Primary Care Partnership
BENDIGO LODDON

Service Coordination Protocols

June 2004

Introduction

The Bendigo-Loddon Primary Care Partnership's Service Coordination Model represents **key inter-agency or inter-service processes** related to mutual clients/patients.

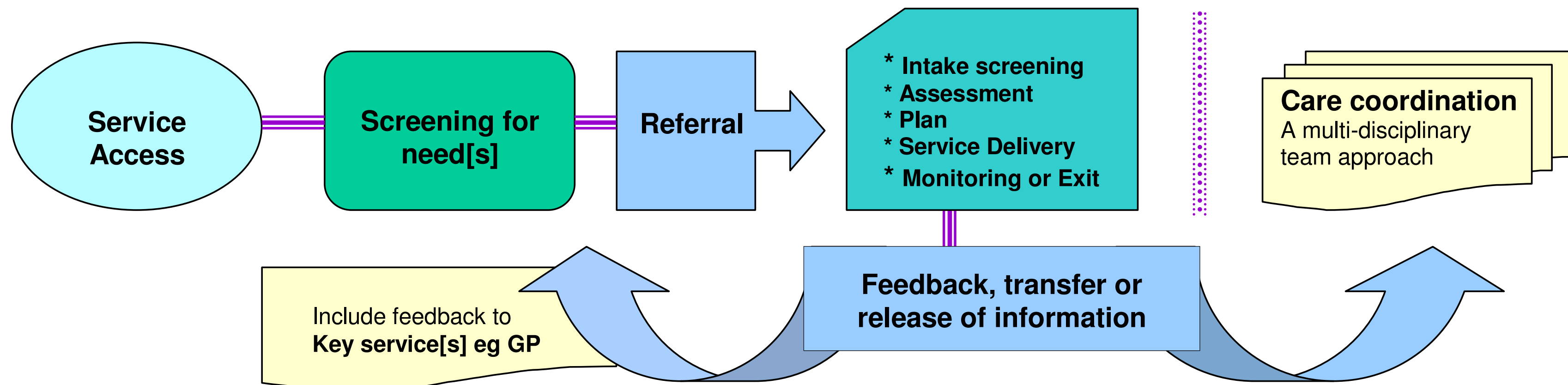
The key inter-agency processes illustrated in the service coordination model are inter-related. The inter-agency processes are:

- Service access
- Screening or needs identification
- Referral
- Feedback, transfer or release of consumer information
- Multi-disciplinary /multi-service care coordination

These processes link to and are supported by **services' internal processes**: intake, assessment, planning, service delivery and monitoring.

The complexity and changing nature of a consumer's situation determines how often and at what points on the care continuum referral and feedback processes occur. The dynamic and multi-layered nature of consumer needs is difficult to represent fully in a two dimensional model. This is a simple representation of the service coordination model:

Bendigo-Loddon Primary Care Partnership's Service Coordination Model



The common feature to all these processes is **information:** client **information exchange** or service and health / care **information provision**

Service Coordination

The purpose of service coordination is to **improve people's access to services** by improving inter-service communication.

The development of **inter-agency / inter-service practice standards**, based on the service coordination model, underpins better access to services.

In the service coordination model, **the common feature of each key inter-service process is information**. Information is either:

- **Exchanges of consumer information** which occurs at: referral; feedback and requests to transfer client/patient/carer information; or care coordination. **Privacy Legislation** applies to these processes.
- **Provision of service information** which can occur at any point in the service coordination model especially service access and referrals.
- **Provision of health or care information** which can occur at any point in the service coordination model.

In this document "consumer" refers to anyone with a service need eg: client, patient or primary care giver. The document aims to be inclusive of all disciplines and service sectors, whilst respecting relevant terminologies of each discipline or sector.

Inter-agency Protocols

In this document "protocol" refers to guidelines that support quality practice standards for inter-agency communication. Internal or intra-agency standards are described within agency Policy and Procedure documentation. The protocols aim to be inclusive for a range of health and community support services.

Inter-agency protocols rely on agencies or services **integrating** the agreed set of practices into their **internal Policy and Procedures**.

For protocols to be functional and implemented there needs to be:

- ✓ Inter-agency or inter-service **trust**
- ✓ Inter-agency or inter-service **consistency**
- ✓ Common core values or **principles**.

Trust

Trust is the foundation for all protocols work:

- Trust is built on the capacity to develop and build good inter-agency / inter-service relationships.
- **Dialogue** is the key to developing trust. Creating open channels of communication and creating opportunities for inter-agency / inter-service dialogue helps develop trust.

Consistency

Protocol work is also built on the premise that inter-agency / inter-service communication requires a degree of consistency to facilitate information exchange and consumer access to services, namely:

- Consistent practice standards and consistent processes.
- Consistent language and a common understanding of key processes.
- Consistent tools, where relevant and applicable.

Principles

Protocol work is also grounded in principles or values that are central to agencies that provide client/patient/carer services. These principles encapsulate consumer centred culture within inter-agency / inter-service communication processes. The guiding principles are:

- **Client/patient/carer focused or consumer centred approaches** are central to each inter-agency process.
- Services have a common **aim: to improve consumer health or care outcomes.**
- The notion of **a team approach** is central to each inter-agency process. Services and the consumer work together. When coordination is required, all relevant services and informal supports are participants.
- Services are **responsible for best possible outcome to consumers** by undertaking practices that:
  - Facilitate access to services.
  - With consent, avoid unnecessary collection or duplication of consumer information. This means providing relevant and critical consumer information to appropriate or key services. For referrals and feedback this may include alerts or risk management information.
- Services strive to **meet practice standards** set to promote quality inter-agency communications: quality exchanges of consumer information; quality provision of service information; and quality provision of health or care information.

Quality inter-agency practices are consumer driven not service driven.

Quality information exchanges are consumer driven practices not paper driven systems.

Implementation Of The Inter-Agency Protocols - Integrating Protocols Into Agency Policies And Procedures

Service Coordination, and the subsequent improvement in consumers' better access to services, can only happen as a result of agencies embracing and **implementing the protocols internally**. This is often, but not exclusively, represented by:

- ✓ Integration of the protocols into agency policy and procedures
- ✓ Service coordination as a standard agenda item at staff, team or management meetings
- ✓ Service coordination as a standard agenda item of network or service provider meetings or forums, to promote inter-service dialogue.

Consumer focused practices require **agencies** and services to be **responsible for**:

- Ensuring Policy and Procedure are inclusive of the key inter-agency processes represented in the service coordination model.
- Ensuring staff have knowledge of or access to information about the broader service system.
- Ensuring staff have skills and competencies related to their inter-agency roles.
- Providing infrastructure, tools and resources to facilitate quality inter-agency processes: consumer information exchanges, service information, and health or care information.
- Nurturing consumer focused inter-agency work practices: inter-agency practices driven by consumer needs and best client outcomes.
- Nurturing the principles that underpin inter-agency work.

Framework For The Bendigo-Loddon Inter-Agency Protocols

The inter-agency protocols consist of 6 key linking processes:

- ✓ 5 processes are inter-agency information processes
- ✓ Service Provision is an internal agency process, but the elements of intake and assessment are linked to, supported by or support the processes of referral and feedback

Protocols have been developed for the 6 linking service coordination processes:

- Service Access
- Screening
- Referrals
- Assessment
- Feedback, transfer or release of information
- Care Coordination

Each protocol describes a component of inter-agency information management. Each protocol is described within the following framework.

The Bendigo Loddon Primary PCP Inter-agency Protocols framework

Process: *Name of the service coordination process*	
1. **What** – definition and links	*Description of what the process is and the process links*
2. **Why** – Consumer focused goals	*Consumer focused description of why the process is needed*
3. **Practices**: a. **How** b. **When** c. **Where** d. **Whom**	*Description of the set/s of practices that make up the process:* ***a. How*** ***b. When*** ***c. Where*** *d.* ***Whom***
4. **Tools or resources**	*Suggested tools or resources that support the process (systems)*
5. **Workforce development and capacity building**	*Suggested workforce development or capacity building that may support the process (i.e. systems)*
6. **Practical hints**	*Hints and checklists that may support implementation, integration or functional application of the protocols*
Practice Pathway/s *Visual representation of the process or sets of practices that make up the process*	

Inter-agency protocols refer to an agreed **set of practices** that constitute the key inter-agency communication **processes**. **Systems,** or tools and resources, are informed by and support good information management practices.

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The purpose of service coordination is to improve people's access to services.

Access to services means that:

1. Consumers have access to up-to-date service and health or care information that supports their care needs.
2. Consumers have access to a range of services appropriate to their care needs. Needs can be identified and services delivered in a timely and efficient manner.
3. Consumers can be sure of quality inter-agency / inter-service exchanges of client information. Health or care information is shared in a way that respects consumers, meets privacy requirements and supports their care needs.
4. Consumers have access to cross-agency multi-disciplinary teams, through the development and agency support of an integrated service system.

The service coordination protocols take in 6 linking inter-agency processes.

- ✓ Service Access
- ✓ Screening
- ✓ Referral
- ✓ Assessment
- ✓ Feedback, transfer or release of information
- ✓ Care Coordination.

The provision of quality user-friendly service or care information is dependent on agencies keeping their own information accurate and up-to-date.

Quality information exchanges require services to impart information relevant and appropriate to the consumer's care needs, thus reducing duplication.

Informed consent is sought for all information exchanges to comply with:

- The Privacy Legislation
- Legislation related to a discipline or sector (e.g. Disability, Mental Health, Aged Care, Child Care Acts)
- Agency and funding accreditation standards.

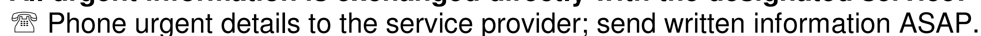
All key information exchanges are written, using mutually relevant tools for:

- Referrals
- Feedback
- Care Coordination.

Quality indicators for all consumer information exchanges include:

- ID on each page that meets Australian Medical Records standards – client name; DOB; gender; date & time sent; sender and receiver contact details.
- Content that is meaningful, clear and concise, and critical to care provision.
- Content meets any identified referral data set or feedback pro-forma.
- Content is understandable, legible and acronym / jargon free.
- Timely exchanges or responses, with frequency and communication modalities appropriate:
  - To meet consumers' needs
  - To meet services' planning or response capacity
  - **To meet urgent exchange responses.**

All urgent information is exchanged directly with the designated service:



☏ Phone urgent details to the service provider; send written information ASAP.

Agencies have systems in place for the notification to all relevant services of:

- Any identified risks or alerts
- Receipt of messages and response confirmation.

The 6 Linking Inter-Agency Processes At A Glance

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Service Access (see page 7 of the Regional Protocols)

This process describes activities that support the provision of accurate, up-to-date service information and other health or care promoting information. It supports consumers being **directed** to the right service[s] as quickly as possible.

