



Campaspe PCP

Service Coordination Protocols

November 2005

Version 2

Introduction to Service Coordination

What is meant by Service Coordination?

Service Coordination aims to place consumers at the centre of service delivery –

- ensuring that they have access to the services they need,
- opportunities for early intervention and health promotion and
- improved health outcomes.

Service Coordination enables health and welfare professionals to work together to ensure a coordinated and integrated response to consumer needs.

Why do we need Service Coordination?

The concept of Service Coordination was introduced in response to problems experienced by consumers, including:

- A lack of information about what services are available and how the service system works.
- Inconsistent practice in identifying needs, assessment, and privacy.
- A lack of coordination between agencies and health professionals.
- A lack of clear and transparent referral pathways.
- Inconsistent quality in information provision, screening, assessment, care planning and referral.
- Poor information sharing and feedback when referrals are made.

The objectives of Service Coordination are to:

- Ensure that consumers and carers can access the accurate and relevant information.
- Enable consumers to make choices and informed decisions about their care.
- Ensure that consumers and carers are able to access appropriate services in a timely and convenient manner.
- Increase the engagement of consumers and carers in the services and programs they need.
- Improve access to services and service outcomes by providing a seamless and coordinated system.
- Facilitate consumer participation in the management of their health care and service needs.

What are the Service Coordination Tool Templates?

A common set of forms (Service Coordination Tool Templates - SCTT) has been developed for agencies to;

- record and share client registration information,
- undertake initial needs identification,
- make referrals and
- collect client consent to share information between providers.

The introduction of these common tool templates across the health and community sector allows for;

- **improved communication** between multiple care providers because, with client consent, common information can be collected and shared.
- **improving the quality of referrals**, and therefore reducing the burden on consumers of repeating the same information to each new service provider.

Introduction to the Service Coordination Protocols

The Service Coordination principles mentioned above are underpinned by the development and use of inter-agency / inter-service practice standards and protocols based on the Service Coordination processes of;

- **Service access;** the point where a person makes contact with the service system seeking service, advice or information
- **Screening and initial needs identification;** is an initial screening for risk and service requirements
- **Referral;** transmission of personal and/or health information from between health professionals
- **Assessment;** requires a more in-depth collection , weighting and interpretation of relevant information
- **Feedback;** exchanges of shareable consumer information, and
- **Care coordination;** supports consumers access to a multidisciplinary team approach supportive of their care needs

The common feature of inter-service communication is the process of information;

- Exchanges of consumer information
- Provision of service information
- Provision of health care information

Agencies agree to undertake and maintain the following internal processes to ensure effective Service Coordination and subsequent improvement in consumer's access to services;

- Integration of the protocols into agency policy and procedures
- Service Coordination will be a standard agenda item at staff, team and management meetings to facilitate embedding of practices
- Ensure that staff have knowledge and access to information about other services across the region and Campaspe area
- Undertake to maintain up to date/current service information on the electronic service directory – Connentingcare.com
- Ensure that staff are trained, have the necessary skills and competencies to support their interagency roles
- Provide infrastructure, support and resources to encourage quality interagency processes, consumer information exchanges, service information and health or care information.
- Conduct regular reviews of client intake processes, including eligibility and risk assessment criteria, an examination of referral mechanisms and a systematic approach to the management of waiting lists.
- Encourage consumers to make self-referral and provide consumers with alternative options to assist them to make informed choices of care
- That systems are in place for crisis response and management
- That consent is gained to ensure privacy regulations are adhered to in the collection and sharing of consumer information. Agencies shall have systems in place for situations where consent cannot be gained without compromising service availability for the consumer

SERVICE ACCESS

**Description/
Purpose** The moment a consumer makes contact with the primary health care system seeking advice or information regarding health and community services.

Service access is the provision of information that directs consumers to the service system. Service access information links and supports the processes of screening, referrals and care coordination.

**Practices/
Actions** Agencies will ensure their service information is maintained in a range of formats (ie. pamphlets, information sheets, web sites and service directories).

Agencies will ensure they have access to a directory of current primary health care services and health information to assist the consumer and agency staff.

Agencies shall maintain their own agencies current, accurate service information including the electronic services directory of Connectingcare.com.

Health and care information can be provided by initial contact staff for the consumer and no further service required if appropriate.

Consumers are encouraged to make self-referrals to services.

Consumers and/or initial contact staff are to assist in information collection using the Consumer Information tool.

If consent by the consumer is not obtained, information is to be provided and this should not preclude them from re-entering the service system (as per the HACC Manual).

Service information can be accessed at any point along the care continuum.

Agencies will provide information about the initial contact within 24 hours/next working day of a consumer making initial contact with a service or service provider.

