

Central Victorian Health Alliance
Service Coordination Continuum of Care:

Multidisciplinary Care
Practice, Processes, Protocols, Systems

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Membership

The Central Victorian Health Alliance is the following member agencies:

- Bendigo and District Division of General Practice
- Bendigo Health Care Group
- Castlemaine and District Community Health Centre
- Central Goldfields Shire Council
- Central Highlands Division of General Practice
- Cobaw Community Health Service
- Kyneton District Health Service
- Loddon Mallee Women's
- Macedon Ranges Health Service Health
- Macedon Ranges Shire Council
- Maldon Hospital
- Maryborough District Health Service
- Mount Alexander Shire Council
- Mt Alexander Hospital
- St. Luke's Anglicare

Foreword

The Central Victorian Health Alliance (CVHA) *Service Coordination Continuum of Care: Multidisciplinary Care Practice, Processes, Protocols and Systems* is the culmination of collaborative work undertaken by staff of CVHA member agencies between 2001 and 2003. The work has been refined over time, and together with the Service Coordination Tool Templates implementation and increased interagency collaboration the applicability of this work has been further realised.

Thanks must be given to the following people, who were members of the Service Coordination Sub-committee, Service Coordination Implementation and Workforce Development Working Group, Initial Needs Identification and Service Coordination Care Planning Projects, CVHA General Practice EPC / Service Coordination Projects and the CVHA Feedback Trial Project:

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Introduction

CVHA Continuum of Care: Multidisciplinary Care Practice, Process, Protocol and Systems - Framework

The CVHA Continuum of Care

The CVHA vision is to adopt common pathways, practice standards and protocols for multi-disciplinary care, and align service systems to improve health and wellbeing outcomes.

The CVHA Continuum of Care broadly describes the multidisciplinary care processes that are common to primary care agencies. Refer to previous page for the *Central Victorian Health Alliance Service Coordination Continuum of Care* model.

The CVHA Continuum of Care model has 3 functional sections:

1. Entry into the Primary Care System. This section includes the elements of Initial Contact and Initial Needs Identification
2. Service Provision within the Primary Care System. This section includes the usual practices that are common to all services:
 - Assessment
 - Plan, for Service Delivery
 - Information Provision
 - Review and Monitoring Plan
 - Exchange of Consumer Information (referrals, feedback)
3. Care Coordination within the Primary Care System. This section is for consumers with multiple and complex needs, encompassing the element of Service Coordination Care Planning (or GP Multi-disciplinary Care Planning):

Information Management is integral to and embedded within these 3 sections:

- Referral process
- Feedback process
- Privacy Legislation requirements for consumer information exchange process
- Systems that support Information Management within multidisciplinary care.

The CVHA Continuum of Care processes

The common multidisciplinary care processes for primary care agencies are:

- o Initial Contact
- o Initial Needs Identification
- o Assessment (plus plans, service delivery, review and monitoring)
- o Service Coordination (Multidisciplinary) Care Planning
- o Referral
- o Feedback (referral and assessment / re-assessment outcomes)

Duty work, Intake and Allocation, and Exit processes are viewed by CVHA agencies as the responsibility of individual agencies. Transition of care from one agency to another is considered integral to the care planning process. The storage of consumer information is also generally viewed as an agency internal process.

The systems that support the CVHA Continuum of Care processes

To enable multidisciplinary care, each process requires systems to be in place and integrated. The systems that support multidisciplinary care include:

- o Tools and resources - Service Directories, forms, personnel
- o Communication and IT systems – phones, faxes, emails, IT software, encryption (PKI)
- o Multi-disciplinary care pathways – referral, feedback and care planning

These systems are in turn supported by:

- o Training and workforce development
- o Organisational development

Protocol Framework for CVHA Continuum of Care

A framework has been developed for the CVHA Continuum of Care that articulates the multidisciplinary care practices, processes, protocols and systems. 9 protocol categories have been developed, each describing the practices and systems that support the CVHA multidisciplinary care processes. The protocol categories are grouped as follows:

1. **Staffing:** roles and responsibilities; skills and knowledge
2. **Specific implementation practices:** access to that specific process; the specific details of the process; facilitating access to the next process
3. **Information:** health and service information; consumer information collection and exchange
4. **Systems:** tools and resources; and workforce development to support that process

The Protocol Framework for CVHA Continuum of Care

Protocol Area:	
Process:	
Goals	
Protocol Category	Practices that support the process
Roles and responsibilities	
Skills and knowledge	
Access to.... (this process)	
(Specific practices for this process)	
Facilitating access to.... (next process)	
Health / Service Information	
Sharing consumer information	
Tools/resources	
Workforce Development	

Practice Standards for the CVHA Continuum of Care

The following practice standards underpin the CVHA Continuum of Care protocols:

1. Consumers have access to quality care
2. Consumers have access to a range of services appropriate to their care needs, which can be delivered in a timely and efficient manner
3. Consumers have access to health and service information that supports their care needs, and their health/care information is shared with others in a way that respects them, meets privacy requirements and supports their care needs
4. Agencies support multi-disciplinary care through the development of integrated systems

Pathways that support the CVHA Continuum of Care Protocols

Each multidisciplinary care process has a pathway that details the series of steps (practices) in the process. It provides a visual 'how to' for implementation of the process.

**CENTRAL VICTORIAN HEALTH ALLIANCE
SERVICE COORDINATION CONTINUUM OF CARE**

ENTRY INTO THE SERVICE SYSTEM

This phase includes the elements of:

- INITIAL CONTACT
- INITIAL NEEDS IDENTIFICATION

GENERAL PRACTITIONERS

Need/s met with information provision;
Or no need/s identified at first screening



Need(s) identified at screening = referral(s)

INDIVIDUAL SERVICE PROVISION

This phase includes the element of:

- ASSESSMENT [identifies issue(s)]

Every assessment results in:

- ⇒ Information Provision
(Health, care and/or service information)
- ⇒ Planning (assessment outcomes)
- ⇒ Service Delivery (related to plan)
 - ⇒ Monitor and Review plan
 - Issue(s) or goal(s) unchanged
 - ✓ Continue with the plan

Or

- Plan not effective
- ✓ Screen for new needs

Need/s met



New needs identified

- Need/s can be met by this service
 - ⇒ Re-assessment; revise plan etc
- Need/s cannot be met by this service
 - ⇒ Referral/s for new service/s

Referral(s)

Multiple / complex / unresolved needs.
3 or more ongoing services involved

GENERAL PRACTITIONERS

CARE COORDINATION

This phase has the element of:

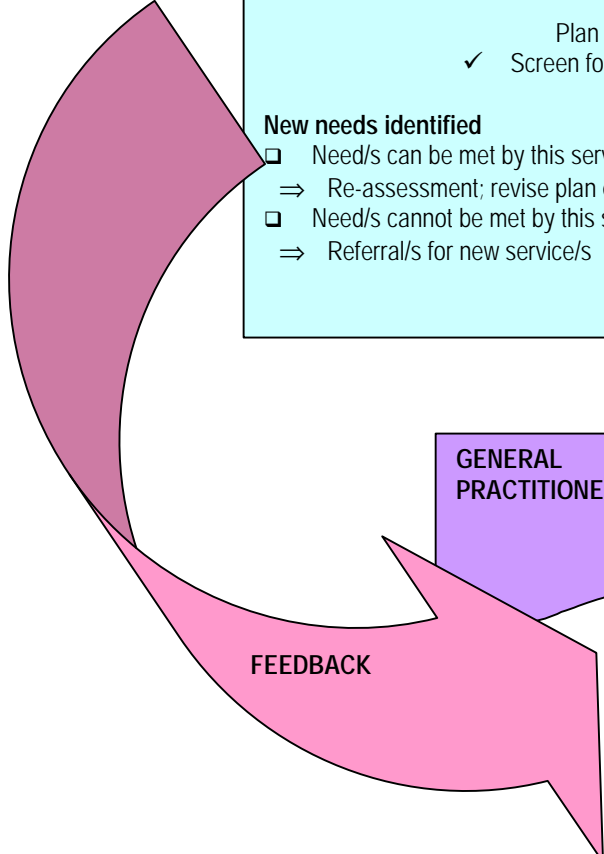
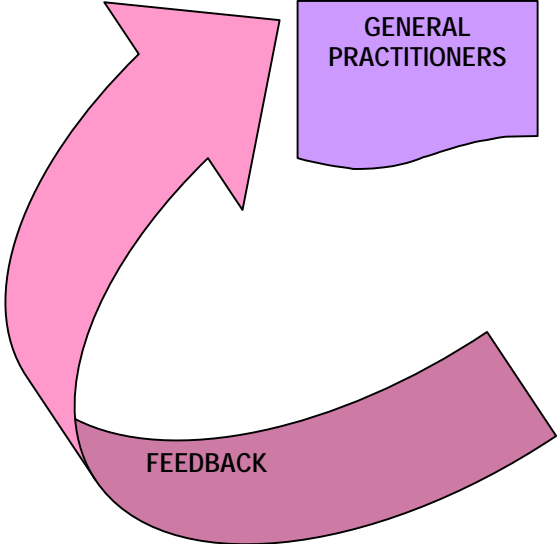
- SERVICE COORDINATION CARE PLANNING

All services involved **feedback assessment outcomes** to a **KEY WORKER** and work as a **multi-disciplinary team** to collectively

- Identify and manage overall risks
- Develop a comprehensive plan
- Review and monitor the plan

FEEDBACK

FEEDBACK



CVHA Continuum of Care: – Multidisciplinary Care Practice, Process, Protocols and Systems

Practice Standards for the CVHA Continuum of Care

The following practice standards underpin the CVHA Continuum of Care protocols. These standards link with existing program standards.

1. Consumers have access to quality care
 2. Consumers have access to a range of services appropriate to their care needs, which can be delivered in a timely and efficient manner
 3. Consumers have access to health and service information that supports their care needs, and their health/care information is shared with others in a way that respects them, meets privacy requirements and supports their care needs
 4. Agencies support multi-disciplinary care through the development of integrated systems
-

Protocol Summary

There are **key inter-agency practices** that are integral to each of the CVHA multi-disciplinary processes of:

- Initial Contact
- Initial Needs Identification
- Referral
- Assessment (incorporating the Service's Care Plan)
- Feedback
- Care Coordination

The key CVHA inter-agency practices are:

- o **All Consumer information exchanges are written**
 - o Referral
 - o Feedback
 - o Care Coordination
- o **Urgent exchanges of information are phone through to the designated worker / service**
 - o 📞 Urgent information. Talk directly to worker or service
 - o Send written information to worker /service ASAP
- o **Informed consent is sought for all information exchanges**
 - o Record that consent has been given
 - o Obtain a signature where practicable
- o **"Quality" indicators are followed for all information exchanges**
 - o Timely exchanges
 - o Tailor information to meet the needs of the receiving service i.e. relates to the receiving service's intervention or service provision for that consumer
 - o Information is succinct
 - o Information is legible and understandable
- o **All information exchanges use the State-wide referral or care plan forms (Service Coordination Tool Templates) as appropriate**
 - o Use and update the appropriate forms with each information exchange
- o Follow the CVHA Service Coordination Protocols and Pathways

