



ACI Clinical Innovation Program

Service access & coordination centres

Acknowledgements

This document reflects the work of clinical leaders, management and supportive organisations in the development and implementation of innovative models of care. This document highlights the work of South Western Sydney Local Health District in developing and implementing the Triple I (Hub) – a service access and care coordination centre that has been successful in doing more for local communities within existing resources, and improving access to services. It also shares some of the successes of three other models across the state. The Agency for Clinical Innovation (ACI) takes this opportunity to thank all creative and visionary leaders in NSW who are working toward the implementation of evidence based services to achieve the best outcomes for their clients and communities.

In particular, the ACI takes this opportunity to thank the following organisations and their staff for giving their time and efforts in the preparation of this document, and sharing their ideas with the rest of the State:

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NSW ACI Clinical Innovation Program

The NSW Agency for Clinical Innovation (ACI) is a leader in the design and implementation of innovation in healthcare. The ACI's Clinical Innovation Program supports clinical innovation in the NSW health system, by focussing on supporting the spread of local innovations.

In the context of the ACI Clinical Innovation Program, innovation means finding a better way to do something¹, or “the intentional introduction and application within a role, group, or organisation, of ideas, processes, products or procedures, new to the relevant unit of adoption, designed to significantly benefit the individual, the group, or wider society”². The ACI Innovation Cycle consists of five stages: innovation, evaluation, adoption, optimisation and disinvestment.

Across NSW, clinicians, managers and consumers are designing and delivering new, efficient and effective ways to deliver services, achieving positive change for consumers, communities and clinicians. The ACI Clinical Innovation Program outlines new models of care that have been developed locally by teams of local healthcare providers in NSW; clinical innovators who identified a need for change and addressed the need by designing and implementing new models of care. These models are not clinical practice guidelines, but models based on “real life” examples of local practises, developed and implemented to improve experiences and outcomes for patients and communities. These models of care are available to support providers across the state to reflect, and identify local opportunities for change for improvement.

The ACI Clinical Innovation Program methodology for identifying, prioritising and working to spread innovations involves:

- Identification of local innovations currently occurs via the NSW Health Innovation Award Finalists and Centre for Healthcare Redesign school.
- Evaluation and examination for sustainability, and review to ensure the model is a priority for the ACI and its Networks/Taskforces/Institutes, and provides the best outcomes for patients, staff and the health system. ACI Clinical Networks also identify leading initiatives which add significant knowledge and value to the relevant field.
- The identified innovation and other leading initiatives, are drawn together to develop a model which effectively addresses the specific need, problem or opportunity. The model is examined to ensure it meets the needs of metropolitan, regional and rural services.
- The model is documented to support replication across NSW.
- Implementation planning is the next stage in the process, with support for implementation of the innovation.

Purpose of this document

This document has been developed to highlight some of the innovative work of NSW Local Health Districts to improve service access and coordination. The document outlines central elements of various services across the state which aim to improve the experience of consumers, to enhance access and information sharing, to provide service coordination and to manage resources to facilitate timely access to services.

This document outlines the work by South Western Sydney Local Health District (SWSLHD) in developing and implementing their Triple I (Hub), a central hub for Intake, Information, Intervention. In addition, it highlights the leading work of the Health Contact Centre (Northern Sydney Local Health District), Access and Referral Centre (ARC) in Illawarra Shoalhaven Local Health District and the Referral and Information Centre (RIC) in Hunter New England Local Health District which add value to the model of care. This document describes the enablers of the service design and provides some cues for local system improvements.

It is acknowledged that there may be many examples of similar services already in place across NSW, some of which may have been operating for some time. This *service access & coordination* model aims to describe a model which is derived from a number of service models operating across the state. The term *service access & coordination* does not apply to any one of the sites visited, but is a descriptive term developed during the process of writing this document.

This document aims to share experiences, illustrate commonalities across services and describe some points of difference. It is hoped that by reading this document, Local Health Districts, together with local partners, may identify opportunities for change for improvement; may learn about alternatives to existing service models; and may be able to implement local changes to improve the experience and outcomes for consumers.

Endorsement

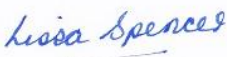
This document has been endorsed by the co-chairs of the Chronic Care Network.

“It will be very useful and a good advocacy document to try and provide development in this vital area for integrated care”.



Linda Soars

Chronic Care Integration Manager
Ambulatory and Primary Health, SESLHD



Lissa Spencer

Clinical Specialist Physiotherapist
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The innovation: service access and coordination centres

Case for change

Jo's* experience of care

[Care was] disjointed, with too many points of contacts for differing services, and long waiting times for contact from [the] service provider.

Client feedback, pre-implementation of the Triple I (Hub), SWSLHD¹

*Not the patient's real name

Coordinated care has long been a goal of the Australian health, community and social care sector³. Well-coordinated care involves sharing health information over time, working across services, organisational and sectoral boundaries to meet the needs of individual clients and their families. Working in this way improves the quality, experiences and outcomes of care for clients and their families.

With an increasingly ageing population and the growth of chronic conditions, there is an even greater need to better coordinate care. Care that is fragmented puts patients at risk of communication failures, medication and clinical error and hospital readmission⁴. Addressing fragmented care, and moving toward integration requires an approach that is multidisciplinary, adaptive and flexible, and that works to support coordination across services, organisations and sectors. Coordinated care requires system-wide thinking, and places the patient and their carer(s) at the centre, with care planned and coordinated together with the patient over time and across the continuum of care⁵. Ultimately, care coordination aims to achieve integrated care, through partnerships and collaboration across the whole of the health and aged care system. Achieving coordinated care requires a vision, commitment and dedicated energies and time to commit to improvement work.

The innovation

The Triple I (Hub) in SWSLHD aims to support clients' self-management, informed and participative decision making, and improve access to and coordination of services. The Triple I (Hub) also aims to reduce duplication of effort by service providers. Triple I (Hub) operates on the principle of 'no wrong door'¹ and providing the 'right care, right place, right time'. In November 2012, Triple I (Hub) brought together and collocated six previously disparate services and assumed responsibility for Intake, Information and Intervention (the 'Triple Is') for SWSLHD.

¹ Every door in the system is the right door for community members to access services; clients will be supported to access the appropriate service regardless of point of entry

Triple I (Hub) brought together the following services:



Triple I (Hub) established a space for co-location of a team to deliver a single point of contact (telephone, email and fax), to improve ease of access for local service providers and community members. This single point of service was to provide a client focussed intake, information and intervention service.

Processes and protocols were developed to support the Triple I (Hub) team members to:

- Integrate care, linking clients with required services
- Provide individualised information
- Facilitate assessment and care planning within a multidisciplinary team
- Ensure general practice engagement during clients' transition of care.

Five months after "go live", the Triple I (Hub) had:

- experienced an increase in service calls and referrals, with the number of incoming calls increasing by 200%
- improved staff job satisfaction
- built strong relationships with service providers, resulting in the ability to work together to allocate resources across the LHD (data from the NGO and staff survey in 2013).

One of the achievements of the Triple I (Hub) has been its ability to achieve significant organisational change, design and implementation and manage a significant increase in demand for services, within existing resources. The Triple I (Hub) shifted existing staff from intake services into the Triple I (Hub) on establishment, with additional costs in information technology and office set up costs. 86% of Triple I (Hub) staff are clinical staff.

Service	FTE	Salary (\$)
Referral Information Centre (RIC)	5	373,103
CHAIN	3	228,479
ComPACKs	No addition staff transitioned – no cost provided	
PEACH		
Connecting Care		
Child and Family	9.3	631,897
TOTAL	17.3	1,233,479

The services supported by Triple I (Hub) are expected to change and expand over time. In early 2013, the SWSLHD Connecting Care Program intake was transferred to Triple I (Hub). In mid 2013 the Triple I (Hub) commenced the after hours on-call service for the Transitional Aged Care Program (TACP) and the Liverpool/Fairfield Home Care Package Level 2 Program (formerly known as the Community Aged Care Packages CACP Program). This service has been important for clients contacting the service after hours to request additional assistance or cancel services. On the part of the SWSLHD this has reduced the costs of additional on-call allowances paid to staff attached to the TACP and CACP teams. In December 2013, the commissioning of the NSW Palliative Care Home Support Packages (PEACH) intake and referrals also commenced with the Triple I (Hub). Opportunities to expand with similar services are clear, for example Hospital in The Home, Community Acute/Post Acute Care. Other services to come on board may be less similar in terms of potential client groups, but require the same service access and coordination processes; Child and Family Health services commenced with Triple I (Hub) in February 2014.

