

# Service Coordination: Tool Templates

---

Guideline 4: Developing a Service Coordination Plan

May 2002

## Acknowledgments

The Service Coordination Tool Templates and guidelines have been developed as part of the Primary Care Partnership Strategy. Primary Care Partnerships (PCPs) are currently developing an integrated approach to service coordination through the implementation of shared practice, processes, protocols and systems across member agencies.

Local service coordination practice will be supported through agency implementation of the Service Coordination Tool Templates which are designed to support Initial Contact, Initial Needs Identification and Care Planning and sharing of health and care information (such as referral) between service providers.

It is important that appropriate practice implemented by PCPs in combination with the Service Coordination Tool Templates Guidelines determine how the Service Coordination Tool Templates are used.

The Department of Human Services contracted the Australian Institute for Primary Care at La Trobe University and HDG Consulting to develop Initial Needs Identification and Care Planning tools for agencies and practitioners involved in PCPs.

Other members of the consortium were the Centre for Health Services Development at the University of Wollongong and the Health Issues Centre.

The first four of these forms and guidelines were prepared by the Centre for Health Service Development, University of Wollongong, May 2002. The Consumer Consent Form, Guidelines and Consumer Information Brochure were prepared by the Department of Human Services.

We would also like to acknowledge the efforts of service providers and workers who have participated in the Tool Template pilots and provided invaluable feedback to support and validate the development of the Service Coordination Tool Templates and these guidelines.

Department of Human Services, May 2002

# Contents

---

4.1 Overview	1
4.1.1 About the Service Coordination Plan	1
4.1.2 Overview of the Service Coordination Tool Templates	1
Overview of the Service Coordination Tool Templates	2
Design Issues Common to All Forms	5
Information Superseded	5
Using the Service Coordination Tool Templates	5
Developing the Service Coordination Tool Templates	5
4.2 How To Use the Service Coordination Plan Form	7
Who Should Have a Service Coordination Plan?	7
What is the GP's Role in Care Planning?	8
Summary Guidelines for Undertaking a Service Coordination Plan	8
Explanation of the Items in the Service Coordination Plan Template	9
Consumer Name, Key Worker and Review Details	10
Participants in the Service Coordination Planning Process	11
Evidence of Assessment of Need	11
Case Conference	12
Copy to:	12
Service Coordination Plan Documented by:	12
Consumer Issues/Problems	12
Consumer Goals	12
Coding the Goal of Care	13
Actions To Be Undertaken	13
4.3 Minimum Requirements for GPs	15
Consumer Consent	15
Biopsychosocial Assessment	15
EPC-Specific Guidelines	16
EPC Multidisciplinary Care Planning	16
Chronic conditions and complex care needs	16
Preparation of an EPC Multidisciplinary Care Plan	16
Frequency	17
General Requirements	17
Appendix	
Service Coordination Plan Form	19



# 4.1 Overview

---

## 4.1.1 About the Service Coordination Plan

This is the fourth guideline in the Service Coordination Tool Template suite and is designed for those completing the Service Coordination Planning tool.

The Service Coordination Plan (SCP) should be used with consumers with both multiple agency involvement and complex needs.

## 4.1.2 Overview of the Service Coordination Tool Templates

This document is part of a set of five guidelines for completing the Service Coordination Tool Templates. This set includes a complementary Consumer Consent Form and guidelines (Guideline 5). This is obviously part of a larger process that staff undertake in Initial Contact (IC) and INI, and it may prompt referral and/or further assessment, and lead on to provide information useful to complete a Service Coordination Plan using the form (form 4) described in Guideline 4.

Issues relating to assessment (service specific, specialist and comprehensive) are not included. Table 1 describes the scope of the activities covered by these tools and summarises the distinction between the IC, INI and various types of Assessment and Care Planning. These distinctions essentially relate to the depth and breadth of the information sought from the consumer.

**Table 1: Service Coordination Elements**

Activity	Depth	Scope	Used for Referral Purposes?	Current Status
<b>INITIAL CONTACT (IC):</b>				
Consumer Information	Shallow	Narrow	Yes	Required
<b>INI:</b>				
Consumer Information	Shallow	Narrow	Yes	Required
Summary and Referral Information	Shallow	Narrow	Yes	Required for all referrals and should be used for INI summary functions
Supplementary Profiles	Shallow	Broad	Yes, where relevant	Optional, to be used at discretion of the professional, except in the case of HACC referrals where the living arrangements and functional profiles should be used (both to make and receive a referral)
<b>Assessment:</b>				
Service specific*	Deep	Narrow	No	Out of scope
Specialist*	Deep	Narrow	No	Out of scope
Comprehensive*	Deep	Broad	Yes, where relevant	Out of scope
<b>Care Planning:</b>				
Service Coordination Plan	Deep	Broad	Yes, where relevant	Should be used with consumers with both multiple agency involvement and complex needs

\*Indicates activity is not covered by the current suite of Service Coordination Project tools.

There are five guidelines in this series:

Guideline 1: Completing Consumer Information

Guideline 2: Completing the Summary and Referral Information

Guideline 3: Completing the Profiles

Guideline 4: Developing a Service Coordination Plan

Guideline 5: Completing Consumer Consent

This introduction and summary of key points is included in each section to make them mostly self-contained.

