CS4.2 Specialist Support Coordination

Purpose

1. To outline P4 Movement's processes and procedures for providing effective support coordination to Participants inline with their goals and needs.

Alignment with Practice Standards

1. Module 3: Provision of supports
2. Specialist Support Coordination Module
3. Specialist Behaviour Support Module

Legislative Alignment

1. National Disability Insurance Scheme Act 2013

Key Responsible Executive

General Manager

For More Support

General Manager

Policy Statement

1. P4 Movement is committed to strengths-based, person-centred approach to care coordination, to support Participants to identify their needs, achieve their goals in the service user plans, promote their independence and optimal wellbeing, and social participation.

2. P4 Movement will:
   a. Clarify the role and responsibilities of Participants, carers, Care coordinators and any other people involved in realising the Participant's plan
   b. Ensure Participants are involved in their care coordination and planning
   c. Assist and support active involvement and decision making by Participants and relevant carers, family members, advocates and substitute decision makers
   d. Strive to identify and use Participants' strengths, resources and abilities so as to minimise the intrusiveness and involvement of formal services in Participants lives
   e. Coordinate, monitor, review and document changes to the service user's plan
   f. Employ care coordination staff with the necessary skills and experience to undertake the role, and provide them with regular support, supervision and staff development.

Definitions

1. Assessment - the process of gathering information from and about the service user in order to develop an understanding of their needs and to determine suitable options and support planning.

2. Care coordination - care coordination practice is a collaborative, person-centred process. It aims to ensure access to multiple support systems and services at key life stages to achieve optimal wellbeing and social participation

3. Person centred planning – a process of continually listening and learning, focused on what is important to someone now and for the future, and acting on this in alliance with their family, carers, friends and substitute decision makers.

4. Intake - the systematic process of gathering information about people's current situation in order to facilitate their access to P4 Movement services and assist them to make informed decisions about the needed service.

5. Referral - a request for a specialist consultation or service that occurs when an organisation is not able to meet the service user's needs or has insufficient resources to manage the service user's situation.

6. Care Plan - a document which provides a shared understanding for the Participant, their carers and service providers of the Participants;
   a. Goals and needs
   b. Strategies to achieve the Participants goals and needs, including any positive behaviour support strategies
   c. Specific requirements to meet the Participants needs such as high intensity daily support processes
   d. Individual preferences, such as communication preferences, persona preferences, likes and dislikes that can inform how a service is delivered
   e. A risk assessment of the Participants needs, the delivery environment and support provision

Delegations

Roles	Responsibilities
Board of Directors	• Endorse and ensure compliance with the Specialist Support Coordination Policy and Procedure • Be familiar with legislative requirements of this policy
GM	• Manage and monitor compliance with this policy • Support staff competence and compliance with this policy and procedure, and ensure staff receive appropriate training, supervision and debriefing to comply with this policy • Collate report information on adverse service user events as required • Review Feedback, Complaint and Incident reports for insights into the effectiveness of the policy and take action where necessary • Ensure operational decision making is informed by this policy and the Conflicts of Interest Policy

Management	• Support staff competence and compliance with this policy and procedure, and ensure staff receive appropriate training, supervision and debriefing to comply with this policy • Collate report information on adverse service user events as required • Act on feedback, complaints and incidents that relate to a Participants support coordination. • Provide regular practice supervision • Ensure operational decision making is informed by this policy • Support the review of clinical processes
Staff, volunteers, contractors and students	• Comply with the Specialist Support Coordination Policy and Procedure • Maintain knowledge of the current evidence-based interventions available to Participants • Participate in regular practice supervision • Maintain registration with relevant associations and/or peak bodies, where appropriate

Procedures

1. Clarifying roles and responsibilities
    a. Effective care coordination is collaborative, planned, transparent and confidential. For that reason care coordination staff work with service providers to bring together the various components of the care plan by clarifying everyone's roles and responsibilities and to achieve the best fit between Participants' identified needs, goals and available support and services.
    b. The care coordinator will take responsibility for engaging the Participant in the coordination process and support them in exercising their choice and control.

2. Staff support and training
    a. Care coordinators will be trained in person-centred and strengths-based approaches along with engagement skills, care coordination and coordination best practice.
    b. Care coordinators will be supported to continually develop their professional networks and skills.
    c. Care coordinators will be provided with supervision monthly during which caseloads will be reviewed.
    d. There will be a monthly Care Coordination case review that will allow coordinators to seek ideas and input from the border group to address a Participants needs. Coordinators will bring a new Participant plan or plan in review, at least quarterly as part of continuous development of care planning

3. Participant evaluation of their supports
    a. The first step in care coordination at P4 Movement is engagement with the Participant to understand their goals, aspirations and support needs.
    b. The Intake process for care coordination is a self assessment of a Participants needs, which can be supported by a Participants carer, parent, guardian, advocate or other supporter(s). P4 Movement bases this assessment on the NDIS "Booklet 2 - Planning". Using this support, keeps the language consistent and clear for Participants and builds capability to utilise the NDIS resources more independently.

