

# E-Care Planning “deliverables”

**A governance** model for electronic care planning



**Practices, processes, protocols and systems** for electronic care planning (building on the standards in the Victorian Service Coordination Practice Manual and the Service Coordination Tool Template User Guide)



**Functional specifications** for electronic care planning (building on the Service Coordination Tool Template and Victorian Statewide Referral Form information standards, functional specifications, and HL7 messaging specifications)



*E-Product*

**Evaluation** report and case studies for broad PCP dissemination and presentation at a state or national forum / conference

# Key Themes of Health “Reforms” .....over the decades

- ➔ “Funding reforms”, “structural reforms”
- ➔ Chronic disease, Complex care, Population subgroups
- ➔ Integrated care, coordinated care, seamless care, continuing care



...but for the first time, in Australia(?), .....specifically  
“E-health!”

# Integrated Care, Coordinated Care & Service Coordination

(Note: Concepts arising from Coordinated Care Trials and range of integrated service delivery programs, clinical governance issues etc)



Processes of “care” Agreed /accepted/ evidence based



Systems of “care”- developed and negotiated with clinical governance rules

*Need to consider process design/redesign concepts and constructs.....“Handover” points, transfer points... closing the loop.....*

Data/Information is the medium..... that is what is elicited, analysed and moved

forms to record/collect and transmit Information

*Coordination of services for “Care”*

# Care Planning

- Care Planning is a process of deliberation that incorporates a range of existing activities such as care coordination, case management, referral, feedback, review, re-assessment, monitoring and exiting.
- Care planning involves the judgment / determination of relative need as well as competing needs, and assists consumers to come to decisions that are appropriate to their needs, wishes, values and circumstances. Care planning also provides a means of synthesizing assessment information and agreed strategies”. *Victorian Service Coordination Practice Manual 2007*

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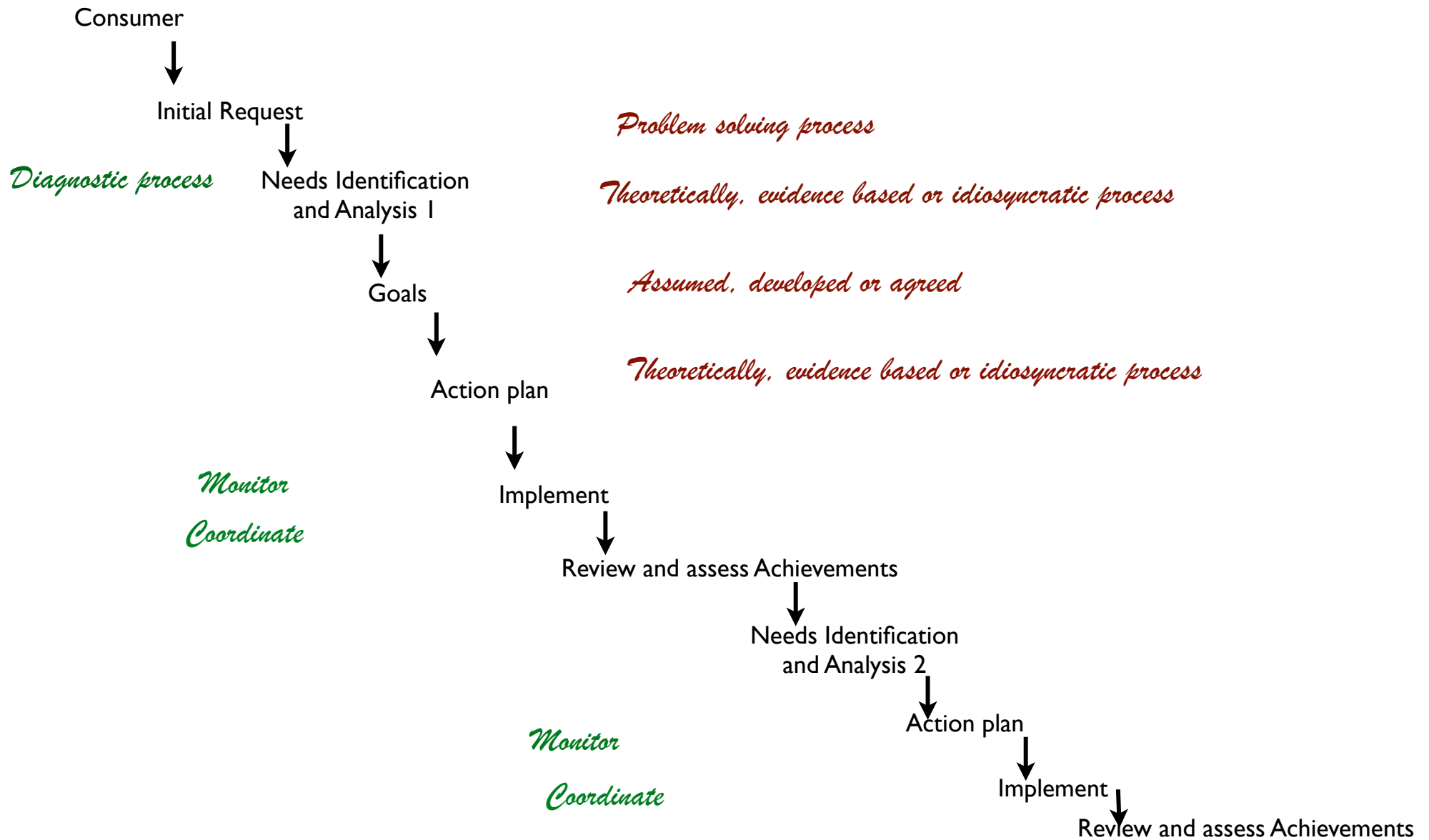
# Care Planning

