

Continuous Improvement Framework 2009

A resource of the Victorian Service Coordination Practice Manual



A STATEWIDE PRIMARY CARE PARTNERSHIPS INITIATIVE

Service coordination publications

1.
Victorian
Service
Coordination
Practice
Manual

2.
Good Practice
Guide

3.
Continuous
Improvement
Framework

4.
SCTT 2009
User Guide

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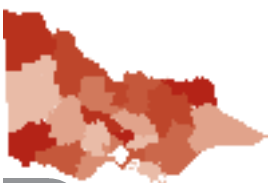
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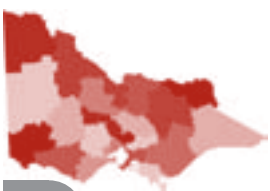
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This document may also be downloaded from the Department of Human Services website at: <http://www.health.vic.gov.au/pcps/coordination>



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1. Introduction

1.1 Service Coordination

Service Coordination places consumers at the centre of service delivery, to ensure that they have access to the services they need, opportunities for early intervention, health promotion and improved health and care outcomes. The operational elements of Service Coordination, as described in the *Better Access to Services Policy and Operational Framework* (DHS, 2001),¹ are **Initial Contact, Initial Needs Identification, Assessment and Care Planning**.

Service Coordination enables organisations to remain independent of each other, while working in a cohesive and coordinated way to give consumers a seamless and integrated response.

This document is one of a set of four publications designed to support the implementation of Service Coordination in Victoria. For a detailed description of Service Coordination see the *Victorian Service Coordination Practice Manual*. The documents and other related resources are available at: www.health.vic.gov.au/pcps/coordination

1.2 A Service Coordination implementation resource

The *Service Coordination Continuous Improvement Framework* is designed to assist organisations implementing Service Coordination. It has been designed to:

- support service providers to monitor and continuously improve their Service Coordination implementation and practice
- enable an agreed process for Primary Care Partnership (PCP) member organisations to monitor Service Coordination implementation for reporting and planning purposes
- assist new program areas to assess their Service Coordination readiness and identify required systems, infrastructure and practice changes
- provide a mechanism for PCP Service Coordination groups to assess and improve compliance with Service Coordination practice standards, if the need arises.

The *Service Coordination Continuous Improvement Framework* is based on:

- the continuous improvement cycle: Plan Do Study Act (PDSA) which is a proven improvement framework for implementing small-scale changes while focusing on one improvement area
- the knowledge that service providers already have quality assurance systems in place and the *Service Coordination Continuous Improvement Framework* will complement but not replicate these
- the assumption that all service providers regularly undertake self-assessment performance review processes using the Service Coordination good practice indicators and practice standards contained in the *Victorian Service Coordination Practice Manual*
- recognition that continuous improvement criteria for Service Coordination may change as implementation of Service Coordination across Victoria evolves and develops.

¹ *Better Access to Services: A Policy and Operational Framework*, p. 1, DHS June 2001.

Use of the *Service Coordination Continuous Improvement Framework* can support organisational quality and accreditation processes as it is consistent with EQUIP, QICSA and HACC National Service Standards Quality Frameworks.

Implementation of the framework provides evidence of quality improvement activity, which may contribute to government-funded services reporting and monitoring frameworks, such as:

- registration Standards for Community Service Organisations (Children, Youth and Families Services)
- quality of Care Reports including Consumer, Carer, and Community Participation Performance Indicators (Community Health Services)
- consumers and Carers Experience of Care Survey of Public Mental Health Services and Strengthening Consumer Participation in Victoria's Public Mental Health Services Action Plan (Mental Health Services)
- integrated Quality Management Approach and Quarterly Data Collection (Disability Services)
- Victorian Quality Council's Safety and quality framework (Post-Acute and Sub-acute Ambulatory Care Services, Hospital Admission Risk Program)
- Housing Support Services accreditation (Housing and Community Building Services).

The framework addresses the requirements evaluated in the Victorian Service Coordination survey, which is part of PCP annual reporting requirements.

1.3 The Plan Do Study Act model for improvement

The Plan Do Study Act (PDSA) model for improvement is a simple yet powerful tool for accelerating improvement. The ability to develop, test, and implement change is essential for any individual, group, or organisation that wants to continuously improve.

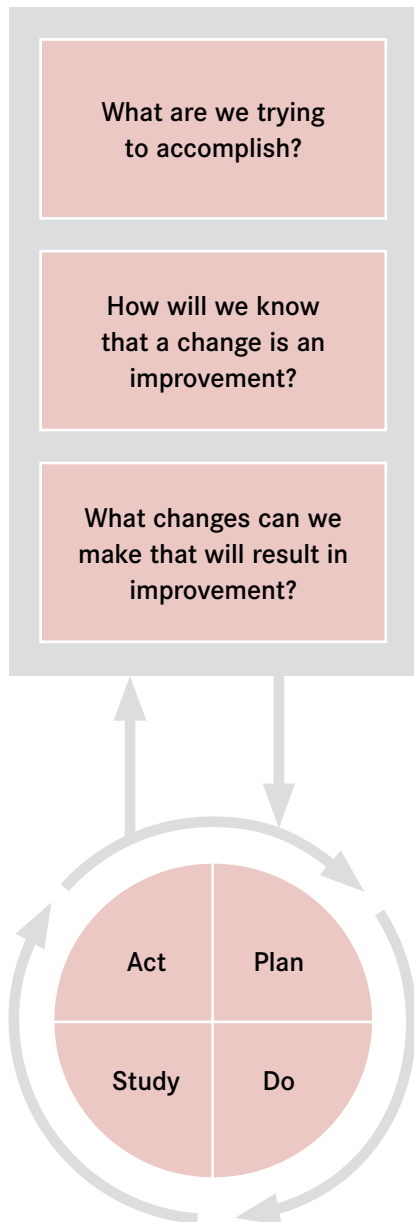
The PDSA model is not meant to replace change models that organisations may already be using, but rather accelerate improvement. This model has been used successfully by organisations to improve many different processes and outcomes.

