Coordination of care and service navigation

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Acknowledgement

We acknowledge the Aboriginal and Torres Strait Islander Peoples as the Traditional Owners of the lands. We wish to pay our respects to their Elders – past, present and emerging – and acknowledge the important role Aboriginal and Torres Strait Islander people continue to play within our community.

Acknowledgement

This webinar has been developed by Eastern Melbourne PHN on behalf of the Victorian and Tasmanian PHN Alliance, which is a collective platform for the seven PHNs in Victoria and Tasmania.

The webinar was made possible with funding support from the Australian Government Department of Health.

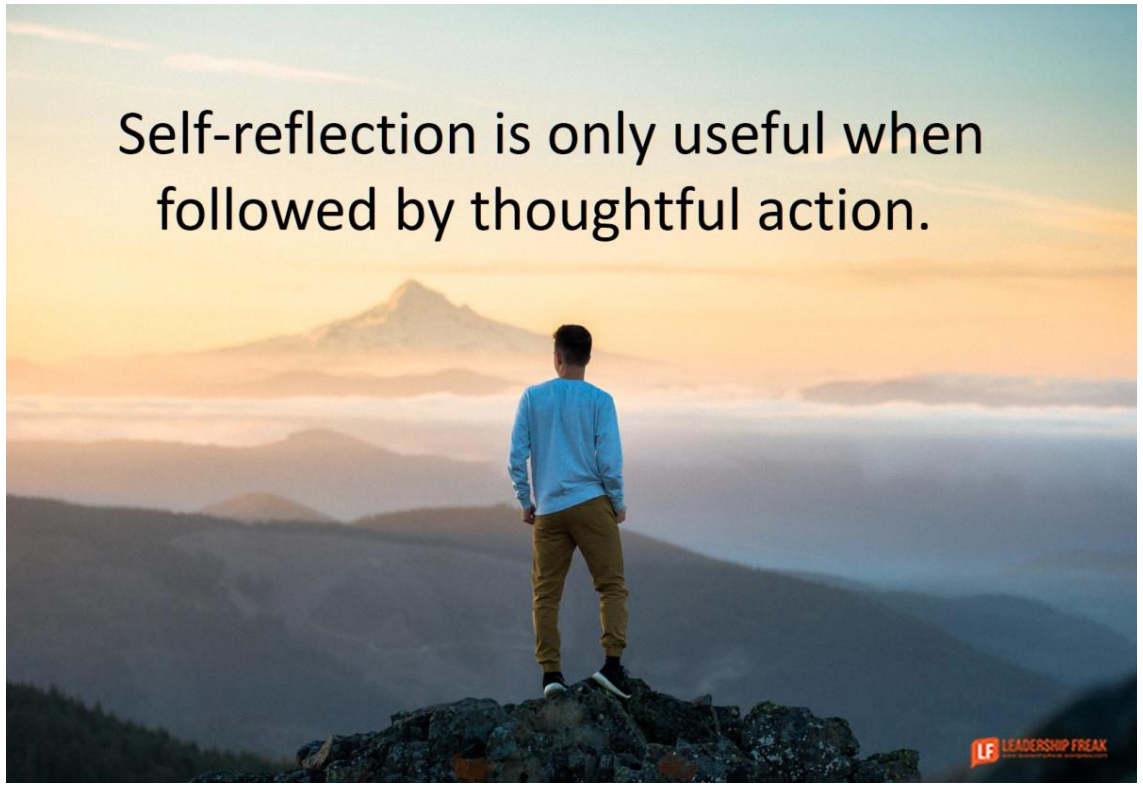
Disclaimer

The Commonwealth of Australia, Eastern Melbourne PHN, and the participating Victorian and Tasmanian PHNs do not accept any legal responsibility for any injury, loss or damage suffered as a result of the use, reliance upon, or interpretation of the information contained in this webinar. This webinar is to be used as a guide only and practices should read and refer to the additional resources and references provided with this webinar.

