

Victorian Service Coordination Practice Manual 2009



A STATEWIDE PRIMARY CARE PARTNERSHIPS INITIATIVE

Service coordination publications

1. Victorian Service Coordination Practice Manual
2. Good Practice Guide
3. Continuous Improvement Framework
4. SCTT 2009 User Guide

Published by Primary Care Partnerships, Victoria

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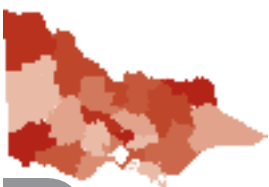
Sponsored by the statewide Primary Care Partnerships Chairs' Executive with funding received from the Victorian Department of Human Services

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Foreword

The Victorian Service Coordination Practice Manual (VSCPM) and associated resources have been designed for practitioners and managers involved in the implementation of Service Coordination. The VSCPM was initially developed in 2006 by the Statewide Primary Care Partnership (PCP) Chairs' Executive, with funding from the Department of Human Services Primary Health Branch. The manual and associated resources include the:

- Victorian Service Coordination Practice Manual
- Good Practice Guide for Practitioners
- Continuous Improvement Framework

These documents describe how PCP member and associated agencies will implement Service Coordination and conduct business when dealing with clients in common. The suite of documents outline:

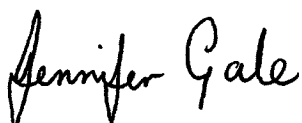
- An agreed minimum standard across Victoria for how agencies work together to improve consumer care
- Common concepts and language to ensure improved Service Coordination across sectors
- An improved approach that enables organisations to adopt the principles behind Service Coordination

This update has a greater emphasis on care planning to reflect the principles of person-centred, coordinated and integrated care; and to ensure current legislation and service provider quality standards are met.

A shift is occurring towards a standardisation of Service Coordination practices across a broader range of sectors and program areas than those originally considered in developing the initial VSCPM. Emerging areas of work have also become more sophisticated. In recognition of this, the Primary Care Partnerships Chairs' Executive requested funding from the Department of Human Services Primary Health Branch to undertake a content update of the VSCPM and associated documents.

The content update of the VSCPM and associated resources coincided with the release of the Service Coordination Tool Templates (SCTT) in July 2009 and the associated SCTT 2009 User Guide, to ensure the relevant changes were reflected in each document.

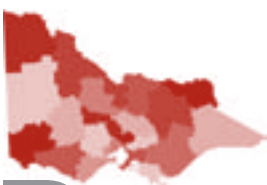
The contribution made by Steering Committee members is acknowledged and greatly appreciated in guiding the project through a tremendous dedication of time and effort in a short timeframe. The funding provided by the Primary Health Branch of the Department of Human Services is also acknowledged and appreciated as is the willingness of the 31 Primary Care Partnerships to engage in the process along with the many programs across DHS that contributed to the content of the resources. This broad representation has facilitated the inclusion of the different needs of current and new sectors and ensured a better response by services to consumers and the community. The proficiency of the consultants must also be acknowledged in achieving an ambitious task.



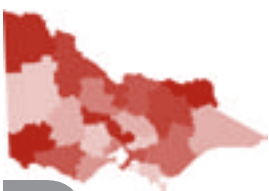
Jennifer Gale
Chair, Statewide PCP Chairs' Executive

Contents

Section 1 Introduction	1
1.1 The Service Coordination context	1
1.2 Purpose of the Victorian Statewide Service Coordination Practice Manual	2
1.3 Navigating the manual	3
Section 2 Service Coordination in Victoria	5
2.1 What is Service Coordination?	5
2.2 What is the Service Coordination Framework and what are the elements?	6
2.3 What is expected of service providers involved in Service Coordination?	8
2.4 What is the link between general practice and Service Coordination?	8
2.5 What are the benefits of Service Coordination?	9
2.6 What is the consumer pathway through Service Coordination?	10
Section 3 Victoria's Service Coordination Practice Standards	11
3.1 Victoria's Service Coordination Practice Standards	11
3.2 Practice Standards: All elements of Service Coordination	11
3.3 Practice Standards: Initial Contact	13
3.4 Practice Standards: Initial Needs Identification	16
3.5 Practice Standards: Assessment	20
Section 4 Care Planning Practice Standards	25
4.1 What is Care Planning?	25
4.2 The objectives and principles of Care Planning	25
4.3 Key features of Care Planning in Victoria	26
4.4 What is a Care Plan?	27
4.5 The key worker role in Care Planning	30
4.6 GP involvement in Care Planning	31
4.7 What is expected from services providing Care Planning?	32
4.8 How to develop a Care Coordination Plan	35



Section 5 Referral Practice in Victoria	39
5.1 What is Referral?	39
5.2 Where does referral fit into Service Coordination?	40
5.3 Which staff are involved in referral?	41
5.4 Referral to and from general practice	41
5.5 What is expected from service providers making and receiving referrals?	42
5.6 Consumer Pathway through referral	45
5.7 Tools and resources—referral	46
Section 6 Resources and tools to support Service Coordination	47
6.1 How do the Service Coordination Tool Templates support Service Coordination?	47
6.2 Links between the Service Coordination elements and the Service Coordination Tool Templates	49
6.3 Publications to support Service Coordination	51
6.4 Secure e-referral to support Service Coordination	52
6.5 Electronic Service Directories	52
6.6 Service Coordination Training	53
Section 7 Terminology and Acknowledgments	55
7.1 Terminology	55
7.2 Manual development	58
List of figures	
Figure 1: Supports for implementation of Service Coordination	1
Figure 2: Service Coordination elements	6
Figure 3: Consumer Pathway through Victoria’s Service Coordination Model	10
Figure 4: Consumer Pathway through Initial Contact	15
Figure 5: Consumer Pathway through Initial Needs Identification	18
Figure 6: Consumer Pathway through Assessment	23
Figure 7: Consumer Pathway through Care Planning	37
Figure 8: Consumer Pathway through referral	45
Figure 9: Governance structure and communication	59



Section 1

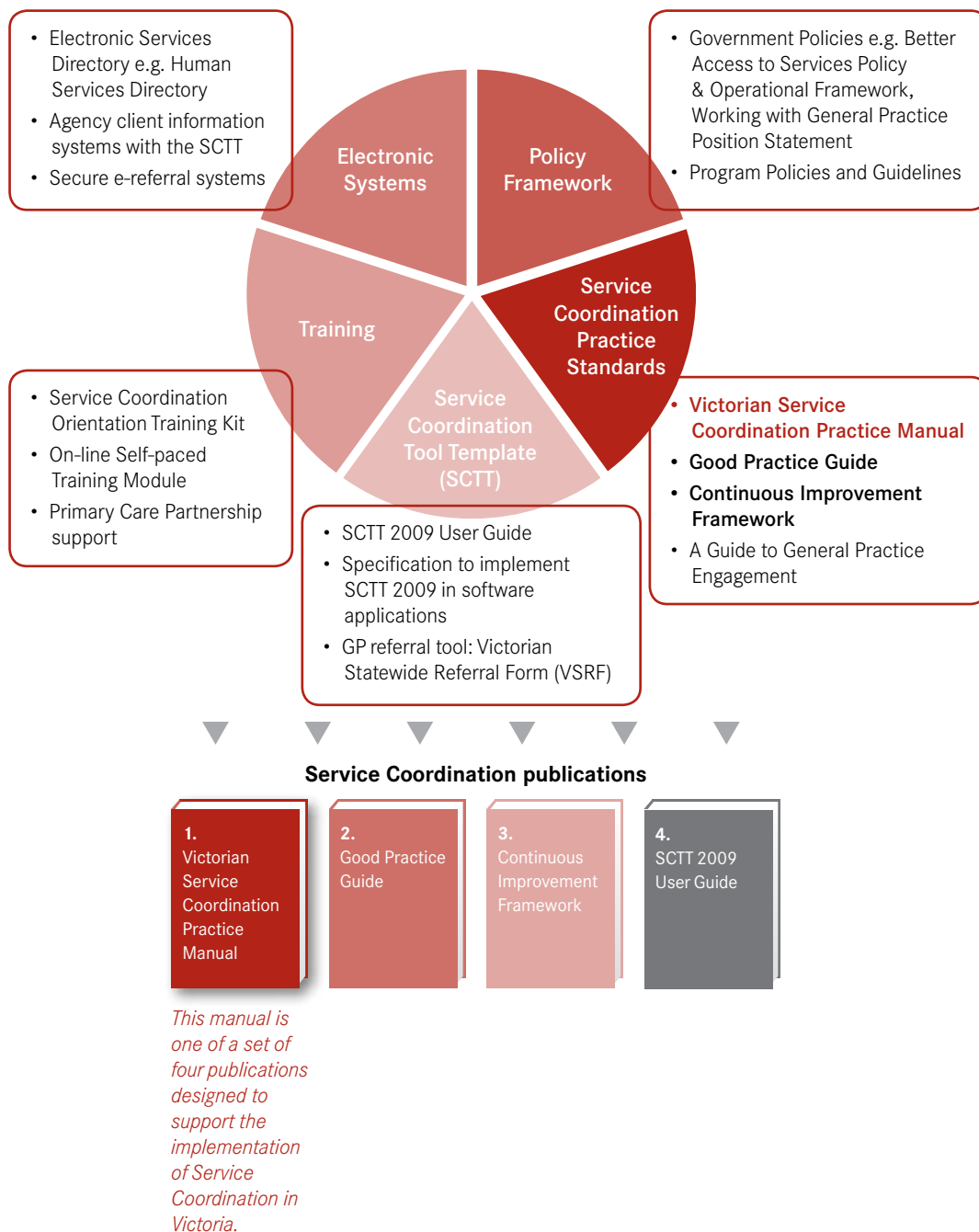
Introduction

1.1 The Service Coordination context

Service Coordination stems from the *Better Access to Services: A Policy and Operational Framework* (DHS, 2001). Implementation of Service Coordination is supported by policy, practice standards, training and other resources. The information resources indicated in *figure 1* can assist you to learn about and implement Service Coordination. For details of these resources and where to find them, refer to *section 6*.

Figure 1: Supports for implementation of Service Coordination

Available at: www.health.vic.gov.au/pcps/coordination



1.2 Purpose of the Victorian Statewide Service Coordination Practice Manual

In Victoria, a broad range of sectors and service providers are implementing Service Coordination. Since Service Coordination was introduced in Victoria in 2001, government-funded health and community services have been progressively implementing Service Coordination to achieve better outcomes for their consumers.

The purpose of this document, the Victorian Service Coordination Practice Manual (VSCPM), is to assist service providers to implement Service Coordination in a consistent manner. The manual has been designed as a reference guide for leading and implementing the practices and standards that underpin Service Coordination.

The practices and standards of the service coordination model, outlined in this manual, are consistent with the Australian Council of Healthcare Standards (ACHS) Evaluation, Quality Improvement Program (EQulP) and the Quality Improvement Council (QIC)¹ standards.

The practices outlined in the VSCPM are supported by locally identified and agreed systems, protocols and processes that reflect service configuration in each area.

The manual is designed to:

1. Define practices which support Service Coordination, in particular to:
 - articulate Victoria's Service Coordination vision and practice standards
 - document clear expectations for service providers
 - provide information about statewide tools, resources and support available to services implementing Service Coordination
 - guide the implementation of Service Coordination practices at a service provider level
 - provide a resource for managers and service providers involved in Service Coordination
 - improve the consumer journey and experience by implementing Service Coordination in a consistent, high quality manner.
2. Provide the basis for monitoring, benchmarking and continuous improvement of Service Coordination across Victoria, enabling individual organisations and Primary Care Partnerships² (PCPs) to:
 - embed Service Coordination standards in organisational practice and documentation, such as policy and procedures
 - compare existing practice against statewide practice standards
 - ensure Service Coordination is conducted in accordance with the statewide vision and practice, and the Department of Human Services (DHS) *Better Access to Services: A Policy and Operational Framework*.

Within a PCP, member organisations can develop local protocols to complement the practices and standards outlined in this manual. For example, a protocol could be developed to define and document agreed practice for electronic referral (e-referral), consumer pathways for chronic disease management or requirements specific to particular consumer groups.

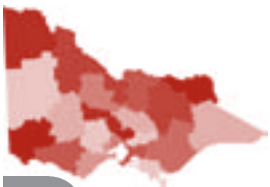
¹ In Victoria, the Quality Improvement & Community Services Accreditation (QICSA) provides quality support and accreditation services under licence from the QIC.

² A Primary Care Partnership or PCP is a group of service providers that have formed a voluntary alliance to work together to improve health and wellbeing in their local community.

1.3 Navigating the manual

The manual is set out in seven sections.





Section 2

Service Coordination in Victoria

2.1 What is Service Coordination?

Service Coordination places consumers at the centre of service delivery, to ensure that they have access to the services they need, opportunities for early intervention, health promotion and improved health and care outcomes³. Service Coordination enables organisations to remain independent of each other, while working in a cohesive and coordinated way to give consumers a seamless and integrated response. Service Coordination is underpinned by the following principles:⁴

Service Coordination principles

Principle	Description
A central focus on consumers	service delivery needs to be driven by the needs of consumers and the community rather than the needs of the system, or those who practice in it
Partnerships and collaboration	service providers work together and take responsibility for the interests of consumers, not only within their own service but across the service system as a whole
The social model of health	a distinct conceptual framework for thinking about health. This framework is concerned with addressing the social and environmental determinants of health and wellbeing, as well as biological and medical factors. This includes the spiritual and family connections that contribute to wellbeing
Competent staff	the six elements of Service Coordination must be undertaken by staff who are appropriately skilled, qualified, experienced, supervised and supported
A duty of care	a duty to take reasonable care of a consumer. The duty of care extends to Service Coordination, where staff have a duty of care to provide accurate and timely information, and assist consumers with referrals
Protection of consumer information	improved information management is critically linked to <i>Better Access to Services</i> . The brochure <i>Your Information—It’s Private</i> and the Consumer Consent Form are designed to improve information flow, practice and consumer outcomes
Engagement of other sectors	Service Coordination embraces the broadest range of partnerships across service provider types (small, large, non-government, government, etc) and across disciplines, including general practice. A key role for Primary Care Partnerships includes: developing strategic links with acute care, residential aged care, children’s and family services and disability services
Consistency in practice standards	Service Coordination enables services to remain independent of each other, while working in a cohesive and coordinated way to deliver consumers a seamless and integrated service response

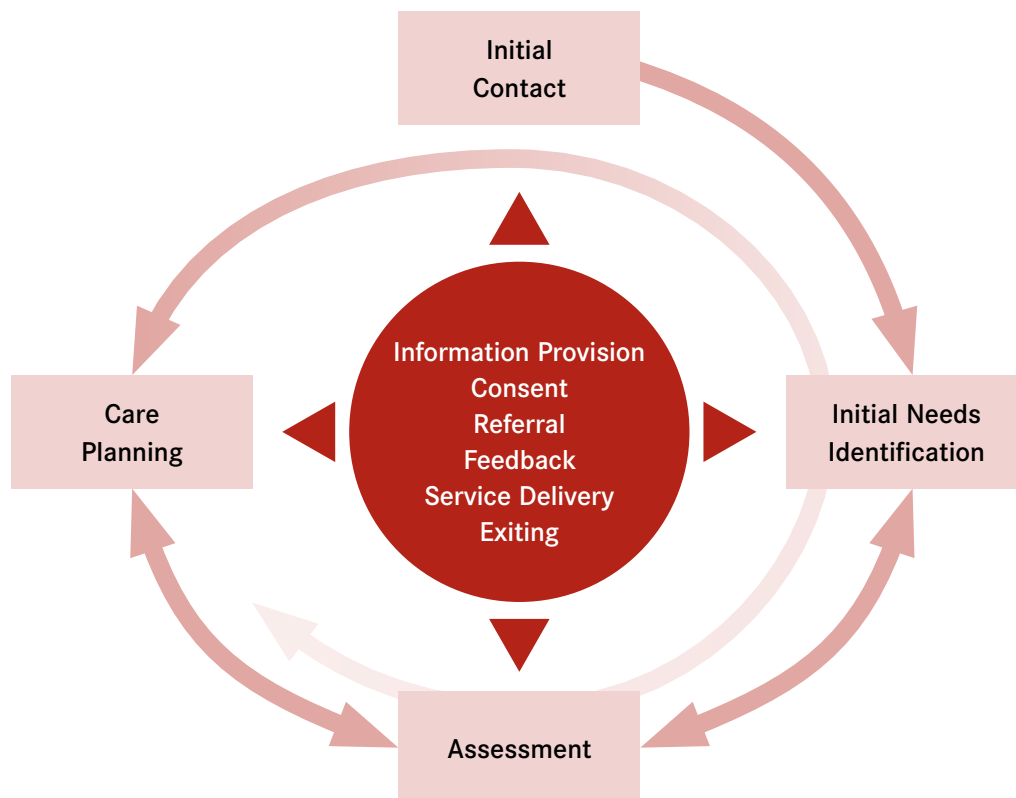
³ *Better Access to Services: A Policy and Operational Framework*, p. 1, DHS June 2001.
⁴ *Better Access to Services: A Policy and Operational Framework*, p. 9–13, DHS June 2001.

