

PART D

Appendices

APPENDIX 1: Members of the South West & Southern Grampians & Glenelg Primary Care Partnerships

South West PCP Members	Southern Grampians and Glenelg PCP Members
Aspire	Aspire
Brophy Family & Youth Services	Balmoral Bush Nursing Centre
Cobden District Health Services Inc	Brophy Family & Youth Services
Community Connections	Casterton Memorial Hospital
Corangamite Shire Council	Coleraine District Health Services
Gunditjmara Aboriginal Co-operative	Community Connections
Kirrae Health Services	Dartmoor & District Bush Nursing Centre
Koroit & District Memorial Health Service	Glenelg Shire Council
Lyndoch Warrnambool Inc	Hamilton Community House
Moyne Health Services	Heywood Rural Health
Moyne Shire Council	Kyeema Centre
Otway Division of General Practice	Mulleraterong Centre
South West Access Network	Old Courthouse Community Centre
South West Healthcare	Otway Division of General Practice
St John of God Healthcare	Portland & District Hospital
Terang-Mortlake Health Service	Portland & District Community Health Centre
Timboon & District Health Care Service	Portland Neighbourhood House
Vantage Incorporated	South West Access Network
Vision Australia Foundation	Southern Grampians Shire Council
Warrnambool City Council	Western District Health Service
Western Region Alcohol and Drug Service	Winda Mara Aboriginal Corporation
Warrnambool & District Accommodation Support Service	
	Associates
	South West Primary Mental Health Team
	Glenelg Outreach Health
	Barwon South West Women's Health (Area3)
	Baptist Community Care

South West Alliance of Rural Health – South West Health and Community Members	
Balmoral Bush Nursing Centre	Moyne Health Services
Brophy Family & Youth Services	mpower
Casterton Memorial Hospital	Portland and District Health
Casterton /Coleraine Medical Center, Coleraine	Portland and District Medical Centre
Coleraine District Health Services	
Coleraine District Health Services - Merino Bush Nursing Centre	Robinson St. Medical Clinic Camperdown
Coleraine Medical Center Coleraine	South West Healthcare
Community Connections	Terang-Mortlake Health Service
Dartmoor & District Bush Nursing Centre	Timboon & District Health Care Service
Hamilton Community House	Western District Health Service
Heywood Rural Health	Western Region Alcohol and Drug Service

APPENDIX 2: Glossary of Acronyms and Terms

ACAS	Aged Care Assessment Service
Assessment	<p>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).</p> <p>The purpose of assessment is to assist people to define their own needs and goals and make informed choices about the service options available to them. Assessment is the process of shared exploration and identification of consumer needs, leading to the formulation of a mutually agreed care/service plan. Assessment is not a simple process of matching people and the services available, but rather a complex process of joint exploration, information sharing and problem solving.</p> <p>Depending on the consumer’s needs as identified through Initial Needs Identification, three assessment types that encompass a holistic approach will be available:</p> <ul style="list-style-type: none">• Service Specific Assessment - involves assessment for consumers with relatively straight forward, obvious and distinct need for a specific service.• Specialist Assessment - involves assessment for consumers with more complex issues where the presenting issue is relatively easily identified and clearly requires a specialist service response such as mental health, women’s health, sexual assault or drug treatment services.• Comprehensive Assessment - involves assessment for consumers whose needs are complex, not easily identifiable or unclear. A comprehensive assessment will incorporate health, medical, physical, social, cultural, psychosocial, environmental and functional aspects. Comprehensive assessment will also incorporate risk assessment. Service providers may deliver one or more of these assessment functions. However, each service/provider must demonstrate that staff have the agreed competencies to undertake the assessment option(s).
CALD	Culturally and linguistically diverse
Care Coordination	Where the range of services required by the consumer are coordinated so that they are delivered in the most efficient and effective way to meet individual consumer’s needs. Care coordination should ensure continuity of care, avoid duplication of services and ensure that the meeting of consumer needs is paramount over the needs of individual service providers and is not hampered unnecessarily by program boundaries.

Glossary of Acronyms and Terms (Continued)

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.
Carer	Anyone who provides unpaid assistance to a person with support needs based upon a previously existing relationship. Usually a partner or a family member but can also be a friend, neighbour, work colleague or other acquaintance. The informal carer can provide a little or a lot of assistance in terms of tasks undertaken or time spent providing care. Carers should be considered in any plans for the consumer and, if appropriate, be actively involved in the care planning process.
Case Management	Is a collaborative process, which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality and cost-effective outcomes.
Complex Needs	Consumers with complex needs are those with a combination of physical, medical, social and emotional needs, which require services from more than one agency to address those needs. These consumers may or may not have case management as part of their care.
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 consumer's personal and health information.
Consumers	Those members of the community who currently use services, are seeking to use services and who are potential service users, as well as their carers, families and support people.
Consumer Participation	The process of involving consumers in decision making about their own healthcare, health and community services planning, policy development, setting priorities and addressing quality issues in the delivery of health community support services.
DHS	Department of Human Services
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.

Glossary of Acronyms and Terms (Continued)

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.

HACC

Home and Community Care

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 and 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 (IC)

Refers to a potential consumer's first contact with the service system. Contact may be made by the potential consumer, or by a referral from another person or organisation. The contact may be made by presenting at a service provision point, by telephone, fax, email, or other form of communication.

Initial Needs

Identification (INI)

Is an initial screening process where the presenting issues as well as the underlying issues are uncovered to the extent possible. Initial Needs Identification determines the consumer's risk, eligibility and priority for service and a balancing of the service's capacity and the consumer needs.

INI considers the consumer's social, psychological, medical and physical aspects of health and the consumers presenting circumstances will determine how brief or intensive this process is.

INI is characterised by the collection of common care information about the consumer by all participating PCP agencies that have the agreed and demonstrated competencies to undertake this function. INI incorporates referrals to one or more services for a service specific, specialist, and/or comprehensive assessment.

Interagency Care Coordination

Meetings

Interagency Care Coordination Meetings support the range of care planning activities by providing a forum for the discussion of consumers who will generally have complex care needs and whose care requires special attention, and for the further development and operation of sustainable service networks.

IT

Information Technology

Glossary of Acronyms and Terms (Continued)

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
Primary Care	<p>Primary Care Health is essential health care based on practical, scientific and socially acceptable methods and technology. It is made universally accessible to individuals and families in the community through their full participation and at an affordable cost to the community and country.</p> <p>Primary Health Care is the central function and main focus of the country's health system. It is the first contact of the individual, the family and the community with the national health system, bringing health care as close as possible to where people live and work.</p>
Privacy	The protection of the interests of the individual, and the individual's right to control how their personal or health information is used, and for what purposes.
Privacy Officer	The nominated person within an organisation responsible for the development, implementation and monitoring of privacy requirements and compliance with privacy legislation.
Process	A series of actions and changes for a particular purpose.
Protocols	An agreed way of working which sets out standards for the various issues.
Procedure	An ordered set of tasks for performing some action.
Service Directory	A comprehensive information source on the range and scope of health and community based services available to consumers within PCP catchments to be used to inform consumers and providers.
Service Provider	Funded agency or General Practitioner
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.
System	A combination of components that work together. For example, an information system is a combination of computer hardware and software, people and the procedures used to process the data.