Screening for Needs (see page 11 of the Regional Protocols)

Screening refers to a systematic way of uncovering a consumer's underlying health, care and social issues **to help** ascertain service needs.

This is not a diagnostic process, rather an aid to determining a need for further investigation or an assessment.

Referral (see page 15 of the Regional Protocols)

A referral is the physical **transmission of personal, health or care information** relating to an individual from one service to another service[s].

As an outcome of a need being identified the referrer (who cannot address the identified need[s]) makes a **request** for an assessment or service and transfers relevant supporting information.

Assessment (see page 20 of the Regional Protocols)

Assessment is a more **in-depth process** than screening. It is an investigative process using professional and interpersonal skills to **uncover or diagnose** the consumer's problem[s] and then address them. This decision-making methodology collects, weighs and interprets relevant information and then **develops a plan** for the consumer.

Feedback (see page 24 of the Regional Protocols)

Feedback is an information exchange that is in response to any **new or changed personal, health or care information**. This includes transfer and release of information processes. It is not a referral or a multidisciplinary care plan. Hence, feedback includes any exchanges of shareable consumer information from across the spectrum of care including:

- **New or changed consumer demographic information**
- **New or changed risks or alerts information**
- **Screening outcomes**
- **Referral or intake outcomes**
- **Assessment and planned service outcomes**
- **Exit or discharge or transitional information**.

Care Coordination (see page 30 of the Regional Protocols)

Care Coordination is a multidisciplinary process that requires **a cross agency team approach**. A team approach involves shared responsibilities and **collaborative monitoring and planning**.

Service Access

WHAT Is Service Access? What Does It Link To?

Service access underpins service coordination. The process describes activities that support the provision of accurate, up-to-date service information and other health or care promoting information. It supports consumers being **directed** to the right service[s] as quickly as possible.

Inter-agency service access is essentially the provision of information that **directs** consumers to the service system. Service access information links and supports the processes of screening, referrals, and care coordination.

WHY - Consumer Focused Service Access

1. Consumers have a right to access the service system in a timely and appropriate manner.
2. Consumers have a right to access quality service and health / care information that supports their care needs.

Access to quality service and care information is dependent on agencies keeping their own information accurate, up-to-date and user-friendly.

Service Access Practices

HOW

Agencies maintain all their service information contained in pamphlets, information sheets, web sites and service directories.

Service information is made available across a range of mediums.

Quality indicators for service information include:

- Language is user-friendly, jargon and acronym free
- Information is succinct and comprehensive. For example:
  - Essential service access details
  - Standardised eligibility criteria
  - Service description (see checklist for further description).

Consumers and service providers can obtain service information by:

1. Contacting services directly and obtaining essential access details:
   a. Service Name
   b. Service Address
   c. Service phone number
   d. Title of the person to contact.
2. Contacting 1800 services or web sites for printed information.

WHEN

Service information can be accessed at any point in the care continuum.

1. At initial contact or first contact with the service system.
2. Any time service information is needed in order to facilitate a referral: screening or needs identification, and care coordination.

WHERE

Access points to obtain service information can be direct or indirect.

1. Direct access is where contact is made directly with a service. It includes face-to-face, phone or electronic communication modalities. These access points are available across a range of service sites:
   a. Reception, Triage, Duty Service, Outreach, 1800 numbers, and front line or first contact points at any agency.
   b. Any point in the care continuum a service needs to access service information to facilitate a referral.
2. Indirect contact is where information is sourced via printed materials. These access points include pamphlets, information sheets, agency web sites, web-based information services and service directories.

WHOM

All services provide service information and facilitate service access. A range of staff can provide access to service information:

1. Reception staff can act as human service directories, sourcing service information and **directing** people to the right service (NB this is not a referral).
2. Direct care workers can source and provide service information to clients/patients when a need has been identified. The information either assists in consumer self-directed or service facilitated referrals.

Service Access Tools and Resources

The *Service Access and Service Entry Pathway* tool (see page 9)

The *Service Information Pro-forma Tool* is a checklist for creating pamphlet, information sheets, web site and service directory information (see tools section).

Useful and functional service directories (also see information management / health and care information section) include:

- Visual medium: print and web-based directories:
  - Phone book (white and yellow pages).
  - Loddon Mallee PCP directory: www.connectingcare.com
  - DHS State-wide service directory: http://pcpdirectory.health.vic.gov.au
- 1800 service information centres eg:
  - Commonwealth Care Link **1800 052 222** (Australia wide).

Health and care information can also be accessed through:

- Agency information sheets.
- Useful or functional websites (also see information management section) eg:
  - Better Health Channel (InfoXchange) www.betterhealthchannel.vic.gov.au

Workforce Development And Capacity Building That Supports Service Access

Agencies ensure front line staff access knowledge, skills, training and orientation in:

- Local services and the broader service system.
- Use of service directories, including accessing electronic service information.
- Customer engagement, enquiry, and directing or re-directing to services.

Agencies have systems in place to enable:

- Consumers to access information.
- Quality Assurance processes to detect and amend incorrect information.

Service Access Helpful Hints

Think of the process as **directing** consumers to services.

Delegate at least one staff member to be responsible for maintaining service information.

To save time and reduce staff workloads in filling out service directory information, develop one comprehensive information sheet per service that can be distributed to a range of service directories (see the *Service Information Pro-forma Tool – page 10*).

- Use this for your web site, pamphlets and for information requests.

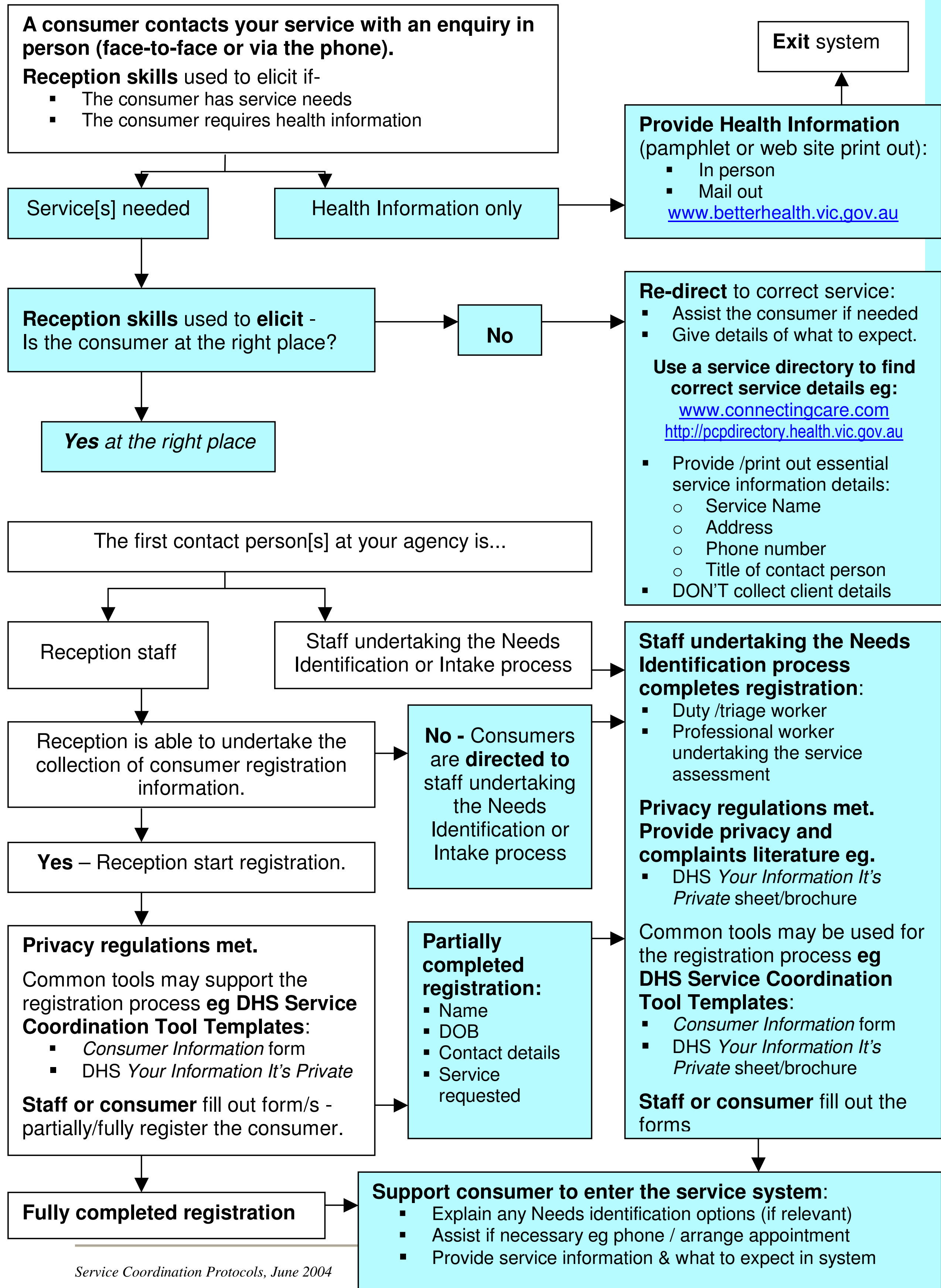
Check the quality and user-friendliness of service information against the *Pro-forma Tool* or with consumer reference groups and other services.

For quick access to websites:

- **Make links** to other useful directory websites on your agency website.
- Add the above websites to all staff's **favourites** lists on all computers.

Service access is dependent on your quality service information being available.

Service Access and Service Entry Pathway



Suggested Service Information Pro-forma – Checklist

The pro-forma covers standard information required to develop a comprehensive service information sheet. It doubles to provide service directory and website details.

Essential Service Information: Service name; service address; phone and fax numbers; service email address; website address; title of the person to contact.

Service Description (Keep it: succinct; user-friendly; jargon and acronym free.)

Service Access/ Entry Criteria (include boundaries or limitations):

- How does the consumer gain **entry to the service**:
  - **Directly:**
    - No special requirements
    - Can access service without a referral
  - A **special entry requirement[s]** exist or needs to be in place:
    - Needs a diagnosis
    - Needs to have referral from another service
    - Needs to have a specific or multiple services in place
    - Needs a level of complexity (define) or have multiple needs eg for specialist or case management services
- **Eligibility criteria** – i.e. eligibility to receive a service (defined by funding):
  - **Demographics details** eg:
    - Age; gender; etc
    - Cultural; ethno-specific; language etc
    - Living arrangement – financial; accommodation
    - Dependents or primary care-giver
    - Service boundaries (LGA; Towns; Regions etc)
  - **Target issues** / **target group** eg drug and alcohol; homelessness
- **Service delivery criteria (boundaries and limitations)**
  - **Service provision type** eg:
    - Crisis / emergency type interventions
    - Restorative / Maintenance type interventions
    - Education or prevention type interventions
  - **Target type** eg individuals, couples, families, community, group etc
  - **Length of service delivery**:
    - One off
    - Short term (define time and what ends episode of service)
    - Long term (define time and what ends episode of service)
  - **Specific intake screening** information not mentioned above
- **Time of service operation** eg:
  - Daytime; evening; 24 hours etc
  - Weekdays; weekends etc

Service fees – include full fees, concessions or Medicare rebates

Waiting list details – general wait time; advise interim measures if long waits

Is the information user friendly, acronym and jargon free? Is it meaningful? Check it with your consumer reference group or another service; or your reception staff.

