eCare Planning in the Grampians Pyrenees:

Increasing the uptake and use of cdmNet to improve the client experience

Project Report 2015

A partnership project between the Grampians Pyrenees Primary Care Partnership and the Grampians Medicare Local

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Acknowledgements

Project Partners:

- Stawell Regional Health
- Stawell Medical Centre
- Grampians Medicare Local
- Grampians Community Health
- East Grampians Health Service
- Beaufort and Skipton Health Service

Resources shared by eCare planning projects:

- Outer East PCP
- Upper Hume PCP
- Western District Health Service

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1. The Project: What is it?

Delivered in partnership between the Grampians Pyrenees Primary Care Partnership (GPPCP) and the Grampians Medicare Local (GML), this project aimed to significantly enhance and extend electronic care planning in the Grampians Pyrenees catchment. The method was to directly engage with key agencies and services to address barriers and gaps, provide training and work together to enable uptake and sustained use of the cdmNet electronic care planning product.

The objective of the project was to improve inter-agency shared care planning and enrich client experience of the health system in the Grampians Pyrenees catchment by:

- Increasing the uptake and sustained use of cdmNet by multiple health providers.
- Enabling service providers to develop shared protocols, Local Agreements, MOUs and common practice to clarify and commit to a Shared Care Planning process.

Proposed outcomes of the project:

- Well educated staff using cdmNet to create and contribute to shared care plans
- Full integration of cdmNet use, with the local GP, private providers, allied health, non-MBS staff and the client engaged in utilising the product for all chronic disease patients with multiple providers.
- Best practice resources and final report compiled supporting this work into the future.

2. Background and Context

2.1 eHealth Policy

eHealth is a key priority on both Victorian and Federal health reform and innovation agendas. The Victorian primary care sector has seen significant increases in cross sector collaboration in patient care, particularly in aged care, chronic disease and disability services and programs. This has been accompanied by service coordination support work by PCPs and Medicare Locals, particularly in terms of care planning and use of tools such as Service Coordination Tool Templates (SCTTs). The roll out of the National Broadband Network and review of the Person Controlled Electronic Health Reform (PCEHR) facilitate further an integrated and streamlined eCare planning environment.

2.2 What is Shared Care Planning and why is it important?

Service coordination places consumers at the centre of service delivery to maximise their opportunities for accessing the services they need. Each consumer has different needs, aspirations, priorities and resources and these inform the development of individual goals. A collaborative approach to service delivery that actively involves the consumer, their family, carers, support people and service providers facilitates the best possible outcomes for the consumer. Shared care/case planning can occur at any point in the service coordination process, wherever an assessment or review takes place.

Shared care planning involves discussion, negotiation and decision making between service providers and consumers to define their goals and strategies, resulting in identifying actions and services to meet those goals. This partnership approach, where consumers and service providers share knowledge values, experience and information enables collaborative, holistic health care (Department of Health 2012).

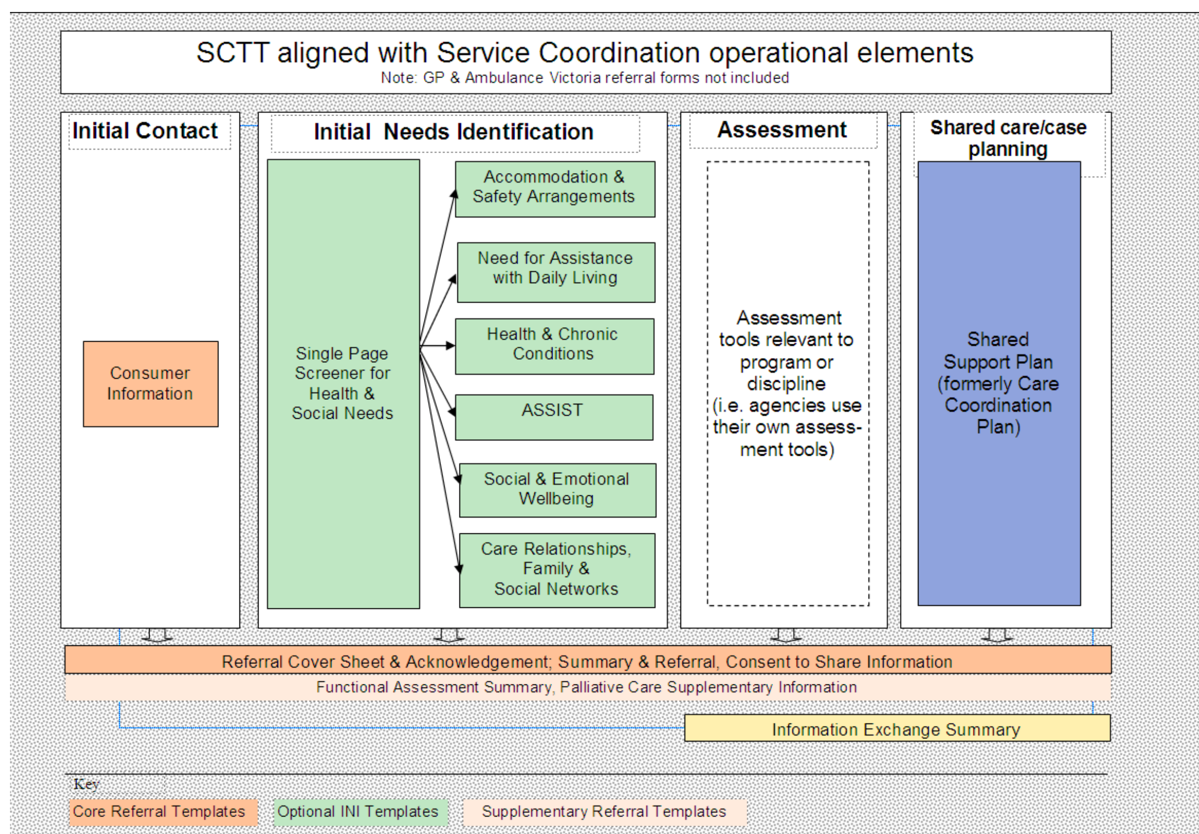


Diagram 1: Consumer pathway through Victoria's Service Coordination Model. *(Source: Victorian Service Coordination Practice Manual 2012)*

2.3 What is cdmNet?

> "cdmNet is a cloud-based service enabling effective care coordination. It helps manage the complete cycle of care for people with chronic and other illnesses." (Precedence Healthcare)

The tool cdmNet, created by Precedence Healthcare, is a web-based service aimed at assisting General Practitioners (GP) and allied health providers to create shared care plans, GP management plans (GPMPs) and team care arrangements (TCA) that are accessible to all members of the patient's care team. This includes specialists, allied health professionals and nurses, as well as the GP and the patient themselves.

