Continuous Improvement Framework 2012

A resource of the *Victorian Service Coordination Practice Manual*

A STATEWIDE PRIMARY CARE PARTNERSHIPS INITIATIVE

Service coordination publications

1. Victorian Service Coordination Practice Manual
2. Good Practice Guide
3. Continuous Improvement Framework
4. SCTT 2012 User Guide

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A statewide primary care partnerships initiative

Published by statewide Primary Care Partnerships, Victoria.

June 2012

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

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

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

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1. Introduction

1.1 Service coordination

Service coordination places consumers at the centre of service delivery to 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 stems from *Better Access to Services: A Policy and Operational Framework* (DHS, 2001).[1] The operational elements of service coordination, as described in the *Better Access to Services Framework,* are initial contact, initial needs identification, assessment and care/case planning.

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

1.2 A service coordination implementation tool

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

- support service providers to monitor and continuously improve their service coordination implementation and practice
- enable an agreed process for organisations to monitor service coordination implementation for reporting and planning purposes
- assist program areas that are new to service coordination to assess their readiness and identify required systems, infrastructure and practice changes
- provide a mechanism for organisations to assess and improve compliance with service coordination practice standards, if the need arises
- use of the *Continuous Improvement Framework* can support organisational quality and accreditation processes.

The *Continuous Improvement Framework* is based on:

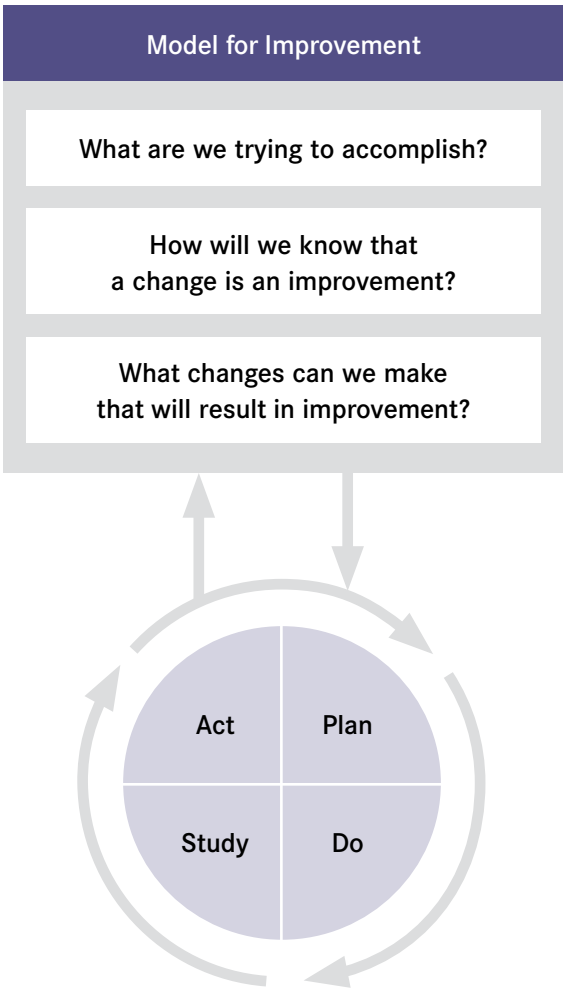
- the Model for Improvement – a simple yet effective tool for implementing changes for improvement
- the knowledge that service providers already have quality assurance systems in place and the *Continuous Improvement Framework* will complement but not replicate these
- the assumption that all service providers regularly undertake self-assessment performance review processes using the service coordination good practice indicators and practice standards contained in the *Victorian Service Coordination Practice Manual*
- recognition that continuous improvement criteria for service coordination may change as implementation of service coordination evolves and develops.

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

1.3 The Model for Improvement

The Model for Improvement[2] is a simple yet effective tool for implementing changes for improvement. It consists of two parts, a thinking part and a doing part, and is used to test incremental changes for improvement.

By testing changes on a small scale, consecutive improvement cycles can be used to collect information about the effectiveness of these incremental changes. This cyclic process allows the quality improvement work to be broken down into smaller portions that consistently move projects forward. By working small in terms of scope, the impact of change can be managed. For example, if what is tried does not work as well as planned, you can always go back to the way things were done and try something different. When you have built up enough information, you will have built up enough confidence to implement the required change.



