

Section 2

Review of current Service Access infrastructure, systems and practice

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Section 2: Review of current Service Access infrastructure, systems and practice

2.1 Sample Proposal to Review of Service Coordination infrastructure, systems and practice ⁶

Background:

The following proposal for a review of Service Coordination undertaken at has been developed by [name], Primary Health Care Program Manager and [name], Service Coordination Team Leader, and endorsed by [name], CEO. It has been developed in response to external factors including significant policy directions and an increased awareness of the demographic profile of X local government area. There is recognition of the need to review current Service Coordination (SC) practice in conjunction with related internal systems. It is also in keeping with the agency's commitment to continuous improvement and leading the way in service innovation and integration.

Aim: To review Service Coordination infrastructure, systems and practice from a quality perspective, in order to inform the development of the 200X – 200Z Strategic Plan and to embed quality structures and processes that will inform an integrated care model.

Objectives:

- To measure performance against a set of criteria that will enable review the quality of SC at both an organisational level and at the practice level. [Propose use of Victorian SC Practice Manual and Continuous Improvement Framework (2006) & Service Access Models: A Way Forward Resource Guide (2006)]
- To capture (map) accurate information in regards:
 - agency features, infrastructure and systems
 - documented policies and procedures
 - actual implementation at a practice level
 - barriers and enablers to quality SC activity
- To recognise achievements to date [against 2004 - 07 Strategic Plan and 2004 SC Implementation Plan].
- To identify gaps, identify key themes and reflect on changes required in response to sector developments
- To analyse information and make recommendations for discussion and endorsement by Management Team and BOM
- To generate a discussion paper that:
 - articulates findings and key themes
 - identifies potential priorities (or further work to determine them)
 - articulates staff SC orientation, position descriptions and performance monitoring requirements
 - articulates resource requirements
 - identifies potential partnerships in developing/implementing strategies & considers the application of this at a broader (statewide) level
 - identifies potential service redevelopment recommendations to Management Team and BOM for consideration
 - informs the integrated care model and strategic plan

⁶ Adapted from document produced by Whitehorse CHS and the Service Coordination Industry Consultant.

Preparation for Discussion Paper:

Key (internal & external) issues/themes/risks/opportunities should be collected during the data gathering stage and be used to prepare the Discussion Paper. This information should inform consideration around:

- direction and priority setting,
- resource requirements,
- potential additional partnerships,
- how inter-related issues/initiatives may be progressed,
- integration factors,
- timing of potential strategies in relationship to each other etc

Analysis of data

Analysis of the data per each SC element and related functions, as well as these overall considerations, will be used to develop recommendations for the Discussion Paper.

Key guiding directions &/or initiatives:

Fundamental Principles as per the BATS Framework:

- A central focus on consumers
- Partnerships and collaboration
- The social model of health
- Competent staff
- A duty of care
- Protection of consumer information
- Engagement of other sectors
- Consistency in practice standards (XCHS specific principle)

External:

Primary Health Branch Policy & Funding Guidelines 2006 (including mandate for Dental)
 Victorian Service Coordination Practice Manual & Continuous Improvement Framework
 Service Access Models Resource Guide - Review of Current systems; Principles for model selection; Core and Additional Functions; Evaluation; Service access models comparative chart etc
 Community & Women’s Health Branch Demand Mgt Review & Discipline-specific Prioritisation Guidelines Work
 Draft HACCC Assessment Framework
 PCP eReferral Plan
 Embedding of eReferral uptake
 PCP care planning discussion paper (pending)
 Integration of School Dental Service
 GP EPC items & Div GP Practice Nurse Education
 Diabetes Service Development - interface at Health Service
 Draft Regional Integrated Early Childhood Health and Intervention Services Review
 HARP development and Public Report 2006
 VHA clinical governance initiative (includes credentialing, scope of practice etc)
 Better Links to Health Project – CHS/CRU interface

Internal:

Time line to strategic plan development
 X LGA Community Health Profile
 Review of Psychosocial service provision at XCHS
 Review of Client Records
 Integrated Care Plan XCHS
 Chronic Disease Mgt Development XCHS
 Internal Performance Mgt processes XCHS

Implications of each of these should be identified & considered

Authority Structures:

These will consist of two time limited groups tasked with this specific activity.

A Steering Group chaired by the PHC Manager will be established to guide and undertake review activities. Tasks will include data gathering and analysis, determination of key issues and priorities, and the development of the Discussion Paper. The PHC Manager has responsibility for development of the Discussion Paper, with support from the Steering Committee. As appropriate, the PHC Manager may delegate the coordination of the data gathering and analysis activity as well as the writing of the Discussion Paper.

Membership is to include all team leaders, the Health Development Manager or delegate, Dental Manager or delegate, PCP representative and the SC Industry Consultant as available.

