Victorian Service Coordination Practice Manual 2012

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 2012 User Guide

Victorian Service Coordination Practice Manual 2012

A statewide primary care partnerships initiative

Published by Primary Care Partnerships, Victoria.

June 2012

Sponsored by the statewide Primary Care Partnerships Chairs' Executive with funding received from the Victorian Department of Health.

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Foreword

The *Victorian Service Coordination Practice Manual* (VSCPM) and associated resources have been designed for managers and service providers involved in the implementation of service coordination. Initially developed in 2006 by the statewide Primary Care Partnership (PCP) Chairs' Executive, with funding from the Department of Health, the resources now aim to provide an overarching service coordination framework applicable to a range of sectors and services including:

- Aboriginal community-controlled organisations (ACCO)
- Ambulance Victoria
- disability services
- family violence services
- general practice
- health
- housing
- mental health
- multicultural and ethno-specific services
- welfare and community services
- youth and family services

Representatives from each of these sectors were involved in the revision of the documents.

The VSCPM and associated resources include:

- *Victorian Service Coordination Practice Manual* (VSCPM)
- *Good Practice Guide* (GPG)
- *Continuous Improvement Framework* (CIF)

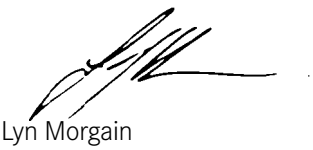
These documents describe how organisations will implement service coordination and conduct business when dealing with consumers. The suite of documents outlines:

- an agreed minimum standard across Victoria for how organisations work together to improve services to consumers
- common concepts and language to ensure improved service coordination across sectors
- an approach that enables organisations to adopt the service coordination principles.

The most recent revision of these documents was undertaken in conjunction with the 2012 revision of the Service Coordination Tool Templates (SCTT) and the associated *SCTT 2012 User Guide.*

The contribution of representatives from a range of sectors as outlined above is greatly appreciated. In particular, the contributions made by Project Reference Group members in guiding the consultation and review is acknowledged and appreciated. This broad representation has facilitated accommodating the differing needs of the current and expanding sectors and enhancing responsiveness to consumers and the community.

The 2011 review of the *Victorian Service Coordination Practice Manual* and its associated resources was funded by the Department of Health Integrated Care Branch.



Lyn Morgain
Chair, Statewide PCP Chairs' Executive

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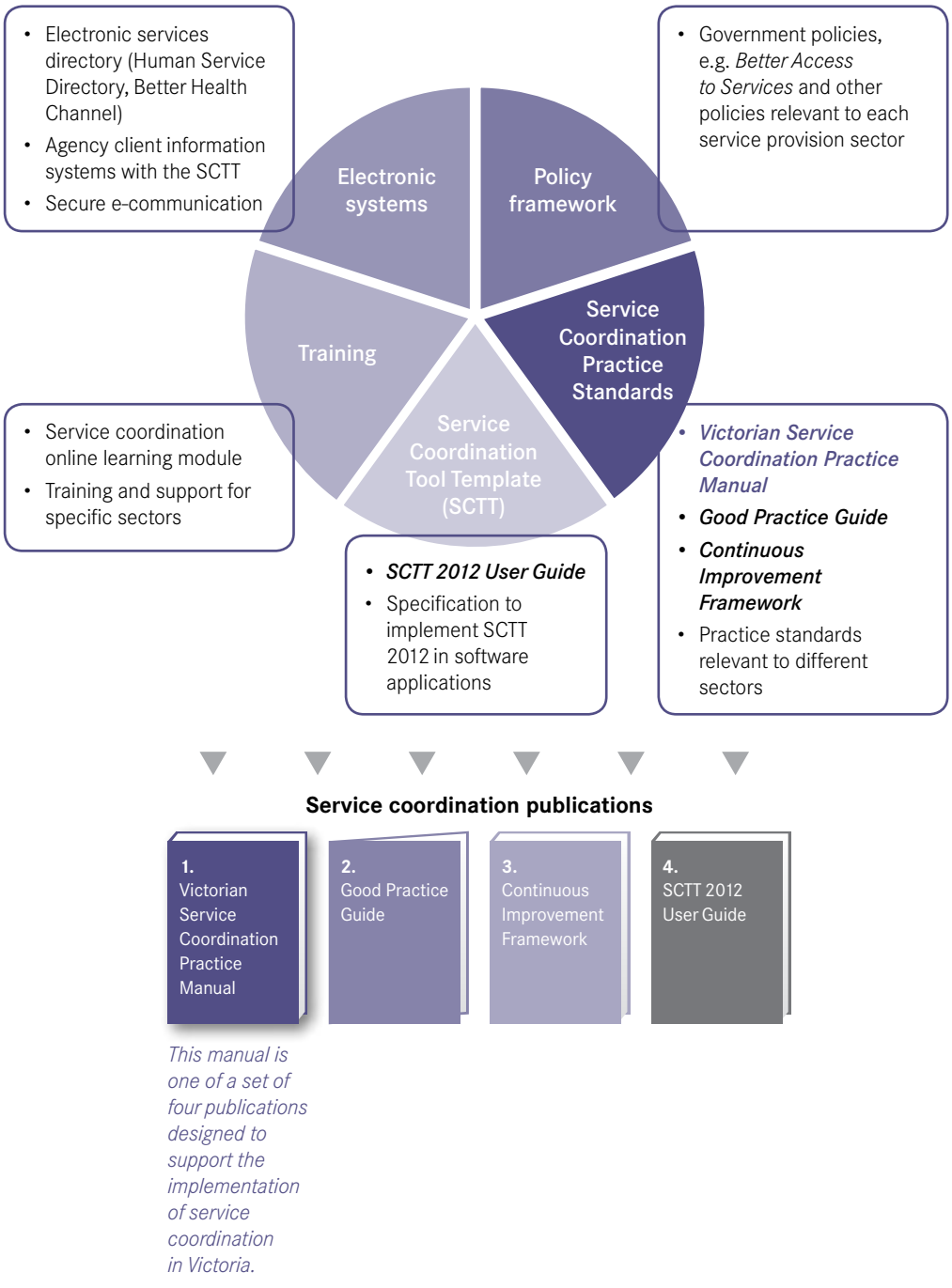
Section 1
Introduction

1.1 The service coordination context

Service coordination stems from *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. The information resources indicated in Figure 1 can assist you to learn about and implement service coordination. For more information about these and other resources that support service coordination, see Section 5.

Figure 1: Supports for implementation of service coordination



1.2 Purpose of the *Victorian Service Coordination Practice Manual*

Since the introduction of service coordination in Victoria in 2001, a range of government-funded and broader health and community sectors and service providers have been progressively implementing it to achieve better outcomes for their consumers. The purpose of the VSCPM is to assist service providers across sectors to consistently implement service coordination. The manual is designed to:

1. Define practices which support service coordination. In particular to:
   - improve services to consumers by implementing service coordination in a consistent, high-quality manner
   - articulate Victoria's service coordination principles and practice standards
   - document clear expectations for service providers
   - provide information about statewide tools, resources and support available to services implementing service coordination
   - guide the implementation of service coordination practices at a service provider level
   - provide a resource for managers and service providers involved in service coordination
2. Provide the basis for monitoring, benchmarking and continuous improvement of service coordination across Victoria, enabling organisations to:
   - embed service coordination standards in organisational practice and documentation, such as policy and procedures
   - compare existing practice against statewide practice standards
   - ensure service coordination is conducted in accordance with the statewide vision and practice and *Better Access to Services: A Policy and Operational Framework.*

Primary Care Partnerships member organisations and other service networks can develop locally identified and agreed systems, protocols and processes that reflect service configuration in each area to complement the practices and standards outlined in this manual. For example, a protocol could be developed to define and document agreed practice for electronic communication specific to particular consumer groups.

Section 2
Service Coordination in Victoria

2.1 What is service coordination?

Service coordination places consumers at the centre of service delivery to maximise their opportunities for accessing the services they need. 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.

Service coordination is underpinned by the principles shown in Table 1:[1]

Table 1: Service coordination principles

Principle	Description
Central focus on consumers	Service delivery is 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 and the social model of disability	The social model of health[2] is a distinct conceptual framework for thinking about health and wellbeing. This framework is concerned with addressing the social and environmental determinants of health and wellbeing, such as education and housing, as well as biological and medical factors. This includes the spiritual and family connections that contribute to wellbeing. The social model of disability[3] adopts a human rights approach to disability and differentiates between physical impairment and the disabling effects of society.
Competent staff	Elements of service coordination must be undertaken by staff who are appropriately skilled, qualified, experienced, supervised and supported.
Duty of care	A duty to take reasonable care of a consumer. 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	All confidentiality and consumer information requirements are met. The brochure *Your information – It's private*[4] and the SCTT *Consent to share information* template are designed to improve consumer outcomes, information flow and practice.
Engagement with a broad range of service sectors	Service coordination embraces the broadest range of partnerships across sectors including non-government, government and private providers.
Consistency in practice standards	Service coordination procedures and tools are developed to provide consistent, coordinated service delivery.

1 Better Access to Services: A Policy and Operational Framework, DHS, June 2001, pp. 9–13.

2 Social model of health: <www.vha.org.au/?c_id=1065>.

3 Social model of disability: UN Convention on the Rights of Persons with Disabilities <www.un.org/disabilities/convention/conventionfull.shtml>.

4 <www.health.vic.gov.au/pcps/publications/languages_privacy.htm>.

2.2 What are the benefits of service coordination?

Service coordination can offer many benefits to consumers and service providers.

Benefits for consumers:

- provision of up-to-date information about local service availability and support options to contact the most appropriate service
- *no wrong door* – every door in the services system can be the right door for consumers to access services
- clear entry points, plus transparent and consistent referral pathways and processes that are easy to navigate
- improved and timely identification of needs through the initial needs identification process
- improved response times to requests for information and referral
- confidential transfer of information for referral purposes in a way that does not require the consumer to repeat their information
- improved access to assessment and coordinated shared care/case planning
- clarity regarding who is involved in service provision and what their responsibilities are to meet the consumer's goals
- reduced duplication of assessments and services and identification of service gaps
- increased knowledge of the local service system and access to resources that support service coordination, such as the Human Services Directory
- consistent service standards from each service provider
- a positive experience of the service system.

Benefits for service providers:

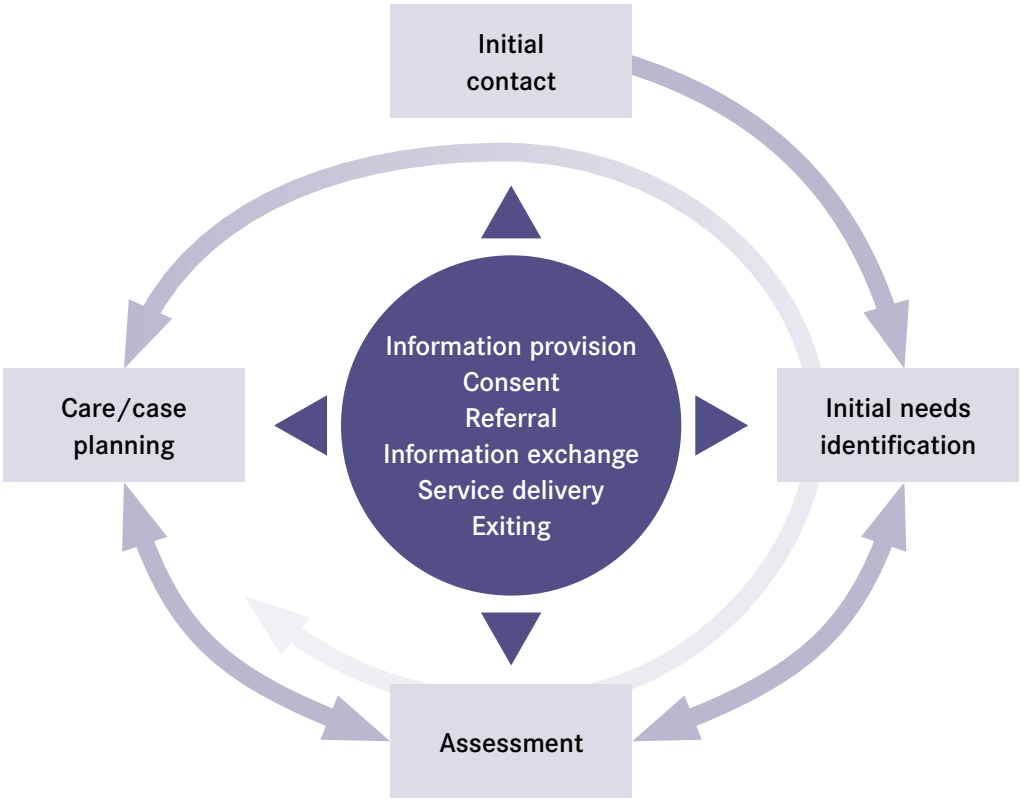
- practices, processes, protocols and systems that set out clear guidelines and expectations around key areas of work and inter-organisation practice, including continuous quality improvement strategies aligned with accreditation standards
- documented practice standards for initial contact, initial needs identification and shared care/case planning, providing a common language between services
- improved consistency and quality of consumer information through the use of common tools such as the Service Coordination Tool Templates
- more efficient use of resources through improved information and feedback from referrals, fewer inappropriate referrals and less duplication of services
- streamlined services through the provision of a consistent, agreed, standardised way for practitioners within and across organisations to identify consumer needs, identify appropriate services, make referrals, provide feedback, communicate and coordinate care, leading to improved operational efficiency.

2.3 What is the Service Coordination Framework and what are the elements?

The operational elements of service coordination, as described in the *Better Access to Services: A Policy and Operational Framework* are depicted in Figure 2. Initial contact, initial needs identification, assessment and care/case planning are the key service coordination elements. Additional processes such as information provision, consent to share information, referral, information exchange, service delivery and exiting can occur at any stage.

