Service Coordination Protocol Manual

Representing the Practices, Processes, Protocols and Systems (PPPS) of member agencies of the North Central Metro Primary Care Partnership

May 2003

ACKNOWLEDGMENTS

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Relevant websites

North Central Metro PCP	www.ncmpcp.org.au
Primary Health Knowledge Base	http://hnb.dhs.vic.gov.au//rrhacs/phkb.nsf
Statewide Health Services Directory	http://pcpdirectory.health.vic.gov.au/

Reference Documents

- Better Access to Services - A Policy and Operational Framework for Primary Care Partnerships 2001
- Department of Human Services: Service Coordination Tool Guidelines 2002

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Part A:

Introduction & Service Coordination Model

1.0 Introduction

1.1 Context

The **North Central Metro Primary Care Partnership** is a voluntary alliance of over 60 health and community service agencies in the Cities of Yarra, Darebin, and Whittlesea. The goal of the Partnership is to make positive, sustainable improvements to services, from the perspective of clients, their carers and their families. In doing so, the aim is to build upon existing community strengths, particularly volunteer effort and commitment, and local pride and spirit. The partnership values the diversity of its communities and holds this diversity as one of its major strengths.

By agencies working in partnership, the aim is to:

- Plan cooperatively, to better understand the impact of socio-economic status and the social and physical environment upon the health and well-being of consumers
- Improve the coordination of the service system including intake, referral and assessment processes
- Be more responsive and accountable to our consumers
- Enable more equitable access to services
- Provide services that are more culturally and gender sensitive, relevant and appropriate
- Promote service models that meet the diverse needs of consumers and communities across the sub-region.

1.2 Service Coordination Vision

The vision for a coordinated health and community services system is articulated in the North Central Metro Primary Care Partnership's Community Health Plan 2002-2003.

The vision statement is that people who use health and community services provided by Primary Care Partnership member agencies in the Cities of Darebin, Yarra and Whittlesea, will enter and move through the service system with minimal effort, duplication and disruption. Guided by input from service users, local service networks will work together to eliminate duplicated and unnecessary processes and provide a well-coordinated response to client need.

Clients will:

- Receive consistent and high quality information about the range of services available to meet their needs from anywhere in the service system
- Be closely involved in the identification of their needs in a standard way across the service system
- Be supported to locate, move into, through and across a range of services using clear and transparent information and referral processes
- Benefit from simplified, standardised and service user driven approaches to shared case management
- Benefit from standard approaches to the collection, use and storage of information they provide in line with the Information Privacy Act (IPA) and the Health Records Act (HRA)

The development and implementation of this Protocol Manual outlining the agreed practices, protocols, processes and systems, by member agencies, is an essential step towards achieving this vision. By improving service coordination and increasing consistency in practice between member agencies, service providers can actively facilitate better access to services and care outcomes for consumers.

1.3 Purpose and Interpretation of the Manual

The purpose of this Protocol Manual is to describe and document the common understanding and common approach to practices, protocols, processes and systems to support improved and integrated service coordination between member agencies. It recognises that the decisions and actions made by one agency have implications for other agencies and thus a shared documented and transparent approach is in the best interests of all agencies and improves care outcomes for consumers.

The Protocol Manual is designed as an umbrella document and member agencies are committed to ensuring their internal agency policies and procedures are consistent with and reflect the outcomes intended. It is intended for use by managers and practitioners, as a reference document to guide agency procedures and everyday practice and service delivery.

It has been structured and written in a manner to:

- Allow for diversity of different organisational types, organisational structures and technological applications
- Be respectful of individual agencies' autonomy and provide guidance in relation to organisations' own operational policies and procedures
- Provide adequate detail to be useful to managers and practitioners in implementing service coordination
- Support any partnership agreements or arrangements between specific agencies
- Be broad enough to cater for agencies that span multiple Primary Care Partnerships. It is acknowledged that a number of agencies have cross-PCP involvement and are therefore encouraged to espouse the protocols, practices and processes of multiple partnerships. Agencies with multi-PCP involvement are requested to ensure that their agency protocols, practices and processes reflect the outcomes intended by those outlined in this Protocol Manual.
- Embrace privacy requirements. It should be noted that some agencies may have elected to integrate consumer privacy information into their own agency Consumer Information Brochure. Where this is the case, the statewide Consumer Information Brochure `Your Information: Its Private' referred to throughout the Protocol Manual, can be taken to mean an agency's own consumer information brochure provided that it reflects at a minimum the information stated in the statewide brochure.

Where the term Service Directory is used throughout the Manual, this is taken to mean the statewide electronic service directory http://pcpdirectory.health.vic.gov.au/ and/or other relevant up-to-date regional and local service listings and resources.

2.0 Service Coordination Model

2.1 Principles

The following principles[1] and values underpin the North Central Metro Primary Care Partnership service coordination model.

Service providers are committed to:

- Ensuring consumers are fully informed, and empowered to make decisions and give consent
- Providing services focused on meeting consumers' needs in a culturally relevant manner
- Respecting that each service provider operates within their own organisational and structural arrangements, and can simultaneously work in a functionally integrated manner
- Ensuring there is a high quality, integrated and coordinated service system for residents of the Cities of Darebin, Yarra and Whittlesea
- Collaborative and cooperative working arrangements, including acknowledging a shared duty of care for clients
- Using the service coordination tools
- Respecting the confidentiality of consumer information and ensuring that consumer information is collected, documented and stored in accordance with the relevant privacy legislation and privacy principles
- Developing and using technology and information systems that will assist in making inter-agency sharing of information easier
- Ensuring that eligibility for services is based on consumer needs, eligibility and priority of access criteria (need and priority of access are assessed by each service provider)
- Knowing the service system and the part played by each service provider or referral source
- Maintaining up-to- date service information in the service directory (service available, intake processes, eligibility criteria, priority of access criteria, waiting times) to assist the referral process and support service coordination
- Service providers are committed to establishing a mechanism for collecting data on unmet needs and service gaps and joint planning

[1] Adapted from the Darebin Referral and Intake Project 2002

North Central Metro PCP

2.2 Service Coordination Model and Features

The North Central Metro Primary Care Partnership[2] service coordination model is consumer focussed and offers a well coordinated and integrated services system for consumers by virtue of common practices and processes across member agencies.

Key features of the interpretation of the Service Coordination Model are:

- That every service site is an entry point for consumers - consumers will receive a response consistent with the Protocols regardless of where they first make contact or which agency they approach.
- That some agencies provide a generalist information, intake and referral service for consumers and are identified as a prominent point of access to the service system.
- That some agencies provide a more specific intake service as part of their service provision.
- That consumers will be given relevant information needed to make an informed decision about the services they may use to meet their needs.
- That Initial Needs Identification will occur as soon as possible after Initial Contact. In some cases Initial Needs Identification will occur seamlessly following Initial Contact, in other cases there will be a short time delay between these processes.
- That Initial Contact and Initial Needs Identification may be undertaken by the same or by two different workers - in some agencies the same practitioners may perform both functions; in other agencies Initial Contact may be undertaken by one staff member and Initial Needs Identification by another staff member or agency.

That to facilitate and streamline the process, where the agency undertaking Initial Contact does not offer Initial Needs Identification[3], the worker will offer to:
  - Provide relevant details verbally and/or in hard copy to the consumer who is able and elects to proceed without the practitioners assistance; or
  - Make an immediate and direct telephone link with an agency that does provide Initial Needs Identification; or
  - Make an appointment for the consumer at a suitable time at an agency that does provide Initial Needs Identification; or
  - Make arrangements for the person to be contacted.

- At a minimum and where practical, practitioners complete as much of the Consumer Information and Summary and Referral sections of the Service Coordination Tool Templates in order to have a clear consumer record and identify consumer issues. Supplementary profiles that are relevant to the consumer and their presenting needs are completed as appropriate.
- That practitioners undertaking Initial Needs Identification will form professional judgements about the breadth and depth of Initial Needs Identification inquiry. This will vary between individual consumers.
- That referrals, and the gaining of consent to disclose consumer information, may occur at multiple points throughout the service coordination model.
- To ensure the mode of communication facilitates the consumer communicating with ease. For example:
  - The use of interpreter services, bi-lingual workers, or translated information with consumers from Culturally and Linguistically Diverse (CALD) backgrounds
  - Responding to special communication needs
  - Respect for anonymity where practical
- That practitioners will facilitate consumer advocacy support at the consumers' request and/or when legally required (ie. where a legal guardian or authorised representative exists).
- That protection of consumer privacy is inherent throughout the model and incorporated into agency practice.
- That consumers are informed about the overall service coordination process (refer Appendices).

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[2] Note: Service providers who are not members of the North Central Metropolitan Primary Care Partnership are welcome to adopt this service coordination model. Member agencies, in making referrals to non-member agencies, will normally use the service coordination documentation, unless other specific agreements have been entered into.

[3] For example, Citizens Advice Bureau

North Central Metro PCP

Service Coordination Model

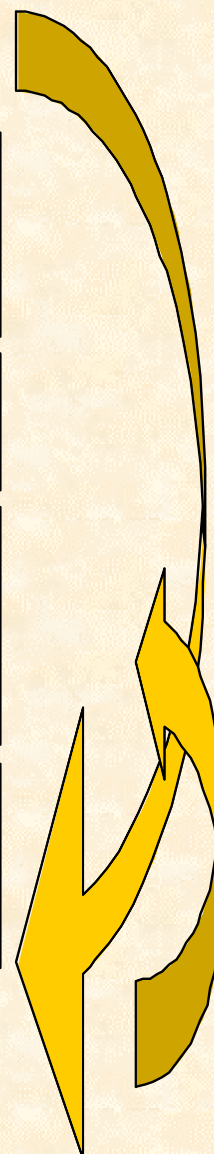
North Central Metropolitan Primary Care Partnership Member Agencies

Consumer entry to any member agency

Service Coordination functions offered and/or provided

Initial Contact	Member agencies provide Initial Contact: – As a result of being a prominent point of access for the general public to a wide range of primary care services (eg: Community Health Services, Councils) – As part of entry and access to their own service plus others as required
Initial Needs Identification	Member agencies provide Initial Needs Identification: – For any consumer as part of broad needs identification and basis of referral to internal and external services – As a pre-assessment and part of specialist service provision
Assessment	Member agencies *may* provide: – Service specific assessment where the consumer has a distinct need for a specific service – Specialist assessment where the need for a more specialist service response is required – Comprehensive assessment where the consumer has multiple, complex or unclear needs
Care Planning	Member agencies provide care planning: – Specific to their own service where the consumer has single service needs eg: care Plan, treatment plan – In close coordination with other services where the consumer has complex needs / is involved with multiple services, using a Service Coordination Plan

Consumer Outcomes



2.3 Service Coordination Tools

Service Coordination Tools have been developed following comprehensive consultation and liaison with the primary care sector in Victoria. The tools have been designed to replace existing tools[4] and conform to technical and ethical requirements. North Central Metro Primary Care Partnership member agencies are committed to the use of the tools to aid consistency in practice across services and benefit consumers. The Service Coordination Tools and Guidelines are available at the Primary health Knowledge Base site at http://hnb.dhs.vic.gov.au//rrhacs/phkb.nsf

The Service Coordination Tools comprise five components:
1. Consumer Information - used for the function of Initial Contact
2. Summary and Referral Information - used for the functions of Initial Needs Identification and Referrals
3. Supplementary Profiles (5 Profiles) - used to gather additional information
4. Consumer Consent and the Consumer Privacy Information brochure - used to obtain consumer consent to the sharing or disclosure of consumer information and to advise consumers of their rights in relation to this
5. Service Coordination Plan - used for the function of Care Planning, particularly with consumers with complex needs and multiple agency involvement

In addition, Primary Care Partnership referral cover sheets are available.