It is anticipated that to achieve the objectives in line with strategic planning timelines, this group will meet on a fortnightly between [month A - C] 200Y, with representatives facilitating data gathering from staff and data analysis activities between meetings. Expectations regarding the associated time contribution, including potential work plan alterations, should be negotiated between team leaders and their managers.

The representative role needs to be clear, particularly the capacity to act as a representative of team/discipline as well as providing representation of the steering group back to each team/discipline. This is a global issue and needs to be done as an addition to or within the development of this group's TOR.

To complement the Steering Group, a staff **Reference Group** will also be convened approximately twice during the review period. The role of this group will be to provide additional reflective input on practice issues, clarification of work to date, validation of the data gathered from the SWOT analysis, and contribution to the Discussion Paper. Disciplines additional to those represented on the Steering Group should form the core membership, as well as the Community Participation Coordinator, the CQI Coordinator, other staff with key roles or relationships with the broader service system, and key members of the Steering Group.

A community focus group may also be convened to provide input into the review process.

Project plan and time lines:

What	When/Who
Establish Steering group and define: <ul style="list-style-type: none"> ➤ Membership ➤ ToR ➤ Roles & Responsibilities ➤ Meeting Schedule 	November 200X
Clarification of the implications within key guiding directions &/or initiatives listed above	Dec – Jan External – SCIC Other - PHC Mgr Support from PCP to be sought in regards PCP initiatives
1st Steering Group meeting: <ul style="list-style-type: none"> ➤ confirm TOR, membership, meeting schedule, roles & responsibilities ➤ clarify objectives ➤ ensure mutual understanding of guiding directions & initiatives ➤ develop communication and consumer participation strategies ➤ establish timelines, milestones and key deliverables ➤ develop SWOT analysis plan ➤ clarify data gathering role of members ➤ clarify coordination role 	Mid - ?late Jan 200Y
Carry out SWOT data gathering within teams	First 2 weeks of Feb
2nd Steering Group meeting <ul style="list-style-type: none"> ➤ provide support for data gathering phase 	2 nd week Feb
Analyse raw data per each SC element & related functions ID key strengths, weaknesses, opportunities, threats, gaps, issues and themes.	Mid-late Feb Delegation of Steering Committee

<p>3rd Steering Group mtg: Interpret findings and identify key overarching issues and themes. Utilise these to inform strategic thinking around:</p> <ul style="list-style-type: none"> ➤ direction and priority setting, ➤ resource requirements, ➤ potential additional partnerships, ➤ inter-related issues, ➤ integration factors, ➤ timing of potential strategies in relationship to each other etc 	Late Feb/early March
<p>Convene 1st meeting of Reference Group:</p> <ul style="list-style-type: none"> ➤ Present preliminary findings, issues, themes etc ➤ Seek clarification re any outstanding issues/queries ➤ Obtain further input 	Early March – Steering Comm delegation
Develop draft Discussion Paper	Late Feb - mid March - PHC Manager/delegate
<p>4th Steering Group meeting</p> <ul style="list-style-type: none"> ➤ Progress Discussion Paper and Recommendations 	Late March
<p>2nd meeting of Reference Group</p> <ul style="list-style-type: none"> ➤ Obtain further input into Discussion Paper <p>and</p> <p>Possible community consultation (e.g. focus group)</p> <ul style="list-style-type: none"> ➤ Provide update, background and aims ➤ Present preliminary analysis, issues, themes etc ➤ Seek clarification re any outstanding issues/queries ➤ Seek input into Discussion Paper 	Late March
Finalise Discussion Paper	March – early April
<p>Final Steering Group meeting</p> <ul style="list-style-type: none"> ➤ Endorse Discussion Paper 	Early April
Present Discussion paper to Management Team/BOM	Early April
Feed into Strategic Planning Process	April - June

2.2 Service Access Terminology and Activities ⁷

Based on the BATS framework and further developed to measure demand in CHSs:

See DHS 'Waiting Time Measurement in CHSs' document at:

<http://www.health.vic.gov.au/communityhealth/index.htm>

Process of service delivery begins in response to a: phone call/presentation at Reception by a consumer (new or registered client) or phone call or correspondence from an external agency or internal referral arriving via eReferral/fax/mail/hand delivery.		May be currently described as:
Initial Consumer Contact	<i>The point of first contact for a new episode of care with the consumer. It marks the entry point into the service system.</i>	
Initial Contact – Information only	Resulting in information only. For example an enquiry about service provided by CHS or eligibility, sending out health promotion information, details of a specific service eg. A & D service May also include taking down basic consumer details for service providers to contact the caller back.	Reception General enquiry
Initial Contact – appointment only	Resulting in an appointment. For example: <ul style="list-style-type: none"> • Consumer rings for an appointment with a GP. • RDNS nurse makes contact to organise an appointment with a dietician. • Consumer has a referral from GP for an audiology appointment. • Making an appointment for an internal referral. 	Appointment

(cont'd on next page)

⁷ Adapted from document developed by Juliet Frizzell, Effective Change Pty. Ltd.