Learning objectives

- Describe a process for the identification of patients most likely to benefit from coordination of care
- Describe the four key components necessary for care coordination
- Identify actionable steps that can be taken at general practice level to improve coordination of care

Reflections on this webinar



Strachan, Dorothy (2007). Making Questions Work: A Guide to How and What to Ask for Facilitators, Consultants, Managers, Coaches, and Educators. San Francisco, CA: Jossey-Bass.

https://youtu.be/vGyjF9Ngd8Y

Communication

Care planning

My goals

I can plan my care with people who work together to understand me and my carer(s), which allows me control and brings together services to achieve the outcomes important to me.

Transitions

Decision making

Information

Source: https://www.nationalvoices.org.uk/publications/our-publications/principles-integrated-care

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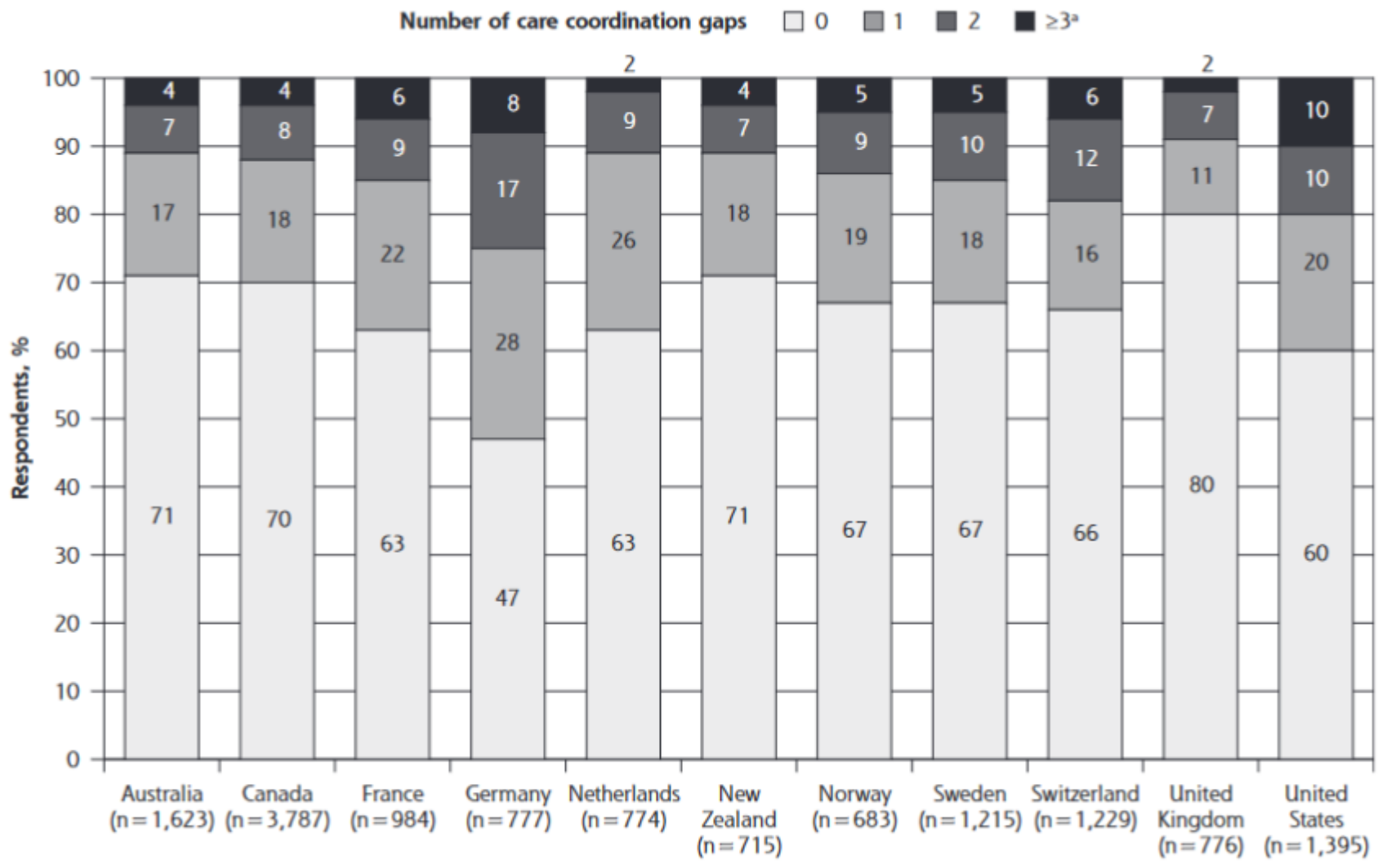
Figure 1. Percentage of respondents with care coordination gaps by country.