Reference: Langley G. Nolan K. Norman C. Provost L (1996), *The improvement guide: a practical approach to enhancing organisational performance,* Jossy Bass Publishers, San Francisco.

2 The Improvement Model, developed by Langley, Nolan, Norman and Provost.

1.3.1 The 'thinking' part of the Model for Improvement – the three questions

The thinking part consists of the three fundamental questions for achieving improvement. People tend to want to jump straight to the 'solution' rather than really work out what the root of the problem is. If you use these three fundamental questions it will help to ensure you are dealing with the issue that really needs to be addressed. These questions guide the improvement work and lead to the action part on the improvement cycle, known as PDSA (plan, do, study, act).

1. What are we trying to accomplish? (goal)

   To answer this question you will need to write a clear and concise goal for improvement. Identify the objective in simple language that is easy to understand.

2. How will we know that a change is an improvement? (measurement)

   Measurement is fundamental to answering this question. The objective should be quantitatively measurable if possible. While some improvements may feel intuitively a good thing, it's always best to make sure that you can prove that the change was an improvement. Without measurement, how do we know if what we have done has led to an improvement?

3. What changes can we make that can lead to an improvement? (ideas for change)

   To answer this question you will need to decide what ideas you will test in order to obtain your goal. Remember, your change should be able to bring about differences that are measurable. This is where you generate ideas that may lead to an improvement.

1.3.2 The 'doing' part of the Model for Improvement – the PDSA cycle

The second part of the model represents the 'doing' part. PDSA is a rapid quality improvement activity. It was developed in the early 1990s by Langley et al. as a way to approach and break down change into manageable components, testing each small part to make sure services are improving and no effort is wasted. First published in *The improvement guide: a practical approach to enhancing organisational performance* (1996) it is a proven approach to achieving successful change management.

Facts about the Model for Improvement

No PDSA is too small.

You should expect to complete a series of PDSAs to reach your goal.

You can achieve rapid results.

Small rapid cycles of PDSA help you to be systematic and to learn from your work.

Aim big, test small.

Selecting the correct measure is important – measures demonstrate effectiveness of any tested changes

Just do it (think 'What can be done by next week?' and so on).

Teams can achieve a lot more than an individual. Including the right people on a process improvement team is critical to a successful improvement effort.

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

Most of all, keep it simple.

2. Using the *Continuous Improvement Framework*

2.1 Components of the *Continuous Improvement Framework*

The *Continuous Improvement Framework* comprises:

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

2.2 Performance-rating scale

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

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

2.3 Process for implementation

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

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

3. Service Coordination Continuous Improvement Framework

3.1 Overview

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

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

There are eight criteria:

- **Criterion one** relates to implementation of service coordination at a systems level, that is, across organisations
- **Criterion two** relates to service coordination at an organisational level, that is, across multiple programs within an organisation
- **Criteria three to eight** relate to service coordination at a practice level. If your agency does not implement particular elements of service coordination, then you would not complete the checklist.

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

In applying the *Continuous Improvement Framework*, organisations should ask the questions:

- How can our agency demonstrate that this occurred?
- What evidence is there to support this?
- How can we improve in this area?
- What action can we take to improve?

3.2 Service coordination continuous improvement criteria

Systems level	
Criterion 1:	There is substantial evidence that service coordination elements are embedded within organisational operations and practice.
Agency level	
Criterion 2:	There is substantial evidence that service coordination has been integrated and accepted in all relevant program areas within an individual organisation and is embedded into usual practice.
Practice level	
Criterion 3:	There is substantial evidence that **initial contact** with consumers, has occurred in accordance with Victorian service coordination practice standards.
Criterion 4:	There is substantial evidence that the **initial needs identification** process has occurred in accordance with Victorian service coordination practice standards.
Criterion 5:	There is substantial evidence that the **assessment** process has occurred in accordance with Victorian service coordination practice standards and program-specific guidelines and requirements.
Criterion 6:	There is substantial evidence that **care/case planning** has occurred with consumers and service providers participating in their care in accordance with the Victorian service coordination practice standards.
Criterion 7:	There is substantial evidence that **Additional Processes** including information provision, consent, referral, information exchange, service delivery and exiting have occurred in accordance with the Victorian service coordination practice standards.
Criterion 8:	There is substantial evidence of compliance with privacy and consent requirements.