## Overview of the Service Coordination Tool Templates

The **Consumer Information** form contains a core set of items designed to collect demographic and social details about individual consumers. The **Summary and Referral Information** form records a summary of the consumer's problems/issues and outlines an initial action plan. It can be used for referral. There is also a one-page **Consumer Consent** form that provides a uniform approach to obtaining consumer consent for sharing information in compliance with the *Health Records Act 2001*.

The five **supplementary profiles** allow further information to be collected on those areas relevant to the consumers' circumstances and presenting problems. Not all profiles will be relevant for every consumer and, in some cases, some specific information within a profile will not be required. In these cases, simply record NA (not applicable) or code 99, depending on the instructions on the top of each page. The final form in the series is a **Service Coordination Plan** form to be completed for those consumers with both multi-agency involvement and complex needs.

Each PCP will need to develop its own protocol (who, what, when, how) for collecting and sharing information using the Service Coordination Tool Templates. It is likely that many of the items in the Consumer Information form will be collected during the initial contact with the consumer or the person referring the consumer. Some items, however, may not be collected until the first time a consumer is seen by a clinician. The content and purpose of the different components are summarised in the following table:

**Table 2: Purpose of the Service Coordination Tool Templates**

<b>Component</b>	<b>Purpose</b>	<b>Pages</b>
<b>CONSUMER INFORMATION</b>		
p.1	Demographic and social details of the consumer, contact person/s and GP, and how the information was obtained	CI p.1 of 2
p.2	Codes to record source of referral, other demographic information and benefits, entitlements and insurance status	CI p.2 of 2
<b>Summary and Referral Information</b>		
p.1	Summary of presenting problems and a text box to record other relevant information	SRI p.1 of 2
p.2	Describes current services used in last three months, and proposed initial action plan. Completed at the end using information from other profiles if appropriate.	SRI p.2 of 2
<b>Supplementary Profiles</b>		
Living Arrangements	Codes and comments for living arrangements, legal, financial and employment, carer profile	LA 1 of 1
Health Conditions	Overall health, pain, vision hearing and falls, list of conditions and medications.	HC 1 of 1
Psychosocial Profile	Covers mental health, wellbeing, social and family supports and disability criteria	PP 1 of 1
<b>Functional Profile</b>		
p.1	Functional screen for activities of daily living and self-care	FP 1 of 2
p.2	Screening questions for cognitive and behavioural problems, with prompts for further assessments	FP 2 of 2
Health Behaviours	Screen for risk factors, nutrition and physical activity, with prompts for further investigation	HB 1 of 1
<b>Developing a Service Coordination Plan</b>		
p.1	Key worker, review date, participants' list, evidence of assessment of need, case conference/date and information given to consumer	SCP 1 of 2
p.2	Action plan for each goal including dates, action, review date, who is responsible	SCP 2 of 2

The tools are designed so that the first two pages (the Consumer Information form) cover the core consumer information that should be collected on all consumers. The next form (two pages) is for a summary of the action to be taken. The core INI process thus consists of two forms over four pages and includes:

- **Consumer information** which is information about the consumer, other agents and their GP and information with codes for categories to cover demographic details, benefits and entitlements, and insurance status. The Notes box at the top on page 2 has space for comments that can be used for information on risk and urgency.
- **Summary and referral information** to record why the consumer is seeking services, describe the problem or issue as identified by the consumer or referring agency, describe other issues as identified by the consumer or in the INI process. Record current services and an initial action plan including listing the agency/health professional to receive the referral, the reason, whether consumer consent has been obtained, the referral method, whether feedback is required and the date.

The Summary and Referral form is informed by any relevant detail from the additional profiles that are used for the particular consumer or from the areas usually investigated by a particular agency or clinician. These are either used or left out depending on the consumer's presenting problems or as a result of any issues arising during the initial contact. As a result this page will usually be completed at the end and is used as a basis (in conjunction with subsequent assessments and care plans) for putting together the service coordination plan (if required).

The Summary and Referral form may be used in a duplicate fashion to cover multiple problems with differing levels of confidentiality requirements. It can be used if the information is sensitive and not to be shared, in which case the interviewer can complete a separate copy of page 2 for each issue. For example there may be two issues—seeing the dentist and getting referred to a sexual assault service—and it may not be relevant or necessary to share all information for both referrals.

The **Profiles** are completed **only** if they are relevant to the client's presenting problems and needs and after the core information has been collected. The core information is recorded in the Consumer Information and Summary and Referral components. The assumption is that the next stages of referral, assessment or care planning, or service coordination, is a continuation of that process, and that the core consumer information will therefore already be available.

There are five supplementary profiles. The five supplementary forms cover profiles of living arrangements, health conditions, psychosocial factors, a functional screen and health behaviours. These are domains that can be investigated at the discretion of the contact worker and depending on the nature of the consumer's problem. In some cases, there will be no need to complete any of these supplementary domains. However, for consumers with complex needs, contact workers may choose to use several forms to identify their initial needs.

