[insert organisation/name/logo]

Service Coordination Procedure

1. Overview of the Procedure

This procedure provides guidance on service coordination by service coordinators.

Staff, students, and volunteers with service coordination functions should be aware of the **[insert organisation name]** Service Coordination Policy and this procedure.

2. Definitions
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Service coordination involves the coordination of all necessary services for a consumer, along the continuum of care, including hospital-based and community-based, medical and non-medical, vocational, social and support services. This may include referrals to services, information about other services or assisting consumers where multiple appointments with government, non-government and local community services are required.

A service coordinator coordinates the planning and delivery of a suite of services to support a consumer's recovery journey. It is assumed the consumer has, or will have, capacity to be their own service coordinator. However, when informed consent from the consumer (or substitute decision-maker) is provided, a mental health worker may take on the role of service coordinator.

Service coordination from a mental health worker is usually needed for consumers who:

- have more complex needs than most other consumers
- need extra help to organise treatment, care and support from more than one agency
- have inadequate community supports, are financially disadvantaged or geographically isolated
- have a carer who is ill or highly stressed

[insert organisation name] service coordination may be short term, intermittent or ongoing.

Support Network includes people and organisations who have a supportive relationship with a person; for example, service providers, teachers, employers, and the natural support network.

Natural Support Network includes people who have an unpaid, natural, supportive relationship with a person; for example, family, carers, friends, and neighbours.

4. Considerations

[Insert organisation name] ensures staff have adequate skills and knowledge to carry out service coordination responsibilities through orientation, training and ongoing professional development considerations.

5. Procedure Steps

5.1 Entry to "Service Coordination"

A comprehensive and collaborative assessment process that explores all relevant aspects of the consumer's situation is completed for all consumers accessing service coordination. Information gathered in this process provides the basis for flexible, consumer-focused service delivery.

Tasks completed in this stage can include:

a) *Before the comprehensive and collaborative assessment process*
- from the first point of contact, having a focus on a positive and mutually respectful relationship, with engagement with the consumer being central
- confirming that the consumer or their representative has given permission for the referral to service coordination
- determining eligibility for **[insert organisation name]** service coordination
- referring to more appropriate programs or services and providing contact details, if the consumer is not eligible or needs higher levels of service than **[insert organisation name]** can offer
- reviewing referral information about the consumer and completing initial documentation
- contacting the consumer and arranging a suitable time for a comprehensive assessment
- arranging for interpreters, advocates, guardians, family members, carer/s and assessment partners to attend the assessment, if appropriate.

b) *During the comprehensive and collaborative assessment process*

- listening to the consumer's and the carer's story, and identifying cultural and/or language needs
- gathering information on consumer strengths, needs, supports, values and daily activities
- conducting a carer profile, where appropriate
- identifying and prioritising the consumer's needs for service coordination, including community partners who may be able to assist
- identifying work, health, and safety risks and risk management strategies for both consumer and staff member(s)
- giving information on services provided by the **[insert organisation name]** service coordinator and other available community and health services
- gaining consumer consent to exchange consumer information with support providers and referral agencies
- discussing and reaching agreement on the key elements and strategies of the Integrated Recovery Plan and exit plan and how they will be reviewed.

c) *After the comprehensive assessment process*

- contacting the referrer and existing support providers for any further information if necessary
- arranging for specialised assessments, if needed
- completing all necessary paper based and electronic (including computer-based) documentation.
- researching treatment, care and support options with client and carer input
- determining the consumer's capacity to pay for service coordination and other needed support options **[if fees charged]**
- prioritising the consumer's need for service coordination and determining status on waiting lists using validated priority rating tools, if relevant
- arranging a service coordination meeting, if necessary, to discuss the consumer's situation and negotiate appropriate responses
- advising the consumer of the complaints/feedback and appeals process, if relevant
- allocating an available service coordinator to work with the consumer, taking into account where possible preferences such as gender, age, cultural and other relevant factors
- advocacy, as required

5.2 Recovery / Wellness Planning, with linked Integrated Recovery Planning

Each consumer accessing **[insert organisation name]** service coordination should have a documented Integrated Recovery and Relapse management Plans developed in consultation with the consumer and/or carer and service coordinator. This plan should be linked to the consumer's Wellness / Recovery plan and include consumer

goals, strategies to meet those goals, timeframes, people and services involved, [cost and fees, if necessary], allocations of responsibility, and review strategies. The plan is a guide to treatment, care and support that is adapted when necessary. Tasks completed in this stage include:

- setting short term and long term goals and timeframes with the consumer and carer (where applicable)
- prioritising care and support needs in consultation with the consumer and carer
- identifying realistic and affordable options for meeting these needs
- identifying the roles of support networks in overall treatment, care and support
- identifying culturally appropriate services to be involved (if any), what they will provide and cost
- investigating alternate funding sources if needed
- negotiating an agreed service coordination role with the consumer
- determining the consumer's fee for inclusion in the service agreement
- entering a service agreement which includes information about rights and responsibilities and signing off agreed referral action
- documenting the Integrated Recovery Plan and completing paperwork
- giving the consumer a copy of the Integrated Recovery Plan
- where appropriate and with consumer knowledge and permission, providing the consumer's general practitioner and other involved service providers with a copy of the Integrated Recovery Plan
- providing information to consumers on the role of advocates and their right to use an advocate
- advocacy, as required.
- determining outcomes and how/when they will be measured.