Screening

WHAT - Defining The Screening Process

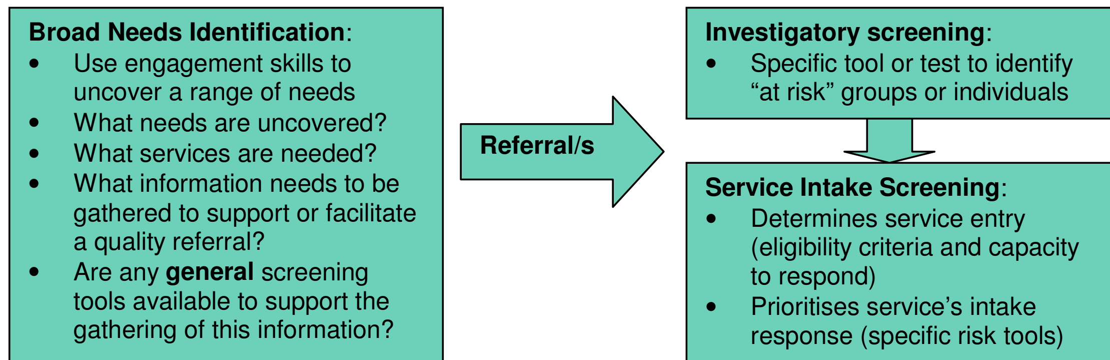
Screening refers to a systematic way of uncovering a consumer's underlying health, care and social issues to help ascertain service needs.

This is not a diagnostic process, rather an aid to determining a need for further investigation or an assessment.

The Bendigo Loddon Primary Care Partnership Service Coordination Protocol Review Working Group has identified 3 types of screening:

- Needs identification screening broadly identifies a range of needs
- Specific or specialist investigatory screening identifies specific needs
- Intake screening aids in indicating risk, service eligibility and priority for a service balanced against service capacity.

The screening process is intrinsically linked to the referral process.



WHY Undertake Screening – Consumer Focused Goals

Consumers' needs are met in a social model of health context. Screening uncovers underlying health, care and social issues beyond the presenting issues. It also can identify individuals at risk of developing health, care or social related problems.

Consumers can access a broad holistic needs identification screening when they enter the service system. Needs identification facilitates early or timely access to a range of appropriate health and care services appropriate to the consumer's needs.

Consumers have access to health promotion and illness prevention opportunities.

Screening Practices

HOW

Systematically gathering information to find out a consumer's health, care or social needs is accomplished by using screening tools or systematic inquiry method to assist in identifying:

- Areas of needs
- Alerts and risk indicators
- Service eligibility, level of risk and priority at intake.

Quality Indicators for all types of screening include:

- Inquiry skills to check or find out what other service[s] are involved and what informal supports are available.
- Information gathered in a way that is sensitive to the consumer's physical, social, psychological, emotional, and cultural needs.

How

- The screening information recorded:
  - Meets documentation standards relevant to a discipline / service
  - Meets inter-agency standards or quality indicators (see summary)
  - Is relevant or appropriate to the presenting and identified need[s]
  - Accurately records the identified needs and the response plan
  - Is at the level of the practitioner skills
- Consent is gained to gather and share screening information:
  - Written consent is gained were possible
  - Record of which services are able to share what information.

HOW - Related To 3 Types Of Screening Processes

Needs identification screening:

- Gathers broad information to identify service needs beyond the presenting issue. The broad non-specialist categories of need include:
  - Health issues
  - Social issues
  - Psychosocial issues
  - Functional abilities or disabilities
  - Issues related to healthy behaviours and wellness promotion or illness prevention.
- Gathers relevant information to support a referral[s].
- Information gathered can be documented on common inter-agency tools to support the referral. This enables the information to be built on over-time and updated with each new referral (see Tools Section).

Specific or investigatory screening:

- Gathers information using a test or tool that aims to identify at risk groups or individuals for specific conditions/ issues that are amenable to prevention or early intervention.
- Part of health promotion activities.

Intake screening:

- Uses a specific/specialist intake tool or systematic intake inquiry method to determine service eligibility and entry. On entry, additional minimum data can then be gathered for program statistics.
- Uses the screening information to prioritise the service response to the intake or assessment process.
- Confirms, or not, the referral action.

WHEN - Related To All 3 Types of Screening

Screening can **occur** or be **updated at anytime** in the service continuum including:

- Initial needs identification, or intake.
- Exit or transfer
- Ongoing needs identification, or monitoring for deterioration or change.

Needs identification screening gathers information to support the referral process. Needs identification can occur at:

- Initial entry to the service system.
- Any time in the service delivery continuum when a new need[s] or a change[s] arises eg at assessment or re-assessment, monitoring and care coordination.

Specific or investigatory screening may occur as:

- Part of a primary prevention or population-based health strategy.
- Part of implementing a specific prevention or early intervention strategy within individual service provision or multi-disciplinary care coordination.

Intake screening occurs in response to a referral as a part of service entry.

WHERE - Related To All 3 Types of Screening

Needs identification screening can occur at:

- Any service access point where a direct service worker can gather broad screening information face-to-face or via the phone eg:
  - Triage
  - Front line points
  - Outreach
  - 1800 referral numbers.
- Any service delivery point eg intake, monitoring, care coordination.

Specific or investigatory screening:
- May be used as part of a primary prevention or population-based health strategy, or any service delivery point eg intake, monitoring, care coordination

Intake screening can be an entry process at any agency, often specialist services.

WHOM - Related To All 3 Types of Screening

NOTE: reception or administration staff DO NOT undertake screening or referrals. They **direct** consumers to screening or a requested service on the basis of their issue.

Needs identification screening
All direct workers can undertake needs identification screening:
- Triage, Duty or Intake workers
- Assessment Officer
- First direct service worker
- Direct service workers at any time.

Direct service workers have skills to uncover underlying health, care or social issues beyond the presenting issue. However the degree of depth or rigor in the information gathered is appropriate to and dependent on their level of training and skills/expertise in the area.

Specific or investigatory screening: is done by a specific or specialist worker.

Intake screening is undertaken as a response to a referral. The structure or processes within a service determines who does intake screening:
- **Specific intake process**: a specific or specialist Intake Worker.
- **No specific intake process**: each direct worker responding to a referral.

Screening and Needs Identification Tools and Resources

The *Screening or Needs Identification Pathway* aids common practices (see page 14).

Ensure that your service information clearly articulates what referral information is relevant to support the service need. This may include eligibility and entry criteria.

Common tools can support needs identification processes that are general but not specialised. Eg the *Profiles* in the suite of *DHS Service Coordination Tools:*
- ☑ *Health Conditions Profile*
- ☑ *Living Arrangements Profile*
- ☑ *Functional Screen* (daily living abilities)
- ☑ *Psychological Profile*
- ☑ *Health Behaviours Profile* (i.e. broad health promotion enquiries).

Some Specialist Intake services exist and have specialist tools for screening eg: Child Protection, Carers Support, Mental Health, Disability, Specialist Children's Services. Intake screening tools help identify risk and service priority

The *DHS Privacy Kit* assists services in meeting the privacy legislation (see section 4).

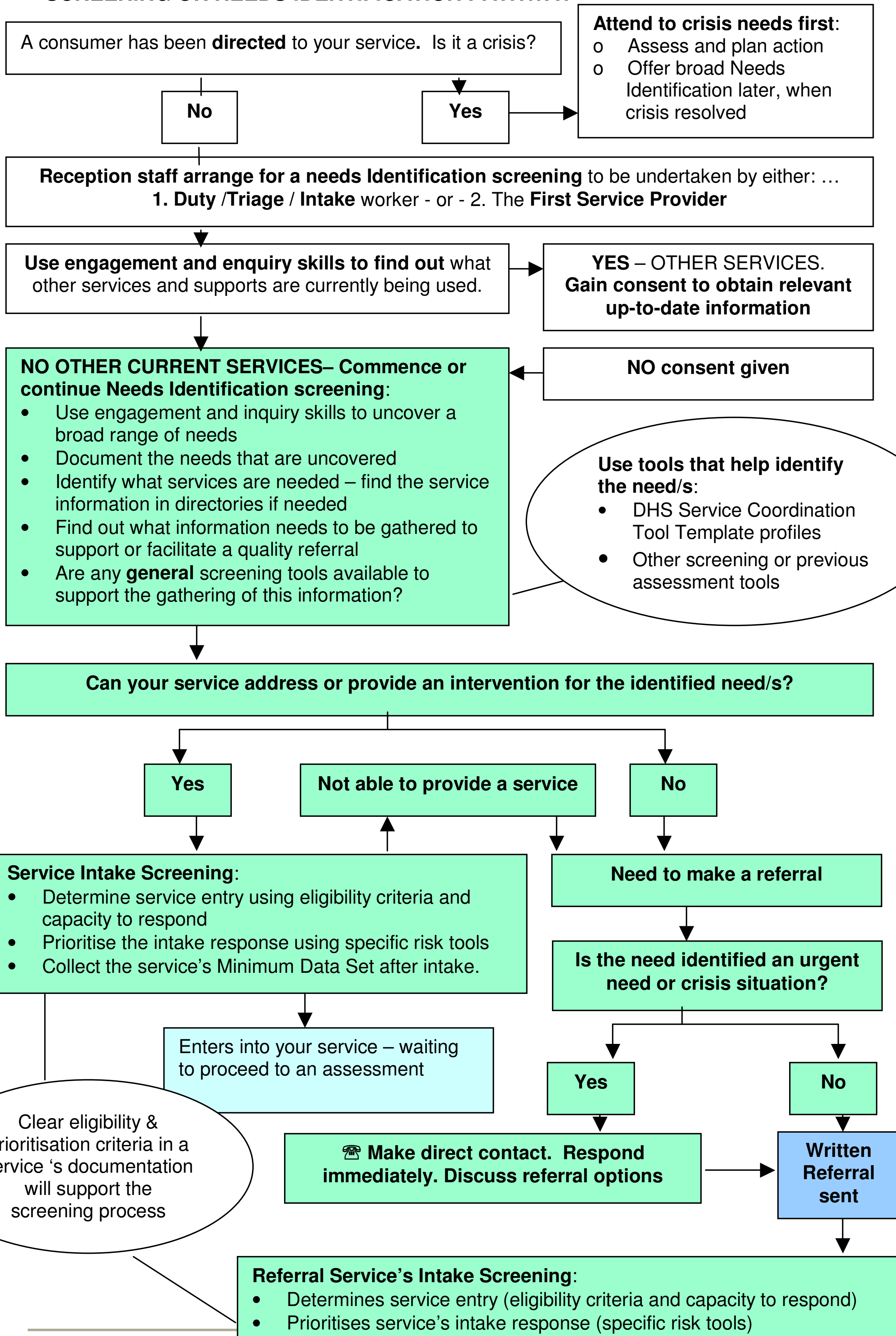
Workforce Development and Capacity Building that supports screening

Agencies determine the screening practices for each service. Agencies ensure staff access to relevant knowledge, skills, orientation and training re screening process[s]:
- Enquiry methods to uncover underlying health, care or social issues.
- Systematically gather, synthesise and record information on a range of needs.

