



Better Access to Services – A Policy & Operational Framework

PRIMARY CARE PARTNERSHIPS

June 2001

AGED, COMMUNITY AND MENTAL HEALTH

**Human
Services**



Peoplefirst

Primary Care Partnerships

Better Access to Services

A Policy and Operational Framework

Aged, Community and Mental Health Division

June 2001

Acknowledgments

Many individuals and groups contributed to the development of *Better Access To Services: A Policy And Operational Framework*. Their assistance is gratefully acknowledged. The framework has also evolved through discussion with consumers, carers, service providers/managers/practitioners, general practitioners and peak and professional bodies. It builds on the work of the *Streamlined Assessment Services, Consultation Paper* released in September 1998 and more recently the *Better Access to Services: Draft Policy Framework* released in July 2000. Thanks go to all who participated in the consultations and who provided written and verbal comment.

Formal internal and external working groups have overseen the policy and operational framework's development. A Streamlined Assessment Reference Group comprising a range of service providers undertook the initial developmental work. As part of the Primary Care Partnership strategy, a Better Access To Services Reference Group was convened. An internal steering group comprising representation from a range of divisions within the Department of Human Services has overseen the cross divisional implications of the project. We would like to thank all those who have contributed to both the steering group and reference group and look forward to their continuing roles in the developmental work fundamental to the success of the reform.

We would also like to acknowledge the efforts of service providers and workers and the many quality projects and practices that have informed this paper. These local initiatives have played a major role in informing the thinking underpinning this paper and will continue to inform the work of Primary Care Partnerships in achieving *Better Access to Services* for consumers.

It is important to acknowledge the different roles and perspectives of people who use services—consumers and their carers/advocates/families. We would like to acknowledge the contributions of a wide range of individuals and we appreciate their investment in service re-development.

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For further information about *Better Access to Services: A Policy And Operational Framework*, or for additional copies of this document please contact your local regional office of the Department of Human Services or Jan Child, phone (03) 9616 8721.

This paper is also published on the Primary Health Knowledge Base at <http://www.dhs.vic.gov.au/phkb>

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Foreword

Effective coordination among primary care services is increasingly important to service users, service providers and government alike. *Better Access to Services: A Policy and Operational Framework* provides a guide to achieving service coordination and a basis to enable service managers and practitioners to integrate and synchronise the range of service activities they undertake. It has been developed in tandem with the *Information Management Strategic Directions Paper* on the understanding that effective information management is essential for achieving *Better Access to Services* and neither can be considered in isolation.

Better Access to Services in this context means creating effective systemic links between primary care providers in Primary Care Partnerships, based on common practices, to assist people to gain access to those services.

Consultations were undertaken from July to November 2000 (HDG 2001) with other government departments, service users, service managers, service practitioners, Divisions of General Practice, General Practitioners and peak and professional bodies. *Better Access to Services: A Draft Policy Framework* and the *Information Management Discussion Paper* were released prior to consultations to promote discussion and debate. The consultations revealed a remarkable consistency of view across the state in support of the concepts in the draft documents. The consultations also identified a number of consistent themes that have been incorporated in this final document. The final document recognises the significant investment to date in current work practices and aims to build on the many examples of good work in a systemic and collaborative way.

Adequate resources for the delivery of services is a critical issue and the Government has demonstrated its commitment to delivering improved services by reinvesting in primary and community care. However, achieving better access to services is only partly about resources. It is clear that problems such as a lack of reliable information for both practitioners and consumers about what is available in the service system and a partial approach to identifying the range of service needs as well as strengths of people seeking to use services, are blocking those people's access to needed services. This is a message that has come through from the extensive consultations undertaken in finalising this document. *Better Access to Services: A Policy and Operational Framework* aims to balance the needs of consumers with the needs of service providers and to ensure opportunities for consumers and the broader community to be actively involved in service development. Another clear message that has come through the consultations is your expectation as practitioners and consumers of publicly funded services that the Government and the Department take a leadership role in assisting you to achieve these objectives.

The Government recognises that the changes involved in implementing the *Better Access to Services Framework* are significant and that their implementation will need to be incremental. The document aims to be a dynamic, flexible yet abiding framework that will guide you through the changes you decide to make. It recognises the need for both statewide consistency and local flexibility and takes account of differing capacity in the sector to progress.

We look forward to working with you to achieve better access to services and to improve health and care outcomes for Victorians.



The Hon Bronwyn Pike MP
Minister for Housing and Aged Care



The Hon John Thwaites MP
Minister for Health

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Executive Summary

As part of the Primary Care Partnership Strategy in Victoria, the Department of Human Services is working collaboratively with Primary Care Partnerships and consumers to improve service coordination. Our shared primary aims are to place consumers at the centre of service delivery and to ensure that they have access to the services they need, opportunities for early intervention and health promotion and improved health and care outcomes.

As part of their Community Health Plans, Primary Care Partnerships will develop service coordination models that delineate roles and responsibilities between providers and provide for a seamless continuum of care for consumers. Primary Care Partnerships will also outline the strategies for implementing Better Access to Services and Information Management in the short term, and longer term.

The models and strategies for service coordination need to be underpinned by a number of fundamental principles. These include:

- A central focus on consumers
- Partnerships and collaboration
- The social model of health
- Competent staff
- A duty of care
- Protection of consumer information
- Engagement of other sectors

In addition, to facilitate statewide consistency across Primary Care Partnerships, *Better Access to Services: A policy and operational framework* outlines the range of assessment and service delivery processes that currently exist within the present health care system. These processes are;

- Initial contact
- Initial needs identification
- Service specific assessment

- Specialist assessment
- Comprehensive assessment; and
- Care planning.

To assist in developing a common language and understanding, each of these elements is separately defined in this paper. In practice consumers will experience Primary Care Partnerships' implementation of *Better Access to Services* as a seamless and usual part of service delivery. These six elements and the further developmental work forecast in the paper, provide a common framework for providers to work together to ensure that consumers have equitable access to services.

Better Access To Services; A Policy And Operational Framework aims to provide Primary Care Partnerships with a consistent statewide framework rather than a blueprint for service delivery. Partnerships are developing their own approaches to implementing this framework through local service coordination models, reflecting local consumer and community characteristics, local circumstances and service availability. *Better Access to Services* is about developing a sustainable and systematically supported capacity for service providers to work together across Victoria. Primary Care Partnerships are building on existing good practices in further developing their local collaborative working arrangements.

The changes proposed in this reform are significant and their implementation will need to be an incremental and cooperative process. As such, the Department will take a 'problem solving' approach to any difficulties that arise and will work in partnership with service providers to arrive at workable solutions.

This framework should be considered in conjunction with other Primary Care Partnership resources such as the *Information Management Strategic Directions*, *Community Health Planning Template*, *Better Access to Services: An Information Resource*, *Literature Review of Effective Models and Interventions for Chronic Disease Management in the Primary Care Sector*, *Primary Care Partnerships: Draft Health Promotion Guidelines* and *Going Forward: Primary Care Partnerships*.

Section One: The Policy Context

1.1 The Informal Care Environment

A diverse range of individuals and relationships makes up the Victorian community. Each Victorian is an individual with values, perspectives, ambitions and capacities. Each person requires different levels of information, support and assistance at different times: individuals' needs fluctuate. The environment in which people live and work, and the level of community participation and support they enjoy also varies. Some individuals have few community connections and no informal care from others. Other individuals have strong connections with their families, friends and work colleagues. Some individuals are sustained through broad community networks such as

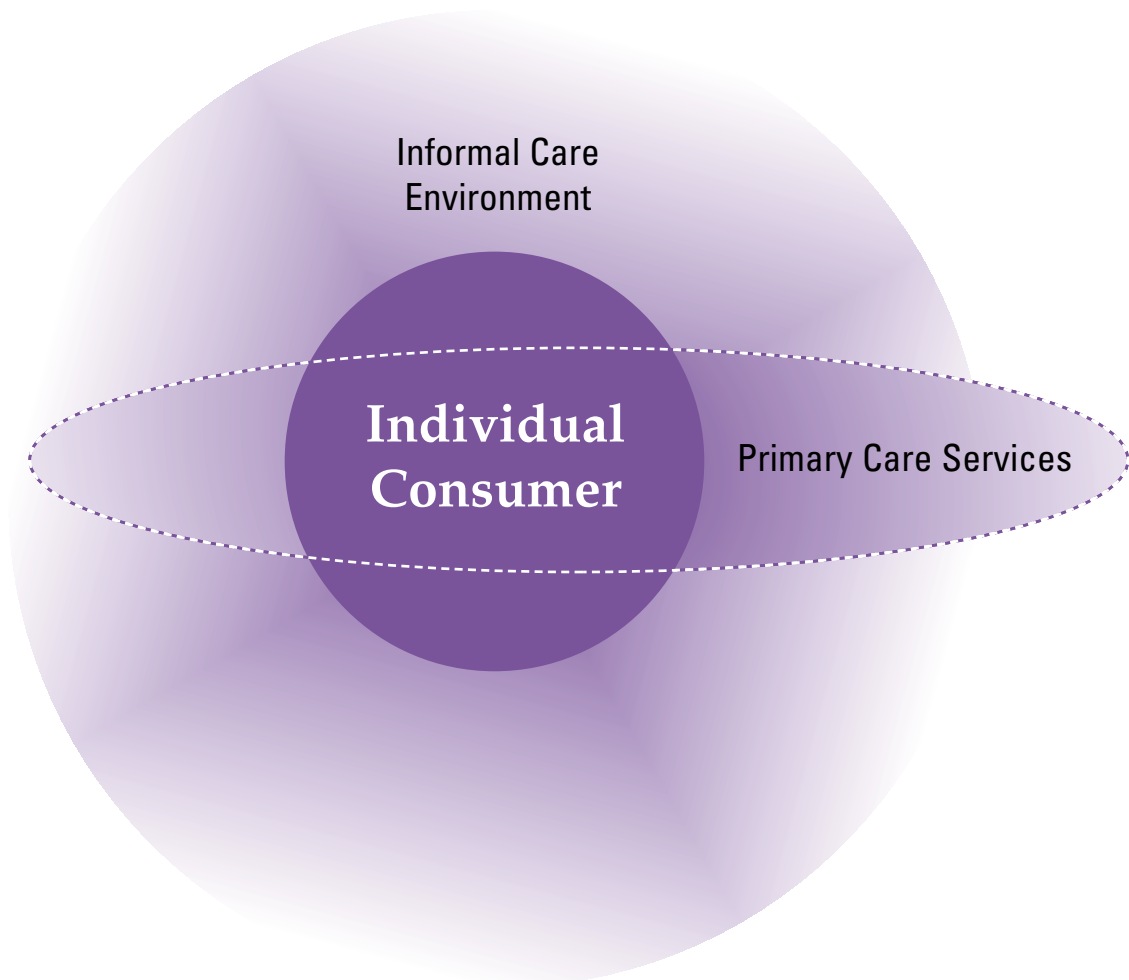
neighbours, social groups and community domains such as churches or voluntary organisations.