Terminology: What is substantial evidence?

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

3.3 Service coordination systems criterion

Criterion 1: There is substantial evidence that service coordination elements are embedded within organisational operations and practice.

What this means: Organisations and services continue to operate as independent entities under their existing organisational and structural arrangements while working collaboratively on processes to ensure coordinated services for consumers.

Criterion 1: There is substantial evidence that service coordination elements are embedded within organisational operations and practice. *You may wish to address this criteria in consultation with other organisations within your network or with which you have partnerships.*	Met	Partially met	Not met	Not applicable
Look for the points of evidence, listed below.				
1.1 Service providers have documented service coordination policies that reflect the requirements of the *Victorian Service Coordination Practice Manual.*				
1.2 Service providers participate in regular reviews of service coordination implementation.				
1.3 Coordination priorities are informed by the full range of relevant and available data.				
1.4 There are structures in place to continually discuss, plan, measure, evaluate and improve service coordination implementation at: ■ a strategic level ■ an operational level.				
1.5 Service providers have agreed benchmarks for the target level of electronic referral.				
1.6 There are procedures and systems in place to facilitate access to initial contact, initial needs identification, assessment, care/case planning, referral and service delivery within and between service providers.				
1.7 There are agreements and processes in place within and between services, including GPs, for communication, information sharing, care pathways, referral, information exchange and exiting.				

3.4 Service coordination agency criterion

Criterion 2: There is substantial evidence that service coordination has been integrated and accepted in all relevant program areas within an individual organisation and is embedded into usual practice.

What this means: Individual service providers are implementing service coordination in all relevant program areas and service coordination is accepted as the usual way of doing business

Criterion 2: There is substantial evidence that service coordination has been integrated and accepted in all relevant program areas within an individual organisation and is embedded into usual practice. (The points of evidence under Criterion 2 relate to the Practice standards for all elements of service coordination – see Section 3.2 of the VSCPM.)	Met	Partially met	Not met	Not applicable
Look for the points of evidence, listed below.				
2.1 Access and intake structures facilitate streamlined and integrated access to information and services.				
2.2 The service provider has integrated service coordination practice standards and program requirements into organisational policy.				
2.3 The service provider has integrated service coordination roles, responsibilities and requirements into work plans and position descriptions.				
2.4 The service provider has integrated service coordination roles, responsibilities and requirements into performance appraisal systems.				
2.5 The workforce development or training plan of the organisation includes professional development and training activities related to service coordination.				
2.6 The service provider has integrated service coordination roles, responsibilities and requirements into meeting agendas.				
2.7 The service provider has made available to workers documented service delivery procedures and work instructions covering: ■ initial contact ■ initial needs identification ■ assessment ■ care/case planning ■ additional processes.				
2.8 The service provider ensures that training is available for practitioners to complete the *Service Coordination Tool Templates (SCTT).*[3]				
2.9 The service provider promotes and has established targets for the use of electronic referral.				
2.10 Service coordination data is regularly analysed and used by the organisation in planning processes.				
2.11 The service provider has integrated service coordination principles into consumer feedback systems, for example: ■ surveys of consumer satisfaction or experience ■ complaints procedures ■ informal mechanisms.				
2.12 The service provider has integrated service coordination practice standards and program requirements into quality improvement processes.				
2.13 The service provider maintains up-to-date information about its services, eligibility criteria, priority of access requirements and waiting times in service directories such as the Human Services Directory.				
2.14 The organisation has systems and guidelines in place to respond to situations where family violence has been identified.				

3 In accordance with the *SCTT 2012 User Guide* (Department of Health, 2012)

3.5 Service coordination implementation criteria

Criterion 3: There is substantial evidence that initial contact with consumers has occurred in accordance with Victorian service coordination practice standards.

What this means: **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.