<p>Initial Needs Identification</p> <p>NB: Needs Identification can also occur at any stage along the client journey through the service system, and may take more than one day/contact.</p>	<p><i>An initial screening 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.</i></p> <p>Consumers are provided with the opportunity to partake in a broad based discussion regarding their health and wellbeing.</p> <p>Discussion involves exploration of needs and screening for risk and/or priority. May also involve investigation of issues other than presenting issue. Consumer may be given appointment(s) to one or more services, placed on a waiting list, deemed ineligible for services or referred to another agency.</p> <p>For example:</p> <ul style="list-style-type: none"> • Supporting a consumer to sort through circumstances and explore broader needs • Facilitating consumer navigation of the service system • Determining if a consumer can be squeezed in to see a GP. • Offering and providing assisted referrals • Identifying health promotion opportunities • Dealing with a client in crisis. • Provision of short-term support or interim care strategies 	<p>Screening, information and referral, risk screening, prioritisation, 'intake'.</p>
<p>Intake</p>	<p><i>A discrete component that relates specifically to acceptance by an agency of a request for service, and the arranging of subsequent service provision within that agency.</i></p> <p>For example:</p> <p>Completing SCTT & discipline-specific prioritisation form/s then providing consumer with an appointment with one or more services, or placing them on a waiting list.</p>	
<p>Registering new clients</p>	<p>Completing documentation, entering consumer information into SWITCH etc and posting out relevant information.</p>	<p>Registration</p>
<p>Waiting List Management</p>	<p><i>A Waiting List is a dynamic management instrument for an identified service. It contains a list of eligible clients with identified need and urgency for a specific service.</i></p> <p>Adding eligible consumers to a waiting list once needs and priority have been determined.</p> <p>Contacting clients on the waiting list to offer an appointment, according to priority, etc</p>	<p>Waiting list appointment</p>

What is **not included**:

- Telephone calls and presentations from existing clients ringing to change appointments, make review appointments, or speak to staff about current treatment.
- General business calls or calls not related to service provision.
- Assessment - when consumer is assessed for treatment or care. For example with GP, or first physio appointment.
- Local/regional service specific system queries from practitioners
- Clinically specific queries from practitioners

2.3 Sample Mapping Current Service Access Processes Questionnaire⁸

1. *What are the current Service Access processes for your agency?*

- What steps does a consumer have to go through from when they first come into contact with your agency whether they telephone or present at the counter until they receive their first assessment?
- Either draw a flowchart or note the pathway the client follows as part of your current intake process noting:

Which staff members are involved at each step?

What is the average time between each step?

What information is collected at each step?

2. *What tools, infrastructure, clinical pathways, etc. support access into your agency?*

- Identify all the tools and infrastructure that support the current Service Access process, eg. forms, risk assessment tools, eligibility criteria, service profiles, consumer information brochures.
- Identify how these structures, pathways, tools etc support consumer needs e.g. identification of underlying issues, navigation of the service system

3. *How much time is spent on Service Access into your agency?*

Estimate the level of resources that are currently being dedicated to Service Access within your agency for each discipline:

- The number of enquiries per week (Initial Contact) from new clients, existing clients with new episodes of care or from external agencies making referrals (by phone/fax/eReferral).
- The number (and %) of enquiries which continue into a discipline-specific screening or Initial Needs Identification process per week.
- The number (and %) of clients who continue on from screening or INI to assessment per week.

For each discipline please estimate the amount of time (hours) per week spent:

- Dealing with enquiries or providing information (Initial Contact)
- Undertaking screening (including beyond presenting need) and risk assessment (INI)
- Providing feedback to referrers
- Conducting assessments (if separate from service delivery)

Ascertain the number and volume of internal referrals, that you/your service receive from other disciplines/services:

- How many internal referrals would each service receive each week?
- What Service do these internal referrals come from?
- How do you prioritise these internal referrals?

Ascertain the number and volume of referrals that are made by your agency per week:

- How many referrals do Reception staff make each week?
- How many referrals does each discipline/team make each week?
- How many are provision of alternate agency contact details only?
- How many are 'assisted' referrals (documented and sent by eReferral or fax on behalf of the consumer)?

⁸ Adapted from document developed by Juliet Frizzell, Effective Change Pty. Ltd.

4. How could your current your current system be improved?

- What works well about the current system/s? Why?
- How does it support consumer needs, particularly those with complex needs or chronic conditions?
- What do you feel needs improvement? Think about consumers, staff, external agencies, etc.

NB: Numbers and percentages can fluctuate during the year so estimate an average.

2.4 Sample Consumer Pathway Questionnaire

Consumer/Referrer contacts CHS.

> Initial Contact:

- Do all enquiries come through reception? What are the alternate 1st points of contact?
- What screening or info given at this point?
- Is eligibility/risk /prioritisation assessed here? If so, how?
- Are any SCTT forms filled in here?
- Are appointments made for this service either initially or ongoing with Reception?

