Department of Health

health

Eastern Metropolitan Region Alcohol and Other Drug Sector

Service Coordination Toolkit

State Government Victoria

Eastern Metropolitan Region Alcohol and Other Drug Sector

Service Coordination Toolkit

Toolkit developed by: Kate Pascale
AOD EMR Service Coordination Project Consultant

If you would like to receive this publication in an accessible format, please phone **03 9843 1750** using the National Relay Service **13 36 77** if required.

Published by Mental Health Partnerships and Planning, Mental Health and Drugs, Eastern Metropolitan Region, Victorian Government, Department of Health, Melbourne, Victoria.

This document is available as a PDF on the internet at: www.health.vic.gov.au/aod/pubs/index.htm

Authorised and published by Victorian Government, 50 Lonsdale Street, Melbourne.

May 2013 (1302004)

Foreword

People who use Victoria's alcohol and drug services and their families consistently tell us that they want to be able to easily access the right service at the right time. Service coordination describes the systems and practices that enable staff within and between services to facilitate easy access to services. Service coordination is an essential component of a client-centred approach to care that enables individual care that is coordinated and collaborative.

The Department of Health Eastern Metropolitan Region (EMR) has maintained a steady focus on promoting service coordination over recent years. This has been integrated into practice using a multi-pronged approach – through the inclusion of service coordination in the regional office's strategic priorities, active advocacy, education and by leading, participating in, and funding a range of practical initiatives.

We commend the sector's commitment and investment in a client-centred system has been further reinforced through the EMR Drug and Alcohol Strategy Group which brings together local AOD agencies to action a range of quality improvement initiatives. This project has been an excellent example of this, with representatives from all regional AOD organisations working together to identify and understand local service coordination issues, develop and implement relevant solutions, work through persistent challenges and celebrate successes.

This work builds on the Eastern region's track record of strong partnership initiatives and highlights our commitment to providing services for our community services that are accessible, coordinated and easy to navigate. We are therefore pleased to present the Eastern Metropolitan Alcohol and *Drug Service Coordination Toolkit* – a practical and user-friendly guide to assist organisations to work together and develop relevant policies and practices to support a collaborative, high-quality, client-centred approach to health service delivery.

We are confident that this toolkit will build on the good practice that is occurring in the region and be a valuable resource for many sectors, supporting staff to deliver quality, coordinated, client-centred care for our community.

Therese Robinson
Acting/Director, Health and Aged Care
Department of Health
Eastern Metropolitan Region

Gregg Nicholls
Chairperson
Drug and Alcohol Strategy Group
Eastern Metropolitan Region

Acknowledgements

This *Service Coordination Toolkit* is the culmination of three years of hard work by Melbourne's Eastern Metropolitan Region (EMR) Alcohol and Other Drug (AOD) sector through the EMR AOD Service Coordination Project. All 14 of the local AOD agencies have been actively involved, as have many stakeholders who represent a broad range of health and community service sectors. Thank you to everyone involved for sharing your knowledge, expertise and time to complete this project. Your commitment, expertise and passion to deliver high quality, client-focussed services, has enabled the project to action a number of key initiatives and achieve tangible success, contributing to the development of a cohesive and coordinated local service system.

The EMR AOD Service Coordination Working Group has been the driving force of this project. Thank you for your continued dedication, time and energy, for your openness, enthusiasm and ideas, for spreading the word and becoming champions within your teams. Please refer to Appendix 1 for a list of the EMR AOD Service Coordination Working Group members.

Special thanks also to the EMR Department of Health and the EMR Alcohol and Drug Strategy Group for your unwavering commitment and valuable input throughout the project.

Kate Pascale
Project Consultant
EMR AOD Service Coordination Project

Contents

Glossary of key terms

AOD	Alcohol and other drug, also referred to as alcohol, tobacco and other drugs (**ATOD**) and alcohol and drug (**A&D**)
CCCC	Counselling, consultancy and continuing care
CIF	Continuous Improvement Framework (a component of the Victorian Service Coordination framework)
COAG	Council of Australian governments
DH	Department of Health, formerly part of the Department of Human Services (DHS)
DHS	Department of Human Services
EMR	Eastern Metropolitan Region
EOC	Episode of care
EQuIP	Evaluation and Quality Improvement Program
FASA	Funding and service agreement
HR	Human resources
IC	Initial contact (the first point of contact with a service)
INI	Initial needs identification (broad, shallow screening process to identify client needs)
IRP	Integrated recovery plan
KPG	Key practice guideline
KPI	Key performance indicator
MCDS	Ministerial Council on Drug Safety
MoU	Memorandum of understanding
PCP	Primary care partnership
PPPS	Policy, procedures, processes and systems
PDRSS	Psychiatric disability rehabilitation and support services
QICSA	Quality improvement and community services accreditation
SCTT	Service coordination tool templates
VAADA	Victorian Alcohol And Drug Association

Chapter 1: Introduction and background

The Australian health system faces considerable challenges to meet growing demands in the face of an ageing population, changing health care needs and workforce pressures. As such, governments and service providers are required to reconsider their approach to the planning, development and delivery of health care services (DH 2011a, NPHT 2008). Over the last decade, the coordination and integration of Australian health and community services has been increasingly on the agenda of federal, state and local governments. This is reinforced through the inclusion of these concepts in a broad range of public policies that articulate a commitment to an integrated, responsive and coordinated approach to service delivery (COAG 2006; COAG 2009; DHS 2001; DoHA 2008; MCDS 2011; NPHT 2008). These policies describe the necessity of partnerships at various levels – between governmental departments, service providers (within and beyond the health sector) and with clients, families and carers. The policies consistently demonstrate a focus on promoting continuity of care for clients and report the need for:

- a comprehensive, accessible and acceptable mix of services
- a coherent and integrated service system
- consistent standards for service delivery
- a local approach to planning and service delivery.

There has also been a concurrent shift towards evidence-based practice, in which organisations are increasingly asked to demonstrate the efficacy, appropriateness and efficiency of their approaches and the associated outcomes. This is reflected not only in policy, but also through funding and service agreements (FASA) and the creation of organisational accreditation systems.

Despite this shift, many health and community services continue to experience challenges in the delivery of effectively coordinated care (VAGO 2011). These challenges relate to a range of factors including:

- variability of client pathways
- complexity of the service system and related policy structure
- inconsistent referral practices
- demand for services outstripping supply
- complex governance structures and disparate organisational policies reinforcing a silo approach to service delivery
- focus on quantitative measures in funding and reporting systems
- resource limitations.

As a result, consumers often experience a service system that is fragmented, difficult to navigate and at times, not responsive to their needs (DHS 2008, VAGO 2011). Inconsistent referral systems, long waiting lists and lack of coordinated planning have created gaps at the beginning and end of clients' engagement with each service. These create significant fragmentation, poor continuity of care and inefficiencies in risk screening, needs identification and assessment duplication (Pascale 2009). Some clients also risk 'falling through the gaps' when they experience challenges accessing the correct services (DH 2010).

It is evident however, that despite these challenges, clinicians are committed to the principles of client-centred practice and often go out of their way, to work around the current system, to ensure clients can access the services they need, as quickly and easily as possible (Pascale 2009).

What is service coordination?

In order to address these common issues, significant work has been done over the last decade to improve the coordination and collaboration of health services. A key initiative has been the development and implementation of the *Victorian Service Coordination Framework*.

Service coordination is a statewide initiative that seeks to promote functional service integration across the Victorian health sector (DHS 2001). Grounded in a social model of health, service coordination promotes client-centred care and outlines strategies to effectively link services, provide a more seamless system and ensure clients can access a cohesive service system. The goal of service coordination is to provide a seamless and integrated service system to maximise client outcomes and organisational efficiency (PCP Victoria 2012a).

Service coordination is underpinned by the following principles:

- a central focus on consumers
- partnerships and collaboration
- the social model of health
- competent staff
- a duty of care
- protection of consumer information
- engagement of other sectors.

This integrated, inter-organisational model of service provision is identified as appropriate, cost effective and efficient (Institute of Medicine 2001; Wagner, Glasgow et al. 2001). It supports an organisation's ability to achieve service objectives and facilitates sustainability in the delivery of high quality, safe and effective health care (NSW Health 2001; ACSQHC 2003; NPSA 2003).

Given a relatively small investment, service coordination can achieve tangible benefits for clients, staff and services including:

- a more systematic approach for clients with complex needs
- access to the right service at the right time
- earlier identification of client needs
- better management of waiting lists
- improved service navigation
- reduced assessment duplication
- increased coordination and collaboration in service delivery, planning and development
- greater operational efficiency.

(DHS 2001, KPMG 2004; PCP Victoria 2005)

Service coordination promotes consistency in practice and a common language to define and describe the range of processes that commonly occur across the health system (DHS 2001). It provides a framework that outlines key practices, processes, protocols and systems across key elements of clients' care. These elements are designed to be incorporated into the context of existing organisational structures. This approach seeks to enable services to work together to develop and implement effective local solutions. The key elements of service coordination, as described in *The Victorian Service Coordination Practice Manual* are outlined below (PCP Victoria 2012a).

Initial contact

Initial contact is the first point of contact with the service system. It includes the provision of information and directing the client's access to services.

Initial needs identification

Initial needs identification (INI) is an initial assessment process within which client issues are explored to understand the client's risk, eligibility and priority for service.

Assessment

Assessment involves the collection and interpretation of information about the consumer in order to understand relevant issues and develop a care plan.

Care planning

Care planning commences at the first point of contact with the AOD system and is completed on final exit from the system. It incorporates a range of activities including care coordination, case management, referral, feedback, monitoring and review. Care planning involves understanding and prioritising client needs and collaboratively developing appropriate actions.

Referral

Referral can occur at, or out of, any of the elements of service coordination. Referral is defined as "the transmission, with consent, of a consumer's information from one service provider to another for the purpose of further assessment, or service provision" (PCP Victoria 2012a).

Primary care partnerships (PCP) have taken a lead role in service coordination throughout Victoria. PCP Victoria have developed a range of assessment tools, referral forms and provided training to health professionals. Please refer to Chapter 6 for links to relevant resources and support tools.

Despite this plethora of information, many agencies continue to experience challenges implementing service coordination within the context of their practice.

The EMR AOD Service Coordination Project

The *Eastern Metropolitan Region (EMR) AOD Service Coordination Project* was established in 2009 by the EMR Drug and Alcohol Strategy Group, in order to understand and address the existing barriers to service coordination in the local AOD sector. It sought to enhance the integration of AOD services across Melbourne's Eastern region by promoting strong interagency relationships and creating systems that support accessible, coordinated and client-centred care.

The aim of the project was to support effective service coordination for AOD services in the EMR in order to:

- enhance continuity of care for clients
- improve client access to, and transfer between AOD services and the broader service system
- support clients to negotiate care pathways in the AOD sector
- maximise client outcomes by reducing risk during the transition period between service engagement
- reduce need for clients to provide duplicate information
- maximise efficiency in use of finite resources
- reduce demands on organisations through effective information sharing
- support the provision of quality, effective care through timely information gathering and sharing appropriate information.

The project focussed on creating a shared understanding and commitment to service coordination among all staff in the EMR AOD sector, piloting best practice processes and embedding relevant organisational policies and systems. Over three years, significant and tangible improvements were achieved across a number of key areas, including:

- the sector's capacity to deliver more streamlined, coordinated, client-centred AOD services
- the quantity, quality and effectiveness of interagency communication
- minimisation of duplication and repetition for staff and clients
- appropriate and timely service access
- fostering robust working relationships and partnerships between key stakeholders
- staff understanding of the importance of a holistic and coordinated approach to support effective client-centred care.

(Pascale 2011)

Key project learnings

Adoption of effective service coordination needs to be acknowledged as a long term change management initiative. This requires dedicated support, education and collaboration with the sector to generate buy-in and ensure that all staff are actively engaged in the change. Experience demonstrates that while the principles of service coordination are relevant to all sectors, there is no 'one size fits all' approach to implementation. Rather, it is essential to ensure that the unique structures, contexts and needs of each agency are considered in the development of relevant policies and practices (Ryan, Voon et al 2009, Turning Point 2009).

The EMR AOD Service Coordination Project reinforced existing evidence that describes the need for a flexible, holistic and multi-factorial approach to service coordination (Pascale 2009). It is evident that effective change requires a thoughtful approach and action at multiple levels:

1. Strong local partnerships

A partnership approach is fundamental to effective service coordination and success is largely dependent on systems in which all partners hold responsibility for appropriate practice. The project has further reinforced that the sustainability of service coordination initiatives is enhanced when participating staff experience reciprocal benefits.

2. Individual practice change

The delivery of care needs to be refocussed so that staff are encouraged to consider the client's episode of care in their service, as one component of a client's journey towards and through recovery. This client-centred approach supports a shift away from fragmented and episodic care, towards seamless, integrated and interagency service delivery.

Effective service coordination requires consideration to the way services are delivered throughout a client's engagement with the service system – from the first point of contact, to the development of appropriate discharge plans and provision of relevant ongoing supports (Pascale 2009, PCP Victoria 2012a). Throughout this journey, there are a number of key processes that support good practice, these include:

- flexible and appropriate service access pathways
- early identification of the client's previous treatment history

- appropriate and timely handover of client information
- efficient and effective referral pathways including the provision of consistent referral feedback
- holistic assessments that include a thorough exploration of the client's broader health and social needs
- clear guidelines regarding duty of care for clients during transition between services
- guidelines for the management of clients after unplanned discharges.

These practices must be underpinned by a high level of commitment from staff. This is supported by comprehensive knowledge of:

- the local service system
- privacy and consent legislation
- the principles of service coordination.

3. Supporting change through organisational change

In order to successfully operationalise the principles of service coordination, systems are required that make holistic, coordinated service delivery the easiest and simplest option for clinicians and clients (Pascale 2011). This is dependent on the creation of policy, guidelines and service structures that promote consistency, clearly articulate expectations of services, staff and clients (DHS 2001; MCDS 2006).

A holistic, flexible and client-centred approach is required to recognise and manage the complexity of clients' needs and ensure that the risk of relapse is not exacerbated by weaknesses in service delivery or organisational processes (DHS 2008; Wilson 2008). Additionally there is a need to support clients through sustained engagement with the broader health system as well as welfare and other sectors (DHS 2002; DHS 2004; DHS 2008). It is therefore essential that organisations remain committed to collaborative practice and open communication (DHS 2008).

The Service Coordination Toolkit

Formal and informal consultation with key stakeholders across Victoria and from other health and community service sectors has demonstrated that the challenges and opportunities experienced in the EMR are consistent across many health and community service sectors. This toolkit has therefore been developed in order to share the learnings of the EMR AOD Service Coordination Project and to provide a range of practical tools and strategies that can help other partnerships embed effective practice.

The toolkit is designed to be flexible and dynamic, providing agencies with a range of key considerations, decision making supports and tools to guide you through the changes you decide to make. While it promotes consistency, it also recognises the need for local flexibility and takes into account the differing priorities, context and capacities of agencies to progress this work.

It is important to note this toolkit has been developed in consideration of best practice literature, organisational accreditation and reporting requirements. As such, all of the recommendations, strategies and tools included in this toolkit are consistent with the best practice guidelines (in particular, the *Victorian Service Coordination Practice Manual*) and should be embedded within relevant ongoing quality improvement systems.

Chapter 2: Creating strong local partnerships

A partnership approach is fundamental to effective service coordination and success is largely dependent on systems in which all partners hold responsibility for appropriate practice. The project has further reinforced that the sustainability of service coordination initiatives is enhanced when participating staff experience reciprocal benefits.

When creating local partnerships, it is important to consider opportunities to include other sectors, promote effective inter-sectorial communication and ensure that all staff have the skills, knowledge and systems in place to simplify and support effective partnership practice (Flatau, Connroy et al. 2010). This requires a multifaceted approach including consideration of the need for:

- consistent and congruent policy that prioritises and supports the delivery of holistic, person-centred care through a partnership approach
- agreed language and pathways that enable staff to communicate effectively across multiple sectors
- professional networking opportunities and strategies to develop and maintain strong working relationships.

(DHS 2001, Pascale 2009, PCP Victoria 2012a).

This chapter details three strategies that we propose are particularly relevant and effective to support a partnership's focus on service coordination:

- a shared vision
- a service coordination memorandum of understanding (MoU)
- communicating your service coordination approach with your partners.

Creating a shared vision

Partnerships are most effective when they have a clearly defined purpose (Social Compass 2007). One way to facilitate this is to create a shared vision (Tennyson 2003). A vision can be used in a number of ways, including as a platform to:

- articulate the goals of the partnership
- describe the change sought through the partnership
- guide the partnership in priority setting and decision making
- enhance members' understanding of the relevance of the initiative
- build commitment and staff buy-in.

When done collaboratively, the process of developing the vision is also beneficial. It provides a forum within which members can openly discuss their own perspectives, needs and priorities. Relevant issues can therefore be identified and proactively managed.

As part of the EMR AOD Service Coordination Project, staff worked together to formulate the following vision for substance users in the EMR. It is important to note that the primary audience for this vision was local AOD staff and project stakeholders.

Example of a shared vision

Our vision for the Drug and Alcohol Sector

Staff working across the Eastern Region's Drug and Alcohol sector, have agreed upon the following principles as defining the way we seek to provide services for our community stakeholders.

