Primary Care Partnership
BENDIGO LODDON

Inter-Agency Process Tools: -

Pathways Pack

June 2004

Service Access Pathway

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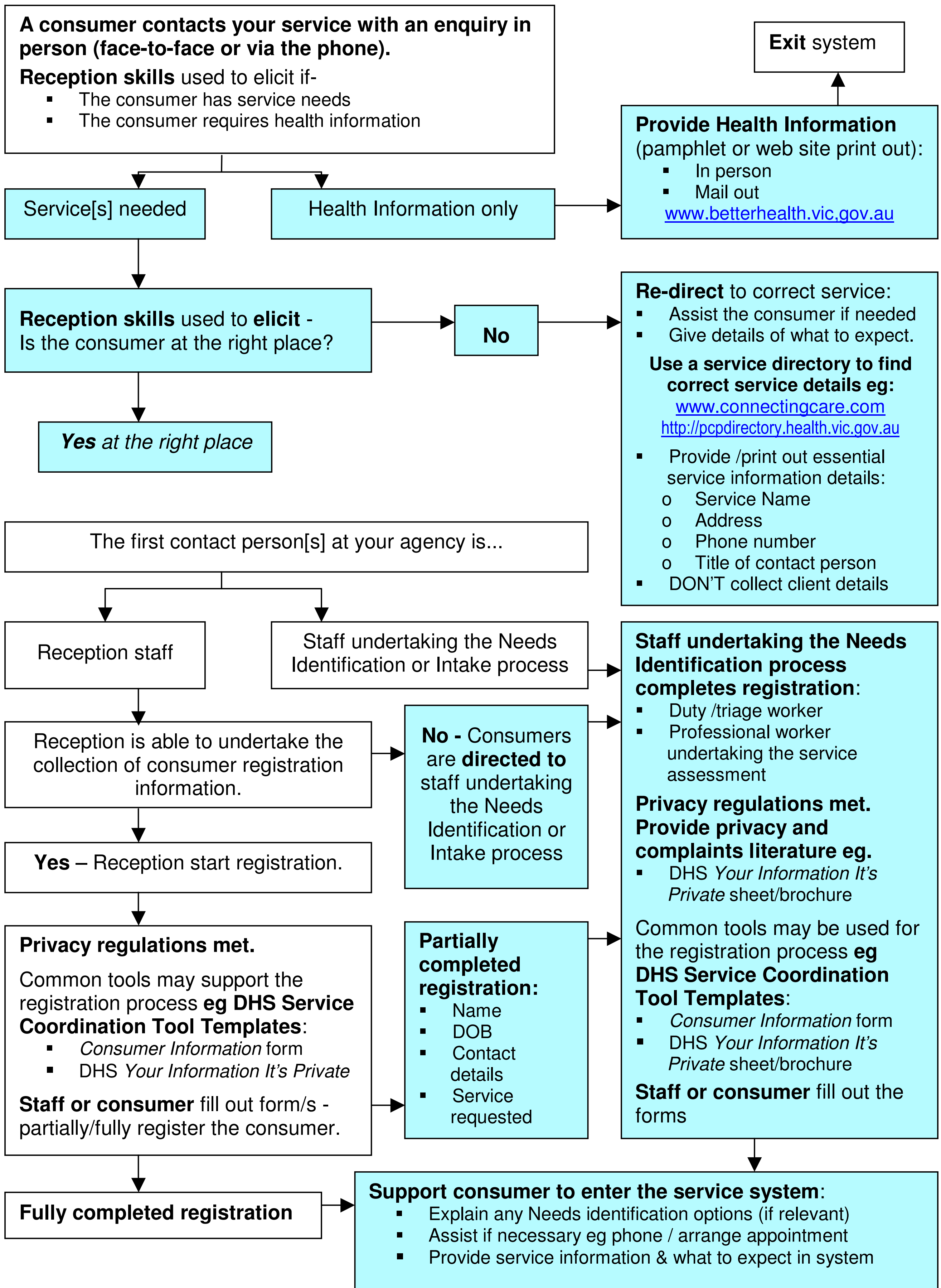
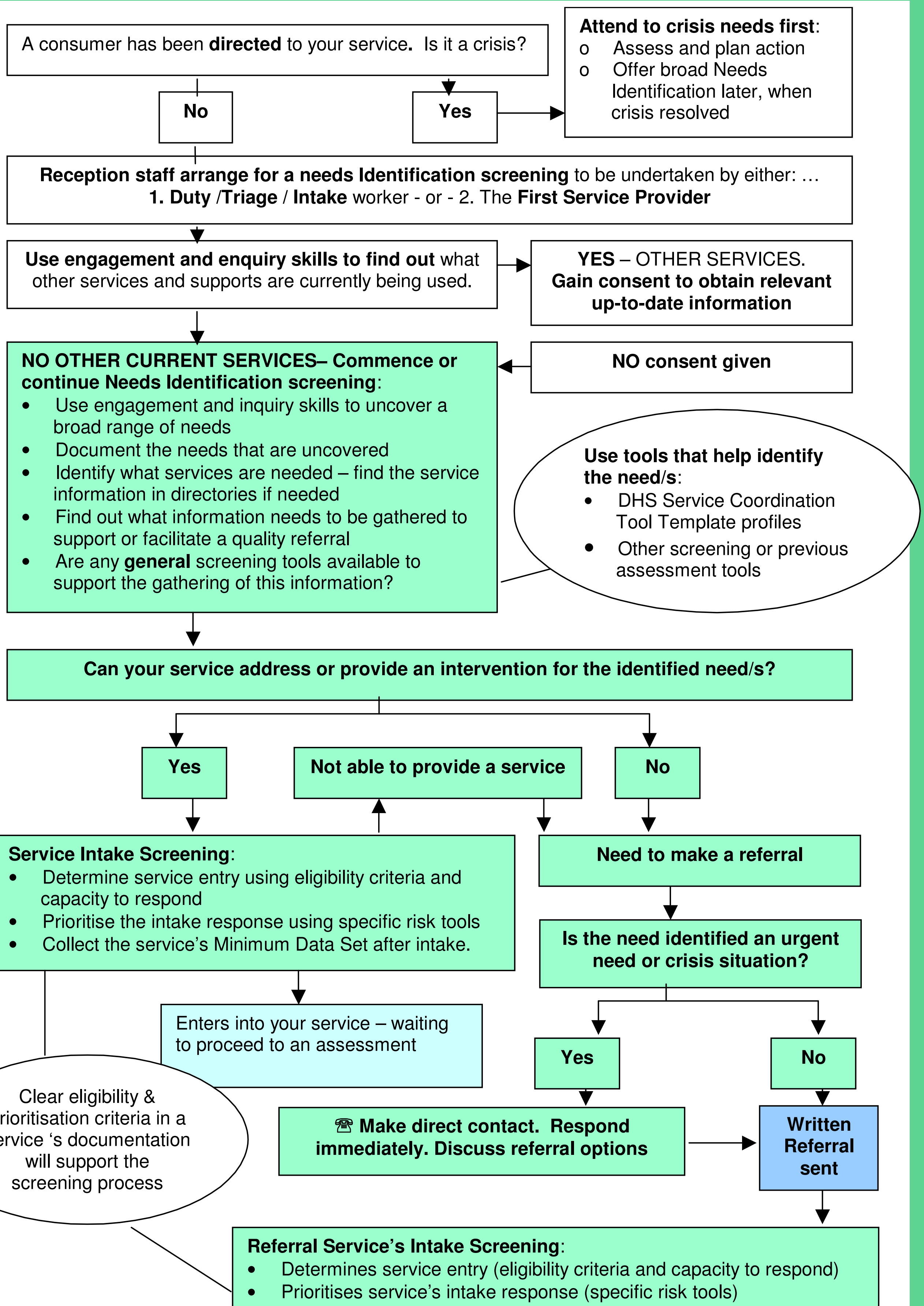