> Initial Needs Identification:

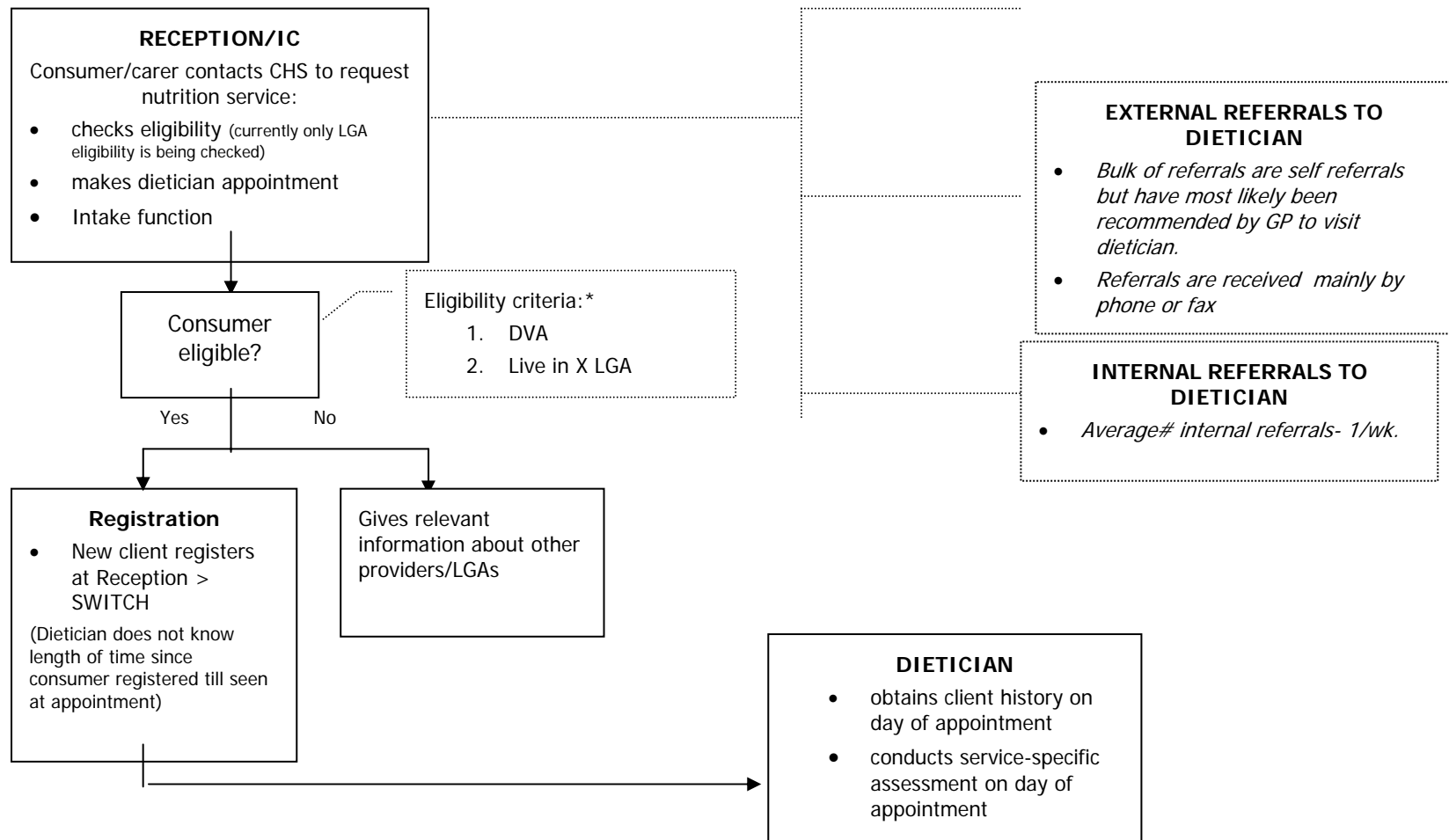
Consumer comes through to service provider.

- What initial questions are asked?
- Are consumers supported to identify a broad range of needs, in addition to the presenting issue?
- What info do you collect to determine eligibility for service?
- Is risk or prioritisation assessed here? If so, how?
- Are assisted referrals offered to obtain alternate services?
- At what point are SCTT form/s completed & which ones?
- Are appointments made, consumers placed on waiting lists etc?
- What happens then?

