

ABCD

**Department of Human Services**

**Analysis of the Impacts of  
Service Coordination on  
Service Capacity in the  
Primary Health Care Sector**

KPMG Government

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## **Glossary of acronyms**

ABS	Australian Bureau of Statistics
ACAS	Aged Care Assessment Service
BATS	Better Access to Services
BNPCA	Banyule Nillumbik Primary Care Alliance
BPM	Best Practice Manual
CEPCP	Central Eastern PCP
CHP	Community Health Plan
CHS	Community Health Service
CIARR	Client Information and Referral Record
COATS	Community Offenders Advice and Treatment Service
DHS	Department of Human Services
FTE	Full Time Equivalent
GP	General Practitioner
HACC	Home and Community Care
IC	Initial Contact
ICT	Information and Communications Technologies
INI	Initial Needs Identification
IT	Information Technology
KPI	Key Performance Indicator
LGA	Local Government Area
MVM	Moonee Valley / Melbourne PCP
OH&S	Occupational Health and Safety
PCP	Primary Care Partnership

PPPS	Practices, Processes, Protocols and Systems
SC	Service Coordination
SKK	Sharikat-Khoo
SWITCH	State Wide Information Technology for Community Health
South Coast HSC	South Coast Health Services Consortium
SWPCP	South West PCP
WMR	Western Metropolitan Region
Agencies:	
BCCHS	Bass Coast Community Health Service
BCHS	Banyule Community Health Service
NCHS	Nillumbik Community Health Service
MSC	Moyne Shire Council
MVCC	Moonee Valley City Council
PDH	Portland District Health
WCC	Whitehorse City Council
WCHS	Whitehorse Community Health Service

## 1 Executive Summary

The flexibility of Service Coordination and the capacity of its underpinning principles to be applied in a range of settings with different players is central to the inherent strength of Service Coordination as an approach.

***SC, as a new way of doing business, provides a real mechanism for change. SC, when supported by change management processes, leads to resilient partnerships between providers and benefits being delivered in ways that we have only been able to theorise about until now.***

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Service Coordination is effective; it produces tangible benefits so rarely achieved in many reform strategies. By vesting responsibility for the process of change with service providers and through a small level of investment in infrastructure and training, the partnerships and networks formed by providers have highlighted the real potential of Service Coordination

Even in its early stages it is clear that Service Coordination delivers a range of quantifiable benefits, that by all accounts are not only sustainable, but will continue to be realised. As more agencies join the networks that have been established, they will be able to develop effective responses to local issues and to the changing needs of their clients, particularly chronic and complex multiple service users.

For a small investment of funds Service Coordination acts as a key catalyst for change. Service Coordination provides the means by which agencies can come together to develop localised systems and processes to improve response times, to provide better target response to client needs, to streamline the means by which services are provided, and to generally improve operational

efficiency.

Enhanced flexibility of service responses, single points of entry, increased partnerships between providers and sectors and greater alignment of service structures and supports are the medium to longer-term benefits that are expected to be derived from increased participation in Service Coordination.

This study has only been able to identify and quantify the early benefits that can be realised from Service Coordination. Ongoing analysis is required, supported by targeted data capture strategies, to further assist in quantifying the full extent of the tangible benefits that Service Coordination brings to service provision.

At this stage however there is sufficient evidence to recognise the benefits that Service Coordination brings. To maximise and realise the full effects of these benefits there is real merit in considering the implementation of Service Coordination across the broader service system. For example, during the review a number of the participating agencies identified that the capacity of the primary health care sector to respond to clients leaving the acute care system was adversely affected by the lack of a functioning network and referral relationships between the

acute and primary care systems. The extension of Service Coordination into acute system practices (or coordination of Service Coordination systems with acute systems) would enable the partnering systems better respond to post acute clients. This issue is particularly relevant to community health services which have substantial relationships with the acute system (in the review some metropolitan Community Health Services received up to thirty percent of their referrals from the acute system and services such as rehabilitation centres).

## 1.1 Scope of review

The Department of Human Services' (DHS) PCP strategy is intended to improve health and well being outcomes for Victorians accessing the primary health care system through the creation of better networks, a coordinated approach to service provision, and health care promotion.

The PCP strategy is designed to deliver these outcomes at a local level, through the operation of 32 local partnerships.

A significant component of the PCP strategy is Service Coordination, which aims to place consumers at the centre of service delivery. In particular, the strategy seeks to ensure that clients have access to the services they need, including opportunities for early and appropriate health services and the receipt of targeted health education.

Service Coordination requires service providers, and their PCPs, to develop protocols and processes to improve consumers' experience and provide more streamlined pathways through the service system. A key component of Service Coordination is the development and use of common tools and templates that agencies use for client initial contact, initial needs identification, care planning and referral processes.

The PCP strategy was introduced in 2000 and since then Service Coordination has progressively been introduced into local primary health care systems.

It is noted that as at the date of this review, the implementation of Service Coordination within participating agencies and PCPs has generally being limited to the planning, development and implementation of new initial contact and initial needs identification processes, based predominately on the Service Coordination Tool Templates, and referral processes, including some basic forms of e-referral. Further development and implementation of these components of Service Coordination is expected to continue across participating agencies together with development of approaches to care planning.

Those PCPs and agencies that are more advanced in the implementation of the PCP strategy have reported that Service Coordination has delivered a number of benefits, which include:

***Service coordination delivers a number of benefits.....earlier identification of client needs, better management of waiting lists, improvements in service navigation and coordination and greater operational efficiency...all for a relatively small investment.***

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- elimination of, and reduction in, business inefficiencies resulting in more resources for additional service delivery;
- improved management of client waiting lists;
- early identification of client needs;
- clients are better informed about services;
- clients receive services according to their needs;
- improved cross program coordination and response;
- clearer roles for reception staff; and
- improved response rates to clients seeking services.

However, little data has been collected to verify and quantify actual outcomes. The absence of such evidence potentially hinders the further implementation of Service Coordination by other agencies.

The review was commissioned by DHS to address that deficiency, and:

- to inform DHS regarding whether its PCP strategy and Service Coordination is successfully meeting their stated objectives;
- to inform DHS of the factors that are likely to impact upon a successful application of the initiative across the broader health sector;
- to provide persuasive evidence to agencies that have not begun to implement Service Coordination what, if any, worthwhile benefits can be achieved through Service Coordination; and
- to provide an analysis of the critical factors that will influence the degree to which an agency is likely to receive those benefits.

## **1.2 Participants to the review**

The following agencies participated in the review:

- Banyule Community Health Service
- Bass Coast Community Health Service
- Moonee Valley City Council

- Moyne Shire Council
- Nillumbik Community Health Service
- Portland District Health
- Whitehorse City Council
- Whitehorse Community Health Service

These agencies were selected because they:

- had each encountered a range of different issues whilst implementing Service Coordination;
- had adopted a range of service approaches to Service Coordination;
- were spread across the state, experiencing different issues as a result of their locations within the Victorian health network;
- were from a range of PCPs;
- had a range of IT systems and local ICT capacity; and
- covered a range of different services.

As such, whilst they do not represent a statistically representative sample of all agencies that have undertaken Service Coordination, they can provide an evidentiary base of the outputs of Service Coordination under a range of diverse conditions.

## **1.3 Findings**

### **1.3.1 Agency intake models**

Each agency that participated in the review adopted one of three distinct Service Coordination models for undertaking initial contact (IC) and initial needs identification (INI) activities. These were:

- a standalone intake and assessment unit staffed by non-service staff (but with professional qualifications) undertaking IC and INI for the whole organisation;
- a standalone intake and assessment unit staffed by service staff under a shared roster undertaking IC and INI for the whole organisation; and
- an integrated intake and assessment function where service staff undertake IC and INI within their own service structure.

Agencies adopted particular service models in response to agency service profiles and particular agency needs. In particular:

- all of the Community Health Services adopted standalone intake and assessment units which enabled them to create single point of entries to their multiple service streams. In contrast, each of the city councils (providing HACC services) maintained their existing integrated intake functions; and
- most Community Health Services staffed their intake units with professional staff specifically employed to undertake centralised intake and assessment for the whole organisation. One agency adopted a model where direct service staff, in addition to their practitioner roles, undertake intake and assessment on a rostered basis. In this case, this approach was adopted to assist the development of a common organisational culture and greater cross service understanding in its service staff.

Each of the models adopted deliver specific benefits to agencies, these are shown in Table 1.1.

**Table 1.1: Benefits of alternative Service Coordination models**

Standalone unit with dedicated staff	Standalone unit with direct care staff	Integrated unit
<ul style="list-style-type: none"> <li>• Consistency in procedures for intake and initial assessment (use of common forms and tools)</li> <li>• Capacity to undertake an initial risk assessment at time of contact which assists in determining urgency and priority</li> <li>• Training for staff is focused and targeted at the core processes</li> <li>• Minimised amounts of training required (fewer staff required)</li> <li>• Decreased management costs associated with maintaining the intake and assessment process as there are fewer staff required</li> <li>• Relatively easy to establish from an operational perspective</li> <li>• Capacity to provide a brief intervention at the time of intake, in particular for health promotion</li> <li>• Enables the service to have dedicated staff with specific skills in intake and assessment activities</li> </ul>	<ul style="list-style-type: none"> <li>• Development of cross program understanding of what different services streams do and encouragement of staff to think outside of their service silos. This has the potential benefit of increasing the likelihood of an integrated multi-service response to clients when they access the health system</li> <li>• Consistency in procedures for intake and initial assessment (use of common forms and tools)</li> <li>• Capacity to undertake an initial risk assessment at time of contact which assists in determining urgency and priority</li> <li>• Sharing of the role provides diversity and minimises the risk of burnout</li> <li>• Relatively easy to establish from an operational perspective</li> <li>• Capacity to provide a brief intervention at the time of intake, in particular for health promotion</li> </ul>	<ul style="list-style-type: none"> <li>• Targeted intake to specific disciplines</li> <li>• Enables the intake function to be spread according to geographic need</li> <li>• Intake undertaken within the service system</li> </ul>

### 1.3.2 Outcomes of Service Coordination

The costs and benefits of Service Coordination experienced by participating agencies were consistent to those previously reported informally by agencies. Service Coordination delivers three types of costs and benefits to the agencies and their clients, namely:

- financial cost and benefits – where Service Coordination effects the costs of an agency providing its services;

*A small investment of one to two percent of an agency's operating costs in the first year to assist in the implementation of service coordination with investment in technology, staff training and the design of new operation procedures and processes .....not only produces tangible benefits for the agency and for their consumers but it is expected to lead to improved operational efficiencies and quantifiable savings over time.*

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- qualitative benefits – where Service Coordination effects the quality of the services received by clients; and
- quantitative benefits – where Service Coordination effects the time it takes for agencies to provide services to clients or the volume of services delivered to clients.

Broadly, the value delivered by Service Coordination is expressed through the following equation:

$$\text{Value of Service Coordination} = +/- \text{Financial costs/benefit} +/- \text{Qualitative costs/benefit} +/- \text{Quantitative cost/benefit}$$

Under the Service Coordination value formula it is important to note that:

- Service Coordination may deliver a net benefit to an agency even if Service Coordination causes a net cost within one component of the value formula. For example, Service Coordination can deliver a net benefit to an agency even if its net financial costs have increased if it also delivers net qualitative and/or quantitative benefits. This was the case in agencies that established a centralised intake unit requiring the recruitment of additional staff;
- each agency will form its own view regarding the total value it receives from Service Coordination

depending the relative importance it places on receiving different types of benefits. In the three agencies in the review that established a specialist staffed intake and assessment unit the agencies each stated that the service benefits achieved outweighed the net additional financial costs incurred. It is noted however that other agencies may have formed a different view with the same outcomes depending on their own priorities; and

- the recognition of qualitative benefits in the value formula reflects the fact that Service Coordination may have an impact on more than output efficiency (i.e. units of output per dollar) alone.

### **1.3.2.1 Financial outcomes of Service Coordination**

The financial impact of Service Coordination on the selected agencies was as follows:

#### *Implementation costs:*

Generally, the cost of the development and implementation of Service Coordination within an agency was between one and two percent of an agency's costs base. The highest cost of Service Coordination implementation was \$117,000 and the lowest cost was \$21,000.

The level of cost incurred appears to be independent of which Service Coordination model an agency elected to adopt, the level of resources available from the local PCP to support the implementation of Service Coordination in an agency, and the level of technology investment made. The single exception to the above was in a small agency where implementation cost four percent of annual operating expenditure.

In all but one of the agencies, staff training and development, planning, and change management costs made up between 85 and 90 percent of total Service Coordination implementation costs. System hardware and software costs consistently made up only a small portion of implementation costs.

The one agency, which was an exception to the above undertook considerable investment to develop an IT capacity that allowed staff to directly record client information onto laptops whilst visiting client homes.

#### *Operating costs*

In six of the eight participating agencies Service Coordination increased the agencies total operating cost, where the increased cost ranged between zero and two percent of agency turnover. The largest increase in net costs was \$83,000.

In two agencies Service Coordination delivered a net operating cost saving of between one and two percent of agency turnover. The largest net cost saving was \$108,000.

In all agencies staffing costs (permanent or temporary staff) was responsible for the most of the increase or decrease in operating costs. The only exception to this occurred in the single agency that adopted a standalone intake unit staffed by service staff, where only minor marginal operating costs were incurred and staff costs were not impacted.

### **1.3.2.2 Qualitative outcomes**

Qualitative benefits experienced by the agencies are illustrated in Table 1.2.

**Table 1.2: Benefits of Service Coordination**

Client Benefits	Organisational Benefits	Network Benefits
<ul style="list-style-type: none"> <li>• Clients are provided with better information about services and intake processes</li> <li>• Agencies have increased their capacity to respond to CALD</li> <li>• Clients are better informed about their rights and about privacy and confidentiality</li> <li>• Clients receive immediate attention</li> <li>• Service Coordination can improve the time required to complete the entire intake and assessment process</li> <li>• Reduced client waiting times for intake</li> <li>• Consistent information provided to clients</li> <li>• Consistent intake and assessment processes</li> <li>• Minimised risk of duplication of intake and assessment activities</li> <li>• Agencies can prioritise client response and respond better to client urgency</li> </ul>	<ul style="list-style-type: none"> <li>• Improved documentation of client information</li> <li>• Staff develop better understanding of intake, assessment and referral</li> <li>• Staff develop a better understanding of their agency service structures</li> <li>• Reduced reliance on administration</li> <li>• Reduced double processing of data</li> </ul>	<ul style="list-style-type: none"> <li>• Staff develop understandings of local primary health care system</li> <li>• Improved referral practices</li> </ul>

It is critical to recognise that the client benefits provide agencies the capacity to manage crisis events more effectively and to minimise the risk of deterioration to clients, both physically and psychologically, which can be experienced from delayed service responses.

### 1.3.2.3 *Quantitative outcomes*

Quantitative outcomes reported by the participating agencies including:

- one half hour to one hour reductions in time to complete intake and assessment activities, although some agencies reported increases in time to complete intake and assessment activities due to a more comprehensive approach and improved practices (i.e. qualitative benefits) in more holistic assessment, and greater attention to occupational health and safety and client confidentiality issues;
- reductions in numbers of service sessions required for some clients due to the ability to move toward single session therapy as service times are longer due to reduced administrative load;
- reduced waiting times for services.

However, it is noted that commonly these quantitative benefits could not be evidenced directly by the agencies due to lack of available data due to these measures not being measured by the agencies or due to agency data systems not recording these types of data.

## 1.4 Factors influencing Service Coordination outcomes

A number of factors were identified as having an impact on the likely success of Service Coordination within an agency. Table 1.3 provides a summary of those factors.

**Table 1.3: Factors that influence the achievement of Service Coordination outcomes**

Factor	Impact
Location	<p>Locational issues may adversely impact the implementation of Service Coordination for <u>rural</u> providers, where:</p> <ul style="list-style-type: none"> <li>• Referrals occur more frequently from beyond network boundaries where different protocols and procedures may operate.</li> <li>• Poor standards of public and private ICT infrastructure can adversely effect the capacity of an agency to undertake Service Coordination.</li> <li>• The requirement to provide services from multiple locations may impact the capacity of an agency to operate enterprise wide IT based systems, including centralised processes critical to Service Coordination (e.g. diaries and scheduling).</li> <li>• Providers in rural networks may have lower capacity to undertake Service Coordination because of their generally smaller size. However, this may be offset by there being fewer providers and as a result local networking may be more effective.</li> </ul> <p>Locational issues may be solved in part by participation in larger Regional networks, however the objectives of these networks may not necessarily be consistent with local PCP objectives.</p>
IT Infrastructure	<p>The IT software needed to undertake Service Coordination is available and relatively inexpensive. However at the date of the report the unavailability of e-referral messaging standards prevents agencies from achieving full functionality from their IT systems.</p> <p>Any problems with IT experienced by agencies are agency specific relating to either internal IT configurations or local conditions such as unavailability of broadband in certain rural areas.</p>
PCP input	<p>PCPs provide a critical role to agencies implementing Service Coordination through the provision of resources, advice, information and the development of PPPSs.</p>

Factor	Impact
	<p>In particular, the provision of resources for training and IT support and the development / adoption of a common set of PPPS have a critical impact on the level of benefits achieved from Service Coordination and costs incurred by the agency.</p>
Position in local network	<p>There appears to be a perception within Councils providing HACC services that they are primarily recipients of referrals, where the majority of their referrals received are from self-referral and the acute system. As such, the emphasis on Service Coordination within a council may focus more on activities that give benefits directly rather than as part of a network, including:</p> <ul style="list-style-type: none"> <li>• better data collection practices;</li> <li>• better understanding and relationships with clients; and</li> <li>• staff engaged in improving quality of intake and assessment services to clients, for example information and empowerment.</li> </ul> <p>In contrast, CHSs have higher levels of referrals between primary health care agencies and generate significant numbers of referrals. As such, in addition to the above, CHSs also achieve higher levels of Service Coordination benefit from:</p> <ul style="list-style-type: none"> <li>• e-referral; and</li> <li>• better coordination of referral practices with the post acute system and local GPs.</li> </ul> <p>It is noted that, despite the above, Councils in practice would be expected to generate referrals both through their own assessment and re-assessment processes, as a result of observations of service staff and through referral to Aged Care Assessment Services, and as such should pursue improved network practices.</p>
Change management	<p>Agencies participating in the review commonly noted that the successful introduction of Service Coordination requires that the agency adopt a change management approach. In particular critical activities include:</p> <ul style="list-style-type: none"> <li>• consultation programs with staff, board of management and other key service providers;</li> <li>• involvement of staff in any system design;</li> </ul>

Factor	Impact
	<ul style="list-style-type: none"> <li>• involvement of staff in policy review and development; and</li> <li>• monitoring and responding to any perceived changes in staff morale.</li> </ul>
Champion for change	In each agency, the presence of a key person ‘championing’ the cause of Service Coordination was fundamental to the effective establishment and implementation of the program.

## 1.5 The way forward

The early benefits delivered from Service Coordination highlight the real and tangible benefits that come from improved coordination and navigation across the service system for not only clients but for agencies as well.

It is clear that Service Coordination is a positive and effective mechanism and warrants consideration and support for broader implementation across the human service sector. Wherever there is the potential of clients in common or clients with similar needs, Service Coordination has a capacity to not only streamline the way services work, resulting in improvements in operational efficiency and effectiveness but also it has the capacity to be directly beneficial to clients by reducing waiting times and ensuring that service responses are coordinated in response to their needs.

By realising these benefits locally there is also direct benefit for DHS as a funder of the service system. Improvements to service quality are important for both direct client outcomes and in terms of the investment proposition for the service system.

***With DHS and the sector working in partnership, with a shared vision for the future, Service Coordination has the capacity to be expanded to encompass a greater variety of service responses...providing to greater benefits to consumers and participating agencies alike.***

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### 1.5.1 The role for DHS

The key role for DHS is to facilitate further implementation of Service Coordination and support its ongoing success. This includes:

- Promotion and support of Service Coordination as a model across the broader service system (particularly the acute sector) with marketing information around Service Coordination and its benefits.

- Promotion of potential network Service Coordination benefits to Council HACC services to address the incorrect perception that their role is primarily as the recipient of referrals.
- Encouraging and supporting the sector to look for more flexible service responses outside of the traditional service types.
- Continued support of the PCP structure and promotion of their role and capacity. Network benefits can be slow to emerge as the benefits only arise when a large proportion of the network participates in Service Coordination. PCPs are clearly able to take a leadership role in supporting agencies within their network to implement Service Coordination, thus maximising the benefits.
- Supporting Service Coordination through ongoing program development structures and policy and operational guidelines. Taking a lead role in the development of referral tools and processes enables the sector to focus on internal agency requirements rather than systemic development issues.
- Incentives and rewards for good practice. This could include incentives to ensure that any cost savings achieved by agencies can be redirected into direct service provision.
- Facilitating technology structures and systems to support Service Coordination, which would assist in removing the current administrative burdens created by the referral tools and systems. For example, the messaging standards being developed by DHS will increase the connectivity of e-referral to the agency data systems and provide an improved interface between systems.
- Developing a strategy to support the primary health sector in the engagement of the acute sector to broaden the application of the referral tools and process including e referrals. The review consistently identified that the broader the application of Service Coordination the more effective the network benefits are. In particular this greater benefit would be gained if all sectors involved in referral processes were linked to the same referral tools and systems.
- Financial assistance for training for smaller and/or rural agencies, in particular around IT and systems where their size and infrastructure makes this difficult to achieve as they have little capacity to invest in this area.
- Financial support for IT system upgrades and hardware purchase, for example assisting agencies to achieve improved interfaces between systems and functional links between their software packages and e-referral systems. This would assist to maximise network efficiencies and eliminate the current duplication of effort.

## **1.6 The role for the sector**

### **1.6.1 Primary Care Partnerships**

The PCPs play a critical role in providing:

- resources, particularly training and IT support;
- development of PCP wide PPPS;
- advice on governance, service planning and strategic issues;
- a leadership role in developing protocols and relationships with other sectors (such as referral protocols with local GPs and the acute sector); and
- information and discussion forums for staff at various levels of the service system from CEO through to direct service staff for agencies implementing Service Coordination.

It is important that PCPs continue this leadership role to grow and support the effective implementation of Service Coordination across the service sector. The implementation of the PCP Strategic Directions should result in broader implementation, which may assist this process.

In addition PCPs should take a leadership role in promoting the benefits of Service Coordination and leading discussion with other service sectors such as the acute sector.

### **1.6.2 The individual agency**

For those agencies that have successfully implemented Service Coordination it will be important that they promote Service Coordination through existing service networks at all levels from CEO to service staff. In doing this agencies can provide support and mentoring to agencies seeking to establish Service Coordination.

In particular it will be important to communicate the message that Service Coordination can be used effectively as a driver or catalyst for change to improve business inefficiencies.

For rural services, Service Coordination has established that there are potential advantages in building and participating in network alliances to minimise differences in procedures and establishing agreed protocols to maximise the efficiency of service intake and referral processes. This could also be supported by agreements around software packages to support the resolution of interface issues.

## 2 Context of report

### 2.1 Primary Care Partnerships

The Primary Care Partnership (PCP) strategy was launched by the Victorian Government in 2000 with the intention of improving health and well being outcomes for Victorians accessing the primary health care system as well as reducing the avoidable use of hospital, medical and residential services.

Through a partnership approach, the PCP strategy was intended to enhance the capacity of the primary health care system through the creation of better networks, a coordinated approach to service provision, and health care promotion.

The PCP strategy was designed to deliver these outcomes at a local level so that local issues are recognised and responded to. Thirty-two PCPs were created comprising local primary health care providers. Each PCP catchment was based on local government area (LGA) and Department of Human Services (DHS) regional boundaries.

### 2.2 Service Coordination

*SC places consumers at the centre of service delivery...making sure that they have access to the services they need, while providing opportunities for early intervention.....health promotion, education and targeted management of chronic illness are all important components of SC.*

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A significant component of the PCP strategy, expressed in DHS's Better Access To Services (BATS) policy and operational framework, is Service Coordination.

Service Coordination is designed to enable service providers to develop protocols and processes to improve consumers' experience and provide more streamlined pathways through the service system. A key component of Service Coordination is the development and use of common tools and templates that agencies use for client registration, initial needs screening, care planning and referral processes.

Those PCPs and agencies that are more advanced in the implementation of the PCP strategy have reported that Service Coordination is delivering a number of benefits, which include:

- elimination of, and reduction in, business inefficiencies resulting in more resources for additional service delivery;
- improved management of client waiting lists;
- early identification of client needs;
- clients are better informed about services;

- clients receive services according to their needs;
- improved cross program coordination and response;
- clearer roles for reception staff; and
- improved response rates to clients seeking services.

However, little data has been collected to verify and quantify actual outcomes. Such an assessment process is desirable for a number of reasons, namely:

- to inform DHS regarding whether its PCP strategy and Service Coordination is successfully meeting their stated objectives;
- to inform DHS of the factors that are likely to impact upon a successful application of the initiative across the broader health sector;
- to provide persuasive evidence to agencies that have not begun to implement Service Coordination what, if any, worthwhile benefits can be achieved through Service Coordination; and
- to provide an analysis of the critical factors that will influence the degree to which an agency is likely to receive those benefits.

The evidence as to whether Service Coordination provides a sufficient return to individual agencies will be a key driver for further implementation of Service Coordination across Victoria. As such, the purpose of this report is to provide evidence to guide further implementation of Service Coordination.

## 2.3 Terms of reference

This review was commissioned by DHS to undertake an assessment of Service Coordination in a selection of agencies and to provide an analysis of the actual costs and benefits of Service Coordination and the factors that influence those costs and benefits.

The terms of reference for the review were to:

- investigate whether the cited outcomes of Service Coordination, particularly an improvement in service capacity and agency efficiency, can be substantiated by evidence and whether these benefits can be quantified;
- identify the changes to business practice that has resulted in the increased service capacity and/or other benefits;
- identify and detail the initial and ongoing costs associated with implementing and maintaining Service Coordination;

- determine whether there is a net benefit in implementing Service Coordination and how long it will take individual agencies to reach a breakeven point where the benefits gained outweigh the initial and ongoing costs;
- describe any other benefits of Service Coordination identified as part of this project; and
- identify the key success factors in realising maximum benefits from implementing Service Coordination.

Eight agencies were selected for the review. Whilst the selected agencies are not necessarily a statistically representative group, those selected were chosen because:

- each had encountered a range of different issues whilst implementing Service Coordination;
- they had adopted a range of service approaches;
- they were spread across the state, experiencing different issues as a result of their locations within the Victorian health network;
- they were from a range of PCPs;
- they had a range of IT systems and local ICT capacity; and
- they covered a range of different services.

The participating agencies are listed in Table 2.1.

**Table 2.1: Service Coordination review agencies**

	Metropolitan Melbourne	Non-Metropolitan Victoria
<b>Community Health Service</b>	Whitehorse Community Health Service Nillumbik Community Health Service Banyule Community Health Service	Bass Coast Community Health Service Portland District Health
<b>City Councils</b>	Whitehorse City Council Moonee Valley City Council	Moyne Shire Council

## 2.4 Methodology

The methodology for the review comprised the following activities:

- formation of a Project Steering Committee comprising representatives of each of the participating agencies<sup>1</sup> and representatives from the Primary and Community Health Branch and the Home and Coordinated Care Unit from Rural and Regional Health and Aged Care Services;
- an initial Steering Committee meeting held in order to:
  - approve the methodological approach proposed for the collection and review of agency information required to form a view on the objectives outlined in the terms of reference, and to provide direction to the project team regarding project critical issues;
  - review and provide input into the design of a Service Coordination assessment tool. The Service Coordination assessment tool set out the range of questions to be asked by the review and the data required to be collected in order for the review team to be able to form a view on the costs and benefits relating to Service Coordination in each agency.