Screening and Needs Identification



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Referral Pathway

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:
- Intake and Assessment
- 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]**:
- 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.
- 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:
- Discuss other options with the consumer eg self-request for service.
- 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:
- Use a new referral form for each service.

The *DHS Summary and Referral form* enables this.

Multiple referrals per form
- 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**:
- Checked and updated Consumer details – eg *DHS Consumer Information form.*
- Completed referrals eg *Summary and Referral Form*
- Relevant updated screening information using relevant forms *eg DHS Profiles or other screening tools.*
- 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**:
- **Email** (digitally signed & encrypted)
- **Fax** (receiving fax area meets Privacy Legislation)
- **Post** (**non-urgent** referrals)
- **Consumer** takes to the designated service.

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

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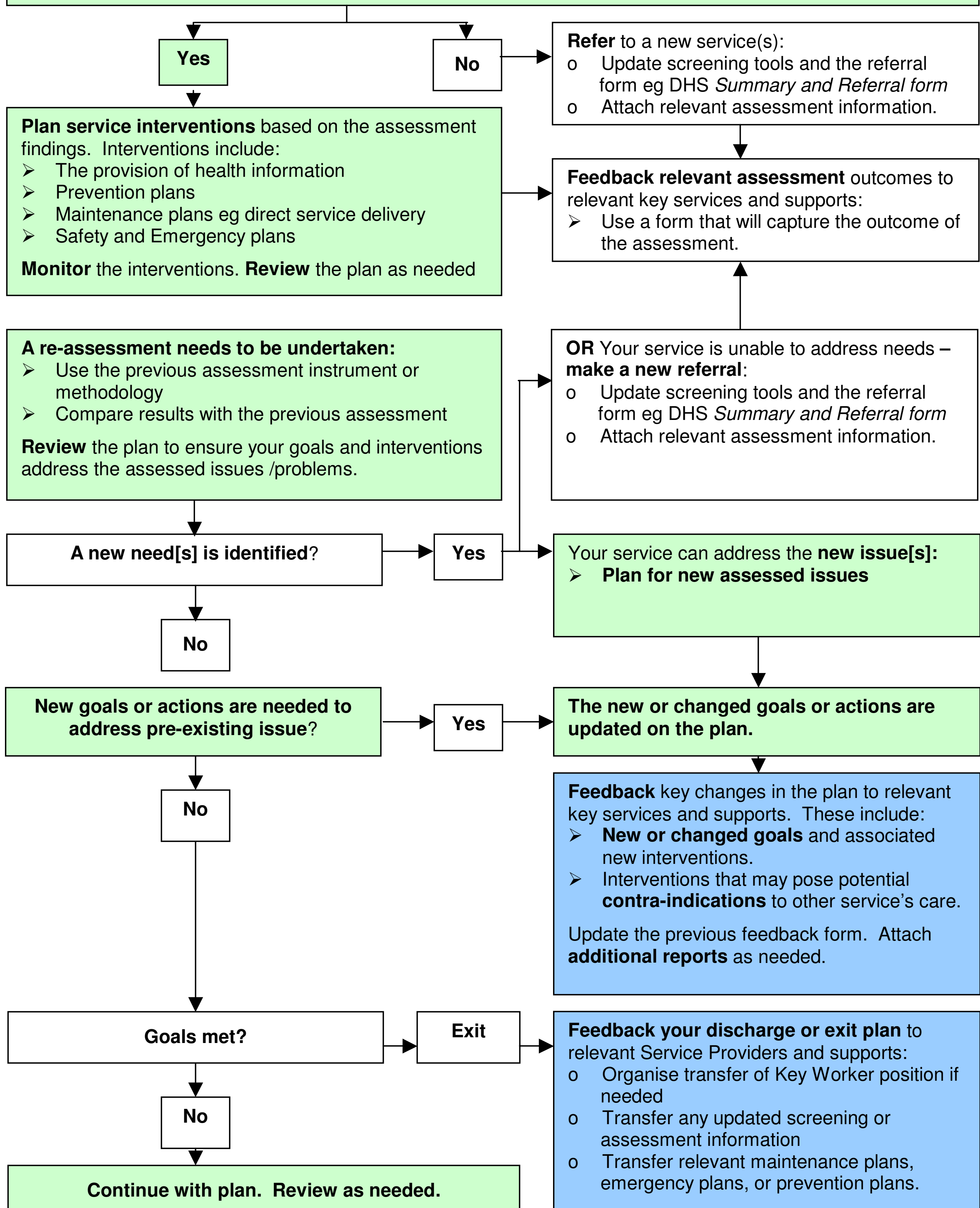
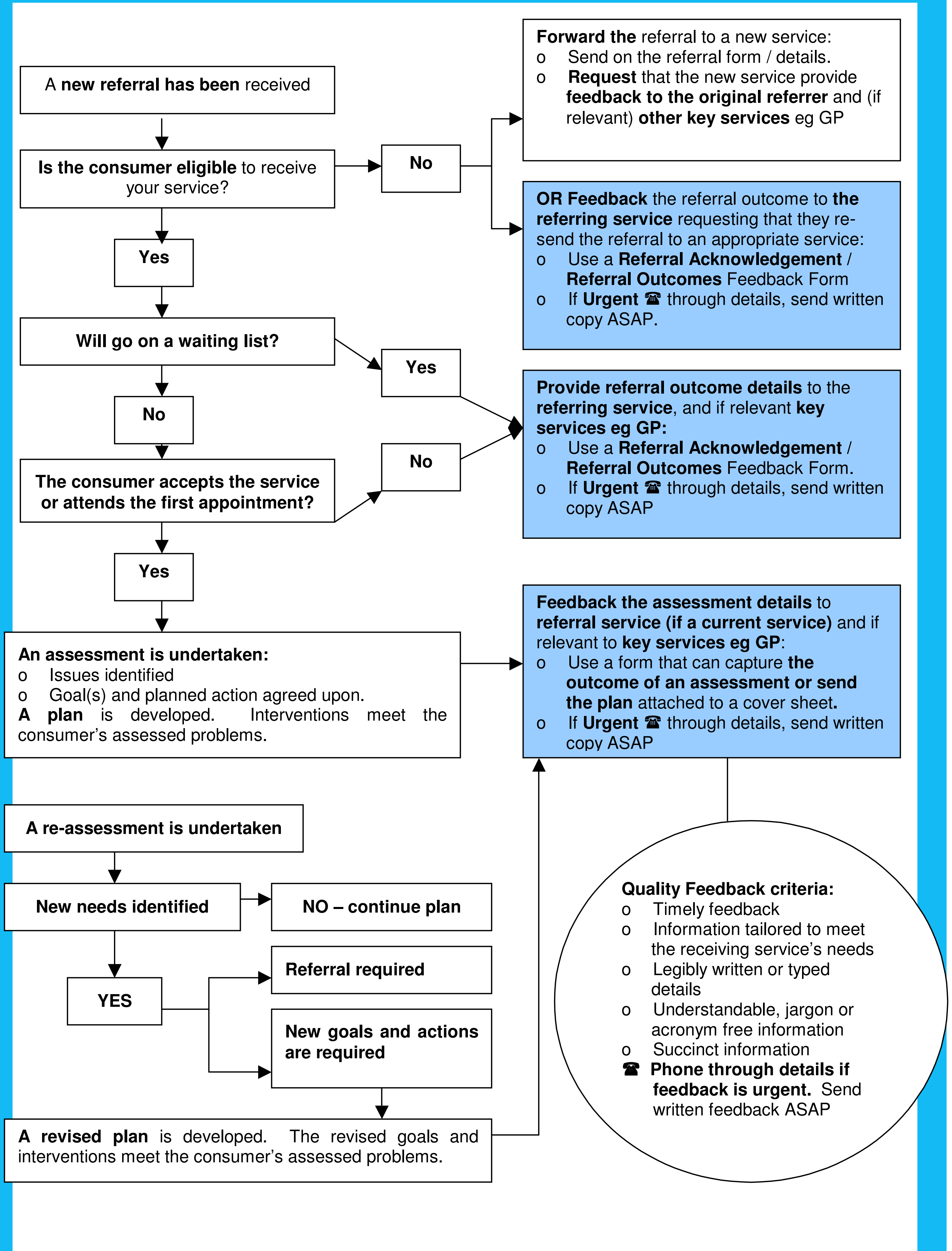
Assessments