APPENDIX 3: CALD Guidelines

The Best Practice Guidelines outlined below have been taken from the WMR Service Coordination Best Practice and Continuous Improvement Manual.

The Work Practice Guidelines highlight the specific needs of CALD consumers regarding the collection and utilisation of information. They are to be used in conjunction with the following DHS Service Coordination Tool Template Guidelines.

Guideline 1: Completing Consumer Information

Guideline 2: Completing the Summary and Referral Information

Guideline 3: Completing the Supplementary Profiles

They should also be used in conjunction with the South West Service Coordination Practices and Processes Manual Section 2: Practice and Processes for IC and INI.

To ensure CALD consumers have optimal opportunity to enter and use primary health and community support services and are equally benefited by the South West Service Coordination Practices and Processes for IC and INI, consideration of the following is critical.

- The use of a **trained accredited interpreter** where communication support is necessary. Awareness and sensitivity to the need for ethnically and culturally appropriate interpreters is also required. It is not appropriate to **rely** on family and friends as interpreters for the purpose of undertaking the INI process
- Practitioners having the necessary **training in joint work** with an interpreter
- The practitioner being informed of approaches which are **culturally relevant and responsive**. This can be done through connection with ethno specific agencies and other relevant ethnic resources
- Practitioners **understanding the fears and misunderstandings** which some people from some CALD communities have about receiving services from outside the family/community, for example:
 - Stigma of needing help outside the family network
 - Concerns about invasion of privacy
 - Concerns about judgemental attitudes over differing values and lifestyles
 - Feared loss of independence
 - Fears of 'failing' IC/INI processes
 - A sense of guilt and failure felt by female carers who cannot meet cultural expectations that women care for family members
- Practitioners being sensitive to norms, traditions, religious and meanings attached to critical life events in the relevant culture to facilitate an accurate understanding of the Consumer's needs and preferences.
- Some service types may be totally unfamiliar to some CALD communities and more direct translation to convey meaning about services will be required
- The appointment of **bilingual staff** whose language skills reflect the CALD communities
- Use of **age and gender appropriate practitioners** to undertake INI. These factors can influence the willingness of CALD consumers to share information

CALD Guidelines (Continued)

Initial Contact

- ❑ Signage is in appropriate languages in areas where CALD consumers might present
- ❑ Reading material is in appropriate languages and provided where appropriate
- ❑ Specific language dialect and communication needs of consumers are identified
- ❑ Consumer is informed of their right to professional interpreter services
- ❑ Professional gender and culturally appropriate interpreter services are arranged if required
- ❑ Practitioner is aware of possible areas of personal/cultural values and sensitivities
- ❑ The practitioner is aware of which strategies are effective and suitable for using the IC tool with CALD consumers
- ❑ The consumer is informed of the purpose of details being recorded and how the information will be used, bearing in mind cultural sensitivity around disclosure of information
- ❑ Practitioners have a comprehensive knowledge of organisations that provide appropriate professional support to CALD communities, or if not, knowledge of how to access that information

Initial Needs Identification

- ❑ Specific language dialect and communication needs of the consumer have been identified
- ❑ Consumer is informed of their right to professional interpreter services
- ❑ Wherever possible arrangements to meet with the consumer are made directly with the consumer. The purpose of the visit is explained at this time, using telephone interpreting services if language assistance is required
- ❑ A professional interpreter who is gender and culturally acceptable to the consumer is arranged
- ❑ Only ask questions from INI that are relevant to the effective and responsive identification of service provision needs provided through your agency
- ❑ Practitioner is aware of which strategies are effective and suitable for using the INI tool with members of different CALD communities
- ❑ The styles of the interview questions have been modified to suit the particular cultural/personal/gender situation
- ❑ Practitioners are sensitive to family issues, which may result in different cultural values or attitudes

CALD Guidelines (Continued)

- ❑ Allocate sufficient time for the process of INI, which may occur over more than one visit
- ❑ The consumer is informed in non-jargonised language (everyday language) of the purpose of the INI
- ❑ Provide a clear and simple explanation of the Consent Form and a translated copy of the sheet 'Your Information - It's Private'
- ❑ Reading material is available in appropriate languages and provided where appropriate
- ❑ Practitioners have a comprehensive knowledge of organisations that provide appropriate professional support to CALD communities, or if not, knowledge of how to access that information

Appendix 4: Initial Contact: Core Skills and Knowledge Related to this Role

Functions:

1. **Collect and organise consumer information details**

Knowledge and skills required:

- Agency procedures and policies relating to provision of first point of contact for potential consumers
- Basic knowledge of culturally specific behaviour
- Requirements for consumer registration-paper based or electronic
- Waiting times for services
- Organisational policies and procedures for confidentiality
- Organisational activities and timetables - transport
- Consumer rights and responsibilities
- Knowledge specific to working with people from CALD/Koorie backgrounds
- Knowledge specific to working with people at risk of self-harm
- Understanding of relationships between internal service providers

2. **Communication Ideas and Information**

- Consumer information to staff is distributed within sufficient timelines
- The request for information consumer is understood
- Information is located from internal/external sources and information records
- The request for service provision is understood

3. **Planning and Organising Activities**

- Being able to complete consumer information details within a specified time
- Being able to meet the needs of consumers for telecommunication arrangements

4. **Working with Others and in Teams**

- Frontline decision making under pressure
- Urgent requests are responded to promptly

5. **Understanding Ideas and Techniques**

- Becoming familiar with information standards requirements when using electronic formats of the service coordination suite of tools
- Relevant literacy skills to meet reporting requirements
- Requests for services are received and recorded

6. **Solving Problems**

- Understanding complex information presented by consumer
- Understanding referrals over the phone
- Monitoring pathways for consumers to access INI staff if required quickly

7. **Using Technology**

- Using intranet
- Using the service directory for service information needs
- Using the service directory to download educational material 7

7 DHS Service Coordination Core Skills Set for IC, Draft, June 2002

Appendix 5: DHS INI Guidelines for Recording Risks

Using the INI Summary to Record Risks:

Page 2 of the Consumer Information form has a comment box that can be used to make a note of risks and questions of urgency where appropriate, depending on the practices adopted by PCPs and agencies.