The PDSA model has two parts:

- three fundamental questions, which can be addressed in any order
- the Plan Do Study Act (PDSA) cycle² to test and implement changes in real work settings. The PDSA cycle guides the test of a change to determine if the change is an improvement.

2 The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-Do-Check-Act (PDCA) cycle. W. Edwards Deming modified Shewhart's cycle to PDSA, replacing *Check with Study*. See Deming WE. *The New Economics for Industry, Government, and Education*. Cambridge, MA: The MIT Press; 2000.

Figure 1: PDSA

**Team composition**

including the right people on a process improvement team is critical to a successful improvement effort. Teams vary in size and composition. Each organisation builds teams to suit its own needs

Setting goals

improvement requires setting goals. The goals should be time-specific, measurable, and identify the population that will be affected

Selecting changes

all improvement requires making changes, but not all changes result in improvement. Organisations therefore must identify the changes that are most likely to result in improvement

Measurement

a critical part of testing and implementing changes. It indicates whether the changes actually lead to improvement

Testing Changes

the Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting—by planning it, trying it, observing the results, and acting on what is learned

Implementing changes

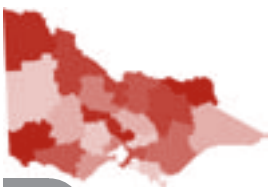
after testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the change can be implemented on a broader scale

Spreading changes

after successful implementation of a change or package of changes, the team can spread the changes to other parts of the organisation or to other organisations

PDSA³ process

Step	Description
1: Plan	Plan the test or observation, including a plan for collecting data: <ul style="list-style-type: none">■ state the objective of the test■ make predictions about what will happen and why■ develop a plan to test the change: who? what? when? where? what data needs to be collected?
2: Do	Try out the test on a small scale: <ul style="list-style-type: none">■ carry out the test■ document problems and unexpected observations■ begin analysis of the data.
3: Study	Set aside time to analyse the data and study the results: <ul style="list-style-type: none">■ complete the analysis of the data■ compare the data to your predictions■ summarise and reflect on what was learned.
4: Act	Refine the change, based on what was learned from the test: <ul style="list-style-type: none">■ determine what modifications should be made■ prepare a plan for the next test■ implement improvements on wider scale, if appropriate.



3 Sources: Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organisational Performance.

2. Using the Service Coordination Continuous Improvement Framework

2.1 Components of the Continuous Improvement Framework

The Continuous Improvement Framework comprises:

- a set of continuous improvement criteria, based on Better Access to Services Policy and Operational Framework (DHS, 2001) and the practice standards outlined in the Victorian Service Coordination Practice Manual
- lists of sample evidence, which can be used to show the extent to which the criteria have been met.

2.2 Performance-rating scale

The suggested scale for rating performance in relation the criteria is:

■ Met	■ Partially met	■ Not met	■ Not applicable
Clear evidence that performance meets or exceeds the standard	Clear evidence that performance meets some, but not all, of the standard	Clear evidence that performance does not meet the standard	The item is not applicable

2.3 Process for implementation

Service providers are encouraged to use the following process to self-assess current performance and identify areas for improvement. It is recommended that service providers undertake this process regularly.

Step 1	Use the Continuous Improvement Criteria to systematically review the performance of your service in relation to each of the criteria
Step 2	Rate your current performance according to the rating scale provided: met, partially met, or not met. You may choose to do this with your team. Consider using the PDSA cycle, described above
Step 3	If your organisation partially meets or does not meet the Continuous Improvement Criterion, determine the action required. Again your team may have ideas about how you can improve your performance
Step 4	Develop a plan to make the changes required
Step 5	Reassess your performance annually

2.4 Annual Service Coordination survey

The Department of Human Services, Primary Health Branch, works in collaboration with PCPs across Victoria to conduct an annual Service Coordination survey. The survey contains key questions, based on those included in this *Continuous Improvement Framework*, to monitor the implementation of Service Coordination by organisations across Victoria.

The annual Service Coordination survey assists service providers to measure and record their level of Service Coordination implementation and practice. Service providers will be able to benchmark their practice from year to year and against other service providers within their PCP. DHS provides the results of the survey to service providers, PCPs and DHS programs to identify areas that require further resources and development.

In addition, PCPs and organisations can monitor the level to which Service Coordination has been implemented, in accordance with this *Continuous Improvement Framework*, by using the format below. PCPs and organisations may wish to monitor all criteria and all evidence, or they may wish to target specific criteria and evidence each year.

PCP example

Criterion four: there is substantial evidence that the Initial Needs Identification process has occurred with consumers, according to Victorian Service Coordination practice standards	Met	Partially met	Not met	Not applicable
Evidence				
the service provider conducts Initial Needs Identification within no more than 7 working days of Initial Contact.	10 organisations	2 organisations	0	Reason not applicable

3. Service Coordination Continuous Improvement Framework

3.1 Overview

The following criteria have been developed to promote a consistent standard of Service Coordination practice across Victoria, and enable PCPs and service providers implementing Service Coordination to assess and continually improve their performance.

By measuring performance against the criteria, service providers can judge the quality of their Service Coordination implementation at three levels: systems level, organisation level and practice level. This can occur through service provider self-audits, audits of a sample of files by an independent person, cross-referencing and links with organisation quality assurance systems, and discussion and review at team meetings.