Which Service Coordination Tool to use when

Process	Relevant Service Coordination Tool
Initial Contact	• Consumer Information Form • Consumer Privacy Information Brochure
Initial Needs Identification	• Summary and Referral Form • Optional Supplementary Profiles[5] – Living Arrangements Profile (required for HACC services) – Functional Profile – Health Conditions Profile – Health behaviours Profile – Psychosocial Profile
Assessment	• Agency or Program Assessment Tool – Service specific Assessment – Specialist Assessment – Comprehensive Assessment
Care Planning	• Agency Care Plan or Treatment Plan • Service Coordination Plan (for consumers with complex needs and/or multiple agency/program involvement)
Referrals	Minimum requirements: • Consumer Consent Form • Consumer Information Form • Summary and Referral Form Plus, with the consumers consent to disclosure, and as relevant: • Supplementary profiles that may be been completed • Assessment information

Note: Individual agencies may have additional supplementary tools to those listed above.

4 For example: CIARR, agency intake tools, consumer registration forms etc (not assessment tools)

5 Refer DHS FAQ Sheet for HACC Agencies (August 2002) which specifies that those HACC agencies funded for Assessment and Care Management should implement the Living Arrangements profile and the Service Coordination Plan; and those HACC agencies participating in the 2002-03 pilot collection of dependency data should implement the Functional Screen profile which has the required dependency items.

2.4 Supporting Systems

Systems that support the practices, protocols and processes outlined in this Protocol Manual are:

- The PCP Statewide Electronic Health Services Directory available at http://pcpdirectory.health.vic.gov.au/ or http://pcpserviceseeker.com.au/
- Other service directories
- Agency information systems
- Agency unique client identifier systems
- Internal agency operational systems
- Internal agency guidelines and procedures (Policy and Procedure Manuals)
- Professional supervision and decision support procedures within agencies

External documents:

- DHS Guideline 1: Completing Consumer Information for Initial Contact
- DHS Guideline 2: Completing Summary and Referral Step of Initial Needs Identification
- DHS Guideline 3: Completing the Supplementary Profiles as part of Initial Needs Identification
- DHS Guideline 4: Developing a Service Coordination Plan
- DHS Initial Needs Identification: Consent Guideline
- DHS Privacy Kit: August 2002
- DHS Better Access to Services Policy Framework, July 2000
- DHS Information Management Strategic Directions, January 2001
- Legislation: Health Records Act 2001; Information Privacy Act 2000
- Various professional Codes of Conduct.

Part B:

Practices & Processes

3.0 Initial Contact

3.1 Initial Contact Practice

Description

Initial Contact is the first point of contact a consumer has with the service system - it is an interaction between the consumer and the first staff member of any agency with whom they communicate.

As indicated in the flow chart, Initial Contact may take the form of: a request for information only; a single uncomplicated service request; a request that is unclear or that potentially requires complex service delivery; or responding to a service inquiry or referral from another agency.

Following Initial Contact, the consumer may (or may not[6]) proceed to Initial Needs Identification either at the same, or another agency.

It is the practice of:

- Collecting basic information about the consumer, including their expressed needs, through dialogue with them or the referrer
- Providing clear information about the agency's own services and services provided by other agencies
- Providing other health related information
- Facilitating the consumers' access to relevant and desired service/s.

Key modes of Initial Contact include face-to-face dialogue (in-agency and outreach) and telephone dialogue, implemented in a manner responsive to the differing needs of consumers. Initial Contact will usually (but not always) proceed to Initial Needs Identification, assessment, care planning and service delivery

Tools

Service coordination tools (forms) used to support the practice of Initial Contact are:

- Consumer Information form - for collection of consumer details including the service requested[7]
- Consumer Consent - consent by the consumer to the disclosure of information for referral purposes (eg: to pass on their Consumer Information form to a practitioner in another agency to undertake Initial Needs Identification)
- *`Your Information - It's Private'* - Consumer privacy information brochure (or the equivalent information contained within an agency brochure)

Responsibility

Initial Contact may be completed by front-of-house staff (eg: receptionist) who passes the Consumer Information form to a competent practitioner to undertake Initial Needs Identification. Alternatively, Initial Contact may be completed by competent practitioners (eg: Intake and Assessment worker) who undertake the Initial Contact and Initial Needs Identification functions seamlessly.

[6] For example: information provision only

[7] In some cases, consumers will be provided with information about appropriate services, and not require assistance from the agency to contact those services. In such cases, the agency will adhere to its own procedure about the extent of information collected/recorded about the consumer, and the use of the Consumer Information form.

Initial Contact Practice

Consumer Outcomes

- Consumers are informed about services available in a prompt and responsive manner, and their options in relation to these
- Consumers can access information and/or enter the service system at any member agency regardless of whether or not that agency provides the service the consumer requests
- Consumers are informed about their rights in relation to services and privacy provisions in relation to personal and health information
- Consumers are empowered to make informed choices regarding referrals and access to services, and provided with assistance to do so as required
- Following Initial Contact, consumers have access to Initial Needs Identification as soon as practicable

Standards

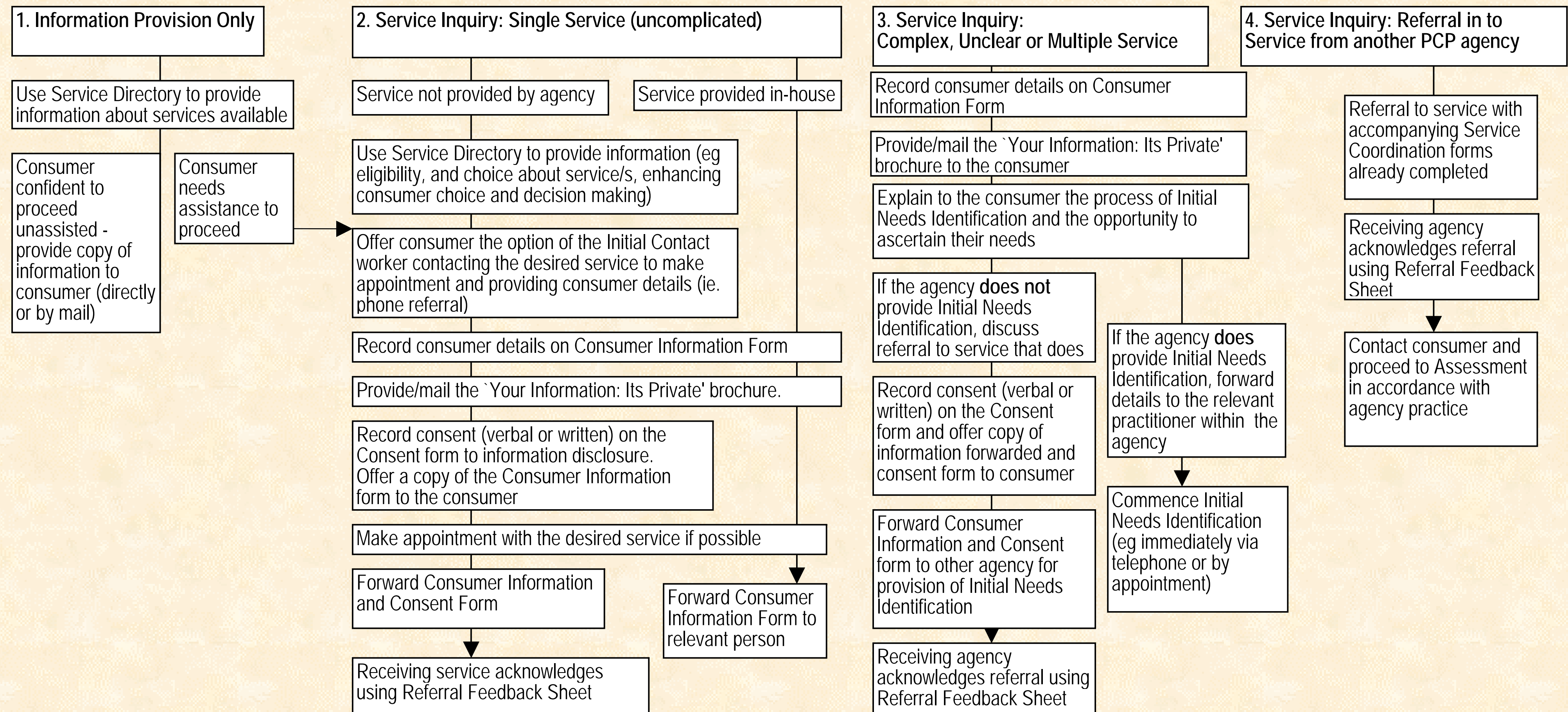
- All member agencies will provide Initial Contact as a component of their intake function or equivalent
- Consumer inquiries will be responded to within 1 working day wherever possible and Initial Contact occur
- Staff providing the function of Initial Contact will be trained and competent

3.2 Initial Contact Processes

Initial Contact Process

Four types of Initial Contact are shown in the flow chart below:

- Requests for information only
- Single uncomplicated service request (regarding either services provided by the agency or by another agency)
- Unclear or potentially complex service inquiry
- Referral from another service provider agency



- The Consumer Information form is collected and filled in for all consumers on Initial Contact or as soon as practical. Initial Contact information may be collected from the consumer at the front counter, over the telephone, or in the location or manner responsive to the consumer's needs. Judgement is used in relation to degree of detail and amount of information collected - it is not expected that all items will be completed for every consumer. In some cases information may not be collected at this contact.[8]
- The Service Directory is used to provide information about services to the consumer, including print-outs of the information where appropriate.
- The needs identification process is explained to the consumer.
- The Consumer Information Form is provided to the practitioner undertaking Initial Needs Identification after the consumer's consent to the disclosure of their information is gained. Where Initial Needs Identification is through another agency[9], the Consumer Information form is transmitted either electronically or by fax (using the referral cover sheet), or given to the consumer to provide to the other agency.
- The Consumer Consent form is completed at or after Initial Contact but prior to consumer information being disclosed. The Consumer Consent form is completed after the Consumer Information Brochure has been provided and/or explained to the consumer.
- Provide relevant details verbally and/or in hard copy to the consumer who is able and elects to proceed without the practitioner's assistance
- Agencies receiving referral information provide feedback to the referring agency including confirmation of receipt of referral information and the outcome of this (see Referral Protocol).
- Copies of the Consumer Information form and Consent form are offered and/or provided to the consumer at the point of contact or as soon after as practicable.
- In completing the Initial Contact process, practitioners should refer to the DHS Service Coordination Guideline 1: Completing Consumer Information.

