

# The Demand Management Framework

## 1. What is demand management for Community Health Services?

Demand management refers to the ability of Community Health Services (CHSs) to provide high quality and timely services that are targeted at the needs of clients. Demand management supports the capacity of Community Health Services to:

1. review the effectiveness and efficiency of service provision,
2. work with clients and potential clients to improve health status and reduce current and future demands for services (health promotion and early intervention).

## 2. What is the Demand Management Framework?

The Demand Management Framework has been documented in a publication called *Towards a Demand Management Framework for Community Health Services*. This was released for consultation in August 2007.

This Framework:

- provides a consistent approach for CHSs to manage demand, that supports equity of access, accurate waiting time measurement and benchmarking;
- enables the identification of opportunities for improvement on current practice; and
- provides tools to assist CHSs to provide timely access to their services and acknowledges that the sector will increasingly participate in the development of comprehensive demand management strategies within an integrated health service system.

The Framework has 3 main elements:

- inflow
- flow through
- outflow

A comprehensive model of managing demand will address the structures and practices in place across this continuum. Available at:

<http://www.health.vic.gov.au/communityhealth/downloads/demand/elements.pdf>

It is important to note that the Priority Tools (see Questions 7 – 30) are one part of the Demand Management Framework, and whilst agencies are encouraged to use them they should also review their practices across this continuum.

## 3. Why should we implement the Demand Management Framework?

The Framework will:

- improve the consistency of practices in measuring and managing demand, providing improved data that can be used for benchmarking, service planning, and funding allocation;
- support fair and equitable access to services based on equal access across the state for equal needs, with disadvantaged people provided priority access to reduce the inequality in health status; and
- provide improved access to services for clients, by assisting CHSs to provide high quality, efficient, effective, evidence based services.

#### **4. Does the Demand Management Framework apply to all services provided by CHSs?**

The Demand Management Framework is recommended for use across **all** services provided from the CHS where practicable.

However, eligibility criteria, contractual arrangements and the requirements of Funding and Service Agreements need to be respected and may require agencies to modify the implementation across some funded programs.

#### **5. How has the feedback provided on the Demand Management consultation paper and forum been used?**

General comments about the Demand Management Framework have been reviewed and considered in a revision of the consultation paper Towards a Demand Management Framework for Community Health Services.

Feedback related to the Priority Tools has been provided to the working groups that developed them. The working groups have modified the tools where necessary.

An updated version will be available in January 2008. It will include the revised Priority Tools.

#### **6. How do we measure demand?**

In July 2006 the *Waiting time measurement within Community Health Services* Practice Guidelines were released. The Guidelines will allow waiting times to be measured consistently across the sector. Data will be collected at key points through the client journey in a CHS, with waiting time calculated from the date of Initial Needs Identification (INI) to the date of service provision.

Upgrades to computer software have delayed implementation of these guidelines. It is anticipated they will be implemented early in 2008.

## **CHS Priority Tools**

#### **7. Why prioritise?**

Prioritisation ensures that clients with high clinical needs and/or disadvantage are provided a timely assessment and access to services.

#### **8. How do the priority tools link with 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 outcomes (*Better Access to Services: A Policy and Operational Framework*, DHS, 2001).

Service Coordination includes Initial Contact, Initial Needs identification (INI), Assessment, Care planning, and Referral.

INI is an initial assessment process where the underlying issues as well as presenting issues are uncovered to the extent possible. It is not a diagnostic process but is a determination of the consumer's risk, eligibility and priority for service and a balancing of the service capacity and the consumer's needs.

There are a number of tools and resources to support this practice, such as:

- o *Victorian Service Coordination Practice Manual* (DHS, 2007)
- o The Service Coordination Tool Templates (SCTT)
- o The Human Services Directory
- o Regional and local agreed referral pathways, including the use of e-referral
- o Agency specific policies, procedures and work instructions

The CHS Priority Tools add to this suite of resources and tools to support decision-making regarding priority of access during the INI process.