Service coordination elements are implemented in a range of ways according to the consumer, the service provider and context in which services are provided. For example, in some services, initial contact and initial needs identification are carried out by the same person and assessment is conducted by a different person; in other services, one person may conduct both initial needs identification and assessment processes at the same time.

Figure 2: Service coordination elements



Initial contact

Initial contact is the consumer's first contact with the service system. It is an important function of every service provider and usually includes the provision of accurate, comprehensive service information and facilitated access to initial needs identification.

Initial needs identification

Initial needs identification is a brief, broad, screening process to uncover underlying and presenting issues. Initial needs identification canvasses the consumer's needs as well as opportunities for intervention and information provision early in their contact with the service system. The service provider engages in a broad conversation to identify these needs. It is not a diagnostic process, but includes identification of the consumer's risk, eligibility and priority for service. Initial needs identification involves a whole-of-person, consumer-centred approach.

Assessment

Assessment is a decision-making methodology that collects and interprets relevant information about the consumer. Assessment is not an end in itself, but part of an ongoing process of delivering services. It is an investigative process using professional and interpersonal skills and in-depth enquiry to identify relevant issues that will guide a responsive intervention.

Care/case planning

Care/case planning is a dynamic process that incorporates assessment coordination, care/case management, referral, information exchange, review, reassessment, monitoring and exiting. Care/case planning involves balancing relative and competing needs, and helping consumers make decisions appropriate to their needs, wishes, values and circumstances. Care/case planning may occur at an individual provider level and both within and across agencies.

Additional processes

Information provision

Providing information that is relevant to the consumer's needs may be undertaken at any and all stages of the service coordination process. When choosing the type and complexity of information to provide, service providers will be receptive to and guided by the consumer's needs, learning styles and their capacity to understand information (taking into account issues such as preferred language and visual or cognitive requirements). Service providers will check that consumers have understood and, importantly, are able to utilise the information that is being provided.

Consent to share consumer information

Privacy legislation requires the protection of an individual's personal information and their right to decide how the information is used, disclosed to or shared with others. Consumer consent is a compulsory part of the information exchange process. The primary purpose of information collection is the purpose for which the information was originally provided. The secondary purpose is any additional use that is not directly related to the consumer's original disclosure. Consumers must agree to the disclosure of information for secondary purposes.

Referral

Referral may occur at or result from any stage of the service coordination process. Referral is the transmission, with consent, of a consumer's information from one service provider to another for the purpose of further assessment, or service provision.

Information exchange

Information exchange is essential to provide consumers with a seamless, coordinated service delivery. Information exchange includes:

- acknowledgement that a referral has been received and the subsequent action to be taken
- provision of summary information to other service providers at key points in the consumer's pathway, such as following assessment, care/case planning, review or change in service delivery, handover, transition, exiting, or at other points in the consumer's service delivery pathway as appropriate.

Service delivery

Service delivery is generally undertaken in accordance with local protocols and in keeping with the needs of the consumer and the level of skill of the person providing the service.

Exiting

Exiting can occur at any stage of the service coordination process and is generally managed in accordance with local protocols.

2.4 Systems and processes for implementing service coordination

The aim of service coordination is to ensure consumers receive a seamless and integrated service response. This does not mean that one service provider must provide all services. However, it is each service provider's responsibility to provide access and coordinated care to meet the consumer's full range of needs in a timely manner. This requires a high level of trust, communication and information exchange between service providers, so that assessment and service provision is coordinated and not duplicated.

Systems and processes that support consumer access to the service system and the range of services required include:

- clear entry points
- accurate and reliable service information
- access to and an understanding of the initial needs identification, assessment, care/case planning and referral processes
- information about a consumer's rights and responsibilities
- practice that is sensitive to cultural, communication and/or cognitive requirements
- documented service delivery pathways that include early identification for consumers with complex and multiple issues
- clearly defined processes for monitoring, review and recall
- up-to-date evidence and resources for staff, including service directories, e.g. *Human Service Directory*
- competent staff with access to relevant ongoing training, for example in goal setting, case conferencing, initial needs identification, communication, care/case planning, referral and an understanding of consent and privacy requirements
- documentation for staff that defines responsibilities, practices, processes, protocols and systems to enable different program areas and organisations to work together in partnership in the delivery of services to consumers
- documented protocols to guide a person-centred approach, including multi-disciplinary and interdisciplinary practices
- participation in local multiagency service coordination networks
- agreements between services, including general practitioners (GPs), for communication and information sharing.

2.4.1 Guiding principles for enabling person-centred practice

Services ensure that the following principles of person-centred practice[5] are incorporated into their service coordination processes:

- a partnership approach to service delivery, where consumers and service providers share knowledge, values, experience and information, and collaborate to develop goals and plan actions
- practice that considers social, emotional and health needs (beyond presenting issues) and is based on values, culture, background and choice as much as possible
- open, clear communication that is sensitive to the consumer's culture and beliefs, based on practice that is sensitive to the cultural, communication and cognitive needs of the consumer (for example, use of interpreters, translated material, easy-English, pictures)
- respect for privacy
- consideration and value for the role of family and carers
- respect for the consumer's own styles of coping or bringing about change
- respect for consumers' expertise in their own lives

5 What is person-centred health care: A literature review <www.nari.unimelb.edu.au/pchc/downloads/PCHC_literature_review.pdf>.

- flexibility and responsiveness in planning service delivery within the parameters of safety and service guidelines
- mechanisms to address consumer safety and risk if family violence has been identified.

2.5 What is the link between private providers, including general practice and service coordination?

In addition to general practice, Victorians are increasingly receiving services from a range of other private providers, such as private allied health, medical specialists and pharmacists. The fact that these providers are private businesses may impact on how they participate in service coordination. For some private providers, the type and amount of service coordination they are able to provide is largely determined by requirements of Medicare, such as the Medicare Benefits Schedule (MBS).

General practices, including general practitioners (GPs), are essential participants in service coordination particularly for people with complex and chronic health conditions. GPs are the primary point of health care for the majority of the community and often act as an access point to the broader health and human services system. Ideally, general practices and other service providers work closely with each other to ensure that their consumers in common have access to coordinated care to meet their needs.

The main service coordination interface between general practices and services is in the areas of referral, information exchange and collaboration with other organisations for care/case planning. The Department of Health has produced several resources that support services engaging with general practice, including the *Working with General Practice Resource Guide, Guidelines on Feedback to General Practitioners for Community Health Services* and *General Practice Engagement in Integrated Chronic Disease Management* (see Section 5.3 for links to these resources).

GPs can be reimbursed under the MBS for undertaking certain comprehensive health assessments, health checks, care plans, medication reviews and cycles of care. Information about local programs or initiatives related to these items is available from divisions of general practice/Medicare Locals,[6] General Practice Victoria or the Department of Health and Ageing website (see Section 5.3).

See Section 3.6.9 regarding GP involvement in care/case planning and Section 4.3.3 regarding referral to and from general practice.

2.6 The importance of partnerships and service networks

Local service networks include:

- Aboriginal community-controlled health organisations (ACCHOs)
- aged care networks
- culturally and linguistically diverse service networks
- general practice divisions/Medicare Locals
- integrated cancer services
- local area service networks
- local government service provider networks
- mental health alliances
- palliative care consortiums
- PCPs
- others.

6 Medicare Locals, which are evolving largely from divisions of general practice, play a key role in improving service coordination. For further information see divisions of general practice/Medicare Locals in Section 6.2.

These networks provide an important platform to facilitate service coordination implementation and review. Through service coordination networks, service providers can be supported to work together and, where relevant, develop local agreements within and across service providers. Agreements can include: processes for communication, information sharing, joint assessment, reassessment, service delivery pathways, referral, feedback and exiting. Local agreements, based on defined service delivery pathways can assist consumers to access the best mix of services, regardless of where they enter the service system, and whether the service is State Government, Australian Government or locally funded.

2.7 Cultural competency and responsiveness

All organisations are responsible for providing services to people from Aboriginal and other culturally diverse backgrounds. All Victorians, regardless of their background and culture should feel confident in receiving a quality and culturally sensitive service when opening the door of every organisation in Victoria.

Australia's First Peoples have a specific status, rights and needs. In addition culturally diverse people who have come to Australia from predominantly non-English-speaking countries often have low levels of health literacy, lack access to health and aged care information in languages other than English and hold a range of different cultural beliefs. Ethno-specific service providers and multicultural centres provide culturally responsive support and welcome partnership opportunities with other organisations.

It is important that people from Aboriginal and other culturally diverse backgrounds trust those who are providing services, and know that those service providers understand their needs and culture. They should feel confident to ask questions and to seek the services and help to which they are entitled – whether the provider is a mainstream organisation, Aboriginal community-based organisation or other ethno-specific service provider.

The term 'cultural responsiveness' refers to services being respectful of, and relevant to, beliefs, practices and culture needs of the community. Cultural responsiveness describes the capacity to respond to the issues and needs of people from Aboriginal and other culturally diverse backgrounds. Cultural responsiveness is more than just cultural awareness. Awareness is only a first step. What matters is how organisations and individuals within organisations behave as a result of that awareness. Organisations will have processes and systems in place if they are to achieve cultural change that is embedded in everyday behaviour. Cultural awareness, sensitivity and competence are building blocks; cultural responsiveness is the desired outcome.

Cultural awareness training in mainstream organisations has an important place in any strategy to improve cultural responsiveness, but the development of partnerships with local Aboriginal and other ethnic communities as well as Aboriginal community-based organisations and other ethno-specific service providers is at least as important. This ensures that the cultural training and knowledge obtained is relevant, and recognises that the concept of cultural responsiveness is meaningless without responsiveness to the local community.

For links to further resources and information, see Section 5.

2.7.1 Working in partnership with Aboriginal communities

Victorian Aboriginal and Torres Strait Islander people experience significantly more ill health than other Victorians. They typically die at much younger ages and are more likely to experience disability and reduced quality of life because of ill health.

The following summary highlights some areas in which inequalities exist between Aboriginal and non-Aboriginal Victorians.

Homelessness: Aboriginal people experience homelessness at a rate almost four times that of non-Aboriginal Australians (1.9% and 0.5% respectively).

Mental health: Aboriginal males are almost six times more likely and Aboriginal females more than three times more likely to die from mental and behavioural disorders than other Australians.

Infants: Aboriginal babies are twice as likely to be of low birth weight and are more likely to die in their first year.

Disability: Aboriginal people overall are twice as likely as non-Aboriginal people to have a profound/severe core activity limitation.

Smoking: Aboriginal people are twice as likely as non-Aboriginal people to be current daily smokers.

Chronic disease: Aboriginal people experience higher rates of injury, and respiratory and circulatory disease – often associated with disability.

Family violence: Aboriginal people in Victoria are eight times more likely to be a victim of family violence than non-Aboriginal people.

Child abuse: Aboriginal children are the subject of substantiated child abuse at more than seven times the rate for non-Aboriginal children.

Child mortality: In Victoria, child mortality rates for Aboriginal children under five years are more than double the non-Aboriginal rate.

Hospitalisation: Rates for most causes of hospitalisation in Victoria are higher for Aboriginal people. Overall, admission rates for Aboriginal people are one and a half times those for non-Aboriginal people. Rates are more than double for a number of clinical specialities, including dental, dialysis, psychiatry, neonatology, obstetrics and ante-natal care.

Life expectancy: At the national level for 2005–2007, the gap between Aboriginal and Torres Strait Islander and non-Aboriginal life expectancy was 11.5 years for males and 9.7 years for females.

The Victorian and Australian governments are committed to 'closing the gap' between Aboriginal and non-Aboriginal Victorians on these and many other measures. Working in partnership with Aboriginal people and communities as well as with Aboriginal organisations is critical to achieving equality.

Aboriginal community controlled health organisations (ACCHOs) are a critical part of the service system for many Aboriginal people. ACCHOs are multifunctional service delivery centres with services that, as well as primary and allied care, often include aged care and disability, housing, drug and alcohol management, legal and justice support and the prevention of family violence. Other programs include cultural and social and emotional wellbeing programs.

ACCHOs are unique in Australia. Each organisation is community controlled with an annually elected board of directors, a majority of Aboriginal staff and management including Aboriginal health workers, who are an integral part of service delivery. Each organisation is important as it is a place where people come together to maintain family and community connections. Service delivery is shaped to meet the needs of the local community.

The following guiding principles for working in partnership with Aboriginal communities have been adapted from the Koolin Balit Victorian Government strategic directions for Aboriginal health 2012–2022.[7]

Guiding principles for working in partnership with Aboriginal communities:

- **Cultural respect** in the design and delivery of culturally responsive services.
- **Consultation with Aboriginal community** members, ACCHOs and representative structures to ensure that all policy and activity has their support, and that they have input into the design, monitoring and evaluation of initiatives, programs and services.
- **A holistic approach** to service delivery, with attention to physical, spiritual, cultural, emotional and social wellbeing.
- **Whole-of-sector accountability**, with delivery of services to Aboriginal consumers being a core responsibility and a high priority.
- **Working in partnership with ACCHOs** as major providers of comprehensive primary care to Aboriginal communities in Victoria, recognising community decision making, participation and control as a fundamental component of the service system.
- **Localised decision making** through regional committees defining local community needs and priorities and informing implementation strategies.
- **Building the capacity of services and communities** to respond to needs and take shared responsibility for outcomes.
- **Accountability** for services provided and for effective use of funds by government as well as Aboriginal community-controlled and mainstream services.
- **Evidence-based** decision making, policy and program design, with support for external providers to contribute to the generation of evidence.

2.8 What is the consumer pathway through service coordination?

See flow chart in Section 7 or the *Good Practice Guide* (GPG).