Agencies have systems in place to support screening:
- Staff are qualified, with skills and competencies to undertake their role.
- Systems to distinguish screening processes from the assessment process.
- Tools to support the screening role and aid referral information exchanges.
- Supervision and internal Policy and Procedures to support the role.

Helpful Hints	**To reduce duplication**, separate your screening and assessment tools. This aids updating and information transfer processes.

SCREENING OR NEEDS IDENTIFICATION PATHWAY



Referral protocol

WHAT is a referral? WHAT does it link to?

A referral is the request for an assessment or a service. This comes after a need is identified. The referrer cannot address the identified need[s] and transfers relevant supporting personal, health or care information to a service that can address the consumer's needs.

A referral links 2 services through the exchange of consumer information. It connects the needs identification screening with assessment or feedback processes. The process of sending and receiving referrals makes up one aspect of an Information Management system.

A Referrer cannot determine the type or level of service provision; only identify a need for service.

WHY – Consumer Focused Referral

Consumers have access to a coordinated and seamless service system. For the best care outcomes agencies ensure that all relevant consumer information is shared with the receiving service. Information exchanges adhere to Privacy Legislation.

Consumers have access to a secure information management system**.** Written information assists referral outcomes and facilitates service access.

Consumer access to appropriate services is made possible by timely and quality referral practices.

Referral Practices

HOW The referral process consists of the sending of referrals and the receiving of referrals.

Sending Referrals

Quality information exchanges – **quality indicators for sending referrals include:**

- Identifying services that are involved and informal supports that are available.
- Deciding whether the needs identified require an urgent response.
- Gathering relevant and appropriate information to support the referral eg:
  - Consult service information details to ensure that the referral covers the entry and eligibility criteria of the service
  - Tailor the referral information to the needs of the receiving service.
- Using the needs identification information (refer to the screening section) and other relevant supporting documents.
- Obtaining consent to record and send the referral information, covering:
  - What the information is to be used for
  - Which services are able to share what information.
- Consumer information being exchanged is **written**.
- The sending of referral information meets inter-agency information exchange standards including:
  - Clear labelling of each record - Client ID on each page
  - No jargon / no abbreviations / Legible user-friendly language
  - Secure method to send the referral

A **referral action plan** is developed with the consumer. This referral plan records:

- The service[s] the consumer is being referred to
- The reason[s] for the referral
- Consent details for each referral
- Feedback requirements from each service
- Date and method of sending the referral

Refer to the DHS *Summary and Referral Information* form page 2 (see Section 3).

Service providers have a process to respond to urgent or non-urgent referrals.

- **Urgent referrals** require an immediate response to the identified needs by the referrer and consultation with the referral service as to the action[s] to be taken:
  - ☎ Make direct contact with the proposed referral service to ensure the referral is accepted. Send written documentation later.
  - Urgent referrals don't get sent without this initial direct referral discussion.
  - Discuss next or interim steps with the referral service, and planned action.
  - Send written documentation as soon as possible to support the referral.
- Contact someone (in person) ASAP to facilitate other urgent action. For example, ring the emergency service/s, speak with your supervisor, or ring the consumer's emergency contact/s to determine next steps / urgent action.
- Contingency plans need to be in place for when you cannot contact the required person eg know who else can be contacted; check with your supervisor.

Consent is gained to ensure privacy regulations are adhered to in the collection and sharing of consumer information. Agencies need to have systems in place for sending referrals without consent. (Refer to the Privacy Kit in the Section 4)

Baseline information that needs to be sent with a referral consists of:

- Consumer demographic information that has been **checked and updated** eg:

Name	Date of Birth	Gender
Residential address	Contact number[s]	Next of Kin – contact
Preferred language	Require an Interpreter	Other contacts

- Reason for the referral
- Current services and informal supports
- Referral action plan

Referrals can be sent via a range of system options, depending on urgency and the systems available to the receiver. For example a copy can be sent via:

- Consumers, who take a written copy of the referral with them for the designated service / worker.
- Australia Post mail service.
- A fax to the designated worker. Fax areas or systems meet Privacy Legislation.
- A secure e-referral system:
  - Intranet systems, for internal emailing of referrals
  - Internet systems require digitally signed and encrypted e-referrals.
- ☎ Baseline information phoned to the designated service, and then followed up with written information.

The sending service keeps a record of the referral action in line with Privacy Legislation.

Receiving Referrals

Agencies have systems in place to record incoming referrals and the responses eg:

- Intake actions if eligible to receive the service eg:
  - Screen risk levels to determine priority and service response time
  - If on a waiting list, ensure consumers can access interim strategies.
- Feedback to the referrer to inform of actions taken or required eg:
  - Inappropriate referrals
  - Lack of capacity to meet the consumer's needs in a timely manner.
- Document lack of capacity to meet referral needs.

WHEN and WHERE

Referrals can occur at any time or point in the care continuum, if needs are identified:

- Initial needs identification
- Ongoing needs identification.

A timely referral exchange or response and its communication mode is determined by:

- ➢ Consumer's needs
- ➢ The level of urgency
- ➢ Service's need to plan for a consumer
- ➢ Service's response capacity.

WHOM Any qualified staff member can make or receive a referral. However agencies may have dedicated staff undertaking either task.

Tools and Resources that support quality referral practices

The *Referral Pathway* aids common referral practices. (Refer to page 19).

Service information can facilitate a quality referral if it clearly articulates what referral information is required to support service eligibility and entry criteria.

Common baseline information also supports a quality referral. This information exists in the *DHS suite of Tools* to support Service Coordination (see section 3):

- ☑ *DHS Summary and Referral Form* (especially a fully completed page 2).

For a quality referral, baseline referral information needs to be supplemented with demographic consumer details and any relevant tools that resulted from information gathered and updated at screening or assessment. These may include:

- ☑ *DHS Consumer Information Form*
- ☑ Relevant updated *DHS Profiles* **or other** specialised screening tools
- ☑ Relevant assessment[s] summaries
- ☑ Relevant risk management tools.

NB: It is important to record the names of any attachments on the referral form.

The *DHS Privacy Kit* assists services in meeting the privacy legislation (see section 4). There is also a consent form and information sheet in the *DHS suite of Tools* to support Service Coordination and Privacy Legislation:

- ☑ *Consumer Consent Form*
- ☑ *Your Information: Its Private sheet.*

A referral may also attach a *Feedback Form* outlining the person[s] who requires feedback and the type of feedback required (refer to feedback section p 24).

Systems for secure transfer of information, i.e. the sending or receiving of referrals.

Workforce Development and Capacity Building that supports referrals

Agencies ensure staff have the relevant knowledge, skills, orientation and training to enable effective referral practices, i.e. sending and receiving a referral[s]:

- Recording and sending information related to any health, care or social needs identified in the screening process. It includes using relevant referral tool[s].
- A broad knowledge of the service system to ensure appropriate referrals or knowledge of how to find service information to choose appropriate services for the service need identified; matching service needs to roles and eligibility.

Agencies have systems in place to support the referral process:

- Staff are qualified, with skills and competencies to undertake their role.
- There is a process distinction between the needs identification screening and assessment. This enables common tools to be reviewed and updated with each referral. The incoming referral can also support the assessment process.
- Outgoing referrals are sent or incoming referrals actioned in a timely efficient manner; the action /mode and response time is dependent on urgency level.
- Secure transfer and receipt of referrals:
  - Confidential fax area
  - Capacity to digitally sign and encrypt e-referrals for all Internet mail.
- Supervision and internal Policy and Procedures to support the referral process. This includes processes to action urgent and non-urgent referrals.
- Risk or alerts are identified and communicated eg:
  - Consumer at risk
  - Consumer presents a physical or emotional risk to others
  - Consumer presents a risk to a worker (un/intentional)
  - Occupational health risk.

Helpful Hints

An "*If urgent, make direct contact with the proposed referral service before sending this referral*" **prompt** could exist on referral cover fax sheets/ letters and e-mails.

When consulting service access information (eg service directory or information sheets) and referral information is not clear, inform the relevant service of the ambiguity or lack of clarity.

Discuss quality referral processes with your software developer. The embedding of common tools in the software with auto-population features, links to data collection functions and capacity to select existing collected data help reduce workloads when sending a referral. Messaging standards aids the receipt of data.

A referral is the actual transmission of consumer health / care information from one service to another for the purpose of requesting an assessment for either a service or a consultation plan.

