



## Service Coordination Planning Workshop 31<sup>st</sup> March 2009: Outcomes

### Activity 1: Achievements over last three years

Agency	Network	Client
Collaborative responses <ul style="list-style-type: none"> <li>• Responsiveness of service system to manage and negotiate change</li> </ul>	Share information <ul style="list-style-type: none"> <li>• discharge planning meetings</li> <li>• local service providers meetings</li> </ul>	Not having to repeat information
Improved understanding of collaborative work <ul style="list-style-type: none"> <li>• Service coordination framework - action plan</li> </ul>	E-referral	Stability with a 'Go to' (intake) person
Implemented service coordination <ul style="list-style-type: none"> <li>• Professional sharing and support</li> </ul>	Education	Staff more aware to respond to client
Employed intake worker - part time <ul style="list-style-type: none"> <li>• Overlap between part time workers</li> </ul>	Networking	Active service model
Some General Practices involved in Service coordination <ul style="list-style-type: none"> <li>• Demonstrated commitment by all programs into developing better access and referrals</li> </ul>	Daily liaison with discharge planner (including A.S.M.) Demand management	Discharged with a plan and services

<p>Changes in referral process</p> <ul style="list-style-type: none"> <li>• Mapping client and management pathways</li> <li>• Demand Management system model, service coordination as a whole of agency approach.</li> </ul>	<p>Support</p> <ul style="list-style-type: none"> <li>• when come across glitches</li> <li>• help each other</li> </ul>	<p>Collaborative / holistic response</p>
<p>Improvement of team meetings including complex clients</p> <ul style="list-style-type: none"> <li>• Partnership activities that reflect Service Coordination</li> </ul>	<p>PCP meetings</p> <ul style="list-style-type: none"> <li>• monthly motivator</li> </ul>	<p>Expediency and clarity of referrals</p>
<p>Service access unity - single point of entry that is well promoted</p> <ul style="list-style-type: none"> <li>• Health coaching training approach</li> </ul>	<p>Work with other agency closely</p> <ul style="list-style-type: none"> <li>• reduce duplication</li> </ul>	<p>Unimpeded links to service provision</p> <ul style="list-style-type: none"> <li>• instills client confidence re appropriate service</li> </ul>
<p>Including use of e-referral</p> <ul style="list-style-type: none"> <li>• Diabetes assessment tool - intake staff integral to this</li> </ul>	<p>More accurate timely feedback re referrals</p> <ul style="list-style-type: none"> <li>• 'feedback loop co-location: increase service coordination</li> </ul>	<p>Intake and screening clients linked much earlier to range of services</p>
<p>Implemented and trained whole organisation in use of SCTT tools</p> <ul style="list-style-type: none"> <li>• "No Wrong Door" protocol</li> </ul>	<p>Language and thinking - common approach</p>	<p>Model of health coaching gives client knowledge to support their Health and Well Being</p>
<p>Quality framework and established priorities in organization's Quality Plan</p>	<p>Protocol guidebook to service coordination - 'No Wrong Door'</p>	<p>Better Access to Service at right time</p> <ul style="list-style-type: none"> <li>• less waiting</li> </ul>
<p>Improvement of Active Service Model - empowering clients</p>	<p>Overall access</p> <ul style="list-style-type: none"> <li>• Referral</li> <li>• Intake</li> </ul>	<p>Co-location</p> <ul style="list-style-type: none"> <li>• increases client response and outcomes</li> </ul>
<p>Meetings with local providers</p> <ul style="list-style-type: none"> <li>• Training forums</li> </ul>	<p>Improve use of SCTT tools and access</p>	<p>Timely connection with agency</p>
	<p>Include knowledge of what providers do</p>	<p>Principles of 'No Wrong Door'</p> <ul style="list-style-type: none"> <li>• They should be supported</li> </ul>