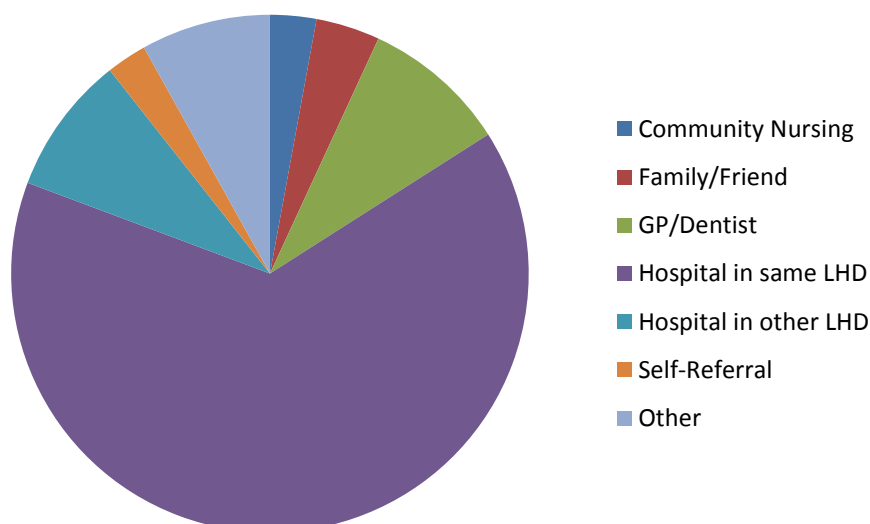
The following Table shows the total Referral activity for 2012 to 2014. It is important to note that Triple I (Hub) commenced mid-2012/13 financial year, and for most of 2013 had 8 FTEs.

YEAR	Aged Care	Community Nursing	ComPACKS	Connecting Care	Resp Chronic Care	TOTAL	% Referral Growth
2011	8,128	9,122	0	0	0	17,250	
2012	8,631	10,008	0	0	0	18,639	8%
2013	8,117	11,722	1791	382	287	22,299	20%
2014	11,999	17,353	2,634	785	478	33,249	49%

*Also note that Child and Family referrals are not included in this data, due to transitioning into Triple I (Hub) recently, in Feb 2014.

The Triple I (Hub) is being used by clients and service providers alike. The graph below provides a snapshot of the source of referrals for Community Nursing.

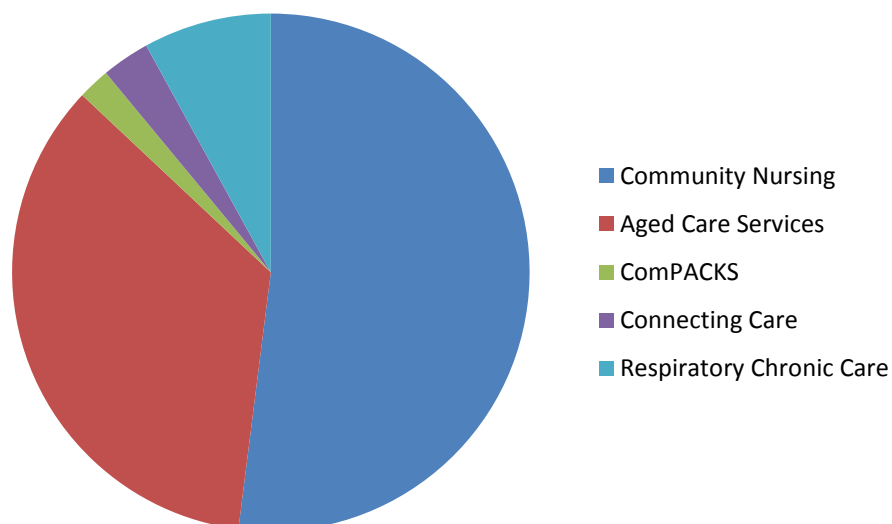
Community Nursing Referrals, for January-July 2014.



The Triple I (Hub) also has access to service vacancy lists generated by the Aged and Disability Forums, government and non-government organisations across south western Sydney. These lists provide up to date information about the availability of ComPacks, personal care, domestic assistance, respite services,

transport and Home Care Packages that are available in south western Sydney but not directly provided by the SWSLHD. If the service type requested by the referrer cannot be provided directly by the SWSLHD, Triple I (Hub) staff can provide information and contact details for external services and can facilitate appropriate referrals on behalf of the client.

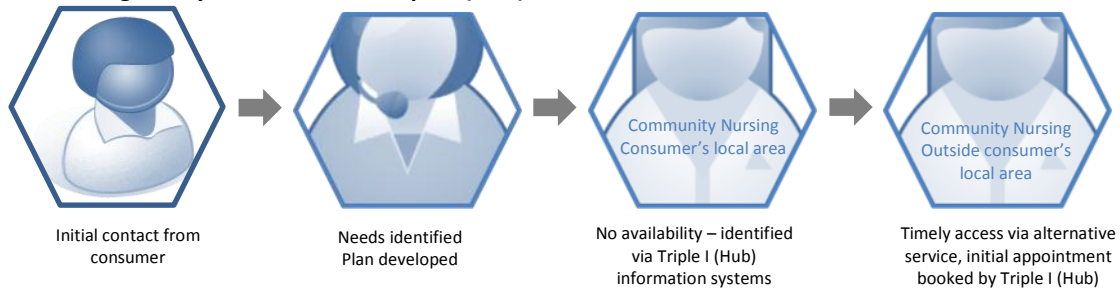
Services Supported by Triple I (Hub)



The SWSLHD conducted surveys with consumers of Triple I (Hub) in 2013. Clients showed a high level of satisfaction for the service with 97% responding that they were satisfied or very satisfied with the service that they received. Satisfaction with the service ranged across a variety of areas including the ease of access of Triple I (Hub), being easy to understand and meeting consumer needs as well as a variety of other areas.

The Triple I (Hub) team work in an environment of constant change, as they improve their processes, systems and scope over time. One of the aspects of Triple I (Hub) that is significantly different from other service access and care coordination centres around the state is their ability to work together with service providers to meet demand as it arises across the Local Health District (LHD). This works due to Triple I (Hub)'s nature as the local "eye" or "control centre", with access to information and ability to book appointments for services across the Local Health District. Armed with this information and support from partner providers, the Triple I (Hub) has the ability to work together with SWSLHD providers to allocate resources. For example, if the Triple I (Hub) is unable to access a service for a client in one area within the Local Health District, but is aware of the same services available in a neighbouring area, the Triple I (Hub) works together with the provider to support cross-area, flexible and timely access to care. This is currently occurring with Community Nursing, the Aged Care Assessment Teams ACAT, Transitional Aged Care Program PEACH packages and ComPacks.

Facilitating timely access to care: Triple I (Hub)



The model of care: service access & care coordination centres

Coordinating care for consumers at the initial point of contact is capable of transforming experience and outcomes of care. Supporting self-management and a patient-centred approach from initial contact results in empowered patients who are informed and actively participate in their own care.

What success looks like

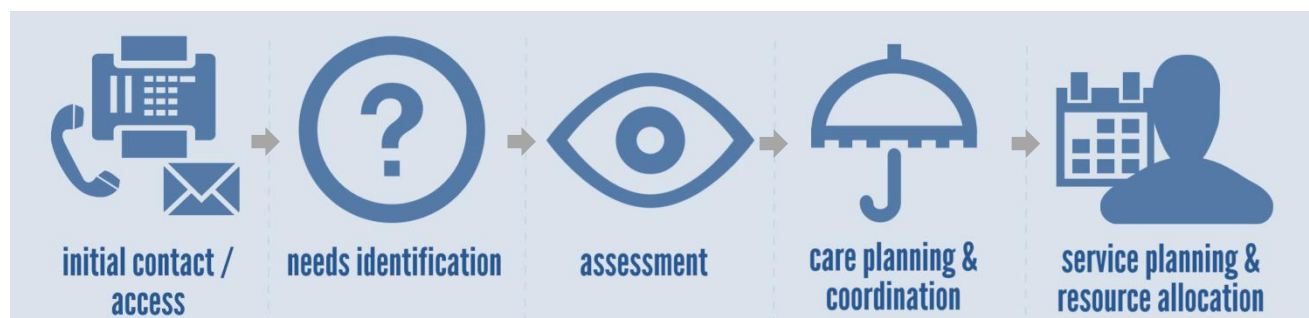
My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes.