#### **Complete only those profiles that are relevant for the consumer**

The Profiles are not a structured interview. Do not ask consumers about issues in the order that they are listed if they are inappropriate in the context. The Profiles are designed to be completed based on all sources of information available to the person completing them (observation, information contained in a referral letter, consumer notes or information provided to you by a carer or referring agency). Record NA for any issues that you have either not canvassed or that are inappropriate for the consumer unless otherwise instructed. The design of the set of profiles assumes that children and adolescents will be directly referred for a relevant assessment to be completed.

The Profiles are not designed as a diagnostic tool, nor are they considered to be an assessment. They are tools to help determine the consumer's risk, eligibility, priority for service and health promotion opportunities as early in their contact with the service system as possible.

This set of optional domains has been chosen by combining evidence from the literature, a review of the range of forms currently in use, and consultations with the field on different draft versions of data collection tools. They can be used to further investigate the scope of the consumer's needs at the initial contact point.

The Living Arrangements and Functional Profile forms should be completed for all consumers requiring Home and Community Care (HACC) services. These two profiles contain HACC minimum data set (MDS) items and the collection of this information during the INI process will mean that the information will not need to be collected at a later time. The remainder of the HACC MDS will be collected at the assessment stage.

The Service Coordination Plan form brings together all the different information that is useful for service coordination for those consumers that require this level of intervention. It covers the contact details of the key worker and other participants, a series of prompts for the collation or collection of evidence of consumer needs, a description of the consumer's problems/issues and associated goals, and the current required approach to consent and information disclosure as part of planning. The Service Coordination Plan is only completed for those consumers with both multiple agency involvement and complex needs.

The use of the term 'consumer' refers to the person for whom the INI form relates. Consumer is used in all cases, except where there is another term used in a MDS (for example, 'care recipient' is a HACC MDS term) or in validated questions from other sources (for example, person or client).

## Design Issues Common to All Forms

Each page of every form has the same space at the top for an agency-assigned consumer identifier to be recorded and a space at the bottom for identifying the person and agency completing the form. There is also a box for recording at a later time that the information on the page has been superseded and updated. This allows the superseded information to be kept as a historical record in the file.

## Information Superseded

Each page has a box on the bottom to record if the consumer's situation has changed. If new issues or problems are identified after a page has been completed or an INI process has been completed, subsequent presenting issues or changes to consumer information should be recorded on a new page. The new page is used to record any changes or additions, not to repeat issues recorded on the previous form. Indicate on the existing form that the information on the page has now been superseded. This will indicate to other health professionals that a new page has been created. Do not change the original record as the original record forms part of the consumer history and should be stored on the clinical record.

## Using the Service Coordination Tool Templates

The Consumer Information, Summary and Referral and Profile forms used in an INI process should trigger what formal assessments or urgent services are required. Consumers should be informed about the range of service options that are available to meet their needs. This is not limited to the services provided by your own agency. Consider the wider range of services supports and resources such as for-profit services, information services, financial entitlements or other alternative services.

The design of the tool templates assumes that most of the Profiles information will not be relevant for children and adolescents. The core information, however, is likely to be relevant. A separate profile for this group is not included because it is assumed they will be referred directly for a more detailed assessment by an experienced agency or professional.

## Developing the Service Coordination Tool Templates

The selection of the content of the Service Coordination Tool Templates has been the result of a separate literature review that examined both international and Australian experience. For example, in developing a consumer assessment instrument for the National Long Term Care Demonstration<sup>1</sup>, the factors considered important included physical health, mental health, ability to perform activities of daily living, social support and participation, financial and related resources, physical environment and living arrangements, and services.

In a review of published randomised controlled trials of health assessments for older people, Byles<sup>2</sup> noted the components most commonly included in health assessments. These included the following: height/weight, blood pressure, vision/hearing, teeth or oral examination, balance and gait testing, medications, activities of daily living, instrumental activities of daily living, functional status, medical problems, nutrition, alcohol, smoking, exercise, depression, cognition, social support, service use and home environment.

Detailed references for each item selected have not been included in the guidelines, however the rationale is contained in a separate literature review and a summary statement on the source of each item is included in the guidelines.

---

<sup>1</sup> An initiative to improve care for functionally impaired adults, particularly the elderly. Consumer assessment and case management used to provide care to meet individual need and control long term care expenditure.

<sup>2</sup> Byles, J. E. (2000). A thorough going over: Evidence for health assessment for older persons. *Australian and New Zealand Journal of Public Health*, 24(2), 117–123.

The design of the Service Coordination Tool Templates to be used at the entry point to services and INI involved a number of background assumptions:

- That service structures will vary according to the local setting and agency type.
- That the various intervention strategies will also vary according to local needs;
- That the data collected needs to be consistent and conform to a number of technical and ethical requirements. As much as possible, information should be recorded in a way that allows for it to be subsequently computer coded.
- That, during the pilot, the forms supporting the INI process should be designed for completion by staff. After the pilot, a consumer-completed version would be developed, with both then being available for use.
- That each consumer will be assigned a unique record number at the initial contact agency, but this is not a common statewide identifier.

The tools were developed based on a review of literature and current practice and then pilot testing was undertaken using draft tools in order to improve their usefulness. The tools developed in this process are regarded as Generation 1, with further developments and refinements being expected to occur over time.