2.2 What is the Service Coordination Framework and what are the elements?

The operational elements of Service Coordination, as described in the Better Access to Services Framework, are depicted in *figure 2*. **Initial Contact**, **Initial Needs Identification**, **Assessment and Care Planning** are the key elements. Processes such as information provision, consent to share information, referral, provision of feedback, service delivery and exiting can occur at any stage.

Service Coordination elements are implemented in a range of ways to suit the consumer group and service provider setting. For example, in some services, Initial Contact and Initial Needs Identification are carried out by the same person (such as an intake worker) and Assessment is conducted by a different person; in other services, one person may conduct both Initial Needs Identification and Assessment processes at the same time.

Figure 2: Service Coordination elements



In addition to this manual, there is a range of supporting resources and tools to support the practice of Service Coordination. Key resources and tools include:

- **Service Coordination Tool Templates (SCTT) 2009** and the *SCTT 2009 User Guide*. Service Coordination Tool Templates (SCTT) are a suite of templates developed to facilitate and support the collection, recording and sharing of consumer information in a standardised way
- **Human Service Directory** www.humanservicesdirectory.vic.gov.au
- **Service Coordination privacy resources** www.health.vic.gov.au/pcps/coordination

Initial Contact

Initial Contact is the consumer's first contact with the service system. It is an important function of every service provider and usually includes the provision of accurate, comprehensive service information, including health promotion literature, and facilitated access to Initial Needs Identification.

Initial Needs Identification

Initial Needs Identification (INI) is a broad, shallow screening process to uncover underlying and presenting issues. During Initial Needs Identification the service provider engages in a broad conversation about the consumer's health and wellbeing to identify the full range of consumer needs, including health promotion, illness prevention, early intervention, self-management capabilities and restorative options. Initial Needs Identification is not a diagnostic process, but is a determination of the consumer's risk, eligibility and priority for service, with the aim of reaching a balance between service capacity and consumer needs. The Initial Needs Identification process is sensitive to the consumer, their needs and the service setting. The service provider must use judgement and discretion to decide the extent and intensity of the process. The gathering and analysis of information through Initial Needs Identification reduces consumer risk and informs the urgency and type of assessments required.

Assessment

Assessment is a decision-making methodology that collects, weighs and interprets relevant information about the consumer. Assessment is not an end in itself, but part of a process of delivering care and treatment. It is an investigative, often incremental, process using professional and interpersonal skills to uncover relevant issues and to develop a care plan. *Better Access to Services: A Policy and Operational Framework* identifies three types of Assessment:

- Service Specific Assessment, where consumers have a relatively straightforward, obvious and distinct need
- Specialist Assessment, where the presenting issues require a specialist service response
- Comprehensive Assessment, where the consumer has multiple or complex needs or the situation is unclear and a comprehensive approach is indicated.

Service providers typically conduct Assessment relevant to their services type or particular discipline. For Assessment requirements, refer to program specific guidelines.

Care Planning

Care Planning is a process of deliberation that incorporates a range of existing activities, such as: care coordination, case management, referral, feedback, review, re-assessment, monitoring and exiting. Care Planning involves a judgement and determination of relative need as well as competing needs, and assists consumers to come to decisions that are appropriate to their needs, wishes, values and circumstances. Coordinated Care Planning between services is particularly important for people with chronic and complex needs.

Additional processes

Referral

Referral is integral to working with many consumers and may occur at, or result from, any stage of Service Coordination. Referral is the transmission, with consent, of a consumer's personal and/or health information from one service provider to another for the purpose of further assessment, care or treatment.

Consent to share consumer information

Privacy legislation requires the protection of an individual's personal information and their right to decide how the information is used or disclosed (shared) with others. Due to the transfer of a consumer's information, as part of the referral process, it is necessary to obtain the consent of consumers prior to the disclosure of information for any secondary purpose. The primary purpose is the purpose for which the information was originally provided, while the secondary purpose is any additional information, such as information identified in the Initial Needs Identification process, which is not directly related to the consumer's original request. See: www.health.vic.gov.au/hsc/infosheets/disclosure.pdf

Feedback

Feedback is essential for good communication between services. Feedback can include acknowledgment that a referral has been received and the subsequent action to be taken. Feedback between services, including general practice, is essential to communicate the outcomes of Assessment, treatment and Care Planning.

2.3 What is expected of service providers involved in Service Coordination?

The aim of Service Coordination is to ensure consumers receive a seamless and integrated service response. This does not mean that one service provider must provide all services. However, each service provider should have in place the means by which a consumer can be linked to other services to provide access and coordinate holistic care to meet the consumer's full range of needs in a timely manner. This requires a high level of communication and feedback between service providers, so that assessment and care is coordinated but not duplicated.

Primary Care Partnerships support consistent Service Coordination practice

Primary Care Partnerships (PCPs) provide an important platform to facilitate the development and review of Service Coordination implementation. Through PCP Service Coordination networks (or similar) PCPs support service providers to work together, and where relevant, develop local agreements within and across service providers, including general practice. Agreements can include: processes for communication, the sharing of information, joint assessment, re-assessment, care pathways, referral, feedback and exiting. Local agreements, based on defined care pathways, can assist consumers to access the best mix of services, regardless of where they enter the service system, and whether the service is State Government, Commonwealth Government or locally funded.

Information about PCPs is available at: www.health.vic.gov.au/pcps/webpages

2.4 What is the link between general practice and Service Coordination?

General practitioners (GPs), general practice and divisions of general practice are essential participants in Service Coordination. They work closely with service providers to give 'comprehensive, coordinated and continuing medical care drawing on biomedical, psychological, social and environmental understandings of health.'

The main Service Coordination interface between GPs and services are in the areas of referral (and referral feedback) and collaboration for inter-agency Care Planning. The DHS Primary Health Branch has produced several resources that support services engaging with general practice, including the *Working with General Practice: Department of Human Services Resource Guide* and *General Practice Engagement in Integrated Chronic Disease Management* (see section 6).

There are specific opportunities for general practice to interface with service coordination with access to reimbursement through the Medicare Benefit Schedule (MBS) and the Practice Incentives Program. GPs can be reimbursed for undertaking certain comprehensive health assessments, health checks, care plans, medication reviews and cycles of care. Information is available from:

- Division of general practice *Medicare Benefits Schedule Project*.

See *section 4.6* regarding GP involvement in Care Planning and *section 5.4* regarding referral to and from general practice.

2.5 What are the benefits of Service Coordination?

Service Coordination offers multiple benefits to consumers and service providers.

Benefits for consumers:

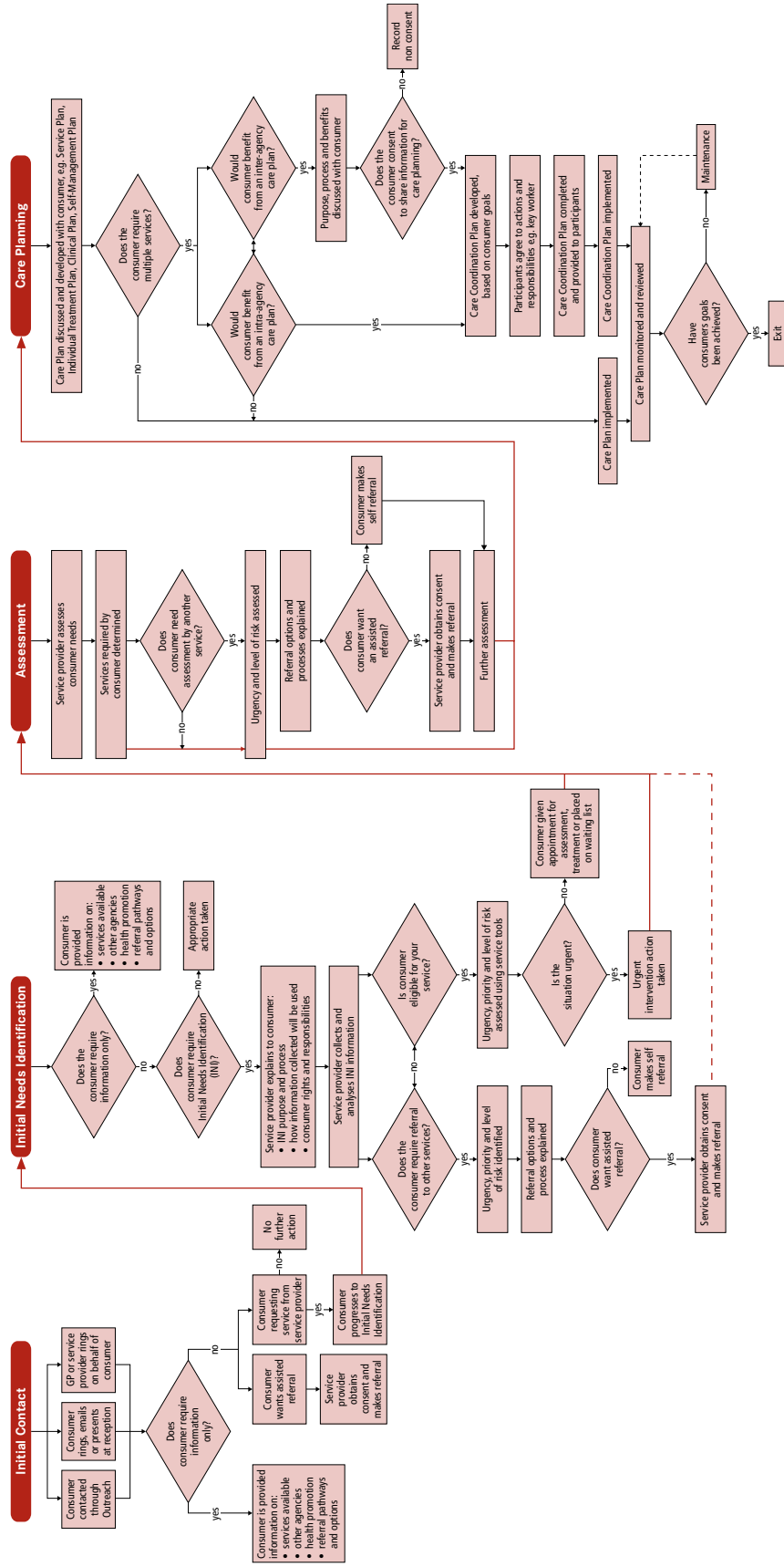
- provision of up-to-date information about local service availability and support options to contact the most appropriate service
- *no wrong door*—every door in the health and community services system can be the right door for consumers to access services
- clear entry points, plus transparent and consistent referral pathways and processes that are easy to navigate
- improved and timely identification of needs through the Initial Needs Identification process
- improved response times to requests for information and referral, for example, as a result of central intake systems
- confidential transfer of information for referral purposes in a way that does not require the consumer to repeat their information
- improved access to Assessment and coordinated Care Planning
- improved ability of service providers to deliver a coordinated response to consumers from multiple service providers
- increased knowledge of the local service system and access to resources that support Service Coordination, such as the Human Services Directory (HSD)
- consistent service standards from each service provider.

Benefits for service providers:

- practices, processes, protocols and systems that set out clear guidelines and expectations around key areas of work and inter-agency practice, including continuous quality improvement strategies aligned with core accreditation standards
- documented practice standards for Initial Contact, Initial Needs Identification and Care Planning
- improved consistency and quality of consumer information, and information sharing through the use of Service Coordination Tool Templates
- more efficient use of resources through improved information and feedback from referrals, fewer inappropriate referrals and less duplication of services
- streamlined services through the provision of a consistent, agreed, standardised way for practitioners within and across organisations to identify consumer needs, identify appropriate services, make referrals, provide feedback, communicate and coordinate care, leading to improved operational efficiency.

2.6 What is the consumer pathway through Service Coordination?

Figure 3: Consumer Pathway through Victoria's Service Coordination Model



For a larger scale version of Figure 3, please see fold out inside the back cover.

Section 3

Victoria's Service Coordination Practice Standards

3.1 Victoria's Service Coordination Practice Standards

The Victorian Service Coordination Practice Standards set out agreed process objectives, consumer outcomes, good practice indicators, statewide tools and resources for service providers involved in Service Coordination across Victoria. The aim of the Service Coordination Practice Standards is to provide:

- a shared vision for the delivery of quality Service Coordination across Victoria
- a basis for services to compare existing practice against the Victorian Service Coordination Practice Standards to identify areas for improvement
- a monitoring tool to ensure that Service Coordination Practice Standards are being implemented by services across Victoria.

Service Coordination Practice Standards are set out as:

- Process Objectives
- Consumer Outcomes and Good Practice Indicators
- Consumer Pathway
- Tools and Resources.

The Service Coordination Practice Standards set out in this section of the manual cover:

- Initial Contact
- Initial Needs Identification
- Assessment
- Care Planning.

The Practice Standards for Care Planning are described in *section 4* of this manual.

The Practice Standards for Referral are described in *section 5* of this manual.

3.2 Practice Standards: All elements of Service Coordination

This section provides an overview of the process objectives, consumer outcomes and Good Practice Indicators, which are common across all elements of Service Coordination.

Process Objectives—All Elements of Service Coordination

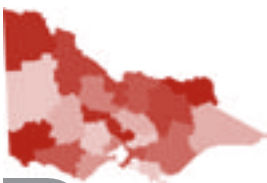
To ensure each consumer is offered access to effectively and efficiently managed and resourced: Initial Contact, Initial Needs Identification, Assessment, Care Planning and referral processes.

Consumer Outcomes and Good Practice Indicators—All Elements of Service Coordination

Consumer Outcomes	Good Practice Indicators
<p>Consumers experience a timely, coordinated, planned, non-discriminatory and reliable service that is sensitive to cultural, communication and cognitive needs</p> <p>Consumers can be certain that their information is collected, stored, shared and updated in accordance with the <i>Health Records Act</i>, and other privacy requirements.⁵</p>	The service provider gives consumers relevant, up-to-date information using the Human Services Directory and other relevant service directories
	The service provider empowers the consumer by providing information and decision-making support to access Initial Needs Identification, Assessment, Care Planning, and where relevant, referrals
	The service provider collects information in a sensitive manner, with particular regard to cultural requirements, language issues, communication and cognition needs, privacy and confidentiality, and where practical, anonymity
	The service provider collects only relevant information required for good practice care, minimum data set requirements and making referrals
	The service provider gives consumers a copy of the brochure <i>It's Private</i> , or other relevant service provider information, and ensure consumers have understood it
	The service provider has clear procedures and processes for obtaining and documenting consumer consent and complying with privacy requirements
	The service provider obtains informed consent before sharing information with another service provider for Initial Needs Identification, Assessment, Care Planning or service delivery
	The service provider shares information without consent in accordance with the Health Records Act, and other requirements such as Duty of Care, Mandatory Reporting and information sharing provisions
	The service provider has clear written policies, procedures and work instructions for Service Coordination
	The service provider has structures and systems to facilitate streamlined access to Initial Contact, Initial Needs Identification, Assessment, Care Planning and referral and service delivery processes
	The service provider ensures information documented on the Service Coordination Tool Templates is consistent with the <i>Service Coordination Tool Template 2009 User Guide (DHS, 2009)</i>
	The service provider has appropriately skilled service providers available to assist consumers
	The service provider ensures that staff members understand their role and are accountable for their work
	The service provider has a clearly defined and understood procedure for effectively managing consumers in crisis or emergency situations, including the provision of information on after-hours services
	The service provider monitors the elements of Service Coordination provision and regularly evaluates whether it is meeting objectives
	The service provider maintains up-to-date information about services, eligibility criteria, priority for service and waiting times in the Human Services Directory and other relevant service directories
The service provider participates in PCP groups and forums, and broader collaborations and networks, to ensure the continuous improvement of Service Coordination	
The service provider has integrated Service Coordination performance indicators into consumer feedback systems, such as consumer satisfaction or consumer experience surveys	

⁵ Privacy and consent are key issues to be considered in all elements of Service Coordination and referral. Service providers are encouraged to visit the following websites to ensure they are meeting the relevant privacy and consent requirements:

- www.privacy.vic.gov.au
- www.health.vic.gov.au/pcps/coordination/index.htm
- www.dhs.vic.gov.au



3.3 Practice Standards: Initial Contact

3.3.1 What is Initial Contact?

Initial Contact is the first element of Service Coordination and the consumer's first contact with the service system. It is the entry-point into other elements of Service Coordination, including Initial Needs Identification and Assessment.