Entry into the Primary Care System

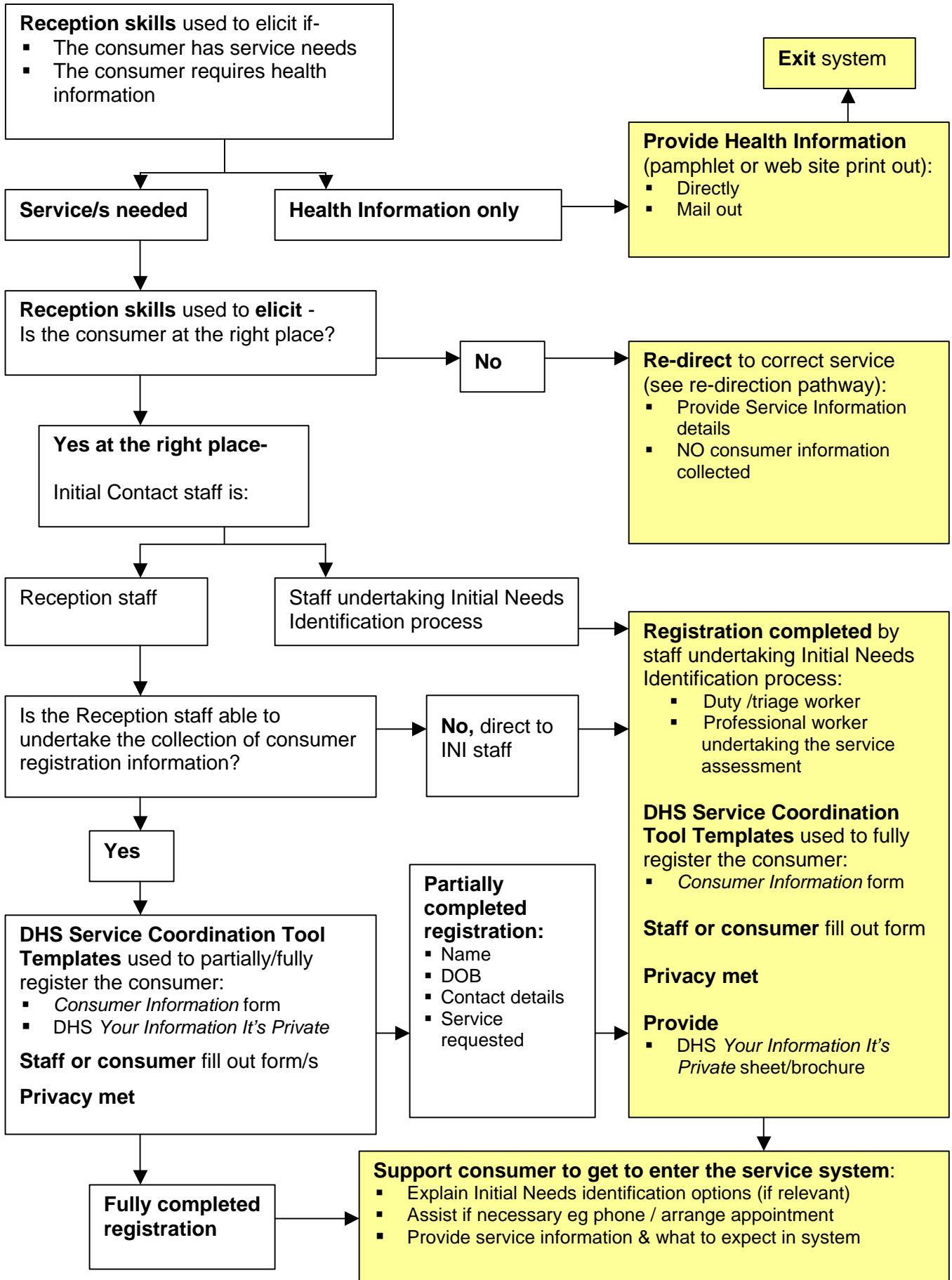
Protocol Area: Initial Contact	
Process:	Initial Contact is the process that occurs when a consumer first makes contact with the service system. The process ensures that systems and practices are in place so that consumers can be directed to the right health information or right service as quickly as possible. (It is <u>not</u> a referral process)
Goals	<p>Consumers can make first contact with the service system at any agency site, even if the consumer does not become a client of that agency:</p> <ul style="list-style-type: none"> ▪ All CVHA member agencies provide Initial Contact <p>Consumers have correct health or service information to ensure they are directed to the right service in a timely and appropriate manner</p> <p>Consumers have access to a variety of Initial Contact options:</p> <ul style="list-style-type: none"> ▪ Agencies offer personal contact options or contact via a print medium
Protocol Category	Practices that support the process
Roles And Responsibilities	<p>The role of the Initial Contact worker is:</p> <ul style="list-style-type: none"> ○ To direct or facilitate access to the service system (<u>not</u> a referral process) i.e. direct to the next process - Initial Needs Identification ○ If appropriate, to collect basic consumer registration details ○ To assist consumers in finding health or service information <p>Agencies are responsible for ensuring systems are in places for initial contact to occur at any agency site or via any agency print medium.</p>
Skills And Knowledge	<p>Agencies are responsible for ensuring Initial Contact staff have skills in:</p> <ul style="list-style-type: none"> ○ Customer service engagement, enquiry, and directing or re-directing consumers to services ○ Use of service directories, including electronic service directories <p>Initial Contact staff have knowledge of local services and service systems, and the broader primary health care service system</p>
Access To Initial Contact	<p>Initial Contact can be offered by a range of workers</p> <ul style="list-style-type: none"> ○ Reception staff ○ Staff undertaking Initial Needs Identification (next process) <p>Agencies provide a range of Initial Contact options eg</p> <ul style="list-style-type: none"> ○ Personal contact: face to face, phone, or other electronic medium contact ○ Via printed materials: brochures, information sheets, service directories <p>Agencies provide specific access to address physical, functional, cultural, and psycho-social needs eg Interpreter Service, Deaf Link, Wheelchair access</p> <p>Information is available in a variety of formats to inform consumers on how they make initial contact with agencies, and who in the agency can help direct them into the service system / to the right service</p>
Directing Or Re-Directing	<p>Initial Contact staff direct consumers to the appropriate service/program within their agency or redirect to an agency that meets their service request</p> <p>Provide consumers with printed service information. Baseline details are:</p> <ul style="list-style-type: none"> ○ Service/program name ○ Service address and phone number ○ Who to contact (title) at the service/program <p>Follow the CVHA "Initial Contact" or "Re-directing Consumers" Pathways</p>

<p>Facilitating Access To Initial Needs Identification</p>	<p>Initial Contact workers ensure consumers can access Initial Needs Identification</p> <ul style="list-style-type: none"> ▪ Provide support/assistance as needed ▪ Options of Initial Needs Identification systems made available (as applies to an agency). For example Initial Needs Identification can be undertaken with <ul style="list-style-type: none"> ○ The service being requested - First Service Provider ○ A Duty worker or Assessment Officer system
<p>Provision Of Health And Service Information</p>	<p>Agencies have systems to enable Initial Contact workers to source and provide requested Health Information eg access to pamphlets or <i>Better Health Channel</i></p> <p>Agencies have systems to resource and provide service information eg electronic service directories, or service information brochures/sheets.</p> <p>Agencies allocate designated workers to ensure service information is user-friendly, correct, has clear eligibility criteria and is up-to-date.</p> <p>Initial Contact workers provide consumers with information on what to expect in the service systems, eg</p> <ul style="list-style-type: none"> ▪ DHS <i>Your Information It's Private</i> ▪ Baseline service information details ▪ Outline of the agency's system for Initial needs Identification, service provision and complaints mechanisms
<p>Sharing Consumer Information: Collection And Exchange</p>	<p>Agencies collect, store and exchange consumer information in accordance with the Health Records Act 2001 or Privacy Act 2002 – see <i>DHS Privacy Kit</i></p> <p>Written information starts being collected at the agency in which the Initial Needs Identification is being undertaken (refer to section in <i>Initial Needs Identification</i>)</p> <ul style="list-style-type: none"> ▪ When a consumer is being re-directed to another agency no written information will be collected by the Initial Contact agency. However, DHS <i>Consumer Information</i> (registration) form can be given to the consumer. Follow the CVHA <i>Re-directing Consumers pathway</i> <p>Agencies determine if reception staffs register consumers who are to become clients of their agency. If not, this is undertaken at Initial Needs Identification</p> <ul style="list-style-type: none"> ▪ Follow the CVHA <i>Initial Contact pathway</i> ▪ Collection site and process ensures privacy met
<p>Tools And Resources</p>	<p>Tools and resources to provide service information:</p> <ul style="list-style-type: none"> ▪ Local service directories and brochures ▪ Local electronic service directory: www.connectingcare.com ▪ State-wide electronic service directory: http://pcpdirectroy.health.vic.gov.au/ ▪ Consumer telephone resource service: Commonwealth Carelink Centre – Freecall 1800 052 222 <p>Tools to support health information provision:</p> <ul style="list-style-type: none"> ▪ Better Health Channel: www.betterhealth.vic.gov.au <p>Tools and resources to support consumer information flow:</p> <ul style="list-style-type: none"> ▪ <i>DHS Privacy Kit</i> ▪ DHS Service Coordination Tool Templates <ul style="list-style-type: none"> ○ <i>Your Information It's Private</i> sheet ○ <i>Consumer Information</i> (registration) form <p>CVHA <i>Initial Contact</i> and <i>Re-directing Consumers at Initial Contact</i> Pathways</p>
<p>Workforce Development</p>	<p>Agencies ensure Initial Contact Staff have access to and training in:</p> <ul style="list-style-type: none"> ▪ DHS Service Coordination - all staff aware of Initial Contact practices ▪ Use of electronic service directories and health information sites ▪ CVHA Initial Contact protocols ▪ Privacy legislation / practices relating to Initial Contact



CVHA - Initial Contact Pathways

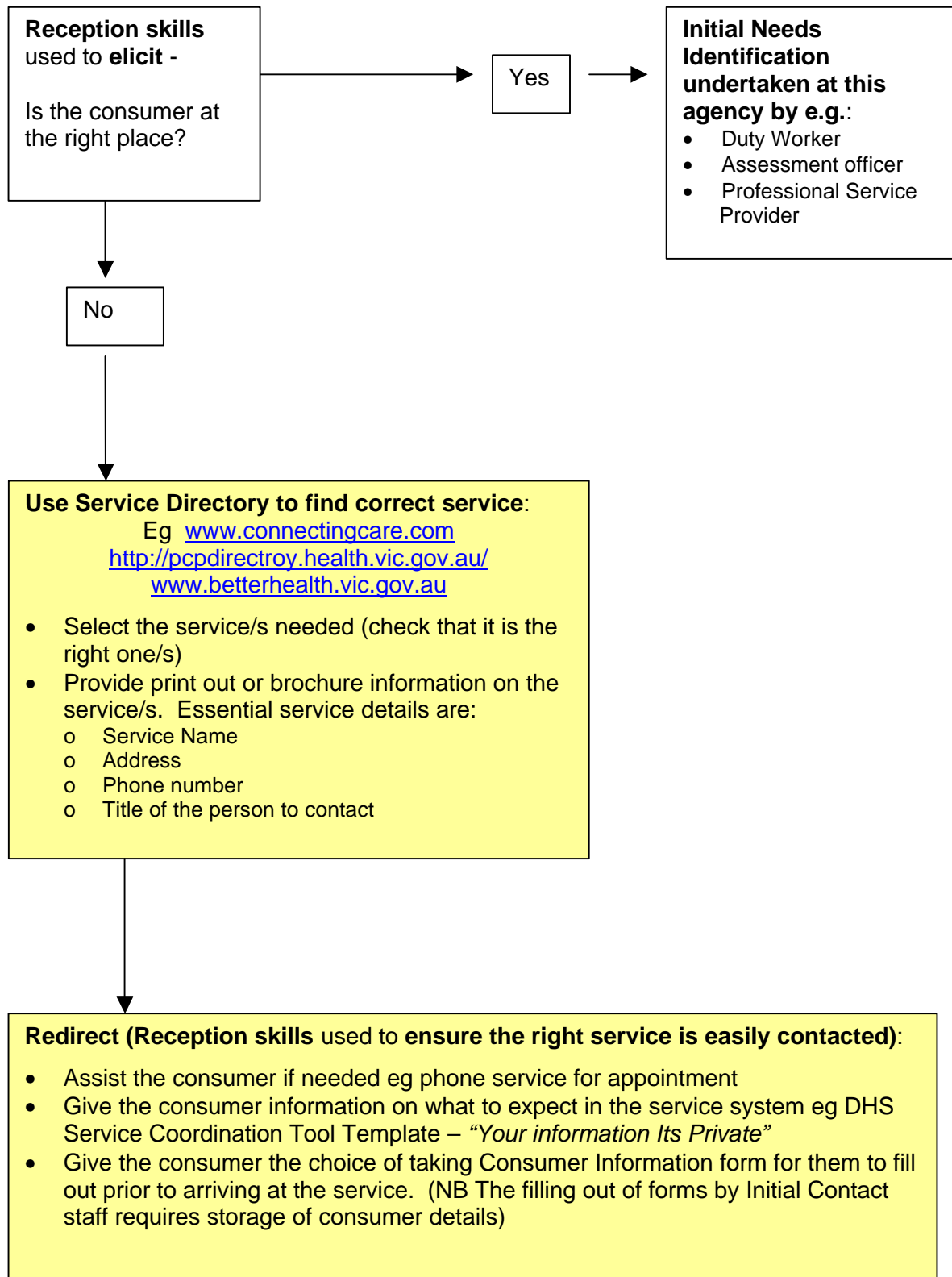
What if a consumer makes an Initial Contact enquiry in person (face-to-face or via the phone)?





CVHA - Initial Contact Pathways

What if a consumer needs redirecting at Initial Contact (or on reception)?



Protocol Area: Initial Needs Identification	
Process:	Initial Needs Identification is the process where the first agency that works with a consumer, with consent, undertakes a broad holistic general screening to help identify the consumer's service need/s: determines risk, service eligibility and priority of needs. (Screening <u>does not</u> diagnose health issues or problems, i.e. is <u>not</u> an assessment).
Goals	<p>Consumers have access to Initial Needs Identification when they first enter the service system:</p> <ul style="list-style-type: none"> ▪ Agencies provide a variety of Initial Needs Identification options ▪ Agencies can re-offer Initial Needs Identification later if required ▪ Agencies can also build on the process over time <p>Consumers have access to a range of services appropriate to their needs:</p> <ul style="list-style-type: none"> ▪ Agencies offer consumers broad screening to identify service need/s: determines risk, service eligibility and priority of needs ▪ Agencies provide health promotion and illness prevention opportunities <p>Consumers have opportunity to access appropriate services in a timely manner:</p> <ul style="list-style-type: none"> ▪ Agencies link consumers with appropriate services early <p>Consumers have access to a coordinated service system:</p> <ul style="list-style-type: none"> ▪ Agencies reduce duplication of information gathering through the sharing of common information, with consent.
Protocol Category	Practice Standards that support the process
Roles And Responsibilities	<p>The role of the Initial Needs Identification worker is to:</p> <ul style="list-style-type: none"> ○ Undertake a broad holistic screening for service needs ○ Screen for risk, service eligibility and priority of needs ○ Identify and provide early referrals for assessment/s &/or health information ○ Collect and share general consumer information to reduce duplication <p>Agencies are responsible for ensuring systems are in place at the sites in which Initial Needs Identification can be undertaken:</p> <ul style="list-style-type: none"> ○ Information on how Initial Needs Identification is provided by the agency ○ Provide systems and infrastructures that promote confidentiality / security
Skills	<p>Agencies are responsible for ensuring Initial Needs Identification workers are qualified (i.e. professional staff) to undertake the role.</p> <p>Agencies are responsible for ensuring Initial Needs Identification workers have skills in, and knowledge of:</p> <ul style="list-style-type: none"> ○ Customer service, engagement and appropriate way to provide information ○ Explanation of the screening process and its distinction from assessment ○ Collection of screening details in an engaging manner (eg write up later when summarising the needs identified – i.e. don't focus on forms) ○ Enquiry skills to identify a broad range of service needs through screening, but without going beyond professional abilities and service boundaries ○ Ability to prioritise needs and to collect the required screening details in a systematic way ○ General knowledge of local services and service systems, and the broader primary care service system ○ Use of electronic information sites, including electronic service directories