BASELINE REFERRAL INFORMATION

Name

Residential address

Contact number

Date of Birth

Gender

Next of Kin and other contacts

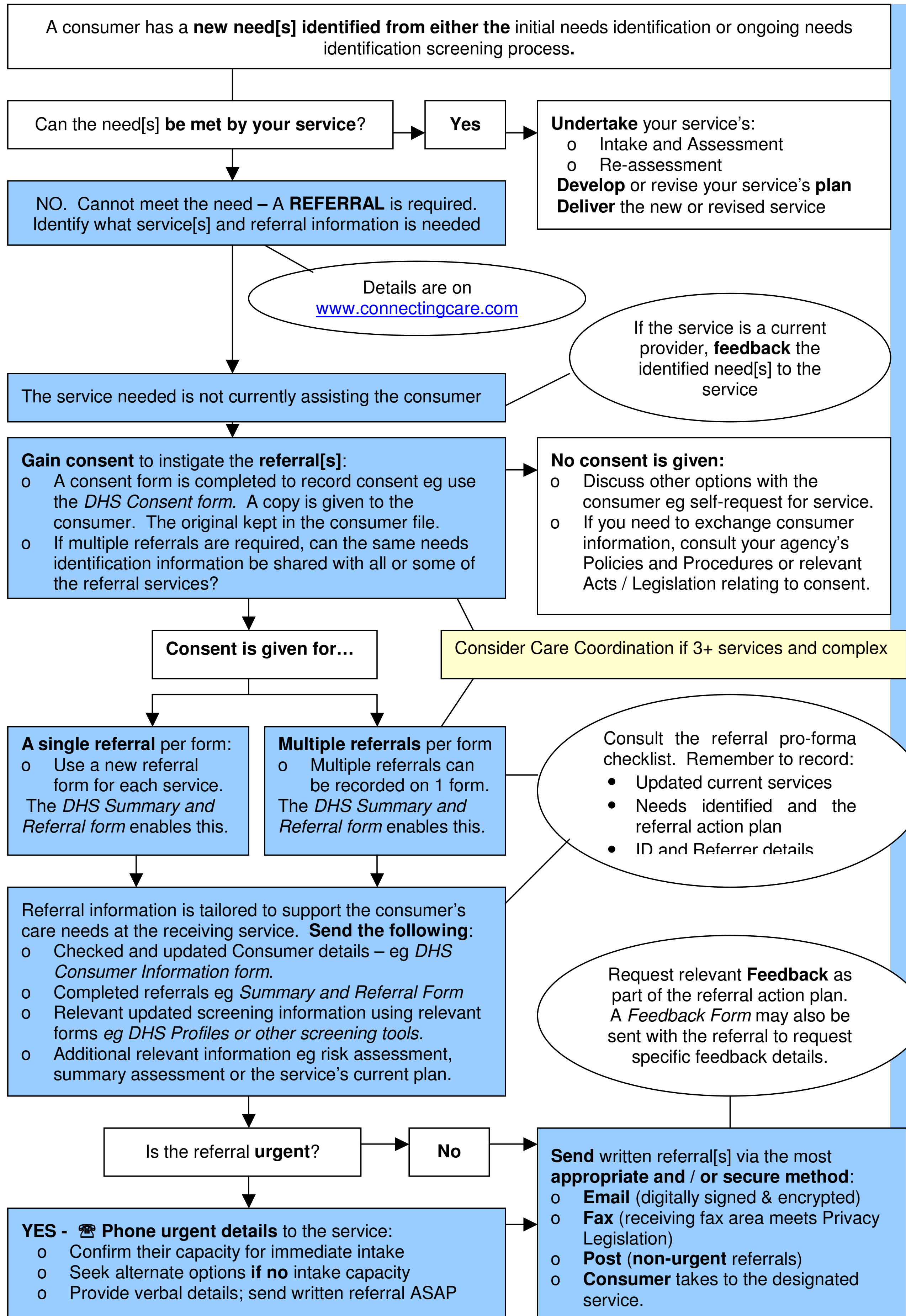
Preferred Language

Interpreter service required

Reason for the referral

Current services and informal supports

Referral action plan:
- ✓ The service[s] the consumer is being referred to
- ✓ The reason[s] for the referral
- ✓ Consent details for each referral
- ✓ Feedback requirements from each service
- ✓ Date and method of sending the referral


A consumer has a new need[s] identified from either the initial needs identification or ongoing needs identification screening process.
Can the need[s] be met by your service?
Yes
Undertake your service's:
o Intake and Assessment
o Re-assessment
Develop or revise your service's plan
Deliver the new or revised service
NO. Cannot meet the need – A REFERRAL is required. Identify what service[s] and referral information is needed
Details are on www.connectingcare.com
If the service is a current provider, feedback the identified need[s] to the service
The service needed is not currently assisting the consumer
Gain consent to instigate the referral[s]:
o A consent form is completed to record consent eg use the DHS Consent form. A copy is given to the consumer. The original kept in the consumer file.
o If multiple referrals are required, can the same needs identification information be shared with all or some of the referral services?
No consent is given:
o Discuss other options with the consumer eg self-request for service.
o If you need to exchange consumer information, consult your agency's Policies and Procedures or relevant Acts / Legislation relating to consent.
Consent is given for…
Consider Care Coordination if 3+ services and complex
A single referral per form:
o Use a new referral form for each service.
The DHS Summary and Referral form enables this.
Multiple referrals per form
o Multiple referrals can be recorded on 1 form.
The DHS Summary and Referral form enables this.
Consult the referral pro-forma checklist. Remember to record:
• Updated current services
• Needs identified and the referral action plan
• ID and Referrer details
Referral information is tailored to support the consumer's care needs at the receiving service. Send the following:
o Checked and updated Consumer details – eg DHS Consumer Information form.
o Completed referrals eg Summary and Referral Form
o Relevant updated screening information using relevant forms eg DHS Profiles or other screening tools.
o Additional relevant information eg risk assessment, summary assessment or the service's current plan.
Request relevant Feedback as part of the referral action plan. A Feedback Form may also be sent with the referral to request specific feedback details.
Is the referral urgent?
No
Send written referral[s] via the most appropriate and / or secure method:
o Email (digitally signed & encrypted)
o Fax (receiving fax area meets Privacy Legislation)
o Post (non-urgent referrals)
o Consumer takes to the designated service.
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

Assessments

WHAT is an assessment? WHAT does it link to?

Assessment is a more in-depth process than screening. It is an investigative process using professional and interpersonal skills to uncover or diagnose the consumer's problem[s] and then address them. This decision-making methodology collects, weighs and interprets relevant information and then develops a plan for the consumer.

Assessment links to activities before and after it i.e. needs identification and planning:

- The assessment builds on the needs identification process: either initial needs identification or ongoing needs identification. It uses the needs identification as a baseline to direct a more in-depth investigation process than screening.
- The assessment process is not an end in itself but part of a process of delivering a service. Service delivery is dependent on the development of a plan eg: care plan, service plan, action plan, intervention plan, specific management plan, nursing plan, treatment plan, individual service plan etc. The plan is the basis for monitoring progress or functionality of interventions.

The outcome of an assessment, **the plan** is:

- A functional tool for setting the **direction of interventions** and **monitoring** service delivery to meet the needs of each individual.
- A valuable tool for providing feedback or transfer of information to key services and persons involved in a consumer's care or support. The plan is thus also valuable for multi-disciplinary care planning or care coordination.

Re-assessment is a formal process of undertaking a subsequent assessment of a consumer who has been previously assessed due to a perceived change in the requirements. The re-assessment process should mirror the original assessment in order to maximise identification of changes in the consumer. The outcome of reassessment is a new plan.

WHY – consumer focused assessments

Consumers have access to a coordinated and seamless service system, including a transparent transition from referral to service provision.

Consumers have a plan that is developed to meet their assessed needs. The plan underpins monitoring and the feedback of information to key people.

Consumers' needs are met in a social model of health context.

Assessment Practices

How

The assessment process is an internal process that determines the need for service provision. **Quality indicators** are the responsibility of each service, often set by existing quality assurance measures, performance indicators and program funding guidelines.

However, assessments link to and support other inter-agency processes. Core elements that support quality inter-agency interactions include:

- Clear roles and boundaries articulated in service information, including skills or training, specialised assessment tools, or practice methods related to the assessment and service provision task[s].
- Assessments are undertaken as **face-to-face interactions**.
- Core elements of assessments are (refer to assessment pathway page 23):
  - Detection, classification or diagnosis of the **issue or problem.**
  - Development of a **plan** that addresses the issue and level of risk assessed.

- Other activities that support assessments are:
  - Provision of **health or care and service information.**
  - **Availability** of the plan to aid workers in the **delivery of** planned care.
  - **Review the plan** i.e. monitor interventions as to whether working or not.

Services are funded to provide holistic assessments as per their funding guidelines. These are summarised as three [3] assessments types:

Assessment Type	
Service Specific Assessment	Generalist services undertake assessments related to the specific presenting need i.e. relatively straightforward need. Eg a physiotherapist for a specific assessment (back or knee pain). The assessment can be undertaken for a range of reasons and requires the skills and expertise of that specific discipline.
Specialist Assessment	Specialist services undertake assessments when the presenting issue requires a specialist service response. The assessment requires the use of a common specialist assessment tool[s] or plan for that related area. Also in addition to a discipline's skills, the specialist area requires specialist skills knowledge and expertise.
Comprehensive Assessment	Comprehensive assessments are the most intense level of inquiry, gathering information from a range of sources. Comprehensive assessment services are independent of service delivery eg Aged Care Assessment Service or A Case Management Service, and work in a multi-disciplinary context. The assessment compiles information on a range of multiple and complex issues and develops a comprehensive plan to address these issues and assessed risks.

WHEN

Assessments are undertaken either following a referral or as a result of monitoring i.e.:

- **Initial** assessment occurs following intake screening and entry into the service.
- **Re-assessment** occurs either at a **specified time** or when **monitoring** identifies that the plan is not working.

After monitoring, the following outcomes indicate when a re-assessment is needed:

- The plan is working and the issues are all addressed – No need to re-assess - proceed with exit, discharge or transfer procedures.
- The plan is working and no new needs are identified – continue plan.
- The plan is not working and new needs are identified:
  - **Reassess** if the needs identified can be addressed by your service. Compare results against previous assessment and **revise or develop a new plan.**
  - **Refer** if the needs cannot be addressed by your service

WHERE

Face–to–face assessments are undertaken in a private space or room eg: the agency; the consumer's home; facility-based setting.

WHOM

Professional staff have skills and qualifications to undertake the assessment type required for the service.

Tools And Resources That Support Quality Assessments

Services undertaking specific service assessments may use one or several discipline related assessment tools or methods to assess the identified needs.

Specialist assessment services use special assessment tools and / or specialist plans to meet each specialist program areas' requirements or clinical standards.

Comprehensive assessment services gather information from other services (i.e. screening and assessments details, and / or plans) to aid in the formulation of a comprehensive assessment and comprehensive multi-disciplinary plan.

Standardised assessment tools are recommended where possible. Improved consumer outcomes are enhanced by inter-agency standardisation of tools.

A common plan format can assist information exchange between services as a means of supporting service coordination.