It may be useful to consider risk from four different perspectives:

- Situations in which the consumer is at risk for any reason
- Situations in which the consumer presents a physical or emotional risk to other people, including family, friends and neighbours
- Situation in which the consumer represents a risk to a health or community care worker, either intentional or unintentional
- Situation in which there is an occupational health risk to a health or community care worker for any other reason

Consider whether the Consumer is at Risk for any reason

This may be quite straightforward. For example, the consumer is allergic to medications or foods and this needs to be taken into account when developing a care plan or providing treatment. Record the products/s to which the consumer is allergic.

However, the consumer may also be at risk for other reasons, examples of which are given below.

Fragile living/social conditions: Are where the consumer's living situations or social supports are likely to break down. A contingency plan may be required to allow the consumer to move to alternative accommodation or to allow alternate social support.

Examples:

- Consumer recently became unemployed. Can no longer afford existing rent
- Elderly consumer lives with son and daughter-in-law. Daughter-in-law is primary carer and the marriage is in trouble.
- Consumer lives in a caravan and has degenerative physical condition

The consumer's **physical environment** is dangerous and puts the consumer at risk. Action may be required to make the physical environment safer.

Examples:

- Frail elderly consumer has no grab rails, there are broken concrete paths
- Family with two young children lives on busy road and property has no fences
- Consumer is homeless and lives on the streets

The consumer is living in a **domestic** situation in which they are at risk of physical or emotional abuse or danger. A plan may be required to ensure the safety and protection of the consumer and legal action may also be required.

Examples:

- Domestic violence
- Child abuse
- Incest

The consumer is at risk of suicide or engages in high-risk behaviour with the intention of self-harm.

DHS INI Guidelines for Recording Risks (Continued)

For the purposes of the recording of risk and urgency, it excludes behaviours that might in the longer term be considered as damaging or health reducing, such as smoking generally or non-compliance with a specialised diet. It applies where there is an imminent risk of harm. Record long-term risky behaviour on the Health Behaviour profile if relevant.

Current and future service providers may need to observe the consumer and take appropriate intervention. Specific situations or triggers that are likely to give rise to the behaviour may need to be addressed in a Service Coordination Plan to minimise the likelihood of occurrence.

Examples:

- Self mutilation
- Suicidal intentions
- Non-compliance with medication, which, if not taken, will result in damage or danger in the short term (for example, insulin-dependent diabetic who not does comply with medication regime).

The consumer engages in high-risk behaviour but not with the intention of deliberate self-harm. It excludes behaviours, which might in the longer term be considered as damaging or health reducing, such as smoking generally or non-compliance with a specialised diet. It applies only where there is an imminent risk of harm. Record long-term risky behaviour on the Health Behaviour profile if relevant. Current and future service providers may need to observe the consumer and take appropriate intervention. Specific situations or triggers that are likely to give rise to the behaviour may need to be addressed in a Service Coordination Plan.

Examples:

- Elderly consumer with dementia who wanders from home
- Consumer abuses alcohol and smokes in bed
- Consumer walks without required aids

Consider whether the Consumer presents a Physical or Emotional Risk to other people

This includes family, friends and neighbours. For example, the consumer engages in behaviour with the intention of **intimidating or harming** another person. Current and future service providers may need to observe the consumer and take appropriate intervention. Specific situations or triggers that are likely to give rise to the behaviour may need to be addressed in a Service Coordination Plan to minimise the likelihood of occurrence.

Examples:

- Consumer engages in abusive language and verbalised threats directed at family, carers, neighbours or others
- Consumer behaviour causes sufficient noise to distress other people
- Consumer's physical conduct is threatening and has the potential to harm someone else
- Consumer engages in significant active and passive resistance, including attention seeking, manipulative behaviour and/or withdrawal

The consumer's needs or behaviour may also have the unintentional consequence of putting the health of another person at risk. Current and future service providers may need to observe the situation and take appropriate intervention. This may include interventions directed at the carer or family. Examples:

- Consumer engages in abusive language and verbalised threats directed at family, carers, neighbours or others when under the influence of alcohol or drugs

DHS INI Guidelines for Recording Risks (Continued)

- Due to brain injury, consumer's physical conduct is threatening and has the potential to harm someone else.

Care of the consumer is demanding on the carer to the point that the physical or emotional health of the carer is at risk in the short term.

Examples:

- Physical and/or emotional care of the consumer is demanding on carer to the point that the physical and/or emotional health of the carer is at risk in the short term.

Consider whether the Consumer represents an Occupational Health Risk to a Health or Community Care Worker

This is the case when the consumer engages in behaviour with the intention of intimidating or harming the health or community care worker. Current and future service providers may need to observe the consumer and take appropriate action.

Examples:

- Consumer engages in abusive language and verbalised threats directed at the health professional
- Consumer's physical conduct is threatening and has the potential to harm the health professional

Alternatively, the consumer's needs or behaviour may have the unintentional consequence of intimidating or harming the health or community care worker. Current and future service providers may need to observe the consumer and take appropriate action. Specific situations or triggers that are likely to give rise to the behaviour may need to be addressed.

Examples:

- Consumer engages in abusive language and verbalised threats directed at the health professional
- Consumer's physical conduct is threatening and has the potential to harm the health professional
- Physical care of the consumer is demanding to the point that the health of the health professional is at risk and occupational health measures are required.

Consider whether there is an Occupational Health Risk to a Health or Community Care Worker for any other reason

For example, the consumer's home environment is dangerous and may put a visiting health or community care worker at risk. Occupational Health action may be required.

Examples:

- The building is unsafe
- The consumer has a dog likely to attack a visiting health professional

The consumer's neighbourhood environment is dangerous and puts a visiting health or community care worker at risk. Occupational health action may be required.

Examples:

- The next door neighbour has a dog likely to attack a visiting health professional
- The house is located on a blind corner and entering or leaving the property is dangerous ⁸

⁸ Department of Human Services, Primary Care Partnerships Service Coordination Tool Templates Guidelines 1, Guidelines for Recording Risks

Appendix 6: DHS Draft Job Profile: Initial Needs Identification Service Provider (As at June 2002)

Characteristics of INI Service Provider/Practitioner

Decisions made by staff undertaking identification of initial needs require complex cognitive processes.

- Individual service providers should be competent, sensitive and committed to representing the interests, preferences and visions of the individual, carer and when appropriate, the family. They must provide reliable information, help explore options, guide individuals, families and carers in making informed decisions and gaining access to services and supports.

Staff undertaking the initial needs identification role should:

1. Be competent and able to function independently
2. Perform to the minimum practice standards as identified
3. Perform to the minimum environment standards as identified
4. Perform to the minimum consumer standards as identified
5. Demonstrate accountability for his/her INI decisions

Role of the INI Provider/Practitioner

The Initial Needs Identification role is an autonomous one and is essential to the efficient delivery of primary care. This role is underpinned by the service provider or practitioner's communication and questioning skills.