[8] For example: Where information provision only occurs; or where rapport building with the client means that information is best built upon over time.

[9] Where an agency has provided some information to a consumer and completed the Consumer Information form, but will not be having any further contact with the client, the agency's own procedures in relation to the keeping/storage of client information should be followed. It is assumed agency practices comply with the Health Records Act and Privacy Act and any legal advice in relation to this matter.

4.0 Initial Needs Identification

4.1 Initial Needs Identification Practice

Description

Initial Needs Identification is an initial process of inquiry and screening for service where the underlying issues as well as presenting issues are uncovered to the extent possible, and allows health promotion opportunities to be identified. It includes a determination of the consumer's risk, eligibility and priority for service.

It is the practice of:

- Building on information gathered at Initial Contact (refer Initial Contact Protocol)
- Seeking information from the consumer in relation to their presenting needs
- Identifying (as far as possible, given the client's readiness and willingness to divulge information) the full range of the consumer's needs, (social, psychological, medical and physical needs) and underlying issues, health promotion or illness prevention opportunities, as well as capabilities and potential
- Being sensitive to the consumer's needs and making a professional judgement about the extent of inquiry possible, which may best occur over a period of time
- Providing information to the consumer/carer about the agency's own services and the range of services provided by other agencies which is reliable, up-to-date and relevant to the consumer/carer's needs
- Forming a professional judgement as to risk and priority for service
- Facilitating consumer choice, decision making, access to assessment and service, and making referrals

Tools

Service Coordination Tools (forms) used to support the practice of Initial Needs Identification are:

- Consumer Information form - building on the information collected on this form at Initial Contact
- Summary and Referral form - a documented summary of the consumers needs as a result of the Initial Needs Identification process; and the action (eg: referral for assessment and/or service) that is to follow
- Consumer Consent - consent by the consumer to the disclosure of information for referral purposes
- `*Your Information - It's Private*' - Consumer privacy information brochure (or the equivalent information contained within an agency brochure)
- Supplementary profiles as appropriate

Responsibility

Initial Needs Identification is undertaken following Initial Contact by competent practitioners. In some agencies, it is undertaken as a discreet needs identification process; in other agencies it may be incorporated in the assessment process. Initial Needs Identification will normally proceed to assessment, care planning and service delivery.

Consumer Outcomes

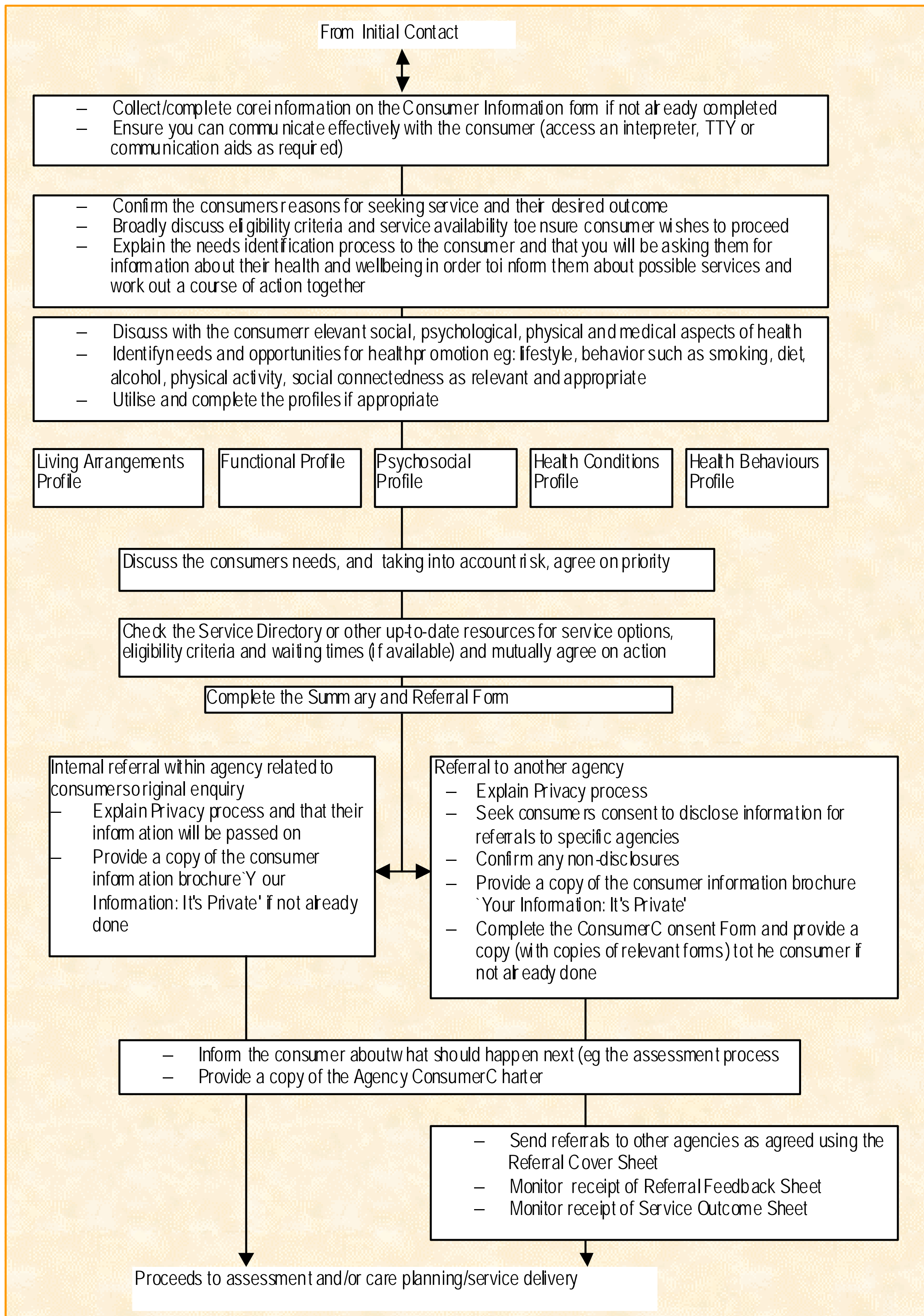
- Consumers have their needs identified in a holistic manner as early as possible in their contact with the service system
- Following Initial Needs Identification, consumers have prompt access to assessment and referrals
- Consumers are empowered to make informed choices regarding referrals and access to services
- Consumers are informed of their rights in relation to services and privacy provisions in relation to personal and health information

Standards

- All member agencies will ensure clients have access to the process of Initial Needs Identification (either internally of externally)
- Member agencies will use competent[10] practitioners to provide Initial Needs Identification
- Initial Needs Identification will occur within a time period specified within the agencies own policies/procedures/quality systems

[10] Refer Appendices

4.2 Initial Needs Identification Processes



- Initial Needs Identification occurs as soon as possible after Initial Contact. In some cases Initial Needs Identification occurs immediately and seamlessly following Initial Contact, in other cases there will be a time delay between these processes. Initial Needs Identification will be available to all consumers regardless of where they enter the service system.
- The process for the undertaking of Initial Needs Identification following Initial Contact may vary between agencies:
  - In some agencies, the practitioner who provided Initial Contact may also undertake Initial Needs Identification
  - In some agencies Initial Contact and Initial Needs Identification will be undertaken by two different workers as discreet processes
  - In some circumstances Initial Contact will be undertaken by a worker at one agency and Initial Needs Identification undertaken by a practitioner from a different agency
  - In some agencies Initial Needs Identification may be included as part of the assessment process
- Initial Needs Identification may occur face-to-face, over the telephone, in the location or manner responsive to the consumer's needs. The Initial Needs Identification process does not necessarily occur at a single point in time - it may be completed over time. Practitioners undertaking Initial Needs Identification will form professional judgements about the breadth and depth of Initial Needs Identification inquiry that will vary between individual consumers. This includes professional judgements about which (if any) of the supplementary profiles are applicable to the consumer's presenting needs.
- At the conclusion of the Initial Needs Identification process, the Summary and Referral Information form will be used to record a summary of the consumer's problems/issues and outline an initial plan of action (eg: referral for assessment, information provision). Notes regarding risk, urgency and priority of service, as appropriate, will be included on this form. Referrals may be made using the electronic referral system or via fax. Agencies receiving referral information will provide feedback to the referring agency including confirmation of receipt of referral information and the outcome of this (see Referral Protocol).
- The Consumer Consent form will be completed at or after Initial Needs Identification but prior to a referral being made whereby information is disclosed. A copy of the consumer privacy information brochure `Y*our Information - It's Private'* (or agency equivalent) - is provided to the consumer (refer Consumer Consent Protocol).
- Copies of forms utilised are provided to the consumer at the point of contact or as soon after as practicable.
- In completing the Initial Needs Identification processes practitioners should refer to the DHS Service Coordination Guidelines 2: Completing Summary and Referral Information and Guideline 3: Completing the Supplementary Profiles.

5.0 Referral

5.1 Referral Practice

Description

Referral is the practice of linking clients to other services.

Referral is the practice of:

- Identification of service needs and analysis of information gathered, decisions reached and professional judgements made, during the Initial Contact and Initial Needs Identification processes as to services required, risk and priority.
- Explaining and seeking consent from the consumer to the referral and transmission of personal information (refer Consumer Consent Protocol).
- Providing information to the receiving agency (or consumer) so they can proceed with further action (eg: assessment, service provision, treatment or care).
- Response by the receiving agency to the referral
- Monitoring the outcome of the referral (eg: acknowledgement of receipt of referral, service response to referral).

Tools

Service coordination tools (forms) used to support the practice of referral are[11]:

- Consumer Information
- Summary and Referral
- Profiles (where used)
- Consumer Consent form
- Referral cover sheets for paper-based and electronic referrals (Appendix 1)

Responsibility

Referral is completed by competent practitioners and can occur at many points through the service continuum. For example: referral following Initial Needs Identification for assessment; referral for service provision.