There are eight criteria:

- **Criterion one** relates to implementation of Service Coordination at a systems level, that is, across PCP member agencies
- **Criterion two** relates to Service Coordination at an individual organisation level, that is, across multiple programs within an organisation
- **Criteria three to eight** relate to Service Coordination at a practice level, that is, implementation of Victorian Service Coordination Practice Standards. If your organisation does not implement particular elements of Service Coordination, then you would not complete the relevant checklist.

Each criterion has an associated list of evidence to show to what extent the criterion has been met.

In applying this continual improvement framework, organisations should ask the questions:

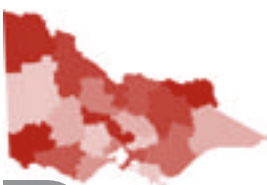
- how can our organisation demonstrate that this occurred?
- what evidence is there to support this?
- how can we improve in this area?
- what action can we take to improve?

3.2 Service Coordination continuous improvement criteria

Systems level	
Criterion one:	there is substantial evidence of functional integration of Service Coordination across PCP member organisations
Organisation level	
Criterion two:	there is substantial evidence that Service Coordination has been integrated and accepted in all relevant program areas within an individual organisation and embedded into usual practice
Practice level	
Criterion three:	there is substantial evidence that the Initial Contact process has occurred with consumers, according to the Victorian Service Coordination practice standards
Criterion four:	there is substantial evidence that the Initial Needs Identification process has occurred with consumers, according to the Victorian Service Coordination practice standards
Criterion five:	there is substantial evidence that the Assessment process has occurred with consumers, according to the Victorian Service Coordination practice standards and program-specific guidelines and requirements
Criterion six:	there is substantial evidence that Care Planning has occurred with consumers and service providers participating in their care, according to the Victorian Service Coordination practice standards
Criterion seven:	there is substantial evidence that the referral and feedback processes have occurred, according to the Victorian Service Coordination practice standards
Criterion eight:	there is substantial evidence of compliance with privacy and consent requirements

Terminology: What is substantial evidence?

The word *substantial* should be taken to mean considerable, large, sizeable, extensive.



3.3 Service Coordination systems criterion

Criterion one: There is substantial evidence of functional integration of Service Coordination across PCP member organisations

What this means—Achieving functional integration⁴ enables organisations to remain independent of each other while working in a cohesive and coordinated way to deliver consumers a seamless and integrated response. Organisations undertake particular functions (for example: Initial Contact, Initial Needs Identification) in a common, integrated manner to ensure coordinated services for consumers.

Criterion one: there is substantial evidence of functional integration of Service Coordination across PCP member organisations <i>To be answered in consultation within your local PCP</i>		Met	Partially met	Not met	Not applicable
Look for the points of evidence, listed below					
1.1	Service providers within a PCP have documented Service Coordination policies, which reflect the requirements of the Victorian Service Coordination Practice Manual				
1.2	Service providers within a PCP participate in regular PCP-wide reviews of Service Coordination implementation				
1.3	PCP Service Coordination priorities are informed by the full range of relevant and available data, including the annual statewide Service Coordination survey				
1.4	There are structures in place to continually discuss, plan, measure, evaluate and improve Service Coordination implementation at a: <ul style="list-style-type: none"> ■ strategic level ■ operational level 				
1.5	Service providers within a PCP have agreed benchmarks for the target level of electronic referral				
1.6	There are procedures and systems in place to facilitate access to Initial Contact, Initial Needs Identification, Assessment, Care Planning, referral and service delivery within and between service providers				
1.7	There are agreements and processes in place within and between services, including general practice, for communication, information sharing, care pathways, referral, feedback and exiting				

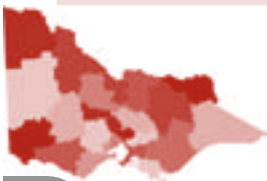
⁴ *Better Access to Services: A Policy and Operational Framework*, p. 32, DHS June 2001.

3.4 Service Coordination organisation criterion

Criterion two: there is substantial evidence that Service Coordination has been integrated and accepted in all relevant program areas **within an individual organisation** and is embedded into usual practice

What this means—individual service providers are implementing Service Coordination in all relevant program areas and Service Coordination is accepted as the usual way of doing business.

Criterion two: there is substantial evidence that the Service Coordination framework and practices have been integrated and accepted throughout all relevant program areas within an individual organisation		Met	Partially met	Not met	Not applicable
Look for the points of evidence, listed below					
2.1	Access and intake structures facilitate streamlined and integrated access to information and services				
2.2	The service provider has integrated Service Coordination practice standards and program requirements into organisational policy				
2.3	The service provider has integrated Service Coordination roles, responsibilities and requirements into work plans and position descriptions				
2.4	The service provider has integrated Service Coordination roles, responsibilities and requirements into performance appraisal systems				
2.5	The workforce development or training plan of the organisation includes professional development and training activities related to Service Coordination				
2.6	The service provider has integrated Service Coordination roles, responsibilities and requirements into meeting agendas				
2.7	The service provider has made available to workers documented service delivery procedures and work instructions covering: <ul style="list-style-type: none"> ■ Initial Contact ■ Initial Needs Identification ■ Assessment ■ Care Planning ■ Referral ■ Exiting 				
2.8	The service provider ensures that training is available for practitioners to complete the Service Coordination Tool Templates (SCTT) ⁵				
2.9	The service provider promotes and has established targets for the use of electronic referral				
2.10	Service Coordination data is regularly analysed and used by the organisation in planning processes				
2.11	The service provider has integrated Service Coordination principles into consumer feedback systems, for example: <ul style="list-style-type: none"> ■ surveys of consumer satisfaction or experience ■ complaints procedures ■ informal mechanisms 				
2.12	The service provider has integrated Service Coordination practice standards and program requirements into quality improvement processes				
2.13	The service provider maintains up-to-date information about its services, eligibility criteria, priority of access requirements and waiting times in service directories such as the Human Services Directory				