## 4.2 How To Use the Service Coordination Plan Form

---

These guidelines for using the SCP are derived from the work on the content and structure of the INI process and the Service Coordination Tool Templates and from considering examples of other coordination and care planning forms. Examples were gathered from consultations with the field, by discussions with the Department of Human Services project managers, together with an analysis of current practice across the 32 PCPs. Documentary evidence was also considered and particular attention was paid to what is known from relevant literature and from related projects, like demonstration projects and trials of care coordination.

A key requirement in developing the SCP was to ensure that the requirements were met for General Practitioners (GPs) claiming a rebate for relevant items for eligible patients under the Enhanced Primary Care (EPC) program (refer to Medicare Benefits Schedule book). The requirements for an EPC care planning proforma are incorporated in the SCP form (see Section 4.3).

GPs who are using this form should refer to the Medicare Benefits Schedule (MBS) book (item descriptors and explanatory notes) as the authoritative and up-to-date source of information on what is required to undertake an EPC service. The MBS book is published on 1 November each year, with a supplementary edition usually published in May of the following year. In addition, the Department of Human Services will develop supplementary guidelines to this document for GPs.

The guidelines for using the form are divided into five sections:

1. Who should have a Service Coordination Plan
2. Summary
3. Item descriptions
  - 3.1 Issues/problems
  - 3.2 Goals, action, target date, responsible agents
  - 3.3 Review
  - 3.4 Participants
  - 3.5 Checklist – evidence of need
  - 3.6 Method of planning
4. Consent
5. Further explanations.

### Who Should Have a Service Coordination Plan?

The SCP is only completed for those consumers with both multi-agency involvement and complex needs. There is no one definition of 'complex' that is appropriate to all age groups and service types and PCPs will need to develop protocols over time to identify those consumers who would benefit from a SCP. As a general guide, consumers who should have a SCP are those who:

- Are being seen by more than one agency and more than one discipline.
- Have multiple issues/problems that need to be addressed concurrently.  
and
- Whose outcomes are likely to be better if the care and services they receive are coordinated across agencies and over time.

Many SCPs will be developed for consumers who meet the criteria for a GP to prepare a care plan, for which there is a Medicare rebate under the General Practice EPC items. More information about EPC requirements is in Section 4.3.

To be eligible for a Medicare rebate, EPC multidisciplinary team care plans and case conferences may only be provided for:

Patients with one or more chronic, or terminal, conditions and complex care needs requiring multidisciplinary care from a team of health and care providers, including the patient's GP. (from MBS book, May 2002).

However, other agencies may develop SCPs for consumers who do not meet the EPC criteria but still require a multidisciplinary approach to care planning.

## What is the GP's Role in Care Planning?

The GP may undertake the following roles in care planning (where a care plan is referred to it would be relevant that this SCP form would be used):

- Simply making a straightforward referral.
- Responding to a care plan developed by other primary health service providers, which requests a GP assessment.
- Formally contributing to a care plan for which an MBS item applies (the GP must be formally requested to contribute for this to apply). (See MBS book: Item descriptors and explanatory notes.)
- Preparing and reviewing a care plan under the MBS requirements and seeking contribution from other service providers (see MBS book: Item descriptors and explanatory notes). The GP would be the key worker in this case.

## Summary Guidelines for Undertaking a Service Coordination Plan

The process for undertaking a SCP will be familiar to most staff taking part in the pilot testing of the Service Coordination Tool Templates. These Tool Templates are an attempt to see the potential for a more standardised approach.

1. **Identify all issues/problems** based on the documents indicated in the Evidence of Assessment of Need check box. If new issues or problems are identified, record these in a new document. For example, create a new INI and use it to record any changes or additions. Indicate on the existing INI that the information on the page has now been superseded. Do not change the original record as the original record forms part of the consumer history and should be stored on the medical record.
2. **Identify the primary problem or issue** to be addressed in this current SCP and list it first. The primary problem or issue is the one that is expected to be the major focus of the care. In the case of a multi-agency plan, it is the one that is expected to require the most interagency planning and coordination.
3. **Identify all other problems and issues** to be addressed in this current SCP. If possible, list them in priority order. Attach additional sheets of page 2 of this form if necessary.
4. If the consumer does not already have a key worker, **identify a key worker**. This will generally be the health professional who accepts responsibility for the primary problem or issue.
5. **Identify one or more goals** for each problem or issue. **The goal is the best outcome that can realistically be achieved during the period covered by the current SCP.** The goal can be recorded in text.
6. As an additional aid to making sense of the goal of the consumer and provider's plan, by using one of the following five codes, more generic and mutually exclusive goals can be coded and described:
  - **Safety and protection.**
  - **Acute/post-acute**—the goal is restoration of the person's pre-acute level of health and function within a short time frame (weeks to months).
  - **Functional gain**—the goal is to improve (not maintain) current levels of independence and/or optimise (not maintain) current living arrangements (weeks to months).
  - **Maintenance and support**—the goal is to maintain function, quality of life or current health status (required action may be indefinite in some cases).
  - **Prevention and early intervention**—the goal is early identification and intervention to promote health and prevent problems developing.