During Initial Contact the consumer is given information on services, eligibility criteria and intake processes, plus other relevant health promotion literature and direct access to Initial Needs Identification.

Initial Contact is usually made by the consumer or a friend, relative or carer by telephone, in person, or via electronic media (such as websites and service directories). Services can also use assertive outreach and case-finding approaches to generate Initial Contact with consumers.

Initial Contact is a function of all service providers. Importantly, formalising the role of Initial Contact has meant a change to the responsibilities and practice of some staff, such as receptionists. Referral to external services may also occur as a result of Initial Contact.

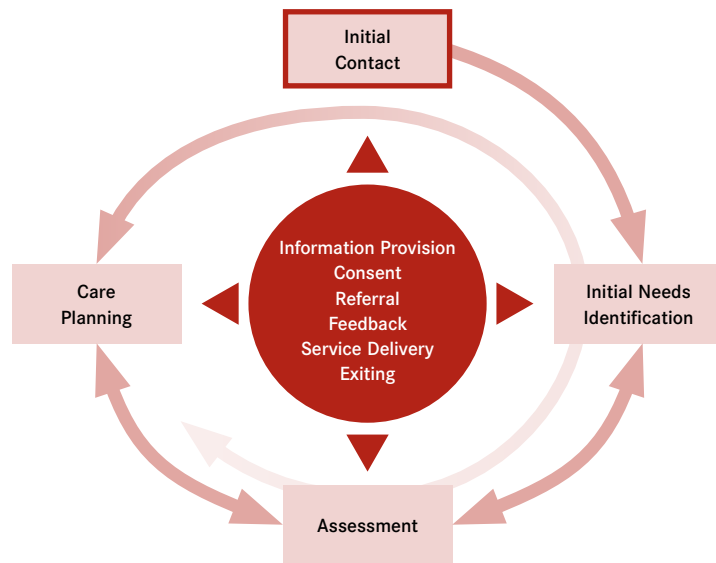
Consumers usually progress from Initial Contact to Initial Needs Identification. Initial Contact ends when a consumer requires information supported by advice, such as when the Initial Needs Identification process begins.

3.3.2 Which staff are involved in Initial Contact?

In some services, Initial Contact and Initial Needs Identification will be carried out by a single staff member at the one time, such as the service coordinator (or a duty or intake worker). In other services, Initial Contact may be the responsibility of a range of different staff, and Initial Contact and Initial Needs Identification may be completed over a number of days.

Initial Contact is implemented by a range of staff, such as:

- Receptionist
- Intake worker
- Service coordination worker
- Duty worker
- Triage staff
- Care coordinator
- Outreach worker
- Information worker
- Individual service provider (where consumers contact them directly such as in some community health services)
- Volunteer, for example in Neighborhood Houses, Community Centres
- Housing officer
- Key worker.



3.3.3 What is expected from services providing Initial Contact?

This section sets out the Victorian Practice Standards for Initial Contact. Service providers implementing Service Coordination are expected to meet these practice standards.

Process Objectives—Initial Contact

To ensure that each consumer's access to the service system and the range of services required is supported by:

- multiple entry points
- accurate and reliable service information
- competent staff
- an understanding of the Initial Needs Identification, Assessment, Care Planning and referral processes
- information about a consumer's rights and responsibilities
- practice that is sensitive to cultural, communication and/or cognitive requirements
- access to Initial Needs Identification, Assessment, Care Planning, referral or service delivery.

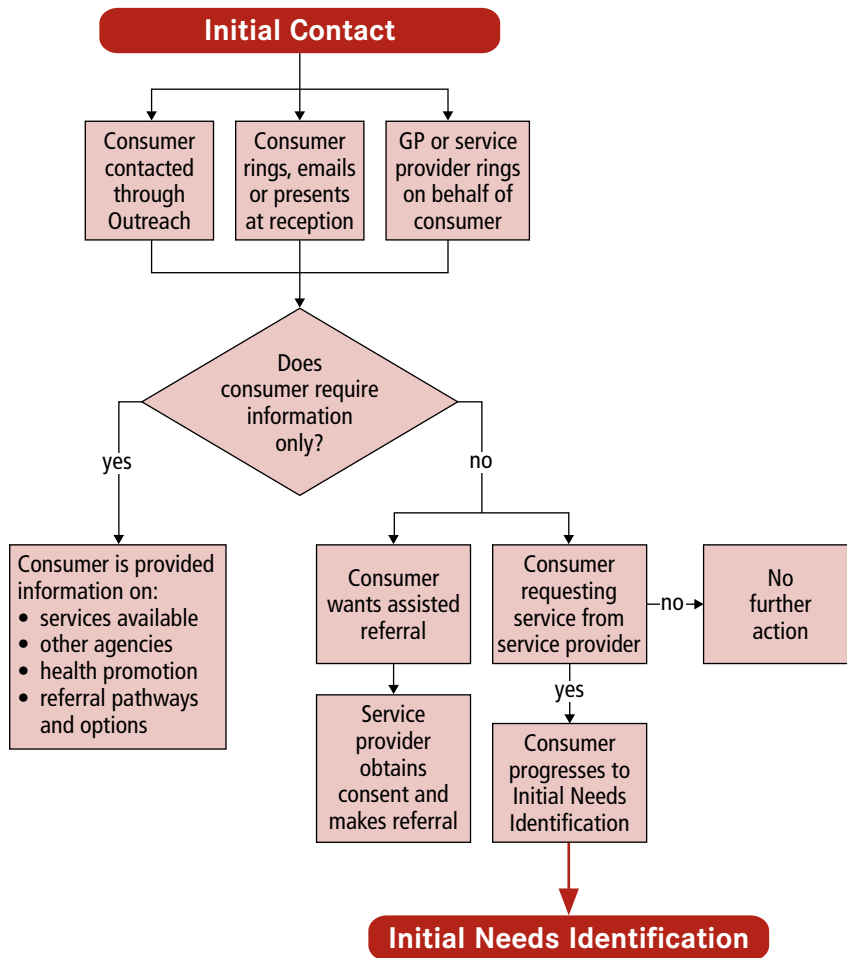
Consumer Outcomes and Good Practice Indicators—Initial Contact

Consumer Outcomes	Good Practice Indicators
Consumers are informed about: <ul style="list-style-type: none"> ■ available services and eligibility criteria ■ entry and Initial Needs Identification processes ■ their rights and responsibilities in relation to accessing services. 	<p>The service provider presents information that empowers the consumer to make informed choices. This may involve the use of interpreters, translated material and practice that is sensitive to cultural, communication and/or cognitive needs</p> <p>The service provider explains the Initial Needs Identification and Assessment processes, including timeframes, to the consumer</p> <p>The service provider gives the consumer information on service availability, eligibility criteria, intake processes and health promotion</p>
Consumers are empowered with the right information and assistance to make informed choices and self-referrals	<p>The service provider, when appropriate, facilitates access to Initial Needs Identification, Assessment, referral or service delivery</p> <p>The service provider provides access to accurate service information within no more than 1 working day of a consumer making Initial Contact</p>
Consumers have streamlined access to Initial Needs Identification, Assessment and referrals	<p>The service provider is an entry point to the full suite of services offered by the service system so they must provide information to help consumers navigate the service system</p> <p>The service provider uses an appropriate model for the specific consumer group, for example an outreach model to engage consumers-at-risk who may be homeless or in child protection services</p>
	<p>The service provider collects information at Initial Contact for the purposes of planning and health promotion, including the number and nature of enquiries and the level of unmet need.</p>

3.3.4 Consumer Pathway through Initial Contact

The consumer pathway through initial contact is set out in *figure 4*.

Figure 4: Consumer Pathway through Initial Contact



3.3.5 Tools and Resources—Initial Contact

- The statewide Human Services Directory has been designed to support Initial Contact. The Human Services Directory can be found at: www.humanservicesdirectory.vic.gov.au
- Your Primary Care Partnership, program area, or local Council may also have service directories which can support Initial Contact
- *Service Coordination Tool Templates (SCTT) Consumer Information*
- *SCTT 2009 User Guide*
- Training resources—refer *section 6*.

3.4 Practice Standards: Initial Needs Identification

3.4.1 What is Initial Needs Identification?

Initial Needs Identification (INI) is a broad, shallow screening process to uncover underlying and presenting issues. It is sometimes referred to as triage or service screening.

Initial Needs Identification allows for the consumer's health, social, emotional and wellbeing needs and health promotion opportunities to be identified, early in their contact with the service system. The service provider engages in a broad conversation to identify consumer needs, including illness prevention, early intervention, self-management capabilities and restorative options. It is not a diagnostic process, but a determination of the consumer's risk, eligibility and priority for service, with the aim of reaching a balance between service capacity and consumer needs.

The Initial Needs Identification process is sensitive to the consumer, their needs and the service setting. The service provider must use judgement and discretion to decide the extent and intensity of the process. The gathering and analysis of information through Initial Needs Identification reduces consumer risk and informs the urgency and type of assessments required.

Consumers can then be informed about relevant service options and the wider range of support services and resources available.

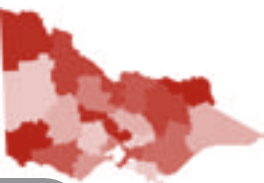
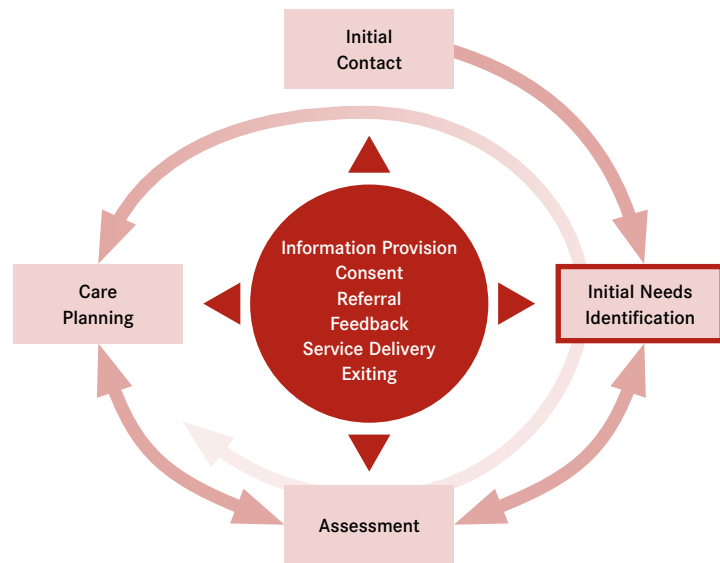
3.4.2 Which staff are involved in Initial Needs Identification?

Initial Needs Identification should be undertaken by qualified staff who possess a broad understanding of the service system, advanced interviewing skills and high-level interpersonal skills, including the ability to develop a rapport with consumers. They should also have easy access to service provider decision support tools, the Human Services Directory and other relevant service directories.

The Initial Contact, Initial Needs Identification and Assessment processes may be completed simultaneously by one staff member (such as an outreach worker) or separately by a range of service providers over several days.

Initial Needs Identification is implemented by a range of staff, including:

- Duty worker or intake worker
- Service coordination worker
- Care coordinator
- Triage nurse
- Assessment officer or nurse
- Outreach worker
- Case manager



- Housing service worker
- Key worker
- Individual service providers (in particular, where consumers contact them directly to make appointments, as happens in some Community Health Services) such as a social worker, physiotherapist, alcohol and drug counsellor or care coordinator in an emergency department

The Victorian government is committed to ensuring all consumers have better access to services. If your service does not provide Initial Needs Identification, you must know where to refer your consumers on to.

3.4.3 What is expected from services providing Initial Needs Identification?

This section sets out the Victorian Practice Standards for Initial Needs Identification. Service providers implementing Initial Needs Identification are expected to meet these practice standards.

Process Objectives—Initial Needs Identification

To provide access for all consumers to initial screening for health promotion opportunities, service requirements and risk, appropriate assessments, care planning and services, using practices that are sensitive to cultural, communication and cognitive needs.

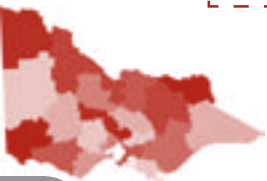
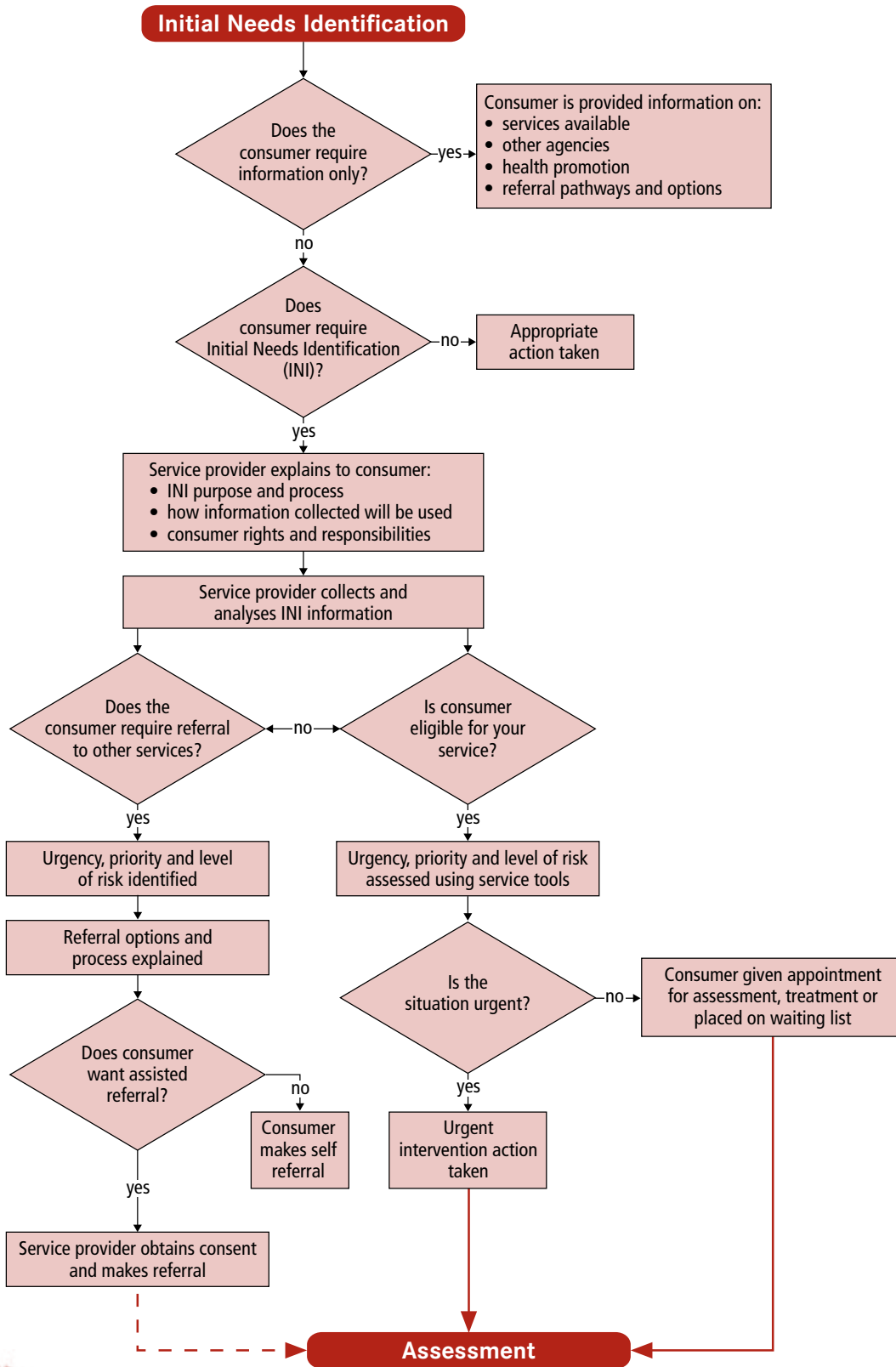
Consumer Outcomes and Good Practice Indicators—Initial Needs Identification

Consumer Outcomes	Good Practice Indicators
<p>Consumers are informed about:</p> <ul style="list-style-type: none"> ■ the Initial Needs Identification process ■ why information is being collected and how it will be used ■ the screening process and how risk and priority are determined ■ their rights and responsibilities, including access to their health records ■ the implications of providing and not providing information ■ consent requirements <p>Consumers are supported and empowered to participate in the Initial Needs Identification process, through the provision of information, decision-making support and direct assistance, such as an assisted referral</p> <p>Consumers have access to appropriate and timely assessments and referrals.</p>	<p>The service provider explains to the consumer the reason for collecting information and how it will be used to screen for broader needs</p>
	<p>The service provider discusses possible choices for consumer support, including those provided by other services. This should be based on practice that is sensitive to the consumers’ cultural, communication and cognitive needs</p>
	<p>The service provider assists the consumer to identify their issues and needs, including opportunities for health promotion and early intervention through the Initial Needs Identification process</p>
	<p>The service provider ensures the consumer is fully informed of the processes for Assessment, referral and Care Planning and is supported to actively participate in those processes</p>
	<p>The service provider uses appropriate risk identification and assessment tools to determine the consumer’s needs, level of risk and priority of access to Assessment, Care Planning and services</p>
	<p>The service provider discusses alternative service options with consumers who are not eligible for service, and refers those consumers to a relevant service where possible. The service provider gives feedback to the referral service provider, including general practice where applicable</p>
	<p>The service provider conducts an Initial Needs Identification within no more than 7 working days of Initial Contact or of receiving a referral identified as <i>low</i> or <i>routine</i> from Initial Contact</p>
<p>The service provider conducts an Initial Needs Identification within no more than 2 working days of Initial Contact or of receiving a referral identified as <i>urgent</i> from Initial Contact</p>	
	<p>The service provider has in place a process for consumers who require <i>urgent</i> services and cannot wait for a formal assessment process to be completed</p>

3.4.4 Consumer Pathway through Initial Needs Identification

The consumer pathway through the Initial Needs Identification process is set out in *figure 5*.