A diagram that highlights the Community Health Service Priority Tools and the Consumer Pathway through Service Coordination is available at:

[http://www.health.vic.gov.au/communityhealth/downloads/demand/priority\\_tools.pdf](http://www.health.vic.gov.au/communityhealth/downloads/demand/priority_tools.pdf)

## **9. Why use these priority tools?**

The use of these tools across the state will provide several benefits:

- o Clients will be prioritised in the same way, which prevents confusion.
- o An ability to compare demand and waiting times across services. This is difficult to achieve when agencies prioritise clients differently.
- o Practice will be based on the best available evidence.

## **10. What do the priority ratings 1, 2 and 3 mean?**

These priority ratings apply to clients accessing CHSs. The priority rating is determined by the CHS when it is identified that clients require services within the CHS.

Priority 1 clients are the highest priority and should be seen as quickly as possible, they should wait the shortest period of time. Priority 3 clients have the lowest priority and will wait the longest.

Once a client receives an assessment the service should tailor their intervention to the client's needs, regardless of their level of priority when they entered the service.

It is expected that all people placed on a waiting list will receive a service.

## **11. What will the priority tools mean for those who refer to CHSs?**

The introduction of clear and consistent prioritisation of clients can assist other agencies and service providers. It is particularly useful for those services that make referrals to more than one CHS. Referring agencies can ensure that referrals include all relevant information for the CHS to determine the client's priority level. This improved communication strengthens collaboration and assists clients to receive the necessary services. Working in partnerships with other local providers, especially GPs, is a key element of best practice.

## **CHS Generic Priority Tool**

### **12. What is the Generic Priority Tool?**

The Generic Priority Tool assists CHSs to identify and to allocate a priority service to clients who belong to the following identified priority groups:

- People with an immediate risk to their safety, or the safety of others,
- Homeless people, and those at risk of homelessness,

- Refugees,
- Indigenous people,
- People with complex care needs that require a priority service to ensure a coordinated team approach.

The Generic Priority Tool is applicable to all CHS clients and, should be applied during the INI, together with the Clinical Priority Tools.

### **13. Why do we need a Generic Priority Tool?**

CHSs and the Community & Women's Health program are underpinned by a model of health that acknowledges the social determinants on health and a focus on addressing health inequalities. Therefore it is important to ensure that people who are disadvantaged have priority access to services, and that services should focus on addressing the needs of those that are most at risk of poor health due to the impact of social determinants on their health status. These clients may not be identified as a priority based on the application of the Clinical Priority Tools.

### **14. How was the Generic Priority Tool developed?**

The Generic Priority Tool was developed following a series of forums in each DHS region in late 2006 and consultation with consumers in early 2007. This process identified potential population groups requiring prioritisation. This directed a review of the literature, and further consultation with CHSs on a draft version of this tool in June 2007, prior to finalising the Generic Priority Tool.

### **15. How will the Generic Priority Tool be evaluated?**

The process for evaluating the Generic Priority Tool is still in development. Further details will be added to this page when available.

### **16. Is this Community Health Service the most appropriate to meet the person's needs?**

During the INI process it is important to consider the most appropriate service to meet the client's needs. This may include services provided within the CHS, those provided by other providers or a combination of both.

To ensure the best outcomes for the client they should be encouraged and assisted, as required, to engage with the most suitable provider. The Generic Priority Tool provides some examples of alternative services that are available, however agencies are encouraged to identify those that exist in their local area and to ensure staff are familiar with the service options that can support their clients.

### **17. Which clients should be prioritised due to complex care needs?**

The Generic Priority Tool prioritises clients who require multiple services over a prolonged period of time, and require planned, coordinated care to meet their needs. This includes people accessing CHSs in conjunction with services from other providers.

Clients with complex care needs should be identified on the basis of the complexity of their need for services, rather than the complexity of their health condition.

This will include people who:

- present with existing Inter- or Intra-agency care plans. For example, Team Care Arrangements (MBS# 723 or #727) and GP Mental Health Care Plans (MBS #2710 or #2712) from GPs, and Disability Support Plans.
- are identified through the INI process as requiring a care plan, such as people with multiple services currently in place that would benefit from a care plan, and those presenting for the first time who require multiple services.

### **18. Why doesn't the Generic Priority Tool prioritise people with low incomes?**

There is considerable evidence that indicates that level of income influences health status, and those with lower incomes have poorer health.

