CS3.4 Continuity of Care

Purpose

1. To outline SAVVY's strategies and practices in place to provide continuity of care for new, current and exiting participants.

Alignment with Practice Standards

1. Module 2: Provider Governance and Operational Management

Legislative Alignment

1. National Disability Insurance Scheme Act 2013

Key Responsible Executive

Chief Executive Officer

For More Support

Your People Manager

Policy Statement

1. Based on the classification of continuity used by WHO, SAVVY works across:
   a. Interpersonal continuity: the subjective experience of the caring relationship between the participant and their care and support workers.
   b. Longitudinal continuity: a history of interaction with the same care and support professionals in a series of discrete episodes.
   c. Management continuity: effective collaboration across care boundaries to provide seamless care
   d. Information continuity: availability of information at all points of care.

2. These categories of continuity are underpinned by three types of coordination:
   a. sequential: planned handover of responsibility and transfer of care
   b. parallel: collaboration among professionals with agreed sharing of responsibility
   c. indirect influence: enabling coordination through tools, incentives or education.

3. Specifically, SAVVY will seek to provide a proactive approach to care coordination that enables continuity of care through six strategies:
   a. Key participant Coordinator
   b. Collaborative planning of care and shared decision-making

c. Case management of complex needs
d. Transitional or intermediate care
e. Technology enabled continuity of care
f. Workforce capability

4. SAVVY's Continuity of Care policy and procedures will be reviewed as part of its quality improvement program on an annual basis with input from care workers, coordinators, participants, management and external advisors.

Definitions

1. Care coordination: a proactive approach to bringing together care professionals and providers to meet the needs of service users to ensure that they receive integrated, person-focused care across various settings.

2. Case management: care that involves case finding, assessment, care planning and coordination to integrate services to meet the needs of people with long-term conditions.

3. Continuity of care: the degree to which a series of discrete healthcare events is experienced by people as coherent and interconnected over time and consistent with their health needs and preferences.

4. eHealth: information and communication technologies that support remote management of people and communities with various health care needs by supporting self-care and enabling electronic communication among health care professionals and patients.

5. Empowerment: supporting people and communities in taking control of their own health and wellbeing, resulting, for example, in healthier behaviour or self-management of illnesses or resources.

6. Engagement: involving people and communities in the design, planning and delivery of support services that, for example, enable them to make choices among care and support options or to participate in strategic decision-making on how resources should be spent.

7. Person-centred care: care approaches and practices in which the person is seen as a whole, with many levels of needs and goals, the needs being derived from their personal social determinants of health and wellbeing.

Delegations

Roles	Responsibilities
Board of Directors	• Endorse and ensure compliance with the Continuity of Care Policy and Procedure • Be familiar with the organisation's legislative requirements related to the policy
CEO	• Manage and monitor compliance with this policy • Support staff competence and compliance with this policy and procedure • Support the development of tools, processes and practices that improve participant continuity of care.
Management	• Manage and monitor compliance with this policy • Support staff competence and compliance with this policy and procedure • Provide support and training to ensure staff are effectively implementing strategies outlined to support continuity of care • Ensure all staff are equipped with the resources and support to provide continuity of care for participants
Staff, volunteers, contractors and students	• Comply with the Continuity of Care Policy and Procedure • Utilise organisational tools effectively to support participant continuity of care

Procedures

1. Key participant coordinator
    a. The Key participant Coordinator is the basis for being the 'connection participants can count on'.
    b. All participants will be assigned to a key participant coordinator, irrespective of their level of need, goals or service provision.
    c. The Key participant Coordinator is responsible for
        i. Onboarding the participant
        ii. Arranging or completing the intake assessment and care planning
        iii. Developing the care plan and service agreement
        iv. Reviewing participant files based on frequency of services to audit participant notes, goal progress, changes to risks or changing needs.
        v. Managing the annual plan and service review
        vi. Building a relationship of trust and transparency with the participant, to ensure they feel confident raising any issues, complaints, questions or suggestions and feel empowered to exercise their choice and control in relation to the services they are receiving through SAVVY.