The Service Coordination assessment tool provided a range of questions on:

- an agency's strategic management position and what it was attempting to achieve from Service Coordination;
- basic agency demographics;
- HR issues related to the introduction and operation of Service Coordination, including staff profiles, remuneration, recruitment, training, and change management;
- operations, including changes to processes and procedures;
- related systems and IT changes;
- outcomes from Service Coordination for staff, clients and the local primary health care network (including linkages into the acute system and local General Practitioners);
- marginal financial costs of the development, implementation and operation of Service Coordination within the agency and costs relating to the participation in Service Coordination activities within an agency's PCP;
- the local PCP context and in particular Service Coordination directions adopted by a PCP and any supports provided to an agency;
- review and provide input into the design of a client attitudes survey tool;

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<sup>1</sup> Portland District Health and Moyne Shire Council declined to sit on the Steering Committee because of issues of distance.

- each agency was visited by the review team, which conducted interviews and group workshops covering each of the assessment components set out in the assessment tool. At each agency, depending on the agency's management and staffing configuration, interviews were carried out with:
  - senior / executive management;
  - operations managers;
  - staff impacted by Service Coordination changes; and
  - local PCP representatives;
- concurrent with the agency visits, each agency conducted a client survey on clients passing through their intake system;<sup>2</sup>
- analysis of the data gathered from the agency visits and development of a draft report; and
- presentation of the draft report and review findings to the steering committee in order to gather feedback and enable finalisation of the review report.

## 2.5 Structure of report

The report is structured as follows:

- A summary and a way forward – providing a number of recommendations for the further development and supports that could be provided to promote the further implementation of Service Coordination across the Victorian primary health care system (Section 1);
- Context of report – providing a description of the contextual setting of Service Coordination in Victoria, the drivers behind the commissioning of the review, the terms of reference and the review methodology (Section 2);
- Findings – providing a summary of the costs and benefits of Service Coordination encountered in each agency and comments on likely future cost benefits (Section 3);
- Themes – providing analysis of the critical factors that impacted upon the agencies achieving those outcomes (Section 4); and
- Agency reports – a report on each agency (Sections A to H) providing details of each agency's:

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<sup>2</sup> It is noted that this client survey was only intended to provide a sample of client views to check against statements made to the review by the agencies. The client survey was not intended to provide a definitive view of client attitudes nor was it able to provide a longitudinal view of those attitudes.

- service profile (services and clients);
- strategic setting;
- PCP and wider network context;
- Service Coordination activities;
- outcomes achieved; and
- issues associated with the implementation of Service Coordination.

### 3 Findings

This section provides a summary of the non-financial and financial outcomes of Service Coordination for each of the agencies reviewed and where appropriate comments on whether the outcomes noted will continue into the future. For context, Table 3.1 provides comparative profiles of the selected agencies that participated in the review.

**Table 3.1: Basic agency profile**

Characteristic	Relative Rating Scale	BCHS	NCHS	WCHS	MVCC	WCC	BCHS	PDH	MSC
<b>AGENCY CATCHMENT</b>									
Location/ Geography	Metropolitan = M, Rural = R	M	M	M	M	M	R	R	R
LGA area	L: < 100 sq kms M: 101 – 1,00 sq kms H: > 3,500 sq kms	L	M	L	L	L	M	H	H
PCP area	L: < 100 sq kms M: 101 – 1,00 sq kms H: > 3,500 sq kms	M	M	M	L	M	H	H	H
Population	L: < 25,000 M: 25,001 – 100,000 H: > 100,001	H	M	H	H	H	L	L	L
Percentage of population from non-English speaking countries (Non Aus/UK/NZ)	L: < 10.0 percent M: 10.1 percent – 20.0 percent H: > 20.1 percent	M	L	H	H	H	L	L	L
Average annual individual income (State average \$21,395)	L: < \$18,000 M: \$18,000 – \$24,000 H: > \$24,001	M	H	H	M	H	L	L	L
<b>AGENCY INFORMATION</b>									
Principle agency services	C: Community Health Services H: HACC services	C	C	C	H	H	C	C	H
Agency total expenditure per annum on health services	L: < \$1,000,000 M: \$1,000,001 – \$4,000,000 H: > \$4,000,001	H	H	M	M	H	M	M	L
Agency health services employees	L: < 50 employees M: 50 – 100 employees L: >100 employees	H	M	M	H	H	M	L	L
Service sites	Number of sites	4	2	1	1	1	6	2	2
Offsite services	Y: Yes (principal service stream) N: No (principal service stream)	N	N	N	Y	Y	N	N	Y

#### 3.1 The Service Coordination model

The participants to the review adopted three distinct service models for their intake and assessment<sup>3</sup> function.

<sup>3</sup> Different agencies adopted different terminology to refer to their intake and assessment function. Terms used included: Intake and Assessment, Intake and Access, and Service Coordination. In each case the agencies referred to units which were undertaking the Initial Contacts (IC) and Initial Needs Identification (INI) as opposed to service specific or specialist assessment and care planning, which in each case was undertaken by service staff after the clients had passed through the 'Intake and Assessment'

The following describes the models implemented by the participating agencies.

- Model one – a stand-alone intake and assessment unit, where non-direct service staff (but with professional qualifications) undertake centralised intake and assessment for the whole organisation. Under this model the organisation recruits staff to solely undertake an intake and assessment role. Importantly, the model operates as a single point of entry for all referrals to the agency. The single point of entry model:
  - assumes responsibility for all incoming client calls and screens all new referrals;
  - determines the eligibility of the caller for service and if they are not eligible advises so or refers the caller elsewhere;
  - undertakes a risk assessment and determines the urgency of client referrals and as appropriate either coordinates an immediate response from the agency or schedules clients for appointments;
  - determines which professional discipline(s) within the service should receive the referral, for example social work, physiotherapy or podiatry; and
  - may make appointments on behalf of the various disciplines.
- Model two – a stand-alone intake and assessment unit, where direct service staff, in addition to their practitioner roles, undertake centralised intake and assessment for the whole organisation. This model operates on a rostered basis with staff sharing responsibility for the intake function. This model also operates as a single point of entry and has the same features as identified in model one.
- Model three – an integrated intake and assessment function where direct service staff undertake intake and assessment within their own service structure and the intake and assessment function may be decentralised to recognise geographic service boundaries. This model does not have a dedicated unit, nor a single point of entry and focuses on multidisciplinary assessment.

It must be noted that none of the models remove discipline specific assessment undertaken by the various professionals within the service streams after the IC and INI processes.

Table 3.2 illustrates which service models were adopted by the review participants.

**Table 3.2: Agency service models**

Service model	Agency
Model One: <ul style="list-style-type: none"> <li>• Stand alone unit staffed by dedicated non direct service staff</li> <li>• Single point of entry</li> <li>• Determines service eligible and risk assessment</li> <li>• Has a referral role</li> <li>• Determines first point for discipline specific service</li> <li>• May make appointments for discipline specific service</li> </ul>	<ul style="list-style-type: none"> <li>• Whitehorse Community Health Service</li> <li>• Banyule Community Health Service</li> <li>• Nillumbik Community Health Service</li> </ul>
Model two: <ul style="list-style-type: none"> <li>• Stand alone unit staffed by direct service staff</li> <li>• Single point of entry</li> <li>• Determines service eligibility and risk assessment</li> <li>• Determines service staff</li> <li>• Has a referral role</li> <li>• Determines first point for discipline specific service</li> </ul>	<ul style="list-style-type: none"> <li>• Bass Coast Community Health Service</li> <li>• Portland District Health (reception IC only)</li> </ul>
Model three: <ul style="list-style-type: none"> <li>• Integrated unit staffed by direct service staff</li> <li>• Multiple point of entry</li> <li>• Discipline specific assessment only</li> </ul>	<ul style="list-style-type: none"> <li>• Whitehorse City Council</li> <li>• Moonee Valley City Council</li> <li>• Moyne Shire Council</li> </ul>

During the review, evidence for the actual levels of benefit achieved within the participating agencies was collated from:

- interviews with agency management and staff;
- clients record systems;
- clients satisfaction surveys or similar activities conducted by the agencies;
- the review's client survey; and

- secondary information sources that provide indicators of organisational health, such as:
  - complaint records; and
  - HR indicators such as staff turnover rates and staff sick rates.

### **3.1.1 Advantages and disadvantages of the models**

A number of outcomes were achieved for the various agencies dependent on the model they implemented.

#### **3.1.1.1 *Model one – Single point of entry with a dedicated intake and assessment unit of non direct service staff***

This model provides the following benefits for agencies:

- a single point of entry provides a more streamlined approach to intake and client referral;
- consistency in procedures for intake and initial assessment (use of common forms and tools);
- capacity to undertake an initial risk assessment at time of contact which assists in determining urgency and priority;
- training for staff is focused and targeted at the core processes;
- minimised amounts of training required (fewer staff required);
- decreased management costs associated with maintaining the intake and assessment process as there are fewer staff required;
- conceptually easy to understand from an operational perspective;
- capacity to provide a brief intervention at the time of intake, in particular for health promotion; and
- enables the service to have dedicated staff with specific skills in intake and assessment activities.

Some of the difficulties associated with this model were:

- potentially high implementation burden;
- risk of staff burnout due to intensity of the role;

- potential for higher staff turnover due to lack of diversity in the role and a perceived deskilling of professional skills; and
- direct service staff not always willing to take ownership of the initial assessment that was made by the intake team and wanting to reassess through the discipline specific process.

**3.1.1.2 *Model two – Single point of entry with a dedicated function but no dedicated team and direct service staff participating on a rostered basis***

This model provides the following benefits for agencies:

- a single point of entry providing a more streamlined approach to intake and client referral;
- development of cross program understanding of what different services streams do and encouragement of staff to think outside of their service silos. This has the potential benefit of increasing the likelihood of an integrated multi-service response to clients when they access the health system<sup>4</sup>;
- consistency in procedures for intake and initial assessment (use of common forms and tools);
- capacity to undertake an initial risk assessment at time of contact which assists in determining urgency and priority;
- sharing of the role provides diversity and minimises the risk of burnout;
- conceptually easy to understand from an operational perspective; and
- capacity to provide a brief intervention at the time of intake, in particular for health promotion.

Some of the difficulties associated with this model were:

- potentially high implementation burden;
- staff having to balance direct service work with intake and assessment, where the intake process may not be viewed as important as their day to day work;
- discipline specific professionals focus on their discipline in the assessment process rather than a holistic approach;
- can be difficult when staff don't see intake as part of their core role and resist participating;

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<sup>4</sup> Such an approach may also be useful in an agency where services are expanding rapidly and an organisation has to establish a cross-organisational culture.

- difficult to backfill rosters if staff are absent; and
- staff do not undertake the role sufficiently to maximise potential expertise in the role.

### **3.1.1.3 *Model three - Multi disciplinary approach, no single point of entry***

This model provides the following benefits for agencies:

- targeted intake to specific disciplines; and
- enables the intake function to be spread according to geographic need.

Some of the difficulties associated with this model were:

- no common approach to intake and assessment;
- less streamlining of entry point for service; and
- reliant on individual disciplines to balance competing demands of service role with the intake function.

### **3.1.1.4 *Impact of models on service networks***

Service Coordination creates linkages both between service streams within an agency and with external service providers.

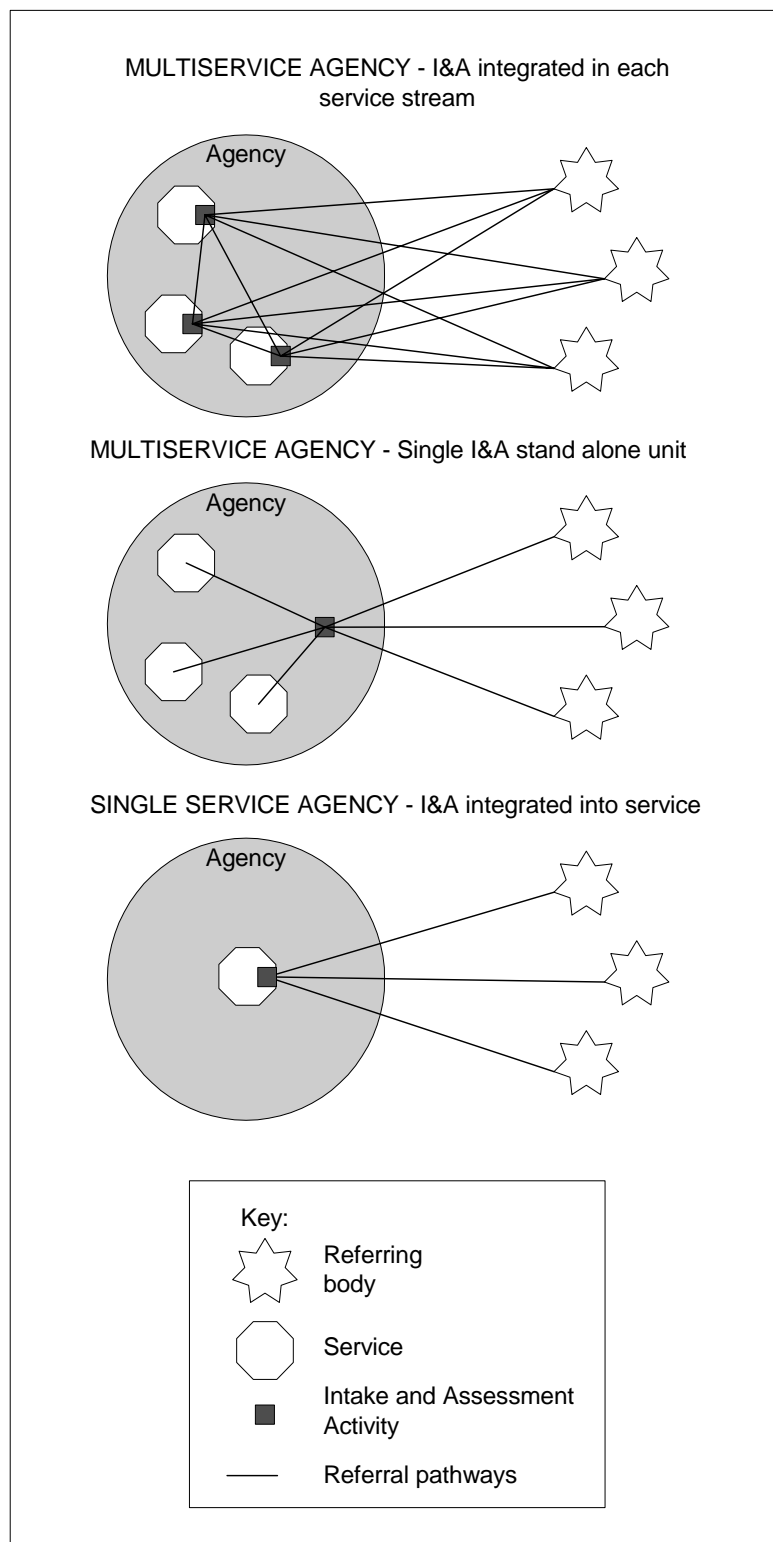
For this reason multi-service agencies (like Community Health Services) developed stand alone intake and assessment units in response to Service Coordination in order to minimise the number of network relationships that the agency has to deal with.

In contrast, single service agencies (like councils, where collectively HACC services can be considered to be a single type of service) are confronted with less complex network issues so they are more readily able to incorporate the intake and assessment role into their existing service system. The integrated model also enables agencies to respond on a local basis which is consistent with assessment occurring in client homes rather than at a single site.

Figure 3.1 illustrates the intake and assessment relationships between services within and external to an agency under different Service Coordination models and types of service.

The first two networks in Figure 3.1 illustrate why agencies with multiple services may choose to adopt a centralised intake and assessment function (irrespective of how it is staffed) in order to avoid complex network relationships, which may be costly to maintain and may lead to service inefficiencies within an agency. The third network diagram in Figure 3.1 illustrates why single service agencies may adopt an integrated intake and assessment functions due to a much simpler set of network relationships.

**Figure 3.1: Service Coordination networks**



***The inherent flexibility that SC brings... ensures that agencies adopting SC can develop approaches that can be tailored to local arrangements. It is the underpinning principles of SC that lead to benefits being realised and better outcomes for consumers... not the rigid application of structures and models.***

***KPMG Review***

It would appear from a network analysis perspective alone that each of the agencies participating in the review have adopted a Service Coordination model appropriate to their service and hence maximised their opportunity of achieving maximum operational efficiency from their Service Coordination model.

During the review no persuasive evidence was found to suggest that adopting either a direct service staff or non-direct service staff approach to centralised intake and assessment should be a preferred model. Instead it was apparent that each model was adopted in response to the particular preferences of the agency.

It is likely that agencies will adopt one of the three models observed during this review in response to their own service conditions. During the review each of the agencies that were operating integrated service models were single service organisations. It is expected that agencies with increasing numbers of service streams (2, 3, 4 or more) would continue to operate under an integrated model, where each service effectively would

operate an integrated model, until a point where the cost and services benefits of a standalone model justify that model.

## 3.2 Overall service outcome

Service Coordination delivers three types of costs and benefits to the agencies and their clients, namely:

- financial cost and benefits – where Service Coordination effects the costs of an agency providing its services;
- qualitative benefits – where Service Coordination effects the quality of the services received by clients; and
- quantitative benefits – where Service Coordination effects the time it takes for agencies to provide services to clients or the volume of services delivered to clients.

Broadly the value delivered by Service Coordination is expressed through the following equation:

$$\text{Value of Service Coordination} = +/- \text{Financial costs/benefit} +/- \text{Qualitative costs/benefit} +/- \text{Quantitative cost/benefit}$$

Under the Service Coordination value formula it is important to note that:

- Service Coordination may deliver a net benefit to an agency even if Service Coordination causes a net cost within one component of the value formula. For example, Service Coordination can deliver a net benefit to an agency even if its net financial costs have increased if it also delivers net qualitative and/or quantitative benefits;
- each agency will form its own view regarding the total value it receives from Service Coordination depending the relative importance it places on receiving different types of benefits; and
- the recognition of qualitative benefits in the value formula reflects the fact that Service Coordination may have an impact on more than output efficiency (i.e. units of output per dollar) alone.

### **3.2.1 Qualitative outcomes**

Agencies that are advanced in their application of Service Coordination have reported a range of qualitative benefits including:

- client benefits, such as improved information for clients on services and service availability through being able to better predict waiting times, reduced waiting lists, and improved response to clients particularly at initial intake;
- organisational benefits, such as increased understanding by staff of the agency's service system, decreased business inefficiencies, and better utilisation of resources; and
- network benefits such as improved relationships within the PCP and with other health providers such as hospitals.

Such benefits suggest that Service Coordination is a positive and effective approach to service delivery and warrants consideration of broader implementation across the sector.

#### **3.2.1.1 Client benefits**

Client benefits were articulated by both clients and staff.

##### *Client perception of client benefits*

During the review many of the agencies noted that a client will not notice the Service Coordination system that they are utilising provided the service is responsive and the client experiences minimal inconvenience. As a result, a client will normally not hold any views on aspects of Service Coordination unless they are negative.

None of the agencies believed that Service Coordination had created widespread negative attitudes in their client base.

This view is borne out by the review's client survey, which found that:

- ninety eight percent of clients surveyed thought they achieved the response they needed from the agency;
- ninety nine percent of clients surveyed thought they received the information they needed from the agency;
- ninety four percent of clients surveyed thought they received the information they needed in a timely manner; and
- all clients understood why the agency asked the questions they did in the intake process.

However, the agencies did note that occasionally clients make negative comments in situations where:

- a client ‘knows’ what service he / she needs, and simply wants an intake officer to make an appointment straight away, rather than collect information;
- a client thinks that the amount of information collected is more than required by the agency to deal with the client’s issues; and
- a client may not understand issues like consent and how they relate to receiving services.

***Service Coordination is seamless to clients....it occurs in the background with the only evidence of its existence being clients’ satisfaction that they are able to have better and more timely access to information and that they receive the assistance they require in response to their assessed needs.***

***KPMG Review***

*Staff perception of client benefits*

The agencies participating in the review consistently noted the following client benefits:

- clients are provided with better information regarding the services they will receive. An example of better information was the development of client information packs by some councils;
- agencies have increased their capacity to respond to cultural and linguistic diversity, including development of non-English publications and use of interpreter services;
- agencies more fully explain to clients their rights around privacy, confidentiality of information and making complaints. The agencies have developed more thorough and responsive privacy and confidentiality practices<sup>5</sup>;
- Service Coordination can improve the time required to complete intake and assessment;

<sup>5</sup> Improved performance in client privacy and confidentiality practices were similarly noted in the Australian Institute for Primary Care study *Evaluation of the Primary Care Partnership Strategy*, July 2002.

- reduced client waiting times for both initial information and direct service;
- the application of a single point of entry intake and assessment models have led to more consistent information being provided to clients as well as improved initial needs assessment;
- minimised risk of duplication within the assessment process, and discipline specific assessments can now focus on discipline only issues; and
- consistent intake and assessment processes have enhanced the accountability and transparency of decision making for eligibility and service access.

Of particular importance, these benefits provide the capacity to manage crisis events more effectively and to minimise the risk of deterioration to clients, both physically and psychologically, which can be experienced from delayed service responses.

### **3.2.1.2 Organisational benefits**

During the review Service Coordination was discussed by many agencies in the context of Service Coordination providing an “opportunity / catalyst / rationale” for the agency to undertake needed organisational reform. Those agencies cited a range of reasons why organisational reform was required, including:

- changing patterns of service were no longer reflected in how service teams were configured;
- changing patterns of delivery across disciplines (for example physiotherapy versus podiatry) requiring the agency to revisit how it both structured its operations and allocated resources to direct service provision;
- identified areas of operational inefficiency or poor practice; and
- the adoption of a continuous improvement culture.

The agencies also noted that changes undertaken during the implementation of Service Coordination cover both Service Coordination specific changes and organisational changes that the agencies would have undertaken regardless, and as a consequence separating the benefits of Service Coordination alone from benefits from other changes was problematic. For the purpose of this review the identification of Service Coordination costs and benefits is based on the agencies’ assessment of whether a cost or benefit is substantially related to Service Coordination as opposed to a cost and benefit that the agency would have incurred anyway responding to the above in the absence of Service Coordination.

Recognising the above, the operational outcomes that appear to arise substantially from Service Coordination are:

- improved documentation of the intake and assessment process. It was noted that those agencies operating within a PCP that had completed its PPPS had substantially more detailed process documentation;
- intake and assessment staff and direct service staff have developed a better understanding of the purpose and procedures for intake, assessment and referral;

***As a catalyst for change  
SC provides the means  
for agencies to tackle  
those issues they have  
been unable to change  
but they know will have  
a dramatic and positive  
benefit for clients and  
the local service  
system.....***

***KPMG Review***

- intake and assessment staff and direct service staff have developed a better understanding of their agencies' service structure and a whole of organisation culture (as opposed to silo based) is starting to emerge;
- administration and double processing of data has been substantially reduced in a number of agencies leading to either staff savings or increased time available for service delivery.

However, in a number of agencies adverse outcomes were noted regarding:

- the administrative burden created by Service Coordination Tool Templates, where either:
  - offsite assessment required greater amounts of administration (specifically where the agency does not use non-laptop computers);
  - increased paperwork where paper based as well as computer based files are required; or
  - Service Coordination Tool Templates requires an increased amount of data collection over pre-existing assessment forms (e.g. CIARR).

The agencies also noted that whilst referral practices had decreased the amount of time required for intake and assessment, an administrative task is still created by the need to key hard copy data into data systems. (This was also true in relation to e-referral where to date no agencies have a functional automated link between a receipt of the electronic format e-referral and their data systems).

In addition, a number of agencies also discussed organisational risks associated with Service Coordination where unless effective change management is in place the Service Coordination changes can potentially have an adverse impact on staff moral due to temporary heavier workloads, the challenge of changing roles, and lack of staff ownership and commitment to the Service Coordination model.

### 3.2.1.3 *Network benefits*

All agencies noted that they had developed a better understanding of their local primary health care networks and relationships between agencies had been strengthened. One agency noted however that this outcome is a natural consequence of PCP structures rather than Service Coordination specifically.

The agencies noted that:

- receipt of referrals in the Service Coordination Tool Templates have led to easier intake (if not necessarily assessment); and
- e-referrals systems have improved the transmission of data between agencies.

However, a number of adverse comments were also made, namely:

- network benefits can be slow to emerge as the benefits only arise when a large proportion of the network participates in Service Coordination;
- non-metropolitan agencies receive referrals from beyond their Service Coordination networks and in these cases it is hard to influence Service Coordination behaviours. This notably occurred in cases where rural patients receive acute services in metropolitan hospitals and subsequently receive post acute services within the local network.

***As part of Service Coordination the more effective use of IT, such as the use of e-referral systems, provide benefits not only to individual agencies but to local primary care networks....by expanding the numbers of agencies involved in these networks there is a greater potential for further benefit realisation.***

***KPMG Review***

The councils participating in the review also noted the high proportion of self-referrals they receive and hence the absence of network benefits associated with those types of clients. This problem was not so evident in the metropolitan CHSs, where e-referral systems are more advanced.

#### **Quantitative outcomes**

The following changes to assessment times were noted:

- one agency noted that the time it takes to carry out intake and assessment had decreased by an hour per client;
- another agency noted that where a Service Coordination Tool Templates based referral was received, assessment was reduced by 45 minutes;
- one agency noted that whilst the time taken to undertake an assessment had not changed that more time during the assessment was spent on the client rather than on data collection thus providing a

greater degree of client focus leading to improved assessment of client need; and

- one agency noted that its intake and assessment time had gone up due to the agency being more thorough in its intake and assessment and information provided to clients.

In contrast, fewer agencies achieved reduced waiting times with only one agency noting that its waiting lists had decreased from three months to five or seven weeks. Two of the councils noted that waiting lists for HACC services occurs post the intake and assessment phase and are driven by service availability rather than any Service Coordination process.

All of the agencies noted that they now respond to a client immediately, or within a half an hour of initial contact to one day of initial contact. This was seen as a significant achievement as previously clients may have waited several weeks to only be advised that they are actually ineligible for service.

It was noted by the review team that commonly agencies could not directly evidence the quantitative benefits that they receive due to lack of available data due to these measures not being measured by the agencies or due to agency data systems not recording these types of data.

***As a consequence of Service Coordination client response times have been dramatically reduced with all agencies reporting that they now respond to a client on the day of contact...this is a significant change on the way agencies operate....***

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### **3.2.3 Financial outcomes**

#### **3.2.3.1 Types of financial outcome**

Organisational reforms like Service Coordination can have a financial impact on an organisation in one of two ways, namely:

- a dollar impact – where actual expenditure or income changes; and
- a value impact – where the value of an activity may change but no dollar impact occurs to the organisation.

The following example illustrates the two types of financial impact:

- if a reform results in an organisation or a service unit purchasing more of resource (for example labour or consumables) the dollar impact of that reform is the cost of that extra purchase; and
- if in contrast, as the result of reform an organisation allocates resources differently between business units the net organisation wide financial cost of a reform is zero, however the value of resources consumed in a individual business unit may change as a result of less or more resource being consumed within that unit. The value impact of a reform is equivalent to the total change in value or resources consumed in business units effected by a reform.

In Service Coordination, a net value impact will only occur when value is transferred between a business unit involved in Service Coordination activity and a non-Service Coordination business activity, i.e. in organisations like councils that undertake activities separate from primary health provision.

This review attempted to identify the following financial impacts of Service Coordination:

- all dollar cost impacts from Service Coordination; and
- net value impacts occurring in business units involved in Service Coordination activity.