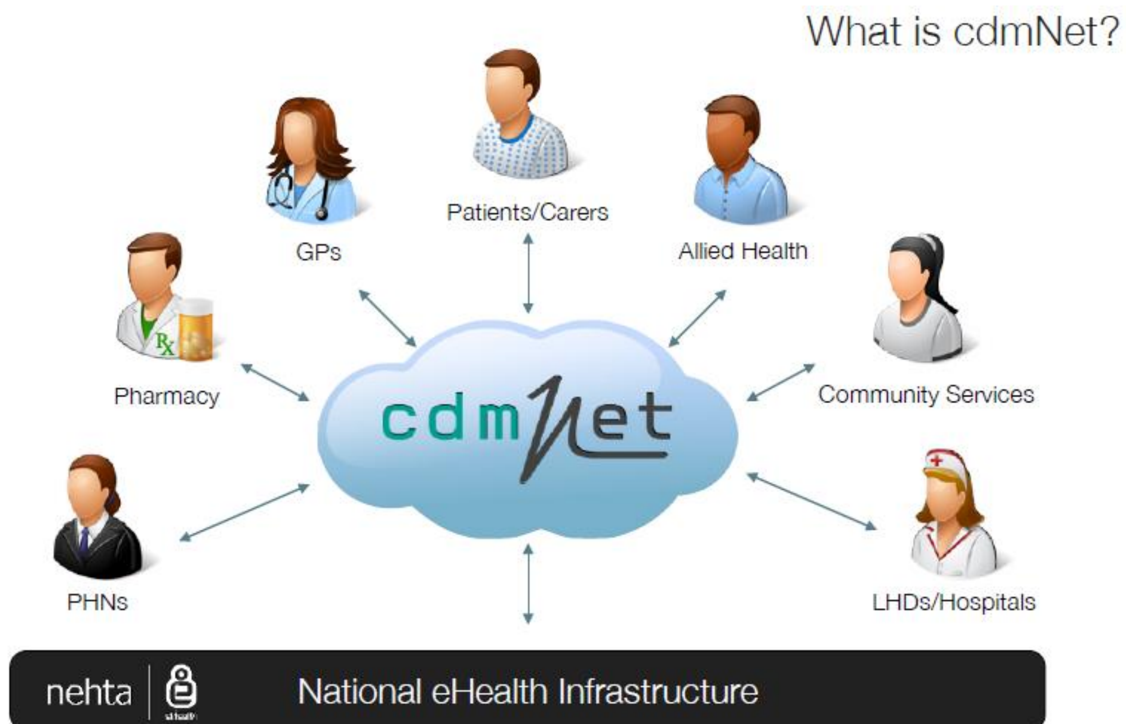


Diagram 2. cdmNet connections and potential users (*provided by Precedence Healthcare*)

cdmNet was chosen for this project because it is compatible with other programs and tailored to the Medicare Benefits Scheme (MBS) and non-MBS providers. This allows coordinated care across multiple sites, providers and episodes of care. It has the facility for non MBS providers, for example, allied health, to create a shared care plan, which can include a lifestyle option and invite GPs and other primary care providers to participate.

cdmNet is widely used and has been adopted nationally for a number of significant programs for example the Department of Health and Humans Service's Diabetes Coordinated Care Trial; Commonwealth Digital Regions Initiative; Department of Health Chronic Disease program; and Victoria's Refugee Hub Initiative to manage the care of refugees and recent immigrants.

2.4 The adoption of cdmNet in the Grampians Pyrenees catchment

This project builds on the momentum from initial work conducted by Grampians Medicare Local and supported by GPPCP which commenced 12 months prior. This involved working with Medical Practices preparing MBS items, such as GP Management Plans and Team Care Arrangements and electronically linking to allied health services.

Other pilot programs in the Barwon region that had integrated the use of cdmNet not only with general practice, but with community services, found positive results in improved communication and access to information.

It was due to the initial interest of cdmNet by the practices in the area, along with the enthusiasm of Stawell Regional Health that the GPPCP catchment was selected to adopt cdmNet.

The need for the project was established through this prior work, together with feedback from local agencies and recommendations from the following quality indicators:

- DHHS Service Coordination Survey
- DHHS Assessment of Chronic Illness Care (ACIC) audit action plans
- Community Health Practice Indicators
- HACC Community Care Common Standards

These indicators identified that further support and drive to better incorporate e-planning tools was required, including shared care planning and communication with GPs.

3. Project Process: How did we do it?

Once the need for the project was established, potential partners were identified and approached at executive level to be involved. This resulted in the Grampians Pyrenees PCP funding the project, the establishment of Grampians Medicare Local as a major partner and key agencies and services endorsing the project.

These included:

- Beaufort and Skipton Health Service
- Stawell Regional Health
- Grampians Community Health
- East Grampians Health Service
- Grampians Medicare Local
- Grampians Pyrenees PCP

A Project Steering Group was then established comprising representatives from:

- GML and GPPCP Managers
- a GP Advisor
- a Practice Manager
- a hospital representative and
- a community health representative

This working group appointed the project workers, provided governance and management oversight, received project reports and provided valuable support and advice as the project unfolded.

In order to engage directly with organisations and provide one on one support project workers were employed. To gain the most from combined experience this position was shared between a staff member from GPPCP and a staff member from GML who each allocated 2 days per week over a period of 4 months to the position. The Project Workers (PWs) had many existing relationships with services across the region. This enabled the project to quickly build off previous work undertaken and gain traction with key staff members.