Figure 2.1: The EMR AOD vision for the Drug and Alcohol Sector (developed 2011)

Our clients will feel:

- Heard
- Supported
- Empowered
- Valued and respected
- Included
- Validated
- Encouraged
- Informed

Our services will be:

- **Appropriate** *(models of care, language, cultural)*
- **Accessible** *(waiting times, hours of operation, geographically, financially)*
- **Inclusive** *(of clients, carers, families and children)*
- **Relevant** *(to clients individual needs and circumstances)*
- **Ethical** *(risk identification and management)*
- **Addressing a range of holistic and practical needs**
- **Effective**
- **Responsive and timely**
- **Evidence-based**
- **Providing a clear plan / pathway**
- **Honest and open**
- **Well resourced**
- **Staffed appropriately** *(capable, supportive and informed teams)*
- **Comfortable, safe and welcoming**
- **Open to feedback**

Our service system will be:

- Person-centred
- Flexible and responsive
- Connected and coordinated *(with other services / sectors)*
- Seamless
- Easy to navigate
- Committed to improvement
- Integrated
- Collaborative
- Equitable
- Human rights based
- Promoting consistent standards
- Strategic

Service coordination memorandum of understanding

Effective service coordination requires a high level of mutual understanding, collaboration and agreement between services. Development of the necessary organisational systems is contingent on support from all levels of management, within and between participating agencies (Pascale 2010, PCP Victoria 2012c). Therefore, engaging executive support is a priority. A service coordination MoU is identified as an effective tool to assist agencies to articulate and clarify the necessary authorising environment.

A service coordination MoU should:

- facilitate a shared understanding of the principles of service coordination
- describe the service coordination initiative being undertaken and the context in which it will be applied
- articulate the principles, protocols and functional working arrangements that will facilitate effective communication and collaboration between agencies
- gain commitment from stakeholders to support the implementation of key actions to deliver effective service coordination
- provide clarification of the roles and responsibilities of participating organisations.

Given the variable organisational structures and policy environments that health and community services operate within, it is often unreasonable to assume that all partners can adopt identical service coordination practices or tools. Therefore, in addition to embedding specific practices, participating agencies need to agree that within their existing policy standards and frameworks, they will:

- develop and maintain organisational policies that are supportive of the overarching principles of service coordination
- provide clear leadership at all levels of their respective organisations to develop and promote a coordinated, client-centred and quality driven system of care
- support and actively participate in initiatives to facilitate effective communication between service providers and contribute to collaborative care planning for shared clients
- embed the agreed protocols and functional arrangements into local work practice and provide ongoing support for the implementation, monitoring and evaluation of service coordination initiatives.

In order to support you to develop an appropriate MoU, included below, are:

- service coordination MoU key inclusions
- example MoU (The EMR AOD Service Coordination MoU).

Service coordination MoU key inclusions

Purpose

- A list of participating agencies and key stakeholders
- A brief description of the purpose of the MoU (what is included and how it will be applied).

Scope

- The programs/services within each participating agency, to which the MoU applies
- Agreed exclusion criteria.

Note: An MoU is not a legally binding contract. It is a voluntary agreement that is intended to support agencies to work together. It does not create legally binding rights and obligations.

Background and introduction

- The context of your partnership
- Service coordination principles and practices relevant to the initiative
- Rationale for the MoU
- Goals and anticipated outcomes of the service coordination initiative
- Relevant policy context
- Best practice guidelines and documents that underpin the approach.

Structural supports

- Any agencies or groups that will provide support for the implementation of the MoU
- A description of the actions that will be undertaken by these supports.

Note: This may include agencies that are not necessarily signatories to the MoU but support its application and have committed to providing relevant support (for example government departments) and/or structures in place to action the initiative (for example Primary Care Partnership or a local working group).

Term

- Timeframe for which the MoU will be applied
- A schedule and strategy for review.

Organisational commitment

- Specific actions that participating agencies agree to taking, to support effective service coordination
- Roles and responsibilities of each agency, team or staff member
- Relevant accountabilities (including strategies for review of processes, risk management and resolution of any challenges that arise through implementation).

Example MoU

EMR AOD Service Coordination Memorandum of Understanding

This MoU between EMR Alcohol and Other Drug Service providers describes the principles and practices of service coordination, roles of stakeholders and endorses the goal of increased coordination and seamless service delivery for AOD clients in the EMR.

This MoU was developed by Kate Pascale, in consultation with the AOD Service Coordination Working Group and key stakeholders. With support from the Department of Health EMR, the MoU was signed by executive officers of all EMR AOD agencies in December 2009. It was subsequently endorsed as a standing document in 2011. This has reinforced the sector's commitment to progress the implementation of service coordination and has provided an excellent foundation for ongoing work.

Purpose

The purpose of this MoU is to:

- describe the Eastern Metropolitan Region (EMR) Alcohol and Other Drug (AOD) service coordination project in the context of work achieved to date
- facilitate a shared understanding of the principles of service coordination
- articulate the principles, protocols and functional working arrangements that will facilitate effective communication and collaboration between AOD services
- gain commitment from stakeholders to support the implementation of key actions to deliver service coordination across the EMR AOD sector
- provide clarification of the roles and responsibilities of participating organisations.

This MoU acknowledges that the EMR AOD sector brings together organisations that offer a range of AOD services. Many individuals with AOD issues need to access a range of services from a range of organisations. This MoU supports the sharing of information to facilitate individual access to the services they need when they need them.

Scope

Included within the scope of this MoU are all funded AOD services provided by the parties to this agreement. It is not intended to create legally binding rights and obligations.

Background and introduction

This MoU has been developed as part of the EMR AOD Service Coordination Project. Initiated in March 2009, the project is an initiative of the Eastern Region's Alcohol and Drug Strategy Group.

The aim of the project is to support effective service coordination for AOD services in the EMR in order to:

- enhance continuity of care for clients
- improve client access to, and transfer between, AOD services and the broader service system
- support clients to negotiate care pathways in the AOD sector
- maximise client outcomes by reducing risk during transition period between service engagement
- reduce need for clients to provide duplicate information
- maximise efficiency in use of finite resources
- reduce demands on organisations through effective information sharing
- support the provision of quality, effective care through timely information gathering and sharing appropriate information.

It is acknowledged that successful implementation of service coordination in the EMR AOD sector requires a high level of mutual understanding, collaboration and agreement between all AOD services. Development of the necessary robust organisational systems is therefore contingent on support from all levels of management within and between AOD agencies.

Service coordination overview

Service coordination is a state-wide initiative to promote functional service integration across the Victorian health sector. Service coordination seeks to achieve consistency in the practices and systems of organisations to enable organisations to work collaboratively, while retaining their organisational autonomy. The goal of service coordination is to provide a seamless and integrated service system to maximise client outcomes and organisational efficiency. Service coordination is underpinned by principles that focus on:

- client-centred care
- partnerships and collaboration, within and between sectors
- a duty of care
- the social model of health.

Service coordination provides a framework that outlines key practices, processes, protocols and systems across elements of client care within the context of existing organisational structures. This approach seeks to enable services to work together to develop and implement effective local solutions.

Benefits of service coordination

Consumers often experience a service system that is fragmented, difficult to navigate and at times, not responsive to their needs. Service coordination aims to link services more closely, provide a more seamless system and ensure clients can access a cohesive service system. Timely and appropriate information sharing is an essential component of effective service coordination with tangible and sustainable benefits for clients and services. This can be facilitated through the development of effective and efficient referral practices. For clients, comprehensive and consistent referral practices can support improved continuity of care, reduced duplication and promote seamless access to and transfer between AOD services.

Additionally, sharing information, as a key component of effective service coordination is proposed as an effective strategy to reduce the risks of relapse and deterioration during the client's transition between services.

This integrated, inter-organisational model of service provision is identified as appropriate, cost effective and efficient. It supports an organisation's ability to achieve service objectives and facilitates sustainability in the delivery of high quality, safe and effective health care (NSW Health 2001; ACSQHC 2003; NPSA 2003). Service coordination can achieve tangible benefits for clients and services including:

- a more systematic approach for clients with complex needs
- access to the right service at the right time
- earlier identification of client needs
- better management of waiting lists
- improved service navigation
- reduced assessment duplication
- increased coordination and collaboration in service delivery, planning and development
- greater operational efficiency.

Structural supports

Department of Health

The Department of Health's EMR endorses this project and is committed to ensuring service coordination is embedded as standard practice in the AOD sector across the region.

EMR Alcohol and Drug Strategy Group

The EMR AOD Strategy Coordination initiative was formed by the Department of Health's EMR in 2007. Following extensive policy and data analysis, stakeholder consultation and evaluation, a strategic action plan was developed in line with Victorian AOD policies. In order to direct, coordinate and monitor the implementation of this plan, the EMR AOD strategy group was established, comprising members from the Department of Health's, government funded AOD services, local government, regional police and mental health. Enhancing collaboration through service coordination was identified as one of four strategic areas for the strategy group.

Existing policy context

A range of federal, state and local policy documents exist that provide key directions for the AOD sector and support and guide service coordination. Selected relevant policies are outlined below:

Federal

- *The National Drug Strategy: Australia's integrated framework 2004–2009*
- *National Cannabis Strategy 2006–2009*
- *The National Action Plan on Mental Health 2006–2011*

Victorian

- *Improving health, reducing harm: Victorian Drug Strategy 2006–2009*
- *A new Blueprint for the Alcohol and Other Drug Treatment Sector*
- *Restoring the Balance: Victoria's Alcohol Action Plan 2008–2013*
- *Shaping the future: The Victorian Alcohol and Other Drug Quality Framework*
- *Victoria's Alcohol and Drug Treatment Services – The Framework for Service Delivery*
- *Better Access to Service: A policy and Operational Framework*
- *Dual diagnosis: Key direction and priorities for service development*
- *Victorian Health Promotion Plan 2007–2012*
- *Care in Your Community: A planning framework for integrated ambulatory health care*

Eastern Region

- *Outer East Health and Community Support Alliance (OEHCSA) Community Health Plan 2006–2009*
- *Inner East Partnership Plan*

Guiding documents

PCP Victoria has developed a range of documents outlining best practice principles, processes and tools to support the implementation of service coordination. These include:

- *The Victorian Service Coordination Practice Manual 2009*
- *Good Practice Guide 2009*
- *Continuous Improvement Framework 2009*
- *Service Coordination Tool Templates 2009 user guide*
- *Service Coordination: What? Why? How?: Self Paced Training Module*

Term

Participants are seeking to achieve the implementation of recommendations within the timeframe of the project (completion April 2010). There is however an expectation that services will continue to embed the principles of service coordination within their organisational policies and procedures, and that strategies will be implemented to support these initiatives as part of ongoing quality improvement processes. The annual review of the MOU will be coordinated by the EMR AOD Strategy Group.

Operational context

The AOD Service Coordination Working Group, with support and direction from the EMR AOD Strategy Group, will provide strategic direction and monitoring of the implementation of the Service Coordination Project and future development of the initiative.

Organisational commitment

The overall intent of the MoU is to foster and promote the development of robust working relationships between AOD services within the EMR to facilitate coordinated, cohesive and client-centred care that is accessible and easy to navigate. The parties to this MoU will work together to create and strengthen working relationships between AOD services and the broader health and social sectors in order to improve joined-up service provision and outcomes for consumers. Across the EMR, the AOD sector provides a range of treatment options through a network of diverse organisations. It is therefore acknowledged that the details of policies and procedures required to embed the principles of service coordination may differ across organisations.

Parties to the MoU will therefore be expected to contribute to the development and implementation of key guidelines that address key priority issues. These address:

- referral pathways
- sharing client information/coordinated care
- managing unplanned discharges
- duty of care at the beginning and end of client's episode of care
- making service details available in public forums
- orientation programs
- accreditation
- collaborative service development/planning.

In line with existing policy standards and frameworks, in signing this MoU, each party agrees to:

- develop and maintain organisational policies that are supportive of the overarching principles of service coordination (as above)
- nominate an appropriate representative to the AOD Service Coordination Working Group who will be responsible for contributing to the Working Group as per the group's terms of reference
- provide clear leadership at all levels of their respective organisations to develop and promote a coordinated, client-centred and high-quality system of coordinated care for consumers
- support and actively participate in initiatives to facilitate effective communication between service providers and contribute to collaborative care planning for shared clients
- embed the agreed protocols and functional arrangements into local work practice and provide ongoing support for the implementation, monitoring and evaluation of service coordination initiatives.

Over time, this open and transparent information sharing will facilitate a better understanding of appropriate referral pathways and the adoption of regional processes and systems that are appropriate in the context of each organisation.

Communicating your service coordination approach with your partners

The following resource was developed in 2011 as part of the EMR AOD service coordination project. It was designed to be shared with key stakeholders and service partners, in order to provide them with a summary of key information about the project and the local service coordination approach.

Example: Overview of service coordination approach

What is the EMR AOD Service Coordination Project?

Alcohol and Other Drug (AOD) agencies across Melbourne's Eastern Region (EMR) are committed to working together and engaging with other service sectors, to deliver the best possible care to our community. Over the last three years, the sector has therefore come together, through the EMR AOD Service Coordination Project, to develop systems and practices that support improved access, continuity and coordination of client care. We have developed and implemented a range of new processes to ensure a consistent approach to service coordination across the sector. These include:

- **streamlined referral processes** to ensure that clients can access services as quickly and easily as possible and that referrers are informed of the client's progress
- **early identification of clients' treatment history** and engagement with other service providers
- **timely communication** with other services involved in a client's care
- ensuring that when an inappropriate referral is received, the **client is supported to access the appropriate service** to meet their needs.

What can you expect from us?

- **When you make a referral** to an EMR AOD agency, we will send you a fax acknowledging that your referral has been received and actioned. Periodic updates will then be provided as the client progresses through the service.
- **When we identify that we are working with a shared client** you will be notified that the person is enrolled in the AOD service and provided with the worker's contact details. Upon discharge, you will be sent another fax including a brief discharge summary and follow up plan.

Please note: The above practices are all conducted with consideration of the relevant privacy and consent legislation and are therefore dependent upon receiving informed consent from the client.

How can you support effective service coordination for your AOD clients?

In order to ensure that we can minimise the duplication of assessment (for both clients and staff), it remains our priority to ensure that we share relevant information across the client's care team. You can assist by:

- **providing the client with a copy of relevant information** (for example, assessment, care plan or discharge summary) that they can take to other relevant appointments
- **making assisted referrals** to the relevant agencies
- **providing relevant handover information** in a timely manner. In order to support timely information sharing, EMR AOD agencies have introduced a '***Request for information***' template that includes details of the service that the client has been enrolled in, evidence of client consent to share information and details about the type of information we require to support their care. It would be much appreciated, if this could be actioned as soon as possible.

To identify the appropriate AOD agency for your client, you can contact:

DirectLine: 1800 888 236
Drug and Alcohol Community Advisory Service (DACAS): 1800 812 804

Chapter 3: Supporting individual practice change

Effective service coordination requires consideration of the way services are delivered throughout a client's engagement with the service system – from the first point of contact to the development of appropriate discharge plans and provision of relevant ongoing supports (DHS 2011; Pascale 2009; PCP Victoria 2012a).

The model of care adopted needs to integrate systems that support coordinated, client-centred service delivery throughout the continuum of care. This includes processes that proactively support clients to navigate the service system, access relevant services and coordinate shared care plans (Pascale 2010).

Evidence and experience indicates that these challenges are not limited to the AOD sector and that solutions to address these issues are equally important in a range of settings. In developing relevant solutions, it is recommended to **focus on the processes** required to achieve high-quality, consistent practice and effective information sharing.

To support good practice, the EMR AOD Service Coordination Project therefore developed the following key process guidelines:

- early identification of client's previous treatment history
- assisted referral guidelines
- FYI assisted referrals
- provision of referral feedback
- sharing of client information
- notification of enrolment and discharge for non-referrers.

It was also identified that simple and easy to use tools and templates were required to support implementation (Pascale 2011). The templates included below have therefore been created to support good practice and aim to promote consistency without becoming burdensome for staff or clients. Agencies are encouraged to refine these templates to meet the needs of their organisation.

Staff across the EMR AOD sector have been actively involved in the development and implementation of each key process guideline and the associated templates. This was an important strategy to ensure buy-in from staff, develop a shared understanding of good practice and provide clinicians with the opportunity to experience the associated benefits of implementation. The project demonstrated that through this highly collaborative process, staff developed a greater sense of value for service coordination and a strong commitment to ongoing work, within and beyond the project.

Each of these key process guidelines are included in this chapter. While these may be appropriate for many sectors, it is important to consider the needs of your organisation and partnership in order to develop relevant solutions. Partnerships may prioritise the development of additional or alternative guidelines.

This chapter also includes the following support tools to guide this process:

1. **Key considerations in the development of process guidelines**

   A list of questions to support staff to brainstorm issues, develop and prioritise potential solutions.

2. **Service coordination risk management framework**

   The framework provides a structured and objective way to discuss potential barriers and risks related to implementing service coordination strategies. It includes a set of risk analysis tools to identify, evaluate and assess relevant risks and develop appropriate mitigation strategies.

Staff knowledge and confidence

Broad consultation has identified that many staff, interpret the coordination of client services, engagement in partnerships and collaborative planning as additional work, beyond their core business (Pascale 2010). The need to upskill staff is therefore evident. In order to support a shared understanding of service coordination, it is recommended that education is provided to all staff, focussing on the principles of service coordination and their alignment within your practice context. Education should include:

- the principles that underpin effective service coordination
- the language of service coordination
- relevant organisational policies
- service coordination practices and support tools.

Ongoing support should also be provided in order to clarify recommended practices, discuss implementation issues and facilitate effective monitoring and evaluation processes.