In some cases resources are reallocated within single business units (i.e. at no dollar or value costs) in order to achieve more efficient outcomes. Where these outcomes can be quantified by some quantitative measure (for example number of clients seen, or waiting lists) the costs and benefit of these changes is apparent. If however the reallocation is undertaken in order to build Service Coordination capacity an explicit outcome may not be apparent. In these cases the value of the capacity build (for example time spent on training) is recognised as a cost of Service Coordination in order that its impact is recognised and quantified in some way

Figure 3.2 provides an illustration of which financial costs are included in assessing the financial impact of Service Coordination.

**Figure 3.2: Financial costs of Service Coordination**

	Agency cost areas			Counted as an net Service Coordination financial impact
	Service Coordination units		Non Service Coordination units Other activities	
	Delivery of Services	Support of services		
Service Coordination creates new actual costs	Dollar impact			Yes
		Dollar impact		Yes
Service Coordination creates a transfer in value	+ Value ←	- Value		No – zero net Service Coordination cost
	- Value →	+ Value		No – zero net Service Coordination cost
	+ Value ←		- Value	Yes
Service Coordination creates a transfer in value that builds enduring capacity		- Value ↓ + Value		Yes – cost impact is value of purchasing capacity

**3.2.3.2 Costs reviewed**

None of the agencies participating in the review kept separate cost records on the cost of Service Coordination to the agency. As a result the review team had to build up a series of cost estimates based on:

- the agencies’ description of activities undertaken prior to, during implementation, and after the introduction of Service Coordination;

- the agencies' description of resources used in each of those periods; and
- valuation of that resource usage based on, either details of items of expenditure (for example the cost of a computer), or unit cost and unit usage information (for example gross hourly pay rates and estimates of hours worked on a task).

The costs reviewed fell under the following categories:

- implementation costs:
  - training and staff development – including costs of development of training materials, staff attending training, purchased training, and staff meetings;
  - temporary staff – including costs of staff coverage purchased during the implementation phase but excluding back fill costs (unless it resulted in an overtime payment);
  - planning and change management – including costs of management participating in Service Coordination activity within the PCP, development of new processes and procedures, and change management activities;
  - recruitment cost – costs of recruiting new staff (time and purchased services);
  - software and system processes – including costs of any purchased upgrades to IT packages, and internal IT services specific to the Service Coordination system; and
  - hardware – including costs of new computers and other infrastructure.
- operating costs:
  - staff costs – costs of new staff employed for intake and assessment;
  - staff costs – costs of reduced requirement for service staff;
  - other costs – including costs of marginal consumables used in Service Coordination activity, and the continuing participation in Service Coordination activity within the PCP.

Corporate overheads were excluded from the cost analysis because:

- each agency has a different overhead rate specific to that organisation, and inclusion of the overhead rates into the cost analyses could potentially obscure meaningful comparisons of the direct financial impact of Service Coordination across the agencies; and
- the impact of Service Coordination on an agency's wider overhead structure is likely to be quite small. As such, any changes in charging of corporate overheads would most likely represent an accounting cost change only, arising from changed recharging of existing costs rather than any increase costs incurred.

### 3.2.3.3 *Financial impact of Service Coordination*

Table 3.3 illustrates the financial impact of Service Coordination on each agency's financial position.

The following points are noted regarding the agencies' costs analyses.

#### *Implementation costs*

- Generally, the cost of the development and implementation of Service Coordination within an agency was between one and two percent of an agency's costs base. This appears to be independent of which Service Coordination model an agency has elected to adopt, the level of resources available from the local PCP to support the implementation of Service Coordination in an agency, and the level of technology investment made. The single exception to this rule is MSC where implementation cost four percent of annual operating expenditure – this variation is explained by MSC's smaller size and certain Service Coordination costs being semi-fixed.
- Service Coordination commonly requires that an agency invest up to \$3,000 to make its client data systems Service Coordination Tool Templates compatible.
- Those agencies that established a separate intake unit did not need to invest significant funds in additional IT hardware, however those agencies that are beginning to use laptops for remote data entry face significantly higher IT hardware costs. Whilst Service Coordination does not directly call for the use of laptops, the use of the Service Coordination Tool Templates drives the increased utilisation of laptops for off-site intake and assessment activity in order to minimise resultant higher levels of administration. As such the cost of laptops has been included as a financial cost of Service Coordination.
- CHSs spent significantly more funds on planning and change management than councils. This was because CHSs had to undertake greater levels of organisational restructuring to establish a centralised intake unit, compared to councils that did not need to restructure their services significantly to adopt Service Coordination.
- The level of training cost incurred by an agency appears to be independent of both the training model adopted or what type of services an agency provides. However it does appear that non-metropolitan agencies spend less on training. This is likely to be driven by the smaller size of non-metropolitan agencies and their lack of capacity to pay for proportionality larger amounts of training.

#### *Operating costs:*

- Net annual operating costs / savings of Service Coordination in all the agencies was less than two percent of an agency's operating cost base.
- However, the net costs incurred in Bass Coast Community Health Service (BCCHS) and Moyne Shire Council (MSC) were both less than one percent of those agencies' cost bases.

This may reflect a structural inability in the smaller agencies to finance larger increased costs due to less opportunity for funds switching.

- Service Coordination primarily affects an agency's labour costs. An exception to this rule may occur when an agency adopts an intake model based upon service staff working under a roster in an intake unit.
- The largest cost that an agency incurred as a result of Service Coordination was for the recruitment of additional intake workers. CHSs are particularly exposed to increasing labour costs as a result of them implementing a centralised intake model (none of the CHSs in the review was able to entirely offset the cost of new intake workers through a reduction in other staff). In contrast, councils providing HACC services operated an integrated intake model and hence did not incur significant additional labour costs.
- Both MVCC and WCC accessed net labour cost savings as a result of Service Coordination and a general rebalancing of their services. In both cases the savings achieved may have been achieved independently of Service Coordination due to reform of existing inefficient practices where the saving made came from a reduced need for team leaders and administration as a result of better allocation of work load.

#### *Break-even*

Service Coordination did not deliver net operating cost savings to CHSs. Both Whitehorse City Council (WCC) and Moonee Valley City Council (MVCC) accessed net cost savings from the reduction of staff and a reduced reliance on temporary staff. For these agencies the break even period for Service Coordination was four months and three years respectively. However, it is noted that both agencies stated that Service Coordination provided a rationale for a necessary rebalancing of their services and hence the cost savings and break-even position may not reflect the impact of Service Coordination alone.

#### *Sustainability of net cost / benefits achieved*

During the review all of the agencies indicated that they believed that changes to their operating costs are permanent and that any cost savings achieved would not deteriorate over time. This view appears likely because, with the exception of WCC, all labour cost changes are related to the permanent addition or removal of a staff position.

A significant proportion of cost savings in WCC were caused by a reduced reliance on temporary staff to clear a backlog of reassessments and billing. At present no such backlog is reoccurring so it appears that in the short to medium term at least the current level of costs savings will be sustained within that agency.

**Table 3.3: Financial impact of Service Coordination**

	BCHS	NCHS	WCHS	MVCC	WCC	BCCHS	PDH	MSC
<b>IMPLEMENTATION COSTS</b>	\$	\$	\$	\$	\$	\$	\$	\$
Training and staff development	49,073	5,989	11,018	19,487	1,950	21,321	13,260	12,330
Temporary staff	5,979					2,000		
Planning and change management	52,051	46,544	3,969	19,605	5,742	10,096	23,280	6,225
Recruitment cost		1,029	6,419					700
Software and system processes		900	1,859	2,400	3,000	1,296	5,000	1,500
IT Hardware		3,961	6,600	5,000	28,000	2,350	500	0
IT Undifferentiated capital investment	10,000							
<b>Total implementation cost</b>	<b>117,102</b>	<b>58,153</b>	<b>29,865</b>	<b>46,492</b>	<b>38,692</b>	<b>37,063</b>	<b>42,040</b>	<b>20,755</b>
<i>Total implementation costs as a percentage of total operating expenditure</i>	2 %	1 %	1 %	2 %	1 %	2 %	<i>not available</i>	4 %
<b>OPERATING COSTS</b>								
Staff costs - intake and assessment	79,532	48,000	109,391	(25,000)	(109,626)		60,000	
Staff costs - other staff			(49,255)					
Other costs	4,000			7,146	1,322	2,979		2,400
<b>Net change to annual operating costs Cost/(Saving)</b>	<b>83,532</b>	<b>48,000</b>	<b>60,136</b>	<b>(17,854)</b>	<b>(108,304)</b>	<b>2,979</b>	<b>60,000</b>	<b>2,400</b>
<i>Total Service Coordination operating costs/(saving) as a percentage of total operating expenditure</i>	1 %	1 %	2 %	(-1 %)	(-2 %)	0 %	<i>not available</i>	0 %

### 3.3 Benefits and the Better Access to Services (BATS) framework

The outcomes cited in the previous sections have been identified as arising from the implementation of Service Coordination within the agencies.

The design and application of Service Coordination within agencies, and across PCP's, is driven by DHS's BATS policy and operational framework. This framework is designed to promote processes that are more responsive to consumer needs, build understanding about a person's needs, and assists the formation of informed decision making about responding to those needs. The key component of BATS is Service Coordination which promotes the development and use of common tools and templates that agencies use for client registration, initial needs screening, care planning and referral processes.

Whilst acknowledging that Service Coordination models will vary between agencies and between PCPs, the BATS policy and framework identifies a series of key features (outcomes) that should occur in an agency's Service Coordination model.

Table 3.4 maps the key features of the BATS model, as described in the framework and policy against the outcomes achieved in particular agencies.

**Table 3.4: BATS outcomes in selected agencies**

BATS Element	Feature (outcome) L = Low, M = Medium, H = High	BCHS	NCHS	WCHS	MVCC	WCC	BCCHS	PDH	MSC
Initial contact	Client access to service information regarding entire local network	H	H	H	M	M	L	L	M
	Client access to service information regarding agency	H	H	H	H	H	H	M	H
	Staff capable of communicating the range of services and information available	H	H	H	H	H	H	M	H
	Recording of basic client information	H	H	H	H	H	H	H	H
	Provision to clients of information about processes	H	H	H	H	H	M	M	H
	Provision to clients of information about their rights and responsibilities	H	H	H	H	H	H	M	H
	Utilisation of common IC tool	H	H	H	H	H	H	H	H
	Facilitation of direct access to INI	H	H	H	M	M	H	M	M
Initial needs identification	Processes and practices that identify clients need	H	H	H	H	H	H	M	H
	Process and practices that identifies urgency, risk an priority for access to services	H	H	H	M	M	H	M	M
	Staff with knowledge of service system	H	H	H	H	H	H	L	H
	Staff with experience in needs identification	H	H	H	H	H	H	H	H
	Collection of core consumer information	H	H	H	H	H	H	H	H
	Utilisation of common INI tool	H	H	H	H	H	H	H	H

BATS Element	Feature (outcome) L = Low, M = Medium, H = High	BCHS	NCHS	WCHS	MVCC	WCC	BCCHS	PDH	MSC
Assessment and care planning	Builds on IC-INI	H	H	H	H	H	H	H	H
	Coordinated referral processes	H	H	H	M	H	L	H	H
	Referral response within appropriate timeframes	H	H	H	H	H	H	H	H
	Feedback loops to referrer	H	H	H	L	H	L	H	H
Consumer focus	Allows clients to make informed decisions about agency and network services	H	H	H	H	H	M	M	H
Consumer focus (cont'd)	Responsive to client diversity	H	M	H	H	H	L	L	L
	Responsive to clients circumstance including urgency	H	H	H	M	M	H	M	M
	Avoidance clients experiencing duplicative practices	H	H	H	H	H	M	M	H
	Informs clients of their rights – to complain	H	H	H	H	H	H	M	H
	Informs clients of their rights – to privacy and confidentiality	H	H	H	H	H	H	H	H
Competent staff	Staff appropriately skilled, qualified, and experienced.	H	H	H	H	H	H	H	H
	Staff appropriately supported	H	H	H	H	H	H	L	H
Protection of consumer information	Improved information management processes	H	H	H	H	H	H	H	H
	Client consent is obtained	H	H	H	H	H	H	H	H

It should be noted that:

- the rating scale used above presents a relative measure between agencies; and
- a low or medium rating for one agency in comparison to another agency does not imply a failure by an agency to fully develop a feature of the Service Coordination model.

Variations in outcomes achieved by the agencies are driven by each agency’s specific strategic priorities and external factors unique to that agency (such as networks or client population).

For example, one of the features of the Service Coordination model is that it should be responsive to client diversity. In the table above each of the rural agencies have been given a low rating against this feature, however this low rating is made whilst recognising that client diversity is lower in rural environments, whilst in some metropolitan environments agencies may have to respond to extreme variations in client issues and client background. For example, a number of the metropolitan agencies reviewed have developed extensive policies for dealing with differing CALD backgrounds.

## 4 Factors influencing success

This section provides details of the key factors that impacted upon the agencies achieving the Service Coordination outcomes set out in Section 3 and the influence of those factors on different agencies.

The characteristics listed below have been identified as important, and as having influenced the effectiveness of individual agency Service Coordination. The core factors identified are not listed in order of importance. Various characteristics were more important than others in different agencies. Table 4.1 summarises the impact of these factors from each agency's perspective.

**Table 4.1: Summary of factors influencing success**

Characteristic	Relative Rating Scale	BCHS	NCHS	WCHS	MVCC	WCC	BCCHS	PDH	MSC
<b>LOCATION IN STATE</b>									
Distance from Metro health network	L: Low M: Medium H: High	L	L	L	L	L	M	H	H
Local health infrastructure density	L: Low H: High	H	H	H	H	H	L	L	L
Need to decentralise services in response to distance issues (and public transport availability) for clients	L: Low M: Medium H: High	L	L	L	L	L	H	M	H
<b>IT INFRASTRUCTURE AND RELATED NETWORKS</b>									
SC Tool Templates compliant packages	Y: Yes N: No	Y	Y	Y	Y	Y	Y	Y	Y
E-referral system in place	Y: Yes N: No	N	N	Y	Y	Y	N	Y	Y/N
Functional link between data systems and e-referral	Y: Yes N: No	N	N	N	N	N	N	N	N
Access to dominant rural ICT network	Y: Yes N: No	-	-	-	-	-	N	Y	N
Poor quality of local public telecommunications	Y: Yes	-	-	-	-	-	Y	-	-
<b>PCP AND NETWORKS</b>									
PPPS finalised	Y: Yes N: No	Y	Y	Y	Y	Y	N	N	N
Influence of PCP in influencing Service Coordination development in PCP catchment and Agency	L: Low M: Medium H: High	H	H	H	H	H	L	M	M
Influence of region wide networks in influencing Service Coordination development in PCP and Agency	L: Low M: Medium H: High	L	L	L	H	L	M	M	M
Joint PCP partnerships	Y: Yes N: No	N	N	N	Y	N	N	Y	Y
<b>CHANGE MANAGEMENT</b>									
Use of change management strategies to implement Service Coordination	L: Low M: Medium H: High	H	H	H	H	H	H	L	M

Characteristic	Relative Rating Scale	BCHS	NCHS	WCHS	MVCC	WCC	BCCHS	PDH	MSC
Impact on pre-existing services model	L: Low M: Medium H: High	H	H	H	L	L	H	L	L
<b>CHAMPION FOR CHANGE</b>									
Presence of Service Coordination Leader/Champion	L: Low M: Medium H: High	H	H	H	H	H	H	M	H
Perception of Service Coordination as part of wider business reform	L: Low M: Medium H: High	M	M	H	H	H	H	M	M

The influence of each of these factors is described in the following sections.

## 4.1 Location in state

Nearly all services in Victoria, whether health services or general infrastructure services, are provided within radial networks where the service stream radiates outwards from metropolitan Melbourne. This has two implications, namely:

- where services are based around large pieces of infrastructure (for example hospitals), these services are not fungible (i.e. dividable into smaller parts which can be distributed around the network), hence these services are provided from fewer locations and these locations occur more frequently towards the centre of the network and less frequently away from the centre of the network; and
- towards the ends of the network both population and services density becomes increasingly low.

As a result, the location of the primary health care network within the state may influence:

- whether general services required by a resident population can be sourced entirely from within the local network, or where the population has to source services from beyond the local service system area (and typically has to move closer to the network centre); and
- the size and number of services within a local network, where in the more distant areas there are likely to be fewer and smaller providers in a network serving a smaller population over a wider area.

### 4.1.1 Impact of location on rural Service Coordination

The influences outlined above have an impact on how Service Coordination can be undertaken within an agency.

Table 4.2 summarises the potential effects that a rural network's location may have on its capacity to undertake Service Coordination.

**Table 4.2: Locational effects acting on rural Service Coordination**

Rural PCPs (Distal networks)
Referrals occur from providers beyond network boundary who may operate to different protocols and procedures.
Poor standards of public and private ICT infrastructure can adversely effect the capacity of an agency to undertake Service Coordination.
The requirement to provide services from multiple locations may impact the capacity of an agency to operate enterprise wide IT based systems, including centralised processes critical to Service Coordination (e.g. diaries and scheduling).
Providers in rural networks may have lower capacity to undertake Service Coordination because of their generally smaller size. However, this may be offset by there being fewer number of providers so local networking may be more effective.

PCPs solve the first two of these problems by adopting or participating in larger networks, for example:

- South Coast HSC's (BCCHS) inclusion within Better Health Care in Gippsland and Gippsland Health Alliance; and
- the alliance between South West PCP (MSC) and Southern Grampians Glenelg PCP (Portland District Health) and the regional use of SWARH.

The downside of larger networks is that the design of the networks' systems may be driven by objectives other than Service Coordination or local service issues (for example the SWARH has a strong medical focus and is not directed at councils). This can have an adverse impact on an agency achieving local Service Coordination objectives.

Local public ICT infrastructure should not normally be an issue other than at the most distant parts of the infrastructure networks. BCCHS's problems with broadband connection reflect the location of San Remo. In most agencies this would not occur.

## 4.2 IT infrastructure and related networks

The capacity of an agency to implement Service Coordination is effected by:

- its internal IT capacity; and
- the IT capacity of the regional network, including e-referral.

#### 4.2.1 Agency IT capacity

There are a wide range of IT packages used across the primary health care system to record clients' data. For example, in a report by the Department's HACC Data collection and Analysis Team<sup>6</sup> 16 different packages used by agencies providing HACC services were identified.

The following factors will influence the costs and benefits that arise from implementation of Service Coordination in an agency:

- whether the package can record data in fields defined by Service Coordination Tool Templates;
- whether the package data entry system can be configured to mimic Service Coordination Tool Templates;
- whether the package is able to generate reports in, paper or data form, either:
  - containing the Service Coordination Tool Templates fields; or
  - within the Service Coordination Tool Templates format;
- whether the package can be used to remote record data and down load into the main data base at a later time; and
- whether the package is able to interface automatically into other systems (for example e-referral) for the automatic transfer of client data.

Each of the above elements provides increasing Service Coordination functionality to the agency and the potential to minimise service and administration costs. During the review it was noted that the development of messaging standards will have a dramatic impact on data management efficiency as they will close the link between different agencies' IT systems and eliminate the current administration burden of re-keying e-referral data.

Each of the review agencies have Service Coordination Tool Templates compliant packages capable of the above elements up to generating hard and soft copies of Service Coordination Tool Templates. Upgrading of existing packages to this level of functionality costs up to approximately \$3,000. However, it is noted that this review only evidenced four packages being used in the review agencies - the costs of upgrading for other packages may be different.

Only one agency had implemented use of remote laptops, which reduced administration and increased the thoroughness of assessment, at the cost of approximately \$3,500 per laptop.

During the review agencies noted three particular deficiencies in their IT environments:

- no agency has yet achieved a functional link between their packages and e-referral systems, which limits the capacity of agencies to maximise network efficiencies and eliminate duplication of effort;

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<sup>6</sup> *Comparative guide to HACC software products in Victoria*. Department of Human Services. April 2004

- there is low levels of connectivity between the acute system and the primary care agencies;  
and
- the agencies' data systems are primarily used to record client data. Generally, either the agencies do not use the systems to provide performance data through which they can measure the impact of Service Coordination on service standards, or the systems are not able to produce that type of data.

These limitations potentially limit the further implementation of Service Coordination and its linkages to the wider non-Service Coordination participating health services system.

Table 4.3 provides summary information on the status of each agencies IT environment.

**Table 4.3: Agency and regional IT capacity**

Agency	IT clients records system	E-referral	Networks and external infrastructure
Banyule Community Health Service	SWITCH		Member of Banyule-Nillumbik PCP
Bass Coast Community Health Service	SWITCH	Gippsland Health Alliance is developing infrastructure that will become the platform for e-referral system. BCCHS has initially opted out of the program due to broadband connectivity problems into San Remo. BCCHS looked at local email based referral system with Wonthaggi Medical Group but did not implement due to problems with public key (PKI) encryption.	Member of - South Coast HSC PCP. - Better Services in Gippsland for the development of regional protocols and practices between primary health care providers, hospitals and general practitioners, building on work of PCPs, Div'ns of GP, and hospital discharge and admission plans. - Gippsland Health Alliance development of regional broadband for hospitals and eligible primary care providers.
Moonee Valley City Council	Sharikat-Khoo	MVCC makes and receives e-referral through connectingcare.com	Member of: - Moonee Valley – Melbourne PCP - connectingcare.com provides e-referral systems covering all PCPs in the Grampians, Loddon-Mallee and (former) Western Region.
Moyne Shire Council	Carelink	Participant in e-referral trial of encrypted e-mails from South West Alliance of Rural Health (SWARH). Non-participant of SWARH so not able to send e-referrals.	Member of: - South West PCP - South West PCP in joint operation with Southern Grampians – Glenelg PCP - <i>Not a member SWARH.</i>
Nillumbik Community Health Service	SWITCH		Member of Banyule-Nillumbik PCP.

Agency		IT clients records system	E-referral	Networks and external infrastructure
Portland Health	District	PJB Data Manager	Full participant in SWARH e-referral system.	Member of: - Southern Grampians – Glenelg PCP - Southern Grampians – Glenelg PCP in joint operation with South West PCP - Member of SWARH.
Whitehorse Council	City	Sharikat-Khoo (SKK) (Laptops used for offsite processing of IC/INI and electronic download into Sharikat-Khoo)	CEPCP e-referral system operated by Info-exchange.	Member of CEPCP.
Whitehorse Community Service	Health	SWITCH	CEPCP e-referral system operated by Info-exchange.	Member of CEPCP.

### **4.2.2 Regional IT capacity**

Different PCPs (and wider networks) have developed different levels of IT capacity.

These include:

- web pages containing a library of information to support an agency in its Service Coordination activity;
- access to local services directories and participation in development of the state services directory; and
- e-referral systems.

Most of the PCPs of the agencies in the review had developed the above, except:

- BCCHS – South Coast HSC did not have a local services directory due to a contract problem with a supplier and had elected out of the regional e-referral program due to local infrastructure problems. Each of these problems were beyond BCCHS's control.
- MSC was only a part participant in the local e-referral program because it is not a member of SWARH and could only receive e-referrals sent from SWARH but not refer back out.

In both cases the absence of a e-referral capacity was not considered detrimental to the current potential for the agency to maximise Service Coordination benefits, because:

- the absence of capacity to link e-referrals directly into software systems means that an e-referral receipt has the same functionality as a fax referral (as all information has to be entered into the client system), which the agencies already handle; and
- in the case of MSC it is primarily a recipient of referrals.

However, it is noted that when the messaging systems that connect e-referral to client software systems are introduced e-referral should begin to deliver considerable savings in reduced duplication and rural network issues.

It is expected that this issue will also become more important as PCPs develop agreed e-referral protocols between local GPs and the Acute Sector.

## **4.3 PCP input**

The PCPs played a critical role in providing:

- resources, particularly training and IT support;
- development of PCP wide PPPS;

- advice on governance, service planning and strategic issues; and
- information and discussion forums for staff at various levels,

for agencies implementing Service Coordination. The absence of the first two points in particular appeared to have an adverse impact on the success of Service Coordination within an agency as:

- the agency does not have a blue print for change; and
- the changes adopted by an agency may only provide internal benefits rather than wider network benefits as well.

This appeared to be the case in:

- the South Coast HSC where a common PPPS had not been developed and the PCP appeared to be in transition into the wider Better Health Care in Gippsland program. As a result the changes made in BCCHS were focused primarily on internal services efficiencies and organisational change. (It is stressed these alone provided BCCHS a return from undertaking Service Coordination reform); and
- MSC where changes were focused on client information practices because:
  - the scope for network efficiencies were limited due to SWARH's emphasis on the medical sector; and
  - the current low levels of Service Coordination practice in the network.

In contrast, both MVM PCP (through the WMR BPM) and CEPCP had developed and issued their PPPS, which the member agencies could use as a road map for the design of changes to be made. In the case of MVCC and WCC these resources acted as the change management tool for wider organisational reform.

Interestingly, the cost of Service Coordination implementation in both MVCC and WCC were less than the cost in BCHS and NCHS where the agencies undertook Service Coordination without a PCP PPPS but with implementation support from the PCP staff and guidance from external PPPSs.

#### **4.4 Position on local network**

The position of an agency on the primary care network may influence what types of benefits are achieved. There are two broad types of agency defined by network position:

- a recipient of referrals; and
- a generator and recipient of referrals.

Councils providing HACC services identify themselves as principally being recipients of referrals, where the majority of their referrals received are from self-referral and the acute system. As such, network benefits available from Service Coordination to councils whilst present may be comparatively less than that available to community health centres and as a consequence the emphasis on Service Coordination within a council may focus more on activities that give benefits directly rather than as part of a network.

These may include:

- better data collection practices;
- better understanding and relationships with clients; and
- staff engaged in improving quality of intake and assessment services to clients, for example information and empowerment.

In contrast, CHSs have higher levels of referrals between primary health care agencies and generate significant numbers of referrals. As such, CHS agencies encounter a greater incentive to focus on activities that address the capacity of the network as well as focus on internal activities.

Consequently, in addition to the activities listed above, CHSs appear to place additional focus on:

- e-referral; and
- better coordination of referral practices with the post acute system and local GPs.

## 4.5 Change management

A number of agencies indicated that for the introduction of Service Coordination to be successful it needed to be clearly seen as a change management process. This meant that agencies needed to be cognisant of the need to manage the change process, in particular staff and key stakeholders. By seeing it as a change process many agencies were able to use the introduction of Service Coordination as an opportunity to undertake a timely review of their practices and organisational structures. A number of agencies implemented a change process that included:

- a consultation program with staff, board of management and other key service providers;
- involvement of staff in any system design;
- involvement of staff in policy review and development;
- discussions with other providers around system changes, in particular intake and referral forms and data collection processes;

- monitoring and responding to any perceived changes in staff morale; and
- transparency of decision making with regard to resource allocation.

By managing the introduction of Service Coordination as a change management process, ownership by staff of new systems and procedures was able to be achieved.

It is noted that workforce development and change management are closely related and that in those agencies which achieved significant outcomes from Service Coordination, significant and continuing staff participation was an essential element of the change processes and that participation was essential to develop staff and agency capacity to undertake Service Coordination.

#### **4.6 A champion for change**

The presence of a key person ‘championing’ the cause of Service Coordination was fundamental to the effective establishment and implementation of the program. Having someone with strong leadership skills (generally the CEO) who could harness the energy and drive of staff, market the benefits of Service Coordination to staff and other agencies, and convince the Board of the merits of the program, was influential in determining how quickly Service Coordination was accepted/established, and the perceived value of Service Coordination by staff and the Board.