5.3 Integrated Recovery Plan Implementation

The strategies in the Integrated Recovery Plan are implemented after the service coordinator, consumer and carer have reached agreement on the Integrated Recovery Plan. **[insert organisation name]** Service coordinators are able to use three approaches to Integrated Recovery Plan implementation depending on the situation. These approaches, which can be used in combination, include:

- provision of direct services by staff employed by the **[insert organisation name]**
- arrangement of support services to be provided by other health and community services.
- the use of brokerage funds to purchase needed support services not readily available in the service system.

a) *General Tasks*

Irrespective of the approach, general tasks completed in this stage may include:

- using recovery based tools to identify client values and priorities
- prioritising support service implementation based on a hierarchy of needs and OH&S requirements
- making and following–up agreed referrals to support services in line with agreed Integrated Recovery Plan and local referral and information exchange protocols
- negotiating individual service delivery requirements with support agencies
- purchasing or hiring equipment
- negotiating consumer contributions towards service provision
- negotiating commencement dates and schedules of service provision
- providing advocacy where needed
- using non-clinical language that is comprehensible to the consumer, and within his/her understanding of their illness
- ensuring all documentation is kept up–to–date and **[insert organisation name]** data collection requirements are met
- flagging with the consumer end dates if applicable, and possible reasons for exit
- establishing a monitoring and review schedule and feedback mechanisms between the service coordinator, the consumer and carer and other support services

b) *Additional Tasks Associated with Direct Service Provision*

- recruiting and training direct care staff
- matching available direct service staff with consumers
- briefing direct care staff on relevant aspects of the Integrated Recovery Plan
- supervising and supporting direct care staff, as required.
- liaising with clinical service providers for input and case direction
- monitoring costs of direct service provision.

c) *Additional Tasks That May Be Associated with Brokering Service Provision*

- identifying needs that cannot be met by mainstream services where a brokerage approach is required and appropriate
- identifying exit options in situations where brokerage is being used as a short–term, interim strategy to meet consumer need. This could include exploring the potential for the consumer to take on the cost and/or to become independent from the service coordination service
- determining the hours, rates and staffing qualifications required to provide needed care and support
- allocating an appropriate brokerage budget to address unmet need

- researching brokerage options
- negotiating comprehensive service agreements with brokered service providers that comply with **[insert organisation name]**, insurance and legal requirements
- completing work health and safety (WHS) checklists and, wherever possible, acting on the WHS checklist before sending the service order to the brokered service providers.
- sending service orders to brokered service providers
- completing a weekly service plan where applicable, and ensuring all services are costed correctly
- clarifying service coordination roles and responsibilities with the brokered service
- setting up the accounting system and periodic budget reconciliation.

5.4 Monitoring and Evaluation

Each consumer's situation is monitored by the service coordinator. When service coordinators identify changes in the consumer's situation, they negotiate appropriate support service responses and adjust the Integrated Recovery Plan. Case managers are also responsible for formally evaluating the effectiveness of the Integrated Recovery Plan in meeting agreed goals.

Tasks completed in this stage of the service coordination process include:

- coordinating services through regular liaison with all stakeholders and ensuring that the Integrated Recovery Plan is followed by support services
- overseeing external purchasing
- maintaining regular contact with and seeking feedback from the consumer, informal networks and service providers
- monitoring the consumer's ability and needs and the effectiveness of the Integrated Recovery Plan in these needs
- monitoring budgets associated with delivery of support and care services
- providing advocacy, counselling, mediation, education, employment and vocational support and social support when needed
- conducting regular formal reviews of the Integrated Recovery Plan with the consumer and carer at least every six months
- evaluating the effectiveness of the Integrated Recovery Plan in meeting agreed goals
- negotiating changes to service provision and adjusting the Integrated Recovery Plan and consumer contribution accordingly
- providing written and verbal feedback to the consumer and carer on the outcome of reviews, including progress on outcomes
- ensuring all documentation is kept up–to–date, and that progress notes record activities in service delivery in an objective and accurate manner.

5.5 Exit from Service Coordination

[See attachment for example of Exit Flow Chart for one program]

Exit planning begins during the development of the Integrated Recovery Plan and continues throughout the service coordination process. The overall aim is to ensure that the consumer experiences a smooth, seamless transition from **[insert organisation name]** service coordination to other levels and types of support provision when appropriate.

[insert organisation name] consumers exit service coordination for a variety of reasons such as changes in their living situations, entry to residential care and service coordination support needs – including regaining capacity to take on the role of service coordinator on their own behalf. It is important to note that a **[insert organisation name]** consumer cannot be exited to make way for another consumer with higher service coordination needs and that service coordination services are not guaranteed indefinitely.

In situations where the consumer is receiving episodic service coordination, a consumer is exited on the understanding that they will have ready access to service coordination support in the future if needed.

Tasks completed in this service coordination stage include:

- identifying the need to exit from the program and involving the consumer and carer or advocate, if required, in decision making
- advising the consumer, referrer, and carer if relevant verbally and in writing of the decision and reasons to withdraw service coordination services
- conducting an exit interview with the consumer and other relevant parties to facilitate transition to other services, if appropriate
- exploring referral options if ongoing support or care is needed
- referring to more relevant services, if appropriate
- negotiating handover arrangements with other providers, where appropriate
- reviewing the achievements of the Integrated Recovery Planning in meeting agreed goals
- completing transition planning
- sending the final account
- collecting supplied equipment
- notifying the consumer, all service providers and informal support networks of relinquishment of the service coordination role
- completing and securely storing all documentation.

Adapted from: NSW Department of Ageing, Disability and Home Care (2006). *Good Practice Guide for HACC Funded Case Management Projects.* http://www.adhc.nsw.gov.au/__data/assets/file/0018/228204/GoodPracticeGuidefinal.pdf Accessed 14th November, 2011.