Additional education is also required to ensure that staff have the relevant skills to deliver care in a manner that supports effective service coordination. This includes:

Privacy and consent/Managing client information

Staff understanding of privacy and consent remains inconsistent across sectors, disciplines and organisations. The processes for sharing consumer information, including duty of care requirements and mandatory reporting are comprehensively legislated through the *Victorian Health Records Act 2001*, the *Charter of Human Rights and Responsibilities Act 2006*, and the *Commonwealth Privacy Act 1988*. Organisations are also required to maintain protocols and systems to ensure client privacy and guide sharing information. Despite this legislation, concern about breaching confidentiality was identified by staff in the EMR AOD Service Coordination Project as the most common reason why clinicians did not share information between services (Pascale 2009). Concerns around client privacy have created anxiety among clinicians and had significant consequences on organisations' information sharing processes.

Staff expressed a range of concerns including:

- potentially breaching their duty of care (to maintain the safety of their clients) in order to adhere to privacy agreements (for example not disclosing risk information that client has requested remain private)
- lack of clarity regarding their responsibility and capacity to share information (including relapse and harm minimisation strategies) in the case of unplanned discharges
- reduced confidence in their processes to discuss the rationale for collecting information with clients.

Ongoing staff education and support is required to up-skill staff regarding privacy and consent legislation and strategies to support effective information sharing whilst respecting client confidentiality. This should then be supported by guidelines that clearly articulate expectations related to sharing clinical information and should be documented, endorsed and consistently applied across the sector.

Please refer to Chapter 6 for a range of resources regarding privacy, consent and sharing client information.

Clinicians' knowledge of local services

While a range of service information directories exist (for example *Human Services Directory* and *Service Seeker*), these are often out of date or incomplete. The lack of up to date information about local programs and their referral pathways is a major barrier for staff, clients and other agencies to make appropriate referrals and assist effective system navigation (Pascale 2009).

All health and community services therefore need to ensure that they maintain accurate, up to date information about their service in public forums. Services need to ensure that a process is in place (including dedicated accountability for completion) to ensure information remains up to date and accurate. This should include information provided in:

- brochures and marketing materials
- websites and internet-based resources
- service information directories (for example *Human Services Directory, Service Seeker* and other local directories).

Chapter 4: Implementing good practice

While there are a range of guidelines and tools to support effective service coordination, the EMR AOD Service Coordination Project identified the need to break this down and develop concrete processes to address priority issues. This chapter includes information, advice and tools that have been identified as relevant to support effective service coordination across the continuum of care.

All of the processes included align with existing best practice literature, good practice guides (such as the *Victorian Service Coordination Practice Manual*) and quality improvement/ accreditation requirements.

When applying these principles, it is essential that:

- organisations and partnerships consider how to adapt the guidelines to ensure their applicability within the unique context of their work
- staff are empowered to use their skill, expertise and clinical reasoning skills to work in a client-centred-way.

On the following page a flowchart that summarises key processes that support effective service coordination. Each of these processes is outlined in more detail throughout the chapter.

Good practice in action: A flowchart of key processes that support service coordination

Initial contact

For ALL clients:

Identify client's engagement with other service providers.

If client has been engaged with other services:

– Gain client consent to share information.
– Send a *request for information* and collect relevant handover information.

When referral received from another agency: Send Level 1 feedback via *referral feedback template (acknowledgement of referral)*.

If your service is not best placed to address this client's need/s: provide information and offer client option of an *FYI referral*.

Initial needs identification

For ALL clients:

Conduct a broad, needs identification in order to understand the clients presenting needs and priorities for service (within and beyond the scope of your agency's practice).

When client has been engaged with other services (but you did not receive a referral from that service): inform the service of your involvement by sending a *Notification of Enrolment.*

Assessment

For ALL clients:

Conduct a holistic assessment seeking information about the client's broad issues and needs.

Seek to reduce duplication of information wherever possible (utilise the information you have collected during IC & INI as well as any handover information provided to date).

When referral received from another agency: Provide Level 2 feedback via *referral feedback template* (*commencement of service*).

Care planning

For ALL clients:

Work with other relevant services to develop collaborative solutions

Consider opportunities for shared care planning

Establish processes to share relevant client information throughout their episode of care.

Discharge planning (Transition and exit)

For ALL clients:

work with the client to identify ongoing needs and link the client in with appropriate supports.

When referral was received from another agency: Send Level 3 feedback via *referral feedback template* (*completion of service*).

When client has been engaged with other services (but you did not receive a referral from that service): inform the service of your involvement by sending a *Notification of Discharge.*

Information sharing and referral

Ensure that processes are in place to accept referrals (and handover information) in a variety of formats and from all relevant sources

For ALL clients: Provide clients with the option to initiate self referrals, or be supported to make referrals

When sending assisted referrals: ensure that relevant information is provided to enable the other services to understand the clients needs and your intervention

When clients make self referrals: provide clients with appropriate support and written information that will facilitate easy access and handover to other services

Service access

Clients access the service system via a range of entry points, for a range of reasons, with diverse treatment goals and with a range of co-morbid conditions or issues (DHS 2008; DH 2011). Services are therefore set up to support clients across the spectrum, through a network of specialist agencies, each of which are funded to provide specific services within a defined catchment area (DHS 2008). Subsequently, clients' care pathways are varied. While this enables clients to receive care that is specific to their needs, it also creates difficulties in locating appropriate services (for clients, staff and other service providers). A range of other barriers including organisational capacity, geographic and financial barriers also impact on the accessibility of services for clients.

An important component of effective service coordination is providing service access systems that are accessible, responsive and that support clients to access the services they require efficiently and easily (DHS 2004; DHS 2008). The ability to easily and efficiently access relevant services is therefore critical to the delivery of high quality services (Hamer 2004). As such, consideration should be given to simplifying service access points and ensuring that systems are in place to support clients, carers and staff to navigate the system.

This can also be supported by the provision of effective decision support tools that enable clinicians to identify appropriate treatment options for their clients across a broad range of sectors. The Victorian Service Coordination Framework includes *Service Coordination Tools Templates (SCTT)*, which is a suite of template designed to support service coordination.

Effective initial engagement

The need to engage clients effectively upon their initial access is also essential in order to build rapport, ensure that clients feel valued and listened to and provide a sense of confidence about the service's ability to respond appropriately. This requires a timely response, excellent communication and listening skills, the provision of relevant information and respect for the client's privacy, needs and goals (DHS 2008a). The quality of interaction during a client's first contact also has implications on their likelihood to engage in ongoing intervention and ultimately achieve positive outcomes. Particularly for clients who have been considering seeking help (for example for dependency issues) for a long period of time, it is essential to capitalise on their attempt to actively seek support.

Clients frequently report frustration and concern when they are told to contact one service, but then told that they are not the correct service and given a list of other numbers to call. When clients do access an inappropriate service, systems should be consistently introduced that ensure that services can actively support clients to identify and access the most appropriate agency to meet their needs. Access staff are also required to respond to clients who may be anxious, distressed and/or in crisis. While many agencies do not provide specific crisis services, staff must have the skills and supports available to manage the situation effectively and facilitate appropriate links.

At times, it is also necessary for clinicians to engage with a client over an extended period of time, prior to commencing formal service access processes. This enables clinicians to build rapport with the client and create a safe environment for ongoing intervention. The level of skill required to effectively engage clients at their first point of contact should therefore be considered, recognised and supported by dedicated and appropriate resources.

Early identification of treatment history

Key process guideline – Early identification of treatment history

Rationale

The first step to effectively coordinating a client's care is to identify whether the client is, or has been engaged with other service providers. When staff are unaware of the client's treatment history, the opportunity to obtain handover, share information and collaboratively plan care is lost.

Enabling early identification of the client's treatment history is beneficial for:

- supporting clients through their transition between services
- gaining an understanding of the client's strengths, barriers to care and strategies to maximise their engagement
- improving the timeliness and quality of risk screening (including identification of issues that may impact on the safety of clients and staff) and develop appropriate risk management plans
- increasing the likelihood of adherence to treatment plans, when plans are developed that reflect the clients experience and context
- supporting effective, high quality discharge planning.

Guideline

Standard practice of all AOD agencies is to include strategies for the early identification of every client's previous treatment history during their initial contact or initial needs identification.

Procedure/Protocol

- inclusion of questions regarding engagement with other AOD services (and other sectors) in initial screening and assessment tools
- disclosure of information form to be signed during first contact (or verbal consent gained and documented accordingly)
- request that client include previous worker's details (for example on assessment form or key contact list) to enable staff to collect and provide handover information

Dependencies

Successful implementation of this practice guideline is supported by:

- clinicians building rapport with the client and providing appropriate rationale for sharing of client information
- client willingness and ability to provide accurate information related to previous history
- clinicians' understanding of other service providers.

Monitoring and review

This practice guideline should be applied within the context of each organisation's policies and procedures, with mechanisms for ongoing monitoring and review built into organisational quality improvement processes. The benefits will be maximised by collaborative interagency evaluation opportunities, in which organisations can work together to identify the strengths of the guideline and identify strategies for ongoing refinement.

KPI: It is anticipated that a random audit of client files would identify a minimum of 80 per cent compliance with this guideline.

Risk assessment: In the development of this protocol, the following risks were identified for consideration:

Risk	Mitigation strategies	Risk rating (following implementation of relevant mitigation strategies)		
		Likelihood	Consequence	Rating
Client is denied service or discriminated against if investigation into previous treatment history identifies behaviour that is perceived negatively	Staff utilise their experience and expertise to ensure that all clients maintain equal opportunity to access the services they require to support their health and wellbeing. Appropriate systems and policies are in place to ensure that clients who pose a risk to staff or consumer safety, are supported appropriately.	Unlikely (2)	Moderate (3)	**Low**
Failure to collect relevant handover information if client does not disclose treatment history	Clients maintain the right to choose whether they disclose information about their treatment history. Staff complete a comprehensive assessment and collect the information required to ensure appropriate care planning. Opportunities to collect handover information and collaborate with relevant services will remain open throughout the client's engagement.	Possible (3)	Insignificant (1)	**Low**
Increased assessment time and administrative requirements resulting in reduced time available for direct clinical care	Streamlined tools and templates available to support timely and efficient information collection. Education provided to all staff to ensure that processes reduce duplication wherever possible.	Rare (1)	Minor (2)	**Low**

This guideline has been designed to mitigate these risks wherever possible. Given appropriate education, supervision, tools and support, the EMR Service Coordination Working Group believes this level of risk is acceptable and advocates for the implementation of this guideline. Open and transparent communication is required to support ongoing evaluation of these risks and amendment of the guideline as appropriate. Consideration should also be given to expanding the scope of the guideline to include the provision of feedback regarding referrals received from other sectors to promote effective communication and inter-sectoral collaboration.

Holistic needs identification and assessment

Holistic service delivery can only be achieved through the completion of a comprehensive, holistic needs identification and assessment process. Many staff however report a lack of confidence around holistic needs identification and express concern regarding their skills and duty of care to address issues that are beyond the scope of their clinical expertise (Pascale 2009). Ongoing education and support is therefore required to address this, and promote effective holistic needs identification and assessment.

Consideration should also be given to developing strategies that integrate prompts to coordinate care into screening and assessment forms.

Duplication of information collection creates significant frustration for clients and staff alike. Throughout their engagement with health and community services, clients are often required to re-tell their story multiple times and provide information over and over again. While it is essential that each discipline conducts a comprehensive service specific assessment, effective sharing of client information enables staff to re-frame their approach to assessment and adapt the conversation accordingly to focus on their specialist assessment.

Referral pathways

Referrals are an important component of service delivery across all health and community service sectors (PCP Victoria 2012a). Referrals are the mechanism by which staff communicate with other agencies and support a client to access appropriate services and transition between providers. As such, comprehensive and consistent referral practices can support improved continuity of care, reduced duplication and promote seamless access to, and transfer between, AOD services (PCP Victoria 2012a; Pascale 2011). From a service perspective, consistent and effective referral systems support staff in maximising client outcomes and using limited resources efficiently. They also hold the potential for increasing service capacity (KPMG 2004; PCP Victoria 2005).

Referrals are often considered part of discharge planning, however for many clients, referrals need to be considered throughout their entire episode of care (PCP Victoria 2012a). Evidence demonstrates that effective initial engagement has positive impacts on clients' satisfaction with a health service and is linked to the likelihood of successfully accessing and completing AOD 'treatment' and achieving positive health and wellbeing outcomes. Challenges accessing appropriate services are factors that can have a significant impact on a client's successful engagement. Reports indicate that at times, clients feel as though they are 'shuffled' between agencies, given multiple contact numbers and then left to navigate the system alone (Pascale 2011). Supporting clients to navigate the system can be greatly improved through the implementation of streamlined referral pathways.

Definitions

An **assisted referral** describes a referral in which a staff member makes a referral on behalf of a client (PCP Victoria 2012a). Assisted referrals can occur via a verbal referral (for example phone based communication between agencies), fax, letter, secure email or via an electronic referral system.

This is in contrast to a **self-referral**, where a client or carer makes contact with the service directly (including when the client is encouraged by the practitioner to refer him/herself by, for example, providing a telephone number).

It is important to note that all assisted referrals are subject to consent procedures and should be documented according to relevant legislation.

Identifying appropriate referral mechanisms

Driven by the principle that 'a self-referral is an empowered referral', the AOD sector broadly promotes clients independently initiating referrals for treatment. The reasons for this include placing the onus clearly on the client to take responsibility for his/her treatment with a view to encouraging commitment and compliance. In some cases, this reliance on self-referrals has reduced the formal interaction between service providers and places responsibility solely on the client to initiate and track referrals and repeat baseline information throughout their engagement with the sector.

While self-referrals remain an appropriate option for many clients, there are occasions where a formal written referral is either highly desirable or, as a matter of professionalism, obligatory.

Additionally, it is important to note that assisted referrals are not the only strategy by which agencies can share client information and promote continuity of care. It remains appropriate for many clients to initiate self-referrals, however services should still provide background information to support both the client and clinicians (given consumer consent). As such, information sharing does not need to be mutually exclusive from the process of self-referrals.

Agencies are therefore encouraged to consider their approach to referrals and ensure that a range of referral pathways are in place to support timely and efficient communication and transition between services.

An assisted referral should be considered when:

1. A client is cognitively impaired (for example suffers acquired brain injury/intellectual handicap/ dementia) to a point where a successful self-referral is unlikely.
2. Medical treatment is strongly indicated (for example, if the client does not receive medical treatment in the near or immediate future then life may be put at risk).
3. The mental health of a client would make it unlikely that he/she would follow through on a self-referral.
4. The client is experiencing grief or loss to the point where it is unlikely that he/she would follow through on a self-referral.
5. A client is insecure or has personality characteristics that would make it unlikely that he/she would follow through on a self-referral.
6. A client's lifestyle is so chaotic that a successful self-referral is a low probability.
7. A carer looking after the client may not be sufficiently reliable or capable of making a referral.
8. An assisted referral may be what is needed to move the client to the next point in the stages-of-change cycle. That is, where the client would be unlikely to be sufficiently self-motivated to take the next step but may feel obligated or encouraged to do so by a written referral.
9. It is desirable to place on record those actions taken to assist a client (for example for duty of care reasons).
10. A client specifically requests support to make a referral.
11. An assisted referral is specified by the receiving agency.
12. For the sake of clarity and professionalism.

These guidelines have been adapted (with permission) from the *IEPCP Written Referral Guidelines* 2011 available at www.iepcp.org.au/resources-links-1

Key process guideline – FYI assisted referral

Rationale

Many agencies' referral processes dictate that a comprehensive initial assessment and/or detailed referral form be completed prior to making a referral to another agency. However, when it is identified that a client does not meet a service's eligibility criteria, or the agency is not best placed to meet a client's needs, it can be inappropriate and inefficient for that service to complete a full assessment solely for the purpose of making a referral to a more appropriate service. It is therefore appropriate to ensure that when relevant, strategies are in place to make assisted referrals without completing a full assessment. Within this toolkit, such referrals are referred to as 'FYI referrals'.

FYI referrals should contain basic information such as the client's contact details, identified concerns, evidence of consent to share client information and information about the support service requested. This provides clients with an option to have the relevant service call them back to complete intake and assessment information or they may choose to make a self-referral. This also ensures that services can optimise their initial contact with the client, effectively engaging them and demonstrating a commitment to ensuring their needs are met.

Guidelines

Staff will provide clients with the choice of being given the contact details of an alternative service provider or making an FYI referral on the client's behalf for:

- clients (or carers) who contact the service and it is identified, before the completion of a full initial assessment, that the agency is not best placed to meet that client's needs (for example when a client does not meet the agency's eligibility criteria or for clients whose needs would be more effectively met by another service provider)
- regardless of whether the information was collected by phone or in person
- given consent from the client in accordance with the Victorian Health Records Act and the Commonwealth Privacy Act.

Procedure/Protocol

Staff will inform the client (or carer) that their agency is not the most appropriate service to meet their needs and provide the client with the option to be given the contact details of an alternative service provider OR that the staff member can send a referral to that agency on the client's behalf.

For clients that request an assisted referral, the staff member should complete and send a FYI referral:

- in writing to the relevant service provider **by the end of the business day for an urgent referral or within no more than three business days for a routine referral**
- using the service's *FYI referral template* (see attachment 1) or appropriate alternative which should include (at a minimum):
  - the client's contact details
  - a summary of the presenting issues and services sought (identified during initial contact)
  - level of urgency and evidence of client consent.

The agency is not required to collect detailed referral information for the sole purpose of assisted FYI referral.