A multidimensional approach was taken in order to embed shared care planning and ensure long term sustainability of the process. All professional levels were engaged in the project as outlined below.

a. **Executive and senior management level:** to ensure whole organisation support, supervision and commitment. Signed project agreements served to outline aims, objectives and processes together with clarifying expectations and roles.

b. **Middle management level:** to identify agency champions and gain more in depth information about organisation/program culture, process mapping, protocols and policies. The GPPCP Person Centred Care (PCC) working group was also reviewed with a collaborative aim to focus on 'a regional approach to shared care planning'. This group includes those agencies involved in the project together with other services and organisations across the catchment, enabling important project discussion and learnings to have wider benefit.

c. **The Practitioner level:** to understand and unpack individual barriers and enablers and provide face to face training and support to increase and extend cdmNet use.

Many opportunities were also built into the project to encourage all levels to be present at the table for example, project meetings and training sessions. This allowed protocols and policies, assumptions and individual concerns or issues to be shared, discussed and dispelled or resolved.

Project Phases

The project was structured into three distinct phases, each incorporating a number of tasks or deliverables (Appendix 2). A comprehensive evaluation plan was built into the project from the outset. The full project evaluation plan can be found in Appendix 1.

Phase 1) Project management and governance

Phase 2) Project implementation

Phase 3) Project evaluation and final report

The project workers' role was to engage relevant agencies to educate and inform staff, address barriers, promote successful strategies and document learnings. The project work commenced in Stawell and rolled out to other sites based on agency availability and readiness.

Each participating agency appointed a 'key contact' for the project who acted as the conduit between the Project Worker and the agency. This person was responsible for assisting the coordinator with sourcing relevant agency information and orienting them to the individual service. The agency representative also facilitated access to other internal members of staff.

Engagement with GPs was supported and enabled by GML. GPPCP supported agency engagement through the Person Centred Care Working Group and other existing service provider networks. Key project deliverables are shown in the box below.

Key Project Deliverables:

- Project workers will engage with relevant agencies and strengthen relationships particularly between GPs and other primary health providers including private providers.
- Using change management principles, project workers will assist in development of protocols and local agreements regarding eCare planning between key stakeholders.
- Project workers will facilitate the extended use of cdmNet as an eCare planning tool and undertake comprehensive training, documentation of actions, outcomes, review and learnings.
- Each agency will be provided with a project report, specific to their site, containing recommendations and action plans that have been mutually determined.
- A key focus of the project will be sustainability through identifying local champions and ensuring ongoing auditing and compliance via local agreements with each participating agency.

As the project progressed it soon became apparent that Phase 2 of the project plan was overestimating the amount of work and outcomes that could be achieved in the required time frame, largely due to the challenging nature of systems change.

The outcomes of the project in phase 2 were therefore refined to:

- Northern Grampians Shire – a focus on implementation and refinement
- Ararat Rural City – a focus on engagement and training
- Pyrenees Shire Council – a focus on awareness raising

4. Results: What was achieved?

Results and outcomes occurred at every stage of the project and in every participating organisation. These are consolidated and presented in the below themes.

1. Consultation and collaboration
2. Awareness raising
3. Implementation and refinement
4. Engagement and training
5. Shared Care plan Trials
6. Practice and systems review
7. cdmNet tool refinement
8. Sharing of information and production of resources

4.1 Consultation and collaboration:

- Building relationships with stakeholders at executive, middle management and service provider meetings
- Working with specific contacts within the participating agencies to better understand internal processes and culture
- Consulting with other eCare planning projects being conducted across Victoria which lead to considerable support and sharing of resources with GPPCP
- Attendance at the HACC eCare planning information day organised by DHHS enabled networking with other project workers
- Consultation with DHHS and acceptance of using cdmNet as a trial for shared care planning compliant to the criteria in the Service Coordination Practice Manual
- Discussion with HACC to clarify and understand terminology and processes.

4.2 Awareness raising:

- Presentations at medical practices, health and community services to demonstrate cdmNet capabilities
- Presentations at GPPCP Person Centred Care and Service Providers' meetings to demonstrate the potential of cdmNet as a central repository for storing care plans and progress notes for sharing information
- Including shared care planning and identifying the Care Coordinator role in the discussion at local government Service Provider meetings.

4.3 Implementation and refinement:

- The concepts of shared care planning, eCare planning and cdmNet being promoted to medical practices and health services
- Working with medical practices to increase the number and content of the MBS care plans
- Identification of a model to increase productivity in medical practices with a business case being developed to present to other practices.

4.4 Engagement and training:

- Additional practitioners being trained and registered on the system
- An additional medical practice agreeing to trial cdmNet
- Working with a health service at executive level to encourage coordinated practice for shared care planning through local agreements
- Working with a community health centre to incorporate shared care planning via cdmNet.

4.5 Shared care planning trials were conducted for:

- A HARP client who did not have an existing shared care plan
- A client who had an existing MBS care plan and the HARP coordinator added to this plan
- New care plans were created by medical practices and allied health were then included
- A HARP client accessed and added information to their own shared care plan electronically.

4.6 Practices and systems were reviewed and refined:

- Agreement was reached to enable access for GP practice and HARP Care Coordinators to share care plans.

- An MOU was created to facilitate shared eCare planning which included permitting editing rights to the HARP Care Coordinator
- Resources and service specific protocols were developed to assist the process flow particularly between electronic and paper based systems
- Clarification of terminology and processes eg. The difference between a referral for a new service via cdmNet and an "invitation to participate" in a shared care plan
- Existing local agreements and MOUs were identified and flagged for review to be more inclusive of shared care planning
- The practice of case conferences and shared appointments was successfully introduced by HARP.

4.7 Refining the cdmNet tool:

- Discussion with Precedence Healthcare occurred when the project identified that the existing care plan presently in cdmNet was designed as a clinical tool to ensure compliance for Medicare MBS
- Advocating for a care plan format that included person centred care and client identified goals with Precedence Healthcare
- Due to the need to refine the care plan format it was decided not to increase the number of service providers participating in the project until the care plan format was made more "client friendly".