A Plan addresses the issue and level of risk assessed. A plan includes:

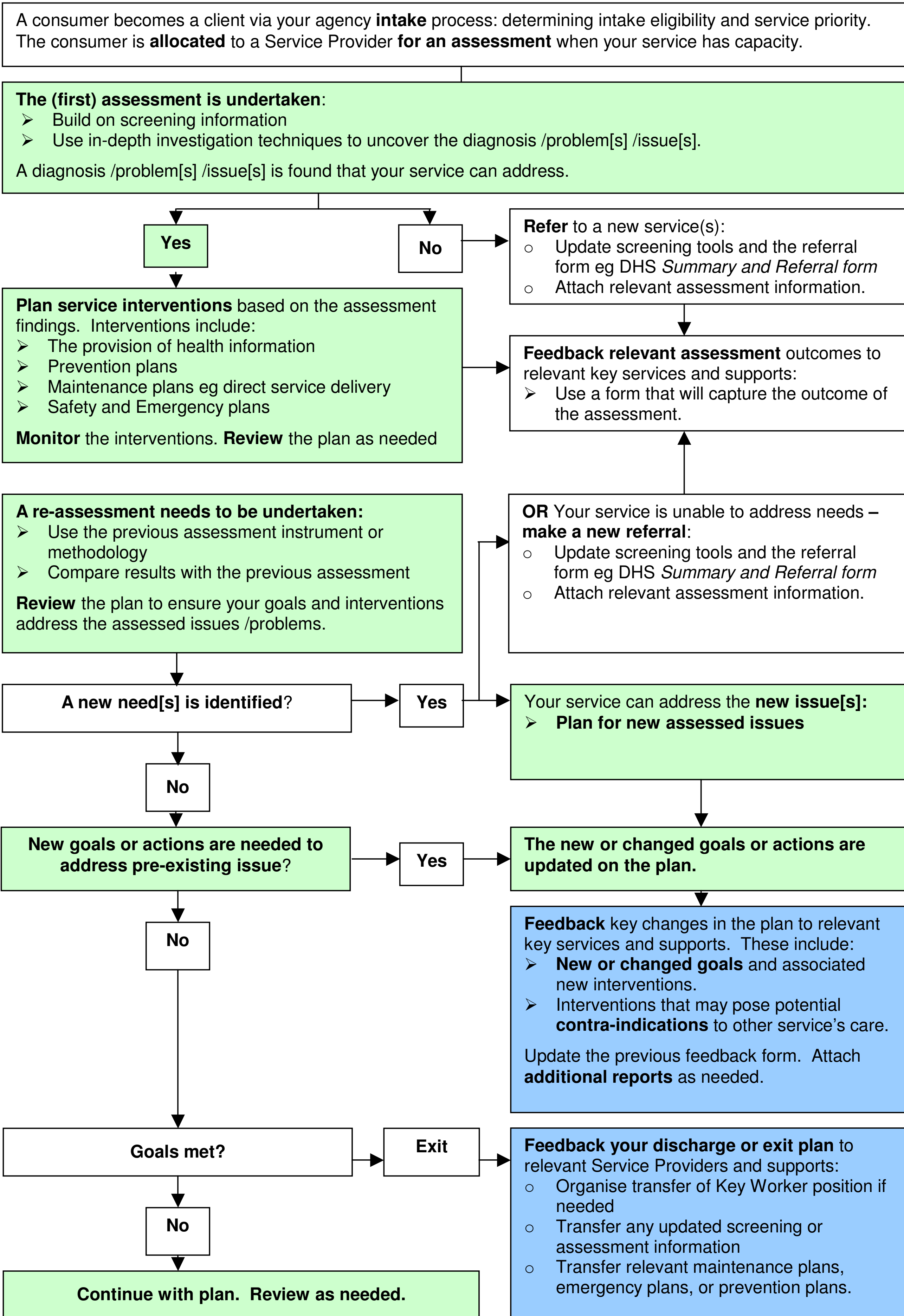
- **The assessed problem[s] or issue[s]**
- **Goal[s]** – clear, achievable and consumer focused
- **Target dates** or anticipated end or review dates
- **Actions or interventions:** Interventions can be crisis, restorative or maintenance in nature; or preventative or safety related information.
    - **Type** of intervention[s]
    - **Level** of service intervention[s]
    - **Frequency** of the interventions
- Provision of **crisis intervention strategies or a crisis plan**
- Provision of **prevention strategies**
- Provision of prevention and health promoting **information**

Suggested Goal Headings - A Checklist For The Plan:

A range of interventions can be expressed in a plan eg **physical, psychosocial, social, environmental, cultural or spiritual interventions**.

Some or all of these goals may be used in the plan:

- **Safety and Protection** of consumer and / or support systems.
- **Management of the episode / acute event** or post episode / post acute event. (Interventions covering a short time frame of days to weeks.)
- **Functional gain** to improve or optimise levels of independence, wellness, quality of life etc. (Interventions covering weeks to months.)
- **Maintenance and support** interventions maintain levels of independence, wellness, quality of life etc. (Interventions covering a longer time frame.)
- **Prevention and early intervention** strategies to promote wellness and prevent re-occurrences.


A consumer becomes a client via your agency **intake** process: determining intake eligibility and service priority. The consumer is **allocated** to a Service Provider **for an assessment** when your service has capacity.
The (first) assessment is undertaken:
➢ Build on screening information
➢ Use in-depth investigation techniques to uncover the diagnosis /problem[s] /issue[s].
A diagnosis /problem[s] /issue[s] is found that your service can address.
Yes
No
Refer to a new service(s):
o Update screening tools and the referral form eg DHS *Summary and Referral form*
o Attach relevant assessment information.
Plan service interventions based on the assessment findings. Interventions include:
➢ The provision of health information
➢ Prevention plans
➢ Maintenance plans eg direct service delivery
➢ Safety and Emergency plans
Monitor the interventions. **Review** the plan as needed
Feedback relevant assessment outcomes to relevant key services and supports:
➢ Use a form that will capture the outcome of the assessment.
A re-assessment needs to be undertaken:
➢ Use the previous assessment instrument or methodology
➢ Compare results with the previous assessment
Review the plan to ensure your goals and interventions address the assessed issues /problems.
OR Your service is unable to address needs – **make a new referral**:
o Update screening tools and the referral form eg DHS *Summary and Referral form*
o Attach relevant assessment information.
A new need[s] is identified?
Yes
Your service can address the **new issue[s]:**
➢ **Plan for new assessed issues**
No
New goals or actions are needed to address pre-existing issue?
Yes
The new or changed goals or actions are updated on the plan.
No
Feedback key changes in the plan to relevant key services and supports. These include:
➢ **New or changed goals** and associated new interventions.
➢ Interventions that may pose potential **contra-indications** to other service's care.
Update the previous feedback form. Attach **additional reports** as needed.
Goals met?
Exit
Feedback your discharge or exit plan to relevant Service Providers and supports:
o Organise transfer of Key Worker position if needed
o Transfer any updated screening or assessment information
o Transfer relevant maintenance plans, emergency plans, or prevention plans.
No
Continue with plan. Review as needed.

Feedback

WHAT Is Feedback? WHAT Does It Link To?

Feedback, transfer or release of consumer information all have the same characteristics and are all underpinned by the same principles. Like referrals, the sending and receiving of this information is part of an Information Management system that adheres to Privacy Legislation. All are **linked to** the processes of needs identification and referral, assessment and re-assessment, and care coordination.

Feedback, for this document, refers to any exchange of consumer information that is not a referral request for a service or not a multidisciplinary care plan. This **includes transfer or release of information** that supports any aspect of service provision. Hence, feedback includes any exchanges of shareable consumer information from across the spectrum of care including:

- **Consumer demographic information**
- **Risks or alerts information**
- **Screening outcomes**
- **Referral or intake outcomes**
- **Assessment and planned service outcomes**
- **Exit or discharge or transitional information**.

To avoid confusion, agency documentation needs to distinguish feedback relating to consumer information exchanges from other types of consumer feedback that refers to either Quality Assurance activities or complaints procedures. Information Management is not to be confused with Consumer Evaluation processes.

WHY – Consumer Focused Feedback:

Consumers have access to a coordinated and seamless service system. For the best consumer outcomes agencies ensure that all relevant consumer information is shared with key services and support persons. This facilitates multi-disciplinary team approaches.

Consumers have access to a secure information management system that exchanges feedback information in a timely manner and adheres to Privacy Legislation.

Consumers have access to feedback practices that are supportive of their care needs.

Feedback Practices

HOW

The feedback process shares consumer information only with relevant and current services or supports. **Check these details each time any information needs to be shared.**

A request for information to be transferred or fed back must clearly articulate what information is required, how and when it is required.

The sending or receiving of feedback is always **recorded**. Written records are kept in line with **Privacy Legislation**.

Quality feedback elements:
Quality feedback is information that is useful, meaningful and relevant. This means:

- It relates to a consumer's care or support needs.
- It is relevant to the receiver's service provision, including occupational health and safety issues. This means tailoring the information for the receiver.
- The process defines when and what is to be fed back. That is there is not over or under sending of feedback and the information sent is kept succinct.

Feedback or transfer information to service providers is **written**:

- Written feedback is needed when there are changes in a consumer's details.
- If **urgent** ☏ - speak directly to the relevant service provider[s] and send written details as soon as possible.
- Written feedback is often elements of a plan, and includes discharge plans.

Feedback can be sent via a range of system options, depending on urgency and the systems available to the receiver. For example a copy can be sent via:

- Consumers, who take a written copy of the feedback with them for the designated service / worker.
- Australia Post mail service.
- A fax to the designated worker. Fax areas or systems meet Privacy Legislation.
- A secure e-communications system:
  - Intranet systems, for internal emailing of feedback
  - Internet systems require digitally signed and encrypted e-feedback.
- ☎ Information is phoned to the designated service, and then followed up with sending written feedback.

Send information that is relevant and informative of **new or changed situations**. This includes changes in a consumer's health, care, social, psychosocial, environmental status, or personal details eg:

- **Consumer demographic information** – new or updated consumer details.
- **Risks or alerts information** - new or updated consumer risks or alerts; or worker occupational health and safety alerts.
- **Screening outcomes** – i.e. new or updated needs identification information.
- **Referral outcomes** - i.e. the intake and eligibility status especially when alternate action needs to be taken, including:
  - Waiting list details, especially if long waiting lists exist
  - Description of why the consumer was ineligible for the service
  - Informing the referrer that they need to take other referral options
  - Informing the referrer that alternate actions have been taken by your service e.g. referred onto to an alternate service.
- **Assessment outcomes** – i.e. summary of the assessment and plan:
  - Description of the issue[s], problems[s] or diagnosis
  - Goal[s] to address the issue[s]
  - Target / end date[s] or notification that the intervention is ongoing
  - Action planned or service interventions
  - Other outcomes:
    - Results specific to the issue eg special tools / tests / details
    - List any new referrals made
    - Care coordination is needed and actions taken.
- **Exit or discharge information**:
  - Information that is not previously recorded in the above.
  - Information that is not but could be part of a multi-discipline care coordination process.

  For example, consider Hospital Emergency Departments and Hospital Discharge Plans or Post Acute Care plans.

The above points describe workflow practices within the service coordination model. Agency systems need to differentiate between these workflow practices. Separation is useful for services and inter-agency communication for the following reasons:

- It aids in aligning the service system.
- It aids in understanding what information is required and what tools support or are relevant for each section of the feedback process.
- It makes reviewing and updating consumer information easier for services.