- FYI referral templates should be documented and stored in line with privacy legislation.

Note: Organisations will need to ensure that an appropriate system is in place to record and store FYI referral information as it is unlikely that the client will have a client record.

Dependencies

Successful implementation of this practice guideline is supported by:

- clinician's capacity to complete the referral within appropriate timeline
- clinician's understanding of other service providers
- maintenance of current contact details for relevant services (including fax and/or email details) in publically available forums
- clinician's understanding and adherence to appropriate consent practices
- clinicians building rapport with the client and providing appropriate rationale for sharing of client information
- clinicians having the necessary skills, knowledge and tools to provide clear rationale for information sharing (including purpose and scope)
- use of a common language related to clinical care across services
- trust between agencies and staff about the accuracy of information collected by other clinicians
- client's willingness and ability to provide accurate information related to their presenting issues and needs.

Monitoring and review

This practice guideline should be applied within the context of each organisation's policies and procedures. It is therefore anticipated that mechanisms for ongoing monitoring and review will be built into organisational quality improvement processes. The benefits will be maximised by collaborative interagency evaluation opportunities, in which organisations can work together to identify the strengths of the guideline and identify strategies for ongoing refinement.

KPI: It is anticipated that a random audit of client files would identify a minimum of 80 per cent compliance with this guideline.

Risk assessment: In the development of this protocol, the following risks were identified for consideration:

Risk	Mitigation strategies	Risk rating (following implementation of relevant mitigation strategies)		
		Likelihood	Consequence	Rating
Additional paperwork becomes burdensome for staff resulting in delays for all clients accessing services (will create a bottle-neck at intake)	Clients will be given the choice of an FYI referral OR providing appropriate contact details. Creation of simple FYI referral template to ensure efficiency of implementation. Guideline clearly articulates that staff are required to only collect the information necessary to identify the most appropriate service for referral – a complete initial assessment is not necessary.	2	2	**Low**
Staff fail to correctly identify the most appropriate service resulting in delays in service access and frustration for clients	Staff have access to relevant contact details via a range of resources including public service directories such as the *Human Services Directory* and *Service Seeker* to assist in their decision support.	2	2	**Low**

This guideline has been designed to mitigate these risks wherever possible. Given appropriate education, supervision, tools and support, the EMR Service Coordination Working Group believes this level of risk is acceptable and advocates for the implementation of this guideline. Open and transparent communication is required to support ongoing evaluation of these risks and amendment of the guideline as appropriate.

Assisted ‘FYI’ referral template

Date: ...../...../.....

Dear .....

Service provider:.....

Client name:			
Gender	Male / Female	Date of birth:	
Address:			
Contact numbers:	Business hours:	A message can be left: Yes / No	
	After hours:	A message can be left: Yes / No	
	Client’s preferred method and time to be contacted:		

Consent to share information gained from client: Yes verbal / Yes written / No

This client contacted XXXXX service on , ……by phone / in person / ……..

requesting ……..

……

I have collected the following information about the client’s circumstances:

……

……

……

Following a discussion with this client, we believe your service is best placed to meet their needs.

The client has requested that you please phone them to follow up this request.

Urgency of request: Urgent / Routine

The client has been given a copy of this referral: Yes / No

Please do not hesitate to contact me if you have any queries.

Yours sincerely,

Name of clinician
Role, Service

Phone: …….. Fax: ……

Email:……..

Assisted 'FYI' referral example

Date: .....01 / 08 / 2011

Dear ..... Margaret Changelives

Service provider: ..... On-The-wagon (Ph: 4985 266 548)

Client name:	Joe Drinker		
Gender	Male / Female	Date of birth:	25/12/1945
Address:	180 Drinkers Lane, Drinktown Melbourne		
Contact numbers:	Business hours: 0499 999 999	A message can be left: Yes / No	
	After hours: 47777 666 655	A message can be left: Yes / No	
	Client's preferred method and time to be contacted:	SMS only - Weekday before 4pm	

Consent to share information gained from client: Yes verbal / Yes Written / No

This client contacted Sober House on ..... 1/8/11 ..... by phone / in person / .....

requesting .....Drug and Alcohol Counselling.....

I have collected the following information about the client's circumstances by:

Joe lives in rented accommodation in Mt. Coordination with his partner and 4 children. He currently drinks 3 bottles of Jack Daniels and smokes marijuana 5 - 6 times a day. Joe has recently lost his job and his partner has reported she will leave Joe if he does not reduce his drinking and drug use. Joe has never sought AOD treatment before but reports he is now keen to commence one-on-one counselling and hopes to be able to reduce his current intake, return to employment and remain at home with his family.

Following a discussion with this client, we believe your service is best placed to meet their needs.

The client has requested that you please phone them to follow up this request.

Urgency of request: Urgent / Routine

The client has been given a copy of this referral: Yes / No

Please do not hesitate to contact me if you have any queries.

Helpful Harry,
Sober House 105 Merry Way, Mt. Coordination 3999

Ph: 03 9876 5432 .....Fax: 03 9123 4567.....

Email: info@sober.com.au .....

Key process guideline – Provision of referral feedback

Rationale

Effective referral practices are a key strategy to promote consistency and support the appropriate sharing of client information between services. The *Victorian Service Coordination Practice Manual* (2012) outlines an expectation that service providers will acknowledge referrals received and provide feedback to referring services about referral outcomes.

The implementation of this guideline does not circumvent the need for direct communication between services. Rather, it provides additional support to facilitate interagency communication, promote timely feedback and reduce demands on staff.

Guidelines

Clinicians will instigate this feedback loop for referrals received for clients:

- upon receipt of a formal/assisted referral from another service
- upon receipt of a self-referral (from client or carer) when it is identified that the client has been engaged with another service within 30 days immediately prior to receipt of referral, or as deemed clinically relevant.

Staff will gain consent from the client prior to sending acknowledgement of referral in accordance with the Victorian Health Records Act and the Commonwealth Privacy Act. Unless requested, the consent form does not have to be sent to the referring service.

As per the 2012 *Victorian Service Coordination Practice Manual*, if a client does not consent to their information being shared between services, relevant referrals can still be made. In these circumstances, the agency receiving the referral is required to collect relevant information directly from the client.

Procedure/Protocol

- Feedback can be sent via fax or email using the service's *Referral feedback template* or appropriate alternative which will include a brief introduction to key service information including an outline of referral pathways, eligibility criteria and relevant practice details.
- It remains the responsibility of the agency receiving the referral to liaise with the client regarding the outcome of referral (unless specifically negotiated and agreed by staff in extenuating circumstances).
- Referral feedback forms and associated communication will be filed appropriately in client records.

If the client is not eligible or appropriate for the receiving service:

- Where possible, staff may provide advice about an alternative, more appropriate program or community service. It will remain the responsibility of the agency sending the referral to follow this up (unless specifically negotiated and agreed).
- In order to promote a high standard of customer service and facilitate continuity of care, staff may forward the referral on to an alternative, appropriate service. Ongoing referrals must be agreed in advance by both parties and be made in accordance with client consent.

Level one feedback: Acknowledgement of referral

- Clinicians will provide an acknowledgement **within two working days** of receipt of an **urgent** referral, or **no more than seven days** of receipt of a **routine** referral.
- Feedback to the referring agency should include, as a minimum, an acknowledgement of the referral, the service's decision to accept or decline the referral and key contact details. Further detail regarding information to be included is identified in the attached feedback provision guidelines.

Level two feedback: Commencement of service

- Clinicians will provide feedback relating to the referral outcome **within seven days** of the client's initial assessment.
- As a minimum, feedback should include the outcome of assessment and an action plan including the nature and frequency (if relevant) of service to be provided, anticipated date for commencement of service and key contact details. Further detail regarding information to be included is identified in the attached feedback provision guidelines.
- Based on the waiting period between initial assessment and commencement of service, services may deem it appropriate to provide additional feedback upon commencement of service.

Level three feedback: Completion of service

- Clinicians will provide feedback **within seven days** of completion of service or when a **significant change** occurs to the nature of service being delivered that will impact on the referring agencies ongoing interaction with the client.
- As a minimum, feedback should include the rationale for cessation of care and a summary of referrals made for ongoing support and management. Further detail regarding information to be included is identified in the attached feedback provision guidelines.

Dependencies

Successful implementation of this practice guideline is supported by:

- provision of clear referral rationale and adequate detail from referring agency regarding that services plan for ongoing client engagement, transitional supports and/or discharge
- accurate estimation of referral priority
- early identification of client's previous engagement with relevant service
- ongoing commitment from the referring agency to support client through transition, as per duty of care requirements
- clinician's understanding of different services and their respective eligibility criteria
- maintenance of current contact details for relevant services (including fax and/or email details) in publically available forums
- appropriate completion of previous phases of feedback provision (validity and usefulness of level two feedback is dependent on the timely and accurate provision of level one feedback)
- effective relapse prevention and management strategies embedded in services.

Monitoring and review

This practice guideline should be applied within the context of each organisation's policies and procedures. It is therefore anticipated that mechanisms for ongoing monitoring and review will be built into organisational quality improvement processes. The benefits of this will be maximised by collaborative interagency evaluation opportunities, in which organisations can work together to identify the strengths of the guideline and identify strategies for ongoing refinement.

KPI: It is anticipated that a random audit of client files would identify a minimum of 80 per cent compliance with this guideline.

Risk assessment: In the development of this protocol, the following risks were identified for consideration:

Risk	Mitigation strategies	Risk rating (following implementation of relevant mitigation strategies)		
		Likelihood	Consequence	Rating
Referring service prematurely cease service delivery upon receipt of acknowledgement of referral	Skilled staff employed with knowledge of their duty of care to deliver services appropriately. Partnership agreement (MoU), staff education and KPG clearly articulate the appropriate application of this practice. Organisation's PPPS articulate guidelines for transition and exit practices.	Rare (1)	Moderate (3)	**Low**
Provision of referral feedback and storing/ filing additional paperwork becomes an arduous and overwhelming process, particularly for smaller services	Creation of simple referral feedback template to maximise efficiency of implementation – agencies encouraged to redesign template to ensure it is appropriate to the context of each service.	Possible (3)	Minor (2)	**Low**
Introduction of additional paperwork reduces the time available for clinical intervention	Creation of simple referral feedback template to maximise efficiency of implementation.	Unlikely (2)	Minor (2)	**Low**

Risk	Mitigation strategies	Risk rating (following implementation of relevant mitigation strategies)		
		Likelihood	Consequence	Rating
If standard practice assumes provision of level three feedback and it is not provided, referring agency (for example CCCC counsellor) may not re-commence service delivery in a timely manner based on assumption that client continues to receive service from receiving agency (for example residential rehab)	Agencies retain the professional responsibility to maintain communication with their client and/or other services in order to deliver appropriate care.	Rare (1)	Moderate (3)	**Low**
Loss of good-will and willingness for open-communication and collaboration if services do not engage in the provision of consistent feedback	Professional and committed staff employed to deliver service. Partnership agreement (MoU) includes commitment to reciprocal practice across all participating agencies.	Unlikely (2)	Moderate (3)	**Medium**

This guideline has been designed to mitigate these risks wherever possible. Given appropriate education, supervision, tools and support, the EMR Service Coordination Working Group believes this level of risk is acceptable and advocates for the implementation of this guideline. Open and transparent communication is required to support ongoing evaluation of these risks and amendment of the guideline as appropriate.

Consideration should also be given to expanding the scope of the guideline to include the provision of feedback regarding referrals received from other sectors to promote effective communication and inter-sectoral collaboration.

Referral feedback template

Consumer Information:

Name:	
Date of Birth:	
Gender:	
Contact Number:	

Service Name:	
Contact Details:	

Referral Received on (Date):

Form of Referral (circle appropriate)		
Self Referral	Assisted Referral	Referrers Name:

LEVEL 1 FEEDBACK

THE REFERRAL HAS BEEN ACCEPTED		DATE:			
Client Placed on Waiting List	Yes / No	Approximate Waiting Time			
Initial Assessment Booked	Yes / No	Date of Assessment			
Supports in place during transition	Yes / No	Details			
Key Contact	Worker Name: Phone: Email:				
THE REFERRAL HAS BEEN DECLINED		DATE:			
Wrong place	Capacity constraints	Ineligible for service	Information Inadequate	Client declined	Other
Comments and any further actions required:					

LEVEL 2 FEEDBACK

COMMENCEMENT OF SERVICE		DATE:	
Initial Assessment completed	Yes / No	Date:	
Service Commenced	Yes / No	Date:	
Nature of Service delivery (e.g. Counselling 1/14, residential rehab)			
Key Contact	Worker Name: Phone: Email:		
SERVICE NOT PROVIDED		DATE:	
Client declined	Service no longer required	Service no longer available	Other
Additional Information (e.g. additional referrals made, ongoing plan, additional information required, issues):			

LEVEL 3

COMPLETION OF SERVICE	DATE:
Service Provision Completed	Change of Service Delivery
Client Plan:	

Feedback provision guidelines: Information for inclusion

First level feedback: Acknowledgement of referral

Response	Type of response	Response reason	Response detail
Acceptance	1. Waiting time for assessment or service provision	Approximate time	Worker name and contact information
	2. Supports in place during transition / wait list	Yes/No	Details of transition plan (expectations of referring service)
Rejection of referral	1. Wrong place	Service not provided	Action plan including responsibility and/ or details for further referrals
	2. Capacity constraints	Service is offered (right place) but currently unavailable	Rationale (for example staffing constraints, long waiting time, Waiting list closed)
	3. Ineligible for service	Criteria	Action plan including responsibility and/ or details for further referrals May provide detail of alternative service (optional)
	4. Information inadequate	Not enough information provided Referral information out of date	Request for information required to process referral
	5. Client declined	Rationale	Action plan including responsibility and/or details for further referrals

Second level feedback: Commencement of service

Response	Type of response	Response reason	Response detail
Commencement of service	Service commenced	Service type Commencement date Frequency Worker/s contact details	Additional referrals made Ongoing action plan Any ongoing expectations of referring agency?
Validity of referral information	Was all relevant information provided in referral?	Yes/No	Requests for additional information/clarification Identified concerns/ issues for discussion
Service not provided	1. Client declined service 2. Service no longer required 3. Service no longer available	Rationale	Additional referrals made Ongoing action plan Any ongoing expectations of referring agency?
Validity of referral information	Was all relevant information provided in referral?	Yes /No	Requests for additional information/clarification

Third level feedback: Completion of service

Response	Type of response	Response reason	Response detail
Care complete	Service provision completed	No further action Referrals to other services	Details of referrals made/required Ongoing action plan Any ongoing expectations of referring agency?
	Change of service delivery	Changing social or health status resulting in changing care needs,	Ongoing action plan Key contact details Additional information/ support required

Sharing client information

Timely and appropriate information sharing is an essential component of effective service coordination with tangible and sustainable benefits for clients and services (KPMG 2004). In addition to promoting continuity of care and reducing duplication, sharing clinical information is proposed as an effective strategy to reduce the risks of relapse and deterioration during the client's transition between services. Effective information sharing can achieve these benefits by:

- supporting effective transition between services
- enabling timely risk identification and management
- reducing duplication for clients and staff
- facilitating shared care planning
- developing strong working relationships between AOD services and staff.

Currently, many organisations do not have systems in place that ensure information is routinely shared with other services. Limited handover of client information is identified as a major barrier to timely risk screening, coordination of care and effective information sharing. The EMR AOD Service Coordination Project identified a number of challenges to effective information sharing. These included:

- existing practices to follow up previous service providers can be labour intensive
- policies of some services to only accept self-referrals from clients
- requirement to use specific referral forms to share client information
- clinicians being unaware of client's previous treatment history
- current practice not routinely including a request for client consent to share relevant information with other service providers
- clinicians' lack of confidence and inconsistent practice in providing clients with an explanation for the rationale for information sharing.

Clear guidelines should therefore be established that promote:

- appropriate and timely handover of client information regardless of whether a self-referral or assisted referral is made
- acceptance of referral information from other service providers in a range of formats
- routine collection of client consent to share information with other service providers
- provision of necessary support, guidelines and tools for clinicians to provide clear rationale for sharing client information.

Services should be encouraged to utilise the clinical reasoning skills of their staff, harness their commitment to providing high quality care and develop information sharing strategies that maximise the use of existing information. Whilst maintaining minimum standards set in overarching practice guidelines, organisational policies and procedures should reflect this flexibility.

The project identifies that effectively sharing information is not reliant on the use of specific tools or templates, nor does it require uniform information collection strategies across the sector. Services are therefore encouraged to share that information, with a view of reducing duplication and assisting the client to move forward in their journey.

Key process guideline — Sharing of client information

Rationale

It is common practice for services to provide clients with contact details for a range of agencies that may be appropriate to provide ongoing support and treatment. Clients are then encouraged to initiate self-referrals to the agencies they believe will meet their needs. Subsequently, clients do not become engaged with all of the services that are discussed. It was therefore determined that implementing a process that requires agencies to send handover information to every agency that they have discussed with clients, may result in personal information being shared unnecessarily and create unnecessary paperwork for staff. It is also acknowledged that appropriate referrals and handover of clinical information is the responsibility of both the organisation sending and receiving the referral. As such, it is recommended that, upon receipt of a new referral, standard practice should include questions related to the client's previous treatment history and requests for information being sent to relevant agencies.

Guidelines

Clinical information will be shared for clients:

- when it is identified that the client has been engaged with another relevant service provider within 30 days immediately prior to receipt of referral, or as deemed clinically relevant
- regardless of whether a self-referral or assisted referral has been made
- in a timely manner via an appropriate format
- given consent from the client in accordance with the Victorian Health Records Act and the Commonwealth Privacy Act.