¹ National Voices 2012. Principles for Integrated Care. Accessed May 2013 at <http://www.nationalvoices.org.uk/coordinated-care-0>

Service access and care coordination centres operate significantly differently across the state. Centres operate differently in terms of staffing, practices, policies and protocols. They also use different tools to identify needs and support patients. Service management tools are also dramatically different. This section of the document aims to identify leading practice examples across four centres in NSW; identify what works in different contexts and suggest opportunities for adaptation by other local areas.

Key elements

The key elements of the service access and care coordination centres are outlined below. Importantly, these elements are underpinned by a person-centred approach to care⁶.



These elements may not all be provided by all centres, but reflect the potential of the centres in service access and coordination.



Initial contact/access

What it is

Initial contact / access refers to the initial point of contact with the single point of entry (service access and care coordination centre) by the:

- patient
- carer, or
- provider.

It is important for centre staff to recognise that this may be the patient's first point of contact with the health system, or it may be another encounter in a series of health system interactions. The purpose of initial contact/access is to acknowledge initial concerns and reasons for contact, and provide simple information about services if this is the nature of the contact. In some service access & coordination centres, initial contacts may be managed by a non-clinical customer service officer. An initial contact may determine that a person is ineligible for services, in which case information may be provided for any relevant services, and the encounter would be 'closed'.

In most cases, initial contact/access will continue on to the needs identification stage. If the initial contact is made via telephone, initial contact and needs identification are most likely to take place within the same telephone call. Where an initial contact is managed by a customer service officer, the call may be transferred to a clinical staff member to continue with the initial needs identification, assessment and later stages of care. It is at this stage that consent is obtained from the patient to share information across providers, and that the patient is 'registered' on the Local Health District's patient management system.

The innovation

Referral and intake phone lines have been in place across the state for many years. What differentiates the service access and care coordination centres is their pathways into and across a number of services, and their use of new and developing technologies to support care processes.

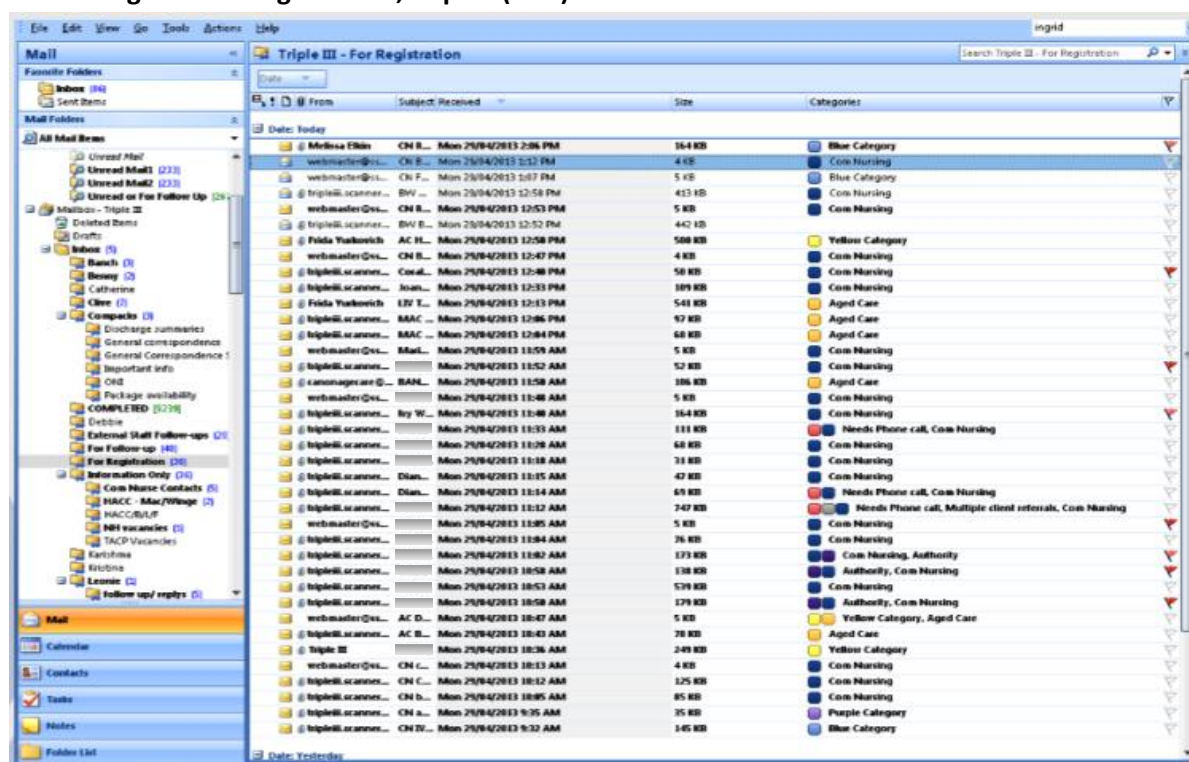
Service access and care coordination centres across the state are using a single phone number, fax line and email address to receive referrals.

The single point of contact can be implemented through a number of systems and via various providers. The use of a 1300 number as a single point of contact is being used by a number of Centres in NSW. The 1300 numbers have advantages including:

- being able to build/increase capacity over time (one provider has informed the ACI that they have an infinite number of phones which could be linked to their 1300 number)
- availability of service use, staff performance and efficiency data
- ability to support remote working – staff can “log on” to the 1300 number from a remote phone/internet connection. This can be beneficial for staff and workplace flexibility, and may also offer some advantages when physical office/centre space is limited. Additionally this may prove useful for regional/rural areas where centre staff may be based at different locations
- queue management when there are numerous incoming calls. There are also tools which enable the team to see how many staff are actively engaged on the phone, how many lines are still available for incoming calls, and which staff may be available to provide support or a second opinion.

Email is also proving useful for receiving referrals and supporting information. The Triple I (Hub) uses its email address as a way of receiving, tracking, prioritising and allocating their referrals (which are all managed in Outlook, see below). One of the significant advantages of using a software that staff were familiar with, was that staff required training on business rules only (e.g. relating to allocating referrals, storing referral information, labelling information), as opposed to needing to learn an entirely new software system.

Referral management using Outlook, Triple I (Hub)



Many of the service access and care coordination centres are operating in a paper-free environment. This is being achieved by investing in relatively simple technology which automatically converts fax referrals into PDFs and emails these to the referral email address. The Triple I (Hub) also utilise the CERNER System which provides an electronic medical record for clients registered on the system. These systems were feasible in the early days of the Triple I (Hub) when referrals were only being registered for Community Nursing, ComPacks and for Aged Care and Rehabilitation Services. The growing number of new services introduced to the Triple I (Hub) since early 2014, accompanied by the growing number of referrals has created the need to

review the existing IT system sustaining the Triple I (Hub). To support the Triple I (Hub) in becoming a fully functioning integration service, software packages with connectivity to the Cerner eMR will need to be explored.

The Health Contact Centre at Northern Sydney Local Health District (NSLHD) uses the Single Point of Access Interface (SPAIn) software to manage referrals, needs identification and care coordination processes. This system communicates with the hospital's electronic medical record system, and auto-populates patient data, reducing opportunity for data entry error and increasing efficiency at the point of initial contact.

Central to the success of the service access and care coordination centres are the teams that operate the centres. Teams may be comprised of a blend of administrative, nursing (ENs, EENs, RNs, NPs), allied health and service management staff. In some centres, customer service officers/representatives (also known as customer service officers) are responsible for initial contacts and incoming calls. These administrative staff are able to work with patients, carers and providers in initial contact and initial needs identification to a point, until the interaction becomes clinical. In this instance, the system relies on staff having a clear and shared understanding of roles and professional boundaries. Likewise, many service access and care coordination centres have senior clinical supports built in to the staffing mix, whether this is a nurse unit manager role, nurse practitioner or in one case a senior psychologist to support the staff working with large volumes of contacts with mental health issues.

With the aim of improving timely access to care, service access and care coordination centres have either extended contact hours or have negotiated local working arrangements to ensure new referrals can be accepted and acted upon seven days a week. The Triple I (Hub) operates seven days a week (currently 8am-6pm weekdays, 8am-4pm weekends). Quieter periods (with fewer incoming referrals) allow more time to manage complex cases requiring greater care coordination efforts. For some centres, it may not be appropriate or financially viable to operate a seven day a week service. The Health Contact Centre (NSLHD) is staffed five days a week (Mon-Fri), and uses automated messages on the Health Contact Centre telephone line on the weekend to redirect calls to seven day a week service providers (e.g. "To make a referral to Community Health Nursing, press 1").