WHEN AND WHERE

The sending of feedback occurs when there is **new or changed information** that requires sharing. Feedback can occur **at any point** in the care continuum:

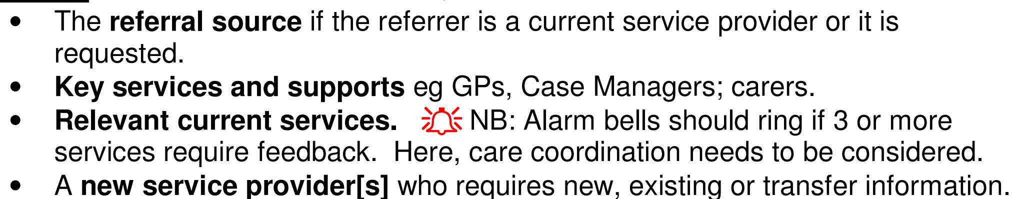
- **At service intake after intake screening** eg long waiting lists or ineligibility.
- **After monitoring and an assessment:**
  - After a 1st assessment
  - After a re-assessment
  - At exit or discharge.
- When a **new or existing service provider** requires or requests information.

Timely feedback exchanges and the communication mode is determined by:

- Consumer's needs
- The level of urgency
- Service's need to plan for a consumer
- Service's response capacity.

WHOM

To Whom: if relevant and with consent, feedback information is shared with:



- The **referral source** if the referrer is a current service provider or it is requested.
- **Key services and supports** eg GPs, Case Managers; carers.
- **Relevant current services.** NB: Alarm bells should ring if 3 or more services require feedback. Here, care coordination needs to be considered.
- A **new service provider[s]** who requires new, existing or transfer information.

From Whom: Any qualified staff member can send or receive feedback. However agencies may have dedicated staff undertaking either task.

Tools And Resources That Support Feedback

The *Feedback Pathway* aids quality feedback practices (refer to page 29).

Specific feedback tools can be used. For example:

- A specific *Feedback Form*. Refer to page 28 for a feedback pro-forma –checklist.
- A *Cover Sheet* that details the attachments being sent as feedback. This includes [discharge] plans.
- A cover letter with details of the attachments being sent.

Forms or tools that differentiate workflow practices support the feeding back of relevant sections of new or updated consumer information. These forms include:

- ☑ *DHS Consumer Information Form*
- ☑ *DHS Profiles* **or other** specialised screening tools
- ☑ Relevant assessment summaries
- ☑ Relevant risk management tools
- ☑ A service related plan or discharge plan.

NB: It is important to record the details of any attachment sent as feedback on a *Feedback Form* or cover sheet / letter that indicates the information is feedback.

The *DHS Privacy Kit* assists services in meeting the privacy legislation (see section 4). There is also a consent form and information sheet in the *DHS suite of Tools* (section 3) to support Service Coordination and Privacy Legislation:

- ☑ *Consumer Consent Form*
- ☑ *Your Information: It's Private* sheet

Workforce Development And Capacity Building That Support Quality Feedback

Agencies ensure staff have the relevant knowledge, skills, orientation and training regarding the feedback process, i.e. sending and receiving of feedback:

- Recording and sending relevant health, care or social information including using any relevant tools.
- A broad knowledge of the service system to ensure relevant or appropriate feedback information is sent to relevant and key services, this may include systems for networking or dialogue.

Agencies have systems in place to support the sending and receiving of feedback:

- Staff are qualified, with skills and competencies to undertake their role.
- A differentiation of demographic consumer details, screening, assessment, and plans. This enables the easy reviewing and updating of feedback information and common and specialised tools to be used as part of a feedback system.
- Outgoing feedback is sent or incoming feedback actioned in a timely efficient manner; the action /mode and response time is dependent on urgency level.
- Secure transfer and receipt of feedback:
  - Confidential fax area
  - Capacity to digitally sign and encrypt e-information for all Internet mail.
- Supervision and internal Policy and Procedures to support the feedback process. This includes processes to action urgent and non-urgent feedback.

Helpful hints to support quality inter-agency practices that link to feedback.

To reduce workloads, think about practices that assist in preventing over-feedback:

- Separate your systems for the acknowledgement of receipt of a referral or feedback from other types of feedback. Acknowledgements can occur separate to other types of written feedback. This will aid in the provision of relevant feedback.
- Include anticipated end dates on your plan as this reduces the need to feed back when a service ends, if there are no major changes.

To reduce workloads, think about developing systems that allow staff to combine multiple processes when required eg:

- The differentiation of demographic consumer details, screening, assessment, and plans supports information gathering and updating as well as sending and receiving. Tools that differentiate processes aid in the multiple use of a section[s].
- If your service has an existing summary plan that meets the criterion of a quality plan then it could be used as feedback. Either:
  - Add a section to record that it has been used as feedback, and who it was shared with and when it was sent, so it can become correspondence.
  - Have the capacity within your record system to be able to share plans or software allows for auto-population into a correspondence document.
  - Have a cover sheet that covers all types of information exchanges. The cover sheet indicates whom the information was sent to and when it was sent, as well as having a heading to list all attachments and the document dates. The plan can then be one of these attachments if it is classed as correspondence and not part of a non-exchangeable record.

Software: Discuss quality feedback processes with software developers. The embedding of common tools in the software with auto-population features, links to data collection functions and capacity to select existing collected data help reduce workloads when sending feedback. Messaging standards aid the feedback of data.

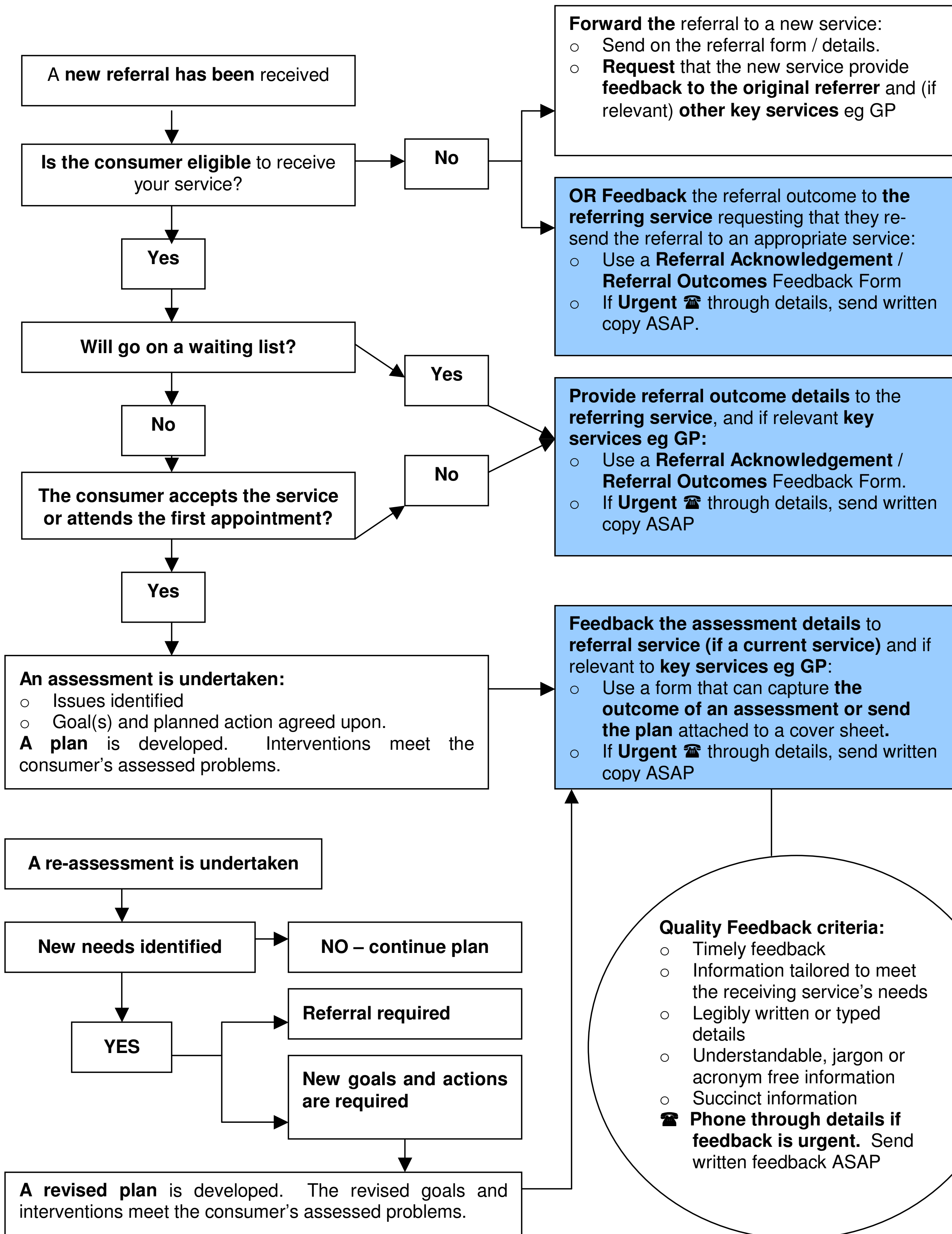
People implement good practices, so before sending any information:
STOP – THINK – ASK- is this relevant to the consumer's care needs?

A FEEDBACK PRO-FORMA CHECKLIST

A specific *Feedback Form* may support quality feedback. As written feedback is more than the acknowledgement of receipt of consumer information, a form needs to cover all aspects of feedback. A feedback form may include:

- ID on each page that enables the recording of consumer ID details, sender of the feedback ID, and date feedback is requested and sent.
- Space to list who requires feedback or who the feedback is sent to.
- The type of feedback being requested eg a referral acknowledgement, the referral outcomes, and assessment or re-assessment outcomes.
- Headings that cover the core elements of a service's summary plan eg:
  - Issue / problem / diagnosis
  - Goal[s] to address this issue[s]
  - End dates or target dates to meet goal[s] or action[s]
  - Action: including the type and level of interventions [to be] provided.
- Headings for other information – required or provided
- Headings that help identify care coordination needs or
- Headings for attachments eg: referral details, profile updates, special assessment tools.

Feedback Pathway



Care Coordination

WHAT Is Care Coordination? WHAT Does It Link To?

Care Coordination is a multidisciplinary process that requires a cross agency team approach. A team approach involves shared responsibilities and collaborative monitoring and planning.

Multidisciplinary care planning is the primary element of care coordination. Together with the consumer, relevant services and supports involved in a person care discuss, monitor and plan the most efficient and effective way to meet that individual's needs.

Multidisciplinary care planning involves the judgment/ determination of relative need as well as competing needs, and assists consumers to come to decisions that are appropriate to their needs, wishes, values and circumstances.