- A process to outline how the issues identified in an assessment or review of the client's needs are to be best managed. This may involve linking into a range of existing services, how self management and education are to be provided and involves setting up communication between the General Practitioner and other people involved in providing care to the client.
- Care planning involves balancing competing needs, and assisting consumers to come to decisions that are appropriate to their needs, wishes, values and circumstances. *HARP Guidelines*

# *The Care Plan*

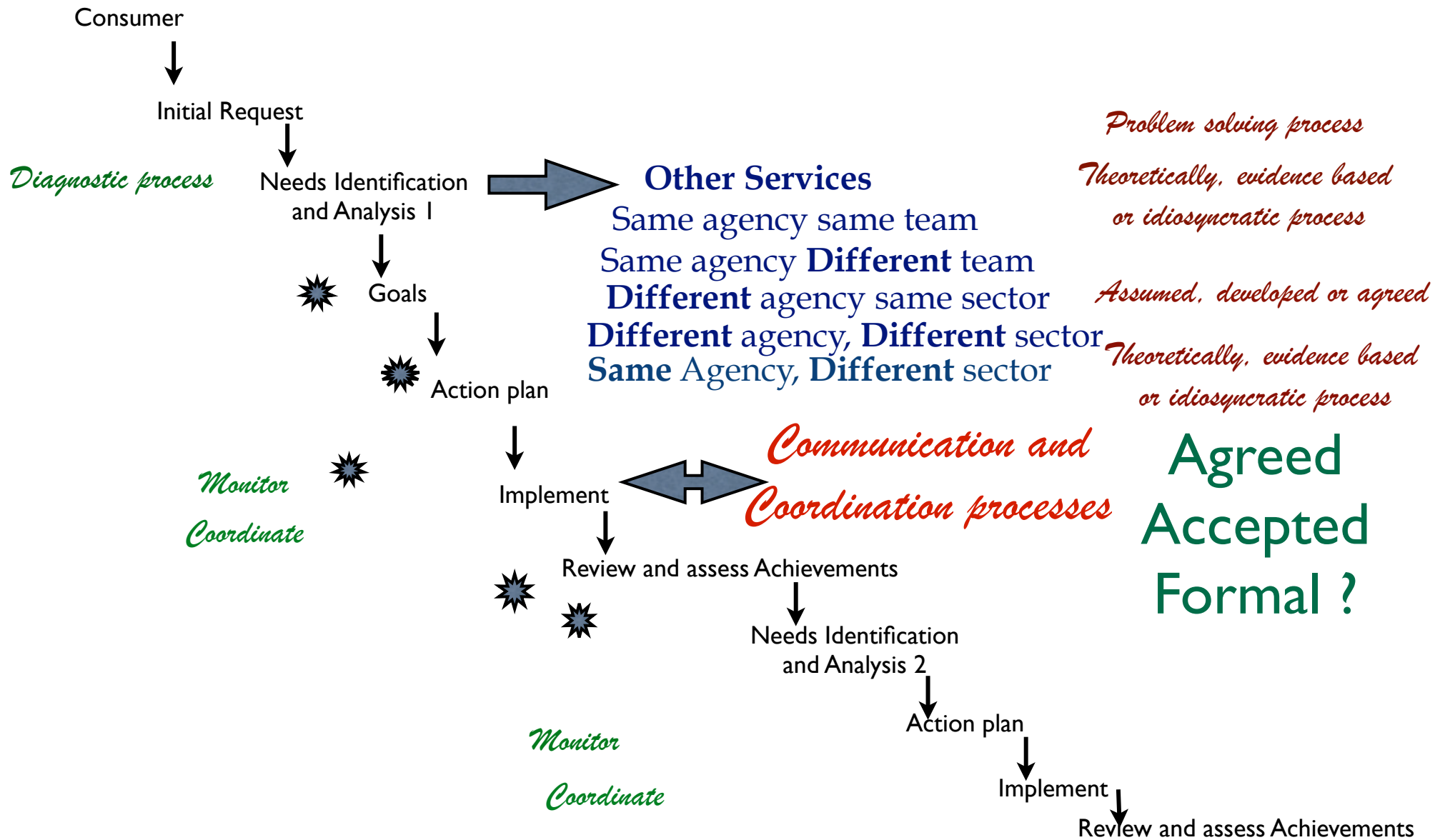
- A care plan is developed which includes client goals and needs, self-management strategies, carer needs, ongoing proactive monitoring, regular review mechanisms and appropriate recommendations from evidence based clinical guidelines.
- The care plan is developed with active participation by client and carer and relevant community services including GPs and is shared by all parties involved in providing care. *Source....*