Evidence base

Fragmented care is associated with risks as clients move between health care providers. Care transitions (responsibility for care is transferred from one professional/service/organisation to another) may be associated with medication error, communication breakdown, adverse events and readmissions, and increased health care system costs⁷. This is particularly true for those transitions from hospital to home. Safer transitions of care are facilitated by engaging the client in their own care from an early stage in their care, timely sharing of information across service boundaries⁸ and developing approaches that are supported by a systematic approach to ensure all needs are met.

Enablers/supportive structures

Information technology (IT) is used in service access and care coordination centres to varying degrees. It may be as simple as a photocopier that converts incoming faxes into emails and sends these directly to the centre

email address, to adaptation of a familiar software tool for a different use (SWSLHD), or a highly complex purpose designed IT system (such as the SPAln in NSLHD) that autopopulates data and supports e-referrals.

Information technology should always have the primary objective of improving care. Triple I (Hub) worked together with the Medicare Local in their region to develop a single referral form for use by general practice. The Medicare Local has since developed this form into a format that sits within general practice electronic medical record systems and auto-populates key information from the patient record. The referral is then able to be sent via email or fax directly to Triple I (Hub), facilitating simpler and faster referrals from local general practices.

The success of the service access and care coordination centres is largely dependent on its people. Workforce planning is essential in this context, with varying roles in the team, and activities being allocated to different members on different days. Clear position descriptions, role clarity for individuals and for the team, and regular team meetings that review cases and the team members' roles in managing these facilitate the success of these multidisciplinary teams.



Needs identification

What it is

Needs identification involves broad and shallow screening to identify the patient's needs across a range of medical, functional and social dimensions. This stage is particularly important for determining priority and timelines required for service access, identifying where there may be further information or documentation required, and making appropriate service linkages at an early stage in the process.

In centres with a focus on service access (as opposed to service access *and* care coordination), the needs identification process will result in referrals and the encounter with the centre will end at this point. In centres operating across the full breadth of service access and care coordination, the encounter will continue onto assessment from this point.

The innovation

Needs identification in the service access and care coordination centres is supported by standard broad and shallow screening processes which are guided by forms within the electronic system. Teams have access to eligibility criteria for the available local services, and the information requirements for a referral to these local services. Team members are able to use these criteria to determine appropriateness and eligibility for the patient, and ensure that all of the information required for a referral to a service is included in the referral.

In the Triple I (Hub), SWSLHD, initial contact/referral information is grouped together with information determined during the needs identification process, using Outlook messages and attachments. Messages (referrals) are then 'categorised' according to need and 'flagged' according to priority level.

triplett.scanned...	by W...	Mon 29/04/2013 11:40 AM	164 KB	Com Nursing	
triplett.scanned...		Mon 29/04/2013 11:33 AM	111 KB	Needs Phone call, Com Nursing	
triplett.scanned...		Mon 29/04/2013 11:28 AM	68 KB	Com Nursing	
triplett.scanned...		Mon 29/04/2013 11:18 AM	31 KB	Com Nursing	
triplett.scanned...		Mon 29/04/2013 11:15 AM	47 KB	Com Nursing	
triplett.scanned...		Mon 29/04/2013 11:14 AM	65 KB	Needs Phone call, Com Nursing	
triplett.scanned...		Mon 29/04/2013 11:12 AM	247 KB	Needs Phone call, Multiple client referrals, Com Nursing	
webmaster@sc...		Mon 29/04/2013 11:05 AM	5 KB	Com Nursing	
triplett.scanned...		Mon 29/04/2013 11:04 AM	26 KB	Com Nursing	
triplett.scanned...		Mon 29/04/2013 11:02 AM	173 KB	Com Nursing, Authority	
triplett.scanned...		Mon 29/04/2013 10:58 AM	138 KB	Authority, Com Nursing	
triplett.scanned...		Mon 29/04/2013 10:53 AM	579 KB	Com Nursing	
triplett.scanned...		Mon 29/04/2013 10:50 AM	179 KB	Authority, Com Nursing	
webmaster@sc...	A.C.D...	Mon 29/04/2013 10:47 AM	5 KB	Yellow Category, Aged Care	
triplett.scanned...	A.C.D...	Mon 29/04/2013 10:43 AM	20 KB	Aged Care	
Triple I		Mon 29/04/2013 10:36 AM	249 KB	Yellow Category	

The staffing mix at the service access and care coordination centres allows for a range of staff backgrounds, knowledge and skillsets. Staff roles in conducting initial needs identification processes need to be clear to all staff and supported by IT systems as well as systems and processes for clinical and/or supervisory support.

Who's working in the Triple I (Hub)?

1.0 FTE Triple I (Hub) & Connecting Care Manager
 14.8 FTE Clinicians (ENs, RNs, SW, OT)
 4.4 FTE Customer Service Representatives
 - supported by 1.0 FTE Nurse Practitioner

Evidence base

The needs identification process enables early identification of risk and determination of priority for service, supporting timely access to services⁹. Importantly, the needs identification process aims to identify issues and determine appropriate actions together with the client, reinforcing the client's role in self-management. Central to a needs identification process are tools which enable the entry, collection and safe storage of data and tracking of referrals and service and care coordination processes¹⁰.

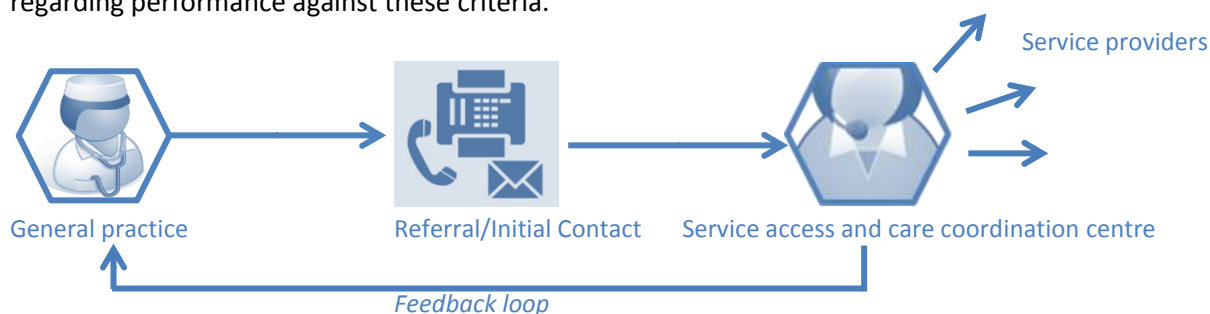
Enablers/supportive structures

There is a need for clear practice protocols and guidelines relating to data entry, to support standardisation and ensure patient information is meaningful, appropriately entered and stored, and not "lost". Data entry guidelines include items such as what information is entered, by whom, at which point in time, and where information is stored. Guidelines should also provide direction about what may constitute a priority or urgent referral.

Decision support tools (such as eligibility criteria for services) are also useful in supporting centre staff in their role in identifying needs, facilitating access to services and coordinating care. The SPAIn software in use at the Health Contact Centre (NSLHD) includes a decision support tool which includes prompts for follow up questions or additional information, dependent on the data entered.

On some electronic information systems, service providers are able to send referrals out to multiple providers simultaneously.

Guidelines should also outline feedback loops. For example, in the case of a general practice referral, guidelines should be in place regarding the feedback provided to the general practice; a simple receipt of referral letter autogenerated from within the information system, or a more detailed letter outlining the actions and referrals arising from the initial general practice referral. Measures can then be put in place regarding performance against these criteria.





Assessment

What it is

Assessment involves a comprehensive, detailed analysis of a client's needs. This assessment process requires clinical assessment and problem solving skills. Assessment is sometimes prompted by the entry criteria of the service the patient requires, or the need for further assessment may be prompted through discussion with the patient, carer or service provider(s). Further assessment may involve making judgements based on information from multiple providers, discussions with general practice about medications, checking community nursing support needs, and obtaining details about housing and any need for home modifications.

The innovation

The Triple I (Hub) supports patients by coordinating their care from the point of initial contact to the point of care at the relevant service(s). As a result, there is an expectation that the patient will be "service ready" when they are booked for the service; that is, that all paperwork is completed, medications confirmed, correct and medication orders available, with all needs clarified so agencies can deliver services on the date booked by Triple I (Hub). This expectation requires a higher level of assessment, problem solving and care coordination than many other centres around the state. Shifting these activities to the service access and care coordination centres enables care providers to commence providing services at the first contact, without delays associated with additional administrative tasks requiring completion.

Evidence base

Placing skilled clinical staff within centres allows for detailed assessments to be completed, for example checking medications, checking any contraindications and obtaining current medical orders, in turn minimising risk to clients and reducing the risk of readmission. Medication reconciliation is central to minimising risk at transitions of care¹¹.