7 Koolin Balit Victorian Government strategic directions for Aboriginal health 2012–2022.

Section 3
Practice standards

3.1 Service Coordination Practice Standards

The Victorian Service Coordination Practice Standards describe the processes and outline the desired consumer outcomes and good practice indicators for each element of service coordination. The consumer outcomes and good practice indicators provided in the tables will assist organisations to meet the practice standards. The service coordination *Continuous Improvement Framework* is a complementary tool to assist services achieve a consistent standard of service coordination. This is achieved through evaluating their performance against the practice standards using eight sets of performance criteria relating to system level, organisational level and practice level implementation of service coordination.

The Service Coordination Practice Standards set out in this section of the manual cover:

- all elements of service coordination
- initial contact
- initial needs identification
- assessment
- care/case planning.

Section 4 describes practice standards for additional processes

3.2 Practice standards: all elements of service coordination

Table 2: Consumer outcomes and good practice indicators – applicable to all elements of service coordination

Consumer outcomes	Good practice indicators
Systems in place	
Consumers experience a timely, coordinated, planned, non-discriminatory and reliable service that is sensitive to cultural, communication and cognitive needs.	The service provider has clear procedures and processes for obtaining and documenting consumer consent, for example using the SCTT *Consent to share information* template and complying with privacy requirements.
	The service provider has clear written policies, procedures and work instructions for service coordination.
	The service provider has structures and systems to facilitate streamlined access to initial contact, initial needs identification, assessment, care/case planning, referral and service delivery processes.
	The service provider ensures information documented on the Service Coordination Tool Templates (SCTT) is consistent with the *Service Coordination Tool Template 2012 User Guide* (Department of Health, 2012).
	The service provider has appropriately skilled staff members, who understand their roles and are accountable for their work.
	The service provider has clearly defined procedures for effectively managing consumers in crisis or emergency situations, including the provision of information on after-hours services.
	The service provider monitors the elements of service coordination provision and regularly evaluates whether it is meeting objectives.
	The service provider maintains up-to-date information about services, eligibility criteria, priority for service and waiting times in relevant service directories, e.g. the Human Services Directory.
	The service provider participates in forums, and broader collaborations and networks, to ensure the continuous improvement of service coordination.

Consumer outcomes	Good practice indicators
Systems in place *(continued)*	
	The service provider has integrated service coordination principles into consumer feedback systems, such as consumer satisfaction or consumer experience surveys.
	The service provider has procedures and systems in place that reflect the requirements of relevant Aboriginal and Torres Strait Islander and other cultural responsiveness frameworks.
	The service provider has systems in place that ensure sufficient time is allowed to provide services to consumers with additional needs, such as those requiring supporting equipment or a support person.
	The service provider has protocols and processes in place to ensure that the carer is involved in all aspects of consumer's care, as appropriate.
	The organisation has systems and guidelines in place to respond to situations where family violence has been identified. Sections 5.3 and 6.2 contain more information about family violence and safety planning.
	Organisational protocols or policies indicate that if family violence is identified, further needs assessment is undertaken by a qualified or trained clinician/practitioner in an appropriate environment (e.g. with adequate privacy).
Information collection and sharing	
Consumers can be certain that their information is collected, stored, shared and updated in accordance with the *Health Records Act 2001,* and other privacy requirements.[8]	The service provider collects information in a sensitive manner, with particular regard to cultural requirements, language issues, communication and cognition needs, personal safety and risk of violence, privacy and confidentiality and, where practical, anonymity.
	The service provider collects only relevant information required for good service delivery, minimum data set requirements and making referrals.
	If the consumer has the capacity to give informed consent, the service provider obtains informed consent before sharing information with another service provider for initial needs identification, assessment, care/case planning or service delivery. If the consumer does not have the capacity to give informed consent, see Section 4.2.
	The service provider shares information in accordance with the *Victorian Health Records Act 2001,*[9] *Privacy Act 1988* and other requirements such as duty of care,[10] mandatory reporting[11] and *Victorian Information Sharing Guidelines.*[12]

8 Privacy and consent are key issues to be considered in all elements of service coordination and referral. Service providers are encouraged to visit the following websites to ensure they are meeting the relevant privacy and consent requirements:
- www.health.vic.gov.au/pcps/publications/index
- www.betterhealth.vic.gov.au
- www.dhs.vic.gov.au.

9 *Victorian Health Records Act 2001* <www.health.vic.gov.au/healthrecords>.

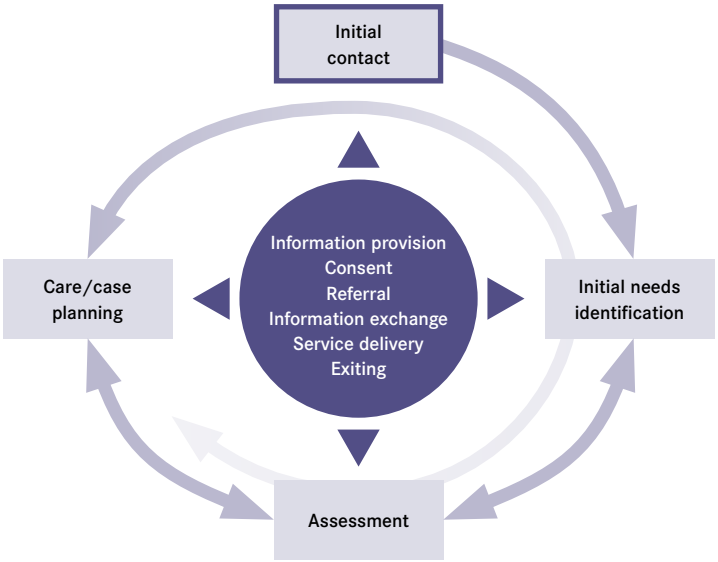
10 Duty of care policy, <www.chp.org.au/homepages_accr/items/174538-upload-00001.pdf>.

11 Mandatory reporting requirements, <www.dhs.vic.gov.au/office-for-children/cpmanual/Output%20files/Practice%20phases/Output%20files/Execute/1122_mandatory_and_other_required_report.pdf>.

12 Information sharing guidelines, <www.cyf.vic.gov.au/every-child-every-chance/library/publications/information-sharing-guidelines>.

3.3 Practice standards: initial contact

3.3.1 What is initial contact?



Initial contact is the first element of service coordination and the consumer's first contact with the service system. It is the entry point into other elements of service coordination, including initial needs identification, assessment and care/case planning. During initial contact the consumer is given information on services, eligibility criteria and intake processes, plus other relevant literature and direct access to initial needs identification. Initial contact is usually made by the consumer or a friend, relative or carer by telephone, in person, or via electronic media (such as websites and service directories). Services can also use assertive outreach to generate initial contact with consumers. Initial contact is a function of all service providers. Referral to external services may also occur as a result of initial contact.

3.3.2 Which staff are involved in initial contact?

Initial contact may be undertaken by a range of staff but is often the domain of front-of-house staff, such as receptionists or administrative staff. In some services initial contact and initial needs identification are undertaken by a single staff member and this may be completed over a number of sessions with the consumer.

3.3.3 Practice standards: initial contact

Table 3: Consumer outcomes and good practice indicators – initial contact

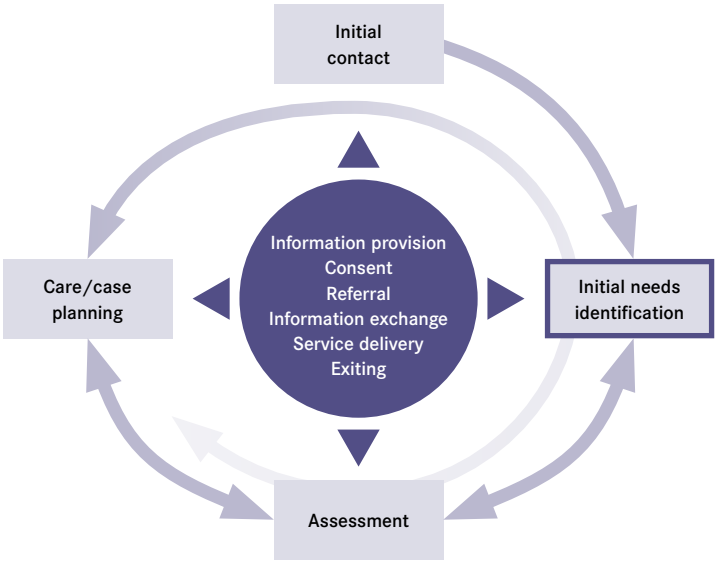
Consumer outcomes	Good practice indicators
Consumers are informed about: ■ available services and eligibility criteria ■ entry and initial needs identification processes ■ their rights and responsibilities in relation to accessing services. Consumers are empowered with the right information and assistance to make informed choices and self-referrals. Consumers have streamlined access to initial needs identification, assessment and referrals.	The service provider presents information that empowers the consumer to make informed choices. This may involve the use of interpreters, translated material and practice that is sensitive to cultural, communication and/or cognitive needs and may include adjustments to their standard practice to accommodate cultural difference or disability.
	The service provider explains the initial needs identification and assessment processes, including timeframes, to the consumer.
	The service provider gives the consumer information on service availability, eligibility criteria, and service processes.
	The service provider, when appropriate, facilitates access to initial needs identification, assessment, referral or service delivery.
	The service provider provides access to accurate service information within no more than 1 working day of a consumer making initial contact.
	The service provider is an entry point to the full suite of services offered by the service system, so they provide information to help consumers navigate the service system.
	The service provider uses an appropriate model for the specific consumer group, for example an outreach model to engage consumers at risk, who may be homeless or in child protection services.
	The service provider collects and documents relevant information at initial contact for the purposes of planning, including the number and nature of enquiries and the level of unmet need.
	All consumers are asked at every admission/intake if they are of Aboriginal and/or Torres Strait Islander origin. This is documented on a consumer registration form or the SCTT *Consumer information* template.

3.3.4 Consumer pathway through initial contact

See flow chart in Section 7 or the *Good Practice Guide* (GPG).

3.4 Practice standards: initial needs identification

3.4.1 What is initial needs identification?



Initial needs identification is a brief, broad, screening process to uncover underlying and presenting issues. Initial needs identification canvasses the consumer's needs as well as opportunities for intervention and information provision early in their contact with the service system. The service provider engages in a broad conversation to identify these needs. It is not a diagnostic process, but an identification of the consumer's risk, eligibility and priority for service. Initial Needs identification involves a whole-of-person, consumer-centred approach.

The service provider must use judgement and discretion to decide the extent and intensity of the initial needs identification process. Gathering and analysing information through initial needs identification may reduce consumer risk and informs the urgency and type of assessments required. Consumers can then be informed about relevant service options and the wider range of support services and resources available.

3.4.2 Which staff are involved in initial needs identification?

Initial needs identification should be undertaken by qualified staff who possess a broad understanding of the service system, advanced interviewing skills and high-level interpersonal skills, including the ability to develop a rapport with consumers. They should also have easy access to service provider decision support tools, and relevant service directory, e.g. the Human Services Directory.

The initial contact, initial needs identification and assessment processes may be completed simultaneously by one staff member or separately by a range of service providers over several days. Victoria is committed to ensuring all consumers have easy access to initial needs identification. If your service does not provide initial needs identification, you may refer your consumers to a service that does.

3.4.3 Practice standards: initial needs identification

Table 4: Consumer outcomes and good practice indicators – initial needs identification

Consumer outcomes	Good practice indicators
Consumers are informed about: ■ the initial needs identification process ■ why information is being collected and how it will be used ■ the screening process and how risk and priority are determined ■ their rights and responsibilities, including access to their records ■ the implications of providing and not providing information ■ consent requirements Consumers are supported and empowered to participate in the initial needs identification process, through the provision of information, decision-making support and direct assistance, such as an assisted referral. Consumers have access to appropriate and timely assessments and referrals.	The service provider explains to the consumer the reason for collecting information and how it will be used to screen for broader needs.
	The service provider discusses alternative service options for consumer support, including those provided by other services. This should be based on practice that is sensitive to the consumers' cultural, personal safety and risk of violence, communication and cognitive needs and within a cultural competency framework.
	The service provider assists the consumer to identify their issues and needs, including opportunities for information provision and early intervention through the initial needs identification process.
	The service provider ensures the consumer is fully informed of the processes for assessment, referral and care/case planning and is supported to actively participate in those processes.
	The service provider uses appropriate risk identification and tools to determine the consumer's needs, level of risk and priority of access to assessment, care/case planning and services.
	The service provider considers the consumer's safety in relation to family violence.
	The service provider conducts an initial needs identification within no more than 7 working days of initial contact or of receiving a non-urgent referral.
	The service provider conducts an initial needs identification within no more than 2 working days of receiving an urgent referral.
	The service provider has in place a process for consumers who require urgent services or who are viewed as 'at risk' and cannot wait for a formal assessment process to be completed.
	All consumers are asked at every admission/intake if they are of Aboriginal and/or Torres Strait Islander origin.

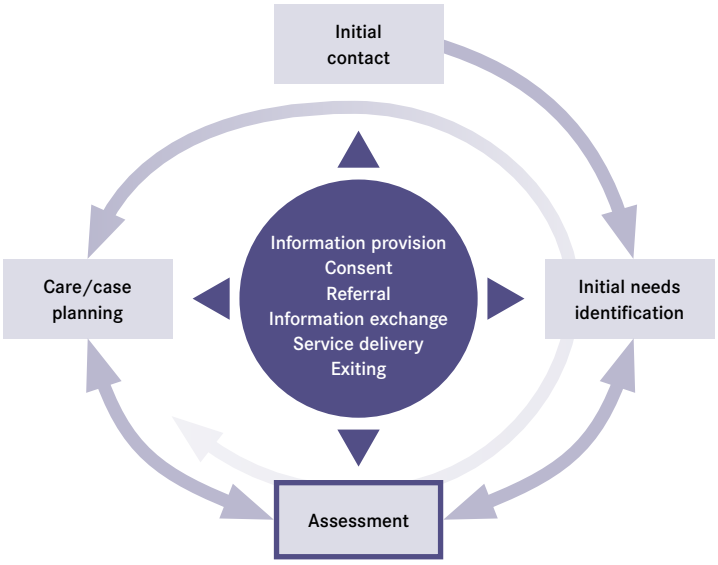
3.4.4 Consumer pathway through initial needs identification

See flow chart in Section 7 or the *Good Practice Guide.*

3.5 Practice standards: assessment

3.5.1 What is assessment?

Assessment is a decision-making methodology that collects and interprets relevant information about the consumer. Assessment is not an end in itself, but part of an ongoing process of delivering services. It is an investigative process using professional and interpersonal skills and in-depth enquiry to identify relevant issues that will guide a responsive intervention.



