

# Community Health Service Priority Tools and the Consumer Pathway through Service Coordination

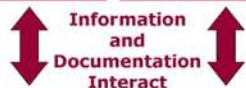
Service coordination places consumers at the centre of service delivery, to ensure they have access to the services they need, opportunities for early intervention, health promotion and improved health and care outcomes.<sup>1</sup> There are a range of resources and tools available to support this practice, and this poster describes the relationship and use of the Community Health Service (CHS) Priority Tools that have been developed to assist CHSs to decide which clients to see first, and the consumer pathway through service coordination. Service Coordination is underpinned by the following principles:<sup>1</sup>

- a central focus on consumers
- partnerships and collaboration
- the social model of health
- competent staff
- a duty of care
- protection of consumer information
- engagement with other sectors

## Initial Needs Identification (INI)

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 consumers need.<sup>1</sup>

### Service Coordination Tool Templates (SCTT)<sup>2</sup>



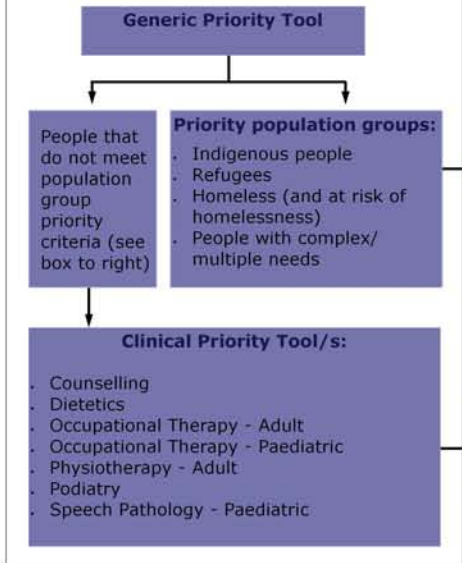
### People with Complex/Multiple Needs

These people require coordination and care planning to best meet their needs. Includes people:

- with care plans
- that need care plans (have or require multiple services that need coordination).<sup>1</sup>

The discipline specific priority tools may also be useful in exploring the needs of these clients.

### CHS Priority Tools<sup>3</sup>



## Assessment

A decision-making methodology that collects, weighs and interprets relevant information about the client. Assessment is not an end in itself but part of a process of delivering care and treatment. It is an investigative process using professional and interpersonal skills to uncover relevant issues to develop a care plan.<sup>1</sup>

★ Assessment processes depend on agency structure

### Comprehensive Assessment

A face-to-face interaction with a consumer, involving an intense level of inquiry, and an advanced dimension of history taking, examination, observation and measurement/testing. It facilitates a more extensive process of inquiry that requires analysis and interpretation of the assessment information and a clinical judgement, diagnosis and differential diagnosis.<sup>1</sup>

This may be conducted by a key worker or a multidisciplinary team.

Service Specific (Individual Discipline) Assessments may also be required.

### Service Specific (Individual Discipline) Assessments

### Service Specific (Individual Discipline) Assessment/s

A face-to-face interaction undertaken when consumers have a relatively straightforward, obvious and distinct need for a specific service.<sup>1</sup>

## Care Planning

A process of deliberation that incorporates a range of existing activities such as care coordination, case management, referral, feedback, review, reassessment and monitoring. Care planning involves the judgment/determination of need as well as competing needs, and assists consumers to come to decisions that are appropriate to their needs, wishes, values and circumstances.<sup>1</sup>

### Inter- or Intra-agency Care Plan

The outcome of the assessment and care planning process that documents the services to be provided. It specifies service type, levels and frequency of service provision.<sup>1</sup>

SCTT<sup>2</sup>

Service Coordination Plan

### Individual Discipline Treatment Plan/s

## Service Delivery

The structure, frequency and delivery of services should be tailored to suit the client.

Service delivery should:

- Be evidence based
- Be goal focussed (client-centred)
- Encourage and support self management and client empowerment

It may include:

- Individual intervention
- Group sessions
- Information/education sessions
- Home programs
- Recall appointments

### Team Intervention and Care:

- Individual disciplines

### Individual Discipline/s Intervention and Care

Information provision (including referral), Feedback, Service Provision, Exiting (these can happen at any point)<sup>1</sup>

References:  
 1. Department of Human Services (2001). Better Access to Services—A Policy & Operational Framework  
 2. Department of Human Services (2006). Service Coordination Tool Templates  
 3. Department of Human Services (2007). Towards a Demand Management Framework for Community Health Services - consultation paper  
 Department of Human Services (2007). Victorian Service Coordination Practice Manual