7. **Identify a realistic target date** for achieving each goal. If the goal is maintenance and support or prevention and early intervention, a target date of 'indefinite' may be used.
8. **Identify the action to be taken** (this may include self-help as well as the services required) to achieve each goal within the period covered by the service coordination plan.
9. **For each service required**, identify the priority for service relative to other consumers requiring this same service. Priority for service can be recorded in text.
10. **Identify the individual or service that will be responsible for implementing** or managing the required action and enter the date that the responsible person/agency accepted this responsibility.

Note that the SCP and its goals may differ from recommendations made in the INI process or in a previous assessment. If so, the reason for the change should be noted in the SCP by including these as the last item listed under 'Consumer Issue/Problem'.

Note: an EPC plan does not require coding of goals or assigning service priorities, it involves agreeing management goals with the consumer in collaboration with the other members of the care planning team and identifying and documenting the treatment or services required to achieve those goals with arrangements for their provision.

11. **Once the SCP is developed**, provide a copy to the consumer and to all team members. Where the SCP is an 'EPC plan', a copy must be 'offered' to the consumer and relevant parts provided to the other team members (see MBS book).
12. **As consumer issues are resolved**, record the date under the 'Issue Resolved Date'. The date of consumer discharge from a particular service can also be subsequently recorded under the 'Issue Resolved Date'.

## Explanation of the Items in the Service Coordination Plan Template

The SCP form is a way of linking the information contained in the INI with a more detailed planning process. The SCP is not an assessment tool, but assumes that assessment tools (for comprehensive, service specific or specialist assessments) will be used to inform planning.

The SCP is designed to allow consumers and carers to discuss their needs with service providers, gps and others, to create an ordered approach to issues of consent, and to agree on plans to meet the consumer's needs. The consent issues need to be explained to all concerned parties in plain language and with suitable assistance available. All the participants to the SCP are listed, and a key worker role is assigned.

The SCP form covers two pages of mainly free text and tick boxes. Goals can also be coded into generic categories, and the comment box can be used to indicate risk or service access priority issues.

<b>ITEM</b>	<b>Data Type</b>	<b>Code Set</b>
Consumer Name	Alphanumeric	No
Key Worker	Alphanumeric	No
Whole Review Date	Alphanumeric	No
Participants—Consumer + List	Alphanumeric	No
Checklist—Evidence of Need	Tick box	Yes
Case Conference	Tick box	Yes
Issues/Problems	Alphanumeric	No
Goals, Goal Target Date	Alphanumeric	No
Actions, Responsible Agents	Alphanumeric	No
Proposed Start Date, Review Date	Numeric	No
Issue Resolved Date	Numeric	No
Copy to Consumer and Team Members	Tick box	Yes
Case Conference/Date	Tick box	No

The SCP is not meant to imply any particular structure should be in place. The Service Coordination Tool Templates are not for introducing new structures or micro managing processes of reform. The assumptions about structures in the design of the forms do not go beyond the separation of initial screening from further assessment. The forms are not expected to closely direct the local processes and roles around assessment and care. The assumptions in the Service Coordination Tool Templates are about using the forms for information sharing and making information on initial needs more standardised and useful.

Service Coordination Planning follows the process of INI where a more detailed assessment was required. It should be undertaken on the basis of the full range of material gathered to inform decisions on meeting the consumers’ needs.

The participants in the service coordination planning process are listed on the form. It also is expected that the consumer will be given the opportunity to have the respective roles of the different participants explained and clarified. If there is agreement at this point, then the negotiation over the goals of service coordination should be straightforward and can be summarised in the recommended format.

The final step is to address consent issues at three levels—to share information between providers, to consent to the planning process, and to consent to the actual plan of care. Service coordination planning must also assess individual needs in the context of competing demands upon service providers so as not to generate expectations that are inequitable or cannot reasonably be met. Comments can be made about relative risk and urgency in the comments box on SCP page 1 of 2.

### Consumer Name, Key Worker and Review Details

The first page contains the consumer and key worker names so that information is not lost (and to document the members of the multidisciplinary team—this is an EPC requirement). The plan may be documented by someone other than the key worker (see Office Use Only section).

The review may be for the plan as a whole or in part. It may be reviewed by someone other than the key worker, and a date for review should be recommended last (if the review of the plan is to be claimed as an EPC MBS item, the review must be for the whole of the plan—another EPC requirement). A decision about who will review the whole plan and when, will be recorded here. This decision will depend on the goals of care identified in the service coordination planning process. If only part of the plan is to be reviewed, this will be recorded for each issue on SCP page 2 of 2 and the ‘Whole Plan To Be Reviewed’ will be recorded as ‘no’ on SCP page 1 of 2.

Consumers with acute or post-acute care needs may have short term goals of care and providers may expect that care will be completed within weeks or, at most, months. Consumers whose goals are of the maintenance and support type will have goals that cover a much longer time scale and may be indefinite, since no change is anticipated until their condition changes. Setting a regular review date of three months, six months or when a person's needs change is common practice.

Particular goals may require review before the whole SCP is reviewed. Note the problem and the goal, the name of the person reviewing and the date recommended for the review.