Figure 5: Consumer Pathway through Initial Needs Identification



3.4.5 Tools and Resources—Initial Needs Identification

- *Service Coordination Tool Templates (SCTT) Consumer Information and profiles*
- *SCTT 2009 User Guide*
- Service provider: Eligibility Criteria, and Priority Access Policy
- The Human Services Directory or other relevant service directories
- Training resources—refer *section 6*.

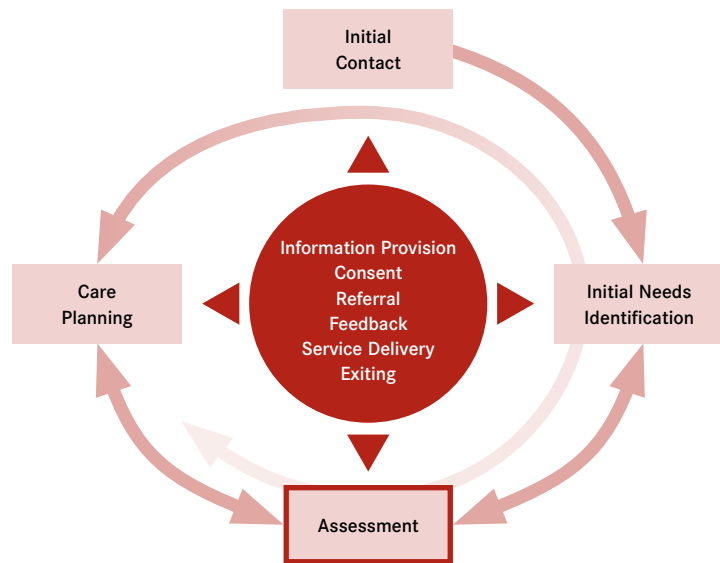
3.5 Practice Standards: Assessment

3.5.1 What is Assessment?

Assessment is a decision-making methodology that collects, weighs and interprets relevant information about the consumer. Assessment is not an end in itself, but part of an ongoing process of delivering care and treatment. It is an investigative process using professional and interpersonal skills to uncover relevant health and wellbeing issues to develop a care plan.

One or more skilled service providers assess in detail the current and ongoing specific needs of a consumer. More than one assessment may be necessary, since service providers typically gather information relevant to their discipline, such as the consumer’s social, functional, emotional, lifestyle and health needs.

Service providers should use assessment relevant to their services type or particular discipline that meet consumer, service, reporting and program requirements. Most government-funded programs have Assessment frameworks, guidelines, templates and tools to guide this process, for example the Home and Community Care (HACC) Assessment framework, Disability Service Target Group Assessment, Domestic Violence Risk Assessment framework, Opening Doors—Better Access for Homeless People to Social Housing and Support Services in Victoria.



3.5.2 Where does Assessment fit into Service Coordination?

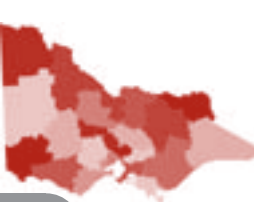
Assessment builds on the information gathered through Initial Contact, Initial Needs Identification and other relevant sources. The information can build over time to develop a holistic picture of the consumer, especially where multiple issues are identified. Assessment is completed by a qualified service provider to:

- identify consumer needs and capacity
- discuss care goals with the consumer and relevant others
- determine services required
- inform the development of a care plan
- determine appropriate referrals required and share information with the consumer’s consent.

The *Better Access to Services Policy and Operational Framework* describes three types of Assessment.

Service Specific Assessment

A face-to-face interaction with a consumer who has a straightforward and distinct need for a specific service (such as home care, physiotherapy, dental services, domestic assistance, nursing, or a planned activity group). The assessment is conducted by the service provider responsible for delivering the service. This leads to the development of a service specific care plan or individual service plan.



Specialist Assessment

A face-to-face interaction with a consumer who clearly requires a specialist service response (such as specific women's services, mental health, alcohol and drug services, or problem gambling). It usually follows an Initial Needs Identification or other relevant assessment that has identified specific needs. These may be fairly straightforward, such as a request for a pap smear or a request for alcohol and drug services where a range of interventions will be required.

Comprehensive Assessment

A face-to-face interaction with a consumer on a broader and more intense level of inquiry, including history-taking, examination, observation and measurement, or testing. It involves medical, physical, social, cultural and psychological dimensions of need and incorporates the consumer's abilities and capacity for improvement.

Comprehensive Assessment leads to further analysis in the form of a clinical judgment, diagnosis or differential diagnosis. It is necessary for consumers with multiple, complex or unclear needs, or those who require long-term or extensive service provision. Information is gathered from a wide range of sources to build a comprehensive picture.

Comprehensive Assessment is undertaken by experienced multi-disciplinary workers across a range of services, including Aged Care Assessment Services (ACAS), Home and Community Care (HACC) services and Community Health Services. This inter-disciplinary approach ensures all consumer needs are identified and an appropriate response formulated, sometimes from outside the assessing organisation. Comprehensive Assessment incorporates risk identification and assessment, so the response may be stratified according to severity. A Comprehensive Assessment will link into a coordinated Care Planning process.⁶

3.5.3 Which staff are involved in Assessment?

Assessments must be conducted by trained service providers with appropriate qualifications, skills and knowledge in the particular area of service delivery. Staff undertaking Assessments require a broad understanding of the service system, advanced interviewing skills, and high-level interpersonal skills, including the ability to develop a rapport with consumers.

Initial Needs Identification and Assessment may be conducted simultaneously by one staff member, or separately by different staff members over several days.

General practitioners often conduct comprehensive health assessments, since general practice is the primary point of health care for most people in the community. It acts as a gateway to the broader health system. Many consumers have already consulted a general practitioner and undergone Assessment. General practitioners can access reimbursement for particular comprehensive health assessments and checks through the Medicare Benefits Schedule (MBS) and the Practice Incentives Program.

⁶ Further information about the three types of Assessment can be found in the *Better Access to Services Policy and Operational Framework*, a copy of which can be downloaded from: www.health.vic.gov.au/pcps/publications

3.5.4 What is expected from services providing Assessment?

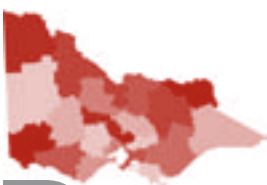
This section sets out Victoria’s Practice Standards for Assessment. Service providers are expected to meet the practice standards outlined below.

Process Objective—Assessment

To ensure that each consumer has access to the appropriate Assessment that meets their individual needs and service requirements.

Consumer Outcomes and Good Practice Indicators—Assessment

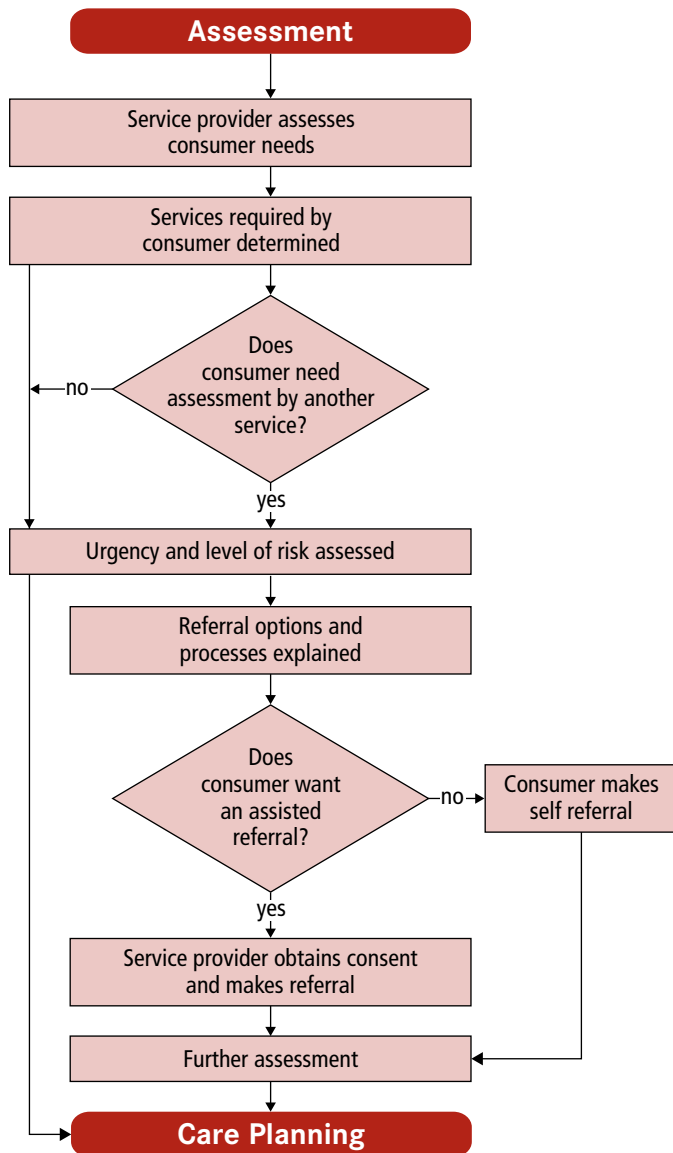
Consumer Outcomes	Good Practice Indicators
<p>Consumers are informed about:</p> <ul style="list-style-type: none"> ■ the Assessment process ■ why information is collected and how it will be used ■ their rights and responsibilities, including access to their health records ■ the implications of providing, and not providing information ■ consent requirements 	<p>The service provider explains the reason for collecting information and how it will be used to assess their needs</p>
<p>Consumers are supported and empowered to participate in the assessment process</p>	<p>The service provider discusses choices for support and services, including those provided by other services. This may involve the use of interpreters, translated or easy-English material, and practice that is sensitive to cultural, communication and cognitive requirements</p>
<p>Consumers have direct access to assessments and referrals.</p>	<p>The service provider collaborates with the consumer to identify the full range of consumer issues, needs and circumstances, including opportunities for health promotion and capacity for self-management</p>
	<p>The service provider ensures the consumer fully understands decision-making processes and is encouraged to actively participate in them</p>
	<p>The service provider uses appropriate assessment tools to determine the consumer’s needs, existing supports, ability, level of risk and priority of access to services or further referrals</p>
	<p>The service provider discusses alternative service options with consumers who are not eligible for service and refers the consumer on to a relevant service where possible. The service provider gives feedback to the referral service provider if applicable</p>
	<p>The service provider has an Assessment process and protocols in place to meet accepted discipline and inter-discipline specific requirements, and minimises duplication</p>
	<p>The service provider has in place a process for consumers who require <i>urgent</i> services and cannot wait for a formal assessment process to be completed.</p>



3.5.5 Consumer Pathway through Assessment

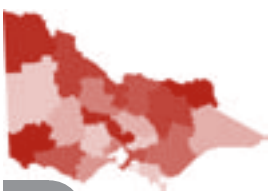
The consumer pathway through the Assessment process is set out in *figure 6*.

Figure 6: Consumer Pathway through Assessment



3.5.6 Tools and Resources—Assessment

- Program Guidelines, requirements and templates
- Service provider or service specific assessment policies, work instructions and tools
- DHS Service Coordination Tool Templates (SCTT)
- *SCTT 2009 User Guide*
- The Human Services Directory and/or other relevant service directories.



Section 4

Care Planning Practice Standards

4.1 What is Care Planning?

Care Planning is a dynamic process that incorporates care coordination, case management, referral, feedback, review, re-assessment, monitoring and exiting. Care Planning involves balancing relative and competing needs, and helping consumers make decisions appropriate to their needs, wishes, values and circumstances.

Care Planning involves gathering and interpreting Assessment, consumer self-reported and other information to make care decisions with the consumer and the carer.

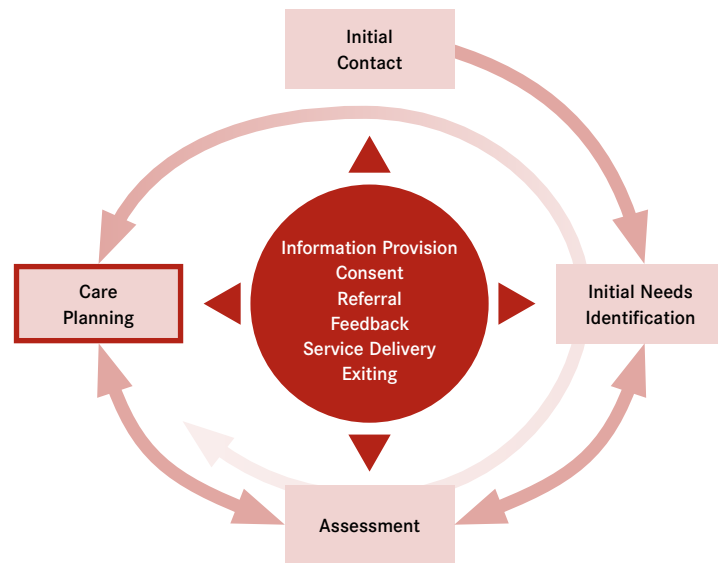
Coordinated Care Planning between services is particularly important for consumers with multiple or complex needs, such as those with a chronic condition, high or ongoing support needs.

Care Planning involves discussion, negotiation and decision-making between service provider and consumer to define their goals and strategies, then identify actions and services to meet those goals.

This may involve linking the consumer to a range of services and identifying how self-management support, education and health promotion will be provided. Effective communication must be established between the consumer and the participants in their care, including their general practitioner. Each consumer has different needs, aspirations, priorities and resources that will inform the development of individual goals.

A collaborative approach to care that actively involves the consumer, their family, carers, support people and service providers ensures the best possible outcomes for the consumer.

Care Planning is not merely a care plan document, or an end in itself. Care Planning can occur at any point in the care process, wherever an assessment or review takes place.



4.2 The objectives and principles of Care Planning

The overall objectives of Care Planning ensure:

- services are planned and delivered, based on best-available evidence in the most timely and effective way, and are underpinned by the principles of a person-centred, coordinated and integrated approach
- consumers are actively engaged in the planning and delivery of care and receive support appropriate to their needs, wishes, circumstances, abilities and cultural background
- social, emotional, and health needs (beyond presenting issues) are considered
- care provided is based on agreed and documented needs, goals and actions
- care includes health education and encourages and empowers consumers to self-management, where appropriate
- monitoring and review processes are included
- Care Planning is underpinned by communication between all participants
- Care Planning complies with current legislation and service provider quality standards.

It is critical that the Care Planning process is embedded in a person-centred culture, so that professional and organisational boundaries do not create artificial barriers. The care plan should be worded in a way which is able to be understood by the consumer and any professionals involved in the consumer's care.

Benefits of Care Planning

- assists the consumer in setting and achieving goals
- encourages the consumer to be involved in their care, and incorporates self-management support, where possible
- manages long-term care in a clear, concise way
- provides an essential checklist to ensure continuity of care
- provides a way of documenting essential information to be shared by others, including life saving actions for emergencies
- encourages a team approach, with the consumer at the centre
- focuses on being proactive rather than reactive
- increases consumer and carer awareness of support services available, and how and when to access them
- ensures effective monitoring of the consumer's health and wellbeing

4.3 Key features of Care Planning in Victoria

Features of Care Planning in Victoria, in accordance with Service Coordination are⁷:

- nomination of a single key worker or contact person to promote effective communication between the consumer and service providers. The key worker may have a specific role, such as care coordinator. They are responsible, within the scope of their role, for ensuring the care plan is delivered and monitored, review dates are set, re-assessments are initiated, and feedback is given to referring service providers
- incorporation of care planning activities (from the simple booking of services through to comprehensive case management) for consumers, where a consumer requires multiple services, or has complex or multiple needs
- acknowledgement of the potential contribution of education and self-management to effective care
- provision of effective monitoring (both formal and informal) of a consumer's health and wellbeing, and the effectiveness of services being delivered, for example, through regular reviews
- referral and other information is coordinated, planned and efficient, and specific feedback loops are in place for other service providers and the consumer
- maximising the opportunities inherent in the federal government's MBS items, to facilitate and support collaborative Care Planning with GPs
- using the Care Coordination Plan Template for consumers with complex or multiple needs, who require more than one service provider.