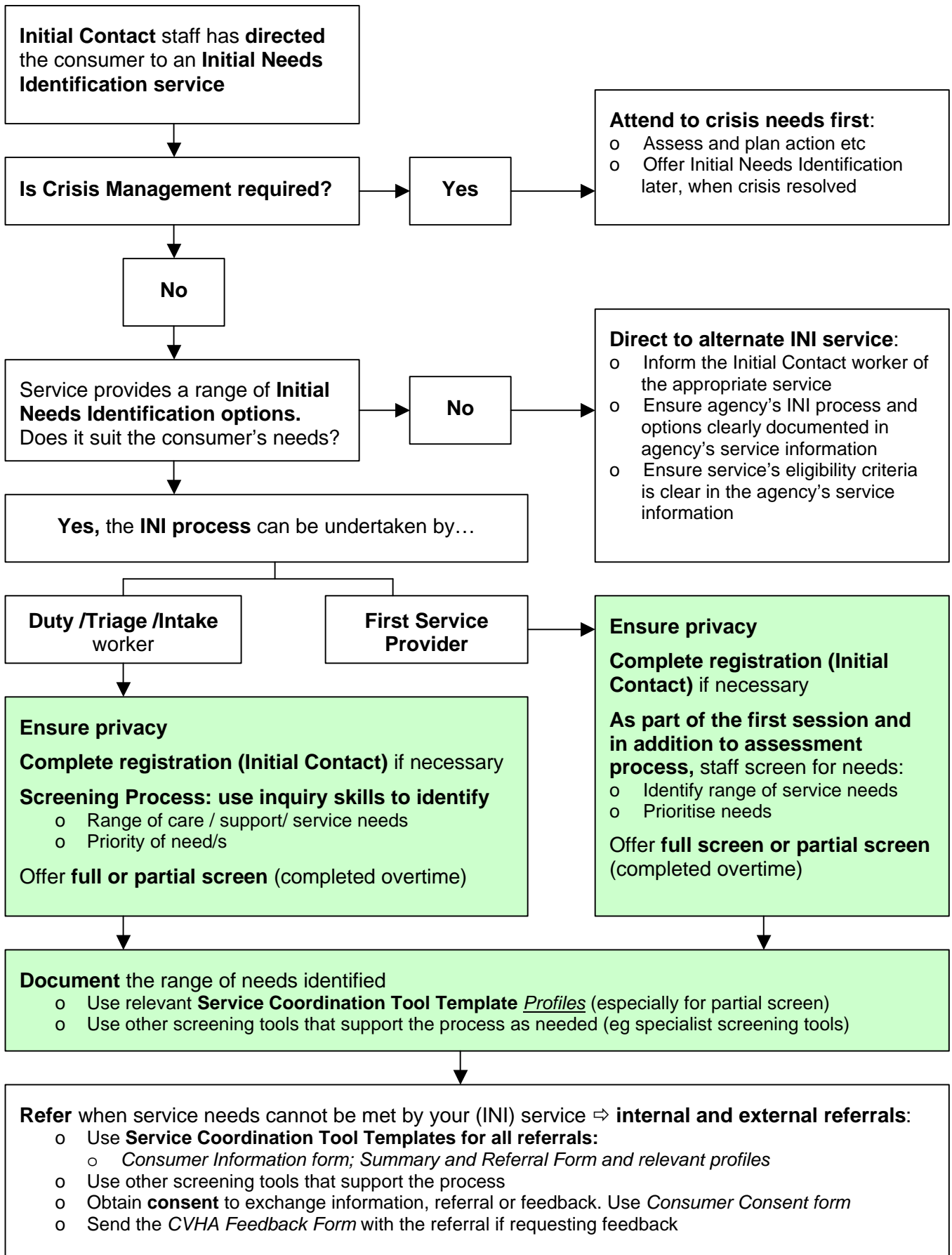
<p>Access to Initial Needs Identification</p>	<p>Agencies ensure consumers have access to the Initial Needs Identification e.g.:</p> <ul style="list-style-type: none"> o Systems and infrastructure in place in agency/ at agency sites o If unable to provide, facilitate access to the process at another agency o Re-offer the Initial Needs Identification process later if it is not undertaken at the first Service Provider’s contact e.g. 1st need is crisis management <p>Initial Needs Identification can be offered by a range of professional staff e.g.:</p> <ul style="list-style-type: none"> o Duty Worker / Intake Worker/Triage Worker o Assessment Officer o Individual Service Worker who provides the first service contact <p>Agencies may provide a range of Initial Needs Identification contact options:</p> <ul style="list-style-type: none"> o Phone contact o Face-to-face contact o Other electronic medium contact, eg email (secure), TTY <p>Specific access to address physical, functional, cultural and psycho-social needs eg Interpreter Service, Deaf Link, wheelchair access</p>
<p>Screening</p>	<p>Initial Needs Identification workers offer a broad and general screening of needs; it is not an assessment:</p> <ul style="list-style-type: none"> o The screening process can be: <ul style="list-style-type: none"> ▪ Built on over time ▪ Reviewed /updated with each successive referral as new needs arise o Screening is a self-reporting process i.e. not diagnostic but a need indicator o Priority of service need/s is also a self-identifying process o Screening tools can be used as needed to support identifying needs eg: <ul style="list-style-type: none"> ▪ Relevant sections of DHS Service Coordination Tool Template profiles ▪ Preferred/funding determined screening tools ▪ Specialist screening tools eg disability, carers, family and children etc <p>This information is summarised on and /or attached to the DHS Service Coordination Tool Template Summary and Referral Form</p> <p>Screening precedes all referrals (refer to Referral Protocol)</p> <p>Crises are always managed before undertaking Initial Needs Identification:</p> <ul style="list-style-type: none"> o Internal agency policy and procedures apply to crisis management practice o Initial Needs Identification is revised at the first most appropriate time after the crisis intervention / management
<p>Facilitate Referral(s) Or Access To Assessments</p>	<p>Initial Needs Identification workers ensure consumers can access assessments with the service/s that meet their identified need/s:</p> <ul style="list-style-type: none"> o Provide the consumer with options for the most appropriate means of making appointments with the service/s identified o Provide support/assistance to consumers as needed <p>Access is facilitated through the referral process (refer to referral protocol)</p>
<p>Provision of Health and Service Information</p>	<p>Agencies ensure that information re the Initial Needs Identification process is available to consumers in a variety of formats (written information sheet, web-site, agency pamphlet details). The information is to inform consumers on:</p> <ul style="list-style-type: none"> o What initial needs identification is, and the benefits to the consumer o How initial needs identification is provided by the agency o Options available for screening later if it is not provided initially <p>Agencies have systems to enable Initial Needs Identification Workers to source and provide Health Information eg electronic sites or health information brochures</p> <p>Agencies have systems to enable Initial Needs Identification Workers to source and provide Service Information eg electronic directories, or brochures/sheets</p>

<p>Sharing Consumer Information: Collection, Storage And Exchange Of Consumer Information</p>	<p>Written information starts being collected at the agency in which the Initial Needs Identification is being undertaken (refer to <i>Initial Contact protocol</i>)</p> <p>Agencies collect, store and exchange Consumer Information in accordance with the Health Records Act 2001 or Privacy Act 2000 – see <i>DHS Privacy Kit</i>.</p> <ul style="list-style-type: none"> o Consumers must be made aware of the agency's processes for collection, storage and exchange of consumer information o Consent is required at all times to exchange consumer information. See the <i>DHS Privacy Kit</i> exchange of consumer information without consent o Secure storage must be provided for all written consumer information <p>Agencies ensure there are internal policies and procedures to address collection or disclosure of consumer information without consent</p> <p>Consumers are given a copy of their information (where possible)</p>
<p>Tools And Resources To Support The Initial Needs Identification Process</p>	<p>Tools to support the Initial Needs Identification process and information flow:</p> <ul style="list-style-type: none"> o DHS Service Coordination Tool Templates: <ul style="list-style-type: none"> ▪ <i>Consumer Information Form</i> (registration form) – general minimum data ▪ <i>Summary and Referral Form</i> ▪ Partly or fully complete screening Profiles as needed; the profiles support the process of determining risk, service needs and priority <ul style="list-style-type: none"> □ <i>Living Arrangements profile</i> – (for HACC services) □ <i>Functional Screen</i> (for HACC services) □ <i>Health Conditions profile</i> □ <i>Health Behaviours profile</i> □ <i>Psychosocial profile</i> ▪ <i>Consumer Consent Form</i> ▪ <i>Your Information It's Private</i> – Consumer Information Brochure o Other specialised screening tools as relevant eg required for Carers Services, Psychiatric Services, Children's Services or Disability services o <i>DHS Privacy Kit</i> - collection, storage & exchange of Consumer Information o <i>CVHA Initial Needs Identification Pathways</i> <p>Tools and resources to provide service information:</p> <ul style="list-style-type: none"> o Local service directories and brochures o Local electronic service directory: www.connectingcare.com o State-wide electronic service directory http://pcpdirectroy.health.vic.gov.au/ o Consumer telephone resource service e.g.: <ul style="list-style-type: none"> ▪ Commonwealth Carelink Centre – Freecall 1800 052 222 o Agency information sheet that explains what to expect in the system <p>Tools to support health information provision:</p> <ul style="list-style-type: none"> o Better Health Channel: www.betterhealth.vic.gov.au
<p>Workforce Development</p>	<p>Agencies ensure Initial Needs Identification staff have access to & training in:</p> <ul style="list-style-type: none"> o DHS Service Coordination Orientation - all staff aware of Initial Needs Identification process, and use of Service Coordination Tool Templates o CVHA Initial Needs Identification protocols o Use of electronic service directories and health information sites o Privacy legislation/practices relating to Initial Needs Identification's collection, storage and exchange of consumer information



CVHA - Initial Needs Identification Pathway

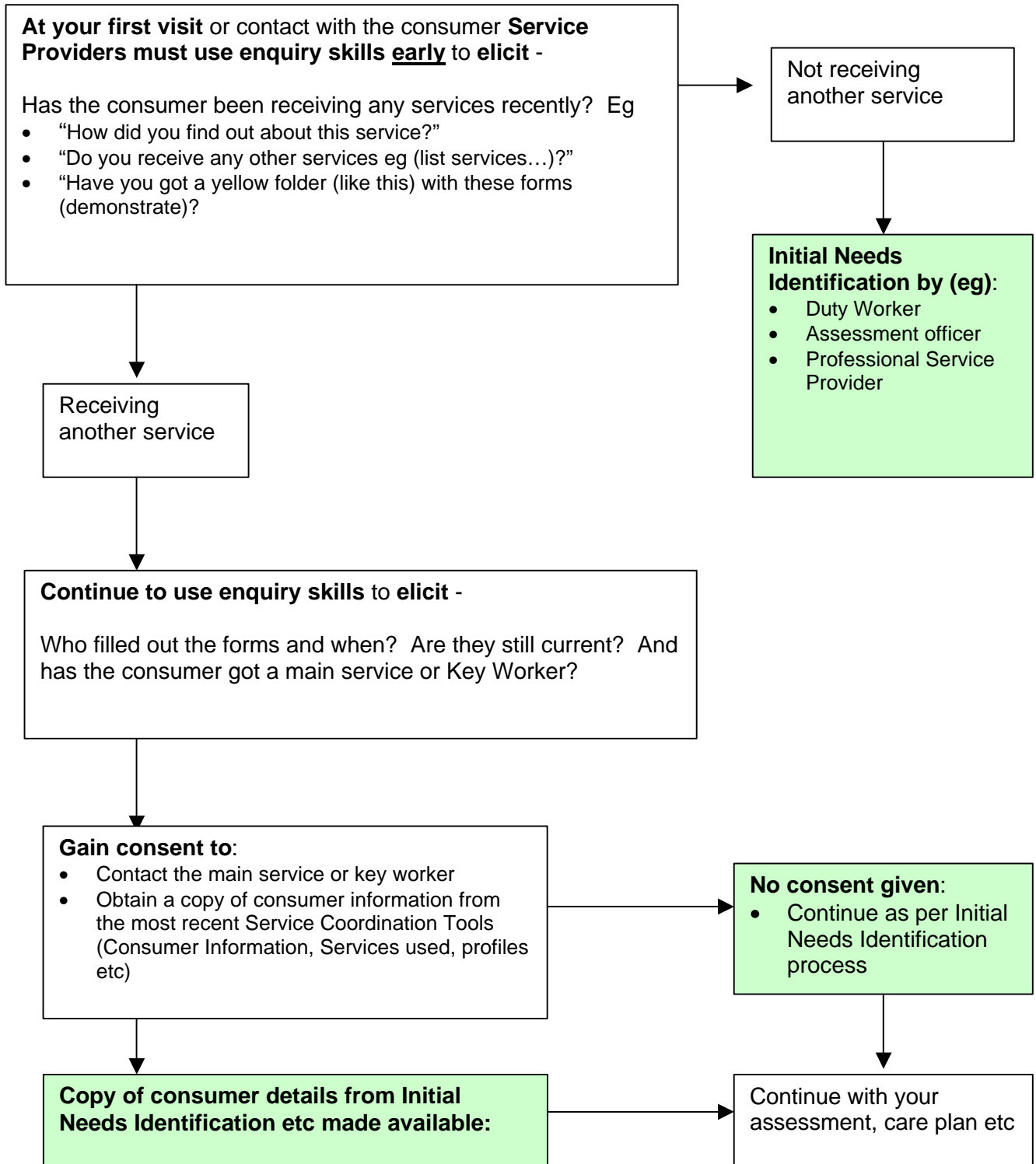
Staff facilitated access to Initial Needs Identification. What are the Initial Needs Identification options available for the consumer?