Procedure/Protocol

Receiving agency

- Upon identification of previous treatment history, clinician will initiate a request for information (via fax or email) regarding previous (or concurrent) care.
- The request for information can be sent via fax or email using the service's *Request for Information* template or appropriate alternative.
- The form will include details related to the source of the request, nature of the program client will be entering, timeline for acceptance into the program, indication of urgency and evidence of consent.
- Handover information will be accepted in a variety of formats including sending agency's assessment, care planning, discharge or referral tools and/or verbal handover.
- Request for information and subsequent handover information will be documented and filed appropriately in client records.
- Handover information will be used:
  - to inform the delivery of client care (including assessment and care planning) with a goal to reduce the need for the client to re-tell their story and optimise both continuity of care and the delivery of effective, appropriate and respectful clinical service delivery
  - in a way that respects the professional skill and competence of other service providers.

Referring agency

- Handover information will be provided (via phone, fax or email) **within two days** of receipt of an **urgent** request for information, or **no more than five days** of receipt of a **routine** request for information.
- Upon receipt of request for information clinicians will provide relevant handover information utilising data collected during the client's episode of care (the agency is not required to collect additional information for the sole purpose of handover).
- Handover information should include relevant details (as available) such as: demographics, social status, drug history, co-morbidities, risk screening, medications, psychiatric history, legal history, treatment history and details of other relevant service providers such as GP, AOD and other health and community services.
- Request for information and subsequent handover information will be documented and filed appropriately in client records.

Dependencies

Successful implementation of this practice guideline is supported by:

- early identification of client's previous treatment history
- willingness of other agencies to share information
- culture of trust and goodwill to reciprocally share information between services
- clinician's understanding and adherence to appropriate consent practices
- ongoing commitment from the referring agency to support client through transition, as per duty of care requirements
- clinician's understanding of different services
- use of a common language related to clinical care across services
- maintenance of current contact details for relevant services (including fax and/or email details) in publically available forums
- clinicians having the necessary skills, knowledge and tools to provide clear rationale for information sharing (including purpose and scope)
- trust between agencies and staff about the accuracy of information collected by other clinicians.

Monitoring and review

This practice guideline should be applied within the context of each organisation's policies and procedures. It is therefore anticipated that mechanisms for ongoing monitoring and review will be built into organisational quality improvement processes. The benefits of this will be maximised by collaborative interagency evaluation opportunities, in which organisations can work together to identify the strengths of the guideline and identify strategies for ongoing refinement.

KPI: It is anticipated that a random audit of client files would identify a minimum of 80 per cent compliance with this guideline.

Risk assessment: In the development of this protocol, the following risks were identified for consideration:

Risk	Mitigation strategies	Risk rating (following implementation of relevant mitigation strategies)		
		Likelihood	Consequence	Rating
Inappropriate assessment and/or care planning as a result of clinical decision making being driven by information received from other services (resulting in reduced client satisfaction and frustration)	The receipt of handover information does not negate the need for a holistic initial assessment. Staff are empowered to utilise handover information to support, rather than replace their own assessment.	Unlikely (2)	Minor (2)	**Low**
Reduced client confidence, satisfaction or engagement as a result of clinician communicating with other services rather than the client	Handover information only provided with client consent, which requires that the client is informed about what information will be shared, how and why it will be used.	Unlikely (2)	Minor (2)	**Low**
Ineffective or delayed care planning as a result of information being interpreted incorrectly	Staff encouraged to utilise their clinical reasoning and make contact with other service providers as required to ensure information is understood.	Unlikely (2)	Minor (2)	**Low**
Breach of client confidentiality if information shared without appropriate consent	KPG and request for information template clearly articulate need for client consent in accordance with relevant legislative requirements.	Possible (3)	Minor (2)	**Medium**

(continued over page)

Risk	Mitigation strategies	Risk rating (following implementation of relevant mitigation strategies)		
		Likelihood	Consequence	Rating
Introduction of additional paperwork reduces the time available for clinical intervention	Creation of simple request for information template to maximise efficiency. KPG states that clinicians should utilise the information and documentation that is already available to provide relevant handover (staff should not collect additional information for the sole purpose of handover). KPG and MoU articulate that handover information must be accepted in a range of formats to avoid unnecessary duplication.	Unlikely (2)	Minor (2)	**Low**

This guideline has been designed to mitigate these risks wherever possible. Given appropriate education, supervision, tools and support, the EMR Service Coordination Working Group believe this level of risk is acceptable and advocate for the implementation of this guideline.

Open and transparent communication is required to support ongoing evaluation of these risks and amendment of the guideline as appropriate. Consideration should also be given to expanding the scope of the guideline to include the provision of feedback regarding referrals received from other sectors to promote effective communication and inter-sectoral collaboration.

Request for information template

Date: ...../...../.....

Attention: .....

Service provider: .....

Our service (name) has received a referral for the following client:

Name:	
Gender	
Date of birth:	
Contact number:	

It has been identified that this client has recently received services from your organisation. We would be grateful if you could please forward any relevant assessment, care planning or discharge information which will assist their transition into our service.

Consent to share information gained from client: Yes / No

Urgency of request: Urgent / Routine

Timeline for acceptance / commencement of service: .....

The client will be entering the following program:

Program details:

- Type of service (withdrawal, residential recovery, XXXXXXX etc)
- Nature of program client will participate in (for example weekly counselling)
- Timeline for acceptance / commencement of service

Please do not hesitate to contact me if you have any queries.

Yours sincerely,

Name of clinician
Contact details (Address, phone, fax, email)

Request for information example

Date: 01/01/10

Attention: .....Margaret Changelives

Service provider:.....On-the-Wagon

Sober House has received a referral for the following client:

Name:	Joe Drinker
Gender:	M
Date of birth:	25/12/1945
Contact number:	0499 999 999

It has been identified that this client has recently received services from your organisation. We would be grateful if you could please forward any relevant assessment, care planning or discharge information which will assist their transition into our service.

Consent to share information gained from client: Yes / No

Urgency of request: Urgent / Routine

Timeline for acceptance / commencement of service: 1st March 2010

Program details:

Sober House is a 100 bed, residential recovery service for people with alcohol and drug addictions. Auspiced by LongLife Australia, it is a state wide service and accepts referrals via a range of pathways, predominantly self initiated and forensic referrals. Sober House provides a 10 week program for adults (18 years +), incorporating a range of individual and group interventions.

Please do not hesitate to contact me if you have any queries.

Yours sincerely,

Helpful Harry,
Sober House 105 Merry Way, Mt. Coordination 3999

Ph: 03 9876 5432 .....Fax: 03 9123 4567.....

Email: info@sober.com.au .....

Key process guideline – Notification of enrolment and discharge for non-referrers

Guidelines

In order to facilitate effective information sharing, enhance continuity of care and create opportunities for shared care planning, staff will notify all relevant service providers (within and beyond the AOD sector) when a shared client is enrolled in and subsequently discharged from their program. Notifications will be provided:

- when it is identified that the client is engaged with another service provider (within or beyond the AOD sector) and/or it is deemed clinically relevant to share handover information with another agency
- regardless of whether a self-referral or assisted referral has been made
- in a timely manner via an appropriate format
- when consent has been given by the client in accordance with the Victorian Health Records Act and the Commonwealth Privacy Act.

Procedure/Protocol

Notification of enrolment

- Notification of enrolment information will be provided in writing to all relevant services within a timely manner following the client's acceptance into the program.
- Notification of enrolment will be sent using the service's *Notification of enrolment template* or appropriate alternative. The template should include (at a minimum), the client's contact details, source of referral, relevant service information (for example nature of the program the client is enrolled in, waitlist information, admission date), staff contact details and evidence of client consent to share information.
- Notification of enrolment and any subsequent communication will be documented and filed appropriately in client records.

Notification of discharge

- Notification of discharge information will be provided in writing to all relevant services within a timely manner of the client's discharge. Appropriate timing will be dependent on the context of service delivery (for example residential or community based AOD service, the availability of client file post discharge) and the nature of the client's engagement with the other service/s.
- Notification of discharge will be sent using the service's *Notification of discharge template* or appropriate alternative. The template should include (at a minimum), the client's contact details, discharge date, referral action plan, issues for follow up and evidence of client consent to share information.
- Notification of discharge and any subsequent communication will be documented and filed appropriately in client records.

Notes

- Appropriate timing for notification of enrolment will be dependent on the individual's needs and circumstances, the context of service delivery and the client's readiness to discuss their engagement with other services. As such, staff should utilise their clinical reasoning to determine when it is appropriate to collect and share relevant information – this may occur upon acceptance into the program, commencement of service and/or throughout the client's episode of care.

- In order to reduce demands on staff, organisations may consider asking clients to bring relevant contact information to their first appointment (or when relevant) to facilitate efficient information sharing. This could be supported by the creation of a simple letter or information sheet that outlines the rationale for sharing information and the associated privacy and consent legislation.

Dependencies

Successful implementation of this practice guideline is supported by:

- timely identification of other relevant service providers involved in the client's care
- availability of accurate contact information for relevant services
- clinician's understanding and adherence to appropriate consent practices
- clinicians having the necessary skills, knowledge and tools to provide clear rationale for information sharing (including purpose and scope)
- clinicians building rapport with the client and providing appropriate rationale for sharing of client information
- culture of trust and goodwill to reciprocally share information between services
- the creation of relevant organisational policies, procedures, monitoring and evaluation systems.

Monitoring and review

This practice guideline should be applied within the context of each organisation's policies and procedures. It is therefore anticipated that mechanisms for ongoing monitoring and review will be built into organisational quality improvement processes. The benefits of this will be maximised by collaborative interagency evaluation opportunities, in which organisations can work together to identify the strengths of the guideline and identify strategies for ongoing refinement.

KPI: It is anticipated that a random audit of client files would identify a minimum of 80 per cent compliance with this guideline.

Risk assessment: In the development of this protocol, the following risks were identified for consideration:

Risk	Mitigation strategies	Risk rating (following implementation of relevant mitigation strategies)		
		Likelihood	Consequence	Rating
Additional paperwork upon initial engagement results in clients feeling overwhelmed, frustrated and may potentially disengaging from service	Guideline revised to ensure that notification of enrolment can be completed progressively, throughout the client's episode of care (based on the client's readiness and staff's clinical reasoning)	Unlikely (2)	Minor (2)	**Low**
New process results in reduction in time available for direct clinical care and associated staff frustration and dissatisfaction	Creation of simple notification templates to ensure efficiency of implementation. Agencies to consider asking clients to bring relevant contact information to first appointment (or as required throughout episode of care).	Unlikely (2)	Minor (2)	**Low**

This guideline has been designed to mitigate these risks wherever possible. Given appropriate education, supervision, tools and support, the EMR Service Coordination Working Group believe this level of risk is acceptable and advocate for the implementation of this guideline. Open and transparent communication is required to support ongoing evaluation of these risks and amendment of the guideline as appropriate.

Notification of enrolment template

Date: ……/……/……

Dear ……

Service provider: ……

Client name:			
Gender	Male / Female	Date of birth:	
Address:			
Contact number/s:			

Consent to share information gained from client: Yes verbal / Yes written / No

Your client has been accepted into the …… the XXXXXXX Program…… following a referral from:

Brief service description:

- Type of Service (withdrawal, residential recovery, CCCC etc)
- Nature of program client will participate in (for example weekly counselling)
- Timeline for acceptance / commencement of service

In relation to this client's condition:

……

……

Waitlist information: ……Admission date: ……/……/……

We would be grateful if you could please forward any relevant information, which will assist with this client's care while enrolled in ……XXXXXX……

☐ Care plan
☐ Pathology results
☐ Other ……

Please do not hesitate to call me if you have any queries.

Yours sincerely,

Name of clinician
Role, Service

Phone: …… Fax: ……

Email:……

Notification of enrolment example

Date: 12/08/2011

Attention: .....Margaret Changelives

Service provider:.....On-the-Wagon

Client name:	Joe Drinker		
Gender	Male / Female	Date of birth:	25/12/1945
Address:	180 Drinkers Lane, Drinktown Melbourne		
Contact Number/s:	0499 999 999		

Consent to share information gained from client: Yes verbal / Yes written / No

Your client has been accepted into Sober House following a referral from: his GP

Program details: Sober House is a 100 bed, residential recovery service for people with alcohol and drug addictions. Auspiced by LongLife Australia, it is a state wide service and accepts referrals via a range of pathways, predominantly self initiated and forensic referrals. Sober House provides a 10 week program for adults (18 years+), incorporating a range of individual and group interventions.

In relation to this client's condition:

Following increasing physical health concerns and difficulties tolerating his medications, Joe has accepted a place in Sober House in a commitment to cease his daily alcohol consumption. Joe's goals are to stop drinking, develop alternative strategies to manage his anxiety and ultimately return to part time work.

Waitlist information:...6 weeks.....Admission date:...19/08/2011.....

We would be grateful if you could please forward any relevant information, which will assist with this client's care while enrolled in Sober House.

In particular could you please forward copies of his:

- ☐ Mental Health Care Plan
- ☐

Please do not hesitate to call me if you have any queries.

Yours sincerely,

Helpful Harry

Sober House
105 Merry Way, Mt. Coordination 3999

Ph: 03 9876 5432 .....Fax: 03 9123 4567.....

Email: info@sober.com.au .....

Notification of discharge template

Date: ……/……/……

Dear ……

Service provider: ……

Client name:			
Gender	Male / Female	Date of birth:	
Address:			
Contact Number/s:			

Consent to share information gained from client: Yes verbal / Yes written / No

Your client completed their involvement with the ……XXXXXXXX…… program on ……(discharge date).

The following services have been engaged to assist with ongoing management:

Agency	Contact number	Services

Ongoing issues that may require follow up are:

……

……

Other relevant information:

……

……

If you have any comments or questions, please do not hesitate to phone us.

Yours sincerely,

Name of clinician
Role, Service

Phone: …… Fax: ……

Email: ……

Notification of discharge example

Date: 01/08/2011

Dear ..... Dr. Greatdoc

Service provider: ..... Mt. Coordination Medical Centre

Client name:	Joe Drinker		
Gender	Male / Female	Date of birth:	25/12/1945
Address:	180 Drinkers Lane, Drinktown Melbourne		
Contact Number/s:	0499 999 999		

Consent to share information gained from client: Yes verbal / Yes written / No

Your client completed their involvement with the Sober House program on __31/7/11 _____

Referral action plan:

Agency	Contact number	Services
We care	4777 777 777	Weekly Alcohol Counselling - commenced 31/7/11 with counsellor John

Ongoing issues that may require follow up are:

BGL Monitoring .....

.....

Other relevant information:

Joe self discharged from Sober house after 6 weeks, reporting that he could no longer tolerate living away from his family. On his exit, Sober House staff reinforced education regarding abstinence and harm minimisation strategies. An urgent referral was made for counselling and he was able to attend his initial appointment on the day of discharge.

If you have any comments or questions, please do not hesitate to phone us.

Yours sincerely,

Helpful Harry

Sober House
105 Merry Way, Mt. Coordination 3999

Phone: 03 9876 5432 .....Fax: 03 9123 4567.....

Email: info@sober.com.au .....

Unplanned discharges

Exploration of current practice and opportunities to enhance processes to support clients following unplanned discharges is required. It is acknowledged that in different service settings, the implications of an unplanned discharge are varied (that is, client disengaging from counselling service versus a client being discharged from a residential service) (Pascale 2009). Opportunities to provide appropriate education, resources and opportunities to re-engage with appropriate supports need to be considered and guidelines established to promote a consistent approach across the sector.

Key considerations in the development of process guidelines

To ensure the applicability and relevance of the process guidelines, the following key questions were posed:

Scope

- Who is this appropriate for/relevant to? (for example, specific organisations, service types, client groups, locations)
- What are the barriers to implementing this effectively?

Benefits and Risks

- Compared to the status quo, what are the potential benefits associated with implementing this guideline?
- What can we gain, who can benefit and how?
- What are the risks or potentially negative consequences?
- How or when could these arise?
- What is the likelihood of this occurring?
- Are there ameliorating measures that can be built into the guideline?

Dependencies

- What is this practice dependent on? (for example, staff knowledge/skill/confidence/training, organisational supports, systems)
- What are the relevant key definitions/core principles that everyone needs to understand in order to implement this protocol?
- What systems, processes, tools and/or practices currently support (or are required to support) successful implementation?

Practice

- What are the necessary practice elements that will ensure this can be actioned successfully?
- Can you provide a flowchart of the process?
- Are there situations where the process no longer becomes feasible/relevant/appropriate?

Risk assessment framework

The *AOD service coordination risk assessment framework* was developed to support the development and ongoing evaluation of the service coordination process guidelines. It provides a useful framework within which to discuss and evaluate staff concerns, understand potential barriers to effective implementation and then revise processes to ensure their relevance and applicability.

This framework was developed using tools and guidelines available in federal and state policy and through review of local organisational risk management guidelines.

The framework provides an objective method to:

- understand the nature of risks associated with the implementation of the process guidelines
- evaluate the identified risks (using consequence and likelihood rating scales) within the context of existing controls
- determine the acceptability of risks
- consider the need for additional mitigation strategies and/or refinement of the guidelines
- document and monitor the eventuation of risks.