Other Questions

- How many referrals/enquiries do you get per month? How many of these become registered clients? How many have info provided and/or are referred on? How many are provided with 'assisted' referrals to alternate/additional services (written/fax or eReferral on behalf of the consumer)?
- How long does it take to address a Service Access call (on average)?
 - IC: gathering consumer info to ascertain eligibility, provision of information, providing details of alternate services if ineligible
 - INI: gathering and documenting consumer info, exploring & determining broad range of needs, ascertaining eligibility and priority, determining services required, arranging intake/access to those services?
 - How much extra time for each of the above when you use interpreting services?
- Who performs these duties? (staff profile please)
- How much time (EFT or hours) is currently used for Service Access i.e. taking calls from new (or returning) clients, conducting IC and INI, assessing eligibility for services, determining risk and priority, replying to referrals, info & referral on to other services, appointment scheduling, waitlist management etc?
- How often in 1 month would you use interpreting services for Service Access purposes? Are these internal or purchased services? Are there more common languages that you use?

2.5 Sample discipline-specific mapping of current Service Access practice: Nutrition Services ⁹



⁹ Adapted from document developed by Lyn McKay, Inner East Primary Care Partnership

TIME SPENT ON SERVICE ACCESS

# enquiries/wk	20
	(past clients - 1/2/wk)
# enquiries/wk > intake	11
# intake > assess	8
Amt time enquiries/wk	-
Amt time > INI/wk - 1 hour/client (or service specific ass't?)	
Amt time > assess/wk -	

Tools used:

- SCTT
- Nutrition diagnostic & assessment tool

REFERRALS MADE BY DIETICIAN

- Does not generally make referrals. Mainly information provision.
- Some internal referrals made to other disciplines, podiatry, Diabetes Education Group
- Making external referrals - process generally the same as internal

Consumer information used:

- Diabetes info
- Heart Foundation brochure
- Sundry dietary specific brochures eg. high calcium foods, etc.
- Sanitarium dietary information

Internal Referral Process:*Internal referral form used*

- Document client history
- Discuss with client
- Phone referral/speak directly with service provider
- Document need in client record
- Goes to reception for client appointment

* NB: 2006 – 09 Primary Health Branch Policy and Funding Guidelines specify that CHSs must not restrict access for CH program services to people living or working in a specified catchment area.

NOTES:

1. Prioritisation of client urgency for appointment being undertaken by discipline-specific practitioner:
 - Dietician calls back client to ask questions re condition
 - Makes judgement on urgency
 - Admin time allotted during each day for this process. This time is also sometimes used to see urgent clients.
2. External referrals are primarily phone calls, written documentation, faxes.
3. Some streamlining of processes in proposed new system may reduce one on one consultations e.g. setting up groups.
4. Dietician does sometimes make contact with GP but does not follow up with GP if no written communication available. Does contact if referral received.

WHAT IS WORKING WELL:

- Clients are being seen within appropriate timeframes (no waiting list currently) – demand driven.

PROBLEM IDENTIFICATION:

- Doesn't support identification of broader needs:
 - Lack of good information about consumer condition prior to service –specific assessment presentation
 - Quality of information provided by GPs re patients to ascertain prioritisation is not optimal
 - INI not being conducted (mostly service-specific assessment)
 - Small % of clients not appropriate to see dietician
 - Holistic consumer needs not being identified early in client journey /?at all
 - Other needs not being addressed early
 - Potential referrals to additional services not being made early
 - Urgency/risk determined by practitioner call-back process – valuable practitioner time taken
 - Prioritisation process not clear or documented
 - Consumer still needs to repeat story
- Assisted referrals are not being offered to ineligible consumers
- Staff/worker skills sets to undertake Service Access work an issue
- Volume of calls & time taken to make phone calls back to clients/drs – in some instances multiple phone backs to clients/drs not available at time of call.
- FTAs are not always followed up with a phone call.
- Amount of time to see clients is not spelled out. Generally determined by client load.
- Doesn't support integrated approach to care
- Practitioner admin time – writing up of patient records. Need to factor in record keeping into client appointment time.

2.6 Sample discipline-specific mapping of current Service Access practice: Physiotherapy Services¹⁰

Current consumer pathway:

1. Consumer brings a referral letter to CHS Reception for physiotherapy (from GP, specialist or other service provider)
OR a referral is faxed or sent directly to CHS
2. Reception checks referral contains consumer contact details, explains it goes to daily physio meeting and is assessed for program eligibility and priority. Then consumer is contacted for an appt.
Eligibility – Lives, works, studies in LGA*
- also see sheet on determining eligibility between CRC & CH physio programs
3. Referral letters go to daily 8:30am physio meeting (CH & CRC) and they are allocated into whether CH category (eg. musculoskeletal problems, knee, neck, back) or CRC (eg. cardio, respiratory, rehab) clients.
4. CH Physio then goes through referral & checks for priority and marks them P1: Urgent or P2: Non-urgent clients. These then go to admin staff.
5. Admin staff then spends Tuesdays making appt's for clients – Priority 1 clients get an appt within approx. 2 weeks of receiving referral and Priority 2 clients get an appt within 2 - 3 months. Admin also books interpreters when needed, and sends a letter to every client confirming appt date and details. All referrals are written up in a pink book which is kept at Reception.