Department of Human Services recommends that the INI function is performed by a suitably qualified health professional or a service provider.

The role of the INI provider/practitioner is to:

- I. Allocate eligibility into the primary care agency based on initial needs
- II. Allocate non-eligibility and refer to an appropriate primary care agency
- III. Initiate appropriate service specific interventions which includes:
 - Appropriate referral to other health professionals
 - Service specific assessment
 - Initiation of organisational guidelines e.g. waiting lists
- iv. Liase with other agencies and/or other health professionals

Minimum Practice Standards

Clinical/service decisions made by INI practitioners must be informed by knowledge of the social support system and of a wide range of health issues and supporting research literature.

Department of Human Services recommends that the INI provider/practitioner will:

- As first priority assess all clients who present at a primary care setting and allocate a risk/urgent category
- Initiate service interventions in conjunction with organisational guidelines
- Initiate referrals as indicated by clinical judgement
- Provide client education where necessary
 - Health promotion and education
 - Community resource information

DHS Draft Job Profile: Initial Needs Identification Service Provider (Continued)

- Demonstrate accountability for practice through accurate and ongoing documentation and use of information management systems
- Participate in processes of audit and evaluation of INI practice

Minimum Environmental Standards

- Allow for consumer privacy
- Be immediately accessible to any distressed/angry consumer
- Ensure safety of staff
- Have access to emergency numbers

Minimum Consumer Standards

- Respect for dignity, religious and cultural beliefs
- Arrangements to ensure everyone, including people with special needs can use services
- Respect for privacy and confidentiality protection
- Arrangements to ensure that consumers are involved in decision making
- Provision of current, appropriate and detailed information about services
- Reduce waiting time for initial needs identification
- A qualified health professional, key worker or service provider responsible for each consumer
- Respect for 'a right to know' about personal information 9

9 DHS Draft Service Coordination Core Skills, June 2002

Appendix 7: Referral Coversheet and Acknowledgement Form Example*

	Insert Name of Organisation
REFERRAL COVERSHEET & ACKNOWLEDGEMENT FORM	

*The agency receiving this referral should respond by ticking and signing the 'Referral Acknowledgement' section and returning it to the referring agency within **48 hours**, by fax/mail/secured email*

TO AGENCY RECEIVING THIS REFERRAL:	FROM AGENCY SENDING THE REFERRAL:
Name:	Name:
Organisation:	Organisation:
Position:	Position:
Phone:	Phone:
Fax:	Fax:
Date Sent:	No of Pages:(including this page)

CLIENT NAME:

CONSENT: Has client consented to this referral on their behalf? *(tick appropriate box)*

Yes No

ATTACHED SUMMARY INFORMATION: *(tick appropriate box)*

- | | |
|--|--|
| <input type="checkbox"/> Consumer Information
<input type="checkbox"/> Summary & Referral
<input type="checkbox"/> Functional Screen
<input type="checkbox"/> Living Arrangements
<input type="checkbox"/> Health Conditions | <input type="checkbox"/> Health Behaviours
<input type="checkbox"/> Psychosocial Profile
<input type="checkbox"/> Service Coordination Plan
<input type="checkbox"/> Assessment |
|--|--|

OTHER INFORMATION: *(please specify)*

COMMENTS: *(may include reason for referral, urgency of referral, any feedback required, follow up phone call required etc)*

REFERRAL ACKNOWLEDGEMENT: (Tick box)

<input type="checkbox"/> Referral and all documents received	Name of Receipt: Initials:
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This form is intended solely for the named addressee and may contain confidential and legally privileged information. If you are not the intended recipient and have received this message in error, please phone:

***Copies of actual form should be obtained from SW PCP Office**

Appendix 8: Referral Outcome Form *Example**

	Insert Name of Organisation REFERRAL OUTCOME FORM
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Outcome: Please acknowledge that an assessment has occurred and an outcome decided for the referred client by completing and signing this form and returning it to the referring agency by fax/mail/secured email within 5 days of the referral

FROM AGENCY RECEIVING THIS REFERRAL:	TO AGENCY SENDING THE REFERRAL:
Name:	Name:
Organisation:	Organisation:
Position:	Position:
Phone:	Phone:
Fax:	Fax:
Date Sent:	No of Pages:(<i>including this page</i>)

CLIENT NAME:

REFERRAL STATUS:

<input type="checkbox"/> The referral is proceeding	Estimated date of contact with client:		
<input type="checkbox"/> The referral is not proceeding for the following reason:			
<input type="checkbox"/> Client declining	<input type="checkbox"/> Waiting list closed.	<input type="checkbox"/> Client ineligible for services	<input type="checkbox"/> Other
Comments:			
Provider Name:	Signature:	Date:	

REFERRAL OUTCOME:

<input type="checkbox"/> Services will be provided to this client	<input type="checkbox"/> Services will not be provided to this client		
Comments: (<i>specify service type, frequency and start date or reason for non acceptance</i>)			
<i>(Attach additional sheets if required)</i>			
Provider Name:	Signature:	Date:	

This fax is intended solely for the named addressee and may contain confidential and legally privileged information. If you are not the intended recipient and have received this message in error, please phone :

***Copies of actual form should be obtained from SW PCP Office**

Appendix 9: Summary of Privacy Principles

This information sheet sets out in summary form definitions and key Privacy Principles from the new Victorian privacy laws:

- The Health Records Act 2001 (HRA) and
- The Information Privacy Act 2000 (IPA)

This summary is provided as a quick reference tool and as such sets out only selected Principles in abbreviated form. It does not include all the Principles, nor the full form of those selected - so it excludes the exceptions that qualify many Principles. Those are set out in the Principles themselves (Schedule 1 to the respective Acts). They are also explained in practical terms in the Information Sheets in the DHS information Privacy Resource pack.

