Service Coordination: Definitions & Resources

Terminology	Definition	Resources
Advance Care Planning	Advance care planning is the process of planning for a person's future health and personal care. Advance care planning helps ensure that an individual's choices are respected for future medical treatment. Their beliefs, values and preferences are made known, in order to guide future care in the event that the person is unable to make decisions of communicate.	Department of Health Victoria https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning
Care Planning	Care planning is a dynamic process that incorporates assessment coordination; care/case management; referral; information exchange; review; reassessment; monitoring and exiting. Care planning involves balancing relative and competing needs, and helping consumers make decisions appropriate to their needs, wishes, values and circumstances. Care planning may occur at an individual provider level and both within and across agencies	Department of Health Victoria, Primary Care Partnerships Good Practice Guide 2012 Care Planning p. 21 https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination/service-coordination-practice-manual Department of Health Victoria Strengthening assessment and care planning; a guide for HACC assessment services in Victoria 2010 (Care planning p. 143) https://www2.health.vic.gov.au/about/publications/policiesandguidelines/strengthening-hacc-assessment-guide-2010 Department of Health Victoria, Primary Care Partnerships Service Coordination Tool Templates 2012 User Guide Shared Support Plan p. 47 https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination/service-coordination-tool-templates
Case Conference	Case conferencing involves an inclusive process for making decisions about the care of a consumer. Assessment findings and options for ongoing care and support are presented to other practitioners/clinicians, who can be from the same or different organisations. The presentation includes conclusions of the assessment that are supported by a range of information sources. Case conferences are often multidisciplinary and incorporate the views and preferences of the consumer and their carers.	Department of Health Victoria, Primary Care Partnerships Service Coordination Practice Manual 2012 https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination/service-coordination-practice-manual Service coordination Tool Templates 2012 User Guide Case Conference Checklist p. 51 https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination/service-coordination-tool-templates

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Case Management	Case management includes the roles and tasks described for care/case coordinator as well as arranging additional services needed by the consumer by means of brokerage, purchase of services or maintenance of effort agreements between organisations. If there is a case manager involved in the service provision they may be best placed to take on the care/case coordinator role.	Department of Health Victoria, Primary Care Partnerships Victorian Service Coordination Practice Manual 2012 Care Coordinator role p. 25 https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination/service-coordination-practice-manual
Goal Directed Care Planning	Goal directed care planning recognises that clients are the experts in their health and should be actively involved in setting their own priorities and making decisions about their care. Services should build on a client's strength and capabilities and adopt a "doing with, not for" approach. Depending on the person's circumstances, the goals will be developed in conjunction with carers, family members, support workers and other key people.	Department of Health Victoria, Primary Care Partnerships Victorian Service Coordination Practice Manual 2012 Goal Directed Care Plan p. 24 https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination/service-coordination-practice-manual Department of Health, Victoria Doing it with us not for us: participation policy 2006 – 2009 https://www2.health.vic.gov.au/getfile//?sc_itemid={34B9E1D3-ED76-4835-82CC-AC1D48C52E04} Doing it with us not for us: Strategic Direction 2010 – 2013 https://www2.health.vic.gov.au/getfile//?sc_itemid={B6BF906E-43CE-4868-86AA-01733155F338} Goal Directed Care Planning Toolkit: Practical strategies to support effective goal setting and care planning 2015 http://www.iepcp.org.au/sites/default/files/Goal%20Directed%20Care%20Planning%20Toolkit%202nd%20Edition%202015.pdf http://www.oehcsa.org.au/sites/default/files/Goal%20Directed%20Care%20Planning%20Toolkit.pdf Department of Health Victoria Strengthening assessment and care planning; a guide for HACC assessment services in Victoria (Care planning p. 143) https://www2.health.vic.gov.au/about/publications/policiesandguidelines/strengthening-hacc-assessment-guide-2010
GP Management Plans (GP MP)	**MBS Item 721**. This is a care and treatment plan developed by a GP, for a patient of any age with one or more chronic or terminal	Commonwealth Department of Health – Medicare Benefits schedule August 2014

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	conditions, who will benefit from a structured approach to management of their care needs. A GPMP need not involve any other parties. However, practices can combine it with a Team Care Arrangement (TCA). The GP may be assisted by their practice nurse, Aboriginal Health Worker or other health professional in the GP's medical practice or health service.	http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Downloads-201408 http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=721
Information Exchange	Information exchange is essential to provide consumers with a seamless, coordinated service delivery. It includes acknowledgment that a referral has been received and the subsequent action to be taken and a provision of summary information to other service providers at key points in the consumer's pathway to support service coordination.	Department of Health Victoria, Primary Care Partnerships Victorian Service Coordination Practice Manual 2012 Information exchange p. 36 https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination/service-coordination-practice-manual Department of Health Victoria, Primary Care Partnerships Service coordination Tool Templates 2012 User Guide Information Exchange p. 45 https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination/service-coordination-tool-templates
Informed Consent	Privacy legislation requires the protection of an individual's personal and health information and their right to decide how the information is used, disclosed to or shared with others. Consumer consent is a compulsory part of the information exchange process. There are two recognised stages: • Collection and management • Use of disclosure of information Organisations must only collect information that is reasonably necessary for, or directly related to one or more of the organisation's functions or activities. Generally, organisations must not use or disclose the information for another purpose unless the individual has consent to the use or disclosure of the information.	Department of Health Victoria, Primary Care Partnerships Victorian Service Coordination Practice Manual 2012 Consent to share information p. 33 https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination/service-coordination-practice-manual Australian Privacy Principle 1 – Open and transparent management of personal information Australian Privacy Principle 2 – Collection of personal information Australian Privacy Principle 6 – Use or disclosure of personal information http://www.oaic.gov.au/images/documents/privacy/privacy-resources/privacy-fact-sheets/privacy-fact-sheet-17-australian-privacy-principles_2.pdf