Agencies will assist referral to initial needs identification/screening.

The referral cover sheet and Consumer Information Tool will be forwarded to the appropriate service required.

**Resources/
SCTT forms** *Consumer Information* SCTT form

DHS *Your Information It's Private* sheet/brochure

www.betterhealth.vic.gov.au

www.connectingcare.com

SCREENING AND NEEDS IDENTIFICATION

Description/ Purpose	<p>Needs identification is an initial screening for risk and service requirements. The service provider undertaking the needs identification looks beyond the presenting issues to what underlying issues may exist.</p> <p>Needs identification is not a diagnostic process. It is a determination of the consumer's risk, eligibility and priority for services and a balancing of the service capacity and the consumer's needs.</p> <p>To provide common information and screening questions that assist practitioners to identify the initial needs of consumers.</p>
Practices/ Actions	<p>On completion or receipt of the <i>Consumer Information</i> tool, the service provider will arrange a suitable appointment time.</p> <p>Agencies will undertake to develop appropriate systems to ensure that initial needs identification are completed within seven (7) working days from receipt or completion of the <i>Consumer Information</i> tool.</p> <p>Professional judgement is to be used to determine use of the Supplementary Profiles in identifying initial needs.</p> <p>Information gathered in the course of completing the profile will be shared with another service when making a referral.</p> <p>Consent shall be gained at two levels as required to;</p> <ol style="list-style-type: none">1. share a consumer's information with another service2. agree to receive another service/ make a referral to another service <p>On identification of the need for referral to another service, completion of the Summary and Referral Information tool shall occur.</p> <p>A referral cover sheet accompanied by the <i>Consumer Information</i> tool; relevant <i>Profile(s)</i>; and <i>Summary and Referral Information</i> tools.</p>
Resources/ SCTT forms	<p><i>Supplementary Profiles; living arrangements; health conditions; psychosocial; functional screen; health behaviours</i> SCTT forms</p> <p><i>Summary and Referral Information</i> SCTT form</p> <p><i>Consumer Information</i> SCTT form</p> <p>DHS <i>Your Information It's Private</i> sheet/brochure</p> <p>www.connectingcare.com</p>

REFERRAL

**Description/
Purpose** To record and share a summary of the consumer's problems/issues and an initial action plan.

To ensure consumers have access to a coordinated and seamless service system.

**Practices/
Actions** Services/ providers must have a process to respond to urgent and non-urgent referrals.

Consent must be gained to ensure privacy regulations are adhered to in the collection and sharing of consumer information.

Agencies need to have systems in place for sending referrals without consent.

Referrals can be sent via a range of options, depending on urgency and the systems available to the receiver;

1. **Consumers take a written copy** of the referral with them to the designated service
2. Australia **Post mail** service
3. **Fax** to the designated service where fax areas/systems meet Privacy Legislation
4. **Secure electronic** referral system using intranet or internet system with encryption and digital signing
5. **Telephone** referral where baseline information is provided to designated service and then followed up with written information.

Agencies must have systems in place to record incoming referrals and the responses to

- Determine urgency and priority;
- Ensure consumers access to interim strategies if waiting list present;
- Provide feedback on acknowledgement and receipt of referral

Referrals can occur at any time or point in the care continuum if needs are identified.

A referral will attach a Feedback form.

All forms will be fully completed to facilitate the exchange of consumer information.

**Resources/
SCTT forms** *Summary and Referral Information* SCTT form

Relevant updated *Supplementary Profiles* SCTT forms or other specialised screening tools

Consumer Consent SCTT form

Feedback form

www.connectingcare.com

ASSESSMENTS

**Description/
Purpose** Assessment is a more in-depth process than screening. It is an investigative process using professional and interpersonal skills to uncover or diagnose the consumer's problem(s) and then address them.

**Practices/
Actions** Assessment uses the needs identification as a baseline to direct a more in-depth investigation process.

The assessment process is not an end in itself but part of the process of delivering a service. Service delivery is dependent on the development of a plan (eg. care plan, service plan, action plan, intervention plan, specific management plan, nursing plan, treatment plan, individual service plan etc). The plan is the basis for monitoring progress or functionality of interventions.

The outcome of an assessment, the Plan is;

- A functional tool for setting the direction of interventions and monitoring of service delivery to meet consumer needs
- A valuable tool for providing feedback

Assessment types are categorised as follows;

- **Service Specific:** generalist services undertake assessments related to the specific presenting need.
- **Specialist:** specialist services undertake assessments when the presenting issue requires a specialist service response.
- **Comprehensive:** comprehensive assessments are the most intense level of inquiry, gathering information from a range of sources. Comprehensive assessment services are independent of service delivery (eg. Aged Care Assessment Service, Case Management Service etc). The assessment compiles information on a range of multiple and complex issues and develops a comprehensive plan to address these issues and assessed risks.

