

SERVICE COORDINATION PPPS TEMPLATE/IMPLEMENTATION GUIDE

Practices, Processes, Protocols and Systems

This template is designed to assist agencies to draw up documentation to set out the practices, processes, protocols and systems (PPPS) necessary for the efficient implementation of service coordination within their agency. Template content may be cut and pasted and amended in any way the agency sees fit. This document will also assist agencies to implement service coordination.

Definition

Service Coordination is the management and quality assurance approach used to achieve optimum results in the delivery of health and social support services through effective inter-agency collaboration. The Inner East Primary Care Partnership (IEPCP) provides support to member organisations across the local government areas of Monash, Manningham, Boroondara and Whitehorse to implement best practice service coordination initiatives across the catchment.

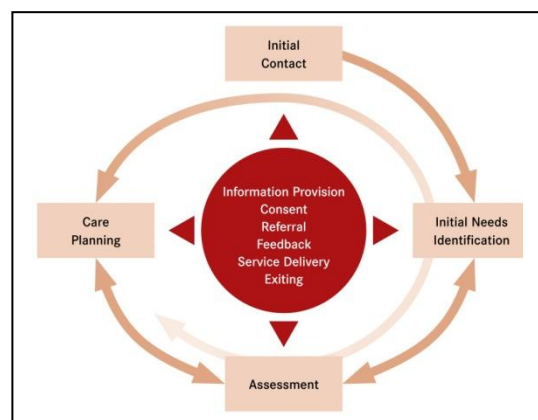
Service coordination is a policy and operational framework which aims to:

- place consumers at the centre of service delivery
- ensure that consumers have access to the services they need
- support opportunities for early intervention, health promotion and improved health and care outcomes

with the overall goal of keeping consumers in their home or community as long as possible and reducing avoidable hospitalisation.

Service Coordination Processes

The operational elements of Service Coordination, as described in the *Better Access to Services Framework*, are depicted in the adjacent diagram. Initial Contact, Initial Needs Identification, Assessment and Care/Case Planning are the key service coordination elements. Additional Processes such as information provision, consent to share information, referral, information exchange, service delivery and exiting can occur at any stage.



A brief description of the various elements is given below.

Initial Contact

Initial Contact is when a person makes his or her first contact with the service system and will most commonly include:

- the provision of accurate service information,
- the provision of other information such as health promotion literature, and/or
- direct access to services via Initial Needs Identification.

Initial Contact is the first stage of Service Coordination, and the entry point into other elements of Service Coordination including Initial Needs Identification and Assessment. Referral to external agencies may also occur out of Initial Contact.

Initial Contact happens differently in every agency. For example:

- In some agencies Initial Contact will be carried out by Reception or Front of House staff, in other agencies it may be done by a Duty Worker or Information Officer. Elsewhere it may be the responsibility of the Service Coordinator (or Intake Worker). Outreach Workers also provide an important point of Initial Contact.
- Initial Contact and Initial Needs Identification may be carried out by a single staff member at the one time such as the Service Coordinator (or Duty Worker). In other agencies Initial Contact may be the responsibility of a range of different staff, and Initial Contact and Initial Needs Identification may be completed over a number of days.

Initial Needs Identification

Initial Needs identification (sometimes referred to as INI) is a broad and shallow initial screening for risk and service requirements. The practitioner undertaking Initial Needs Identification looks beyond the presenting issues to underlying issues that may exist.

Initial Needs Identification is not a diagnostic process but is a determination of the consumer's risk, eligibility and priority for services and a balancing of the service capacity and the consumer's needs. Initial Needs Identification allows for the consumer's needs and health promotion opportunities to be broadly identified, early in their contact with the service system.

Initial Needs Identification may be conducted by one or more of the following staff:

- Service Coordination Workers (often referred to as Intake Workers).
- Duty Workers.
- Triage Nurses.
- Assessment Officers/Nurses.
- Outreach Workers.
- Individual Practitioners (in particular, where clients contact health professionals directly to make appointments such as in some community health services) such as a Physiotherapist, Alcohol and Drug Counsellor, Care Coordinator in Emergency Department.
- Case Managers.
- Clinicians.
- Doctors.

Assessment

Assessment builds on information collected at Initial Contact and Initial Needs Identification. Assessment requires a more in-depth collection, weighting and interpretation of relevant information.

Assessment is completed by a qualified practitioner to:

- develop a care plan,
- set care goals,
- determine services required and/or course of action,
- make appropriate referrals with the consumer's consent.