Enablers/supportive structures

The staffing mix of service access and care coordination centres is dependent largely on the centre's model of care. A local model of service access and coordination needs to take into account local resources and opportunities for staff support. Having greater expectations of the level of assessment of clients prior to service contact places greater demands on staff, and impacts on the workforce able to participate in the needs identification and assessment process. Due to the clinical nature of some of the work at the Triple I

(Hub) associated with their working with clients up until their first contact with a service, Triple I (Hub) has a large component of clinical staff, supported by senior clinical staff.



Care planning & coordination

What it is

Care planning and coordination is a process that involves supporting the client to make decisions regarding their needs, and arranging the services to meet these needs. Care planning and coordination also requires relative prioritisation of different needs and may involve urgent, short-term or long-term support.

The Commonwealth Fund¹² describes the aim of care coordination as *high-quality referrals and transitions*. It describes the elements of care coordination as:

- assuming accountability (accepting responsibility for the role of care coordination)
- providing patient support
- building relationships and agreements among providers (including community agencies) that lead to shared expectations
- Developing connectivity via electronic or other information pathways

In service access and care coordination centres, the process may involve needs identification, assessment, referrals (incoming and outgoing), information exchange and transfer within and across services. The process should also ensure that service providers are aware of the other participants in care.

Care planning and coordination by the centres is reliant on good information gathering, broad needs identification and thorough assessment. It requires the ability to manage information, to work with the client to develop goals and make clinical decisions around service needs, identify the appropriate service/provider and to support the client's transition to the appropriate service.

Importantly, care planning and coordination should inform all involved providers of the goals of the client and strategies in place to achieve these goals. This involves communicating with service providers (e.g. general practice) to support the development of a care plan, as well as forwarding information to providers following development of a care/ care coordination plan by the client.

The innovation

In the Triple I (Hub), staff make contact with current service providers to clarify client needs, to share the client's care plan, negotiate service needs, and have discussions with potential future service providers regarding appropriateness for service, access times and availability. This is facilitated by strong and positive working relationships with local providers. In this context, this is considered standard practice, and is supported by service policies, protocols and practice tools. Staff responsible for care coordination in this

context are skilled in facilitating client-centred care, supporting self-management, are strong communicators and skilled navigators in a complex environment.

The Triple I (Hub) has worked together with local service providers (e.g. Community Health Nursing) to change how client appointments are made. Community Health Nursing now works similarly to an outpatient clinic, with clinic spaces available to be booked for clients. Triple I (Hub) staff have the ability and authority, to book clients directly into appointments, reducing administrative duties required of service providers and improving timeliness of access to services. Conversely, clients only need to recall the number for Triple I (Hub) staff to cancel service provider appointments, with Triple I (Hub) staff able to do this on behalf of the client.

In addition, in the Access & Referral Centre (ARC, ISLHD), patients with chronic conditions who are discharged by the hospitals are flagged by administrative access and care coordination centre staff, for contact by health professional staff. Clinical staff make contact with these patients, work with the patient to determine chronic care needs, and where appropriate refer to outbound telecoaching, also based within the centre.

Evidence base

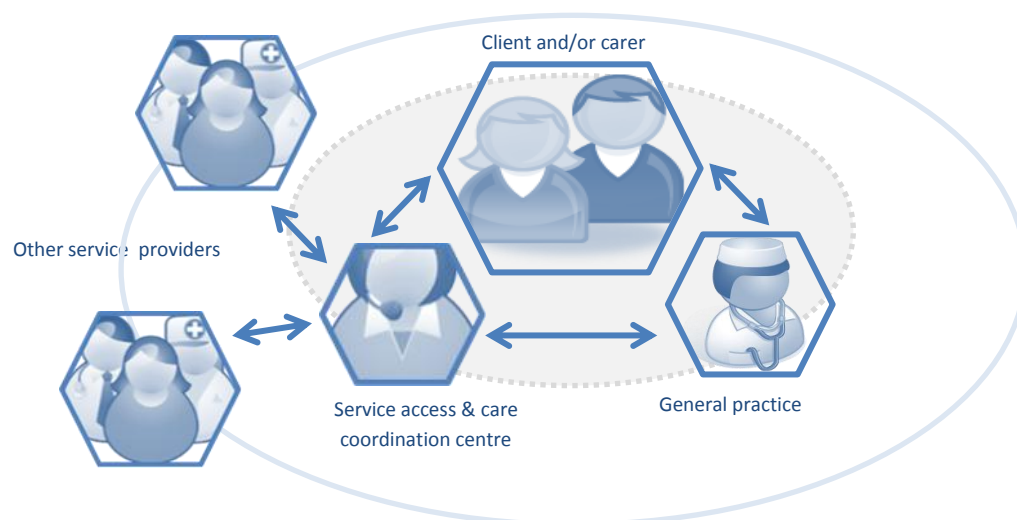
A coordinated approach to treatment and care is essential to improve the experience and outcomes for clients, as well as to address the increasing demands and pressures on the health care system (REF). Care planning and care coordination facilitates communication between clients, health care professionals and community and social care providers to support individualised and planned care for clients REF. Importantly, care planning and coordination aims to address the common experience of fragmented care. The role of the care coordinator is identification of an individual's health goals and coordinating services and providers to meet those goals¹³.

Enablers/supportive structures

The care planning and coordination aspect of the service and care coordination centres is based on strong partnerships with local service providers. Importantly, it is also based on sound processes and protocols, including the development, use and updating of service eligibility criteria (to ensure informed referrals, and referrals going to the right place), service provider information including available packages or appointment availability. The ability to work so closely with the service providers, and to transform how these work together has also been facilitated by the Triple I (Hub) governance structures, outlined in the *Making it happen* section.

Systems that enable feedback loops are vital to ensuring a truly patient centred approach, and an informed clinical team with access to key health information about the client. Service access and care coordination centres, in accepting the care coordination/care navigation role for clients, also need to accept the responsibility for ensuring that general practice remains involved, that general practitioners and the broader healthcare team are involved on developing client care plans and that service providers are made aware of actions arising from care planning and care coordination and when referrals have been made or accepted by relevant services.

Care coordination and communication by service access and care coordination centres





Service planning & resource allocation

What it is

Service planning and resource allocation in this context refers to the planning of health services (location, throughput, reach), distribution and allocation of service provider resources related to the demand for services coming through the centre.

This component of the service access and coordination centre model involves a clear understanding of the service landscape across the local area, service criteria, eligibility and availability. It involves partnerships with local service providers, to support development of local agreements for service access and utilisation. It requires agreements with local providers to enable service access and coordination centre staff to make flexible decisions regarding care for consumers. Importantly, it requires a mechanism for consumer demand to influence service design to improve access and coordination of services in the local community.

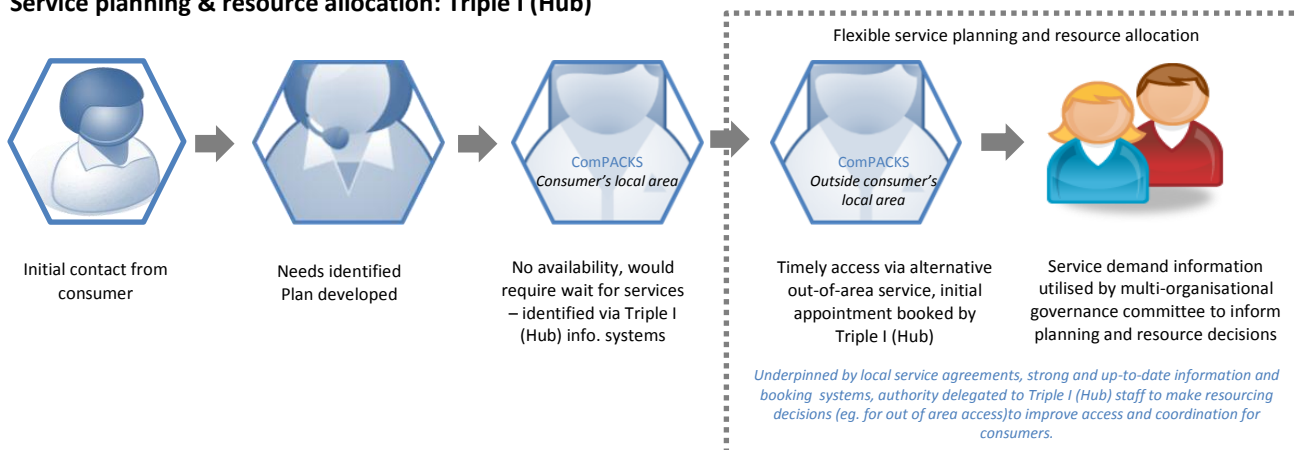
The innovation

The Triple I (Hub) has adopted a role quite different from the others in the state; that of service planning and resource allocation. The Triple I (Hub) plays a significant role in SWSLHD in driving client-centred health service delivery. This is not only limited to interactions with individual patients, but also extends to shifting resources to meet individual or local demand. This is an innovative expansion of the role of the centres; where consumer demand has a direct relationship with, and impact on service planning and resource allocation.