Criterion 3: There is substantial evidence that initial contact with consumers has occurred in accordance with Victorian service coordination practice standards.	Met	Partially met	Not met	Not applicable
Look for the points of evidence, listed below.				
3.1 Consumers have been provided with information about services available in response to their enquiry or as part of an outreach approach, such as: when and where the service is provided, eligibility or access criteria, and how to make an appointment, within 1 working day of making contact (VSCPM Section 3.3.3).				
3.2 Consumers have been asked following their initial enquiry if there is any other information or assistance they require.				
3.3 Consumers have been provided with information about services provided by other organisations; for example, through the use of the Better Health Channel/Human Services Directory and other service directories (VSCPM Sections 3.3.3 and 1.1).				
3.4 Consumers have been provided with information in a manner appropriate to cultural, communication and cognitive needs (VSCPM Sections 4.1 and 4.7).				
3.5 The initial contact process has resulted in a decision about proceeding to initial needs identification or referral.				
3.6 Relevant SCTT have been completed in accordance with the *SCTT 2012 User Guide* (VSCPM Section 3.2).				
3.7 Consumers have been provided with privacy information, such as a brochure, and the service provider has ensured the consumer understands the information (VSCPM Section 3.2).				
3.8 Action taken as a result of the initial contact process such as service provision or referral has occurred and been documented.				
3.9 Action has been taken to resolve immediate issues for the consumer experiencing a crisis or emergency (VSCPM Section 3.2).				
3.10 Staff undertaking initial contact have completed the Service Coordination Online Learning Module <www.health.vic.gov.au/pcps/workforce> or attended service coordination training, and know how to use statewide and local service directories (VSCPM Sections 5.5 and 5.6).				
3.11 Service providers have a process to ensure that staff undertaking initial contact are competent and have the ability to communicate effectively about internal and external services (VSCPM Section 3.2).				
3.12 Consumer records indicate that all consumers have been asked if they identify as being of Aboriginal and/or Torres Strait Islander origin (VSCPM Section 3.3.3).				

Criterion 4: There is substantial evidence that the initial needs identification process has occurred in accordance with Victorian service coordination practice standards

What this means: 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, client-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.

Criterion 4: There is substantial evidence that the initial needs identification process has occurred in accordance with Victorian service coordination practice standards.	Met	Partially met	Not met	Not applicable
Look for the points of evidence, listed below.				
4.1 An explanation of the initial needs identification process has been provided to consumers, including the reason for the process and what will be covered (VSCPM Section 3.4.3).				
4.2 The service provider has conducted initial needs identification within 7 working days of initial contact (VSCPM Section 3.4.3).				
4.3 The consumer has been provided with the opportunity to participate in a broad-based screening process early in their contact with the service system, in a manner appropriate to cultural, communication and cognitive needs (VSCPM Section 3.4.3).				
4.4 Consumer records indicate where consumers did not wish to participate in a broad-based screening process, and any reasons for this have been documented.				
4.5 Consumer records indicate that consumers' underlying and presenting issues have been documented through the initial needs identification process (VSCPM Section 3.4.1).				
4.6 The initial needs identification process has resulted in opportunities for intervention and information provision early in consumers' contact with the service system (VSCPM Section 3.4.1).				
4.7 Relevant SCTT have been completed in accordance with the *SCTT 2012 User Guide* (VSCPM Section 3.2).				
4.8 The initial needs identification process has resulted in decisions as to further referrals and assessments required, and information has been provided to consumers about these options (VSCPM Section 3.4.3).				
4.9 Where appropriate, action arising from the initial needs identification process has occurred and been documented.				
4.10 Consumer consent to disclose personal information has been gained for referrals arising from the initial needs identification process (VSCPM Section 4.2).				
4.11 Where SCTT have been used for referral, they have been used in accordance with established policies (system-wide or organisational policy) and the *SCTT 2012 User Guide* (VSCPM Section 3.2).				
4.12 Staff undertaking initial needs identification have completed the Service Coordination Online Learning Module <www.health.vic.gov.au/pcps/workforce> or attended service coordination training, and know how to use statewide and local service directories (VSCPM Sections 5.5 and 5.6).				
4.13 Service providers have a process to ensure that staff undertaking initial needs identification are qualified and have advanced interviewing skills (VSCPM Section 3.4.2).				
4.14 Consumers have been given information about complaints and grievance processes.				
4.15 Consumer records indicate that all consumers have been asked if they identify as being of Aboriginal and/or Torres Strait Islander origin (VSCPM Section 3.3.3).				

Criterion 5: There is substantial evidence that the assessment process has occurred in accordance with Victorian service coordination practice standards and program-specific guidelines and requirements.

What this means: 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.

