

*Tools to Support the Service
Coordination Processes:*

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Pro-forma and Checklists*

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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]** exists 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.

BASELINE REFERRAL INFORMATION

Consumer Details:

Name

Residential address

Contact number

Date of Birth

Gender

Next of Kin and other contacts

Preferred Language

Interpreter service requirements

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

This baseline referral information is requested on the **DHS state-wide referral forms** i.e.

Service Coordination Tool Templates:

- ◇ *Consumer Information Form*
- ◇ *Summary and Referral Form*
- ◇ *Consent Form* (also part of the Tool Template suite).

Assessment and Plans— Checklists

Suggested Content For A Plan

A Plan addresses the issue and level of risk assessed. It 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

The following information may also be provided as part of the plan:

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.

FEEDBACK TYPES AND POTENTIAL CONTENT

Feedback is an information exchange that is in response to any **new or changed personal, health or care information**. Feedback is any exchanges of shareable consumer information from across the spectrum of care that is not a referral or multidisciplinary care plan:

- 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:
 - o Waiting list details, especially if long waiting lists exist
 - o Description of why the consumer was ineligible for the service
 - o Informing the referrer that they need to take other referral options
 - o 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:
 - o Description of the **issue[s]**, problems[s] or diagnosis
 - o **Goal[s]** to address the issue[s]
 - o Target / end **date[s]** or notification that the intervention is ongoing
 - o **Action planned** or service interventions
 - o **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:**
 - o Information that is not previously recorded in the above.
 - o 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.

A FEEDBACK FORM PRO-FORMA CHECKLIST

As written feedback is more than the acknowledgement of receipt of a referral, a feedback form needs to cover all aspects of feedback. It may include:

- Identification details:** ID on each page that enables the recording of:
 - Consumer identification details
 - Detailed list of who the feedback is sent to
 - Sender identification
 - The date feedback is requested and sent.
- The **Feedback Type** eg a referral acknowledgement, the referral outcomes, and assessment or re-assessment outcomes.
- Headings** that cover the core elements of a service's plan eg:
 - o Issue / problem / diagnosis
 - o Goal[s] to address this issue[s]
 - o End dates or target dates to meet goal[s] or action[s]
 - o Action: including the type and level of interventions [to be] provided.
- Other information – required or provided
- Question[s] to help identify if care coordination needed
- Attachments eg: referrals, profile updates, special assessment tools.

3 MODES TO FACILITATE A MULTIDISCIPLINARY CARE PLAN

Multidisciplinary care planning can be undertaken using one or combinations of 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.

SUGGESTED GOAL HEADINGS - A CHECKLIST FOR A COMPREHENSIVE MULTIDISCIPLINARY CARE PLAN:

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

Some or all of these goals 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.

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