Triple I (Hub) is ideally placed to understand the local demand for services in the local area, as clients access services via the Triple I (Hub). Triple I (Hub) is aware of which services are available for which patients and when, and can look at access/availability levels for services. With information regarding service availability and current client demand across the Local Health District, service access and care coordination centres may be well-placed to make decisions about resource allocation. Once this is understood and agreed locally, resources can be shifted or flexed to create availability for clients across the area.

An example of how this works in practice can be seen in Triple I (Hub)'s work with Community Packages (ComPacks). Local Home and Community Care (HACC) providers and non-government organisations (NGOs) inform Triple I (Hub) of any local vacancies. This information enables Triple I (Hub), with an overview of the availability of packages in the area, to determine how needs can be best met across the local area, together with providers. This may involve shifting resources from one area to another, or supporting a client to access services in a neighbouring area to their own home.

Service planning & resource allocation: Triple I (Hub)



Evidence base

Integration of care around the client is the primary goal of the service and coordination centres. Integration of services, complete or functional integration only, enables resource distribution and allocation to greatest area of need. Partnering enables development of cooperative strategies to research, design and implement services¹⁴.

Enablers/supportive structures

Triple I (Hub)'s ability to be involved in this area is enabled by the local partnerships which provide opportunities for discussion about resource sharing and allocations. Additionally, Triple I (Hub) authority in this area is enabled by its multi-organisational governance structure with senior representation.

Making it happen

Enablers of coordinated and integrated care in the literature have spanned areas including workforce and organisational capacity, clinical and service systems and processes of care, policy and leadership support, governance, accountability and quality structures and systems. Additionally, local (LHD) commitment, investment in community based care (and inversely, potential disinvestment in acute based care) and support for innovation have been found to support the achievement of high levels of care integration^{15,16}.

There is some suggestion in the literature that focussing on integrating *services* may not achieve the desired outcome, without a primary focus on integrating *care*. Instead, in making it happen at a local level, a planning approach which begins from the perspective of individual clients and frontline staff, and then from the perspective of service planning may best inform how care could be integrated to meet local needs¹⁷. This approach enables a focus on *care*, as opposed to *services*, and begins from a viewpoint which is less focussed on arbitrary service boundaries and funding sources.

The Triple I (Hub) team provided some recommendations for those establishing or further developing their local service access and coordination centre:

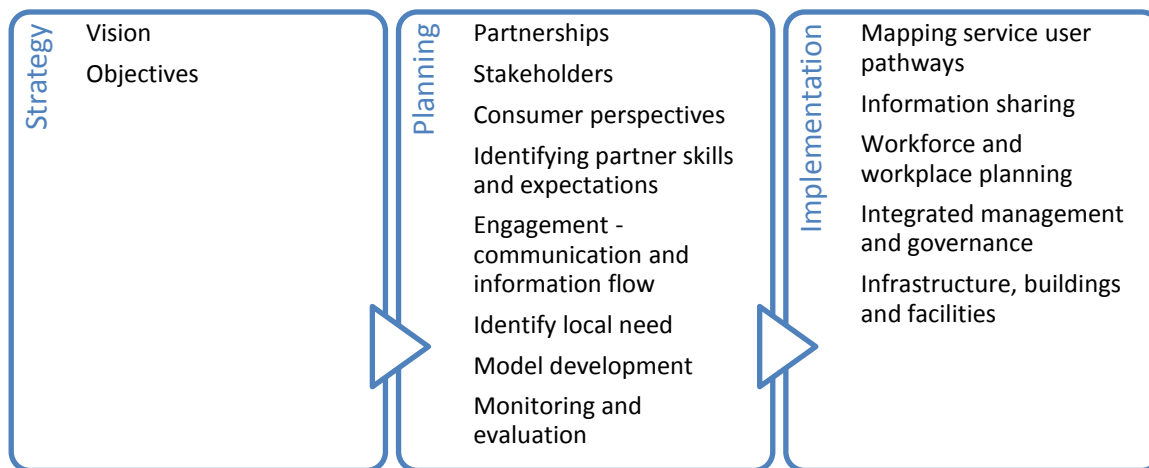
- *develop a clear shared vision*: know where you all want to go, and keep heading in that direction
- *ensure strong commitment and leadership*: ensure commitment and leadership at all levels, and across organisational boundaries
- *use what you have*: draw on existing resources, from staff to furniture, computers and phones
- *allow time*: staff have to maintain current caseload whilst training. This may result in extra costs (eg. extra staff) in the short term, for the long term benefit
- *support engaged staff*: engage the 'right people', engage the team in planning, set up, execution
- *build a prepared team*: use tools, policies, protocols, guidelines, training
- *invest in the technology*: set up the technology that will support the work the centre needs to do
- *set a 'go live' date*: understand that it may not all be 'figured out' before you begin; what is important is to begin somewhere
- *expect change, prepare for the unexpected*.

Adapting to local context

The ACI's *Framework for Building Partnerships - Integrated care for the older person with complex health needs* outlines local planning to support the provision of integrated care. Whilst focussed on older people, the tasks to support integration are the same, and may prove useful in the establishment and development of a service access and coordination centre:

1. Establish a dedicated multi-sector governance structure to lead and drive integrated care
2. Align stakeholders to a regional shared vision and purpose of integrated care
3. Undertake a joint gap analysis/needs assessment and service planning
4. Develop shared processes, tools and guidelines to support regional implementation
5. Implement the vision¹⁸

The framework below may be useful in designing service access and coordination centres in that it looks at the different stages of the service design, as well as the different components of an integrated service. This framework highlights planning aspects such as working together with partners to clarify expectations prior to engaging staff and selecting information systems and tools.



Adapted from Integrated Care Network, Community Health Partnerships 2010 ¹⁹

A self-assessment tool at Appendix A may provide organisations with some additional support in terms of identifying strengths in service access and care coordination, and opportunities for improvement.

In taking on new services, it is helpful to understand service demand, number of calls likely to come through the centre. Determining the service levels and impacts on the centre, and resources required to manage the transition and ongoing services may be made easier through asking some structured questions of providers. The following questions are currently used by the Referral and Information Centre (HNE LHD) when new services are considered for integration with the RIC:

- Is your service aware of the centralised process?
- How many referrals do you have per month/year?
- Do you keep records on enquiry calls? How many per month/year?
- Did you want a template with your service request?
- Have you identified your Core Business?
- Have you determined your Inclusion/Exclusion criteria?
- Are there any special issues or information that the Referral & Information Centre (RIC) staff needs to be aware of regarding your service?
- Would you be prepared to offer an in-service to RIC staff prior to commencement with RIC
- Do you have a timeframe that you need/want to work to?
- Are there any other questions you have?

Process

Central to the success of the service access and care coordination centres is the vision and leadership supporting the models. The design, development and implementation of the centres has been reliant on engagement at all stages of the innovation, at all levels, as well as with partners across service, organisational and sectoral boundaries. Identification and development of a case for change, leading to a clear plan with executive sponsorship and drive has been key to the development and pursuit of these models.

Service access and care coordination centres across NSW have developed over time, sometimes in a planned and structured way, and sometimes in a more 'organic' way, slowly evolving over time. It is worth noting that the SWSLHD Triple I (Hub) was implemented just three months after its inception, located outside a public hospital premises, in the same building with the SWS Medicare Local.

Facilitators/enablers

Vision

Each service access and care coordination centre expressed the importance of vision to the achievement of objectives and shifting toward person-centred, coordinated care. A shared vision together with partnering organisations and services was reported to be essential to the success of the centres. The Triple I (Hub) team expressed that there is one constant: change. With services expanding, growing and evolving over time, it is important for organisations to hold onto their original vision, to ensure changes support achievement of the vision for the service.