d. Where Buji does not provide specific ‘Care Coordination’ or ‘Plan Management’ in line with the NDIS price guide, the Key participant Coordinator is responsible for liaising with the participants Coordinator, Plan Manager, Advocate, Plan Nominee and participants support network (with participant consent).
e. The purpose for assigning a Key participant Coordinator is to provide interpersonal and longitudinal continuity for the participant. This is achieved through the Coordinator taking responsibility for the participants care and advocating for them throughout their time with SAVVY, as well as building up institutional knowledge on the participants needs, goals and history in order to provide a service which better understands and reflects each participants individuality.

2. Collaborative planning of care and shared decision-making
   a. SAVVY’s approach to care planning focuses on participant engagement and decision making.
   b. SAVVY seeks to collaborate as broadly as possible (with participant consent) in developing care plans and service supports to ensure the resulting plan and supports reflect the most appropriate, targeted and least intrusive supports possible for the participant.
   c. When completing assessments and care planning, SAVVY works with the participant to understand their existing and desired support network to incorporate these stakeholders into the planning process.
   d. participants are notified or engaged to support decisions around any changes to their care provision, such as changes to care worker or service availability.

3. Case management of complex needs
   a. SAVVY’s systems support employees to manage the complex needs of participants.
   b. Using a single participant record management system (TurnPoint) provides a single source of participant information that can be accessed by coordinators, care workers and schedulers. This allows for a coordinated approach to care for each participant.
   c. For participants where SAVVY provides care coordination or plan management, SAVVY prioritises building collaborative relationships with, and knowledge of, a breadth of NDIS and mainstream providers. This allows SAVVY coordinators to develop highly targeted plans in collaboration with the participant to meet their goals and needs in a personalised and cost effective manner.
   d. The following resources are maintained in order for SAVVY to assess and deploy the right resources throughout a participant's care with SAVVY, irrespective of their changing needs and employee turnover;
      i. Professional Development, Training and Competency Register
      ii. Risk assessed roles register
      iii. Employee compliance reporting (for qualifications, licenses, certifications and relevant checks)
      iv. Training needs analysis to identify skill levels required in the organisation based on participant needs and risk assessments.

4. Transitional or intermediate care
   a. When participants transition into SAVVY, SAVVY requests the existing care provider to complete a transfer form which supports SAVVY in assessing the participants needs and SAVVY’s ability to meet their immediate support needs.
   b. Similarly, when a participant transitions out of SAVVY care into another the care of another service provider, SAVVY seeks to provide the same level of information at least 5 days prior

to the participant starting services with the new provider. This will allow the provider to more effectively plan for support provision during the onboarding processes.

c. Where a participant transitions into SAVVY during an existing NDIS plan, SAVVY will seek to provide the same services as previously provided until a full assessment and care plan is developed as part of a new plan.
d. Where care is transitioned to a new care worker internally, the new care worker, depending on the participants needs and service provision, be provided with a handover either;
    i. Through a buddy shift with an existing care worker
    ii. In a shift note and task list that has been developed by and existing care worker
    iii. Through a brief from the Key participant Coordinator
    iv. Via a shift request to read and acknowledge the participants care plan prior to starting the shift.
e. SAVVY will utilise a Transition Support Plan to ensure a smooth and positive transition, for both temporary or permanent transition. The form includes a client profile, key objectives, actions to implement a smooth transition, risks identified and planned outcomes.

