



South West Region

Service Coordination Plan

Guidelines for Use

Developed in consultation with: the Primary Care Service Coordination sub Committee of SWARH and South West & Southern Grampians PCP agency staff.

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1.0 BACKGROUND

The Service Coordination Plan is one of the Service Coordination Tool Templates (SCTT). It should be used for consumers with complex needs who are receiving multiple services.

It provides for a list of agencies/ services involved and contact person and identifies a key worker/ case manager. It also includes a series of prompts for the collation or collection of evidence of consumer needs, a description of the consumer's problems/ issues, associated goals and action to be taken with a target date.

Up until now, the focus of the Regional Service Coordination Steering group (the SWARH Primary Care and Service Coordination Committee) has been on the Initial Needs Identification (INI) and referral aspects of service coordination.

While some agencies in the South West region have used the Service Coordination Plan, the SWARH Primary Care and Service Coordination Committee has only recently taken a formal position on its use and has established a working group to facilitate the development of guidelines. The working group comprised two case managers, a community health nurse, a Home and Community Care coordinator, an acute hospital discharge planner, an Aged Care Assessment Service manager, a representative from the Otway Division of General Practice and Service Coordination staff. The working group met twice and has developed the following guidelines.

These guidelines provide the agreed practice for developing and maintaining a Service Coordination Plan (SCP) using the DHS Service Coordination Tool Templates (SCTT).

2.0 PRINCIPLES

The following principles underpin the implementation of the Service Coordination Plan:

- Agencies, where appropriate, should use the Service Coordination Plan for coordinating services where the consumer has complex needs, is receiving multiple services, has multiple problems which need to be addressed concurrently and is likely to have an improved outcome if services are coordinated.
- The consumer and/ or carer must give their consent prior to the preparation of a Service Coordination Plan, sharing information with other services, and must consent to the content of the Plan and to any changes to the Plan.
- A Key Worker will be appointed to coordinate services for the consumer, and any changes to service delivery will be reported to the Key Worker.
- The SCP is used in addition to the INI tool templates, assessment and referral tools and complements individual service plans such as a nursing care plan or a full case manager's plan. It is completed on the basis of the full range of material gathered to inform decisions on meeting the consumer's needs.

3.0 WHEN TO USE THE SERVICE COORDINATION PLAN

The Service Coordination Plan should be used for a consumer with complex needs who is receiving services from more than one agency and more than one discipline (DHS Guidelines).

The SCP is designed to allow consumers and carers to discuss their needs with service providers, GPs or others to address issues of consent and agree on plans to meet the consumer's needs.

The working group identified current or potential use of the SCP in instances such as:

- people with complex needs discharged from hospital,
- people receiving extended aged care at home,
- people with disabilities requiring multiple services and care,
- people experiencing "repeat issues" where issues have not been fully addressed and there are recurring problems.

In the discharge planning process the SCP could form the basis of discussion at a family meeting. It can provide a more comprehensive plan than a discharge plan.

For a case manager or key worker, the SCP is a good planning tool as it includes goals, action required, and target dates which can improve care and accountability. Since the SCP records all the participants involved in a consumer's care and their contact details, it makes for more effective communication, especially if the consumer's circumstances change (e.g. admitted to hospital). A case manager may have a very detailed case management plan/ care plan; the SCP can be used as a summary of care and key contacts which can be provided to the consumer, carer and service providers.

The SCP is a good reference if there is a follow up meeting/ review required, for example, where a patient has been discharged from hospital for a trial period.

4.0 PROCESS FOR DEVELOPING A SERVICE COORDINATION PLAN

- 4.1 Identify that a Service Coordination Plan is required for the consumer.
- 4.2 Obtain the consumer's and/or carer's consent to the preparation of a Service Coordination Plan (and the holding of a case conference).
- 4.3 Identify an appropriate Key Worker (see 'Role of Key Worker').
- 4.4 The Key Worker prepares a Service Coordination Plan. The needs of the consumer are identified using the referral documentation, assessment and discussion with person making referral and discussion with the consumer and/or carer.
- 4.5 Review the Service Coordination Plan as per agreed review date or as required. Any changes to the Service Coordination Plan must be communicated to the Key Worker, and consumer and/or carer.

5.0 ROLE OF KEY WORKER

The Key Worker is the practitioner who takes responsibility for developing and/or maintaining the Service Coordination Plan. The practitioner dealing with the primary issue will generally be the Key Worker - this could be a case manager, nurse, allied health practitioner or GP. Due to changes in circumstances the practitioner undertaking the Key Worker role may change but only after consultation with the consumer.