Care Coordination relies on the sharing of information within a multidisciplinary team approach. The information to be shared is described in the Feedback process: referral outcomes, assessment/ re-assessment outcomes and plans. **Feedback** informs and facilitates multidisciplinary care planning.

Care coordination is aided by the nomination of a key service / person to collate information and facilitate the development of a multidisciplinary plan.

Care coordination requires a high level of interagency discussion, collaboration and agreement as to the practices and role delineations within care coordination. The Protocol Review working group found the **notion of a continuum** useful to describe some of the elements of the care coordination process eg how information can be coordinated, who facilitates coordination and when. The continuum allows for flexibility and the reassigning of the key service/ worker depending on the complexity of the consumer's assessed problems and changes in a service provision status.

WHY – Consumer Focused Care Coordination

Consumers have access to a cross agency multidisciplinary team approach that:

- Facilitates continuity of care and improved health and care outcomes.
- Avoids duplication or gaps in service delivery.
- Avoids contra-indicated or competing service interventions.
- Ensures that meeting consumer needs is paramount over the needs of individual service providers. Enables monitoring and planning to be collaborative and comprehensive.
- Ensures that meeting consumer needs is not hampered by program boundaries. Enables unmet needs to be addressed via a team approach.

Consumers, especially those with multiple complex and/or chronic care needs, have access to a coordinated and seamless service system. Agencies ensure that all relevant consumer information is shared with key services and support persons.

Consumers have access to a secure information management system that exchanges information in a timely manner and adheres to Privacy Legislation.

Consumers have access to care coordination practices that are supportive of their care needs. Consumers have choices within and ownership of the process:

- Consumers and their key supports are part of the team
- Consumers, wherever possible, are involved the process of choosing the key service / person.

Care Coordination Practices

HOW

Developing a comprehensive care plan requires a team approach. This involves shared responsibilities and collaborative practices.

- It is the shared responsibility of all services to feedback relevant information to key services or the nominated key service / worker as part of the normal agency workflow practices.
- Collaborative practices include being available for and/or providing information that informs collaborative monitoring and planning.

A key service / person may be required to collate information and facilitate the development / review of a multidisciplinary plan. The key worker role can be an interim role or a more ongoing role i.e. until the service provision status changes:

- Confirm the capacity of services / workers before nominating the position.
- Re-confirm the capacity at each review of the multidisciplinary plan.

The notion of a continuum is useful to describe some of the elements of the care coordination process eg **how** information can be **shared** and **coordinated** in a way that meets the changing needs of the consumer.

Agencies ensure that workflow practices enable inter-agency gathering / sharing of care coordination information in the following three ways:

The sharing of information is between all relevant services, with no key service / worker nominated.	**The sharing of information is to an interim key service. The interim key service facilitates the initial care coordination process.**	**The sharing of information is to a nominated key service / worker. The key service facilitates the care coordination process and develops a comprehensive plan.**
• Care needs are multiple but relatively straightforward. • No key worker is required. • No single comprehensive plan is required.	• Care needs are multiple and /or complex. • The need for Care Coordination is raised during the referral / feedback processes or by a temporary service. • The interim service facilitates the initial care coordination actions and / or plan. • If needed, the interim service facilitates the nomination of a key service / worker. • The interim services hands over to the nominated key service.	• Care needs are multiple and /or complex. • The need for Care Coordination is raised at any stage during the service coordination model. • An ongoing service is nominated as a key service / worker. • Care coordination actions are based on feedback provided. • The development of a single comprehensive multidisciplinary care plan aids coordination. • The key worker role is regularly reviewed - transfers as needed.

FEEDBACK UNDERPINS CARE COORDINATION

There are three ways in which feedback is synthesised into a multidisciplinary care plan. The mode chosen is dependant on (1) the consumer's preference, (2) the complexity of communications and (3) the capacity/availability of services:

- The key service / worker finds the best mode[s] to facilitate multidisciplinary care planning.
- Agencies ensure that there are systems in place to enable staff to undertake care planning using <u>one</u> or <u>combinations of</u> the following **3 modes**:

  - **Printed information** (i.e. written feedback). Individual plans are collected. The issues, goals and actions are analysed and made into a single plan. The draft plan is disseminated for checking by all those involved.
  - A **teleconference** is arranged. Written feedback prepares the facilitator for the teleconference. Collaborative planning and identification of unmet needs occurs at the teleconference, followed by dissemination of the plan.
  - A **case conference** is arranged. Written feedback prepares the facilitator for the case conference. Collaborative planning and identification of unmet needs occurs at the case conference, followed by dissemination of the plan.

  NB. Written feedback gives direction to care planning. It aids preparation, analysis of issues, and synthesis of the goals and actions into a single plan.

A comprehensive care plan entails multidisciplinary involvement. The facilitator ensures the multidisciplinary <u>team checks</u> and explores a <u>range of holistic</u> goals and interventions for each issue.

1. List all the assessed issues and the planned or current interventions.
2. Confirm the current and planned interventions across the disciplines involved are suitable and compatible. Resolve any conflicting interventions.
3. Confirm there are no gaps in the plan. Identify any unmet needs.
4. Explore other strategies available for each problem.
5. Decide who does what and when for any new interventions. Ensure everyone is aware of who is doing what. Write up the plan based on these agreed discussions.

Suggested Goal Headings - A Checklist For A Comprehensive Plan:

A range of interventions are expressed in a comprehensive plan eg **physical, psychosocial, social, environmental, cultural or spiritual <u>interventions</u>**.

Some or all of these <u>goals</u> may be used in the multidisciplinary plan:

- **Safety and Protection** of consumer and / or support systems.
- **Management of the episode / acute event** or post episode / post acute event. (Interventions covering a short time frame of days to weeks.)
- **Functional gain** to improve or optimise levels of independence, wellness, quality of life etc. (Interventions covering weeks to months.)
- **Maintenance and support** interventions maintain levels of independence, wellness, quality of life etc. (Interventions covering a longer time frame.)
- **Prevention and early intervention** strategies to promote wellness and prevent re-occurrences.

Where possible involve the consumer in the development of the plan. At minimum:

- Gain consent to involve relevant services and supports in the development of the plan. List those whom can provide information and to whom information can be sent.
- Ensure that the consumer signs the plan before it is disseminated.

WHEN and WHOM

Care coordination is needed when services with common / mutual consumers need to feedback or transfer consumer information in a coordinated way. The need for coordination is evident at any point along the service coordination model when:

- The care needs, situation or interventions are complex and/ or multiple.
- There are 3 or more services involved and the situation is complex:
  - Complex communications.
  - Complex care needs.
  - Frequent changes in care / interventions
  - Advocacy is required.
- There is an ongoing or chronic problem and the situation is complex as above.

Early recognition of the need for and facilitation into care coordination will provide the best outcomes for consumers. Eg recognition at screening that the referral is for an additional 2 or more ongoing services or that the situation is complex.

The **notion of a continuum** is useful to describe **who can facilitate** care coordination **when**. The continuum allows for the reassigning of the key worker depending on the complexity of the consumer's problems and changes in a service provision status.

Generalist Services	Specialist Services	Case Management Services
Less complex needs	Moderately complex needs	Very complex needs
Infrequent changes		Frequent changes
Infrequent advocacy		Frequent advocacy
Works within service boundaries.	Provides case management related to that service. Often time limited service provision.	Works across service sectors. No service boundaries.

Care Plan initiation or facilitation:

Any professional worker **can initiate or facilitate** a care plan development.

However, General Practitioners are required to follow the Enhanced Primary Care (EPC) Medicare Benefits Schedule (MBS) guidelines to claim for preparation time. These guidelines specify that claims can only be made when there are 3 or more ongoing services involved in the care of consumers with chronic and complex care:

- **Community Care Plan**: initial plan - item 720; 12 month review – item 724.
- **Discharge Care Plan:** initial plan – item 722; 12 month review – item 724.

Care Plan participation or contribution:

Any professional worker **can participate in or contribute to the** care plan.

However, General Practitioners are required to follow the Enhanced Primary Care (EPC) Medicare Benefits Schedule (MBS) guidelines to claim for contribution time:

- **Community Care Plan contribution** - item 726.
- **Discharge Care Plan contribution** – item 728.

Care Plan reviews:

A multidisciplinary care plan **review** is required when care needs, goals and service interventions change. A review is decided by the key service / worker in consultation with the consumer. Change may be frequent or irregular, with case management services reviewing more frequently than general services. A maximum review interval is 12 months.

Tools and Resources that support quality Care Coordination practices

The *Care Coordination Pathway* aids care coordination practices (refer to page 35).

The use of a standardised care plan tool assists in transferring the key service / worker role as the service needs of the consumer changes. Specific care coordination tools are available, including:

- ☑ *DHS Service Coordination Plan*
- ☑ *General Practice Enhanced Primary Care Multidisciplinary Care Plan*

Tools that facilitate feedback of new or updated consumer information aid care coordination. These include:

- ☑ *DHS Profiles* **or other** specialised screening tools
- ☑ Relevant assessment summaries
- ☑ Relevant risk management tools
- ☑ A service related plan or discharge plan.

The *DHS Privacy Kit* assists services in meeting the privacy legislation (see section 4). There is also a consent form and information sheet in the *DHS suite of Tools* (see section 3) to support Service Coordination and Privacy Legislation:

- ☑ *Consumer Consent Form*
- ☑ *Your Information: It's Private* sheet

Workforce Development And Capacity Building That Supports Care Coordination

Promote the notion of a team approach that it permeates the culture of individual work practices so there is a shared responsibility to:

- Develop systems to inform services and supports of relevant information.
- Develop systems to enable cross agency collaborative monitoring and planning.

Agencies are responsible for ensuring all workers who are nominated to the role of Key Worker are professional / qualified staff.

Agencies are responsible for ensuring staff have skills in and knowledge of how to work with other agencies in relation to direct service provision, including:

- The process of care coordination and multidisciplinary care planning.
- The role and responsibilities of a key worker.
- The appropriate use of multidisciplinary care planning tools.
- The responsibilities of multidisciplinary team members to look beyond one's own assessment and service provision boundaries, to the total needs of and best outcome for the consumer.
- Privacy Legislation.

Helpful hints to support the Care Coordination process.

NB: It is the *level of complexity* that underpins care coordination. The *level of severity* is an element of intake related to service eligibility criteria or prioritisation.

Ensure that your feedback processes are functional prior to embarking on care coordination. Feedback underpins care coordination.

Suggested systems that facilitate the recognition of the need for care coordination. Ask TRIGGER questions on range of agency forms (eg referral and feedback forms):

- *Are there 3 or more services involved in this persons care?*
- *Are the care needs complex?*

FOR SUCCESSFUL CARE COORDINATION REPSECT AND TRUST IS REQUIRED.

CARE COORDINATION PATHWAY