The change agent, as a key driver of change, was most successful if he or she harnessed the skills of staff, and provided them with the authority to be innovative.

This factor was an often-cited feature of a successful local program.

#### **4.7 Summary**

Most agencies ultimately rated Service Coordination as of considerable benefit to their organisation. In the main the presence or not of different elements described above did not have significant varying influence on the overall success or not of Service Coordination for each agency. However, those agencies that did not take a change management approach nor have a champion for change present rated the success of Service Coordination slightly lower than other agencies.

## **A Whitehorse City Council**

### **A.1 Service profile**

Whitehorse City Council's (WCC) Aged and Disability Services Unit provides the following services:

- Disability Services:
  - Recreation and Social Support;
  - Planned Activity Group;
  - Assisted Transport;
- HACC services:
  - Assessment;
  - Personal Care;
  - Home Care;
  - Visiting nurses;
  - Respite;
  - Linkages;
  - Property Maintenance;
  - Community Transport;
  - Delivered Meals (Meals on Wheels); and
- Residential care.

WCC delivers the above services through four teams:

- Disability;
- HACC;
- Food Services; and
- Residential Care.

The Aged and Disability Services Unit comprises 291 employees (approximately 180 FTE) and 350 volunteers (primarily in Meals on Wheels).

This review concentrates on the impact of Service Coordination on the HACC team's operations.

### **A.1.1 HACC service structure**

WCC's HACC team provides HACC services within the WCC LGA. For service delivery, the LGA has been subdivided into four Regions (A, B, C, and D) where each Region is staffed by a service team comprising:

- two in-home support coordinators;
- an administration officer; and
- service staff, comprising personal carers, home carers, home maintenance workers, and nurses.

The coordinators and administration officers are all located at WCC's Nunawading office.

### **A.2 Client base**

WCC's HACC team provides HACC services to the residents of the WCC LGA.

During the review, WCC described the following characteristics in its client population:

- approximately 25 percent of WCC's residents come from cultural and linguistically diverse backgrounds. WCC has an interpreter service available to assist its Aged and Disability Services clients to translate council information or assist with enquiries and provides information in English, Chinese, Greek, Italian, Vietnamese and German;
- the WCC resident population is aging; and
- despite perceptions that WCC is a relatively affluent suburb the LGA does contain clusters of socio economic disadvantage and public housing.

Table A.1 provides demographic profile of the agency's catchment from the ABS based on 2001 census data. This profile is consistent with WCC's comments.

**Table A.1: Agency LGA Demographics<sup>7</sup>**

Agency Catchment	Whitehorse City Council LGA, covering Box Hill, Blackburn, Nunawading, Burwood and Vermont
Total population	139,549
Age profile	Population 0 – 19 years – 24 percent Population 20- 39 years – 29 percent Population 40-59 years – 26 percent Over 60 years – 21 percent (Victorian average 16 percent)
Country of Birth	Australia – 72 percent UK – 5 percent China – 3 percent Greece – 2 percent Italy – 2 percent Other – 16 percent Victorian average: 19 percent from non English speaking countries
Annual individual income	\$1 - \$6,240 – 9 percent \$6,240 – \$15,600 – 28 percent \$15,600 - \$26,000 – 17 percent \$26,000 - \$36,400 – 15 percent \$36,400 - \$52,000 – 15 percent \$52,000 - \$78,000 – 10 percent \$78,000 or more 6 percent Average annual income \$24,100 (Victorian State average income \$21,395).
Household type	Family household – 71 percent Lone person – 25 percent Group household – 4 percent
Family types	Couple with children – 47 percent Couple without children – 37 percent Single parent family – 14 percent Other family – 2 percent
Occupied private dwelling tenure	Fully owned – 51 percent Being purchased – 27 percent Renting – 20 percent Other – 2 percent

### A.3 Service demand

WCC receives approximately 1650 HACC referrals per year and at any time has between 2,800 to 3,200 active clients receiving HACC services.

Each year WCC provides approximately:

- 120,000 hours of home care;

<sup>7</sup> Census 2001. Australian Bureau of Statistics

- 70,000 hours of personal and respite care;
- 29,000 hours of other HACC services;
- 42,000 hours of disability adult day care and social support;
- 142,000 meals; and
- 18,000 transport trips.

### **A.3.1 Source of service demand**

WCC is primarily a recipient, rather than a generator, of referrals. A sample report<sup>8</sup> from the Central Eastern PCP's e-referral system (described below) indicates that WCC receives approximately eight and a half more referrals from its e-referral partners than it makes.

Analysis of WCC's entire population of referral received<sup>9</sup> (e-referral and non-e-referral) indicate:

- clients on average are each referred for on average 1.9 different services;
- referral source - percentage of requests for services:
  - self referral – 39 percent;
  - friend or family – 17 percent;
  - Peter James ACAS and rehabilitation providers – 15 percent;
  - hospitals (Box Hill Hospital (the LGA's main public hospital) and others) – 15 percent; and
  - GPs – 2 percent.

These figures are supported by a client survey, which found that 53 percent of clients were not referred by another service provider.

- percentage of requests for services:
  - additional assistance and social support – 30 percent;
  - meals – 13 percent;
  - home care – 12 percent;

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<sup>8</sup> E-referral activity for week ending 6 April 2004.

<sup>9</sup> Referral data for the period 1 July 2003 to 11 June 2004. WCC Sharikat-Khoo database.

- home maintenance – 12 percent; and
- personal care – 6 percent.

## **A.4 Primary Care Partnership context**

### **A.4.1 PCP status**

WCC is a member of the Central Eastern PCP, which covers Monash, Whitehorse, and Manningham LGAs in Melbourne's inner east.

The Central East PCP was established in March 2001 to promote and facilitate excellence in the planning, organising and delivery of primary health care services to the community within the PCP catchment. At least 80 percent of the community within the PCP catchment is expected to use or have some contact with primary health services in each year<sup>10</sup>.

At the time of the review the following Service Coordination activities at the PCP level have been completed or are in progress:

- participation in DHS referral tool trials (superseded by Service Coordination Tool Templates);
- development of Service Coordination practice manual, incorporating:
  - rationale for Service Coordination within Central Eastern PCP;
  - design of Central Eastern PCP Service Coordination model;
  - definition of Practices, Processes, Protocols and Systems (PPPS), covering:
    - Initial Contact (IC);
    - Initial Needs Identification (INI);
    - referral; and
    - care planning.

Within the PPPS, process objectives, intended consumer outcomes, quality indicators, process maps, good practice examples and guidelines, system tools and linkages to external requirements (policy and funding) are identified for each process;

- mapping of consumer pathways through Service Coordination model;
- information for agency professional development and training;

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<sup>10</sup> Community Health Plan, June 2002. Central Eastern PCP

- information for monitoring and continuous improvement;
- development of PCP web site incorporating:
  - links to service directories;
  - electronic copies of PCP and DHS documentation and resources;
  - news, including details of meetings, training, forums and other events;
- a CD based resource (incorporating the above) for non-internet connected personal computers;
- trailing and implementation of a web based e-referral system (sourced from Infoxchange). The e-referral system currently has ten participating agencies, of which the major participating agencies are:
  - senders of referrals - Peter James ACAS, Box Hill Hospital and Monashlink CHS; and
  - recipients of referrals – Monash City Council, WCC, Monashlink CHS, Whitehorse CHS, and Peter James ACAS.

#### **A.4.2 PCP location and staff**

Central Eastern PCP rents office space within WCC's Nunawading offices adjacent to WCC's Aged and Disability Services Unit.

The PCP is staffed by three members:

- the PCP Manager;
- a Service Coordination worker; and
- a consultant for the development and roll out of the PPPS.

During the review, members of the PCP identified that one of the strengths of Central Eastern PCP was that the three PCP staff had remained the same from the commencement of SC.

The role of the PCP has been to:

- provide the driving force behind, and act as a resource for, the development of the initiatives outlined above;
- work with PCP committees comprising members of the PCP to develop and control the direction of PCP activities; and

- act as a resource (training and advice) during the implementation of initiatives for the individual PCP members.

#### **A.4.3 WCC involvement in PCP activities**

WCC's input into the development of Central Eastern PCP's approach to Service Coordination has occurred through the participation by the Manager for Aged and Disability Services in:

- PCP governance committee;
- Central Eastern PCP set-up meetings;
- PCP INI - Service Coordination Tool Templates development; and
- Central Eastern PCP Service Coordination Sub-Committee.

At the implementation of the PPPS within WCC, the agency accessed training time funded by the PCP and delivered by the PCP's consultant (agencies within the PCP were given the choice of taking this training or receiving an equivalent value sum of money from the PCP).

### **A.5 Agency's Service Coordination experience**

#### **A.5.1 Strategic background**

WCC has a three-year corporate plan and annual business plan that set the strategic direction for WCC. These plans set a number of objectives that are relevant to the implementation of Service Coordination by the Aged and Disability Services Unit, namely:

- work in partnership with other service providers and community groups;
- respond to community issues and needs; and
- deliver quality<sup>11</sup>.

However, the plans do not specifically include participation of WCC in Central Eastern PCP or in Service Coordination as identified actions.

Instead, the Aged and Disability Services Unit develops and implements programs like Service Coordination or best practice programs at the Unit level through the Manager Aged and Disability Services guided by the WCC's general planning context. The unit does not produce a specific Aged and Disability Services plan. (The review team was told that such a plan may potentially be produced in the future).

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<sup>11</sup> Council Plan 2003 – 2006. WCC.

Other than the objectives expressed within WCC's general strategic direction, the key drivers behind WCC's adoption of Service Coordination comes from:

- the mandated requirement associated with WCC's HACC funding to participate in the PCP and adopted Service Coordination initiatives such as Service Coordination Tool Templates; and
- the need in 2001 to 'rebalance' WCC's services, where operations did not reflect underlying patterns in service demand or minimise inefficient operational practices.

The Manager of Aged and Disability Services advised the review team that the WCC executive has adopted a hands off approach and been prepared to let the Unit get on with managing how Aged and Disability Services are planned and delivered (subject to budgetary limits).

### **A.5.2 SC processes**

Within WCC the main operational impact of the PCP and Service Coordination has been the adoption of PPPS practices in its intake and assessment functions (including adoption and use of the Service Coordination Tool Templates in accordance with the DHS Service Coordination Tool Templates guidelines) and adoption of new referral practices.

#### *Intake and assessment*

The main features of WCC's intake and assessment model are as follows:

- Aged and Disability Services receives an enquiry for services at a single point of contact. An administration officer filters the initial contact to ensure that the contact has come to the correct location, whether the contact is a request for information or services. If the enquiry is a request for services an appointment for an in-home support coordinator is made to visit the potential client to undertake the INI;
- one of the relevant area's two in-home support coordinators makes a visit to undertake an assessment. Each in-home support coordinator has a lap top computer that holds a template version of the Service Coordination Tool Templates which the coordinator completes whilst undertaking the assessment;
- during the assessment the potential client receives an information pack that provides information regarding:
  - the basis under which services are delivered;
  - service pricing;
  - relevant contact numbers (for both WCC and other services providers);
  - information on privacy and a consent form; and

- a task list and service summary form for completion during the assessment so that the clients is fully informed regarding the range of services to be provided, the frequency of services and the cost of services.

In addition the coordinator also completes a check list to ensure that all assessment and information items are completed (covering the above and other issues such as waiting lists, OH&S, EEO, and complaints procedure); and

- on return to the office the information in the coordinator's laptop is down loaded into WCC's client management system (Sharikat-Khoo) and any additional hand written notes are entered by the administration assistant and any services that were agreed with the client are arranged.

### *Referral*

Where WCC needs to make a referral to another service provider the referral can be either by:

- e-referral, where electronic Service Coordination Tool Templates forms can be generated by Sharikat-Khoo and attached to a referral on the Central Eastern PCP's e-referral system ; or
- fax, where the Service Coordination Tool Templates forms are printed from Sharikat-Khoo and faxed to the recipient.

When WCC receives an e-referral there is not an interface between Central Eastern PCP's e-referral system and Sharikat-Khoo so the referral is manually processed into Sharikat-Khoo as part of the initial contact process.

### *Changes to processes*

WCC's did not change its core intake and assessment activities as a result of SC. Broadly the key roles and activities of staff haven't changed, where previously:

- WCC received requests for services or referrals;
- all assessments were undertaken by coordinators Intake and Assessment: Service Coordinators visited referred clients and undertook manual client assessments using the Client Information and Referral Record (CIARR). Assessment data was then keyed into the Whitehorse City Council data system by administration staff;
- administration support was provided to the coordinators; and
- services were provided by service staff.

However, Service Coordination provided the rationale for WCC to respond to the drivers for change identified above, resulting in:

- changes to re-organise its operations on a more rational basis, where:

- PPS processes allowed WCC to reduce the number of administration workers by two;
- the balance between areas covered by coordinators and level of work required in each area, and hence undertaken by each coordinator, was spread more equitably. (Previously some coordinators had double the referral load of others);
- the provision of improved support to WCC staff, where the PPS provides:
  - clarity of purpose;
  - information for agency professional development and training;
  - information for monitoring and continuous improvement;
- changes to technology to streamline and reduce redundant activity, where:
  - the introduction of lap tops and linkages between laptops, Sharikat-Khoo and e-referral for coordinators has eliminated manual completion of forms and reprocessing of information by administration;
  - reduced paperwork;
  - wider range of data collection for both service and organisational uses;
- enhancement of processes to make them more client centric, where as a result of the way WCC works with clients, the clients are:
  - more fully informed and involved about the intake and assessment process and the services they receive; and
  - receive greater assurance regarding issues of data confidentiality and privacy.

## **A.6 Outcomes of SC**

This section sets out the identified outcomes of the Service Coordination and related business changes.

It is noted that within WCC the Service Coordination changes occurred in the context of a wider rationalisation of business organisation and practices and that some of the changes noted (and resultant benefits) may have been achieved even if Service Coordination had not been adopted. For example, WCC had already developed a business case for use of laptops during assessment prior to Service Coordination being adopted. In many cases, this report is not able to differentiate between exclusively Service Coordination costs and benefits and other costs and benefits associated with the rationalisation of operations. The following outcomes noted should be read in the context of that limitation.

### *General outcomes and assessment*

During the review WCC expressed positive views that Service Coordination and its other business changes were achieving the objectives established for them.

Of the following general objectives:

- achieve better (service) outcomes for members of WCC's community;
- enhance links with other providers in area; and
- provide better levels of support for its staff,

the Manager of Disability and Aged Care made an informal assessment that the objectives were over 80 percent met. However, she also noted that the benefits the changes will continue to emerge over the immediate future. In particular she noted:

- "... WCC [staff] still has some way to go [in learning]... that clients are centric to the way we do things.";
- "... WCC staff still need to understand better the way the service system hangs together.";
- and
- network relationships were still developing.

The Manager of Disability and Aged Care expressed the view that Service Coordination has had a central role in being a catalyst for changes within the business and the outcomes achieved.

The following sections identify specific outcomes arising from SC. All dollar values shown in the following sections are shown in greater detail in Tables A.2 and A.3

### *Service delivery*

- WCC has reduced the average time taken to undertake an assessment by an estimated half an hour to one hour per assessment.
- WCC has reduced the total time spent processing a client in intake and assessment from two and a half hours to one and a half hours.
- SC has not effected the number of new clients it processes per year (1,440).
- Two less administration officers are required for intake and assessment support, due to the efficiency savings noted above. (Cost saving accessed - \$76,000 per annum).
- WCC no longer has to employ additional staff to catch up on the backlog of annual re-assessments undertaken with existing clients. (Cost saving accessed - \$15,018 per annum).

- WCC no longer has to employ additional staff to catch up on backlogs of client billing. (Cost saving accessed - \$15,960 per annum).
- Coordinators currently spend a third of their week on assessment, compared to previously one eighth of their time. (Benefit of time released - \$89,741 per annum).

Note: the value of the coordinators time released to undertake assessment is notionally offset by the marginal cost savings noted in the two preceding points – however in practice cost savings from redirected activity are not included in calculating actual real savings as the benefit of time released is offset by an identical loss of benefit on alternate activities.

#### *Service response and clients*

- SC has not impacted on clients' waiting time for services, where the average waiting times of between 7 days and 21 days is driven by the capacity of WCC to schedule new client services into existing service timetables.
- SC has meant that clients either receive an assessment or are contacted within 24 hours of the initial contact.
- Clients receive more information at assessment (a client survey showed 84 percent of clients at assessment received information they believe they need).
- Clients are increasingly satisfied with service outcomes, indicated by:
  - client complaints reduced from approximately 40 complaints per month to five per month;
  - 100 percent of clients in client survey said they were satisfied with the services they are referred to; and
  - WCC's general home care clients showed a 82 percent satisfaction level in 2004, up 2 percent from 2001.

#### *Staff conditions*

- Staff turnover has reduced from 25 percent to 12.5 percent per year. (Cost saving accessed - \$8,125 per annum).
- Staff sick leave rates have reduced from eleven to eight days a year. (Cost saving accessed - \$11,263 per annum).
- Staff expressed to the review team positive views about new processes, noting:
  - laptops systems have reduced administration of work, but use of a laptop in assessments can reduce the amount of eye to eye contact established with clients and hence rapport developed;

- information packs for clients useful for ensuring that client is fully informed and is advised of all things they need to be aware of; and
- staff service manuals useful as a resource. However, some comments made by staff would also indicate that staff are still learning to use them.

*Administration*

- The Manager of Aged and Disability services noted that the development of the PPPS and Service Coordination and attendant adoption of consistent and documented service practices provided was beneficial for WCC when it took its HACC audit.
- During the establishment of SC, and subsequently, the Manager of Aged Care and Disability services has participated in a number of PCP committees and meetings. The costs of those meetings are show in Table A.2 below.

Costs

**Table A.2 Actual costs impact of SC**

Name: Whitehorse City Council				Net Cost /	IMPLEMENTATION (One off expenses)	
Pre Service Coordination		Post Service Coordination		(Saving)		
CAPITAL		OTHER			CAPITAL	
					Laptops 8 @ \$3,500 each	\$ 28,000
					Interface	\$ 3,000
<b>Total</b>	\$ -	<b>Total</b>	\$ -		<b>Total</b>	\$ 31,000
INCOME		INCOME			INCOME	
<b>Total</b>	\$ -	<b>Total</b>	\$ -		<b>Total</b>	\$ -
EXPENSES		EXPENSES			EXPENSES	
Sick Leave 11 days X 13 staff 7.6hrs/day X \$38p/hr	\$ 41,298	Sick Leave 8 days X 13 staff 7.6hrs/day X \$38p/hr	\$ 30,035	(\$11,263)		
Staff turnover costs \$5,000 per staff member X 13 Staff X 25% of staff per annum	\$ 16,250	Staff turnover costs \$5,000 per staff member X 13 Staff X 12.5% of staff per annum	\$ 8,125	(\$8,125)		
Administration staff 2 persons @ \$38000	\$ 76,000			(\$76,000)		
On call staff 1 person X \$80p/wk X 52 weeks	\$ 4,160	On call staff 1 person @ 30,000pa	\$ 30,000	\$25,840		
Call out staff 1 person X \$175p/wk X 52 weeks	\$ 9,100			(\$9,100)		
Catch-up staff (reassess) 1 person X \$288.8p/wk X 52	\$ 15,018			(\$15,018)		
Billing staff 1 person X \$35p/hr X 38 X 12 weeks	\$ 15,960			(\$15,960)		
		S.C meeting 1 person X 2 hrs X \$42p/hr X 4/yr	\$ 336	\$336	S.C meeting 1 person X 3hrs X \$ 38p/hr X 10 times	\$ 1,140
		Governance meeting 1 person X 2 hrs X \$42p/hr X 4/yr X 50%	\$ 168	\$168	Governance meeting 1 person X 3hrs X \$38p/hr X 12 times X 50%	\$ 684
		Division of GP's meeting 1 person X 1hr X \$42 X 4/yr	\$ 168	\$168	Division of GP's meeting 1 person X 1hr X \$42 X 6/yr X 80%	\$ 202
		Training Administration 13 people X 2 hrs X \$25 p/hr	\$ 650	\$650	Training Administration 13 people X 3 hrs X \$25 p/hr X 2 times	\$ 1,950
					PCP set-up meeting 1 person X 7.6hrs X \$38p/hr X 21 days @50%	\$ 3,032
					SCoTT development 1 person X 3hrs X \$38p/hr X 6 meetings	\$ 684
<b>Total</b>	\$ 177,786	<b>Total</b>	\$ 69,482	(\$108,304)	<b>Total</b>	\$ 7,692

**Table A.3 Redirected costs**

Name: Whitehorse City Council Pre Service Coordination		Post Service Coordination		Net Cost / (Saving)	IMPLEMENTATION (One off expenses)	
<i>Redirected value</i>						
8 Co-ordinators 12.5% of the week on assessments 38hrs X \$30p/hr X 0.125 X 8 X 48 weeks	\$ 54,720	8 Co-ordinators 33% of the week on assessment 38hrs X \$30p/hr X 0.33 X 8 X 48 weeks	\$ 144,461	\$89,741		

The following points are noted regarding the costs and savings arising from SC:

- SC has delivered a net annual cost saving of \$108,000 that the Aged and Disability Services unit can apply to other activities – this represents approximately two percent of the unit’s annual expenditure.

The savings achieved have primarily come from the loss of two administration staff and reduced requirement for temporary staff;

- WCC’s low levels of implementation costs reflect:
  - the performance of Central Eastern PCP in delivering a PPPS readily implementable by WCC;
  - the development and provision of training by the PCP on PPPS – as opposed to WCC having to incur those costs itself; and
  - low degree of changes required by WCC to core intake and assessment arrangements.

## A.7 Summary

On balance it appears that WCC has been successful in terms of implementing SC. In particular:

- implementation and service costs have not had a material adverse impact on the agency’s finances;
- operational efficiencies have been accessed;
- standards of client service (information provided and empowerment of clients) have improved; and
- staff support has improved.

On the other hand, significant benefits associated with network efficiency or clients’ waiting lists have not occurred. (We would expect this to be limited at this stage but the broader

implementation described in the PCP Strategic Directions document should improve network efficiency.) In the case of the former this reflects still developing network relationships and the fact that WCC receives a high number of self and family referrals. In the case of the latter, no benefits have been achieved as waiting times for clients being referred and clients receiving services are primarily driven by scheduling of services rather than any factors associated with intake and assessment queuing.

The factors that appear to have had a strong influence WCC achieving these benefits are:

- WCC was ready for organisational change, where Service Coordination became an means rather than an end to achieving benefits that were generally achievable from operational reform;
- by successfully undertaking the development of the PPPS Central Eastern PCP provided a critical resource to WCC for undertaking change. In particular the PPPS provided a road map for how systems should be developed and also saved WCC the considerable cost of having to develop an equivalent document;
- The capacity of the Central Eastern PCP to influence / support the successful achievement of Service Coordination outcomes in its member agencies appear in part to be driven by Central Eastern PCP being well funded. In the two years to June 2003 the PCP received approximately \$950,000 of funds;
- WCC had IT infrastructure that was compatible to and could support the Service Coordination changes. In particular the ability of Sharikat-Khoo to interface to laptops and to generate e-referrals or Service Coordination Tool Templates documentation was essential to ensuring administrative efficiencies were accessed;
- WCC's management (Manager Aged and Disability Services) was committed to change and had a longer term strategic view regarding how Service Coordination was consistent with WCC developing its services; and
- WCC's organisational changes did not represent a radical departure from existing intake and assessment practice with the result that WCC would have been confronted by lower change management challenges.

## **B Bass Coast Community Service**

### **B.1 Service profile**

Bass Coast Community Health Service (BCCHS) provides the following services, organised under four service teams:

- Child Family and Allied Health Services:
  - Maternal and Child Health;
  - Physiotherapy;
  - Podiatry;
  - Dietetics;
  - Paediatric Occupational Therapy;
  - Family Violence;
  - Case Work and Counselling;
- Aged and Disability Services:
  - District Nursing;
  - Occupational Therapy;
  - Community Aged Care Packages;
  - Making a Difference;
  - Palliative Care;
  - Planned Activity Groups;
- Mental Health, Youth, Drug and Alcohol services:
  - Counselling;
  - Accommodation and Rehab;
  - Mental Health;
  - Needle and Syringe Program;
- Health promotion and Clinical Support:
  - Regional Health Service – physiotherapy, podiatry, nursing, health promotion and community development;
  - Volunteer co-ordination;
  - Diabetes Education; and
  - Emergency Relief.

The four service teams are supported by a Corporate Services team, which includes a Reception team.

CCHS has 55 employees (approximately 35 FTE) allocated between the teams as follows:

- Child Family and Allied Health Services – 12 staff, 6.8 FTE;
- Aged and Disability Services – 17 staff, 8.7 FTE;
- Mental Health, Youth, Drug and Alcohol Services – 9 staff, 7.9 FTE;
- Health Promotion and Clinical Support -6 staff, 5.2 FTE; and
- Corporate Services – 10 staff, 5.4 FTE, plus one CEO.

BCCHS also has approximately 130 volunteers who assist in occupational therapy, transport, community outreach and at the BCCHS op-shop.

In addition to the above, BCCHS has a multi-disciplinary Intake and Access team comprising members from each of the four service teams. The Intake and Access team is the core component of BCCHS's SC approach. The composition and roles of the Intake and Access team is discussed below.

## **B.2 Client base**

BCCHS provides community health services to the residents of the Bass Coast LGA. BCCHS primary sites are at San Remo and Wonthaggi as well as providing services from a house in Cowes and rented rooms in Corineella, Grantville, Inverloch and Wonthaggi.

During the review, BCCHS made the following observations regarding its client population:

- Bass Coast is predominately a rural shire with a low population density;
- a significant section of the rural population is ageing, of low socio economic status and isolated;
- employment opportunity in the shire is low;
- Bass Coast is part of the Victorian retirement belt; and
- the population of the Coast and Phillip Island changes significantly during the year as a result of holiday makers and residents with holiday houses coming to the area.

These characteristics have an impact on both the range of services demanded and patterns in service demand across the year.

Table B.1 provides a summary of the demographic characteristics of the agency's catchment.

**Table B.1: Agency LGA Demographics<sup>12</sup>**

Agency Catchment	Bass Coast LGA, covering Phillip Island, San Remo, Wonthaggi, Inverloch and Corinella
Total population	21,769
Age profile	Population 0-19 years – 24 percent Population 20-30 years – 20 percent Population 40-59 years – 28 percent Over 60 years – 28 percent (Victorian average 16 percent)
Country of Birth	Australia – 84 percent UK – 9 percent New Zealand – 1 percent Italy – 1 percent Netherlands – 1 percent Other – 4 percent Victorian average: 19 percent from non English speaking countries
Annual individual income	\$1 - \$6,240 – 7 percent \$6,240 - \$15,600 – 44 percent \$15,600 - \$26,000 – 22 percent \$26,000 - \$36,400 – 13 percent \$36,400 - \$52,000 – 8 percent \$52,000 - \$78,000 – 4 percent \$78,000 or more – 2 percent Average annual income \$16,528 (Victorian State average income \$21,395)
Household type	Family household – 67 percent Lone person – 31 percent Group household – 2 percent
Family types	Couple without children – 50 percent Couple with children – 35 percent One parent family – 14 percent Other – 1 percent
Occupied private dwelling tenure	Fully owned – 55 percent Being purchased – 23 percent Renting – 19 percent Other – 3 percent

<sup>12</sup> Census 2001. Australian Bureau of Statistics

## **B.3 Service demand**

BCCHS receives on average 5.2 new referrals for service per day<sup>13</sup> (1,900 per year), in addition to the continuing services provided to existing clients.