Criterion 5: There is substantial evidence that the assessment process has occurred in accordance with Victorian service coordination practice standards and program-specific guidelines and requirements.	Met	Partially met	Not met	Not applicable
Look for the points of evidence, listed below.				
5.1 The initial needs identification process leads to assessment that has guided responsive interventions for consumers (VSCPM Section 3.5.1).				
5.2 Service providers have a process to ensure that practitioners undertaking assessments are skilled, qualified and competent to perform the role (VSCPM Section 3.5.3).				
5.3 Assessment activity is integrated and the potential for duplication of assessment has been reduced through the sharing of consumer information (with consumer consent) (VSCPM Section 4.2).				
5.4 Where a waiting period between the referral and assessment occurs, the health and wellbeing of consumers has been monitored[4] according to risk (VSCPM Section 4.7).				
5.5 Consumer records or peer review processes indicate that the assessment process has occurred in accordance with the accepted practice standards and guidelines for the particular discipline or program area (VSCPM Section 3.5.4).				
5.6 Relevant SCTT have been completed in accordance with the *SCTT 2012 User Guide* (VSCPM Section 3.2).				
5.7 Assessments are documented in a standardised, common format and identify: ■ needs beyond the presenting issue ■ consumer-stated issues and aspirations ■ consumer capability for self-management and behaviour change (VSCPM Section 3.5.4).				
5.8 The outcomes of the assessment have been clearly documented and are evident in the care/case plan goals (VSCPM Section 3.6.4).				
5.9 The need for re-assessment has been considered, and if appropriate, review dates noted (VSCPM Section 3.6.10).				
5.10 Consumers have been given the opportunity to discuss the findings of the assessment in a manner appropriate to cultural, communication and cognitive needs, with the assessing practitioner (VSCPM Section 3.5.4).				
5.11 Consumers have been given the opportunity to discuss options for support and services, including those provided by other agencies, in a manner appropriate to cultural, communication and cognitive needs, with the assessing practitioner (VSCPM Section 3.5.4).				
5.12 Consumers have been given information about complaints and grievance processes.				
5.13 The outcomes of assessment are communicated to consumers and, with consumer consent, other participants in their care such as the GP (VSCPM Sections 3.5.4 and 4.4.1).				

4 A referring agency retains responsibility for monitoring a consumer between a referral and action by the receiving agency. The extent and detail of the monitoring will be based on the target group and risk factors and documented in agency procedures.

Criterion 6: There is substantial evidence that care/case planning has occurred with consumers and service providers participating in their care in accordance with the Victorian service coordination practice standards.

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 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.

Criterion 6: There is substantial evidence that care/case planning has occurred with consumers and service providers participating in their care in accordance with the Victorian service coordination practice standards.		Met	Partially met	Not met	Not applicable
Look for the points of evidence, listed below.					
6.1	Consumer records demonstrate that care/case planning has occurred following assessment (VSCPM Section 3.6).				
6.2	Consumer consent to share information has been recorded prior to care/case planning discussions occurring with other participants or service providers (VSCPM Section 3.6.8).				
6.3	Consumer records indicate that the consumer and service provider have discussed the benefits and purpose of the care/case plan, in a manner appropriate to cultural, communication and cognitive needs (VSCPM Sections 3.6.3 and 3.6.8).				
6.4	Consumer records demonstrate that care/case plans include the following 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) (VSCPM Section 3.6.5).				
6.5	Service-specific care/case plans have been used where a consumer has one or more issues that can be managed with the support of a single program area (VSCPM Section 3.6.1).				
6.6	Care/case plans have been based on all available assessment information and taken into account the full-range of consumer needs (beyond presenting issues) as well as their expressed, wishes, values and circumstances (VSCPM Section 3.6.3).				
6.7	Service providers have policies and protocols to guide a person-centred approach to care/case planning, including that the consumer, carer and advocate are actively supported to participate in the care/case planning processes, unless they choose not to (VSCPM Section 3.6.3).				
6.8	Specific and measurable goals have been written from the consumer's perspective, in relation to each identified need (VSCPM Section 3.6.4).				
6.9	Care/case planning goals demonstrate that the consumer has been empowered to make decisions about their care and support (VSCPM Section 3.6.4).				
6.10	The name of the person or service responsible for implementing each care/case plan action has been clearly documented (VSCPM Section 3.6.8).				
6.11	Consumer records indicate that GPs are included in care/case planning where relevant (VSCPM Section 3.6.9).				
6.12	Consumer records indicate that care/case plan reviews have occurred when a consumer's needs or circumstances change (VSCPM Section 3.6.8).				
6.13	Consumer records indicate that planned reviews have occurred within one month of the date listed for review (unless the service provider procedures states otherwise) (VSCPM Section 3.6.8).				