CVHA - Initial Needs Identification Pathway

What if a consumer has been recently seen by another service but you don't have a copy of the Service Coordination Tools?



Information Exchange

Protocol Area: Referral	
Process:	<p>A referral is the request by a Service Provider for a service. The process occurs as an outcome of a service need/s being identified; the referrer cannot meet this need/s. A referral is an inter-agency link: it connects the needs identification and assessment processes. (Referrals <u>cannot</u> determine the level of service needed).</p> <p>Sending and receiving referrals is part of the Information Management system.</p>
Goals	<p>Consumers have opportunity to access appropriate services in a timely manner:</p> <ul style="list-style-type: none"> ▪ Agencies link consumers with appropriate services early <p>Consumers have access to a coordinated, and seamless service system:</p> <ul style="list-style-type: none"> ▪ Agencies reduce duplication of information gathering through the sharing of common information, with consent ▪ Agencies ensure that all the relevant consumer information is shared with the receiving service, with consent; referral systems are enhanced <p>Consumers have access to a secure information management system:</p> <ul style="list-style-type: none"> ▪ Agencies ensure that systems are in place adhere to privacy legislation
Protocol Category	Practice Standards that support the process
Roles And Responsibilities	<p>The role of the professional worker making a referral/s is to enhance the response time of receiving service(s) and enhance consumer health outcomes:</p> <ul style="list-style-type: none"> ○ Adhere to privacy legislation; informed consent (see <i>DHS Privacy Kit</i>) ○ Collect or update and share demographic consumer information with the receiving service(s) via the <i>DHS Consumer Information Form</i>: ○ Ensure quality referral information: <ul style="list-style-type: none"> ▪ Information is tailored to meet the needs of the receiving service ▪ Details are appropriate and comprehensive ▪ Written referrals: legible or typed ▪ Information is easy to understand eg jargon free ▪ Use profiles or screening tools to augment/ standardise the process ○ Identify needs early and make referrals for assessment/s early (see the Initial Needs Identification process) ○ Ensure referrals are sent to the most appropriate services, via an appropriate communication system as determined by the level of urgency eg 📞 if URGENT <p>Agencies are responsible for ensuring systems are in place at the sites in which referrals are sent and received:</p> <ul style="list-style-type: none"> ○ Provide systems and infrastructures that promote the speedy sending and receiving referral. ○ Provide systems and infrastructures that promote confidentiality / privacy
Skills	<p>Agencies are responsible for ensuring that all workers who send and receive referrals are qualified / professional staff</p> <p>Agencies are responsible for ensuring Professional workers have skills in, and knowledge of:</p> <ul style="list-style-type: none"> ○ The appropriate use of the DHS Service Coordination Tool Templates ○ Collecting, documenting and imparting of relevant referral information to augment the receiving agency's intake and assessment processes ○ What constitutes "Quality" referrals ○ Working with other agencies in providing seamless multidisciplinary

	<p>care. E.g. to look beyond one's own assessment and service provision to the needs of, and best outcomes for, the consumer</p> <ul style="list-style-type: none"> o Local service systems, and the broader primary care service system o Use of service directories, including electronic service directories
<p>Access To The Referral Process</p>	<p>Agencies ensure consumers have access to timely referrals e.g.:</p> <ul style="list-style-type: none"> o Systems and infrastructure in place in agency/ at agency sites o Needs are identified early through the Initial Needs Identification or the Review / Monitoring [Ongoing Needs Identification] processes that reveal new or unmet needs <p>Referrals can be made by a range of professional workers at various times in the care continuum (entry, service provision review, care coordination review):</p> <ul style="list-style-type: none"> o Duty Worker / Intake Worker/ Triage worker / Assessment Officer o Individual Service Providers o Key Worker/ Care Coordinator/ Case Manager <p>Specific access to address physical, functional, cultural and psycho-social needs eg Interpreter Service, Deaf Link, wheelchair access</p>
<p>Referrals</p>	<p>All referrals are always documented by the sending service. Documentation supports the practices of determining service eligibility and intake prioritisation.</p> <p>Written documentation is <u>always</u> sent by the referrer to the receiving service:</p> <ul style="list-style-type: none"> ▪ Send the relevant DHS Service Coordination Tool Templates. <ul style="list-style-type: none"> NB: Forms are reviewed, updated or added as needed with each successive referral/s, i.e. as new needs arise o The <i>Consumer Information</i> (registration form) and <i>Consent/s forms</i> are <u>fully</u> completed o The <i>Summary and Referral</i> form is <u>always</u> completed and sent o The relevant <i>Profiles</i> are either partially or fully completed. ▪ DHS Service Coordination Tool Templates can be supplemented by other relevant information: <ul style="list-style-type: none"> o Specialist screening tools eg disability, carers, family and children o Assessment outcomes information relevant to the referral (e.g. assessment summary) o An individual service's care plan summary <p>This information is summarised on and /or attached to the DHS Service Coordination Tool Template Summary and Referral Form</p> ▪ A copy of the referral/s is to be kept in the client record ▪ A copy of the referral can be given to the consumer, where possible <p>Screening (identifying needs) precedes all referrals: i.e. Initial Needs Identification or Review/Monitoring to identify new needs (see Initial Needs Identification, Assessment and Care Coordination Protocols)</p> <p>A range of systems options can be provided for sending referrals, depending on the urgency of need and systems availability:</p> <ul style="list-style-type: none"> ▪ Consumer takes a copy of the details with them to designated worker ▪ A copy is faxed to designated worker (if confidential fax area) ▪ A copy is mailed to designated worker (if confidential mail system) ▪ Digitally signed, encrypted copy emailed to designated worker (only if receiver can decrypt) ▪ Baseline consumer details are phoned through to the designated worker. The full written referral is sent at the earliest opportunity as per above <ul style="list-style-type: none"> <input type="checkbox"/> Name, full residential address, and contact number <input type="checkbox"/> Date of Birth <input type="checkbox"/> Gender <input type="checkbox"/> Reason for the referral <p> If URGENT phone referral details. Send written copy ASAP</p>

<p>Facilitate Access To Assessments</p>	<p>Professional staff ensure consumers can access the service/s that meet their identified need/s:</p> <ul style="list-style-type: none"> o Provide the consumer with options for the most appropriate means of making appointments with the service(s) that they are being referred to o Provide support/assistance to consumers as needed <p>Intake to a service assessment is facilitated through the provision of all relevant documentation from either the Initial Needs Identification or Review process</p> <p>Referral/intake or assessment feedback can be requested by the referring service</p>
<p>Provision Of Health And Service Information</p>	<p>Agencies ensure that information re the referral process, and how information sharing is managed is made available to consumers:</p> <ul style="list-style-type: none"> o Provide the consumer with a copy of the DHS Service Coordination Privacy / Consumer Information brochure - <i>Your Information It's Private</i> <p>Agencies have systems to enable Professional Workers to source and provide Health Information eg electronic sites or health information brochures</p> <p>Agencies have systems to enable Professional Workers to source and provide Service Information eg electronic directories, or brochures/sheets</p>
<p>Sharing Consumer Information: Collection, Storage And Exchange Of Consumer Information</p>	<p>Agencies collect, store and exchange Consumer Information in accordance with the Health Records Act 2001 or Privacy Act 2000 – see <i>DHS Privacy Kit</i>.</p> <ul style="list-style-type: none"> o Consumers must be made aware of the agency's processes for exchange of consumer information and "what" is being exchanged o Consent is required at all times to exchange consumer information o Secure storage must be provided for all written consumer information <p>Agencies ensure there are internal policies and procedures to address collection or disclosure of consumer information without consent. (See the <i>DHS Privacy Kit</i> for disclosure / exchange of consumer information without consent).</p> <p>Consumers are given a copy of their information (where possible)</p>
<p>Tools And Resources To Support The Referral Process</p>	<p>Tools to support the Referral process and information flow:</p> <ul style="list-style-type: none"> o DHS Service Coordination Tool Templates: <ul style="list-style-type: none"> ▪ <i>Consumer Information Form</i> (registration form) ▪ <i>Summary and Referral Form</i> ▪ Partly or fully complete screening Profiles as needed <ul style="list-style-type: none"> □ <i>Living Arrangements profile</i> (for HACC services) □ <i>Functional Screen</i> (for HACC services) □ <i>Health Conditions profile</i> □ <i>Health Behaviours profile</i> □ <i>Psychosocial profile</i> ▪ <i>Consumer Consent Form</i> ▪ <i>Your Information It's Private</i> – Consumer Information Brochure o Other specialised screening tools as relevant eg disability, carers, family and children, mental health o Other relevant documentation e.g. referrer's assessment outcomes summary or individual service's care plan summary o <i>CVHA Feedback form</i> (see Feedback Protocol) o <i>DHS Privacy Kit</i> - exchange of Consumer Information o <i>CVHA Referral Pathways</i> <p>Tools and resources to provide service information:</p> <ul style="list-style-type: none"> o Local service directories and brochures o Local electronic service directory: www.connectingcare.com o State-wide electronic service directory: http://pcpdirectroy.health.vic.gov.au/

	<ul style="list-style-type: none"> o Consumer telephone resource service: <ul style="list-style-type: none"> ▪ Commonwealth Carelink Centre – Freecall 1800 052 222 <p>Tools to support health information provision:</p> <ul style="list-style-type: none"> o Better Health Channel: www.betterhealth.vic.gov.au
Workforce Development	<p>Agencies ensure that Professional staff have access to & training in:</p> <ul style="list-style-type: none"> o DHS Service Coordination Orientation - all staffs aware of information management as it relates to the referral process, and use of Service Coordination Tool Templates o CVHA referral protocols o Use of electronic service directories and health information o Privacy legislation/practises relating to the collection, storage and exchange of consumer information o Information Management processes

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CVHA Referral Pathway

What do you do if you need to make a referral(s)?

At either Initial Needs Identification screening or Review or Monitoring of care you **identify** that the consumer you are working with has **new or previously unidentified need/s**. **What do you do?**

Can these needs **be met by your service?**

Yes

Undertake your services':
o Assessment
o Re-assessment

Develop or revise your service's plan
Deliver the new or revised service

No

Gain consent to undertake the referral/s:
o Record details on *Consent form*. This is your service's record
o If multiple needs identified, can the referral information be shared with all or some of the required services?

No consent is given:
o Discuss options for self referral with consumer
o If you need to exchange consumer information without consent, follow your agency's Policies and Procedures

Consent is given for....

Individual referral per form:
o Use a new *Summary and Referral form* for each service

Multiple referrals per form:
o Multiple referrals included on one *Summary and Referral form*

Remember to attach any information that is relevant to or supports the referral and a service's intake or assessment processes eg:
o Profiles
o Care Plan

Proceed with the referral/s:
o *Consumer Information form* completed or checked and updated
o Screening information recorded or updated on relevant *Profiles* or *other tools*
o *Summary and Referral Form/s* completed depending on consent (as above)
o *Consent form* completed and copy given to the consumer, original kept in consumer file

Request relevant **Feedback:**
CVHA Feedback Form

Is the referral **urgent?**

No

Yes..... Phone urgent details to the service:
o Confirm their capacity for immediate intake
o Seek alternate options **if no** intake capacity
o Provide verbal details; send written referral ASAP

Send written referral/s via the most appropriate and secure method:
o **Email** (digitally signed & encrypted)
o **Fax** (secure fax number)
o **Post** (**non-urgent** referrals)
o **Consumer** takes to designated service (referral phoned through)



What if you need to do another referral to another agency or service?

You have deemed a referral as eligible; you undertake your assessment and are undertaking your planned care (treatment or management). However you find on your assessment or review that the consumer has other **new or previously unidentified need/s**. This requires that you **make a referral**.
What do you need to do?

Professional Workers use enquiry skills to elicit –
Is the agency you need to refer to **already working with or involved in the care of this consumer?** Eg:
o “Have you recently received any services from this agency?”

Not currently receiving a service from this agency

Is currently receiving a service from the agency

Use the Service Coordination Tool Templates for the referral:
o Update the relevant profile/s
o Undertake a new referral completing the Summary and Referral form

NB
Only change the details on the forms that you are updating

The Summary and Referral form always records new referral details:
o Referrer details (bottom section of each page)
o Need/s you identified
o Update current services:
▪ Include your service
▪ Include/delete others
o Record your referral action plan for this referral

Continue to use enquiry skills to elicit -
If so, when, by whom, etc...?
Does the main service or key worker know?