In 2003-2004 BCCHS's service delivery targets for funded activity were<sup>14</sup>:

- 12,612 hours of services;
- 36 packages; and
- 359 episodes of Drug and Alcohol service.

However, it is noted that the actual levels of service is considerably higher where BCCHS delivered 23,340 hours of service in 2002-2003<sup>15</sup> against the same KPIs.

### **B.3.1 Source of service demand**

BCCHS is primarily a recipient, rather than a generator, of referrals. A sample period<sup>16</sup> from BCCHS's referral record book shows that inward referrals comprise:

- 59 percent – referral by self, family, friend or other non health system participant;
- 18 percent – referral by doctor;
- 11 percent – referral by hospital (including metropolitan Melbourne hospitals); and
- 13 percent – referrals from other sources (including COATS, district nurse, magistrates court).

Only five percent of income referrals are made on a SCoTT form (received by fax), from a mixture of agencies including a local doctor, Wonthaggi hospital, a metropolitan hospital and an out of region CHS.

## **B.4 Primary Care Partnership context**

### **B.4.1 PCP status**

BCCHS is a member of the South Coast Health Services Consortium PCP (South Coast HSC), which includes the Bass Coast LGA and South Gippsland LGA, covering the Victorian coast and hinterlands between Phillip Island and Wilsons Promontory.

South Coast HSC has not had a major influence on the implementation of SC reorganisation within BCCHS:

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<sup>13</sup> Based on referral summary book 5 April 2004 to 6 May 2004

<sup>14</sup> 2003-2004 Business Plan and Budget

<sup>15</sup> Annual Report 2003-2004

<sup>16</sup> Activity for period 5 April 2004 to 6 May 2004

- South Coast HSC has not developed a common set of PPPS. Any agencies undertaking process reorganisation as a result of SC have had to design and implement their own policies, practices, procedures and systems. Some work was undertaken by South Coast HSC to develop a PPPS, however because a large range of South Coast HSC's activities and objectives are currently being rolled into the Gippsland Region's Better Health Care in Gippsland program, South Coast HSC is currently debating whether it will finish the PPPS development or not;
- South Coast HSC has been involved in the development of a regional services directory. In expectation of this BCCHS discontinued the maintenance and production of its own local services directory (produced in book form). However, as the regional services directory is not available in book form this has caused a problem for those BCCHS's staff that provide client services away from BCCHS's main sites where internet access to the regional services directory is not possible. Consequently staff are still having to use the increasingly out of date local services directory;
- BCCHS has opted out of involvement in the PCP's ICT and e-referral program as there is presently not a compelling case for participation. (South Coast HSC's ICT project is being led by the Gippsland Health Alliance to develop a regional network portal, which ultimately will become the vehicle for regional e-referral, accommodating the members of the PCP and the acute care system); however
- BCCHS is driving a Bass Coast pilot program using public key infrastructure (PKI) for secure transmission of e-referrals with Wonthaggi Hospital, Bass Coast Shire and a local GP practice.

South Coast HSC's SC subcommittee has acted as a sounding board and information sharing forum for agencies undertaking SC and implementation of SCoTT.

South Coast HSC does not have a dedicated SC project worker, instead responsibility for SC is held by the PCP Coordinator.

During the review the Coordinator of South Coast HSC identified that the use of the (mandated) SCoTT tool within BCCHS is potentially at risk of being discredited, this risk arises from:

- a lack of critical mass of users of SCoTT in the region where service providers accept it as the primary means of referral;
- BCCHS having a referral base where a large majority of clients are not referred from SCoTT users (from self referral or non-SCoTT users) or are referred from out of region (for example metro hospitals); and
- the SCoTT becomes an additional bureaucratic inconvenience due to limitations in ICT infrastructure.

#### **B.4.2 BCCHS involvement in PCP activities**

BCCHS's involvement in South Coast HSC SC programs has occurred through the participation by the Chief Executive Officer and the Team Leader Youth Drug and Alcohol Services in:

- South Coast HSC's governance committee; and
- the SC Working Group.

## **B.5 Agency's SC experience**

### **B.5.1 Strategic background**

BCCHS has a three-year strategic plan (2002-2005) and develops an annual business plan and budgets.

Within the three-year plan the following objectives relevant to SC are expressed:

- to increase access through more flexible service models;
- to improve information, systems, processes and structure; and
- to develop a point of access and information for primary health services.

During the review the CEO of BCCHS stated that the objectives for SC within BCCHS were to:

- implement a consistent and formalised intake/access system, where duty workers became the first point of entry;
- deliver a higher quality service to the client;
- increase communication internally and between agencies;
- increase the number of appropriate and timely referrals; and
- increase service times for clients.

### **B.5.2 SC processes**

In response to SC BCCHS has developed a stand alone intake and access function separate from service delivery, where previously clients were initially referred into BCCHS through a reception.

#### *Intake and access*

The main features of BCCHS intake and access model are as follows:

- When a contract is received by BCCHS reception staff make an assessment as to whether the contact is a referral for service (for the purpose of this section referral includes self referral) or, for example, a request for information. All new client referrals are passed directly to the Duty Officer in the Intake and Access Unit.
- A referral may be in person, by phone, by fax or by email (non SCoTT).
- If the contact is a client wishing to make a second appointment (for example for continuing physiotherapy) the receptionist may make an appointment for the client directly.

- The Intake and Access Unit is staffed five days a week during business hours by a Duty Officer.
- BCCHS's Duty Officers are service staff who have been trained to undertake the Intake and Access role. There are 18 Duty Officers and most are rostered to act in the Duty Officer role for one half day per fortnight in addition to their normal service roles. BCCHS selected which service staff would undertake the Intake and Access role based on the following criteria:
  - the Duty Officer role could only be undertaken by staff members who undertakes assessment as part of their own service role;
  - only staff with a work load in excess of 0.6 would be required to work as a Duty Officer; and
  - the 20 rostered Duty Officer positions should be shared equitably between the four service teams and within the teams.
- The Duty Officer undertakes the IC and INI data collection, identifies which services are required and makes an appointment for the referred person.
- The Duty Officer uses the SWITCH database system to record the necessary IC and INI data. For SC BCCHS's SWITCH system was upgraded to:
  - incorporate the fields contained in the SCoTT forms;
  - be able to generate printed SCoTT forms; and
  - incorporate appointment diaries so that the Duty Officer can make bookings directly into each provider's diary.
- After an appointment is made the Duty Officer:
  - sends the client an appointment confirmation letter; and
  - prints out the SCoTT forms for inclusion on the client's physical file, which is then placed in the pigeon hole of the service provider with whom the appointment has been made.
- If the Duty Officer is busy when a referral is received the receptionist makes an arrangement for the Duty Officer to call the referrer/client back, usually any call back will occur within half an hour.
- The Duty Officer has a separate office so that when a potential client presents for service intake and access can be undertaken in privacy (compared to previously where a potential client was asked questions in the reception area, prior to being booked in for services).
- Each Duty Officer was trained in the use of the SWITCH system and the SCoTT templates (as well as in providing emergency relief, needle exchange and risk management). BCCHS initially attempted to undertake group training sessions (two half days) but due to back fill issues subsequently moved to a one-on-one training model where each Duty Officer received two days of separate training and on the job mentoring.

### *Referral out*

Where BCCHS needs to refer a client to another service the client is either:

- redirected by the receptionist to the correct service, if the contact is a client looking for a service not provided by BCCHS; or
- referred by the service staff, where the SCoTT forms are printed out from SWITCH and faxed to the appropriate service.

### *Change to processes*

Prior to SC the intake and access role was undertaken jointly by reception and service staff, where:

- the receptionist was the first point of contact between all the clients and practitioners. The receptionist was responsible for:
  - answering telephone calls and passing messages to the relevant practitioners;
  - asking clients initial questions about their service needs and completing the Client Information and Referral Record forms (CIARR);
  - rostering and creating appointments for all practitioners;
  - explaining the overall service process to the client; and
  - asking the client to sign forms that authorise the distribution of client information to the relevant parties.

This initial service was previously undertaken in the reception area which created congestion problems as well as issues for client confidentiality; and

- at the client appointment the practitioner assessed the client, and if necessary, made additional appointments for the client. As a result of this, if a client required multiple services they may have had to visit BCCHS a number of times.

## **B.6 Outcomes of SC**

This section sets out the identified outcomes of SC and related business changes.

It is noted that within BCCHS the SC changes occurred in conjunction with an expansion of BCCHS and the CEO noted that SC provided a useful tool to enact changes. As such, any changes noted (and resultant benefits) may have been achieved even if SC had not been adopted.

### *General outcomes and assessment*

During the review BCCHS management expressed positive views that SC was providing worthwhile benefits for BCCHS.

In particular, BCCHS's CEO identified that the adoption of a team based Intake and Access Unit has:

- made the intake function more customer focused where it is able to identify and respond to client needs in a more timely and appropriate manner;
- allowed BCCHS to recognise and respond to issues of client confidentiality and the need for privacy when discussing personal matters;
- ensured that intake occurs consistently for all clients;
- increased cross-service understanding between practitioners regarding the services provided by BCCHS; and
- increased actual service time received by clients during appointments by approximately half an hour per client due to pre-completion of IC and INI.

However, the CEO did acknowledge a number of operational issues related to its intake and access function, namely:

- service staff were initially not keen on the concept of a team based Intake and Access Unit, in particular they questioned why they were being asked to do something that 'isn't my job or what I am funded to do';
- the mandated requirement for BCCHS to use the SCoTT tool created an additional burden that can appear to be unnecessary to staff. This comment reflected the fact that BCCHS is primarily a recipient of referrals (of which the majority are from self referrers, GPs and the acute system, all of which do not widely use SCoTT); and
- using multi disciplinary teams created problems for staff in identifying lines of responsibility and accountability which were different to their normal service lines.

When discussing the general benefits and drawbacks of SC for BCCHS neither the CEO nor staff referred to any benefits arising from increased capacity of the local service network. This seems likely to reflect:

- the nature of BCCHS referral patterns from other providers;
- location, where a significant number of referrals, excluding self referrals, come from the acute system in metropolitan Melbourne;
- BCCHS problems regarding connectivity due to the absence of e-SCoTT to the rest of the PCP and Region; and
- problems experienced by the PCP in establishing the new local service directory. This has disadvantaged BCCHS in particular as it discontinued maintenance of its own (highly successful) directory when the PCP assumed responsibility for the development of a PCP based one.

The following sections identify specific outcomes arising from SC. All dollar values shown in the following sections are shown in greater detail in Tables B.2 and B.3.

#### *Service delivery*

- Practitioners are no longer responsible for all initial assessments and paper work and filing. This has reduced the time needed for administrative tasks and created an estimated extra 30 minutes for added value quality client service for direct service appointments.

On the basis of 1,900 new referrals a year, this equates to \$22,000 of added value to client appointments. This value is notionally contained within the additional single full time equivalent position in work load that BCCHS has extracted from the 18 Duty Workers, valued at \$45,500 (see Table B.3 below).

- SC has not resulted in BCCHS increasing or decreasing its staffing levels and staff turnover rates do not appear to have been effected by the introduction of SC.
- Duty Workers find that they have a broader knowledge of the services and staff specialisations offered within the organisation.
- The centralised diary system makes booking client appointments quicker. Some staff have retained their manual diaries for making appointments when off site with existing clients. These diaries require subsequent coordination into the electronic diary system.

#### *Service response and clients*

- BCCHS believes that response times to clients has improved as the majority of clients' needs are now assessed immediately (or within half an hour) and referred to the appropriate practitioner. BCCHS did not have any statistics to support this statement.
- Prior to and after the introduction of SC BCCHS did not have any waiting lists for services.
- The review team were advised that some clients express feelings of frustration as they do not understand why they need to go through such rigorous and formalised intake/access procedures, especially when their service needs were relatively simple, for example wanting an appointment to have their toe nails cut with a podiatrist. These complaints in particular are focused on the level of information required by SCoTT. However, only three percent of respondents to the review's client survey thought that it was not clear why they were being asked the questions that they were in the intake and access.
- In general service staff suggested that new clients would not perceive a lot of the SC related changes, however staff did express the opinions that clients are better informed about services and availability, are more likely to be referred to the services they need, benefit more service time from practitioners and their confidentiality and privacy issues are better addressed.

#### *Staff conditions*

- Receptionist staff stated that SC has created less work pressure and higher work satisfaction levels.

As part of this review a Duty Worker survey was undertaken. The survey showed that:

- 31 percent of Duty Workers agreed that intake and access should be staffed by service staff (as is currently the case) but only 16 percent (3 staff) expressed strongly negative views that

this should not be the case. This result is seen as a positive by BCCHS as initially service staff were considerably less accepting of the idea of the service staff Duty Worker role. This improvement is likely the product of successful change management by BCCHS and staff perceiving the benefits of system changes;

- approximately one third of Duty Workers surveyed stated that having to undertake the Duty Officer role has had a positive impact on how much they enjoy their job, however one third also expressed a negative view. This distribution would indicate that the BCCHS has successfully managed the introduction of the Duty Officer role in staff roles, but for some staff further attention may be required; and
- those staff that expressed positive views about their SC roles, were also those that consistently noted benefits in better services for clients, increased internal service capacity, and increased capacity of the local network.

Costs

**Table B.2 Actual costs impact of SC**

Name: Bass Coast Community Health Service							
Pre Service Coordination		Post Service Coordination		Net Cost / (Saving)		IMPLEMENTATION (One off expenses)	
CAPITAL		CAPITAL				CAPITAL	
						Computer Upgrade	\$ 2,000
						ISDN installation	\$ 350
						Computer license	\$ 296
						Programs	\$ 1,000
<b>Total</b>	\$ -	<b>Total</b>	\$ -			<b>Total</b>	\$ 3,646
INCOME		INCOME				INCOME	
<b>sub-total</b>	\$ -	<b>sub-total</b>	\$ -			<b>sub-total</b>	\$ -
EXPENSES		EXPENSES				EXPENSES	
Annual training reviews \$29 p/hr X 7.5 X 31 days	\$ 6,743	Annual training reviews \$29 p/hr X 7.5 X 12 days	\$ 2,610	(\$4,133)		Training development \$29 p/hr X 7.5 X 20 days	\$ 4,350
		Staff meeting 18 ppl X 1 hr X \$23/hr X 12	\$ 5,048	\$5,048		Facilitator for group training \$29 p/hr X 7.5hrs X 2 X 0.5 days	\$ 210
		A4 paper @ \$6.00 X 2 a month X 12 months	\$ 144	\$144		Group training \$23 X 7.5hrs X 18 X 0.5 days	\$ 1,577
		Monthly internet fees \$60.00 X 12 months	\$ 720	\$720		Facilitator for one to one training \$29 p/hr X 7.5hrs X 2 days X 18 staff	\$ 7,830
		Printer ink \$50.00 X 2 cartridge X 12 months	\$ 1,200	\$1,200		One to one training \$23 p/hr X 7.5hrs X 2 days X 18 staff	\$ 6,310
						Replacement of 1 staff member that left because of SCoTT	\$ 2,000
						Staff meetings 18 ppl X 2hrs X \$23.37 X 12	\$ 10,096
						Trainer trainee 1 person X 3hrs X 12 months X \$29 p/hr	\$ 1,044
<b>Total</b>	\$ 6,743	<b>Total</b>	\$ 9,722	\$2,979		<b>Total</b>	\$ 33,417

**Table B.3 Redirected costs**

Name: Bass Coast Community Health Service Pre Service Coordination		Post Service Coordination		Net Cost / (Saving)	IMPLEMENTATION (One off expenses)	
Redirected value		Additional activity by Duty Workers: 1 FTE @ \$23/hr	\$ 45,572	\$ 45,572		

The following points are noted regarding the costs and savings arising from SC:

- SC has increased BCCHS annual costs by less than \$3,000 or approximately 0.1 percent of the organisation's annual expenditure. This low cost reflects that SC in BCCHS was based almost entirely on reallocating existing resources; and
- BCCHS implementation costs were relatively high compared to other agencies due to the large number of staff that required training.

## B.7 Summary

BCCHS believes that SC has been a success in the organisation, as:

- the organisation is better able to respond to clients, who receive a more timely, consistent and appropriate referral; and
- there is increased cross service understanding within the organisation.

In addition SC has not had a material impact on BCCHS's recurrent cost base because SC has primarily been achieved through the changed utilisation of existing resources and staff, although it did incur higher implementation costs as a result of the large number of staff requiring training.

The outcomes achieved by BCCHS primarily relate to the service or clients, it appears that only limited network benefits have been achieved because:

- as a CHS the bulk of new clients are self referred rather than obtained through the local network;
- as a rural provider, BCCHS has a significant out of area referral stream which only rarely incorporates SCoTT (primarily post acute);
- BCCHS is located in an area where poor standards of telecommunication infrastructure has had a negative impact on the capacity of the organisation to participate in technology networking; and
- the lack of development of a PCP PPPS and the increasing absorption of the PCP rationale into Gippsland regional structures.

Both management and staff advised the review team that the introduction of a staff based intake and access model was a challenge to staff as traditionally staff had operated in service silos and had a fixed view about their roles. As a result staff morale was significantly adversely effected when SC was introduced. Staff morale has since improved. However, it would appear that there is still, in some sections of the Intake and Access team, adverse attitudes to the model and its identified benefits. Potentially these adverse views could in the long-term have an adverse impact on the continuing benefits of SC.

## **C Moonee Valley City Council**

### **C.1 Service profile**

Moonee Valley City Council's (MVCC) Aged and Disability Services Unit provides the following services:

- Food and Transport Services:
  - Community Transport; and
  - Delivered Meals (meals on wheels);
- Community Care
  - Client Services;
    - Personal Care;
    - Home Care;
    - Property Maintenance;
    - Aged Counselling and Advocacy;
    - Home and Community Care Assessment;
    - Disability services;
  - Flexible Respite and Activities; and
  - Aged Care Packages.

MVCC delivers the above services through two teams:

- Food and Transport Services, comprising 21.33 FTE staff and 100 Volunteers; and
- Community Care, comprising 10.7 FTE in team leadership of administration, 4.0 FTE home maintenance and 76.0 FTE (143) care workers

This review concentrates on the impact of Service Coordination on the Aged and Disability Services Unit.

### **C.1.1 HACC service structure**

MVCC's Community Care team provides HACC services within the MVCC LGA. The LGA has been subdivided into four areas (Southern, Central, Northern and Western) where each area is staffed by a service team comprising:

- a team leader;
- one half of an administration worker (shared with another HACC team); and
- area service staff, comprising direct care workers.

MVCC's home maintenance workers (4 full time positions) work across the whole MVCC LGA and are administered centrally.

Community Care has a LGA-wide Disability Team, comprising:

- a team leader;
- 0.7 of an administration worker; and
- disability care workers.

All of the team leaders and administration officers are located at MVCC's Moonee Ponds office.

## **C.2 Client base**

MVCC's HACC team provides HACC services to the residents of the MVCC LGA. Each of the HACC area teams services at any one time between 435 and 450 active clients (approximately 2,000 clients in total). MVCC also provides disability services to approximately 200 clients.

During the review, MVCC noted the following characteristics in its client population:

- significant variations in social-economic profile across the LGA, noting particularly areas of socio economic disadvantage in Flemington;
- high numbers of migrant communities in Flemington and Airport West.

Table C.1 provides a summary of the s demographic characteristics of the agency's catchment.

**Table C.1: Agency LGA Demographics<sup>17</sup>**

Agency Catchment	Moonee Valley City Council, covering Essendon, Moonee Ponds, Ascot Vale, Flemington and Kensington.
Total population	Total population – 105,615
Age profile	Population 0 – 19 years – 25 percent Population 20- 39 years – 32 percent Population 40-59 years – 25 percent Over 60 years – 18 percent (Victorian average 16 percent)
Country of Birth	Australia – 70 percent Italy – 7 percent U.K – 3 percent Vietnam – 2 percent Greece – 2 percent China – 1 percent Other – 15 percent  Victorian average: 19 percent from non English speaking countries
Annual individual income	\$1 - \$6,240 – 7 percent \$6,240 – \$15,600 – 30 percent \$15,600 - \$26,000 – 17 percent \$26,000 - \$36,400 – 16 percent \$36,400 - \$52,000 – 15 percent \$52,000 - \$78,000 – 10 percent \$78,000 or more 5 percent  Average annual income \$23,674 (Victorian State average income \$21,395).
Household type	Family household comprises the majority – 69 percent Lone person – 27 percent Group household – 4 percent
Family types	Couple with children – 48 percent Couple without children – 34 percent Single parent family – 15 percent Other – 3 percent
Occupied private dwelling tenure	Fully owned – 48 percent Renting – 28 percent Being purchased – 22 percent

<sup>17</sup> Census 2001. Australian Bureau of Statistics

### **C.3 Service demand**

MVCC undertakes approximately 750 assessments of new clients and reviews about 560 existing clients per year.

In 2002/03 MVCC provided approximately<sup>18</sup>:

- 105,000 hours of home care support (DHS service agreement target 66,000 hours) to more than 2,500 frail aged, people with disabilities and their carers;
- 5,000 hours of home maintenance and over completed 3,000 home maintenance tasks;
- 1,400 clients transported to hospital and other health appointments; and
- 150,000 home and centre based meals.

#### **C.3.1 Source of service demand**

MVCC receives referral from:

- self referral and families – 55 percent;
- hospitals and the post acute system – 26 percent;
- ACAS – 5 percent;
- RDNS – 5 percent; and
- other sources – 9 percent.

### **C.4 Primary Care Partnership context**

#### **C.4.1 PCP status**

MVCC is a member of Moonee Valley / Melbourne (MVM) PCP, which covers the Moonee Valley, Melbourne, and Manningham LGAs.

MVM PCP has since its initiation adopted a cross-region approach to Service Coordination with the other two PCPs (Brimbank / Melton PCP and Westbay PCP) within the (former) DHS Western Region (WMR).

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<sup>18</sup> Annual Report 2002/03. Moonee Valley City Council

At the time of the review Service Coordination related activities within MVM PCP and the Western Metropolitan Region PCP Cross Alliance, included:

- development of a common set of PPPS (the Western Metropolitan Region Service Coordination Best Practice and Continuous Improvement Manual (WMR-BPM))
- development and implementation of WMR 'Do It Yourself Privacy for Primary Care Agencies' kit;
- development of WMR PCP Website, local Service Directory, e-Referral system (connectingcare.com);
- WMR CALD Needs Project, which developed guidelines for the implementation of IC and INI for people from a CALD background;
- completion of WMR Carers Needs Project 14, which developed a carers profile to compliment the state-wide Service Coordination Tool Templates;
- WMR Service Coordination Training for Ethno-specific and Smaller Agencies Project to understand the Service Coordination reform and implement the Service Coordination Tool Templates using the WMR BPM;
- encouragement and support for the use of the Service Coordination Tool Templates with Melbourne Health, in addition to the HARP Project; and
- continuing local and regional Service Coordination meetings.

#### **C.4.2 MVCC involvement in PCP activities**

MVCC participation within MVM PCP occurs through membership of:

- MVM Steering Committee (chaired by MVCC Manager Aged and Disability Services);
- MVM PCP Executive;
- Service Coordination Implementation Group;
- WMR BPM Steering Committee;
- Cross Regional Alliance Committee; and
- Consumer Reference Group.

MVCC described itself as the lead agency within MVM PCP.

## **C.5 Agency's Service Coordination experience**

### **C.5.1 Strategic background**

MVCC has an annual council plan that sets out the strategic goals for MVCC and specific objectives / strategies for the year ahead. However, the council plan is silent on any goals or objectives for the Aged and Disability Unit relevant to aspects directly or peripherally relevant to SC.

Instead, the implementation of Service Coordination is guided by the MVCC general values and mission and developed through Service Planning and Best Value Reviews, which are undertaken annually. In addition, the development of Service Coordination is also guided by MVM PCP's CHP.

The key drivers behind MVCC's adoption of Service Coordination comes from:

- the mandated requirement associated with MVCC's HACC funding to participate in the PCP and adopted Service Coordination initiatives such as Service Coordination Tool Templates; and
- a requirement to rebalance MVCC's HACC operations where operations did not reflect underlying patterns in service demand or to minimise inefficient operational practices.

The prime influences / constraints on the design of operations within the Aged and Disability Unit are:

- budgetary constraints imposed by MVCC;
- service delivery targets contained in the service agreements; and
- demand patterns for services (and presumably clients' capacity to pay certain levels of fees).

### **C.5.2 SC processes**

Within MVCC the main operational impact of Service Coordination have been:

- the adoption of the BMP PPPS practices into its intake and assessment functions (including adoption and use of Service Coordination Tool Templates in accordance with the DHS Service Coordination Tool Templates guidelines); and
- adoption of new referral practices.

#### *Intake and assessment – Initial Contact*

MVCC's initial contact processes are guided by its Initial Contact Practices and Procedures policy which interprets the WMR BMP Initial Contact Protocol.

The main features of MVCC's Initial contact model are:

- all contacts (phone calls, faxes, in person) regarding enquiries and requests for services from the Aged and Disability Unit are passed to the intake duty desk;
- the intake duty desk is manned during weekday business hours by the ten team leaders. Each Intake Officer is rostered to do one half day per week on the duty desk
- where a contact is a request for services the Intake Officer completes the IC and initial parts of the ICI forms on the Service Coordination Tool Templates on Sharikat-Khoo; and
- the Intake Officer makes an appointment for the relevant team leader to visit the person requiring service to complete the INI process.

*Intake and assessment –Assessment*

- MVCC's initial contact processes are guided by the Initial Needs Identification, the MVCC Best Practice Policy and Procedures Manual and the Assessment and Care Management Policy and Procedures Manual, which interpret the relevant protocols on WMR BPM.

The main features of MVCC's assessment model are:

- the relevant team leader visits the person requiring services to fulfil the INI assessment process. During the visit the team leader:
  - complete a hazards check list at the site;
  - manually completes the INI Service Coordination Tool Templates, including asking the client to sign the privacy / confidentiality consumer consent form;
  - provides the potential client with information regarding clients' rights and responsibilities (including providing the client with a copy of the consumer care customer and service charters), service contact numbers, and confidentially;
  - will agree with the client the range and price of services to be delivered and complete the associated client requirements form which the client will sign; and
  - have the client sign a confidentiality statement that allows their data to be released to DHS for statistical purposes.
- the relevant team leader returns to the office where an administration assistant completes Sharikat-Khoo with the information collected at the visit, files any relevant paperwork, and schedules services to be provided to the client.

### *Referral*

Where MVCC needs to make a referral to another service provider the referral can be either by:

- e-referral, where electronic Service Coordination Tool Templates forms can be generated by Sharikat-Khoo and transmitted as an attachment to a referral made using connectingcare.com; or fax, where the Service Coordination Tool Templates forms are printed from Sharikat-Khoo and faxed to the recipient.
- when MVCC receives an e-referral there is not an interface between connectingcare.com and Sharikat-Khoo so the referral is manually processed into Sharikat-Khoo as part of the initial contact process.

### *Identification Development of Service Coordination processes*

As identified above, MVCC based its IN and ICI procedures on the WMR BPM. As a change management exercise for the development and implementation of SC, MVCC included the intake staff group in the development process around changes to systems and procedures. Staff developed an agreed set of activities that were to be incorporated into the final design of the IC and INI processes.

### *Changes to processes*

Prior to the introduction of SC, MVCC's intake and assessment function had the following activities different to the current process:

- requests for services were assessed by the team leaders directly (instead of the IC role being undertaken by a Duty Desk); and
- all assessments were undertaken by team leaders (as currently) using the Client Information and Referral Record (CIARR).
- Simultaneous to the PCP driven initiative for Service Coordination and the mandated requirement for MVCC to participate in elements of Service Coordination (for example Service Coordination Tool Templates) MVCC was encountering pressure to reconfigure its HACC operations.