⁷ Adapted from *Better Access to Services: A Policy and Operational Framework*, p. 20–21, DHS June 2001.

Guiding principles for enabling person-centred practice⁸

- a partnership approach to care, where consumers and service providers share knowledge, values, experience and information, and collaborate to develop goals and plan actions
- a holistic approach to practice
- open, clear communication, which respects a consumer's values, culture and beliefs, based on practice that is sensitive to the cultural, communication and cognitive needs of the consumer (for example, use of interpreters, translated material, Easy-English)
- respect for privacy
- consider and value the role of family and carers
- support consumers to identify their own needs and develop their own goals
- encourage consumers to choose outcomes they define as meaningful
- encourage consumers to participate in decision-making partnerships in treatment, program planning and policy formation
- base practice on consumer values, background and choice as much as possible
- support consumers to examine risks and consequences
- encourage consumers to use their own strengths and natural supports
- provide information to involve consumers in decision-making choices and to streamline access to services
- respect the consumer's own styles of coping or bringing about change
- support autonomy and choice
- encourage consumers and participants to take responsibility for their part in the plan
- be flexible and responsive in planning care within the parameters of safety and service guidelines.

4.4 What is a Care Plan?

A care plan is the documentation of items agreed to in the Care Planning process. All care plans should include these items:

- date care plan developed
- participants in development of care plan
- consumer-stated and agreed issues or problems
- consumer-stated and agreed goals
- agreed actions and the name of person or service responsible for each action
- timeframe for attaining goals and actions
- planned review date
- consumer acknowledgement of the care plan (signed or verbal)
- actual review date.

Service specific care plan

A service specific plan is developed by a *single service*. Service specific care plans are usually documented using program specific tools or formats, such as an Individual Treatment Plan, an Asthma Management Plan, an Advanced Care Plan, a GP Management Plan or an Individual Support Plan.

⁸ http://www.nari.unimelb.edu.au/pchc/downloads/PCHC_literature_review.pdf

Intra-agency care plan

An intra-agency care plan is used for consumers who require *multiple services from within a single organisation*, in order to coordinate service delivery. Consumers may have service-specific care plans and an overarching intra-agency care plan. An intra-agency care plan can be documented using the [SCTT Care Coordination Plan](#) to:

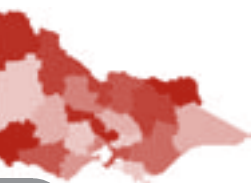
- articulate shared goals and outcomes
- outline the roles and responsibilities of each practitioner
- coordinate internal service provision to support the consumer to achieve their goals
- facilitate communication of agreed strategies and interventions, to ensure all involved in the consumer's plan are well-informed and working towards the same goals
- identify the person responsible for care coordination, such as a key worker, care coordinator or case manager, as appropriate
- monitor and review service provision (including recall), and plan for discharge, transition or exit from the service.

Inter-agency care plan

An inter-agency care plan is used with consumers who have complex or multiple needs and require services from *more than one organisation* (for example, the consumer has a chronic disease). An inter-agency care plan can be developed using the [SCTT Care Coordination Plan](#) for consumers who:

- are involved with more than one organisation
- have multiple issues or problems that need to be addressed concurrently, such as chronic or terminal conditions
- are likely to experience a better outcome if the care and services they receive are coordinated between organisations over time.

Effective inter-agency Care Planning enables a proactive rather than reactive approach to care for people with multiple support needs. It is the most complex form of Care Planning, requiring a person in a specific role to coordinate information and assist the consumer to access appropriate care (see *section 4.5*). An inter-agency care plan provides a document for the coordinated and consumer-centred approach to addressing consumer needs. The SCTT Care Coordination Plan is useful for documenting essential information, including life-saving actions for emergencies. It has been designed to encourage a team approach with the consumer at the centre. The development of a Care Coordination Plan can increase consumer and carer awareness of the support services available to them. Service providers can use secure electronic forms of the Care Coordination Plan for efficient information sharing and on-line case conferencing.



Examples of different types of Care Plans

Service Specific Care Plan	
Use when	The consumer has one or more issues that can be managed with the support of <i>a single program area</i>
Tools	Specific program or service tools, or the SCTT Care Coordination Plan
Examples	Consumer Care Plan, Individual Treatment Plan, Self-management Plan Personal Action Plan, Individual Support Plan, Asthma Management Plan Clinical Plan, Continence Management Plan, GP Management Plan Service Plan, Advanced Care Plan, Nursing Care Plan, Child and Family Action Plan, Housing Support Plan, Crisis Intervention Plan, Relapse Prevention Plan
Intra-agency Care Plan (single organisation)	
Use when	The consumer has numerous issues that require the coordinated support of <i>multiple program areas</i> from within <i>a single organisation</i>
Tools	SCTT Care Coordination Plan
Examples	<ul style="list-style-type: none"> ■ a care plan involving a range of health practitioners (such as podiatrist, health coach, diabetes nurse educator and dietitian) who work within the same organisation ■ a care plan involving a range of workers (such as counsellor, support worker, GP) who work within the same organisation
Inter-agency Care Plan (between organisations)	
Use when	The consumer has a range of issues that require the coordinated support from <i>two or more</i> separate organisations
Tools	SCTT Care Coordination Plan
Examples	<ul style="list-style-type: none"> ■ a care plan for an older person with a chronic condition, who receives services from a GP, uses a range of HACC services and allied health services from a Community Health Centre ■ a care plan for a person with an acquired brain injury who lives semi-independently and receives outreach support from a disability support worker, delivered meals and domestic assistance through HACC and counselling from an alcohol and other drug service ■ a care plan for a family that receives housing support, financial counselling and parenting support ■ a care plan for a person who is receiving mental health support from a GP, support from a mental health worker, assistance to locate alternative housing through a housing worker, and counselling from an alcohol and other drug service ■ a care plan for a person following surgery, receiving outpatient follow-up, rehabilitation in the home through the Health Services and nursing wound-care from a district nursing service

4.5 The key worker role in Care Planning

The **key worker role** in Care Planning should be fulfilled by a trained service provider with the skills and competence to undertake care coordination. Each program area and local service system will have different guidelines, which determine availability of staff to perform the key worker role. Service providers may elect to create a specific key worker role to support the implementation of Service Coordination.

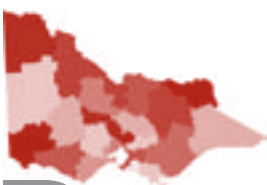
A range of staff may participate in Care Planning by communicating outcomes and progress to the key worker. People who may perform key worker functions, within the scope of their role, include: family support case managers, aged care case managers, disability support workers, integrated cancer services professionals, mental health case managers, housing support workers, nurses, discharge planners, social workers, care coordinators, GPs, HACC Aboriginal liaison staff, or assessment staff. When determining the key worker, consider consumer preference, relationship to consumer, level of engagement, frequency of contact, skill and capacity of the worker. The key worker may change over time.

The role is likely to involve:

- engaging and empowering the consumer and acting as an advocate if required
- consolidating existing information, such as assessments or care plans
- having a good knowledge of available services and management options
- developing and documenting agreed goals and actions in collaboration with the consumer, ensuring they are specific, measurable, achievable, realistic and time-specific
- facilitating the creation, documentation and communication of the initial care plan
- monitoring and review of the care plan, including arrangement of re-assessments as required, and updating of the care plan
- liaising and communicating with all participants, including the consumer, carer and GP
- organising and facilitating case conferences
- working in a virtual, multi-disciplinary or inter-disciplinary team
- ensuring the care plan remains current
- discussing exit options and procedures
- providing feedback to referrers, GPs and support workers
- ensuring documentation and processes meet the requirements of the *Health Records Act* and other privacy legislation.

Monitoring

Care Planning includes monitoring to ensure service is delivered as intended and is fulfilling the agreed goals. The role of the key worker and monitoring processes will continue to be developed in the future.



4.6 General practitioner involvement in Care Planning

The involvement of general practitioners in Care Planning for people with complex or multiple needs or chronic diseases is essential. Importantly, GPs can be involved in Care Planning led by other service providers, or they can lead Care Planning, which involves other service providers.

When a multi-service care plan is needed, service providers should consider communicating with the consumer's GP to establish if there is already an existing care plan and determine the roles and responsibilities of the participants in the care planning process. When a care plan is developed a copy of the care plan should be sent to the GP, with the consumers consent.

The ways GPs can be involved in Care Planning are guided by the MBS Guidelines and general practice tools, which have been developed to meet MBS rules.

As part of the Chronic Disease Management (CDM) items available to general practice is a service for GP-only Care Planning, which is the General Practice Management Plan (GPMP). This is for consumers who have a chronic or terminal medical condition without multi-disciplinary care needs. The Team Care Arrangement (TCA) is for consumers who have complex care needs and require other service providers in their care. If eligible, the consumer can access multi-disciplinary services, such as subsidised access to allied health, through a TCA. GPs can be assisted by practice nurses, Aboriginal health workers and other health professionals in providing these items.

Further information about how GPs can be involved in Care Planning can be obtained from your PCP, local division of general practice or from:

- <http://www9.health.gov.au/mbs/search.cfm>
- http://www.health.vic.gov.au/communityhealth/downloads/gp_engagement_icdm.pdf
- <http://www.health.gov.au/internet/main/publishing.nsf/Content/pcd-programs-epc-chronicdisease.htm>

4.7 What is expected from services providing Care Planning?

This section sets out the Victorian Practice Standards for Care Planning.

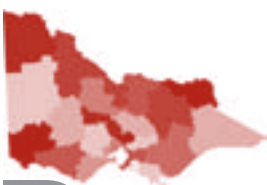
Service providers implementing Service Coordination are expected to have these systems and processes in place:

- documented protocols to guide a person-centred approach, including multi- and inter-disciplinary practices
- documented care pathways that include early identification for consumers with complex and multiple issues
- up-to-date evidence and resources for staff, including service directories
- relevant staff training, for example in goal-setting and case conferencing
- documentation for staff that defines practices, processes, protocols and systems for intra-agency and inter-agency Care Planning
- documentation for staff such as position descriptions and service delivery models that defines the role, functions and responsibilities of the key worker
- agreements between services, including GPs, for communication, sharing information, referral, feedback, and exiting processes with other services including GPs
- clearly defined processes for monitoring, review and recall.

Process Objectives—Care Planning

To ensure that consumers are offered and have access to Care Planning and service coordination that:

- takes into account social, emotional, and health needs (not just the presenting issues)
- is based on documented needs, consumer-centred goals and actions
- is person-centred
- provides health education and empowers consumers to self-manage, where appropriate
- includes an agreed monitoring process and review dates
- is underpinned by communication between the consumer and service providers.

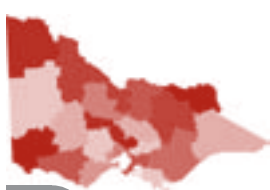


Consumer Outcomes and Good Practice Indicators—Care Planning

Consumer Outcomes	Good Practice Indicators
<p>Consumers are informed about and understand:</p> <ul style="list-style-type: none"> ■ the value of planned and coordinated care ■ Care Planning options and processes ■ roles and responsibilities of service providers, including the service provider fulfilling the key worker role ■ privacy, confidentiality and consent procedures and their right in relation to these procedures <p>Consumers (and their representatives) are empowered to collaborate in the development, implementation, monitoring and review of their care plan</p> <p>Consumers have direct access to Care Planning and care coordination processes</p>	<p>Practice that is sensitive to the consumer’s cultural, communication and cognitive needs to support their participation in Care Planning (for example, use of interpreters, translated material, easy-English)</p>
	<p>The service provider has a process for consumers who require <i>urgent</i> services and cannot wait for a formal assessment or Care Planning processes to be completed</p>
	<p>The consumer, carer and advocate are actively supported to participate in the Care Planning process (unless they choose not to)</p>
	<p>The service provider ensures that the appropriate participants in care, are included (with consumer consent) in the development of the care plan</p>
	<p>The service provider fully explains the consent process and documents the consumer’s consent to information sharing and to the actions and services listed in the care plan</p>
	<p>Existing care plans, such as Team Care Arrangements or self-management plan, or advanced care plan,⁹ for a consumer with a chronic disease, complex or multiple needs, are identified and considered</p>
	<p>The consumer and service provider discuss the benefits and purpose of the care plan, including its relationship to care delivery and improved outcomes</p>
	<p>The consumer and service provider identify the consumer’s needs and risks, including consideration of medical, social, psychological, environmental, lifestyle factors</p>
	<p>Health promotion and illness prevention opportunities, self-management and recovery supports are discussed and included in Care Planning where possible</p>
	<p>If a consumer with complex needs does not already have a Care Coordination Plan or equivalent, the service provider initiates (with consent) the development of a Care Coordination Plan</p>
	<p>Care plans are written in a way that is easily understood by the consumer, expressing specific, measurable, realistic and time specific goals</p>
	<p>The consumer and service provider discuss the roles and responsibilities of all participants involved in Care Planning, including the key worker</p>
	<p>Care plans are documented and contain:</p> <ul style="list-style-type: none"> ■ date care plan developed ■ participants in development of care plan ■ consumer-stated and agreed issues or problems ■ consumer-stated and agreed goals ■ agreed actions and the name of person or service responsible for each action ■ timeframe for attaining goals and actions ■ planned review date ■ consumer acknowledgement of the care plan (signed or verbal) ■ actual review date.
	<p>The service provider has a system and criteria to identify consumers who would benefit from having a Care Coordination Plan (<i>refer to step 1 in 4.8.1</i>)</p>
	<p>The service provider and consumer nominate a key worker for consumers who require a Care Coordination Plan</p>
	<p>The key worker role is defined in position descriptions of the service provider</p>

9 <http://www.respectingpatientchoices.org.au/general-public-faqs/what-is-an-advance-care-plan.html>

Consumer Outcomes	Good Practice Indicators
	The service provider and key worker liaise with the consumer and other care participants, including GP's, to develop, monitor and review the care plan
	Staff involved in Care Planning have access to training in goal-setting and case-conferencing
	The service provider has communication systems in place for referral, feedback and case-conferencing
	The service provider has a process and system for recall and reminder, monitoring and reviewing consumer needs, and updating care plans when consumer needs change or actions are completed
	The service provider has a process for planning and communicating exit or discharge and re-entry, if required

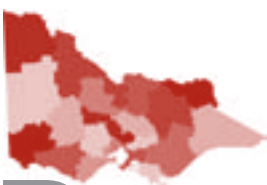


4.8 How to develop a Care Coordination Plan

4.8.1 Steps to develop a care plan

1.	<p>Identify the need for Care Coordination Plan, for example a consumer who:</p> <ul style="list-style-type: none"> ■ has chronic, terminal or complex conditions ■ has multiple needs ■ requires multiple services or multiple service providers ■ would benefit from a coordinated Care Coordination Plan ■ requests a Care Coordination Plan.
2.	<p>Check if an inter-agency care plan, case management plan, team care arrangement, mental health plan, disability support plan or Care Coordination Plan exists. Avoid duplication, decide if there is a need to add to the existing plan or develop a Care Coordination Plan. The Care Coordination plan should not repeat the content of other plans, but focus on priority goals that require a coordinated approach.</p>
3.	<p>Explain to consumer what a Care Coordination Plan is and why you think they would benefit. This involves listening to their issues, respecting choice and discussing the advantages of having a Care Coordination Plan. During this discussion, identify a reason for the Care Coordination Plan that will be recorded in the document. This may include providing written information such as: <i>Care Planning Information for Consumers</i> http://www.health.vic.gov.au/pcps/coordination/care_initiatives.htm</p>
4.	<p>Obtain consumer consent to the Care Planning process. Once the person has understood the reason for the plan, they can consent to the process.</p>
5.	<p>Identify the people who need to be involved in the Care Planning process. Ask the consumer: <i>Who are the people who support you at the moment?</i> This may include family members, specialists, GP, allied health professionals, or counsellors. Explain the role of the key worker to the consumer. Identify the preferred key worker or care plan coordinator from the consumer's perspective. The consumer may also need an advocate, interpreter, carer or family member involved in Care Planning. Where the consumer is not able, or chooses not to be involved in the Care Planning discussions, a substitute decision-maker may participate on their behalf.</p>
6.	<p>Obtain and record consumer consent to share information with participants involved in the planning process. Record consent to share information with the participants identified using <i>Consumer Consent to Share Information</i> form. Consumers have the right to specify which participants they want their information shared with and who they want involved in the Care Planning. This is recorded on the <i>Consumer Consent to Share Information</i> form recording <i>Care Planning</i> or <i>care coordination</i> in the purpose column.</p> <p><i>Examples:</i></p> <ul style="list-style-type: none"> ■ a personal carer, neighbour, son or daughter may be an important participant in care and be listed on the plan with their contact details and role. They may not be involved in the discussion but may receive a copy of the plan ■ a GP may be listed as a participant in care and receive a copy of the plan but may not be involved directly in the development of the plan.

