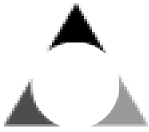
Outer East Health
& Community Support Alliance

Service Coordination Protocol Manual

Representing the Practices, Processes, Protocols and Systems (PPPS) of member agencies of the Outer East Health and Community Support Alliance

November 2002



Outer East Health
& Community Support Alliance

Member Agencies

Organisation	*Telephone*	*Email*
Angliss Health Service	03 9764 6111	angliss.health@angliss.org.au
Care Connect	03 9724 1666	rmatthies@careconnect.org.au
Eastern Access Community Health	03 9871 1800	info@each.com.au
Eastern Drug & Alcohol Service Consortium	1300 650 705	info@each.com.au
Eastern Health	03 9895 3263	info@easternhealth.org.au
Eastern Ranges GP Association	03 9739 6751	ergpa@ergpa.com.au
Knox City Council	03 9298 8000	knoxcc@knox.vic.gov.au
Knox Community Health Services	03 9757 6200	info@kchs.org.au
Knox Division of General Practice	03 9720 2044	admin@knoxdiv.com.au
Maroondah City Council	1300 88 22 33	maroondah@maroondah.vic.gov.au
Maroondah Hospital	03 9871 3333	maroondah.hospital@maroondah.org.au
Outer East Aged Care Assessment Service	03 9724 1610	oeacas@ozemail.com.au
Ranges Community Health Service	03 9739 4577	referral@rangeschs.org.au
Royal District Nurses Service	03 9759 0000	getinfo@rdns.com.au
Richmond Fellowship of Victoria	03 9418 2328	semmett@rfv.org.au
Shire of Yarra Ranges	1300 368 333	mail@yarraranges.vic.gov.au
Villa Maria Society	03 9854 5122	receptioncarerlinks@villamaria.com.au
Whitehorse Division	03 9894 3755	admin@wdgp.com.au
Women's Health East	03 9879 2199	health@whe.org.au
Yarra Valley Community Health Service	1300 130 381	referrals@yvchs.org.au

The Alliance acknowledges HDG Consulting Group who developed the Protocol Manual in consultation with the member agencies listed above.

This document has been prepared by the Outer East Health and Community Support Alliance and it is requested that in using or reproducing this information, appropriate acknowledgment is given to its source.
For further information please contact the Program Manager, Primary Care Partnership, Outer East Health and Community Support Alliance.

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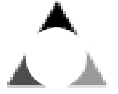
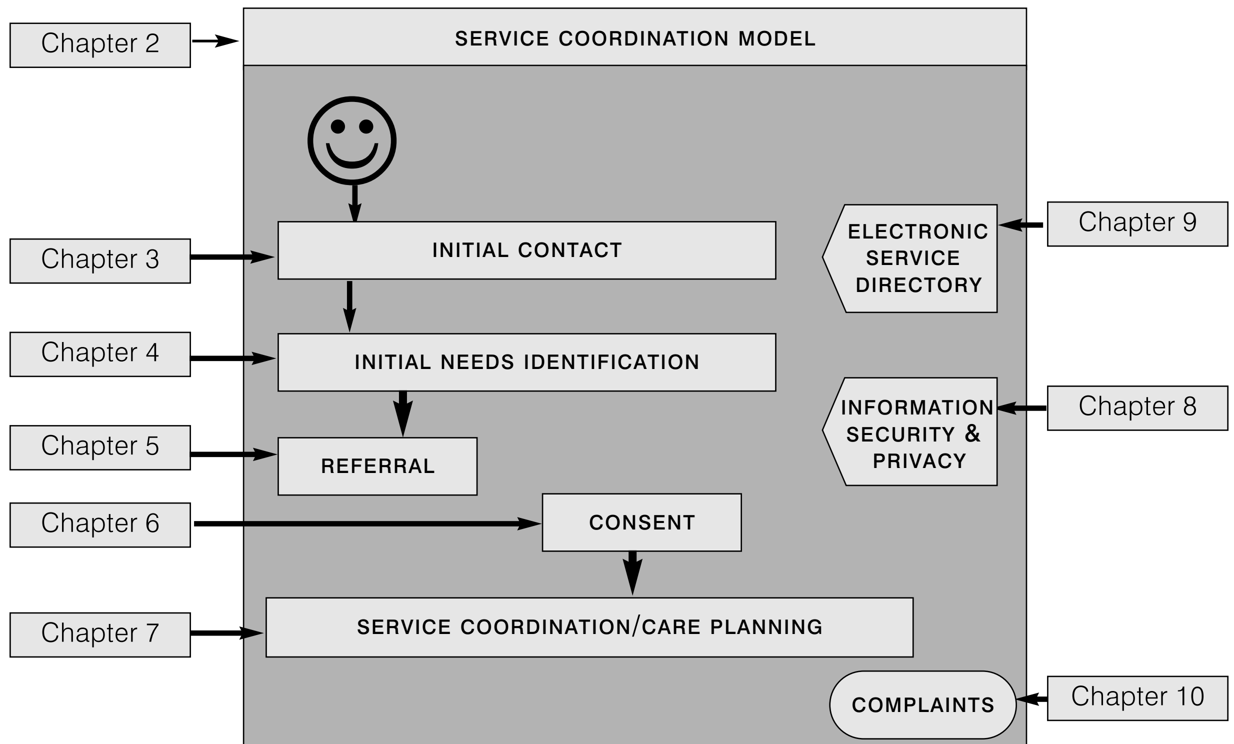


1.0 INTRODUCTION

1.1 Structure of Protocol Manual



1.2 Preamble

In accordance with the Outer East Community Health Plan, the Outer East Health and Community Support Alliance has undertaken to implement a Service Coordination Model across member agencies. The Service Coordination Model reflects the desire to facilitate better access and care outcomes for consumers by improving service coordination and increasing consistency in practice between member agencies. The Service Coordination Model focuses on improving practices, processes, protocols and systems to achieve this.

The Outer East Service Coordination Model is described in section 2. Key components of the Service Coordination Model include the functions of Initial Contact, Initial Needs Identification, Assessment and Care Planning supported by documented protocols, an electronic Service Directory and the capacity for electronic referrals.

One essential part of implementation of the Service Coordination Model by member agencies is the introduction and use of the statewide Department of Human Services Service Coordination Tools and Guidelines, available at www.dhs.vic.gov.au/phkb.

1.3 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[1] and conform to technical and ethical requirements. The use of the tools is intended to aid consistency in practice across primary care agencies.

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. Profiles (5 Profiles) – used to gather additional information.
4. Consumer Consent and the Consumer 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.

1.4 Implementation

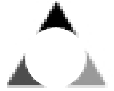
An Implementation and Support Strategy was developed by the Alliance to support implementation of the Service Coordination Model and Service Coordination Tools by agencies and practitioners in the Outer East. Implementation has commenced in a staged approach reflecting the readiness of agencies, and initially has focussed on the Department of Human Services priority program areas for implementation of Home and Community Care (HACC), Aged Care Assessment Services (ACAS), Community Health and Alcohol and Drug services. Implementation of the electronic referral system to support service coordination has commenced with a group of agencies, and will be updated, enhanced and made available to all member agencies in early 2003.

The Implementation and Support Strategy in the Outer East comprises:

- Finalisation of the Protocol Manual.
- Information, education and training sessions for staff.
- The development of a Key Practitioner Reference Group, comprised of practitioner representatives from each agency, to inform, lead, support and market implementation within agencies.
- Support to agencies to plan and achieve implementation.
- Continuation of implementation of the electronic referral system (currently called the Maroondah On Line Referral System) to enable electronic referrals between agencies.
- Introduction of the electronic Service Directory.

For further information regarding the implementation and support strategy please contact the Outer East Alliance PCP Program Manager, Maroondah City Council on 0407 887 801.

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



1.5 Supporting Systems

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

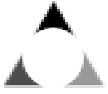
- The Outer East electronic referral system and User Manual
- The Better Health Channel
- The Outer East Service Directory (The PCP statewide Electronic Service Directory is currently available at http://pcpdirectory.health.vic.gov.au)
- Agency information systems
- Agency unique client identifier systems
- Internal agency operational systems
- Internal agency guidelines and procedures
- 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.

