

Good Practice Guide 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

Published by Primary Care Partnerships, Victoria

August 2009

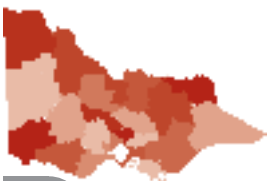
Sponsored by the Statewide Primary Care Partnerships Chairs' Executive with funding received from the Victorian Department of Human Services

© Copyright State of Victoria 2009

This publication is copyright. No part may be reproduced by any process except in accordance with the provisions of the *Copyright Act 1968*

Authorised by the State Government of Victoria, 50 Lonsdale Street, Melbourne

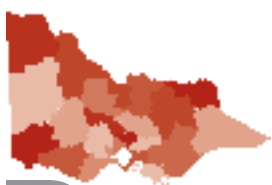
This document may also be downloaded from the Department of Human Services website at: <http://www.health.vic.gov.au/pcps/coordination>



Contents

1. Introduction	1
1.1 What is Service Coordination?	1
1.2 The Service Coordination Framework	2
1.3 What tools and resources support Service Coordination?	3
2. Practice Standards: Initial Contact	4
2.1 What is Initial Contact?	4
2.2 Which staff are involved in Initial Contact?	4
2.3 What can consumers expect from Initial Contact?	5
2.4 Good practice guidelines	5
3. Practice Standards: Initial Needs Identification	6
3.1 What is Initial Needs Identification?	6
3.2 Which staff are involved in Initial Needs Identification?	6
3.3 What can consumers expect from Initial Needs Identification?	7
3.4 Good practice guidelines	8
4. Practice Standards: Assessment	9
4.1 What is Assessment?	9
4.2 Which staff are involved in Assessment?	10
4.3 What can consumers expect from Assessment?	11
4.4 Good practice guidelines	11
5. Practice Standards: Care Planning	12
5.1 What is Care Planning?	12
5.2 Key features of Care Planning in Victoria	12
5.3 What is a Care Plan?	13
5.4 Steps to develop a care plan	14
5.5 Which staff are involved in Care Planning?	16
5.6 What can consumers expect from Care Planning?	17
5.7 Good practice guidelines	18

6. Practice Standards: Referral	19
6.1 What is referral?	19
6.2 Using the SCTT for referral	20
6.3 Referral to and from general practice	20
6.4 Which staff are involved in referral?	21
6.5 What can consumers expect from referral?	21
6.6 Good practice guidelines	22
7. Where to learn about Service Coordination	23
7.1 The Service Coordination context	23
7.2 Terminology	24
7.3 Development of the Good Practice Guide	26



1. Introduction

1.1 What is Service Coordination?

Service Coordination stems from the *Better Access to Services Policy and Operational Framework* (DHS, 2001). Service Coordination is a statewide approach to align practices, processes, protocols and systems through functional integration.¹ Achieving functional integration enables organisations to remain independent of each other as entities and still work in a cohesive and coordinated way so that consumers experience a seamless and integrated response.

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.² Service Coordination is underpinned by these principles:³

Service Coordination principles

Principle	Description
A central focus on consumers	service delivery needs to be driven by the needs of consumers and the community rather than the needs of the system, or those who practice in it
Partnerships and collaboration	service providers work together and take responsibility for the interests of consumers, not only within their own service but across the service system as a whole
The social model of health	a distinct conceptual framework for thinking about health. This framework is concerned with addressing the social and environmental determinants of health and wellbeing, as well as biological and medical factors. This includes the spiritual and family connections that contribute to wellbeing
Competent staff	the six elements of Service Coordination must be undertaken by staff who are appropriately skilled, qualified, experienced, supervised and supported
A duty of care	a duty to take reasonable care of a person. The duty of care extends to Service Coordination, where staff have a duty of care to provide accurate and timely information, and assist consumers with referrals
Protection of consumer information	improved information management practice is critically linked to <i>Better Access to Services</i> . In addition, the brochure <i>Your Information—it's Private</i> and the Consumer Consent Form are designed to improve information flow, practice and consumer outcomes
Engagement of other sectors	Service Coordination embraces the broadest range of partnerships across service provider types (small, large, non-government, government) and across disciplines, including general practice. A key role for Primary Care Partnerships includes: developing strategic links with acute care, residential aged care, children's and family services and disability services
Consistency in practice standards	Service Coordination enables services to remain independent of each other as entities but work in a cohesive and coordinated way to ensure that consumers experience a seamless and integrated service response

¹ Functional integration is a form of integration in which organisations and service providers continue to operate as independent entities but agree to undertake particular functions (for example: Initial Contact, Initial Needs Identification) in a common, integrated manner. *Better Access to Services: A Policy and Operational Framework*, p. 32, DHS June 2001.

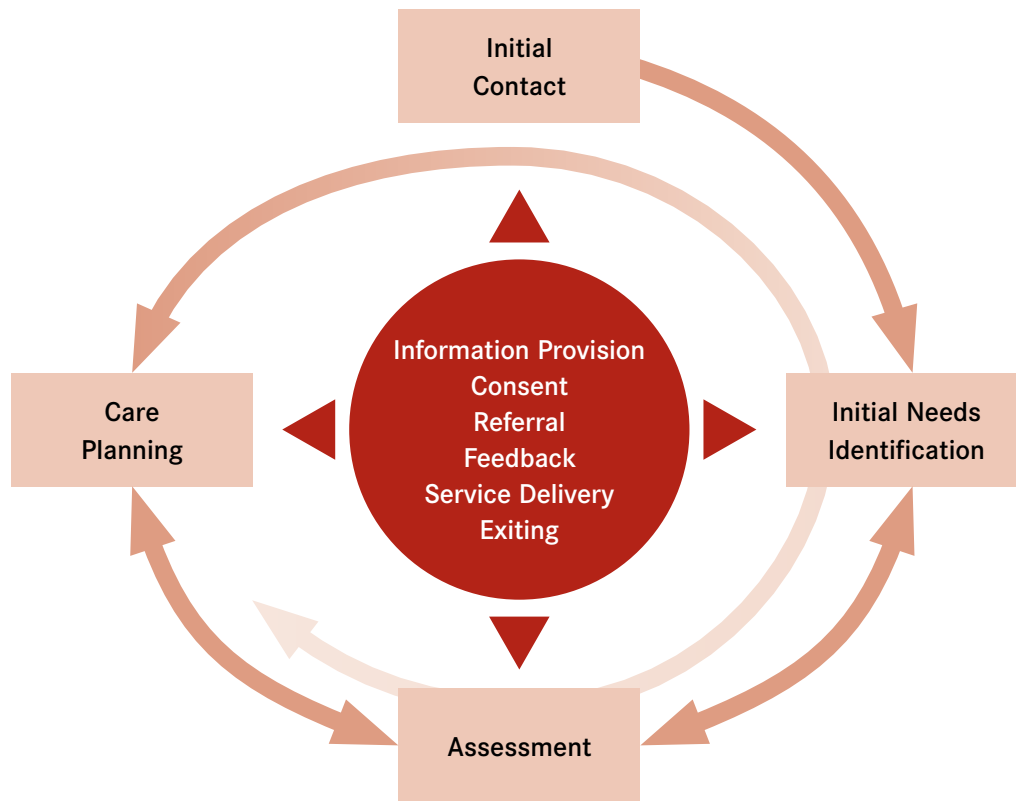
² *Better Access to Services: A Policy and Operational Framework*, p. 1, DHS June 2001.

³ *Better Access to Services: A Policy and Operational Framework*, p. 9–13, DHS June 2001.