Gain consent to:
• Contact the service provider
• Contact the main service or key worker
Obtain a copy of the consumer details on the most current Service Coordination Tools
Feedback the **need** you **identified** to the Service Provider, if not already addressed

If no main service or no key worker allocated

Consider Care Coordination if there are 3 or more ongoing services and the needs are complex and multiple/chronic



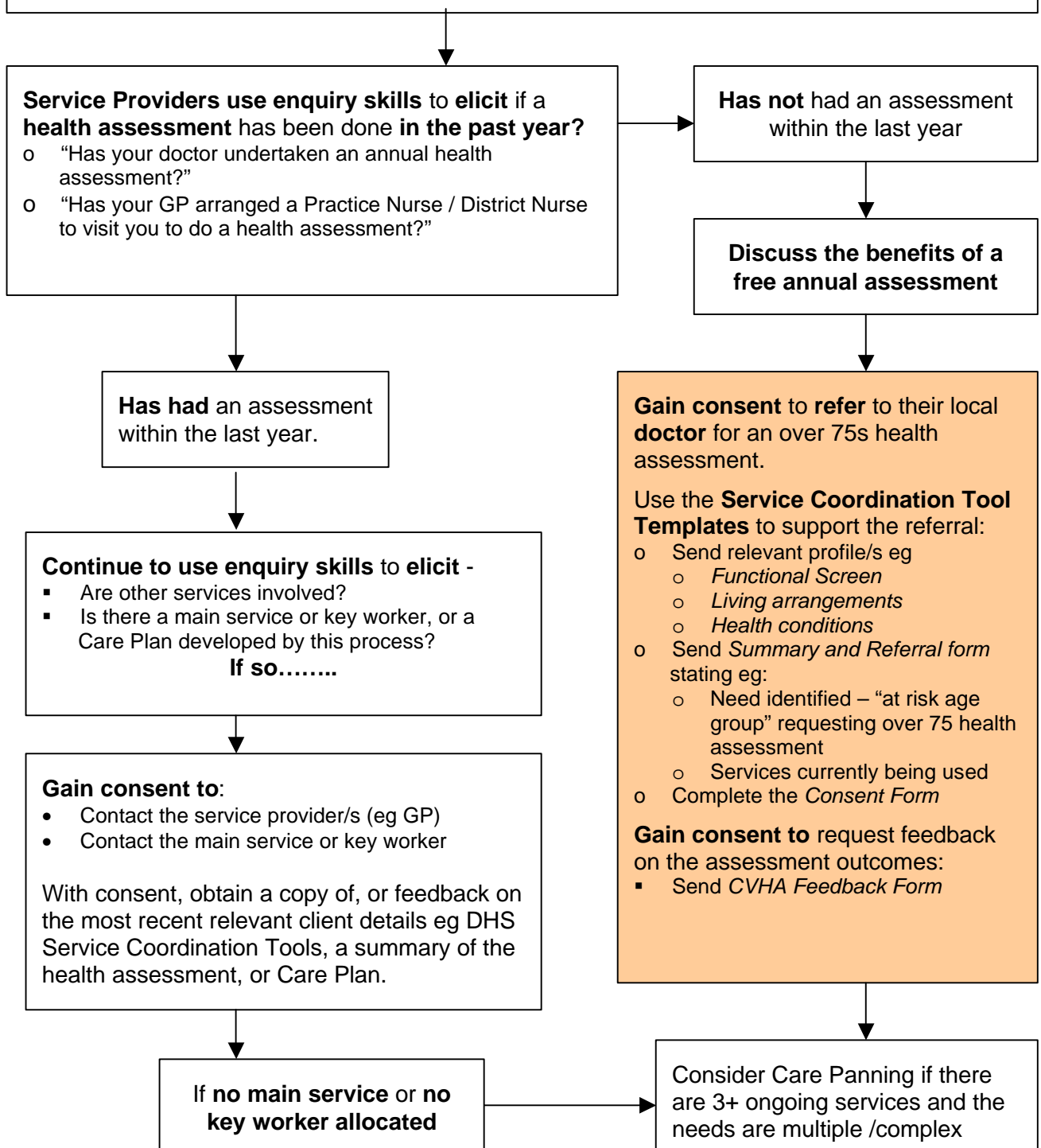
CVHA Referral Pathway

What if you are working with a client who is 75 or over? (Or an Aboriginal or Torres Straight Islander 55 or over?)

You are about to work with, or are already working with, a client who is 75+. You are organising to undertake your assessment or review of their care needs (re-assessment).

You **identify** that their age deems them as an “at risk group” that would benefit from an annual free **health assessment**. They are also potential users of other services, and may benefit from a **care plan** if their care needs are multiple and complex.

What do you need to do?



Individual Service Provision

Individual service provision consists of 2 service coordination elements: assessments, progressing to provider developed care plan (determining service strategies/actions)

There are no protocols per se for individual service provision, rather a mutual understanding of the processes. CVHA member agencies will continue to implement their own individual intervention and review systems: Services Providers adhering to their program guidelines and developing relevant internal pathways (eg intake, allocation, exit)

Protocol Area: Assessment	
Process:	Assessment builds on the Needs Identification process (Initial Needs or Reviewed Needs). It is more in-depth process than screening. The aim of an assessment is to diagnose /identify the consumer/patient's problem/s and then to address the problem/s. The outcome is the development of a plan of action: a care plan.
Goals	[Determined at individual agency level]
Protocol	Practice Standards that support the process
Roles And Responsibilities	[Determined at individual agency level]
Access To Assessment	Via needs identified in a referral: either the Initial Needs Identification process, or new needs identified following an Assessment Care Plan Review processes (Refer to Initial Needs identification– screening section and the Referral processes) [Specifics determined at individual agency level – eg Intake, Allocation processes]
Assessments	Services are funded to provide holistic assessments as per their funding guidelines. Assessments are either: <ul style="list-style-type: none"> o Service Specific – generalist services undertake a range of assessments related to the specific presenting service need/s o Specialist – specialist services undertake assessments that use specialist tools and plans related to that specialist area o Comprehensive – case management or assessment services are funded to gather assessment and diagnostic data from several sources, and compile a comprehensive overview of the multiple and complex issues and develop a comprehensive plan to help resolve these issues <p>New needs may be identified as a consequence of the assessment process that the assessing service cannot meet: a referral/s need to be made. Referrals are a separate process and require screening of the new need/s (Refer to Initial Needs Identification and the Referral protocols)</p>
Access to Service Provider Care Plans	Action/Treatment/Management/Service/Care Plans etc are developed from all Assessments, even if it is an informal process eg treatment/ plan is written in notes [Specifics determined at individual agency level]
Skills	[Determined at individual agency level]
Health / Service Info	Agencies provide consumers with relevant health and service information. [Specifics determined at individual agency level]
Tools	[Specifics determined at individual agency level]
Information Sharing	Not applicable – no information is shared with other agencies as this is not a referral or feedback process; collection and storage is an internal process
Workforce Development	[Determined at individual agency level]

Protocol Area: Assessment Outcomes (Service Provider Care Plans)	
Process:	A Service Provider Care Plan is an Action /Treatment /Management /Service /Care Plan etc derived from the assessment process: agreed strategies or actions addressing the issue/s identified in the assessment. Care Plans are the basis of service delivery and subsequent review and monitoring: the assessment outcome.
Goals	[Determined at individual agency level]
Protocol Category	Practice Standards that support the process
Roles and responsibilities	[Determined at individual agency level]
Access to Service Provider Plans	Via an Assessment (see above) [Specifics determined at individual agency level – eg Intake, Allocation processes]
Service Provider Care Plans	<p>Care Plan process includes goal and action setting, service delivery and review.</p> <p>Services develop plans based on the assessment – i.e. the Assessment Outcome:</p> <ul style="list-style-type: none"> o Plans are the basis of service delivery or management. They outline the problem/s, the goals and the action to be taken to achieve the goals o Plans can be an informal process eg treatment/ plan is written in notes o Plans may be useful/relevant referral or feedback information <p>Service delivery is provided to the consumer as per the Care Plan:</p> <ul style="list-style-type: none"> o Service Providers implement their care plans o Responsible for own service delivery, even when a Key Worker involved <p>Review of the Care Plan:</p> <ul style="list-style-type: none"> o CVHA member agencies are responsible for monitoring and reviewing their clients/patients’ care, as required: <ul style="list-style-type: none"> ▪ If plans are effective, goals met then clients/patients are exited ▪ If goals are not met but plans are effective, plans are continued ▪ If plans are not effective then the review screens to identify new needs: for either re-assessment or referral to another service. o New needs may be identified as a consequence of the review process and a referral/s need to be made. Referrals are a separate process and require screening of the new need/s (Refer to Initial Needs identification – screening section and the Referral processes) o If a Key Worker is allocated, collaboratively review the consumer’s Service Coordination Plan with the Multi-disciplinary Team. The Service Provider plans may need revising to adopt any agreed goals or actions.
Access to Multidisciplinary Care	See Feedback and Care Coordination (Multidisciplinary Care Planning) protocols [Specifics determined at individual agency level]
Skills	[Determined at individual agency level]
Health / Service Information	Agencies provide consumers with relevant health and service information. Health promotion is incorporated at all levels of service delivery: primary prevention, and prevention of secondary and tertiary complications of an illness or problem. [Specifics determined at individual agency level]

Tools	[Specifics determined at individual agency level]
Information sharing	Not applicable – no information is shared with other agencies as this is not a referral or feedback process; collection and storage is an internal process
Workforce Development	[Determined at individual agency level]



Agency Assessment Pathway

Information Exchange

Protocol Area: Feedback	
Process:	<p>Feedback is the process where agencies communicate the outcome/s of referral, assessment or service delivery. As an interagency link, feedback connects the needs identification and assessment, or the assessment and care coordination processes. Feedback completes the cycle in the continuum of care. (Feedback is <u>not</u> a referral).</p> <p>Sending and receiving feedback is part of the Information Management system.</p>
Goals	<p>Consumers have access to a coordinated, seamless service system:</p> <ul style="list-style-type: none"> ▪ Agencies inform and are informed of the relevant outcome/s of referral, assessment or service delivery, with consent ▪ Agencies reduce duplication of information gathering through the sharing of relevant service provision information, with consent <p>Consumers have access to quality care through the provision of quality feedback:</p> <ul style="list-style-type: none"> ▪ Agencies tailor feedback or make it relevant to the receiving service ▪ Agencies ensure that feedback is timely, succinct and legible <p>Consumers have access to a secure information management system:</p> <ul style="list-style-type: none"> ▪ Agencies ensure that systems are in place and adhere to privacy legislation
Protocol Category	Practice Standards that support the process
Roles And Responsibilities	<p>The role of the professional worker in providing feedback is to:</p> <ul style="list-style-type: none"> ○ With informed consumer consent, share all information that is deemed relevant_or applicable to the receiving service's interventions, or key worker: <ul style="list-style-type: none"> ▪ To reduce duplication, or contra-indicated care ▪ To improve response times for, or information that enhances intake, assessments, care plans and service provision ▪ To improve consumer health outcomes through this process ○ Adhere to the privacy legislation ○ Ensure quality feedback: <ul style="list-style-type: none"> ▪ Sent as soon as possible, within 7 days ▪ Tailor feedback information to meet the needs of the receiving service in relation to planning care/treatment for the consumer ▪ Write legibly or type information ▪ Keep information succinct (not too much or too little) eg summarise ▪ Use a consistent format i.e. <i>CVHA Feedback Form</i> ▪ Build on feedback information over time if time-lapse between referral acceptance and assessment (eg on waiting list) ○ Send feedback to the most appropriate services, including the GP routinely ○ Send feedback via an appropriate communication system as determined by the level of urgency <p>Agencies are responsible for ensuring systems are in place at the sites in which feedback is sent and received:</p> <ul style="list-style-type: none"> ○ Provide systems and infrastructures that promote the speedy sending and receiving of feedback. ○ Provide systems and infrastructures that promote confidentiality / privacy

<p>Skills</p>	<p>Agencies are responsible for ensuring that all workers who send and receive feedback are qualified / professional staff</p> <p>Agencies are responsible for ensuring Professional staff have skills in, and knowledge of:</p> <ul style="list-style-type: none"> ○ The appropriate use of the <i>CVHA Feedback form</i> ○ Quality feedback (relevant to the receiver, timely, succinct, and legible) ○ Determining what is relevant / appropriate to feedback, and to whom ○ Documenting and imparting of relevant feedback information to augment the receiving service's assessment and care planning processes ○ Working with other agencies in providing seamless multidisciplinary care. E.g. to look beyond one's own assessment and service provision boundaries, to the total needs of, and best outcomes for the consumer
<p>Access To The Feedback Process</p>	<p>Agencies ensure consumers have access to timely feedback options e.g.:</p> <ul style="list-style-type: none"> ○ Systems and infrastructure in place in agency/ at agency sites ○ Multidisciplinary care is enhanced by speedy the feedback of consumer information from intake, assessment, care plans or service provision: <ul style="list-style-type: none"> ▪ It reduces duplication, or contra-indicated care, or hearsay ▪ It improves services' individual care plans and service provision ▪ Ultimately, it improves consumer health outcomes <p>Feedback can be made by a range of professional workers at various times in the care continuum (referral intake, assessment, review/monitoring)</p> <ul style="list-style-type: none"> ○ The <i>CVHA Feedback Form</i> can be: <ul style="list-style-type: none"> ▪ Requested as part of the referral or care coordination processes ▪ Initiated as the service provider who has either received a new referral or provided an initial assessment or re-assessment <p>Specific access to address physical, functional, cultural and psycho-social needs eg Interpreter Service, Deaf Link, wheelchair access</p>
<p>Feedback</p>	<p><u>All</u> feedback is <u>written</u>. Documentation supports the practices of multidisciplinary care in determining coordinated service provision</p> <ul style="list-style-type: none"> ○ A copy of the feedback information is kept as correspondence in the client record or documented that it has been sent in client notes <p>Written feedback is <u>always</u> sent by a service when:</p> <ul style="list-style-type: none"> ○ Received a new referral or have provided an initial assessment ○ Undertaken a re-assessment and goals or issues have changed. <p>The following principles are used to ensure quality feedback. Feedback is:</p> <ul style="list-style-type: none"> ○ Always sent to relevant service providers eg referrer ○ GPs and nominated Key Workers always receive a copy of feedback information ○ Sent as soon as possible, within 7 days depending on urgency and service provider's planned action or capacity to reply <ul style="list-style-type: none"> ☎ If Urgent: details are phoned through to the designated worker. ○ Tailored to meet the receiving service's need ○ Written legibly or typed ○ Succinct (not too much or too little) eg summarised assessment and service information ○ Built on over time <ul style="list-style-type: none"> ▪ If there is a time-lapse between the referral acceptance and assessment (eg consumer is on waiting list)