Criterion 6: There is substantial evidence that care/case planning has occurred with consumers and service providers participating in their care in accordance with the Victorian service coordination practice standards.	Met	Partially met	Not met	Not applicable
Look for the points of evidence, listed below.				
6.14 Consumers are provided with a copy of their care/case plan, where appropriate, in a format which they can easily understand (VSCPM Section 3.6.8).				
6.15 Service providers have a system for recall, reminder, monitoring and review of care/case plans (VSCPM Section 3.6.10).				
6.16 Service providers have in place processes for planning and communicating exit or discharge, and consumer exit or discharge processes have been recorded, including the reason for exit or discharge (VSCPM Section 3.6.10).				
6.17 Consumer feedback processes indicate that consumers feel supported to participate in the care/case planning process and are provided with information to assist in decision-making (VSCPM Section 3.6.8).				
6.18 Consumer feedback processes indicate that consumers are provided with information about exit, discharge and re-entry (VSCPM Section 3.6.10).				
The items below relate to shared care/case planning.				
6.19 Service providers have practices and systems for early identification of consumers with multiple or complex needs (VSCPM Section 3.6.10).				
6.20 Consumer records indicate that shared care/case plans have been used with consumers who have numerous issues that require the coordinated support of multiple program areas from within a single organisation (VSCPM Section 3.6.1).				
6.21 Service providers have in place agreed systems for communicating between organisations and processes for referral, information exchange and shared care/case planning (VSCPM Section 3.6.10).				
6.22 Consumer records indicate that shared care/case plans have been used with consumers who have numerous issues that require coordinated support between two or more separate organisations (VSCPM Section 3.6.1).				
6.23 Consumer records indicate shared care/case plans have been documented for consumers with complex or multiple needs using the SCTT *Shared Support Plan* Template, in accordance with the *SCTT 2012 User Guide,* including: ■ all the participants in care/case planning, contact details and their role are listed on the plan (VSCPM Section 3.6.8) ■ a care/case coordinator who is responsible for communication, monitoring and review of the care/case plan, in accordance with agreed policy and procedures (VSCPM Section 3.6.6 and 3.6.8) ■ with consumer consent, all the participants in care/case planning, including the consumer's GP, have been offered a copy of the plan (VSCPM Section 3.6.8).				
6.24 Service providers have an agreed process with other organisations for developing shared care/case plans and identify, nominate, train and support care/case coordinators (VSCPM Section 3.6.10).				
6.25 Consumer records indicate that shared care/case planning meetings have occurred to support and monitor implementation of the care/case coordination plan, and individual practitioners have provided feedback to the care/case coordinator (where available) in relation to the progress and outcome. (VSCPM Section 3.6.10).				

Criterion 7: There is substantial evidence that additional processes have occurred in accordance with the Victorian service coordination practice standards

What this means: Additional processes include information provision, consent to share consumer information, referral, information exchange, service delivery and exiting. These processes may occur at any and all stages of the service coordination process.