Carers in particular fulfil crucial roles and can need assistance and support in their own right to continue in this role. Primary carers, whether a family member or friend of the person cared for, have their own distinct needs.

Each person's requirements need to be recognised in the context of his or her own environment

The informal care environment, therefore, is of critical importance given that the capacity and preparedness of carers to continue in that role will directly influence the formal care and support needs of an individual (as illustrated in *'Putting Carers in the Picture'*, 1998).

Figure 1: The Consumer in the Care Environment



At the point where an individual's needs are no longer sustainable within his or her informal care environment, additional support may be sought through the primary care sector.

While the directions outlined in this paper are based on the existing good practice of many different primary care service providers, both providers and consumers acknowledge that good practice is often built up in an ad hoc way. They also note that good practice is frequently dependent on the particular skills and experience of individual assessors and therefore vulnerable when key staff leave. The Primary Care Partnerships Strategy aims to build on this good practice in a systemic way and enable primary care services to achieve high quality outcomes for consumers and deliver improved health and wellbeing for the community.

1.2 Primary Care Partnerships

The Primary Care Partnership strategy, broadly outlined in the document *Primary Care Partnerships: Going Forward, April 2000*¹ provides a framework for improving the planning and delivery of primary care services and for ensuring they work effectively together.

To achieve these goals, funding has been provided to groups of primary care providers that have formed voluntary alliances in their local communities. These alliances, called 'Primary Care Partnerships', include agencies with a wealth of knowledge and practical day-to-day experience in meeting their community's needs. A core group of services are typically included in each Primary Care Partnership – these services are outlined in the *Going Forward* document.

This core group of services provides an opportunity to create a comprehensive and local primary care response to consumers. Some Primary Care Partnerships will include other service agencies such as dentists and pharmacists to achieve their aims. Providers in other Primary Care Partnerships may also be delivering Community Care, Housing and/or Emergency Services.

The vision for Primary Care Partnerships is to align systems and practices across primary care agencies to improve health and well being outcomes for people using their services.

One of the major priorities for Primary Care Partnerships is to align systems and practices across primary care agencies in order to make access for people seeking to use services easier, so improving health and well being outcomes for those people. The voluntary nature of Partnerships creates opportunities for a range of agencies to be involved throughout the public and private sectors. Those opportunities bring with them their own challenges.

Whatever the local alliance makeup, Primary Care Partnerships provide a basis for relationship building and service development. This approach will be underlined by development of community, individual and corporate relationships, a corresponding respect for dissent and diversity, and recognition that process is as important as outcome. Changes implicit in the Primary Care Partnership strategy are significant. Primary Care Partnerships won't 'fix' all the problems or issues of the current primary care service sector. However, Primary Care Partnerships provide a planning and operational framework to enable this broader work to occur. This framework, the Community Health Plan, will address the three key areas of:

- Partnerships—defining how the partnership will engage the relevant stakeholders and work together.
- Service coordination—defining how local systems and practices such as information management and the *Better Access to Services* elements will enable services to be better coordinated and therefore more easily accessible to local communities.
- Integrated Service Planning—identifying the population health needs of the community and proposing strategies to address those needs, such as integrated, multi-sectoral health promotion and disease management programs and services.

¹ <http://www.dhs.vic.gov.au/acmh/ph/pcp/forward/index.htm>

As part of coming together, Primary Care Partnerships will work with consumers, their broader local communities and Government to develop and implement their Community Health Plans.

1.3 Service Coordination in Primary Care Partnerships

The service coordination element of Community Health Plans provides a framework to develop local models, systems and processes to facilitate functional integration across services in Primary Care Partnerships. The purpose of functional integration is to make the Primary Care Partnerships' range of services more readily visible to people seeking to use those services and consequently easier to gain access. Achieving functional integration will enable service providers to remain independent of each other as entities and still work in a cohesive and coordinated way so that consumers experience a seamless and integrated response. The service coordination component of community health plans includes three initiatives that provide the infrastructure for providers to work together for the benefit of their local communities. These initiatives are Better Access to Services, Information Management and Local Services Information. These three initiatives are interdependent. They need to be progressively developed and implemented together at a statewide level while supporting accomplishments locally.

The Better Access to Services, Information Management and Local Services Information initiatives are interdependent and need to be progressively developed and implemented together.

The effectiveness of these initiatives will be best evidenced by consumers' experiences of improved service coordination, but the impact will not be confined to service coordination alone. These three initiatives support the Integrated Service Planning component of Community Health Plans by facilitating service delivery that focuses on health promotion, early intervention and disease management and by providing the infrastructure for collecting consistent service utilisation data for population health planning. The three initiatives also support the Partnerships component of Community Health Plans by

providing a tangible basis for providers to work collaboratively together as well as opportunities for meaningful consumer and GP engagement.

All three elements of the Community Health Plan are integrally linked and must take account of the others in their evolution and implementation. Primary Care Partnerships need to consider how they can implement their local arrangements based on *Information Management Strategic Directions*, and *Better Access to Services: A Policy and Operational Framework* so that they contribute to and interconnect with the other strategies in their Community Health Plans, enabling greater definition of roles, responsibilities, practices and approaches.

1.4 Better Access to Services in Primary Care Partnerships

The aim of *Better Access to Services* is to improve people's access to services by assisting Primary Care Partnerships achieve functional integration.

The aim of *Better Access to Services* is to provide a policy and operational framework that will improve people's access to services by assisting Primary Care Partnerships (their member organisations and practitioners) to achieve functional integration. A significant move towards achieving functional integration will be through PCPs developing their own local service coordination models, based on agreements between member providers and building on the *Better Access to Services policy and operational framework*.

Better Access to Services—a policy and operational framework is based on the premise that integrating and articulating the different assessment activities in primary care settings and supporting these assessments through improved entry, needs identification and care-planning, can benefit consumers and communities by facilitating early intervention to prevent ill health and by reducing preventable or premature admission to acute and residential care.

In local pockets of the sector, good work has been done in building collaborative working relationships between providers that enables a more coordinated and integrated response to consumers. It is also apparent that in some areas, significant work has been done to enable consumer information collected at one service to be transmitted to another service provider in a referral with routine feedback to referring practitioners. The aim of Better Access to Services is to support these local pockets of development in a systemic and systematic way.

Better Access to Services provides a consistent framework that recognises generic categories of assessment that are already in use in the sector. The framework also identifies those points that, from the consumer's perspective, need attention, namely initial contact, initial needs identification and care planning.

Section Two: The Way Forward for Primary Care Partnerships; Implementing an Operational Framework

2.1 The Service Coordination model and the Better Access to Services strategy

Better Access to Services: A Policy And Operational Framework has been developed to support service re-development through functional integration. Functional integration means that service providers within Primary Care Partnerships operate within their existing organizational structures but as part of 'virtual organizations' created by Primary Care Partnerships. *Better Access to Services* aims to provide a basis for consistent practices across the State where appropriate, while enabling Partnerships to develop workable local approaches and define and delineate roles and responsibilities. Partnerships may choose to develop parts or the entire framework in collaboration with neighbouring Partnerships to achieve common practices across a region. The success of the framework will be measured by practical gains made when the service coordination models result in service providers accepting and acting on information gathered by another provider, about a consumer, and working together to meet all the needs of all consumers.

The development and implementation of a local Service Coordination model is the key Service Coordination task for each Primary Care Partnership. The process each Primary Care Partnership uses for developing its model for service coordination is as important as the final model that is developed. In coming together to work through the issues inherent in this task, Partnership members will develop an improved understanding about the variety of approaches used among Partnership members and by other organizations and practitioners with whom the Partnership has relationships. Shared definition and understanding of the issues, commitment to work the issues through, and agreement about the steps to achieve resolution are all necessary. In undertaking this work, Primary Care Partnerships will be able to negotiate a common set of norms and practices for working together. At the same time, Partnership relationships will be strengthened.

Roles and responsibilities can be clarified. Points of duplication between providers can be resolved. Interfaces between agencies can be improved. *The Better Access to Services* elements can be aligned between agencies, taking into account local factors such as service and staff availability, local community needs and current best practice approaches. In developing and implementing their Service Coordination models members of PCPs will generate opportunities to work through the concerns and issues of different professional groups and organisations and help them develop their vision of what is possible.

Partnerships will need to make local collaborative and pragmatic decisions about who will do what and how. The *Better Access to Services* framework will assist by providing clarity about the key elements, their features and linkages but there is no science about which organisation fits where. Individual services within each Primary Care Partnership, taking account of their overall program direction, will need to reach agreements between them about who does what.

Each Primary Care Partnership's development and implementation of its local Service Coordination model is the key task.

All service coordination models developed by Primary Care Partnerships need to take account of the following process considerations:

- Have consumers and the broader community been meaningfully involved in the model's design and development
- Have all Primary Care Partnership member agencies agreed to the new model
- Have the affiliate members/other relevant primary care service agencies in the PCP catchment had the opportunity to contribute to the model development
- Does the model reflect the Primary Care Partnerships' integrated service planning outcomes and priorities

In addition, models need to:

- Describe how/where/when/why and by whom Initial Contact, Initial Needs Identification, Service Specific Assessment, Specialist Assessment, Comprehensive Assessment and Care Planning are undertaken
- Describe the relationships and interface between Initial Contact, Initial Needs Identification, Service Specific Assessment, Specialist Assessment, Comprehensive Assessment and Care Planning
- Include all Primary Care Partnership member agencies including smaller, state-wide and specialist services
- Outline the ongoing roles and responsibilities of all Primary Care Partnership member agencies
- Accommodate the specific service needs of and pathways for all consumers, including people of Aboriginal/Torres Strait Island origin/descent; people who are homeless; people from culturally and linguistically diverse backgrounds; people living in rural and remote areas; people with conditions or circumstances that hinder access e.g. dementia, cognitive problems, illicit drug use; people with a disability.
- Incorporate Initial Needs Identification and Care Planning Tool templates
- Incorporate the Service Directory into Initial Contact, Initial Needs Identification, and Care Planning
- Interface with secondary and tertiary sectors including acute and residential care
- Include the GP engagement strategy such as incorporation of the Medicare Benefit Schedule items such as Health Assessment, Care Planning and Case Conferencing.
- Incorporate practices and processes (including referral options) that enable early intervention and health promotion.
- Where relevant, incorporate the practices, processes and tools required as part of the Integrated Disease Management projects, into the broader service coordination model
- Where relevant, reflect an interface with Coordinated Care Trial initiatives.