	<ul style="list-style-type: none"> ▪ When care needs and interventions change on re-assessment (eg crisis management interventions) o An ongoing process that needs updating as the situation/ care changes <p>For consistency in feedback information use the <i>CVHA Feedback Form</i>:</p> <ul style="list-style-type: none"> o The <i>CVHA Feedback Form</i> can be used for: <ul style="list-style-type: none"> ▪ Referral Acknowledgement /Intake Outcomes ▪ Assessment outcomes o The <i>CVHA Feedback Form</i> can be: <ul style="list-style-type: none"> ▪ Requested as part of the referral or care coordination processes ▪ Initiated as the service provider who has either received a new referral or provided an initial assessment or re-assessment o The <i>CVHA Feedback Form</i> can be supplemented with other information: <ul style="list-style-type: none"> ▪ Specialist screening tools eg disability, carers, family and children ▪ Specialised Assessment forms (e.g. Over 75's Health Assessment) ▪ An individual service's care plan summary <p>This information is summarised on and /or attached to the <i>CVHA Feedback Form</i></p> <p>Use one of the following options for sending the CVHA Feedback Form, depending on the urgency of need and systems availability:</p> <ul style="list-style-type: none"> ☎ A copy is faxed to designated worker (if confidential fax area) ✉ A copy is mailed to designated worker (if confidential mail system) 📧 Digitally signed, encrypted copy emailed to the designated worker (only available if the receiver can decrypt the email) 📞 If Urgent: Consumer details are phoned through to the designated worker: <ul style="list-style-type: none"> ☐ Summarise feedback details <p>The full <u>written feedback</u> is sent at the <u>earliest opportunity</u> as above</p>
<p>Facilitate Access To Quality Service Provision</p>	<p>Service provision is facilitated through the exchange of all relevant feedback information from the Referral Intake, Assessment or Care Plan Review processes</p> <p>Feedback is given, with consent, to <u>all</u> the relevant service providers in the care continuum (entry, service provision or care coordination):</p> <ul style="list-style-type: none"> o Duty Worker / Intake Worker/ Triage worker / Assessment Officer o Individual Service Providers eg GPs o Key Worker/ Case Manager
<p>Provision Of Health And Service Information</p>	<p>Agencies ensure that information re the feedback process, and how information sharing is managed, is made available to consumers:</p> <ul style="list-style-type: none"> o Provide the consumer with a copy of the DHS Service Coordination Consumer Information brochure - <i>Your Information It's Private</i>
<p>Sharing Consumer Information: Collection, Storage And Exchange Of Consumer Information</p>	<p>Agencies collect, store and exchange Consumer Information in accordance with the Health Records Act 2001 or Privacy Act 2000 – see <i>DHS Privacy Kit</i>.</p> <ul style="list-style-type: none"> o Consumers must be made aware of the agency's processes for collection, storage and exchange of consumer information o Consent is required at all times to exchange consumer information. (See the <i>DHS Privacy Kit</i> for disclosure / exchange of consumer information without consent) o Secure storage must be provided for all written consumer information <p>Agencies ensure there are internal policies and procedures to address collection or disclosure of consumer information without consent</p>

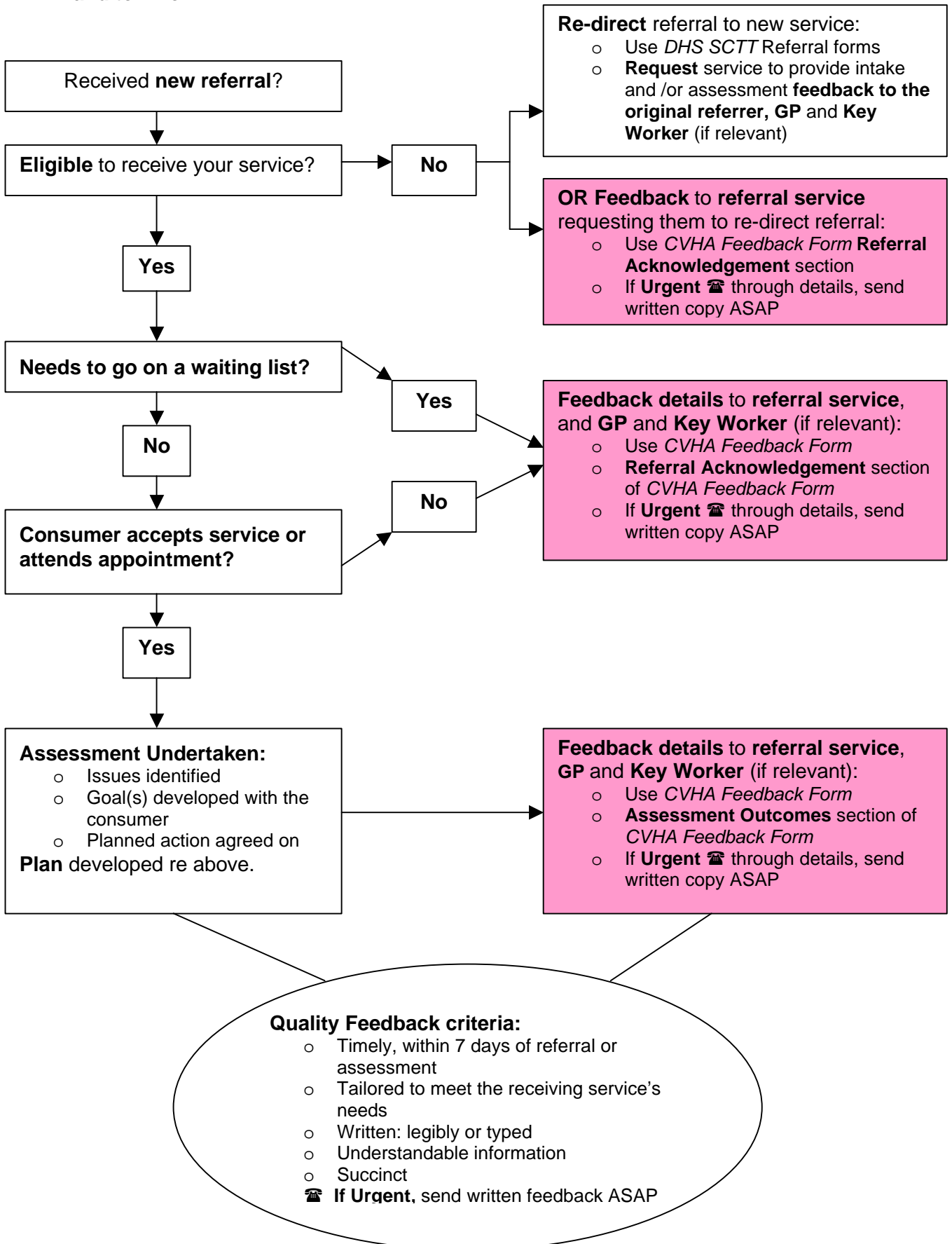
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<p>Tools And Resources To Support The Referral Process</p>	<p>Tools to support the Feedback process and information flow:</p> <ul style="list-style-type: none"> o CVHA Feedback form o DHS Service Coordination Tool Templates and guidelines: <ul style="list-style-type: none"> ▪ Consumer Consent Form ▪ Your Information It's Private – Privacy / Consumer Information Brochure o Other relevant documentation tools e.g. assessment summary or individual service's care plan summary o DHS Privacy Kit - collection, storage & exchange of Consumer Information o CVHA Feedback Pathways
<p>Workforce Development</p>	<p>Agencies ensure that Professional staff have access to & training in:</p> <ul style="list-style-type: none"> o CVHA Feedback Form and quality feedback o CVHA feedback protocols o DHS Service Coordination Orientation - all staffs aware of information management as it relates to the feedback process, and use of Service Coordination Tool Templates o Privacy legislation re collection and exchange of consumer information o Information Management processes



Feedback Pathway

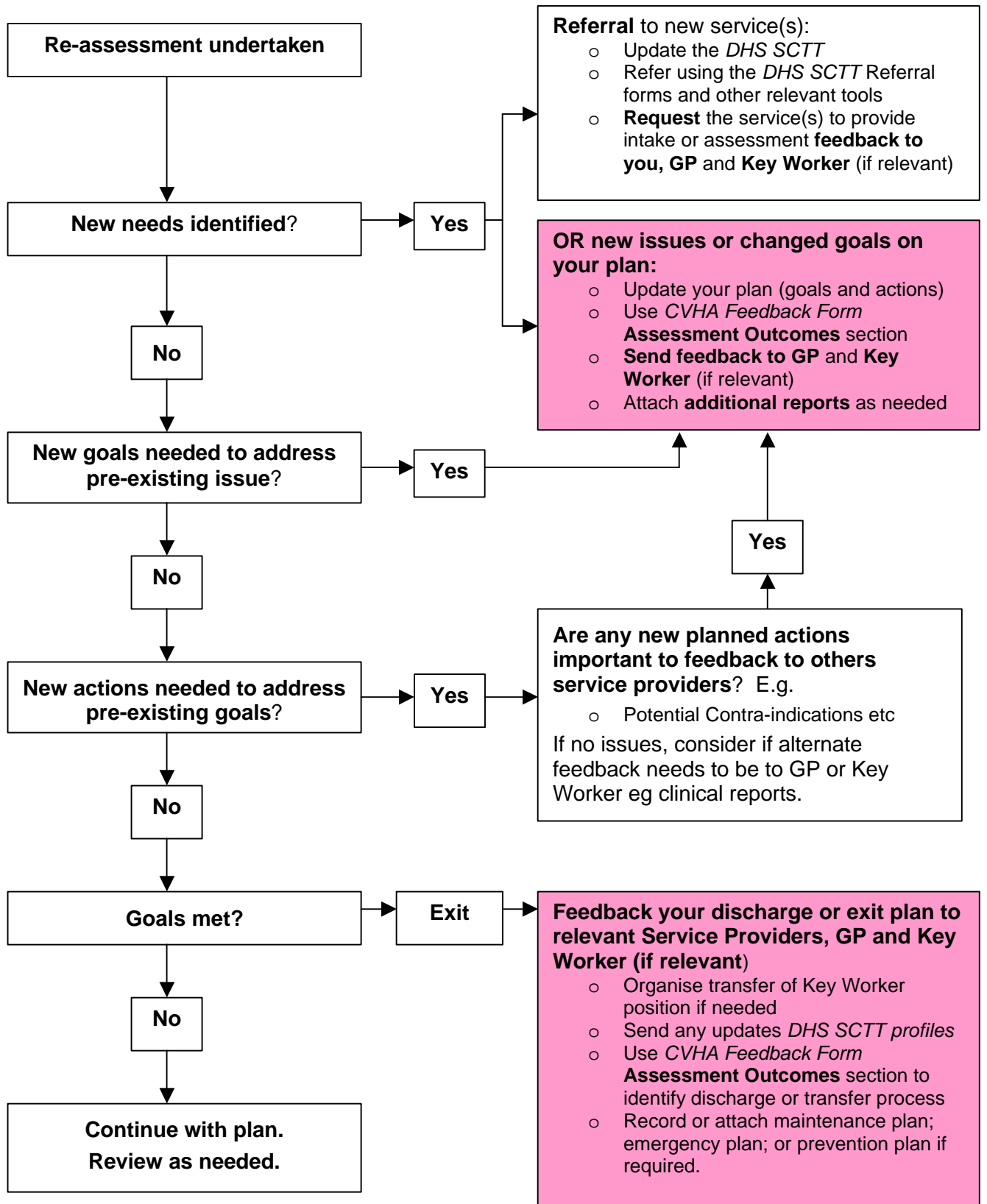
You have received a new referral and have actioned it. What feedback do you give and to whom?





Feedback Pathway

You have just undertaken a re-assessment or review of your client's / patient's plan. What feedback do you give and to whom?