[a] Poor primary care coordination was defined as having at least 3 gaps out of a possible 5.

Source: Penm J, MacKinnon NJ, Strakowski SM, Ying J and Doty MM. The Annals of Family Medicine March 2017, 15 (2) 113-119; DOI: https://doi.org/10.1370/afm.2028

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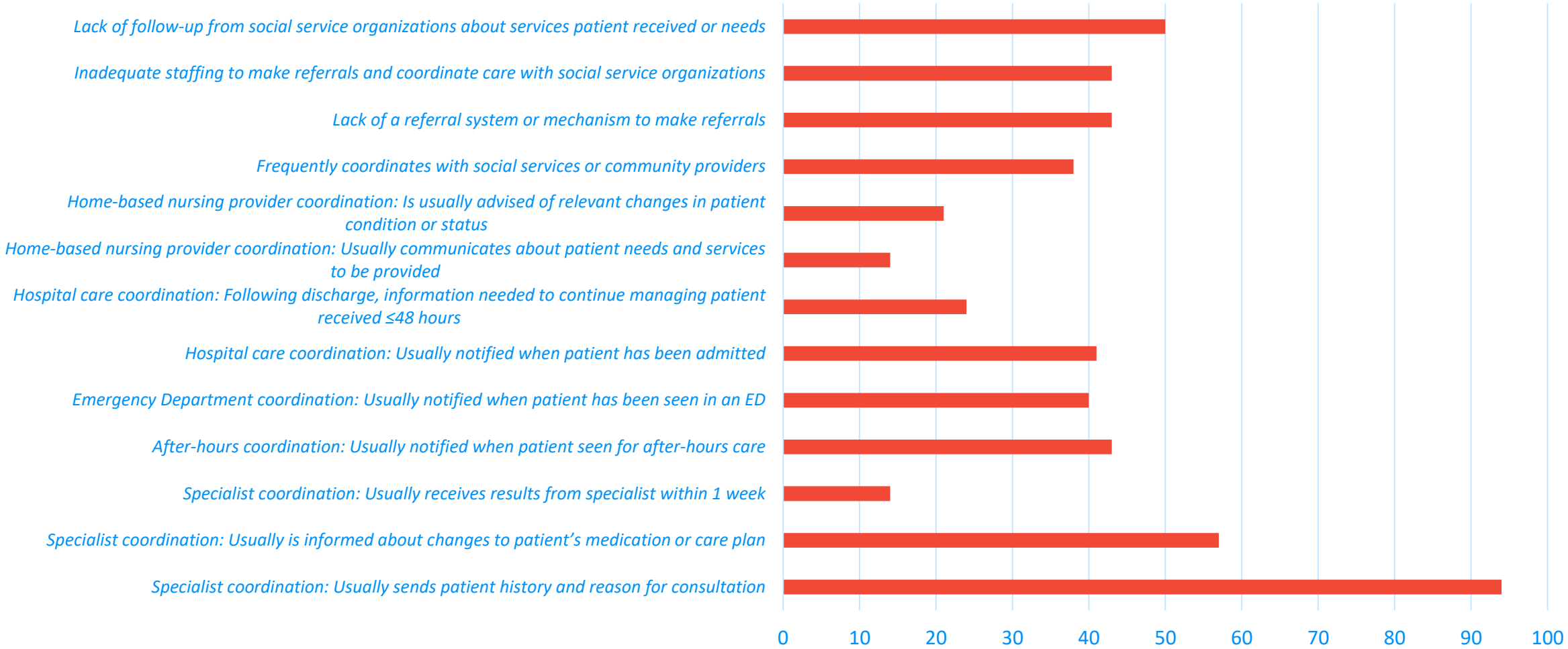
Australian data on care coordination