5 The *SCTT 2009 User Guide* can be downloaded at: www.health.vic.gov.au/pcps/coordination

3.5 Service Coordination implementation criteria

Criterion three: there is substantial evidence that the **Initial Contact** process has occurred with consumers, according to Victorian Service Coordination practice standards

What this means—Initial Contact is the first point of contact for a consumer with the service system. In accordance with the *no wrong door* approach, Initial Contact is available through every service provider. Initial Contact usually includes the provision of accurate, reliable, comprehensive service information and other information, such as health promotion literature and facilitated access to Initial Needs Identification.

Criterion three: there is substantial evidence that the Initial Contact process has occurred with consumers, according to Victorian Service Coordination practice standards	Met	Partially met	Not met	Not applicable
Look for the points of evidence, listed below				
3.1 Consumers have been provided with information about services available in response to their inquiry or as part of an outreach approach, such as: when and where the service is provided, eligibility or access criteria, and how to make an appointment, within 1 working day of making contact				
3.2 Consumers have been asked following their initial enquiry if there is any other information or assistance they require				
3.3 Consumers have been provided with information about services provided by other organisations for example, through the use of the Human Services Directory or other service directories				
3.4 Consumers have been provided with information in a manner appropriate to cultural, communication and cognitive needs				
3.5 The Initial Contact process has resulted in a decision about proceeding to Initial Needs Identification or referral				
3.6 Relevant SCTT have been completed in accordance with the <i>SCTT 2009 User Guide</i>				
3.7 Consumers have been provided with privacy information, such as a brochure, and the service provider has ensured the consumer understands the information				
3.8 Action taken as a result of the Initial Contact process has occurred and been documented				
3.9 Action has been taken to resolve immediate issues for the consumer experiencing a crisis or emergency				
3.10 Practitioners undertaking Initial Contact have completed the self-paced training module <i>Service Coordination What? Why? How?</i> or attended Service Coordination training, and know how to use statewide and local service directories				
3.11 Service providers have a process to ensure that practitioners undertaking Initial Contact are competent and have the ability to communicate effectively about internal and external services				

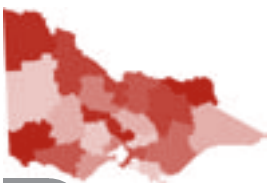
Criterion four: there is substantial evidence that the **Initial Needs Identification** process has occurred with consumers, according to Victorian Service Coordination practice standards

What this means—Initial Needs Identification is a broad, shallow screening process wherein the service provider looks beyond the presenting issues to what underlying issues may exist.

Initial Needs Identification identifies the consumer’s health, social, emotional and wellbeing needs and health promotion opportunities early in their contact with the service system. The service provider engages in a broad conversation to identify consumer needs, including illness prevention, early intervention, self-management capabilities and restorative options. Consumers can then be informed about the range of service and support options available to meet their needs.

The Initial Needs Identification process is sensitive to the consumer, their needs and the service setting. The service provider must use judgement and discretion to decide the extent and intensity of the process. The gathering and analysis of information through Initial Needs Identification reduces consumer risk and informs the urgency and type of assessments required.

Criterion four: there is substantial evidence that the Initial Needs Identification process has occurred with consumers, according to Victorian Service Coordination practice standards		Met	Partially met	Not met	Not applicable
Look for the points of evidence, listed below					
4.1	An explanation of the Initial Needs Identification process has been provided to consumers, including the reason for the process and what will be covered				
4.2	The service provider has conducted Initial Needs Identification within 7 working days of Initial Contact				
4.3	The consumer has been provided with the opportunity to participate in a broad-based discussion regarding their health and wellbeing, in a manner appropriate to cultural, communication and cognitive needs				
4.4	Consumer records indicate where consumers did not wish to participate in a broad-based discussion regarding their health and wellbeing, and reasons for this have been documented				
4.5	Consumer records indicate that issues, needs and aspirations of consumers has been documented through the Initial Needs Identification process				
4.6	The Initial Needs Identification process has resulted in opportunities for health promotion, early intervention or illness prevention				
4.7	Relevant SCTT have been completed in accordance with the <i>SCTT 2009 User Guide</i>				
4.8	The Initial Needs Identification process has resulted in decisions about referrals and assessments required and information has been provided to consumers about these options				
4.9	Where appropriate, action arising from the Initial Needs Identification process has occurred and been documented				
4.10	Consumer consent to share personal information has been gained for referrals arising from the Initial Needs Identification process				
4.11	SCTT have been used for referrals arising from Initial Needs Identification, in accordance with established policy (including DHS or organisation policy) and the <i>SCTT 2009 User Guide</i>				
4.12	Practitioners undertaking Initial Contact have completed the self-paced training module <i>Service Coordination What? Why? How?</i> or attended Service Coordination training				
4.13	Service providers have a process to ensure that practitioners undertaking Initial Needs Identification are qualified and have advanced communication skills				
4.14	Consumers have been given information about complaints and grievance processes				



Criterion five: there is substantial evidence that the **Assessment** process has occurred with consumers, according to Victorian Service Coordination practice standards and program-specific guidelines and requirements

What this means—Assessment is a decision-making methodology that collects, weighs and interprets relevant information about the consumer. Assessment is not an end in itself, but part of an ongoing process of delivering care and treatment. It is an investigative process using professional and interpersonal skills to uncover relevant health and wellbeing issues to develop a care plan. One or more skilled service providers assess in detail the current and ongoing specific needs of a consumer. More than one assessment may be necessary, since service providers typically gather information relevant to their discipline, such as the consumer’s social, functional, emotional, lifestyle and health needs.