Care Coordination

Protocol Area: Care Coordination (Service Coordination/ Multi-disciplinary Care Plans)	
Process:	<p>Care Coordination is a multi-disciplinary process: a consumer uses multiple services (3 or more) and their care needs/issues are chronic and/or complex.</p> <p>Care Coordination includes:</p> <ul style="list-style-type: none"> ▪ With consent, the synthesis of assessment feedback from the range of services involved in the consumer's care, and carer / support information ▪ Collaborative development of a multi-disciplinary plan with all the services and supports to ensure common achievable goals and strategies, and to cover the breadth of the consumer's care needs ▪ Collaborative monitoring and reviewing of the multi-disciplinary plan goals. <p>All this is facilitated by a nominated Key Worker / Person.</p> <p>Feedback informs Care Coordination: Care Coordination relies on the sharing of information within the multi-disciplinary team to develop a Service Coordination / Multi-disciplinary Care Plan. (A Care Plan is <u>not</u> a referral nor is it feedback).</p>
Goals	<p>Consumers, who have multiple, complex and /or chronic care needs, have access to a coordinated, seamless service system:</p> <ul style="list-style-type: none"> ▪ With consent, a nominated Key Worker informs and is informed of relevant referrals and assessment outcome/s (plans, service delivery, reviews) ▪ With consent, agencies reduce duplication or service delivery gaps through the sharing of information culminating in a multi-disciplinary care plan <p>Consumers have access to coordinated care through a multi-disciplinary care plan:</p> <ul style="list-style-type: none"> ▪ Agencies provide assessment outcome feedback to the Key Worker ▪ Agencies reduce duplication, or contra-indicated care ▪ Agencies improve consumer health outcomes through this process <p>Consumers / primary carers have choices within and ownership of the process:</p> <ul style="list-style-type: none"> ▪ Processes enable consumers to be part of the multi-disciplinary team ▪ Processes enable consumers to choose a Key Worker, or where-ever possible and appropriate the consumer / primary carer is the Key Person and support is provided from service providers to enable this to occur
Protocol Category	Practice Standards that support the process
Roles and responsibilities	<p>With consent, a nominated Key Worker collects, collates then coordinates the sharing of <u>all</u> relevant information within the nominated multidisciplinary team. The role of the Key worker is:</p> <ul style="list-style-type: none"> o Prior to developing/reviewing a Service Coordination / Multidisciplinary Plan: <ul style="list-style-type: none"> ▪ To facilitate the feedback of all new / updated assessment outcomes. The <i>CVHA Feedback form</i> augments this process ▪ To Collect and collate / synthesise the assessment feedback. ▪ To update Service Coordination Tool Template information (eg Consumer Information, Summary of Services/Supports Involved, and relevant Profiles etc), and disseminate within multi-disciplinary

	<p>team</p> <ul style="list-style-type: none"> o To arrange face-to-face / teleconference meetings, or printed information exchanges (or combinations of these 3) to enable the development of one multidisciplinary plan, derived from services' feedback o To ensure consumers and / or primary carers are part of the team: <ul style="list-style-type: none"> ▪ Facilitating agreements with issues, goals, actions and priorities set ▪ Where possible, co-developing of the multi-disciplinary care plan o To ensure the multi-disciplinary care plan is signed by the consumer/ carer o To ensure written consent is given to enable exchange of consumer information between those nominated to be involved in the development and receipt of the multi-disciplinary care plan o To distribute the plan to all those involved and nominated to receive it. <p>Agencies are responsible for ensuring systems are in place to enable coordinated, collaborative multi-disciplinary approaches:</p> <ul style="list-style-type: none"> o Provide systems that promote development of multi-disciplinary care plans: <ul style="list-style-type: none"> ▪ Enable sending and receiving consumer information ▪ Promote privacy eg conference rooms or teleconferencing facilities o Include the role and boundaries of Key Worker in position descriptions o Enable worker/s availability to be part of a multi-disciplinary team/s (via print, phone or conferencing)
Skills	<p>Agencies are responsible for ensuring that all workers who are nominated to be Key Workers are qualified / professional staff</p> <p>Agencies are responsible for ensuring staff have skills in, and knowledge of:</p> <ul style="list-style-type: none"> o The role of a Key Worker o The appropriate use of the <i>CVHA Feedback form</i> and feedback protocols o The appropriate use of either: <ul style="list-style-type: none"> ▪ DHS Service Coordination Tool Template Service Coordination Plan ▪ General Practice EPC MBS Multi-disciplinary Care Plan o Working with other agencies in providing seamless multidisciplinary care. E.g. to look beyond one's own assessment and service provision boundaries, to the total needs of, and best outcomes for, the consumer
Access To The Care Coordination Process	<p>The need for Care Coordination can be identified by any Service Provider at various times, whenever 3 or more services become involved in care provision:</p> <ul style="list-style-type: none"> o At the time of referral/s, especially when there are referrals to multiple services or as soon as multiple needs are identified o At assessment, review or monitoring, when complexity / multiple needs are identified <p>Access to Care Coordination is facilitated by the professional identifying the need:</p> <ul style="list-style-type: none"> o An Interim Key Worker may be required until a Key Worker is nominated <p>Any professional worker can facilitate Care Coordination. The capacity of a worker is dependent on the level of coordination needs: A Care Coordination Continuum.</p> <ul style="list-style-type: none"> o Generalist Services – the situation is less complex, there is infrequent change in care needs, and less complex or no advocacy is required o Specialist Services – the situation requires Case Management related

	<ul style="list-style-type: none"> o to that specialist service o Case Management Services – the situation is very complex and multiple services are involved, frequent changes in care needs and advocacy is complex and frequent or across service sectors (no service boundary) <p>Agencies ensure consumers have access to Care Coordination options e.g.:</p> <ul style="list-style-type: none"> o Interim or direct access to a Key Worker, depending on worker capacity o Confirm the capacity of workers before nominating the Key Worker position and also re-confirm capacity at times of multidisciplinary care plan reviews o Systems and infrastructure in place at the agency/ service site <ul style="list-style-type: none"> ▪ Conference rooms and / or Teleconferencing facilities ▪ Systems to enable written exchanges of Assessment Outcome Feedback and draft <i>Service Coordination /Multi-disciplinary Care Plans</i> o Multidisciplinary care planning is informed by quality feedback: <ul style="list-style-type: none"> ▪ The <i>CVHA Feedback form</i> augments feedback <p>GP involvement in Care Coordination can be facilitated via the Practice Manager.</p>
<p>Care Coordination</p>	<p>Care Coordination includes:</p> <ul style="list-style-type: none"> o Synthesis of assessment outcome feedback, collated from the range of services involved in the care of the consumer o Collaborative development of a multi-disciplinary plan; common achievable goals that comprehensively cover the breadth of the consumer’s care needs o Identifying and addressing unmet needs via a team approach o Collaborative team monitoring and reviewing of the multidisciplinary plan o Nominating a Key Worker to facilitate all the above. <p>Nomination of a Key Worker occurs when:</p> <ul style="list-style-type: none"> o Organising the first plan o Reviewing goals in subsequent plans o Reviewing service provision changes in subsequent plans <p>2 broad Care Coordination models exist:</p> <ul style="list-style-type: none"> o Single consumer per session = One multi-disciplinary plan only o Multiple consumers per session = Multiple multi-disciplinary plans are developed by the nominated “team members” in one session (or “clinic”): <ul style="list-style-type: none"> ▪ Several assessments or re-assessments/ reviews are undertaken by the “team members” (at one session or over time), then all feedback to a “team meeting” to develop/review multi-disciplinary plans <p>Any professional worker can be a nominated Key Worker who initiates / prepares the <i>Service Coordination /Multi-disciplinary Care Plan</i>:</p> <ul style="list-style-type: none"> o General Practitioners are required to follow the Enhanced Primary Care (EPC) Medicare Benefits Schedule (MBS) to claim for preparation time: <ul style="list-style-type: none"> ▪ Community Care Plan - item 720; 12 month review item 724 ▪ Discharge Care Plan - item 722; 12 month review item 724 <p>With consent, any worker or support person can participate in Care Coordination and contribute to a Service Coordination /Multi-disciplinary Care Plan:</p>

	<ul style="list-style-type: none"> o Contribution to a Care Plan can be: <ul style="list-style-type: none"> ▪ Directly, via personal feedback at the conference / teleconference ▪ Indirectly, via written feedback eg CVHA Feedback Form ▪ Combination of both o General Practitioners are required to follow the Enhanced Primary Care (EPC) Medicare Benefits Schedule (MBS) to claim for any contribution: <ul style="list-style-type: none"> ▪ Community Care Plan contribution – item 726 ▪ Discharge Care Plan contribution – item 728 <p>All Service Coordination /Multi-disciplinary Care Plans are written, and the goals agreed to and signed by the consumer.</p> <p>A care plan review is required when care needs and service interventions change: changing the goals of the plan. This may be a frequent or infrequent process</p> <p>A Multidisciplinary Care Plan is a comprehensive plan. Goals cover the full range of care needs: physical, psychological, emotional, social and environmental needs. A checklist can prompt / facilitate a comprehensive approach. The physical, psychological, emotional, social, environmental needs are within the goals of: <ul style="list-style-type: none"> ▪ Safety and Protection ▪ Episode/acute event and post episode/acute event ▪ Functional gain or improving wellness / wellbeing ▪ Maintenance and support ▪ Prevention and early intervention </p>
<p>Facilitate Access To Coordinated Service Provision</p>	<p>Coordinated service provision is facilitated through the development, dissemination and review of a <i>Service Coordination Multi-disciplinary Care Plan</i>:</p> <ul style="list-style-type: none"> o Service Providers implement the multi-disciplinary plan, and refine their individual service plans accordingly o Service Providers inform the Key Worker when service needs or service goals change <p>Exit from the Care Coordination process:</p> <ul style="list-style-type: none"> o Multiple services no longer involved o Care needs are no longer complex o Goals have been met
<p>Provision Of Health And Service Information</p>	<p>Agencies ensure that information about the Care Coordination process, and how information sharing is managed, is made available to consumers:</p> <ul style="list-style-type: none"> o Provide the consumer with a copy of the DHS Service Coordination Privacy / Consumer Information brochure - <i>Your Information It's Private</i>
<p>Sharing Consumer Information: Collection And Exchange Of Consumer Information</p>	<p>Agencies collect and exchange Consumer Information in accordance with the Health Records Act 2001 or Privacy Act 2000 – see <i>DHS Privacy Kit</i>.</p> <ul style="list-style-type: none"> o Consumers must be made aware of the agency's processes for collection, storage and exchange of consumer information o Consent is required at all times to exchange consumer information. (See the <i>DHS Privacy Kit</i> for disclosure / exchange of consumer information without consent) o Agencies ensure there are internal policies and procedures to address collection or disclosure of consumer information without consent

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<p>Tools And Resources To Support The Referral Process</p>	<p>Tools to support the Care Coordination process and information flow:</p> <ul style="list-style-type: none"> o DHS Service Coordination Tool Templates and guidelines: <ul style="list-style-type: none"> ▪ <i>Service Coordination Plan (or GP EPC Multi-disciplinary Care Plan)</i> ▪ <i>Consumer Consent Form</i> ▪ <i>Your Information It's Private – Privacy / Consumer Information Brochure</i> o <i>CVHA Feedback form</i>, to facilitate Multi-disciplinary Care Planning o Other relevant documentation e.g. assessment summary or individual service's care plan summary o <i>DHS Privacy Kit</i> - collection, storage & exchange of Consumer Information <ul style="list-style-type: none"> ▪ <i>CVHA Care Coordination Pathways</i>
<p>Workforce Development</p>	<p>Agencies ensure that Professional staff have access to & training in:</p> <ul style="list-style-type: none"> o Care Coordination and Multi-disciplinary Care Planning o CVHA Care Coordination protocols o General Practice Enhanced Primary Care (EPC) Care Plan criteria o DHS Service Coordination Orientation - all staff are aware of information management as it relates to the Care Planning process, and use of Service Coordination Tool Templates o Privacy legislation re collection and exchange of consumer information o Information Management processes



CVHA - Care Coordination Pathway

What if a consumer has 3 or more ongoing services and complex and multiple/chronic care needs?

A Service Provider has identified that **3 or more services** are/or will be involved in a consumer's care. **Flagged** when needs identified at referral: *Summary and Referral Form lists services* used/referred

Are the Consumer's care needs
➤ **Complex and Multiple?**
➤ **Chronic and complex?**

No

➤ Gain **consent to Feedback Assessment Outcomes** with relevant services
➤ **Continue service delivery**, reviewing coordination needs with other services

Yes

Explain Care Coordination process and benefits to consumer:
➤ Common comprehensive goals for all service providers
➤ Reduces contra-indicated care/treatments
➤ Reduces duplication / gaps in service delivery
➤ Improves communication between service providers

Yes

Consent given to proceed?

No

Organise the nomination of a Key Worker. Agreement between Service Providers and Consumer / Primary Carer
➤ Is there a **Main Service** Provider / Support person?
➤ Who has the **capacity** to facilitate the process?
➤ Is there a need for an **Interim Key Worker**?

If Interim Key Worker:
➤ Review before next plan
➤ Organise new Key Worker at end of plan

Book facilities for conferencing

Decide method for developing a Multi-disciplinary Care Plan
➤ Face-to-face Conference
➤ Telephone Conference
➤ Written exchange of information
➤ Combinations of 2 or all of above to cater for all the team
Nominate a date to develop the Multi-disciplinary Care Plan