Consumer Outcomes

- Consumers are informed about referral options
- Consumers provide their consent prior to the disclosure of any personal or health information as part of the referral
- Consumers receive feedback as to the outcome of the referral
- Where the referred to service is not available, consumers are supported to select alternatives

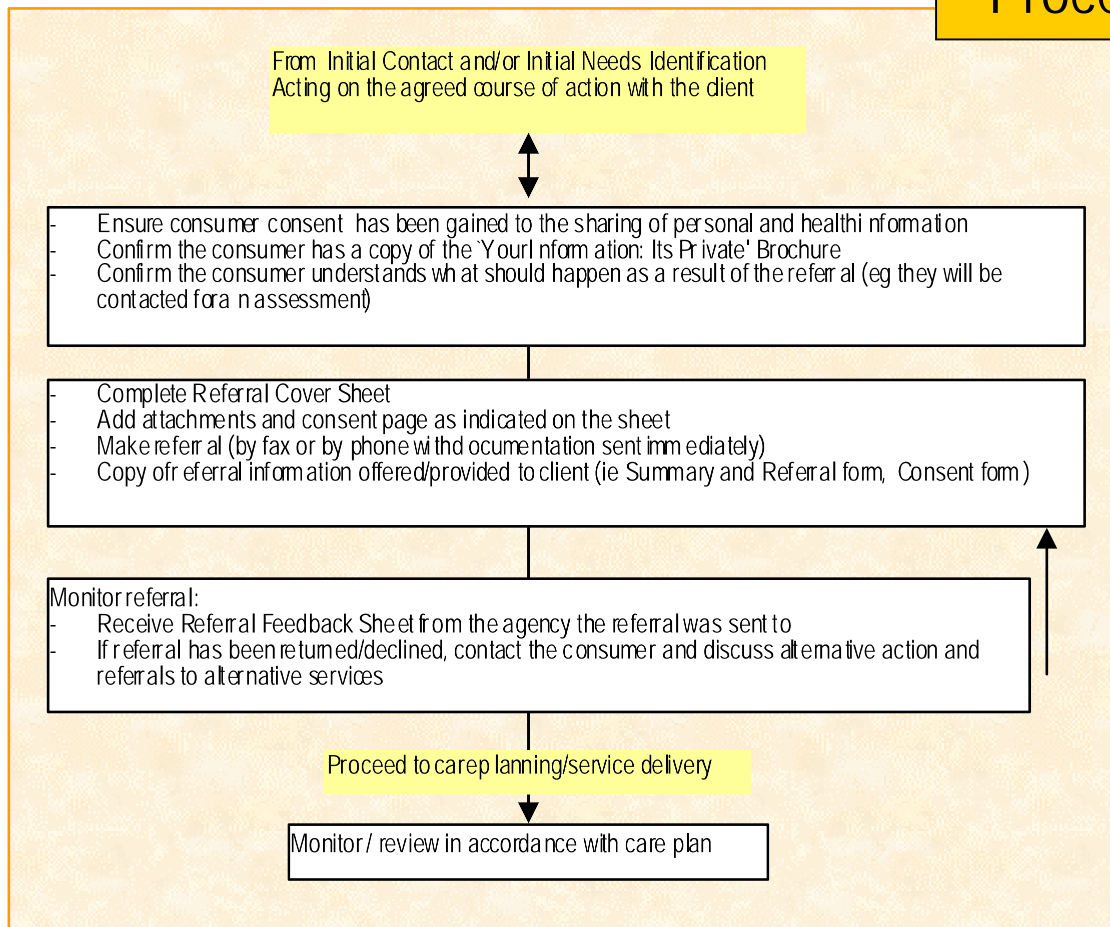
Standards

- All referrals will be made with consumer consent
- Consumers will be offered copies of referral information
- Referrals will be monitored to ensure action and/or feedback
- Referrals will be acted upon within a time period specified within the agencies own policies/procedures/quality systems

[11] Note: In some cases, consumers will be provided with information about appropriate services, and not require assistance from the agency to contact those services. In such cases, the agency will adhere to its own procedure about the extent of information collected/recorded about the consumer, and the use of the Consumer Information and/or Summary and Referral form.

5.2 Referral Processes

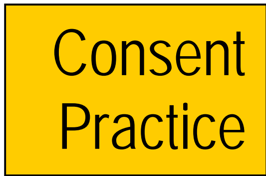
Referral Process



- Referral occurs as part of, or immediately following, Initial Contact and/or Initial Needs Identification and/or assessment. In most cases referral will occur immediately and seamlessly as part of or following these processes, and will also occur at other stages of the cycle as consumers divulge more information or their circumstances change. Referral will be available to consumers regardless of where they enter the service system.
- Practitioners use the Consumer Information form, Summary and Referral form, Supplementary Profiles (as appropriate) and the referral cover sheets to make referrals to appropriate agencies identified from the Service Directory.
- Where a consumer seeks information only and requires no further assistance from that agency, and it is not relevant to proceed to Initial Needs Identification, staff will adhere to their agency procedure about the extent of information recorded and the use of the Consumer Information and/or Summary and Referral form.
- The Summary and Referral form may be used in duplicate fashion to cover multiple problems with different levels of confidentiality requirements, where the practitioner completes a separate copy for each referral.
- Consent is to be gained from the consumer for the sharing of information for referral purposes.
- The process for referrals may vary between agencies.
- Agencies receiving referral information provide feedback to the referring agency including confirmation of receipt of referral information and the outcome of this using the referral cover sheets[12]
- Where practicable hard copies of referral information are provided by practitioners to consumers/carers.
- In undertaking referrals, practitioners should be familiar with the DHS Services Coordination Guideline 2: Completing the Summary and Referral Information.
- The service coordination tool templates are increasingly becoming available in electronic format and embedded into data systems. Future agency capacity and processes for electronic referral should support the use of the service coordination forms.

[12] Where an appointment has been by the referral source by telephone for a client, the referral fax-back response sheet acknowledging the referral is not required.

6.0 Consumer Consent



6.1 Consumer Consent Practice

Description

The practice of gaining consumer consent for the use and disclosure of health information is required in accordance with the Information Privacy Act (IPA) 2000 and the Victorian Health Records Act (HRA) 2001. Information privacy applies to all forms of personal and health information and a key concept of privacy is that a consumer should be able, as far as practicable, to control the use and disclosure of personal information. Personal information is information about a person (eg: name, age, gender) that identifies them; health information is broadly defined to include information about a person's physical, mental or psychological health or disability plus all personal information collected by health services. The HRA is the privacy law that applies to most information handled by member agencies and contains 11 legally binding Health Privacy Principles with which organisations must comply.

Information privacy refers to the control, collection, use, disclosure and disposal of information and the individual's right to control how their personal information is handled. The term `use' means sharing information within a particular organisation (eg: between individual practitioners, different program areas or services, or healthcare provider groups that operate under the one organisation or legal entity). The term `disclosure' means sharing or communicating health information to organisations or individuals outside a particular organisation.[13] Health information collected about an individual can only be used for the primary purpose for which it was collected, or, for a directly related secondary purpose without seeking further consent if this is within the *reasonable expectations* of the consumer.

Consumer consent is required to disclose their personal or health information. Consent can be express or implied (ie. reasonably inferred from the action or inaction of the individual) and must be current, informed, specific (ie. relate to a clearly defined use of information for a specific period of time) and voluntary. In order to provide consent, a consumer must have legal capacity to make the decision to agree. Generally speaking it is reasonable for a practitioner to assume that a consumer has legal capacity unless there is evidence before them that raises significant doubt.[14]

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13 DHS Privacy Kit August 2002: Information Sheet 5 - Use and Disclosure
14 DHS Privacy Kit August 2002: Information Sheet 6 - Capacity and Consent

Consent Practice

Gaining consumer consent is the practice of:

- Discussing service and referral options and providing the consumer with enough information to understand what will be done with the referral or service coordination information
- Ensuring the consumer understands what information is being disclosed or shared
- Specifically listing the services to which information is being disclosed
- Ensuring the consumer understands the nature of what they are agreeing to and what is likely to happen as a result of it (eg: it will lead to contact by an assessment officer, it will be stored in a secure electronic database)
- Gaining and recording the consumer's consent to the disclosure of their information on the standard DHS Consumer Consent Form
- Updating consent so it is current where there has been a lapse of time or change in circumstances

Tools

- Consumer Consent Form: - consent by the consumer to the disclosure of information for referral purposes
- `*Your Information - It's Private'* - Consumer privacy information brochure or agency equivalent to this that complies with Privacy legislation

Responsibility

Gaining consumer consent is undertaken during and/or following Initial Contact and/or Initial Needs Identification prior to referrals being made; and during care planning/service coordination where this occurs between agencies.

Consumer Outcomes

Consumers legislative rights in relation to privacy and consent are upheld

Standards

- All member agencies will gain consumer consent prior to the disclosure of personal or health information
- Consumers will be offered a copy of the consent form and any associated documentation

6.2 Consumer Consent Processes

The gaining of consumer consent for the use and disclosure of personal and health information is an important part of the processes of Initial Contact and/or Initial Needs Identification and/or Assessment and/or Service Coordination/Care Planning. Consent should be sought at various stages of the service delivery cycle as required.

- The gaining of written consent may occur face-to-face; where written consent is not practicable, the gaining of verbal consent may occur over the telephone as an interim measure; in the location or manner responsive to the consumers needs.
- Practitioners seeking consent will form professional judgements about the consumer's capacity to give consent.
- Where a consumer elects to share partial information only, practitioners will make duplicate copies of the consent form and attached information, so that partial information only can be disclosed.
- Practitioners will use the consent form to record consent and specify the information for disclosure.
- Following consent, the consent form will be provided (electronically, by fax, mail) as evidence of consent to referring agencies, with the information to be disclosed.
- A copy of the consent form and attachment/s (eg: Consumer Information form, Summary and Referral form) are provided to the consumer as soon as practicable.
- In obtaining consumer consent, practitioners should refer to the DHS Service Coordination Guideline 5: Completing Consumer Consent, and the DHS Information Privacy Kit, Information Sheet 6: Capacity and Consent.

[18] Authorised representative (ie. legal guardian, attorney with enduring power of attorney, parents where the individual is a child, person empowered by law under the Guardianship and Administration Act) or where no such person exists and the information needs to be disclosed to provide a necessary health service, an immediate family member. (Refer DHS Information Privacy Kit, Information Sheet 6: Capacity and Consent)

7.0 Assessment

Assessment is an important element in achieving better access to services and health and care outcomes for consumers.

Assessment is an investigative process using professional and interpersonal skills, to uncover relevant issues, collect, weight and interpret relevant information, and inform recommendations for treatment and care planning. Assessment includes a face to face interaction with a consumer and occurs where a service need is identified following Initial Needs Identification.

- Service specific assessments are undertaken where consumers have a relatively straightforward, obvious and distinct need. They are undertaken by most agencies prior to service provision and are the means by which the clients needs are determined for service provision.

- Specialist assessments are undertaken where the consumers presenting issues clearly requires a specialist service response. They aim to determine specialist needs and may include clinical assessment and treatment.

- Comprehensive assessments are undertaken when consumers have multiple, complex or unknown needs. They involve an intense level of inquiry and may incorporate an advanced level of history taken, examination, observation, measurement/testing about medical, physical, social cultural and psychological dimensions of need.

Member agencies will continue to use their own assessment forms (ensuring that information collected in the Initial Needs Identification process is not duplicated).

8.0 Care Planning

8.1 Care Planning Practice

Description

Care planning and service coordination planning is the outcome of the needs identification and assessment process and involves the determination of appropriate actions and services to meet the consumer's needs and goals. Care plans document the care or treatment goals for the consumer/carer and services to be provided. They specify key agencies, the service type, levels and frequency of service provision, review dates and key workers. The needs identification, assessment and care planning cycle is dynamic with constant review as the consumer's circumstances and needs change.