Recommendations for implementation of the risk assessment framework

Throughout the development, pilot and implementation of new service coordination practices, it is recommended that partnerships develop a strategy to collaboratively utilise and manage the risk assessment framework. This requires a commitment by partners to:

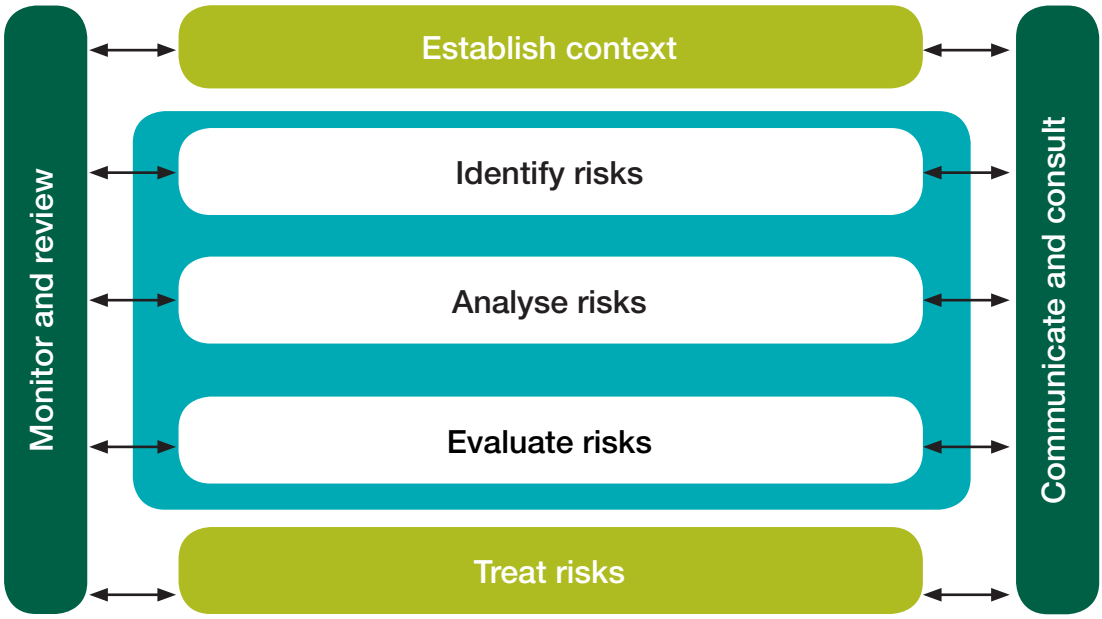
- develop a communication and risk reporting strategy within their organisation
- share risk information and develop an agreed risk escalation and management strategy
- maintain a 'no blame' culture, in which risk reporting and management is encouraged as an important and effective quality improvement strategy
- collaborate regarding interagency risk management/treatment when the risk has an actual, or potential, impact across multiple agencies.

It is essential to note that these guidelines are intended to support, not replace organisational risk management guidelines. Monitoring and evaluation of the application of service coordination processes should be conducted within the ongoing quality improvement mechanisms of each individual organisation.

The risk management cycle

It is widely agreed that effective risk management requires a cyclical approach, each stage informing the next and based on an ongoing commitment to review and refinement. The components of risk management can therefore be represented diagrammatically as outlined in Figure 4.1 below:

Figure 4.1: Components of a risk management framework – reproduced from Australian/New Zealand Risk Management Standard AS/NZS 4360:2004



Communicate and consult – develop and maintain open and efficient communication regarding risk identification (including agreed risk escalation strategies) and the agreed risk management process.

Establish the context – clearly articulate the context of the risk management process, its goals and parameters and the criteria against which risk will be assessed.

Identify risks – embed risk identification system to proactively and reactively collect information about where, when, why, and how risks could occur.

Analyse risks – using agreed risk rating tools, identify and evaluate the likelihood and consequence of risks, the existing controls/mitigating factors and use that information to understand and objectively rate (and record) the residual level of risk.

Evaluate risks – evaluate the acceptability and priority of risks, considering the balance between potential benefits and adverse outcomes, in order to develop and prioritise appropriate treatment plans.

Treat risks – Following a review of options, develop and implement appropriate treatment plans. Plans should specify actions, accountability, timeframes and evaluation measures.

Monitor and review – Risks and the effectiveness of controls and risk treatments should be evaluated (for example, effectiveness, cost efficiency and appropriateness) as well as the efficacy of the risk management process itself. Evaluation findings should then be used to inform ongoing quality improvement processes.

AOD service coordination risk management tools

Consequence rating scale

A risk consequence is defined as the potential outcomes or impacts (to the client, organisation and/or staff) of each risk event. To ensure systematic measurement, a risk consequence table was developed which rates the impact of potential consequences against a scale of 1 (insignificant) to 5 (catastrophic).

When assessing risk consequences, the most likely consequence should be identified and rated using the consequence rating scale.

Likelihood rating scale

Risk likelihood is defined as the probability or frequency of a risk event occurring within the context of current practice and existing controls. While a plethora of likelihood rating scales exist, to ensure the applicability and validity of assessment across different AOD agencies, a likelihood rating scale was developed that rates the frequency of a risk event against a percentage of client interactions.

Risk matrix

Measurements from the consequence and likelihood rating scales are collated using the risk matrix to provide an overall risk rating.

Risk register

To support consistent data collection and recording, a risk register was developed. It is recommended that partnerships develop a strategy to manage their risk register centrally and use this as a prompt for the ongoing discussion and review of identified risks.

Risk evaluation and treatment

Clinical expertise and consistency are required to appropriately evaluate and treat risks. It is therefore recommended that a core group represents the partnership and is responsible for the coordination of risk management. It is essential however, that strategies are in place to efficiently escalate risks both within individual agencies and across the sector.

AOD service coordination risk consequence rating scale

Level and descriptor	Health impacts	Client wellbeing	Service coordination/ collaborative service delivery	Business interruptions	Reputation and image per issue	Financial
Insignificant (1)	Minor decline in health status/first aid or one off AOD intervention required	Client and/or family inconvenienced, minimal time delay	Little impact	No material disruption	No media exposure, not at fault. Resolved during day to day meetings	Little or no impact
Minor (2)	Temporary minor decline in health status. Requires minor increase in intervention over 1 – 14 days	Client/family inconvenienced due to delays in service delivery. Reduced confidence in AOD services	Inconvenient delays, duplication of processes to ensure coordination	Short term temporary suspension – backlog cleared < 1 day	Non-headline media exposure, clear fault settled quickly; negligible impact Senior Management involved	1–5% of operating budget compromised
Moderate (3)	Decline in health status, requires increased intervention over 2 – 12 wks	Client refuses intervention and/or disengages from AOD service system due to significant delays / inconvenience	Coordination not optimised, breadth of service not utilised. Material delays; marginal under-achievement of target performance	Medium term temporary suspension – backlog cleared by additional resources	Negative local community industry feedback, negative media exposure; DHS involvement	5–10% of operating budget compromised
Major (4)	Major health decline, client requires hospitalisation or significant increase in service delivery	Client disengagement results in significant health status decline	Uncoordinated care provision. Significant delays; performance significantly under target	Prolonged suspension of work – additional resources required; performance affected	Negative statewide media; at fault or unresolved complexities; government inquiry	10–30% of operating budget compromised
Catastrophic (5)	Major injury, health crises or death	Client refuses all community services and hospitalisation resulting in major injury or death	Breakdown in partnership, integration of care	Indeterminate prolonged suspension of work; non-performance.	Maximum high level media exposure; Ministerial censure, public inquiry, loss of credibility	More than 30% of operating budget compromised

AOD service coordination risk likelihood rating scale

Rating	Descriptor	Description	Anticipated frequency
1	**Rare**	No identified or known incidents	Only occurs in exceptional circumstances Less than 1% chance
2	**Unlikely**	Few identified or known incidents	Unlikely to occur, Less than 10% chance
3	**Possible**	Some incidents have been identified	Could occur at some time, 10–30% chance
4	**Likely**	Several incidents have been identified	Will probably occur in some circumstances, 30–65% chance
5	**Almost certain**	Multiple incidents have been identified	Can be expected to occur in most circumstances; More than 65% chance

AOD service coordination risk assessment matrix

Likelihood	Consequence				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost certain (5)	Medium	High	High	Extreme	Extreme
Likely (4)	Medium	Medium	High	High	Extreme
Possible (3)	Medium	Medium	High	High	High
Unlikely (2)	Low	Low	Medium	Medium	High
Rare (1)	Low	Low	Low	Medium	Medium

AOD service coordination risk register

Date	Risk descriptor	Existing controls	Most likely consequence	Consequence rating	Likelihood rating	Residual risk rating	Mitigation strategy	Treated risk score	Closure date

Chapter 5: Creating organisational change

Creating a supportive organisational culture

In addition to the maintenance of relevant policy, organisations have a responsibility to:

- provide clear leadership at all levels of their respective organisations to develop and promote a coordinated, client-centred and high quality system of coordinated care for consumers.
- support and actively participate in initiatives to facilitate effective communication between service providers and contributing to collaborative care planning for shared clients.
- embed the agreed protocols and functional arrangements into local work practice and providing ongoing support for the implementation, monitoring and evaluation of service coordination initiatives (as a component of their ongoing quality improvement systems) (DHS 2001; Pascale 2010; PCP Victoria 2012c).

Organisational policy inclusions

In order to effectively embed service coordination, it is essential that the principles of service coordination are reflected within organisational policies. This not only articulates the organisation's commitment to service coordination, but stands as a platform to operationalise supportive practice as a core element of service delivery.

Across the health and community services sector, a range of treatment options are provided through a network of diverse organisations. It is therefore acknowledged that the details of policies and procedures required to embed the principles of service coordination may differ across organisations. Regardless of the sector within which this is applied, or the services offered, service coordination should be considered throughout a range of key organisational policy areas. These include:

- the organisation's vision and mission statements
- human resources (HR), recruitment and performance management
- orientation (for staff, students and volunteers) and professional development
- ongoing quality improvement
- collaborative service development and planning
- service marketing and information provision (to staff, other agencies, clients and the broader community)
- service delivery approach (including initial contact, needs identification, assessment, care planning and referral pathways).

The following table provides a description of key policies and practices that organisations can use as a checklist to review existing policies and identify areas for improvement. It is recommended that these principles and practices be incorporated into organisational policy documents and then actioned through relevant processes (including practices, systems, business rules and work instructions) as appropriate within the context of each organisation.

Service coordination key policy and process inclusions

Policy/Practice standard		Processes and procedures
Vision and mission statements	The organisation's commitment to service coordination is reflected appropriately in vision and mission statements and other relevant organisational documentation.	Inclusion of and reference to the principles that underpin effective service coordination (for example, person-centred, coordinated, collaborative, holistic, tailored service delivery) in relevant organisational statements.
HR • **Recruitment** • **Performance management**	The organisation is committed to ensuring appropriately qualified and skilled staff are employed who are capable of providing effective and appropriate client-centred, coordinated care.	Roles and responsibilities for service coordination are integrated into relevant: • position descriptions • staff workplans • staff supervision sessions • performance appraisal tools.
Orientation and professional development (for paid and unpaid staff)	All paid and unpaid staff (including volunteers and students) participate in a formal orientation program that includes an introduction to service coordination.	The organisation's orientation program includes information related to the: • service coordination principles and relevant organisational practices • full scope of services provided by the organisation (beyond the staff member's discipline and team) • privacy and consent legislation and practices. Staff are provided with opportunities to participate in (and contribute to the development of) interagency orientation programs for local/relevant service networks.

Policy/Practice standard		Processes and procedures
Orientation and professional development (for paid and unpaid staff) *(continued)*	The organisation provides opportunities for staff to participate in ongoing professional development opportunities to build and maintain skills relevant to effective service coordination.	Periodic training opportunities are available to support staff to review the principles of service coordination, review practice, identify challenges and assist with problem solving. A communication strategy is identified to disseminate information and updates relevant to service coordination best practice. The organisation operates a 'champion' system to support effective service coordination and openly acknowledges and rewards success. Clinical staff are supported to develop a broad understanding of the service system, advanced communication and interpersonal skills. Staff knowledge is supported by access to relevant decision making tools and service information tools such as the *Human Services Directory* and *Service Seeker*
Ongoing quality improvement *(refer to Chapter 5 for the Service Coordination Evaluation Framework)*	The organisation supports a cyclical approach to quality improvement, which provides systematic review, evaluation and refinement of service delivery. Service coordination is considered in strategic and operational planning processes as an element of core business.	Service coordination is considered a key element of service delivery, reflected through inclusion in: • quality indicators for appropriate, efficient and effective service delivery • risk management framework • staff performance and competence measures. Appropriate data collection and reporting mechanisms are in place to support the evaluation of service coordination initiatives. Service coordination principles are integrated into consumer feedback mechanisms (for example client satisfaction surveys, complaints and compliments). Consumer participation opportunities are available to assist the organisation to embed relevant, client-centred service coordination into practice.

Service coordination key policy and process inclusions (cont)

Policy/Practice standard		Processes and procedures
Collaborative service development and planning	Consistent, cohesive and coordinated delivery of care is supported by ongoing, open communication with relevant stakeholders. Mutually beneficial and equitable relationships are prioritised as a mechanism to support both the delivery of coordinated client care and collaborative quality improvement initiatives.	Mechanisms are maintained to facilitate: • coordinated, interagency/inter-sectoral care planning • timely and efficient transfer of information between agencies • ongoing communication, feedback and review The organisation maintains up to date information in relevant public forums (for example websites, local networks, brochures, *Human Services Directory* and *Service Seeker*). Opportunities are actively sought to participate in interagency and inter-sectoral networking and shared quality improvement processes.
Initial contact	The organisation acknowledges the importance of successfully engaging the client during their first contact in order to facilitate appropriate and efficient access to relevant care. Clients will be assisted to navigate the service system in order to access the services required to meet their needs.	Objective eligibility criteria and prioritisation mechanisms are clearly articulated. During their initial contact, clients are: • provided with relevant and appropriate information regarding services (within and external to the organisation) within the agreed timeframe • asked if they require additional information or assistance as standard practice • informed of the services available and, where possible, their eligibility criteria. Relevant information is collected, documented and mechanisms are in place for the efficient transmission of information to relevant staff members. Initial contact results in a clear action plan (including crisis/urgent response plans) with the provision of key contact information and concrete next steps. Documented processes are in place to support the transfer of client information within the organisation (in order to reduce duplication and support client flow).

Policy/Practice standard		Processes and procedures
Initial contact *(continued)*	Clients are empowered to make informed choices about their care through the timely provision of accurate and appropriate information.	Information provision is appropriate to the client's cultural, communication and cognitive needs. Mechanisms are established for obtaining informed client consent (for example provision of relevant client education, privacy and/or rights and responsibilities brochures). Mechanisms are in place to adequately support consumers awaiting service provision based on an assessment of their risk and need.
Initial needs identification (INI) and assessment	Clients will participate in holistic needs identification and assessment processes in which they have the opportunity to explore their underlying and presenting issues with consideration of their health, social, emotional and wellbeing needs. The provision of appropriate and effective INI and assessment assists in understanding the client's risk, eligibility and priority for service (within and beyond the scope of organisational practice) and is identified as an important tool with which to inform ongoing care planning.	Consumers are informed of the organisation's INI and assessment processes, scope, rationale and their relevance to the provision of quality client care. INI and assessments are consistently performed within a set timeframe (relevant to the service context). INI and assessment tools are in place to support the identification of the client's health and wellbeing needs, including, but not limited to their presenting issue. Consistent processes and tools are utilised to: • identify the client's needs and capacity • objectively assess client risk • discuss the client's goals and priority issues • determine services required • inform the development of appropriate care plans (including shared care plans where appropriate) • identify key contacts.

Service coordination key policy and process inclusions (cont)

Policy/Practice standard		Processes and procedures
Initial needs identification (INI) and assessment *(continued)*	Needs identification is identified as an ongoing process that will continue to be supported throughout a client's engagement with the organisation. Clients will be informed of relevant care options and empowered to make appropriate choices.	INI results in a concrete, documented action plan. Staff are empowered to use their experience and clinical decision making skills to determine the necessary extent and intensiveness of INI and assessments. Clients' needs are listened to in a sensitive and non-intrusive manner. Consent is obtained to share client information relevant for referrals, care planning etc. Objective eligibility criteria and prioritisation mechanisms are clearly articulated. A process exists to enable clients to opt-out of INI (including process for documentation of refusal).
Care planning	The organisation supports a client-centred model of service provision, in which clients are empowered to be actively involved in the development, implementation and review of their goals and care plans. The organisation facilitates opportunities for client engagement in relevant health and community services and/or health promotion initiatives through integrated care planning and collaborative service provision.	Client goals are discussed, recorded and reflected in care planning and goal setting processes. A consistent process for discharge planning is established including relevant communication strategies (with consumer, internal and external clinicians). Intra/interagency care planning processes and tools are available to support clients who are engaged with multiple clinicians/services. These include mechanisms for: • identification of other service providers as key contacts • established communication mechanisms • collaborative planning, review and discharge planning strategies (for example interagency case conferencing and established feedback loops) • understanding the roles and responsibilities of the client (and carer/s), staff and organisations involved • gaining informed consent to share client information.