In the late 1990's in response to a service environment based on competitive tendering MVCC developed a very lean HACC organisation. Then early in the current decade MVCC had to respond to high levels of service demand, this provided an impetus for the organisation to look at the structures it had in place to respond to changing demand pressures. One of the responses was to create three administrative support positions to support the team leaders. This change was also made in response to MVCC participating and then adopting the early Service Coordination Tool Templates where the work load for some team leaders was beginning to subsume them in the administrative side of their role.

Further, MVCC reviewed the areas managed by team leaders and by changing the area boundaries reallocated the work load between team leaders more equitably<sup>19</sup> and were able to reduce one team leader position.

## C.6 Outcomes of SC

This section sets out the identified outcomes of the Service Coordination and related business changes.

It is noted that within MVCC the Service Coordination changes occurred in the context of a wider rationalisation of business organisation and practices and that some of the changes noted (and resultant benefits) may have been achieved even if Service Coordination had not been adopted. The listed outcomes below should be read in the context of that limitation. (It is important to note that without Service Coordination, the changes would have been harder to achieve i.e. Service Coordination provided the catalyst.)

### *General outcomes and assessment*

During the review MVCC expressed strongly positive views that Service Coordination and its other business changes were achieving providing a net benefit to MVCC.

- The Manager Aged and Disability Services in an informal assessment rated Service Coordination as a success in MVCC and identified the following critical success factors in MVCC's adoption of SC:
- the cross regional cooperation between the three PCPs within Western Region meant that:
  - there was a coordinated approach between all participants in Western Region which is important in a metropolitan environment where client interface into the primary, acute and general practice areas occurs frequently across PCP boundaries;
  - each of the PCPs got 'more bang for their buck' through the pooling of PCP funds for projects and initiatives;
- involvement in the PCP and regional alliance provided MVCC with a context for its own internal changes, without Service Coordination the changes would have been much more difficult;
- effective change management practices, particularly the involvement of staff in the definition of what the PPPS meant to MVCC, meant that staff developed an ownership and commitment to Service Coordination and wider PCP change;
- as lead agency in the PCP, MVCC was able to set the agenda for changes in the network; and

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<sup>19</sup> Example of variations in load: the team leader Airport West – 500 active clients, team leader Flemington/Kensington 200 active clients.

- strong commitment from MVCC executive for change, and a continuing commitment to fund council a percentage of HACC costs (increased from 27 percent to 29 percent in period) even when demand was growing.

The following sections identify specific outcomes arising from SC. All dollar values shown in the following sections are shown in greater detail in Tables C.2.

The Clint Service Coordinator however stated that in his opinion although the development of closer networks has occurred there is still a considerable way to go in this area and that ethnic service agencies in particular had not yet been brought into the networks.

#### *Service delivery*

- MVCC staff identified that the time to take assessments had increased. An assessment may now take one to two hours, where previously it was less than an hour. However, the enhanced completeness of assessment has had a real benefit in developing an understanding of client requirements. This is particularly helpful for clients with complex problems.
- A review of MVCC operations has estimated that MVCC has saved approximately one hour per assessment time per week per officer. The basis of that assessment is not known. However, the Manager Community Care estimated that approximately half of the savings associated with the reduction in team leaders from six to five could be related to Service Coordination at a saving of \$25,000, which was created by that efficiency saving (n.b. this efficiency saving is distinct from changes to unit assessment times in the point above).
- SC has not influenced the number of new clients it processes per year.

#### *Service response and clients*

- SC has not impacted on clients' waiting time for services, the average waiting times of eight days between initial contact and provision of service has not changed.
- Staff report that some clients find the detailed assessment frustrating but there was a consistent view that the more detailed assessment provided good data on which to base services, and "we listen to client stories that might be missed";
- Clients receive more information at assessment (a client survey showed 98 percent of clients at assessment received information they believe they need).
- 100 percent of clients that participated in the client survey responded that they were satisfied with services they are referred to.
- Client focus groups undertaken as part of a best practice review noted that assessments were thorough and systematic and MVCC and other agencies were seen to cooperate well together; and
- MVCC customer satisfaction index for Health and Human Services was on target at 72 percent.

*Staff conditions*

- Staff did not express any negative views on the impact of Service Coordination on their positions.
- Staff turnover rates and sick leave rates have not been affected by SC.

*Networks and Referral*

- Staff noted that referring agencies are not all using Service Coordination Tool Templates or only part completing (particularly noted a hospital) and that Service Coordination needs to be applied more broadly to begin to increase the rate at which MVCC receive Service Coordination Tool Templates based referrals.
- Staff noted that even with Service Coordination Tool Templates compliant referrals, MVCC has to re-perform some parts of assessments for service reasons. For example OH&S audits need to be administered by MVCC. Also assessment of clients is undertaken by MVCC at a client's house rather than at provider and as a result MVCC may develop a different assessment.
- During the establishment of SC, and subsequently, the Manager Aged and Disability Services and Client Service Coordinator has participated in a number of PCP committees and meetings. The costs of those meetings are show in Table C.2 below.

Costs

**Table C.2 Actual costs impact of SC**

Name: Moonee Valley City Council				Net Cost / (Saving)		IMPLEMENTATION (One off expenses)	
Pre Service Coordination		Post Service Coordination					
CAPITAL		CAPITAL				CAPITAL	
						SKK Upgrade	\$ 2,400
						Computer	\$ 5,000
<b>Total</b>	\$ -	<b>Total</b>	\$ -			<b>Total</b>	\$ 7,400
INCOME		INCOME				INCOME	
<b>sub-total</b>	\$ -	<b>sub-total</b>	\$ -			<b>sub-total</b>	\$ -
EXPENSES		EXPENSES				EXPENSES	
		Reduction in 1 team leader 50%	(\$25,000)	(\$25,000)		Fortnightly team meeting 2 hrs per f/n X 15 ppl X \$26/hr X 8mth	\$ 12,480
		Weekly team meeting 14 ppl X 20 mins	\$ 3,785.60	\$3,786		Development time A: 6 wks X 37.5 X \$26/hr X 80% B: 6 wks X 37.5 X \$26/hr X 20% A: 6 wks X 37.5 X \$35/hr X 40%	\$ 4,680 \$ 1,170 \$ 3,150
						WMR BPM training 11ppl X 3hr X \$26/hr 8wks X 1hr/wk X 11ppl X \$26/hr	\$ 858 \$ 2,288
						State SC training 11ppl X 5 hrs X \$26/hr	\$ 1,430
						e-referral training 11ppl X 2.5hrs X \$26/hr 11 ppl X 2 hrs X 3 times X \$26/hr	\$ 715 \$ 1,716
		SC subcommittee 2hrs/mth X \$35/hr	\$ 840.00	\$840		SC subcommittee 18 mths X 2.5hr X 1/wk X \$35/hr	\$ 6,825
		PCP Steering committee 2ppl X 3hr/mth X \$35/hr	\$ 2,520.00	\$2,520		PCP Steering committee 2ppl X 3hr/mth X \$35/hr X 18 mths	\$ 3,780.00
<b>Total</b>	\$ -	<b>Total</b>	(\$17,854)	(\$17,854)		<b>Total</b>	\$ 39,092

The following points are noted regarding the costs and savings arising from SC:

- SC has delivered a net annual cost saving of \$21,000 that the Aged and Disability Services unit can apply to other activities. This represents less than one percent of the unit's annual expenditure.

The savings achieved have primarily come from the loss of a Team Leader position; and

- MVCC's high level of implementation costs reflect:
  - training of a large group of intake officers on Service Coordination practices and protocols; and
  - high levels of participation by MVCC with PCP and WMR committees.

## **C.7 Summary**

On balance it appears that MVCC has been successful in terms of implementing SC. In particular:

- implementation and service costs have not had a material adverse impact on the agency's finances;
- operational efficiencies have been achieved;
- standards of client service (information provision) have improved;
- consistent organisation wide practices have been developed; and
- staff engagement and support of the Service Coordination reforms has been high.

On the other hand, significant benefits associated with network efficiency or client waiting lists have not occurred. In the case of the former this reflects still developing network relationships and the fact that MVCC receives a high number of self and family referrals. In the case of the latter, no benefits have been achieved because waiting times for clients being referred and clients receiving services are driven by scheduling of services rather than any factors associated with queuing.

The factors that appear to have had a strong influence MVCC achieving these benefits are:

- MVCC was ready for organisational change, so Service Coordination became a means rather than an end to achieving benefits that were generally achievable from operational reform;
- the development of the WMR BMP provided a critical resource to MVCC for undertaking change. In particular it provided a change management vehicle for the development of staff

commitment and ownership for change, it also saved MVCC a considerable cost of having to develop an equivalent document if it had undertaken reform without SC;

- MVCC plays a leading role in the PCP and WMR ensuring policy developments were influenced by MVCC requirements;
- MVCC IT infrastructure was compatible to and could support the Service Coordination changes; and
- MVCC's organisational changes did not represent a radical departure from existing intake and assessment practice. As such MVCC was less confronted by change management challenges.

## **D Nillumbik Community Health Service**

### **D.1 Service profile**

Nillumbik Community Health Service (NCHS) provides the following services:

- adult day care;
- community health nursing;
- counselling;
- dental;
- dietetics;
- emergency relief service;
- enhanced home visiting;
- health planing and promotion;
- immunization;
- making a difference program;
- maternal and child health nursing;
- needle exchange;
- disability linkages;
- legal advice;
- occupational therapy (adult and specialist paediatric);
- physiotherapy;
- podiatry;
- planned activity groups;
- speech pathology (adult and specialist paediatric);

- Youth and Family program (school and family focussed programs); and
- same sex attracted youth program.

NCHS provides these services through two service units supported by a Corporate Services unit. The service units are:

- Child, Youth and Family Services; and
- Primary Health Services.

NCHS has 100 employees (or 58 EFT).

NCHS also has a volunteer base that provides support to the legal service, planned activity groups, administration, the Arthritis Water Exercise and the Strong People Stay Young programs. The Allied health Program utilise volunteers for admin support and for paediatric speech treatment groups.

## **D.2 Client base**

NCHS provides services to the residents of Nillumbik LGA. The majority of NCHS's services are provided from its main site at Eltham. Case management services are also provided from a site in Rosanna who service clients in other LGA of the old DHS Northern region. These include Banyule, Darebin, Yarra, Moreland Hume and Whittlesea.

NCHS has identified the following key client groups that require increased levels of service than Nillumbik's general population:

- people with complex care needs;
- people with mental health problems;
- children and young people with a developmental delay or a disability; and
- young people who are socially disadvantaged<sup>20</sup>.

Table D.1 provides an overview of the demographic profile of Nillumbik LGA.

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<sup>20</sup> Strategic Plan 2003 – 2006. NCHS.

**Table D.1: Agency LGA Demographics<sup>21</sup>**

Agency Catchment	Nillumbik LGA, covering Eltham, Research, Kangaroo Ground and Wattle Glen, Arthurs Creek, Strathuen, St Andrews, and parts of Warrandyte.
Total population	Total population – 57,931
Age profile	Population 0-19 years – 34 percent Population 20-39 years – 26 percent Population 40-59 years – 31 percent Over 60 years – 9 percent (Victorian average 16 percent)
Country of Birth	Australia – 85 percent Places other than Australia, UK, Italy and New Zealand – 8 percent UK – 5 percent Italy – 1 percent New Zealand – 1 percent  Victorian average: 19 percent from non English speaking countries
Annual individual income	\$1 - \$6,240 – 10 percent \$6,240 – \$15,600 – 20 percent \$15,600 - \$26,000 – 17 percent \$26,000 - \$36,400 – 16 percent \$36,400 - \$52,000 – 17 percent \$52,000 - \$78,000 – 12 percent \$78,000 or more – 8 percent  Average annual income \$24,377 (Victorian State average income \$21,395).
Household type	Family household type comprises the majority – 87 percent Lone person – 12 percent Group household – 1 percent
Family types	Couple with children – 65 percent Couple without children – 24 percent Single parent family – 10 percent Other – 1 percent
Occupied private dwelling tenure	Fully owned – 44 percent Being purchased – 44 percent Renting – 10 percent

NCHS has noted that whilst the majority of its residents are couples between 25 and 59 years old, in the next ten years the number of residents over 60 is projected to increase by 73 percent with a resultant impact on NCHS's service demand. Nillumbik Shire Council has also identified an ageing population as an issue that will impact on the demand for health services<sup>22</sup>.

<sup>21</sup> Census 2001. Australian Bureau of Statistics.

<sup>22</sup> Nillumbik Municipal Health Plan.

## **D.3 Service demand**

### **D.3.1 Source of service demand**

NCHS receives approximately 2,500 new client referrals per year<sup>23</sup>, of which:

- 61 percent are referrals by the client or their family or friends;
- 14 percents are from GPs;
- 11 percent are from other community health services; and
- seven percent are from public hospitals.

NCHS receives new clients through referral by phone, fax, letter, or by a client visiting the service:

- 81 percent of new clients contact NCHS by phone;
- nine percent of new clients visit NCHS;
- six percent of new clients are referred to NCHS by letter, of which nearly all are referred by other community health services; and
- four percent are referred by fax, of which approximately half are referred by GPs and half referred by local hospitals.

## **D.4 Primary Care Partnership context**

NCHS is a member of the Banyule Nillumbik Primary Care Alliance (BNPCA), which covers the Banyule and Nillumbik LGA in Melbourne's north east.

BNPCA's strategic objective in relation to Service Coordination is as follows:

*"... the development and implementation of a service coordination model that will consolidate and enhance current best practice in the service sector through a coordinated and integrated approach to: service system entry and navigation, initial needs identification, assessment, care planning, and delivery of services. The model aims to facilitate improved access and health outcomes for primary care service users, their carers and communities."*<sup>24</sup>

<sup>23</sup> Based on sample of new client referrals 1 April 2004 to 30 April 2004.

<sup>24</sup> BNPCA Community Health Plan 2002-03

At the time of the review the following Service Coordination activities at the PCP level have been completed or are in progress:

- formation of an Service Coordination Working Group (SCWG) responsible for the development and implementation of Service Coordination across BNPCA;
- development of Service Coordination strategy, incorporating a common Service Coordination model for BNPCA;
- participation in DHS referral tool trails (superseded by Service Coordination Tool Templates);
- development of an interagency communication protocol;
- development of an interagency referral protocol; and
- development of the BNPCA Interagency Service Coordination Protocol Manual containing common Practices, Processes, Protocols and Systems (PPPS).

The Interagency Service Coordination Protocol Manual sets out:

- BNPCA's service coordination model, describing the context of the model, its purpose, the processes covered by the model and the tools and systems that support the operation of the model;
- the objectives of BNPCA's Service Coordination model and the general principles and values that it operates under;
- details of each process covered by the model, including definition of the following for each process:
  - general practices;
  - guiding principles;
  - activity protocols;
  - process diagrams, describing the activities undertaken in each process;
  - description of activities; and
  - consumer outcomes.

The Interagency Service Coordination Protocol Manual covers the following processes:

- initial contact (IC);

- initial needs identification (INI);
- referral;
- consumer consent;
- assessment;
- care planning;
- information privacy and security;
- complaints; and
- data collection.

In addition the manual also provides a number of ancillary resources, including:

- position descriptions for staff undertaking IC and INI;
- referral guidelines and tools (based on the Northern Metropolitan Region Referral Tools Guidelines) for making referrals, acknowledging referrals and notify referrers of referral outcomes;
- information on duty of care and at-risk assessment; and
- BNPCA's consumer charter.

#### **D.4.1 NCHS's involvement in PCP activities**

NCHS participates in the activities of the PCP through:

- NCHS's Chief Executive Officer sitting on the BNPCA's governing Project Management Group; and
- NCHS's Manager Primary Health sitting on the Service Coordination Working Group.

### **D.5 Agency's Service Coordination experience**

#### **D.5.1 Strategic background**

NCHS has identified the delivery of quality services as one of its strategic objectives<sup>25</sup>. Under that objective NCHS has identified the following:

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<sup>25</sup> Strategic Plan 2003 – 2006. Nillumbik Community Health Services

- services are to be coordinated to maximise client outcomes;
- services are to be client focused; and
- services are to be evidence based.

These objectives provide the strategic context for the implementation of Service Coordination within NCHS. During the review NCHS's CEO reiterated the link between Service Coordination and NCHS's strategic goals by stating that Service Coordination in NCHS is about delivering better services to clients, by taking a holistic approach and providing more timely services.

## **D.5.2 SC processes**

Within NCHS, the introduction of Service Coordination has led to the establishment of a single point of entry Service Co-ordination unit staffed by dedicated service co-ordinators. Service Co-ordination undertakes IC and INI activities prior to clients being filtered into NCHS's service streams. The design and operation of the service co-ordination unit was influenced by the BNPCA's Interagency Service Coordination Protocol Manual and the Service Coordination Tool Templates framework.

### *Intake and assessment*

The main features of NCHS's intake and assessment model are as follows:

- all referrals and contacts from clients seeking service are initially received by NCHS's reception. The receptionist filters the contacts where:
  - existing clients currently receiving services are transferred to the service provider;
  - existing clients who have not received services within a set period of time (as defined for each service) are transferred to service co-ordination unit;
  - new clients seeking services are transferred to service co-ordination unit; and
  - service providers making a referral by phone, fax or by letter are transferred to Service Co-ordination;
- Service Co-ordination is staffed by service co-ordinators during NCHS's business hours. NCHS employs two service co-ordinators (total 1.0 EFT). NCHS's service co-ordinators must have a relevant tertiary qualification in a health service and a demonstrated ability to undertake assessment activities;
- the service co-ordinators initially screens the contact to determine:
  - whether the client is only seeking information – in which case that information (whether regarding NCHS's services, health issues and health promotion, the health care system,

and referral pathways and options) is provided by the service co-ordinators to the client;  
and

- whether the client is eligible for services;
- the service co-ordinators completes the IC and INI process and enters the collated information onto SWITCH<sup>26</sup>;
- the service co-ordinators will prioritise the urgency of a client's requirements for services using a risk assessment tool;
- based on the above, the service co-ordinators will:
  - make an appointment(s) for the client to receive services;
  - make a referral for the client to another service provider;
  - place the client on a waiting list for services; and
- where a client is placed on a waiting list, the service co-ordinators will send to the client information on how the waiting list process works and information on approximate waiting times.

#### *Inter- agency referrals*

NCHS's interagency referral practices are defined within BNPCA's Interagency Service Coordination Protocol Manual. Broadly, all interagency referrals are made where:

- referrals are made under a standard cover sheet, which includes whether the referral is urgent or routine;
- an agency receiving a referral will acknowledge the receipt of an urgent referral within 24 hours and a routine referral within five working days. An agency acknowledging a referral will notify the referrer whether the referral has been accepted or rejected. In cases where the referral is rejected, the referral may be forwarded to another service provider, referred back to sender, or withdrawn; and
- an agency receiving a referral will (if requested by the referrer) subsequently inform the referrer of the referral outcome.

Within NCHS, the Service co-ordinator/s is responsible for operation of interagency referral system.

At the time of the review NCHS was not participating in any e-referral systems.

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<sup>26</sup> This process may require written collection of information and then subsequent data entry due to the incapacity of NCHS's SWITCH client information system to allow the service co-ordinators to take a phone call and use SWITCH simultaneously.

### *Changes to processes*

Prior to SC, NCHS operated a decentralised intake model where:

- contacts and referrals were received at the NCHS reception and were passed directly on to service providers;
- internal multi-disciplinary service providers had to respond directly to clients; and
- data collection and assessment procedures would occur at a client appointment.

## **D.6 Outcomes of SC**

### **D.6.1 General outcomes and assessment**

During the review NCHS's CEO rated Service Coordination as a successes within NCHS. In particular, it was noted that:

- clients have benefited from:
  - the organisation now responding immediately to clients and clients being referred in a more timely manner to appropriate services; and
  - improved communication with clients, where they are better informed about the intake and assessment process and they now receive information on issues such as privacy and confidentiality;
- NCHS has developed better communication links and service relationships with external service providers; and
- internally, NCHS has benefited from 'knowledge consolidation' where a holistic view of NCHS's service system and intake process has developed across the organisation.

NCHS's management observed that the delivery of Service Coordination benefits has depended on NCHS successfully managing:

- the challenge for staff of moving to a new service model – where staff needed to be involved and continuously informed about the developments of the new Service Coordination model; and
- issues with IT and ICT systems, which do not fully meet the requirements of the Service Coordination model.

NCHS's management also noted that BNPCA's Service Coordination forums have allowed NCHS and other service providers to exchange and develop best practice ideas and to recognise what network benefits may be achieved from closer coordination.

The following sections identify specific outcomes arising from SC.

### **D.6.2 Service delivery**

- Implementation of a centralised intake and assessment process has provided an increased capacity within the client appointment to focus solely on service delivery issues. Previously approximately 20 percent of the interview was dedicated to data collection and initial needs identification.
- Clients are assessed and responded to utilising a consistently applied assessment framework, which includes the capacity to prioritise clients.
- Referrals between NCHS and other agencies are made under a protocol that enables referring agencies to be informed about the outcomes of referrals.
- Due to reduced assessment time during an appointment, Service Coordination has allowed NCHS to provide some services within a single session, which has had a positive impact on waiting lists. (NCHS was not able to quantify this impact).

### **D.6.3 Service response and clients**

- Clients receive an initial response to their referral or contact within a day.
- Due to the reduction in assessment time during an appointment, Service Coordination has allowed NCHS to provide some services within a single session, minimising inconvenience to clients.
- Clients are clearly informed about services and the likely timing of services they will receive.
- Clients are clearly informed about privacy issues and explicitly asked for consent.
- Emergency client contacts are recognised and responded to immediately, providing capacity for immediate intervention
- Clients may be assessed and scheduled for multiple services simultaneously, with a reduction in duplication of data collected and faster referral to multiple services.

### **D.6.4 Staff conditions**

- Staff morale has not been adversely effected by the introduction of SC. NCHS actively managed potential impacts from the Service Coordination changes through encouraging staff involvement in the development and implementation of Service Coordination and through the visible commitment of NCHS's CEO to the Service Coordination changes and change process.

- Program specific service staff have developed a greater understanding of NCHS's wider service structure.

*Costs*

Table D.2 sets out the cost impact of Service Coordination on NCHS.

**Table D.2: Costs of implementing and operating Service Coordination in NCHS**

Name: Eltham Community Health Centre				Net Cost /		
Pre Service Coordination		Post Service Coordination		(Saving)	IMPLEMENTATION (One off expenses)	
CAPITAL		CAPITAL			CAPITAL	
					Purchase new computer	\$ 3,500
					Upgrade switch program	\$ 900
<b>Total</b>	\$ -	<b>Total</b>	\$ -		<b>Total</b>	\$ 4,400
INCOME		INCOME			INCOME	
					DHS Grant	\$ 2,000
					BNPCA Grant	\$ 6,000
<b>sub-total</b>	\$ -	<b>sub-total</b>	\$ -	<b>\$0</b>	<b>sub-total</b>	\$ 8,000
EXPENSES		EXPENSES			EXPENSES	
		Recruitment of staff 2 part time positions	\$ 48,000	\$ 48,000	Consultant hired to evaluate SC	\$ 10,000
					Recruitment of staff Advertising costs	\$ 300
					Interview for recruitment of staff 7.5 hrs X 2 days X 2 staff X \$24.3 p/hr	\$ 729
					IT training 1.5 hrs X \$24.3 p/hr X 55 ppl	\$ 2,005
					Develop training package 2ppl X \$24.3 p/hr X 20hrs	\$ 972
					Implement training for each team 55ppl X \$24.3 p/hr X 2hrs	\$ 2,673
					Develop practices, flow charts 3ppl X \$24.3 p/hr X 6hrs	\$ 437
					Setting up of the SC system 7.5hrs X 20 days X 6 months @ \$24.3 p/hr	\$ 21,870
					S.C meetings 5 people X 1.5hrs X 4 sessions X \$24.3 p/hr X 6 months	\$ 4,374
					Monthly meetings 5 people X 2 hrs X 6 sessions X \$24.3 p/hr	\$ 1,458
					Trainer Trainee 5ppl X 16hrs X \$24.3 p/hr	\$ 1,944
					Working Party Meeting 5ppl X 3hrs X 3 sessions X \$24.3 p/hr	\$ 1,094
					Meeting with SC Project Officer for support 5ppl X 3hrs X 3 sessions X \$24.3 p/hr	\$ 1,094

					Service resource directory training for 10 staff X 3 hours X \$25.00/hr	\$ 750
					Purchase service resource directory CD rom	\$ 66
					Trial of the INI in late 2001 for the Allied Health team. 2hrs/wk X 12 staff X 13 weeks X \$25/hr	\$ 7,800
					Review and feedback on INI trial. 1 Staff X 4hrs X \$29.50/hr plus 12 staff X 1 hr X \$25.00/hr	\$ 418
					Set up of the service co-ordination work station to include hands free telephonist head gear	\$ 125
					Pre-implementation staff meeting 15ppl X 10 sessions X 1hr X \$24.3 p/hr	\$ 3,645
<b>Total</b>	<b>\$ -</b>	<b>Total</b>	<b>\$48,000</b>	<b>\$48,000</b>	<b>Total</b>	<b>\$ 61,753</b>
<b>Net Income - Expenditure</b>	<b>\$ -</b>	<b>Total</b>	<b>\$48,000</b>	<b>\$48,000</b>	<b>Total</b>	<b>\$ 53,753</b>

NCHS operating costs have increased by \$48,000 per annum as a result of SC. This increase was driven entirely by the requirement to recruit additional staff to fill the service co-ordinators' role. NCHS did not decrease staff numbers elsewhere to fund this cost.

## D.7 Summary

SC appears to be a substantial success in NCHS, in particular it has had significant client benefits where:

- NCHS now responds to clients within 24 hours;
- reception less needed to navigate clients to other appropriate service systems;
- clients are more fully informed about services and the intake process;
- NCHS's is able to recognise and respond more effectively to emergency and high priority clients;
- SC has allowed NCHS time for integration of Health Promotion planning;
- implementation widened into Disability State funded program, Commonwealth Youth and Family program and Maternal and Child Health program.

In addition SC, appears to have had organisational benefits where:

- NCHS now has consistent assessment and referral practices;
- staff have an increased cross organisational understanding of the organisation's programs and services; and

- NCHS's links to other service providers have been strengthened and standardised practices introduced.

## **E Whitehorse Community Health Service**

### **E.1 Service profile**

Whitehorse Community Health Service (WCHS) provides the following services:

- allied health services:
  - adult and children's occupational therapy;
  - dentistry;
  - dietetics;
  - physiotherapy;
  - podiatry;
  - social work;
  - speech pathology;
- community health nursing;
- outreach programs;
- self-help and support groups;
- mobile drug safety service;
- needle and syringe program;
- health education and promotion; and
- information service.

At June 2003 WCHS had approximately 35 EFT spread over 68<sup>27</sup> employees and approximately 35 volunteers.

### **E.2 Client base**

WCHS provides services from a single site at Box Hill within the Whitehorse LGA.

Agency statistics<sup>28</sup> indicate that:

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<sup>27</sup> Annual Report 2002/03. Whitehorse Community Health Services.

- over 95 percent of WCHS's clients are residents of Whitehorse LGA;
- WCHS registers about 2,500 new clients per year;
- approximately 62 percent of WCHS's clients are women;
- approximately 80 percent of WCHS's client base is more than 50 years old;
- 38 percent of WCHS's clients are born overseas; and
- 29 percent of its clients are born overseas in countries where English is not the first language.

Table E.1 provides an overview of the demographic profile of Whitehorse LGA.