It is the practice of:

- Organising service responses based on the information gathered, findings and options identified at Initial Contact, Initial Needs Identification and Assessment taking into account relative risk, urgency and priority
- Coordinating service responses (as far as possible) to the full range of the consumer's needs including health promotion or illness prevention opportunities, as well as capabilities and potential
- The provision of care coordination and/or case management including case conferences, the management of brokerage funds, etc
- Review, re-assessment and monitoring
- Discharge/service exit

Tools

Service coordination tools (forms) used to support the practice of care planning are:

- Individual agency or program care or treatment plans
- Service Coordination Plan - this form has been designed for use with consumers with both multiple agency involvement and complex needs

Responsibility

Care planning is undertaken by competent practitioners, following Initial Needs Identification and/or assessment and/or review/re-assessment

Consumer Outcomes

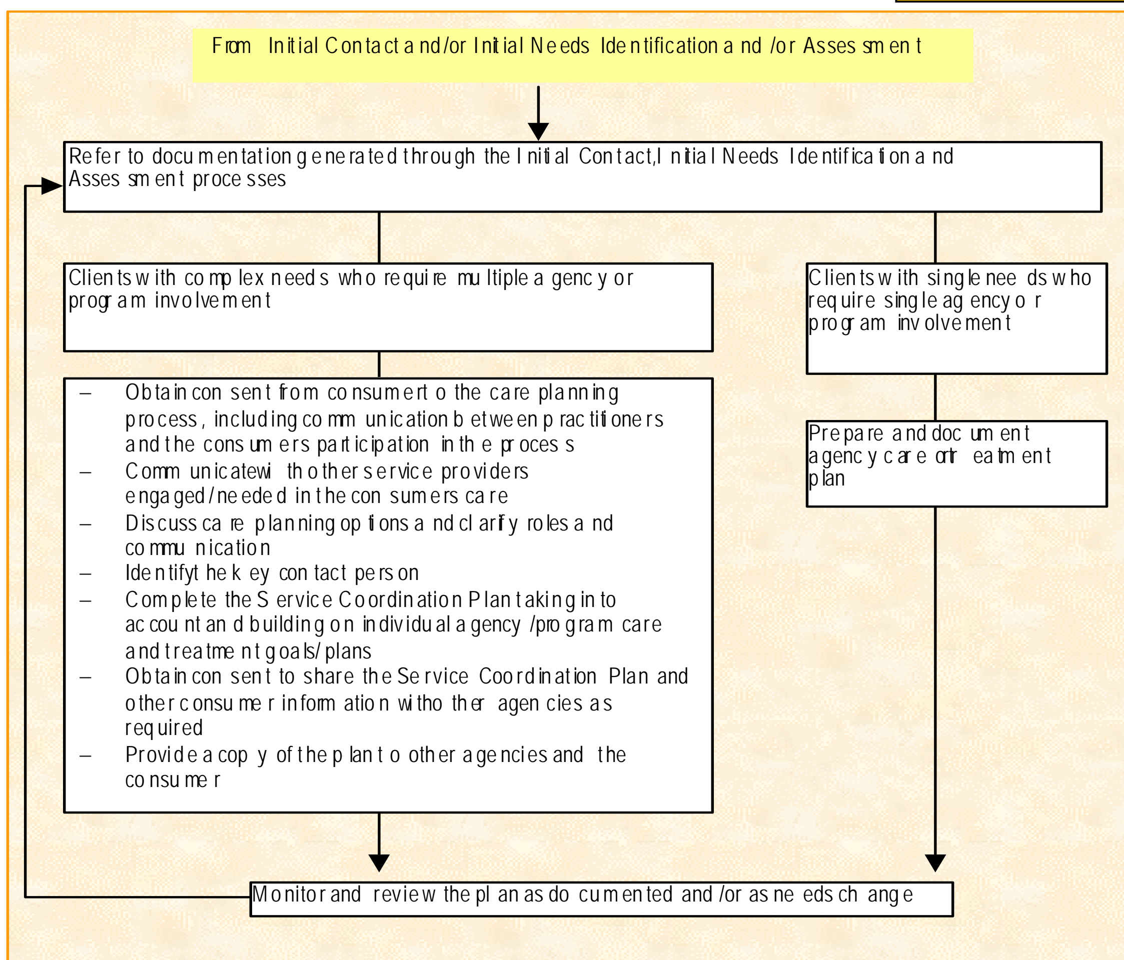
- Consumers are empowered to make informed choices regarding their care/treatment/service delivery and participate in the development of their care plan
- Consumers have a nominated contact person to communicate with in relation to service delivery outlined in the care plan
- Consumers with complex needs and/or involved with multiple services will benefit from a service coordination plan jointly developed by participating agencies with the consumer

Standards

- Consumers are involved in the care planning process where practicable
- Member agencies document goals for the clients care or treatment
- Where consumers require multiple services, member agencies contribute to a coordinated care planning process, using the Service Coordination Plan template or equivalent
- Care plans document an agency contact person
- Privacy of the consumer is upheld at all times
- A copy of the care plans is offered and/or provided to the consumer/carer[18] as practicable

8.2 Care Planning Processes

Care Planning Process



- Obtain agreement from consumer to participate in care planning process
- Practitioners undertake Service Coordination Planning/Care Planning during and after Initial Needs Identification and Assessment. In some cases Service Coordination/Care Planning will occur immediately and seamlessly following Initial Needs Identification and Assessment; in other cases there will be a short time delay between these processes.
- Practitioners undertaking Service Coordination/Care Planning will form professional judgements following Initial Needs Identification and Assessment that feed into and inform Service Coordination Planning/Care Planning. The process used by practitioners for the undertaking of Service Coordination Planning/Care Planning may vary depending on consumers' needs.
- In some cases the practitioner will prepare individual care plans or treatment plans and will not need to communicate with other agencies.
- In cases where the consumer has complex needs and requires multiple program/agency involvement, practitioners will prepare Service Coordination Plans.
- In the absence of a funded case manager, a contact person may be nominated to act as a link person and to coordinate services and prepare a care plan within a particular agency.
- Agencies will exercise appropriate duty of care when implementing the care plan.
- Consent is gained from the consumer to the planning process, the plan of care and the sharing of information contained in Service Coordination Plans.
- In preparing and documenting a Service Coordination Plan practitioners should refer to DHS Service Coordination Guideline 4: Developing a Service Coordination Plan (refer Appendix 5).
- Copies of Service Coordination Plans are transmitted/provided to participating service providers. Where practicable hard copies of referral information are provided by practitioners to consumers/carers.

20 Where a member agency has received legal advice as to the use of `opt out' clauses in relation to privacy and consent, the said legal advice will take precedence over these protocols.

Part C: Protocols

9.0 Initial Contact Protocol

Initial Contact is an important element in achieving better access to services and health and care outcomes for consumers.
In accordance with the North Central Metro Primary Care Partnership Service Coordination Model, all member agencies have committed to provide Initial Contact as an entry point to the service system.

Member agencies have undertaken to adapt their current practices and procedures to reflect this umbrella protocol, and/or ensure that their own agency protocols are consistent with and incorporate mechanisms which give effect to the outcomes intended by these protocols. Within this context member agencies have agreed to revise as appropriate and retain their own agency-specific detailed policies, procedures and guidelines for staff.

In providing Initial Contact, member agencies agreed to the following protocols:

- Use of the Consumer Information form to record basic demographic and consumer details and note the service requested. (It also collects information required for MDS reporting).
- Use of the Service Directory to provide service information to inquirers and consumers/carers about relevant health and other community services.
- To ensure the mode of communication facilitates the consumer communicating with ease. For example:
  - the use of interpreter services with consumers from Culturally and Linguistically Diverse (CALD) backgrounds
  - the use of TTY for consumers with hearing impairments
  - Response to special communication needs
  - Respect of anonymity where practical
- To facilitate the consumer's access to Initial Needs Identification (where they require more than simply the provision of information).
- To make a referral to another agency to undertake Initial Needs Identification if the first contact agency does not have the capacity or competent practitioners to undertake Initial Needs Identification.
- Use of the Consumer Consent form to obtain consumer consent to the sharing/disclosure of consumer information for referral purposes to other service provider/s (Refer Consumer Consent Protocol). This includes advising consumers of their rights and about what happens to their personal information, through the provision of a consumer privacy information brochure.
- Use of the Referral Cover Sheet.
- To facilitate access in response to the consumer's request for a service, directly to services as appropriate (eg: single service request) including direct telephone transfers and/or making appointments where this facility is available.
- To collect client information as appropriate.
- To ensure staff members undertaking Initial Contact meet critical factors in relation to skill, expertise and competency. For example:
  - Understanding of the Service Model and an in-depth knowledge of the service system
  - The ability to use the Service Directory
  - The ability to use electronic referral systems where available
  - Demonstrated knowledge of and practical application of the Protocol Manual
  - Ability to establish rapport with consumers and maintain confidentiality
  - Knowledge and compliance with Privacy legislation
  - Access to professional decision support (eg: peer support, staff supervision)
  - Other competency standards as applicable.

10.0 Initial Needs Identification Protocol

Initial Needs Identification is an important element in achieving improved health outcomes for consumers. In accordance with the North Central Metro Primary Care Partnership Service Coordination Model, member agencies have agreed that all agencies will provide Initial Needs Identification, or facilitate access to it at another agency.

Member agencies have undertaken to adapt their current practices and procedures to reflect this umbrella protocol, and/or ensure that their own agency protocols are consistent with and incorporate mechanisms which give effect to the outcomes intended by these protocols. Within this context member agencies have agreed to revise and retain their own agency-specific detailed polices, procedures and guidelines for staff.

To provide Initial Needs Identification, member agencies have agreed to the following protocols:

- Staff will build upon (and complete as appropriate) consumer information collected at Initial Contact on the Consumer Information form.
- Staff will use their professional judgement and sensitivity regarding the consumer's presenting circumstances to determine how brief or intensive the process of Initial Needs Identification is. Initial Needs Identification aims to consider the social, psychological, physical and medical aspects of health and identify health promotion opportunities with the consumer.
- To ensure the mode of communication facilitates the consumer communicating with ease.
- Staff will use the Summary and Referral Information form to list and summarise needs, record action and make referrals between agencies. Notes regarding risk, urgency and priority of service, as appropriate, will be included on this form.
- Staff will use their professional judgement about which (if any) of the supplementary profiles are applicable to the consumer's presenting needs. The use of the five optional profiles will be based on the professional judgement of the staff member in consultation with the consumer. It is preferable that the Living Arrangements profile is completed for referrals to HACC services.
- Staff may need to gather information from more than one source to complete Initial Needs Identification.
- Staff will use the Service Directory to ascertain appropriate services, communicate the range of options potentially available to the consumer, and assist the consumer in making decisions and informed choices.
- Staff will make professional decisions and facilitate access to Service Specific Assessment, Specialist Assessment, Comprehensive Assessment and/or directly to services as appropriate, considering the risk, urgency and priority of the consumers range of needs.
- To facilitate access directly to services as appropriate (eg: single service request) including direct transfers and or making appointments.
- Staff will use the Consumer Consent form to obtain consumer consent to the sharing/disclosure of consumer information for referral purposes to other service provider/s. This includes advising consumers about their rights and about what happens to their personal information, through the provision of the consumer privacy information brochure, and/or agency consumer charter.
- Staff will offer a hard copy of Initial Needs Identification information and the Consent form to the consumer.
- Staff will refer to DHS Guideline 2: Completing the Summary and Referral Step as part of Initial Needs Identification and DHS Guideline 3: Completing the Supplementary Profiles as part of Initial Needs Identification.
- Member agencies will send, acknowledge and provide feedback about referrals (with the consumer's consent) resulting from Initial Needs Identification using the Referral Cover Sheet, Feedback Sheet and Assessment Outcome Sheet (Appendix 1)
- To ensure that competent practitioners perform this function (refer Appendices)

11.0 Referral Protocol

Referral is an important function in achieving better access to services and health outcomes for consumers. Member agencies have undertaken to adapt their current practices and procedures to reflect this umbrella protocol, and/or ensure that their own agency protocols are consistent with and incorporate mechanisms which give effect to the outcomes intended by these protocols. Within this context, member agencies have agreed to revise and retain their own agency-specific detailed policies, procedures and guidelines for staff.