* NB: 2006 – 09 Primary Health Branch Policy and Funding Guidelines specify that CHSs must not restrict access for CH program services to people living or working in a specified catchment area.

Time spent on intake:**

8 hrs / week approx.– Reception

2.5 hrs / week approx. – Physios

? hrs/week approx. – Admin staff

**This does not include Initial Contact with reception staff re info on 'intake' process, nor does it include documenting or gaining any other info other than what is on the GP's referral (i.e. broad INI).

Issues

- As above +
- See Nutrition example

Integrated Centralised model

- Service Access worker would need to have a risk/priority guideline and Physio Service Guide

¹⁰ Adapted from document developed by Greater Dandenong CHS

2.7 Sample Summary of Current Service Access Data

Introduction

This document sets out the Service Access Mapping information collected in month/year.

Please note that not all data has been received and the information presented in this report should be interpreted as indicative only.

Summary of Data

Key points:

- 3495 minutes (58 hours) – 4405 mins (73 hours)
- X client contacts per week across the three sites
- Reception reported X client contacts per week
- Reception time:
 - Allied Health Intake X minutes (X hours),
 - Medical Intake X minutes (X hours) and
 - Dental X minutes (X hours)
- Percentage of Reception Intake time spent on enquiries and appointments: X %

Example: X Site

Discipline	Summary of Intake Time			Breakdown of Intake Time			# of Clients			
	EFT	Total Time on Intake ¹¹	% of EFT	Time Enquiries only	Time on INI	Time on Rego or Assessments	Total # of client contacts	# Enquiries	# INI	# Assessment
Reception - Allied Health	3.53	330 mins		85 120	75	40 ¹²	63	-	-	-
Sub Total		330 mins		290 mins	75 mins	40 mins	63	-	-	-
Physiotherapy	1.0	600 mins		180 mins	420 mins	-	10	10	8	8
OT	1.0	125 mins		25 mins	100 mins	300-400 mins	5	5	4	4
Podiatrist	0.8	300 - 600 mins		60 - 120 mins	240-480 mins	240-360 mins	5-10	5-10	5-10	5-10
Speech	0.7	90 mins per/mth		-	-	-	.5	.5	.5	.5
Audiology	0.8	90 mins		90 mins	-	-	15	15	14	14
Strength and Groups		-		-	-	-	11	10	5	-
Sub total		1205 - 1505 mins		355 -415 mins	760- 1000 mins	540-760 mins	46.5-66.5	45.5- 50.5	36.5-41.5	31.5-36.5
ESTIMATED TOTAL		1435 - 1835 mins		645-705 mins	835- 1075 mins	580-800 mins	511.5- 531.5	45.5- 50.5	36.5-41.5	31.5-36.5

¹¹ Does not include Assessment for Disciplines

¹² 10 minutes not classified

2.8 Sample Summary of current Eligibility/Demand Management, Tools, Prioritisation across all Disciplines ¹³

DISCIPLINE	ELIGIBILITY CRITERIA I.E. L/W/S	DEMAND MANAGEMENT				PRIORITISATION	TOOLS	REFERRALS
		PENSION	AGE	DISCIPLINE SPECIFIC	OTHER			
Podiatry	<ul style="list-style-type: none"> DVA Lives, works or studies (LWS) in LGA 	Pension/ health card Income	-	-	-	Prioritisation determined by a set of clinical indicators within each category <ul style="list-style-type: none"> Low risk (eg. non pathological) Medium risk (eg. recurrent foot pathology, biomechanical, etc) High risk (eg. ulceration, infection, etc.) Children <ul style="list-style-type: none"> Reception books next available app't No waitlist issue If urgent – double books to fit client in 	<ul style="list-style-type: none"> SCTT Clinical checklist Podiatry - new client waiting list Client data recording sheet Income dec Client letter – acknowledgement of referral 	<ul style="list-style-type: none"> External referrals –bulk are self referrals Come from GPs, PAC, RDNS, Stay @ Home, COM OPT, Council Home Care, Community Day Centres, physio, OT Internal referrals prioritised same as external Pod sends acknowledgement letter (after treatment) No correspondence till client seen Referrals made via: fax, mail, phone
Physiotherapy – Site A	LWS	-	-	Ongoing rehabilitation/chronic problem	Transport	Rating criteria for urgency: <ul style="list-style-type: none"> Level of pain Effective function Chronicity How long had pain Reason for Treatment <ul style="list-style-type: none"> Management of day to day activities Length of problem Prior patient Urgent referrals from GPs are slotted in ASAP Allocated priority of normal, emergency, YHS GP Ax	<ul style="list-style-type: none"> New Physio referrals Form Physiotherapy Screening Tool Confirmation of appointment letter 	<ul style="list-style-type: none"> Makes external referrals to more appropriate services eg. CRC Receives external referrals from local GPs, hospitals other services Internal referrals from GPs and other centre services