1.2 The Service Coordination Framework

The operational elements of Service Coordination, as described in the Better Access to Services Framework, are depicted in *figure 1*. **Initial Contact**, **Initial Needs Identification**, **Assessment and Care Planning** are the key elements. Processes such as information provision, consent to share information, referral, provision of feedback, service delivery and exiting can occur at any stage.

Figure 1: Service Coordination elements

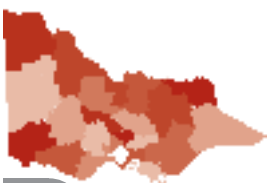


Different agencies and program areas will have differing roles in the implementation of Service Coordination. The nature and level of involvement by service providers will depend on program requirements, size, service profile, funding, target groups and resources. Service Coordination elements are implemented in a range of ways to suit the consumer group and service provider settings. For example, in some services, Initial Contact and Initial Needs Identification are carried out by the same person (such as an intake worker) and Assessment is conducted by a different person, whereas in other services, one person may conduct both Initial Needs Identification and Assessment processes at the same time.

It is important that consumers living in Victoria can access all elements of Service Coordination in a timely and seamless way. Therefore if your service does not deliver all elements of Service Coordination, it is important that you know where consumers can be referred to for these services.

General practitioners (GPs), general practice and divisions of general practice are essential participants in Service Coordination. They work closely with service providers to provide 'comprehensive, coordinated and continuing medical care drawing on biomedical, psychological, social and environmental understandings of health.'⁴

The main Service Coordination interface between GPs and services is in the areas of referral (and referral feedback) and collaboration for inter-agency Care Planning.

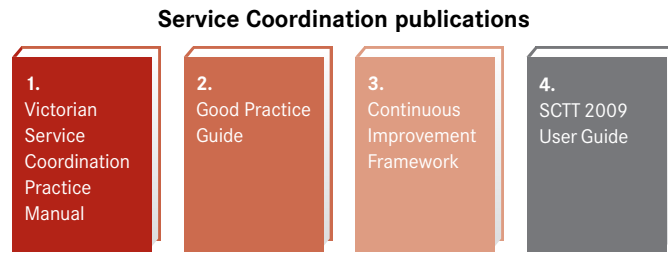


⁴ Royal Australian College of General Practitioners (RACGP) Council 2001.

1.3 What tools and resources support Service Coordination?

A range of statewide, regional and service provider specific resources and tools have been developed to support Service Coordination.

This guide is one of a set of four publications designed to support the implementation of Service Coordination in Victoria. It sets out agreed good practice for the implementation of Service Coordination across Victoria. For a comprehensive description of Service Coordination, including good practice indicators, see the *Victorian Service Coordination Practice Manual*. For planning and achieving quality improvement in Service Coordination, see the criteria and points of evidence listed in the *Continuous Improvement Framework*.



www.health.vic.gov.au/pcps/coordination

In addition to these four publications, there is a range of supporting resources and tools to support the practice of Service Coordination. Key resources and tools include:

- **Service Coordination Tool Templates (SCTT) 2009** and the *Service Coordination Tool Templates 2009 User Guide*. SCTT is a suite of templates developed to facilitate and support the collection, recording and sharing of consumer information in a standardised way
- **Human Service Directory** www.humanservicesdirectory.vic.gov.au
- **Service Coordination privacy resources** www.health.vic.gov.au/pcps/coordination
- **Service Coordination—What? Why? How?** an on-line, self-paced training module, available at: www.health.vic.gov.au/pcps/coordination
- **Service Coordination Orientation Training Kit** available at: www.health.vic.gov.au/pcps/coordination

Refer to *section 7* for information about further resources available.

Service Coordination is supported at a regional and catchment level by:

- Primary Care Partnerships
- locally agreed Service Coordination protocols that build and enhance the *Victorian Service Coordination Practice Manual*
- agreed referral pathways, including the use of secure e-referral systems
- service provider networks and groups.

Service Coordination is supported at a service provider level by:

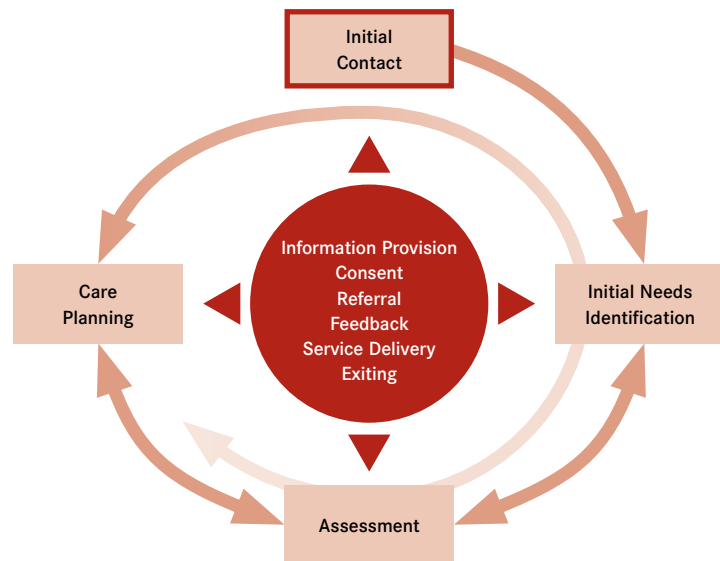
- service provider specific policies, procedures and work instructions
- resources, such as decision-making tools, forms, resource folders and checklists
- information technology and telecommunications
- client management software applications
- information management processes and procedures related to service access, consumer registration and consumer records
- service directories, such as the Human Service Directory.

2. Practice Standards: Initial Contact

2.1 What is Initial Contact?

Initial Contact is the first point of contact for a consumer with the service system. It is available through every service provider. Initial Contact usually:

- includes the provision of accurate, reliable, comprehensive service information, for example: available services, eligibility criteria and service access/intake processes
- includes the provision of other information, such as health promotion literature from the service or via websites such as the *Better Health Channel*
- facilitates access to Initial Needs Identification by your service or by another service provider.



Initial Contact is initiated by the consumer or a friend, relative or carer, most commonly by telephone, in-person, or via electronic media (such as websites and service directories). Assertive outreach and case-finding approaches by services can also result in Initial Contact with consumers.

Consumers usually progress from Initial Contact to Initial Needs Identification. Initial Contact ends when a consumer requires information that is supported by advice and when a process of inquiry begins, that is, the Initial Needs Identification process commences.

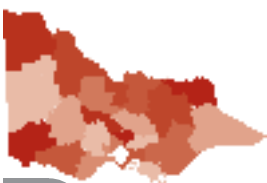
2.2 Which staff are involved in Initial Contact?

Service providers implement Initial Contact differently. For example:

- in some services, Initial Contact is carried out by a receptionist. In other services, it may be undertaken by a duty worker or information officer. Elsewhere, it may be the responsibility of the service coordinator, intake worker, or a specific service provider. Care coordinators and outreach workers also provide an important point of Initial Contact
- in some services, Initial Contact and Initial Needs Identification are carried out by a single staff member at the one time, such as a service coordinator, duty worker, intake worker or outreach worker. In other services, Initial Contact may be the responsibility of a range of different staff, and Initial Contact and Initial Needs Identification may be completed over a number of days.

Initial Contact is implemented by a range of staff, such as:

- Reception staff
- Intake worker
- Service coordinator
- Duty worker



- Triage staff
- Care coordinator
- Outreach worker
- Information worker
- Individual service providers (where consumers contact them directly such as in some Community Health services)
- Volunteers, for example in Neighborhood Houses, Community Centres
- Housing staff
- Key worker.