	<ul style="list-style-type: none"> <li>• Meetings</li> <li>• Connectingcare</li> </ul>	wherever they enter
	Two way placement of staff in other agencies including knowledge and comfort of service coordination	Relationship between providers working to same goal with client
	Improve relationships with GP's	Quicker response less wait
		Quality referrals and less inappropriate referrals
		Decrease confusion
Better coordination and care		
	Chronic Disease Self Management	

## Activity 2: One word to describe your future vision for Service Coordination

Single point of entry

No Wrong Door

Streamlined services No barriers when sharing information

Better

Knowledge

Learning

Simplicity

Organised

Structure - all on the same page

M.O.U.s

Simpler funding

Trust in the process

Responsiveness

Responsibility

Good will passionate

Clarity

Positive, caring, helpful experience

Consumer friendly

Client centered

Empowered with workers and clients

Supportive team with workers and clients

Clear pathways

Transparent

E-health record

Integrated

Seamless

Holistic care

E-referral

Pro-active area

Respond to demands of community

### Activity 3: Table Group Priorities

#### Table 1

\*Embedded communication  
(Including feedback) between general practice and other service providers

\*Formalised communication  
Between agencies to streamline client care / prevent duplication of assessment (e.g. M.O.U.'s)

\*Align care planning across services

#### Table 2

\*Demand management

- DHS Prioritization tools (INI)
- Embed Service Coordination as a quality approach across agency - IC, INI, Ax, Care planning.
  - Improve care planning across sectors, disciplines and intra agency
  - Improve person centered (care) - approaches eg Health coaching, Active Self Management Service
- Commitment to Service Co principles and networks
- E-referral
  - IT services
  - Roles out to other programs
  - Procedures and processes supporting the implementation

\* Integrated Chronic Disease P & M

- Knowing service coordination as starting point
- Our responsibilities

\*Quality Framework

- Clinical risk management / clinical governance
- Clinical indicators in Community Health

### Table 3

- \*Easily identify the broader service network for all to be able to link into
- \*Integrated into an accreditation system
- \*Incentives and service agreement
- \*Benchmarking
- \*Framework - timeline
- \*Regional 'No Wrong Door' - eg like the Direct2care model
  - Central Intake (Identify Agency, eg NH centre/community info) (this is a resource and time issue for smaller agencies)
  - Human approach - not a call centre model

### Table 4

#### Achievable

- Single point of entry for agency
- Support via admin system if required
- Demand management tools eg, electronic and processes

#### No Wrong Door

- Adopt and integrate into first contact agencies
- Protocols, training, policies, guidelines
- Unity / interagency assessments

#### Compatible IT / information sharing capabilities

- Training for staff
- Technical support

#### Revisiting Service Coordination

- Embed current learning
- Reinvigorate interest in key concepts to all staff
- Ownership
- Cross-sector learning

### Table 5

#### Clear mapping of referral pathways and services

- Interface of software between public and private providers
- Interface between medical model and social model of health
  - Cultural shift
  - People need to understand each other's model
  - Build relationships

## Activity 4 Priorities

### a. Themes from all groups

- \*Information technology
- \*No Wrong Door
- \*Communication and relationships
- \*Care planning
- \*Quality: adopting, integrating, embed
- \*Common architecture eg a single point of entry

- \*Broader view (not just e-referral)
- \*Person centered care, e.g. health coaching
  - Would need to redefine case management, and develop common language and meanings
- \*Service coordination framework and it's measures, e.g. audit client journey (is x client centered? Equity lens)

### b. Service Coordination Priorities for 2009 -2012

#### 1. Continuous Quality Improvement in Service Coordination

- Statewide survey and feedback
- Improve IT
- Communication strategy
- Processes and protocols
- Client journey - referral pathways

#### 2. Client Centered Care Planning across Sectors

- Develop protocols and ensure these are CQI
- Referral pathways
- Communication

#### 3. Build sustainable support for service coordination to improve access and outcomes

- Processes and protocols
- Referral pathways
- Communication
- Equity frameworks
- Common language and meanings
- Dedicated resources to achieve these priorities
- Share information between agencies regarding systems, processes and PD's....