1.6 Protocol Manual Development

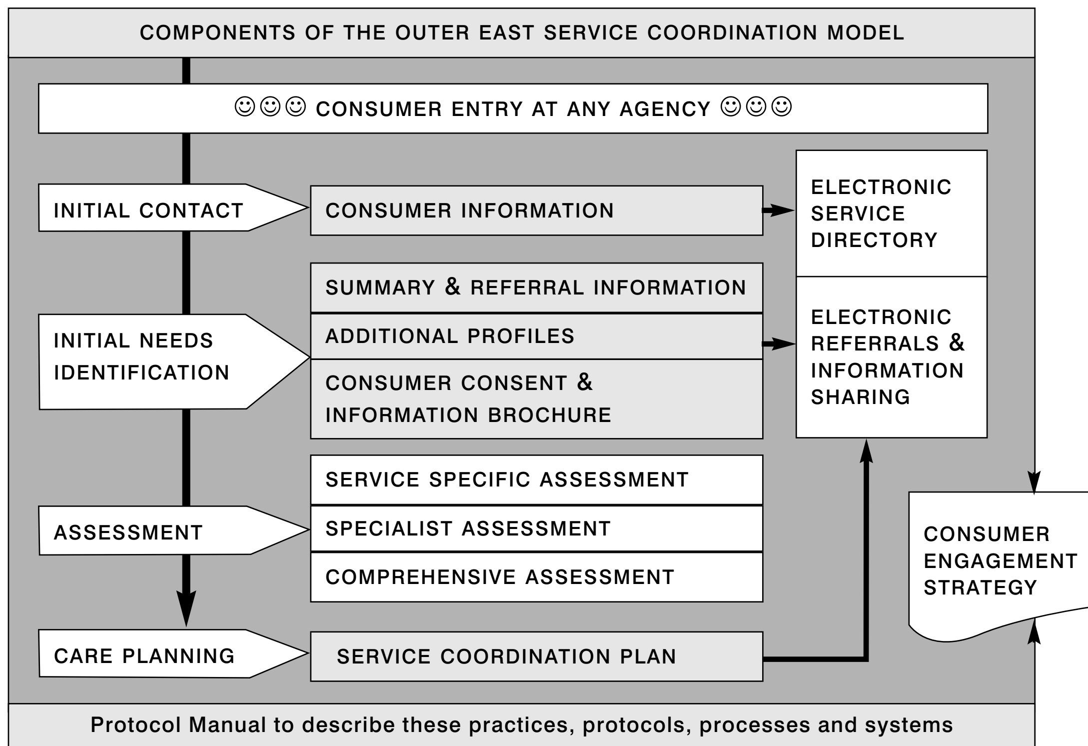
Activity	***Process***	***Date***
First draft of individual chapters	Draft prepared based on source material	April 2002
Consultation on individual chapters	Distribution/consultation at forums	April/May 2002
Second draft	Collation as draft manual and distribution to member agencies	June 2002
Consultation	Feedback via agency visits and information sessions	August 2002
Refined/finalised	Refined based on feedback and final release of DHS Service Coordination Tools and Guidelines and DHS Privacy Kit	August/ November 2002
Endorsed	Alliance Executive	November 2002



2.0 SERVICE COORDINATION MODEL

2.1 Service Coordination Model

The vision of the Outer East Alliance is 'to provide a framework for a functionally integrated and coordinated service system, with the aim to provide a better understanding and improved access for service users and providers'.

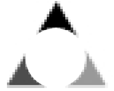


In interpreting this vision, the Outer East Service Coordination Model incorporates the six elements outlined in the Department of Human Services policy document 'Better Access to Services – A Policy and Operational Framework' (June 2001). These are:

- Initial Contact
- Initial Needs Identification
- Service Specific Assessment
- Specialist Assessment
- Comprehensive Assessment
- Care Planning

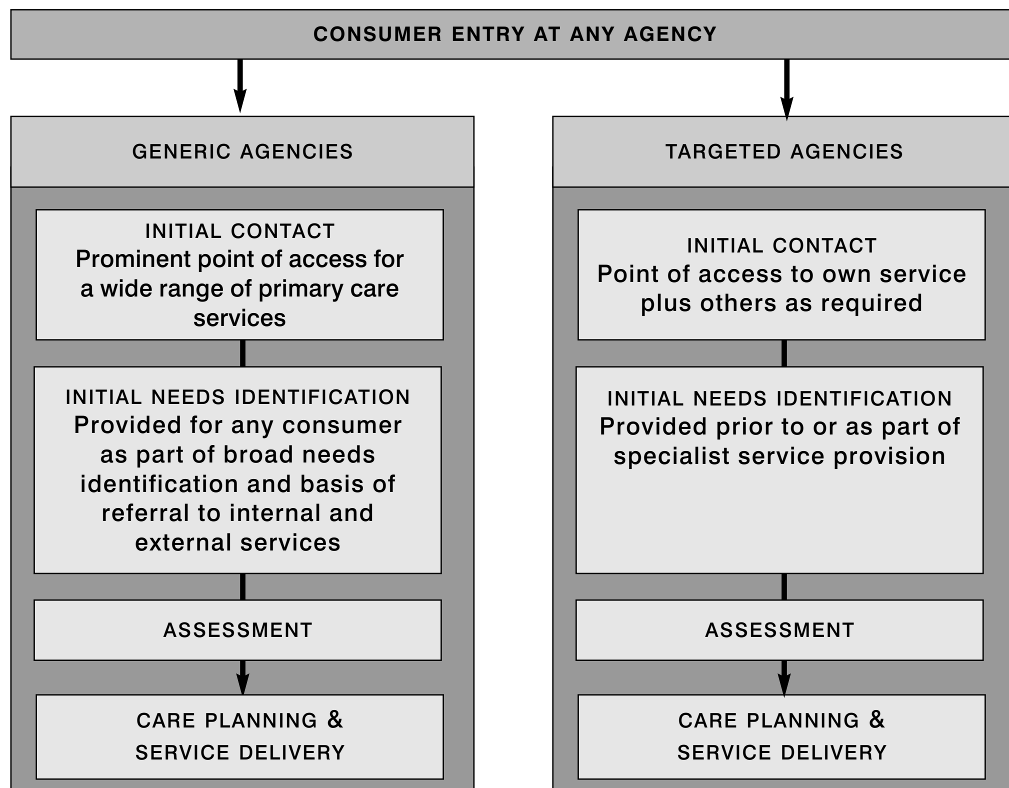
In addition to these elements are:

- Consumer Consent and a Consumer Information Brochure *'Your Information: It's Private'*
- Protocols
- Electronic Service Directory and electronic referrals/consumer information transfer.



2.2 Interpretation and Application of the Outer East Service Coordination Model

The Outer East Alliance provided an interpretation of this model in its Community Health Plan (June 2001) and more recently during the consultation forums and agency information sessions (May–August 2002).

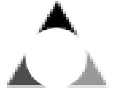


Key features of the interpretation of the Service Coordination Model by the Outer East Alliance are:

- That every service site is an entry point for consumers – consumers will receive a consistent response in accordance with the Initial Contact Protocol regardless of where they first make contact or which agency they approach.
- That some agencies provide a generalist Information, Intake and Referral service for all consumers as part of a broad needs identification process. In the Outer East for this purpose these agencies are termed ‘Generic Agencies’. These generic agencies undertake the Initial Needs Identification process for a broad range of consumers with a wide range of presenting issues, and are identified as a prominent point of access to the service system.
- That some agencies provide a targeted intake service as part of their specialist service provision. In the Outer East for this purpose these agencies are termed ‘Targeted Agencies’. These targeted agencies undertake the Initial Needs Identification process for an identified target population for whom they also provide specialist services.
- That agencies may have periods when they do not have the capacity or skilled health professionals to provide Initial Needs Identification and will after the Initial Contact process refer to other agencies for Initial Needs Identification accordingly.

Table 1: Differentiation between Generic Agencies and Targeted Agencies

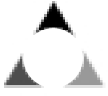
	Generic Agencies	*Targeted Agencies*
Identification	Identified and prominent point of access to broad service system	Perceived by the community as a particular service type
Inquiries	Broad range	Usually regarding a specific service
Age	Wide age range and/or specified target populations	Usually specified target populations
Presenting issues	Broad range, may be related or not related to services agency provides	Usually related to service type
Initial Contact	Point of access for a broad range of primary care services	
Initial Needs Identification	Increased emphasis on provision of broad needs identification as a discreet and thorough screening process prior to further action such as referral to a range of services or assessment	Provision of needs identification often leading directly to assessment or service provision by the agency
Skills	Information, Intake and Referral workers are skilled in the broad needs identification process	Practitioners with specialist skills to match agency target population and service type
Referral	Tend to make a large number of referrals to internal and/or external programs	Generally provide services on referral from another agency (rather than direct contact by a consumer) Make referrals as required
Assessment	Service specific and/or comprehensive and/or specialist	
Care Planning	As appropriate	
Service Delivery	Often offer multiple services across a range of program areas	Tend to be more service specific
Systems	Systems to enable seamless transition through initial contact, initial needs identification, referral, assessment and service provision	
Technology	Electronic referral capacity is important due to the large number of referrals. Access to Service Directory	May or may not have electronic referral capacity. Access to Service Directory
Infrastructure	Specific resourced Information, Intake and Referral setting. Information, Intake and Referral practitioner support and training	Intake often shared by practitioners



Alliance member agencies have considered their position as to whether they are best represented as a Generic Agency or a Targeted Agency for the purposes of the Service Coordination Model. Table 2 indicates individual positions as Generic or Targeted for those agencies falling within the Department of Human Services identified priority areas for implementation of the Service Coordination Tool Templates. The Alliance plans to develop a functional brief to further clarify the vision and expectation of Generic Agencies in relation to service coordination.

Table 2: Agency Focus for Service Coordination (Indicative only)

Agency Name	*Generic Agency*	*Targeted Agency*
ACAS		✓
Care Connect		✓
Eastern Access Community Health	✓	
Eastern Drug & Alcohol Service Consortium		✓
Knox City Council	✓	
Knox Community Health Service	✓	
Maroondah City Council	✓	
Ranges Community Health Service	✓	
RDNS		✓
Shire of Yarra Ranges	✓	
Women's Health East		✓
Yarra Valley Community Health Service	✓	



3.0 INITIAL CONTACT

3.1 Initial Contact: Practice

The practice of Initial Contact is the first essential element of the Alliance's vision to achieve better access to services and outcomes for consumers. 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 they communicate with. It is the practice of:

- Collecting basic information about the consumer, 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 service.

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.

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.
- 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).

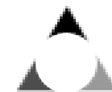
Initial Contact will usually (but not always) proceed to Initial Needs Identification, assessment, care planning and service delivery.

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

3.2 Initial Contact: Protocol

In accordance with the Outer East Service Coordination Model, all member agencies have committed to provide Initial Contact as an entry point to the Outer East 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 have undertaken to:

- Use 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 the Service Directory to provide service information to inquirers and consumers/carers about relevant health and other community services.
- 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[2] for consumers with hearing impairments
  - – Response to special communication needs
  - – Respect of anonymity where practical.
- Facilitate the consumer's access to Initial Needs Identification (where they require more than simply the provision of information).
- Make a referral to another agency to undertake Initial Needs Identification if the first contact agency does not have the capacity or skilled health practitioners to undertake Initial Needs Identification.
- Use 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 the electronic referral system to transmit consumer information contained on the Consumer Information form to another agency; or use the fax Referral Cover Sheet (see Chapter 5: Referral Protocol).
- 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.
- Ensure staff members undertaking Initial Contact meet critical factors in relation to skill, expertise and competency. For example:
  - – Understanding of the Outer East Service Model
  - – In-depth knowledge of the Outer East service system
  - – The ability to use the Service Directory
  - – The ability to use the electronic referral system 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 etc
  - – Access to professional decision support (eg: peer support, staff supervision)
  - – Competency standards being developed by the Department of Human Services.

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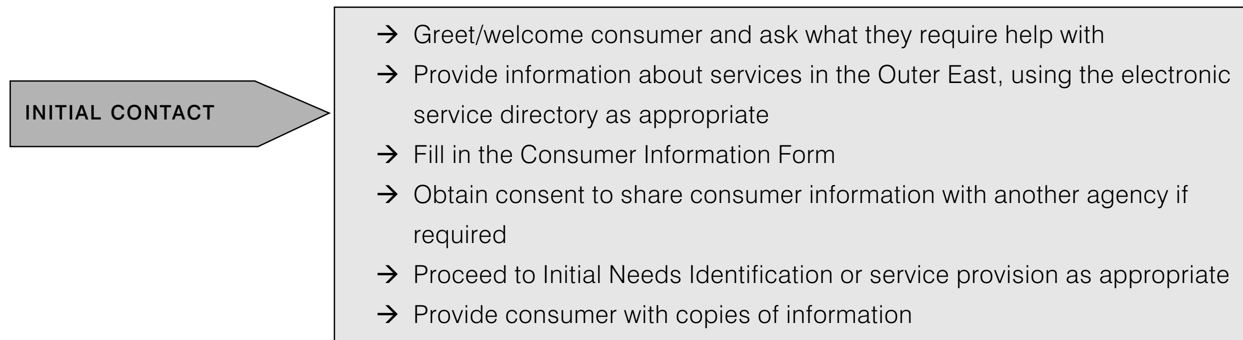
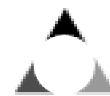
2. Telephone typewriter communication system used by people with hearing impairments

3.3 Initial Contact: Processes



- 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. The degree of detail and amount of information collected will vary from individual to individual. It is not expected that all items will be completed for every consumer. Information may not be collected at the first contact but may be built upon over time.
- The Service Directory is used to provide information about services to the consumer, including print-outs of the information where appropriate.
- The Consumer Information Form is provided to the practitioner undertaking Initial Needs Identification. Where this is through another agency, the Consumer Information form is transmitted either electronically or by fax (using the fax referral cover sheet) after the consumer's consent to the disclosure of their information is gained.
- 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.
- 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 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.



4.0 INITIAL NEEDS IDENTIFICATION

4.1 Initial Needs Identification: Practice

Initial Needs Identification is an essential element of the Alliance's vision to achieve better access to services and outcomes for consumers. 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.

Initial Needs Identification can consider the consumers' social, psychological, medical and physical needs and allows health promotion opportunities to be identified. It includes a determination of the consumer's risk, eligibility and priority for service. The consumer's presenting circumstances determine how brief or intensive this practice is. Following the process of inquiry, the practitioner undertaking Initial Needs Identification informs the consumer about the range of service options available across the Outer East to meet their needs. The outcome of Initial Needs Identification may be referral for assessment and/or referral to services.

Initial Needs Identification 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) the full range of the consumer's needs including 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.
- 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, and access to service.
- Making referrals using the electronic referral system or via fax.

Initial Needs Identification is undertaken following Initial Contact. In some agencies, it is undertaken as a discreet needs identification process; in other agencies it may be incorporated in the assessment process[3]. Key modes of Initial Needs Identification include face-to-face dialogue (in-agency and outreach) and telephone dialogue, implemented in a manner responsive to the differing needs of consumers.

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3. See section 2.2 regarding Generic and Targeted agencies

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 – an analysis of the consumer's request and referral for assessment and/or service, building on the information collected at Initial Contact and completed at the conclusion of the Initial Needs Identification process.
- 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.
- Living Arrangements and Functional supplementary profiles for HACC referrals[4].
- Other profiles as appropriate.

Initial Needs Identification will normally proceed to assessment, service coordination/care planning and service delivery.

4.2 Initial Needs Identification: Protocol

In accordance with the Outer East Service Coordination Model, member agencies have agreed that all agencies will provide Initial Needs Identification (refer Chapter 2: Service Coordination Model). Accordingly, Generic Agencies will offer and supply the Initial Needs Identification function broadly and as a discreet and widely promoted function; whilst Targeted Agencies will incorporate it into their normal agency specialist functions.

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 undertaken to:

- Ensure that practitioners are competent to perform this function, based on competency standards to be developed by the Department of Human Services and the Alliance. For example:
  - Ability to establish rapport with consumers, communicate sensitively, respectfully 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)

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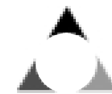
4. Refer DHS FAQ Sheet for HACC Agencies (August 2002) which specifies that those HACC agencies funded for Assessment and Care Management should implement the Living Arrangements profile and the Service Coordination Plan; and those HACC agencies participating in the 2002–03 pilot collection of dependency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

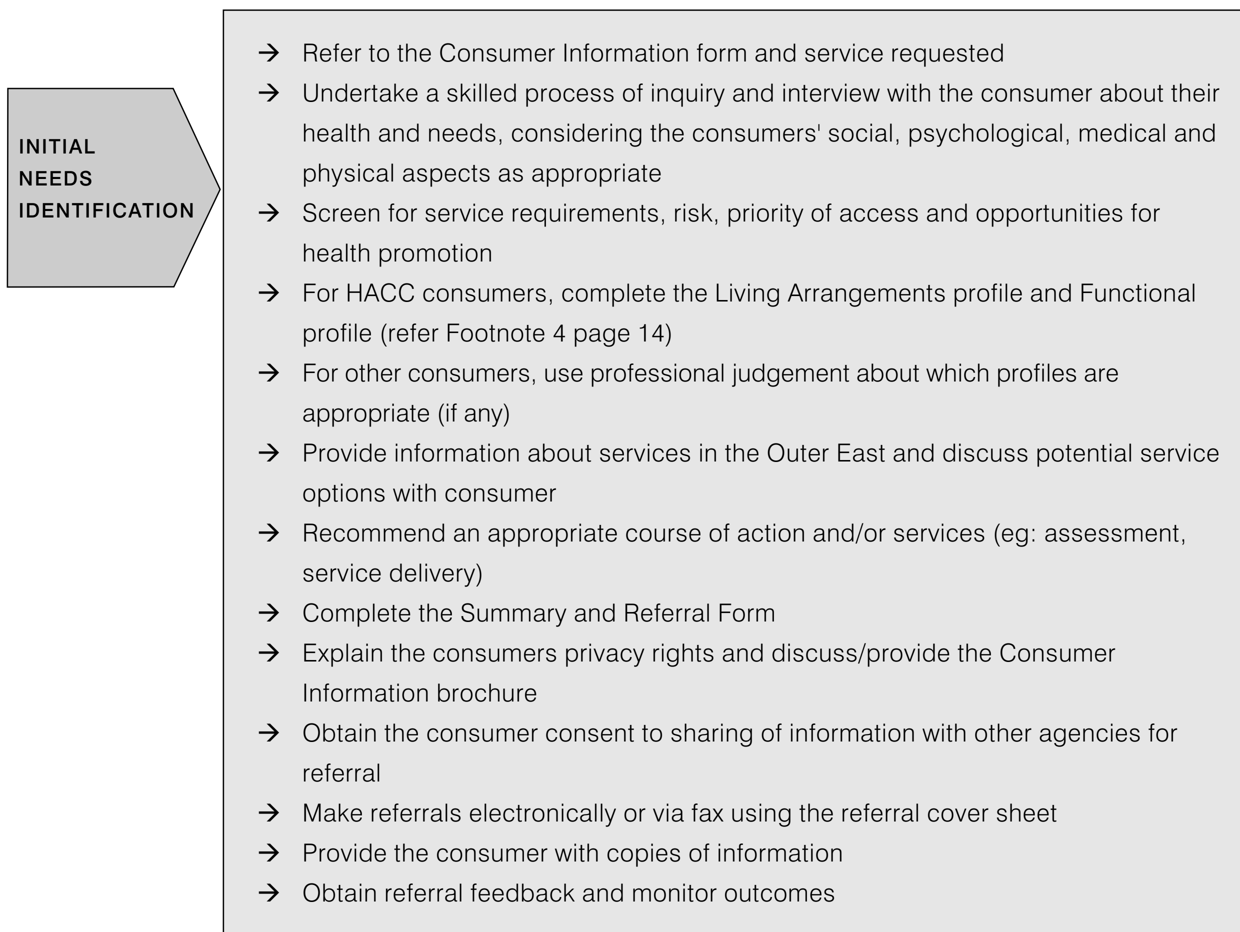


  - Ability to gather information from more than one source
  - Ability to make professional judgements in relation to risk, eligibility and priority for service
  - Ability to attend to the core business of the agency to which they belong
  - Ability to provide a response to manage urgent situations and immediate risks to consumer
  - Ability to identify health promotion opportunities
  - Knowledge of crisis response services and response mechanisms for consumers who require services urgently
  - Knowledge of circumstances in which referral can be made without the consumer's s consent (eg: serious imminent threat to the person's life)
  - Knowledge and compliance with Privacy legislation etc.
- Ensure staff members undertaking Initial Needs Identification meet critical factors in relation to the Outer East service system and statewide services. For example:
  - Understanding of the Outer East Service Coordination Model and in-depth knowledge of the Outer East service system
  - The ability to use the Service Directory and the Outer East electronic referral system to make electronic referrals (when available)
  - Demonstrated knowledge of and practical application of the Outer East Protocol Manual
  - Knowledge of statewide services.
- Build upon consumer information collected at Initial Contact on the Consumer Information form.
- Undertake an in-depth process of Initial Needs Identification for the purpose of screening for service requirements, risk, priority of access and opportunities for health promotion.
- Use the Service Directory to ascertain appropriate services, checking eligibility for services, geographical and cultural considerations.
- Communicate the range of services and options potentially available to the consumer and assist the consumer in making decisions and informed choices.
- Use 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).
- Make professional decisions 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.
- Use the Summary and Referral Information form to list and summarise needs, record action and make referrals between agencies. Referrals will be made electronically as this becomes available, or via fax. The referral cover sheet will be used for paper-based referrals.
- Facilitate access directly to services as appropriate (eg: single service request) including direct telephone transfers and/or making appointments where this facility is available.
- 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[5] for consumers with hearing impairments
  - Response to special communication needs
  - Respect of anonymity where practical.

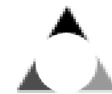
5. Telephone typewriter communication system used by people with hearing impairments

- Advise consumers of their rights and about what happens to their personal information, through the provision of the consumer information brochure.
- Provide a hard copy of Initial Needs Identification information to the consumer/carer as practicable.
- Ensure Privacy Standards are met (refer Privacy and Security Protocol).

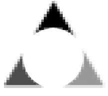
4.3 Initial Needs Identification: Processes



- 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 (eg: Targeted Agencies), Initial Needs Identification may be included as part of the assessment process.
- To facilitate and streamline the process, where the agency undertaking Initial Contact does not offer Initial Needs Identification, the worker will offer to:
  - Make an immediate and direct telephone link with an agency that does provide Initial Needs Identification
  - Make an appointment for the consumer at a suitable time at an agency that does provide Initial Needs Identification and provide relevant details on the agency conducting Initial Needs Identification 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.
- 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 *'Your 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

Referral is the practice of transmitting and receiving requests for action and personal and/or health information relating to an individual from one service provider(s) to another for the purpose of assessment, service delivery, care or treatment. As referral includes the transmission or disclosure of consumer information, the individuals' consent is gained.

The introduction of the electronic referral system is an essential element of the Alliance's vision to achieve better access to services for consumers. The electronic referral system is designed with the capacity for agencies to centrally refer consumers, as well as to store referrals and consumer details. This means that practitioners can both send referrals (outgoing referrals) and receive referrals (incoming referrals).

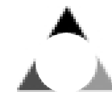
Referral is the practice of:

- Analysing 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 transmit personal information (refer Consumer Consent Protocol).
- Making referrals to services to generate further action on behalf of the consumer, including assessment, service provision, treatment or care.
- Monitoring the outcome of the referral (eg: acknowledgement of receipt of referral, service response to referral).
- Receiving referrals for action (eg: assessment, service delivery).

The practice of referral can occur at many points through the service continuum. For example: referral from Initial Contact in one agency for Initial Needs Identification at another agency; referral following Initial Needs Identification for assessment; referral directly for service provision.

Key modes of referral are electronically via the electronic referral system (refer Appendix 1), via fax using the referral cover sheet (refer Appendix 2) telephone, or mail. Forms used to support the practice of referral are:

- Consumer Information.
- Summary and Referra.l
- Profiles (where used).
- Consumer Consent form.
- Alliance fax cover sheets for paper-based referrals (Appendix 2).



5.2 Referral: Protocol

In accordance with the Outer East Service Coordination Model member agencies have agreed to implement and use the electronic referral system as it becomes available, where it has the capacity to interact with existing systems where required, and where it is acceptable to individual consumers. Agencies can visit a demonstration site at www.maroondah.infoxchange.net.au (a test username and password is required) for on-line viewing and to see how this system works.

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.

To send outgoing referrals and receive incoming referrals, member agencies have undertaken to:

- Ensure staff members base referrals on analysis of information gained through the Initial Contact and Initial Needs Identification processes.
- Use the Summary and Referral Information form to record a summary of the consumer's problems/issues, outline an initial action plan and document referral information and action.
- Ensure consumers have a choice between accessing the electronic referral (and storage) system and/or requesting that their information is limited to a paper based non-shared referral system.
- Use the electronic referral system to transmit referral and consumer information as this becomes available and practicable and where it is acceptable to consumers; and ensure staff members using the electronic referral system are trained in the use of the system and comply with relevant guidelines including User Responsibilities established by the information system provider.
- Ensure practitioners usually responsible for sending outgoing referrals and/or receiving incoming referrals electronically have access to a secure computer that is permanently 'on-line' and located in individual agency settings where Initial Contact/Initial Needs Identification occurs.
- Ensure the Outer East electronic referral system is managed and maintained by a suitably qualified information technology systems provider through a contract incorporating all participating agencies as respondents.
- Where this electronic referral capacity is not available, agencies will send referrals via fax using the following fax cover sheets:
  - The Referral Cover Sheet, for sending referrals
  - The Feedback Sheet, to provide feedback to the referring agency about the action taken in response to the referral by the receiving agency, in accordance with the timeframes indicated on the sheets,
  - The Service Outcome Sheet, to notify the referring agency of the service outcome as a result of the referral.
- Use 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). The consumer may decline consent for some of the information to be sent provided there is adequate information to make the referral.

- 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 (refer Consumer Consent Protocol).

5.3 Referral: Processes

- 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 Consumer Information, Summary and Referral Form and supplementary Profiles (as appropriate) to make referrals to appropriate agencies identified from the Service Directory.
- 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 issue.
- Consent is to be gained from the consumer for the sharing of information for referral purposes.
- The process for referrals may vary between agencies:
  - In some agencies referrals will be made (outgoing referrals) and received (incoming referrals) using the electronic referral system
  - In some agencies, referrals will be made (outgoing referrals) and received (incoming referrals) using a paper-based secure fax with the fax cover sheets (see Appendix 2).
- Agencies receiving referral information provide feedback to the referring agency including confirmation of receipt of referral information and the outcome of this:
  - Agencies using the electronic referral system will use that system to provide referral feedback
  - For agencies using a paper-based secure fax, the referral cover sheet and feedback form will be used.
- 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.

6.0 CONSUMER CONSENT

6.1 Consumer Consent: Practice

This consent protocol relates only to consent for the use and disclosure of personal and health information. The practice of gaining consumer consent for the use and disclosure of health information is an essential element of the Alliance's vision to achieve better access to services and improve service coordination for consumers.

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.

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[6]. 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.

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[7].

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 kind of 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 consumer consent at specific points when using the Outer East electronic referral system to view, store or transmit data.
- Gaining and recording the consumer's consent on the standard DHS Consumer Consent Form to record consent.
- Updating consent so it is current where there has been a lapse of time or change in circumstances.

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6. DHS Privacy Kit August 2002: Information Sheet 5 – Use and Disclosure
7. DHS Privacy Kit August 2002: Information Sheet 6 – Capacity and Consent

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 care plans are shared between agencies.

Key modes of gaining consent include face-to-face dialogue (in-agency and outreach) and telephone dialogue, implemented in a manner responsive to the differing needs of consumers.

Forms used to support the practice of gaining consumer consent are:

- Consumer Consent Form: – consent by the consumer to the disclosure of information for referral purposes
- *'Your Information: It's Private'* – Consumer privacy information brochure

The reference document is the DHS Privacy Kit: August 2002.

6.2 Consumer Consent: Protocol

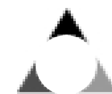
In accordance with the Outer East Service Coordination Model and relevant legislation, all member agencies have committed to implement this protocol. This includes compliance with advice, information sheets and guidelines regarding this matter as provided by the Department of Human Services.

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[8].

To obtain consumer consent for the use and disclosure of information, member agencies have undertaken to:

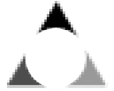
- Communicate the range of services and options potentially available to the consumer and assist the consumer in making decisions and informed choices.
- Request and obtain consumer consent to the use and disclosure of information.
- Utilise professional judgement as to the consumer's capacity to provide consent.
- Where the professional judges that the consumer **DOES NOT** have the capacity to provide consent, to consult an authorised representative to make decisions on behalf of the consumer. In doing so, the practitioner will:
  - obtain consent from a 'nominated' authorised representative (eg: a person with enduring power of attorney), or
  - obtain consent from an 'appointed' authorised representative (eg: person appointed through a statutory order such as a Guardianship or Administration order), or

8. 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.



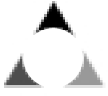
  - obtain consent from a person nominated by the consumer, such as a family member, carer or friend, whose position is supported by a signed and witnessed statement to that effect
  - verify the status of this person by sighting the relevant documentation, or
  - will record the fact they were unable to sight the documentation and note all relevant details, where sighting the documentation is not possible.
- 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. In doing so:
  - The practitioner will document the grounds for this judgment
  - This person may be a family member, carer or friend who is able and willing to act in the consumer's best interests
  - This person may be an independent practitioner not involved in the consumer's treatment who is able and willing to act in the consumer's best interests
  - Where no suitable person is available, advice will be sough from the Office of the Public Advocate.
- Where the professional judges that the consumer **DOES** have the capacity to provide consent but has instructed or nominated a carer or family member to make contact with the service on their behalf, the practitioner will make contact with the consumer to verify their nomination of this person as their authorised representative regarding future communication.
- Consent may not be required in a limited number of circumstances where:
  - It is necessary to provide a health service to an individual, the individual is incapable of giving consent and there is no authorised representative or it is not practicable to get consent from that representative
  - There is a serious threat to the health, safety or welfare of the individual; or to public health, safety or welfare
  - It is permitted or required by law.
- The practitioner will document the grounds for this judgment 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) it is permissible for the practitioner to act without consent to lessen or prevent the threat.
- In relation to children and adolescents under 18 years of age, the practitioner will request consent from the child or young person 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 or young person does not have the capacity to give consent, consent can be given by their parent or authorised representative.
- Ensure the mode of communication facilitates the consumer communicating with ease. This includes the use of interpreter services with CALD consumers; and the use of TTY for consumers with hearing impairments.
- Respect the cultural requirements of consumers.
- Use the Consumer Consent form to obtain consumer consent to the sharing/disclosure of consumer information in accordance with the DHS Guidelines for doing so. This includes:
  - Gaining written consent wherever possible, signed by the consumer and witnessed (by another person or the practitioner)

  - Accepting verbal consent only where it is not reasonably practical to obtain written consent. (eg: where the Initial Needs Identification is being undertaken by phone)
  - Gaining written consent where part of the Initial Needs Identification is completed by phone and the consumer subsequently attends an appointment for completion of the Initial Needs Identification process or to access assessment or service provision from the same agency.
- Comply with the requirements for consent in viewing, storing or transmitting consumer information via the Outer East electronic referral system. This includes:
  - Advising the consumer that their consent to view the system will provide information about them
  - Advising the consumer that the information collected will be stored in a permanent electronic record that should only be viewed by other practitioners in other agencies with the consumer's consent to do so
  - Advising the consumer that any viewing of their record will identify the practitioner doing so
  - Showing and/or explaining to the consumer sample screens to assist them in making a decision about giving consent
  - Gaining consent to search the system for the consumer's details
  - Gaining consent to view a list of Initial Needs Identification and/or referral events
  - Gaining consent to view Initial Needs Identification and/or referral content
  - Gaining consent to transmit referral information
  - Advising the consumer that they can refuse their consent to any of these activities
  - Advising the consumer that if consent is not given they may have to repeat information previously provided or alternatively that their information can be transmitted by fax and stored only by the generating and receiving agencies
  - Advising the consumer they may vary or withdraw their consent at any time.
- Provide the consumer with the consumer privacy information brochure.
- Provide a hard copy of the consent form and any attachments (eg: Consumer Information form, Summary and Referral form) to the consumer/carer as practicable.
- 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.
- Ensure Privacy Standards are met (refer Privacy and Security Protocol).



6.3 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, ideally 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.



7.0 CARE PLANNING

7.1 Care Planning: Practice

Care planning is an essential element of the Alliance's vision to achieve better access to services for consumers. It is aimed at improving and supporting communication and the sharing of information between service providers.

Care 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 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.

Service coordination may be required where consumers require multiple services. Documented Service Coordination Plans are designed for use with consumers with both multiple agency involvement and complex needs.

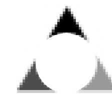
Care Planning is the practice of:

- 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 (where appropriate).

Care Planning is undertaken following Initial Needs Identification and/or Assessment.

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 and meets the 10 minimum requirements of General Practitioners claiming for relevant items under the Enhanced Primary Care (EPC) program.



7.2 Care Planning: Protocol

In accordance with the Outer East 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.

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

- Utilise health care practitioners who are competent to perform this function, based on competency standards to be developed by the Department of Human Services, and ensure staff members undertaking Service Coordination meet critical factors in relation to the Outer East service system. For example:
  - Understanding of the Outer East Service Model and in-depth knowledge of the Outer East service system
  - The ability to use the Service Directory to inform Service Coordination Plans
  - Demonstrated knowledge of and practical application of the Outer East Protocol Manual
  - The ability to facilitate communication between service providers and coordinate service provision across Outer East, regional and statewide agencies.
- 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.
- Use the Service Coordination Plan form to record consumer goals, action to be taken, service provision agency responsible and review dates.
- Nominate a key worker[9] to promote effective communication between all service providers. Where case management is available, this will provide more detailed management of all aspects of care provision.
- Ensure multiple agency service delivery is efficient, effective, avoids duplication of services and ensures continuity of care.
- 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 (Refer Consumer Consent Protocol).
- Provide a copy of the Service Coordination Plan to the consumer.
- Ensure Privacy Standards are met (refer Privacy and Security Protocol).

9. The key worker role may be undertaken by the consumer or other responsible person including a practitioner involved in their care.

7.3 Care Planning: Processes

CARE PLANNING

- → Refer to documentation generated through the Initial Contact, Initial Needs Identification and Assessment processes
- → Obtain consent to share the Service Coordination Plan and other consumer information with other agencies if required
- → Communicate with other service providers engaged/needed in the consumer's care
- → Discuss care planning options and clarify roles and communication including identification of the key worker
- → Complete the agency care plan for consumers with single agency needs
- → Complete the Service Coordination Plan for consumers with complex needs and multiple program/agency involvement
- → Provide a copy of the plan to other agencies and the consumer
- → Monitor and review the plan as documented and/or as needs change

- 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.
- 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.
- 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.

8.0 INFORMATION PRIVACY AND SECURITY

8.1 Information Privacy and Security: Practice

Information privacy and security is an essential element of the Alliance's vision to achieve better access to services and improve service coordination for consumers.

Information privacy and security applies to all forms of personal and health information whether paper based, electronic or in some other form. 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 Information Privacy Act (IPA) 2000 and the Victorian Health Records Act (HRA) 2001 guides the approach of the Alliance to information privacy and security. The HRA is the privacy law that applies to most information handled by Alliance 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[10].

Information privacy is the practice of:

- Identifying the primary purpose/s for collection of information with the consumer and collecting only the information needed for that purpose.
- Informing the consumer why the agency/practitioner needs the information and how it will be handled.
- Not sharing the information collected for one purpose for another purpose without the consumer's consent.
- Respecting consumer confidentiality and gaining consent prior to disclosure of consumer information (refer Consumer Consent Protocol).
- Providing the consumer with access to their information on request in accordance with the agreed protocol and process.
- Provision for correction or amendment of information.

Information security refers to the protection, retention and disposal of personal and health information to safeguard it from loss, unauthorised access or misuse[11].

10. DHS Privacy Kit August 2002: Information Sheet 1 – Introduction to Information Privacy
11. DHS Privacy Kit August 2002: Information Sheet 8 – Security of Information

Information security is the practice of:

- Keeping and storing consumer information (paper based and electronic) securely.
- Disposing of consumer information in accordance with statutory requirements and time lines.

Information privacy and security practices occur throughout the entire service delivery continuum.

Forms used to support the practice of privacy and security are:

- Consumer Consent Forms (refer Consumer Consent Protocol.
- *'Your Information: It's Private'* – Consumer privacy information brochure.
- Fax Referral, Feedback and Service Outcome sheets (see Referral Protocol).
- Forms embedded within the electronic referral system.

8.2 Information Privacy and Security: Protocol

In accordance with the Outer East Service Coordination Model and relevant legislation, all member agencies have committed to implement this Information Privacy and Security protocol. This includes compliance with advice, information sheets and guidelines regarding this matter as provided by the Department of Human Services.

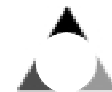
Member agencies have undertaken to adapt their current practices and procedures to reflect this umbrella protocol, and/or ensure that their own agency protocols are consistent with and incorporate mechanisms which give effect to the outcomes intended by these protocols. Within this context, member agencies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

All member agencies will identify a Privacy Officer[12] with key responsibility for the implementation of this Privacy and Security Protocol and the handling of complaints (refer Complaints Protocol). Privacy Officers from member agencies will coordinate a Privacy Officer Network and meet periodically throughout the course of a year (eg: to monitor privacy practice, complaints, trends etc). One agency may be nominated as the lead privacy agency to handle all privacy related issues that cannot be resolved internally, on behalf of member agencies.

To ensure information **PRIVACY**, member agencies have undertaken to:

- Ensure staff are trained in relation to this Information Privacy and Security Protocol.
- Only collect information about a consumer that is necessary for Initial Contact, Initial Needs Identification, Assessment and Service Coordination/Care Planning and reporting requirements.
- Notify the consumer about the purpose and use of their information.

12. Draft Role Statements for Privacy Officers are included in the Western Region DIY Privacy Kit for Primary Care Agencies available on the Primary Health Knowledge Base

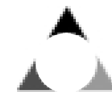


- Gain consumer consent to the disclosure of their personal and health information (refer Consent Protocol).
- Ensure the information collected, used or disclosed is reasonably up-to-date, accurate and relevant to the current provision of care.
- Ensure only authorised staff can access consumer health information. Administrative staff will not have permission to access information beyond consumer contact details for administrative purposes.
- Make the Privacy and Security Protocol available to anyone upon request.
- Advise, on request, the consumer about how and why their health information is held.
- Provide access on request and in accordance with a formal process to consumers about their own personal and health information. This includes:
  - For information collected before 1 July 2002, access to factual clinical, diagnostic and treatment or planned management material in summary form, at a minimum
  - For information collected after 1 July 2002, access to all relevant health information, in full and in the agreed form
  - Exceptions to access can occur when access would: provide a serious threat to the life or health of the consumer; the information was given in confidence by another person unless that person consents; affect the privacy of another person; be unlawful; or be likely to prejudice law enforcement
  - Advising consumers of their right to access and correct information.
- Notify consumers of the formal process for seeking access and implement this process. This includes:
  - The provision of user-friendly information for consumers about the formal process
  - The use of proforma letters for acknowledging requests for access to information, requests for clarifications, decisions etc
  - Giving access to the information within 45 days of receiving the request
  - Providing a written decision to the consumer and include any grounds for refusal
  - Reaching agreement about a mutually acceptable form of access (eg: viewing document, providing copies etc)
  - Charging a fee for access as prescribed in the Health Records Act
  - Advising consumers of their right of appeal through either the Health Services Commissioner (for health information) or the Victorian Privacy Commissioner (for non health information)
  - Where similar requests for information have been made to member agencies by the same consumer, privacy officers from these member agencies establishing a procedure to enable a coordinated response.
- Release information to another person only:
  - With the consent of the consumer (refer Consumer Consent Protocol)
  - To the consumer's senior next of kin, or another individual with the consent of the senior next of kin if the consumer is deceased.
- Respect anonymity of consumers and allow consumers the option of not identifying themselves when entering transactions with an organisation where lawful and practical.

- Use Manager and practitioner's judgement to endorse informal access to information for consumers where this is determined to meet the following criteria:
  - The information is easy to find and retrieve
  - The amount of information is relatively small in volume
  - The information is easily separated from other information that may be exempt from release (eg: through FOI or Privacy laws)
  - An agency procedure for inspection of information by the consumer exists
  - The decision for informal access to information is supported by the practitioner and Manager
  - A record is kept of the informal access (eg: consumer name, date and summary of material accessed).
- Utilise promotional and information materials to advise consumers of their rights in relation to Information Privacy.

To ensure information **SECURITY**, member agencies have undertaken to:

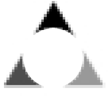
- Ensure staff are trained in relation to this Information Privacy and Security Protocol.
- Ensure consumer personal and health information is safely and securely stored. This includes:
  - Access control measures and safe storage of paper based consumer information (eg: locked filing cabinets with limited access; positioning of fax machines and computer terminals so consumer information is not visible from public area or by unauthorised staff; security alarms; clear-desk policies)
  - Access control measures and safe storage of electronic information (eg: user passwords and the protection thereof; firewalls; dedicated lines for remote access; e-mail encryption; audit trails; disclaimers/headers/footers/watermarks)
  - File management tracking system
  - Protection of computer and hard copy files (eg: back up systems and emergency procedures)
  - Undertaking risk management assessments of existing electronic and physical security measures to determine if additional safeguards are required.
- Ensuring security of consumer information on the Outer East electronic referral system. This includes:
  - Advising consumers that their information entered in to the Outer East electronic referral system will be stored for a minimum of seven years
  - Ensuring all users of the system have a user name and password
  - Assigning access controls to all users
  - Ensuring all users adhere to the Standards for User responsibilities established by the Alliance in consultation with the information system provider, including that staff only view consumer information after obtaining and recording consent to do so
  - Not using the system for consumers who wish to maintain anonymity and/or who do not give their consent (refer Consent Protocol).



- Retain consumer information for a minimum of seven years after the date of the consumer's last contact with the service; or in the case of a child until the child is 25 years of age. After this date the information will be securely destroyed. This includes:
  - Closing and archiving consumer information after a specified period of inactivity as determined by each member agency
  - Ensuring closed or archived files can easily be retrieved where the consumer re-presents for service or requests access to information
  - Preserving closed or archived files against degradation
  - De-identifying and/or destroying health information in accordance with the Health Records Act (eg: secure shredding; removal from the electronic systems).
- Protect the information held from misuse, loss, unauthorised access, modification or disclosure.
- Advise the consumer, on request, where and how their health information is held.
- Utilise promotional and information materials to advise consumers of their rights in relation to Information Security.
- Notify former consumers and the public if the service is to transfer or close in accordance with a prescribed set of procedures.

8.3 Information Privacy and Security: Processes

- Information privacy and security is the ongoing responsibility of all practitioners and occurs throughout the service delivery cycle.
- Member agencies and practitioners will integrate the information privacy and security protocols outlined above in to their daily work processes.
- The process for responding to requests by consumers for access to their personal and health information may be informal or formal.
- Information privacy and security processes will be monitored by the privacy officer who will undertake periodic audits in regards to the above protocols.
- In ensuring information privacy and security processes, agencies should refer to the DHS Privacy Kit.



9.0 LOCAL SERVICE DIRECTORY

9.1 Local Service Directory: Practice

The Service Directory[13] is an essential element of the Alliance's vision to achieve better access to services for consumers. It is part of the information technology and information management infrastructure required to support functional integration between agencies.

The Alliance is committed to the use of an effective Service Directory that is able to support the requirements of practitioners and consumers/carers. Use of the Service Directory most commonly occurs at the point of Initial Contact and/or Initial Needs Identification and/or Care Planning. Use of the Service Directory assists practitioners in:

- Seeking information.
- Providing information to consumers/carers 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 consumers/carers needs.
- Providing other health related and reference information to consumers/carers.
- Facilitating consumer choice, decision making, and access to services.
- Making appropriate referrals.

The Service Directory contains information on health and community based services and is an information resource and referral tool. It is a tool used to support practice and provide practitioners and consumers/carers with accurate, comprehensive, timely and relevant information. The Service Directory assists in providing a local Outer East identity and presence for the community.

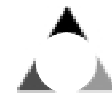
Following introduction of the Outer East Service Coordination Model incorporating the Service Directory, consumers/carers will be able to access information about health services by:

- Accessing the PCP statewide Electronic Service Directory at http://pcpdirectory.health.vic.gov.au
- Directly accessing the Alliance website to access the local Service Directory (when available).
- Contacting or visiting an Alliance member agency that has access to the local Service Directory.
- Accessing the Better Health Channel www.betterhealth.vic.gov.au to search the statewide directory of health services.

9.2 Service Directory: Protocol

In accordance with the Outer East Service Coordination Model, all member agencies have committed to use the Service Directory. The Service Directory will be available on-site at all member agencies and via any Internet connection. The Service Directory provides information on services available to the community. It contains information about service types and their descriptions, locations, hours of operation, eligibility criteria, priority of access and other relevant information where available.

13. The local Service Directory will be available in early 2003.



In utilising the Service Directory, member agencies have undertaken to:

- Meet the security and privacy standards set for Health Service providers as defined in the relevant legislation (Health records Act, 2001; Information Privacy Act 2000) (refer Privacy and Security Protocol).
- Ensure the Service Directory is accessible to all through permanent and reliable Internet connections and computers. Where preferred, this may be supported by up-to-date printed hard copies of Service Directory information.
- Use the Service Directory to provide service information to practitioners and consumers/carers about relevant health and other community services. This includes quick access to information using search categories (eg: service type, suburb) and the use of advanced search features to provide more detailed information (eg: after hours services, gender specific, waiting periods[14]) in relation to more extensive queries.
- Ensure staff members communicate the information to the consumer/carer with confidence and discuss the range of services potentially available to assist them in making decisions and informed choices.
- Ensure staff members undertaking Initial Contact and Initial Needs Identification are trained in the use of Service Directory and can utilise it to identify services and information with accuracy and confidence.
- Adhere to the standards for User Responsibilities between the information system provider and Alliance members (eg: appropriate use of passwords); and ensure staff members who use the Service Directory comply with both Alliance and individual agency guidelines and procedures regarding its use.
- Ensure the information in the Service Directory is credible, reliable, current and updated in a timely manner. This includes the updating of service information regularly in accordance with the negotiated procedure for this and the procedures for adding and changing content.
- For the Better Health Channel this requires submitting a ‘change notification’ to the content manager available on line at the Better Health Channel.
- For the PCP Statewide Service Directory, data is centrally maintained and updated on the central database by InfoXchange, with the exception of facilities information (eg: parking, disabled toilet etc) which can be updated directly by agencies once they are registered as an agency administrator.

9.3 Service Directory: Processes

- The statewide Service Directory is now available for use by practitioners at http://pcpdirectory.health.vic.gov.au
- The Service Directory is permanently ‘on-line’ and accessed from individual agency settings where Initial Contact occurs (eg: interview room, reception area, inquiry desks, intake rooms) for use by practitioners.

14. The extent of more detailed information available will vary between agencies based on individual agency policies, procedures and guidelines.

- The Service Directory is used during Initial Contact as appropriate to provide the consumer/carer with relevant information about the range of services available in the Outer East. This includes the provision of information about service location, hours of operation, contact details, eligibility criteria, fees and charges, and waiting periods (as available[15]).
- The Service Directory is used to empower the consumer/carer and assist them in making decisions about services. It is used to facilitate referrals to services and is linked to the electronic referral process. (see Referral Protocol).
- The Service Directory is also used to provide the consumer/carer with relevant information about services available outside of the Outer East area where this appropriate, including multi-catchment services, regional and statewide services.
- Where practicable, hard copies of information from the Service Directory are provided by practitioners to consumers/carers.
- Where information requested by a consumer/carer is not available through the Service Directory, practitioners will pursue other avenues of inquiry.

15. The extent of information available will vary between agencies based on individual agency policies, procedures and guidelines.

10.0 COMPLAINTS

10.1 Complaints: Practice

A consistent and established process for the handling of complaints is an essential element of the Alliance's vision to achieve better access to services and improve service coordination for consumers.

The practice of responding to complaints includes:

- Handling privacy complaints – the provisions of the Health Records Act 2001 and Information Privacy Act 2000 allow for a consumer or their representative to make a complaint regarding breach of privacy. Privacy laws defines practices that are inconsistent with the privacy principles outlined in the Information Privacy Act 2000 as an 'interference with privacy'. This can include:
  - Any act or practice that breaches the requirements of any privacy principle in relation to personal or health information of an individual
  - Failure on the part of an organisation to provide access to a consumer's personal or health information.
- Handling complaints and grievances about other aspects of service delivery – program documentation, funding agreements and best practice guidelines require agencies to have clear processes for the handling of complaints and grievances.

Forms used to support the practice of responding to complaints are:

- *'Your Information: It's Private'* – consumer information privacy brochure.
- Alliance and member agency brochures outlining the complaints process.
- Alliance and member agency proforma letters (eg: acknowledgement of complaint).

10.2 Complaints: Protocol

In accordance with the Outer East Service Coordination Model and legislation, 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 their own agency-specific detailed polices, procedures and guidelines for staff.

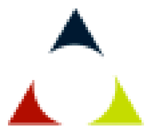
To provide a consistent process for responding to privacy complaints and complaints related to other aspects of service delivery, member agencies have undertaken to:

- Nominate a Privacy Officer to deal with complaints.
- Ensure staff are educated regarding privacy principles and the process for complaints.
- 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 Alliance 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)
  - Adherence with the Alliance Information Privacy and Security Protocol.
- Advise consumers of their rights and the process for making complaints in relation to:
  - A breach of privacy
  - Complaints about another aspect of service delivery.
- Resolve complaints quickly and effectively and wherever possible through a conciliatory process directly with the consumer.
- 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 endeavour to resolve the complaint directly with the consumer
  - The agency will endeavour 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 relevant Guidelines provided by these Commissioners (to be developed).
- In relation to a complaint about another aspect of service delivery:
  - In the first instance, the member agency which is the subject of the complaint will respond to the complaint
  - The agency will endeavour to resolve the complaint directly with the consumer
  - The agency will adhere to its own agency guidelines regarding complaints.
- Ensure consumer's special communication or cultural needs are addressed.

10.3 Complaints: Processes

- Consumers may make verbal or written complaints.
- Complaints may occur at any point during the service delivery cycle.
- Where complaints relate to a breach of privacy of information, the practitioner will advise their manager and the Privacy Officer who will respond to the complaint in accordance with the protocol detailed above.
- Where complaints relate to another aspect of service delivery, the practitioner will advise their manager who will respond to the complaint in accordance with their own agency complaints and grievances procedure which complies with relevant DHS program requirements and guidelines.
- 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.



Outer East Health
& Community Support Alliance

Appendices

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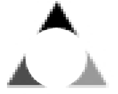


Appendix 1: Received Referrals Flow Chart (Electronic System)

REFERRAL RECEIVED

Is consumer eligible for service?

Yes

Is there a waiting list?

If consumer unable to be contacted, refer back

No

Yes

See Protocol manual for detail on this step. It may be preferable to refer back rather than consulting consumer.

Advise consumer of alternatives

Yes

Is there a more appropriate service?

No

Advise consumer of waiting period

No

No

Is consumer able to wait?

Does consumer consent to be referred on?

No

Does consumer wish to continue with referral?

Yes

No

Yes

Yes

FORWARD REFERRAL

WITHDRAW REFERRAL

REFER BACK

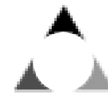
ACCEPT REFERRAL

A Practitioner receives a referral. The practitioner may then forward, withdraw, accept or send the referral back to the originating agency for action.
Within **ACCEPT REFERRAL**, feedback of referral status is either “Appointment made” or “Added to waiting list”. Within **FORWARD REFERRAL**, feedback reasons are “Consumer ineligible”, “Waiting list too long”, “Referred on to more appropriate service”. Within **WITHDRAW REFERRAL**, options are “Requested by consumer”, “Waiting list too long”. Within all referral feedback there is an option to indicate “Other” and an area for entry of reasons.

Referral Cover Sheet

Record Agency Assigned Consumer Identifier	
Consumer name	DOB
Agency	

In this space insert your Agency Details
(eg from letter head – agency logo, name, address)



Outer East Health
& Community Support Alliance

DATE

TO

Agency: Fax No:

Service Requested:
(Eg: assessment, specific service)

FROM

Name: Role/Position:

Agency/Site:

Phone No: Fax No:

REPLY

Please reply with a referral feedback sheet
- ❑ Within 24 hours (For urgent referrals only)
- ❑ Within 5 working days (For routine and all other referrals)

REFERRAL

- ❑ Urgent Cannot wait
- ❑ Routine Attend in date order
- ❑ Low Hold during peak demand
- ❑ ACAS Renewal

Waiting time for requested service indicated to consumer:

ATTACHMENTS

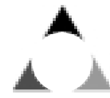
Consumer Information Form (required)	✔	Living Arrangements Profile (HACC)	
Summary and Referral Form (required)	✔	Functional Profile (HACC)	
Consumer Consent Form (required)	✔	Health Conditions Profile	
Service Coordination Plan		Psychosocial Profile	
Other Information or notes:		Health Behaviours Profile	

The information contained in this facsimile is privileged and cannot be disclosed to any other party. If you have received this facsimile in error, copying or distribution is prohibited. Please notify the sender immediately on the listed number and return the original. Thank you for your cooperation.

Referral Feedback

Record Agency Assigned Consumer Identifier	
Consumer name	DOB
Agency	

In this space insert your Agency Details
(eg from letter head – agency logo, name, address)



Outer East Health
& Community Support Alliance

DATE

TO

Agency: Fax No:

Service Requested:
(Eg: assessment, specific service)

FROM

Name: Role/Position:

Agency/Site:

Phone No: Fax No:

REFERRAL ACCEPTED

ACTION TAKEN

❑ Appointment arranged for (insert date/time): ______________________

❑ Assessment arranged for (insert date/time): ______________________

❑ Placed on waiting list
Consumer advised of estimated waiting time of:

REFERRAL NOT ACCEPTED

REASON

❑ Consumer not eligible
❑ Consumer declined service
❑ More appropriate service
❑ Waiting period too long

ACTION TAKEN

❑ Referred back to sender
❑ Referral withdrawn
❑ Forwarded on

NOTES

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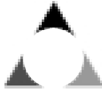
Service Outcome

Record Agency Assigned Consumer Identifier	
Consumer name	DOB
Agency	

In this space insert your Agency Details
(eg from letter head – agency logo, name, address)



Outer East Health
& Community Support Alliance

DATE

TO

Name	Agency	Fax

FROM

Name: Role/Position:

Agency/Site:

Phone No: Fax No:

SERVICE COMMENCED

Service type:
Date of service commencement:

- ❑ Care Plan or Service Coordination Plan attached
- ❑ Service Coordination Plan will be provided in due course
- ❑ For details of service delivery please contact the sender

SERVICE STATUS

- ❑ Service ongoing
- ❑ Anticipated date of service completion:_______________
- ❑ Service and/or treatment no longer required/completed
- ❑ Consumer declined or withdrew
- ❑ Other:

NOTES

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Appendix 3: Glossary of Terms

ACAS	Aged Care Assessment Service.
ALLIANCE	The Outer East Health and Community Support Alliance formed as the Primary Care Partnership in the Outer East region of metropolitan Melbourne. The Alliance covers the local government areas of Knox, Maroondah and Yarra Ranges.
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.
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.

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.

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.

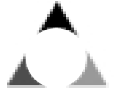
PROCEDURE An ordered set of tasks for performing some action.

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.

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.