Assessment is usually undertaken face-to-face but may be undertaken in other ways if required.

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 the service that they are providing. It may involve collecting information on the consumer's medical, physical, social (such as housing), functional, emotional, lifestyle, cultural, religious, spiritual and psychosocial needs.

Assessment may include history-taking, examination, observation and measurement or testing. Service providers should use assessment tools that meet consumer, service, reporting and program requirements. Many government-funded programs have assessment frameworks, guidelines, templates and tools to guide this process.

3.5.2 Where does assessment fit into service coordination?

Assessment builds on the information gathered through initial contact, initial needs identification and other relevant sources. The information can build over time and be gathered from a wide range of sources to develop a comprehensive picture of the consumer's needs. This is particularly important for consumers with multiple, complex or unclear needs, or those who require long-term or extensive service provision. Assessment is completed by a qualified service provider to:

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

3.5.3 Which staff are involved in assessment?

Assessments must be conducted by trained service providers with appropriate qualifications, skills and knowledge in the particular area of service delivery. Staff undertaking assessments require a broad understanding of the service system, advanced interviewing skills, and high-level interpersonal skills, including the ability to develop a rapport with consumers.

Experienced multidisciplinary workers across a range of services and sectors can undertake consumer assessment. Assessment may also be undertaken by a specialist service using a multidisciplinary approach. This approach will assist consumer needs to be identified and an appropriate response formulated, sometimes from outside the assessing organisation. Initial needs identification and assessment may be conducted simultaneously by one staff member, or separately by different staff members over several days.

Many consumers may have already seen a GP by the time they access other services. GPs often conduct health assessments as part of good medical care and prevention. Communication with general practice to determine what current services, assessments and or care plans are already in place is encouraged. General practice could also be encouraged to share this information to avoid duplication of services.

3.5.4 Practice standards: assessment

Table 5: Consumer outcomes and good practice indicators – assessment

Consumer outcomes	Good practice indicators
Consumers are informed about: ■ the assessment process ■ why information is collected and how it will be used ■ their rights and responsibilities, including access to their records ■ the implications of providing, and not providing information ■ consent requirements. Consumers are supported and empowered to participate in the assessment process. Consumers have direct access to assessments and referrals.	The service provider explains the reason for collecting information and how it will be used to assess their needs.
	The service provider discusses assessment findings and options for support and services, including those provided by other organisations. This may involve the use of interpreters, translated or easy-English material, and practice that is sensitive to cultural, communication and cognitive requirements.
	The service provider collaborates with the consumer to identify the full range of consumer issues, needs and circumstances.
	The service provider ensures the consumer fully understands decision-making processes and is encouraged to actively participate in them.
	The service provider uses appropriate assessment tools to determine the consumer's needs, existing supports, ability, level of risk and priority of access to services or further referrals.
	The service provider has in place a process for consumers who require urgent services or who are viewed as 'at risk' and cannot wait for a formal assessment process to be completed.
	The service provider has an assessment process and protocols in place that minimises duplication and meets accepted discipline and inter-discipline-specific requirements.

3.5.5 Consumer pathway through assessment

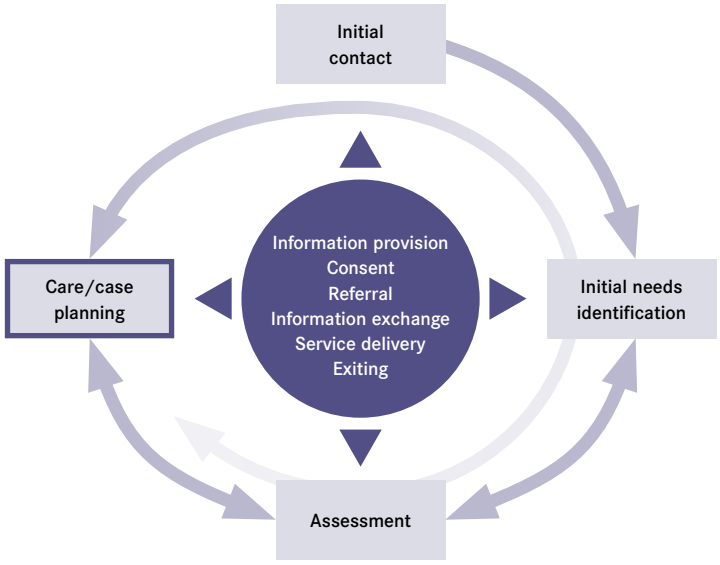
See flow chart in Section 7 or the *Good Practice Guide.*

3.6 Practice standards: care/case planning

3.6.1 What is care/case planning?

Care/case planning is a dynamic process that incorporates assessment, coordination, case management, referral, information exchange, review, reassessment, monitoring and exiting. Care/case planning involves balancing relative and competing needs, and helping consumers make decisions appropriate to their needs, wishes, values and circumstances.

Care/case planning may occur at an individual provider level and both within and across organisations.



Service-specific care/case planning may occur when the consumer has one or more issues that can be managed with the support of a single program area. Services need to refer to their program guidelines to implement their service-specific care/case planning and will have their own tools to document this information. Some examples are individual treatment plan, GP management plan, service plan, advance care plan, child and family action plan, housing support plan, crisis intervention plan, relapse prevention plan and disability support plans.

Shared care/case planning is required when the consumer has numerous issues that require the coordinated support of multiple program areas from within or between organisations. Service assessments and service-specific care/case plans will inform the shared care/case planning process.

3.6.2 What is shared care/case planning?

Shared care/case planning involves discussion, negotiation and decision making between service providers and consumer to define their goals and strategies, resulting in identifying actions and services to meet those goals. This may involve linking the consumer to a range of services and supports. Effective communication must be established between the consumer and the participants in service delivery.

Each consumer has different needs, aspirations, priorities and resources and these will inform the development of individual goals. A collaborative approach to service delivery that actively involves the consumer, their family, carers, support people and service providers facilitates the best possible outcomes for the consumer. Shared care/case planning can occur at any point in the service coordination process, wherever an assessment or review takes place. The SCTT *Shared support plan* may be used to document and share this information.

Examples of shared care/case planning include planning undertaken for:

- a person with an acquired brain injury who lives semi-independently and receives outreach support from a disability support worker, delivered meals and domestic assistance through HACC, and counselling from an alcohol and other drug service
- a woman with a small child that receives housing support, financial counselling and support from a family violence service
- a person who is receiving mental health support from a GP, support from a mental health worker, assistance to locate alternative housing through a housing worker, and counselling from an alcohol and other drug service
- a person who has undergone surgery at an acute hospital and is receiving outpatient follow-up, rehabilitation in the home through the health service and nursing wound care from a district nursing service.

3.6.3 The principles of shared care/case planning

The overall principles of shared care/case planning include:

- a proactive approach for people with multiple support needs
- services that are planned and delivered, based on best available evidence in the most timely and effective way
- services based on person-centred practice and a coordinated and integrated approach
- support for consumers to play an active role in coordinating their services
- providing information on the range of service options available
- goal-directed planning
- nomination of a main contact person to support the shared care/case plan
- processes to facilitate communication between all participants
- monitoring and review processes
- compliance with current legislation and service provider quality standards.

Benefits of shared care/case planning

Shared care/case planning:

- provides consumers with a single point of contact
- assists the consumer in setting and achieving goals and enables these to be made known to all service providers involved
- encourages the consumer to be actively involved
- manages long-term service delivery in a clear, concise way
- provides an essential checklist to ensure continuity of service delivery
- provides a way of documenting essential information to be shared by others, including life-saving actions for emergencies
- encourages a team approach, with the consumer at the centre
- focuses on being proactive rather than reactive
- increases consumer and carer awareness of support services available, and how and when to access them
- facilitates effective monitoring of the consumer's health and social wellbeing
- allows diversity needs to be identified and taken into account.

It is critical that the shared care/case planning process is embedded in a person-centred culture, so that professional and organisational boundaries do not create artificial barriers (see Section 2.4.1). In a person-centred practice, consumers are supported to:

- participate in decision-making partnerships at service delivery level, program planning and policy formation
- be actively engaged in the planning and delivery of services and receive support appropriate to their needs, wishes, circumstances, abilities, safety and cultural background
- identify their own needs and develop their own goals
- choose outcomes they define as meaningful
- examine risks and consequences
- use their own strengths and natural supports
- be involved in decision-making choices
- be autonomous
- take responsibility for their part in the plan, including family and support people
- take responsibility for self-management, where appropriate

Examples of shared care/case planning

Kylie is an adolescent in care and used to become angry and disruptive in formal education transition reviews and placement and support reviews. Kylie felt that the meetings did not move at her pace, that she was not being listened to and that the meetings did not address issues of importance to her. Her person-centred planning meeting however, did address her needs. Kylie was supported to set the agenda and she co-chaired the meeting so that she could control the pace. Kylie felt more responsibility for the outcomes of these meetings and felt that she had more control of her future.

Julia and her daughter Cassandra transferred from their public housing in rural Victoria to a public housing property in metropolitan Melbourne. Julia had very little knowledge of the area she was being transferred to. At sign-up, Tim, the housing service officer, asked Julia if she required support to settle into her accommodation and what would she like to know about the local neighbourhood services. Tim referred Julia to the local housing support program, which offered practical assistance in the form of whitegoods, household items and furniture. She was also able to discuss what services she wished to be referred to, which included access to a GP and other health professionals. The support program was able to obtain funding to buy a school uniform for Cassandra and assisted the family in acquainting themselves with the local public transport system and neighbourhood house.

3.6.4 Goal-directed Care/Case Planning

Evidence shows that an assessment process alone is insufficient to improve outcomes. It has to be followed by goals, actions and interventions to address the issues identified. Goal development is the process by which goals are developed and agreed. Depending on the person's circumstances, the goals will be developed in conjunction with carers, family members, support workers and other key people.

Goal development assists with:

- ensuring a person-centred and family-centred approach
- ensuring people are empowered to make decisions about their services and support
- providing purpose and motivation for the person
- linking between assessment and care/case planning
- communication across organisations and between staff
- fostering greater satisfaction with services and a sense of achievement for individuals
- providing a focal point for integrating and coordinating service delivery between organisations.

Example of goal development

Jenny is 26 years old and has a disability, which requires her to use a wheelchair. Her family relationship has deteriorated and she has been couch surfing for the last month. Jenny's priority is to live in a house on her own. To achieve this goal requires services to support Jenny to:

- find a suitable home (such as public housing)
- live independently (through support from HACC, Disability Services: Individual Support Packages)
- be financially secure (through support from Centrelink, financial counselling)
- manage her health needs (through her general practice, district nurse)
- develop social networks (through local government leisure and recreation programs and reconnecting with her day support program).

Tip[13]

If it is difficult to identify a clear goal, several strategies can be used:

- Ask the person what they would like to achieve, what is important to them and to think about their wishes/desires.
- Ask the person if there is something they have not done for a while that they would like to do again.
- Pick a cue from the conversation; for example they might mention that they normally go to a club or meeting but have stopped this for some reason.
- Ask the person if they have a special family event coming up that they would like to attend.
- Discuss activities that the person used to do but now finds difficult.
- Encourage the person to take time to think about their goals. This may mean you have to return at a later date to continue with goal setting (with the person's permission you might like to arrange a family member to help with the goal-setting exercise).

13 Reference: *Strengthening Assessment and Care Planning: A Guide for HACC Assessment Services in Victoria.*

3.6.5 What is a shared care/case plan?

A shared care/case plan is the documentation of items agreed to in the planning process. The care/case plan should be worded in a way that the consumer and any of their service providers can understand. All care/case plans, whether they are service-specific plans or shared care/case plans, should include these items:

- date plan developed
- participants in development of the plan
- consumer-stated and agreed issues or problems
- consumer-stated and agreed goals
- agreed actions and the name of the person or service responsible for each action
- timeframe for attaining goals and actions
- planned review date
- consumer acknowledgement of the care/case plan (signed or verbal)
- actual review date
- goal attainment (met or partially met)

3.6.6 The care/case coordinator role in shared care/case planning

It is important to individuals who have more complex needs that service provision is coordinated and that a lead person makes sure this happens. The care/case coordinator acts as a single point of contact for the consumer. Ideally the person is someone they can trust and who can engage them in making choices, navigating their way through the system and effecting change. The term 'care/case coordinator' may also be referred to as 'key worker', 'lead professional' or 'case worker'.

The nomination of a single care/case coordinator promotes effective communication between the consumer and service providers to reduce duplication and inconsistency. The care/case coordinator is responsible for ensuring the shared care/case plan is delivered and monitored, review dates are set, reassessments are initiated and relevant information is shared with participating service providers.

The care/case coordinator role in shared care/case planning will be fulfilled by a trained service provider with the skills and competence to undertake service coordination. Each program area and local service system will have different guidelines to determine availability of staff to perform the care/case coordinator role. Organisations may elect to create a specific care/case coordinator role to support the implementation of service coordination. A range of staff may participate in care/case planning by communicating outcomes and progress to the care/case coordinator.

When choosing the care/case coordinator, consider consumer preference, relationship to consumer, level of engagement, frequency of contact, and skill and capacity of the worker. The care/case coordinator may change over time. The role is likely to involve a range of different functions as outlined below.