4.8 Sharing of information and production of resources

The GPPCP eCare planning project was presented at the:

- Central Highlands PCP Service Coordination meeting
- State-wide PCP Service Coordination and ICDM meeting.

Key resources were also produced these included:

- Draft Memorandum of Understanding
- Planning Protocol draft
- eProcess Guide, service specific
- cdmNet User Guide

5. Enablers and Challenges

5.1 Project Enablers

a. **The participating Health Services were very supportive of the project**. Shared care planning and communication with GPs had been identified in previous quality audits and surveys as an area needing improvement. It was identified that cdmNet could meet this need. Discussion with DHHS also supported the decision to trial cdmNet as it met the mandated criteria for care planning.

b. **Sharing the Project Worker role** assisted in collaboration with the various service providers. The GML Project Worker was involved predominantly with the MBS care plans and medical practices, whereas the GPPCP Project Worker was mainly involved with the non MBS care planning and community and health services.

c. **Having a specific agency contact person** greatly assisted with working with key staff, reviewing work practices and liaising with Precedence Healthcare to find solutions to identified issues. Working within the agency allowed trials to be conducted and then the review and refinement of systems.

   These internal champions were critical in promoting the cdmNet tool, driving systems change and improving quality of use. In addition, group staff discussion and training served to dispel myths and generate constructive solutions.

d. **Identifying the existing relationships and building on structures and agreements** already in place was important. The aim was to 'value add' to this work and not duplicate. This included:
   - Reviewing existing local agreements.
   - Identifying additional MOUs between organisations where shared care planning is relevant.
   - Adding shared care planning as agenda items at service provider meetings.

e. **The project's multidimensional approach,** specifically having executive support from participating organisations, assisted in utilising multiple pathways and levels of management, to work around blocks and approach problems from different angles. It also supported the conversation at a higher level within organisations and medical practices when required, to raise awareness of the potential to improve the coordination of care.

f. **Service providers' prior understanding of the importance of consumer involvement and health literacy** assisted in reviewing the format of shared care

planning and recognition of the work required to further improve this mechanism in cdmNet to ensure it is “client/consumer friendly”.

g. **The short time frame of the project** provided momentum for change and concentrated the effort which in turn spurred action.

h. **The responsive and timely support provided by Precedence Healthcare** facilitated the clarification and resolution of difficulties experienced by service providers. Precedence Healthcare support was provided through:
   - site visits, webinars and phone support
   - training and registration of additional staff
   - the development of User Guides and Tip Sheets

i. **Learning from other eCare planning projects** being conducted across the state greatly assisted this project. This enabled existing resources to be utilised, networks to be established with others undertaking the same journey. The majority of these projects have been conducted over a number of years, so a great deal of information and many resources were kindly shared.

j. **Demonstrating areas of good practice, developing a business case and sharing the learnings** assisted in showcasing the benefits of delivering quality collaborative person centred care.

5.2 Project Challenges

In working with a number of organisations a variety of challenges or barriers can arise which can be difficult to navigate and can impact on momentum. It is important to remain positive and look for solutions to the issues that arise. An example was provided from another eCare planning project of the ‘stream flowing around the rocks, not letting the rocks impede the progress.’ The rocks that caused some turbulence in this project are explored below.

a. **Organisational culture** significantly affected the willingness of staff to learn and adapt internal and external systems. Gaining buy in and changing workflows of staff with long standing practice traditions was challenging. Possible reasons for this resistance may have been previously receiving incorrect information, lack of experience or general resistance to change.

   Internal agency culture and attitudes towards technology, sharing of information and a reluctance to embrace systems change did cause the momentum of the project to sometimes suffer. Agency systems may rely on one or two key staff to generate Care Plans. Current work practices may limit the system being utilised to its true capacity.

These key staff are influential in their organisation and it was felt it was vitally important to provide training to a number of staff in each organisation to ensure the information of the process and product was accurate.

b. **Changes to program funding, staff and systems** was experienced to varying degrees at all organisations involved in the project. This challenged the time frame of the project and was a risk to the continuity of the work. The benefit was that it reinforced the necessity for policies, protocols and agreements to be in place to ensure the sustainability and continuity of the work.

c. **Security and lack of interoperability with existing systems** was a frequently raised issue. Presently cdmNet links with medical practice software but does not link with health and community services' client management systems. The added complication is that paper based client files are still in place in many of the organisations involved in the project. Protocols needed to be developed to link the electronic system to the paper based files. Precedence Healthcare was able to provide reassurance around the security of the cloud based system for organisations.

d. **Engagement of key people** to be involved in the project was supported by the agency contact. Whilst there were agency representatives involved, other key decision makers also needed to be involved and brought on board from the beginning to ensure appropriate technology and systems were in place.

e. **Terminology** varied greatly between individual service providers, organisations and funding bodies. This was identified earlier at a PCC meeting and was felt it restricted the conversation, and frequently lead to misunderstandings of what is or is not happening in practice. A glossary was developed and circulated widely to improve the understanding of acronyms and common terms. This glossary is presented as Appendix 3.

f. **Lack of a solid understanding of service coordination elements** was identified during the project as a barrier to shared care planning. This included the terminology as mentioned previously. Service providers identified that additional training in the practical aspects of conducting a case conference, such as empowering a client to participate, body language and terminology, would improve provider confidence and the case conference experience for both clients and providers involved in the care.

g. **Due to the short time frame of the project** the original project outcomes for organisations within each local government area were identified as not being realistic. Rather the timeframe was more appropriate for a focus on one location. Lessons learned and optimal processes and procedures could then be shared with other project participants, organisations and locations.

6. Recommendations and Next Steps

Training & Resource Development

- Provide training to support and improve case conferencing
- Develop resources for consumer participation and health literacy in care planning
- Further develop and put in place agency specific Local Agreements to progress interagency shared care planning.

Organisations

- Support staff to undertake training on case conferencing and shared care planning
- Support organisations to develop and embed agreements, policies and protocols in practice.