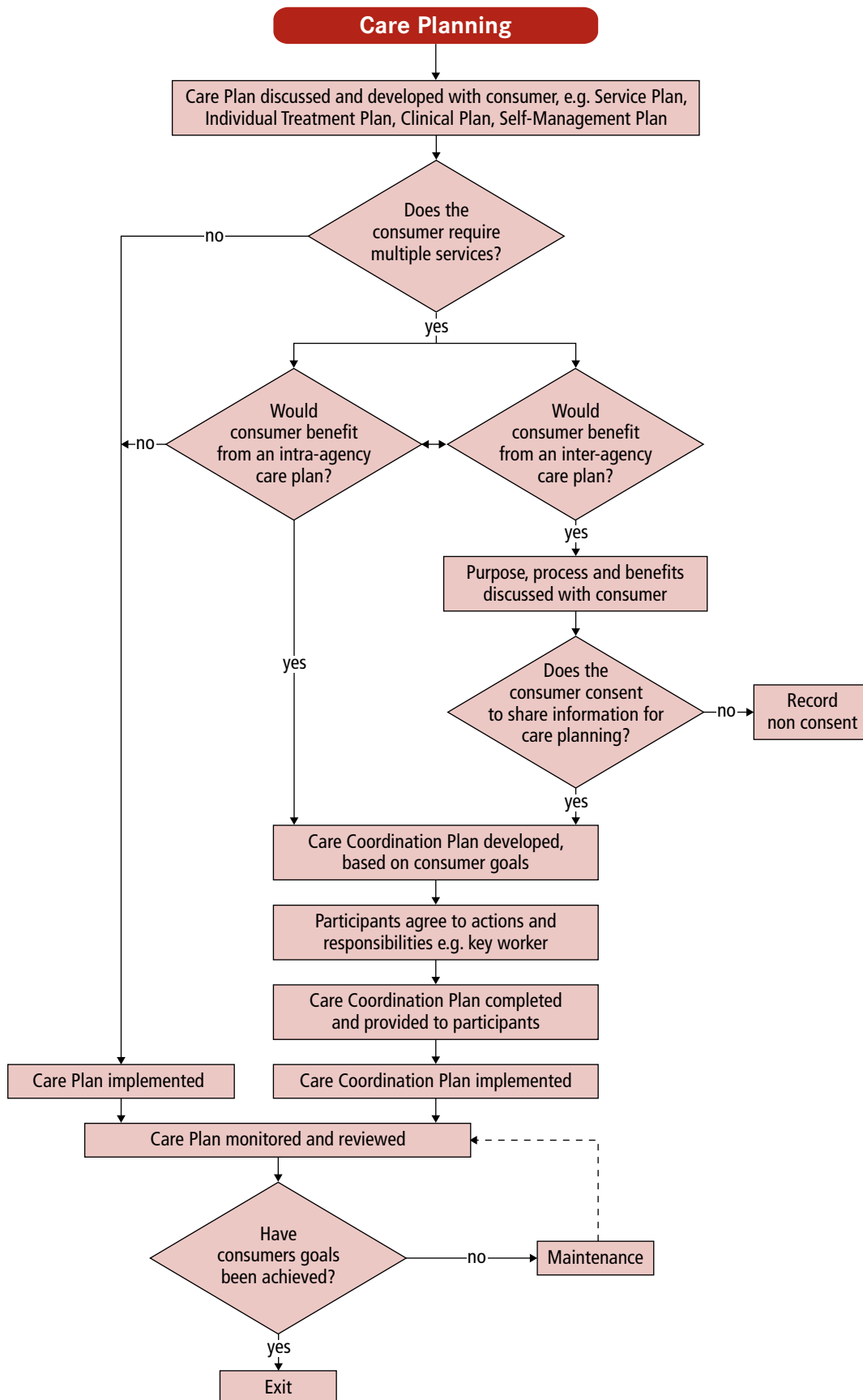
7.	<p>Discuss with participants a time and method of participation in planning or case conference. Communication with participants may include: discussing the reason for the plan, clarifying their role, locating relevant assessments and information to include in the Care Coordination Plan, and setting a time, place and method for the discussion. When engaging a GP in a case conference, allow sufficient preparation and timing. Divisions of general practice can provide guidance in this area.</p> <p><i>Example:</i></p> <ul style="list-style-type: none"> ■ Care Planning discussions may occur in the service setting, at the consumer's home, at a case conference/teleconference, with participants at their computers, or in stages over time.
8.	<p>At the planning session, agree on the key worker or care plan coordinator or facilitator. Consider the service provider, program guidelines, position descriptions, consumer preference, the person who has regular contact or a rapport with the consumer, and the skills and capacity of the worker.</p>
9.	<p>Record all participants in care, their role and contact details and who is involved in planning. This can be useful in future as a contact list for the consumer and other participants.</p>
10.	<p>Discuss and develop the plan together. Identify key issues, agree goals (specific, measurable, achievable and realistic) and the actions planned to achieve the goal, responsible individuals/ services for each action, and target date for each goal.</p>
11.	<p>Agree on the proposed date to review plan and record it. The key worker is responsible for ensuring the Care Coordination Plan is reviewed by the nominated date, or earlier if necessary. The timeframe for review will depend on the consumer's situation, goals and types of services involved. For example, a post acute Care Coordination Plan may be reviewed after two weeks, while a plan for someone with multiple ongoing issues may be reviewed after six months.</p>
12.	<p>Ensure the consumer understands and agrees to the plan. Record this on the plan and obtain a signature, where available. The signature of the consumer is important in some sectors but not all, so this practice will vary according to the service and program area.</p>
13.	<p>Record on the plan the participants who are to receive a copy and provide them with one. Consumers have the right to choose which participants have a copy of the Care Coordination Plan.</p>
14.	<p>Participants in care provide feedback to the key worker. Changes, or progress on planned actions, must be sent to the key worker or care plan coordinator to be recorded on the <i>Review of Care Coordination Plan</i>.</p>
15.	<p>The key worker or care plan coordinator is responsible for facilitating a review of the care plan via a meeting, case conference or by contacting individual participants. A decision follows as to whether a new Care Coordination Plan should be developed.</p>
16.	<p>Use the <i>Review of Care Coordination Plan</i> template to record the progress of each goal. A copy of the completed Review of Care Plan will then be provided to the selected participants.</p>



4.8.2 Consumer Pathway through Care Planning

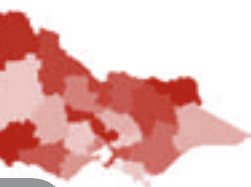
The consumer pathway through Care Planning is set out in *figure 7*.

Figure 7: Consumer Pathway through Care Planning



4.8.3 Tools and resources—Care Planning

- Service provider or program Care Planning Guidelines and tools
- *Service Coordination Tool Templates (SCTT): Care Coordination Plan*
- *SCTT 2009 User Guide*
- Service provider policies: Eligibility criteria, priority access
- The Human Services Directory and other relevant service directories
- MBS care planning items
- Integrated Health Promotion Tool Kit
- Training resources—refer *section 6*.



Section 5

Referral Practice in Victoria

5.1 What is Referral?

Referral is the transmission, with consent, of a consumer's personal and/or health information from one service provider to another for the purpose of further needs identification, assessment, care or treatment.

Referrals may be made by a staff member involved in Initial Contact, an Initial Needs Identification service provider, or a service provider seeking further assessment and treatment for a consumer. As consumer needs change, further referrals may be required.

The *Service Coordination Tool Templates (SCTT)* facilitate Service Coordination, through the standardised collection and recording of Initial Contact, Initial Needs Identification, Care Planning and referral information. The SCTT is designed to improve communication, information sharing, the recording of information generated by screening and assessment and the quality of referrals and feedback between service providers. This assists service providers to share relevant information to support better outcomes for consumers. Service providers should complete relevant sections of the SCTT in accordance with the DHS *Service Coordination Tool Template Guidelines: SCTT 2009 User Guide*.

Core templates are the Confidential Referral Cover Sheet, Consumer Information template and Summary and Referral Information templates. They are used to send a referral after consumer consent has been recorded on the Consumer Consent to Share Information template. The consent form does not have to be sent to the service receiving the referral, unless they request it.

In cases where a receiving service requires information in addition to that contained in SCTT, additional information can be attached to the SCTT referral as required.

Optional and supplementary templates can be sent with the referral, depending on consumer need, service provider business rules, local protocols and program specific requirements (refer to relevant program guidelines).

A consumer in crisis will require immediate referral, which can be followed by a more detailed referral using the SCTT.

Service providers collect consumer information for many reasons—to identify needs, make good quality assessments and referrals, to provide a service, meet program or data collection requirements and for effective Care Planning. Service providers should not collect information that is not relevant to their practice, such as collecting another service provider's minimum data set requirements.

5.2 Where does referral fit into Service Coordination?

Referral may occur at, or result from, any stage of Service Coordination. A consumer may be referred for:

- information about services available, health promotion and chronic disease management
- Health Promotion activities, including groups and preventative support
- Initial Needs Identification
- Assessment
- service provision or treatment
- development of a Care Coordination Plan
- re-assessment, monitoring and review.

Self-referral

Self-referral is a consumer's choice to contact another service provider on their own behalf. Service providers should support this choice by providing:

- information, such as the service provider contact details
- advice and decision-making support
- a copy of completed SCTT (if appropriate).

Assisted referral

Assisted referral is where service providers make a referral on behalf of the consumer, using the SCTT. Consumer consent to share their information with other services is required.

Active or crisis referral

In some situations a service provider may make an immediate referral by speaking directly to the receiving service provider. Active referral is needed when a consumer is extremely anxious or in crisis (for example: attempted suicide, serious self-harm, behaviour endangering self or others, threats of violence) and is followed by a more detailed referral using the SCTT.

A referral can be made without consumer consent to statutory services, such as Child Protection, Mental Health, or where an immediate referral is in the best interests of the consumer.

If the consumer does **not have the capacity** to consent (they are unable to understand the nature of what they are consenting to, or the consequences), consent must be sought from the consumer's authorised representative (see definitions in *section 7*). If it is not reasonably practical to obtain consent from an authorised representative or the consumer does not have an authorised representative, health information can still be shared in the circumstances set out under *Health Principle 2.2 of the Health Records Act 2001*. This includes the sharing of information by a health service provider and that is reasonably necessary for the provision of a health service, or where there is a statutory requirement. For further circumstances for disclosure, see www.health.vic.gov.au/hsc/infosheets/disclosure.pdf

If the consumer **refuses consent** to share information, a referral can still proceed. However, the receiving service provider will need to obtain the information they require from the consumer.

5.3 Which staff are involved in referral?

All service providers involved in Service Coordination or service delivery will make or receive referrals at some time. Therefore, they must be familiar with their service provider practice and the practice standards that govern how referrals can occur.

There are several key requirements for all service providers making referrals:

- make referrals in accordance with service provider guidelines, policies, procedures and work instructions
- adhere to Victoria's Service Coordination Practice Standards and prioritise referrals as *low, routine* or *urgent*
- use the Service Coordination Tool Templates (refer *SCTT 2009 User Guide*) to share consumer information when making referrals
- meet privacy and consent requirements
- utilise local or regional systems, such as using a secure e-Referral system.

5.4 Referral to and from general practice

Health and community service providers should have in place policies and procedures to support systematic referral and feedback to general practitioners and other services. In addition, service providers are expected to acknowledge referrals received and to provide feedback to referring services, including GPs, about referral outcomes.

Referral to a general practitioner

Referrals to a GP should be completed using the Service Coordination Tool Templates (SCTT) as with service coordination referral practice standards.

Feedback to a general practitioner

Feedback is a critical component of the referral process. GPs value feedback, and are particularly interested in receiving information they need to act on or be aware of, when they next see the consumer. Agency policies and procedures should guide communication with general practice, including acknowledgement of referrals received. DHS has a fact sheet summarising the practices and principles of good general practice feedback and communication. Feedback to a GP must include the consumer's Medicare number and contain only information that is relevant and for the GP to action. Further information can be found at: <http://www.health.vic.gov.au/communityhealth/gps/index.htm>

Referral from a general practitioner

Victorian Statewide Referral Form

The Victorian Statewide Referral Form (VSRF) is a simple electronic template for referral from general practice. Its purpose is to assist general practice provide a standardised, quality referral from general practice to health and community services.

The Department of Human Services and General Practice Victoria promotes and supports general practice to use the VSRF instead of the multitude of service specific referral forms. Some local divisions of general practice provide on-the-ground support to help general practice integrate the VSRF into their practice. The VSRF has been incorporated in most clinical software applications used by general practice.

Health and community services may encourage general practice to use the VSRF but should not refuse referrals in other formats. The VSRF includes referrer and referee information, consumer/patient information, clinical summary including medications, free text fields for additional information.

The VSRF+ is used in addition to the VSRF for referrals to Maternity, Urology and Osteoarthritis Hip and Knee Specialist Clinics. These clinics are in high demand and the additional data facilitates timely access to specialist services.

5.5 What is expected from service providers making and receiving referrals?

This section sets out Victoria's Practice Standards for referral.

Process Objectives—Referral

The referral process aims to:

- assist consumers in a seamless and timely manner, by streamlining access to appropriate services through self-referral or assisted referral
- empower consumers to participate in decisions about their care
- respect a consumer's rights and privacy
- facilitate choice and understanding
- enable referrals to be conducted efficiently and effectively
- minimise risk and meet duty-of-care requirements.

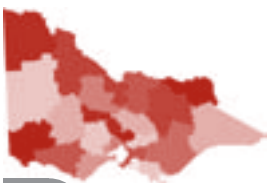
Service providers will:

- work in partnership
- take responsibility for agreed roles and tasks in a timely manner
- meet moral, ethical and legal obligations
- refer consumers to the right service, at the right time, and right place
- aim to meet a consumer's needs and goals, in respect to their quality-of-life
- operate in accordance with consent gained
- communicate statutory and duty-of-care arrangements
- operate within a quality and continuous improvement framework.

The *Service Coordination Tool Template 2009 User Guide* has the following priorities for processing incoming referrals:

- **Low** means *hold-over during peak demand*
- **Routine** means *attend in date order*. This may include the consumer being placed on a waiting list
- **Urgent** means the referral *cannot* wait. It is good practice to contact a service provider prior to sending an urgent referral, to ensure the referral can be handled in a timely manner.

The Good Practice Indicators set-out the expected response times for sending and actioning referrals. The phrase *within no more than* is used because many services and program areas will send and action referrals within shorter timeframes.



Consumer Outcomes and Good Practice Indicators—Referral

Consumer Outcomes	Good Practice Indicators
<p>Consumers are referred at the right time, to the right service, to maximise health and wellbeing outcomes and quality-of-life</p> <p>Consumers are involved in decision-making about their care and referrals.</p>	<p>The service provider making a referral explains referral options and processes to the consumer. This may involve:</p> <ul style="list-style-type: none"> ■ assisting the consumer to identify their issues and define their needs ■ practice that is sensitive to cultural, communication and cognitive needs ■ sourcing information from the Human Services Directory and/or other relevant service directories, or calling the service/s directly ■ explaining waiting times and service limitations ■ discussing the pros and cons of self-referral ■ offering to make the referral on their behalf (particularly if the consumer finds their options confusing, distressing or frustrating) ■ facilitating referrals and/or assisting with navigation and negotiation of the service system when appropriate ■ explaining the use of information for referral and explaining referral options providing the consumer with information about their rights, including the option of sharing all, or some, information ■ assisting the consumer to make an informed choice. <p>The service provider sending a referral is expected to:</p> <ul style="list-style-type: none"> ■ send urgent referrals within no-more-than 1 working day of obtaining consumer consent ■ send low or routine referrals within no-more-than 7 working days of obtaining consumer consent ■ send referral information using the SCTT ■ make immediate referrals (for example, over the phone when a consumer is in crisis), and follow this up with a more detailed referral using the SCTT. <p>The service provider supports the consumer to make a self-referral, if they choose to do so, and may support the consumer, by providing:</p> <ul style="list-style-type: none"> ■ information, such as service provider contact details ■ advice and decision-making support ■ a copy of completed SCTT, if appropriate. <p>The service provider making a referral:</p> <ul style="list-style-type: none"> ■ offers the consumer a copy of the <i>Your Information—it's Private</i> brochure or relevant service provider information, and checks the consumer has understood it ■ completes the relevant sections of the SCTT ■ makes an assessment of risks faced by the consumer and/or staff ■ prioritises the referral as low, routine or urgent ■ sends referrals in accordance with privacy requirements ■ transmits referrals using a secure e-referral system, or through secure fax or post ■ contacts the service provider/s receiving the referral, if appropriate, to prioritise the referral, provide additional consumer information or discuss Assessment, Care Planning or service delivery options ■ may make an immediate referral over the telephone when a consumer is in crisis and follow with a more detailed referral using the SCTT.