# The Care Planning Activity Flow Base Layer



# The Care Planning Activity Flow

## Network Layers

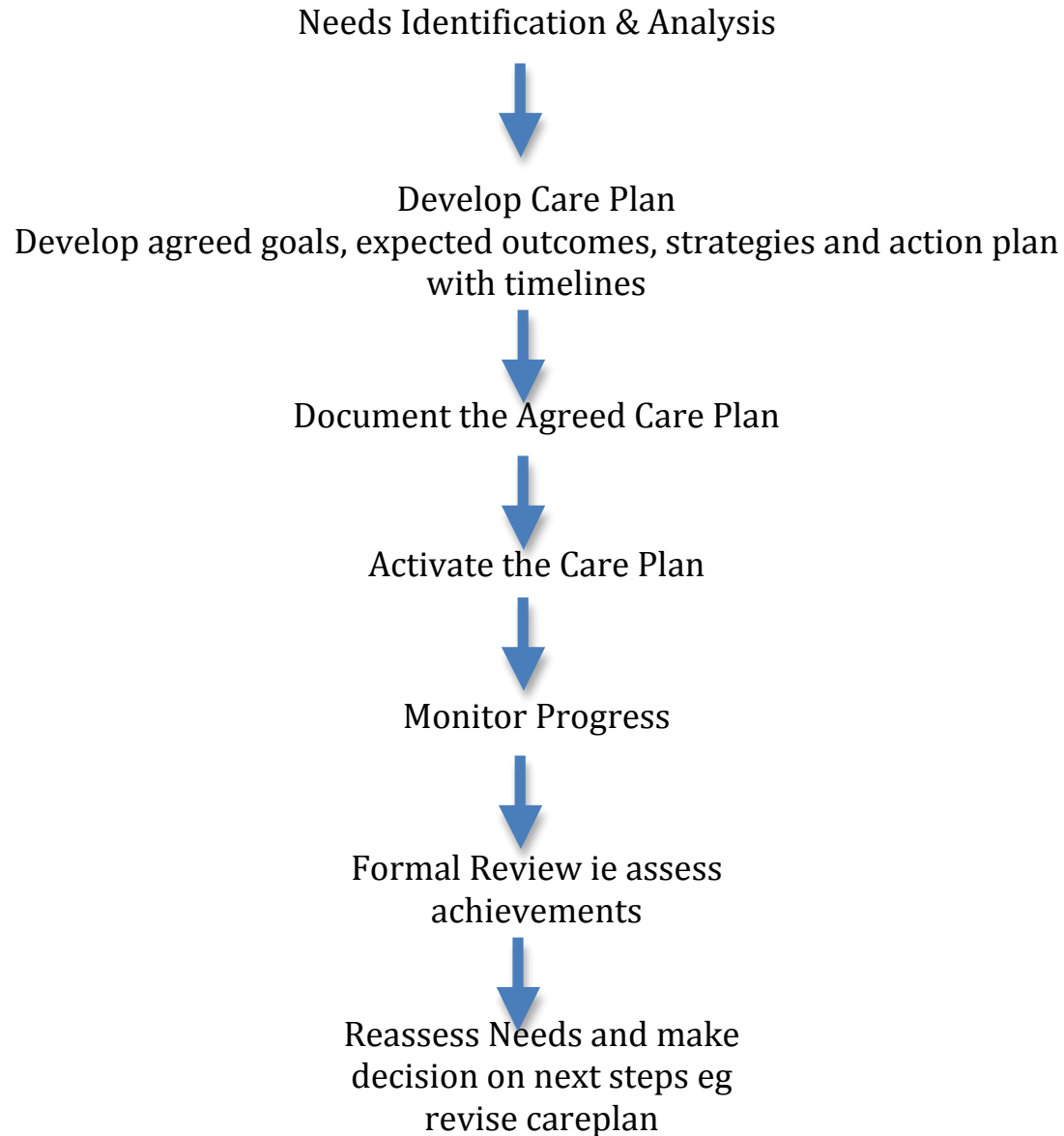


# The key requirements for participation

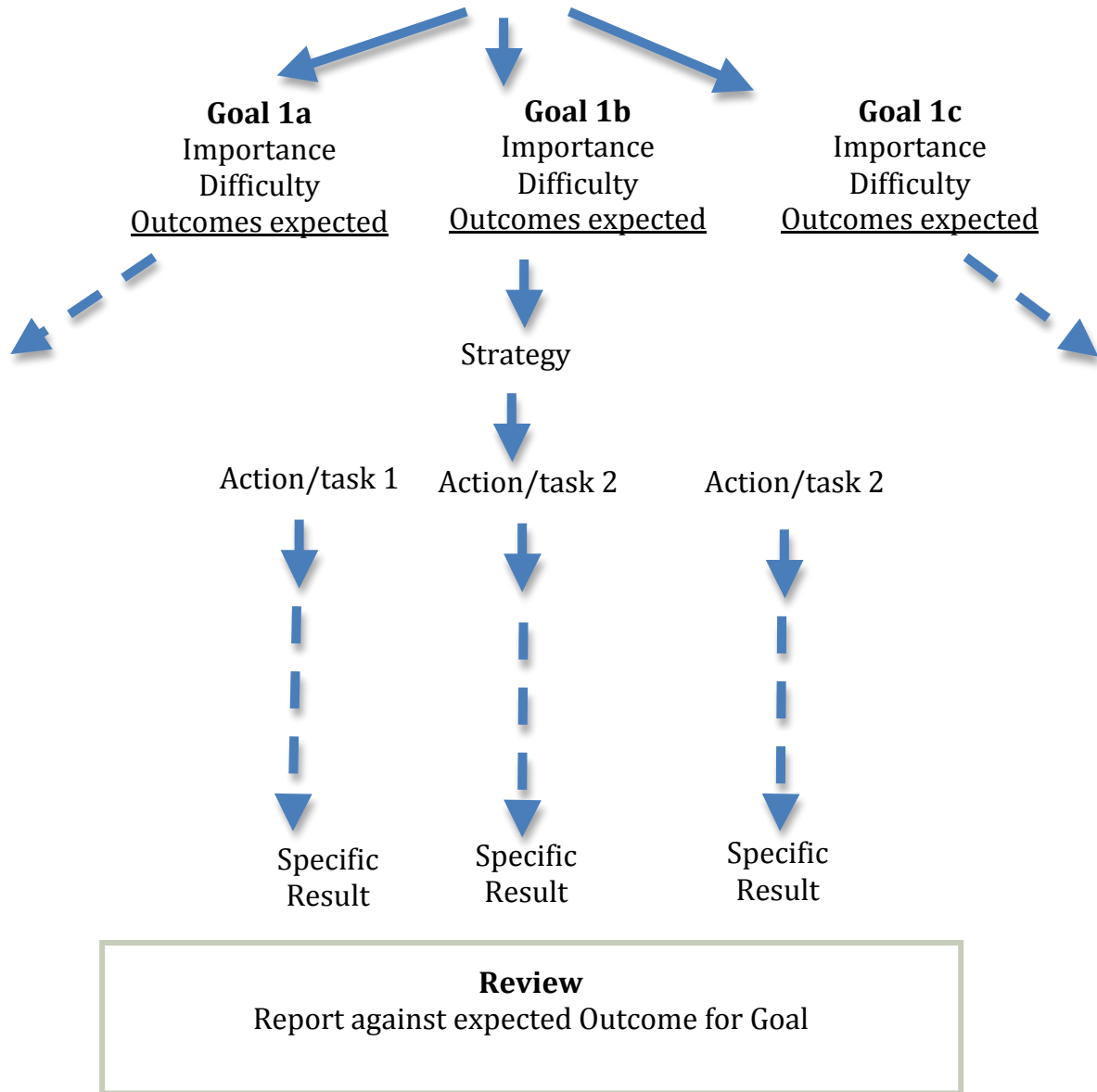
- **Evidence of Agency Level commitment at strategic/ operational levels**
  - ➔ Strategic Agency Commitment formal (ie fits with their strategic plans)
  - ➔ Management Level/Operational Level commitment to care planning
  - ➔ Practice level commitment (for actioning care planning)
  