Michelle M. Doty, Roosa Tikkanen, Arnav Shah, and Eric C. Schneider, "Primary Care Physicians' Role in Coordinating Medical and Health-Related Social Needs in Eleven Countries," *Health Affairs,* published online Dec. 10, 2019.

% of patients	No. of patients	% of cost	Nature of Morbidity	Potential Intervention
1%	100	10%	High risk - multiple LTCs, frail, social care needs, unstable, end of life	Intensive case management
4%	400	17%	High risk – multiple LTCs, less unstable, some social care needs	Case management & disease management
15%	1500	25%	Moderate risk – one or two chronic illnesses and/or risk factors. Health likely to deteriorate over time	Condition management , health coaching & lifestyle management
80%	8000	48%	Low risk – morbidity due to time limiting, or acute illness rather than chronic conditions. Patients at risk of developing chronic conditions	Health education, health promotion & prevention strategies, lifestyle change programmes

Source: Agency for Clinical Innovation. Risk stratification: a discussion paper for NSW Health's approach to risk stratification. Chatswood, NSW: ACI, 2014. Available from: https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0015/253005/Risk_Stratification_discussion_paper.PDF

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The health ecosystem

Patients

Family and carers

General practice, community health and social services

Hospital and specialist care

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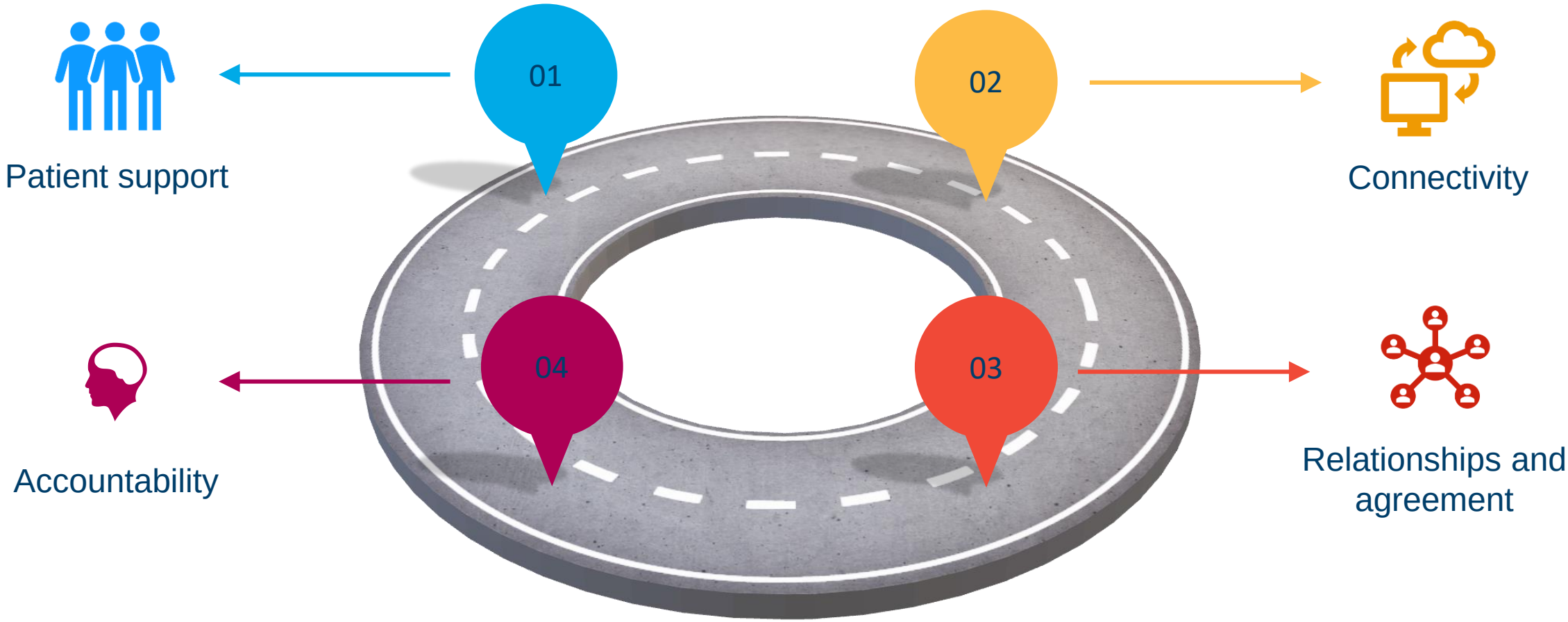
Care Coordination Model