Typical assessment skills and knowledge include:

- Listening and communication skills.
- Clinical judgement.
- Decision making skills.
- Interpretation and analysis skills.
- Knowledge of service system and services available.
- Understanding of Service Coordination and referral pathways.
- Knowledge of privacy and consent requirements.
- Ability to use IT and other resources to support assessment e.g. Human Services Directory and e-referral systems.
- Understanding of the needs of consumers from Culturally and Linguistically Diverse Backgrounds

Care/Case Planning

Care/Case Planning is a dynamic process that incorporates assessment coordination, case management, referral, information exchange, review, re-assessment, monitoring and exiting.

Care/Case Planning involves balancing relative and competing needs, and helping consumers make decisions appropriate to their needs, wishes, values and circumstances. Care/Case Planning may occur at an individual provider level and both within and across organisations.

Service Specific Care/Case Planning may occur when the consumer has one or more issues that can be managed with the support of *a single program area*. Services need to refer to their program guidelines to implement their service specific Care/Case Planning and will have their own tools to document this information. Some examples are Individual Treatment Plan, GP Management Plan, Service Plan, Advance Care Plan, Child and Family Action Plan, Housing Support Plan, Crisis Intervention Plan, Relapse Prevention Plan, Disability Support Plans.

Shared Care/Case Planning is required when the consumer has numerous issues that require the coordinated support of *multiple program areas* from within or between organisations. Service Assessments and service specific Care/Case Plans will inform the shared Care/Case Planning process.

The overall principles of Shared Care/Case Planning include:

- a proactive rather than reactive approach for people with multiple support needs
- services are planned and delivered, based on best-available evidence in the most timely and effective way
- services have in place person-centred practice and a coordinated and integrated approach
- support for consumers to play an active role in co-ordinating their services
- providing information on the range of service options available
- goal-directed planning

- incorporation of Active Service Model principles
- nomination of a main contact person to support the Care/Case plan
- processes to facilitate communication between all participants
- monitoring and review processes and timelines
- compliance with current legislation and service provider quality standards.

Referrals

Referral is the transmission, with consent, of a consumer's personal and/or health information from one service provider to another for the purpose of further assessment or service provision.

The referral process is aimed at:

- assisting consumers in a seamless and timely manner, by streamlining access to appropriate services through self-referral or assisted referral
- empowering consumers to participate in decisions about their care
- respecting a consumer's rights and privacy
- facilitating choice and understanding
- enabling referrals to be conducted efficiently and effectively
- minimising risk and meeting duty-of-care requirements.

There are five key requirements for all service providers making referrals:

- make referrals in accordance with service provider guidelines, policies, procedures and work instructions
- adhere to Victoria's Service Coordination Practice Standards and prioritise as urgent or non-urgent
- use the Service Coordination Tool Templates (refer SCTT 2012 User Guide)
- meet privacy and consent requirements
- utilise local or regional systems, such as using a secure e-referral system, in which case all additional confidentiality provisions and procedures must be observed.

Resources

Resources used to implement service coordination include:

- Victorian Service Coordination Practice Manual 2012
- Practitioners' Good Practice Guide 2012
- Continuous Improvement Framework 2012
- Service Coordination Online Learning Module 2012
- Service Coordination Tool Templates (and SCTT User Guide) 2012
- ESCS/s2s e-referral system
- Statewide Service Coordination and ICDM Survey (annual).¹

The Manual is the main source document, a copy of which should be held by Managers and be available for other staff to consult. The Good Practice Guide is an A3 sheet containing a very succinct summary – it is to be made freely available to practitioners. The Continuous Improvement Framework is the reference document underpinning the Statewide Service Coordination survey. The Online Learning Module is intended for training, particularly new staff. The SCTT User Guide

¹ 2012 documents should be available in mid-2012.

contains all the SCTTs together with instructions on their use. A number of copies should be kept for staff to consult and for training purposes. Contact the IEPCP for hard copies of these documents.

Service Coordination Contacts

The Service Coordination Contact is the most senior person in an organisation, other than the CEO, with overall responsibility for service coordination (or as otherwise decided by the agency). The Service Coordination Contact must be able to speak authoritatively on service coordination implementation within the agency and have delegated authority to make decisions and recommendations on matters relating to service coordination.

The Service Coordination Contact is, as the name implies, the person whom the IEPCP will contact on any issues relating to service coordination where the view of the agency is sought. Service Coordination Contacts are also entitled to be members of the IEPCP Service Coordination Steering Committee.