- **Potential for agency(s)**
  - ➔ To form a care planning cluster or
  - ➔ Formed care planning cluster
  
- **Practice level requirements**
  - ➔ Understanding of developed PPPs
  - ➔ VSCPM –Standards/Compliance
  - ➔ Using S2S/E-SCS

Region	PCP	Agency Cluster	Common areas
Southern	SEHPCP	City of Greater Dandenong- Aged and Disability Services South Eastern Region Migrant Resource Centre Royal District Nursing Service - Springvale Centre Dandenong Casey General Practice Association Monash Division of General Practice Women's Health in the South East	Older Adult Falls  <i>(An ASM project commenced August 2011)</i>
North West	NEPCP	Northern Area Mental Health Service North East Area Mental Health Service NEAMI PDRSS To include other agencies such as CHS as they develop	Clients of Care Coordination Initiative Project
Gippsland	Central West	Latrobe Community Health Service Central West Division of GPs Latrobe City Council Latrobe Regional Hospital (HARP)	Type 2 Diabetes
EMR	OEHCSA	Knox Community Health Service Knox City Council Royal District Nursing Service Greater Eastern Primary Health	HACC population-Active Service Model Approach  <i>(Another ASM Project commenced Oct 11)</i>

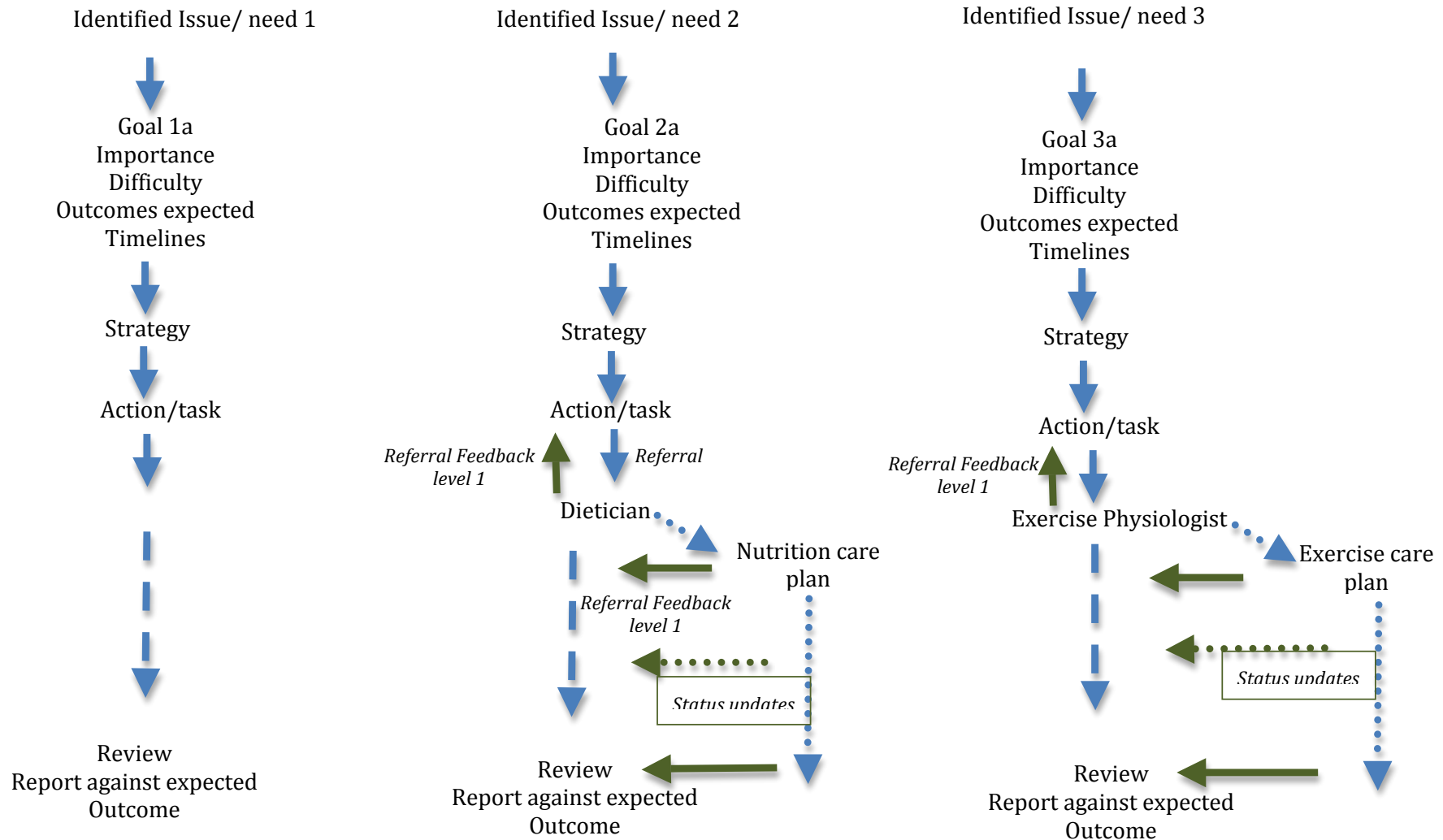