2.3 What can consumers expect from Initial Contact?

Service providers are expected to provide access to Initial Contact within **1 working day** of a consumer making contact. In addition, consumers can expect to:

- receive a timely response and appropriate information at Initial Contact
- be informed about:
 - the services available and eligibility criteria
 - entry and Initial Needs Identification processes
 - their rights and responsibilities in relation to accessing services
- be empowered to make informed choices about the service system and referrals through the provision of accurate and appropriate information
- have access to Initial Needs Identification, Assessment and referral
- experience a coordinated, planned and reliable response with practice that is sensitive to cultural, communication and cognitive needs.

2.4 Good practice guidelines



- Greet and welcome the consumer
- Ask the consumer what they require help with
- Listen to the consumer in a sensitive and non-intrusive manner
- Collect information in a sensitive manner, with particular regard to cultural requirements, language issues, special communication needs, privacy, confidentiality and anonymity. Source an interpreter or advocate, if required
- Complete the relevant Service Coordination Tool Templates (SCTT)
- Provide information about the services available from your organisation and from other service providers, using the Human Services directory or other relevant service directories
- Provide the consumer with information in a manner which enables them to make informed choices and decisions
- Provide the consumer with copies of relevant information
- Assist the consumer to proceed to Initial Needs Identification, Assessment or referral, as appropriate
- Assist a consumer to make a self-referral by providing contact details for a service, or obtain consumer consent to share information and make the referral on their behalf (an assisted referral)
- Thank the consumer for contacting your service and check that the consumer is clear about what will happen next.

3. Practice Standards: Initial Needs Identification

3.1 What is Initial Needs Identification?

Initial Needs Identification (sometimes abbreviated to INI) is an initial broad, shallow, screening process, where the underlying issues as well as presenting issues are uncovered to the extent possible. The service provider undertaking Initial Needs Identification looks beyond the presenting issues to what underlying issues may exist. Initial Needs Identification is sometimes referred to as triage or service screening.

Initial Needs Identification allows for the consumer's health, social, emotional and wellbeing needs and health promotion opportunities to be broadly identified early in their contact with the service system. Initial Needs Identification provides an opportunity for the service provider to engage the consumer in a broad conversation about their health needs, so that the full range of consumer needs, including health promotion, illness prevention, early intervention, self-management capabilities and restorative options are identified. Consumers can be subsequently informed about the range of service options available to meet their needs, and consideration can be given to the wider range of service support and resources.

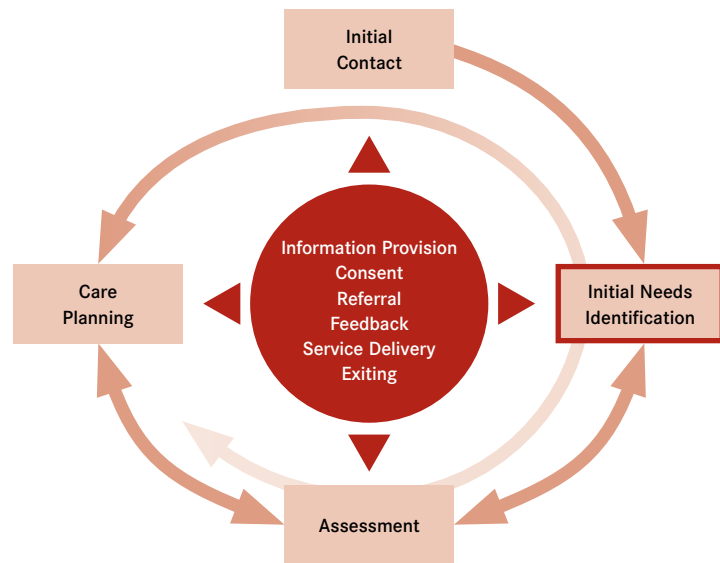
The Initial Needs Identification process is sensitive to the consumer, their presenting needs and the service setting, and requires judgment by the service provider as to the extent and intensiveness of the process. Initial Needs Identification is not a diagnostic process but is a determination of the consumer's risk, eligibility and priority for service and a balancing of the service capacity and the consumer's needs. The gathering and analysis of information arising from Initial Needs Identification reduces risk for consumers and informs the urgency and type of assessments that may be required.

This Service Coordination element supports referrals by offering screening that helps identify consumer needs in an efficient, timely and sensitive manner.

3.2 Which staff are involved in Initial Needs Identification?

Initial Needs Identification is carried out by a qualified service provider. Decisions made by staff undertaking Initial Needs Identification require a broad understanding of the service system, advanced interviewing skills, and high-level interpersonal skills, including the ability to develop rapport with consumers.

Service providers should have easy access to service provider decision support tools, the Human Services Directory or other relevant service directories.



Initial Needs Identification happens differently in every service provider and across programs. For example:

- Initial Needs Identification may be undertaken by a centralised or dedicated service coordination worker, intake or duty worker, in one organisation, and by individual services in another organisation
- Initial Contact and Initial Needs Identification may be done by one staff member all at the same time, or by different service providers and over a period of days
- Initial Needs Identification and Assessment may occur together and at the same time in one service provider, and by separate service providers over a period of time in another service provider
- Certain workers (such as an outreach worker) may be responsible for Initial Contact, Initial Needs Identification and Assessment. These activities may happen all at once, or over time.

Initial Needs Identification is implemented by a range of staff, such as:

- Duty worker
- Intake worker
- Service coordination worker
- Care coordinator
- Triage nurse
- Assessment officer or nurse
- Outreach worker
- Individual service providers (in particular, where consumers contact them directly to make appointments, as happens in some Community Health Services) such as a social worker, physiotherapist, alcohol and drug counselor, care coordinator in an emergency department
- Case manager
- Housing service worker
- Key worker.

Victoria is committed to ensuring that all consumers can easily access Initial Needs Identification, when required. If your organisation does not provide this service, it is important that you know where consumers can be referred to for Initial Needs Identification.

3.3 What can consumers expect from Initial Needs Identification?

Service providers are expected to commence Initial Needs Identification:

- within no more than **7 working days** of Initial Contact by a consumer, or receiving a referral identified as *low* or *routine* from Initial Contact
- within no more than **2 working days** of Initial Contact by a consumer where their situation is urgent, or receiving a referral identified as *urgent* from Initial Contact

Consumers can expect to:

- be informed about:
 - the Initial Needs Identification process
 - why information is being collected and how that information is used
 - their rights and responsibilities, including access to their health records
 - consent requirements and the implications of providing or not providing consent
- receive support and assistance to determine their issues, identify their needs and options available
- have their needs identified in a timely manner
- have access to appropriate assessments and referrals, including assisted referrals
- experience a coordinated, planned and reliable Initial Needs Identification process and outcomes with a practice that is sensitive to cultural, communication and cognitive needs.

3.4 Good practice guidelines



- Undertake a skilled process of inquiry with the consumer about their health and wellbeing needs, including their social, psychological, medical and physical aspects, as appropriate. This may require you to explore issues other than the presenting issues
- Collect information in a sensitive manner, with particular regard to cultural requirements, language issues, special communication needs, privacy, confidentiality and anonymity. Source an interpreter or advocate, if required
- Assist consumers to determine their issues, identify their needs and refer on, if required
- Screen for service requirements, risk, priority of access and opportunities for health promotion
- Provide information about services and discuss potential service options
- Recommend an appropriate course of referral action, such as a service, or recommend health promotion literature or strategies
- Be aware of the consumer's right to refuse recommended referrals and services, record their refusal and discuss other options
- Consider duty-of-care and mandatory reporting requirements
- Apply professional judgment as to the extent and intensiveness of the process so it is sensitive to the consumer, their presenting needs and the service setting
- Use the Human Services Directory or other relevant service directories to access current information on services available, eligibility criteria and waiting times
- Complete the relevant Service Coordination Tool Templates (SCTT)
- Explain the consumer's privacy rights and ensure they are understood
- If a referral is needed, request the consumer's consent to share information
- Document the consumer's consent (or non-consent) to sharing of information
- Use SCTT to make a referral, in accordance with the *SCTT 2009 User Guide*
- Make referrals using a secure e-referral system or via secure fax or post using the SCTT Confidential Referral Cover Sheet.