Primary Care Partnerships will set out their approach for implementing their service coordination model in their Better Access to Services strategy and Information Management strategic plan that will form a part of their Community Health Plans.

The *Better Access to Services* strategy will provide an overview of the short term (2001/02) and long term (2002/2005) strategic management of *Better Access to Services* and must address the key requirements set out in the Community Health Planning Template, specifically:

- How will information (including personal and health information about individuals) be collected, used, stored and destroyed?
- How will information sharing and consent work (including how protection of privacy and security of information will be achieved)?
- How will you implement changes to roles and responsibilities of providers?
- How will changes in practice and culture be facilitated in each participating agency/provider?
- What infrastructure will you need?
- How will you ensure that providers have the skills required to participate in the strategy?
- How will you involve key stakeholders?
 - Consumers
 - Other primary care providers (including small, specialist and statewide)
 - General practitioners
 - Acute
 - Residential care
- How will issues of liability and duty of care be addressed within and between participating agencies?
- How will issues of eligibility and priority be addressed?
- How will the PCP manage the implementation of the strategy?
- How will the strategy be evaluated to support shared learning across the State?

Developing and implementing these strategies is a significant task and will give rise to a range of competing professional and organisational issues that will need to be resolved. Open identification of these issues early in the process and open discussion to achieve resolution, will assist Primary Care Partnerships to manage the change process effectively and open the way for innovation in achieving better outcomes for consumers.

2.2 Fundamental requirements underpinning Service Coordination

Development of the Service Coordination model and implementation of the Better Access to Services and Information Management strategies will provide the critical foundation from which Primary Care Partnerships can coordinate service delivery for the benefit of consumers. It is equally critical that these models and strategies are underpinned by the following fundamental principles:

- A central focus on consumers
- Partnerships and collaboration
- The social model of health
- Competent staff
- A duty of care
- Protection of consumer information
- Engagement of other sectors

A Central Focus on Consumers

Improving the health and well being of consumers and maintaining people in the community is the reason health and community care services are funded.

Service delivery needs to be driven by the needs of consumers and the community rather than the needs of the system or those who practice in it.

Service Coordination models developed by Primary Care Partnerships need to provide a seamless pathway for consumers, adapted to the needs and characteristics of

their local communities. In developing and implementing their models, Primary Care Partnerships should incorporate the following principles for consumer responsiveness.

- Sensitivity to the issues of age, religion, gender and language.
- Consumers' expectations are taken into account, their personal capacity to make informed choices about their health and well-being is paramount and self-management is encouraged.
- Diversity among consumers is respected and the individual needs of all consumers including those who are marginalised, vulnerable and/or have special or urgent needs are taken into account.
- Women's and men's differing needs are taken into account.
- The contribution of carers and their expertise, needs and approach to care giving are taken into account.
- The importance of health promotion/capacity building is emphasised.
- Assessment is made available in a way that meets consumers' particular circumstances either on site or in their home with supporting access to interpreters, signers or other aids.
- Unnecessary, duplicative and/or intrusive practices are avoided.
- Recognition that consumers' needs change over time and extensive engagement may be required before the full extent of a person's circumstances and requirements become clear.
- Consumers have the right to disagree with their assessment and recommended care plan.
- Consumers must be informed of their rights, including their right to a review of any assessment by a third party. They must have access to a dispute resolution process managed by a third party. They must be informed about the outcomes of an assessment and

why a publicly subsidised service may not be provided in a particular case. Information about review and grievance procedures must be provided in culturally appropriate forms.

Simply put, the way in which Primary Care Partnerships can achieve a consumer and community focus is to inform, engage and actively involve consumers and the broader community in all aspects of the development, implementation and evaluation of *Better Access to Services* and *Information Management Strategic Directions*. The Documents *“Preparing a Consumers and Carers Charter—a draft guideline for discussion”*, November 2000, *“An Information Resource – Consumer and Carer Participation in Primary Care Partnerships”* and *“Improving Health Services through Participation—A Resource Guide for Organisations”* will assist Primary Care Partnerships in achieving consumer and community engagement.

Partnerships and Collaboration

Implementing the *Better Access to Services framework* will be most effectively achieved through collaborative and collegial partnerships.

This process of partnering requires people to take responsibility for the interests of ‘the whole’ as well as for their own individual interests.

There are a number of differing levels and types of partnering relationships involved in Primary Care Partnerships. There are partnerships between the different levels of government, between consumers/community and government, between the government and providers, between consumers/community and providers, between different providers such as general practitioners and acute services. Developing partnerships is complex and there are a range of competing cultural, historical, political, professional and organisational differences to work through.

A collaborative approach will assist all stakeholders to constructively explore their differences and search for solutions². There need to be visible gains to the work being undertaken to maintain consumer confidence,

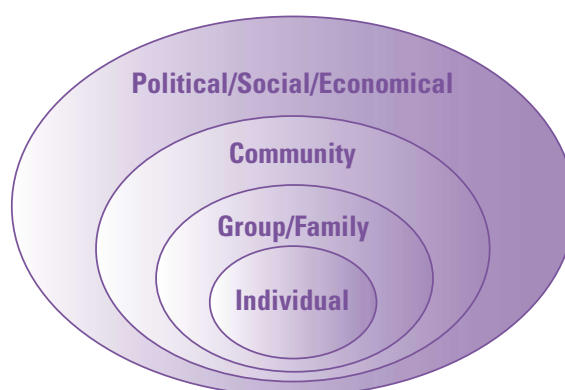
community engagement and support for the undertaking. This needs to start with fostering relationship building and trust. Achieving shared commitment, mutual respect and trust is no small accomplishment and requires the Primary Care Partnership to reach consensus on the nature of the problems and the outcomes sought. Once achieved, they also require ongoing maintenance. Further detail on partnership development can be found in the *“Partnership Issues Information Resource”*.

The Social Model of Health

The Primary Care Partnership strategy recognizes the need for primary care service providers to work with consumers and the community to improve health and well being. The strategy aims to support that work by assisting providers to address the broad determinants of health and well being and applying a social model of health to service planning and provision.

A social model of health is a distinct conceptual framework for thinking about health. This framework is concerned with addressing the social and environmental determinants of health and wellbeing as well as biological and medical factors. The World Health Organisation’s definition of health (refer glossary) highlights the importance of understanding health and disease within the personal, social and cultural context specific to the person or community whose health is being considered. It is not possible to decide how best to support the improvement of health without understanding this context. The context of health is simply illustrated in Figure 2. below.

Figure 2: The Context of Health



² (Walker, July 2000).

The *Better Access to Services policy and operational framework* aims to enable Primary Care Partnerships to ensure their approach to consumers considers this broader context and that people seeking to use their services are dealt with holistically. The framework also aims to ensure that service coordination models trigger considerations beyond those associated with the immediate circumstances or conditions a person may present with, whether social, environmental, biological or medical.

More detailed information can be found in the Primary Care Partnerships *Draft Health Promotion Guidelines*.

Competent Staff

The Service Coordination model will be as good as the people who work within it.

This means that the six elements described within *Better Access to Services* must be undertaken by staff that are appropriately skilled, qualified, experienced, supervised and supported.

Until statewide competencies are developed, (refer section 3), organisations must continue current arrangements for ensuring staff have the appropriate skills to match their responsibilities. Practice must continue to be guided by practitioners' clinical and professional expertise and not by the application of specific data collection forms and assessment tools.

Where a consumer has unstable health and/or personal care needs, assessments must include a registered Division 1/Division 3 nurse or medical officer.

Duty of Care

Duty of care is an issue for each individual worker and service provider and the Service Coordination environment does not necessarily affect duty of care considerations. For example, agencies and practitioners will have similar responsibilities in a Service Coordination environment in the event that a consumer is referred from one service to another and the other service has closed its waiting list.

However some new issues may arise. For example, when a service provider acts on another service provider's assessment there is a new question about who is

responsible if inappropriate or inadequate care is provided as a result of reliance on information which is incomplete, incorrect or outdated.

Each agency within a Primary Care Partnership must be able to agree to and endorse the model, practices and processes developed, agree that they are reasonable and that they meet their individual agency needs and the needs of their consumers. Agencies in Primary Care Partnerships will need to consider seriously what information they can share with confidence, and what information their professional responsibilities require them to gather themselves. Confidence in sharing consumer information can evolve over time as roles and responsibilities become clearly defined and consistent information management practices are embedded.

Agencies and workers need to ensure that they provide the best outcome for consumers using their professional skill and judgment in all cases and not abdicate their responsibilities because a practitioner in another agency has done an assessment. This means that if there is any doubt about the adequacy, reliability, validity, currency or the outcome of an assessment, a re-assessment is probably required. However the Service Coordination environment provides a framework to provide feedback between participating organisations and practitioners, to correct deficiencies and to ensure unnecessary repetition does not occur.

Protection of Consumer Information

The development of improved information management practices is critically linked to *Better Access to Services*. Ensuring that information about consumers and services flows through the service system in a timely and efficient way will greatly enhance consumers' access to services and improve the capacity for effective service coordination.

Improved information management practice is critically linked to *Better Access to Services*.

Policy on information management is therefore being developed and implemented in parallel with *Better Access to Services* as part of the Service Coordination component

of the Primary Care Partnership Strategy. Improved information management will ensure that Service Coordination models and strategies incorporate clear arrangements for maintaining consumer confidentiality, protecting the privacy of consumers' personal information and for obtaining consumers' consent to their information being collected and used for specified purposes, including being transmitted to another provider as part of a referral. In particular, Partnerships should seek to minimise the risk of any breach of consumers' privacy arising from sharing consumer information, without consumers' consent. *Primary Care Partnerships Information Management Strategic Directions* sets out the basis for privacy protection practices. These practices must:

- Be consistent with the *Information Management Strategic Directions*, and the Department of Human Services' Information Privacy Principles;
- Comply with all relevant Commonwealth and Victorian legislation and standards; and
- Be reflected in the Partnership's consumer charter.