Terminology	Definition	Resources
		Department of Health Victoria, Primary Care Partnerships SCTT 2012 Consent to Share Information http://docs.health.vic.gov.au/docs/doc/Consent-to-share-information Department of Health Victoria, Primary Care Partnerships Service coordination Tool Templates 2012 User Guide Consent to share information p. 17 https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination/service-coordination-tool-templates
Inter-agency agreement	An inter-agency or partnership agreement is a document outlining the basis of a new relationship and the agreed objectives between partners which includes the agreed terms and conditions or collaboration between separate agencies and/or sectors.	Community Door Developing Interagency protocols and service agreements http://communitydoor.org.au/collaboration/developing-interagency-protocols-and-service-agreements
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.	Community Door Developing Interagency protocols and service agreements http://communitydoor.org.au/collaboration/developing-interagency-protocols-and-service-agreements
Protocols	A protocol is the more detailed process by which inter-agency partners will work together. Protocols document how partner agencies will interact and what each partner can reasonably expect from each other. Protocols can provide legitimacy to relationships and processes already in place but have not been formally documented.	Community Door Developing Interagency protocols and service agreements http://communitydoor.org.au/collaboration/developing-interagency-protocols-and-service-agreements
Referral	Referral is the transmission, with consent, of a consumer's information from one service provider to another for the purpose of further assessment, or service provision. Referrals may be made by a staff member involved in initial contact or initial needs assessment, or a service provider seeking assessment and service provision for a consumer. As consumer needs of circumstances change, further referrals may be required.	Department of Health Victoria, Primary Care Partnerships Victoria Service Coordination Practice Manual 2012 Referral p. 34 https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination/service-coordination-practice-manual Department of Health Victoria, Primary Care Partnerships Service coordination tool templates 2012 User Guide Referral templates p. 11 https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination/service-coordination-tool-templates

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SCTT **Service Coordination Tool Templates**	What is SCTT? SCTT is a suite of templates designed to facilitate service coordination. They support the collection, recording and sharing of initial contact, initial needs assessment, referral, information exchange and care planning information in a standardised way. The SCTT provide consistent information standards to facilitate electronic sharing of information and provide a common language between a wide range of services	Department of Health Victoria, Primary Care Partnerships SCTT https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination/sctt-forms
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.	Department of Health Victoria, Primary Care Partnerships Good Practice Guide 2012 https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination/service-coordination-practice-manual
Service-specific Care planning	Service-specific care 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 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	Department of Health Victoria, Primary Care Partnerships Victorian Service Coordination Practice Manual 2012 Care Planning p. 21 https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination/service-coordination-practice-manual
Shared Care Plan	A shared care plan 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. A care/case plan should be worded in a way that the consumer and any of their service providers can understand. Typically developed for consumers with complex needs and multi-service involvement. The SCTT shared support plan may be used to document and share this information.	Department of Health Victoria, Primary Care Partnerships Victorian Service Coordination Practice Manual 2012 Shared Care Plan p. 25 https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination/service-coordination-practice-manual Department of Health Victoria, Primary Care Partnerships Shared Support Plan SCTT https://www2.health.vic.gov.au/getfile/?sc_itemid={0AC05C1C-0030-489F-8D02-9A5064CCE345}&title=Shared%20support%20plan

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		Department of Health Victoria, Primary Care Partnerships Service coordination tool templates 2012 User Guide Shared support plan p. 47 https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination/service-coordination-tool-templates
Shared Care Planning	Shared care 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. Share care planning involves discussion, negotiation and decision making between service providers and consumer to define their goals and strategies, resulting in identifying actions and services to meet those goals.	Department of Health Victoria, Primary Care Partnerships. Victorian Service Coordination Practice Manual 2012 Shared Care Planning p. 25 https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination/service-coordination-practice-manual
Team Care Arrangements	**MBS Item 723**. A care and treatment plan developed by a GP, for patients with a chronic or terminal medical condition **and** who require ongoing care from a multidisciplinary team of their GP and at least two other health or care providers. The GP may be assisted by their practice nurse, Aboriginal Health Worker or other health professional in the GP's medical practice or health service. The collaboration between the coordinating GP and participating providers at A.28.18 (d) must be based on two-way communication between them, preferably oral, or, if this is not practicable, in writing (including by exchange of fax or email, but noting that the means of communication used must enable privacy to be safeguarded in relation to patient information). It should relate to the specific needs and circumstances of the patient. The communication from providers must include advice on treatment and management of the patient.	Commonwealth Department of Health – Medicare Benefits schedule August 2014 http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Downloads-201408 http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=723

Online training is available through the following links: Service coordination tools and templates and Service coordination

Office of the Commissioner for Privacy and Data Protection's training portal

Department of Health Victoria, Primary Care Partnerships Continuous Improvement Framework 2012