4. Practice Standards: Assessment

4.1 What is Assessment?

Assessment is a decision-making methodology that collects, weighs and interprets relevant information about the consumer. It is not an end in itself, but part of a process of ongoing care delivery and treatment.

It is an investigative process using professional and interpersonal skills to uncover relevant health and wellbeing issues and leads to the development of a care plan.

Assessment ensures that the current and ongoing needs of the consumer are identified and documented. Assessment

is a process by which one or more skilled service providers investigate in detail the specific needs of a consumer. A consumer may require more than one Assessment, as specific disciplines collect and interpret particular information, such as: social, functional, lifestyle, emotional and health needs.

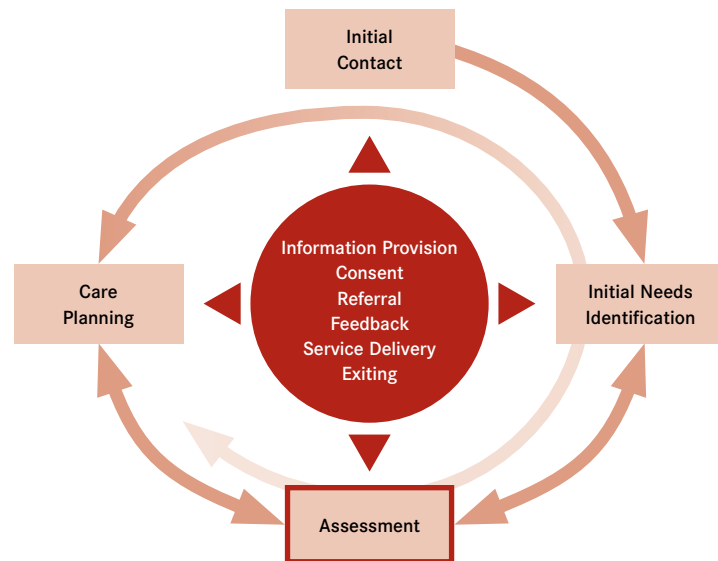
Service providers typically conduct Assessment relevant to their services type or particular discipline. Each service provider should have Assessment tools in place which meet consumer, service provider, reporting and program requirements. Most government-funded program areas have developed Assessment frameworks, guidelines, templates and tools to support assessment practices and processes. For example: the Home and Community Care (HACC) Assessment framework, Disability Service Target Group Assessment, Domestic Violence Risk Assessment framework and Opening Doors—Better access for homeless people to social housing and support services in Victoria, initial Assessment.

Assessment builds on the information gathered through Initial Contact, Initial Needs Identification and other relevant sources. The information can build over time to develop a holistic picture of the consumer, especially where multiple issues are identified.

The *Better Access to Services Policy and Operational Framework* describes three types of Assessment.

Service Specific Assessment

A face-to-face interaction undertaken when consumers have a relatively straightforward, obvious and distinct need for a specific service (such as: home care, physiotherapy, dental services, domestic assistance, nursing, planned activity group). The purpose of a service specific Assessment is to identify specific service requirements to meet a consumer's assessed need. It is conducted by the service provider responsible for delivering the service and occurs as part of the delivery of service. Service specific Assessment leads to development of a service specific care plan or individual service plan.



Specialist Assessment

A face-to-face interaction with a consumer, and is undertaken when the presenting issue clearly requires a specialist service response, such as a need for specific women's services, mental health, alcohol, other drug services and problem gambling. It occurs where a specialist need is identified, following Initial Needs Identification and/or any other relevant Assessment or information collected through the process of service delivery. A specialist intervention may be straightforward, such as a request for a pap smear or it may be more comprehensive in nature, such as in the case of specialist alcohol and drug services, where a range of interventions will be required.

Comprehensive Assessment

A face-to-face interaction with a consumer, involving a broader and more intense level of inquiry, including an advanced dimension of history-taking, examination, observation and measurement or testing. It involves medical, physical, social, cultural and psychological dimensions of need, as well as consideration of abilities and capacity for improvement. It facilitates a more extensive process of inquiry requiring analysis and interpretation of the Assessment information and a clinical judgment, diagnosis and differential diagnosis. It occurs where consumers have multiple, complex or unclear needs, and with consumers who often require long-term or extensive service provision. Information is gathered from a wide-range of sources to build a comprehensive picture. Comprehensive Assessment is undertaken by a range of competent and experienced workers with a multi-disciplinary, as well as inter-disciplinary approach and ensures that all identified needs are considered, and an appropriate response is accessed, even if not available at the assessing organisation. Comprehensive Assessment may be carried out by a range of providers, such as: Aged Care Assessment Services (ACAS), Home and Community Care (HACC) services, Community Health Services. A comprehensive Assessment incorporates a risk identification and assessment approach, which enables strategies to be stratified according to severity. A comprehensive Assessment links into a coordinated care planning process.⁵

4.2 Which staff are involved in Assessment?

Assessments can only be carried out by trained service providers, with expertise in the particular area of service delivery. Decisions made by staff undertaking Assessments require a broad understanding of the service system, advanced interviewing skills, and high-level interpersonal skills, including the ability to develop rapport with consumers.

Assessment is completed by a qualified service provider to:

- identify consumer needs and capacity
- discuss care goals with the consumer and relevant others
- determine services required
- inform the development of a care plan
- determine appropriate referrals required and share information with the consumer's consent.

The transition from Initial Needs Identification to Assessment happens differently in every service and across program areas, and at times the transition is blurred. For example, an Initial Needs Identification and Assessment may be carried out by one staff member at the same time, or by different staff and over a period of days. Staff undertaking Assessments are required to have appropriate qualifications, skills and knowledge.

General practice is the primary point of healthcare for the majority of the community, and as such is the gateway to the broader health system. Many consumers may have already consulted with a general practitioner about their care and undergone Assessment. To undertake particular comprehensive health assessments and health checks, GPs can access reimbursement through the Medical Benefits Schedule (MBS) and payment through the Practice Incentives Program.

⁵ Further information about the three types of assessment can be found in the *Better Access to Services Policy and Operational Framework*, a copy of which can be downloaded from: www.health.vic.gov.au/pcps/publications

4.3 What can consumers expect from Assessment?

Consumers can expect to:

- be informed about:
 - the Assessment process
 - why information is being collected and how that information is used
 - their rights and responsibilities, including access to their health records
 - the implications of providing and not providing information
 - consent requirements
- actively participate in determining their issues and assessing their needs
- actively participate in the planning of interventions that are solution focused
- have direct access to further Assessments, Care Planning and referrals
- experience a coordinated, planned and reliable Assessment process and outcomes with practice that is sensitive to cultural, communication and cognitive needs.

4.4 Good practice guidelines



- Undertake a skilled process of Assessment based on program, organisation and professional guidelines, assessment frameworks, tools and protocols that meet accepted discipline and inter-discipline specific requirements, and minimises duplication
- Collect information in a sensitive manner, with particular regard to cultural requirements, language issues, special communication needs, privacy and confidentiality, and anonymity
- Assess the full range of consumer issues, needs and circumstances, including opportunities for health promotion and opportunities and capacity for self-management, through the assessment process
- Discuss assessment outcomes with the consumer
- Assist the consumer to actively participate in determining their issues, identifying their needs and planning solution-focused interventions
- Provide information about the interventions, treatments or therapies available through your and other services
- Utilise the Human Services Directory or other relevant service directories to access current information about services available, eligibility criteria and waiting times
- Respond to consumers who require urgent services and who cannot wait for a formal assessment process to be completed
- With the consumer's consent, consult and share information with other practitioners, as necessary
- Consider duty-of-care and mandatory reporting requirements
- If further referral is required, complete relevant sections of the Service Coordination Tool Templates (SCTT)
- Feedback outcomes (for example, service commencement dates, assessment findings, treatment goals, agreed interventions) to the service provider which initiated the referral, the consumer's GP and other stakeholders, as appropriate.