The Key Worker is responsible for:

- Developing the Service Coordination Plan.
- Ensuring that all relevant services have a copy of the Service Coordination Plan.
- Ensuring that the Service Coordination Plan is reviewed in a timely manner; and
- Advising relevant service providers of any changes to the Service Coordination Plan

6.0 HOW TO PREPARE A SERVICE COORDINATION PLAN

Before preparing a Service Coordination Plan, the practitioner must obtain the consent of the consumer or carer to develop the plan. Also see 'Evidence of Assessment of Need' below.

6.1 *Complete page 1 of the Plan* as far as possible at this stage - consumer name, Key Worker, when a review is required, participants in care planning process including carer, evidence of assessment of need checklist.

6.2 *Identify the consumer's needs/ issues* and list in order of priority. The primary problem is the one which is expected to be the major focus of care or require the most interagency coordination. The consumer's and practitioner's assessments of priority may differ and may need to be negotiated.

6.3 *Identify one or more goals* for each issue. The goal is the best outcome that can be realistically achieved within the life of this Service Coordination Plan.

The goals can be coded for ease of use using the following list:

* **Safety & Protection**

* **Acute/ Post Acute** - the goal is the restoration of pre-acute level of health and function within a short time frame (weeks to months)

* **Functional Gain** - the goal is to improve current levels of independence and/ or optimize current living arrangements (weeks to months)

* **Maintenance and support** - the goal is to maintain function, quality of life or current health status (action may be required indefinitely).

* **Prevention and Early Intervention** - the goal is early identification and intervention to promote health and prevent problems developing.

6.4 *Identify a realistic target date* for achieving each goal. If the goal is maintenance and support or prevention and early intervention, a target date of 'indefinite' may be used.

6.5 *Identify the action to be taken* to achieve each goal - this may include referral to other services.

6.6 *Identify the individual or service that will be responsible for implementing* or managing the required actions and enter the date that this responsibility was accepted.

6.7 *Complete the Service Coordination Plan* including review dates and whether a case conference was held.

6.8 *Provide a copy of the Plan* to the consumer or carer and to all service providers involved. Ensure the consumer understands and consents to the actions outlined in the Plan and understands the respective roles of the service providers involved.

6.9 *Key Worker files original of the Service Coordination Plan* on consumer's record.

7.0 EVIDENCE OF ASSESSMENT OF NEED

The SCP has a checklist of evidence of assessment of need. It prompts the gathering together of information useful for service coordination planning. Working through the checklist requires a review of the consumer's file and a search for current or previous SCPs and other relevant documents (e.g. hospital discharge plan, a GP's care plan). These will help you identify all issues and problems. New issues identified at this stage or changes in circumstance should be recorded in a new document and added to the existing INI, *i.e. without duplicating whole INI process.*

8.0 REVIEWING THE PLAN

The review will occur according to the needs identified within the Service Coordination Plan.

- A review date will be noted on the SCP and will not be more than 3 months from the date the Plan was prepared. A review can be done before the review date if required, or a particular goal may need review before the whole SCP is reviewed.
- The Key Worker will usually convene the review and/ or case conference if required.
- The Key Worker will communicate outcomes of the review to other service providers.
- A new SCP should be completed if the review identifies that changes are needed.

9.0 GP INITIATED CARE PLANNING

As well as participating in a Service Coordination Planning process initiated by others, GPs may also initiate care planning. Under the Commonwealth's Medicare Benefits Scheme GPs can claim a rebate for care planning for patients with chronic medical conditions including those who need multidisciplinary care. The Chronic Disease Management items (under Medicare) allow GPs to claim rebates for coordinating team care planning and review services. If GPs initiate care planning they will be most likely to use the relevant Medicare forms rather than the Service Coordination Plan.

10.0 GLOSSARY OF TERMS

Initial Contact is the point a person makes his or her first contact with the service system and most commonly includes provision of service information, health promotion literature and/ or direct access to services via INI.

Initial Needs Identification (INI) is an initial screening for risk and service requirements. The practitioner undertaking Initial Needs Identification looks beyond the presenting issues to what underlying issues may exist. The INI forms include Consumer Information, Summary & Referral, Supplementary Profiles, where required, and Consumer Consent.

SCP - Service Coordination Plan

11.0 FURTHER REFERENCE

For further reference please see the Department of Human Services 'Service Coordination: Tool Templates'.