Policy/Practice standard		Processes and procedures
Referral and feedback	Facilitating relevant and appropriate referrals is identified as an essential element of coordinated service delivery to assist clients in a seamless and timely manner by streamlining access to appropriate services. The organisation identifies the relevance and importance of sharing client information with other service providers (with client consent) in order to assist client navigation, reduce duplication of assessment and provide seamless service delivery.	Documented strategies are in place to facilitate internal and external referrals across disciplines, service areas and sectors, at relevant points throughout a client's engagement with the organisation. Established referral processes and tools (with agreed timeframes) support both self-initiated and assisted referrals including: • identification of referral priority • feedback mechanisms • transfer of information • maintenance of client privacy. Consent to share information with other relevant service providers is sought as standard part of practice. Mechanisms for the documentation of referrals required, made, their outcomes, follow up mechanisms and the provision of interim support are established (including negotiation with client). When a client chooses to make a self-referral, staff will support this choice by documenting the client's decision and providing: • relevant contact details • advice and decision making support • copies of relevant documentation • background information and documents directly to the other agency (with consent). The organisation proactively maintains linkages and open communication channels with relevant stakeholders to facilitate effective referrals. Staff have access to accurate, up-to-date service information to support appropriate referrals.

The Service Coordination Evaluation Framework

The Service Coordination Evaluation Framework was developed to ensure that services can build indicators for service coordination into their quality improvement systems. It also provides strategies to assist partnerships, funding bodies and government departments understand how services are progressing with service coordination and monitor improvements and ongoing challenges across the region.

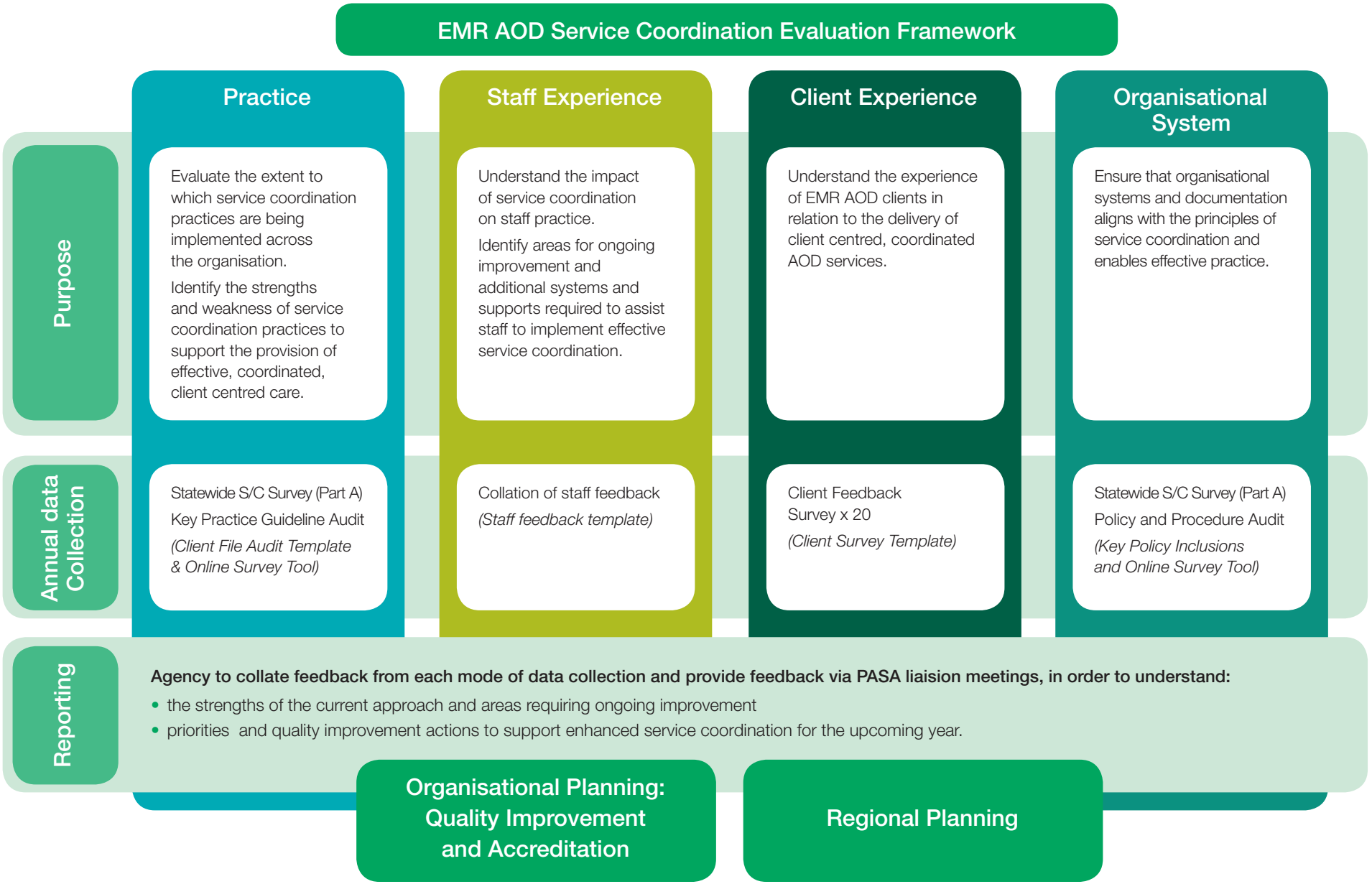
The framework provides indicators regarding the development of relevant organisational systems and documentation (for example policies and procedures), compliance with service coordination practices, the impact and experience of the framework for staff and for clients. The framework includes information about how each element links back to accreditation and the *Victorian Service Coordination Practice Manual* and the associated *Continuous Improvement Framework*.

It is important to note that the tools and information collection strategies included in the framework are suggestions only, and should be modified to fit into each agency's broader quality improvement systems. The framework is identified as appropriate and useful to:

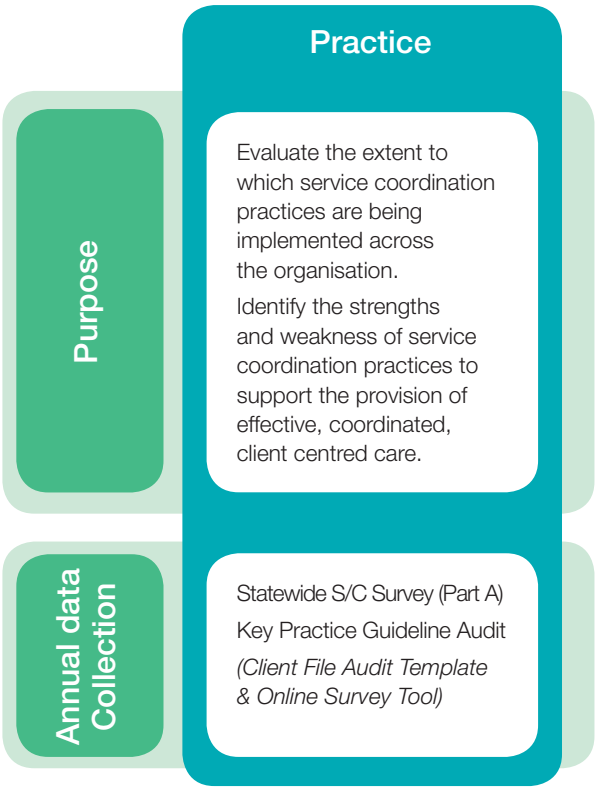
- support staff understanding of where service coordination fits in ongoing quality improvement
- highlight the links with accreditation
- promote and allow time for, reflection and more dedicated consideration of the practices and impacts of service coordination.

In order to maximise its usefulness and transferability, the framework includes references to how each of the suggested activities links with best practice guidelines and resources. A key for acronyms used in the service coordination framework is provided in the table below.

Key for acronyms used in the Service Coordination Evaluation Framework	
QICSA	*Quality Improvement and Community Service Accreditation (QICSA)* is a not-for-profit organisation that conducts organisational accreditation processes for a number of Australian health and community service organisations. QICSA conducts objective external reviews of organisations' practice, processes, systems and infrastructure against a set of key criteria.
EQuIP	*Evaluation and Quality Improvement Program (EQuIP)* provides accreditation assessment and support to healthcare organisations against a set of agreed standards. The standards address a range of elements of quality care across the organisation to support the delivery of effective care.
CIF	As part of the Victorian Service Coordination initiative, PCP Victoria developed a *Continuous Improvement Framework (CIF)* that can be used to assist agencies monitor and improve service coordination implementation and practice.
EMR AOD KPG	The EMR AOD service coordination project, developed a number of key practice guidelines (KPG) to support service coordination (as outlined in Chapter 4)


EMR AOD Service Coordination Evaluation Framework
Practice
Staff Experience
Client Experience
Organisational System
Purpose
Evaluate the extent to which service coordination practices are being implemented across the organisation.
Identify the strengths and weakness of service coordination practices to support the provision of effective, coordinated, client centred care.
Understand the impact of service coordination on staff practice.
Identify areas for ongoing improvement and additional systems and supports required to assist staff to implement effective service coordination.
Understand the experience of EMR AOD clients in relation to the delivery of client centred, coordinated AOD services.
Ensure that organisational systems and documentation aligns with the principles of service coordination and enables effective practice.
Annual data Collection
Statewide S/C Survey (Part A)
Key Practice Guideline Audit
(Client File Audit Template & Online Survey Tool)
Collation of staff feedback
(Staff feedback template)
Client Feedback Survey x 20
(Client Survey Template)
Statewide S/C Survey (Part A)
Policy and Procedure Audit
(Key Policy Inclusions and Online Survey Tool)
Reporting
Agency to collate feedback from each mode of data collection and provide feedback via PASA liaision meetings, in order to understand:
• the strengths of the current approach and areas requiring ongoing improvement
• priorities and quality improvement actions to support enhanced service coordination for the upcoming year.
Organisational Planning: Quality Improvement and Accreditation
Regional Planning

Practice

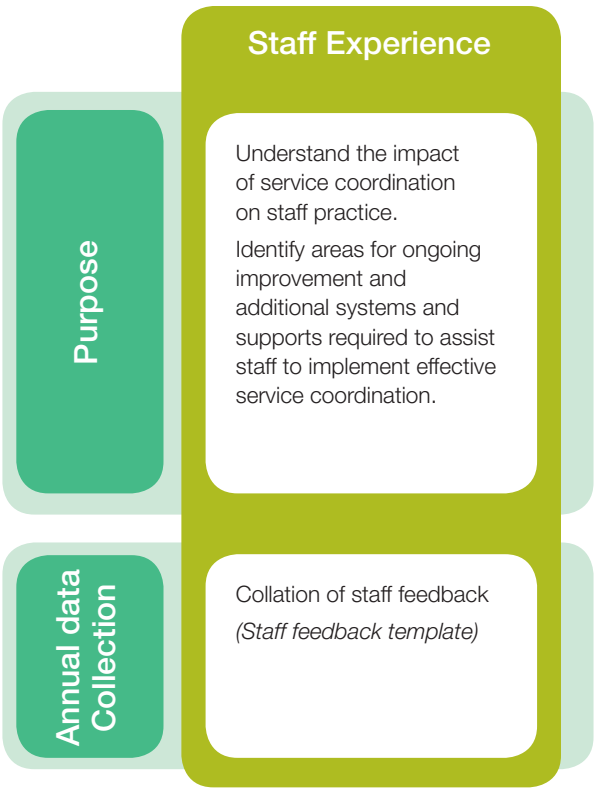


Information collected via:	Client file audit (Questions derived from 2011 Statewide Service Coordination Survey and AOD Service Coordination Key Practice Guidelines)
How many?	10% of clients up to a maximum of 30
How often?	Annually (Sept – Oct)
Resources/ supports available:	AOD Service Coordination Key Practice Guidelines Continuous Improvement Framework Victorian Service Coordination Practice Manual PCP and Department of Health staff

Rationale	Client file audit: Proposed data for collection
QICSA / EQuIP CIF Criterion: 3.1 EMR AOD KPG (Ph 4)	Consumers have been provided with information about services available in response to their inquiry or as part of an outreach approach within one working day of making contact
QICSA / EQuIP EMR AOD KPG (Ph 4)	*FYI Assisted Referral* is sent to relevant agencies with prescribed time frame
QICSA / EQuIP CIF Criterion: 4.2 EMR AOD KPG	Initial Needs Identification (INI) is conducted within no more than seven working days of Initial Contact (IC)
QICSA / EQuIP CIF Criterion: 7.4	*Service Coordination Tool Templates (SCTT)* have been used for referral in accordance with policy and the SCTT user guide
QICSA / EQuIP EMR AOD KPG	Previous treatment history is identified and documented
EMR AOD KPG	Worker details are listed on relevant documentation to enable handover
EMR AOD KPG	*Client enrolment* information is sent to other relevant services within prescribed time frame
QICSA / EQuIP CIF Criterion: 6.2	*Care/case plans (meeting specified criteria)* have been documented for consumers

Rationale	Client file audit: Proposed data for collection
QICSA / EQuIP CIF Criterion: 6.12	Planned reviews for care planning have occurred within one month of the date listed for review
QICSA / EQuIP CIF Criterion: 6.21	*Care coordination/shared plans* have been documented for consumers with multiple of complex needs who are receiving services from more than one organisation / service.
QICSA / EQuIP CIF Criterion: 6.22	When there is a *Care Coordination plan*, the consumer's GP has been provided with a copy of it.
QICSA / EQuIP CIF Criterion: 7.7 & 7.8 EMR AOD KPG	*When* 'urgent' referrals are received, *a Referral acknowledgment* is sent within two working days of receipt
QICSA / EQuIP CIF Criterion: 7.7 & 7.8 EMR AOD KPG	When 'low' or 'routine' referrals are received, a *Referral acknowledgment* is sent within seven working days of receipt
QICSA / EQuIP EMR AOD KPG	*Request for information* initiated in a timely manner
QICSA / EQuIP CIF Criterion: 8.1 EMR AOD KPG	When a referral is sent, the consent form has been completed for all referrals requiring the disclosure of personal information.
QICSA / EQuIP EMR AOD KPG (Ph 4)	Upon discharge, all relevant service providers are informed and provided appropriate details

Staff experience



Information collected via:	Staff feedback template – to be completed within a team meeting. (Supported by inclusion of relevant questions on staff supervision, appraisal and feedback mechanisms and inclusion of service coordination or regular team meeting agendas).
How many?	One
How often?	Annually
Resources/ supports available:	AOD Service Coordination Key Practice Guidelines Organisational documentation (for example, policies and procedures)

Rationale	Staff feedback template: Proposed questions
QICSA/EQuIP **Staff experience/ impact on staff**	1. Do your current practices make it effective and efficient for you to communicate with staff from other agencies (within and beyond AOD services) about your clients? Why/Why Not? How could this be improved? 2. Do you have the skills, knowledge and confidence required to talk to clients about how and why you share information with other service providers and obtain the appropriate client consent? 3. What is currently working really well that enables you to communicate with other service providers and coordinate your client's care? 4. What are the challenges that you face in communicating with other organisations and coordinating client care? 5. Who are the agencies or sectors that remain difficult to engage and/or communicate with? 6. What other service coordination initiatives or practices are you aware of that we could utilise to improve our systems? 7. Do you have the appropriate resources and supports in place to effectively coordinate your client's care? Why/Why not? What would make it easier?

Client experience

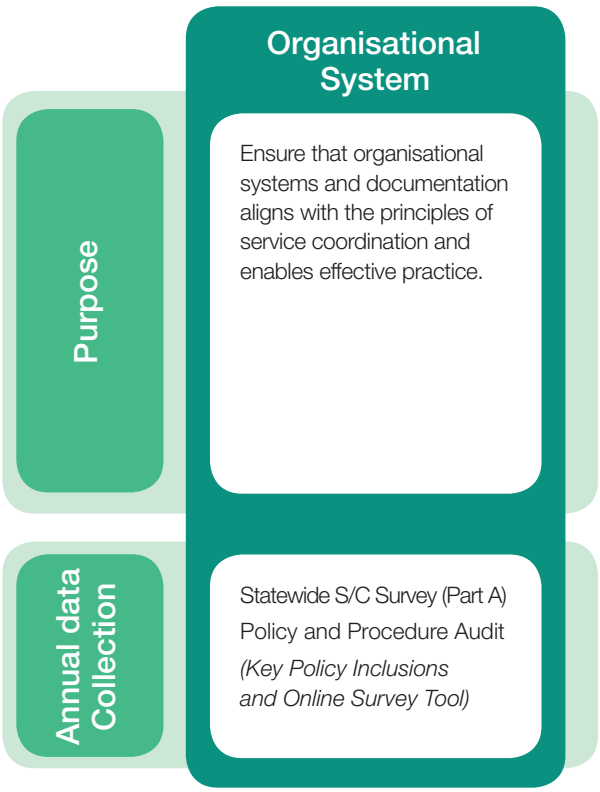
Information collected via:	Client Feedback Survey (surveys could be provided in waiting room, given directly to clients by their clinician, conducted online and/or completed face to face or over the phone as appropriate)
How many?	20
How often?	Annually
Resources/ supports available:	

Client feedback template: proposed questions

1. How easy was it to find/access our service? Note: Consider how easy it was to find the service, make contact and get the information you needed to be sure this was the right service to meet your needs	**Very difficult**						**Very easy**
	1	2	3	4	5	6	7
Why/Why not?							
2. Did you get what you needed from us? Note: Consider whether we provided the type and quality of services that you needed to meet your goals?	**Didn't meet any of my goals**						**Met all of my needs**
	1	2	3	4	5	6	7
Why/Why not?							
3. Did we help you access and get into the other **services/supports that you need?** Note: Did we link you into to other agencies or professionals that could help you address your concerns and assist you to achieve other goals?	**Not at all**						**Definitely**
	1	2	3	4	5	6	7
Why/Why not?							

Note: It is not realistic to expect that survey findings will provide evidence of the impact or effectiveness of specific interventions, however this should provide an overall impression of the strengths and weaknesses of a service's approach.