Criterion 7: There is substantial evidence that additional processes have occurred in accordance with the Victorian service coordination practice standards.	Met	Partially met	Not met	Not applicable
Look for the points of evidence, listed below.				
7.1 Consumer records indicate that referrals have occurred within the specified timeframe following initial needs identification, assessment or care plan review (VSCPM Sections 3.4.3, 3.5.4 and 3.6.10).				
7.2 Consumer records indicate that consent to disclose personal information for referral purposes has been documented (VSCPM Section 4.2).				
7.3 Consumers are provided with a copy of referral and consent documentation, if requested.				
7.4 Relevant SCTT have been completed in accordance with the *SCTT 2012 User Guide* (VSCPM Section 4.3.2).				
7.5 Consumer records indicate that referrals prioritised as urgent have been sent within no more than 1 working day of obtaining consumer consent (VSCPM Section 4.7).				
7.6 Consumer records indicate that referrals prioritised as non-urgent have been sent within no more than 7 working days of obtaining consent (VSCPM Section 4.7).				
7.7 Receiving service providers have transmitted a referral acknowledgement to the referring service provider for urgent referrals within no more than 2 working days of receiving the referral (VSCPM Section 4.7).				
7.8 Receiving service providers have transmitted a referral acknowledgement to the referring service provider for non-urgent referrals within no more than 7 working days of receiving the referral (VSCPM Section 4.7).				
7.9 Receiving service providers have completed and transmitted the referral outcome information to the initiating service within no more than 14 working days of the consumer being assessed (VSCPM Section 4.7).				
7.10 Communication and/or information exchange with the consumer's GP has occurred as relevant (VSCPM Section 4.4.1).				
7.11 Consumer records indicate that where there is a waiting period between referral and service access, alternative options and choices have been discussed with consumers (VSCPM Section 4.7).				
7.12 Consumer records indicate that where there is a waiting period between the referral and subsequent action, the health and wellbeing of consumers have been monitored in accordance with program guidelines and organisational procedures (VSCPM Section 4.7).				

Criterion 8: There is substantial evidence of compliance with privacy and consent requirements.

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

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. If this is not possible or reasonably practical, health information can still be shared in circumstances set out under Health Principle 2.2 of the *Health Records Act 2001.* For further circumstances for disclosure, see: <www.health.vic.gov.au/hsc/infosheets/disclosure.pdf>.

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.

Criterion 8: There is substantial evidence of compliance with privacy and consent requirements.	Met	Partially met	Not met	Not applicable
Look for the points of evidence, listed below.				
8.1 Consumer records indicate that consumer consent processes occur using the SCTT *Consumer Consent to Share Information* Template in accordance with the *SCTT 2012 User Guide* for all referrals and care/case planning discussions requiring the disclosure of personal information. This includes: ■ a record of proposed information use and disclosure ■ a record of consumer consent, either written or verbal ■ an explanation about the use of the information and rights, including provision of a privacy brochure such as *Your information – It's private* in a format the consumer can understand (VSCPM Section 4.7).				
8.2 Consumer records indicate that where consent has not been given, this is clearly documented along with any action arising and confirmation that the consumer is aware of any implications as a result of not providing consent (VSCPM Section 4.7).				
8.3 Service provider policies and procedures have documented the requirements for situations in which consumer consent is not required or is provided by another person (VSCPM Sections 3.2 and 4.2).				
8.4 Service providers have access to training and information about privacy and consent requirements (VSCPM Section 3.2).				
8.5 Service provider information management systems, policies and procedures comply with privacy requirements in relation to the collection, use, disclosure, storage and disposal of a consumer's personal information, including e-referral systems (VSCPM Section 3.2).				
8.6 Service provider processes indicate that information has been provided to any consumer who feels that a breach of their privacy may have occurred.				
8.7 The service provider shares information in accordance with the *Victorian Health Records Act,*[5] and other requirements such as *Duty of Care,*[6] *Mandatory Reporting*[7] and *Information Sharing Guidelines*[8] (VSCPM Section 3.2).				

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

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

7 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>.