Facilitating Cross Sector Alignment

The Department has outlined the core services for inclusion in primary care partnerships. In the first stage of development, there are three focus points where engagement is essential. These are:

- Engaging the full range of primary care services
- Engaging General Practitioners
- Aligning with other sectors

Engaging the full range of primary care services

Partnerships need to actively involve the broad range of community-based service providers in their catchments in developing and implementing local Service Coordination models. Particular consideration needs to be given to the difficulties smaller, specialist, regional and statewide services face in attempting to relate to subregionally based PCPs. These services offer opportunities to positively influence and strengthen locally based services.

Some smaller and specialist providers experience practical impediments to their level of involvement with PCPs. These impediments are important to consider and will require local strategies.

While most providers in Partnerships will have a local area focus, regional and statewide service providers will be in the difficult position of needing to communicate with and contribute to multiple Partnerships. Solutions for facilitating involvement should recognize that it is not a simple matter of backfilling. People need time to explore the common purpose and time to understand the inherent advantages of participation in building partnerships both for themselves and for their clients.

The Primary Care Partnership strategy is based on inclusive partnership development and aims to develop an open structure that accommodates different players. The process for developing models in each Partnership needs to include larger and smaller agencies and be developed in a way that can be applied by each agency and be beneficial to each agency's consumer groups.

Engaging General Practitioners

Developing strong links with Divisions of General Practice and individual general practitioners will be critical in achieving Better Access to Services. The Guide to GP engagement in Primary Care Partnerships will assist Primary Care Partnerships in achieving this. Importantly, Primary Care Partnerships should build on the opportunities made available through the Commonwealth government's Medicare Benefits Schedule (MBS) items as part of the Enhanced Primary Care Package. These MBS items reimburse GPs for involvement in comprehensive assessments for older people, multi-disciplinary care planning and case conferencing with other primary care service providers for people with chronic conditions and multi-disciplinary care needs.

Aligning with other Service Sectors

The development of strategic links between Primary Care Partnerships and service sectors (such as acute care, residential aged care, children's and family services and

disability services) is important to providing a comprehensive and coordinated response to consumers. There are a range of factors that require consideration in order to improve service coordination and relationships between these sectors. These factors include different accountability lines and requirements, differing legislative drivers such as those within statutory and non-statutory services, disparate organisational cultures and practices, and varying professional values and philosophies. Partnerships need to build on the relationships that already exist with these service sectors and develop an understanding of and protocols, links and interface with the relevant service sectors taking into account relevant eligibility requirements and other access issues.

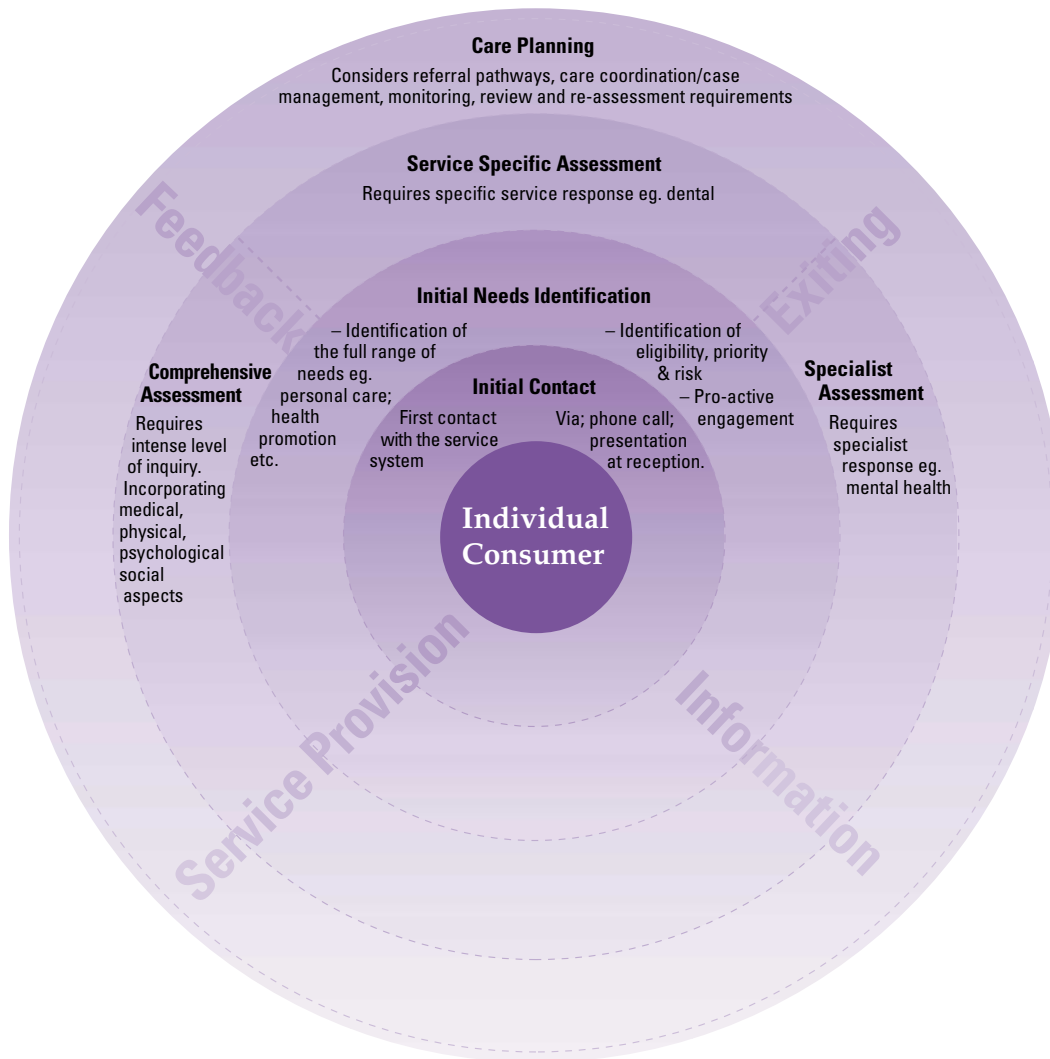
Including information about these services in local service directories may assist in this process.

2.3 The Better Access to Services Elements

The following elements have been identified as priorities for action on the basis of consultation with providers, peak bodies, consumers and consumer advocates. All of the elements are already established in one form or another across the primary care sector. The terms chosen to describe them are terms of convenience. Those terms have been endorsed through the consultation process. This operational framework aims to define them, to show how they can be linked and to establish a basis of common language for Primary Care Partnerships to further develop them. These elements are:

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

Figure 3: The Better Access to Service Operational Framework



These six elements have been highlighted as a result of examining current good practice locally, nationally and internationally³. They have been endorsed by the sector as the right elements with the provisos that they be integrated into service delivery and that those undertaking them have the necessary skills and competencies to do so. (HDG 2001).

The purpose of the operational framework is to make explicit these key elements and the necessary links between them. A systemic approach to providing better access to services relies, at its core, on:

- Responding to the needs of consumers identified at the point of entry, including need for information about service choices available

³ BATS Information Resource

- Developing an understanding about a person's needs and potential, and identify health promoting opportunities,
- Improving and integrating current assessment activities
- Making a judgment about service options that can meet consumers' needs and maximise their potential, and putting this judgment into action.
- Making sure that if referral of a person to another practitioner or provider is necessary, the inconvenience to the person is minimised.

For ease of reference, each of these elements are separately defined below. In practice, consumers will experience PCPs' implementation of their Service Coordination models as a seamless and usual part of service delivery. The six elements and the further developmental work forecast in this paper, provide a common framework for providers to work together to ensure that consumers have equitable and effective access to services.

Initial Contact

This is the point a person makes his or her first contact with the Primary Care Partnership. Consumers initiate initial contact, most commonly by telephone or in person but possibly through a friend, relative, or other service provider such as financial counsellors, police or hospital staff.

Often this point of contact will result in the presenting person either accessing a service or making an appointment to do so. It may simply be the point where basic information is provided and no further service or intervention is necessary.

The initial point of contact is important to consumers who have had little experience with the service system.

The HDG report noted that service providers "emphasized that consumers are not a homogenous group and flexible pathways are needed to cater for different consumer segments". This was endorsed by the consumer

consultation. Participants observed that many "younger consumers (aged less than 55 years) wanted the opportunity to access the information they required via the Internet while older consumers preferred contact with a person who could guide them through the service options." General Practitioners were "also keen to have a point of contact for information about all services, particularly if they could telephone this point and make bookings while the patient was still with them".

Key Features of Initial Contact

While each Better Access to Services model developed by Primary Care Partnerships will vary, every model will clarify where the points of initial contact are undertaken and by whom. They will:

- Ensure that every service site is an entry point to the full suite of services offered by Partnerships, as well as information about non-member services. This means that those who aren't aware of the service system can present at any Primary Care Partnership service and have access to information about services within and external to the Primary Care Partnership from the Primary Care Partnership Service Directory.
- Include access to comprehensive, accurate and reliable service information by phone from the Primary Care Partnership Service Directory.
- Involve staff who can communicate with accuracy and confidence the range of services offered and access the range of information available.
- Where appropriate and with the consumers agreement, record basic information (name, contact details, name and contact details of referring practitioner if relevant).
- Provide consumers with information about what they can expect from the processes that will follow including information about their rights and responsibilities.
- Facilitate direct access to initial needs identification, whether it is conducted at that site or elsewhere. Creative approaches to deliver direct access will be developed (for example, a shared/centralised initial

needs identification telephone service or teleconferencing arrangements). This is particularly important for managing vulnerable consumers, or consumers with special or urgent needs.

Initial contact ends when consumers require information that is supported by advice and when a process of inquiry begins. (At that point, the initial needs identification has commenced and as such, the competencies required to undertake the task are different).

Initial Needs Identification

Throughout the consultations, there was overwhelming endorsement from the sector that this element is the most critical and yet the least developed systematically. There was also a recognition that effective initial needs identification positions Partnerships to implement consistent targeting strategies to assist in the equitable prioritisation of consumer demand and to identify priorities for resource allocation and service planning. It would also enable Primary Care Partnerships to consistently and broadly identify and capture unmet need.