Service providers should use assessment tools that meet consumer, service, reporting and program requirements. Most government-funded programs have Assessment frameworks, guidelines, templates and tools to guide this process. Each service provider should have Assessment tools in place which meet consumer, service provider, reporting and program requirements.

Criterion five: there is substantial evidence that the Assessment process has occurred with consumers, according to Victorian Service Coordination practice standards and program-specific guidelines and requirements		Met	Partially met	Not met	Not applicable
Look for the points of evidence, listed below					
5.1	The Initial Needs Identification process leads to service specific, specialist or comprehensive Assessment				
5.2	Service providers have a process to ensure that practitioners undertaking Assessments are skilled, qualified, and competent to perform the role				
5.3	Assessment activity is integrated and the potential for duplication of assessment has been reduced through the sharing of consumer information (with consumer consent)				
5.4	Where a waiting period between the referral and Assessment occurs, the health and wellbeing of consumers has been monitored according to risk				
5.5	Consumer records or peer review processes indicate that the Assessment process has occurred in accordance with the accepted practice standards and guidelines for the particular discipline or program area				
5.6	Relevant SCTT have been completed to inform the assessment process, in accordance with the <i>SCTT 2009 User Guide</i>				
5.7	Assessments are documented in a standardised, common format and identify: <ul style="list-style-type: none"> ■ needs beyond the presenting issue ■ consumer-stated issues and aspirations ■ consumer capability for self-management and behaviour change 				
5.8	The outcomes of the assessment have been clearly documented and are evident in the care plan goals				
5.9	The need for re-assessment has been considered, and if appropriate, review dates noted				
5.10	Consumers have been given the opportunity to discuss the findings of the assessment in a manner appropriate to cultural, communication and cognitive needs, with the assessing practitioner				
5.11	Consumers have been given the opportunity to discuss treatment or care options, in a manner appropriate to cultural, communication and cognitive needs, with the assessing practitioner				
5.12	Consumers have been given information about complaints and grievance processes				
5.13	The outcomes of assessment are communicated to consumers and, with consumer consent, other participants in their care such as the general practice				

Criterion six: there is substantial evidence that **Care Planning** has occurred with consumers and service providers participating in their care, according to the Victorian Service Coordination practice standards

What this means—Care Planning involves gathering and interpreting Assessment, consumer self-reported and other information to make care decisions with the consumer and the carer. Care Planning supports the consumer to identify goals and agree on strategies, action and services to achieve those goals. The Care Planning process ensures that consumers are actively engaged in the planning and delivery of care and receive support appropriate to their needs, wishes, circumstances, abilities and background. It is based on practice that is sensitive to the consumer’s cultural, communication and cognitive needs.

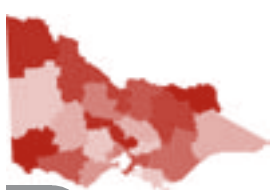
Care Planning ensures timely and effective service delivery, based on the best available evidence and underpinned by the principles of a person-centred, coordinated and integrated approach. Care Planning is a dynamic process that incorporates care coordination, case management, referral, feedback, review⁶, re-assessment⁷, monitoring and exiting.

Coordinated Care Planning between services is particularly important for consumers with multiple or complex needs, such as those with a chronic condition, high or ongoing support needs.

Criterion six: there is substantial evidence that Care Planning has occurred with consumers and service providers participating in their care, according to the Victorian Service Coordination practice standards		Met	Partially met	Not met	Not applicable
Look for the points of evidence, listed below					
6.1	Consumer records demonstrate that Care Planning has occurred following Assessment				
6.2	Consumer consent to share information has been recorded prior to Care Planning discussions occurring with other participants or service providers				
6.3	Consumer records indicate that the consumer and service provider have discussed the benefits and purpose of the care plan, in a manner appropriate to cultural, communication and cognitive needs				
6.4	Consumer records demonstrate that care plans include the following items: <ul style="list-style-type: none"> ■ date care plan developed ■ participants in development of care plan ■ consumer-stated and agreed issues or problems ■ consumer-stated and agreed goals ■ agreed actions and the name of person or service responsible for each action ■ timeframe for attaining goals and actions ■ planned review date ■ consumer acknowledgement of the care plan (signed or verbal) ■ actual review date. 				
6.5	Service specific care plans have been used where a consumer has one or more issues that can be managed with the support of a single program area				
6.6	Care plans have been based on all available assessment information and taken into account the full-range of consumer needs, including: health promotion, illness prevention, early intervention, self-management capabilities, restorative options and the expressed needs, wishes, values and circumstances of the consumer				

6 Formal follow-up of a consumer, usually on a date specified in the care plan, or due to a sudden change in the consumer’s situation, where the suitability of the care plan in meeting the needs of the consumer is considered.

7 A formal process of undertaking a subsequent Assessment of a consumer who has been previously assessed, due to a perceived change in their requirements, or after a 12-month period. The re-assessment process should mirror the original Assessment in order to maximise identification of changes in the consumer. It is considered best practice for re-assessment to also occur where there has been no change in requirements for a period of 12 months. Where the outcome of re-assessment identifies a change, a new care plan is required.