In providing referral, member agencies have agreed to the following protocols:

- Staff members will base referrals on analysis of information gained through the Initial Contact and Initial Needs Identification processes to make referrals to appropriate agencies identified from the Service Directory.
- Staff members will use the Summary and Referral Information form to record a summary of the consumers problems/issues, outline an initial action plan and document referral information and action. (Staff members should refer to DHS Service Coordination Guideline 2: Completing the Summary and Referral Information). Where appropriate, additional information (eg: from assessment) shall be attached to the referral.
- Staff members will use the Consumer Consent form to obtain consumer consent to the sharing/disclosure of consumer information for referral purposes to other service provider/s. The client may decline consent for some of the information to be sent provided there is adequate information to make the referral. Where the client declines consent to the disclosure of information to some agencies not others, the Summary and Referral Form will be used in duplicate fashion by the practitioner with a separate copy for each issue.
- Staff members will advise consumers of their rights and about what happens to their personal information, through the provision of the consumer privacy information brochure to the consumer.
- Where practicable hard copies of referral information will be provided by staff members to consumers.
- Staff members will use the Referral Cover Sheet. This includes indicating the priority of the consumer in relation to the consumers needs.
  - An urgent priority referral indicates that there is an imminent risk to the consumers health and wellbeing. The urgency relates to the level of risk to the consumer. Normally *a small number* of referrals made by any one agency/staff member would be considered urgent and agencies will need to monitor this (the exception to this is crisis/emergency services).
  - A routine priority referral indicates that the receiving agency should treat the referral according to its normal processes
- Staff members will use the Feedback Sheet to provide information back to the originator of the referral, within the timeframes specified on the sheet. Where this is impractical, feedback may be given by telephone.
- Where a client is referred and placed on a waiting list, the client should be advised who to contact during the waiting period - this will depend on the nature and urgency of the situation.
- Staff members will use the Assessment Outcome Sheet to provide information as to assessment recommendations and service provided to the originator of the referral. The timeframe will vary from consumer to consumer, but timely outcome information is to be provided .

  If a client refuses consent to the disclosure of information but wishes the referral to proceed, staff may make the referral without providing information beyond that which is necessary to make the referral (ie name, contact details and service requested). Staff will explain to the consumer that the next agency will ask them to repeat personal and health information.

12.0 Consumer Consent Protocol

In accordance with the North Central Metro Primary Care Partnership Service Coordination Model and relevant legislation, all member agencies have committed to implement this protocol. This includes compliance with advice, information sheets and guidelines regarding this matter as provided by the Department of Human Services and/or the agencies own legal advisers.

Member agencies have undertaken to adapt their current practices and procedures to reflect this umbrella protocol, and/or ensure that their own agency protocols are consistent with and incorporate mechanisms which give effect to the outcomes intended by these protocols[20].

In obtaining consumer consent, member agencies have agreed to the following protocols:

- Staff members will request and record consumer consent to the use and disclosure of their personal and/or health information on the consent form. Written consent will be gained wherever possible. Verbal consent will be gained only where it is not reasonably practical to obtain written consent.[21]
- Staff members will note if an interpreter is used to explain the consent to the consumer.
- Staff members will utilise professional judgement as to the consumer's capacity to provide consent.
  - Where the professional judges that the consumer does not have the capacity to provide consent, they will consult an authorised representative[22] to make decisions on behalf of the consumer
  - Where the professional judges that the consumer does not have the capacity to provide consent and there is no authorised representative, the practitioner will make a judgement about who can act in the best interests of the consumer (eg: family member, carer or friend but not a practitioner involved in the care or treatment of the consumer). In doing so, the practitioner will document the grounds for this judgment. Where no suitable person is available, advice will be sought from the Office of the Public Advocate
  - In emergency situations where there is a serious imminent threat to the person's life and no access to an authorised representative (if any exists) the practitioner may act without consent to lessen or prevent the threat.
  - In relation to children and adolescents under 18 years of age, request consent from the child where they demonstrate their capacity through their intelligence and maturity to understand the nature and effect of the proposed decision and consent. If the child does not have the capacity to give consent, consent can be given by their parent or authorised representative.
- Staff members will offer/provide the consumer with copies of:
  - \`Your Information: Its Private' consumer information brochure
  - Agency consumer charter or equivalent
  - The consent form and attachments (ie the information the consumer has consented to disclose such as the Consumer Information form and/or Summary and Referral form)
- Staff members will respect a consumer's right to refuse to consent to the disclosure or sharing of information. Where consent to the disclosure and sharing of information is not gained, consumer information will not be disclosed. The consumer can request a referral to proceed and the practitioner can offer to make/facilitate an appointment and advise the referring agency that consent to the disclosure of information has not been received.
- For more detailed information refer to the:
  - DHS Service Coordination Guideline 5: Completing Consumer Consent
  - DHS Privacy Kit August 2002
  - DIY Privacy Kit (available on Primary Health Knowledge Base website listed at the front of this document

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[21] For example, where part of the Initial Needs Identification is completed by phone and gives verbal consent for referral, written consent can be gained when the consumer subsequently attends an appointment

[22] For example, a person with enduring power of attorney, appointed through a statutory order such as a Guardianship or Administration order; a person nominated by the consumer (such as a family member, carer or friend) whose position is supported by a statement to that effect

13.0 Assessment Protocol

In accordance with the North Central Metro Primary Care Partnership Service Coordination Model, all member agencies have agreed to the following protocols:

- To undertake assessment as appropriate following the process of Initial Contact and Initial Needs Identification
- In cases where urgency, risk or other factors have resulted in assessment occurring prior to Initial Needs Identification, to complete Initial Needs Identification and the related service coordination tools prior to referral to other agencies
- To review their own assessment forms to ensure that information collected in the Initial Needs Identification process is not duplicated
- To utilise specific assessment forms/tools where these are required by program guidelines (ie: Department of Human Services or Commonwealth guidelines)
- Where review or re-assessment is required, and the consumer is involved with multiple agencies, to ensure this is undertaken in a coordinated manner

14.0 Care Planning Protocol

Care planning and cross program/agency service coordination is an important element in achieving better outcomes for consumers. In accordance with the North Central Metro Service Coordination Model, member agencies have agreed that where consumers have both multiple program/agency involvement and complex needs a process of service coordination between agencies will be used.

To provide Service Coordination for consumers with both multiple program/agency involvement and complex needs[23], member agencies have undertaken to:

- Use competent practitioners who will build upon consumer information collected, decisions, professional judgements and consumer preferences from the Initial Contact, Initial Needs Identification and/or Assessment processes to inform Service Coordination
- In consultation with consumers, develop care or treatment goals.
- For consumers receiving multiple services, use the Service Coordination Plan form or equivalent to record consumer goals, action to be taken, service provision agency responsible and review dates. The Service Coordination Plan acts as an umbrella plan to document and coordinate agencies individual care or treatment plans.
- Where appropriate and agency resources permit, nominate a key worker to promote effective communication between service providers. In the absence of funded case managers, a key workers role will be limited to:
  - Linking and coordinating internal services
  - Communication and liaison with relevant practitioners from other agencies
- Where case management is available, this will provide more detailed coordination and management service provision and monitoring across agencies.
- Ensure that service delivery for a consumer from multiple agencies is efficient, effective, avoids duplication of services and ensures continuity of care. The contact person may change over time as the needs and involvement of a clients with agencies changes.
- Advise consumers of their rights and about what happens to their personal information, through the provision of the consumer privacy information brochure `*Your Information: It's Private*' to the consumer
- Use the Consumer Consent form to obtain consumer consent to the sharing/disclosure of consumer information for Service Coordination purposes to other service provider/s
- Provide a copy of the Service Coordination Plan to the consumer/carer (refer footnote 18).
- Ensure Privacy Standards are met
- Collect data in relation to the number of clients with a Service Coordination plan (refer section 9.2) to inform planning and provide evidence of resource implications

[23] DHS Service Coordination Guidelines suggest that as a general guide, consumers with complex needs are those who: are being seen by more than one agency and more than one discipline; have multiple issues/problems that need to be addressed concurrently; and whose outcomes are likely to be better if the care and services they receive are coordinated across agencies and over time.

Part D: Continual Improvement

15.0 Data and Evaluation

Data and evaluation are related concepts. Data collection and analysis informs evaluation processes and outcomes.

At a statewide level, evaluation of the Primary Care Partnership strategy is ongoing. This includes both evaluation from a service provider and consumer perspective. The Department of Human Services intends to review the Service Coordination Tools in the future. A Carer Profile (which would form an additional supplementary profile) is currently under development and trial. Pending the outcome of the trial it is possible that a Carer Profile will form part of the Service Coordination Tools.

The collection and reporting of data is part of agency's management reporting and quality systems. Software packages used by service providers are in the process upgrade to comply with the Service Coordination Tools, which will enhance consistent data collection and analysis across member agencies.

The North Central Metro Primary Care Partnership may, in future, develop an additional evaluation framework utilising a range of quantitative (eg: data analysis) and qualitative (eg: client interviews) information. This could encompass evaluation at the Primary Care Partnership, individual agency, staff and consumer levels. For example:

- the development and analysis of baseline data to enable comparisons over time
- acceptance and non-acceptance of referrals
- the frequency and impact of the key worker role and implications in relation to case management
- the impact to member agencies of implementing service coordination and the protocols outlined within this manual
- outcomes in relation to improved access to services for consumers, particularly those with complex needs

Evidence arising from such evaluation would potentially provide encouragement for non-member agencies to adopt the service coordination model.

The implementation of the Protocol Manual provides the opportunity for some specific data (that may or may not already be collected by agencies) to be collected and analysed across member agencies and the Primary Care Partnership. Ultimately this will assist in planning, resourcing and evaluation of service delivery. The matter of data collection and evaluation will continue to be discussed by the NMPCP Service Coordination Sub Committee.

North Central Metro PCP

Protocol Manual Development and Review.

The chart below indicates the process undertaken for the development of the Protocol Manual. A review date of January 2004 is recommended. The process and timing for review will need to be discussed by the Service Coordination Sub Committee, taking into account resource capacity and priorities.