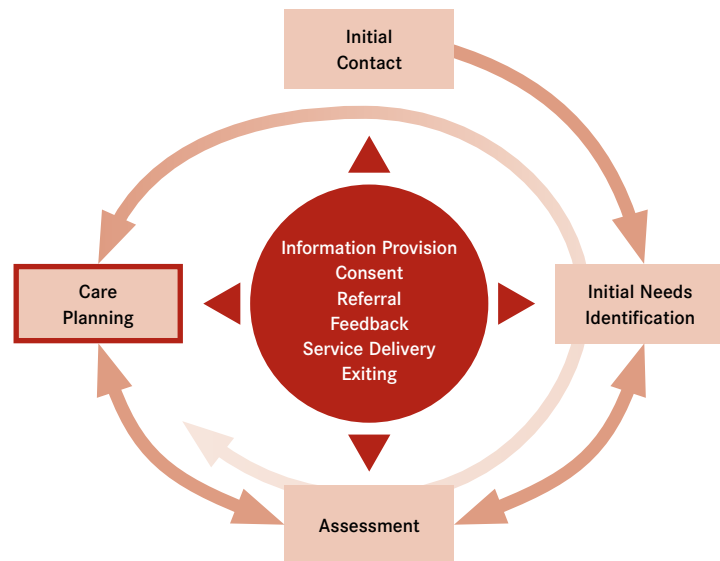
5. Practice Standards: Care Planning

5.1 What is Care Planning?

Care Planning involves the gathering and interpretation of Assessment, consumer self-reported and other information, and making decisions with the consumer and the carer about strategies for their care and support.

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

Care Planning supports the consumer to identify goals and agree on strategies, actions and services to achieve those goals. This involves discussion with the consumer to define their goals and establish how the goals can be met. The Care Planning process includes: discussion, negotiation and decision-making in conversation between the service provider and consumer. Care Planning involves balancing relative and competing needs, and assisting consumers to make decisions that are appropriate to their needs, wishes, values and circumstances. This may involve linking the consumer to a range of services, identifying how self-management support, education and health promotion will be provided, and establishing effective communication between all the participants in care, including the consumer and their general practitioner. Each consumer will have different needs, aspirations, priorities and resources and there is the expectation that these will inform the development of individual goals.



5.2 Key features of Care Planning in Victoria

Care Planning is not merely a care plan document, or an end in itself. Care Planning can occur at any point of the care process, wherever an assessment or review takes place.

Care Planning is a dynamic process which incorporates a range of activities, such as: decision support, care coordination, case-management, referral, feedback, review,⁶ re-assessment,⁷ monitoring and exiting.

The following points outline the features of Care Planning in Victoria, in accordance with Service Coordination:⁸

- nomination of a key worker or contact person for the consumer to promote effective communication between the consumer and service providers. The key worker may have a specific role, such as a care coordinator, and is responsible, within the scope of their role, for ensuring that the care plan is delivered and monitored, review dates are set, re-assessments are initiated, where appropriate, and feedback about the outcome of the referral is provided to a referring service provider, where appropriate

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.

⁸ Adapted from *Better Access to Services: A Policy and Operational Framework*, p. 20–21, DHS June 2001.

- incorporation of the care-delivery process (from the simple booking of services through to comprehensive case management) for consumers, where a consumer requires multiple services or has complex or multiple needs
- acknowledgement of the potential contribution of education and self-management to effective care
- provision of effective monitoring (both formal and informal) of a consumer's health and wellbeing, and the effectiveness of services being delivered, for example, through regular reviews
- the requirement that referral and other information is coordinated, planned and expedited in an efficient manner, and specific feedback loops are in place for other service providers and the consumer
- maximising the opportunities inherent in the Federal government's MBS items, to facilitate and support collaborative Care Planning with GPs
- use of the SCTT Care Coordination Plan for consumers with complex or multiple needs, who require the services of more than one service provider.

5.3 What is a Care Plan?

All care plans should include the following items:

- 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.

Service specific care plan

A service-specific plan is developed by a *single service*. Service specific care plans are usually documented using program specific tools or formats. Examples include: an Individual Treatment Plan, an Asthma Management Plan, an Advanced Care Plan, a GP Management Plan an Individual Support Plan.

Intra-agency care plan

An intra-agency care plan is used with consumers who require *multiple services from within a single organisation*, in order to coordinate service delivery. Consumers may have service specific care plans as well as the overarching intra-agency care plan to coordinate overall service provision and support the consumer to achieve their goals in an integrated manner. An intra-agency care plan can be documented using the **SCTT Care Coordination Plan**.

An intra-agency care plan is developed to:

- articulate shared goals and outcomes
- outline the roles and responsibilities of each practitioner
- coordinate internal service provision to support the consumer to achieve their goals
- facilitate communication of agreed strategies and interventions, to ensure all involved in the consumer's care plan are well informed and working towards the same goals
- identify the person responsible for care coordination, such as a key worker, care coordinator or case manager, as appropriate
- monitor and review service provision (including recall), and plan for discharge, transition or exit from the service.

Inter-agency care plan

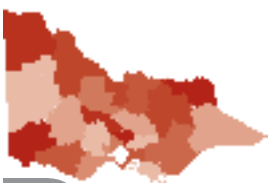
An inter-agency care plan is used with a consumer who has complex or multiple needs and requires services from *more than one organisation* (for example, the consumer has a chronic disease). An inter-agency care plan should be developed using the **SCTT Care Coordination Plan**. An inter-agency care plan is designed for use where consumers:

- are involved with more than one organisation
- have multiple issues or problems that need to be addressed concurrently, such as chronic or terminal conditions
- are likely to experience a better outcome if the care and services they receive are coordinated between organisations and over time.

Effective inter-agency Care Planning enables a proactive rather than reactive approach to care for people with multiple support needs. It is the most complex form of Care Planning, and requires a person who has a specific role to coordinate the information and assist the consumer to access care appropriate to their needs (see *section 5.5*). The purpose of an inter-agency care plan, using the SCTT Care Coordination Plan, is to provide a document that supports a coordinated and consumer-centred approach to addressing consumer needs by working on goals agreed to by the consumer and their support team. The SCTT Care Coordination Plan is useful for documenting essential information to be shared with others, including life-saving actions for emergencies. It has been designed to encourage a team approach with the consumer at the centre. The development of a Care Coordination Plan can increase consumer and carer awareness of the support and services available to them. An inter-agency care plan using the SCTT Care Coordination Plan, developed in discussion with the consumer, their carer and other relevant service providers, such as their GP, can be used to document: participant details, key issues, planned actions and information from the review of the plan. Service providers can use electronic forms of the Care Coordination Plan to enable efficient sharing of information and on-line case conferencing.