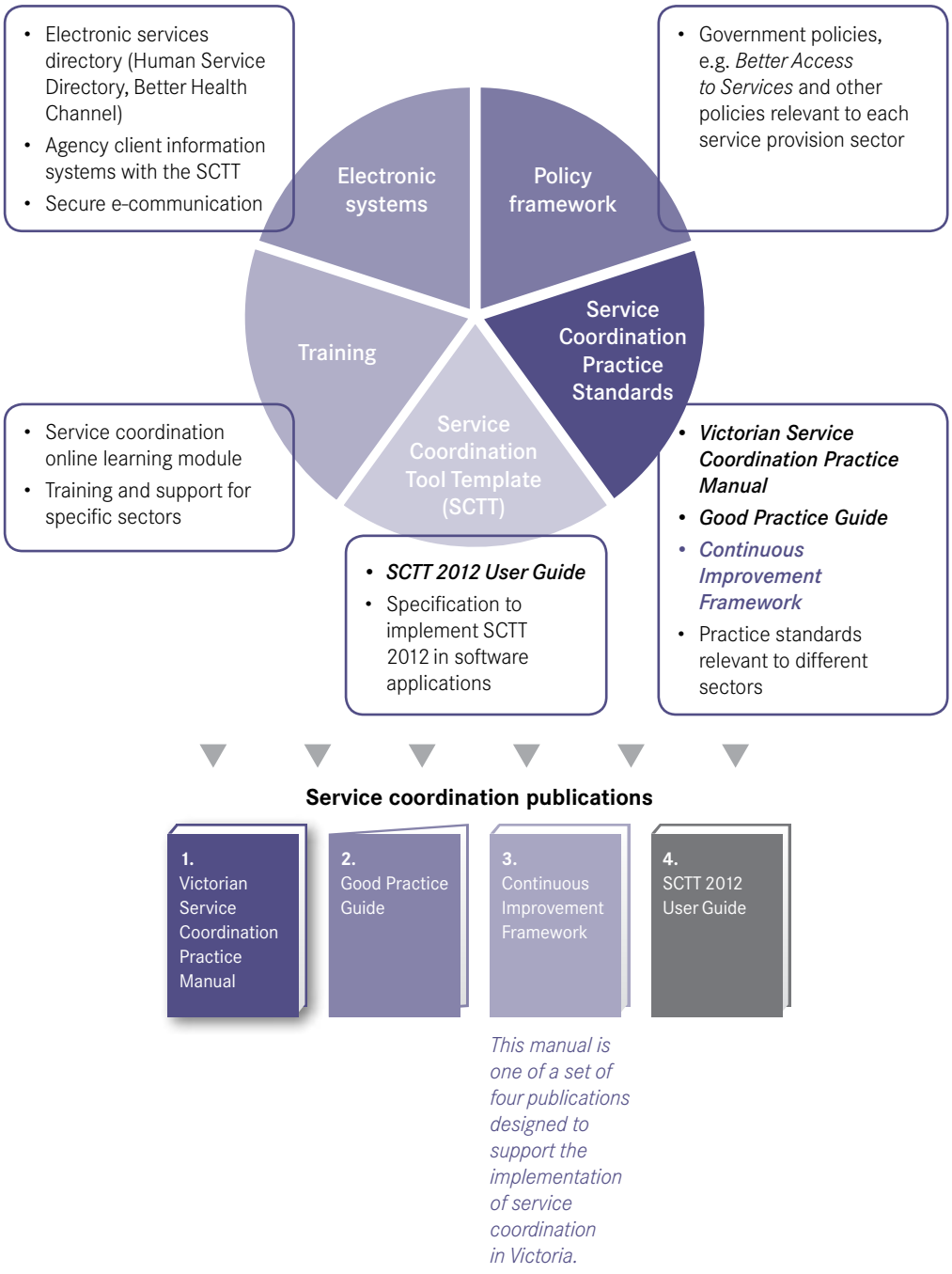
8 Victorian information sharing guidelines: <www.cyf.vic.gov.au/every-child-every-chance/library/publications/information-sharing-guidelines>.

4. Other information

4.1 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 as outlined in Figure 1.

Figure 1: Supports for implementation of service coordination



4.2 Terminology

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'.[9]

Abbreviations

DHS	Department of Human Services
EQuIP	Evaluation and Quality Improvement Program
GP	General practitioner/general practice
HACC	Home and Community Care
PCP	Primary care partnership
PDSA	Plan Do Study Act
QICSA	Quality Improvement and Community Services Accreditation
SCTT	Service Coordination Tool Templates
VSCPM	Victorian Service Coordination Practice Manual

Definitions

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.[10, 11]

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

10 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>.

11 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>.

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.[12]
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.

12 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.

Family violence and safety planning

When family violence has been identified, it is important for the safety of the client 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 client 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.

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.[13]

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

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.[14] 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.

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

14 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.

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.

4.3 Development of the *Continuous Improvement Framework*

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

A comprehensive consultation and review of The *Victorian Service Coordination Practice Manual, Good Practice Guide for Practitioners* and the *Continuous Improvement Framework* was commissioned by statewide PCPs in 2011 with funding from the Department of Health. The 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, the mental health, family violence and homelessness sectors. This process was undertaken in collaboration with the SCTT 2012 revision process.

The project was overseen by the statewide Primary Care Partnerships Executive and a Project Reference Group whose membership is listed in Table 12 of the *Victorian Service Coordination Practice Manual.*

Your feedback is welcome

Do you have comments or feedback about this manual?

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

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