Activity	Process	Date
Design of structure and process for development	Working Group	February 2003
Preparation and consultation	Draft prepared based on source material	March - April 2003
Draft Manual	Distribution for comment to member agencies Workshop with member agencies	April - May 2003
Refined/finalised	Manual refined and finalised based on feedback	May 2003
Endorsed	Executive	May 2003
Recommended Review Date	Working Group	June 2004

16.0 Privacy

Responding to complaints in relation to breaches of privacy forms part of member agencies' quality systems.

To provide a consistent process for responding to privacy complaints, member agencies have undertaken to:

- Institute privacy practices including:
  - Advising consumers of their rights and about what happens to their personal information, through the provision of the consumer privacy information brochure to the consumer
  - Adherence with the Consumer Consent Protocol and use of the Consumer Consent form to obtain consumer consent to the sharing/disclosure of consumer information to other service provider/s (Refer Consumer Consent Protocol)
- Resolve complaints quickly and effectively and wherever possible through a conciliatory process directly with the consumer
- Ensure consumer's special communication or cultural needs are addressed
- Nominate a Privacy Officer to deal with complaints in relation to alleged breaches of privacy
- Advise consumers of their rights and the process for making complaints
- Ensure staff are educated regarding privacy principles and the process for complaints
- In relation to a breach of privacy:
  - In the first instance, the member agency holding the personal or health information about the consumer will respond to the complaint
  - The agency will endeavor to resolve the complaint directly with the consumer
  - The agency will endeavor to respond to the complaint directly with the consumer within 5 working days
  - If the situation remains unresolved, there was no response or the response was considered inadequate, the consumer or their representative may have recourse to either the Health Services Commissioner (for health information) or the Victorian Privacy Commissioner (for non health information)
  - The Privacy Officer will support the consumer in this recourse in accordance with any relevant guidelines provided by these Commissioners
- The Privacy officer will keep a record of all complaints including:
  - the date and reason for the complaint
  - steps taken for resolution
  - outcome
  - an annual summary of complaints in relation to breaches of privacy and complaints regarding other aspects of service delivery
- Other processes according to agencies privacy policies and procedures

17.0 Inter Agency Dialogue

All member agencies will have complaints and grievance procedures that are accessible to consumers. From time to time, issues or misunderstanding between members agencies in relation to service delivery may arise. Where these arise between agencies in relation to the practices, protocols and processes outlined in this manual, the following protocols will apply:

- Agencies will endeavor to discuss and resolve the issue or misunderstanding
- If desired by either member agency, the issue can be raised with the Project Management Group who will discuss the matter and work collaboratively to develop solutions
- Where the issue arises due to different interpretation or lack of clarity of text within the manual, the text will be revised/updated to clarify the matter
- Where the issue cannot be resolved by the Project Management Group, it will be taken to the Department of Human Services, Northern Metropolitan Region, for discussion and resolution.

Likewise, issues in relation to the service system may arise, which are beyond the scope of this Protocol Manual and service coordination per se. (eg: resourcing, demand/workload issues). Member agencies participate in a range of forums in relation to quality service delivery and the service system. The Primary Care Partnership can play a role in facilitating discussion around these issues and leading strategies to address them with government and agencies. Such issues can be brought to the Project Management Group for discussion and action.

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Appendices

North Central Metro PCP

Appendix 1: Referral Sheets

The following sheets are currently being updated and when finalised will be available from Kaye Stevens at the North Central Metro Primary Care Partnership kstevens@ncmpcp.org.au or may be downloaded from the NMPCP website www.ncmpcp.org.au

Referral Cover Sheet

Referral Feedback

Service Outcome

Appendix 2: Glossary of Terms

ACAS	Aged Care Assessment Service
Assessment	A decision-making methodology that collects, weighs and interprets relevant information about the consumer. Assessment is an investigative process using professional and interpersonal skills to uncover relevant issues and to develop a care plan. (See also Comprehensive Assessment, Service Specific Assessment, Specialist assessment).
Care Planning	Care planning is a process of deliberation that incorporates a range of existing activities such as care coordination, case management, referral, feedback, review, reassessment and monitoring. Care planning involves the judgement/determination of relative need as well as competing needs, and assists consumers to make decisions that are appropriate to their needs, wishes, values and circumstances.
Consent	The voluntary agreement of the individual or the individual's authorised representative about a proposed action. In the context of service coordination, consent relates to the use and disclosure of a consumer's personal and health information.
Duty of Care	A duty to take a reasonable care of a person. A duty of care is breached if a person with a duty of care in relation to another behaves unreasonably in relation to that other person. Failure to act can be unreasonable in a particular situation. A duty of care can be breached either by action or inaction. The reasonableness of what a person has done or not done, is assessed by considering how a hypothetically reasonable person would have behaved in the same situation. What is considered reasonable will depend on the circumstances.
Functional Integration	Functional integration means service providers agree to undertake particular functions (initial contact, initial needs identification, referral, information sharing etc) in a common integrated manner. Whilst services remain independent of each other in a structural sense, they work in a cohesive and coordinated way so that the consumer experiences a seamless and integrated response across the Alliance.
Key Worker	A nominated worker who has the responsibility of ensuring the care plan is implemented and that reviews and reassessments are undertaken at the appropriate times by the relevant service providers.

Health Information	Health Information includes personal information that is information or an opinion about an individual's physical, mental or psychological health; a disability of an individual; an individual's expressed wishes about future provision of health services; a health service provided to an individual. It also includes information that is collected in connection with the donation of body parts and/or genetic information in a form that is, or could be, predictive of the health of an individual or any descendants. Health information refers to a person's health information in any form (written, verbal, electronic, video, etc).
Information Privacy	The control of the collection, use, release and dissemination of recorded client information.
Initial Contact	Initial Contact is the point of first contact with the service system and will most commonly include the provision of service information, the provision of other information such as health promotion literature, and/or direct access to services via Initial Needs Identification.
Initial Needs Identification	Initial Needs Identification is an initial process of inquiry where the underlying issues as well as presenting issues are uncovered to the extent possible. It includes a determination of the consumer's risk, eligibility and priority for service.
IT	Information Technology
Practice	The usual or customary way something is done.
Privacy	The protection of the interests of the individual, and the individual's right to control how their personal or health information is used, and for what purposes.
Privacy Officer	The nominated person within an organisation responsible for the development, implementation and monitoring of privacy requirements and compliance with privacy legislation.
Process	A series of actions and changes for a particular purpose.
Protocols	An agreed way of working which sets out standards for the various issues.
Procedure	An ordered set of tasks for performing some action.
Security	Any measures used to protect information and prevent the unauthorised use of data. It includes efforts to maintain the confidentiality of personal and health information, including restricted physical access to the information and protective measures for electronic information such as passwords and encryption.

Service Coordination Model	The Service Coordination Model provides a framework for functional integration between agencies. Functional integration means service providers agree to undertake particular functions (initial contact, initial needs identification, referral, information sharing etc) in a common integrated manner. This means that whilst services remain independent of each other in a structural sense, they work in a cohesive and coordinated way so that the consumer experiences a seamless and integrated response.
Service Specific Assessment	Service Specific Assessment is a face-to-face interaction undertaken when consumers have a relatively straightforward, obvious and distinct need for a specific service. It is conducted by the provider responsible foe delivering the service and occurs as part of the delivery of service.
Specialist Assessment	Specialist Assessment is a face-to-face interaction with a consumer and is undertaken where the presenting issue clearly requires a specialist service response. It occurs where a specialist need is identified following Initial Needs Identification.
System	A combination of components that work together. For example, an information system is a combination of computer hardware and software, people and the procedures used to process the data.

Appendix 3: Competency

Competent Practitioners

Member agencies of the North Central Metro Primary Care Partnership have agreed that competent practitioners will provide Initial Needs Identification and Service Coordination. A competent practitioner is one who would usually, or be capable of, attending to the core business of the agency to which they belong[24] and who has a broad understanding of the service system and advanced interviewing skills.

This includes:

- Ability to establish rapport with consumers, communicate sensitively, respectfully and in a culturally appropriate manner and maintain confidentiality
- Advanced interviewing skills including the capacity to maintain and develop rapport throughout inquiry and an ability to retrieve sufficient information
- The ability to undertake an in-depth process of inquiry, explore issues behind the apparent presenting need
- A knowledge of issues pertinent to various target groups (eg older people, younger people with a disability)
- Ability to gather information from more than one source
- Ability to make professional judgements in relation to risk, eligibility and priority for service; and facilitate access to Service Specific Assessment, Specialist Assessment, Comprehensive Assessment and/or directly to services as appropriate, considering the urgency and priority of the consumers range of needs.
- Ability to attend to the core business of the agency to which they belong
- Ability to provide a response to manage urgent situations and immediate risks to consumer
- Knowledge of crisis response services and response mechanisms for consumers who require services urgently
- Ability to identify health promotion opportunities
- An in depth understanding of the local service system and a basic knowledge of statewide services
- Knowledge of circumstances in which referral can be made without the consumer's consent (eg serious imminent threat to the person's life)
- Knowledge and compliance with Privacy legislation including respect of anonymity where desired
- Ability to communicate the range of services and options potentially available to the consumer and assist the consumer in making decisions and informed choices
- Understanding of the Coordination Model
- The ability to use the Service Directory and other tools to assist in appropriate referrals
- Demonstrated knowledge of and practical application of these Protocols
- The ability to facilitate communication between service providers and coordinate service provision across agencies

[24] For example: a registered nurse in an agency providing a nursing service; a counsellor in a Community Health Centre that provides a Counselling service. Refer also draft Job Profiles for Initial Contact and Initial Needs identification Service Providers available in the DHS Service Coordination Orientation Manual.

Appendix 4: Helping Consumers Understand the Process

Agencies can assist consumers understand the service coordination process.

The way in which this is best done may vary between agencies.

Example 1
The practitioner ensures the consumer is aware of the overall process by:

- Giving an outline of the overall approach
- Always explaining what will happen next
- Giving timelines where possible
- Asking the consumer if they have any questions

Example 2
The text below shows the usual steps involved with simple wording. Agencies may include or adapt this information in their brochures.

Step	Simple wording
1	To start, we will ask you what help you need. We might fill in a form with some information such as your name, address, and telephone number
2	We will then ask you if you would like to talk about any other areas of your health and well being. It is up to you whether you want to or not. If you do, we may also fill in some other forms about the help that you need
3	We will make sure you see the right person or people to help you. These people will talk with you further and provide whatever assistance or treatment you agree to and can be provided
4	We will always ask your permission before we share your information with somebody else involved in your care or treatment. We will offer you a copy of any forms we fill in.
5	If you need and agree to a number of services, an overall plan may be developed to improve your health and wellbeing.