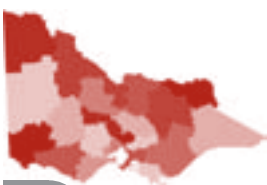


Criterion six: there is substantial evidence that Care Planning has occurred with consumers and service providers participating in their care, according to the Victorian Service Coordination practice standards		Met	Partially met	Not met	Not applicable
Look for the points of evidence, listed below					
6.7	Service providers have policies and protocols to guide a person-centred approach to Care Planning, including that the consumer, carer and advocate are actively supported to participate in the Care Planning processes, unless they choose not to				
6.8	Specific and measurable goals have been written from the consumer's perspective, in relation to each identified need				
6.9	Care Planning goals demonstrate self-management support and recovery strategies				
6.10	Consumer records indicate that general practice is included in Care Planning where relevant				
6.11	Consumer records indicate that care plan reviews have occurred when a consumer's needs or circumstances change				
6.12	Consumer records indicate that planned reviews have occurred within one month of the date listed for review (unless the service provider procedures states otherwise)				
6.13	Consumers are provided with a copy of their care plan, where appropriate, in a format which they can easily understand				
6.14	Service providers have a system for recall, reminder, monitoring and review of care plans				
6.15	Service providers have in place processes for planning and communicating exit or discharge. The reason for exit or discharge have been recorded.				
6.16	Consumer feedback processes indicate that consumers feel supported to participate in the Care Planning process and are provided with information to assist in decision making				
6.17	Consumer feedback processes indicate that consumers are provided with information about exit, discharge and re-entry				
<i>The items below relate to intra-agency and inter-agency Care Planning</i>					
6.18	Service providers have practices and systems for early identification of consumers with multiple or complex needs				
6.19	Consumer records indicate that intra-agency care plans have been used with consumers who have numerous issues that require the coordinated support of multiple program areas from within a single organisation				
6.20	Service providers have in place agreed inter-agency communication systems and processes for referral, feedback and case conferencing				
6.21	Consumer records indicate that inter-agency care plans have been used with consumers who have numerous issues that require coordinated support between two or more separate organisations				
6.22	Consumer records indicate intra-agency or inter-agency care plans have been documented for consumers with complex or multiple needs using the SCTT Coordinated Care Plan, in accordance with the <i>SCTT 2009 User Guide</i> , including: <ul style="list-style-type: none"> ■ all the participants in care, contact details and their role are listed on the plan ■ a key worker is responsible for communication, monitoring and review of the care plan, in accordance with agreed policy and procedures ■ with consumer consent, all the participants in care, including the consumer's general practice, have been offered a copy of the plan 				
6.23	Service providers have an agreed process with other organisations for developing Care Coordination Plans and identify, nominate, train and support key workers				
6.24	Consumer records indicate that meetings or case conferences have occurred to support and monitor implementation of the Care Coordination Plan, and individual practitioners have provided feedback to the key worker (where available) in relation to the progress and outcome of the care				

Criterion seven: there is substantial evidence that the **referral and feedback** processes have occurred according to the Victorian Service Coordination practice standards

What this means—Referral is the transmission of a consumer’s personal and/or health information, with their consent, from one service provider to another for the purpose of further assessment, care or treatment. Referrals may be made from all elements of Service Coordination. Feedback processes ensure that information is shared with the referring organisation.

Criterion seven: there is substantial evidence that the referral and feedback processes have occurred according to the Victorian Service Coordination practice standards		Met	Partially met	Not met	Not applicable
Look for the points of evidence, listed below					
7.1	Consumer records indicate that referrals have occurred within the specified timeframe following Initial Needs Identification, Assessment or Care Plan review				
7.2	Consumer records indicate that consent to disclose personal information for referral purposes has been documented				
7.3	Consumers are provided with a copy of referral and consent documentation, if requested				
7.4	Relevant SCTT have been used for referral in accordance with established policy and the <i>SCTT 2009 User Guide</i>				
7.5	Consumer records indicate that referrals prioritised as <i>urgent</i> have been sent within no more than 1 working day of obtaining consumer consent				
7.6	Consumer records indicate that referrals prioritised as <i>low</i> or <i>routine</i> have been sent within no more than 7 working days of obtaining consent				
7.7	Receiving service providers have transmitted a Referral Acknowledgement to the referring service provider for <i>urgent referrals</i> within no more than 2 working days of receiving the referral				
7.8	Receiving service providers have transmitted a Referral Acknowledgement to the referring service provider for low or routine referrals within no more than 7 working days of receiving the referral				
7.9	Receiving service providers have completed and transmitted the referral outcome information to the initiating service within no more than 14 working days of the consumer being assessed				
7.10	Communication with the consumers general practice has occurred as relevant				
7.11	Consumer records indicate that where there is a waiting period between referral and service access, alternative options and choices have been discussed with consumers				
7.12	Consumer records indicate that where there is a waiting period between the referral and subsequent action, the health and wellbeing of consumers have been monitored, in accordance with program guidelines and organisational procedures				



Criterion eight: there is substantial evidence of compliance with privacy and consent requirements

What this means—privacy legislation requires the protection of an individual’s personal information and their right to how the information is used or shared. It is necessary to obtain consumer consent prior to disclosure of information for any secondary purpose. The primary purpose is the purpose for which the information has been originally provided, and the secondary purpose is any additional reason, such as suggestions by the practitioner about referral to services additional to that originally requested by consumers.