5.4 Steps to develop a care plan

1. Identify the need for Care Coordination Plan. For example, a consumer:
 - who has chronic, terminal or complex conditions
 - has multiple needs
 - requires multiple services or multiple service providers
 - would benefit from a coordinated Care Coordination Plan
 - requests a Care Coordination Plan
2. Check if an inter-agency care plan, case management plan, team care arrangement, mental health plan, disability support plan or Care Coordination Plan exists. Avoid duplication, decide if there is a need to add to the existing plan or develop a Care Coordination Plan. The Care Coordination Plan should not repeat the content of other plans, but focus on priority goals that require a coordinated approach
3. Explain to consumer what a Care Coordination Plan is and why you think they would benefit. This involves listening to their issues, respecting choice and discussing the advantages of having a Care Coordination Plan. During this discussion, identify a reason for the Care Coordination Plan that is recorded in the document. This may include providing written information such as: *Care Planning Information for Consumers* http://www.health.vic.gov.au/pcps/coordination/care_initiatives.htm



4.	Obtain consumer consent to the Care Planning process. Once the person has understood the reason for the plan, they can consent to the process
5.	Identify the participants in care and which ones need to be involved in the Care Planning process. In discussion with the consumer and carer, identify the current participants in care who may participate in the planning. Ask the consumer: <i>Who are the people who support you at the moment?</i> This may include family members, specialists, GP, allied health professionals, or counsellors. Explain the role of the key worker to the consumer. Identify the preferred key worker or care plan coordinator from the consumer's perspective. The consumer may also need an advocate, interpreter, carer or family member involved in Care Planning. Where the consumer is not able, or chooses not to be involved in the Care Planning discussions, a substitute decision-maker may participate on their behalf
6.	Obtain consumer consent to share information with participants involved in the planning process. Record consent to share information with the participants identified using <i>Consumer Consent to Share Information</i> form. Consumers have the right to specify which participants in care they want their information shared with, who they want involved in the Care Planning and this is recorded in the purpose column of the <i>Consumer Consent to Share Information</i> form, recording <i>Care Planning</i> or <i>care coordination</i>
7.	Communicate with participants to arrange time and method of participation in planning or case conference. Communication with participants, may include: discussing the reason for the plan, clarifying their role, identifying and collecting or locating relevant Assessments and information that will inform the Care Planning discussions and establishing a suitable time, location or method for the discussion. When engaging a GP in a case conference, ensure sufficient preparation and timing that will be most suitable and efficient. Divisions of general practice can provide guidance in this area
8.	At the planning session, agree on the key worker or care plan coordinator or facilitator. Consider the service provider, program guidelines, position descriptions, consumer preference, the person who has rapport with the consumer, the one with the most regular contact, and the level of skills and capacity of the worker
9.	Record all participants in care, their role and contact details and who is involved in planning. This can be useful in future as a contact list for the consumer and other participants
10.	Discuss and develop the plan together. Identify key issues, agreed goals (specific, measurable, achievable, realistic and time-specific) and the actions planned to achieve the goal, responsible individuals/services for each action, and target date for each goal
11.	Agree on a proposed date to review plan and record this. It is the responsibility of the key worker to ensure the Care Coordination Plan is reviewed as closely as possible to the review date, or earlier if necessary. The timeframe for review depends on the consumer's situation, the goals and the types of services involved. For example, a post acute Care Coordination Plan may be reviewed after two weeks, whereas a plan for a person with multiple ongoing issues may be reviewed after six months
12.	Check that consumer understands and agrees to the plan. Record this on the plan and obtain a signature, where available. The signature of the consumer is important in some sectors but not all, so this practice will vary according to the service and program area

13.	Record on the plan the participants who are to receive a copy and provide them with a copy. Consumers have the right to choose which participants have a copy of the Care Coordination Plan
14.	Provide feedback to the key worker. Information about changes to or progress on planned actions are to be sent to key worker or care plan coordinator who will record this on the <i>Review of Care Coordination Plan</i> , as required
15.	Key worker or care plan coordinator are to facilitate review of care plan. This may occur at a meeting, case conference or by contacting individual participants. A decision needs to be made following this as to whether a new Care Coordination Plan is developed
16.	Use the SCTT <i>Review of Care Coordination Plan</i> to record progress of each goal. A copy of the completed Review of Care Plan will then be provided to the selected participants

5.5 Which staff are involved in Care Planning?

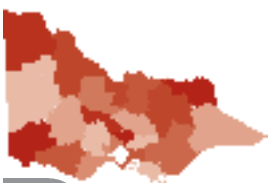
Care Planning should be carried out by qualified staff or a key worker, with skills and competence to:

- engage and empower the consumer and act as an advocate, if required
- draw together existing information, such as assessments or care plans
- consider options based on a good knowledge of available services
- develop and document agreed goals and actions in collaboration with the consumer, ensuring they are specific, measurable, achievable, realistic and time-specific
- facilitate the creation, documentation and communication of the initial care plan
- monitor and review the care plan, including arrangement of re-assessments as required, and updating the care plan
- liaise and communicate with all participants, including the consumer, carer and GP
- organise and facilitate case conferences
- work in a virtual, multi-disciplinary or inter-disciplinary team
- ensure the care plan remains current
- discuss exit options and procedures
- provide feedback to referrers, GPs and support workers
- ensure documentation and processes meet the requirements of the *Health Records Act* and other privacy legislation.

General practitioner involvement in Care Planning

The involvement of GPs in Care Planning for people with complex or multiple needs or chronic diseases is essential. Importantly, GPs can be involved in Care Planning led by other service providers, or they can lead Care Planning, which involves other service providers.

When a multi-service care plan is needed, service providers should consider communicating with the consumer's GP to establish if there is already an existing care plan and determine the roles and responsibilities of the participants in the care planning process. When a care plan is developed a copy of the care plan should be sent to the GP, with the consumers consent.



The ways GPs can be involved in Care Planning are guided by the MBS Guidelines and general practice tools, which have been developed to meet MBS rules.

As part of the Chronic Disease Management (CDM) items available to general practice is a service for GP-only Care Planning, which is the General Practice Management Plan (GPMP). This is for consumers who have a chronic or terminal medical condition without multi-disciplinary care needs. The Team Care Arrangement (TCA) is for consumers who have complex care needs and require other service providers in their care. If eligible, the consumer can access multi-disciplinary services, such as subsidised access to allied health, through a TCA. GPs can be assisted by practice nurses, Aboriginal health workers and other health professionals in providing these items.

Further information about how GPs can be involved in Care Planning can be obtained from your PCP, local division of general practice or from:

- <http://www9.health.gov.au/mbs/search.cfm>
- http://www.health.vic.gov.au/communityhealth/downloads/gp_engagement_icdm.pdf
- <http://www.health.gov.au/internet/main/publishing.nsf/Content/pcd-programs-epc-chronicdisease.htm>

5.6 What can consumers expect from Care Planning?

Consumers can expect to:

- be informed about:
 - Care Planning options and processes
 - the value of a Care Coordination Plan and communication with other participants in their care
 - the roles and responsibilities of the various practitioners, in particular the key worker role
 - privacy, confidentiality and consent procedures and their rights in relation to these procedures.
- be empowered to participate in the development, implementation, monitoring and review of their service specific plan, intra-agency care plan or inter-agency care plan
- be certain that information is collected, stored, shared and updated in accordance with the *Health Records Act* and other privacy requirements
- experience a coordinated, planned and reliable Care Planning process and outcomes with practice that is sensitive to cultural, communication and cognitive needs.

A consultative, collaborative, approach to care that actively involves the consumer, their family, carers, support person and service providers working as a team, ensures the best possible outcomes for the consumer.