¹³ Adapted from document developed by Lyn McKay, Inner East Primary Care Partnership

<p>Counselling – Site C</p>	<ul style="list-style-type: none"> • DVA • Lives, works or studies in LGA 	-	-	<ul style="list-style-type: none"> • Capacity to pay • Questions: What type of counselling do you require? What are some of the issues that you are dealing with? 	-	<ul style="list-style-type: none"> • Intake meeting for discussion &/or allocation to worker • Counselling referral form used as screening to for INI prioritisation 	<ul style="list-style-type: none"> • SCTT • Intake form, social work intake form, psychology intake form • Counselling Referral Form • Outcome sheet • Waiting list • Sundry brochures given to client at assessment • Info on general & specialist resources (need updating) 	<ul style="list-style-type: none"> • Made via: fax, phone • Referring out – done via phone • Internal – call or counselling referral form • External referrals from another service usually done via fax. Usually referrer has not checked out counselling/service appropriateness
<p>Nutrition Services</p>	<ul style="list-style-type: none"> • DVA • Live in LGA 	-	-	-	-	<ul style="list-style-type: none"> • Dietician calls client – questions re condition • Judgement based decisions on urgency • Admin time allotted during each day for this process. This time is also sometimes used to see urgent clients. 	<ul style="list-style-type: none"> • SCTT • Nutrition diagnostic & assessment tool 	<p>Internal Referral Process:</p> <ul style="list-style-type: none"> • Document client history • Discuss with client • Phone referral/speak directly with service provider • Document in client records client need • Goes to reception for client appointment <p>Referrals By Dietician</p> <ul style="list-style-type: none"> • Does not generally make referrals. Mainly information giving. • Some referrals made to other disciplines, podiatry, Diabetes Education Group • Making external referrals - process generally the same as internal

<p>OT (Adult) – Site A</p>	<ul style="list-style-type: none"> • DVA • Live in LGA 	<p>-</p>	<p>-</p>	<p>-</p>	<p>-</p>	<p>Clients are allocated to a predetermined priority category -1 & 2 - prioritisation code and indicators for each category– 1 being urgent</p> <p><u>Priority 1</u></p> <ul style="list-style-type: none"> • Terminal Illness/palliative • Significant change in circumstances: <ul style="list-style-type: none"> - Change in client/carer health or functional status - Death/illness of spouse/other carer or other family crises - Pressure care needs – skin breakdown or deterioration - History of recent falls within past 4-6 weeks <p><u>Priority 2</u></p> <ul style="list-style-type: none"> • Lives alone, frail • Inadequate support ie. No services in place, no family support • Environmental concerns – 3 or more problems identified • Psychological – lack of confidence, fear of falling, anxiety etc. • Requesting wheel chair for primary mobility needs • Aged >85 • Chronic mental condition (eg. Muscular Dystrophy, Parkinson's, Paraplegia, etc.) and deteriorating medical/functional status (eg. exacerbation of MS / arthritis) 	<ul style="list-style-type: none"> • SCTT • OT Screening Tool • Referral prioritisation form • Waiting list template • Client letter – acknowledgement of referral – wait listed • Confidential referral outcome form • Referral Feedback form • Unable to contact follow up letter • Internal referral form 	<p>Phone and faxed referrals – processed the same way – screened for eligibility & acknowledgement sent</p>
<p>Speech (Paed)</p>	<p>Lives in LGA</p>	<p>-</p>	<p>Preschool age</p>	<ul style="list-style-type: none"> • specific communication delayed/disorder • not globally developmentally delayed 	<p>-</p>	<ul style="list-style-type: none"> • Clients are seen on basis of Priority of access - discuss process for service entry and options, waiting periods, fees, other options • Priority of access – stuttering > 6 months with family history, at risk clients, custody, income, etc. • Client phoned for risk screening appointments 	<ul style="list-style-type: none"> • SCTT • Screening waiting list • Screening outcome database • Screening summary • Internal referral forms 	<ul style="list-style-type: none"> • Bulk are calls • Mail – generally service providers • Making referrals and receiving internal referrals use: letters, internal referral forms • Sources of referrals: family, teachers, GPs/Consultants, Mental Health Services, hospitals, etc.