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<sup>28</sup> *ibid.*

**Table E.1: Agency LGA Demographics<sup>29</sup>**

Agency Catchment	Whitehorse City Council LGA, covering Box Hill, Blackburn, Nunawading, Burwood and Vermont
Total population	139,549
Age profile	Population 0 – 19 years – 24 percent Population 20- 39 years – 29 percent Population 40-59 years – 26 percent Over 60 years – 21 percent (Victorian average 16 percent)
Country of Birth	Australia – 72 percent UK – 5 percent China – 3 percent Greece – 2 percent Italy – 2 percent Other – 16 percent Victorian average: 19 percent from non English speaking countries
Annual individual income	\$1 - \$6,240 – 9 percent \$6,240 – \$15,600 – 28 percent \$15,600 - \$26,000 – 17 percent \$26,000 - \$36,400 – 15 percent \$36,400 - \$52,000 – 15 percent \$52,000 - \$78,000 – 10 percent \$78,000 or more – 6 percent Average annual income \$24,100 (Victorian State average income \$21,395).
Household type	Family household – 71 percent Lone person – 25 percent Group household – 4 percent
Family types	Couple with children – 47 percent Couple without children – 37 percent Single parent family – 14 percent Other family – 2 percent
Occupied private dwelling tenure	Fully owned – 51 percent Being purchased – 27 percent Renting – 20 percent Other – 2 percent

## E.3 Service demand

### E.3.1 Source of service demand

WCHS receives requests for services from other agencies through referrals and directly from potential clients.

<sup>29</sup> Census 2001. Australian Bureau of Statistics.

WCHS participates in Central Eastern PCP's (CEPCP) e-referral system where:

- WCHS receives:
  - 69 percent e-referrals from Peter James ACAS;
  - 12 percent e-referrals from Box Hill Hospital;
  - 14 percent e-referrals from Whitehorse City Council;
- WCHS community health integrated response program receives e-referrals from Box Hill Hospital;
- WCHS makes:
  - 71 percent e-referrals to Peter James ACAS; and
  - 29 percent e-referrals to Whitehorse City Council.

A client survey of WCHS's clients found that 44 percent of clients are self referred.

## **E.4 Primary Care Partnership context**

### **E.4.1 PCP status**

WCHS is a member of CEPCP, which covers Monash, Whitehorse, and Manningham LGAs in Melbourne's inner east.

CEPCP was established in March 2001 to promote and facilitate excellence in the planning, organising and delivery of primary health care services to the community within the PCP catchment. At least 80 percent of the community within the PCP catchment is expected to use or have some contact with primary health services in each year<sup>30</sup>.

At the time of the review the following Service Coordination activities at the PCP level have been completed or are in progress:

- participation in DHS referral tool trials (superseded by Service Coordination Tool Templates);
- development of Service Coordination practice manual, incorporating:
  - a rationale for Service Coordination within CEPCP;
  - design of the CEPCP Service Coordination model;

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<sup>30</sup> Community Health Plan, June 2002. Central Eastern PCP

- definition of Practices, Processes, Protocols and Systems (PPPS), covering:
  - Initial Contact (IC);
  - Initial Needs Identification (INI);
  - referral; and
  - care planning.

Within the PPPS, process objectives, intended consumer outcomes, quality indicators, process maps, good practice examples and guidelines, system tools and linkages to external requirements (policy and funding) are identified for each process;

- mapping of consumer pathways through the Service Coordination model;
- information for agency professional development and training;
- information for monitoring and continuous improvement;
- development of PCP web site incorporating:
  - links to service directories;
  - electronic copies of PCP and DHS documentation and resources;
  - news, including details of meetings, training, forums and other events;
- a CD based resource (incorporating the above) for non-internet connected personal computers; and
- trailing and implementation of a web based e-referral system (sourced from Infoxchange).

The e-referral system currently has ten participating agencies, of which the major participating agencies are:

- senders of referrals - Peter James ACAS, Box Hill Hospital and Monashlink CHS; and
- recipients of referrals – Monash City Council, Whitehorse City Council, Monashlink CHS, WCHS, and Peter James ACAS.

#### **E.4.2 PCP location and staff**

Central Eastern PCP is located at Whitehorse City Council's Nunawading offices.

The PCP is staffed by three members:

- the PCP Manager;
- a Service Coordination worker; and
- a consultant for the development and roll out of the PPPS.

During the review, members of the PCP identified that one of the strengths of CEPCP was that the three PCP staff had remained the same from the commencement of SC.

The role of the PCP has been to:

- provide the driving force behind, and act as a resource for, the development of the initiatives outlined above;
- work with PCP committees comprising members of the PCP to develop and control the direction of PCP activities; and
- act as a resource (training and advice) during the implementation of initiatives for the individual PCP members.

### **E.4.3 WCHS's involvement in PCP activities**

WCHS participates in the activities of the PCP through:

- the membership of WCHS's Chief Executive Officer on the CEPCP Governance Committee;
- the membership of the Manager Primary Health Care on the:
  - CEPCP Service Coordination (SC) sub-committee; and
  - CEPCP practitioners group.

## **E.5 Agency's Service Coordination experience**

### **E.5.1 Strategic background**

WCHS has adopted the following key priority for 2002/03 and beyond<sup>31</sup>:

- *"Commitment to Primary Care Partnerships (PCP) in particular, implementation of new service coordination standards and use of the Service Coordination Tool Templates (Service Coordination Tools Template)"*

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<sup>31</sup> Annual Report 2002/03. Whitehorse Community Health Services

## **E.5.2 SC processes**

Within WCHS the introduction of Service Coordination has included the following:

- establishment of a single point of entry Service Coordination unit staffed by dedicated assessment staff. This unit undertake IC and INI activities prior to clients being filtered into WCHS's service streams; and
- participation in CE-PCP's e-referral system.

The design and operation of the above processes are influenced by the CEPCP's PPPS (as set out in the CEPCP's Service Coordination Practice Manual) and the Service Coordination Tool Templates framework.

### *Service Coordination unit*

The main features of WCHS's Service Coordination model are as follows:

- all referrals and contacts from clients seeking service are initially received by WCHS's reception. The receptionist filters the contacts where:
  - the receptionist undertakes basic eligibility screening;
  - contacts seeking information are provided with information;
  - existing clients seeking services have their name taken and a message is passed to the relevant service provider to call the client back. If an existing clients has not received services for longer than a set period of time (as defined for each service) he / she is treated as a new contact;
  - potential clients seeking services are asked whether they are residents of Whitehorse LGA and whether they have a health concession card or are in receipt of a pension and advised if necessary to contact their relevant local community health services or that they may have to wait for services respectively;
  - basic contact details are recorded and the contact passed to the Service Coordination unit;
- fax and letter referrals are recorded and passed to the Service Coordination unit. E-referrals are received directly by the Service Coordination unit;
- the Service Coordination unit is staffed by a Service Coordinator. WCHS employs three Service Coordinators (1.7 EFT). Each Service Coordinator must be tertiary qualified in a relevant health service and have at least three year's experience as a health service practitioner;
- a Service Coordinator calls the new client. All clients are contacted within 48 to 72 hours of the initial receipt of a request for services. If a client is not available, a message is left

asking them to call the Service Coordination unit. WCHS makes at least three attempts to contact the client;

- when a Service Coordinator contacts the client, he / she:
  - undertakes the IC and INI processes completing Service Coordination Tool Templates on the SWITCH system;
  - obtains verbal consent about WCHS's privacy policy and use of information;
  - assesses the clients requirements;
  - makes an appointment for the client using a set of generic and service specific appointment prioritisation criteria;
- the Service Coordinators are supported by an Allied Health Assistant who:
  - sends to clients appointment confirmation letters or confirmation of likely waiting times for services; and
  - sends clients the WCHS information pack..

The establishment of a single entry Service Coordination model staffed by a limited number of dedicated staff has presented a number of management challenges for the organisation. In particular it is recognised that the Service Coordinator role requires a broad knowledge of the Service Coordination system making it difficult to back fill the position in the event of short term staff unavailability or sudden loss of staff.

#### *E-referral and referral acknowledgement*

WCHS participates in CEPCP's e-referral system. E-referrals are received directly by the Service Coordination unit. E-referrals are then dealt with under the process described above, except the information contained in the e-referral Service Coordination Tool Templates is entered into SWITCH directly rather than the clients asked to provide that information again. At present, the information on the e-referral Service Coordination Tool Templates cannot be automatically down loaded into WCHS's SWITCH system but has to be manually entered.

The CEPCP has a separate capacity to generate referral receipt acknowledgments and hence does not require a faxed acknowledgement.

Where WCHS receives a referral by post or fax from another provider, WCHS sends a faxed referral acknowledgement back to that provider that sets out:

- whether the client is eligible for services,
- details of any appointments for services made;
- details of whether the client has been put on a waiting list; or

- details of whether the client has been re-referred to another service provider.

#### *Changes to processes*

Prior to SC, WCHS operated a decentralised intake and assessment model where:

- contacts and referrals were received at the WCHS reception and were passed directly on to service providers within the specific disciplines;
- all discipline specific staff held responsibility for responding to clients;
- variable eligibility criteria were used across the organisation;
- no systematic approach was adopted for assessing need holistically;
- response times to clients were variable across service streams – up to 2 months in some cases; and
- data collection and assessment procedures would occur at a client appointment.

## **E.6 Outcomes of SC**

### *General outcomes*

During the review WCHS noted that Service Coordination had delivered significant improvements in the quality of service response to clients and improved internal practices.

WCHS also made a number of observations regarding ongoing operational issues for SC, including:

- the Service Coordination Tool Templates is not responsive to the needs of WCHS's CALD client base;
- technology development, specifically for SWITCH and e-referral, has not kept up with the requirements of Service Coordination in WCHS. As a result WCHS has had to work around the limitations in these IT systems; and
- the initial introduction of Service Coordination was a challenge for WCHS service staff such that effective change management was required to ensure staff participation and commitment.

However, none of these issues were seen to outweigh the benefits of Service Coordination in WCHS.

The following sections identify specific outcomes arising from SC.

*Service delivery*

- Consistent referral practices have been adopted across WCHS.
- WCHS benefits from adopting the CEPCCP Service Coordination practice manual framework, where consistency of practice with other participating service providers has been achieved.

*Service response and clients*

- Clients are responded to within 48 hours of initial contact or referral.
- Clients are provided with service eligibility information at initial contact.
- Clients receive appropriate information to meet their needs. The review's client survey showed 100 percent of clients received information they believe they need.
- Clients receive appropriate services. 100 percent of clients in the review's client survey said they were happy with services they are referred to.
- Clients requiring multiple services are able to be provided with appointments concurrently where able rather than being required to receive sequential appointments. In addition the centralised appointments system ensures that where possible multiple appointments are coordinated into a single visit.
- Clients are better informed, receiving information from the client information booklet, appointment and waiting list letters, and information provided during the Service Coordination process (for example, explanation of privacy).
- WCHS can respond immediately to crisis clients.
- WCHS is able to prioritise its response to different types of clients based on needs.
- WCHS is able to respond better to the needs of CALD clients through the increased use of interpreters.

*Staff conditions*

- Reception staff are subject to less stress and reduced workloads as there is now greater clarity of role and trained staff are available to deal with the initial enquiry and assessment process.
- There is an improved balance of workloads for service staff, where new clients are allocated by the Service Coordinators to service staff according to a service staff's availability.
- Staff have better role clarity around IC and INI.

- Reception staff are better supported

*Administration*

- There is reduced duplication of client data collection, from both coordinated referral and a reduction in multiple entry by clients into the service system.

*Costs*

Table E.2 sets out the cost impact of Service Coordination on WCHS.

**Table E.2 Costs impact of SC**

Name: Whitehorse Community Health Service Pre Service Coordination		Post Service Coordination		Net Cost / (Saving)	IMPLEMENTATION (One off expenses)	
CAPITAL		CAPITAL			CAPITAL	
					3 computers	\$4,350
					3 Phone sets	\$2,250
					Other IT costs	\$1,859
<b>Total</b>	\$0	<b>Total</b>	\$0		<b>Total</b>	\$8,459
INCOME		INCOME			INCOME	
					Grant	\$50,000
<b>sub-total</b>	\$0	<b>sub-total</b>	\$0		<b>sub-total</b>	\$50,000
EXPENSES		EXPENSES			EXPENSES	
Staff reduction for SC:						
- Podiatrist	\$26,898			(\$26,898)		
- Occupational Therapist	\$22,357			(\$22,357)		
		Staff increase for SC:				
		- 3 Service Coordinators	\$98,346	\$98,346		
		- 1 Allied Health Assistant	\$11,045	\$11,045		
					Design and implementation of SC system (2001, 2002, 2003)	\$53,969
					Design and implementation training - BATS and PPPS	\$3,552
					Recruitment costs	
					- Time	\$4,837
					- Costs	\$1,582
					Service Coordinator Training	
					- Management time	\$2,411
					- IT training	\$2,653
					- Orientation	\$1,989
					Data Manager Training	\$413
<b>Total</b>	\$49,255	<b>Total</b>	\$109,391	\$60,136	<b>Total</b>	\$71,406
<b>Net Income - Expenditure</b>	\$ 49,255	<b>Total</b>	\$109,391	\$60,136	<b>Total</b>	\$ 21,406

It is noted that Service Coordination has had a significant recurrent cost impact on WCHS's operating costs due to the need to finance the new Service Coordination positions. WCHS only partially funded these positions through reductions in service staff.

WCHS noted that the value of Service Coordination in terms of reduced time spent by service staff on Service Coordination activity is approximately \$51,000 per annum. However, this value has been absorbed into improved services rather than achieved as an actual cost saving.

## **E.7 Summary**

On balance Service Coordination appears to have delivered significant benefits to WCHS.

These benefits include:

- clients are assessed and receive appointments more quickly, are better informed and receive services according to their priority;
- access for clients is more equitable through the consistent application of specific and generic eligibility criteria,
- WCHS is more able to respond to the needs of CALD clients; and
- WCHS benefits from a consistent practice of intake and assessment (both internally and as part of coordinated referral practices with PCP agencies) and increased cross service understanding within it service staff.

Then ongoing operational issues include limitations in Service Coordination Tool Templates and IT systems which are beyond the control of WCHS.

## **F Banyule Community Health Service**

### **F.1 Service profile**

Banyule Community Health Service (BCHS) provides the following services:

- Home and Allied Services:
  - dental;
  - occupational therapy;
  - podiatry;
  - physiotherapy;
  - psychology;
  - speech pathology;
  - dietary and nutrition services;
  - carer supports;
  - community health nurse;
- Counselling and Community Development:
  - counselling;
  - drug and alcohol;
- Medical Services:
  - medical;
  - clinic nursing;
- Specialist Services:
  - problem gambling; and
  - youth accommodation services.

BCHS provides services through the four service units shown above, supported by an administrative services unit providing:

- executive management;
- information technology (IT);
- human resources (HR);
- finance;
- quality assurance;
- health promotion;
- reception;
- general administration; and
- infrastructure services.

BCHS has 133 employees (79 EFT) of which:

- 28 employees (16 EFT) are employed within administrative services; and
- 105 employees (63 EFT) are employed within service units.

## **F.2 Client base**

BCHS provides services to the residents of Banyule LGA.

BCHS provides services from its main site in West Heidelberg and sites in Greensborough, Coburg, and Rosanna.

Table F.1 provides an overview of the demographic profile of Nillumbik LGA.

**Table F.1: Agency LGA Demographics<sup>32</sup>**

Agency Catchment	Banyule City LGA, covering Heidelberg, Greensborough, Ivanhoe, Rosanna, Lower Plenty and Montmorency
Total population	113,696
Age profile	Population 0 – 19 years – 26 percent Population 20- 39 years – 28 percent Population 40-59 years – 28 percent Over 60 years – 19 percent (Victorian average 16 percent)
Country of Birth	Australia – 80 percent UK – 4 percent Italy – 2 percent Greece – 1 percent New Zealand – 1 percent China – 1 percent Other – 11 percent Victorian average: 19 percent from non English speaking countries
Annual individual income	\$1 - \$6,240 – 8 percent \$6,240 – \$15,600 – 27 percent \$15,600 - \$26,000 – 18 percent \$26,000 - \$36,400 – 16 percent \$36,400 - \$52,000 – 16 percent \$52,000 - \$78,000 – 10 percent \$78,000 or more – 5 percent Average annual income \$23,509 (Victorian State average income \$21,395).
Household type	Family household type comprises the majority – 75 percent Lone person – 22 percent Group household – 3 percent
Family types	Couple with children – 50 percent Couple without children – 33 percent Single parent family – 15 percent Other family – 2 percent
Occupied private dwelling tenure	Fully owned – 49 percent Being purchased – 28 percent Renting – 21 percent

## F.3 Service demand

### F.3.1 Source of service demand

BCHS receives approximately 4,000 contacts per year<sup>33</sup>, from approximately 3,300 clients.

<sup>32</sup> Based on BCBS SWITCH data for the period September 2003 to February 2004

<sup>33</sup> Based on sample of new client referrals 1 April 2004 to 30 April 2004.

Of the new clients:

- 32 percents are for podiatry services;
- 29 percent are for physiotherapy services; and
- 16 percent are for counselling services.

## **F.4 Primary Care Partnership context**

### **F.4.1 PCP status**

BCHS is a member of the Banyule Nillumbik Primary Care Alliance (BNPCA), which covers the Banyule and Nillumbik LGA in Melbourne's north east.

BNPCA's strategic objective in relation to Service Coordination is as follows:

*"... the development and implementation of a service coordination model that will consolidate and enhance current best practice in the service sector through a coordinated and integrated approach to: service system entry and navigation, initial needs identification, assessment, care planning, and delivery of services. The model aims to facilitate improved access and health outcomes for primary care service users, their carers and communities."*<sup>34</sup>

At the time of the review the following Service Coordination activities at the PCP level have been completed or are in progress:

- formation of an Service Coordination Working Group (SCWG) responsible for the development and implementation of Service Coordination across BNPCA;
- development of Service Coordination strategy, incorporating a common Service Coordination model for BNPCA;
- participation in DHS referral tool trials (superseded by Service Coordination Tool Templates);
- development of an interagency communication protocol;
- development of an interagency referral protocol; and
- development of the BNPCA Interagency Service Coordination Protocol Manual containing common Practices, Processes, Protocols and Systems (PPPS).

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<sup>34</sup> BNPCA Community Health Plan 2002-03

The Interagency Service Coordination Protocol Manual sets out:

- BNPCA's service coordination model, describing the context of the model, its purpose, the processes covered by the model and the tools and systems that support the operation of the model;
- the objectives of BNPCA's Service Coordination model and the general principles and values that it operates under;
- details of each process covered by the model, including definition of the following for each process:
  - general practices;
  - guiding principles;
  - activity protocols;
  - process diagrams, describing the activities undertaken in each process;
  - description of activities; and
  - consumer outcomes.

The Interagency Service Coordination Protocol Manual covers the following processes:

- initial contact (IC);
- initial needs identification (INI);
- referral;
- consumer consent;
- assessment;
- care planning;
- information privacy and security;
- complaints; and
- data collection,

In addition the manual also provides a number of ancillary resources, including:

- position descriptions for staff undertaking IC and INI;

- referral guidelines and tools (based on the Northern Metropolitan Region Referral Tools Guidelines) for making referrals, acknowledging referrals and notify referrers of referral outcomes;
- information on duty of care and at-risk assessment; and
- BNPCA’s consumer charter.

#### **F.4.2 BCCHS’s involvement in PCP activities**

BCCHS participates in the activities of the PCP through:

- BCCHS’s Chief Executive Officer sitting on the BNPCA’s governing Project Management Group; and
- BCCHS’s Manager Primary Health sitting on the Service Coordination Working Group.

### **F.5 Agency’s Service Coordination experience**

#### **F.5.1 Strategic background**

BCCHS strategic plan 2003 – 2005 includes the following statement of purpose:

*“... promote a multidisciplinary approach to community health through teamwork and cooperation with other health and welfare providers...”*

In the BCCHS operational plan, this statement of purpose is addressed through one of BCCHS’s three key strategic directions, namely to:

*“... become a valued contributor to a coordinated community health and welfare system within the City of Banyule...”*

BCCHS has identified that continued participation through BNPCA in the development of:

- a common approach to SC;
- partnerships with local service providers; and
- common IT planning and systems,

are the means through which BCCHS will achieve its strategic objectives.

## **F.5.2 SC processes**

Within BCHS, the introduction of Service Coordination has led to the establishment of a single point of entry intake unit staffed by dedicated intake workers. The intake unit undertakes IC and INI activities prior to clients being filtered into BCHS's service streams. The design and operation of the intake unit was influenced by BNPCA's Interagency Service Coordination Protocol Manual and the Service Coordination Tool Templates framework.

BCHS has adopted a progressive introduction of the centralised intake unit across its services. To date, allied health services and counselling are participating in the centralized intake system.

### *Intake and assessment*

The main features of BCHS's intake and assessment model are as follows:

- all referrals and contacts from clients seeking service are initially received by BCHS's reception. The receptionist filters the contacts, where:
  - existing clients currently receiving services are transferred to their relevant service provider;
  - new clients seeking services are transferred to the intake unit; and
  - service providers making a referral by phone are transferred to the intake unit<sup>35</sup>;
- the intake unit is staffed by an Intake Worker during BCHS's business hours (Monday to Friday 8.00 a.m. to 6.00 p.m.);
- BCHS employs two Intake Workers (total 2.0 EFT). BCHS's intake workers must have a relevant tertiary qualification and a demonstrated ability to undertake assessment activities;
- where BCHS receives a referral by fax, letter or e-mail from a service provider the referral is received directly by the intake unit and a referral acknowledgment sent to referring agency;
- the Intake Worker contacts the client, if he or she is not already on the phone;
- the Intake Worker initially screens the contact to determine:
  - whether the client is only seeking information – in which case that information (whether regarding BCHS's services, health issues and health promotion, the health care system, and referral pathways and options) is provided by the Intake Worker to the client;
  - whether the client is eligible for services;

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<sup>35</sup> Criteria for referral to the intake unit are set out in BCHS's Intake Screening Checklist.

- if the client is distressed, the Intake Worker may request the assistance of a counsellor to assist him or her<sup>36</sup>;
- the Intake Worker completes the IC and INI process and enters the collated information onto SWITCH;
- the Intake Worker prioritises the urgency of a client's requirements for services using a risk assessment tool;
- based on the above, the Intake Worker will either:
  - make an appointment(s) for the client to receive services;
  - make a referral for the client to another service provider;
  - place the client on a waiting list for services<sup>37</sup>; and
- where a client is placed on a waiting list, the intake worker will send to the client information on how the waiting list process works and information on approximate waiting times.

When a client presents for his or her first appointment, the receptionist checks the client files that all the required information has been collected and recorded and collects any additional data as required.

#### *Inter- agency referrals*

BCHS's interagency referral practices are defined within BNPCA's Interagency Service Coordination Protocol Manual. Broadly, all interagency referrals are made where:

- referrals are made under a standard cover sheet, which includes whether the referral is urgent or routine;
- an agency receiving a referral will acknowledge the receipt of an urgent referral within 24 hours and a routine referral within five working days. An agency acknowledging a referral will notify the referrer whether the referral has been accepted or rejected. In cases where the referral is rejected, the referral may be forwarded to another service provider, referred back to sender, or withdrawn; and
- an agency receiving a referral will (if requested by the referrer) subsequently inform the referrer of the referral outcome.

Within BCHS, the Intake Worker is responsible for operation of interagency referral system.

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<sup>36</sup> Procedures for handling crisis clients are set out in the Handling Crisis Clients Policy.

<sup>37</sup> BCHS waiting lists are managed through the SWITCH system.

BCHS participates in BNPCA's e-referral system. At present the e-referral system uses a web-based email system where Service Coordination Tool Templates forms are attached as an electronic file. BCHS's procedures for the receipt of an e-referral are the same as for a fax referral.

#### *Prior processes*

Prior to the introduction of a centralised intake unit, BCHS operated under a decentralised intake model, where different intake practices occurred between different services. These practices varied across sites, between services and sometimes within services<sup>38</sup>. Different practices included:

- use of different assessment forms; and
- variations in eligibility and prioritisation criteria.

In addition, process documentation was low, duplication of client data collection was high, and no data was readily available to identify service gaps or enable effective organisation-wide service planning.

## **F.6 Outcomes of SC**

### *General outcomes and assessment*

Within its Service Coordination Policy, BCHS has identified a set of Service Coordination specific objectives, namely:

- to provide a well coordinated and integrated health system for consumers;
- to develop consistent and sustainable inter-agency and intra-agency referral practices;
- to reduce duplication and streamline processes within the service system;
- to encourage collaboration with all relevant sectors of the service system;
- to allow consumers and carers to obtain appropriate services in a timely fashion; and
- to give consumers access to information to allow them to participate fully in the management of their health.

During the review, BCHS executive management group noted that the objectives of Service Coordination had been met or will be met as the centralised intake model is progressively implemented across the remaining services.

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<sup>38</sup> Review of intake practices. Effective Change Pty Ltd. February 2002.

The executive management group particularly noted that:

- a single intake process allows BCHS's clients to access a greater range of services than was previously possible made through the service based intake model;
- there is now a consistent approach to the intake process;
- the use of a common Service Coordination Tool Templates tool acts as a wider resource, enabling BCHS and other service providers to undertake effective care planning and case conferences.

The group also noted that the successful implementation of Service Coordination within BCHS had been based on:

- an active change management process; and
- significant investments in terms of time and money to plan, develop, and implement SC.

The following sections identify specific outcomes arising from SC.

*Service delivery*

- Clients are assessed and responded to utilising a consistently applied assessment framework, which includes the capacity to prioritise clients and the consistent application of at-risk assessments.
- BCHS has eliminated multiple and duplicative intake and assessment practices.
- BCHS has developed the capacity to review and plan services using reliable and consistent data from the centralised intake process.
- Referrals between BCHS and other agencies are made under a protocol that enables referring agencies to be informed about the outcomes of referrals.

*Service response and clients*

- Clients receive an initial response to their referral or contact within 24 hours.
- Clients are clearly informed about services and the likely timing of services they will receive.
- Clients are clearly informed about privacy issues and explicitly asked for consent.
- Emergency client contacts are recognised and responded to immediately, providing capacity for immediate intervention.

- Clients may be assessed and scheduled for multiple services simultaneously, with a reduction in duplication of data collected and faster referral to multiple services.
- Clients no longer encounter a confusingly different range of intake practices.

*Staff*

- Staff stress relating to the Service Coordination changes has been minimised due to effective change management.
- Staff IT skills have been developed.

*Costs*

Table F.2 sets out the cost impact of Service Coordination on BCHS.

**Table F.2: Costs of implementing and operating Service Coordination in BCHS**

Name: Banyule Community Health Service Pre Service Coordination		Post Service Coordination		Net Cost / (Saving)	IMPLEMENTATION (One off expenses)	
CAPITAL		CAPITAL			CAPITAL	
					Capital investment	\$ 10,000
<b>Total</b>	\$ -	<b>Total</b>	\$ -		<b>Total</b>	\$ 10,000
INCOME		INCOME			INCOME	
<b>sub-total</b>	\$ -	<b>sub-total</b>	\$ -		<b>sub-total</b>	\$ -
EXPENSES		EXPENSES			EXPENSES	
		Intake employees wage	\$ 79,532	\$79,532	Orientation training 96 hours X \$31.14	\$ 2,989
		Annual IT costs	\$ 4,000	\$4,000	Intake staff training 160 hours X \$31.14	\$ 4,982
					Staff information sessions 360 hours X \$31.14	\$ 11,210
					Staff work shops 480 hours X \$31.14	\$ 14,947
					Service Co-ordination training tools 240 hours X \$31.14	\$ 7,474
					PCP training 64 hours X \$31.14	\$ 1,993
					Train the trainer 20 hours X \$33.30	\$ 666
					Staff IT training 132 hours X \$31.14	\$ 4,111
					Training on SCoTT/SWITCH 2 hours X \$350.00	\$ 700
					Original implementation review	\$ 21,000
					Temporary staff used during implementation 192 hours X \$31.14	\$ 5,979
					Time spent on implementation of service co-ordination 638.5 hours X \$40.00	\$ 25,540
					Staff working groups 120 hours X \$34.90	\$ 4,188
					Staff change management Group 42 hours X \$31.50	\$ 1,323
<b>Total</b>	\$ -	<b>Total</b>	\$83,532	\$83,532	<b>Total</b>	\$107,102

BCHS operating costs have increased by \$83,500 per annum as a result of SC. This increase has been caused primarily by the requirement to recruit additional staff to fill the Intake Worker roles. BCHS did not decrease staff numbers elsewhere to fund this cost.