Leadership

Triple I (Hub) was implemented after just three months of rapid planning. This was able to be achieved due to the importance placed on establishing Triple I (Hub) across various levels and areas of the Local Health District, with a groundswell of practitioner support being reinforced by high level strategic intent. Triple I (Hub) is supported by a high-level governance body, the Executive Management Group, comprising the Chief Executive SWSLHD, Director Operations SWSLHD, Clinical Director Aged Care & Rehabilitation SWSLHD, General Manager Community Health, Director of Nursing (Community Health), Service Manager Aged Care and Rehabilitation, Associate Director Strategic Projects; Clinical Director Complex Care and Internal Medicine. and Chief Executive Officer South Western Sydney Medicare Local. This Executive Management Group acts in an advisory capacity to the operational group of the Triple I (Hub).

A number of centres are represented on various meetings and committees across the Local Health District to keep the service access and care coordination centres front of mind. For example, the Referral and Information Centre is a standing agenda item on the NUMs meetings in Illawarra Shoalhaven LHD.



Technology

Technology is an enabler of the work done by the service access and care coordination centres, but is not the end in itself. Centres across the state are operating very differently, in particular in relation to the levels and kinds of technology in use. However, it can be said that technology can impact dramatically on the efficiency of services by reducing duplication of effort, and can also positively influence the coordination of care. Existing centres have collaboratively built GP software-ready referral forms, developed business rules for use with familiar software to transform an email application into a referral and information management system, and have supported the development of a new purpose-built information system. Next steps for the service access and care coordination centres include the development of tools to close feedback loops, so referrers have their referrals acknowledged, so key providers such as general practice are informed about a client's treatment plan and health and community care team.

Technology is important for service integration for the future. This will enable:

- Current updated information about clients of the service from nursing and other field staff working in the community who are undertaking assessment or home visits - using their tablets and other devices to update client progress and this information being accessed directly by staff of the Triple I (Hub)
- Improved efficiencies as staff using SMART phones in the community will be able to receive direct information regarding scheduled appointments/interventions.
- Moving towards consumer directed care where clients of the service are able to access their care plans/service plans and personal financial statements via client portals.
- Telehealth initiatives for patients living in residential aged care facilities and rural communities.

Prepared workforce

The success of the service access and care coordination centres is reliant on the people in the teams that support them. The multidisciplinary teams are dependent on clear practice guidelines, protocols and systems to ensure consistency of practice, as well as training and practice support and supervision over time. Some of the service access and care coordination centres in the state have case review meetings, where a client's journey through the service is reviewed and discussed. Triple I (Hub) also utilises one of the benefits of their phone system in their case review, and use the opportunity to listen back to live-recorded telephone calls for peer discussion and review.

With different staff employed within the centres, there is a need for clear protocols around professional boundaries and the need to seek assistance. Role clarity can be supported by clear position descriptions, as well as clearly designated tasks (e.g. administrative staff can engage in initial contact, registrations and appointment bookings), service policies and protocols and regular opportunities to review cases.

Change is described as a constant in the context of the centres. This environment of constant change (with services and information changing frequently) impacts on staff, with some staff needing additional support through change. Preparing staff to work in an environment of change may be an important component of induction for new staff in these centres.

The Access and Referral Centre (ISLHD) is engaging in some different workforce initiatives, which may prove useful to centres across the state. The ARC is building up a bank of staff who are able to provide leave cover and casual cover for staff in the ARC. This involves training staff who are typically working in direct clinical care environments to work over the telephone with clients, using the local systems for communication and information management. This decision has been made recently as clinical care staff may be easier to 'backfill' with casual staff than staff in the ARC. Illawarra Shoalhaven LHD is also looking at the opportunity to have staff do rotations through the ARC, alternating rotations in the ARC with direct clinical care.

Partnerships

Effective partnerships are central to the success of the service access and care coordination centres, which rely on communication across service, agency and sectoral boundaries to maximize outcomes for clients. Many of the centres reported that positive relationships with other providers was achieved by building slowly, identifying partners with similarities (in terms of vision, strategic intent, caseloads), building success and then expanding. Service relationships are also enhanced by working together with clients and building trust between professionals.

Communication

In service access and care coordination centres, with so much reliance on information, effective communication is essential. Triple I (Hub) relies heavily on multidirectional communication for its success, from accepting incoming referrals to completing needs identification with clients, carers, service providers, to ensuring appropriate care and developing care plans for clients, understanding current waiting lists in services and facilitating access to services. Additionally, centres need to be communicating with local service providers in a way that promotes and markets the service, and highlights the outcomes being achieved by the centres.

Flexibility and adaptability

In an ever-changing environment, it is necessary for teams to be flexible and adaptable. It is also important to recall that many of the centres developed organically and so were not planned out from a business case, but grew over time. Triple I (Hub) was not set up in a new custom-built building with custom furniture, but instead had existing staff from disparate services collecting their desks, computers and phones from offices across the LHD and bringing them into the available space. As new services come on board, staff are learning about new areas of care and adapting to help clients navigate the system. Staff are reliant on their skillsets, whilst their knowledge base changes and grows. The resulting teams in service access and care coordination centres are often quite change adept, and ready to work toward change for improvement.

Sustainability

Sustainability in the context of the centres may mean starting out using only existing resources, or perhaps adding in a phone license. It involves keeping things as simple as possible in a complex environment, and involves embedding smaller steps in information management into larger processes that are non-obtrusive in a patient care environment. Sustainability is dependent on systems that support staff and their practice, with strong staff support and supervision opportunities built in. Importantly, sustainability of the centres is reliant on keeping the vision for the service in front of mind, and recognising the value of such a service to the local area.

Measuring performance

Measuring performance is central to identifying the impact of changes (including the unanticipated impacts), as well as providing motivation to teams in times of change. Innovative teams clearly identify the aims of their work prior to implementation, determine meaningful measures and obtain data against these aims before making changes to local practices.

Service access and care coordination centres are using various measures to quantify their performance:

- Data from phone systems provides quantitative data on number of service calls and length of calls
- Information systems may track the number of referrals made, referral source, referral destination and time taken to access services
- Feedback from service users
- As part of the Excellence Program of HNE LHD, the Referral Information Centre is using rounding processes to obtain data from staff and from service providers about their perceptions and experiences with the service (Appendix C)

Data which is more difficult to obtain, but which may be particularly meaningful is data which might determine if centres are achieving their intended outcomes. This information might include tracking unplanned readmissions (and matching with contact with the centres), 'failed' referrals (where referrals were not accepted), and additional contact with the centre with unidentified concerns from previous contacts. Obtaining this data would require greater planning, but would add significant value to the argument for service access and care coordination centres.

Appendices

Appendix A: Self Assessment

This tool may be used by local organisations engaging in local service improvement around service access and coordination centres. The tool provides agencies with areas to target for improvement, and supports agencies to identify their current level of achievement and track progress over time. It allows organisations to self-rate across three levels of care – basic, advanced, innovative.

	Met	Partially met	Not met	Not applicable
Service access and care coordination centres				
The centre has documented policies and processes for service access and coordination				
The centre has staff who are suitably qualified and have been prepared for their role in service access and coordination				
Local service access and coordination practices are regularly monitored, reviewed and evaluated with a focus on continuous quality improvement				
Centre staff have strong communication skills, and are able to communicate effectively with clients and providers in a way which is culturally, linguistically and cognitively appropriate				
The work of the centre is supported by available information technology				
Clinical support and supervision is available to staff to enhance their clinical and/or professional skills				
The centre has a high-level governance structure, involving senior representatives from the Local Health District together with representatives of other local organisations (eg. non government organisations, Medicare Locals)				
Initial contact				
<i>The initial point of contact with the single point of entry (service access and care coordination centre) by the patient, carer or provider.</i>				
The centre has a single contact point for community members and providers, providing community members and providers with ease of access to a range of services				
Centre staff are appropriately skilled to receive referrals and initial contacts, communicate clearly and provide information to providers and clients, and make appropriate decisions regarding next steps				
The centre has a system for documenting and tracking initial contacts, and the actions arising from the initial contact (initial needs identification, information, referral, exit)				
The centre has a system for documenting and making referrals				
The centre has a system for obtaining and documenting consent from consumers, to share information with other providers				
The centre is utilising the available information technology to receive, track and make referrals				
The centre has a process for informing referring providers when referrals are inappropriate or unable to be processed (e.g. due to insufficient information)				

Needs identification

Needs identification involves broad and shallow screening to identify the patient's needs across a range of medical, functional and social dimensions.