Prior to assessment, the service shall acknowledge receipt of referral within three (3) working days.

**Resources/
SCTT forms** Assessment tools or methods to assess the identified needs.

Service Specific forms as per service.

FEEDBACK

**Description/
Purpose** Feedback includes any exchanges of shareable consumer information from across the spectrum of care including:

- Consumer demographic information
- Risks or alerts information
- Screening information
- Referral or intake outcomes
- Assessment and planned service outcomes
- Exit or discharge or transitional information
- New or changed situations

**Practices/
Actions** The feedback process shares consumer information only with relevant and current services or supports.

Feedback can be sent via a range of system options depending on urgency and the systems available to the receiver.

Feedback shall be provided to the original referrer and other key services eg. GP

That feedback occur at 2 levels;

1. To acknowledge receipt of the referral, and
2. To communicate referral outcomes.

Quality feedback practice shall include;

- Timely feedback
- Information relevant to the receiving service's needs
- Legibly written or typed details
- Uses clear language, and
- Succinct information

**Resources/
SCTT forms** Feedback forms

- Fax cover sheet
- Connectingcare.com cover sheet

CARE COORDINATION

**Description/
Purpose** Care coordination supports consumers access to a multidisciplinary team approach supportive of their care needs that;

- Facilitates continuity of care and improved health and care outcomes
- Avoids duplication or gaps in service delivery
- Ensures that meeting consumer needs is paramount over the needs of individual service providers
- Enables monitoring and planning to be collaborative and comprehensive
- Ensures that meeting consumer needs is not hampered by program boundaries.

The Service Coordination plan should be used with consumers with both multiple agency involvement and complex needs.

**Practices/
Actions**

Care Coordination supports use of the Service Coordination Plan to record the individual care plans of all practitioners or agencies involved in a consumer's care.

Supports a coordinated approach to service delivery that includes what services are to be provided and when they are to be delivered. The Service Coordination plan also identifies the key worker and when the plan will be reviewed.

Consumers have choices within and ownership of the process where consumers and their key supports are part of the team, and wherever possible, consumers are involved in the process of choosing the key service/worker.

Self-management will be encouraged and vary according to the consumer's level of risk, skills and circumstances.

Developing a comprehensive care plan requires a team approach that involves shared responsibilities and collaborative practices where it is the shared responsibility of all services to feedback relevant information to key services or the nominated key worker as part of the normal agency workflow practice.

A key service/worker may be required to collate information and facilitate the development and review of a multidisciplinary plan.

On receipt of needs identification and appropriate assessments, a key worker will be nominated.

The key worker role can be an interim role or a more ongoing role dependent on the service provision status. If this status changes, workers shall;

1. Confirm the capacity of services/workers before nominating

the position

2. Re-confirm the capacity at each review of the multidisciplinary plan.

Agencies shall have systems in place to ask trigger questions to facilitate recognition of the need for care coordination on agency referral and feedback forms. The trigger questions include;

1. Are there 3 or more services involved in this persons care?
2. Are the care needs complex?

The sharing of information is between all relevant services, with no key service / worker nominated.	The sharing of information is to an interim key service. The interim key service facilitates the initial care coordination process.	The sharing of information is to a nominated key service / worker. The key service facilitates the care coordination process and develops a comprehensive plan.
<ul style="list-style-type: none"> • Care needs are multiple but relatively straightforward. • No key worker is required. • No single comprehensive plan is required. 	<ul style="list-style-type: none"> • Care needs are multiple and /or complex. • The need for Care Coordination is raised during the referral / feedback processes or by a <u>temporary</u> service. • The interim service facilitates the initial care coordination actions and / or plan. • If needed, the interim service facilitates the nomination of a key service / worker. • The interim services <u>hands over</u> to the nominated key service. 	<ul style="list-style-type: none"> • Care needs are multiple and /or complex. • The need for Care Coordination is raised at any stage during the service coordination model. • An <u>ongoing</u> service is nominated as a key service / worker. • Care coordination actions are based on feedback provided. • The development of a single comprehensive multidisciplinary care plan aids coordination. • The key worker role is regularly reviewed - transfers as needed.

Generalist Services	Specialist Services	Case Management Services
Less complex needs	Moderately complex needs	Very complex needs
Infrequent changes		Frequent changes
Infrequent advocacy		Frequent advocacy
Works within service boundaries.	Provides case management related to that service. Often time limited service provision.	Works across service sectors. No service boundaries.

Feedback and communication are essential for effective care coordination.

Resources/ SCTT forms

Service Coordination Plan SCTT form