Due to the high number of people on low incomes that access CHS it is not possible to prioritise all people on low incomes. The Fees Policy for HACCC and Primary Health Programs has been developed as a key strategy in improving access to services for people on low incomes. Further details are available at:

[http://www.health.vic.gov.au/communityhealth/downloads/policy\\_fees\\_jul07.pdf](http://www.health.vic.gov.au/communityhealth/downloads/policy_fees_jul07.pdf)

## **Clinical Priority Tools**

### **19. What are the Clinical Priority Tools?**

The Clinical Priority Tools (previously called the Discipline Specific Priority Tools) prioritise clients on the basis of their clinical presentation. They should be used once the need for a particular discipline has been determined.

### **20. How were the Clinical Priority Tools developed?**

From October 2006, discipline working groups met to develop the Clinical Priority Tools. These working groups included representatives from CHSs, universities, and peak bodies (e.g. professional associations). The groups reviewed available evidence, consulted with colleagues, trialled draft versions of the tools and utilised their expertise during the development of the priority tools.

### **21. Why are there Clinical Priority Tools for some disciplines but not others?**

Clinical Priority tools were developed for Counselling, Dietetics, Occupational Therapy- Adult, Occupational Therapy –Paediatric, Physiotherapy – Adult, Podiatry, Speech Pathology – Paediatric. These reflect the most common disciplines in CHSs.

The Community Health Nursing (CHN) working group identified a large but appropriate disparity in practices of its discipline, as well as minimal or no waiting times for accessing services. The working group therefore decided it was not appropriate to develop a clinical priority tool.

Some agencies will have services provided by additional disciplines, and they should review the prioritisation strategies in place for these disciplines.

At this stage, DHS is not planning to facilitate the development of further priority tools.

## **22.How are the Clinical Priority Tools being evaluated?**

CHSs will be invited to participate in the trial and evaluation of each of the Clinical Tools. DHS will pilot the evaluation methodology with the Physiotherapy Priority Tool, commencing in January 2008.

This pilot is informing the process for evaluating the other tools. A working group with academic and CHS representatives has contributed to the development of the evaluation methodology. An external consultant will be sought early in 2008 to evaluate the other Clinical Tools.

The evaluation has four components:

- Reliability study: to determine if different people use the Priority Tool in the same way, and if they make the same decision about priority.
- Validity study: to ensure the Tools measure what they are intended to measure, so people identified as a Priority 1 by the tools are those that require services first.
- Staff consultation: to ensure acceptability and ease of use.
- Consumer consultation: to ensure acceptability.

## **Implementing the Priority Tools:**

### **23.Is it mandatory to use the priority tools?**

At this stage use of the priority tools is not mandatory.

DHS does encourage their use. The research and processes used to develop these tools is extensive. Each Priority Tool will be piloted and evaluated in 2007-2008 to test the reliability, validity, acceptability and ease of use. Following this evaluation it is anticipated that these tools will be accepted for use across the state.

### **24.Can we modify the priority tools to suit our local circumstances?**

The priority tools are intended to guide consistent good practice across the state, however CHSs need to respond to their local community needs. Agencies should consult with their regional DHS Program and Service Advisors (PASAs) regarding any proposed modifications to the Priority Tools. In making modifications agencies may add extra criteria; however it is recommended that criteria should not be removed.

CHSs should consider the following prior to modifying the tools:

- Integrated area-based (CiYC) planning - CHSs should consider inclusion of both their local integrated area-based planning priorities and the broader CiYC target groups and programs as priorities.
- Current demographic profiles - CHSs should utilise documents such as service plans and Integrated Health Promotion Plans to identify the needs of their community and gaps in the local service system.
- Emerging issues – changes within a local community that are not anticipated and have not been planned, such as natural events (e.g. drought or flood) or significant changes in demographics or community structure due to a changing economic and/or political climate.
- Staffing recruitment and staff skills.

### **25.What effect will the priority tools have on demand?**

Managing demand aims to improve client access to services:

- through more efficient and effective practices and processes (e.g. better waiting list management, early intervention to prevent or address problems before they require substantial resources, implementing service models and practices that enable more to be done with the same resources); and
- by helping clients to get the right care at the right time, rather than simply placing everybody in the same queue.