5.7 Good practice guidelines



- Refer to documentation generated through the Initial Contact, Initial Needs Identification and Assessment processes
- Discuss Care Planning options (including service specific care plan, intra-agency care plans and inter-agency care plans) with the consumer
- Where a consumer has a chronic disease and/or complex or multiple needs, check (with consent) if a consumer's GP has completed a GP Management Plan or Team Care Arrangements or other care plans
- Coordinate the development of an intra-agency or inter-agency care plan for consumers with complex or multiple needs using the SCTT Care Coordination Plan
- Empower the consumer to participate in the development, implementation, monitoring and review of their care plan
- Ensure a key worker is identified for consumers with an intra-agency or inter-agency care plan
- Obtain consent to share consumer information with other agencies, if required for care coordination
- Provide a copy of the SCTT Care Coordination Plan to other agencies, the consumer's GP and the consumer
- If you are the key worker, coordinate:
 - development and documentation of the Care Coordination Plan
 - any monitoring activities, reviews and re-assessments
 - liaison and communication with key stakeholders, such as the GP and organise case conferences or meetings, if required
 - development of exit options and procedures
 - information management processes to meet the requirements of the *Health Records Act* and other privacy legislation
- Participate in Care Planning initiated by other practitioners or the consumer's GP.

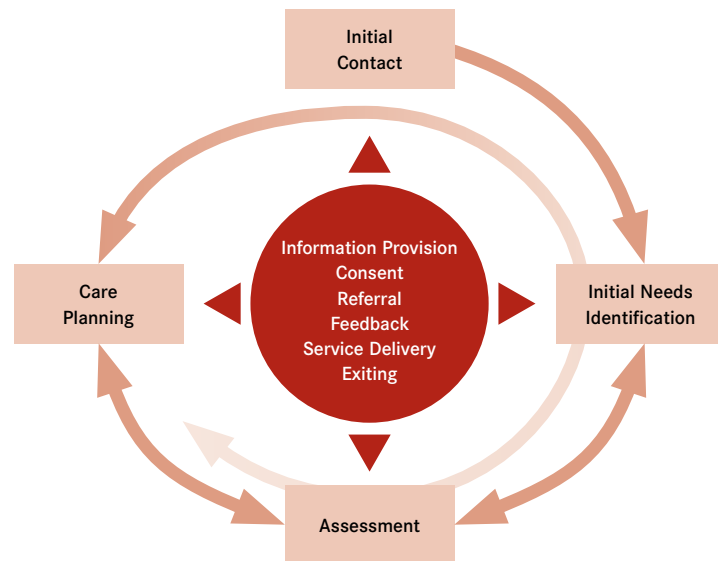
6. Practice Standards: Referral

6.1 What is referral?

Referral describes the transmission of personal and/or health information relating to an individual from one service provider to another service provider, with the individual's consent and for the purpose of further assessment, care or treatment. Referrals may be made from all elements of Service Coordination.

For example:

- a staff member involved in Initial Contact may refer a consumer on to another, or more appropriate service
- an Initial Needs Identification service provider may identify referrals, as part of their screening role
- service providers may identify further assessments and treatments required to meet a consumer's needs, as part of the assessment process
- referral as a result of Care Planning.



Service providers collect information from consumers for a variety of reasons. For example: to identify needs, to make a good quality referral, to undertake an Assessment, to provide a service, for effective Care Planning, to meet data collection requirements, to meet program requirements, and to ensure quality of service. However, service providers should not collect information that is not relevant for their service provider's practice, such as, collect another service provider's minimum data set requirements.

Self-referral

Self-referral is where a consumer takes responsibility for contacting another service provider to make a referral on their own behalf. Where a consumer chooses to make a self-referral, service providers should support this choice by providing:

- information, such as service provider contact details
- advice and decision making support
- a copy of completed SCTT, if appropriate.

Assisted referral

This is where service providers within the service system make a referral on behalf of a consumer. An assisted referral is usually made when a consumer chooses to access the service and consumer consent to share their information with other services is required. A service provider making an assisted referral should use the SCTT.

Active or crisis referral

In some situations a service provider may make an immediate referral, that is, speak directly to the receiving service provider. This may be needed when a consumer is extremely anxious or in crisis (for example: attempted suicide, serious self-harm, behaviour endangering self or others, threats of violence) and follow this up with a more detailed referral using the SCTT.

Consent

In some circumstances a referral can be made without consumer consent. These include referrals to statutory services, such as Child Protection, Mental Health, or where an immediate referral is in the best interests of the consumer. 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 (see definitions in *section 7*). 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*. This includes where the sharing of information is by a health service provider and is reasonably necessary for the provision of a health service, or where there is a statutory requirement. For further circumstances for disclosure, see: www.health.vic.gov.au/hsc/infosheets/disclosure.pdf

If the consumer **refuses consent** to share information, a referral can still proceed. However, the service provider to which the consumer is referred, will need to obtain the information they require from the consumer.

6.2 Using the SCTT for referral

The *Service Coordination Tool Templates (SCTT)* is a suite of templates developed to facilitate and support Service Coordination. The SCTT are designed to support the collection and recording of Initial Contact, Initial Needs Identification, referral and Care Planning information in a standardised way. Service providers should complete the relevant sections of the SCTT in accordance with the *SCTT 2009 User Guide*.

Core templates are the Confidential Referral Cover Sheet, Consumer Information template and Summary and Referral Information templates. These core templates are used to send a referral after the consumer has provided consent to share information. The Consumer Consent to Share Information template is used to record consumer consent. It does not have to be sent to the service receiving the referral, unless it is requested by them.

In cases where a receiving service requires information in addition to that contained in SCTT, additional information can be attached to the SCTT referral.

Use of the **optional and supplementary templates** to support information sharing as part of the referral process will depend on needs of the consumer, service provider business rules, local protocols and program specific requirements. Refer to the relevant program guidelines to determine the optional or supplementary templates to be sent with each referral.

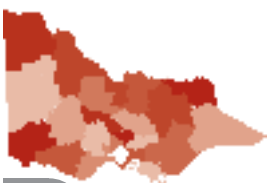
At times a service provider may need to make an immediate referral, such as when a consumer is in crisis, and follow this up with a more detailed referral using the SCTT.

6.3 Referral to and from general practice

Health and community service providers should have in place policies and procedures to support systematic referral and feedback to general practitioners, and other services. In addition, service providers are expected to acknowledge referrals received and to provide feedback to referring services, including GPs, about the referral outcomes.

Referral to a general practitioner

Referrals to a GP should be completed using the SCTT in accordance with Service Coordination referral practice standards.



Feedback to a general practitioner

Feedback is a critical component of the referral process. GPs value feedback, and are particularly interested in receiving information that they need to act on, or be aware of, when they next see the consumer. Feedback to a GP should include the client's Medicare number, be concise, only contain information relevant to general practice and provide information for the GP to action. Information can be found at: <http://www.health.vic.gov.au/communityhealth/gps/index.htm>

Referral from a general practitioner

The Victorian Statewide Referral Form (VSRF) is a simple electronic template for referral from general practice. The purpose is to assist general practice to provide a standardised, quality referral from general practice to health and community services. The VSRF has been incorporated in most clinical software applications used by general practice. Health and community services may encourage general practice to use the VSRF but should not refuse a referral received in other formats.

6.4 Which staff are involved in referral?

All staff implementing processes and practices in Service Coordination may make or receive a referral at some time. There are several key requirements:

- make referrals in accordance with organisational guidelines, policies, procedures and work instructions
- adhere to Victoria's Service Coordination Practice Standards and prioritise referrals as *low*, *routine* or *urgent*
- use the Service Coordination Tool Templates (refer *SCTT 2009 User Guide*) to share consumer information when making referrals
- meet privacy and consent requirements
- utilise local or regional systems, such as using a secure e-Referral system.

6.5 What can consumers expect from referral?

A service provider sending a referral is expected to:

- send **urgent** referrals within no more than **1 working day** of obtaining consumer consent
- send **low** or **routine** referrals within no more than **7 working days** of obtaining consumer consent
- send referral information using the SCTT
- make immediate referrals (for example over the telephone) when a consumer is in crisis, and follow this up with a more detailed referral using the SCTT.

