

Workshop 5: Continuity of care

The following suggestions came from the delegates who attended the quality of care reports and awards training day held for stand alone community health centre's on Monday 9 October 2006.

The suggestions for minimum reporting requirements, timelines, strategies and who is to be responsible for the development of this section of the quality of care report are ideas from the delegates at the training day. The suggestions are not necessarily the only way to develop a quality of care report nor are they endorsed by the Department of Human Services.

Minimum Reporting Requirement/ Selection Criteria	Time line (Month/week)	Strategies (How you are going to do it.)	Who (Person responsible.)
Number of case plans and clinical/care pathways that exist across providers		Data set for capturing this information in place and qualifying pathways between providers	
Describing examples of client patient journeys across health providers, including client satisfaction where ensured		Using vignettes Satisfaction survey outcomes	
Consistent referral templates between different providers and examples of these		Templates developed between providers	
Decrease in duplication of client documentation between providers and increase in common tasks		Primary care partnerships Service co-ordination Enhanced intake mechanism	
Service co-ordination		* Primary Care Partnership work * E-referral * Internal systems * Patient flow collaborative	
		* Focus group/narrative * Site visits by CAG or similar	
Joint initiatives		* IT/eg Health Smart, sharing of health information	
Chronic disease management and similar			
Intake systems and referral pathways			
Consumer self-management within the system			
Intake procedures Waiting Lists Clinical processes Referral systems (holistic)			
Explanation of processes /clinical practices etc In-service training Ethics Consumer focus			

Consumer empowerment Interface systems			
Intake/initial contact		Time for intake Type of referrals in/out Accommodation/information for CALD	
Referrals		e-referrals referral patterns in/out	
Care plans		Policy and procedures Evidence of number of care plans? Hard to do – exist in different form	
Partnership with cross sector programs service programs		Description of shared programs/waiting gaps/networks	
Information management		Electronic data Client records audit	
Client experience of continuity of care		Collect client narratives Add question to consumer opinion survey	
Difficult to develop quantitative indicators in this area, will rely on a lot of qualitative data			
Information travels with the client – pathways between services		Client stories experiences/outcomes of continuous seamless care	
Longitudinal studies (individuals) Life stage			
Intake systems		Map pathway through programs	
Client exit management		Define discharge management plan Preparation for and monitor post discharge	
Care plans and reviews of		Review of client progress against care plan, agreed goals	
Continuity of provider			
Evaluation mechanisms		Clients and providers of care	
Hospital Admission Risk Program		Choose one area, provide story to illustrate outcomes Working with other agencies	
Health promotion		Services provided and programs and stories *Outcomes * Best practice * Partnership	
		Inter program referral program Single UR number – tracking Waiting list management – broken continuity “Gap” funding Hospital Admission Risk Program Feedback and referral to other organisations	
		Triage a range of services available to clients Holistic assessment of the client	