The centre has a system for documenting and tracking initial needs identification, and the actions arising from the needs identification (information, intervention, referral, exit)				
The centre has a process for determination of risk level for client, and appropriate actions				
The centre has access to information about other services to guide decision making about suitable referrals				
The centre has decision support tools in place to support centre team member(s) identify appropriate service and next steps for clients				
The centre has documented processes for providing feedback to referral sources (such as general practice, acute hospital wards) regarding actions arising from needs identification				
The centre has clear policies on staffing requirements for different roles and responsibilities within the centre. This includes clear position descriptions outlining the skills and roles of different staff within the centre.				
Centre staff receive regular updates on new local services available, or changes to existing services				

Assessment

A comprehensive, detailed assessment of a patient's needs

The centre has a process for communicating with clients' general practitioners and other care providers				
The centre has a system for documenting assessment information, and storing additional information from other providers (where relevant)				
The centre has decision support tools in place to support centre team member(s) identify appropriate service and next steps for clients				
The centre has access to information about other services to guide decision making about suitable referrals				
The centre has documented processes for providing feedback to referral sources (such as general practice, acute hospital wards) regarding actions arising from assessment				

Care planning & coordination

A care coordination approach ensures the patient's journey and care transitions are smooth, that multidisciplinary care is planned, and care milestones are communicated to involved providers.

Consent is obtained from clients and documented, prior to sharing information with other providers				
Local policies and procedures outline the process for care coordination and care planning, and represent the patient's active role in this process				
The centre acts as care navigator/coordinator, working across services to support achievement of client's care goals				
The centre has processes for documenting care plan and care coordination efforts				
The centre has documented processes for working together with other providers to develop a shared care plan, where appropriate				
Centre staff have skills in facilitating the development of care plans together with clients, and negotiating service delivery with relevant providers				
Care is coordinated across agency boundaries and care goals and decisions communicated clearly to the members of the treating team				
Coaching staff are available to support clients in their active role in health self-management				

Service planning & resource allocation

Service planning and resource allocation in this context refers to the planning of health services (location, throughput, reach) and distribution and allocation of service provider resources related to the demand for services coming through the centre.

The centre has systems in place to enable staff to determine availability of, and book clinical appointments for clients

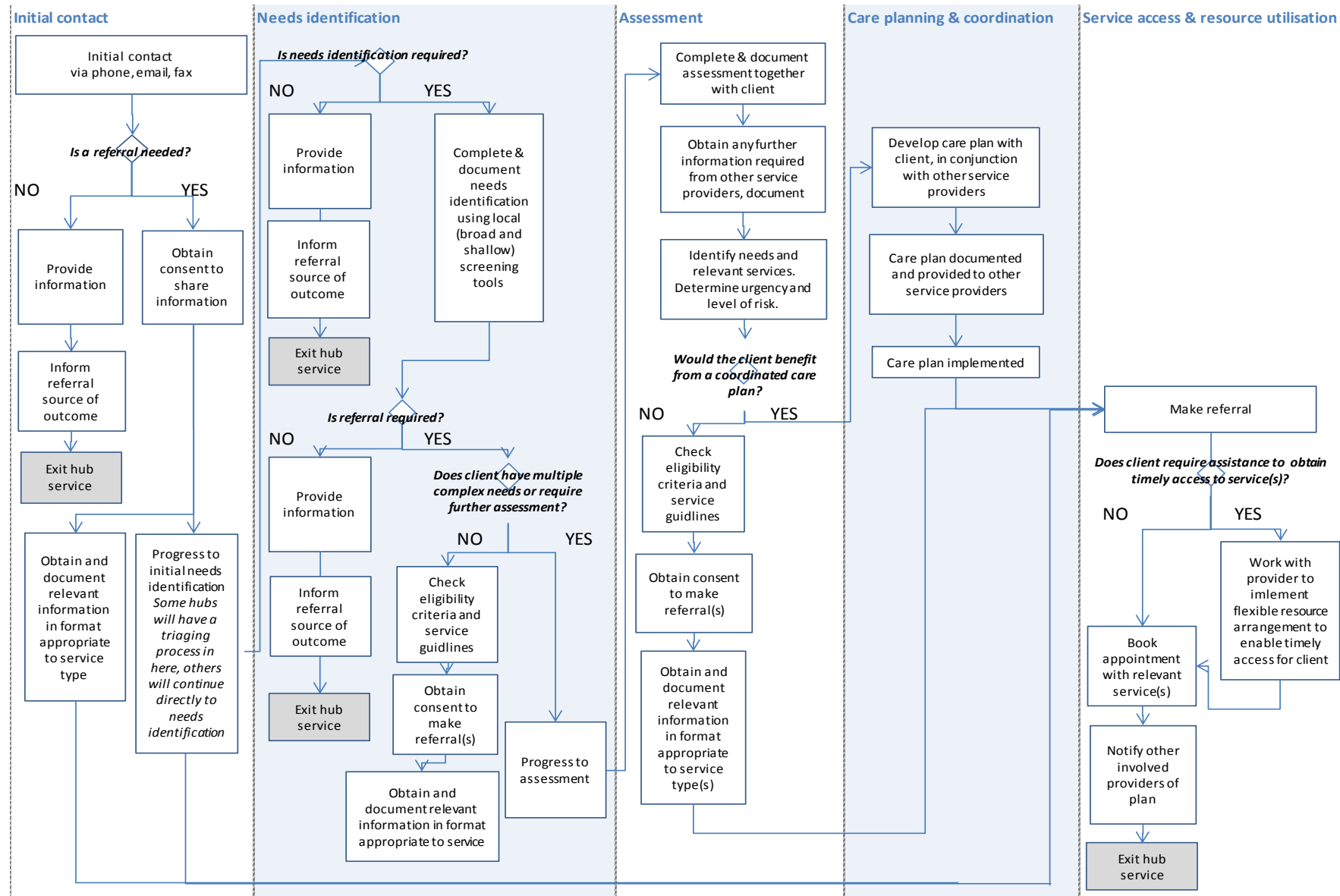
The centre (or Local Health District) has agreements and protocols in place with local service providers for negotiating flexible service arrangements (e.g. when services are required outside their usual area) on behalf of clients

The centre (or Local Health District) has agreements and protocols in place with local service providers, allowing the centre to manage clinic appointments

The local multi-organisational governance committee has the authority to make changes to existing service arrangements, including the ability to share funds and resources to improve access and coordination of care for consumers

Appendix B: service access & care coordination flow chart

This flowchart has been developed by bringing together processes of the various models visited across the state



Appendix C: Rounding (HNE LHD)

All service access and care coordination centres need to be regularly monitoring and evaluating their service to ensure it is meeting the needs of clients, carers and providers and achieving the objectives of the service.

Rounding is a process which is undertaken regularly by Hunter New England LHD as part of the LHD's Excellence Program and supports the service's ongoing monitoring and evaluation. It is a means of obtaining information about the service access and care coordination centre from the perspectives of the clients, carers and services. Rounding involves a selection of clients, carers and services being contacted to obtain feedback about the Referral & Information Centre (HNE LHD).

Key questions asked and information sought during this rounding process is outlined briefly below:

Referral & Information Centre Rounding: Clients (Monthly)

1. Reason for call?
2. Client/Family/Friend/Health Care Professional
3. Did you get through on your first attempt?
4. Were you on hold for long?
5. Did staff identify themselves?
6. Outcome of the call?
7. Was the RIC process explained?
8. Would you be happy to use the service in the future?
9. Any other comments

Connecting Care Rounding: Clients (Monthly)

1. Access, Entry and Contact: Do you find that all staff introduce themselves, are courteous, helpful and polite? If you needed to contact our service do you find it easy or difficult?
2. Patient Education: How well are your health problems / concerns explained to you by the clinician?
3. Care Management: Has our service assisted with your health concerns? Are you happy with the care we are providing?
4. Staff Recognition: Are there any staff who have provided you with very good care and/or customer service that I could compliment?
5. Recommendations for Improvement: Do you have any suggestions to make that could improve our service?
6. Thank You: Thank you for your time in answering these questions. Please do not hesitate to contact me if you should like to make any other suggestions.

Referral & Information Centre Rounding: Services (twice a year)

1. Name of Person Contacted & date
2. What is working well between our services?
3. Is there anything we need to do together to improve our service partnership?
4. Action Plan
5. Completion Date

Referral & Information Centre: Staff (Monthly with all team members)

1. Personal Connection		
2. What's working well?		
3. Is there anyone I should recognise for doing great work?	<u>Who</u>	<u>What/Why</u>
4. Are there any systems that need improvement?		
5. Do you have the basic tools and equipment to do your job?		
6. Behaviors Coached <input type="checkbox"/> AIDET/Key Words <input type="checkbox"/> Customer Service Priorities <input type="checkbox"/> Standards <input type="checkbox"/> Other: _____		
7. Is there anything I can help you with right now? Thank You for making a difference!		

Review findings with next level leader in one-on-one meetings.

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