Source: Adapted from the McColl Centre for Healthcare Innovation

Patient support

Organise the practice team to support patients and families

Who in the team undertakes this task?

How do you decide which patients need support and build support patient enablement?

How do you follow up on referral and discharge?

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Connectivity

Develop and use a reliable, secure and efficient information transfer system

How do you communicate with other providers? How can you improve on this?

Do you have agreed processes for information flows?

How do you share information with your patients?

How do you share care plans in particular?

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Relationship and agreements

Identify, develop, and maintain relationships and agreements with key other groups, hospitals, and community agencies

As a practice consider what the needs for coordination are for your practice population.

Develop links with key other providers who would be involved in the care of your patients

As a practice or group of practices clarify roles and responsibilities across the care pathways and use tools such as HealthPathways

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Accountability

As a practice agree to take accountability for care coordination

How will you monitor and track referrals to other providers and for diagnostics?

How will you ensure your clinical information (key diagnosis, medication lists are up to date)? Do you undertake a medication reconciliation after discharge?

Follow up following discharge?

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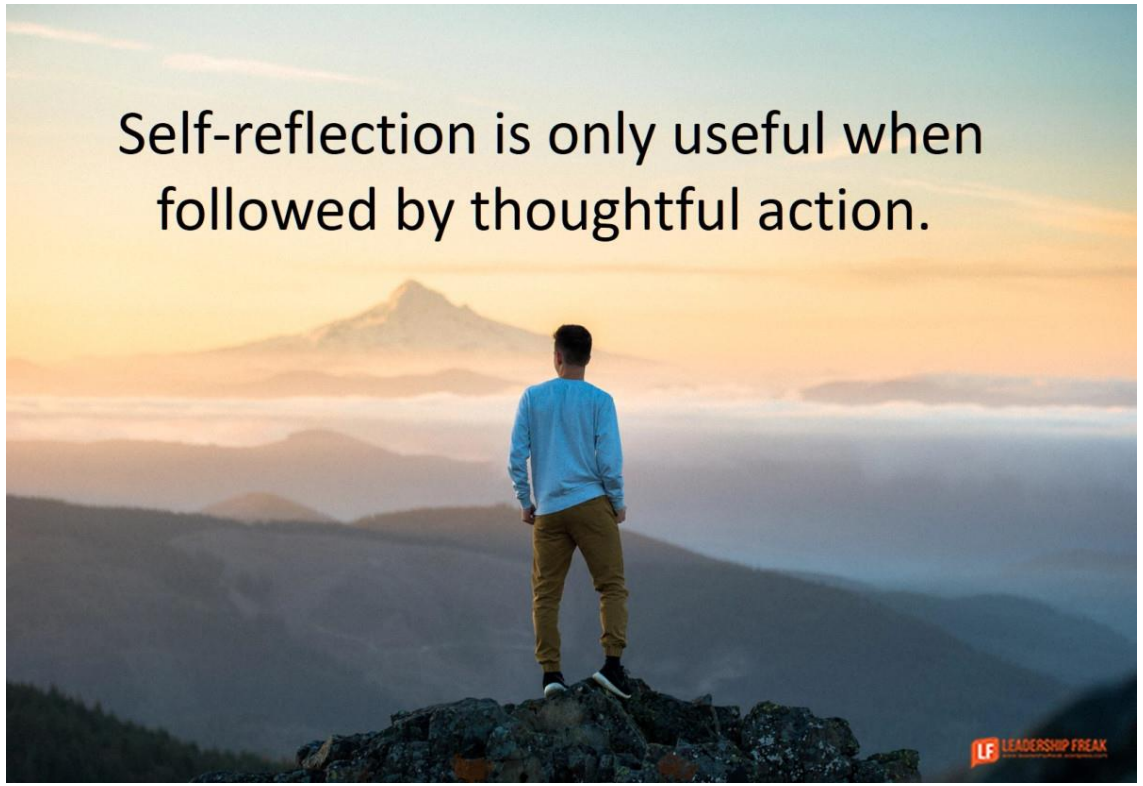