Technical Support

- Advocate for and provide support and guidance to Precedence Healthcare to prepare a cdmNet business case
- Explore the potential to develop user friendly community care plans and specifically shared care plans for people with severe and persistent mental health care needs and complex conditions.

Sustainability

- Explore funding opportunities to support further work in the ehealth shared care planning space, in particular with Grampians Pyrenees Partners in Recovery, the Western Victoria Primary Health Network and the Department of Health and Human Services
- Prepare a project proposal for the next phase of collaborative work to progress Shared Care Planning into the future.

Appendix 1

Evaluation: Was the project effective?

5.1 Pre and Post Electronic Survey Results

At the commencement of the project an electronic survey was circulated to health agencies and possible cdmNet users to identify cdmNet current usage together with barriers and enablers.

A total of 21 people responded to the survey and answers are summarised into themes. Ten of these were clinicians involved in allied health, with the remaining involved in Medical Practices either as a GP, Practice Nurse or Practice Manager.

A total of 57 percent of respondents were current cdmNet users and 43 percent of respondents were non cdmNet users. Themes from the survey are summarised in the box below.

Pre-Project Survey Themes

Key benefits:

1. Promotes collaboration and coordination between services and clinicians
2. Allows increased access to important patient information in the one location
3. Enables effective electronic communication and referrals

Key enablers:

1. Collaborative coordination of patient care
2. Improved patient outcomes
3. Saves time
4. Removes administrative burden

Key barriers:

1. Unsure who users cdmNet
2. Who maintains control of the care plan
3. Staff turnover
4. Implementation of another electronic system
5. Confidentiality control

The survey results also helped inform the approach the project workers used to engage agencies and staff with respondents identifying, one on one meetings to explore cdmNet on an individual basis as one of the most effective strategies. Other strategies that were highlighted included multidisciplinary meetings to discuss systems issues and education with representatives from Precedence Health to learn about how cdmNet works.

At the conclusion of the project a post electronic survey was circulated to health agencies and possible cdmNet users to identify the project impacts.

A total of 10 people responded to the survey and answers are summarised into themes. Whilst this small number of respondents has it limitations, answers remain significant and point to a number of important outcomes. Three of these were clinicians involved in allied health, with the remaining involved in Medical Practices either as a GP, Practice Nurse or Practice Manager.

Respondents varied greatly as to their use of cdmNet and involvement in the project. Themes from the survey are summarised in the box below.

Post-Project Survey Results and Themes

- 50% of respondents indicated an increased awareness, understanding or use of cdmNet as a result of the project, with 2 respondents using cdmNet as an integral part of the way they undertake shared care planning.

- 70% of respondents were unaware as to whether there had been a change in their organisation's capacity to utilise cdmNet.

- 30% of respondents indicated an improvement in the way their organisation utilises cdmNet as a result of the project.

Key benefits:

1. Promotes collaboration and coordination between services and clinicians
2. Allows increased access to important patient information in the one location
3. Enables effective electronic communication and referrals
4. Reduces duplication
5. Is patient focused

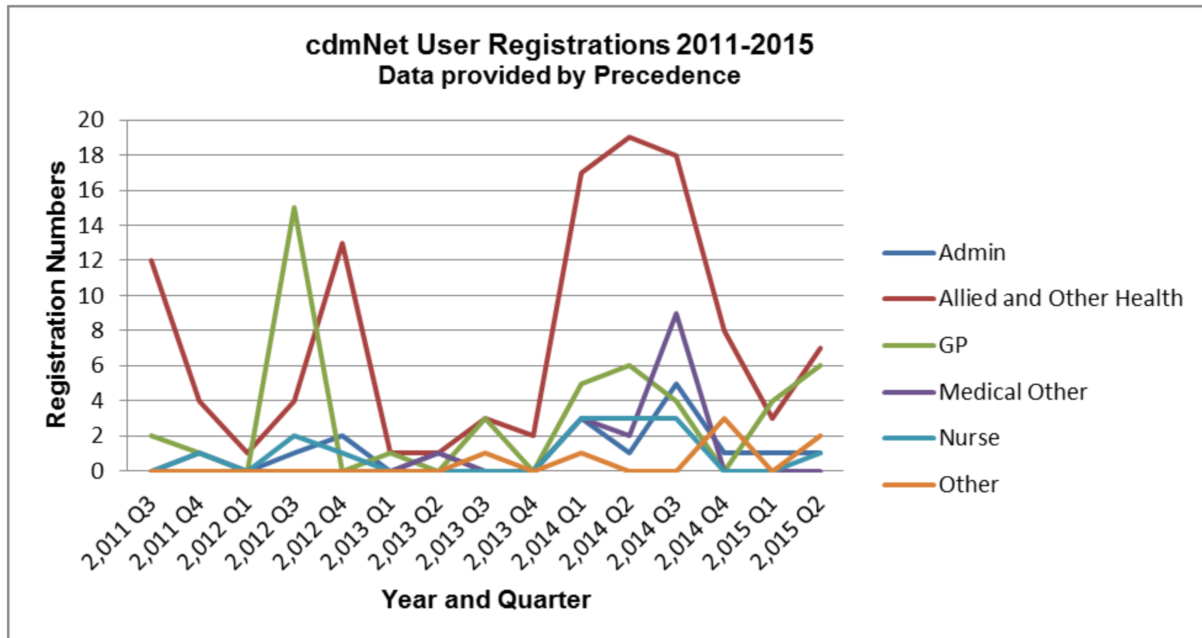
Key barriers remained essentially the same as the pre-survey monkey.