A service provider receiving a referral is expected to:

- respond to **urgent** referrals within no more than **2 working days** of receipt
- respond to **low** or **routine** referrals within no more than **7 working days** of receipt
- transmit a Referral Acknowledgement (to the referring service) within no more than 7 working days of receiving the referral stating the referral has been received, and either the estimated date of consumer assessment or the reason why the referral is not proceeding
- transmit information about the referral outcome (to the referrer) within no more than **14 working days** of the consumer being assessed. Referral outcome information may include: relevant assessment findings, services or interventions to be provided, Care Planning goals.

All service providers are expected to:

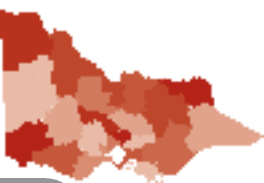
- ensure consumers are referred at the right time, to the right service to maximise health and wellbeing outcomes and quality of life
- assist consumers with navigating and negotiating the service system, in particular when a consumer elects to make a self-referral
- liaise and communicate with other agencies and GPs, as required
- assist consumers in a seamless and timely manner by streamlining access to appropriate services through self-referral or assisted referral.

Local protocols may include specific referral requirements, such as how to use the e-Referral systems and required turn-around-times for specific program areas. Check with your local PCP.

6.6 Good practice guidelines



- When making a referral:
 - advise if an interpreter or advocate is required
 - explain referral options to the consumer
 - consult the Human Services Directory or other relevant service directories, if required
 - obtain informed consent before making a referral and sharing consumer information
 - consider duty-of-care and mandatory reporting requirements
 - complete the relevant sections of the SCTT, in accordance with the *SCTT 2009 User Guide*
 - identify the level of priority for each referral using the SCTT priority definitions: low, routine, urgent
 - send referral in accordance with privacy requirements
 - inform consumer of expected waiting time and provide information on alternative options
- When you have an urgent referral, it is good practice to make contact with the service provider receiving the referral to ensure it has the capacity to respond. If you are unable to make contact with the service provider or it does not have the capacity to respond to the referral, then alternative or interim arrangements should be made
- When receiving a referral:
 - acknowledge receipt of referral using your e-Referral system or the SCTT Confidential Referral Cover Sheet
 - return inappropriate referrals to the sending service with an explanation
 - communicate information about referral outcomes to the referring service and GP
- Encourage GPs to use the Victorian Statewide Referral Form
- When a consumer chooses to make a self referral:
 - document the consumer’s decision to make self-referral
 - document non-consent and explain implications to the consumer
- provide consumer with contact details for services
- provide consumer with a copy of the completed SCTT, if requested.



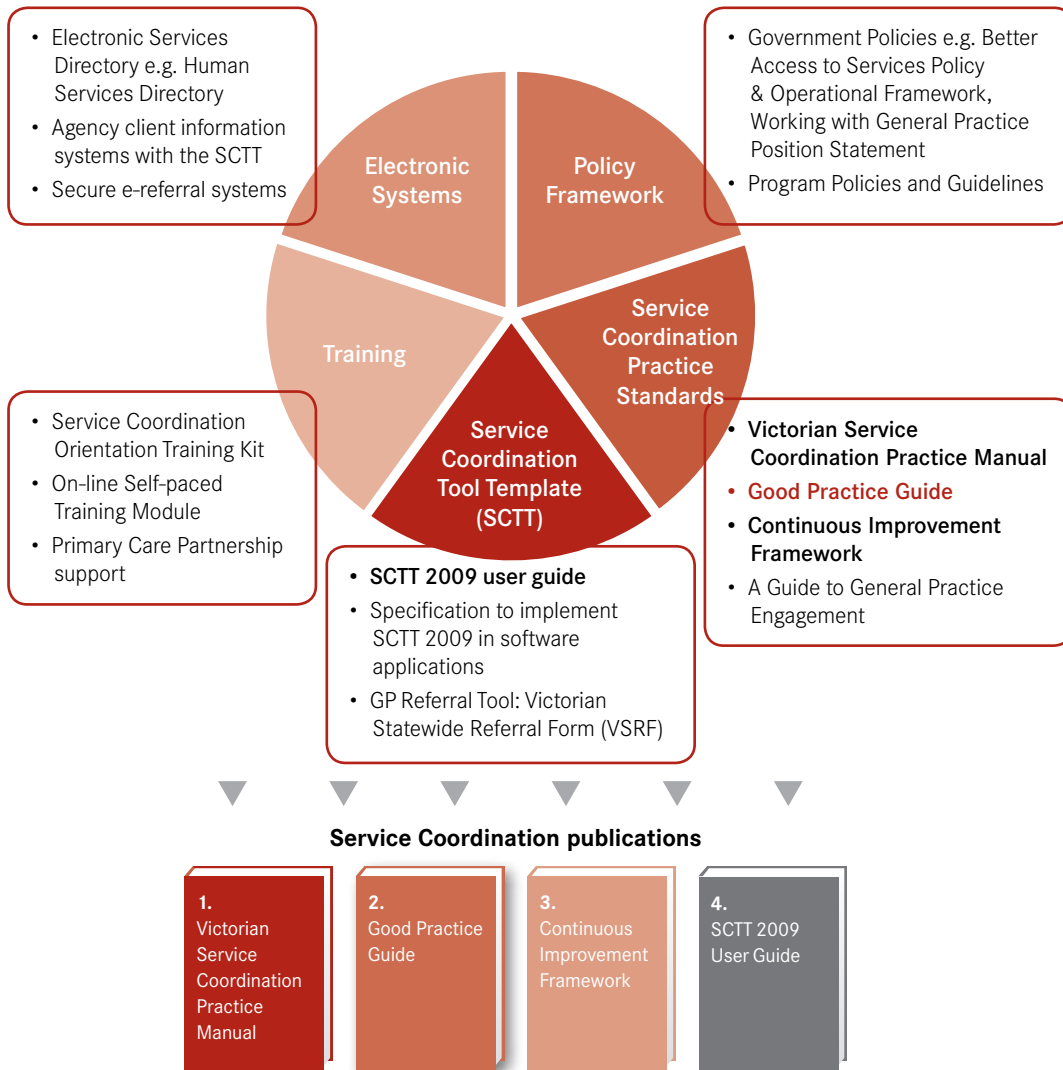
7. Where to learn about Service Coordination

7.1 The Service Coordination context

Service Coordination stems from the *Better Access to Services: A Policy and Operational Framework* (DHS, 2001). 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 guide is one of a set of four publications designed to support the implementation of Service Coordination in Victoria.

7.2 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.

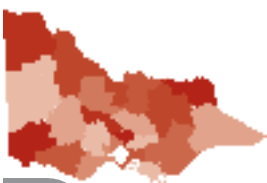
The terminology used by the various program areas and service providers differs significantly, for example the terms consumer, client and patient can be used to describe an individual receiving care concurrently from a general practitioner, alcohol and drug counsellor, social worker, podiatrist and community 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: A 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
MBS	Medical Benefits Schedule
PCP	Primary Care Partnership
SCTT	Service Coordination Tool Templates
VSRF	Victorian Statewide Referral Form

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 practitioner	General practitioner (GP), Doctor



Health Service	Health Service in accordance with the <i>Health Records Act 2001</i> , means: <ol style="list-style-type: none"> an activity performed in relation to an individual to assess, maintain or improve the individual's health or to diagnose or treat the individual's illness, injury or disability A disability service, palliative care service or aged care service 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 agency. 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. See: 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 minimise duplication and service gaps.
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 agency 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.
Practitioner	Health professional, registered 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, and so forth.

7.3 Development of the Good Practice Guide

The *Good Practice Guide* 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* 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 guide?

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

Project consultants

Ro Saxon and Linda Pandita, **HDG Consulting Group**