### Participants in the Service Coordination Planning Process

In normal circumstances, the consumer would be involved in the service coordination planning process. This is indicated by circling either Yes or No. If the consumer is a family unit or more than one person, then the plan is based on the person with the existing unique identifier and completed core INI forms. Make a new INI for additional consumers covered by a common plan.

The **consumer**, or the person representing the consumer, such as a substitute decision maker/carer/family member/friend, should be involved in the discussion of consent issues. A separate consent section is covered in a form and guidelines developed by the Department of Human Services. A **carer** or family friend who attends should be noted as part of the core INI content. See the Living Arrangements profile, which will indicate whether there is a substitute decision maker or legal guardian authorised to act on the consumer's behalf.

The service providers who attend should be listed under provider giving name, designation/agency, contact phone and email or fax number. List the key worker first and other providers in order of importance. All providers who take part should be listed and an additional sheet of page 2 of this form should be inserted in the SCP if necessary.

### Evidence of Assessment of Need

The checklist in this section is designed to prompt for the type of information that will be useful for service coordination planning. It goes through the items typically needed before starting. It is expected that the service coordination planning process will have all the relevant information to hand, and that the type and extent of that information will differ between services and service types and depend also on the goal of care.

Evidence of need is an EPC requirement for GPs (see Section 4.3).

EPC multidisciplinary care planning requires an assessment of the consumer that covers their current and future health and care needs. If a GP is considering preparing an EPC plan, they should check whether the consumer currently has another active care plan and, if so, not duplicate it. There are minimal time intervals between some EPC items, however, this does not preclude preparing a community care plan for a patient who has had a discharge care plan prepared previously, if the patient's condition and circumstances warrant it.

Working through the checklist requires a review of the consumer's file(s) and a search to ensure that current or previous scps and other relevant documents are available. This should take place before service coordination planning begins and the checklist completed before discussions commence.

Identify all issues and problems based on the documents indicated in the check box. If new issues or problems are identified, record these in a new document and add it to the existing INI. Do **not duplicate the whole INI**. Simply record new issues and add to the existing document. Do not change the original record but note any new findings or confirmation of evidence discounting old findings.

The person convening the service coordination planning process should ensure that existing plans are made available before the process begins. It should be possible to discover whether a hospital discharge plan exists by an inquiry to the relevant hospital department.

For consumers in residential care, an inquiry should be made of the DoN or nursing staff to see whether there is a residential care plan. For consumers who meet the EPC MBS item requirements, an inquiry should be made to their GP (the consumer can also check with the Health Insurance Commission). For consumers taking part in coordination trials or demonstrations, relevant negotiations may need to have taken place before plans are finalised.

These inquiries are routine and may be made by the appropriate support staff on instruction from the person convening the service coordination planning process. The agencies asked to provide care plans will need to assess whether consumer consent has been obtained to share the contents of the care plan.

It may also be helpful to ask the consumer and the carer, where appropriate, whether other SCPs exist.

All the relevant care plans that are made available should be ticked (EPC requirement).

The 'care plan' can refer to a plan to provide a single service, for example, a physiotherapy program or a nursing care plan, while the SCP is a plan to provide a multidisciplinary and multi-agency service.

### Case Conference

Tick a box to indicate whether or not a case conference was held and, if so, record the date. Under 'Copy to'. EPC plans must be offered to the patient and (relevant parts) provided to the other members of the team.

### Copy to:

Circle to indicate that copies of the completed SCP have been provided to both the consumer and other members of the team (EPC care plans must be 'offered' to the patient and (relevant parts) provided to the other members of the team).

### Service Coordination Plan Documented by:

This would normally, but not always, be the person who convenes the process of planning.

### Consumer Issues/Problems

SCP page 2 of 2 starts with the consumer name. Identify all issues and problems based on the documents indicated in the Evidence of Assessment of Need check box. If new issues or problems are identified, record these in a new document and add it to the existing Service Coordination forms (Consumer Information and Summary and Referral). **Do not duplicate the whole INI process.** Simply record new issues and add to the existing document. Do not change the original record but note any new findings or confirmation of evidence discounting old findings.

Normally the Issues/Problems would be listed in order of priority, particularly where some goals and actions are contingent on prior goals being achieved or implemented. (EPC planning requires one set of management goals that are agreed with the consumer, then the required treatment and services are identified and arrangements made for their provision; goals and issues are not required to be listed in order of priority).

### Consumer Goals

The goals relate to the consumer issue or the problem being addressed in the SCP and are not specific to each service or agency. Note that service-specific goals will logically relate to these but would not be recorded here. Instead, they would be recorded in agency-level care plans.

A consumer issue or problem may have more than one goal. **The goal is the best outcome that the consumer can realistically achieve during the period covered by the current SCP.** Assessing progress against the agreed goals is a fundamental step in measuring consumer outcomes.

Goals may be coded as suggested below or they may be written in text form. A target date should be inserted for those goals that have clear outcomes that can be dated. It may be necessary to write 'indefinite' for some support/maintenance goals.