Statewide Service Coordination & ICDM Survey

The annual Statewide Service Coordination and ICDM Survey informs future work of the PCPs and relevant government departments by identifying areas that require greater focus. The survey provides evidence of quality service coordination practice that organisations may use for:

- demonstration of accreditation standards through providing quality services and programs and sustaining quality external relationships
- providing evidence of quality improvement activity which may contribute to government funded services reporting and monitoring frameworks
- agencies to benchmark their own performance
- agencies to compare their performance with that of previous years
- agencies to compare their performance with similar organisations
- providing evidence for funding and other resource support
- educating and involving staff in service coordination and ICDM PPS
- and ultimately, delivering benefits to the clients from the above.

Use of the State-wide Service Coordination & Integrated Chronic Disease Management (ICDM) Survey results can support organisational quality and accreditation processes. The survey questions are consistent with Evaluation & Quality Improvement Program (EQuIP), Quality Improvement & Community Services Accreditation (QICSA) and HACC National Service Standards Quality Frameworks. See <http://www.health.vic.gov.au/pcps/coordination/cqi.htm> for mapping.

The greatest benefit will be derived from Statewide surveys if the agency:

- takes the opportunity to involve staff as a group
- conducts a survey for each separate team (at least initially) to ascertain if there are differences in the way service coordination is implemented across the agency
- acts upon survey results to improve performance in areas identified as problematic.

Service Directories

The Human Services Directory (HSD) is used extensively by Nurse on Call, the Better Health Channel, HealthSMART and Disability Online. It will also link in with the Commonwealth Personally Controlled Electronic Health Records project. Up-to-date information is therefore important as many help and information lines look to HSD in the first instance as a reliable source of information.

The HSD should be updated as organisational changes occur but agencies should conduct a minimum of one routine annual review.

Infoxchange's Service Seeker is the directory on which the ESCS/s2s e-referral system is built and is an excellent directory in its own right with over 275,000 entries. It should also be updated as changes occur and reviewed annually.

Service Coordination Tool Templates (SCTTs)

The Service Coordination Tool Templates (SCTTs) comprise a suite of templates to facilitate and support service coordination practice. They can:

- Support service providers to collect and share common consumer information
- Support service providers to consider information across a broad range of health and wellbeing domains in accordance with the social model of health
- Assist service providers to consistently record information generated by service coordination processes such as initial contact, initial needs identification, assessment and care planning
- Assist service providers to record consumer consent to share information
- Assist service providers to make quality referrals, provide feedback and develop care plans
- Reduce the burden on consumers to provide the same information to each service provider.

Using and reviewing SCTTs

Agencies should:

- Review annually which SCTTs are being used and what information is being completed by agency staff
- Review annually which SCTTs are being requested from other agencies for client transfers and service requests
- Review e-referral Protocol Notes to ensure they reflect the information the agency requires when receiving referrals including which SCTTs are required
- Have in place a training/induction program for new staff on the use of SCTTs
- Ensure staff know how and where to access information about SCTT usage.

Information about SCTTs is to be found in the most recent SCTT User Guide, which can be downloaded at <http://www.health.vic.gov.au/pcps/coordination/sctt2009.htm>

Training

The following training is recommended:

- For a general introduction for new staff, use the Service Coordination Online Learning Module. This is available online or as a CD-ROM available from the IEPCP office.² This is a self-paced resource so staff may easily focus on areas that are of particular interest to them e.g. Initial Contact, Initial Needs identification or Care/Case Planning.
- New staff should be made aware of the existence and location of the Victorian Service Coordination Practice Manual and also of the Good Practice Guide, the A3 sheet that should be given to all staff members.

² Note that the 2012 version of this resource will not be available until mid-2012. Contact Christopher.foley-jones@iepcp.org.au for copies of the 2006 version.

- Staff should also be trained in the use of Infoxchange Service Seeker and Human Services Directory.
- Training in the use of the ESCS/s2s e-referral system may be carried out either internally or using IEPCP resources (either on-site or at centralised sessions).
- The IEPCP Service Coordination Network runs regular meetings and also special educational events that all practitioners may attend. See the 2012 Service Coordination Calendar on <http://www.iepcp.org.au/resources-links-1> for details.
- The IEPCP also runs service coordination (and e-referral) forums and workshops from time to time – any interested members may attend.
- For SCTTs training use the 2012 SCTT User Guide, either online or as a hard copy.

It is generally expected that agencies will run their own in-house service coordination training but the IEPCP can be requested to assist for special purposes or advice.