If the consumer does not have the capacity (they are unable to understand the nature of what they are consenting to, or the consequences), consent must be sought from the consumer’s authorised representative. If it is not reasonably practical to obtain consent from an authorised representative or the consumer does not have an authorised representative, health information can still be shared in the circumstances set out under *Health Principle 2.2 of the Health Records Act 2001*. For further circumstances for disclosure, see: <http://www.health.vic.gov.au/hsc/infosheets/disclosure.pdf>

If the consumer refuses consent to share information, a referral can still proceed (see 8.2). However, the service provider receiving the referral must obtain the information they require from the consumer.

Criterion eight: There is substantial evidence of compliance with privacy and consent requirements		Met	Partially met	Not met	Not applicable
Look for the points of evidence, listed below					
8.1	Consumer records indicate that consumer consent processes occur using the SCTT <i>Consumer Consent to Share Information</i> form in accordance with the <i>SCTT 2009 User Guide</i> for all referrals and care planning discussions requiring the disclosure of personal information. This includes: <ul style="list-style-type: none"> ■ a record of proposed information use and disclosure ■ a record of consumer consent, either written or verbal ■ an explanation about the use of the information and rights, including provision of a privacy brochure such as <i>Your Information—It’s Private</i> in a format the consumer can understand 				
8.2	Consumer records indicate that where consent has not been given, this is clearly documented along with any action arising and confirmation that the consumer is aware of any implications as a result of not providing consent				
8.3	Service provider policies and procedures have documented the requirements for situations in which consumer consent is not required or is provided by another person				
8.4	Service providers have access to training and information about privacy and consent requirements				
8.5	Service provider information management systems, policies and procedures comply with privacy requirements in relation to the collection, use, disclosure, storage and disposal of a consumer’s personal information, including e-referral systems				
8.6	Service provider processes indicate that information has been provided to any consumer who feels that a breach of their privacy may have occurred				

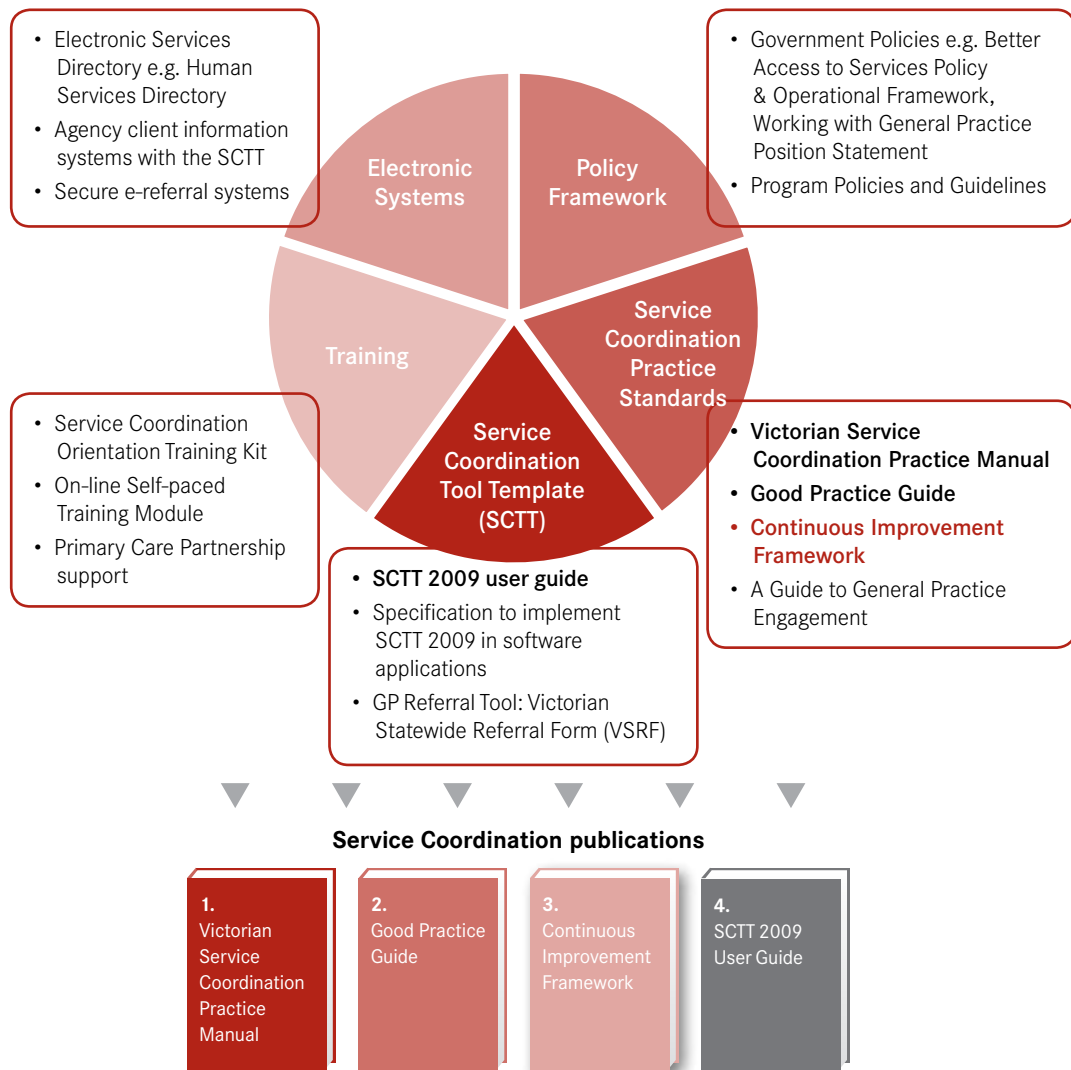
4. Other information

4.1 The Service Coordination context

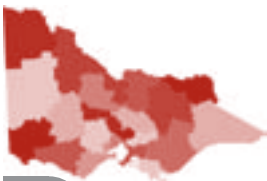
Service Coordination stems from the *Better Access to Services Policy and Operational Framework* (DHS, 2001). The implementation of Service Coordination is supported by policy, practice standards, training and other resources.