5. Technology enabled continuity of care
    a. SAVVY uses technology to support the management of care, making it easier to ensure continuity and care coordination.
    b. Using a single participant record system ensures for easily accessible and shareable participant information irrespective of care worker or service being provided.
    c. All SAVVY employees are responsible for updating a participant's record, according to their role in a timely manner:
        i. The Key Care Coordinator is responsible for managing the participants intake documentation and annual assessment, planning and review documentation. All documents should be uploaded to the participants record using the participant document naming conventions ***within 48 hours*** of receiving or finalising each document. .
        ii. The scheduler is responsible for assigning an appropriate care worker to each particular service provision and ensuring a participants service schedule is maintained. They are also responsible for verifying each service for invoicing and reconciliation within a seven day period. Where possible a scheduler will book recurring appointments for participants with a regular care worker to ensure continuity. However all participants are to be assigned at least two carers in order to maintain participant knowledge in the event of employee leave, sickness, change of role or termination.
        iii. The support worker is responsible for creating accurate, appropriate and comprehensive notes on each shift and notifying the Key Care Coordinator of any requests or changes provided by the participant. Where they are assigned as a regular care worker, they should seek to develop the participants personal profile on a regular basis in order to support new care workers familiarising themselves with the needs and preferences of a new participant.
        iv. All employees are responsible for creating and following through any incident, feedback or complaint regarding the participant, with support of their supervisor. Incidents will be recorded in the participant file, however due to privacy, participant feedback and complaints will not be appended to the participant's file which is visible by all of their care staff. Any outcomes from a complaint that affect scheduling or assigned workers will be fed back through appropriate channels in a way that does not affect the participants right to privacy.

d. SAVVY also utilises mainstream technology platforms to support improved participant management and ease of continuity of care. This includes:
    i. Using an automated transfer form to manage SAVVY's transfer process and expedite the onboarding process.
    ii. Digital incident reporting and feedback forms wherever possible to ensure information is shared efficiently and accurately, in particular with a remote workforce to management for a more timely response.
    iii. Centralised telephony system and cloud based core systems. This enables all employees to contact the on-call Manager using a standardised central number in the event they are unable to make a scheduled shift. As SAVVY's core systems are cloud based, the on-call manager is then able to access a participants file to identify a suitable alternative worker 24 hours a day and organise alternative care arrangements.

6. Workforce capability
    a. participant Record management is included in SAVVY's training plan to develop all employees competence and capability in effectively maintaining a participant's record in a way that enables continuity of care
    b. Employees are also provided training in supporting participant choice and decision making with the expectation that they support participants where possible to take control of their service provision and care.
    c. Where feasible, a participant is allocated at least 2 care workers on a regular basis. This provides an appropriate alternate carer in the event of staff attrition, leave or illness. Maintaining regular care for the participant ensures that there is ongoing knowledge of the participant's needs and reduces the impact of any transition for the participant if a new worker needs to be introduced. The remaining care worker provides knowledge and support for the new carer and provides continuity and consistency for the participant. For participants with high intensity daily needs, two care workers will always be assigned for regular care.
    d. SAVVY utilises a casual workforce that ensures there is always additional capacity to cover any worker absence or vacancy. The casual workforce capabilities are tracked and managed on the Professional Development, Competency and Training Register. Any specific needs outlined in a participant's intake assessment will be flagged to ensure that SAVVY has an appropriate number of suitably qualified employees to deliver the care. Levels of skill and competency are reviewed regularly to inform employee training and development plans.
    e. As a second level of contingency, SAVVY employees qualified and highly skilled carers for coordination, supervision and service management roles. These employees have access to a participant's care records and if needed can provide short term care for participants where a regular carer is absent or there is an unfilled vacancy.

References to other SAVVY policies and external sources

1. World Health Organisation (WHO) Framework on integrated people-centred health services (IPCHS)
2. Continuity and coordination of care; A practice brief to support implementation of the WHO Framework on integrated people-centred health services
3. Org1.5 Continuous Quality Improvement Management
4. Org2.1 Risk Management
5. Org2.2 Information Management
6. Org2.4 Registration and Licensing of Staff
7. CS3.1 Participant Care
8. CS4.4 Support Coordination

Summary of attachments

1. Nil

Version Control

1. 1 April 2023 - New Policy Creation