Key barriers:

1. Unsure who users cdmNet
2. Who maintains control of the care plan
3. Staff turnover
4. Implementation of another electronic system
5. Confidentiality control

5.2 Pre and Post cdmNet Data Results

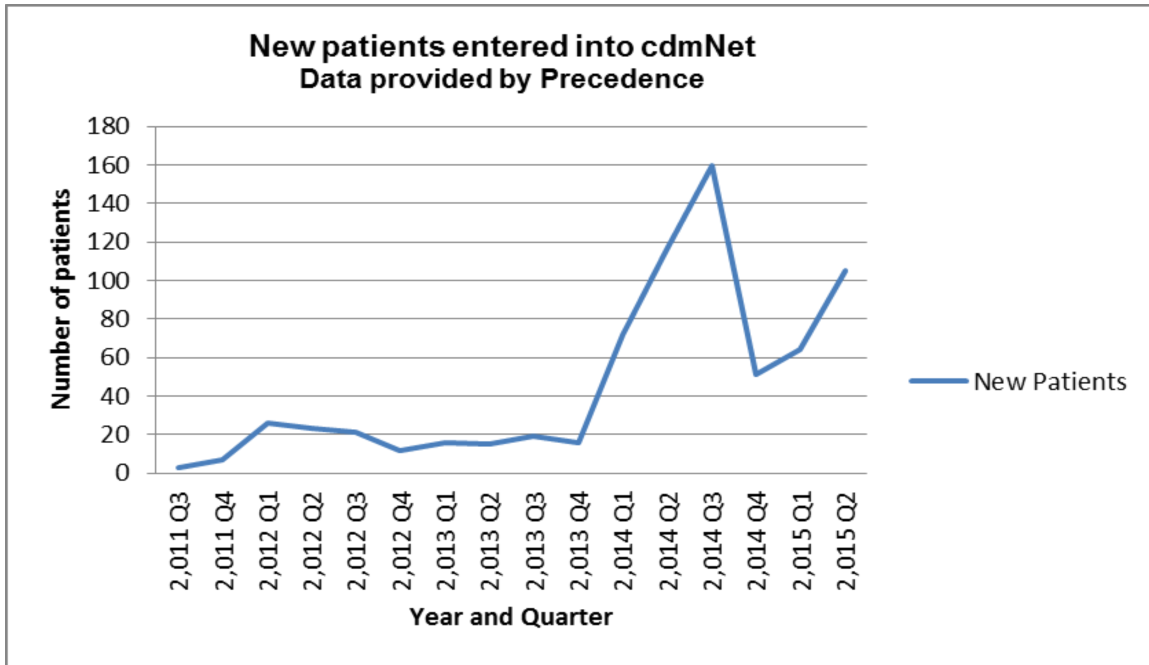
In order to measure the patterns of cdmNet use as a result of the project, data from the Grampians Pyrenees region was extracted from the cdmNet database by Precedence, this data is presented in Graph 1, 2 and 3 below. The project commenced in February 2015 (Quarter 1) however, agency discussions and training would not have had a great impact on 'cdmNet User Registrations' data until Quarter 2, 2015.



Graph 1: Number of cdmNet registrations between 2011 (Q3) and 2015 (Q2) and according to the type of health care provider.

The graph above shows that the history of cdmNet registrations has had many peaks and troughs. The major peaks in 2012 and 2014 can be partly explained by funding being allocated by Precedence Health Care to Divisions of General Practice and Medicare Locals to employ a project worker to promote cdmNet and increase registrations within general practice. In 2012 a project worker was employed through Grampians Medicare Local (GML) to promote cdmNet. In 2014, the GML Primary Care Coordinator was successful in adopting 3 new practices in the catchment to sign up and use the system for Chronic Disease Management care planning

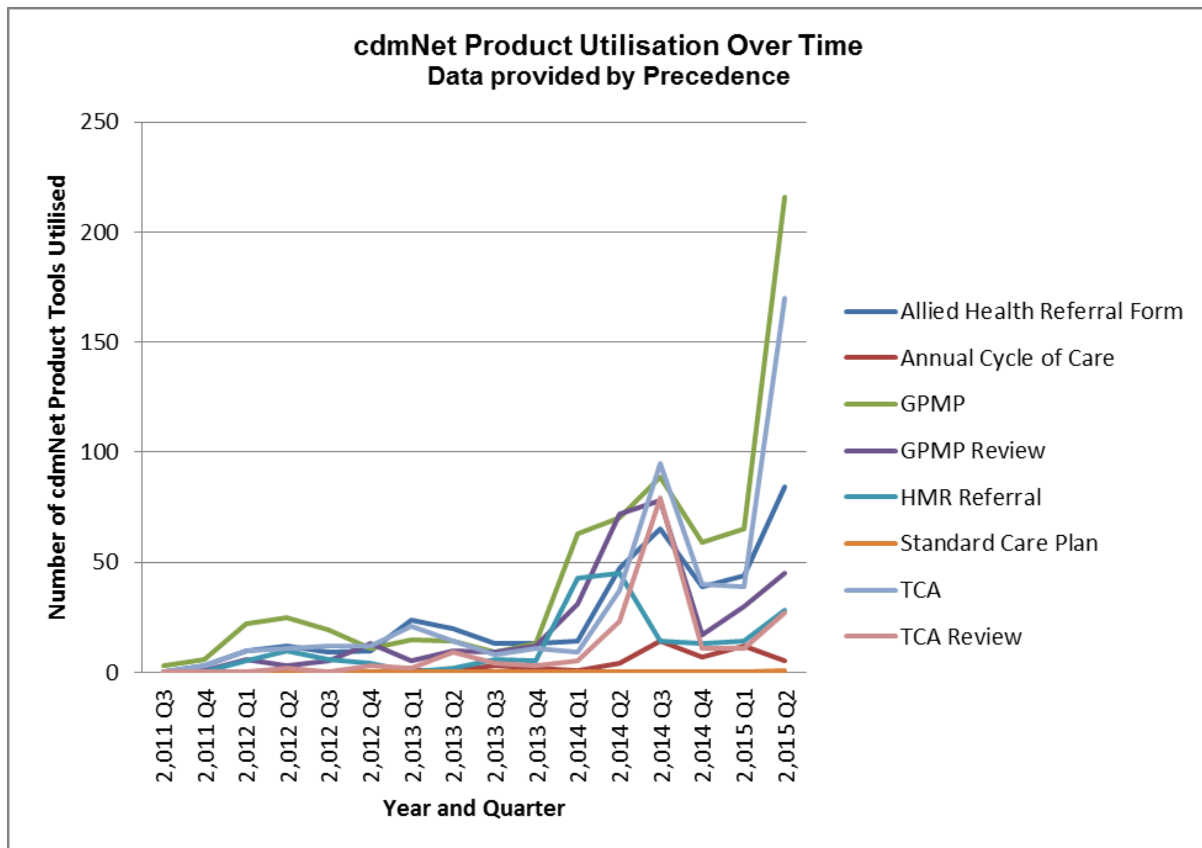
The rise in cdmNet registration numbers between Q1 2015 and Q2 2015 within the region could be attributed to the project however could also be a combination of other external factors, with a moderate rise in numbers across allied health staff, GPs, and staff from other programs.