Consumer Outcomes

Good Practice Indicators

The service provider **making** a referral retains responsibility to the consumer until the referral acknowledgement is received. In accordance with their procedures, the referring service provider monitors the consumer's status until a response to the referral is received and accepted. At this point, both service providers should agree who is responsible for monitoring the consumer if they are placed on a waiting list. If the receiving service provider does not respond within agreed timelines, the sending service provider must check to ensure the referral has been received.

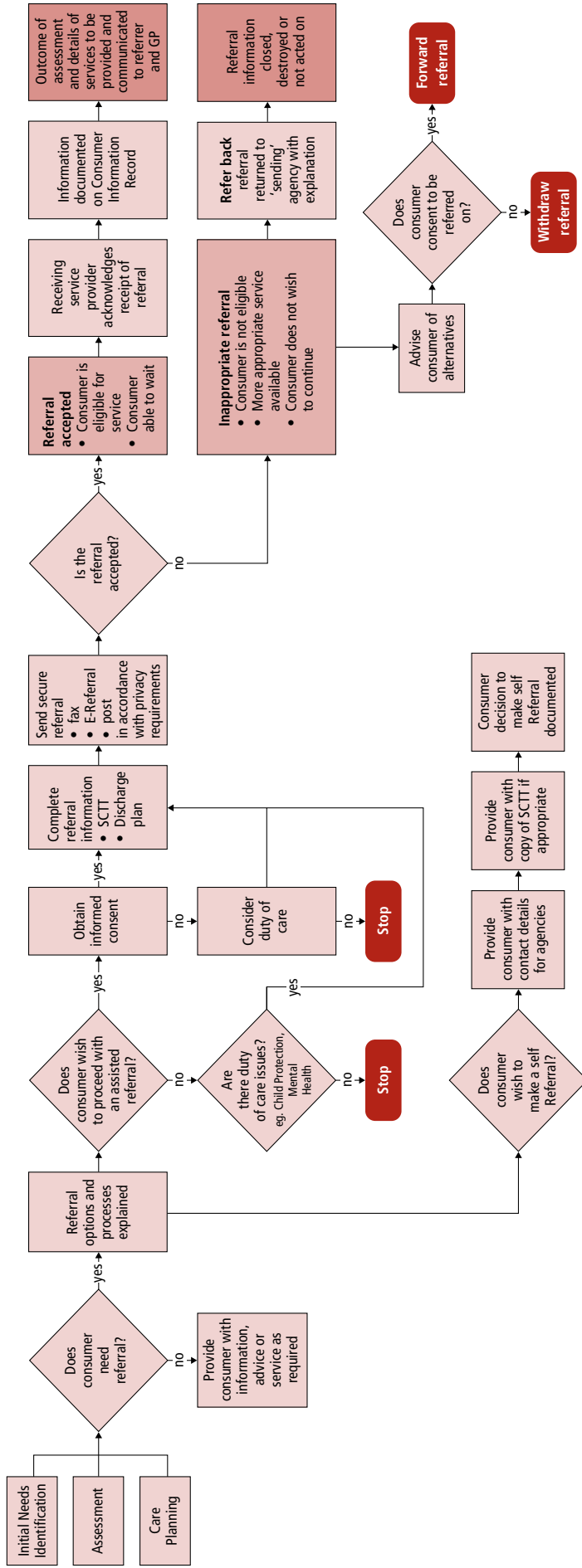
The service provider **receiving** a referral (for example, as a result of Initial Needs Identification or Assessment) is expected to:

- transmit acknowledgement of the referral, using the [SCTT Confidential Referral Cover Sheet](#), Referral Acknowledgement section, to the initiating service, stating that the referral has been received and the estimated date of consumer Assessment, or the reason why the referral is not proceeding
- **urgent** referrals should be acknowledged within no-more-than **2 working days** of receipt
- **low or routine** referrals should be acknowledged within no more than **7 working days** of receipt
- referral outcome information should be transmitted to the initiating service provider within no more than **14 working days** of the consumer being assessed.

5.6 Consumer Pathway through referral

The consumer pathway through referral is set-out in figure 8.

Figure 8: Consumer Pathway through referral



5.7 Tools and resources—referral

- *Service Coordination Tool Templates (SCTT):*
 - *Confidential Referral Cover sheet*
 - *Consumer Information template*
 - *Summary and referral template*
 - *Supplementary and optional templates (as appropriate)*
- *SCTT 2009 User Guide*
- Secure e-referral systems
- Patient and client management system software applications
- Priority of access policy and criteria
- Human Services Directory, and other relevant state/local service directories
- Training resources—refer *section 6*.

Section 6

Resources and tools to support Service Coordination

6.1 How do the Service Coordination Tool Templates support Service Coordination?

The **Service Coordination Tool Templates (SCTT)** is a suite of templates developed to facilitate and support Service Coordination. They support the standardised collection and recording of Initial Contact, Initial Needs Identification, referral and Care Planning information. Using the SCTT can improve communication, the recording of information from screening and assessment processes, information sharing, and the quality of referrals and feedback between service providers. This can assist services share relevant information and provide better outcomes for consumers.

Many program areas have integrated the SCTT into their practice guidelines and reporting mechanisms. For program specific requirements about use of the SCTT, refer to program specific guidelines. The templates are not designed as a minimum data set (MDS) for reporting or as program-specific collection tools.

The SCTT is designed to meet the needs of the many different service types and consumer groups that implement Service Coordination. To meet the needs of new and existing users, a continuous improvement approach has been adopted to update the SCTT: www.health.vic.gov.au/pcps/coordination

Use of the Service Coordination Tool Templates

Information is collected during interaction with consumers. This information forms part of the consumer registration process, provides documentation of consumer needs, informs Assessment, Care Planning and review processes, and may be used for referral purposes. The SCTT provide a standardised way to record this information.

The SCTT are embedded in most client information management software applications used by health and community services. The SCTT data items on a software user interface will not necessarily appear the same on-screen as in the templates. However, the soft or hard copy output will be the same as the templates.

The SCTT comprise a combination of core, optional and supplementary templates. Service providers who implement Service Coordination use the SCTT when sending referrals.

Core templates are the Confidential Referral Cover Sheet, Consumer Information template and Summary and Referral Information templates. They are used to send a referral *after* consumer consent has been recorded on the Consumer Consent to Share Information template. The consent form does not have to be sent to the service receiving the referral, unless they request it. In cases where a receiving service requires information in addition to that contained in the SCTT, additional information can be attached to the SCTT referral as required.

Optional templates record further information on areas relevant to the consumer's circumstances and presenting needs. These profiles are designed to record screening level information. The templates can be used as part of the Initial Needs Identification process to inform Assessment and Care Planning. They should not be used as Assessment tools.

Service providers should use their professional judgement when using the templates. Not all optional templates or profiles will be relevant for every consumer. Depending on available information and relevance to consumer needs, some items within a profile may not be required and it may be appropriate to partially complete templates.

Supplementary templates are designed to be used in particular circumstances by service providers from a specific professional background and with specific skills (see each supplementary template).

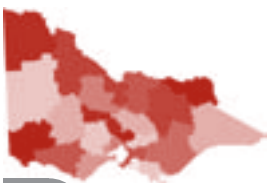
Optional and supplementary templates can be sent with the referral, depending on consumer need, service provider business rules, local protocols and program specific requirements (refer to relevant program guidelines).

Service Coordination Tool Templates

Core templates	Description
	The templates used to make a referral to another service. These templates contain the minimum information required for an effective referral, and for the receiving service to act on the referral
Confidential Referral Cover Sheet	Used when sending or receiving a referral
Consumer Information	Contains: demographic information, contact details, GP details, pension/entitlements and insurance status
Summary and Referral Information	Presenting issues, reason for referral, alerts, current services, referral action plan
Consumer Consent to Share Information	Records consumer consent for the service provider to share information. ¹⁰ It is a requirement to obtain consent to share information, if the consumer has the capacity. The template should be sent to the service receiving the referral, if they request it

Optional templates	Description
	These templates record screening-level information in areas relevant to the consumer's circumstances and presenting needs. The templates can be used as part of the Initial Needs Identification process to inform the need for Assessment, and to inform Care Planning. Service providers should use their professional judgement in deciding which templates and which items are relevant for each consumer.
Profile: Need for Assistance	functional needs such as domestic, personal, mobility, transport, cognition, behaviour and communication
Profile: Living and Caring Arrangements	living arrangements, accommodation, employment or school status, financial and legal profile, consumer's carer information
Profile: Health Behaviours	nutritional risk, smoking, oral health, alcohol use, gambling, physical activity and physical fitness
Profile: Health Conditions	overall health, pain, chronic conditions, oral health, vision, hearing, falls, health conditions, medications
Profile: Psychosocial	personal and social support, mental health and wellbeing
Profile: Family and Social Network (released July 2009)	family network, including: children, young people, adults, parents, guardians, primary carer, grandparents, extended family members, friends, and significant others
Care Coordination Plan (released July 2009)	records a Coordinated Care Plan for consumers with complex and/or multiple needs

Supplementary templates	Description
Functional Assessment Summary	records and shares information following an assessment of the consumer's functional abilities and need for assistance
Palliative Care Information (released July 2009)	extra information required for palliative care referrals



¹⁰ The associated one-page brochure *Your information—it's private*, can also be provided to the consumer

Use of the Victorian Statewide Referral Form

The **Victorian Statewide Referral Form (VSRF)** is a simple electronic referral template for general practice use. It assists general practice to provide standardised, quality referrals to health and community services.

The VSRF+ has been developed for use as an addition to the VSRF when referring to Maternity, Urology, and Osteoarthritis Hip and Knee Specialist Clinics.

Victorian Statewide Referral Form

Victorian Statewide Referral Form

Victorian Statewide Referral Form (VSRF)

used by general practitioners (GPs) to refer to other health and human services providers. It is based on the SCTT and includes items relevant to GPs. The template can be generated from information usually recorded in common GP software

6.2 Links between the Service Coordination elements and the Service Coordination Tool Templates

The Consumer Information template may be used at Initial Contact. In some services, staff begin to collect and document Consumer Information at Initial Contact. Information such as Consumer Details and Services Requested is written on the template or entered directly into the service provider's client information system.

The information required to complete the Consumer Information template is usually collected during the Initial Needs Identification phase. In some services, such as Community Health Services, all the information may not be collected until a consumer presents for their first appointment. In hospitals, Initial Contact information is likely to be collected by a triage nurse or on admission to hospital.

How does Initial Needs Identification link with the Service Coordination Tool Templates?

Initial Needs Identification involves a dialogue with the consumer. The SCTT is used to record relevant aspects of the discussion and should not be used as a checklist.

Initial Needs Identification is supported by the following Service Coordination Tool Templates:

- Core Templates
 - Consumer Information template
 - Consumer Consent to Share Information template
 - Summary and Referral Information template.
- Optional Profiles:
 - Living and Caring Arrangements template
 - Need for Assistance Profile template
 - Health Conditions template
 - Health Behaviours template
 - Psychosocial template
 - Family and Social Network template.

In some services, information is collected and documented straight onto the SCTT by staff responsible for Initial Needs Identification activities. In other services, information is collected and entered directly into a client information system, from which a SCTT can be produced and sent with a referral.

How does Assessment link with the Service Coordination Tool Templates?

Typically, each service provider will have their own tools for assessment, based on relevant program guidelines, requirements and templates. The SCTT is not an assessment tool and should be used in conjunction with service provider assessment tools. Each service should be actively encouraged to consider how the SCTT fits with their assessment tools, to avoid duplication.

How does Care Planning link with the Service Coordination Tool Templates?

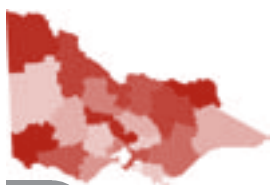
The Care Coordination Plan template is part of the SCTT. The SCTT Care Coordination Plan has been designed to support Care Planning within and across services for consumers with complex or multiple needs. The *SCTT 2009 User Guide* provides a guide to completing the Care Coordination Plan template.

How does referral and referral feedback link with the Service Coordination Tool Templates?

All referrals, whether made by secure, encrypted e-referral systems, printed, faxed or mailed, are to be sent in accordance with privacy requirements. Referral is supported by the SCTT.

SCTT for referral	Notes
Confidential Referral Cover Sheet. This can be used as: <ul style="list-style-type: none"> ■ a cover sheet to accompany the SCTT, when making a faxed referral ■ a tool for acknowledging receipt of a referral ■ a communication tool for informing referring services or GPs about the outcome/s of a referral 	It is expected that service providers: <ul style="list-style-type: none"> ■ faxing referrals will complete the relevant sections of the Confidential Referral Cover Sheet ■ receiving a faxed referral will complete the Referral Acknowledgement section of the Confidential Referral Cover Sheet and return to referrer. Service providers using e-referral systems will not need to use the Confidential Referral Cover Sheet, as the data requirements are built into electronic referral systems
Summary and Referral Information template	This template provides a summary of the outcomes of the Initial Needs Identification process and lists referrals
Optional templates (as relevant)	If optional templates have been completed they can be sent with a referral
Supplementary templates (as relevant)	<ul style="list-style-type: none"> ■ Functional Assessment Summary can be used to transfer Assessment level information, after a face-to-face assessment of the consumer's functional status. If this template is used for referral there is no need to also send the Functional Profile ■ Palliative Care Information template can be used to accompany a referral to provide more information relevant to Palliative Care.

Further information about how to use the SCTT can be found in *Service Coordination Tool Template Guidelines: SCTT 2009 User Guide* at: www.health.vic.gov.au/pcps/coordination

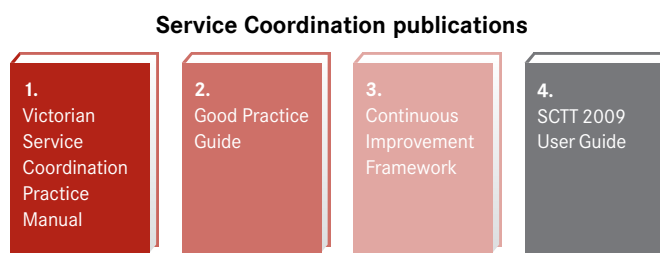


6.3 Publications to support Service Coordination

A range of resources and tools have been developed to support Service Coordination.

Service Coordination practice is supported by a set of four publications:

1. *Victorian Service Coordination Practice Manual*
2. *Good Practice Guide—A resource of the Victorian Service Coordination Practice Manual*
3. *Continuous Improvement Framework—A resource of the Victorian Service Coordination Practice Manual*
4. *Service Coordination Tool Templates (SCTT) 2009 User Guide*



www.health.vic.gov.au/pcps/coordination

These publications are available at: www.health.vic.gov.au/pcps/coordination

Service Coordination is supported at a regional or catchment level by:

- Primary Care Partnerships
- locally agreed Service Coordination Protocols that build on and enhance the *Victorian Service Coordination Practice Manual*
- agreed referral pathways, including the use of secure e-referral systems
- inter-service provider networks and service provider groups.

Service Coordination is supported at a service provider level by:

- service provider specific policies, procedures and work instructions
- resources, such as decision-making tools, forms, resource folders and checklists
- information technology and telecommunications
- consumer management software applications
- information management processes and procedures related to service access, consumer registration and consumer records
- service directories, such as the Human Service Directory.