Appendix 5: Information from DHS Service Coordination Tool Template Guidelines

The information below is partial information only from the DHS Service Coordination Tool Template Guidelines. All practitioners should be familiar with the Guidelines. Copies of the Guidelines may be downloaded from the Primary Health Knowledge Base, in the Service Coordination section, at www.dhs.vic.gov.au/phkb

Overview of the Service Coordination Tool Templates

The Consumer Information form contains a core set of items designed to collect demographic and social details about individual consumers. The Summary and Referral Information form records a summary of the consumer's problems/issues and outlines an initial action plan. It can be used for referral. There is also a one-page Consumer Consent form that provides a uniform approach to obtaining consumer consent for sharing information in compliance with the Health Records Act 2001. The five supplementary profiles allow further information to be collected on those areas relevant to the consumers' circumstances and presenting problems. Not all profiles will be relevant for every consumer and, in some cases, some specific information within a profile will not be required. In these cases, simply record NA (not applicable) or code 99, depending on the instructions on the top of each page. The final form in the series is a Service Coordination Plan form to be completed for those consumers with both multi-agency involvement and complex needs.

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

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

The Summary and Referral form is informed by any relevant detail from the additional profiles that are used for the particular consumer or from the areas usually investigated by a particular agency or clinician. These are either used or left out depending on the consumer's presenting problems or as a result of any issues arising during the initial contact. As a result this page will usually be completed at the end and is used as a basis (in conjunction with subsequent assessments and care plans) for putting together the Service Coordination Plan (if required). The Summary and Referral form may be used in a duplicate fashion to cover multiple problems with differing levels of confidentiality requirements. It can be used if the information is sensitive and not to be shared, in which case the interviewer can complete a separate copy of page 2 for each issue. For example there may be two issues—seeing the dentist and getting referred to a sexual assault service—and it may not be relevant or necessary to share all information for both referrals.

The Profiles are completed only if they are relevant to the client's presenting problems and needs and after the core information has been collected. The core information is recorded in the Consumer Information and Summary and Referral components. The assumption is that the next stages of referral, assessment or care planning, or service coordination, is a continuation of that process, and that the core consumer information will therefore already be available. There are five supplementary profiles. The five supplementary forms cover profiles of living arrangements, health conditions, psychosocial factors, a functional screen and health behaviours. These are domains that can be investigated at the discretion of the contact worker and depending on the nature of the consumer's problem. In some cases, there will be no need to complete any of these supplementary domains.

However, for consumers with complex needs, contact workers may choose to use several forms to identify their initial needs. Complete only those profiles that are relevant for the consumer. The Profiles are not a structured interview. Do not ask consumers about issues in the order that they are listed if they are inappropriate in the context. The Profiles are designed to be completed based on all sources of information available to the person completing them (observation, information contained in a referral letter, consumer notes or information provided to you by a carer or referring agency). Record NA for any issues that you have either not canvassed or that are inappropriate for the consumer unless otherwise instructed. The design of the set of profiles assumes that children and adolescents will be directly referred for a relevant assessment to be completed. The Profiles are not designed as a diagnostic tool, nor are they considered to be an assessment. They are tools to help determine the consumer's risk, eligibility, priority for service and health promotion 0pportunities as early in their contact with the service system as possible. This set of optional domains has been chosen by combining evidence from the literature, a review of the range of forms currently in use, and consultations with the field on different draft versions of data collection tools. They can be used to further investigate the scope of the consumer's needs at the initial contact point. The Living Arrangements and Functional Profile forms should be completed for all consumers requiring Home and Community Care (HACC) services. These two profiles contain HACC minimum data set (MDS) items and the collection of this information during the INI process will mean that the information will not need to be collected at a later time.

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

Design Issues Common to All Forms

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

Information Superseded

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

Using the Service Coordination Tool Templates

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

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

About the Consumer Information Form

This is the first of five guidelines in the Service Coordination Tool Template suite. This first guideline is designed for those completing the Consumer Information form as the first step. The Consumer Information form (CI pages 1 and 2) should be filled in for all clients on initial contact or as soon as practical and kept up-to-date as details change. It is required for all clients as it contains relevant registration and demographic information that can be linked to other forms and transferred to other agencies. Information in this section is at a basic level and includes items collected in a format consistent with various minimum data sets. It can be collected at the front counter or over the phone. It is expected that this section can be completed without requiring the client to go into too much detail or by probing problems in depth. (The exception to this is the Notes box on page 2 which requires professional judgement in identifying alerts and risks. This is where the information collected moves from Initial Contact (IC) to Initial Needs Identification (INI) and the practice for collecting this information should be clarified.) The information collected on this form is information that is narrow in scope but useful for referral purposes. It is not expected that information for all items will be completed for every consumer. 'NA' should be recorded to indicate if the question is irrelevant or information is not known. An item should not be left blank. It is likely that many of the items in the Consumer Information form will be collected during the initial contact with the consumer or the person referring the consumer. Some items, however, may not be collected until the first time a consumer is seen by a clinician.

About the Summary and Referral Form

This is the second of five guidelines in the Service Coordination Tool Template suite. This second guideline is designed for those completing the Summary and Referral form as part of Initial Needs Identification (INI). The Summary and Referral Information form (SRI pages 1 and 2) is required for all referrals and should be used for intake summary functions. Other practitioners may choose to use this template for INI and action planning, but are not required to do so. The Summary and Referral form is informed by any relevant detail from the additional profiles that are used for the particular consumer or from the areas usually investigated by a particular agency or clinician. These are either used or left out depending on the consumer's presenting problems or as a result of any issues arising during the initial contact. As a result this page will usually be completed at the end and is used as a basis (in conjunction with subsequent assessments and care plans) for putting together the service coordination plan (if required).

The Summary and Referral form may be used in a duplicate fashion to cover multiple problems with differing levels of confidentiality requirements. It can be used if the information is sensitive and not to be shared, in which case the interviewer can complete a separate copy of page 2 for each issue. For example there may be two issues—seeing the dentist and getting referred to a sexual assault service—and it may not be relevant or necessary to share all information for both referrals. The Profiles are completed only if they are relevant to the client's presenting problems and needs and after the core information has been collected. The core information is recorded in the Consumer Information and Summary and Referral components. The assumption is that the next stages of referral, assessment or care planning, or service coordination, is a continuation of that process, and that the core consumer information will therefore already be available.

About the Profiles

There are five supplementary profiles. The five supplementary forms cover profiles of living arrangements, health conditions, psychosocial factors, a functional screen and health behaviours. These are domains that can be investigated at the discretion of the contact worker and depending on the nature of the consumer's problem. In some cases, there will be no need to complete any of these supplementary domains. However, for consumers with complex needs, contact workers may choose to use several forms to identify their initial needs. Complete only those profiles that are relevant for the consumer The Profiles are not a structured interview. Do not ask consumers about issues in the order that they are listed if they are inappropriate in the context. The Profiles are designed to be completed based on all sources of information available to the person completing them (observation, information contained in a referral letter, consumer notes or information provided to you by a carer or referring agency). Record NA for any issues that you have either not canvassed or that are inappropriate for the consumer unless otherwise instructed. The design of the set of profiles assumes that children and adolescents will be directly referred for a relevant assessment to be completed. The Profiles are not designed as a diagnostic tool, nor are they considered to be an assessment. They are tools to help determine the consumer's risk, eligibility, priority for service and health promotion opportunities as early in their contact with the service system as possible. This set of optional domains has been chosen by combining evidence from the literature, a review of the range of forms currently in use, and consultations with the field on different draft versions of data collection tools. They can be used to further investigate the scope of the consumer's needs at the initial contact point. The Living Arrangements and Functional Profile forms should be completed for all consumers requiring Home and Community Care (HACC) services. These two profiles contain HACC minimum data set (MDS) items and the collection of this information during the INI process will mean that the information will not need to be collected at a later time. The remainder of the HACC MDS will be collected at the assessment stage.

About the Service Coordination Plan

This is the fourth guideline in the Service Coordination Tool Template suite and is designed for those completing the Service Coordination Planning tool. The Service Coordination Plan (SCP) should be used with consumers with both multiple agency involvement and complex needs. The Service Coordination Plan form brings together all the different information that is useful for service coordination for those consumers that require this level of intervention. It covers the contact details of the key worker and other participants, a series of prompts for the collation or collection of evidence of consumer needs, a description of the consumer's problems/issues and associated goals, and the current required approach to consent and information disclosure as part of planning.

There is no one definition of 'complex' that is appropriate to all age groups and service types. As a general guide, consumers who should have a SCP are those who:

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

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

In relation to goals please note (text from guideline 4 page 8):

6. As an additional aid to making sense of the goal of the consumer and provider's plan, by using one of the following five codes, more generic and mutually exclusive goals can be coded and described:

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

Appendix 6: Frequently Asked Questions (Practitioners)

Problem	Suggestion
A client changes address and the Consumer Information form needs to be superceded	The new address is recorded on a new Client Information form, which is then attached to the old form. (The other information is not duplicated). The `superceded box' at the bottom of the old form is filled in by the practitioner.
A client is referred to another member agency. The Referral Feedback sheet is sent back indicating however that the agency has a long month waiting list	The original practitioner contacts the client and advises them of the long waiting period. The practitioner discusses this with the client and checks whether the client is happy to wait and/or offers alternative strategies/referrals as appropriate.
A client is referred from agency A to agency B who have a waiting list - the client has a question and is not sure who to contact.	The referring practitioner will have received a Referral Feedback sheet from the other agency advising of the long waiting list. The practitioner would discuss this with the client, and advise the client whom to contact (ie the original practitioner or the other agency) during the waiting period. The reply will depend on the capacity of the client and the nature of the question - in some cases, the client would retain contact with the referring practitioner; in other cases, it will be appropriate for the client to contact the agency with the waiting list.
A practitioner makes a referral to another member agency and expects to receive the Referral Feedback sheet. However, the practitioner does not receive the Referral Feedback within the specified time frame.	The practitioner contacts the agency they have made the referral to and checks whether they have received the referral, and if so reminds them about the feedback process.
A practitioner makes a referral to an agency who is not a member of the PCP and who does not use the Service Coordination tools.	The practitioner can make the referral using the Service Coordination tools. However, as the other agency is not a member of the PCP they will not receive the Referral Feedback sheets. The practitioner may need to contact the other agency to monitor the outcome of the referral (ie: whether it has been received, accepted, likely action).
A client requests a service and during dialogue it becomes apparent that there may be other needs to be addressed. However, the client does not wish to discuss them at this stage.	The practitioner responds to the consumer's service request. Over time, as rapport is built up with the client, additional needs are identified, discussed and documented.

Problem	Suggestion
A referral is made to another agency and person is placed on a waiting list. Who is responsible for monitoring and follow up?	This depends on the nature of the referral, presenting issues, judgements about risk and duty of care. Consider whether: – The client has an ongoing relationship with the referring agency/practitioner (eg: is receiving service or treatment) and who clearly has responsibility for monitoring/follow up – Responsibility is shared (eg: the client continues receiving a service from one agency but also requires a specialist service from another agency) – Either agency is able to undertake monitoring and follow up due to resource issues, in which case the client, where able, should be instructed to contact the relevant agency
The service coordination forms look different to the forms on our agency's electronic systems.	Most software packages used by DHS funded service providers are being upgraded to incorporate the service coordination tools. Refer to the DHS Service Coordination Implementation Update May 2003 (available on the Primary Health Knowledge Base) which provides an update about the initiatives to support electronic referral between primary care providers and a listing of the status in relation to service coordination of various software programs used by providers.