## Coding the Goal of Care

As well as, or in addition to, writing in the goals, the following codes can be used:

1. **Safety and protection.**
2. **Acute/post acute**—the goal is the restoration of the person's pre-acute level of health and function, within a short time frame (weeks to months).
3. **Functional gain**—the goal is to improve (not maintain) current levels of independence and/or optimise (not maintain) current living arrangements (weeks to months).
4. **Maintenance and support**—the goal is to maintain function, quality of life or current health status (required action might be indefinite in some cases).
5. **Prevention and early intervention**—the goal is early identification and prevention to promote health and prevent problems occurring.

Alternately, the goal can be recorded in text form. The time scale and rationale of the goals will determine when the full SCP should be reviewed.

## Actions To Be Undertaken

Action to be taken should be clearly stated. One would not expect the action to be an assessment. The assessment should be documented in Evidence of Assessment of Need section. The action should be something designed to improve or maintain health and/or quality of life.

Identify the action to be taken (services required) to achieve each goal within the period covered by the plan. Actions such as reviewing, monitoring, reassessment and feedback to the consumer, referral agencies, GP, family, carer should be listed as specific actions as appropriate. List as many actions per issue as required.

Identify the individual/s or service/s responsible for the required action. Finally, enter the proposed start date and review date. The last section under each issue/problem is the 'Issue Resolved (Date)'. This is completed at a subsequent review if the issue has been resolved and no further action is necessary. The date of consumer discharge from a particular service can also be subsequently recorded under the 'Issue Resolved Date'.



## 4.3 Minimum Requirements for GPs

EPC is targeted at patients with a chronic (present, or likely to be present, for six months or longer) or terminal condition, and complex needs requiring care from a multidisciplinary team. The focus is on the patient's needs and not, for example, solely on whether multiple agencies are involved.

The 10 key criteria for an EPC plan pro forma are shown in the box below. All criteria should be met in order to enable a GP to address the requirements for a valid EPC care planning item.

GPs who are using this form should also refer to the MBS book (item descriptors and explanatory notes) as the authoritative and up-to-date source of information on what is required to undertake an EPC service. The MBS book is published on 1 November each year, with a supplementary edition usually published in May of the following year. In addition, the Department of Human Services will develop supplementary guidelines to this document for GPs.

### Care Plan Pro Forma Criteria for GPs

#### Pro formas used for care planning should include:

1. Reminder to check for previous and current care plans.
2. Patient's name.
3. Patient's consent to share information with other service providers  
(this presents an opportunity to determine if patient has any preferences for which service providers to include in care plan).
4. Patient's agreement to goals at end of care plan.
5. Evidence of biopsychosocial assessment of patient and their care needs as documented by identification of needs and goals.
6. Assessment of the treatment the patient will require as documented by tasks
7. Specify medical and care personnel that can provide the above treatment.
8. Evidence that the other members of the multidisciplinary team have been involved and contributed to the plan, eg signature.
9. Review date.
10. Patient to be offered a copy of the record.

#### Optional

- Carer details (if the patient has a carer)

The SPC meets these 10 criteria, but two require additional comment:

### Consumer Consent

In addition to requirements that apply to consumer consent in general, the EPC requirements regarding consent includes a requirement to inform patients about costs. The consent rules for EPC are:

- A.21.15 When discussing the preparation of the plan with the patient, practitioners should:
- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other care providers; and
  - Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to, or withheld from, the other members of the EPC multidisciplinary care plan team;
  - Inform the patient that he or she will incur a charge for the service provided by the practitioner for which a Medicare rebate will be payable;
  - Inform the patient of any additional costs he or she will incur. (MBS)

## Biopsychosocial Assessment

The form has provision to indicate that relevant assessments have been undertaken and that the required information is available (it meets the EPC requirement). This is based on the assumption that relevant assessments are completed prior to, not during, the development of a SCP. Relevant biopsychosocial assessments that meet EPC requirements should be available during the development of a SCP. This assessment would be classified as a Service Specific Assessment on the SCP. If a GP is claiming an EPC item for preparing a care plan, the GP must undertake a biopsychosocial assessment of the patient as part of the preparation of the plan.

## EPC-Specific Guidelines

The following information is from the May 2002 MBS supplement. GPs are recommended to consult the entire MBS book (item descriptors and explanatory notes).

### EPC Multidisciplinary Care Planning

- A.21.1 EPC multidisciplinary team care planning is a specific, defined approach to care planning. An EPC multidisciplinary team care plan is a written, comprehensive, longitudinal plan for the care of patients with one or more chronic conditions and complex care needs, developed and managed by a multidisciplinary team comprising the patient's GP and other health and care providers. EPC multidisciplinary care planning involves team-based management of the patient's complex care needs.
- A.21.2 The development or review of an EPC multidisciplinary team care plan involves collaboration by the members of the team. Each of the members of the team must contribute to the development or review of the plan and not simply provide a service specified in the plan to the patient.

### Chronic conditions and complex care needs

- A.21.3 To be eligible for a Medicare rebate EPC multidisciplinary team care plans and case conferences may only be provided for patients with one or more chronic, or terminal, conditions and complex care needs requiring multidisciplinary care from a team of health and care providers, including the patient's GP.
- A.21.4 A chronic medical condition is a medical condition that has been, or is likely to be, present for at least 6 months. EPC multidisciplinary team care plans and case conferences have been found to be most useful for patient's with complex care needs, *for example*, where routine management of the condition is compounded by the presence of one or more of the following: unstable or deteriorating condition; increasing frailty and/or dependence; development of complications, including falls or incontinence; co-morbidities; significant change in social circumstances (eg death, illness or 'burnout' of carer); or two or more hospital admissions in the past six months.