Figure 2: Supports for implementation of Service Coordination

Available at: www.health.vic.gov.au/pcps/coordination



This manual is one of a set of four publications designed to support the implementation of Service Coordination in Victoria.



4.2 Terminology

Service Coordination embraces a range of government-funded services, program areas and practitioners including nurses, allied health professionals, case managers, counsellors, welfare workers, community care workers, disability workers, key contact workers, care coordinators, and so forth. In addition, general practitioners and Divisions of general practice play an important part in Service Coordination and are partners in Primary Care Partnerships.

The terminology used by the various program areas and service providers differs significantly, for example the terms consumer, client and patient can be used to describe an individual receiving care concurrently from a general practitioner, alcohol and drug counsellor, social worker, podiatrist and community care worker. For the purpose of this manual when the following terms are used, they should be interpreted as encompassing the related terms.

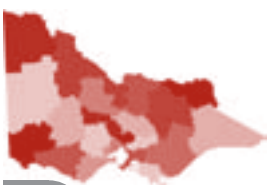
Abbreviations

BATS	Better Access to Services Policy and Operational Framework
DHS	Department of Human Services
GP	General Practitioner
HACC	Home and Community Care
HSD	Human Services Directory
INI	Initial Needs Identification
PCP	Primary Care Partnership
SCTT	Service Coordination Tool Templates

Definitions

Authorising representative	This means the consumer's guardian, or attorney under an enduring power of attorney, or agent under the Medical Treatment Act 1988, or administrator or a parent if the consumer is a child, or the 'person responsible' under the Guardianship & Administration Act 1986. For description of this see http://www.publicadvocate.vic.gov.au . The authorising representative has the legal authority to sign the consent form and make legal decisions for the consumer
Care Coordination Plan	A plan which documents issues and problems for a consumer, goals and actions that will be taken to achieve these goals, and identifies a key worker responsible for liaising between services. Typically developed for consumers with complex needs and multi-service involvement
Consumer	Client, patient, child
Consumer representative	Family, guardian, legal authority, carer
General practice	General practice provides general practitioner services and may include GPs, Practice managers, practice nurses, receptionists and other allied health/ medical specialist services.

Health Service	Health Service in accordance with the Health Records Act 2001, means: <ol style="list-style-type: none"> a) an activity performed in relation to an individual to assess, maintain or improve the individual’s health or to diagnose or treat the individuals illness, injury or disability b) A disability service, palliative care service or aged care service c) The dispensing on prescription of a drug or medicinal preparation by a pharmacist.
Inter-agency care plan	Occurs where a consumer has complex or multiple needs and requires the services of more than one organisation. It ensures that the needs of a consumer are discussed with them, their carer and relevant practitioners such as their GP, in the context of possible options and subsequently worked through to an agreed strategy. Also referred to as multi-agency care plan. (Clinical Indicators in Community Health. Victorian Healthcare Association report, 2008).
Intra-agency care plan	A care plan that involves a number of services or practitioners within the same agency.
Key worker	The nominated person who works with the consumer and carer and other services to facilitate intra-agency or inter-agency Care Planning and care coordination.
Local agreements	An agreement reached by key stakeholders within a given local area. The purpose of the local agreement is to bring together key stakeholders to ensure consistent and appropriate strategies and approaches are employed to address common issues, and to ensure duplication and service gaps are minimised.
Primary Care Partnership	A Primary Care Partnership or PCP is a group of services that have formed a voluntary alliance to work together to improve health and wellbeing in their local community.
Self-management	The consumer (and family/carers as appropriate) working in partnership with their health care provider to: <ul style="list-style-type: none"> • know their condition and various treatment options • negotiate a plan of care • engage in activities that protect and promote health • monitor and manage the symptoms and signs of the condition(s) • manage the impact of the condition on physical functioning, emotions and interpersonal relationships.
Service provider	Community service organisation, service provider, non government organisation, local government, primary care service provider, member of Primary Care Partnership, organisation providing services to improve the health and wellbeing of consumers.
Service specific care plan	A care plan which is developed and documented using specific program or service tools, and may be referred to as a Consumer Care Plan, an Individual Treatment Plan, A self-Management Plan, a Personal Action Plan, a Service Plan, or a GP Management Plan 3.
Practitioner	Health Professional, Nurse, Social Worker, Psychologist, Key Contact Worker, Care Coordinator, Allied Health Professional, Case Manager, Carer Support Coordinator, Counsellor, Welfare Worker, Community Care Worker, Housing Worker, Clinician, etc.



4.3 Development of the Continuous Improvement Framework

The *Continuous Improvement Framework* was initially developed in 2006 as part of the *Victorian Service Coordination Practice Manual* project, which was an initiative of the Statewide Primary Care Partnership Chairs Working Group.

The *Victorian Service Coordination Practice Manual*, *Good Practice Guide for Practitioners* and the *Continuous Improvement Framework* were updated in July 2009 under the leadership of the Statewide Primary Care Partnership Chairs Executive with funding from the Department of Human Services, Primary Health Branch. This process coincided with the release of *SCTT 2009* and updating of the *SCTT 2009 User Guide*.

A Project Steering Committee acted as a broad consultative forum to guide the update.

Your feedback is welcome

Do you have comments or feedback about this manual?

Please contribute to the next update by providing your feedback on-line via the link at www.vha.org.au/pcps

Project consultants

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