Initial needs identification is an initial screening for risk and service requirements. The practitioner undertaking initial needs identification looks beyond the presenting issue to what underlying issues may exist.

Initial needs identification will consider the consumers' social, psychological, medical and physical aspects of health and the consumers presenting circumstances will determine how brief or intensive this process is. For example, consumers who only require access to a specific service (such as physiotherapy for a frame) should be able to access the service without intrusive questioning. The Initial Needs Identification however, should also ensure that any other services/issues are identified at this point. For example, the Initial Needs Identification should be able to pick up that the request for physiotherapy is in response to frequent falls that have to date, not been investigated. The outcome in a situation like this would be referral to Comprehensive Assessment where the issue

of falls can be addressed and the necessity of a frame verses more restorative/rehabilitative solutions can be considered.

Initial needs identification is not a diagnostic process but is a determination of the consumer's risk, eligibility and priority for service.

Initial needs identification is not a diagnostic process but is a determination of the consumer's risk, eligibility and priority for service and a balancing of the service capacity and the consumer needs. Initial Needs Identification allows for the consumer's needs and health promotion opportunities to be broadly identified as completely as possible, early in their contact with the service system. Consumers can be subsequently informed about the range of service options available to meet their needs and consideration can be given to the wider range of services supports and resources such as for-profit services, information services, financial entitlements or other alternative services.

Initial needs identification can be undertaken in a variety of ways and most commonly occurs through telephone interaction or face-to-face presentation. Opportunities exist however for Partnerships to engage consumers who have traditionally had poor access to services through proactive approaches and practices. Service providers can engage consumers through targeted outreach programs or provision of drop-in type venues or other innovative approaches.

Key Features Of Initial Needs Identification

While each Service Coordination model developed by Primary Care Partnerships will vary, every model across the State will clarify how Initial Needs Identification is undertaken and by whom. Models will:

- As far as possible, identify the full range of a consumer's needs including health promotion or illness prevention opportunities, as well as capabilities and potential and not just those needs that can be met by the agency undertaking the assessment. The process will be sensitive to the extent of a person's needs.

- Show how priority of access and eligibility criteria will be transparent and consistently applied.
- Proactively reduce risk for consumers. Judgment of risk requires an analysis of the information obtained and an evaluation of the degree and probability of harm both in the short and longer term. This means that factors that both increase or decrease the probability of risk, such as formal and informal networks, will be considered. Within the Better Access to Services environment, this issue is made complex given the different threshold levels for judgment. Personal, professional, organisational and socio political values and expectations can impact on the way in which an individual worker makes a judgment. Risk reduction will therefore be achieved through;
 - The gathering of information and
 - The analysis of information and subsequent judgment of risk.
- Improve services' capacity to identify and respond to emergency and crisis situations and manage any immediate risks to facilitate better consumer outcomes, safety and well-being.
- Incorporate processes and practices that accurately and consistently assess the urgency of consumers' needs, level of risk and priority of access for services.
- Ensure staff performing initial needs identification are competent to do so and have a broad understanding of the service system and advanced interviewing skills that provide a capacity to maintain and develop rapport throughout inquiry and an ability to retrieve sufficient information through that inquiry.
- Take into account resource availability, service scope as well as community expectations.
 - For those sites that do not have the competent Initial Needs Identification staff at hand, the Primary Care Partnership will develop strategies (such as telephone access) to ensure consumers can access the Initial Needs Identification regardless of where they enter the service system. Specialist services

such as Drug Treatment Services, would not be required to undertake the element of Initial Needs Identification for non drug treatment clients, unless this is agreed to by the agency and is done so in the interest of the particular consumer.

- Provide for a skilled assessor on-site where crisis or emergency situations are likely to present, rather than relying on telephone strategies or asking people to travel to another site
- Complete the collection of core consumer information
- Utilise the common Initial Needs Identification tool across the partnership. (Refer 5(II) in Section Three below.)

Service Specific Assessment

Service Specific Assessments are undertaken where consumers have a relatively straightforward, obvious and distinct need

Service Specific Assessment is a face-to-face interaction with a consumer and occurs where a service need is identified following Initial Needs Identification. It is conducted by the provider responsible for delivering the service and occurs as part of the delivery of service. Service Specific Assessments are undertaken where consumers have a relatively straightforward, obvious and distinct need for a specific service such as physiotherapy, home care or dental services.

Service Specific Assessments will be undertaken by most agencies in the course of service provision and will be the means by which services determine the consumer's particular service requirement and adapt their service provision to the clients assessed need. Service Specific Assessments can be undertaken for a range of purposes. These purposes could include the development of an individual service plan (for example; a meal service may need to establish dietary preferences and delivery arrangements) or development of clinical and discipline specific plans (e.g. a nursing service may need to develop a treatment plan for a wound or a physiotherapist may determine a therapy plan following a fracture).

While there is a recognition that each of the different disciplines (e.g. nurses, social workers, occupational therapists, podiatrists) all have a distinct expertise, a discipline specific assessment is considered as Service Specific Assessment unless the discipline is working in a specialist area such as Drug Treatment or Sexual Assault where there is clearly a requirement to have a breadth of knowledge and expertise beyond that of the discipline.

Key Features of Service Specific Assessment

Whilst each Service Coordination model developed by Primary Care Partnerships will vary, every model across the State will clarify how Service Specific Assessments will:

- Build on information gathered through the Initial Contact and Initial Needs Identification elements and any other relevant assessment and service delivery information
- Have transparent links with the other types of assessment (Specialist and Comprehensive)
- Link into care planning

Specialist Assessment

Specialist Assessments are undertaken where the presenting issue clearly requires a specialist service response such as that provided by mental health, women's health, sexual assault or drug treatment services. They aim to determine the consumer's specialist needs and may include clinical assessment and treatment, as well as community support and assistance with daily living.

Specialist Assessments are undertaken where the presenting issue clearly requires a specialist service response.

Specialist Assessment is a face-to-face interaction with a consumer and occurs where a specialist need is identified following Initial Needs Identification and is undertaken by a provider who has specialist skills, knowledge and expertise. It usually occurs as part of specialist service delivery. Most consumers who use specialist services engage with those services directly and will continue to do so.

Key Features of Specialist Assessment

Whilst each Service Coordination model developed by Primary Care Partnerships will vary, every model across the State will clarify how Specialist Assessments will:

- Build on information gathered through the Initial Contact and Initial Needs Identification elements and any other relevant assessment and service delivery information.
- Be comprehensive or straightforward in nature, depending on the specialist intervention required and the consumer's needs. This means that if the client presents at the Women's Health Service for a routine pap smear, the assessment process will be specific to that request (i.e. a straightforward assessment). However if the presentation is a young woman who requests a pregnancy test and requires counselling about options and choices, then the specialist assessment is more likely to be comprehensive in nature.
- Have transparent links with the other assessment elements (Service Specific and Comprehensive)
- Feed into care planning
- Use common tools among like specialty areas (e.g. Drug Treatment Services) where appropriate.

Comprehensive Assessment

Comprehensive Assessment is a face-to-face interaction with a consumer, involves the most intense level of inquiry, and incorporates an advanced dimension of history taking, examination, observation and measurement/testing. It occurs where consumers have multiple, complex or unclear needs or with consumers who require long-term and/or intensive service provision.

Comprehensive Assessment involves the most intense level of inquiry, and incorporates an advanced dimension of history taking, examination, observation and measurement/testing about medical, physical, social, cultural and psychological dimensions of need.

Comprehensive Assessment is undertaken by a range of providers (Aged Care Assessment Services, some HACC agencies, Community Health Centres) and involves an extensive process of inquiry that requires analysis and interpretation of the assessment information and a clinical judgment, diagnosis and differential diagnosis.

Comprehensive Assessment gathers information about medical, physical, social, cultural and psychological dimensions of need and assesses restorative options/capacity for improvement.

Information is gathered from a wide range of sources to build a comprehensive picture of consumer/family/carer strengths, resources and problems. Comprehensive Assessment has the greatest capacity to investigate and resolve the underlying issues for a consumer's poor health (for example dental problems in older people and dietary problems in younger people) and in this way is a valuable tool for facilitating early intervention and proactive disease management.

A range of Comprehensive Assessment approaches and practices exist within the range of Primary Care Partnership agencies as a result of past incremental program development. To assist Primary Care Partnerships in achieving functional integration of these Comprehensive Assessment approaches, the Department will undertake detailed work to align the range of Comprehensive Assessment activities. This work will be done collaboratively with providers and Program areas in the Department.

Key Features of Comprehensive Assessment

While each Service Coordination model developed by Primary Care Partnerships will vary, every model across the State will clarify how Comprehensive Assessments will be undertaken and by whom and will:

- Build on relevant information gathered through the Initial Contact and Initial Needs Identification elements and any other assessment and service delivery information.

- Be independent of service delivery ensuring that the consumer's needs are considered irrespective of the assessing organization.
- Have transparent links with the other face to face assessment elements (service specific and specialist)
- Link directly into care planning
- Be undertaken by a range of competent and experienced workers with a multi-disciplinary focus and a broad range of expertise.
- Incorporate risk assessment. This will be particularly relevant for those Primary Care Partnerships undertaking Integrated Disease Management (refer *Literature Review of Effective Models and Interventions for Chronic Disease Management in the Primary Care Sector* and the *Integrated Disease Management: Interim Policy Directions and Guidelines*). Risk assessment is a way of assessing an individual's risk of morbidity or mortality, taking account of their disease/condition and existing risk factors/behaviors. By employing a risk assessment approach within Comprehensive Assessment, consumers can be stratified according to the severity of their illness or health risk (typically, into low, medium and high risk groups), with different strategies employed according to the risk profile of each consumer.
- Build on the opportunities inherent in the Federal Government's Enhanced Primary Care Medicare Benefits Schedule (MBS) items.

Care Planning

Care Planning is a process of deliberation that incorporates a range of existing activities such as development of clinical plans, treatment plans, service plans and individual treatment plans. It includes the continuum of navigational and supportive functions such as care coordination, case management, review, re-assessment and monitoring. It also includes referral to other service providers and feedback to referring providers.

Care Planning ensures that the needs of consumers are discussed with them, their carer and other relevant parties in the context of possible options, and subsequently worked through to an agreed strategy.