The priority tools primarily address the second point. Other aspects of the Demand Management Framework address the other aspects of managing demand.

## **26. We don't have central intake – should we still use the priority tools?**

All services make decisions about the priority of access, regardless of the Service Access Model in place. The tools can be used by intake workers, or practitioners undertaking the INI for their own discipline.

## **27. We work in a Team, and the Clinical Priority Tools are for single disciplines... how can we use them?**

Decisions about who to see first occur in all services – for single discipline or team based services.

Depending on the structure of the teams and the systems in place the priority tools can be used in different ways. Staff who work in teams still need to make decisions about who to see first. Clients allocated to a team can have their needs considered as per the priority tools to determine who to see first. This may involve using more than one of the tools, and discussions at an intake or team meeting.

Use of the Clinical Priority Tools should not limit team based care. When clients require multiple services it is best practice to ensure they have these needs met in a coordinated and planned manner. This is one of the main reasons that the Generic Priority Tool prioritises people with complex needs that require a coordinated team approach. This will prevent situations where waiting times for services differ, limiting the ability of staff to work with the client at the same time. It is expected that clients with complex needs are assisted to develop care plans with the services involved in their ongoing management, both within and external to the CHS in order to ensure the client's needs are met.

A diagram that highlights the Community Health Service Priority Tools and the Consumer Pathway through Service Coordination is available at:

[http://www.health.vic.gov.au/communityhealth/downloads/demand/priority\\_tools.pdf](http://www.health.vic.gov.au/communityhealth/downloads/demand/priority_tools.pdf)

It shows the different pathways that exist across services that use different assessment models for people that require multiple services.

## **28. Will using the priority tools mean extra work?**

Using the Priority Tools may lead to a change in practice, but it is not an additional task.

The Priority Tools are designed to support and guide staff who are already undertaking INI as part of their role – this includes intake workers and clinicians that undertake this role for their own discipline.

The identification of client needs, including determining priority, is a key element of good service coordination practice (*Better Access to Services: A Policy and Operational Framework*, DHS, 2001; *Victorian Service Coordination Practice Manual*, DHS, 2007).

### **29. Are the Priority Tools available electronically?**

At this stage the tools are not available electronically, as they are in the process of being evaluated and finalised. The capacity to integrate electronic versions of the tools into HealthSmart and other client management systems has been identified as an area for further development in the DHS Demand Management project.

## **Universal access**

### **30. What is universal access?**

Universal access means that all people are able to access services. This principle underpins delivery of services funded through the Community & Women's Health Program.

### **31. Why can't we close our waiting lists temporarily?**

The Primary Health Branch Policy and Funding Guidelines direct Community & Women's Health Program funded services to maintain an open waiting list.

An open waiting list captures and records the level of demand for services. Closing waiting lists means agencies and DHS are unaware of the actual level of demand. Demand can only be measured meaningfully if all agencies keep waiting lists open for all services provided

A client faced with a long waiting time has the choice of waiting, or seeking other alternatives. Some clients have no other options to access the services they are requesting at the CHSs. In the meantime, the agency can provide supports and inform the client that they can contact them if circumstances change that may affect their prioritisation for the service. If the waiting list is closed, clients are denied that choice and these options.

Closing waiting lists can leave clients with no supports and can place them at risk.

### **32. Can we limit our Paediatric services to a specific age group?**

CHSs should configure services to meet the needs of their population. This includes provision of services to children and their families. Services that have specialist staff that work exclusively with children and families in Paediatric specific services should provide services to children of any age, and should not be limited to specific age ranges.

The Clinical Priority Tools indicate a priority for service for younger children, as there is considerable evidence about the benefits of early intervention. This approach is recommended and supported, however services should also be open to addressing the needs of older children and their families.

### **33. Can we limit our services to those in a geographical area?**

Services funded through the Community & Women's Health Program must not restrict services on the basis of where people live (Primary Health Branch Policy and Funding Guidelines).