4. Planning and coordination of supports to implement plan

a. Care coordinators will liaise with other service providers supporting the Participant and draw up a memorandum of understanding/service agreements to ensure that the Participant's needs are met through these services and duplication is minimised.
b. When considering and offering supports for a Participant, the care coordinator will refer to:
    i. P4 Movement's service provider register when considering support options for Participants
    ii. The care coordinator can also take the plan to a case review meeting in order to gain input and suggestions from other team members and supervisors.
    iii. In planning for a care coordination meeting, the coordinator will ensure they have service provider materials for each alternative provider in order to discuss options with the Participant.
    iv. In developing the Participants capability to set up their supports, the care coordinator will work with the Participant to undertake as much of the following tasks as possible during the process:
        1. Research service options
        2. Contact service providers to find out about their services
        3. Meet with service providers to determine if the provider meets the Participants objectives, needs and preferences
        4. Discuss with the service providers what supports are required
        5. Create contracts or MOU's of agreed supports to be delivered as part of the plan.

5. Provider Engagement and collaboration
    a. P4 Movement Care Coordinators will be provided with capacity and support to build their knowledge and relationships within the service community they operate for both disability specific services and mainstream service providers.
    b. Monthly Care Coordination meetings will provide a forum for Coordinators to share knowledge and updates within the service network
    c. P4 Movement will maintain a register of mainstream and disability services to be updated by Care Coordinators. This list will be audited annually with all contacts on the list contacted and asked to update their details.
    d. To support continuity of care, P4 Movement will, with the Participants consent, share Participant information that enables the engaged service providers to effectively plan for and provide support.

6. Where a Care Coordinator believes a Participant requires specialist support coordination, they will;
    a. support the Participant to identify the most effective support provider (Occupational Therapist, Psychologist, Social Worker etc, where P4 Movement does not have the relevant skills in house) to collaborate with P4 Movement to deliver the specialist support coordination.
    b. If the objective is to move the Participant to a lower level of support coordination in the following year P4 Movement will work alongside the specialist coordinator for the first year, in order to support the Participant in transitioning their skills into the following plan period, supported by the care coordinator.
    c. Where the Participant is unlikely to be able to transition to a lower intensity level of coordination in future, P4 Movement will refer the Participant on to the specialist with the Participant's consent.

7. Risk Management
    a. Throughout the care planning and coordination process, the Participant will be engaged in identifying risks inherent in their needs and plan, considering the impacts of those risks, planning on how to reduce, avoid or work with the risk.
    b. Each service provider engaged through the coordination process will be required to do a risk assessment for the Participant in receiving their services, however P4 Movement will, with the Participants permission, share their risk assessment to reduce administration and improve Participant safety anc care.
    c. P4 Movement will use its care and health assessments which include both personal risk assessments and environmental risk assessments as part of the Participant onboarding process.
    d. This risk assessment will identify whether the Participant needs an additional risk assessment provided by a nurse, behaviour support coordinator or other specialist provider. Where this is the case, P4 Movement would seek first to work with the Participant's existing service providers in order to reduce unnecessary duplication and to improve continuity of care.

8. Monitoring and reporting
    a. Care coordinators will undertake regular monitoring of the Participant's progress against goals and seek feedback from Participants, workers and other services involved in the service user's care etc. Care coordinators may conduct case coordination meetings to gather information from all relevant sources.
    b. Service user plans will be amended as required in discussion with the service user and updated copies provided to the service user.
    c. Participants receiving care coordination services will be reviewed following one or more of the following events: change in Participant's circumstance, request from Participant or carer and every quarter, with an annual formal review in line with their care assessment and planning.

9. Exit and transition planning
    a. Exit and transition planning will be included as part of the care coordination plan, in particular where it relates to achievement of service user goals.
    b. Prior to service user exit, a service exit review will be conducted as part of the transfer process to ensure all appropriate formal and informal supports are in place. (Refer to the Participant Care Policy)

10. Care Coordination records
    a. An individual record will be prepared by the Participants Key Participant Coordinator for each service user receiving care coordination services. The record will contain the Participant's referral, care assessment, care plan, relevant consent forms, care coordination meeting minutes and care notes. (Refer to the Participant Record Management Policy)
    b. The Participant's care plan follows a standard format and all plans should be completed on the P4 Movement Care Plan Template
    c. The care coordination plan will include the Participants goals, strategies for achieving goals, other agencies involved in service provision, other agencies service agreements and schedules of support where relevant, schedule of services and formal and informal support strategies.
    d. When the care coordination plan has been developed the plan will be jointly signed by the case manager and the service user and a copy kept in the service user's record.
    e. The service user's record will be updated and made available to the service user for review at any time.

References to other P4 Movement policies and external sources

1. HR1 Code of Conduct
2. HR10 Workplace Health & Safety
3. CS1.3 Decision Making and Choice
4. CS2.1 Person Centred Practices
5. CS3.1 Participant Care
6. CS3.5 Participant Record Management
7. CS4.1 Responsive Support Provision
8. CS5.1 Restrictive Practices and Behaviour Support
9. CS6.1 High Intensity Care

Summary of attachments

1. Nil

Version Control

1. 1 April 2026 - New Policy Creation