Feedback Pathway



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Care Coordination Pathway

3 or more ongoing services are / or will be involved in a consumer's care.

Note: page 2 of the DHS *Summary and Referral Form* lists current services and planned referrals.

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

No

- Gain **consent** to **exchange** / **feedback** assessment or care information with relevant services
- **Continue service delivery**, reviewing coordination needs with other services

Yes

Does a multidisciplinary plan already exist eg a discharge care plan, or is there a Key Service / worker?

No

Yes – then if relevant gain consent to enable you to contact the Key Service / Worker for inclusion in the care coordination process.

Feedback relevant care information to the Key Worker as new issues arise or goals change.

Explain Care Coordination process and benefits to consumer:
- Availability of one comprehensive plan with common service goals
- Reduces contra-indicated or conflicting treatments between services
- Reduces duplication or gaps in service delivery
- Improves communication between service providers

Consent is given to instigate Care Coordination

No consent gained

With the consumer, **decide who** needs to be part of this shared care **team** (care coordination process).

Provide support if the **carer** / **consumer** chooses to be key person

Organise the **nomination of a Key Service** / **Person.** Ask Service Providers and Consumer / Primary Carer to agree on:
- Is there a **main Service** Provider / main support **person**?
- Who has the **capacity** to facilitate the process?
- Is there a need for an **Interim** Key Service / Worker?

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

Decide **method** for developing a Multi-disciplinary Care Plan eg:
- Face-to-face Conference
- Telephone Conference
- Written exchange of information
- Or combinations of the above to cater for all the **team**

Nominate a date to develop the Multi-disciplinary Care Plan

The Key Person **obtains relevant information** from all services prior to developing the Multi-disciplinary Care Plan eg assessment or planned care is fed back to the Key Person.

Together with the consumer / primary carer, the Key Person:
- Collates and synthesises the feedback information
- Lists and prioritises issues
- Drafts possible goals (use the ***Goal Checklist*** to aid process)
- Disseminates **draft** plan (at a conference or via mail)

Collaborate with all the **team** participants re goals and actions.

Agree on and finalise the plan – consumer signs completed plan.

Use the DHS *Service Coordination Plan form* to record the plan.

Arrange **review** / **exit date,**

Disseminate the multidisciplinary **plan** to all the team participants.

Review **the plan when issues or goals change**. **Team** members inform the Key Person of change.