People are free to choose which CHS they will attend, and CHSs must not restrict access to people living or working in a specified catchment area. This includes people living across state borders but near service sites in Victoria.

While this may increase demand in some organisations for some services, it is an important right of clients. Where difficulties arise these should be addressed in partnership with neighbouring agencies and the department's regional office.

## Flow through

### **34.How do we offer appointments? Do we have to see all Priority 1 clients first?**

Processes for making appointments may vary across CHSs, and will depend on the Service Access Model in place and the resources available (staff and information technology).

The client's level of priority should be considered when booking appointments. Timely access for high priority (Priority 1) clients should be a primary objective for allocation of appointments, however provision of service to ongoing clients and lower priority clients should be considered.

Services may need to configure appointment templates that allocate time for ongoing clients as well as new clients. In order to allocate appointments in a way that reflects the level of services available and the demand for services, CHSs require information about the number and type of referrals they receive. This can be obtained through an audit of current practices.

This will allow staff to maintain a balanced caseload, with a mix of clients.

### **35.What is Single Session Work? What are the benefits? Is it applicable to disciplines other than counselling?**

Single Session Work is a service delivery framework developed for counselling that recognises that many clients attend only once or twice. It is an approach that optimises the possibilities inherent in a single session, but still accommodates clients that require more sessions. Further details are available from The Bouverie Centre website:

[http://www.latrobe.edu.au/bouverie/sst/whats\\_new.html](http://www.latrobe.edu.au/bouverie/sst/whats_new.html)

Single Session Work has benefits in providing a service model that often allows clients quicker access to a service. Research has demonstrated there are positive outcomes for clients, and an improved ability for services to manage demand.

Some CHSs have applied the principles of Single Session Work to other disciplines, and it appears to have potential to achieve similar benefits to those described above. The next stage of the CHS Demand Management Project will further explore the potential application of these principles to other disciplines.

### **36.What mix of staff will best support CHSs to manage demand?**

Redesigning the mix of staff in an agency can improve the ability to manage demand. This may include the use of administrative staff and allied health assistants to support clinicians, and to allow clinicians to focus their time on tasks that require their expertise.

Agencies should also review their ability to provide services to all population groups that require them. This may mean services need to plan to shift resources to cater for an ageing population, or for a growth in children and families depending on their location.

### **37.What information should we provide clients that are on waiting lists?**

Clients should be provided written information at the time they are placed on a waiting list. This should include:

- the anticipated waiting time

- advice that the client can initiate a review of their level of urgency if their condition changes (either improvement or decline)
- who to contact, and how to contact the service, if required
- advice to update the agency if their contact details change
- options available for interim management whilst awaiting individual care.

Agencies should also consider the need for information and/or education sessions that can assist clients to manage their condition whilst waiting for services.

## **Outflow**

### **38.How can recall systems assist in managing demand?**

Clients with chronic conditions and/or complex needs often require services over a long period of time, however there may be periods of time where they are managing their own health needs. Encouraging service use that consists of planned episodes of care can prevent exacerbations of symptoms or problems, and reduce the number of “crisis” presentations by this client group. It can also assist agencies in planning service delivery and scheduling appointments.

Recall systems should be developed as part of a discharge/exit plan for clients that are likely to require future services.

### **39.How can services facilitate client exit from services?**

Developing an exit or discharge policy can assist clients to achieve an appropriate exit from services.

Exit from services should be linked to client needs, goals and progress. Clients’ expectations regarding the length and type of services they receive should be discussed when they first access the service. Clients should be involved in the process of planning for exit from the service. This may include referral to other services, programs or self-support groups.

A discharge policy may be appropriate for your agency as a whole, or individual programs may need to develop their own policies if this is required.

## **What should agencies do next?**

CHSs should use the Demand Management Framework to review their current practices and systems for managing demand. This can contribute to agency quality improvement reviews and plans.

CHSs should consider implementing the priority tools into practice, particularly where no current system is in place.

Workshops will be conducted in each region early in 2008 to support agencies to work through this process.

## How do we get more information?

- In the first instance, organisations should contact their regional Program and Service Advisor for information.
- Information sessions with organisations will be held in each region in early 2008. Details to follow.
- Information available via the project team, details below:

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