Care Planning involves the judgment/determination of relative need as well as competing needs, and assists consumers to come to decisions that are appropriate to their needs, wishes, values and circumstances. Care Planning also provides a means of synthesising assessment information and agreed strategies and is particularly important in facilitating appropriate care for consumers with multiple or complex needs.

Care Planning ensures that the needs of consumers are discussed with them, their carer and other relevant parties such as their GP, in the context of possible options, and subsequently worked through to an agreed strategy.

Key Features of Care Planning

While each Service Coordination model developed by Primary Care Partnerships will vary, every model across the State will demonstrate Care Planning approaches which:

- Nominate a key worker/care coordinator/case manager for the consumer (one contact person instead of several) to promote effective communication. The key worker/care coordinator/case manager will be responsible for ensuring that the care plan is delivered and monitored, review dates are set, re-assessments are initiated where appropriate (e.g. following significant changes to the consumer's circumstances, or to explore new or different options more suited to the consumer's requirements) and feedback is provided to a referring provider, where necessary.
- Incorporate the different ends of the continuum of care management for consumers and provide case management where a consumer requires multiple services or has complex or special needs.
- Take into account the availability of service options and eligibility and priority of access criteria for services.
- Take into account services both within and external to the partnership. This ensures that consumers' needs, and the needs of carers, are addressed in a coherent, coordinated and timely fashion.
- Acknowledge the potential contribution of self-management to effective care. Effective self-management is based on a partnership between consumers, their families and primary care workers and practitioners, in which the consumer is encouraged to play an active role in monitoring and managing symptoms of illness. The intensity and nature of care and self-management should vary according to the consumer's identified level of risk, skills and circumstances.
- Provide for effective monitoring (both formal and informal) of consumers' health and well-being and formal evaluation of the effectiveness of services being delivered. Formal monitoring also includes activities such as regular reviews. Review of consumers' care-plans should occur on a regular basis or when the needs of clients/carers change significantly and should check whether the plan is still meeting the consumer's needs and whether any modifications are required. It can be initiated by, and should include consumers/carers and all relevant service providers where appropriate. Informal monitoring occurs where workers provide regular feedback or updates to the key contact worker/care coordinator about care plan implementation and outcomes.
- Ensure referrals are appropriately expedited, referral information is received and acted upon by the service provider to whom the referral is made and feedback is provided to the referrer.
- Facilitate access to appropriate interim management and support for consumers at (medical, physical, psychological and social) risk. Ensure that consumer

details are only placed on a waiting list when there is a high probability of them receiving the service in a timely manner.

- Build on the opportunities inherent in the Federal government's new Medicare Benefits Schedule (MBS) items as part of the Enhanced Primary Care Package. This opportunity for Partnerships and general practitioners to collaborate in care planning means that GPs will be able to contribute more to the care of consumers with complex and chronic conditions through care planning.
- Ensure referral processes are coordinated, planned, efficient and accountable and that information is efficiently expedited, that referral information is received and responded to within appropriate timeframes, and that specific feedback loops to the referrer and the consumer are incorporated. Referral processes must take into consideration individual service provider's referral requirements, and the specific priority of access and eligibility criteria relevant to the service referred to.
- Utilise the common Care Planning tool across the Partnership (see 5(III) in Section Three below).

Section Three: The Way Forward for DHS; Supporting Service Coordination

The scope of change envisaged through the *Better Access to Services Policy and Operational framework* is significant. It requires change of a practical and cultural nature, at a number of levels (personal, worker, organisational, professional, sectoral)

Developing and implementing a local Service Coordination model is one of several key initiatives engaging service providers in Primary Care Partnerships. Moreover, local models need to be implemented without disruption to existing service delivery arrangements. The process therefore, to achieve Service Coordination, is as important as the eventual outcome and needs to be incremental, flexible and responsive to local circumstances.

The process to achieve Service Coordination is as important as the eventual outcome and needs to be incremental, flexible and responsive to local circumstances.

Primary Care Partnerships expectations of what they can achieve in developing and implementing their local models need to be formulated as an evolutionary pathway. An evidence based learning environment needs to inform ongoing practice review and refinement. Strategies need to take account of differing capacity in the sector to progress. Implementation needs to take a 'problem solving' approach to any difficulties that arise to arrive at workable and agreed solutions.

Whilst each Primary Care Partnership will develop strategic plans that provide both long and short-term directions for implementing its Service Coordination model, the Department has also identified five areas of work that it will undertake to support the Service Coordination work of Primary Care Partnerships. They are:

- Developing Primary Care Partnership Capabilities
- Addressing Particular Rural Issues
- Linking Local, State and National Initiatives
- Improving Planning, Funding and Reporting Arrangements
- Establishing Common Infrastructure

1. Developing Primary Care Partnership Capabilities

The current primary care system is made up of a diverse range of workers with different skills, qualifications, value bases and approaches to assessment and care planning. The result is not only disparate practice and approaches, but also different outcomes for consumers. Increasing complexity and diversity within the service system demands a corresponding increase in the capacity of workers, organizations and of the service system. Capacity building and education are therefore important underpinnings to Service Coordination.

Once mutual respect, trust and good working relationships have been established, the broader issues of recruitment, and skill development need to be addressed. A resounding message from the consultation was that the Department, in conjunction with the sector, should progress development of minimum competency standards through an independent process as an integral and essential component of implementing *Better Access to Services*. The view from the sector is that capacity to undertake the *Better Access to Services* elements should be based on practitioners demonstrating clearly defined competencies, rather than linking them to specific professional disciplines.

Consumers advocated the need for an appropriate level of skill equal to the role assumed by the worker. They believe that good skills are very important at the early points of contact. According to consumers, these workers must have the necessary listening, sorting, questioning and analytical skills to enable them to quickly understand consumer concerns and direct them to appropriate services. It will be difficult to implement a Service Coordination model without reaching agreement about the skills, knowledge and value base required to undertake each of the elements of assessment and care planning, recognizing that the people who currently work in the primary care sector are its foundation.

The Department of Human Services will work with the range of primary care providers and other key stakeholders such as consumers and peak and professional bodies to

facilitate agreement about the required competencies and the best strategy for embedding these competencies among workers and practitioners. This will ensure that in the longer term, consumers can be confident that workers and practitioners with agreed competencies undertake identified *Better Access to Services* elements.

Competencies development will build on previous work undertaken in the area of workforce development in the health and community care sectors. The Department will link this work to training and skills development strategies that build the capacity of workers, organizations and the service system. This training and skills development will build on current opportunities for training and workforce development but be specifically targeted to the *Better Access to Services* elements.

DHS will work with primary care providers and other key stakeholders to facilitate agreement about the required competencies and the best strategy for embedding these competencies among practitioners.

2. Addressing Rural Issues

Achieving *Better Access to Services* for rural Victorians is a key objective of the Primary Care Partnership strategy. There are a number of issues that influence the practical delivery of service in rural communities. These issues include service infrastructure (some services are unavailable or only sporadically available), workforce planning and development (inability to attract and retain qualified staff), transport (inadequate transport infrastructure and the requirement to travel long distances to provide core service), privacy (more difficult to assure anonymity in small communities) and communications (reduced telecommunications capacity).

The Primary Care Partnership strategy will not be the sole vehicle for resolving these concerns. However, the Primary Care Partnership Strategy offers an opportunity for providers to agree on a more flexible approach to primary care service delivery.

For example, Service Coordination models that integrate a number of services' assessment activities can result in

increased capacity to attract primary care workers.

Coordination of the delivery of services to consumers who live long distances from a service delivery site can result in one worker being able to provide a range of service interventions and activities during one visit rather than several workers visiting at different times. Examples of these practices already exist in some rural communities, for example in Multi Purpose Services. Primary Care Partnerships provide opportunities of improved collaboration that can extend these improvements in a more systematically supported way.

The Department of Human Services will continue to work across its own divisions and with other government departments to actively support rural communities to address the broader issues outlined. Within the Primary Care Partnership strategy, it is acknowledged that distance is an important hurdle to be overcome and so the Department will approach implementation of this policy and operational framework flexibly.

DHS will continue its work across divisions and with other government departments to actively support rural communities and will approach implementation of this policy and operational framework flexibly.

3. Linking Local, State and National Initiatives

The success of the Primary Care Partnership Strategy will depend on the Department of Human Services working in partnership not only with Primary Care Partnerships, but also with a range of other stakeholders.

The Department has a regional network that interacts with providers and Primary Care Partnerships on a day to day basis. The Department is working to ensure that regions and the central office are working together to assist Primary Care Partnerships to achieve their objectives. Administration of and policy development for programs involved in Primary Care Partnerships will be integrated into the Primary Care Partnership framework as it develops.

The Department is working to ensure that similar developments across different Divisions are undertaken in a coordinated way, as far as possible. Of particular importance here is work being undertaken on point of entry assessment, needs identification and care planning in DisAbility Division, Community Care Division, the Post Acute Care Program in the Acute Division and Drug Treatment Services in the Public Health Division. The Department is also working with other Victorian Government departments, and other State Governments.

The Commonwealth Government funds directly or indirectly a range of services that are part of the primary care sector. The Department of Human Services will continue to seek better coordination with Commonwealth initiatives and alignment with relevant developmental initiatives such as development of a national dependency measure in the Home and Community Care Program.

The Department will assist Partnerships to negotiate their relationships with complementary initiatives such as Coordinated Care Trials, the enhanced primary care initiatives such as the Health Assessment, Care Planning and Case Conferencing Medicare Benefit Schedule items, and the assessment and care coordination components of Department of Veterans' Affairs Home Care.

Local Governments are key players in Primary Care Partnerships. Local Governments play a key role in planning and the development of community relationships, as well as funding and delivering a range of services. The Common Planning Protocol, agreed between the Department and the Municipal Association of Victoria outlines the commitment of both spheres of government to working together to support Primary Care Partnerships. The generally good working relationships between Local Governments and the Department will continue to underpin the development of Primary Care Partnerships.

4 Improve Planning, Funding and Reporting Arrangements

A major issue facing governments, service providers and the broader community is that demand will always exceed available resources. There will always be tension between client needs and resource availability. This tension results in not only practical considerations for a

service provider such as 'how much is needed to assist' but also raises questions about 'how much to whom'. Enabling consumers to navigate the service system with greater ease and the provision of seamless service at the point of entry, assessment and care planning will not assist if the right service is not available at the right time.

Disparities in resourcing exist across the State as a consequence of a number of factors. Many local governments, for example, make substantial contributions to service delivery because their communities have an expectation that their rates will be spent on these services. Others do not, in response to their communities' expressed preferences.