Graph 2: Trend in the number of new patients entered into the cdmNet system between 2011 (Q3) to 2015 (Q2).

Graph 2 above shows a major peak in 'new patients entered' in 2014 due to Medical Practices' Chronic Disease Management nurses being employed to create care plans through cdmNet. One practice in particular employed a CDM nurse to conduct care plans 4 days per week. This Practice Nurse left the role during 2014 Quarter 3 explaining the decrease and then was re-employed again in quarter 4 again explaining the increase in new patients.

During the Project the graph shows a significant number of new patients entered into the system during the 2015 Quarter 1 and Quarter 2, re-commencing an upward trend. The total number of new patients entered in Quarter 2 being 105 patients.



Graph 3: Trend in the utilisation of cdmNet product tools over time from between 2011 (Q3) to 2015 (Q2).

Graph 3 above shows a significant increase in the utilisation of cdmNet tools during the life of the project. With large increases in the number of Team Care Arrangements (TCA) and GP Management Plans (GPMP) created in particular. Considerable increases in the number of Allied Health and Home Medicine Review (HMR) Referral forms and GP Management Plan reviews are also clear. This graph indicates that the project has most likely had a significant impact on the way and degree to which cdmNet is utilised more comprehensively with users using a range of referral pathways and care plan process options and in dramatically increased numbers.

5.3 Client and service provider interviews

Interviews were carried out with both clients (2) and service providers (4) at the conclusion of the project to ascertain the effectiveness of the project and its impact.

Results were varied and largely depended on the internal system structure of the organisation, the way service providers preferred to operate, GP involvement, education and training and degree to which cdmNet was utilised.

One respondent reported that there was no impact to the way care was provided and five respondents reported there was a significant impact in improving shared care planning, information sharing, case conferencing and client outcomes.

Service provider and patient experiences are summarised into key themes below:

a) The importance of GP involvement

'GPs are not using the system….for it to work well it is reliant on the GP keeping client information up to date in the system eg medication' (service provider)

'Before, there was a lack of information received from GPs re. medical histories, pathology, medication…we often barely received a client contact number. This meant more work for service providers to chase information and the client was repeating information and often re assessed by each practitioner. This has improved two way communication' (service provider)

'Need the GP on board as patient outcomes are greatly improved…changing practice takes commitment from all parties' (service provider)

b) The need for a clear internal process, identified procedures and consistency of system use

'There is a duplication of time and effort using both an electronic and paper system…need a policy, process and guide to be adopted organisation wide. Consent is in place but we need shared care planning' (service provider)

'The process of getting everybody involved was challenging. Only some, about fifty percent of allied health are using the system. I have to print out referrals as well as the cdmNet care plan' (service provider)

'The difficulties are more around the process, cdmNet itself is okay, but there needs to be a commitment to put the time in to make it work.' (service provider)

c) Education and a shared language is key

The need for education on all levels was highlighted throughout the interviews together with a need for the cdmNet system to address health literacy differences and formatting needs depending on the user. In particular the need to better involve the clients in cdmNet training, what to expect and how to participate in a case conference.

'I didn't know what to expect… they were all very interested but what did they want with me? I told my son that I thought it would be pick on me day! But it was exactly the opposite. They made me feel like THE ONE!' (client)

'There is a lack of information provided to clients in a way they can understand.' (service provider)

'The care plan format does not suit the client or provider, it does not include client identified goals' (service provider)

'It was a good opportunity to look at own health in a broader way and identify additional services that could be beneficial. However on reflection I felt the process was a bit intimidating' (client)

d) The power of collaboration

This was a key theme across all interviews with respondents reporting that the project resulted in an increased use of cdmNet, case conferencing and greatly improved collaboration, problem solving and shared decision making. This lead to a greater understanding of what other service providers could offer, the sharing of information and expertise and improved client outcomes.

'Clients are pleased someone is listening and they don't have to repeat their story. We are able to problem solve with other clinicians and look outside the square for strategies' (service provider)

'There was a greater opportunity to discuss and have an overview of my care, a more comprehensive assessment of health conditions, the support required and to identify where additional services would assist' (client)

'It was a completely different way of looking at my own health, more comprehensive, it was previously more crisis management rather than planning. It's better to have the big picture view.' (client)

e) Improved client experience

Whilst the cdmNet system is still in its infancy in many organisations and modifications and improvements are necessary, it was undisputed that with time and consistency of use, this shared eCare planning tool has already and in the future will greatly lead to improved client care.

'It's good as the Diabetes Educator can see reports and information such as pathology and medications which improves the care provided to clients.' (service provider)

'As a result of the case conference and seeing my GP I had a referral to a Respiratory Specialist and sleep clinic. I now have a machine for sleep apnoea which has made a huge difference….I feel so much better, not exhausted or falling…I'm now walking around the block and love going to the YMCA Gym program. ' (client)

'Before I had difficulty finding out what other services were in place. The care depended on circumstances and only worked on the immediate issues.' (service provider)

Appendix 2: Project Plan

Phase 1 Project Plan: Governance and Management

Task/Deliverable	Outcome	Evaluation
Develop MOU between GML and GPPCP	Clear understanding of roles and responsibilities Protocols for information sharing	Review after first month and thereafter
Develop MOU with Precedence re roles and responsibilities and support	Communication process established Support from Precedence	MoU complete – review dates specified
Project Staff commence		
Set working group meeting dates and communication tools	“Basecamp” established for communication and project management	Review incorporated into meeting agenda’s
Develop MOUs with participating agencies	Identified agencies committed to project, roles and expectations understood	
Develop evaluation design and measures	Evaluation design and measures complete and integrated into project plan	- Evaluation design and measures complete and integrated into project plan -CDM Net data collection ‘pre’ project