Developing the initial plan

This may involve:

- engaging and empowering the consumer and acting as an advocate if required
- collaborating to gather existing information, such as in developing assessments or service plans
- having a good knowledge of available services and management options
- developing and documenting agreed goals and actions in collaboration with the consumer
- documentation using the SCTT *Shared support plan* in a language that is suitable for consumer and service providers
- ensuring documentation and processes meet the requirements of the *Health Records Act* and other privacy legislation
- agreement of a system for record keeping, including the use of a person-held record.

Communication

This may include:

- ongoing liaison and communication with the consumer, carer/s, service providers and any other participants
- building rapport and developing trust with all participants in the shared care/case planning
- informing the consumer/carer if their main contact person changes (e.g. as a result of staff changes in an organisation)
- organising and facilitating case conferences
- working in a virtual, multidisciplinary or interdisciplinary team
- ensuring specific feedback loops are in place for other service providers and the consumer.

Review and monitoring

This may include:

- monitoring and review of the plan and arrangement of reassessments as required
- ensuring that formal and informal monitoring of the effectiveness of service delivery in meeting the consumer's goals is in place – this may occur through regular reviews
- negotiating the location, participants and timing of shared care/case planning and reviews in line with the consumer and family's wishes
- ensuring the plan remains current and there is a system in place to manage version control
- discussing exit options and procedures.

Good negotiating and teamwork skills as well as tact and diplomacy are important attributes of this role.

Case management

Includes the roles and tasks described for care/case coordinator as well as arranging additional services needed by the consumer by means of brokerage, purchase of services or maintenance of effort agreements between organisations.

If there is a case manager involved in the service provision they may be best placed to take on the care/case coordinator role.

3.6.7 The consumer's role in care/case coordination

Consumers may be able to take on some of the care/case coordinator responsibilities in consultation with their service providers. Some may require support from family, friends or carers to do this. Consumers can be encouraged to take an active role in coordinating services by taking a copy of their SCTT *Shared support plan* to all their appointments. If the service provider is participating in the shared care/case plan, the consumer and the service provider can discuss the plan and add to it as applicable.

If the service provider is not currently participating in the plan, the consumer may request the service provider to send the assessment summary or the service-specific care/case plan to the care/case coordinator to inform the shared care/case plan.

3.6.8 How to develop a shared care/case plan

Table 6: Steps in developing a shared care/case plan

1.	Identify the need for a shared care/case plan, for example a plan may be recommended for a consumer who: ■ has chronic, terminal or complex conditions ■ requires multiple services ■ would benefit from a shared care/case plan for other reasons ■ requests a shared care/case plan.
2.	Check if a shared care/case plan has already been prepared by another organisation or by the consumer's GP. To avoid duplication, decide if there is a need to add to the existing plan or develop a new plan. The new plan should not repeat the content of other plans, but focus on priority goals that require a coordinated approach.
3.	Explain to the consumer what a shared care/case plan is and why you think they would benefit. This involves listening to their issues, respecting choice and discussing the advantages of having a plan. This explanation should be undertaken with appropriate cultural sensitivity. If necessary, arrange for an interpreter to be present during the discussion. Where there is impaired communication or cognition, use of communication aids or a support person may be required. During this discussion, identify a reason for the shared care/case plan that will be recorded in the document.
4.	Once you are clear the person understands the reason for the plan, obtain consumer consent for the process. Refer to Section 4.2 if the consumer does not have the capacity to provide consent.
5.	The shared care/case plan may be recorded on the SCTT *Shared support plan.*
6.	Identify the people who need to be involved in the shared care/case planning process. Ask the consumer: *Who are the people who support you at the moment?* This may include family members, carers and other service providers. Explain the role of the care/case coordinator to the consumer. Identify the preferred care/case coordinator from the consumer's perspective. The consumer may also need an advocate, interpreter, carer or family member involved in the planning process. Where the consumer is not able, or chooses not to be involved in the planning discussions, a substitute decision-maker or authorised representative may participate on their behalf.
7.	Be clear about and record issues regarding safety and risk if family violence has been identified as this has implications for which services are involved and which family, friends or carers should be involved.
8.	Obtain and record consumer consent to share information with participants involved in the planning and service delivery process. Record consent to share information with the participants identified using the SCTT *Consent to share information* template. Write 'care/case planning' or 'care/case coordination' in the purpose column. Consumers have the right to specify which participants they want their information shared with by recording names on the template. *Example:* ■ a personal carer, neighbour, son or daughter may be an important participant in the consumer's care and be listed on the plan with their contact details and role. They may not be involved in the planning but may receive a copy of the plan.

9.	Discuss with participants a time and method of participation in planning. Communication with participants may include: discussing the reason for the plan, clarifying their role, locating relevant assessments and information to include in the plan, and setting a time, place and method for the discussion. Consider engaging a GP in a case conference, being sure to allow sufficient preparation and timing. Case conferencing items available through the MBS will facilitate GP participation thereby enhancing the benefits to consumers of a planned and coordinated approach. Divisions of general practice/Medicare Locals can provide guidance in this area. *Example:* ■ Shared care/case planning discussions may occur in the service setting, at the consumer's home, at a case conference/teleconference, with participants at their computers, or in stages over time.
10.	At the planning session, agree on the care/case coordinator. Consider the service provider, program guidelines, position descriptions, consumer preference, the person who has regular contact or a rapport with the consumer, and the skills and capacity of the worker.
11.	Record all participants in service delivery, their role and contact details and who is involved in planning. This can be useful as a contact list for the consumer and other participants. Be aware of safety issues if family violence has been identified.
12.	Discuss and develop the plan together. Identify key issues, agree goals (specific, measurable, achievable and realistic) and the actions planned to achieve the goal, responsible individuals/services for each action, and target date for each goal. Refer to Section 2.4.1: Guiding principles for enabling person-centred practice.
13.	Agree on the proposed date to review the plan and record it. The care/case coordinator is responsible for ensuring the plan is reviewed within 1 month of the date listed for review (unless the service provider procedures states otherwise). The timeframe for review will depend on the consumer's situation, goals and types of services involved.
14.	Ensure the 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.
15.	Record on the plan the participants who are to receive a copy and provide them with one (including the consumer). Consumers have the right to choose which participants have a copy of the plan. Be aware of safety issues if family violence has been identified.
16.	Changes, or progress on planned actions, must be sent to the care/case coordinator to inform the review process. This may be documented on the SCTT *Information exchange summary* template.
17.	The care/case coordinator is responsible for facilitating a review of the shared care/case plan via a meeting, case conference or by contacting individual participants. A decision follows as to whether a new shared care/case plan should be developed.
18.	The SCTT *Review of shared support plan* template may be used to record the progress of each goal. A copy of the completed SCTT *Review of shared support plan* may then be provided to the selected participants.

3.6.9 GP involvement in shared care/case planning

The involvement of GPs in care planning for people with chronic health conditions or terminal medical conditions is essential. GPs can be involved in care/case planning[14] led by other service providers, or they can lead care planning.

Whenever a shared care/case plan is required, 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 planning process. When a plan is developed a copy should be sent to the GP with the consumer's consent. General practice should also be encouraged (either upon referral or communication to the service) to include copies of relevant care plans developed by the GP/general practice.

GPs' involvement in care planning is largely guided by the MBS. The main types of care plans and arrangements funded under the MBS that are initiated by GPs with consumers include:

- GP management plans – these are GP-specific care plans that the GP develops with the consumer about the treatment and management of their conditions. Consumers with chronic or terminal medical conditions are eligible under the MBS for these plans.
- Team care arrangements (TCAs) – for consumers that have complex care needs and require additional services, such as public or private allied health.
- Mental health plans – these are plans that the GP has with the consumer about the treatment and management of their mental health conditions. The plan may include referral to other services.

For additional information about these items see Section 5.3 under 'General practice/Medicare Locals'.

If consumers do not already have a GP, efforts should be made to link them in with one. The Human Services Directory/Better Health Channel may be of assistance when locating general practitioners.

14 Shared care in this context refers to consumers with whom the GP and the service provider have in common. When the term shared care is used in general practice it is often referring to a specific arrangement the GP may have, for example in shared maternity care.

3.6.10 Practice standards: case/care planning

Table 7: Consumer outcomes and good practice indicators – care/case planning

Consumer outcomes	Good practice indicators
Shared care/case planning	
Consumers are informed about and understand: ■ the value of planned and coordinated service delivery ■ shared care/case planning options and processes ■ roles and responsibilities of service providers, including the service provider fulfilling the care/case coordinator role ■ privacy, confidentiality and consent procedures and their right in relation to these procedures. Consumers (and their representatives) are empowered to collaborate in the development, implementation, monitoring and review of their care/case plan. Consumers have direct access to care/case planning and coordination processes.	The consumer, carer and advocate are actively supported to participate in the planning process (unless they choose not to).
	The service provider ensures that the appropriate participants in service delivery are included (with consumer consent) in the development of the plan.
	The service provider fully explains the consent process and documents the consumer's consent to information sharing and to the actions and services listed in their plan.
	The consumer and service provider identify the consumer's needs and risks. Service providers ensure that care/case planning processes incorporate mechanisms to address consumer safety and risk if family violence has been identified.
	The consumer and service provider discuss the benefits and purpose of a shared care/case plan, including its relationship to service delivery and improved outcomes.
	Existing plans are identified and considered.
	If a consumer with complex needs does not already have a shared care/case plan or equivalent, the service provider initiates (with consent) its development.
	Shared care/case plans are written in a way that is easily understood by the consumer, expressing specific, measurable, realistic and time-specific goals.
	The consumer and service provider discuss the roles and responsibilities of all participants involved in planning, especially the care/case coordinator.
	Shared care/case plans are documented and contain: ■ date care/case plan developed ■ participants in development of care/case 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/case plan (signed or verbal) ■ actual review date ■ goal attainment (met or partially met).
	A care/case coordinator is nominated for consumers who require a shared care/case plan. The care/case coordinator's contact details are clearly documented on the plan.
	The service provider and care/case coordinator liaise with the consumer and other care participants, including GPs, to develop, monitor and review the shared care/case plan.

Consumer outcomes	Good practice indicators
Systems and processes	
Organisations have effective systems and processes for achieving good practice in shared care/case planning	There are local agreements between services to align processes and systems to facilitate coordinated care.
	The service provider has a system and criteria to identify consumers who would benefit from having a shared care/case plan (Step 1 in 3.6.8).
	The care/case coordinator role is identified in their position description.
	Staff involved in shared care/case planning have access to training in goal setting and care/case planning.
	The service provider has communication systems in place for referral, feedback and shared care/case planning.
	The organisation has a process for recall and reminder, monitoring and reviewing consumer needs, and updating plans when consumer needs change or actions are completed.
	The service provider has a process for planning and communicating exit or discharge and re-entry, if required.
	Organisations foster practice that is sensitive to the consumer's cultural, communication and cognitive needs to support their participation in planning (for example, use of interpreters, translated material, easy-English, pictures, plain English in readable format).
	The service provider has a process for consumers who require urgent services or are at risk and cannot wait for a formal assessment or planning processes to be completed.

3.6.11 Consumer pathway through care/case planning

See flow chart in Section 7 or the *Good Practice Guide.*

Section 4
Practice standards for additional processes

4.1 Information provision

Providing information that is relevant to the consumer's needs may be undertaken at any and all stages of the service coordination process. When choosing the type and complexity of information to provide, service providers will be receptive to and guided by the consumer's needs, learning styles and their capacity to understand information (taking into account issues such as preferred language and visual or cognitive requirements). An understanding of the concept of health literacy may assist service providers to check that consumers have understood and, importantly, are able to utilise, the information that is being provided.

Health literacy has been defined as 'the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health' (World Health Organization 1998). Health literacy goes beyond providing information that is in line with people's specific needs (such as providing a pamphlet in another language or using everyday language in brochures). While it builds on these concepts, it also includes the person's ability to seek, understand and act on information.

While the term 'health literacy' has been defined by the World Health Organization with specific application to health, the concept of 'information literacy' extends beyond health and is equally applicable to other elements of information provision and understanding that underpin service coordination. It is generally accepted that 'information literacy' is the degree to which individuals have the capacity to obtain, understand and use information.

This type of literacy is an important contributor to consumer engagement and person-centred practice, ultimately affecting how services meet the consumer's needs. In situations in which consumer's 'information literacy' is perceived by the service provider to be low, some simple strategies can be implemented to enhance the consumer's understanding of the information that has been provided.

These include:

- the 'teach back' method, which confirms service providers have explained what consumers need to know in a manner that they understand
- asking consumers what strategies may help them to understand and act on the information, acknowledging that many people have difficulty understanding this type of information
- creating an atmosphere of respect and comfort with the consumer
- limiting information given to consumers during each visit
- providing information with visual prompts, simple information and colourful cues.

4.2 Consent to share consumer information

Privacy legislation requires the protection of an individual's personal information and their right to decide how the information is used, disclosed to or shared with others. Consumer consent is a compulsory part of the information exchange process.

The primary purpose of information collection is the purpose for which the information was originally provided, while the secondary purpose is any additional use that is not directly related to the consumer's original disclosure. A broad screening of a person's needs may identify multiple, interrelated issues. This information gives service providers a more comprehensive picture of the consumer's circumstances and wellbeing. However, some of the information may not be directly related to the primary reason for a referral, so consent must be obtained to share this additional information.

For more information on privacy see the *Commonwealth Privacy Act 1988, Victorian Information Privacy Act 2000* or the Victorian Government's *Use and disclosure of health information fact sheets* (see Section 5.3).

Consumer information sharing can occur without consumer consent if the information is being shared with statutory services such as Child Protection or Mental Health, or where an immediate referral is believed to be in the consumer's best interests.

If the consumer does not have the capacity to consent (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 6.2). 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 sharing information by a health service provider that is reasonably necessary for the provision of a health service, or where there is a statutory requirement. For further circumstances for disclosure, see the Victorian Government's *Use and disclosure of health information fact sheets* (see Section 5.3).