SUMMARY DEFINITIONS

Term	Summary Definition (from Section 3 of the HRA and Section 3 of the IPA)
Personal information	Information or an opinion recorded in any form about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion - but does not include health information as defined below
Health information	<p>a. Information or an opinion about:</p> <ul style="list-style-type: none"> i. The physical, mental or psychological health of an individual; or ii. A disability (at any time) of an individual; or iii. An individual's expressed wishes about the future provision of health services to him or her; or iv. A health service provided, or to be provided, to an individual that is also personal (identifying or potentially identifying, recorded) information; or <p>b. Other personal information collected to provide, or in providing, a health service; or</p> <p>c. Other personal information about an individual collected in connection with the donation, or intended donation, by the individual of his or her body parts, organs or body substances</p>
Health Service	<p>a. An activity performed in relation to an individual that is intended or claimed</p> <ul style="list-style-type: none"> i. To assess, record, maintain or improve the individual's health; or ii. To diagnose the individual's illness or disability; or iii. To treat the individual's illness or disability or suspected illness or disability; or <p>b. A disability, palliative care or aged care service; or</p> <p>c. The dispensing on prescription of a drug or medicinal preparation by a pharmacist</p>
Sensitive information	Information or an opinion about an individual's: <ul style="list-style-type: none"> i. Racial or ethnic origin; or ii. Political opinions; or iii. Membership of a political association; or iv. Religious beliefs or affiliations; or v. Philosophical beliefs; or vi. Membership of a professional or trade association; or vii. Membership of a trade union; or viii. Sexual preferences or practices; or ix. Criminal record: <p>that is also personal information</p>
Unique Identifier	An identifier (usually a number) assigned by an organisation to an individual uniquely to identify that individual for the purposes of the operations of the organisation but does not include an identifier that consists only of the individual's name.

Summary of Privacy Principles (Continued)

Health Records ACT 2001 (HRA) Health Information Privacy Principles (HPPs) in Summary

No.	Subject	Key Principles
HPP1	Collection <i>Refer to: Information Sheet 4</i>	1.1 An organisation (including a person) must not collect health information about an individual unless the information is necessary for one or more of its functions or activities. 1.4 At or near the time of collection, the organisation must notify the individual of a range of prescribed matters including who they are, why they are collecting it, how it will be used and disclosed, access rights etc.
HPP2	Use and Disclosure <i>Refer to: Information sheet 5</i>	2.1 An organisation may use or disclose health information about an individual only for the primary purpose for which the information was collected: - Unless a prescribed exception applies (e.g. the individual consents, or the use/disclosure is necessary to prevent a serious and imminent threat to life, safety or welfare, or it is required by another law).
HPP3	Data quality	3.1 An organisation must take reasonable steps to ensure that the health information it collects, uses, holds or discloses is accurate, complete, up to date and relevant to its functions.
HPP4	Data Security & Retention <i>Refer to: Information Sheets 8 & 9</i>	4.1 An organisation must take reasonable steps to protect the health information it holds from misuse and loss and from unauthorised access, modification or disclosure 4.2 A health service provider must not delete health information relating to an individual, even if it is later found or claimed to be inaccurate, unless prescribed conditions apply.
HPP5	Openness <i>Refer to: Information Sheets 3,4,5, & 10</i>	5.1 An organisation must set out in a document its health information management policies, and access rights, and must make the document available to anyone who asks for it. 5.2 On request by an individual, an organisation must take reasonable steps to advise the individual about whether it holds their health information, how and why it is held, and the process for seeking access.
HPP6	Access & Correction <i>Refer to: Information Sheet 7</i>	6.1 If an organisation holds health information about an individual; it must provide the individual with access to the information on request by the individual, unless prescribed exceptions apply. 6.5 If an individual is able to establish that their information held by an organisation is inaccurate, incomplete, misleading or out of date, the organisation must take reasonable steps to correct the information.
HPP7	Identifiers	7.1 An organisation may only assign identifiers to individuals if the assignment of identifiers is reasonably necessary to enable the organisation to carry out any of its functions efficiently. 7.2 A private sector organisation may not adopt as its own identifier of an individual an identifier that has been assigned to that person by a public sector organisation unless prescribed exceptions apply.
HPP8	Anonymity	8.1 Wherever it is lawful and practicable, individuals must have the option of not identifying themselves when entering transactions with an organisation.
HPP9	Transborder Data Flows	9.1 An organisation may transfer health information about an individual to someone (other than the organisation or the individual) who is outside Victoria only if prescribed conditions apply.
HPP10	Transfer or Closure of Practice of Health Service Provider	10.1 If the practice or business of a health service provider is to be transferred or closed, the provider must comply with a prescribed set of procedures, centring on notification to former clients and the public.
HPP11	Making information available to another	11.1 If an individual requests a health service provider to make their health information available to another provider, the former must comply with the request.

Summary of Privacy Principles (Continued)

Information Privacy Act 2000 (IPA)

No.	Subject	Key Principles
IPP1	Collection <i>Refer to: Information Sheet 4</i>	1.1 An organisation (including a person) must not collect personal information about an individual unless the information is necessary for one or more of its functions or activities. 1.3 At or near the time of collection, the organisation must notify the individual of a range of prescribed matters including who they are, why they are collecting it, how it will be used and disclosed, access rights.
IPP2	Use & Disclosure <i>Refer to: Information Sheet 5</i>	2.1 An organisation must not use or disclose personal information about an individual for a purpose (the secondary purpose) other than the primary purpose of collection - unless a prescribed exception applies (e.g. consent, serious and imminent threat, required by law).
IPP3	Data Quality	3.1 An organisation must take reasonable steps to make sure that the personal information it collects, uses or discloses is accurate, complete and up to date.
IPP4	Data Security <i>Refer to: Information Sheets 8 & 9</i>	4.1 An organisation must take reasonable steps to protect the personal information it holds from misuse and loss and from unauthorised access, modification or disclosure.
IPP5	Openness <i>Refer to: Information Sheets 3, 4 5 & 10</i>	5.1 An organisation must set out in a document clearly expressed policies on its management of personal information. The organisation must take the document available to anyone who asks for it. 5.2 On request by a person, an organisation must take reasonable steps to let the person know, generally, what sort of personal information it holds, for what purposes, and how it collects, holds uses and discloses that information.
IPP6	Access & Correction <i>Refer to: Information Sheet 7</i>	6.1 If an organisation holds personal information about an individual, it must provide the individual with access to the information on request by the individual, except to the extent that prescribed exceptions apply. 6.5 If an organisation holds personal information about an individual and the individual is able to establish that the information is not accurate, complete and up to date, the organisation must take reasonable steps to correct the information so that it is accurate, complete and up to date.
IPP7	Unique Identifiers	7.1 An organisation must not assign unique identifiers to individuals unless the assignment of unique identifiers is necessary to enable the organisation to carry out any of its functions efficiently. 7.2 An organisation must not adopt as its own unique identifier of an individual a unique identifier of the individual that has been assigned by another organisation unless prescribed exceptions apply.
IPP8	Anonymity	8.1 Wherever it is lawful and practicable, individuals must have the option of not identifying themselves when entering transactions with an organisation.
IPP9	Transborder Data Flows	9.1 An organisation may transfer personal information about an individual to someone (other than the organisation or the individual) who is outside Victoria only if prescribed conditions apply.
IPP10	Sensitive Information	10.1 An organisation must not collect sensitive information about an individual unless prescribed exceptions apply.