Speech (adult)	Lives, works or studies in LGA	-	-	-	<ul style="list-style-type: none"> Registered HACC clients \$ funding sources (HACC) 	<ul style="list-style-type: none"> Depends on complexity of case Occurs at first visit Clinical judgement No checklist 	<ul style="list-style-type: none"> SCTT Information form and information manager Patient information for referring agencies HACC eligibility Information brochures for internal referrals (GP/Allied Health) 	<ul style="list-style-type: none"> Internal referrals come from GPs, Paediatric Speech Pathology, OT, Physiotherapy, Podiatry, Sir Eric Pearce House Internal referrals are prioritised - especially eating disorders and those from Sir Eric Pearce House
Groups	LWS	-	-	HACC	-	-	<ul style="list-style-type: none"> Medical assessment form Dr Consent form 	<p>Makes referral to appropriate agencies, eg. Falls & balance Clinic, GP, etc.</p> <p>External referrals Self referral, GP or other health professionals</p>
Audiology	<ul style="list-style-type: none"> Lives, works or studies in LGA 	-	-	-	-	-	-	-
Dental	-	-	-	-	-	-	-	-
Medical	-	-	-	-	-	-	-	-

2.9 Sample CHS Intake Mapping – Areas for Improvement (also see Templates) ¹⁴

DISCIPLINE	AREAS FOR IMPROVEMENT	Practice Standards/ Protocols	Information Management	Org Terminology	Skill sets/ training	HR/Role Definition	Resource Avail/ Utilisation	ICT	Internal Systems Issues	External Factors/ System issues
Reception – Sites A, B & C Summary	Multiplicity of systems and requirements is confusing for staff and clients. “All these different systems make us [the CHS] look incompetent”.	✓		✓			✓		✓	✓
	Eligibility Criteria not always documented and known by Reception Teams [e.g. age requirements for Adult Speech, participation in Alternative Therapy session, catchment].	✓		✓						
	Intake for Service Providers using voice mail is not satisfactory for Reception Staff or clients. At times the Reception staff do not know where service providers are or how long it will take them to get back to clients, and cannot then answer client questions regarding timelines and availability. Many staff are part-time or only available for parts of the week (and this seems to change) – this adds to the confusion. Reception staff reported that they receive complaints from clients who are not called back in a timely manner usually when the service provider rings the client back and the client is not available or does not answer their phone.	✓	✓		✓		✓			
	Telephone calls made from the Centre where the number only is left – result in Reception getting calls from clients wanting to know why they have rung etc. Reception do not know who made the call and therefore cannot advise the client.	✓					✓	✓		
	Reception work is often confusing: who can they make appointments for? Who does what? What to tell the client?.	✓					✓			
	There is a lot of calling and calling back. This is time wasting and costly (may more calls are being made to mobile phones).	✓					✓			
	Very little Service Coordination occurring, most activity is discipline specific screening.	✓							✓	
	Terminology is not consistent – what is screening, what is eligibility, what is a waiting list.	✓		✓						
	Not a lot of documentation: services, eligibility criteria, priority for access, processes.	✓		✓					✓	
Groups	Intake process needs more structure and streamlining	✓							✓	
	Roles need clarifying	✓			✓		✓			

¹⁴ Adapted from document developed by Lyn McKay, Inner East Primary Care Partnership

DISCIPLINE	AREAS FOR IMPROVEMENT	Practice Standards/ Protocols	Information Management	Org Terminology	Skill sets/ training	HR/Role Definition	Resource Avail/ Utilisation	ICT	Internal Systems Issues	External Factors/ System issues
Physiotherapy	Calling clients back is not efficient; sometimes it takes 6-7 calls before you reach a client.	✓								✓
	Prioritisation categories not clearly documented. Need urgency criteria to be identified and documented and stricter criteria for "service eligibility".	✓		✓						
	Need to establish an official waiting list	✓	✓							
Nutrition Services	Lack of good information about client condition prior to presentation to dietician.	✓	✓							✓
	Booking people for appointment is time consuming – some are difficult to contact <ul style="list-style-type: none"> – mobile phones – relocations – not home – no answering machines 	✓	✓				✓			✓
OT	Currently because not all calls are being directed to AHA there is some duplication/doubling up. No phone call log is kept.	✓	✓				✓		✓	
	Multiple site issues: <ul style="list-style-type: none"> – Internal referrals – some are getting lost (don't use SCTT) – Registrations are sometimes duplicated – affecting intake – Records management – file retrieval from multiple sites 	✓	✓						✓	
Podiatrist	No written eligibility checklist <ul style="list-style-type: none"> – Lack of knowledge of criteria by GPs for making referrals 	✓		✓	✓					✓
	More systematic and consistent pathway to refer clients for clients waiting to access CHS.	✓	✓	✓				✓	✓	

Summary Notes:

Common elements identified for improvement:

- Need for clearly defined and documented common practice standards/protocols
- Clarification and documentation of:
 - Services available
 - Eligibility criteria - including clarification about suburbs which organisation services.
 - Priority for access
 - Processes
- High utilisation of resources around:
 - Client/service provider follow up - particularly in regard to inappropriate referrals, non eligible clients, clients who are difficult to contact
 - Identification of appropriate service providers by reception and service providers for clients when required – this may indicate a need for training staff in use of Service Directories
 - CALD clients – language issues and followup with interpreters – time consuming
- Identification of internal and external issues that may require greater collaboration with service providers to ensure appropriate practices and information is communicated to both service providers and clients
- Potential for:
 - Greater implementation of Service Coordination practices across the organisation
 - Standardisation of various tools/forms and their use