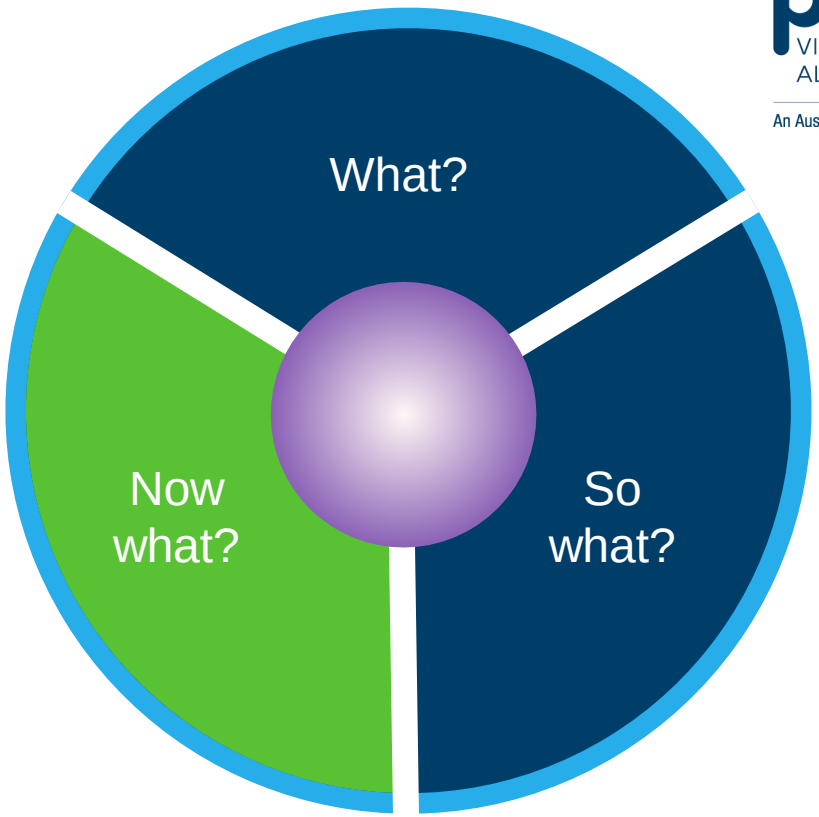

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Resources (1)

Follow the links below to access HealthPathways in your area:

Gippsland

- gippsland.healthpathways.org.au

Melbourne

melbourne.healthpathways.org.au

Murray

murray.healthpathways.org.au

Western Victoria

westvic.communityhealthpathways.org

Tasmania

tasmania.communityhealthpathways.org

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Resources (2)

Care Coordination Model

- www.improvingchroniccare.org/index.php?p=Care_Coordination_Model&s=353

Care coordination (Victoria)

- www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/health-independence-program/care-coordination

Care Coordination (Tasmania)

- www.carecoordination.com.au

Care Coordination (AHRQ)

- www.ahrq.gov/ncepcr/care/coordination.html

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