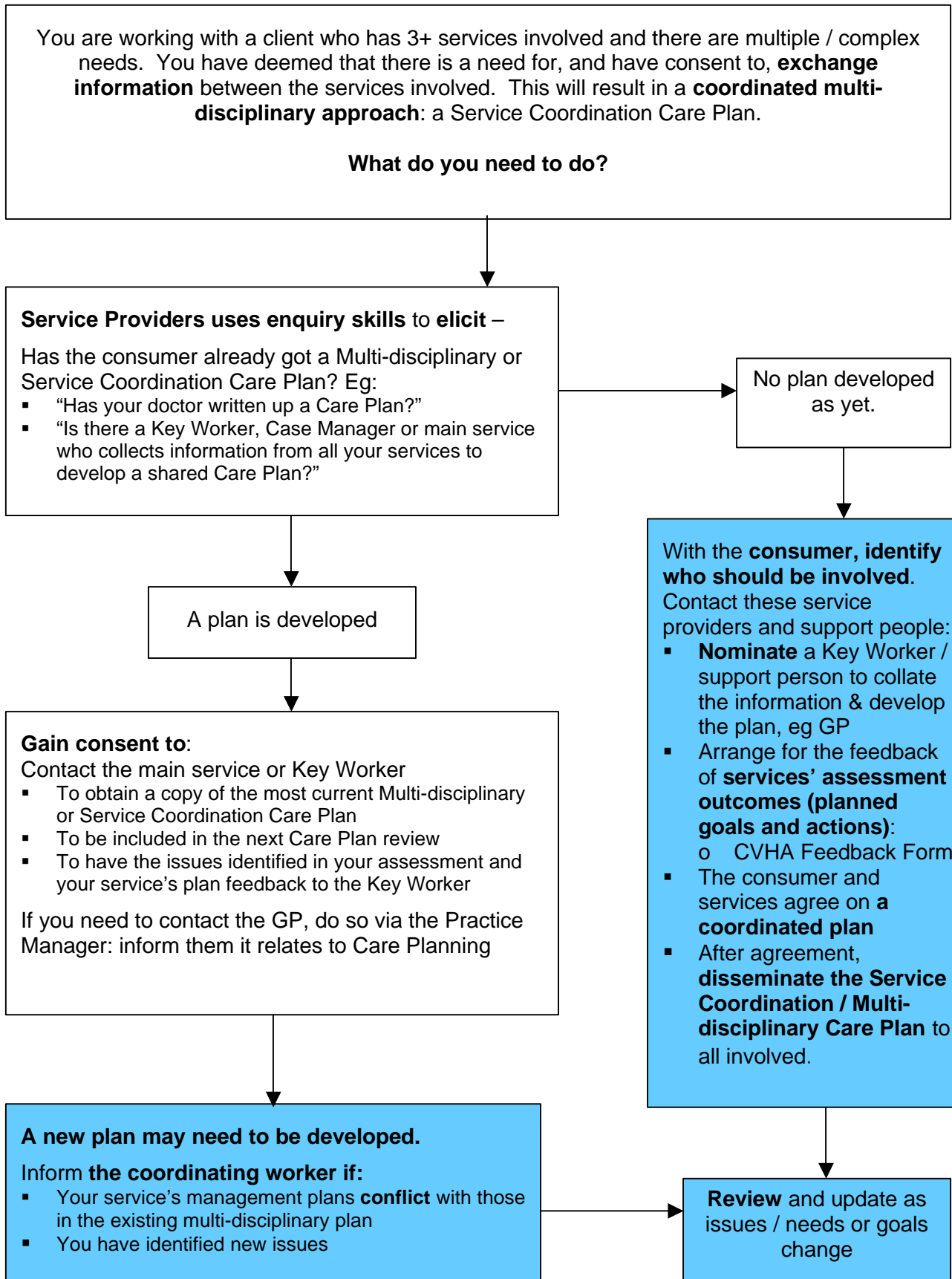
Collaborate with all services on goals and actions
Agree on and finalise plan – consumer signs completed plan
Use **Service Coordination Tool Template Service Coordination Plan** form to record the finalised plan
Arrange review / exit date
Disseminate to all nominated services and supports involves

Key Worker **obtains Assessment Outcome Feedback** from all services prior to developing the Multi-disciplinary Care Plan.
Together with the consumer / primary carer, the Key Worker:
➤ Collates Feedback – synthesises information
➤ Lists and prioritises issues
➤ Drafts possible goals (use **goal checklist** to aid process)
➤ Disseminates draft for discussion (conference or on paper)

Key Worker initiates review process



How do you know if a consumer already has a Service Coordination Care Plan?





CVHA - Care Coordination Pathway

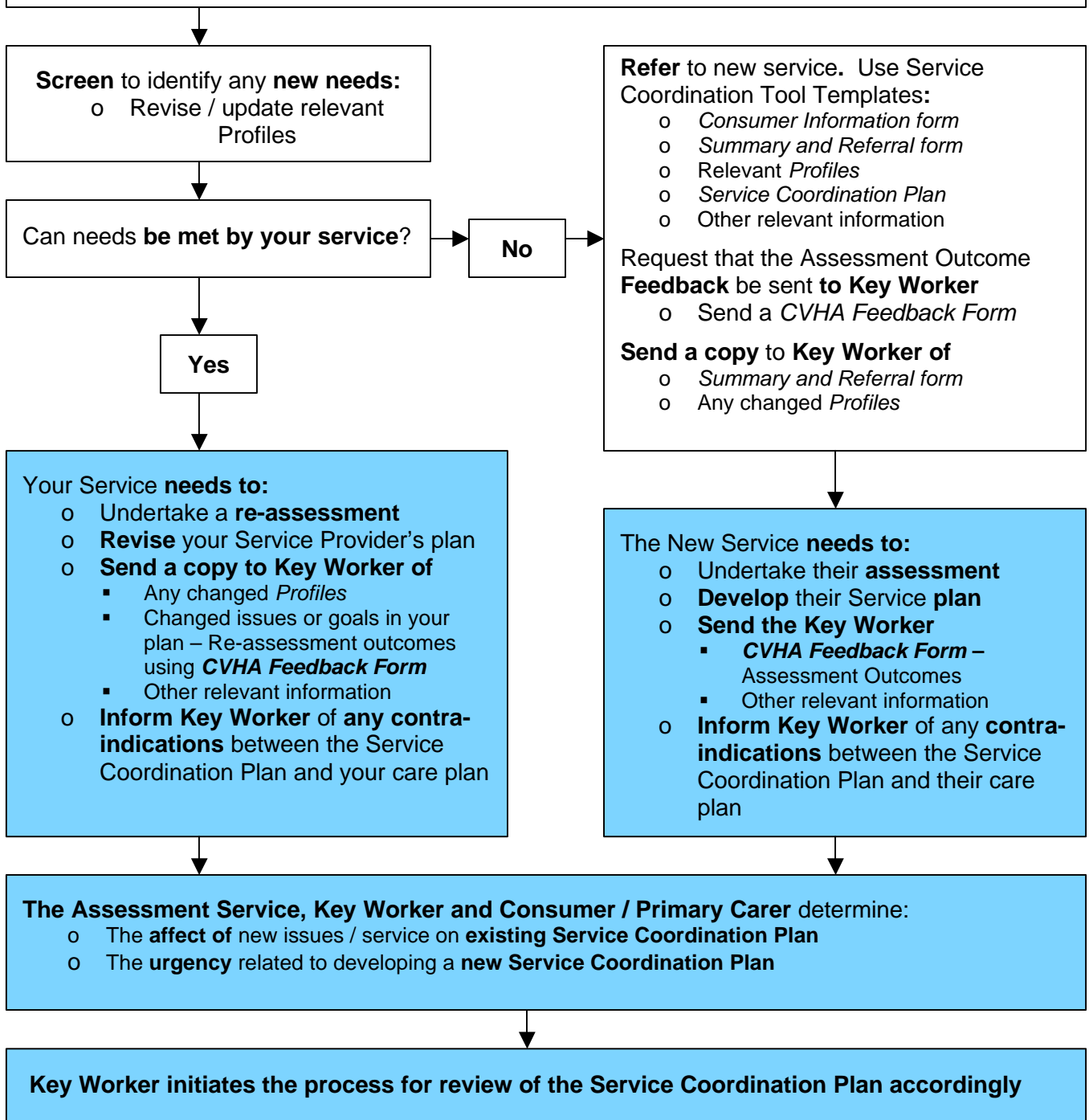
What if a consumer already has a Service Coordination Plan that has been initiated by another service and you identify the need for a Care Plan review?

You are working with a client who sees multiple services (3 or more) and has chronic and / or complex needs. You are a **member of** this consumer's **multidisciplinary care team**. You and others in the team have developed a Service Coordination / Multidisciplinary Care Plan.

You have recently **reviewed your** service delivery **plan** and **identified** that the plan is **not** meeting the consumer's care needs:

- o Consumer's care needs have **changed**
- o Service Provider's **plan is not effective**

What do you need to do?





CVHA - Care Coordination Goals

A *Service Coordination /Multidisciplinary Care Plan* is a comprehensive plan. Goals cover the full range of consumer care needs: physical, psychological, emotional, social and environmental needs.

A **checklist** can prompt / facilitate a comprehensive approach. The **physical, psychological, emotional, social, environmental** needs are within the goals of:

- **Safety and Protection**
 - **Episode/acute event and post episode/acute event**
 - **Functional gain**
 - **Maintenance and support**
 - **Prevention and early intervention**
-

Issue / Problem: X

Goal 1: Safety and Protection (consumer and supports / services):

- Physical safety / protection
- Psychological safety / protection
- Emotional safety / protection
- Social safety / protection
- Environmental safety / protection

Goal 2: Restoration of health and function at episode/acute event and post episode/acute event (short time frame – days to weeks)

- Physical restoration at episode /post episode
- Psychological restoration at episode /post episode
- Emotional restoration at episode /post episode
- Social restoration at episode /post episode
- Environmental restoration at episode /post episode

Goals 3: Functional gain – improve or optimise levels of independence, wellness / wellbeing, quality of life etc (weeks to months)

- Physical gain / improvements
- Psychological gain / improvements
- Emotional gain / improvements
- Social gain / improvements
- Environmental gain / improvements

Goal 4: Maintenance and support – maintain levels of independence, function, wellness / wellbeing, quality of life etc (long time frame)

- Physical maintenance and support
- Psychological maintenance and support
- Emotional maintenance and support
- Social maintenance and support
- Environmental maintenance and support

Goal 5: Prevention and early intervention – promote health and prevent re-occurrences

- Physical prevention and early detection strategies
- Psychological prevention and early detection strategies
- Emotional prevention and early detection strategies
- Social prevention and early detection strategies
- Environmental prevention and early detection strategies



CVHA - Feedback Informs Care Coordination

The CVHA Feedback Form collects both referral acknowledgement and assessment outcome feedback. Feedback can be either requested or routinely sent, thus meeting best practice standards. CVHA assessment prompts match DHS *Service Coordination Plan* data fields.

On completion of the relevant or requested section/s, mail or fax this feedback form to:

Feedback To: Title: Agency	Phone Number: Fax number: Feedback Request Date:
Key Worker: Title: Agency	Phone Number: Fax number: Feedback Request Date:

When feedback is requested please complete the section/s marked with a tick

Referral Acknowledgement Section (circle / cross out & comment as relevant)

Reason for this feedback has been explained to the consumer The Consent form was checked to ensure this feedback is allowable

The referral has been accepted:	Yes / No / NA	Date referral received:	_____
The consumer is on a waiting list:	Yes / No / NA	Waiting list time:	_____
An appointment date has been given:	Yes / No / NA	Date of appointment:	_____
The consumer attended / accepted the service:	Yes / No / NA	Service /intake proceeding:	Yes / No

If you answered **NO** to any of the above referral statements, was it because:

Insufficient information sent Consumer ineligible for service Consumer declined service Other

Comments i.e. other reasons for **NO**, any action taken (eg referred on), or action requested from referrer:

Assessment Outcome/s Section (circle / cross out & comment as relevant)

Reason for this feedback has been explained to the consumer The Consent form was checked to ensure this feedback is allowable

Issue/s or problem/s found: First assessment Re-assessment Assessment date: _____

Planned Goal/s (if relevant)	Target date/s:
1.	1.
2.	2.

Planned Action (include intervention type, frequency, start and review dates)

Other details:

A new referral/s resulted from the assessment	Yes / No	Referral Summary attached	Yes / No / NA
Additional assessment information attached	Yes / No	Other attachments:	Yes / No / NA
3 ongoing services, needs Care Coordination	Yes / No	We will initiate Care Coordination	Yes / No / NA

List attachments: _____

Other Comments: _____

CVHA Member Agency Protocol Agreement, Implementation and Review

In Principle Agreement

- o All member agencies agree to adopt the CVHA Service Coordination Continuum of Care – Multidisciplinary Care Practices, Processes, Protocols and Systems
- o All member agencies will work toward having the capacity to integrate, and work with other agencies in the implementation of, the CVHA Service Coordination Continuum of Care – Multidisciplinary Care Practices, Processes, Protocols and Systems
- o All member agencies agree to developing a system for collaborative annual reviewing of the Protocols and Practice Standards

CVHA Member Agency Name	CEO signature	Date
Maryborough District Health Service		
Maryborough Community Health		
Central Goldfields Shire Council		
Maldon Hospital		
Mt Alexander Hospital		
Castlemaine and District Community Health Centre		
Mount Alexander Shire Council		
Kyneton and District Hospital		
Cobaw Community Health Service		
Macedon Ranges Health Service		
Macedon Ranges Shire Council		
Bendigo District Health Service		
St Luke's Anglicare		
Central Highlands Division of General Practice		
Bendigo and District Division of General Practice		
Loddon Mallee Women's Health		

CVHA Member Agency Protocol Agreement, Implementation and Review

Implementation and review dates

Continuum of Care	Finalised:	01/07/03	12 monthly review:	
Service Coordination Vision	Finalised:	01/07/03	12 monthly review:	
Protocol Framework	Finalised:	01/07/03	12 monthly review:	
Practice Standards	Finalised:	01/07/03	12 monthly review:	
Initial Contact Protocol	Finalised:	01/07/03	12 monthly review:	
Initial Contact Pathway	Finalised:	01/07/03	12 monthly review:	
Tools Implementation – targeted agencies	Start date:	01/07/02	Completed uptake date:	01/07/03
Initial Needs Identification Protocol	Finalised:	01/07/03	12 monthly review:	
Initial Needs Identification Pathway	Finalised:	01/07/03	12 monthly review:	
Tools Implementation – targeted agencies	Start date:	01/07/02	Completed uptake date:	01/07/03
Assessment Protocol	Finalised:	30/09/03	12 monthly review:	
Assessment Pathway	Finalised:	N/A	12 monthly review:	
Tools Implementation – targeted agencies	Start date:	N/A yet	Completed uptake date:	N/A yet
Service Coordination Care Plan Protocol	Finalised:	30/09/03	12 monthly review:	
Service Coordination Care Plan Pathway	Finalised:	30/09/03	12 monthly review:	
Tools Implementation – targeted agencies	Start date:	01/07/02	Completed uptake date:	
Referral Protocol	Finalised:	01/07/03	12 monthly review:	
Referral Pathways	Finalised:	01/07/03	12 monthly review:	
Tools Implementation – targeted agencies	Start date:	01/07/02	Completed uptake date:	01/07/03
Feedback Protocol	Finalised:	30/09/03	12 monthly review:	
Feedback Pathway	Finalised:	30/09/03	12 monthly review:	
Tools Implementation – targeted agencies	Start date:	01/12/03	Completed uptake date:	