Which agency** is best suited to provide the care coordinator/key worker:
  - Is there a main service provider/support person
  - Funded to provide care coordination
  - Preference of consumer if possible
  - Capacity to facilitate process
  - Area of specialization and knowledge meets consumer needs
- **Consumer, Carer or family member as care coordinator/key worker** eg Parents of children with special needs – need for agency to support carer/family member undertaking this role, include an agency "fall-back" person in the plan,
- **Changing the care coordinator/key worker** over time eg ACAS may only be involved in the initial development phase of the plan but the care coordinator/key worker would need to change to someone who has ongoing contact with the consumer/carer

Good Practice Guide for Workers: Role of Care Coordinator/Key Worker

"If you are the key worker, coordinate

- *The implementation of the Service Coordination Plan including review and, re-assessments*
- *Any monitoring activities*
- *Care*
- *The liaison and communication with key stakeholders such as the GP and organise case conferences etc if required*
- *The development of exit options and procedures and*
- *Information management processes to meet the requirements of the Health Records Act and other privacy legislation*
- *Coordinate the development of a SCP for consumers with complex or multiple needs and multiple agency involvement*

- *Empower the consumer to participate in the development, implementation, monitoring and review of their Service Coordination Plan*
- *Obtain consent to share the Service Coordination Plan and other consumer information with other agencies if required*
- *Provide a copy of the Service Coordination Plan to other agencies, the consumer's GP and the consumer"*

Ref: Good Practice Guide for Practitioners – A resource of the Victorian Service Coordination Practice Manual 2007

DEFINITIONS

Care Planning is a process of deliberation that incorporates a range of existing activities such as care coordination, case management, referral, feedback, review, reassessment, monitoring and exiting. Care planning involves the judgement/determination of relative need as well as competing needs, and assists consumers/carers to come to decisions that are appropriate to their needs, wishes, values and circumstances.
Care Planning also provides a means of synthesizing assessment information and agreed strategies and is **particularly important in facilitating appropriate care for consumers with multiple or complex needs.**
Ref: Draft Good Practice Guide for Practitioners: Victorian Service Coordination Manual November 2006

Care Coordination describes activities undertaken following assessment and care planning for consumers with high and complex needs – includes consumers receiving services from **multiple agencies** who are not receiving case management . Care coordination may include a range of tasks such as interagency care planning due to multiple agency involvement in service delivery, monitoring and review of the overall care plan, or assistance with accessing services from a range of program areas.
Care coordination and case management are distinct activities on the same continuum. Consumer care coordination can be regarded as a less intensive form of case management.
Ref: Draft Framework for assessment in the Victorian HACC program.

Case Management includes the roles and tasks described above for care coordination as well as arranging additional services needed by the consumer by means of brokerage, purchase of services or maintenance of effort agreements between agencies: organising case conferences and actively monitoring care plan for changes in consumer or carer circumstances.
Ref: Draft Framework for assessment in the Victorian HACC program.

Complex Needs

- People with multiple disabilities (health, social, cognitive) needing assistance in a number of areas of their life
- People who are vulnerable and live alone and have no effective or immediate support from family or friends, particularly those with confusion and memory loss
- People with behaviours that others find difficult and don't want assistance from services or don't perceive the need for assistance when there is objectively a clear need for it
- People with frequently changing and fluctuating needs
- People who have a multiplicity of disabilities combined with communication and relationship difficulties or social isolation
- Situations where there are two 'consumers' – the person with the disability and the carer, both of whom have significant needs
- People who have considerable disabilities and lose their carer
- People from non-English speaking backgrounds, where language or culture or family expectations mean that traditional service responses are not appropriate, or at least need modification or, where they cannot identify services as they have no understanding of the role of these services
- People who have an acute decline in ability to self manage

Ref: Aged and Community Care Division: Department of Human Services and Health, People with Complex Needs: Effective Support at Home, A Discussion & Resource Document for HACC Service Providers, 1993, pgs 9 & 10

Endorsed by: South East Healthy Communities Partnership Committee of Management

Signed: Mary Rydberg (Chairperson)

Date: May 2007

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