Phase 2 Project Plan: Project Implementation

Task/Deliverable	Outcome	Evaluation
PWs engage with Precedence to determine uptake of cdmNet and challenges	Relationship established	Adaptive and effective communication and responses
Undertake a SWOT analysis relating to usage, barriers and enablers	Understanding and insight gained issues, gaps, barriers and enablers	Survey monkey tool to measure before and after cdmNet ‘before’ data captured
Focus 1:Stawell PW to spend time onsite and troubleshoot at all levels in order to support providers to embed		Agencies asked to identify 1 client who can share their health system journey and may

cdmNet at Stawell Regional Health, Stawell Medical Practice, Patrick St Clinic, Grampians Community Health, Northern Grampians Shire (HACC Programs) • Engage relevant organisations and staff • Develop Action Plans • Deliver training • Develop protocols Focus 2: Ararat (The same process applied to Ararat: East Grampians Health Service, Ararat Medical Centre, Tristar, Ararat Rural City and Grampians Community Health)	Relationships established with agencies, and PW known to key staff. MBS and NonMBS users engaged and trailing product Action plans embraced and progress in train Successful training developed and delivered on an as needs basis Guide and protocols and procedures document developed. As above	experience service change/transition. Also identify 1 allied health 'user' to provide a case study of their experience. Gather cdmNet 'before' and 'mid' data collection from Precedence
Undertake audit of existing uptake of cdmNet in GP practices, allied health providers and other contexts where services are provided to clients with chronic disease	PW has solid understanding of agency systems and barriers	Precedence data Initial benchmarking using Survey Monkey tool
Undertake a SWOT analysis relating to cdmNet usage	SWOT analysis provides context to develop agency action plans	
PW liaise with Quality Staff within agencies to link outcomes of the project to each agency's Quality Improvement strategy	Medical RACGP Quality Improvement criteria identified. Linkages recorded and clear	

Phase 3 Project Evaluation and Final Report

Task/Deliverable	Outcome	Evaluation
Collation of individual agency reports	LGA Catchment Reports completed	
Develop recommendations including sustainability strategies	Recommendations developed and sustainability strategies developed	Canvas documentary evidence of shared protocols, LA's and MOU's.
Complete final evaluation tasks	Evaluation tasks completed	CDM Net 'post' data collection Post Survey Monkey Collection of client stories Collection of semi-structured interviews with service providers Steering Committee debrief
Complete project report Disseminate project report and determine next steps	Project comprehensively documented Project learnings shared and follow up strategies determined	

Appendix 3: Shared Care Planning Definitions

Term	Definition
Care Coordination	Care coordination is a patient- and family-centred, team-based activity designed to assess and meet the needs of patients, while helping them navigate effectively and efficiently through the health care system. Care coordination addresses potential gaps in meeting patients' interrelated medical, social, developmental, behavioural, educational, informal support system, and financial needs in order to achieve optimal health, wellness, or end-of-life outcomes, according to patient preferences
Care coordination plan	See Shared Support Plan
Care planning	Care Planning is a dynamic process that incorporates care coordination, case management, referral, feedback, review, re-assessment, monitoring and exiting. Care Planning involves balancing relative and competing needs, and helping consumers make decisions appropriate to their needs, wishes, values and circumstances.
Care / Care Coordinator	See Key Worker
Case Conference	The group discussion of a client's complex care needs. A case conference normally entails a client's goal or problem that requires a team approach to establish a resolution. This discussion occurs with the patient or guardians consent and commonly involves the general practitioner, care providers, family or next of kin in discussion with the client.
cdmNet	Chronic disease management network. A web-based, secure electronic care planning service accessible to all members of the person's care planning team.
Complex Care Needs	People with complex care needs have multiple health, functional and/ or social issues and are at risk of functional decline and/ or hospital admission.
Connectingcare	Electronic service directory and secure messaging system which includes electronic referrals
GPMP	General Practice Management Plan (an MBS claimable item for GPs)
Health Literacy	The ability to receive, understand and use health information to make

	appropriate decisions.
Inter-agency Care Plan	Inter-agency care plans are developed for clients who have complex or multiple needs and require services from more than one (1) organisation See Shared Care Plan
Intra-agency Care Plan	Intra-agency care plans are developed for clients requiring multiple services from within a single organisation in order to coordinate service delivery . See Shared Care Plan
Key Worker	The nominated person who works with the consumer and carer and other services to facilitate intra-agency or inter-agency Care Planning and care coordination
MBS	Medicare Benefits Schedule
SCTT 2012	Service Coordination Tool Template, 2012 version. A suite of templates designed to provide consistent information standards to facilitate electronic sharing of information and provide a common language between a wide range of services.
Service Plan	See Service-specific Care Plan
Service-specific Care Plan	Service specific care plan: developed by a single service and usually documented using program specific tools or formats. Feeds into shared care plan when appropriate.
Shared Care Plan	An overarching plan which documents issues and problems for a consumer, goals and actions that will be taken to achieve these goals, and identifies a care/case coordinator/key worker responsible for liaising between services. Typically developed for consumers with complex needs and multi-service involvement. A tool included in SCTT 2012 for shared care planning.
TCA	Team Care Arrangement (an MBS claimable item for GPs)
Treatment Plan	See Service-specific Care Plan

References and Resources:

Victorian Service Coordination Practice manual:

http://www.health.vic.gov.au/pcps/downloads/sc_pracmanual2.pdf

SCTT 2012 User Guide:

http://docs.health.vic.gov.au/docs/doc/Service-coordination-tool-templates-2012-user-guide

SCTT 2012 User Guide:

http://docs.health.vic.gov.au/docs/doc/Service-coordination-tool-templates-2012-user-guide

Precedence Health Care cdmNet

eHealth, Australian Government Department of Health

eCare Planning project Outer East PCP

eCare Planning project Upper Hume PCP

eCare Planning project Western District Health Service