LEGAL ADVICE: DISCLAIMER

Information contained within this information sheet is not intended to substitute for legal advice. Primary Care Partnerships and/or member agencies should seek advice from their legal advisors in determining whether their practices, processes, protocols and systems comply with all relevant legislation.

Appendix 10: Key Service Coordination/ Integration Meetings In the SOUTH WEST

REGIONAL MEETINGS
Adult Day & Support Services Regional Coordinator's Network
Barwon South West Breast Care Nurses Network
Corangamite and Regional Primary Health Consortium
Local Government Human Service Managers Network
Regional District Nurses Meeting
South West ACAS
South West CACP Program Coordinators Network Meeting
South West Supported Residential Services Providers
South West Carers Network
South West Respite Network
Wannon Post Acute Care Consortium meetings
LOCAL GOVERNMENT AREA/PCP MEETINGS
Camperdown & Lismore District Nursing & Primary Care Meetings
Corangamite Community Services Network
Glenelg Disability Advisory Group
Casterton Memorial Hospital Primary Care Meeting
Casterton Continuum of Care
Mortlake Network Community Meetings
Mortlake Discharge Planning Meeting
Moyne Primary Care Community Group
Moyne Community Care Coordinator's Meeting
Moyne Primary Care Team Meeting
Moyne Effective Discharge Strategy Group
Moyne Health Service and Moyne Shire Maternal & Child Health Nurse
Terang & District Community Development & Network Services
Terang & Mortlake District Nursing Service Coordination Meeting
Timboon Services Network
Penshurst District Hospital, District Nurses and Community Nurses
Portland District Health Community Continuum of Care meeting
South West Healthcare Continuum of Care meetings
South West Healthcare Effective Discharge Strategy
Warrnambool Cluster Coordination Meeting
Western District Health Service - DNS, SG Shire, CACPs Providers, Aged Care Facilities meeting

Appendix 11: Interagency Meeting Protocol Package

Package summary

The documents, which make up this package include:

1. Definition of Terms
 - Inclusion of a Definition of Terms ensures that all group members have a common understanding of terms such as Initial Needs Identification, Assessment, Care Planning and Case Management
2. Checklist to assist in developing your protocol
 - Setting up the Interagency meetings
 - Care coordination in the meetings
 - Operation of the meetings

Each section of the checklist has a series of questions or issues for consideration by the group
3. Example: the Port Fairy Community Care Coordination Group Protocol
 - a. Protocol Agreement - the agreement which Care Coordination Group members sign
 - b. Terms of Reference
 1. Aims and Objectives
 2. Coordinating Agency
 3. Participating Agencies
 4. Location of meetings
 5. Frequency and duration of meetings
 6. Structure of the meetings
 7. Other guiding information re: the meeting
 - c. Meeting Agenda and Minutes template
 - d. Organisational policies, which support the protocol
 - e. Acknowledgements
4. Blank Protocol documents to assist in developing your Interagency meeting protocol. A set of blank protocol document and templates is available in hardcopy and electronic form from the SW PCP office.
5. 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.

Interagency Meeting Protocol Package (Continued)

1. Definition of Terms

For the purpose of the Protocol the definitions used are those which have been adopted by South West Service Coordination Working Party, as follows:

Initial Contact (IC) - Refers to a potential consumer's first contact with the service system. Contact may be made by the potential consumer, or by a referral from another person or organisation. The contact may be made by presenting at a service provision point, by telephone, fax, email, or other form of communication.

Initial Needs Identification (INI) - Is an initial screening process where the presenting issues as well as the underlying issues are uncovered to the extent possible. Initial Needs Identification determines the consumer's risk, eligibility and priority for service and a balancing of the service's capacity and the consumer needs.

INI considers the consumer's social, psychological, medical and physical aspects of health and the consumers presenting circumstances will determine how brief or intensive this process is.

INI is characterised by the collection of common care information about the consumer by all participating PCP agencies that have the agreed and demonstrated competencies to undertake this function. INI incorporates referrals to one or more services for a service specific, specialist, and/or comprehensive assessment.

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).

The purpose of assessment is to assist people to define their own needs and goals and make informed choices about the service options available to them Assessment is the process of shared exploration and identification of consumer needs, leading to the formulation of a mutually agreed care/service plan. Assessment is not a simple process of matching people and the services available, but rather a complex process of joint exploration, information sharing and problem solving.

Depending on the consumer's needs as identified through Initial Needs Identification, three assessment types that encompass a holistic approach will be available:

- **Service Specific Assessment** - involves assessment for consumers with relatively straight forward, obvious and distinct need for a specific service.
- **Specialist Assessment** - involves assessment for consumers with more complex issues where the presenting issue is relatively easily identified and clearly requires a specialist service response such as mental health, women's health, sexual assault or drug treatment services.
- **Comprehensive Assessment** - involves assessment for consumers whose needs are complex, not easily identifiable or unclear. A comprehensive assessment will incorporate health, medical, physical, social, cultural, psychosocial, environmental and functional aspects. Comprehensive assessment will also incorporate risk assessment. Service providers may deliver one or more of these assessment functions. However, each service/provider must demonstrate that staff have the agreed competencies to undertake the assessment option(s).

Interagency Meeting Protocol Package (Continued)

Care Planning - Is the bridge from assessment to actual delivery of services. It is a process of deliberation that incorporates a range of activities including developing care plans (e.g. clinical plans, treatment plans, service plans), care coordination, case management, referral, review, re-assessment and monitoring.

Care planning is a collaborative process that involves the blending of consumers views about their needs and priorities and the General Practitioners/Assessment Officers/Case Managers professional judgement.

There are many different levels to Care Planning and the extent of care planning activities will depend on individual consumers circumstances, the degree of complexity of the situation and any concerns about risks.

Case Management - Is a collaborative process, which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality and cost-effective outcomes.

Care Coordination - Where the range of services required by the consumer are coordinated so that they are delivered in the most efficient and effective way to meet individual consumer's needs. Care coordination should ensure continuity of care, avoid duplication of services and ensure that the meeting of consumer needs is paramount over the needs of individual service providers and is not hampered unnecessarily by program boundaries.

Complex Needs - Consumers with complex needs are those with a combination of physical, medical, social and emotional needs, which require services from more than one agency to address those needs. These consumers may or may not have case management as part of their care.

Interagency Care Coordination Meetings - Interagency Care Coordination Meetings support the range of care planning activities by providing a forum for the discussion of consumers who will generally have complex care needs and whose care requires special attention, and for the further development and operation of sustainable service networks.