Integrated Service Planning will assist in dealing with some of these issues by creating a common understanding among all stakeholders about local service configuration and its effectiveness in meeting the needs of the community. Through Integrated Service Planning. Primary Care Partnerships, including local governments, and the Department will identify local service needs and agree on priorities and strategies for improving the system. Integrated Service Planning can be enhanced by access to good quality service utilisation data and data about people seeking services, which can be derived from the *Better Access to Services* processes.

Aggregated data collected from Primary Care Partnerships' Initial Needs Identification Tools and Care Planning Tools can provide information about the expressed needs of consumers and the capacity of the service system to meet those needs. This information can be mapped against population data to determine the relationship between projected levels of need (based on population characteristics) and identified levels of need. This can help to identify the proportion and profile of the expected target group that has actually come into contact with the service system. Information gathered from Initial Needs Identification can also be mapped against service utilisation data to determine the relationship between identified levels of need and the corresponding level of service delivery which can help identify how effectively services are meeting known demand and reaching their target groups.

Whilst this information improves the planning capacity of both government and providers, the Aged Community and Mental Health Division in the Department of Human Services has also begun complementary work to streamline its funding and reporting arrangements. This work will be undertaken in an iterative way in partnership with providers, and will provide sustainable improvements for individual organizations.

5. Establish Common Infrastructure

The *Better Access to Services* strategy allows for locally responsive Service Coordination models that incorporate statewide infrastructure to enable consistency. The statewide infrastructure will include:

- The Primary Care Partnership Service Directory
- A Template for Initial Needs Identification
- A Template for Care Planning
- A Common Core Data Set

I A PCP Service Directory

Local Primary Care Partnership service directories must work as a tool to support service coordination. They must meet the needs of both consumers and providers for information about available services. Service directories are essential tools to support all elements of the *Better Access to Services* operational framework and therefore need to be responsive at a local level to service coordination. These local approaches will be based on a common data set and will link to the development and maintenance of a statewide services directory through the *Better Health Channel*. (Refer to the *Information Management Strategic Directions* for further information.)

II A template for Initial Needs identification

A recommendation arising from the consultation was for the Department to take the lead role in coordinating the development of a statewide Initial Needs Identification template in conjunction with the sector and with significant input to its development by practitioners. The Department of Human Services has commenced this through a tender process and, in collaboration with

Primary Care Partnerships and other key stakeholders will develop a template for Initial Needs Identification that will be mandated for use by all Primary Care Partnerships and which can be built on by each Partnership to meet local needs. This template, combined with the care planning template, will support consistent referral for providers within and external to the partnership. The template will also support consistency in priority setting for service provision and, when administered by competent staff, provide triggers for identifying the range of a consumer's needs as well as their potential, and assess urgency, priority and eligibility for services. The template will incorporate core consumer information, and will build on and incorporate the range of tools, guidelines and principles that currently exist, including relevant MBS item tools and tools developed for specific services such as Drug Treatment Services. The template will provide a common data set (incorporating core consumer information) which will provide a basis for information sharing.

III A template for Care Planning

As part of the same tender process for development of an initial needs identification template, the Department of Human Services will develop a template for Care Planning in collaboration with Primary Care Partnerships and other key stakeholders. Each Primary Care Partnership will build on the template developed and implement its own Care Planning tool. This template, combined with the Initial Needs Identification template, will support consistent referral for providers within and external to the partnership and reflect the working arrangements within Partnerships building on the current examples of good practice. Broadly the care planning template will take account of the range of processes explicit in care planning (care coordination, case management, monitoring, review, referral and feedback) and will be mandated for use by Primary Care Partnerships. The template will provide a common data set which will support information sharing.

IV A Common Primary Care Partnership Data Set

Together, the Service Directory Data Set and the data sets contained within the Initial Needs Identification and Care Planning templates, will provide the core of a statewide

common data set for Primary Care Partnerships. The Department of Human Services will continue to build on this data set and will align it with other existing and emerging data standards including the Home and Community Care Minimum Data Set and the Department of Human Services Common Data Set.

A Strategic Approach— The Evolutionary Pathway

Primary Care Partnerships' *Better Access to Services* strategies need to be formulated in terms of an evolutionary pathway for moving forward. The evolutionary pathway needs to allow PCPs the flexibility to proceed in a way that meets their local communities needs.

Correspondingly, local *Better Access to Services* developments need to link to other initiatives within the Primary Care Partnership strategy such as Disease Management, Health Promotion and Information Management. The following evolutionary pathway is aligned with the Information Management initiatives. This pathway is not a blue print for partnerships so much as a guide to explore opportunities.

An Indicative Evolutionary Pathway for Service Coordination

July 2000 – June 2001 Partnership Development Plan	July 2001 – June 2002 Community Health Plan 1	July 2002 – June 2003 Community Health Plan 2	July 2003 – June 2004 Community Health Plan 3	July 2004 – June 2005 Community Health Plan 4
Service coordination management established involving full range of stakeholders.	Participate in first year evaluation – partnership change.	Participate in second year evaluation – consumer experience and process change.	Participate in third year evaluation – consumer outcomes.	Operate within a rationalised electronic client record environment integrated across all sectors delivering health care.
Identified and analysed current practices, processes and infrastructure for service coordination.	Input into competencies development for components of BATS.		Staff with defined competencies delivering a fully operational service coordination model.	
Develop service coordination model.	Implement local services directory.	Participate in workforce capacity building to achieve competencies in the elements of the assessment process.	Functional integration between residential care and acute including streamlined discharge and admission processes.	
Develop BATS and IM strategy.	Implement telecommunications plan to support service coordination model.		Incorporate a rationalised client records environment into the service coordination model.	
Develop local services directory.	Pilot and implement INI and care plan tools.			
Develop telecommunications plan to support the service coordination model.				
Input into the development of INI and care plan tools, core consumer information standards and statewide service directory.				
Address privacy/consent issues with service coordination model.				

Appendix One:

Common Terms and Acronyms

ACAS	Aged Care Assessment Service.
Access	The right of, opportunity and means for entry.
ACMH	Aged, Community and Mental Health – The second largest Division within the Department of Human Services with responsibility for funding a range of different services and activities as well as policy development, regulatory and monitoring roles.
Assessment	A decision-making methodology that collects, weighs and interprets relevant information about the client. Assessment is not an end in itself but part of a process of delivering care and treatment. It is an investigative process using professional and interpersonal skills to uncover relevant issues and to develop a care plan.
BATS	Better Access to Services. The policy and operational framework that will assist Primary Care Partnerships (their organisations and the organisations’ practitioners) to achieve functional integration. Functional integration will be facilitated through a systemic and consistent approach to assessment and service delivery.
BATS model	See Service Coordination model .
BATS Operational Framework	See Operational Framework .
BATS strategy	The agreed proposal for the ongoing planning, implementation and management of the Better Access to Services Operational Framework as part of each Primary Care Partnership’s Service Coordination model . The Better Access to Services strategy is part of the service coordination element of each Primary Care Partnership Community Health Plan , and is based on shared agreement about the PCP’s Service Coordination model. The purpose of this strategy is to improve people’s access to services by making the network of services more visible and hence improving health and well being outcomes.
Best Practice	A concept of organisational change and improvement that has been adopted from the industrial sector where it is seen as the pursuit of ‘world class’ performance. Best practice is considered to be a comprehensive integrated and cooperative approach to the continuous improvement of all facets of an organisation’s operations.
Bio-psychosocial assessment	An assessment that considers the physical, mental and social aspects of a consumer’s life.
Care	Assistance or support given to a person to improve their health and wellbeing and to help them achieve maximum quality of life.
Care Coordination	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 consumers’ needs. Care Coordination enables continuity of care, avoids duplication of services and ensures that meeting consumer needs is paramount over the needs of individual service providers and is not hampered unnecessarily by program boundaries (see Care Planning).

Care Coordinator	A nominated worker who has the responsibility of ensuring that the care plan is implemented, and that reviews and re-assessments are undertaken at the appropriate times by the relevant service providers.
Care Plan	The outcome of the assessment and care planning process that documents the services to be provided. It specifies service type, levels and frequency of service provision.
Care Planning	A process of deliberation that incorporates a range of existing activities such as care coordination, case management , referral, feedback, review, re-assessment and monitoring . Care planning involves the judgment/determination of relative need as well as competing needs, and assists consumers to come to 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.
CASA	Centre Against Sexual Assault.
Case Conference	An inclusive process for making decisions about the care of a consumer. Assessment findings and options for ongoing care and support are presented to other practitioners/clinicians, who can be from the same or different organizations. The presentation includes conclusions of the assessment that are supported by a range of information sources. Case Conferences are often multi disciplinary and incorporate the views and preferences of the consumer and their carers.
Case Coordinator	(see Care Coordinator).
Case Management	The activities undertaken by one central person who assumes overall responsibility for the care plan , in order to streamline the interface between the service system and the consumer and carer (see Care Planning). Activities may include some or all of: <ul style="list-style-type: none"> Assessment Care plan development Referral and/or feedback Implementation of the care plan, including liaison with service providers Monitoring Review Reassessment Management of brokerage funds.
Case Manager	(see Care Coordinator).

CCT	Coordinated Care Trial. The Coordinated Care Trials are a Commonwealth Government initiative as part of the Enhanced Primary Care Package , established to test models of service provision which may achieve better delivery of care within existing resources to people with complex care needs.
CHC	Community Health Centre.
CIARR	Client Information and Referral Record – A record developed by the Commonwealth for use in the Home and Community Care program.
Clinician	See Practitioner .
Common Data Set	An information model that defines and describes a common set of data items for application across new and existing data collections. Examples of common datasets associated with Service Coordination include: the Service Directory Dataset; Core Consumer Information ; and the Department of Human Services Common Data Set.
Commonwealth	The Commonwealth Department of Health and Aged Care and or Department of Veterans’ Affairs.
Community Health Plan	Plans developed by Primary Care Partnerships that identify the priority health and wellbeing needs of the community and describe how the Primary Care Partnership will work to respond to these needs. Community Health Plans consist of three elements: Partnerships, Service Coordination and Integrated Service Planning .
Competencies	The ability to perform the activities within an occupation or function to the standard expected in employment.
Comprehensive Assessment	A face-to-face interaction with a consumer, involving an intense level of inquiry, and an advanced dimension of history taking, examination, observation and measurement/testing. It facilitates a more extensive process of inquiry that requires analysis and interpretation of the assessment information and a clinical judgment, diagnosis and differential diagnosis.
Confidentiality	The restriction of access to information, and the control of the use and release of information about a person, in order to protect the individual’s privacy .
Consent	The voluntary agreement of the individual or the individual’s authorised representative about a proposed action. It can be either express or implied. Express consent is provided explicitly, either orally or in writing. It is unequivocal and does not require any inference on the part of the organisation seeking consent. Implied consent arises where consent may be reasonably inferred from the action or inaction of the individual. Consent must be meaningful, that is, an individual must understand what has been consented to and the implications of this. Consent must be obtained without coercion or undue influence.

Consumers	Those members of the community who currently use services, are seeking to use services or who are potential service users.
Core Consumer Information	The agreed set of consumer information that is common to providers within the Partnership. Will include such data items as name, date of birth.
Department	The Department of Human Services (unless otherwise specified).
DHAC	Department of Health and Aged Care (Commonwealth Government).
DHS	Department of Human Services.
Duty of Care	A duty to take 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 hypothetical reasonable person would have behaved in the same situation. What is considered reasonable will depend on the circumstances.
DVA	Department of Veterans Affairs (Commonwealth Government).
EPC	Enhanced Primary Care (see EPCP).
EPC MBS	Enhanced Primary Care Medicare Benefits Schedule items. These items enable general practitioners to undertake or participate in health assessments, case conferencing and care planning activities.
EPCP	Enhanced Primary Care Package—a Commonwealth Government initiative made up of a range of programs designed to assist people with chronic illnesses and complex care needs.
Formal support	Support provided by professionals, paid services or community volunteers.
Framework	A general description of the six elements of Better Access to Services in which functional integration will be achieved. The six elements are: initial contact, initial needs identification, service specific assessment, specialist assessment, comprehensive assessment, and care planning.
Functional assessment	An assessment of an individual's ability to perform one or more activities of daily living.
Functional Integration	A form of integration in which organisations and service providers continue to operate as independent entities but agree to undertake particular functions (for example: initial contact, initial needs identification) in a common, integrated manner. Under functional integration, service providers continue to operate within their existing organisational and structural arrangements and simultaneously work within the virtual organisation of a Primary Care Partnership.

Gatekeeping	A process of information gathering and judgement which approves access to individual services to ensure that services are provided to people most in need and that criteria for targeting are consistently applied.
Government	The Victorian State Government (unless otherwise specified).
GP	General Practitioner.
HACC	Home and Community Care.
Health	A complete state of physical, mental and social well-being, not merely the absence of disease or infirmity.
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 the future provision of health services to him or her; a health service provided to the individual. It also includes information that is collected to provide a health service, 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 persons health information in any form (written, verbal, electronic, on video etc).
Health Promotion	The process of enabling people to increase control over, and to improve their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and realise aspirations, to satisfy needs, and to change or cope with the environment. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being. (see also Health).
I2MIT2	See IIMITT .
ICT	Information and Communications Technology – often used instead of information technology to acknowledge the systemic links that exist between information technology and telecommunications systems.
IIMITT	Information, Information Management, Information Technology, Telecommunications
IM	Information Management.
IM strategy	The agreed proposal for the ongoing planning, implementation and management of the information management aspects of the Service Coordination model within each Primary Care Partnership. The Information Management strategy is part of the Primary Care Partnership Community Health Plan , and is based on shared agreement about the Service Coordination model. This strategy will provide a detailed overview of the short term (next financial year) and long term (3 year) strategic management of Information, Information Management, Information Technology and Telecommunications and reflects how these support the Service Coordination model.

Informal Support	See Informal Care Environment .
Information Management	The practices, protocols, roles, responsibilities and business processes that support the management of information (personal information, health information, services information, financial and administrative information, planning and performance monitoring information) whether in electronic or other form.
Initial Contact	Initial Contact is the point of first contact with the service system and will most commonly include the provision of accurate service information, the provision of other information such as health promotion literature, and/or direct access to services via an initial needs identification.
Initial Needs Identification	Initial Needs Identification is an initial assessment process where the underlying issues as well as presenting issues are uncovered to the extent possible. It is not a diagnostic process but is a determination of the consumer's risk, eligibility and priority for service and a balancing of the service capacity and the consumer needs.
Integrated Service Planning	One element of a Community Health Plan, Integrated Service Planning involves identifying the priority health and wellbeing needs of the community and developing collaborative strategies to address these needs, such as integrated health promotion and disease management.
IPPs	Information Privacy Principles.
IT	Information Technology.
Key Worker	See Care Coordinator .
LGA	Local Government Area—the geographic area which is administered by a particular local government and which covers the area within which a particular local government delivers services.
MBS	Medicare Benefits Schedule.
MDS	Minimum Data Set—a specified set of data for particular services or client groups that contains data on the number and characteristics of consumers (for example, the Home and Community Care Minimum Data Set).
Medical assessment	Involves history taking, examination and investigation that generally leads to a disease based diagnosis.
Monitoring	Informal observation by people and services involved in the care of a consumer, to see if any significant changes occur in the person's situation that may require a change in the care plan. Monitoring may lead to the recommendation of a formal review, or a full reassessment. Monitoring also refers to the ongoing examination of the performance of a funded service provider by the Department of Human Services.
MOU	Memorandum of Understanding.
MPS	Multi Purpose Service.

Multi-disciplinary Assessment	Multidisciplinary assessment/care-planning allows for inter-professional dialogue and collaboration and a process of deliberation that maximises the care of the client and provides a mechanism for direct involvement and communication between at least two other service providers. It allows for different professionals to bring different perspectives and conclusions, and provides mechanisms to identify, record and reduce these differences.
Multidisciplinary Care planning	See Multidisciplinary Assessment .
Operational Framework	A general description of the six elements of Better Access to Services in which functional integration will be achieved. The six elements are: initial contact, initial needs identification, service specific assessment, specialist assessment, comprehensive assessment, and care planning.
PCP	Primary Care Partnership. A group of primary care providers that have formed voluntary alliances to work together to improve health and wellbeing in their local communities. There are 32 Primary Care Partnerships in Victoria.
PCP Strategy	Primary Care Partnership Strategy. A strategy which aims to enable primary care services to achieve positive outcomes for consumers and deliver improved health and well being for the community. This strategy provides a framework for improving the planning and delivery of primary care services and for ensuring they work effectively together.
Personal Information	Information or an opinion recorded in any form, whether true or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion.
Practitioner	A service provider who has direct contact with and provides direct service to consumers.
Primary Care	Primary Health Care 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. 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.
Primary Carer	Informal carer who has the main responsibility for supporting and providing the care needed.
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.
Providers	Organisations publicly funded to provide services to consumers
RDNS	Royal District Nursing Service

Re-Assessment	A formal process of undertaking a subsequent assessment of a consumer who has been previously assessed due to a perceived change in their requirements. The reassessment process should mirror the original assessment in order to maximise identification of changes in the consumer. The outcome of reassessment is a new care plan.
Referral	The transmission (physically or by other means) of personal and/or health information relating to an individual from one service provider(s) to another service provider(s) with the individual's consent and for the purpose of care or treatment.
Review	Formal follow up of a consumer, usually on a date specified in the care plan, or due to a sudden change in the consumers situation, where the suitability of the care plan in meeting the needs of the consumer is considered.
Risk assessment tool	A structured way of identifying clients who are at risk of developing a specific condition.
Risk assessment	A systematic process that quantifies the level of the client's risk.
RREF	Regional Resource Equity Formula: the basis on which HACC growth funds are allocated across the nine DHS regions each year. Currently undergoing review.
Screening	A process that involves the systematic use of a test or investigatory tool to detect individuals at risk of developing a specific disease that is amenable to prevention or treatment. It is a population-based health strategy to identify specific conditions in targeted groups prior to any systems appearing.
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	The service coordination element of Community Health Plans provides a framework whereby local models, systems and processes for assessment and information management, facilitate functional integration across the range of services. 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. Within the service coordination component of community health plans, there are three initiatives that provide the infrastructure. These initiatives are Better Access to Services, Information Management and Local Services Information and are interdependent. The purpose of service coordination is to improve people's access to services by making the service system function transparently to its local community.
Service Coordination Model	Participating agencies within each Primary Care Partnership will reach agreement about and develop a description of how each of the Better Access to Services elements (Initial Contact, Initial Needs Identification, Service Specific Assessment, Specialist Assessment, Comprehensive Assessment and Care Planning) are to be undertaken and by whom.

These local models will also demonstrate how the six elements will be supported by practices, protocols, roles, responsibilities and systems which support the management of information (personal information, health information, services information, financial and administrative information, planning and performance monitoring information) whether in electronic or other form. The models developed must ensure the elements in a functionally integrated way. Local models will take into account local community circumstances and preferences to ensure their access to services is maximised.

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 Directory Dataset

A **Common Data Set** which contains defined information (data elements) relating to services and service delivery, such as: service type; location; access arrangements; and cultural, linguistic or demographic specialisation. This will ensure easy transmission of information across PCP boundaries.

Service Specific Assessment

Service Specific Assessment is a face-to-face interaction undertaken where consumers have a relatively straightforward, obvious and distinct need for a specific service. It is conducted by the provider responsible for delivering the service and occurs as part of the delivery of service.

Social Model of Health

A conceptual framework within which improvements in health and well-being are achieved by directing effort towards addressing the social and environmental determinants of health, in tandem with biological and medical factors.

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.

Template

Definition of a common statewide framework which allows flexibility for adaptation to local needs. Templates incorporate a common data set and build on existing tools, guidelines and principles in order to provide a common basis to support **functional integration**. See pages 24–25 for details on templates for **initial needs identification** and **care planning**.

Virtual Organisation

Virtual organisation arrangements consist of networks of workers and organisational units, linked by information and communication technologies, which flexibly co-ordinate their activities, and combine their skills and resources in order to achieve common goals but without traditional hierarchical modes of central direction or supervision. In the case of the Primary Care Partnership Strategy, a virtual organization is a partnership model whereby independent organisations work collaboratively and cohesively on a common, agreed basis. In this sense it refers to an organisational entity characterised by **functional integration** rather than organisational or administrative integration.



Better Access to Services – A Policy & Operational Framework

PRIMARY CARE PARTNERSHIPS

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