In addition, BCHS incurred significant implementation costs as a result of detailed planning processes and change management activities.

## F.7 Summary

SC appears to be a substantial success in BCHS, in particular it has had significant client benefits where:

- BCHS's responds to clients within 24 hours;

- clients are more fully informed about services and the intake process;
- clients are able to access more services;
- clients receive a consistent response; and
- BCHS's is able to recognise and respond more effectively to emergency and high priority clients.

In addition SC, appears to have had organisational benefits where:

- BCHS now has consistent intake, assessment and referral practices;
- staff have an increased cross organisational understanding of the organisation's programs and services;
- BCHS has developed a change management culture where the success of the continuing roll out of Service Coordination across services is likely to be maximised; and
- BCHS's links to other service providers have been strengthened and standardised practices introduced.

## **G Moyne Shire Council**

### **G.1 Service profile**

Moyne Shire Council's (MSC) Community Support Unit provides the following services to the residents of Moyne Shire:

- HACC services:
  - assessment;
  - personal care;
  - home care;
  - respite;
  - property maintenance;
  - delivered meals (Meals on Wheels).

This review concentrates on the impact of Service Coordination on HACC services.

#### **G.1.1 HACC services structure**

HACC services has 39 employees, comprising:

- a Manager Aged and Disability Support;
- 2.8 assessment and coordination staff;
- one full time administration and support officer; and
- 34 service staff, comprising personal carers, home carers and home maintenance workers.

HACC services are provided from Port Fairy, for the western half of the shire, and from Mortlake, for the eastern half of the shire. Each region has a separate services team comprising two Support Coordinators and service staff. The Manager Aged and Disability Support manages both regions from the MSC's Mortlake office.

In addition to the above, the unit also has 180 volunteers who provide support primarily to the Meals on Wheels service.

### **G.2 Client Base**

Table G.1 illustrates the demographic profile of Moyne Shire.

**Table G.1: Agency LGA Demographics<sup>39</sup>**

Agency Catchment	Moyne Shire Council covering Port Fairy and Mortlake
Total population	14,986
Age profile	Population 0 – 19 years – 31 percent Population 20- 39 years – 22 percent Population 40-59 years – 29 percent Over 60 years – 18 percent (Victorian average 16 percent)
Country of Birth	Australia – 94 percent UK – 3 percent New Zealand – 1 percent Other – 2 percent Victorian average: 19 percent from non English speaking countries
Annual individual income	\$1 - \$6,240 – 8 percent \$6,240 – \$15,600 – 33 percent \$15,600 - \$26,000 – 24 percent \$26,000 - \$36,400 – 17 percent \$36,400 - \$52,000 – 10 percent \$52,000 - \$78,000 – 5 percent \$78,000 or more – 3 percent Average annual income \$18,063 (Victorian State average income \$21,395)
Household type	Family household – 76 percent Lone person – 22 percent Group household – 2 percent
Family types	Couple with children – 48 percent Couple without children – 38 percent Single parent family – 12 percent Other family – 2 percent
Occupied private dwelling tenure	Fully owned – 55 percent Being purchased – 23 percent Renting – 15 percent Other – 7 percent

MSC's resident base is older than the average Victorian demographic profile and also has a lower average income than the Victorian state average.

Compared to most other LGAs (both metropolitan and non-metropolitan), MSC has a low percentage of residents who were born overseas or whose first language is not English.

### G.3 Service demand

MSC provides HACC services to approximately 500 clients. At any one time MSC provides assistance to approximately<sup>40</sup>:

- 230 home care clients;

<sup>39</sup> Census 2001. Australian Bureau of Statistics

<sup>40</sup> MSC quarterly HACC output data returns. Quarters 1, 2 and 3. 2003-04

- 30 personal care clients;
- 10 respite clients;
- 20 planned activity group clients;
- 175 recipients of home maintenance; and
- 110 delivered meals clients.

### **G.3.1 Source of service demand**

MSC receives approximately 180 referrals for services each year.

Referrals are received by:

- phone – approximately 60 percent of all referrals;
- e-referral – approximately 33 percent of all referrals;
- fax – approximately 5 percent of all referrals; and
- post – approximately 2 percent of all referrals.

Approximately 50 percent of referrals are received from other service providers and 50 percent are received directly from potential clients or their families.

MSC is a participant in the South West Alliance of Rural Health's (SWARH) e-referral system. During the review, MSC stated its main sources of incoming e-referral are from:

- Moyne Health Services (the main community health service in the shire);
- acute care; and
- general practitioners.

Like many HACC service providers, MSC primarily receives rather than generates client referrals.

## **G.4 Primary Care Partnership context**

### **G.4.1 PCP status**

MSC is a member of the PCP South West (PCP-SW), which covers the Corangamite, Moyne, and Warrnambool City LGAs.

In order to share costs and to promote a common approach to Service Coordination in South West Victoria, PCP-SW and Southern Grampians Glenelg PCP (SGG) have formed the joint Service Coordination Work Group (SCWG) to undertake Service Coordination within the two PCPs.

At the time of the review, the SCWG and its member PCPs had undertaken the following activities:

- participation in DHS referral tool trails (superseded by Service Coordination Tool Templates);
- development, in conjunction with Infoxchange, of a services directory of agencies within South West Victoria. This service directory is available in hard copy, on CD Rom, or on the internet through the statewide service directory;
- development of draft Practices, Processes, Protocols and Systems (PPPS) based substantially on the Western Region Best Practice Manual (WMR-BPM); and
- trialling and implementation of an e-referral system based on SWARH infrastructure.

The SCWG works with the Clinical and Primary Care Sub-committee of SWARH to ensure that the development of Service Coordination recognises regional Service Coordination policy settings defined by SWARH.

#### **G.4.2 MSC's involvement in PCP activities**

MSC's has input to development of regional Service Coordination initiatives through participation by:

- a Support Coordinator in the SCWG; and
- the Manager Aged Care<sup>41</sup> in the e-referral working group.

### **G.5 Agency's Service Coordination experience**

#### **G.5.1 SC processes**

Within MSC, the main operational impact of Service Coordination has been the adoption of Service Coordination Tool Templates and improved data collection processes within its intake and assessment functions, adoption of an interagency referral protocol, and participation in SWARH's e-referral system.

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<sup>41</sup> Manager of Aged Care Unit

### *Intake and assessment*

The main features of MSC's intake and assessment model are as follows:

- upon receipt, a referral is passed to the Support Coordinators at the relevant service centre in Port Fairy or Mortlake. If a referral is by phone and no Support Coordinator is available, the MSC receptionist will take the person's contact details and arrange a time for the service centre to call back;
- a Support Coordinator will contact the potential client by phone in order to, collate further information not contained in the referral, and complete the IC and INI processes using the Service Coordination Tool Templates. If as a result of this initial screening a potential client appears to be eligible to receive services an appointment is made to complete a full needs assessment;
- a Support Coordinator will visit a potential client to complete a full needs assessment. If services are warranted the Support Coordinator provides the client with information regarding the services to be delivered, the costs of those services and information on privacy and confidentiality;
- at each service centre a designated Support Coordinator subsequently undertakes the service planning and coordination activity for the delivery of the agreed services to the client; and
- within five days of receipt of a referral, a referral outcome form is sent back to the referrer notifying them of details of the referral status<sup>42</sup> and / or referral outcome.

MSC utilizes an administration support officer within the Community Support Unit. As part of the intake and assessment processes, Support Coordinators are responsible for assessments, undertaking data entry into Carelink, arrangement of appointments and services, and the receipt, despatch and acknowledgement of referrals.

### *Referral*

MSC makes referrals to other service providers by fax. All fax referrals are made under the draft South West Region Interagency Referral Protocol, where:

- a referral is made under a standard fax cover sheet; and
- client information is provided within Service Coordination Tool Templates form printed directly from MSC's Carelink system.

Under the protocol, an agency receiving a referral fax will fax or e-referral back to a referring agency within 48 hours of the referral being made. This acknowledgment confirms that the referral and relevant documents have been received.

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<sup>42</sup> A referral's status may be, either proceeding with an estimated client contact date, or not proceeding as a result of a client declining to participate in the assessment, a closed service waiting list or a client not being eligible for services.

Subsequently, within five days of receipt of a referral, a recipient will also fax back a referral outcome form (as described above) describing the outcome of the referral.

MSC also receives referrals from SWARH's e-referral system. However, as MSC's Carelink system is not integrated to the SWARH's email system, the electronic copies of the Service Coordination Tool Templates received as part of an e-mail referral are processed manually into Carelink under the same procedure used for receipt of a fax based referral.

MSC is not able to make e-referrals due to not being part of the SWARH IT network, but does use a cover acknowledgment sent back a win zip file..

## **G.5.2 Changes to processes**

MSC has not changed its core intake and assessment activities as a result of SC. Changes made cover the system tools used within those activities, namely:

- the adoption of Service Coordination Tool Templates tool templates in replacement of the CIARR template and the resultant collation of more information;
- greater emphasis on privacy / confidentiality and OH&S issues during assessments;
- improvements to information provided to clients; and
- the use of a referral protocol.

## **G.6 Outcomes of SC**

This section sets out the identified outcomes of the Service Coordination and related business changes.

### **G.6.1 General outcomes and assessment**

During the review, MSC noted that Service Coordination had delivered improvements in the quality and consistency of information collected about clients, which allows MSC to better identify client need and deliver more appropriately targeted services to clients.

MSC also made a number of observations regarding the short-term impacts of Service Coordination that MSC had to manage at implementation and structural issues that influence the potential of MSC to maximise the level of benefits it will achieve:

- bringing existing data records up to the new standard defined by Service Coordination Tool Templates was a time consuming and disruptive process. However, it is noted that MSC received a DHS grant to cover the cost of this activity;
- staff initially found the increased requirement for data collection stressful;

- duplication of client data collected has been reduced but not eliminated. This is due to some post acute referral practices still needing to be addressed and due to lack of system connectivity to e-referral;
- MSC is isolated due to lack of connectivity between itself and the (dominant) SWARH network, with the result that regional Service Coordination policy development does not necessarily account for the needs of council based service providers and IT development does not account for MSC IT profile; and
- network driven efficiencies are only emerging slowly because some members of the network have been slow to adopt Service Coordination – in part this reflects the low capacity of small rural agencies to undertake Service Coordination change due to both financial constraints, where the smaller agencies cannot afford to undertake relatively costly change and resource capacity constraints where smaller agencies do not have available staff to undertake system change.

The following sections identify specific outcomes arising from SC.

#### **G.6.2 Service delivery**

- SC has not increased the number of new clients MSC responds to each year, however it has improved the service response made to those clients through more detailed assessment and subsequently more target service delivery.
- Where the Service Coordination Tool Templates is used for inward referral, assessment times have reduced by 45 minutes per assessment.

#### **G.6.3 Service response and clients**

- There was an increase in the quality and appropriateness of referrals to and from other agencies.
- SC formalised MSC's compliance with the privacy and confidentiality requirements.
- Clients receive more information at assessment, and hence have a greater understanding of services.

#### **G.6.4 Staff conditions**

- As a result of Service Coordination training:
  - staff understanding of, and confidence in using, IT systems has improved; and
  - staff have a greater understanding of linkages within the local service system.

- SC and wider PCP initiatives have been successful in engendering in staff an acceptance of continuing service development.
- Staff have been stressed by the additional data work loads associated with bringing client data up to date and into the correct form.

### **G.6.5 Networking efficiencies**

- Improved referral practices have enhanced MSC's links with external agencies, through both the development of formalised referral practices (e-referral and non-e-referral) and the increased communication between agencies about their priorities when receiving a referral. MSC has achieved improved referral practices between itself and local General Practitioners and Acute Care agencies, however it also notes that there are still a lot of network improvements to be made.

### **G.6.6 Administration**

- Staff noted that the development of Service Coordination and the adoption of consistent and documented service practices was beneficial in creating a stronger culture of organisational professionalism.

#### *Costs*

Table G.2 sets out the cost impact of Service Coordination on MSC

**Table G.2: Costs of implementing and operating Service Coordination in MSC**

Name: Moyne Shire Council				Net Cost / (Saving)		IMPLEMENTATION (One off expenses)	
Pre Service Coordination		Post Service Coordination					
CAPITAL		CAPITAL				CAPITAL	
						Computer 1 x \$5000.00	\$ 5,000
						DHS grant	-\$ 5,000
						IT upgrade	\$ 1,500
<b>Total</b>	\$ -	<b>Total</b>	\$ -			<b>Total</b>	\$ 1,500
INCOME		INCOME				INCOME	
<b>sub-total</b>	\$ -	<b>sub-total</b>	\$ -			<b>sub-total</b>	\$ -
EXPENSES		EXPENSES				EXPENSES	
		Printing S.C forms \$20.00 X 12 months	\$ 240	\$ 240		Recruitment costs	\$ 250
						Interview cost 2 people X 7.5hrs X \$30 p/hr	\$ 450
						Worker to bring data up to date DHS grant	\$ 15,000 -\$ 15,000
						Training of new staff \$30 p/hr X 7.5hr X 2.5 days X 12 weeks	\$ 6,750
						Training preparation 1 person X \$30 p/hr X 7.5 hrs X 20 days	\$ 4,500
						Presenting projects \$30 p/hr X 7.5hrs	\$ 225
						Trainer trainee 1 person X 3hrs X 12 weeks X \$30 p/hr	\$ 1,080
		SC committee meetings 2 people X \$30 p/hr X 3 hrs X 12 months	\$ 2,160	\$ 2,160		Time commitment to SC All committees \$30 X 200 hrs	\$ 6,000
<b>Total</b>	\$ -	<b>Total</b>	\$ 2,400	\$ 2,400		<b>Total</b>	\$ 19,255

The implementation costs for Service Coordination were significantly higher than the day to day operational costs of SC. This reflects the fact that Service Coordination did not require that MSC adopt any significant changes to its operational processes. Instead Service Coordination required MSC to make an investment in the resources used in those processes through training, IT upgrades, and participation in local Service Coordination bodies.

## G.7 Summary

On balance Service Coordination appears to be delivering a net benefit to MSC and that this benefit is likely to increase as MSC and the local PCP continue to enhance the performance of the local Service Coordination network.

From a positive perspective:

- some operational efficiencies have been accessed;

- standards of clients service (information provided and empowerment of clients) have improved; and
- staffs' service industry knowledge and acceptance of continuing development of a network based service structure have improved.

However, MSC has only being able to access limited network based efficiencies due to SWARH being the dominant network system and the nature of a network based on smaller rural agencies. These issues will continue to make the accessing of rural efficiencies problematic for MSC.

## **H Portland District Health**

### **H.1 Service profile**

Portland District Health (PDH) was established in 2003 through the merger of the Portland and District Community Health Centre and the Portland and District Hospital. Non-acute health services provided by PDH include<sup>43</sup>:

- community health services;
- community health education;
- community health nurse;
- health assessment and support;
- women's health and family planning;
- men's health;
- counselling;
- dietetics;
- podiatry;
- district nursing;
- physiotherapy;
- occupational therapy;
- post acute care;
- needle and syringe program;
- respite care for high-level nursing care; and
- social monitoring and support service (community transport).

PDH provides non-acute health services from two sites in Portland, at the district hospital and from the former site of the community health centre.

PDH has approximately 250 employees of which, non-acute health services are provided through:

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<sup>43</sup> State-wide service directory: <http://pcp.serviceseeker.com.au>

- 18 employees providing community health services;
- 18 employees providing allied health services; and
- four employees providing drug and alcohol services.

## **H.2 Client base**

PDH provides services to the residents of the Glenelg LGA.

During the review, PDH described the following characteristics in its client population:

- the Glenelg resident population is ageing;
- Glenelg does not have a significant non-English speaking population.
- Glenelg has clusters of socio economic disadvantage.

Table H.1 provides a demographic profile of the Glenelg LGA. This profile is consistent with PDH's comments.

**Table H.1: Agency LGA Demographics<sup>44</sup>**

Agency Catchment	Glenelg LGA – covering Portland, Casterton and Heywood
Total population	<ul style="list-style-type: none"> <li>• 19,250</li> </ul>
Age profile	<ul style="list-style-type: none"> <li>• Population 0 – 19 years – 29 percent</li> <li>Population 20- 39 years – 25 percent</li> <li>Population 40-59 years – 28 percent</li> <li>Over 60 years – 18 percent (Victorian average 16 percent)</li> </ul>
Country of Birth	<ul style="list-style-type: none"> <li>• Australia – 93 percent</li> <li>UK – 3 percent</li> <li>New Zealand – 1 percent</li> <li>Netherlands – 1 percent</li> <li>Other – 2 percent</li> <li>• Victorian average: 19 percent from non English speaking countries</li> </ul>
Annual individual income	<ul style="list-style-type: none"> <li>• \$1 - \$6,240 – 9 percent</li> <li>\$6,240 – \$15,600 – 35 percent</li> <li>\$15,600 - \$26,000 – 20 percent</li> <li>\$26,000 - \$36,400 – 14 percent</li> <li>\$36,400 - \$52,000 – 11 percent</li> <li>\$52,000 - \$78,000 – 8 percent</li> <li>\$78,000 or more – 3 percent</li> <li>Average annual income \$18,552 (Victorian State average income \$21,395)</li> </ul>
Household type	<ul style="list-style-type: none"> <li>• Family household – 70 percent</li> <li>Lone person – 28 percent</li> <li>Group household – 2 percent</li> </ul>
Family types	<ul style="list-style-type: none"> <li>Couple with children – 47 percent</li> <li>Couple without children – 38 percent</li> <li>Single parent family – 14 percent</li> <li>Other family – 1 percent</li> </ul>
Occupied private dwelling tenure	<ul style="list-style-type: none"> <li>Fully owned – 53 percent</li> <li>Being purchased – 27 percent</li> <li>Renting – 20 percent</li> </ul>

<sup>44</sup> Census 2001. Australian Bureau of Statistics

## **H.3 Primary Care Partnership context**

### **H.3.1 PCP status**

PDH is a member of the Southern Grampians Glenelg PCP (SGG), which covers the Glenelg and Southern Grampians LGAs.

In order to share costs and to promote a common approach to Service Coordination in South West Victoria, SGG and South West PCP have formed the joint Service Coordination Work Group (SCWG) to undertake Service Coordination within the two PCPs.

At the time of the review, the SCWG and SGG had undertaken the following Service Coordination related activities<sup>45</sup>:

- development of agreed data and forms for use across primary care categories;
- adoption of Service Coordination Tool Templates forms.

It is noted that PDH only adopted the referral – consumer information (form MR 240), summary and referral information (from MR 241), and referral – consumer consent (form MR 241) forms from Service Coordination Tool Templates;

- train the trainer training provided to agencies for introduction and operation of SC;
- piloting of e-referral process on the SWARH network;
- implementation of a protocol for the despatch and receipt of referrals;
- development of draft protocols for INI and IC (based on the WMR-BPM);
- development of a PCP website, containing Service Coordination relevant content developed by the PCP, including:
  - weekly PCP bulletins, incorporating Service Coordination news and details of Service Coordination related events; and
  - an SGG customer charter.

### **H.3.2 PDH's involvement in PCP activities**

PDH's input into the development of Service Coordination within SGG has occurred through the participation of the Manager Drug and Alcohol Service, Manager District Nursing and Director of Primary Care in SGG committees covering:

- SC Tool Templates development trials;

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<sup>45</sup> [www.swarh.com.au](http://www.swarh.com.au)

- SC training development;
- SC sub-committee; and
- SGG governance.

## **H.4 Agency's Service Coordination experience**

### **H.4.1 Strategic background**

PDH's executive management group noted during the review that Service Coordination was adopted in order to:

- encourage consistent practices across the organisation, including how client privacy issues are responded to; and
- where possible, implement streamlined and simplified processes, for example the referral of clients between agencies and the single point of entry.

However, the executive management group also noted that they were unclear about what the impact of Service Coordination at the PCP level would be.

### **H.4.2 SC processes**

Within PDH the main operational impact of the PCP and Service Coordination has been the adoption of the Service Coordination Tool Templates forms within its intake and assessment functions and the adoption of new referral practices.

#### *Intake and assessment*

The main features of PDH's (non-drug and alcohol services) intake and assessment model are as follows:

- where PDH receives a phone call, or a person presents at the community health service reception, the receptionist:
  - makes an assessment regarding whether the person is seeking services that are available from the PDH community health services (and / or if necessary redirects or provides information to that person);
  - where a person does need services, collects client information to complete the non-clinical parts of the IC and INI sections of the Service Coordination Tool Templates;
  - makes an appointment, through a centralised booking system, for the client to visit a practitioner;

- passes the collated information to the practitioner who will complete the INI when the client comes for his / her appointment; and
- where a referral is received from another agency the information is passed to the practitioner directly, who will arrange a client appointment and complete any further required assessment or data collection when the client comes for his / her appointment.

Drug and alcohol services do not participate in the above process. Instead all potential drug and alcohol clients are redirected immediately to drug and alcohol services where they are assessed directly by practitioners. This exception from the general procedure was developed in response to the needs of the drug and alcohol clients requiring greater levels of confidentiality.

PDH is currently considering options regarding moving to a single point of entry intake and assessment function staffed by a dedicated assessment staff member.

#### *Referral*

PDH receives and makes referrals by fax under the South West Region Interagency Referral Protocol where:

- a fax referral is made using Service Coordination Tool Templates forms (in PDH's case printed directly from its PJB client information system) under a standardised fax cover sheet; and
- a set of referral acknowledgement and referral outcome forms are used by the recipient of the referral to notify the referee of referral outcomes.

PDH is not currently participating in the SWARH's e-referral project due to problems in putting appropriate encryption in place.

#### *Changes to processes*

PDH did not change its core intake and assessment activities as a result of Service Coordination other than adopt Service Coordination Tool Templates and new referral practices.

## **H.5 Outcomes of SC**

This section sets out the identified outcomes of the SC.

#### *General outcomes and assessment*

During the review the executive management group expressed a view that Service Coordination in PDH had begun to address its objectives and that a number benefits (as listed below) were being achieved. It also noted that PDH will achieve additional benefits as the agency works continues to work through implementation issues.

The Manager Drug and Alcohol, after noting that Service Coordination had achieved some significant savings in the administrative time required to undertake assessments, also noted that further benefits would be achieved when the local PCP network works more effectively.

The following sections identify the specific outcomes for PDH arising from SC.

#### *Service Delivery*

- PDH has reduced the average time taken to undertake an assessment by an estimated half an hour per referral received.
- PDH has reduced the total time spent on a client intake and assessment from one and a half hours to forty-five minutes per referral received.

#### *Service response and clients*

- SC has simplified and formalised PDH's compliance with privacy and confidentiality issues and clients are now only required to sign one consent form.
- During a client appointment more time is spent on service delivery due to a reduction in the need to undertake administrative data collection.
- One social worker noted an example where Service Coordination has allowed the social worker to move towards single session therapy as so much can now be achieved in a single session.
- Clients receive an appointment at initial contact.
- Improved access to multidisciplinary services.

#### *Staff conditions*

Staff expressed positive views that Service Coordination has increased their understanding and confidence in using PDH IT systems.

However, staff also made the following observations:

- the Service Coordination Tool Templates are labour intensive to use, and where other agencies do not use Service Coordination Tool Templates, they create an additional burden to either chase information or undertake a fresh assessment; and
- the requirement to collect more information has in some cases added additional work time to complete a day's appointments.

*Networking efficiencies*

SC has increased communication links between PDH and agencies.

However, staff also noted that SGG agencies are not all yet practicing SC. As a consequence PDH is adversely effected by receiving a significant portion of referrals from local GPs and the acute health system that do not meet Service Coordination requirements.

This problem is caused by Service Coordination not being mandatory for those agencies and those agencies having a different set of priorities regarding referral practices. The staff did however note that these issues are gradually being dealt with and benefits of a coordinated Service Coordination approach are beginning to emerge.

*Costs*

Table H.2 sets out the cost impact of Service Coordination on PDH

**Table H.2: Costs of implementing and operating Service Coordination in PDH**

Name: Portland District Nursing Pre Service Coordination		Post Service Coordination		Net Cost / (Saving)	IMPLEMENTATION (One off expenses)	
CAPITAL		CAPITAL			CAPITAL	
					Computer Upgrade for 200 computers	\$ 5,000
					Fax maintenance	\$ 500
<b>Total</b>	\$ -	<b>Total</b>	\$ -		<b>Total</b>	\$ 5,500
INCOME		INCOME			INCOME	
<b>sub-total</b>	\$ -	<b>sub-total</b>	\$ -		<b>sub-total</b>	\$ -
EXPENSES		EXPENSES			EXPENSES	
		Extra staff 1 @ \$60,000 p.a	\$ 60,000	\$60,000	Preparation of training 1 person X 7.5hrs X \$30 p/hr X 20 days	\$ 4,500
					PCP meetings 4 people X 3 hrs X \$30 p/hr X 4 months	\$ 1,440
					SC meetings 4 people X 3 hrs X \$30 p/hr X 4 months	\$ 1,440
					Revision and refining of knowledge 5 people X 2 sessions X 4 months X 2 hrs X \$30 p/hr	\$ 2,400
					SCTT training 61 people X 4 hrs X \$30 p/hr	\$ 7,320
					Attending PCP meetings 5 people X 7.5 hrs X \$30 p/hr X 8 times	\$ 9,000
					Promotion of SC 2 people X 7.5 hrs X \$30 p/hr X 20 days	\$ 9,000
					Trainer trainee 3 people X 16 hrs X \$30 p/hr	\$ 1,440
<b>Total</b>	\$ -	<b>Total</b>	\$60,000	\$60,000	<b>Total</b>	\$ 36,540

SC has not created an ongoing operating cost to PDH. However, implementation of Service Coordination cost the agency approximately \$37,000. This reflects the fact that Service Coordination did not require that PDH adopt any significant changes to its operational processes. Instead Service Coordination required PDH to make an investment in the resources used in those processes through training, IT upgrades, and participation in local Service Coordination bodies.

## H.6 Summary

SC has resulting in successful outcomes for PDH. In particular:

- administrative efficiency savings have been accessed, which have been directly translated into increased levels of services being delivered to clients;
- clients are not asked to provide information at multiple points;

- clients are more informed regarding their rights privacy and confidentiality;
- common IC and INI practices have been developed across the organisation; and
- referrals between agencies are better coordinated.

Less beneficial outcomes included:

- some staff being stressed by additional data collection requirements and in some cases having a resultant larger work load; and
- lack of network participation means that PDH has to bear the cost of being an early adopter of Service Coordination in the network.

On the last point, PDH's executive management group noted that the benefits of Service Coordination may be jeopardised in the future if sufficient funds are not provided to the regional network to ensure that Service Coordination continues to be developed and promoted within SGG.