Interagency Meeting Protocol Package (Continued)

2. Checklist: Setting up the Interagency Meetings

Task	Prompt	Response	What is Required	Designated Person
Participants	<p>Is there already a group, which meets?</p> <p>Are there additional agencies, which may wish to be involved?</p> <p>Is there a commitment from individual agencies to be involved by:</p> <ul style="list-style-type: none"> - Formalising involvement through formal agreement - Allocating staff time - Is one agency taking a lead role in auspicing /coordination of meetings? 			
Defining the purpose of the meeting	<p>Are there existing terms of reference?</p> <p>Checklist for Terms of Reference</p> <ul style="list-style-type: none"> - The aims and objectives of the meetings - The lead agency - The participating agencies - The location of meetings - The frequency and duration of the meetings - The structure of the meetings 			
Policies, procedures and protocols	<p>What policies, procedures and protocols already exist which guide our practice?</p> <p>Are there gaps? How will they be addressed</p> <p>What do they say about interagency communication?</p>			

Interagency Meeting Protocol Package (Continued)

2. Checklist: Care Coordination in the Meetings

Task	Prompt	Response	What is Required	Designated Person
Care Coordination	<p>To what extent will the interagency meeting contribute to care coordination?</p> <ul style="list-style-type: none"> ▪ Are there documented processes for consent? ▪ Is there a standard consent form for disclosure? ▪ Does the consent form allow consumers to choose which information is disclosed? ▪ Is staff aware of consent processes and requirements? ▪ How is the consumer informed in relation to consent and rights? ▪ Is staff aware of when consent is required/not required? ▪ How will referral be made for additional services? ▪ Identifying at risk consumers and carers - Whose responsibility for follow up? ▪ Referring for individual case conferences - identifying the key worker 			
Development of the service system - enhancement of care	<ul style="list-style-type: none"> ▪ Is care coordination the primary focus of the meeting? ▪ Is there an opportunity to consider matters such as waiting lists, service gaps, and unmet needs? 			

Interagency Meeting Protocol Package (Continued)

2. Checklist: Operation of Meetings

Task	Prompt	Response	What is Required	Designated Person
Chairing of meetings - a structured approach to meetings	<ul style="list-style-type: none"> ▪ Who will chair meetings? ▪ Length of time? ▪ What will the duties of the chairperson be? 			
Meeting procedures	<ul style="list-style-type: none"> ▪ What procedures are needed for the operation for the meetings and person/s responsible ▪ Meeting notices ▪ Meeting agendas ▪ Notification of matters for discussion ▪ Minutes of meetings ▪ Any disputes that arise? 			
Agreed action	<ul style="list-style-type: none"> ▪ How will actions that relate to consumer care be documented ▪ How will actions that relate to the services system be documented? 			
Review of meetings purpose and operation to support better service coordination	<ul style="list-style-type: none"> ▪ Will the purpose and operation on interagency meetings be reviewed? ▪ How frequently will this occur? ▪ How will outcomes be addressed and implemented? 			

Interagency Meeting Protocol Package (Continued)

3. Example: Port Fairy Community Care Coordination Group (PFCCC) Protocol Table of Contents:

- A. Protocol Agreement
- B. Terms of Reference
 - 1. Aims and Objectives
 - 2. Coordinating agency
 - 3. Participating agencies
 - 4. Location of meetings
 - 5. Frequency and duration of meetings
 - 6. Structure of the meetings
 - 7. Other guiding information re: the meeting
- C. Appendices
- D. Organisational policies which support the protocol
- E. Acknowledgements

A. Protocol Agreement

This protocol is based on the trust, professionalism and goodwill of the signatories. It provides a framework for conducting the PFCCC group meetings and has been developed for the mutual benefit of consumers and the participating agencies and service providers.

In addition to any of the provisions of the relevant legislation (i.e. the Privacy Act, the Health Records Act and Mental Health Act) all endorsed participants in the Port Fairy Community Care Coordination group must agree to observe the professional conduct ethics of their relevant disciplines, and will be bound by the relevant rules of respect for client confidentiality, consent and participation.

The protocol is not a service agreement or contract.

It will be formally reviewed on an annual basis.

The following parties agree to participate in this protocol for the PFCCC group for a 12-month period.

Agency: Moyne Health Service

Name:

Position: Primary Care Coordinator

Signature:

Date:

Agency: Moyne Health Service

Name:

Position: Primary Care

Signature:

Date:

Agency: Moyne Health Service

Name:

Position: Community Care/CACPS Provider

Signature:

Date:

Interagency Meeting Protocol Package (Continued)

Agency: Moyne Health Service
Name:
Position: District Nurse
Signature: _____ Date: _____

Agency: Moyne Health Service
Name:
Position: Aged Care
Signature: _____ Date: _____

Agency: Moyne Health Service
Name:
Position: ADASS Coordinator
Signature: _____ Date: _____

Agency: Moyne Health Service
Name:
Position: Unit Manager - Acute Care
Signature: _____ Date: _____

Agency: Moyne Health Service
Name:
Position: Home & Community Care Corodinator
Signature: _____ Date: _____

Agency: Moyne Health Service
Name:
Position: Community Liaison
Signature: _____ Date: _____

Agency: Moyne Health Service
Name:
Position: Occupational Therapist
Signature: _____ Date: _____

Agency: Moyne Health Service
Name:
Position: Community Options CACPS Provider
Signature: _____ Date: _____

Agency: Moyne Health Service
Name:
Position: Community Options CACPS Provider
Signature: _____ Date: _____

Agency: Moyne Health Service
Name:
Position: Aged Care Assessment Service
Signature: _____ Date: _____

Interagency Meeting Protocol Package (Continued)

B. Terms of Reference

1. Aims and Objectives

Aim: The aim of the PFCCC group is to provide a forum, which supports and promotes integrated care for the consumers and carers in the Port Fairy community.

Objectives:

- i. To provide a structured forum for interagency discussion using the PFCCC protocol
 - ii. To ensure that the privacy and confidentiality of consumers and their carers are at all times in accord with the provisions of the Health Records Act 2001, The Privacy Act and the Mental Health Act
 - iii. To support the range of elements and activities involved in integrated care by enhancing communication between service providers, consumers and their carers
 - iv. To make decisions regarding appropriate services proportionate to assessed care needs and available resources
 - v. To raise for discussion issues/concerns relevant to identified consumers and their carers with the aim of obtaining a solution based outcome
 - vi. To provide a forum for networking, information and knowledge sharing and the opportunity for support and advice amongst involved service providers
 - vii. To identify service gaps within existing care arrangements and refer to appropriate agencies
 - viii. To document service gaps and unmet needs across the consumer group and determine a process for addressing any identified gaps and unmet needs
2. Coordinating Agency: Reviewed and appointed annually
 3. Participating Agencies:
 - Moyne Health Services
 - Acute
 - Primary Care
 - Community Care
 - Aged Care
 - District Nursing Service
 - ADASS
 - CACPS
 - Moyne Shire HACC
 - South West Healthcare
 - Occupational therapy
 - Lyndoch
 - Community Options
 - Aged Care Assessment Services
 - Dept. Veteran Affairs
 4. Location of Meetings:
Moyne Health Services, Boardroom, Villiers Street, Port Fairy
 5. Frequency and Duration of Meetings:
2nd Tuesday of the month at 1.30pm (1 hour)

Interagency Meeting Protocol Package (Continued)

6. Structure of Meetings:

Chair:

Minute Taker: Using meeting template for recording minutes. Minute taker rotated at each meeting. Minute format template will be provided.