### Preparation of an EPC Multidisciplinary Care Plan

- A.21.9 For items 720, 722, 724, 726, 728 and 730 preparation of a care plan means the preparation of a written plan in collaboration with all of the members of a multidisciplinary care plan team, describing the following matters:
- An assessment of the patient that considers their current and future health and care needs (refer to note A.21.4); and
  - Management goals with which the patient agrees; and
  - An assessment of the kinds of treatment, health services and health care that the patient is likely to need; and
  - An assessment of any other kind of services and care that the patient is likely to need (for example, home and community care services); and
  - Arrangements for giving the treatment, services and care referred to in paragraph (b); and
  - Arrangements to review the plan by a day specified in the plan (if this review is to be claimed as an EPC care plan review item it must be done in collaboration with all of the other members of the EPC multidisciplinary care plan team; if the review is undertaken by the GP alone it should be claimed as a normal consultation item).

- A.21.10 Preparation of the plan must also include:
- a. A meeting with the patient (and the patient's carer, where appropriate in the practitioner's view and with the patient's agreement) to discuss the preparation of the plan; and
  - b. Telling the patient who will be included in the multidisciplinary care plan team; and
  - c. Collaborating with all of the other members of the multidisciplinary care plan team to identify the patient's needs, the management goals that should be documented in the plan, the ongoing care and services to be provided by each member of the team, and any other services that may be required from other health and care providers to achieve the management goals in the plan;
  - d. Recording the plan and the patient's agreement to the preparation of the plan; and
  - e. Giving copies of relevant parts of the plan to the other members of the multidisciplinary care plan team and to any other persons who, under the plan, will give the patient the treatment, service and care mentioned in the plan; and
  - f. Offering a copy of the plan (and evidence of the contribution made to the plan by members of the team) to the patient (and, if appropriate and with the patient's agreement, to the patient's carer).

### Frequency

- A.21.17 It is recommended that a community care plan be prepared only once per year. However, a new plan may be prepared if in the judgement of the patient's usual medical practitioner there have been significant changes in the patient's clinical condition or in the patient's care support arrangements which have significantly affected their clinical condition since the previous plan, but not within 6 months of the previous plan. Any changes to the plan required after 3 months of the plan being prepared would attract a benefit under the review item 724 (see paragraphs A.21.21 and A.21.22).
- A.21.18 Ongoing implementation and maintenance of the plan by the medical practitioner will be covered under normal consultation items.

### General Requirements

- A.21.28 In circumstances where the patient's usual medical practitioner, as defined in A21.8, is not a member of the EPC multidisciplinary care plan team, a copy of the care plan should be forwarded to that medical practitioner (subject to patient's agreement).
- A.21.30 The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided (see general notes section 7).



# Service Coordination Plan

Record Agency Assigned Consumer Identifier (key worker agency)

or affix label here

## Consumer Name

## Key Worker

Name Agency Contact number

## Review

Whole plan to be reviewed  Yes  No

By Date review recommended

## Participants in Care Planning Process

Consumer  Yes  No

### Others:

Name	Relationship to consumer	Contact phone number	Other relevant contact details

Note: List key worker first. Include all participants in developing this plan—e.g. GP, health and community care providers, substitute decision maker, carer, family members, friends. Append sheet to specify any additional persons.

## Evidence of Assessment of Need

Document	Relevant?	Available?	Comments
INI Consumer/Summary and Referral Information	✓		
INI Supplementary Profiles			
Referral letter/form			
Service specific assessment/s			
Specialist assessment/s			
Comprehensive assessment/s			
Current care plan/s			
Previous care plan/s			
Other (specify):			

## Case Conference

No  Yes If yes, date:

Copy to consumer?  Yes  No Copy to team members?  Yes  No

Department of Human Services

1620402H



Office Use Only: Service Coordination Plan documented by:

SCP Page 1 of 2

Name: Designation/Agency:

Sign: Date: Contact number:

If information becomes superseded, indicate below and record updated information on a new form

The information on this form has been superseded  
Date: Name: Sign:

# Service Coordination Plan

Record Agency Assigned Consumer Identifier (key worker agency)

or affix label here

## Consumer Name

Consumer issue/problem:

Goal:

Target date:

Action/s to be taken:

Responsible individual/s or service/s:

Proposed start date:

Review date:

Issue resolved (date):

Consumer issue/problem:

Goal:

Target date:

Action/s to be taken:

Responsible individual/s or service/s:

Proposed start date:

Review date:

Issue resolved (date):

Append more sheets as necessary

**Office Use Only:** Service Coordination Plan documented by:

SCP Page 2 of 2

Name:

Designation/Agency:

Sign:

Date:

Contact number:

**If information becomes superseded, indicate below and record updated information on a new form**

The information on this form has been superseded

Date:

Name:

Sign: