

PART C

Protocols

9.0 Interagency Care Coordination Meeting Protocol

9.1 Introduction and Rationale

Following the introduction of new privacy legislation and in the context of improved service coordination, members of the South West Service Coordination Working Party identified practice issues relating to privacy and obtaining informed consent from clients.

In particular, interagency care coordination meetings were raised as an area of concern.

Issues Included:

- A lack of distinction between “care planning”, “case management” and “care coordination” and no consistent definitions that describe these activities
- The diversity of purpose and function of existing interagency meetings
- The purpose and function of existing interagency meetings is not always clearly understood by all those who participate
- The implications of privacy legislation for interagency meetings

The working party agreed that a protocol which incorporates processes for professional decision making and the sharing of health and consumer care information is required for convening and conducting interagency care coordination meetings.

9.2 Development of the Protocol

A project team was nominated by the working party to develop a protocol, drawing on the work already completed by the Western Region Cross Alliance Primary Care Partnerships. The Project Team comprised the Coordinator Home and Community Care, Moyne Shire, the South West Service Coordination Regional Project Officer and a Project Officer, Southern Grampians & Glenelg Primary Care Partnership.

The draft interagency Care Coordinator Meeting Protocol was developed and piloted by the Port Fairy Community Care Coordination group and a final draft was prepared.

9.3 Scope and Implementation of the Protocol across the South West

It is an expectation that all relevant care coordination groups across the South West region Victoria will adopt the Interagency Care Coordination meeting protocol. A package has been developed to assist groups in this process.

This protocol will provide participating agencies with a framework for defining care coordination meetings through the following:

- Agreement to participate in care coordinating meetings using the Interagency Care Coordination Meeting Protocol as a framework
- Refining the Interagency Care Coordination meeting protocol to reflect local operation
- Formally adopting the Interagency Care Coordination Meeting Protocol by signing an interagency agreement
- Implementing the Interagency Care Coordination Meeting Protocol
- Evaluating the protocol annually

9.4 Goal of the Interagency Care Coordination Meeting Protocol

The goal of the Interagency Meeting Protocol is to provide a means by which primary health and community support services involved in service coordination in the South West can strengthen the focus and operation of such meetings, thus providing quality care outcomes and continuity of care for consumers and carers.

9.5 Objectives of the Interagency Care Coordination Meeting Protocol

1. To provide a structured forum for interagency multidisciplinary discussion that relates to service provision and individual consumer care.
2. To ensure that the privacy and confidentiality of consumers and their carers is maintained at all times in accordance with the Health Records Act 2001, the Privacy Act and the Mental Health Act.
3. To support the range of elements and activities involved in care planning by enhancing communication between service providers, consumers and their carers
4. To raise for discussion issues/concerns relevant to identified consumers and their carers with the aim of obtaining a solution based outcome.
5. To identify service gaps within existing care arrangements and refer to appropriate agencies
6. To identify the need for individual case conferences as appropriate
7. To provide a forum for networking, information and knowledge sharing and the opportunity for support and advice amongst involved service providers
8. To document service gaps and unmet needs across the consumer group and determine a process for addressing any identified and unmet needs.

9.6 Definitions Used

The following activities are considered relevant to the Interagency Care Coordination Meeting Protocol and the definitions for these activities are listed in Appendix 2 of this document.

Initial Contact (IC)	Case Management
Initial Needs Identification (INI)	Care Coordination
Assessment	Complex Needs
Care Planning	

9.7 Participants

The Interagency Care coordination Meeting may include all significant agencies and people involved in the care of the consumer, for example, care manager, psychiatric services, HACC services, ACAS, District Nursing, Community Health, Allied Health and Specialist Services.

The composition of care coordination meetings will reflect the local service network and the focus of care. In most cases such meetings will involve a core group of services. Generally these meetings will only involve service providers.

9.8 Roles and Responsibilities

The adoption of the Interagency Care Coordination Meeting Protocol will require the commitment of agencies. Each participating agency will be responsible for the following:

- Participation by formal written agreement
- Commitment to ongoing operation of the Protocol by incorporating attendance at meetings into the roles and responsibilities of practitioners employed by individual agencies
- Developing and implementing policies and procedures which support the operation of the Protocol, which include:
 - Consumer/carer/ privacy and confidentiality
 - Obtaining consumer/carer consent for the sharing of information
 - Consumer participation in care decisions
- Participation of practitioners in care coordination according to the Protocol

- Developing more effective service coordination by using the care coordinate meetings to address practice issues, which may include:
 - Nomination of a lead agency or key contact person for particular consumer/carers duty of care considerations;
 - Triggers to identify consumer/carers who are at risk;
 - Development of strategies for communication and feedback
 - The involvement of service providers in addition to participating agencies, and in particular GP's
 - Participation in the ongoing evaluation of the Protocol and its development over time

9.9 How to Adopt the Protocol

A number of documents has been developed and packaged which will assist Care Coordination groups to adopt the Interagency Care Coordination Meeting Protocol. These will assist your group to customise the protocol documents to reflect the specific nature of your group and ensure that they meet your needs. The package is listed in Appendix 8 of this document.

9.10 Package Summary

The documents which make up the package include:

9.10.1 Definition of Terms

9.10.2 Checklist

Setting up the Interagency Meetings - Meeting Audit
Care Coordination in the Meetings - Meeting Audit
Operation of the Meetings - Meeting Audit
Each section of the checklist has a series of questions or issues for consideration by the group

9.10.3 Example: The Port Fairy Care Coordination Group Protocol

- a. Protocol Agreement - the agreement which Care Coordination Group members sign
- b. Terms of Reference
 - Aims and Objectives
 - Coordinating Agency
 - Participating Agencies
 - Location of Meetings
 - Frequency and duration of Meetings
 - Structure of the Meetings
 - Other guiding information re: the meeting
- c. Appendices
 - Meeting Agenda Template
 - Meeting Minutes Template
- d. Organisational Policies which support the Protocol
- e. Acknowledgements

9.10.4 Blank Protocol Documents

A set of blank protocol documents for completion by your Care Coordination group are available in hard copy and electronic format from the PCP office.

9.11 Suggested Process for Adoption of Protocol

1. Your Care Coordination Group has preliminary discussions, seeking to review the group's function and meeting procedures in line with the protocol.
2. The group establishes a sub-group to implement the protocol. The sub-group meets separately from the regular Care Coordination Group, keeping the full group informed of progress.
3. Using the checklist, the group audits current meeting function, practice and documentation.
4. The outcomes of the audit and action required (i.e. changes to meeting procedure and documentation) are distributed to the full Care Coordination group for discussion, amendment and endorsement.
5. Once endorsed, all group members will sign the protocol document and new meeting procedures are implemented. Any new members joining the group will sign the protocol.
6. The Care Coordination group will review the protocol and re-sign it annually.

10.0 Protocol Statements - Initial Contact, Initial Needs Identification Referral

This agreement relates to the practices and processes of the following Service Coordination elements.

Initial Contact Initial Needs Identification Referral

All member agencies of the South West and Southern Grampians Primary Care Partnerships agree to adapt their current practices and processes to reflect the overall common practices and processes outlined in this manual.

In addition, while agencies will retain their internal policies and procedures, they agree to revise these to ensure consistency with the sub region's common approach.