Additional information resources

- Service access models: a way forward (a resource guide for Community Health)
www.health.vic.gov.au/communityhealth/publications/chs_guide
- Guide to generating the Victorian Statewide Referral Form (VSRF)
www.gpv.org.au/content.asp?cid=11,137&t=VSRF
- Working with General Practice: Department of Human Service Resource Guide
www.health.vic.gov.au/communityhealth/gps/position_statement.htm
- GP Engagement in Integrated Chronic Disease Management—A resource for Primary Care Partnerships
www.health.vic.gov.au/communityhealth/downloads/gp_engagement_icdm.pdf
- Medicare Benefits Schedule Project
www.health.vic.gov.au/communityhealth/gps/mbs/index.htm

Privacy information resources

- Service coordination privacy resources: www.health.vic.gov.au/pcps/coordination
- DHS privacy resources: www.health.vic.gov.au/pcps/coordination
- Health Records Act 2001: www.health.vic.gov.au/healthrecords
- Information Privacy Act 2000
- Refusal of Treatment Certificate <http://www.publicadvocate.vic.gov.au/Publications/Medical-consent/Refusal-of-Medical-Treatment.html>

Policy

- Better Access to Services: A policy and operational framework, Aged Care and Mental Health Division, June 2001: www.health.vic.gov.au/pcps/coordination
- Primary Care Partnerships overview: www.health.vic.gov.au/pcps/coordination
- Service coordination overview: www.health.vic.gov.au/pcps/coordination
- Working with General Practice: Department of Human Service Position Statement www.health.vic.gov.au/communityhealth/gps/position_statement.htm

6.4 Secure e-referral to support Service Coordination

Secure e-Referral systems support Service Coordination by:

- encouraging good communication between services, providing an opportunity to easily send a referral, acknowledge the referral, and inform on referral outcomes
- reducing duplication of information, and improving the quality and consistency of information exchanged
- enhancing and improving the security of consumer information, privacy and confidentiality.

Client information management software application

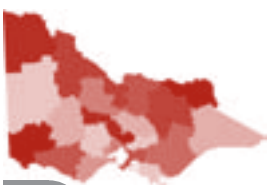
- HealthSmart—Victorian health information communication strategy, in particular the patient and client information management system which includes the SCTT: www.health.vic.gov.au/healthsmart/pcms/patmen.htm
- A range of other agency client information management systems also includes the SCTT (see your software vendor for more information)
- A range of general practice clinical software includes the VSRF

6.5 Electronic Service Directories

The statewide Human Services Directory comprises comprehensive and up-to-date service information to assist referral and access to services. Consumers, carers and service providers may use the Human Services Directory (HSD) to search for health and community services such as: GPs, health service providers, Alcohol and Drug Services, Community Health, Carer Services, and Psychiatric Disability Rehabilitation Support Services, anywhere in the state of Victoria. Service providers are expected to maintain and update their service information on the HSD, in accordance with the HSD Conditions of Use.

Electronic service directories

- Human Services Directory: www.humanservicesdirectory.vic.gov.au
- Better Health Channel: www.betterhealth.vic.gov.au



6.6 Service Coordination Training

The Department of Human Services has developed two training packages to support the implementation of Service Coordination across Victoria. They are:

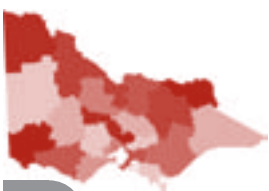
- an on-line, self-paced training module, *Service Coordination—What? Why? How?* available at: www.health.vic.gov.au/pcps/coordination
- Service Coordination Orientation Training Kit available at: www.health.vic.gov.au/pcps/coordination

Service Coordination—What? Why? How? is a self-paced interactive training package for service providers involved in Service Coordination activities. The package comprises five interactive learning modules, which can be tailored to the roles and responsibilities of staff involved in Service Coordination. The package has been designed to be incorporated in the service provider's induction program, and provides learners with:

- an understanding of the policy context, objectives, principles and practical approaches of Service Coordination in Victoria
- an awareness of how Service Coordination enhances service capacity to respond to consumer and carer needs
- an understanding of the benefits of Service Coordination
- an overview of the elements of Service Coordination, including Initial Contact, Initial Needs Identification, Assessment, and Care Planning
- an overview of how referral fits within Service Coordination
- an understanding of the resources available to support Service Coordination, including the SCTT
- a general understanding of Practices, Processes, Protocols and Systems (PPPS) and their role in guiding service provider practice.

The *Service Coordination Orientation Training Kit (2002)* has been developed as an orientation to Service Coordination. Key objectives of the training are for participants to:

- develop an understanding of the policy context, principles and practical approaches of a Service Coordination system
- develop an understanding of how Service Coordination enhances service capacity to respond to consumer and carer needs
- understand the elements of Service Coordination, and the SCTT and Guidelines that support these
- promote the capacity of reflective service providers who may apply their knowledge within any community, organisational or cultural context
- maximise learning opportunities, particularly through experiential learning
- build a sustainable skill-base, and increase local capacity for service providers within a local PCP to deliver courses that ensure relevance for participants.



Section 7

Terminology and Acknowledgments

7.1 Terminology

Service Coordination embraces a range of government-funded services, program areas and practitioners including nurses, allied health professionals, case managers, counsellors, welfare workers, community care workers, disability workers, key contact workers, care coordinators, and so forth. In addition, general practitioners and Divisions of general practice play an important part in Service Coordination and are partners in Primary Care Partnerships.

The terminology used by the various program areas and service providers differs significantly. For example the terms *consumer*, *client* and *patient* can be used to describe an individual receiving care concurrently from a general practitioner, alcohol and drug counsellor, social worker, podiatrist and community care worker. For the purpose of this manual when the following terms are used, they should be interpreted as encompassing the related terms.

Abbreviations

ACAS	Aged Care Assessment Service
BATS	Better Access to Services: A Policy and Operational Framework
CCP	Care Coordination Plan
DHS	Department of Human Services
GP	General practitioner
GPV	General Practice Victoria
HACC	Home and Community Care
HARP	Hospital Admission Risk Program
HSD	Human Services Directory
INI	Initial Needs Identification
MBS	Medicare Benefits Schedule
MDS	Minimum Data Set
PCP	Primary Care Partnership
SACS	Sub-acute Ambulatory Care Services
TCA	Team Care Arrangement
SCTT	Service Coordination Tool Templates
VSRF	Victorian Statewide Referral Form

Definitions

Authorising representative	This means the consumer's guardian, or attorney under an enduring power of attorney, or agent under the Medical Treatment Act 1988, or administrator or a parent if the consumer is a child, or the 'person responsible' under the Guardianship & Administration Act 1986. For description of this see http://www.publicadvocate.vic.gov.au . The authorising representative has the legal authority to sign the consent form and make legal decisions for the consumer.
Carer (unpaid)	A person who, through family relationship or friendship, looks after a frail older person or someone with a disability or chronic illness. Carers look after these people in the community or in their own homes (DoHA, 2006).
Care Coordination Plan	A plan which documents issues and problems for a consumer, goals and actions that will be taken to achieve these goals, and identifies a key worker responsible for liaising between services. Typically developed for consumers with complex needs and multi-service involvement.
Consumer	Client, patient, child
Consumer representative	Family, guardian, legal authority, carer
Decision support tools	Tools that promote clinical care consistent with scientific evidence and client preferences (Wagner EH, Austin BT, Davis C, Hindmarsh, M, Schaefer J & Bonomi A, 2001; Improving Chronic Illness Care: Translating Evidence Into Action. Health Affairs, 20(6), p.64–78.)
Divisions of general practice	Divisions of general practice are local organisations, funded primarily by the Department of Health and Ageing to improve health outcomes for patients by encouraging GPs to work together and link with other health professionals. (<i>Working with General Practice, Department of Human Services Position Statement, DHS, 2007</i>)
General practice	General practice provides primary medical health services and may include GPs, practice managers, practice nurses and other allied health/medical specialist services.
General practitioner	General practitioner (GP), Doctor
Health Service	Health Service in accordance with the Health Records Act 2001, means: <ul style="list-style-type: none"> a) an activity performed in relation to an individual to assess, maintain or improve the individual's health or to diagnose or treat the individual's illness, injury or disability b) a disability service, palliative care service or aged care service c) the dispensing on prescription of a drug or medicinal preparation by a pharmacist.
Health Promotion	The Ottawa Charter (1986) defines health promotion as: "...the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing." World Health Organisation (1986), The Ottawa Charter for Health Promotion, Geneva.

Integrated Health Promotion (IHP)	In Victoria, the term ‘integrated health promotion’ refers to agencies and organisations from a wide range of sectors and communities in a catchment working in a collaborative manner using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues.
Inter-agency care plan	Occurs where a consumer has complex or multiple needs and requires the services of more than one agency. It ensures that the needs of a consumer are discussed with them, their carer and relevant practitioners such as their GP, in the context of possible options and subsequently worked through to an agreed strategy. Also referred to as multi-agency care plan. (Clinical Indicators in Community Health. Victorian Healthcare Association report, 2008).
Intra-agency care plan	A care plan that involves a number of services or practitioners within the same agency.
Key worker	The nominated person who works with the consumer and carer and other services to facilitate intra-agency or inter-agency Care Planning and care coordination.
Local agreements	An agreement reached by key stakeholders within a given local area. The purpose of the local agreement is to bring together key stakeholders to ensure consistent and appropriate strategies and approaches are employed to address common issues, and to minimise duplication and service gaps.
Primary Care Partnership	A Primary Care Partnership or PCP is a group of services that has formed a voluntary alliance to work together to improve health and wellbeing in their local community.
Self-management	The consumer (and family/carers as appropriate) working in partnership with their health care provider to: <ul style="list-style-type: none"> ■ know their condition and various treatment options ■ negotiate a plan of care ■ engage in activities that protect and promote health ■ monitor and manage the symptoms and signs of the condition(s) ■ manage the impact of the condition on physical functioning, emotions and interpersonal relationships.
Service provider	Community service organisation, non government organisation, local government, primary care service provider, member of Primary Care Partnership, organisation providing services to improve the health and wellbeing of consumers.
Service specific care plan	A care plan which is developed and documented using specific program or agency tools, and may be referred to as a Consumer Care Plan, an Individual Treatment Plan, a Self-management Plan, a Personal Action Plan, a Service Plan, or a GP Management Plan.
Practitioner	Health professional, registered nurse, social worker, psychologist, key contact worker, care coordinator, allied health professional, case manager, carer support coordinator, counsellor, welfare worker, community care worker, housing worker, clinician, and so forth.

7.2 Manual development

The *Victorian Service Coordination Practice Manual* (VSCPM) was initially developed in 2006 as part of the statewide Service Coordination Practice Manual project, which was an initiative of the statewide Primary Care Partnership Chairs Working Group, and funded by the Department of Human Services Primary Health Branch. It was based on:

- *Better Access to Services: A Policy and Operational Framework*
- A review of the scope and content of the 16 Service Coordination PPS manuals in use in June 2006
- Feedback from a range of regional and stakeholder consultations
- Feedback on draft materials
- Input from General Practice Victoria (GPV) and the Royal District Nursing Service (RDNS) through Working Groups which were established to support the project
- Input from a range of DHS programs via an Internal Reference Group
- Guidance from a Project Steering Committee and Project Management Group.

As part of a continual improvement and revision process, the VSCPM was further updated in 2009, to align with the release of SCTT 2009. The SCTT, VSCPM and associated resources will continue to be updated in accordance with the three-year continual improvement cycle, to reflect broad range of services participating in Service Coordination.

Governance and Steering Committee

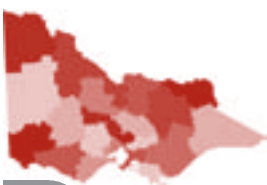
The *Victorian Service Coordination Practice Manual*, *Good Practice Guide* and the *Continuous Improvement Framework* were updated in July 2009 under the leadership of the statewide Primary Care Partnership Chairs Executive with funding from the Department of Human Services. This process coincided with the release of *SCTT 2009* and updating of the *SCTT 2009 User Guide*.

A Project Steering Committee acted as a broad consultative forum to guide the update. Governance and communication processes across related projects ensured that a coordinated, integrated approach was achieved.

The updating method included:

- Consultation by Steering Committee members with their respective constituent groups
- Input from multiple program areas from within DHS and other government departments (refer *figure 9*)
- Feedback on draft versions of the VSCPM and associated resources.

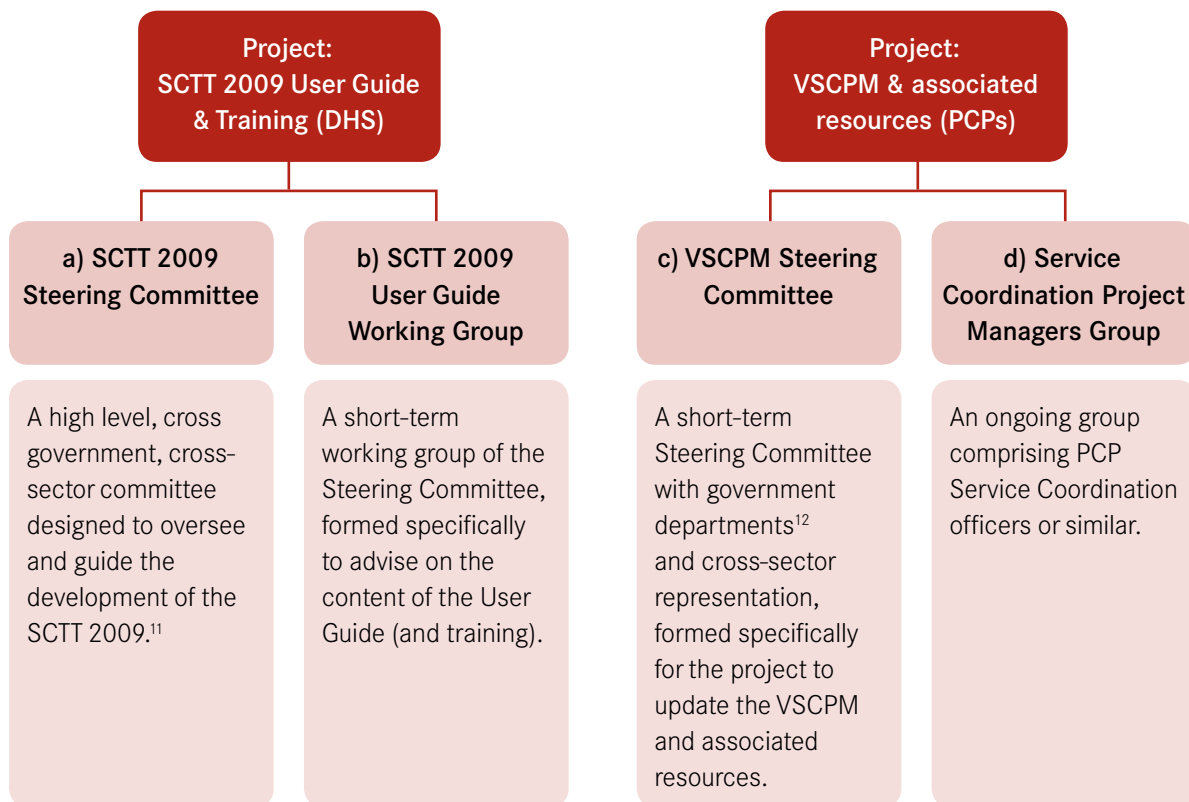
The practices and standards of the service coordination model, outlined in the 'Victorian Service Coordination Practice Manual', are consistent with the ACHS Evaluation and Quality Improvement Program (EQulP) Standards and the Quality Improvement Council.



Steering Committee Members

Name	Representing
Hazel Ingram	North West Metropolitan Primary Care Partnerships
Clare O'Reilly	Executive Officer, Statewide PCPs Chairs' Executive
Tina Beltram	Eastern Region Primary Care Partnerships
Marlene Goudie	Grampians-Pyrenees Primary Care Partnership
Pat Lovelock	Gippsland Region Primary Care Partnerships
Lyn McKay	Southern Region Primary Care Partnerships
Elizabeth Jenkins	Hume Region Primary Care Partnerships
Bronwyn Murray/Catherine Fuller	Loddon Mallee Region Primary Care Partnerships
Patricia Stannus	PCP Statewide Service Coordination Network
Sally Berger/Kerina Princi	North West Metro Primary Care Partnerships
Greg Young/Sophie Argiriou	Acute & Ambulatory Services
Megan Buick	General Practice Victoria
Shelly Lavery	DHS Service Coordination Implementation Group
Sue McIndoe/Kerry Oates/Nicole Mathieson	RDNS

Figure 9: Governance structure and communication



11 DHS Executive Project Board; IM/ICT Reference Group; Consumer and Carers Reference Group; Child and family advisory group; Carers information advisory group; Functional profile advisory group; Acute integration advisory group; Care planning advisory group; Palliative care advisory group.

12 Department of Human Services (Disability service, Mental Health and Drugs, Housing & Community Building, Child, Youth and Family, Family Violence and Sexual Assault Unit, Metro Health & Aged Care Services, Primary Health Branch, Aged Care), Department of Justice (Office of Gaming and Racing)

Your feedback is welcome

Do you have comments or feedback about this manual?

Please contribute to the next update by providing your feedback on-line via the link at www.vha.org.au/pcps

Project consultants

Ro Saxon and Linda Pandita, **HDG Consulting Group**