If the consumer has the capacity to consent and refuses consent to share information, a referral can still proceed. However, the receiving service provider will need to obtain the information they require from the consumer. Service providers collect consumer information for many legitimate reasons: to identify needs, make good quality assessments and referrals, to provide a service, meet program or data collection requirements and for effective care/case planning. But service providers should not collect information that is not relevant to their practice, such as collecting another service provider's minimum data set requirements.

Consent forms are not required to be included in referral information sent to another service provider. It is the duty of care for the service that is collecting and sending the information to ensure that informed consent has been obtained.

4.3 Referral

Referral is the transmission, with consent, of a consumer's information from one service provider to another for the purpose of further assessment, or service provision. Referrals may be made by a staff member involved in initial contact or initial needs identification, or a service provider seeking assessment and service provision for a consumer. As consumer needs or circumstances change, further referrals may be required. A consumer in crisis will require immediate referral, which can be followed later by a more detailed referral, e.g. using the SCTT.

The referral process is aimed at:

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

Service providers involved in referral will:

- work in partnership
- take responsibility for agreed roles and tasks in a timely manner
- meet moral, ethical, professional and legal obligations
- refer consumers to the right service, at the right time, and in the right place
- aim to meet a consumer's needs and goals in respect to their quality of life
- operate in accordance with consent gained
- communicate statutory and duty-of-care arrangements
- operate within a quality and continuous improvement framework.

Good practice involves processing incoming referrals in a timely manner:

- Non-urgent means attend in date order. This may include the consumer being placed on a waiting list
- Urgent means the referral cannot wait. It is good practice to contact a service provider prior to sending an urgent referral, to ensure the referral can be handled in a timely manner.

The good practice indicators for additional processes (Section 4.7) set out the expected response times for sending and actioning referrals. The phrase 'within no more than' is used because many services and program areas will send and action referrals within shorter timeframes.

4.3.1 Where does referral fit into service coordination?

Referral may occur at, or result from, any stage of service coordination. A consumer may be referred for:

- information
- initial needs identification
- assessment
- service provision
- development of a care/case plan
- reassessment, monitoring and review.

Self-referral

Self-referral is a consumer's choice to contact another service provider on their own behalf. Service providers should support this choice by providing:

- information, such as the service provider contact details
- advice and decision-making support
- a copy of the consumer's completed referral form, e.g. the SCTT (if appropriate).

Assisted referral

An assisted referral is where service providers make a referral on behalf of the consumer. Consumer consent to share their information with other services is required. The service provider makes an assisted referral using referral templates that support consistent, quality information that meets the needs of the service e.g. SCTT.

Active or crisis referral

In some situations a service provider may make an immediate referral by speaking directly to the receiving service provider. Active referral is needed when a consumer is extremely anxious or in crisis (attempted suicide, serious self-harm, behaviour endangering self or others, threats of violence) and is followed by a more detailed referral e.g. using the SCTT.

4.3.2 Staff involved in referral

All staff involved in service coordination or service delivery will make or receive referrals at some time. Therefore, they must be familiar with their service provider practice and the practice standards that govern referrals and additional processes.

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

- make referrals in accordance with service provider guidelines, policies, procedures and work instructions
- adhere to Victoria's Service Coordination Practice Standards and prioritise as urgent or non-urgent
- use an appropriate referral tool, such as the Service Coordination Tool Templates (see *SCTT 2012 User Guide)*
- meet privacy and consent requirements
- utilise local or regional systems, such as using a secure e-referral system.

4.3.3 Referral to and from general practice

Service providers should have in place policies and procedures to support systematic referral and feedback to GPs and other services. Referrals to a GP should be completed using an appropriate referral template, such as the SCTT and in accordance with service coordination referral practice standards.

Referral from general practice – the SCTT *General practice referral* template

The SCTT *General practice referral* template (GPRT) is a simple electronic template for referral from general practice. It ensures standardised, quality referral from general practice to services. The Department of Health and General Practice Victoria support and promote the use of the GPRT instead of the multitude of service-specific referral forms. Some local divisions of general practice/Medicare Locals provide on-the-ground support to help GPs integrate the GPRT into their practice. The GPRT has been incorporated into most clinical software applications used by general practice. Health and community services may encourage general practice to use the GPRT but should not refuse referrals in other formats. The GPRT includes referrer and referee information, consumer/patient information, clinical summary including medications, and free text fields for additional information.

GPs value electronic communication and wherever practical, use secure messaging systems for information transfer. In many regions there are secure messaging trials between GPs and local services. Divisions of general practice/Medicare Locals and PCPs have further information about the range of programs available in each area.

4.4 Information exchange

Information exchange is essential to provide consumers with a seamless, coordinated service delivery. Information exchange includes:

- acknowledgment that a referral has been received and the subsequent action to be taken. Acknowledgement of referrals confirms that the service has received the referral, preventing consumers slipping through the gaps. The SCTT *Referral cover sheet and acknowledgement* template may be used to document this information
- provision of summary information to other service providers at key points in the consumer's pathway to support service coordination.

Information exchange between services reduces duplication of assessment and service provision, and highlights gaps in service provision so that they can be addressed. The SCTT *Information exchange summary* template may be used to document this information.

Information exchange between services may occur following assessment, care/case planning, review or change in service delivery, handover, transition or exiting. Information exchange may be provided at other points in the consumer's service delivery pathway as appropriate.

4.4.1 Information exchange with private providers, including general practice

Good service coordination practice involves service providers acknowledging referrals received and providing feedback to referring services, including GPs, about referral outcomes. Information exchange is a critical component of the referral process.

GPs value feedback, and are particularly interested in receiving information they need to act on, or be aware of, when they next see the consumer. Organisation policies and procedures should guide communication with general practice, including acknowledgement of referrals received.

Feedback to general practice should include the following critical information:

- consumer identification details
- referral details, including reason for referral
- staff involved in consumer's care, reason for involvement, and contact details of providers.

Depending upon the nature of the report, communication may also include:

- assessment findings and summary of planned interventions
- outcomes of the service provided
- issues or recommendations that may require follow-up by the GP.

The Department of Health has produced a number of resources about communication and feedback to GPs (see Section 5.3).

4.5 Service delivery

Service delivery is generally undertaken in accordance with local protocols and in keeping with the needs of the consumer and the level of skill of the person providing the service.

4.6 Exiting

Exiting can occur at any stage of the service coordination process and is generally managed in accordance with local protocols.

4.7 Practice standards: additional processes

Table 8: Consumer outcomes and good practice indicators – additional processes

Consumer outcomes	Good practice indicators
Referral	
Consumers are referred at the right time to the right service to maximise outcomes from services they receive and enhance quality of life. Consumers are involved in decision making about the services they receive and referrals made to other services.	The service provider making a referral explains referral options and processes to the consumer. This may involve: ■ assisting the consumer to identify their issues and define their needs ■ practice that is sensitive to cultural, communication, cognitive needs as well as personal safety and risk of violence ■ sourcing information from relevant service directory, e.g. Human Services Directory, or calling the services directly ■ explaining waiting times and service limitations ■ discussing the pros and cons of self-referral ■ offering to make the referral on their behalf (particularly if the consumer finds their options confusing, distressing or frustrating) ■ facilitating referrals and/or assisting with navigation and negotiation of the service system when appropriate ■ explaining the use of information for referral and explaining referral options ■ providing the consumer with information about their rights, including the option of sharing all, or some, information ■ assisting the consumer to make an informed choice.
	The service provider making a referral: ■ offers the consumer a copy of the *Your information – It's private* brochure or relevant service provider information, and checks the consumer has understood it ■ completes the relevant sections of the referral form used, e.g. SCTT ■ makes an assessment of risks faced by the consumer and/or staff ■ prioritises the referral as urgent or non-urgent.

Consumer outcomes	Good practice indicators
Referral *(continued)*	
	The service provider sending a referral is expected to: ■ send referrals in accordance with privacy requirements ■ transmit referrals using a secure e-referral system, or through secure fax or post ■ contact the service provider/s receiving the referral, if appropriate, to prioritise the referral, provide additional consumer information or discuss assessment, care/case planning or service delivery options ■ use referral templates that support consistent, quality information that meets the needs of the service, e.g. SCTT ■ send urgent referrals within no more than 1 working day of obtaining consumer consent – the reason why the referral is urgent needs to be specified ■ send non-urgent referrals within no more than 7 working days of obtaining consumer consent ■ make immediate referrals (for example, over the phone) when a consumer is in crisis, or assessed as being at high risk of family violence and follow this up with a more detailed referral, e.g. SCTT.
	The service provider supports the consumer to make a self-referral. If they choose to do so, and may support the consumer, by providing: ■ information, such as service provider contact details ■ advice and decision-making support ■ a copy of the completed referral forms, e.g. SCTT, if appropriate.
	The service provider making a referral monitors the consumer's status until a response to the referral is received and accepted. At this point, both service providers should agree who is responsible for monitoring the consumer if they are placed on a waiting list. If the receiving service provider does not respond within agreed timelines, the sending service provider must check to ensure the referral has been received.
	The service provider receiving a referral is expected to: ■ transmit acknowledgement of the referral (service providers may use the SCTT *Referral cover sheet and acknowledgement* template for this) to the initiating service, stating that the referral has been received and the estimated date of consumer assessment, or the reason why the referral is not proceeding ■ acknowledge urgent referrals within no more than 2 working days of receipt ■ acknowledge non-urgent referrals within no more than 7 working days of receipt ■ transmit referral outcome information to the initiating service provider within no more than 14 working days of the consumer being assessed.
	If the referral is not appropriate, this must be communicated to the referring service by the organisation to which the inappropriate referral has been made.

Consumer outcomes	Good practice indicators
Information provision	
Consumers have been provided with and understand relevant information to assist their access to services.	The service provider gives consumers relevant, up-to-date information using relevant service directory e.g. the Human Services Directory/Better Health Channel.
	The service provider empowers the consumer by providing information and decision-making support access to initial needs identification, assessment, care/case planning and referral (where appropriate).
	The service provider gives consumers a copy of the brochure *Your information – It's private* or other relevant service provider information, and ensures consumers have understood it.
	In each part of the process, service providers confirm that they have explained to the consumer what they need to know and that the consumer has understood it.
	When providing information to consumers, service providers are to be guided by the consumer's needs, learning styles and their capacity to understand information, taking into account issues such as preferred language and visual or cognitive requirements.
Consent to share information	
Consumers are involved in decision making about information shared with other providers.	If the consumer has the capacity to give informed consent, the service provider obtains informed consent before sharing information with another service provider.
	Consumer consent to share information is obtained and recorded on an appropriate form, such as the SCTT *Consent to share information* template and in accordance with the *SCTT 2012 User Guide.*
	If the consumer does not have the capacity to make informed consent, or if the situation is urgent or the consumer is perceived to be at risk if the referral is not made, the service provider clearly documents why the referral has been made without consumer consent.

4.8 Consumer Pathway – additional processes

These additional processes are referred to throughout the consumer pathway.

See consumer pathway in Section 7 or the *Good Practice Guide.*

Section 5
Resources and tools to support service coordination

5.1 How do the Service Coordination Tool Templates support Service coordination?

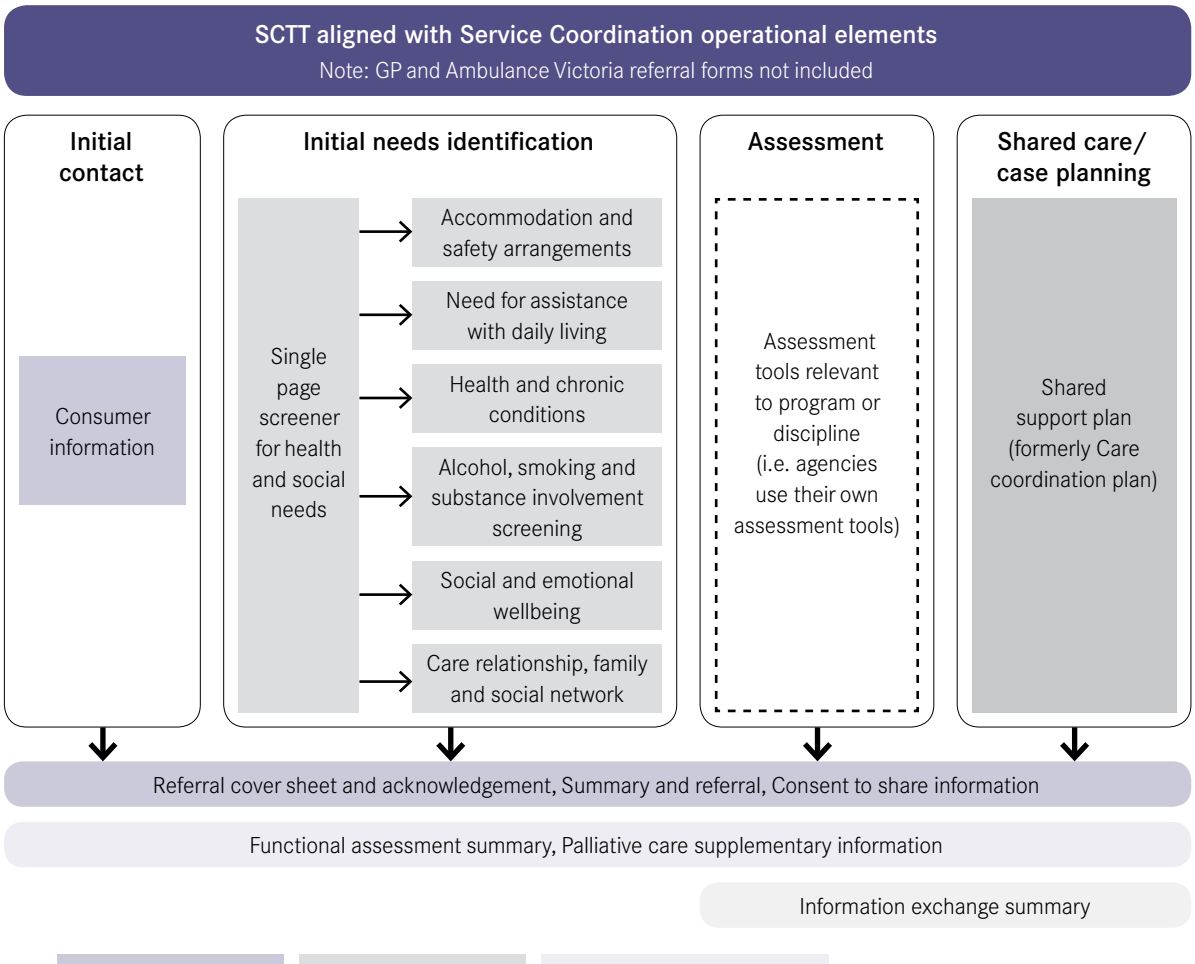
The Service Coordination Tool Templates (SCTT) is a suite of templates developed to facilitate and support service coordination. They support standardised collection and recording of initial contact, initial needs identification, referral and care/case planning information. Using SCTT can improve communication between service providers, consistency of information collected from screening and assessment processes, and improve the quality of referrals. This can help services to share relevant information to support better outcomes for consumers.