# Goal Directed Care Planning

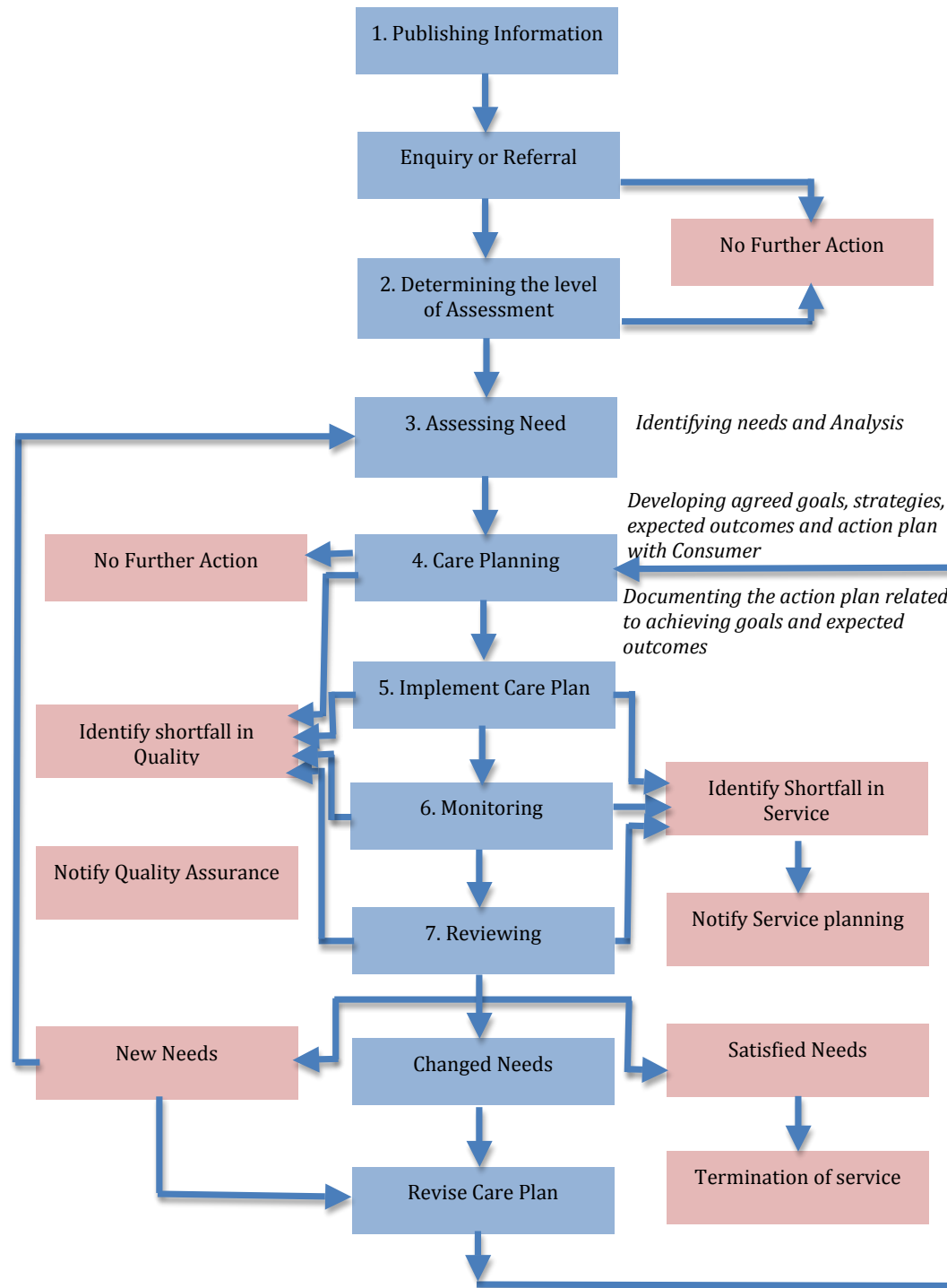


# Identified Issue/ need 1



# Goal Directed Coordinated Care Plan







## **Care Coordination Plan**

To support a coordinated approach for consumer /patients with complex and or multiple issues/needs.

The Care Coordination Plan shows:

- ❖ Who is involved in the consumers care,
- ❖ The participants in the coordinated care plan, “the care team”
- ❖ The main issues that need to be addressed,
- ❖ The agreed goals developed together and the expected outcomes, planned actions and who is responsible for each action.
- ❖ The nominated key worker - or care/service coordinator
- ❖ The Review Date
- ❖ Lists any supporting documentation

*Note: Consent to develop a coordinated care plan and share information ( including electronically) needs to be obtained using Informed Consent.*

*Need to included Clients role and responsibility in the Process*

## Care Coordination Plan

Consumer Label Identifier
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Reason for Plan:
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**Participants in Services/care and support:** List known persons contributing to the consumers/ patients support including the individual and the carer/ advocate , the key worker/ care plan coordinator/ facilitator and known service providers substitute decision maker, family members, volunteers or friend who provide assistance.

Name	Area of Support or Role	Agency if relevant	Contact Phone numbers	Other relevant contact details eg email	Participant in planning process	Consent for information access
	Consumer				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Carer				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	GP				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Key Worker/ care coordinator				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Case Manager				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Employment				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Housing				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/>	<input type="checkbox"/>

**Supporting documentation:** This may include social profile, Needs identification and analysis/ Assessments, service plans, support plans, GP Plans, advance care plans emergency management plans, screening or risk alerts.

Document	Source	Location	Attachment Yes/No	Link to Specific goals/ tasks

Care Plan documented by:

Name	Role	Contact Number	Date	Agency	Sign	Care Plan Reference no.