Minutes are handed on to minute sender at end of each meeting who is appointed annually and responsible for sending out minutes to all members.

Agenda Items:

- i. Present
- ii. Apologies
- iii. Guest Speaker/Special presentations
- iv. Minutes of last meeting. Confirmation of last meeting as an accurate record. Moved and seconded. Accepted
- v. Business arising - follow up and report back
- vi. Reports from all participants: Program and service reports, non-client specific. Includes: Programs, activities, promotions, resources, current issues around service delivery, service gaps, waiting lists, interagency activities etc.
Documentation: General issues, gaps and needs in relation to the service system should be documented
Actions: May also be required for follow up and should also be documented with person/s responsible noted
- vii. Care coordination discussion includes:
 - Specific gaps, issues, unmet needs, resources and services in relation to specific client needs and circumstances
 - *Documentation:* Any outcomes follow up or agreements regarding care and service delivery for specific clients should be noted with name of client. Services involved should also be noted
 - If there is a need for an individual case conference to be planned for a client this is documented with key worker also. Chair or any other person can suggest a case conference if the client issues are taking up too much time at the meeting and there are a number of services involved
 - *Other:* Any official referrals required to be organised for a specific client should be done between services after the meeting
- viii. New Business Includes:
 - Any other issues which need to be addressed through interagency group
 - New business can be flagged in participants reports but deferred to this part of the meeting for full discussion
 - *Documentation:* Include actions and follow up and designated persons
- ix. Date of next meeting
- x. Meeting closed

Interagency Meeting Protocol Package (Continued)

7. Other Guiding Information Regarding the Meetings

- *Role of chairperson:* The Chairperson must be able to run the meeting effectively. This would include elements such as keeping to time making sure minutes are recorded as an accurate representation of what is said, making sure all members have a say and when a discussion must be moved to another time such as a case conference. The chair must also review the group's progress over time and address any issues, in relation to the Terms of Reference. Good documentation of the meetings will support the chairpersons role
- *Role of the participants:* Participants must agree to abide by the documented structure, as per the signed agreement
- *Consent:* Wherever possible consent from individual clients should be sought when completing the ScoTT consent form in relation to care coordination meetings which may be able to create better service coordination outcomes for clients
- *Documentation of Meetings:* A standard format for the agenda and minutes will be adopted. Minute sender types up recorded minutes and sends out to members within seven days of the meeting. Members to notify minute sender if there are items to go on the agenda
- *All minutes* will be sent by secure email to the intended recipient as by arrangement at signing of the yearly agreement

Interagency Meeting Protocol Package (Continued)

C. (Package Appendix) Agenda Template and Instructions *Example**

(INSERT LOGO)

A G E N D A

PORT FAIRY COMMUNITY CARE COORDINATION GROUP (PFCCC)

INSERT DATE

INSERT TIME

at

INSERT VENUE

-
1. **Present:**
 - 2.0 **Apologies:**
 - 3.0 **Confirmation of Minutes of meeting held on:** *(insert date of last meeting and insert name of mover of minutes and seconder)*
 - 4.0 **Guest Speaker/Special Presentations:**
 - 5.0 **Business Arising:**
(List items which have arisen from previous meetings and which need further discussion or action - these items stay in the business arising section until resolved or can be listed as an ongoing item).
Each item should be listed under separate item number .e.g
 - 5.1 Council Services
 - 5.2 Service Coordination Tools etc.
 - 6.0 **Reports:**
List each report separately as above
 - 6.1
 - 6.2 etc.
 - 7.0 **Care Coordination:**
As a rule specific items will not be listed here
 - 8.0 **New Business:**
List any item that is new to the group - new business items can be added to the agenda before the meeting (contact the secretary) or raised at the meeting.
As above, each item is listed separately e.g.
 - 7.1
 - 7.2 etc.
 - 9.0 **Date of Next Meeting**
This is generally inserted before the meeting giving advance notice of next meeting.

***Blank Templates available from SW PCP Office**

Interagency Meeting Protocol Package (Continued)

C. (Package Appendix) Minute Template and Instructions *Example**

INSERT LOGO)

MINUTES
PORT FAIRY COMMUNITY CARE
COORDINATION GROUP (PFCCG)
INSERT DATE
INSERT TIME
at
INSERT VENUE

1.0 Present:

2.0 Apologies:

3.0 Confirmation of the Minutes of the last meeting:

The group is asked to confirm the minutes of the last meeting - a mover and seconder is requested and documented

4.0 Guest Speaker/Special Presentations:

A brief summary of the content is documented

5.0 Business Arising:

*Agenda items listed under business arising are discussed here and outcomes of discussions and action taken is recorded. Discussion items are listed as for agenda e.g.
5.1
5.2*

6.0 Reports from all participants:

*List reports as above and record a summary of key points of each e.g.
6.1 Moyne Shire
6.2 ACAS*

7.0 Care Coordination

*Specific gaps, issues, unmet needs, resources and services in relation to specific client needs and circumstances are discussed here
The issue raised, the outcome and action taken is to be recorded. A report back on action taken is then listed in the next agenda under business arising.*

8.0 New Business:

*Issues alluded to in 'reports' may be referred to New Business for discussion or new items may have been listed prior to the meeting
As above, each item is listed separately e.g.
8.1
8.2 etc.*

9.0 Date of Next Meeting: *Insert date time and venue for the next meeting*

10.0 Meeting Closed: *Insert time meeting closes*

***Blank Templates available from SW PCP Office**

Interagency Meeting Protocol Package (Continued)

D. All Agencies involved have organisational policies, which support the Port Fairy Community Care Group Interagency Protocol

E. Acknowledgements

- WMR Service Coordination Best Practice and Continuous Improvement manual first edition - 2002 - Section 4 Interagency Multidisciplinary Care Coordination Meeting Protocol
- Members of the Port Fairy Community Care Coordination group (PFCCC) 2003
- Primary Care Partnerships - South West Service Coordination Project Officers - Margaret Sinnott and Rowena Wylie
- Project Coordinator: Kathy Sanderson, Home and Community Care Coordinator Moyne Shire