Many program areas have integrated SCTT into their practice guidelines and reporting mechanisms. For program-specific requirements of the SCTT, refer to program-specific guidelines. The templates are not designed as a minimum data set for reporting or as program-specific collection tools. SCTT are designed to meet the needs of the many different service types and consumer groups that implement service coordination. To meet the needs of new and existing users, a continuous improvement approach has been adopted to update SCTT.

The *SCTT 2012 User Guide* is available to assist in the use of the templates. The guide provides an introduction and overview of the templates, and supports service providers in completing them.

Figure 3 illustrates the alignment of the individual templates within the SCTT with the service coordination elements.

Figure 3: Alignment of SCTT with service coordination elements

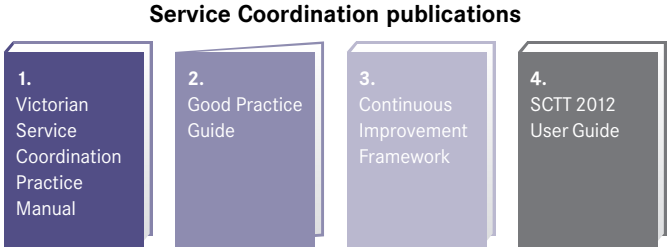


5.2 Resources to support service coordination

A range of resources and tools have been developed to support service coordination practice including a set of four publications:

1. *Victorian Service Coordination Practice Manual*
2. *Good Practice Guide – A resource of the Victorian Service Coordination Practice Manual*
3. *Continuous Improvement Framework – A resource of the Victorian Service Coordination Practice Manual*
4. *Service Coordination Tool Templates (SCTT) 2012 User Guide*

Figure 4: Publications to support service coordination



These publications are available at the Department of Health PCP web page: <www.health.vic.gov.au/pcps/coordination>.

Service coordination is supported at a local and regional level by:

- partnerships, service networks and other service provider groups
- locally agreed service coordination protocols
- agreed referral pathways, including the use of secure e-referral systems

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
- consumer management software applications
- information management processes and procedures related to service access, consumer registration and consumer records
- service directories, such as the Human Services Directory.

5.3 Additional information resources

Many resources have been developed in different sectors that will facilitate implementation of best practice service coordination. The following is a summary of some of the resources available.

Aboriginal health

- The Department of Health's *Cultural Resource Guide* outlines cultural awareness training and related resources that are currently available in Victoria. The resource is available at: **<www.health.vic.gov.au/aboriginalhealth/publications/publications.htm>**
- Closing the Gap – Tackling Indigenous chronic disease
  <www.health.gov.au/internet/ctg/publishing.nsf/Content/home-1>
  <www.health.vic.gov.au/aboriginalhealth>
  AIHW National best practice guidelines for collecting Indigenous status in health data sets (2010):
  <www.aihw.gov.au/publication-detail/?id=6442468342&tab=2>

- Victorian Aboriginal Community Controlled Health Organisation (VACCHO):
  <**www.vaccho.org.au**>
- Cultural respect framework for Aboriginal and Torres Strait Islander Health:
  <**www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-pubs-crf.htm/$FILE/Cultural_Respect_Framework.pdf**>
- Review of audit and assessment tools, programs and resources in workplace settings to prevent race-based discrimination and support diversity:
  <**www.vichealth.vic.gov.au/~/media/ResourceCentre/PublicationsandResources/Discrimination/Workplace_discrim_review.ashx**>

Carers

Over 700,000 Victorians care for family members or friends. *The Victorian Charter Supporting People in Care Relationships* stipulates that carers can expect to be supported in their role as carers and as someone with their own needs.

- The Victorian Charter Supporting People in Care Relationships:
  <**www.health.vic.gov.au/agedcare/downloads/pdf/carers_charter.pdf**>
  <**www.health.vic.gov.au/agedcare/downloads/pdf/carers_factsheet.pdf**>
- Carers Victoria:
  <**www.carersvic.org.au**>

Consumer participation

- Consumer, carer and community participation information:
  <**www.health.vic.gov.au/consumer/**>
- 'Doing it with us not for us': Strategic direction 2010–13:
  <**www.health.vic.gov.au/consumer/pubs/doing.htm**>

Disability

- UN convention on the rights of persons with disabilities
  <**www.un.org/disabilities/default.asp?id=150**>

Electronic service directories

- Human Services Directory:
  <**humanservicesdirectory.vic.gov.au**>
- General health information for individuals and communities:
  <**www.betterhealth.vic.gov.au**>

Family violence

Violence is the biggest cause of death, disability and illness for women aged 15–45 (VicHealth, *Health Costs of Violence)*. The Department of Planning and Community Development has a range of resources on its website including resources for mainstream services encountering people they believe to be victims of family violence and a factsheet on information sharing in the context of family violence:
<**www.dpcd.vic.gov.au/women**>

- Information on technology safety planning:
  <**www.dvrcv.org.au/help-advice/technology-safety-planning**>

Government departments

- Victorian Government Department of Human Services:
  <**www.dhs.vic.gov.au**>
- Victorian Government Department of Health:
  <**www.health.vic.gov.au**>

General practice/Medicare Locals

- Working with general practice position statement – resources to assist effective working with general practice:
  <**www.health.vic.gov.au/pch/gpp/working/position_resource.htm**>
- Medicare Benefits Schedule (MBS) online (you can search the MBS for item numbers and names and retrieve information about MBS criteria):
  <**www9.health.gov.au/mbs/search.cfm**>
- General practice partnerships:
  <**www.health.vic.gov.au/pch/gpp/index.htm**>
  <**www.health.vic.gov.au/pch/gpp/working/pdsa.htm**>
- Medicare health assessments resource kits:
  <**www.health.gov.au/internet/main/publishing.nsf/Content/mha.htm**>
- FAQs about the use of chronic disease management (CDM) Medicare items:
  <**www.health.vic.gov.au/pch/downloads/factsheet06.pdf**>
- CDM Medicare Items:
  <**www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement**>
- The DH resource for community health services on providing feedback to general practice:
  <**www.health.vic.gov.au/pch/gpp/working/pdsa.htm**>
- The Australian Government Department of Health and Ageing website details fact sheets and resources about mental health management items available in general practice:
  <**www.health.gov.au/internet/main/publishing.nsf/Content/pacd-gp-mental-health-care-pdf-qa**>
- Medicare Locals and the National Health Reform:
  <**www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/medilocals-lp-1**>

Guidelines and policies

- Many government policies and guidelines include elements and enablers of service coordination as outlined in this manual. Policies and guidelines relevant to a range of government program areas can be found at:
  <**www.health.vic.gov.au/pcps/coordination/programs.htm**>
- Better Access to Services: A policy and operational framework, Aged Care and Mental Health Division, June 2001:
  <**www.health.vic.gov.au/pcps/coordination**>
- Victorian govt policies:
  <**www.vic.gov.au**>

Health literacy

- Australian Bureau of Statistics summary of findings on health literacy:
  <**www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4233.0Main%20Features22006?opendocument&tabname=Summary&prodno=4233.0&issue=2006&num=&view=**>
- WHO Definition of health literacy from Health promotion glossary:
  <**www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf**>

Health literacy and health promotion

- *Health promotion glossary* (WHO 1998):
  <**www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf**>

Housing

- Opening doors service coordination documents:
  <**www.bswhn.org.au/Forms%20and%20Documents/Opening%20Doors/Framework%20(website).pdf**>

Medicare Locals

- Medicare Locals and National Health Reform:
  <**www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/medilocals-lp-1**>

Multicultural services

- *Multicultural aged care services directory* (Ethnic Community Councils Victoria):
  <**www.activeageingnetwork.org.au/getting_active/resources/Pages/ActiveLivingTips.aspx**>
- Multicultural responsiveness framework for health services:
  <**www.health.vic.gov.au/__data/assets/pdf_file/0008/381068/cultural_responsiveness.pdf**>

Primary and community health

- Primary and community health:
  <**www.health.vic.gov.au/pch**>
- *Service access models: a way forward* (a resource guide for community health):
  <**www.health.vic.gov.au/communityhealth/publications/chs_guide**>

Privacy information resources

Privacy and consent are key issues to be considered in all elements of service coordination and referral. Service providers are encouraged to visit the following websites to ensure they are meeting the relevant privacy and consent requirements:

- Victorian *Health Records Act 2001* (Victoria):
  <**www.health.vic.gov.au/healthrecords**>
- Duty of care policy:
  <**www.chp.org.au/homepages_accr/items/174538-upload-00001.pdf**>
- Mandatory reporting requirements Victoria:
  <**www.dhs.vic.gov.au/office-for-children/cpmanual/Output%20files/Practice%20phases/Output%20files/Execute/1122_mandatory_and_other_required_report.pdf**>
- Victorian information sharing guidelines:
  <**www.cyf.vic.gov.au/every-child-every-chance/library/publications/information-sharing-guidelines**>
- Use and disclosure of health information:
  <**www.health.vic.gov.au/hsc/infosheets/disclosure.pdf**>
- Consumer privacy information brochure: *Your information – It's private:*
  <**www.health.vic.gov.au/pcps/publications/languages.htm**>
- *Information Privacy Act 2000* (Victoria):
  <**www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/LTObject_Store/LTObjSt2.nsf/DDE300B846EED9C7CA257616000A3571/8C508B50F3EA009DCA25776100244507/$FILE/00-98a021.pdf**>
- Refusal of Treatment Certificate:
  <**http://publicadvocate.vic.gov.au/file/file/Medical/Refusal%20of%20Medical%20Treatment.pdf**>

5.4 Secure e-communication to support service coordination

Secure e-communication systems support service coordination by:

- encouraging good communication between services (including private providers and general practice), providing an opportunity to easily send a referral, acknowledge the referral, inform on referral outcomes as well as other relevant information exchange
- reducing duplication of information, and improving the quality and consistency of information exchanged
- enhancing and improving the security of consumer information, privacy and confidentiality.

Client information management software application

Refer to your software vendor for more information on how your client information management software application can facilitate e-communication to support service coordination across the public and private sectors including general practice.

5.5 Electronic service directories

The statewide Human Services Directory comprises comprehensive and up-to-date service information to assist referral and access to services. Consumers, carers and service providers may use the Human Services Directory to search for health and community services such as GPs, health service providers, alcohol and drug services, community health, carer services and psychiatric disability rehabilitation support services. Service providers are expected to maintain and update their service information on the Human Services Directory, in accordance with the Human Services Directory conditions of use.

Electronic service directories

- Human Services Directory: <www.humanservicesdirectory.vic.gov.au>
- Better Health Channel: <www.betterhealth.vic.gov.au>
- Connectingcare: <www.connectingcare.com/>
- Infoxchange: <www.infoxchange.net.au>

5.6 Service coordination training

The Department of Health has developed an online learning package to support the implementation of service coordination across Victoria. The Service Coordination Online Learning Package <www.health.vic.gov.au/pcps/workforce> is a self-paced interactive learning package for service providers involved in service coordination activities. The package has been designed to be incorporated in the service provider's induction program, and provides learners with:

- an understanding of the policy context, objectives, principles and practical approaches to service coordination in Victoria
- an awareness of how service coordination enhances service capacity to respond to consumer and carer needs
- an understanding of the benefits of service coordination
- an overview of the operational elements of service coordination, including initial contact, initial needs identification, assessment, and care/case planning
- an overview of how referral fits within service coordination
- an understanding of the resources available to support service coordination, including the SCTT and Human Services Directory.

Section 6
Terminology and manual development

Service coordination embraces a broad range of services, sectors and program areas. The terminology used by the various program areas and service providers differs significantly. For example the terms 'consumer', 'client' and 'patient' could all be used to describe an individual receiving care concurrently from a range of different services, such as a GP, alcohol and drug counsellor, social worker, podiatrist, housing officer or community care worker.

In the interests of consistency throughout this framework, the term consumers has been used. The definition of consumers used by the Department of Health in *Doing it with us not for us: Strategic direction 2010–13* has been adapted to encompass consumers beyond the healthcare sector. Consumers are therefore defined as: 'people who are current or potential users of health [and community] services. This includes children, women and men, people living with a disability, people from diverse cultural and religious experiences, socioeconomic status and social circumstances, sexual orientations, health and illness conditions'.[15]

6.1 Abbreviations

Table 10: Abbreviations

ACCO	Aboriginal community-controlled organisation
ACCHO	Aboriginal community-controlled health organisation
CDM	Chronic disease management
CIF	Continuous Improvement Framework
DHS	Department of Human Services, Victoria
GP	General practitioner/general practice
GPG	*Good Practice Guide*
GPRT	General Practice Referral Template (SCTT)
HACC	Home and Community Care
MBS	Medicare Benefits Schedule
PCP	Primary care partnership
SCTT	Service Coordination Tool Templates
TCA	Team care arrangement
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VSCPM	Victorian Service Coordination Practice Manual
WHO	World Health Organization

15 *Doing it with us not for us: Strategic direction 2010–13,* Department of Health, 2009.