**Title of Form \_ Coordinating Care Plan**

Purpose : Documentation of Agreed plan

Consumer Label Identifier

Care plan Reference

Related Care Plans

Issues Problems Needs <i>List in order of "priority"</i>	Agreed Goals (Measureable#)			# Outcomes or results you want achieved <i>and describe baseline?</i>	Strategy	Actions or tasks	By When (Target Date)	By Whom	Provider (Identifier ?)
	Goal	Importance Rating*	Difficulty Rating**						
1 Newly diagnosed Diabetes needing assistance to stabilise and manage condition	Goal Index/reference number	<i>Patient being able to manage condition</i>	<input type="checkbox"/> Not at all <input type="checkbox"/> A little <input type="checkbox"/> Moderately <input type="checkbox"/> Very	<input type="checkbox"/> Not at all <input type="checkbox"/> A little <input type="checkbox"/> Moderately <input type="checkbox"/> Very	<i>Assist Patient to have clear role in managing condition</i>	<i>Referral</i> 1. Patient education 2.	30 <sup>th</sup> march 2011	Diabetes educator	<i>Provider name /chs</i>
	Goal Index/reference number	<i>Feel healthy -Prevent tiredness and lethargy/</i>	<input type="checkbox"/> Not at all <input type="checkbox"/> A little <input type="checkbox"/> Moderately <input type="checkbox"/> Very	<input type="checkbox"/> Not at all <input type="checkbox"/> A little <input type="checkbox"/> Moderately <input type="checkbox"/> Very	<i>Get advice and support to Maintain blood glucose levels within normal range with diet.</i>  <i>Weight loss through Diet and exercise</i>	<i>Referral</i> 1. Control and maintain blood Glucose levels within normal levels  2. . Reduce 7kg Weight	1 <sup>st</sup> February April 2011  30 <sup>th</sup> April 2011	Dietician	<i>Jill jones</i>
2	Goal Index number								
	Goal Index number								

Case conference Yes No                      Dates

Planned Review Date

Consumer understands and agrees to this plan Yes No                      Signature ..... Dates

Information collated and documented by  
Name:    Position and Agency    Signature.....Dates                      Contact number

Importance*	Difficulty **
0 = not at all (important)	0 = not at all (difficult)
1 = a little (important)	1 = a little (difficult)
2 = moderately (important)	2 = moderately (difficult)
3 = very (important)	3 = very (difficult)

**Title of Form REVIEW**

*Purpose : Assess and document level of goal achievement*

**Consumer Label  
Identifier**

Coordinating Care plan number    Care Plan Date

Related Care plans

Review Date

Issues Problems Needs <i>List in order of "priority"</i>	Agreed Goals (Measurable#)			# Outcomes or results you wanted achieved  And describe baseline	Review Outcome Achievement  Achievement Level	Comments and Recommendations	
	Goal	Importance Rating	Difficulty Rating			Provider/Participant/Carer	Client/ consumer
1 Newly diagnosed Diabetes needing assistance to stabilise and manage condition	Goal Index /Referen ce number	<i>Patient being able to manage condition</i>	<input type="checkbox"/> Not at all <input type="checkbox"/> A little <input type="checkbox"/> Moderately <input type="checkbox"/> Very	<input type="checkbox"/> Not at all <input type="checkbox"/> A little <input type="checkbox"/> Moderately <input type="checkbox"/> Very	<input type="checkbox"/> Much better <input type="checkbox"/> A little better <input type="checkbox"/> As expected <input type="checkbox"/> Partially achieved <input type="checkbox"/> Same as baseline <input type="checkbox"/> Worse than baseline		
	Goal Index Referen ce number	<i>Feel healthy -Prevent tiredness and lethargy/</i>	<input type="checkbox"/> Not at all <input type="checkbox"/> A little <input type="checkbox"/> Moderately <input type="checkbox"/> Very	<input type="checkbox"/> Not at all <input type="checkbox"/> A little <input type="checkbox"/> Moderately <input type="checkbox"/> Very			
2	Goal Index number						
	Goal Index number						

**Review Summary and recommendations- Agreed (Text)**

**Decision Pane**

- Continue with Plan
- Call Case Conference
- Amend Plan
- Deactivate plan/ close plan
- Create new Plan
- Other

*Flow on to relevant  
screens*

Information collated and documented by :

Name: \_\_\_\_\_ Position and Agency \_\_\_\_\_  
Signature.....Dates    Contact number