Organisational systems



Information collected via:	Review of organisational documentation (for example Policy and procedure manual, quality improvement systems, client feedback mechanisms) Questions included in Statewide Service Coordination Survey
How many?	One
How often?	Annually
Resources/ supports available:	AOD Service Coordination Key Policy inclusions Victorian Service Coordination Practice Manual Continuous Improvement Framework PCP and Department of Health staff

Rationale	Information required
QICSA/EQuIP EMR AOD S/C Project CIF Criterion: 2.2 & 2.3	Service coordination practice standards and program requirements are integrated into policy, work plans and position descriptions where applicable
QICSA/EQuIP CIF Criterion: 2.11 Impact/Change in client experience	Service coordination principles are integrated into consumer feedback systems (for example consumer satisfaction surveys, complaints procedures or informal mechanisms) (Note: Unable to directly correlate findings regarding a client's experience to specific interventions, however should provide an overall impression of the strengths and weaknesses of a service's approach)

Chapter 6: Useful resources

Service coordination resources

Better Access To Services outlines the rationale, principles and strategies to effectively implement service coordination in Victoria. Part of the Primary Care Partnership (PCP) strategy, the framework promotes collaborative practice between agencies in order to create an integrated service system that is easier for clients to access and navigate Available at: www.health.vic.gov.au/pcps/publications/access.htm

The Victorian Service Coordination Practice Manual sets out the agreed practices, processes, protocols and systems (PPPS) which support service coordination across Victoria (PCP Victoria 2012a). Available at: www.health.vic.gov.au/pcps/coordination/ppps.htm

Good Practice Guide is designed for clinicians to understand agreed practice guidelines for the implementation of service coordination (PCP Victoria 2012b). Available at: www.health.vic.gov.au/pcps/coordination/ppps.htm

Continuous Improvement Framework is a tool designed to assist agencies to monitor and continually improve service coordination implementation and practice. This is also identified as useful to assess organisation's readiness and the infrastructure and practice change required (PCP Victoria 2012c). Available at: www.health.vic.gov.au/pcps/coordination/ppps.htm

The *Service Coordination Tool Templates* are a suite of tools that have been developed by the Department of Human Services in consultation with the funded sector. They support service coordination practice by assisting with identifying the initial needs of clients and providing a vehicle to collect and share core client information in a consistent way across diverse programs and agencies. These tools are not assessment tools and are designed to support, not replace agency processes (DH 2012). Available at: www.health.vic.gov.au/pcps/sctt.htm

Electronic service directories

Service Seeker and the *Human Services Directory* are easily accessible, widely used and free electronic service directories that contain details of many Victorian health and community service providers.

Human Services Directory is available at: www.humanservicesdirectory.vic.gov.au/

Service Seeker is available at www.serviceseeker.com.au/

A consumer focussed version of the *Human Services Directory*, is also available on the Better Health Channel website: www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/services_and_support?open

Privacy and consent resources

The Office of the Health Services Commissioner has created a range of resources to assist staff and clients understand the Health Records Act. www.health.vic.gov.au/hsc/index.htm

Of particular interest, may be:

- An *online Health Records Act Training package* that is free of charge for staff. It provides multiple training packages for staff in the Health Records Act and Health Privacy Principles. Available at: www.health.vic.gov.au/hsc/training.htm
- *Health Privacy: it's my business:* Available at: www.health.vic.gov.au/hsc/downloads/hscnew.pdf
- *Use and disclosure of health information* Available at: www.health.vic.gov.au/hsc/infosheets/disclosure.pdf
- Health Records Act FAQ: Available at: www.health.vic.gov.au/hsc/resources/faq.htm

The Primary Care Partnerships *Information Privacy Resource Pack*, aims to assist service providers to understand their legal requirements for the collection, use, disclosure and disposal of information and the individual's right to control how their personal information is handled. Available at: www.health.vic.gov.au/pcps/publications/info_privacy_pack.htm

The Chief Psychiatrist's guideline for *Information sharing between area mental health services and psychiatric disability rehabilitation and support services* provides a useful overview of the legislation and practical considerations for effective information sharing between multiple agencies. While the document looks specifically at clinical mental health and PDRSS, the principles are relevant and applicable in a range of settings. Available at: www.health.vic.gov.au/mentalhealth/cpg/information_sharing.pdf

Partnership tools

The following tools are useful to understand key elements of partnership practice and provide practical strategies to support effective partnership development.

The Partnership Toolkit: Tools for Building and Sustaining Partnerships
Available at: www.pcrs.ca/uploads/7L/_A/7L_ATXdmJl3bp9lgOtVTKA/partnershiptoolkit.pdf

Partnership Working, a consumer guide to resources
Available at: www.nice.org.uk/niceMedia/documents/partnership_working.pdf

The Partnering Toolbook
Available at: www.undp.org/content/dam/aplaws/publication/en/publications/capacity-development/the-partnering-toolbook-english/ToolBook-Eng.pdf

Partnership in Practice Guides

The *Victorian Council of Social Service (VCOSS)* have produced a number *of Partnership in Practice Guides*. These guides provide information, tools and resources that examine the three stages of partnering: preparing to partner; commencing the partnership; and, sustaining the partnership.

- *Guide 1: Preparing to partner* Available at: www.vcoss.org.au/documents/VCOSS%20docs/HSPIC/00911_vcoss_partner_guide_1_WEB.pdf
- *Guide 2: Commencing the partnership* Available at: www.vcoss.org.au/documents/VCOSS%20docs/HSPIC/00911_vcoss_partner_guide_2_WEB.pdf
- *Guide 3: Sustaining the partnership* Available at: www.vcoss.org.au/documents/VCOSS%20docs/HSPIC/00911_vcoss_partner_guide_3_WEB.pdf
- *Guide 4: Partnership governance, models and leadership* Available at: www.vcoss.org.au/documents/VCOSS%20docs/HSPIC/00911_vcoss_partner_guide_4_WEB.pdf

Risk management resources

The following documents outline the risk management standards, relevant policy and best practice guides to supporting effective risk management in the public sector.

Auditor-General Victoria (2004). *Managing risk across the public sector: good practice guide.* Victorian Attorney-General's Office, State of Victoria. Available at: http://download.audit.vic.gov.au/files/Risk_guide.pdf

DTF (2011). *Victorian Government Risk Management Framework*. Department of Treasury and Finance, Victorian State Government. Available at: http://www.dtf.vic.gov.au/CA25713E0002EF43/WebObj/VicGovRiskManagementFrameworkApril2011/$File/VicGovRiskManagementFrameworkApril2011.pdf

Massuger, W. & Pascale, K. (2009). *Bridging Clinical Risk: The development and implementation of an evidence based Clinical Risk Management Framework in an interagency setting*. Available at: www.kchs.org.au/library/items/280016-upload-00002.pdf

Standards Australia (2001). *Guidelines for managing risk in the healthcare sector* HB 228:2001, Standards Australia.

Standards Australia (2004). AS/NZS 4360 *Risk Management, Standards* Australia. Available at: http://www.mwds.com/AS4me_files/AS-NZS%204360-2004%20Risk%20Management.pdf

Further information about the Risk Management Standards and a range of information sheets and tools to support the development and implementation of an effective risk management framework, are available from VMIA: http://www.vmia.vic.gov.au/Risk-Management/Guides-and-publications/Risk-management-standards.aspx

VMIA (2008). *Guide for developing and implementing your risk management framework*, Victorian Managed Insurance Authority. Available at: http://www.vmia.vic.gov.au/Risk-Management/Guides-and-publications/Risk-Management-Guidelines.aspx

VQC (2003). *Better Quality, Better Health Care, A safety and quality improvement framework for Victorian Health Services.* Metropolitan Health and Aged Care Services Division Victorian Quality Council (VQC), Department of Human Services (DHS), Victorian State Government. Available at: http://www.health.vic.gov.au/qualitycouncil/downloads/framework.pdf

Appendix 1: Service Coordination Working Group members

Ann Smith The Salvation Army, Eastcare	**Chris Morley** Youth Substance Abuse Service	**Julie Pedley** Knox Anglicare	**Robyn Jones** Mental Health Alliance Project
Anna McKenry Eastern Health Alcohol & Drug Service	**Christopher Foley-Jones** Inner East Primary Care Partnership	**Kevin Porter** Eastern Health Alcohol & Drug Service	**Rondon D'Antoine** Ngwala
Anne-Maree Rogers EACH – Eastern Drug & Alcohol Service	**Dale Tesone** Maroondah Addictions Recovery Program	**Kim Johnson** Knox Community Health Service	**Rosemary Andrea** New Life Program
Anthony Johnson EACH	**Del Aulich** EACH	**Loretta Zeeck** Knox Anglicare	**Sheryll Kay** Department of Health
Barb Kelly Turning Point	**Eddy Holman** The Salvation Army: The Basin Centre	**Lorrinda Hamilton** Youth Substance Abuse Service	**Stephen Devery** The Salvation Army
Ben Kandelaars Inner East Community Health Service	**Frank Coughlan** Inner East Community Health Service	**Megan Polkinghorne** Whitehorse Community Health Service	**Stephen Ward** EACH
Caroline MacDonald EACH	**Jacky Close** Outer East Primary Care Partnership	**Merissa Judkins** Knox Division of General Practice	**Tanya Cooper** Inner East Community Health Service
Carolyn Bolton Knox Community Health Service	**Jenni Thompson** Knox Community Health Service	**Michele Werner** Department of Health	**Tilak Abeyarama** City of Manningham
Cathy Keenan Department of Health	**Jenny Langlands** Department of Health	**Nia Allen** Whitehorse Community Health Service	**Tom Stylli** EACH
Cheryl Wood Inner East Primary Care Partnership	**Jude Harris** Department of Health	**Peter Luttrell** Ngwala	**Tracey Martin** Youth Substance Abuse Service
Chris Cosgriff Victoria Police	**Judith Shapland** EACH – Reachout program	**Peter Matthews** Odyssey House	**Yogeeta Kiran** Eastern HARP

Reference list

ACSQHC (2003). *Patient Safety, towards sustainable improvement.* Fourth report to the Australian Health Minister's conference. Australian Council for Safety and Quality in Health Care (ACSQHC), Commonwealth of Australia.

COAG (2006). *National Action Plan on Mental Health 2006–2011*. Council of Australian Governments (COAG).

COAG (2009) *National Framework for the protection of Australia's children 2009–2020*. Council of Australian Governments (COAG).

OLDP (1988). *Privacy Act 1988* (119). Office of Legislative Drafting and Publishing (OLDP), Commonwealth of Australia.

DH (2010). *Systems and performance analysis of the Alcohol and Other Drugs treatment system: Final report*. Department of Health (DH), State of Victoria.

DH (2011). *Whole-of-government Victorian alcohol and drug strategy:* Community consultation. Department of Health (DH), State of Victoria.

DH (2012). Service coordination tool templates 2012 user guide. Integrated Care Branch, Department of Health (DH) Victorian Government.

DHS (1997). *Victoria's Alcohol and Drug Treatment Services, The Framework for Service Delivery.* Drug Treatment Services Aged Community and Mental Health Division Department of Human Services, Victorian Government.

DHS (2001). *Better Access to Services: A policy and Operational Framework*. Aged Community and Mental Health Division Department of Human Services (DHS), State of Victoria.

DHS. (2002). "*Alcohol and Drug Services Service Coordination Implementation: Frequently Asked Questions (FAQs)*." Retrieved 3 June 2009, from http://www.health.vic.gov.au/pcps/downloads/publications/w19_ad_faqs3_oct02.pdf.

DHS (2004). Department of Human Services Victoria, *Drug Policy and Services Overview*. Drugs Policy and Services Branch Department of Human Services (DHS), Victorian Government.

DHS (2006). *Care in your community: A planning framework for integrated ambulatory health care*. Department of Human Services (DHS), State of Victoria.

DHS (2006). *Improving health, reducing harm: Victorian Drug Strategy 2006–09*. Department of Human Services (DHS), State of Victoria.

DHS (2007). *Dual Diagnosis: Key direction and priorities for service development*. Department of Human Services (DHS), State of Victoria.

DHS. (2007). "*Health Promotion Priority Setting for 2007–2012.*" Retrieved September 2008, from http://www.health.vic.gov.au/pcps/hp/priority_setting.htm.

DHS (2008). *A new blueprint for alcohol and other drug treatment service 2009–2013: Client-centred, service-focused. Department of Human Services (DHS),* State of Victoria.

DHS (2008). *Service access models: a way forward.* Department of Human Services (DHS), Victorian Government.

DHS (2008). *Shaping the Future: The Victorian Alcohol and Other Drug Quality Framework.* Department of Human Services (DHS), State of Victoria.

DHS (2008). *Victorian amphetamine-type stimulant (ATS) and related drugs strategy 2009–2012.* Department of Human Services (DHS), Victorian Government.

DHS. (2008). *Shaping the Future: The Victorian Alcohol and Other Drug Quality Framework.* Department of Human Services (DHS), State of Victoria.

DoHA (2008). *Towards a National Primary Health Care Strategy:* A discussion paper from the Australian Government. Department of Health and Ageing (DoHA), Commonwealth of Australia

DPC (2006). *Improving Mental health outcomes in Victoria: the next wave of reform.* Prepared by The Boston Consulting Group on behalf of the Department of Premier and Cabinet (DPC), State of Victoria.

Flatau, P., Connroy, E., et al. (2010). *The integration of homelessness, mental health and drug and alcohol services in Australia.* Australian Housing and Urban Research Institute.

Institute of Medicine (2001). *Crossing the quality chasm: a new health system for the 21st century.* Washington, USA, National Academy Press.

KPMG (2004). *Analysis of the impacts of service coordination on service capacity in the Primary Health Care sector.* Department of Human Services (DHS), State of Victoria.

MCDS (2004). *The National Drug Strategy: Australia's integrated framework 2004–2009.* Ministerial Council on Drug Strategy (MCDS), Commonwealth of Australia.

MCDS (2006). *National Alcohol Strategy 2006–2011.* Department of Health and Ageing (DoHA), Australian Government.

MCDS (2006). *National Cannabis Strategy 2006–2009.* Ministerial Council on Drug Strategy (MCDS) Department of Health and Ageing, Commonwealth of Australia.

MCDS (2011). *National Drug Strategy 2010–2015: A framework for action on alcohol, tobacco and other drugs.* Ministerial Council on Drug Strategy (MCDS), Commonwealth of Australia.

MTAPS (2008). *Restoring the balance: Victoria's Alcohol Action Plan 2008–2013.* Ministerial Taskforce on Alcohol and Public Safety (MTAPS), Victorian Government.

NPHT (2008). *Australia: the healthiest country by 2020: A discussion paper.* National Preventative Health Taskforce (NPHT), Commonwealth of Australia.

NPSA (2003). *Seven steps to patient safety – your guide to safer patient care.* National Patient Safety Agency (NPSA), National Health Service (NHS) UK.

NSW Health (2001). *Clinical Practice Improvements Made Easy: A guide for health care professionals.* NSW Health, New South Wales State Government.

Parliament of Victoria (2001). *Health Records Act 2001* Act No.2/2001, Parliament of Victoria.

Parliament of Victoria (2006). *Charter of Human Rights and Responsibilities Act 2006 Act No. 43/2006*, Parliament of Victoria.

Pascale, K. (2009). *EMR AOD Service Coordination Final Project Report.*

Pascale, K. (2010). *The EMR AOD Service Coordination Project Phase 2 Project Report.*

Pascale, K. (2011). *EMR AOD Service Coordination Project Phase 3 Project Report.*

PCP Victoria (2005). *Service Coordination: Achieving tangible benefits through a partnership approach.* Primary Care Partnerships Victoria, Department of Human Services (DHS), State of Victoria.

PCP Victoria (2012a). *Victorian Service Coordination Practice Manual 2012*. Primary Care Partnerships Victoria.

PCP Victoria (2012b). *Good Practice Guide 2012:* A resource of the Victorian Service Coordination Practice Manual. Primary Care Partnerships Victoria.

PCP Victoria (2012c). *Continuous Improvement Framework 2012:* A resource of the Victorian Service Coordination Practice Manual. Primary Care Partnerships Victoria.

Social Compass (2007). *The practical partnering toolkit – Strengthening Australian Communities … it's your business.* The Prime Minister's Community Business Partnership, Commonwealth of Australia.

Tennyson (2003). *The Partnering toolbook.* The International Business Leaders Forum (IBLF) and the Global Alliance for Improved Nutrition (GAIN).

Turning Point (2000). *Victorian Alcohol and Drug Treatment Services – Specialist Assessment Form* (*for general client population*). Turning Point Alcohol and Drug Centre Inc. for the Drugs and Health Protection Services Branch, Department of Human Services, Victorian Government.

Turning Point (2000). *Youth Alcohol and Drug Treatment Services – Assessment and Intervention tool*. Turning Point Alcohol and Drug Centre Inc. for the Drugs and Health Protection Services Branch, Department of Human Services, Victorian Government.

Wagner, E. J., Glasgow, R.E., et al. (2001). "*Quality improvement in chronic illness care: a collaborative approach*." Joint Commission Journal on Quality Improvement 27(5): 63–80.

WHO (2010). *Global Strategy to reduce the harmful use of alcohol*. World Health Organisation.

Wilson, K. (2008). *Eastern Metropolitan Region Alcohol and Other Drugs Strategic Action Plan April 2008–December 2010*. K. W. Consulting, Eastern Metropolitan Region Alcohol and Other Drug Strategy Group.