6.2 Definitions

Table 11: Definitions

Term	Definition
Authorised representative	An authorised representative can give consent on behalf of an individual who is deemed to be incapable of giving consent, that is, not able to understand the general nature and effect of giving the consent or not able to communicate the consent or refusal of consent. An authorised representative under the *Health Records Act 2001* includes: ■ a guardian ■ an agent under the *Medical Treatment Act 1988* ■ a parent ■ an administrator or person responsible as referred to in the *Guardianship and Administrative Act 1986.* An authorised representative must promote the best interest of the client and act in a way that least restricts that person's freedom. An authorised representative has the legal authority to sign a consent form and make legal decisions for the consumer.[16, 17]
Carer (unpaid)	Carers provide unpaid care and support to a family member or friend who is frail and elderly, has dementia, a mental illness, a disability, a chronic illness or complex needs or receives palliative care. Carers help people to remain living at home. The caring experience is a dynamic one with the level of support offered by carers changing in relation to the dependency and health needs of the care recipient. Carers may be entitled to receive carer allowances through Centrelink.
Care/case coordinator	The nominated person who works with the consumer and carer and other services to facilitate shared care/case planning and service coordination.
Care/case 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 care/case coordinator responsible for liaising between services. Typically developed for consumers with complex needs and multi-service involvement.
Consumer	People who are current or potential users of services. This includes children, women and men, people living with a disability, people from diverse cultural and religious experiences, socioeconomic status and social circumstances, sexual orientations health and illness conditions. (adapted from *'Doing it with us not for us: Strategic direction 2010–13,* Department of Health, Victoria)
Consumer representative	Family, guardian, legal authority, carer.
Decision support tools	Tools that promote clinical care consistent with scientific evidence and client preferences.[18]

16 Department of Health *Quarterly Data Collection Information Systems Service Provider Guidelines* <www.dhs.vic.gov.au/for-service-providers/disability/service-quality-and-improvement/disability-services-performance-reporting/quarterly-data-collection-and-reporting-disability-services/quarterly-data-collection-resources-and-tools>.

17 Department of Human Services *Frequently Asked Questions: Privacy* <www.dhs.vic.gov.au/for-service-providers/disability/service-quality-and-improvement/disability-services-performance-reporting/quarterly-data-collection-privacy-frequently-asked-questions>.

18 Wagner EH, Austin BT, Davis C, Hindmarsh, M, Schaefer J & Bonomi A (2001). 'Improving chronic illness care: Translating evidence into action'. *Health Affairs,* 20(6), pp. 64–78.

Term	Definition
Divisions of general practice/ Medicare Locals	Divisions of general practice are local organisations, funded primarily by the Department of Health and Ageing to improve health outcomes for patients by encouraging GPs to work together and link with other health professionals. Evolving largely from current divisions of general practice and in partnership with other services and service networks, as of July 2011, Medicare Locals will play an important role in service coordination. A key component of the Australian Government's National Health Reforms, Medicare Locals will be primary health care organisations established to coordinate and drive improvements in primary health care and ensure that services are better tailored to meet the needs of local communities. It is expected that there will be a total of 17 Medicare Locals operational in Victoria from July 2012. Medicare Locals will carry out the roles currently undertaken by divisions of general practice, with their scope being expanded to include areas such as population health planning, and providing support to a broad range of primary health care professionals.
Family violence and safety planning	When family violence has been identified, it is important for the safety of the consumer and any children that safety planning occurs. Safety planning is the development of a plan that sets out the steps required to optimise safety for the victim and children. It can refer to any aspect of physical, social, emotional, financial and psychological safety, but it typically involves planning to avoid serious injury, to escape violence (crisis management) and to ensure children's safety to prepare for leaving. As such, a safety planning process usually entails working with the consumer to: ■ identify all family members affected by the violence ■ compile or provide a list of emergency contact numbers ■ provide or identify a safe place for the victim to go to in an emergency ■ identify how the victim will get to the safe place ■ identify friends, family and community members who can provide support ■ ensure cash money is readily available ■ provide or identify a place where consumers can store valuable items and important documents. Victims of family violence should also be made aware that the perpetrator can get information about calls from mobile and landline telephones and pages accessed on the internet. Services should encourage victims to regularly clear the 'recently dialled numbers' log of a mobile telephone and dial another 'safe' number after contacting services via the landline. Victims should also be advised about the safety features on family violence websites that prevent the tracing of viewed pages. Safety planning is done as an interim to referral to an appropriately qualified family violence practitioner.
General practice	General practice provides primary medical health services and may include GPs, practice managers, practice nurses and other allied health/medical specialist services.
General practitioner	General practitioner (GP), Medical practitioner.

Term	Definition
Health promotion	The Ottawa Charter (1986) defines health promotion as: '… the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing.[19]
Health service	*The Health Records Act 2001* states that a health service means: (a) an activity performed in relation to an individual … (i) to assess, maintain or improve the individual's health; or (ii) to diagnose the individual's illness, injury or disability; or (iii) a disability service, palliative care service or aged care service; or (iii) to treat the individual's illness, injury or disability or suspected illness, injury or disability; or … (c) the dispensing on prescription of a drug or medicinal preparation by a pharmacist …
Health literacy	'The cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health' (World Health Organization 1998). Health literacy goes beyond providing information that is in line with people's specific needs (such as providing a pamphlet in another language or using everyday language in brochures). While it builds on these concepts, it also includes the person's ability to seek, understand and act on information.
Integrated health promotion (IHP)	In Victoria, the term 'integrated health promotion' refers to organisations from a wide range of sectors and communities in a catchment working in a collaborative manner using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues.
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.
Nominated person	Nominated person schemes are a feature of contemporary mental health laws in Australia and internationally.[20] A nominated person is a person chosen by the consumer to receive information about their treatment and care. The objective of the nominated person scheme is to improve information sharing with a person's carer, family or friend and to promote their involvement in treatment, care and recovery decisions.
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 or clinician.

19 World Health Organization (1986), *The Ottawa Charter for Health Promotion,* Geneva.

20 Department of Health, *Exposure draft mental health bill 2010 explanatory guide* Mental Health, Drugs and Regions Division, Victorian Government Department of Health, Melbourne, Victoria, Australia, 2010.

Term	Definition
Primary care partnership	A primary care partnership (PCP) is a group of services that has 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 service provider to: ■ know their condition and various options ■ negotiate a plan of care ■ engage in activities that protect and promote health ■ monitor and manage the symptoms and signs of the conditions ■ manage the impact of the condition on physical functioning, emotions and interpersonal relationships.
Service provider	An organisation providing services to health and human services consumers.

6.3 Manual development

The initial *Victorian Service Coordination Practice Manual* (VSCPM) was developed in 2006 as part of the Service Coordination Practice Manual project, which was an initiative of the statewide Primary Care Partnership Chairs Working Group, and funded by the Department of Human Services Primary Health Branch. As part of a continuous improvement and revision process, the VSCPM was updated in 2009 to align with the release of SCTT 2009.

In 2011, a more comprehensive update was commissioned by Victorian Primary Care Partnerships with funding from the Department of Health. This review involved consultation with a broad range of service delivery areas, including areas that had not previously been included in the process, such as Aboriginal community-controlled organisations, the disability sector, and the mental health, family violence and homelessness sectors.

The consultation that informed the 2011 review involved interviews with stakeholders from key areas, an electronic survey sent to all PCPs for distribution to their member organisations, and workshops with PCP service coordination staff and Project Reference Group members.

The findings of this consultation indicated that:

- service coordination is being implemented variably across Victoria
- service providers value the *Victorian Service Coordination Practice Manual* and were able to identify opportunities for further improvement of the manual and its associated resources
- areas new to involvement in the review process identified that the manual had the potential to provide a service coordination framework
- the language and philosophy underpinning the manual required some broadening to allow the manual to be applicable to and inclusive of sectors previously not included in the review process.

The 2011 VSCPM review has been undertaken in collaboration with the SCTT 2012 revision process.

The SCTT, VSCPM and associated resources will continue to be updated in accordance with the three-year continuous improvement cycle, to reflect the broad range of services participating in service coordination.

Governance and steering committee

The project was overseen by the statewide Primary Care Partnerships Executive and a Project Reference Group whose membership is listed in Table 12.

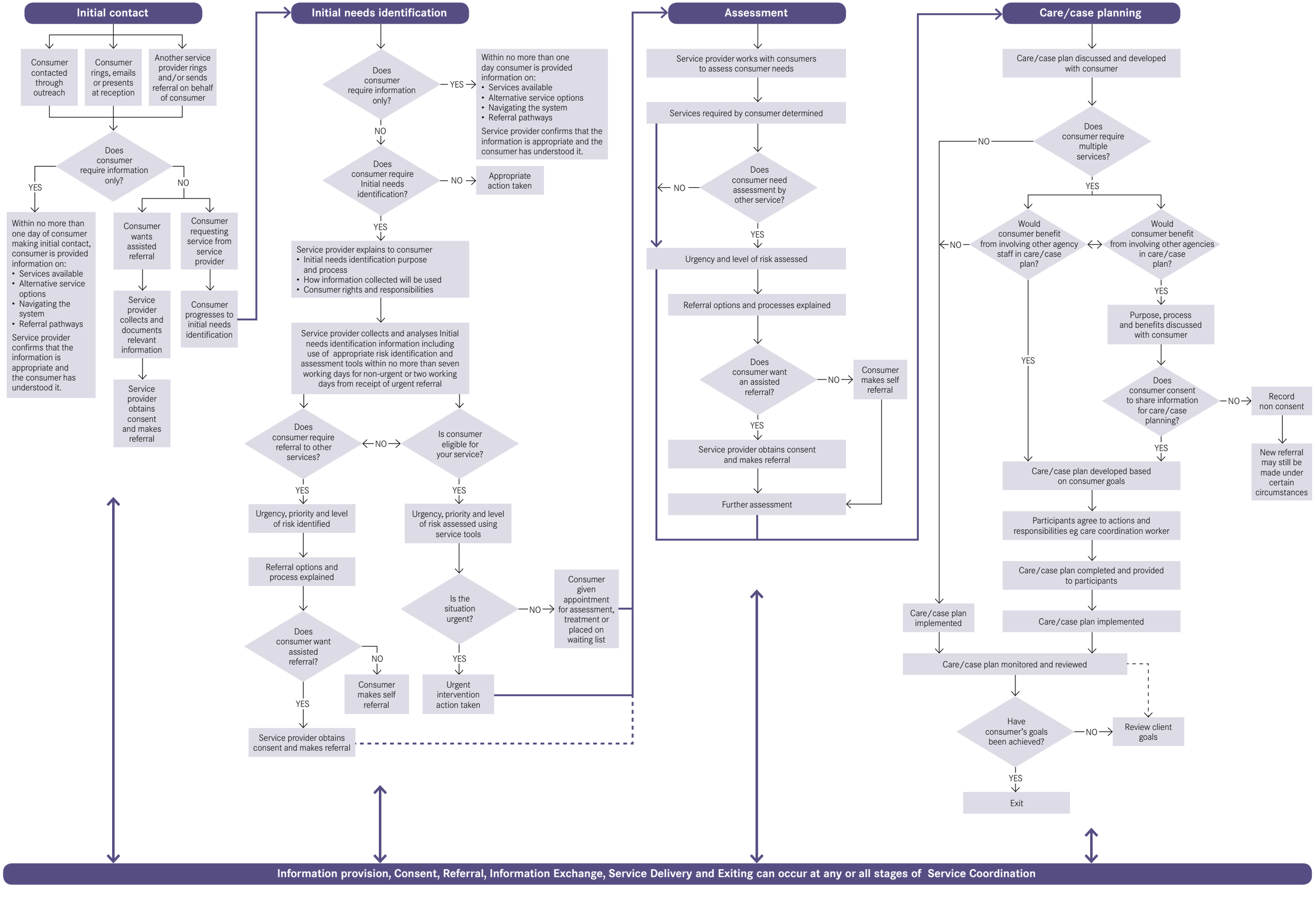
Table 12: Project reference group members

Name	Representing
Erin Armstrong	Department of Education and Early Childhood Development
Megan Buick	General Practice Victoria
Irene Bouzo	Ethnic Communities' Council of Victoria
Tony Cavedon	Uniting Care Community Options (Disability)
Graeme Fletcher	Victorian Aboriginal Community Controlled Health Organisations
Christopher Foley-Jones	Inner East Primary Care Partnership
Gavin Foster	Mental Health Turning Point Alcohol and Drug Program
Joanne Gell (Chair)	Statewide PCPs Chairs' Executive
Bronwyn Hogan	Southern Mallee Primary Care Partnership
Wina Kung	Uniting Care Community Options (Aged care)
Shelly Lavery	Integrated Care Branch, Department of Health
Kerry Oates	Royal District Nursing Services
Clare O'Reilly	Statewide PCPs Chairs' Executive
George Robinson	Central Bayside Community Health Services
Rachael Scott	Uniting Care Community Options (Disability)
Patricia Stannus	Statewide PCPs Chairs' Executive
Annelies Strietman	Pyrenees Shire Council
Marcus Tansing	Division of Housing and Community Building, Department of Human Services
J White	Peninsula Health Integrated Chronic Disease Management

The project consultant for the 2011 review of the VSCPM and associated resources was Alison Boughey.

6.4 Feedback

Do you have comments or feedback about this manual?

Please contribute to the next update by providing your feedback online via the link at the Victorian Healthcare Association website <www.vha.org.au>.

Consumer pathway through Victoria's Service Coordination Model